Promoting Quality Care

Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services

As revised May 2010

Contents

Glossary of Terms

Care Coordinator	The individual responsible for overseeing the work of several Key Workers.
Disengagement	Loss of contact with mental health and learning disability services by the service user.
Dual diagnosis	Used to describe people with a combination of drug and alcohol misuse and mental illness.
Key Worker	The individual with responsibility for co-ordinating the care of mental health or learning disability service users with complex needs and for communicating with others involved in the service user's care.
Mental illness	A range of diagnosable mental disorders that excludes learning disability and personality disorder.
Risk	See Annex C
Risk Assessment	See Annex C
Risk Factor	See Annex C
Service User	An individual who is treated and cared for in secondary mental health and learning disability services for his/her mental health, behavioural or psychological problems. Such individuals may live in their own homes, are staying in care, or are being cared for in hospital.
Vulnerable Adult	A person, aged 18 or over, who is, or may be, in need of community care services, or resident in a continuing care facility by reason of mental or other disability, age or illness, or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.

1.0 Introduction and Purpose

1.1 Introduction

A core function of mental health and learning disability services is to assess the treatment and care needs of people presenting to them. An integral part of such an assessment is the consideration of risks posed by some people with a mental disorder to either themselves or others. Understanding the level of risk that an individual may present forms part of his/her overall assessment, nevertheless it is an integral part of formulating an appropriate care package.

Risk assessment and management is a fundamental part of care within mental health and learning disability services, the responsibility for which is part of the practice of all service providers. Currently, the understanding and practice of good risk assessment and management is becoming increasingly important as local mental health and learning disability services continue to develop a more community-based model of provision. There is, however, great variation in process and procedure between service providers, yet the repetitive nature of serious adverse incidents and the findings of Independent Inquiries suggest a certain consistency to the failures in the system and highlight the need for a more standardised approach, as proposed by this regional guidance.

Whilst it is unrealistic to expect that all adverse incidents can be prevented, the risks for each individual can still be identified, managed and adverse outcomes possibly avoided. In the vast majority of cases, the safe and effective care and good professional practice provided by mental health and learning disability services minimise any risks identified.

However, a significant number of Serious Adverse Incidents (SAIs) do occur, particularly in mental health services and, therefore, a mechanism must be put in place to ensure learning is shared and acted upon. Local mental health and learning disability services report SAIs as part of routine practice, in keeping with the ethos of openness and “learning the lessons”.

1.2 Purpose

This guidance describes the principles of best practice to assist individual mental health and learning disability care professionals, multidisciplinary teams and the organisations within which they work, to make decisions about managing the potential risk that service users may cause harm to themselves or others (including the staff who care for them, their families, carers or the general public).

Not all risks posed by people with mental health problems are linked to their mental health condition: it is predominantly the latter which fall within the ambit of mental health professionals to influence.

This guidance aims to embed risk assessment and management into daily practice and ensure that all individuals who require treatment, care and support from secondary mental health and learning disability services receive this, based on an individual assessment of their care needs. It highlights good practice in the assessment and management of risk for all service users.

The experiences of those working in the field of mental health and learning disability, key lessons from Independent Inquiry reports and SAIs have been drawn together into this document. It details elements and processes that mental health and learning disability service providers should include in their operational protocols and procedures to ensure that effective assessment, care planning and discharge planning take place within the context of risk assessment and management.

Whilst this document replaces *'Discharge From Hospital And The Continuing Care In The Community Of People With A Mental Disorder Who Could Represent A Risk Of Serious Physical Harm To Themselves Or Others'* (DHSSPS 2004a), considerable work has already been undertaken within Health and Social Care (HSC) Trusts since the publication of the 2004 guidance to put in place relevant protocols and procedures. It is important that such work is built upon by the implementation of this new guidance.

1.3 Which Services Does This Guidance Apply To?

Adult Mental Health Services

This guidance and its principles of risk assessment and management are applicable to all secondary mental health services operating within all treatment environments (including hospital inpatient and community-based settings). It is also to be applied across services for co-morbid substance misuse and services for functionally mentally ill older people.

This guidance applies equally to people in contact with mental health services but without a defined functional mental illness, such as people with a personality disorder. Similarly, the guidance is applicable to those in contact with mental health services and who are in settings outside the health and social care sector, such as police stations or prisons.

Specialist Mental Health Services and Learning Disability Services

The broad principles of this guidance should be applied to any individual receiving care and treatment from learning disability and specialist mental health services, i.e. child and adolescent mental health services (CAMHS), forensic mental health and learning disability services and specialist substance misuse services. Supplementary guidance in relation to these services is contained in the addenda in this document.

Services Provided by Non-statutory Organisations

It is the responsibility of HSC organisations to ensure that this guidance is implemented within those non-statutory organisations contracted to provide care and treatment to service users. HSC organisations must also ensure that staff in these organisations receive appropriate training. All agents making a referral to secondary mental health and learning disability services must adhere to this guidance in communicating the appropriate risk information.

1.4 Objectives

The overarching aim of this document is to act as supportive guidance for health and social care staff within mental health and learning disability services to proactively manage the risk of harm and to deliver safe, effective care provision for service users, their families, their carers and for staff.

The objectives which this guidance sets out to achieve are to:

(1) Improve the safety and quality of services available to service users and their families/carers;

(2) Promote consistency and standardisation of best practice which is evidence-based across all care settings in Northern Ireland;

(3) Support fully integrated mental health and learning disability services and interfaces between these services and other service areas, such as family and child care;

(4) Facilitate regional reporting of adverse incidents and dissemination of associated learning; and

(5) Promote good practice which recognises the strengths of service users.

In achieving these objectives, it is necessary to take account of other developments including the modernisation and reform of mental health and learning disability services following the *"Bamford Review of Mental Health and Learning Disability (Northern Ireland)"* (The Bamford Review) and support for the safety and quality of services through the development of Mental Health and Learning Disability Service Frameworks for Northern Ireland.

This guidance will inform the future work of the Regulation and Quality Improvement Authority (RQIA) within mental health and learning disability services, both in terms of governance reviews and in relation to the future discharge of its functions under the Mental Health (Northern Ireland) Order 1986, through assessment of the application of the risk assessment and management principles it contains.

In preparing this document, account was taken of the statutory duties imposed on public bodies by Section 75 of the Northern Ireland Act 1998 and the Human Rights Act 1998. An Equality and Human Rights screening exercise was carried out which showed that a full Equality Impact Assessment was not required.

2.0 Good Practice Principles

There are several principles for good practice upon which the development of this guidance has been based.

Each of the principles below should be integrated into the everyday practice of individual mental health and learning disability care professionals and the multidisciplinary teams within which they work. Mental health and learning disability provider organisations should ensure that staff work in an environment conducive to applying these principles.

Working With Service Users and Carers

(1) Risk management should be person-centred and facilitated in collaboration with the service user and his/her family/carers;

(2) Service users must be assisted to harness their strengths and protective factors to contribute to their own risk reduction;

(3) Assessment of risk needs to include highlighting both the negative and positive aspects of any situation.

Team Working

(4) Risk assessment and management is the shared responsibility of all health and social care professionals. It requires balancing the opinions of different individuals and organisations;

(5) Risk management should be part of a coordinated approach with the relevant services and agencies which combine their efforts to care for service users;

(6) Individual practitioners must be confident to make positive risk management decisions within a supportive organisational culture;

(7) Both clinical and managerial supervision are fundamental to developing safe and effective risk management practice;

(8) A clear system of organisational learning is necessary to ensure key risks in mental health and learning disability services are identified, shared and acted upon. In so doing, services must strive to achieve positive risk management.

Risk Management Process

(9) Risk can only be minimised and not completely eliminated or avoided. It must be recognised, assessed and managed, as far as is possible;

(10) *Risk strategies must adhere to evidence-based practice, where available, and should use a formulation approach with structured professional judgement to translate risk assessment information into appropriate risk management plans;*

(11) *Risk is dynamic and occurs in a context resulting from the interaction between individuals, situation and environments. Assessment is an ongoing process, recognising that risk factors will vary in significance for each individual service user as his/her circumstances change;*

(12) *Risk assessments and management plans should be regularly updated and reviewed as part of the overall care plan;*

(13) *As risk assessment is part of routine practice, training must be ongoing to ensure staff competency is maintained.*

Communication

(14) *Effective verbal and written communication is fundamental to risk minimisation. Systems should be in place to ensure that communication processes are sufficient to minimise potential breakdown;*

(15) *Good record-keeping and appropriate sharing of risk information are vital components in the management of risk. Confidentiality within accepted parameters should not be a barrier to effective communication (see* Code of Practice on Protecting the Confidentiality of Service User Information, http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf*);*

(16) *Communications should be in a format that optimises the likelihood of service user comprehension and participation. For clients who do not have the capacity to fully understand the risk management process, it is good practice to consider the appointment of an independent advocate.*

3.0 Fundamentals of Risk Management

3.1 Recovery and Positive Risk-Taking

The concept of *"recovery"* recognises that people with a long-term mental illness should not be defined by it alone: they have the right to lead a meaningful life beyond their illness. Mental health services must support personal recovery, move beyond risk avoidance and towards positive risk taking, by providing effective care that is personally meaningful to the individual service user and his/her family/carers.

Such recovery-based practice aims to empower the service user through supporting choice, responsibility and self-management and emphasises that treatments, interventions and support must be delivered in consideration of how the service user wishes to live his/her life[1,2]. This involves a shift from the traditional 'assessment-treatment-cure' model of mental health care to engaging, negotiating and collaborating with the service user in the self-management of his/her mental illness[3]. It is important to encourage the service user to take personal responsibility for his/her care.

From a learning disability perspective, this approach reflects the social model of disability recognised within learning disability services.

Positive risk management acknowledges that it is not possible to eliminate all risk of harm, and that risk management plans will inevitably include decisions regarding care and treatment options that carry with them some risks[4]. Reasonable risks must be taken to develop an appropriate positive risk management plan, which is in keeping with the service user's plans for recovery.

It is important that there is an awareness of the risks that must be minimised (i.e. harm to self, harm to others, harm to children/vulnerable adults, and harm from others) and the risks that people have a right to experience in order to progress towards their goals of recovery[5].

Positive risk management is characterised as including[6]:

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[1] *Robert et al (2008)*
[2] *Shepherd et al (2008)*
[3] *RPsych / SCIE / CSIP (2008)*
4 DH (2007a)
[5] *See 6*
[6] *Morgan, S. (2007)*

- *Collaborative working between mental health professionals, the service user and his/her family/carer;*
- *A clear understanding of the responsibilities and consequences for actions that a service user can be reasonably expected to follow;*
- *Taking decisions based on a range of choices available;*
- *Full appreciation of the service user's strengths and weaknesses – based on previous experience;*
- *The availability of support should the positive risk management plan breakdown.*

3.2 Recognising the Strengths of Service Users

Whilst recovery-orientated services may increase risks, it is sometimes necessary in order for the service user to learn and grow. Avoiding all risk is not possible or desirable for either the service user or the general public. Choosing the safest possible option for care and treatment can be dis-empowering for the service user and counter-productive for his/her recovery.

Overstating risks and being overly risk averse carries with it human rights implications for the service user and resource implications for mental health and learning disability services. It can lead to unnecessary exclusion from services, stigmatisation and breakdown in the relationship between the service user and the mental health team.

A balance has to be struck between risk and the individual service user's ability to recover and participate in a normal life. Service users should receive treatment in the least restrictive environment to allow them to take personal responsibility for managing their own condition and avoid creating complete dependency on mental health and learning disability services.

Defensive practice is inappropriate, as it creates a focus on staff rather than the service user. Treatment should always be based on the values of holistic service user-centred care. Mental health and learning disability professionals must ensure that their practice is defensible rather than defensive[7].

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[7] *See 4*

> *"As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at the time" (DH 2007, 8).*

3.3 Safety

The central focus of mental health and learning disability services should be individual and personal autonomy. Risk assessment and management is the proportionate modification of and interference with that autonomy to promote the safety of the service user, his/her family/carers, the general public and mental health staff.

There is always the need to achieve a realistic balance between risk and restrictive practice. An excessively lenient or paternalistic approach serves to dis-empower clients and professionals.

3.4 Partnership Working With Service Users and Carers

Partnership working with service users and their family/carer(s) is one of the most important elements in effective risk assessment and risk management planning. A three-way collaboration of the service user, his/her family/carer and the mental health/learning disability team is essential to planning care[8]. Positive working relationships are based on knowing the service user and his/her individual circumstances. Family members and carers know the service user best and have first-hand information about his/her history, behaviours and situation.

Positive risk-taking may not be suitable for all service users, and it is likely that there will be occasions where the professional's views and those of the service user will differ. These need to be discussed and worked through to reach agreement as to what are acceptable risks, recognising that it may not always be possible to achieve full agreement.

In such circumstances, advocacy services can play an important intermediary role, giving service users the opportunity to express their views and concerns, assisting them to make informed decisions, and encouraging their personal responsibility for their ongoing care and treatment. In order to determine if the arrangements are working, specific measures of success and intended positive outcomes must be documented.

On certain occasions, individual service users may choose not to cooperate, or even obstruct the implementation of a care plan. On these occasions it must be recognised that such uncooperative behaviour will have significant implications for services attempting to manage and ameliorate risk.

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[8] *DH (2007a)*

3.5 Effective Risk Communication

Good communication processes in mental health and learning disability services (both statutory and non-statutory) are particularly important when working with risk. Findings from the various Independent Inquiries in recent years have highlighted serious failings in the communication of service user information which have contributed to the tragic outcomes. Often information indicating an increased risk existed but had either not been communicated and acted upon, or had been overlooked or played down[9].

Therefore, it is essential that information available is recorded and communicated to all those who need to have access to it in order to care for the service user and protect him/her from harming him/herself or others. In completing assessments of risk, information should be shared with other agencies/individuals, where necessary, due to specific risks and in keeping with policies and professional guidance in respect of confidentiality. In recording and sharing such information, clarity is crucial.

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[9] *Morgan S. (2000)*

4.0 Working with Risk as Part of Everyday Practice

Working with risk in mental health and learning disability services as part of the overall care planning process should have two main components: risk assessment, which seeks to identify the specific risks in an individual; and risk management, which is a statement of the plans of treatment and support for the service user as well as individual responsibilities within the multidisciplinary team.

Risk can be minimised but not eliminated. It is dynamic, continually changing according to the individual service user's circumstances. Assessment, therefore, can only have a short-term time perspective and must be subject to review as frequently as the situation demands.

Risk relates to the likelihood of an event happening with potentially harmful or beneficial outcomes for self and others[10].

This guidance focuses on four categories of risk:

- *Risk of harm to self (e.g. deliberate self harm/suicide/self neglect);*
- *Risk of harm to others (e.g. homicide/violence/aggression);*
- *Risk of harm to children/vulnerable adults (either through acts of omission or commission);*
- *Risk of harm from others (e.g. domestic abuse/sexual, physical, emotional abuse/exploitation).*

4.1 The Risk Assessment Process

Risk assessment contains the following tasks:

- *collecting and communicating information on risk behaviour(s);*
- *identifying causes and consequences of risk behaviour(s);*
- *considering individual static and dynamic factors;*
- *identifying external risk factors (e.g. service issues);*
- *formulating a risk statement based upon risk factors and protective factors;*

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[10] *Morgan S (2000)*

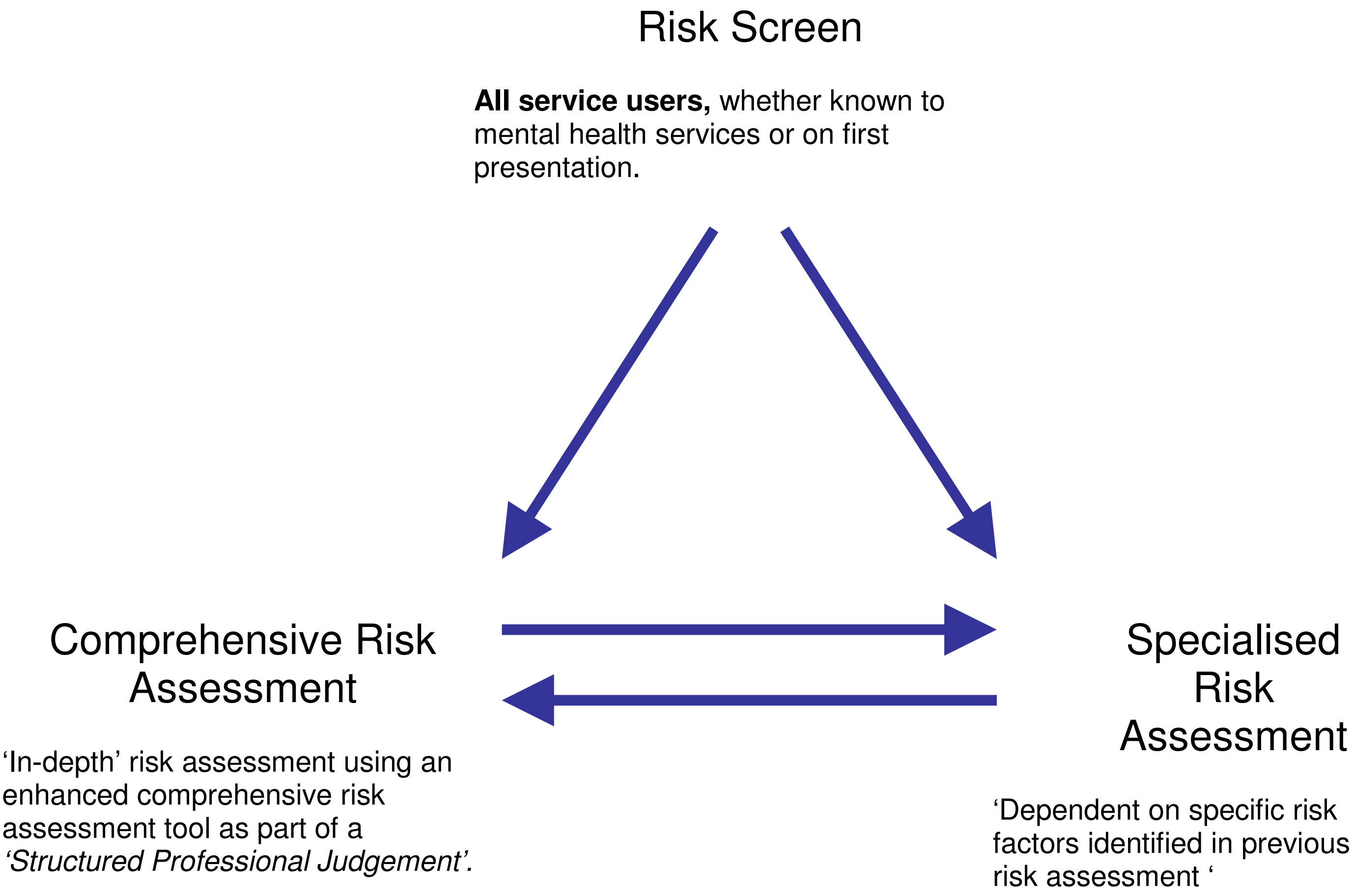
- *developing risk reduction and management plans; and*
- *monitoring, feeding back, evaluating and modifying plans.*

Risk assessments should build on information collated at each step rather than being separate exercises, otherwise there is duplication for users and carers and important information may be lost at each assessment point.

It is good practice that EVERY individual referred to secondary mental health services should receive an initial screening for risk. This is considered to be part of routine mental health assessment[11].

Service users will vary in the degree to which they will require a formal risk assessment and management plan, and there is neither the capacity nor the necessity to carry out an in-depth risk assessment for every service user. Where necessary, service users will be identified as a priority for more in-depth assessment and intervention and scarce resources can be targeted appropriately towards these individuals, proportionate to the level of risk that they pose to themselves or others.

The process for completing risk assessments should be as follows (supporting information for this can be found in **Annex C**):



Risk Screen

All service users, whether known to mental health services or on first presentation.

Comprehensive Risk Assessment

'In-depth' risk assessment using an enhanced comprehensive risk assessment tool as part of a *'Structured Professional Judgement'.*

Specialised Risk Assessment

'Dependent on specific risk factors identified in previous risk assessment '

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[11] *(DH 2007a)*

Risk Screen

Everyone referred to mental health services should receive a Risk Screen, including:

- *People entering services for the first time in all settings; and*
- *All service users currently known to mental health services, i.e. both inpatient and community mental health services.*

All professionals making a referral to secondary mental health services, including General Practitioners, secondary care and community care staff, must provide risk information in an appropriate form, as required by their local mental health services.

A Risk Screen provides a quick overview of the broad areas of potential risk for the service user, and prompts professionals to specify their understanding of risks present on initial contact. The aim is to:

- *Ask pertinent questions about his/her history and current situation;*
- *Identify the risk factors specific to the individual service user;*
- *Enable the multidisciplinary team to make initial decisions regarding the service user's care plan;*
- *Identify those service users presenting with high risk factors which would indicate further examination and a 'Generic Risk Assessment'.*

Screening need not be time-consuming and formalised, but should be conducted as part of the overall assessment of need and not a separate exercise. This approach will encourage a therapeutic relationship and should be seen as part of good clinical practice.

Whilst it is recognised that a risk screen may be completed by an individual practitioner, particularly in community-based services, a joint multidisciplinary risk screen, carried out by at least two or more disciplines, should be undertaken for all mental health inpatients, taking note of relevant information available from the family/ carers, the Approved Social Worker and any other professionals involved in the decision to admit.

In the case of non-statutory organisations contracted by the Board and Trusts to provide care and treatment to service users, it is expected that, where any risk has been identified prior to an individual engaging with these services, the risk assessment would be carried out by secondary mental health and learning disability services "referring" the service user. From this, a risk management plan should be drawn up to support the placement. This would be regularly monitored and reviewed within the placement.

Comprehensive Risk Assessment

According to the risk factors identified in the risk screen, a clinical decision may be taken, as appropriate, to progress to a comprehensive risk assessment where it is needed for reasons of complexity, history or high risk potential[12]. The value which can be gained from this more thorough level of investigation and reflection should be determined on an individual basis.

Assessment should commence as soon as a professional judgement about its need is made. Individual multidisciplinary teams will work to consider relevant risk factors as they carry out the comprehensive risk assessment.

It is important that the widest possible range of sources (i.e. corroborative evidence from all professionals, agencies and sectors) contribute to comprehensive risk assessments.

Specialised Risk Assessment

Dependent upon their history, some service users will require specific risk assessments. Some specialised risk assessment tools are already used within specialist services to assess, for example, violence and aggression, sexual violence, anti-social or offending behaviour and suicide/self-harm. A clear and approachable overview of the main tools available can be referred to in the document *'Best Practice in Managing Risk'* (DH 2007a).

As general mental health and learning disability services and specialist services will have different levels of experience in conducting specialised risk assessments, these services should work closely together to ensure the appropriate level of assessment is carried out.

4.2 Care Planning and Risk Management

The care planning process is underpinned by information gathering and sharing. The Care Plan should provide details of the full range of support services required, focus on the service user's strengths and seek to promote his/her recovery and independence.

Key information about a service user's medical, psychological and social care needs are necessary to inform development of an appropriate care package. The Care Plan specific to each individual service user must be drawn up, as appropriate, following comprehensive assessment of his/her:

- *mental state;*
- *past behaviour;*

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[12] *Morgan S. (2007)*

- *social functioning; and*
- *social circumstances.*

Identifying risk and formulating a management plan to mitigate that risk is an integral part of the care planning process and should not be seen a separate entity.

Indeed, a risk assessment is only useful if it enables the multidisciplinary team to develop an appropriate management plan to address identified risks for the individual service user[13]. Without this, a practitioner can feel stranded with nowhere to move on to.

Good clinical practice dictates that risk assessments should:

- *Be person-centred and prepared in collaboration with the service user and his/her family/carer;*
- *Involve live documents which follow the patient through their treatment journey and are updated regularly;*
- *Be reviewed routinely at regular intervals AND any time there are new concerns;*
- *Be contributed to by the entire multidisciplinary team;*
- *Be an ongoing and dynamic process, recognising that service users' risk status may vary;*
- *Inclusive of factors which reduce risk;*
- *Note any limitations of the risk assessment;*
- *Note the potential effects of not intervening and the possible unintended consequences of intervention;*
- *Inform discharge planning and the Care Plan; and*
- *Be disseminated to the service user and those involved in his/her care.*

Risk Management is the organised attempt to assess, reduce and manage identified risk to service users, their families/carers, healthcare staff and members of the public. A Risk Management Plan is an explicit statement of the planned interventions, treatment and support for the individual service user, based on the recorded risk assessment. The goal is to prevent or, where this is not possible, to minimise the likelihood of adverse incidents occurring which may result in harm to the service user and/or others.

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[13] *DH (2007a)*

This is achieved by formulating a flexible Care Plan, informed by a structured risk assessment and associated risk management plan, contributed to by the widest possible number of health and social care professionals to enhance the accuracy of clinical judgement, and including the input of the service users and their carers. It is recognised that risk assessment and management processes rely on clinical judgement and cannot predict with complete certainty whether harmful outcomes will occur. It is suggested that formalised tools are used as part of risk assessment as they support effective and consistent risk management decision-making.

The outcome of risk assessments and the resulting options for managing any identified risks should be discussed with the service user and, where appropriate, his/her family/carers and advocate. Efforts must be made to include carers, and to actively encourage a partnership with the service user in contributing to formulation of a Care Plan.

The Care Plan will:

- *Identify specific interventions and anticipated outcomes;*
- *Be drawn up in collaboration with the service user and, where appropriate, his/her family/carer and advocate;*
- *Detail the contributions of all named individuals, services and agencies involved in care delivery;*
- *Record all the actions necessary to achieve agreed recovery goals;*
- *Specify a timescale by which the outcomes will be achieved or reviewed; and*
- *Include contingency and crisis plans, where appropriate.*

Efforts must be made to ensure that the service user and his/her family/ carers understand each element of the Care Plan, including the possible outcomes. The Care Plan should be countersigned by the service user and his/her family/carers to show that they have read, understood and agreed it and the associated risk management plan. Where they have not signed, a reason for this should be recorded.

A written copy of the Care Plan must be provided to all staff on the team directly responsible for delivering care and, with the consent of the service user, to any other relevant parties (including external agencies). Any individual named in a Care Plan should be involved in its development and agree his/her role in providing the services recorded in it. The Care Plan should clearly show the name of the Care Coordinator and Key Worker.

Care plans for patients in the community should be available to the patient's General Practitioner so that he/she can see the plan of interventions and anticipated outcomes, can monitor the patient and be aware of any contingency and/or crisis plan.

The Care Plan must recognise the diverse needs of the service user reflecting his/her age, gender, ethnicity, sexuality, disability and culture. Where the service user's first language is not English, or where he/she has shown visual or hearing impairment, all reasonable steps must be taken to ensure that appropriate support is provided and that he/she fully understands the content of his/her Care Plan.

Contingency and Crisis Plans

Contingency arrangements, used to plan for known situations and prevent circumstances escalating into a crisis, should be incorporated into the Care Plan. It should detail the steps to be taken where, for example, the Key Worker/Care Coordinator is unavailable, part of the agreed Care Plan cannot be provided, or the service user is beginning to disengage from care and treatment.

A crisis plan should also be included in the Care Plan and should specify an explicit plan of action when a crisis situation is developing, i.e. the service user's mental state is rapidly deteriorating. As such crises frequently occur out-of-hours, it is beneficial to plan ahead for such an eventuality to ensure that appropriate action is taken. The Plan should detail specific triggers which are likely to exacerbate a service user's individual risk factors. Speaking to the service user and his/her family/carers about managing a crisis situation is essential, as they know their situation best, and what is most likely to alleviate any problems.

The involvement of any individual in crisis and contingency plans should be agreed with the named person, including family/carers and external agencies.

4.3 Review

Regular review dates for risk assessments and management plans must be incorporated into the Care Plan: the level of risk should dictate the frequency of review. Details as to who should take responsibility for communicating changes to the risk management plan must also be clearly recorded. Here there is a clearly defined co-ordination role for the Key Worker (community setting) and the Named Nurse (hospital setting).

Reviews are particularly necessary in the following circumstances:

- *Prior to discharge from inpatient care;*
- *At a change or transfer of care from one treatment environment to another;*

- *At a change in legal status (e.g. detention under the Mental Health (Northern Ireland) Order 1986);*
- *Following a crisis/relapse of illness/significant change in mental health condition; and*
- *Following a serious adverse incident or near miss.*

4.4 Multidisciplinary Team Meetings

Regular multidisciplinary team meetings, often also known as Team Assessment Meetings, must be held with the purpose of reviewing the service user's progress with care and treatment, including discussion of risk assessments and risk management plans. It is important that these team reviews have two or more disciplines present and that the service user and his/her family/carers are encouraged to contribute, where possible. Discussion amongst the various team members is essential for sharing information and forming a holistic view of the service user and his/her current circumstances.

Good practice suggests that ideally service users in general mental health inpatient facilities should have a formal weekly team review. All team reviews must be recorded in the patient's notes and should document the progress of the patient and agreed actions for named individuals with corresponding timescales for their completion. It is important that every professional has an equal opportunity within the team to participate in formulating the Care Plan for managing the service user's care and identified risks.

4.5 Roles and Responsibilities

It is important that individual mental health and learning disability services and their staff have clearly defined roles and responsibilities that address the key elements required for ongoing assessment and management of risk. Every member of the multidisciplinary team caring for a service user must be aware of his/her individual responsibilities in assessing and managing identified risks and the delivery of the agreed care package.

Key roles must be explicitly defined in operational policy documents, and in accordance with local arrangements, e.g. for Key Worker and care coordination roles. It is acknowledged that local arrangements have to be made for designation of such roles, nevertheless their functions and purpose must be consistent in all HSC Trusts.

The following, whilst not exhaustive, outlines the main responsibilities of each.

Named/Primary Nurse

For patients in hospital, the role of the Named/Primary Nurse is pivotal at the point of admission and onwards in identifying key issues and ensuring that care planning with acute inpatient links with all relevant community practitioners. They are also best placed in making and developing links with relatives and significant carers at an early stage of the admission process.

Key Worker

For patients in the community, the role of the Key Worker is pivotal in organising and monitoring the mental health and learning disability services needed by service users under his/her care. The Key Worker may be from any professional background within the multidisciplinary team, e.g. community psychiatric or learning disability nurse, social worker, psychiatrist, psychologist, occupational therapist. The appointment of the Key Worker, where required according to level of assessed risk, should be a formal item on the agenda of the initial care planning meeting.

The decision to appoint a Key Worker will be taken after a Generic or Specialised Risk Assessment and be allocated proportionate to the identified need, complexity and risk. The Key Worker must be named in the Care Plan.

The Key Worker should draw up a written Care Plan which addresses the holistic needs of the service user with his/her involvement and, where appropriate, his/her family, carers and/or advocate. It is vital that the Key Worker represents a single point of contact in mental health and learning disability services for the service user and his/her family/carers.

It is the duty of the Key Worker to ensure that all the necessary elements of the Care Plan are in place prior to discharge including medication, therapy, supervision and accommodation. The Key Worker is responsible for sending a copy of the patient's (written) Care Plan to all the professionals involved in providing care, including the GP and, where appropriate, to the service user and his/her family/carers.

The Key Worker must remain in regular contact with the service user and his/her family/carers, reviewing the Care Plan at frequent intervals to ensure that it is being carried out and to update it, as necessary. The Key Worker must advise other members of the multidisciplinary team when the service user’s circumstances change, particularly when this might require a review or modification of the Care Plan.

Particular efforts must be made by the Key Worker to maintain contact with service users who might pose a risk to themselves or others if they became unwell. At times, an assertive approach to care will be required when the service user is unable or unwilling to maintain contact because of the nature of his/her mental illness: the Key Worker should not rely on service users contacting them. Arrangements for such an eventuality should be discussed with the service user and his/her family/carers at the earliest opportunity.

Where the service user is non-compliant with his/her Care Plan, e.g. not taking medication or attending clinic appointments, all practical and reasonable efforts should be made by the Key Worker and other members of the multidisciplinary team to contact the service user and resolve the situation. It is the responsibility of the Key Worker to lead and coordinate action, as well as to alert and share information with members of the multidisciplinary team and others, e.g. GP, family/carers, voluntary sector agencies who could resolve the situation or anyone who may be at risk of harm (as appropriate). Where there are serious concerns regarding the safety of the service user or the public, then immediate consideration should be given to admission to hospital and informing the police.

The caseload of Key Workers must be carefully managed to ensure the necessary level of support can be provided to all service users. Further, it is the responsibility of the person coordinating care, in liaison with the Key Worker and, if appropriate, the team leader, to have in place arrangements for a deputy who will cover both planned and unplanned absences.

Care Coordination Role

The person fulfilling the care coordination role should be a senior manager responsible for providing health and social care services in the community where the service user resides. His/her role is to support and facilitate the Key Worker and multidisciplinary team in the delivery of agreed Care Plans, to ensure that appropriate services are available, where possible, and to communicate unmet need to commissioning organisations.

The person coordinating care must maintain a close working relationship with community mental health team leaders in their capacity to organise ‘deputies’ and support Key Workers.

The person coordinating care must have knowledge of community services, relevant legislation, the roles of other statutory and voluntary agencies and have access to resources. He/she will oversee several Key Workers and should undertake case supervision for each. He/she should chair multi-agency reviews at intervals of six months or more frequently, as necessary, for each service user who is subject to a comprehensive risk assessment and management plan.

4.6 Recording Information

Working with risk is all about the effective communication of information. The most accurate method of ensuring that information gathered is communicated to all members of the multidisciplinary team is by documentation in a service user’s notes. It is, therefore, an essential part of standard good record-keeping practice for all professionals to document information available to them.

Documentation should describe what has happened and the reasoning for taking chosen responsive actions. It should not be seen as 'defensive' practice, but as an important safeguard to explain why actions were taken in response to particular circumstances. Individual clinical risk assessments naturally suffer from limited reliability and predictive validity, but it is not a test of accuracy: rather, of how reasonable the decisions made are in terms of the clinical situation, current knowledge and standards of good practice. Therefore, a system for recording the rationale for decisions relating to the risk, both supporting action and/or inaction, must be recorded.

Risk assessment and management plans must be documented clearly and legibly, kept up-to-date and be accessible to all professionals directly involved in the care and treatment of the service user concerned. Every agreed action should have a named individual responsible for seeing it through. This should be recorded in the service user's risk management plan along with a timescale for completion.

The information available, including the efforts made to seek all sources of additional information regarding the service user, should be documented. If information is sought but not received, or there is no response from the professional contacted, this should be documented including the time, date and the person with whom contact was attempted. Information acquired from the service user, his/her family/carers and other professionals for the purpose of assessing risk is usually reliable, but not always[14]. The professional must make every effort to substantiate information received, particularly if it is received from an unknown or unreliable source.

Basic principles for recording information include:

- *Seeking any information not available and recording delays in receiving such information;*
- *Recording and accounting for decision-making;*
- *Recording information in line with record-keeping guidelines issued by professional bodies; and*
- *Adhering to organisational policies and procedures relating to report writing and record-keeping.*

4.7 Confidentiality and Disclosure of Information

The use and sharing of service user information is an essential part of providing optimal care and treatment within health and social care[15]. However, when it comes to communicating information about 'risk' many mental health and learning disability professionals are unclear about what they can share and with whom, whilst fulfilling their duty of confidentiality.

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[14] *Morgan S. (2007)*

[15] *DHSSPS (2008)*

Concern stems from having to balance the need to safeguard the service user's right to confidentiality as part of a trusting relationship and the requirement for disclosure of relevant personal, identifiable information to manage the risk of harm that may arise for the individual service user or others.

The Code of Practice on Protecting the Confidentiality of Service User Information, http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf should be referred to for more detailed information on any aspect of confidentiality.

General principles of good practice in relation to information sharing which should be adhered to include:

- *At the earliest opportunity explain to the service user why you may need to share certain information with other professionals to care for him/her appropriately - Duty To Warn;*
- *Gain the service user's written consent to share information;*
- *Explain to the service user that in some cases, the need to protect the public might take precedence over the duty of confidence, e.g. child protection; protection of vulnerable adults; prevention of serious harm to third parties;*
- *Only share information on a "need to know" basis i.e. the recipient will be involved with the patient's care or treatment, or he/she may be at risk of harm from the service user; and*
- *Record the reasons for any information sharing.*

4.8 Involving Service Users and Carers

"Few of us would relish being labelled as a risk" (Morgan S. 2007), therefore it is particularly important that staff are open and honest about the purpose of risk assessment and management, and encourage service users' participation in the process. Family members/carers and service users generally know themselves when something is not quite right, i.e. changes in a mental state[16]. Their concerns should be listened to and recorded, as they can help prevent or minimise behaviours likely to increase risk.

Service users may refuse permission for information to be shared with particular family members and relatives for a variety of personal reasons: such wishes should always be taken into account. Family/carers should be given sufficient knowledge to enable them to provide effective care, i.e. the provision of general information about mental illness, emotional and practical support for carers which does not breach confidentiality[17]. Carers

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[16] *Langan and Lindow (2004)*

[17] *Royal College of Psychiatrists and The Princess Royal Trust for Carers (2004)*

should always be provided with the essential contacts and information necessary to allow them to provide care and access support from mental health professionals, both day-to-day and in times of crisis.

Clarification of those who should and should not be communicated with should be clearly noted in the service user's Care Plan. Clearly mental health professionals will need to fulfil their legal obligations to contact the service user's next of kin, where appropriate, under the Mental Health (Northern Ireland) Order 1986. If a service user requires the support of an advocate and/or nominated person, this service should be provided.

The needs of the service user will almost certainly affect the lives of his/her family and those who provide regular care and support to him/her. Therefore, carers should be offered an assessment of their caring, physical and mental health needs, which should be reviewed on a regular basis. This is particularly important where the service user has young children who may provide care to their parent: their welfare must be addressed.

4.9 Transfer and Transition

There are certain points in a service user's care pathway at which there is an increased potential for communication failures and a risk of information being lost or mis-communicated.

The most common is during **transition**, e.g. admission to hospital, discharge from hospital care to community services, and from child and adolescent services to adult mental health and learning disability services[18]. The need to effectively manage such transitions of care is essential.

It is particularly important that, where possible, all service users, their families and carers are introduced to and linked properly with continuing care and support services prior to moving from one form of care to another. This is particularly important in maintaining continuity of risk management and care planning. Protocols governing the movement of service users between services should be developed by mental health and learning disability service providers to create clear guidance for practitioners in reviewing risk management and care plans.

Transfers between mental health and learning disability services and other general healthcare services are a common occurrence. In addition, transfers between mental health and learning disability services in different provider organisations are becoming increasingly frequent: hence there is a need for explicit policies regarding the process for transfer of clinical responsibility. Services also need to consider the management of interfaces external to the healthcare system, e.g. with housing.

Guidance from the Royal College of Psychiatrists (1996) states that "if the responsibility for care of a service user is passed on to another clinician or

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[18] *DHSSPS (2007b)*

service it must be handed over effectively and accepted explicitly”[19]. All known information which might be relevant to the risk assessment and management plan must be transferred, as should patient records and other relevant documentation to ensure the effective exchange of information. Key Workers can play a pivotal role in the safe management of transfers.

All HSC Trusts have developed their own local protocols based on the principles within the *‘Protocol for the Inter Hospital Transfer of Patients and Their Records’* (CREST 2006). In addition, the Department has recently issued to Trusts recommended good practice principles on the transfer of patients of all ages and their records between psychiatric hospitals and has asked the Trusts to review their local arrangements to ensure that they comply with these principles. Provisions should be made for the transfer of service users to agencies external to the HSC system.

4.10 Interface Issues

Service users within mental health and learning disability services often have a range of care needs which no one treatment, service, or agency can meet. When care needs stretch across service boundaries, a holistic approach is required to view the many complex interfaces between mental health and learning disability services and other service areas in the healthcare system. It is necessary, therefore, for a coordinated approach among the relevant services and agencies which combine their efforts to care for the individual service user.

For instance, where mental health and learning disability services staff are working with a parent, in whatever capacity, they will need to take account of the welfare of the child(ren) in the household. This could mean interacting with family and child care services, as appropriate, to ensure that any perceived risks to children from a parent who has a mental disorder are recognised and assessed. This must meet with the new, strengthened child protection procedures and single assessment process established as part of the Understanding the Needs of Children In Northern Ireland (UNOCINI). Mental health and learning disability services staff have a crucial role in highlighting any child protection concerns and intervening to protect children.

HSC Trusts should make use of the training resource *Crossing Bridges: Learning Materials To Support Mentally Ill Parents and Their Children* (DH, 1998) produced by the Department of Health in England to inform the development of local protocols to manage the interface between mental health and family and childcare services.

4.11 Discharge Planning

Discharge planning should be initiated as soon as possible after the service user is admitted to a psychiatric or learning disability inpatient facility.

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[19] *Royal College of Psychiatrists (1996)*

Where possible, an assessment of his/her risk of harm to him/herself or others needs to take place prior to discharge involving members of the multidisciplinary team (including the clinician, nurse, social worker, and key worker) and the service user, his/her family/carer, and advocate, where necessary. This is dependent on the assumption that risk assessment is regularly carried out throughout the inpatient stay and is used to inform suitability for discharge.

If the appropriate level of risk assessment is not achievable by discharge, one must be completed at the first follow-up appointment with the service user. Prior to discharge from hospital, service users and those who care for them need to be introduced to and linked with those providing ongoing care in the community.

The National Confidential Inquiry report, *Avoidable Deaths*[20], recommends the following action to ensure the safe transition from the inpatient environment to the community:

- *Regular assessment of risk during the period of discharge planning and trial leave;*
- *Agreed plans to address stressors that will be encountered on leave and on discharge;*
- *The patient to have ways of contacting services if a crisis occurs during leave or after discharge;*
- *Early follow-up on discharge, including telephone calls immediately after discharge […] and face-to-face contact within a week of discharge [for high risk patients];*
- *Support arrangements for people who discharge themselves from wards.*

4.12 Promoting Service User Engagement

There is the need for agreed action to be taken when a service user begins to disengage from services. A plan to engage effectively with service users and action to be taken for 'loss of contact' situations is essential. A history of disengagement is clearly an increased risk factor for recurrence: when service users with such a history are identified, mental health staff should proactively try to build engagement by talking with the service user and asking him/her[21]:

- *What are your usual early warning signs for relapse?*
- *What are your usual trigger factors for relapse?*

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[20] *Appleby L, Shaw J, Kapur N, Windfuhr K et al. (2006)*

[21] *Morgan S. (2007)*

- *How would you normally cope when you feel that your mental state is declining?*

- *Who would you like to be involved in your care when you are in crisis? i.e. which family members/carers should be informed?*

The answers to such questions allow the service user to identify his/her own risks, influence the plan for dealing with difficult situations and create the opportunity for him/her to indicate the type of support that they would prefer and feel would suit him/her best. As noted previously, the service user's Care Plan should include crisis and contingency plans, as necessary, to guide professionals, family/carers and others involved in caring for him/her as to what to do when he/she disengages from services.

There will be some service users who do not wish to engage with mental health and learning disability services, despite encouragement. Their right to decline this input and pursue their recovery through other means should be acknowledged, with relevant parties notified, when necessary, of their circumstances.

4.13 Dual Diagnosis

Dual diagnosis is the combination of mental illness and a substance misuse problem. Risk assessment and management plans need to address specific factors relevant for individuals with a dual diagnosis. The severity of substance misuse, including the combination of substances used, is related to the risk of overdose, suicide, violence and/or homicide.

According to the National Confidential Inquiry report[22], service users with a dual diagnosis have high rates of previous violence and self-harm, and are more likely to be inpatients at the time of death than those without the condition. For those in the community, one third had missed their last appointment.

The Department of Health *'Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide'* (DH, 2002) advises that exploration of the possible association between substance misuse and increased risk of aggressive or anti-social behaviour is an integral part of risk assessment, and should be explicitly documented, if present.

The Bamford Review recommends developing expertise within mental health services for the management of dual diagnosis. The Department recognises dual diagnosis services as an area of need for future service development.

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[22] *Appleby L, Shaw J, Kapur N, Windfuhr K et al. (2006)*

4.14 Awareness of the Mental Health (Northern Ireland) Order 1986

It is important that the level of restriction to which the service user is subject is proportionate to the risk that he/she presents. The emphasis should always be on recovery and working with the service user to determine how best to manage any problems that he/she might encounter.

Healthcare staff need to be aware of the powers available to them under the Mental Health (Northern Ireland) Order 1986 that can, if necessary, be used to minimise risk. Detention should always be used as a last measure where a service user is considered a significant risk to him/herself or others. Mental health and learning disability staff should not unduly restrict a service user by detention under this Order.

Where a voluntary inpatient, deemed to be at serious risk of causing harm to him/herself or others, indicates an intention to discharge himself or herself against medical advice, and a package of care has not been arranged, every effort should be made to persuade him/her to remain in the hospital until a package is agreed. In some cases the use of holding powers and detention may be appropriate.

Where holding powers and detention cannot be invoked, e.g. where a service user has been diagnosed as having a personality disorder only and he/she leaves the hospital before a suitable package of care can be put in place, it is essential that the hospital alerts those in the community who need to be aware of the situation. The responsible multidisciplinary team should agree a Care Plan in retrospect and identify a Key Worker and a person to carry out a care coordination role. Service users who discharge themselves against advice may still require and accept aftercare.

5.0 Learning from Adverse Incidents

In 2003, a statutory duty of quality was imposed on the services commissioned and provided by Health and Social Services Boards and Health and Social Care Trusts. Accordingly, these organisations are required to organise their structure to achieve integrated governance[23] in order to give equal priority to corporate, financial, clinical and social care matters.

Since 2003, HSC organisations have been required to comply with the core risk management controls assurance standard. The standard requires that there is "an agreed process for reporting, managing, analysing and learning from adverse incidents"[24].

Safety First: a framework for sustainable improvement in the HPSS (DHSSPS, 2006) sets out the Department's policy on safety. This includes the need to raise awareness of risk and to promote timely reporting of adverse incidents and sharing the learning across HSC environments.

In addition, the *Quality Standards for Health and Social Care* (DHSSPS, 2006) set out standards that the Department considers people should expect from HSC services. The standards are represented in five quality themes applicable to all HSC services and are "essential", i.e. the absolute minimum action necessary to ensure safe and effective practice. They are used by the RQIA to assess service quality and promote quality improvement across organisations.

In the context of this guidance, Theme 2, *Safe and Effective Care* – Criteria 5.3.1, *Ensuring safe practice and the appropriate management of risk and 5.3.2, Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses* have particular relevance to and impact upon risk assessment and management. The rationale for the theme states:

> *"Services must be delivered in a way that appropriately manages risk for service users, carers, staff, the public and visitors. Where an adverse incident has occurred or has been prevented from happening (a near miss), then systems need to be in place to assist individuals and organisations to learn from mistakes in order to prevent a reoccurrence" (DHSSPS 2006, 12).*

Accordingly, all adverse incidents involving service users known to mental health and learning disability services must be reviewed in such a way that enables lessons to be learnt and steps taken to reduce the likelihood of future similar events recurring.

Internal multidisciplinary reviews must be held as soon as practicable following an incident, to examine what happened and to make

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[23] *Establishing an Assurance Framework: A practical guide for management boards of HPSS organisations (DHSSPS, 2006)*

[24] *Criterion 4 of the Risk Management Controls Assurance Standard*

recommendations as to how the service can be improved. These reviews should be in keeping with existing Departmental guidance *Health and Social Care Regional Template and Guidance for Incident Investigation/Review Reports* (DHSSPS 2007b) and regional good practice[25].

Dissemination of the key lessons learned along with the suggested evidence-based practice improvements should be communicated to frontline practitioners and disseminated through governance fora. As part of this, learning from adverse incidents should be targeted by sharing specific themes which occur regularly. It is also advisable that regular reviews of "near miss" untoward incidents take place as a "non-threatening" learning tool. A forum should be provided for all disciplines to record incidents and near misses to promote best practice.

There have been several local Independent Inquiries in recent years following homicides by people with a mental illness. The benefits for relatives in a thorough and transparent process have been apparent. Regional learning and the promotion of public confidence in the service are paramount.

5.1 Organisation and System-wide Learning

As previously stated, risk management is not just the responsibility of individual mental health and learning disability practitioners: it is the collective accountability of the multidisciplinary team and the wider organisation. Many adverse incidents occur as the result of a series of systems failures. However, it is not simply a matter of shifting responsibility from an individual to a blurred collective[26]. Rather, a reasonable balance must be reached between supporting an individual practitioner to make effective risk management decisions and the overall responsibility of the organisation to create a culture where there is a clear understanding of the complex issues surrounding risk. "It is recognised that in any organisation the principles should be 'what has happened' and 'how can we improve' rather than 'who made the error'"[27].

Clear arrangements, both regional and local, are required to ensure risk information is centralised and assimilated, as appropriate. Mental health and learning disability service providers should have robust clinical and social care governance systems in place that link in to the wider corporate risk management structure. This will ensure an integrated, organisation-wide response to tackling recurring risk issues.

HSC Trusts must tie in with established regional governance arrangements, and ensure that adverse incidents are consistently reported in accordance with DHSSPS and Regulation and Quality Improvement Authority Guidelines, and to comply with the Quality Standards for Health and Social Care.

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25 The review should be conducted in accordance with Mental Health Commission guidance (April 2006)
[26] *Morgan S. (2007)*
[27] *DHSSPS (2007a)*

6.0 Improving the Quality of Risk Management

6.1 Collaborative Working

Mental health and learning disability service users often require access to a wide range of interventions offered by various professionals. It is vital that all members of the multidisciplinary team providing care for the service user work closely together. Each discipline will have different professional skills, expertise and experience which, combined, will result in more informed risk assessments and management plans, and the formulation of comprehensive and appropriate Care Plans.

It is only when there is a firm commitment to this kind of team-working that staff will feel comfortable to examine their own practice with colleagues and learn from one another to create better outcomes for service users.

"Change can start now if there is sufficient commitment and vision in individual mental health services to make it happen" (Mental Health Commission Ireland, 2006).

6.2 Standardised Documentation

The RQIA's review of local practice found that there was a lack of consistency in the documentation used to assess and record the management of risk in HSC Trusts. In order to improve the quality of risk assessment and management processes, standardised assessment tools have been developed for use throughout mental health and learning disability services regionally. This should create procedures which are transferable across Trust boundaries and result in a standard approach to care planning. These tools are at section 8.0. The addenda (at section 9.0) also give guidance on appropriate tools for these specialist services.

6.3 Standards and Benchmarking

"What gets measured gets done". Risk assessment and management processes must be subject to audit, both internal and external, to ensure that they are effective in creating better outcomes for the service user. Ongoing monitoring of service delivery is vital to ensure that there are continuous checks and balances in the system, which will hopefully flag up any areas for improvement before an adverse incident occurs.

As noted above, HSC Trusts are to act collaboratively to develop an audit tool to assess compliance with this guidance. Governance reviews will be carried out by the RQIA, during which application of the risk assessment and management principles of this guidance may be assessed.

6.4 Training

Staff training in the assessment and management of risk is essential for improving the quality of risk management, and should be carried out as part of regular mandatory training for all mental health and learning disability staff, appropriate to their level. Staff need to be able to apply risk assessment tools competently and to use them, as appropriate, to inform risk management and care planning. To inform this, a “Training Needs Analysis” should be carried out as part of the implementation of this guidance.

The induction process for mental health and learning disability staff must include an overview of the local risk assessment and management process. Awareness and training sessions should be provided to the full range of mental health and learning disability staff, and other relevant staff who will be referring service users in to mental health and learning disability services. Refresher training should also be carried out, as necessary, where identified as a need through supervision.

HSC Trusts should develop information systems to record details of attendance at training events and be able to demonstrate that all staff have received relevant training on a regular basis.

6.5 Staff Support and Supervision

Clinical supervision is fundamental to developing safe and effective practice. It provides the opportunity to positively challenge professional practice to improve the quality of care.

Mental health and learning disability professionals benefit by continually developing their knowledge, skills, competence and confidence to provide the best care for service users in a protected, supportive environment. Regular supervision can also provide emotional support for this group of staff who regularly deal with difficult and complicated circumstances as part of their daily work. For managers, supervision is an opportunity to ensure that policy is being followed and professional standards are being maintained.

All mental health and learning disability staff should have the opportunity to share learning and receive support through clinical supervision, either on an individual or group basis. By making sure that risk, its assessment and management, is a regular aspect of clinical supervision, a contribution will be made to ensuring higher standards of care in mental health and learning disability services.

The guidelines developed by the DHSSPS Nursing and Midwifery Advisory Group, *Clinical Supervision For Mental Health Nurses In Northern Ireland: Best Practice Guidelines* (DHSSPS, 2004b) should be followed and the recommendations implemented throughout mental health nursing.

In order to further support staff, HSC Trusts should, as good practice, endeavour to put in place some of the following initiatives:

- *Multidisciplinary professional fora;*
- *Mentoring programmes;*
- *Champions at ward/team levels to support staff; and*
- *Group work sessions.*

7.0 The Way Forward

7.1 Implementation

The Department recognises that risk assessment and management cannot be solved by a policy and procedural response alone. These are fundamental systematic issues, which must take into account the anxieties of professionals, service users and their families/carers in order to facilitate improvement. This will require action and commitment by professionals, management teams and organisations, building on current good practice and experience.

Trusts must now:

- *Develop the protocols and procedures required to support implementation of this guidance;*
- *Use the standardised documentation (including the recommended risk assessment tools);*
- *Ensure staff are appropriately trained with regard to the use of risk assessment tools/documentation;*
- *Work collaboratively to develop an audit tool to assess compliance with this guidance; and*
- *Report regularly to the HSC Board on compliance with the elements contained in this guidance.*

7.2 Audit

The Department will commission from the RQIA an audit of compliance with this guidance, through the RQIA's programme of reviews, in 2011.

RISK SCREENING TOOL

NAME		**DOB**		**DATE**		**TIME**	
Outpatient / community		**Inpatient** **(insert Hosp No.)**		***Voluntary***		**Detained**	

INFORMATION SOURCES AVAILABLE / ACCESSED ON COMPLETING RISK HISTORY

Key Worker / Team Leader	Specify:	
Service user	Specify:	
Clinical notes	Specify:	
General Practitioner (GP) via referral	Specify:	
General Practitioner (GP) direct/ by telephone	Specify:	
Carer / relative	Specify:	
Police / probation services	Specify:	
Other (Please Specify)	Specify:	

PLEASE PROVIDE DETAILS UNDER EACH HEADING (HISTORICAL AND CURRENT)

SELF HARM / SUICIDAL BEHAVIOUR

Yes		**No**		**Unknown**	

ALCOHOL/SUBSTANCE MISUSE

Yes		**No**		**Unknown**	

If there is history of drug use, ever injected not under instruction of doctor **Yes** **No** **Unknown**

NEGLECT AND VULNERABILITY

Yes		**No**		**Unknown**	

CHILS CARE AND VULNERABLE ADULT ISSUES (Specify arrangements for Children)

Yes		**No**		**Unknown**	

PHSYICAL IMPAIRMENT (e.g. medical/ sensory)

	Yes		No		Unknown	

DISSOCIAL OFENDING BEHAVIOUR

	Yes		No		Unknown	

VIOLENCE &AGGRESSION

	Yes		No		Unknown	

POTENTIAL DISENGAGEMENT/LOSS OF CONTACT/NON-COMPLIANCE/ABSCONDING

	Yes		No		Unknown	

AREAS IDENTIFIED FROM MENTALSTATE ASSESSMENT

	Yes		No		Unknown	

OTHER INDICATORS OF RISK

	Yes		No		Unknown	

COLLATERAL HISTORY / RELATIONSHIP TO SERVICE USER

SUMMARY OF ACTIVE RISK

SUMMARY OF PROTECTIVE FACTORS

IMMEDIATE MANAGEMENT PLAN OF IDENTIFIED RISK ACTION	**Name of Person(s) responsible**	**Signed:**

CONTINGENCY ARRANGEMENTS
FURTHER ACTION NECESSARY **Discuss with Multidisciplinary Team** ☐ **Comprehensive Risk Assessment** ☐ **Specialised Risk Assessment** ☐ **Keep under review** ☐ **No further action required** ☐
DISTRIBUTION **Service user** ☐ **Key Worker** ☐ **Other** ☐ **(specify)** ____________________________

Service User's signature: _______________________________________ **Date:** ____________________ **Refused to sign** ☐

Where signature refused, indicate reason ____

Signature: ____ **Date:** _____________________________

Designation _______________________________ **Contact Tel No:** ____________

Signature: ____ **Date:** _____________________________

Designation _______________________________ **Contact Tel No:** ____________

On inpatient admission - to be completed jointly by the admitting Doctor and nurse in consultation with the Family/Carers and others (if in attendance at time of admission).

MAHI - STM - 089 - 2089
RISK SCREENING TOOL – RECORD OF REVIEWS

NAME		**DOB**	

DATE/ TIME	**UPDATE/ CHANGE IN RISK**	**ALTERATION TO RISK MANAGEMENT PLAN**	**LEAD RESPONSIBILITY**	**Signed:**

AIDE MEMOIRE

SELF HARM / SUICIDAL BEHAVIOUR

- Current suicidal thoughts, plans
- Previous history of suicide attempts / self harm
- Suicidal ideation / preoccupation
- Family history of suicide / or recent loss
- Access to means

ALCOHOL / SUBSTANCE MISUSE

- Known history of alcohol / substance abuse
- Currently misusing alcohol / substances
- Known history of abusing stimulants
- Previous non accidental overdose?
- Consumption of alcohol, non-prescribed drugs, misuse of prescribed drugs / non concordance
- Injecting drug use – see addictions addendum re hepatitis/HIV risk

NEGLECT & VULNERABILITY

- Previous history of self neglect, inadequate housing, poor nutrition, poor hygiene
- Current risk of self neglect
- Risk of being exploited by others / history of exploitation
- At risk of accidental wandering / falls / harm inside or outside the home

CHILD CARE AND VULNERABLE ADULT ISSUES

- How many children? Ages? Carer? Custody arrangements
- Vulnerable adult in household
- Children currently on child protection register
- Involvement of other services, eg, family and child care team, CAMHS, health visiting
- UNOCINI done or needed
- Threats violence to any child / children
- Emotional abuse or neglect of any child / children
- History of domestic violence

PHYSICAL IMPAIRMENT

- Medical
- Sensory

DISSOCIAL & OFFENDING BEHAVIOUR

- Criminal history, including exclusion orders, bail
- Conviction for violent offences
- Conviction for sexual offences
- Previously been a diagnosis made of psychopathy / antisocial personality disorder
- History of containment - Special hospital, Medium Secure Unit, Locked Intensive Care Unit
- Dissocial behaviours

VIOLENCE AND AGGRESSION

- Previous violence, aggression or assault towards others including – other patients / staff / family / carers / general public
- Talking of or planning to harm others
- Display high anger, hostility, threatening behaviour
- Threats against a particular individual
- History of owning, carrying, using weapons
- History of property damage
- Arson (deliberate fire setting)
- Sexual assault (includes touching / exposure)

POTENTIAL DISENGAGEMENT

- Previous history of poor concordance with treatment / medication
- Does the person understand his/her illness?
- Does the person actively attempt to mislead others with respect to concordance with treatment?
- Severe side-effects of medication
- Unplanned disengagement from services
- History of compulsory admission

MENTAL STATE

- Appearance and behaviour
- Speech
- Mood
- Perception, command hallucinations
- Cognition
- Mini Mental State
- Insight
- Previous history of serious mental illness
- Thought content (over-valued ideas / delusions)
- Relapse signatures

RELATIONSHIP WITH RELATIVE / CARER

- Known history of threat / violence towards the relative / carer
- Current risk of threat / violence towards the relative / carer
- Known history of abuse towards the client

OTHER INDICATORS OF RISK

- Recent severe stress
- Concern expressed by others
- Recurrence of circumstances associated with risk
- Impending stressors e.g. court appearance
- Abuse / victimisation by others
- Social isolation
- Lack of social or carer support system
- High levels of stress of carer / high carer burden
- Volatile personal relationships

PROTECTIVE FACTORS

- Willingness to engage with mental health services
- Compliance with medication
- Abstinence from alcohol/ drugs
- Family/ social support networks
- Faith/ religion
- Financial security
- Support from employer
- Weapons removed
- Fear of physical injury/ disability after failed attempt

- Nomadic lifestyle - Housing problems - Severe financial difficulties - Chronic medical illness - Terminal, painful or debilitating illness - Driving	**IMMEDIATE MANAGEMENT PLAN** - Action to be taken - Who is responsible for action - Date responsibility acknowledged - Need for some action to be recorded, even if discharge to GP. If so, record date GP informed.

COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT TOOL

NAME		**DOB**		**DATE COMPLETED**		**TIME**	
Outpatient/ community		**Inpatient (insert Hosp No.)**		*Voluntary*		**Detained**	

THOSE CONTRIBUTING TO RISK ASSESSMENT AND MANAGEMENT PLAN

NAME	**ORGANISATION/ RELATIONSHIP**	**COPY SUPPLIED**

FOR EACH HEADING WHERE RISK IDENTIFIED THROUGH SCREENING, PLEASE PROVIDE DETAILS (HISTORICAL AND CURRENT) (expand/delete sections below as necessary)
SELF HARM / SUICIDAL BEHAVIOUR
ALCOHOL/SUBSTANCE MISUSE (including injecting drug use)
NEGLECT & VULNERABILITY
CHILD CARE AND VULNERABLE ADULT ISSUES (Specify arrangements for care of any dependent children*)*
PHYSICAL IMPAIRMENT (e.g. medical/ sensory)
DISSOCIAL & OFFENDING BEHAVIOUR
VIOLENCE & AGGRESSION
POTENTIAL DISENGAGEMENT / LOSS OF CONTACT / NON COMPLIANCE / ABSCONDING
AREAS IDENTIFIED FROM MENTAL STATE ASSESSMENT
OTHER INDICATORS OF RISK

SUMMARY OF PROTECTIVE FACTORS

Overall Risk Summary		
Management Plan of Identified Risk Needs	**Intervention**	**Name of Person(s) responsible**
Contingency Plan **Scenario (including Relapse Signatures)**	**Intervention**	**Name of Person(s) responsible**

Service User's signature: ____ **Date:** _____________________ **Refused to sign** ☐

Where signature refused, indicate reason ____

Signature: ____ **Date:** ______________________ _______

Designation _______________________________ **Contact Tel No:** ____________

Signature: ____ **Date:** ______________________ _______

Designation ________________________________ **Contact Tel No:** ____________

COMPREHENSIVE RISK ASSESSMENT TOOL – RECORD OF REVIEWS

NAME		**DOB**	

DATE/ TIME	**UPDATE/ CHANGE IN RISK**	**ALTERATION TO RISK MANAGEMENT PLAN**	**LEAD RESPONSIBILITY**	**Signed:**

AIDE MEMOIRE

SELF HARM / SUICIDAL BEHAVIOUR

- Current suicidal thoughts, plans
- Previous history of suicide attempts / self harm
- Suicidal ideation / preoccupation
- Family history of suicide / or recent loss
- Access to means

ALCOHOL / SUBSTANCE MISUSE

- Known history of alcohol / substance abuse
- Currently misusing alcohol / substances
- Known history of abusing stimulants
- Previous non accidental overdose?
- Consumption of alcohol, non-prescribed drugs, misuse of prescribed drugs / non concordance
- Injecting drug use – see addictions addendum re hepatitis/HIV risk

NEGLECT & VULNERABILITY

- Previous history of self neglect, inadequate housing, poor nutrition, poor hygiene
- Current risk of self neglect
- Risk of being exploited by others / history of exploitation
- At risk of accidental wandering / falls / harm inside or outside the home

CHILD CARE AND VULNERABLE ADULT ISSUES

- How many children? Ages? Carer? Custody arrangements
- Vulnerable adult in household
- Children currently on child protection register
- Involvement of other services, eg, family and child care team, CAMHS, health visiting
- UNOCINI done or needed
- Threats violence to any child / children
- Emotional abuse or neglect of any child / children
- History of domestic violence

PHYSICAL IMPAIRMENT

- Medical
- Sensory

DISSOCIAL & OFFENDING BEHAVIOUR

- Criminal history, including exclusion orders, bail
- Conviction for violent offences
- Conviction for sexual offences
- Previously been a diagnosis made of psychopathy / antisocial personality disorder
- History of containment - Special hospital, Medium Secure Unit, Locked Intensive Care Unit
- Dissocial behaviours

VIOLENCE AND AGGRESSION

- Previous violence, aggression or assault towards others including – other patients / staff / family / carers / general public
- Talking of or planning to harm others
- Display high anger, hostility, threatening behaviour
- Threats against a particular individual
- History of owning, carrying, using weapons
- History of property damage
- Arson (deliberate fire setting)
- Sexual assault (includes touching / exposure)

POTENTIAL DISENGAGEMENT

- Previous history of poor concordance with treatment / medication
- Does the person understand his/her illness?
- Does the person actively attempt to mislead others with respect to concordance with treatment?
- Severe side-effects of medication
- Unplanned disengagement from services
- History of compulsory admission

MENTAL STATE

- Appearance and behaviour
- Speech
- Mood
- Perception, command hallucinations
- Cognition
- Mini Mental State
- Insight
- Previous history of serious mental illness
- Thought content (over-valued ideas / delusions)
- Relapse signatures

RELATIONSHIP WITH RELATIVE / CARER

- Known history of threat / violence towards the relative / carer
- Current risk of threat / violence towards the relative / carer
- Known history of abuse towards the client

OTHER INDICATORS OF RISK

- Recent severe stress
- Concern expressed by others
- Recurrence of circumstances associated with risk
- Impending stressors e.g. court appearance
- Abuse / victimisation by others
- Social isolation
- Lack of social or carer support system
- High levels of stress of carer / high carer burden
- Volatile personal relationships

PROTECTIVE FACTORS

- Willingness to engage with mental health services
- Compliance with medication
- Abstinence from alcohol/ drugs
- Family/ social support networks
- Faith/ religion
- Financial security
- Support from employer
- Weapons removed
- Fear of physical injury/ disability after failed attempt

• Nomadic lifestyle • Housing problems • Severe financial difficulties • Chronic medical illness • Terminal, painful or debilitating illness • Driving	**IMMEDIATE MANAGEMENT PLAN** • Action to be taken • Who is responsible for action • Date responsibility acknowledged • Need for some action to be recorded, even if discharge to GP. If so, record date GP informed.

Addendum on Child and Adolescent Mental Health Services (CAMHS)

Background

To complement the production of the main guidance, it was recognised that there was a need for guidance in relation to the legislation, policies and procedures which staff need to take account of in their day-to-day work with children and young people who have emotional, psychological or psychiatric disorder.

Generally, the main guidance applies equally to children. This addendum, however, identifies circumstances where there are noteworthy differences between practice in the adult and child and adolescent arenas.

This addendum should, therefore, be read in conjunction with the core good practice guidance.

Context

Good assessment and the management of risk is integral to the treatment and care of children and young people.

The State, in accordance with the principle of Parens Patriae, has additional duties to children and young people, which it and its agents, such as Health and Social Care Trusts, Education Services and other statutory providers, must discharge in a responsible manner.

The Children Order requires that children are *children first* regardless of disability or illness. For CAMHS, this means that children and young people with emotional, psychological and psychiatric disorders who are patients should be treated and cared for as *children first*. The value base of CAMHS is family-oriented: this enable families and carers to be partners in the treatment and care of their children and young people. In addition to providing treatment and care directly to children, a key objective of the service is to help parents/carers better understand, manage and care for their children when they have a mental health or psychological problem.

Practitioners working with children and young people are part of a wider network of support. This includes family and other professionals, tasked with providing care, treatment, or support to the child or young person and his or her carers. To achieve effective risk assessment and management requires staff to work within a multi-agency, multidisciplinary and family context.

To assist them to contribute effectively to the multidisciplinary and family support networks, it is important that CAMHS professionals are aware of the additional responsibilities for children placed on statutory agencies, such as the Trusts' Family and Childcare Services which have the lead responsibility for discharging the Trusts' child protection responsibilities.

Generally, children and young people referred to CAMHS are not suffering from a mental disorder requiring their detention and treatment under the Mental Health (Northern Ireland) Order 1986 (the Mental Health Order). The mental health care of children is, therefore, usually provided under the general duty in Article 4 of the Health and Personal Social Services (Northern Ireland) Order 1972, to provide integrated Health Services which promotes the physical and mental health of the people of Northern Ireland.

Legislative Base

Of particular relevance to CAMHS professionals, is the legislative base set out in the Children (Northern Ireland) Order 1995 (the Children Order) to safeguard and promote the welfare of:

- children in need;
- children in need of protection; and
- looked after children.

Health and Social Care Trusts are responsible for discharging statutory functions, delegated to them by the Health and Social Care Board under Schemes for the Delegation of Statutory Functions. These functions are discharged on behalf of each Trust by its Family and Childcare Programme. The HSC Board monitors performance against the Schemes on an annual basis.

Children in Need

Article 18 of the Children Order places a general duty on each Trust to safeguard and promote the welfare of children who are in need: this includes children with emotional, psychological and psychiatric disorders.

Article 17 of the Children Order states that a child is in need if:

a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of personal social services;
b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or
c) he is disabled.

Where children are assessed and identified as children in need under Article 17, Trusts are required under Article 18 to provide a range and level of personal social services appropriate to their needs. In so doing, the Trust discharges its general duty to safeguard and promote the welfare of children in need. A number of children in need will require the support of CAMHS professionals in addition to the Trusts' social care services.

Under the Children Order, there is no authority to admit or detain a competent child or young person in hospital against his or her wishes, or to prevent a child from leaving hospital because of mental health concerns. Such detentions can only be achieved through the provisions of the Mental Health legislation.

Children in Need of Protection

The Department's guidance *Co-Operating to Safeguard Children* (DHSSPS, 2003) and the Health and Social Services Boards' Area Child Protection Committees' Regional Child Protection Policy and Procedures, 2005 (ACPCs'

Policy and Procedures) set out the responsibilities of all agencies, professionals and services working with children to assist with the recognition of potential indicators of abuse and to be aware of their roles and responsibilities to assist with the protection of such children, including the requirement to share information with the Trusts' Family and Childcare Services. The sharing of information ensures that a comprehensive and holistic assessment can be made of the child's needs and circumstances to underpin the development of a Child Protection Plan to ensure the child's safeguarding needs are met.

Compulsory intervention in family life by a Trust is underpinned by its specific duties in Article 66 of the Children Order to safeguard and promote the welfare of children suffering or at risk of suffering harm. Article 50(3) of the Children Order sets out the criteria by which a judgement can be made whether the harm a child has suffered amounts to significant harm. In practice, however, mental health and other professionals' responsibilities are to consider whether there is reason to believe or suspect that a child has been abused, or is at risk of abuse.

Child abuse occurs when a child is neglected, harmed or not provided with proper care and may take the form of physical, emotional and/or sexual abuse, or neglect. CAMHS professionals should familiarise themselves with the ACPCs' Child Protection Policy and Procedures in relation to the definition of abuse (Paras 2.3 – 2.5). Guidance on significant harm is also available at Paras 2.6 – 2.14.

Each CAMHS staff member must be aware of his/her obligation to safeguard children in circumstances where harm or the likelihood of harm to the child is identified. In such cases, Departmental guidance and ACPCs' Policy and Procedures are clear that a referral must always be made to the Trust's Family and Childcare Services, through the relevant Gateway Team or Out-of-Hours Social Work Service. Each CAMHS professional must be aware of his/her obligation to safeguard children and to co-operate with the Trust's Family and Childcare Services, in circumstances where they identify abuse or the likelihood of abuse.

In some circumstances, the harm posed to a child may not come from a member of his or her family. This does not alter the duty to refer such children to the Trust's Family and Childcare Services for assessment.

Children who are in Need of Protection as a Result of Engaging in Risk-Taking Behaviours

In some situations, risks to children result not from the harm that may be caused to them by others, but rather from their own risk-taking behaviours. In these circumstances, the approach often taken is to offer support to the parents or care givers to ensure that they are better able to care for their children. Where risk-taking behaviours include self-harm and/or a risk of suicide, a thorough assessment of treatment and care needs and safety planning must be prioritised by CAMHS. This should be completed on a multidisciplinary and multi-agency basis. Where CAMHS professionals assess that the family situation is contributing to the risk-taking behaviours they should ensure that a referral is made to Trusts' Family and Childcare services to enable an assessment and support to be provided to the children and his/her family, as appropriate.

As a family-orientated service, CAMHS professionals recognise the importance of working with parents and carers. Young people in distress sometimes may, however, have mixed feelings about their parents/carers. This can place CAMHS professionals in a difficult position where risks are identified due to the young person's behaviours. Whilst seeking to preserve the rights of young people to confidentiality, CAMHS professionals should in the first instance work with children to gain their support for sharing information with their families in an effort to keep children safe. Ultimately, however, where the risks are significant, CAMHS professionals may have to breach confidentiality. In such instances, the young person should be advised that disclosures will be made either to parents/carers and/or social services.

No simple definition of a family exists. Sometimes children will be living in one parent families or families which have been reconstituted. When assessing children who are deemed to be in need or at risk, it is important to remember the role that is being played, or could be played, by the absent parent who may still retain parental responsibility for the child and be in a position to offer additional help and support.

Looked after Children

A child or young person is described as *looked after* when provided with accommodation for more than 24 hours by a Trust, either with his or her parents' consent, or through a Court Order placing the child in the care of a Trust. Each Trust has Corporate Parenting responsibilities to children whom it looks after. Like any other parent, the Trust has the duty to ensure the physical, social, emotional, educational and spiritual development of children or young person whom it looks after. The Trust's Family and Childcare social workers are responsible for fulfilling statutory functions on behalf of the Trust as a whole.

A significant number of the children and young people who are looked after have suffered loss, trauma or abuse. They are, therefore, a population with a disproportionate need for CAMHS support. CAMHS staff provide an important element of a wider range of support services which the Trust as a Corporate Parent will need to provide to children whom it looks after.

Article 174 (6) of the Children Order states that where a child or young person has been an inpatient in any hospital setting for more than 3 months, or the intention is that this will happen, then they are regarded as being accommodated. This means that where a child remains in hospital beyond the 3 months (or indeed for any period less than 3 months) for clinical reasons, i.e. is receiving medical care and treatment which cannot be provided in the child's home or in another community setting, the child is not accommodated within the meaning of Article 21 of the Children Order and Looked After Children (LAC) provisions do not apply.

However, where the child is in hospital for 3 months or is likely to be in for 3 months or more for clinical care and treatment, the Trust's community family support team, or the hospital based social worker, should be involved to assess the child and family needs as many families require support even in terms of the needs of other children in the family if they have to visit sick children for long periods. The Trust should, therefore, be asked to undertake an assessment of family needs at or before the conclusion of the 3 month period.

However, if a child's clinical care and treatment has been completed and he/she is fit to be discharged, but a lack of community resources are preventing that discharge, then the child becomes a looked after child and subject to all LAC provisions. The social worker is required to develop, with hospital colleagues, a plan which seeks to meet the child's basic developmental needs and at regular intervals to review and monitor that these needs continue to be met. This arrangement is regulatory in nature and parental responsibilities remain with the child's parents.

Risk Assessment Process

The process identified in the main document can be adopted by CAMHS staff for use with children and young people.

All incoming referrals should be screened in terms of clinical need and risk, to determine which element of CAMHS, or indeed any other service, is most appropriate to deal appropriately with the referral. It is important, therefore, that referrals contain all relevant details about any likely risks and their source.

CAMHS professionals should ensure that their generic assessment of risk is consistent with UNOCINI, the regional multidisciplinary assessment tool utilised within Family and Childcare Services. This will help to ensure a consistent approach for all professionals working within children's services. Further work is necessary for this to be realised.

Many children or young people who need emotional, psychological or psychiatric support can receive assistance from their General Practitioner, education or youth justice services, particularly if these services themselves are supported by an experienced CAMHS professional. Referrals to tier 2 services such as these should be the subject of risk screening.

All tiers 3 and 4 referrals to specialist CAMHS provision should be risk assessed. This includes a mental state assessment, which should address specifically the risk of self-harm or suicide.

CAMHS professionals should adopt the CAMHS FACE Risk Assessment Tool, which has equivalence to the comprehensive assessment as part of the main document. This is an evidence-based, multi-professional tool which has been developed over a 10-year period through collaboration of senior practitioners from around the United Kingdom.

The CAMHS FACE Risk Assessment Tool:

- is a systematic tool structured to enable safe clinical judgement, risk analysis and care formulation. The tool is supported by a validated scoring system designed to quantify both dynamic and static risk factors.
- assesses risk to self, risk to others and from others and places risk formulations in the context of the young persons history, taking full account of both family and social dynamics.
- promotes a "Strengths/Protective" factor based approach to risk management by proactively involving young people and their families in the identification and management of risks and needs.

- supports clinical supervision/governance arrangements through internal validation/clinical audit/outcome measures. The tool also supports the measurement of practitioner, team, and organisational ‘risk-load.
- integrates with case management approaches.
- interfaces with the recording of serious incidents and near misses.
- includes specialist supplement in relation to forensic/substance misuse/dual diagnosis risk assessment
- is supported by in-depth training based on “training the trainer cascade methodology”.
- A FACE risk profile should be completed by all tier 3 and 4 CAMHS services at point of contact with the child, young person and family system. This should be reviewed as part of overall care plan.

The model of initial, comprehensive and specific risk assessments is in keeping with the overall model advocated in the main part of this guidance for adult mental health.

Care Planning and Risk Management

The principles set out in the main guidance are applicable to Child and Adolescent Mental Health Services.

Risk assessments and management plans should always be incorporated into treatment and care plans and not be perceived as separate documents. There is a need to design such a document that could be used across the region.

Roles and Responsibilities of CAMHS Staff

CAMHS staff will fulfil the role of Key Worker or Care Co-ordinator.

Key Worker Role

For children and young people with complex or challenging needs, there are likely to be a number of agencies involved, some of which also will have identified staff as Key Worker. This is particularly the case for the Trusts’ Family and Childcare staff, who in many instances will be discharging statutory duties. It is, therefore, important that there is clarity about the roles, responsibilities and powers ascribed to each Key Worker, where there is more than one.

The main guidance, setting out the roles and duties of a Key Worker, where the role is to organise and maintain the mental health services needed by the patient, is applicable also to CAMHS staff.

The Care Coordinator Role

The Care Co-ordinator role is new to CAMHS. The main guidance describes the role as supporting and facilitating the Key Worker and multi-disciplinary team in the delivery of agreed Care Plans, ensuring that appropriate services are available and coordinating deputies when Key Workers are not available. The Co-ordinator is also responsible for chairing multiagency reviews at intervals of 6 months, or more frequently if required, for each service user who is subject to comprehensive risk assessment and risk management planning. Generally, these are individuals who are deemed to be at greatest risk to themselves or to others.

For CAMHS to introduce Care Co-ordination would require a review of all cases, to determine those which meet the *greatest risk* criterion. It will, however, take some time before such an approach is bedded in.

Where Care Co-ordination is deemed necessary and the Trust has, through its Family and Childcare Programme, other statutory duties to the child, then there should always be discussion to ensure that the these roles are clearly understood to avoid confusion or duplication and to ensure all statutory duties take precedence. Even with clarity regarding the distinct roles of Family and Childcare social workers, the use of Care Co-ordination will have resource implications for CAMHS.

Given that Care Co-ordination is used only in cases where the individual is deemed to be at *greatest risk to him/herself, or to others*, it is clear that the service needs to develop systems and processes to monitor and manage the care of individuals within this category. The concept of a Risk Register is not unanimously supported, albeit that it is recognised that some form of recording arrangements are necessary.
This is an issue which requires further discussion.

Confidentiality

The principles underpinning confidentiality set out in the main document are applicable to children and young people. The duty of care owed to children and young people is, however, in sharper focus given their increased vulnerability and dependence on adults. The ethos of a family-orientated service such as CAMHS should mean that every effort is taken by CAMHS professionals to ensure that parents are aware of the risks that their children's behaviour may pose.

Under the European Convention on Human Rights, children and young people have a right to confidentiality. A case by Gillick established the concept of increased competence to make decisions as children matured (*Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL)). **Gillick competence** is a term originating in England and is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Further information for staff is available in the Consent Guidance issued by DHSSPS in 2003 (*Good Practice in Consent).*

A key determinant of any child or young person's right to confidentiality is his or her competency to make such a decision. The determination of competency is a decision taken by the clinical team. Where it is deemed that the child is not competent, there is no duty on the professional to adhere to the child's request for confidentiality. Best practice requires that sharing information without consent is fully discussed with the young person; provided it will not compromise the safety of others or a possible police investigation.

The main guidance sets out the circumstances in which practitioners may disregard the patient's right to confidentiality, even where the patient is deemed to be competent: that is, where it is believed that there is a significant risk of harm to that adult or a belief that the adult poses a significant risk to the wider public. This guidance applies also to children and young people. Indeed, professionals are under an obligation to take all necessary steps to protect the child or young person or the wider society, and are not bound by the duty of confidentiality.

Transfer and Transitions

The main guidance is deemed to be appropriate to the transfer of children and young people's cases.

Disengagement from the Service

The main guidance covering the circumstances where patients are not keeping appointments or maintaining treatment plans is appropriate for children and adolescents.

Additionally, it is good practice to proactively obtain the individual's and family's consent to share relevant information with other agencies. Given the often multiagency nature of work with children and young people, this would allow the concerns of CAMHS staff about disengagement from the service to be shared with other services/professionals who are still in contact with the child or family, thus enabling them to be better informed and potentially more vigilant.

In every instance, decisions to discharge children and young people from CAMHS should be taken only after assessment, which should include an assessment of any risk factors. The concept of an automatic discharge based upon failure to keep appointments, as a procedural response, should cease.

Discharge Planning

In general terms, the main guidance is applicable to children and young people.

An assessment of risk is necessary in each instance where a young person is discharged.

Where a discharge of a child or young person is taking place contrary to medical advice, consideration should always be given as to whether it is appropriate to detain the patient under the Mental Health Order. Where the threshold for detention does not exist, but CAMHS professionals have concerns about the capacity of the parents to adequately protect and safeguard their child, then these cases should be referred to Social Services. Where a young person is reluctant to return home, this should always be treated as an issue of concern which requires closer investigation and discussions with Family and Childcare social work staff to ensure the child's concerns are appropriately addressed.

Addendum on Forensic Mental Health and Learning Disability Services

Introduction

Forensic Mental Health and Learning Disability Services (forensic services) deal with some of the most disturbed and difficult to manage patients in psychiatric practice. Such services focus on the assessment and treatment of individuals with mental disorder, whose behaviours may bring them into contact with the Criminal Justice System (CJS), either because of the seriousness of their offending behaviour or their potential dangerousness. Their work is carried out predominantly, but not exclusively, at the interface between the Criminal Justice System and Mental Health/Learning Disability Services at both community and inpatient level.

Risk assessment and management is a core activity of HSC organisations and this is particularly evident in the delivery of forensic services. The term 'risk assessment and management' can cover a wide range of activities, ranging across corporate risk, financial risk and clinical risk. This framework, however, deals specifically with the process of assessing 'clinical risk' i.e. the risk posed by an individual to themselves or others because of their behaviours, in those who have been referred to forensic services and to support the development of a robust management strategy that minimises such risks.

As the assessment and management of people who may present a risk is not exclusively the domain of forensic services, the principles outlined in this framework should be assimilated into other areas of service delivery. Applying the principles of this framework alongside the main guidance and the NIO (2009) Guidance on Public Protection Arrangements, Northern Ireland, will support consistency of approach across HSC services.

Risk Assessment and Forensic Services

'Risk assessment informs risk management planning, which in turn informs subsequent assessment and planning in a live and dynamic process that continues throughout the lifetime of the offender,' (Risk Management Authority, 2007).

A significant bulk of the risk assessment work undertaken by forensic services tends to focus around the topic of violence, whether that is purely physical acts of aggression or sexual violence. Various tools have been developed to facilitate this process of risk assessment and management and include, for example, the HCR20, SARA, RSVP, Risk Matrix 2000 and the Stable and Acute Dynamic Assessment (Hanson and Harris 2007). The first three are used predominantly within the Health sector and the last two used predominantly within the Criminal Justice sector. However, although agencies are using a range of risk assessment tools, it is important to note that the tools used have been validated for their specific purpose and can be used together to influence the detail of risk management plans.

Regardless of the tools used in forensic services, as in other services there is a need for sound risk assessment involving appropriate methods used by trained and experienced staff, with risk assessment clearly linked to a risk management plan, and effective inter-agency communication arrangements in place.

Key Principles of the Risk Assessment and Management Process

Risk assessment by forensic services will:

- Be a live, dynamic, proactive process;
- Be based on collaborative multi-agency/multidisciplinary working, with timely communication and responsible information sharing;
- Be undertaken by appropriately trained staff;
- Show evidence of a thorough review of the relevant available information;
- Show evidence of the application of structured professional judgement involving utilisation of evidence-based, validated assessment tools that are fit for purpose;
- Produce a formulation of the risk, to include the robust risk management strategies with contingency planning and regular timely review;
- Address victim issues as part of the process; and
- Show best endeavours to elicit the cooperation of the individual under assessment.

Key Processes

1. Collaborative Working Arrangements

In order to effectively plan and implement risk management strategies, forensic services must put in place robust multi-agency and multidisciplinary working arrangements. This facilitates the collation of the diverse range of views and expert opinion that contribute to improved shared risk management. A central tenet of these arrangements will be effective, timely communication and responsible information sharing. This may involve the Public Protection Arrangements Northern Ireland (PPANI) and will ensure compliance with child protection responsibilities.

2. Client Engagement

Forensic services will use their best endeavours to positively engage, where possible, with the individual being assessed throughout the risk assessment and management process. This has the potential to promote compliance and co-operation with the risk management strategies being developed and implemented.

3. Risk Assessment

Forensic services will carry out risk assessment, not as a static process, but as a dynamic and continuous process that responds to changes in the individual's circumstances, as they occur. Forensic services will also ensure that the frequency of risk assessment reviews is dependent on the situation in which the individual finds him/herself: for example, an individual detained within a secure setting is likely to require less frequent risk assessment reviews than someone in a community setting.

In order for forensic risk assessments to be effective, they will incorporate the following dynamics:

- Clear evidence that there has been a thorough review of the relevant and available information collected from case files, records and interview sessions;
- The information collected must be applied to an evidence-based, validated risk assessment tool that is fit for purpose;
- There should be evidence that structured professional judgement has been utilised to support the identification of relevant and critical risk and protective factors;
- There should be a formulation of the risk that includes the nature, severity, imminence, frequency and likelihood of re-offending.
- Clear working examples of possible future risk scenarios that risk management plans will seek to avert;
- The risk formulation will also include information on the likely impact of the offending behaviours and to whom the offender poses a risk of serious violent or sexual harm:
  - **i.** Relevant risk factors (static, stable dynamic, acute dynamic);
  - **ii.** Active protective factors; and
  - **iii.** Early warning signs that risks are escalating.

For risk management to be effective, the information must be analysed and contextualised as to its soundness and relevance. Agencies/organisations that request a risk assessment from forensic services do not want a catalogue of events drawn from records and presented in a report. They require the information to be set in the context of the individual's experiences and circumstances. Therefore, any risk assessment that does not go beyond the information collection and collation process has no validity and would not support the principle of defensible decision-making.

4. Risk Management Planning

Risk management is the natural progression from risk formulation. It is the process whereby the validated and analysed information is developed into a risk management plan. Forensic services must develop plans which evidence the link between the identified risk factors/active protective factors and the risk management strategies employed to manage the risk.

Robust risk management involves strategies that exert external controls (monitoring, supervision, interventions) whilst attempting to enhance or maintain the individual's internal controls (motivation, self-agency, personal control, self-determination).

The risk management strategies being employed in forensic services must be:

Sufficient to manage as effectively as possible the risk posed;
Appropriate to the individual and the individual's situation;
Relevant to the risk factors;
Evidence-based; and
The *least restrictive* necessary.

Although all risk management plans will undergo regular review, particularly in the earlier stages of implementation, it is important to identify a review date, ideally in the near future, but certainly no longer than three months from last review or the initial implementation to ensure that the principles of risk management, i.e. that the level of intervention is guided by the individual's level of risk, still applies. Adopting this approach promotes the principles of defensible decision-making, thus ensuring necessity, proportionality, non-arbitrary, evidence-based, transparent processes in the decision-making process.

Risk management is enhanced considerably if the individual is motivated to participate in establishing and attaining the goals of the risk management plan.

5. Roles, Responsibilities, Communication, Co-ordination

All risk management plans developed by forensic services will clearly identify the roles and responsibilities of the various agencies/personnel involved in the implementation of the plan. Lines of communication, including contact numbers and names, will be included. Contingency plans should describe the course of action to be taken should the risk scenario change. The risk management plan should also clearly identify the case coordinator who will carry overall responsibility for the implementation of the risk management plan, and be the single point of contact for others involved in the delivery of the plan.

Addendum on Addictions Services

Introduction

Most addiction treatments are delivered within a menu-led service. In this way, most people negotiate their own management plan within the first few appointments and most people referred to Addiction Services play an active part in their own risk reduction plan.

Intravenous Drug Use

Use of the intravenous route to administer drugs carries particular risks to well-being. These include direct injecting risks with a danger of ischemia or embolus, both of which may lead to limb loss or death. In the early stages of injecting drug use there is a particularly high risk of accidental overdose because of the rapid onset of the drug effect. Over time, veins become sclerosed and the intravenous drug user may start to use significantly more dangerous injection sites such as groin or neck injecting, either of which may lead to significant illness or death. Infection may be introduced to the body without the normal means of defences. In particular, sharing of injecting equipment may lead to transmission of viruses including HIV and the various forms of hepatitis.

Harm Reduction

Because of the significant risks associated with intravenous drug use, management of those who do inject drugs normally follows a “harm minimisation” route. Individuals are encouraged to move away from more risky injecting behaviour into slightly safer oral drug use. This is encouraged through the Substitute Prescribing Services, which deliver high quality, focused education and direct intervention to reduce these risks. At Public Health level, needle exchange schemes, operated through community pharmacies, provide geographic access to injecting equipment with education to reduce the likelihood of sharing equipment.

The harm minimisation interventions have been shown to have effectiveness in reducing the spread of viruses at population level and should be acknowledged as risk reduction within the population.

Substitute Prescribing

Substitute Prescribing Services, in addition to the provision of substitute medication, give counselling and significant levels of psychosocial support to those attending for this service. In addition, they provide counselling and testing for the blood borne viruses: HIV; hepatitis B; and hepatitis C. They also provide vaccination against hepatitis B in people who have not developed antibodies, as well as onward referral and continued support to engage in treatment services for hepatitis C and HIV. This requires good liaison with Hepatology Services and the HIV Services for affected individuals. Such intensive, consistent client working as been shown to reduce the likelihood of continued illicit drug use and to reduce the medical and psychiatric morbidity associated with it. It has also been shown to significantly reduce associated criminal behaviours and to reduce the chaotic nature of the person’s lifestyle.

Outreach

Those who inject drugs (usually Opiates) are frequently reluctant to engage in mainstream service treatment because of the very intensive nature of this treatment, as described in the previous paragraph. Outreach Services may provide a means of encouraging such people to access the mainstream services. They can also encourage use of other forms of harm minimisation, such as education about the dangers of injecting, safer injection techniques and safe sex. They can also encourage attendance at the needle exchange facilities available through the community pharmacies.

Reinstatement Overdose

Services must be alert to the risks of reinstatement overdose and death in injecting drug users, following voluntary or enforced abstinence. (Education of patients in this area forms part of recognised good practice in harm minimisation work. It is particularly important in custodial settings such as Prisons and Custody Suites as well as in services which encourage abstinence from Opiate drugs).

Children Affected by Drug Use of Others

Children may be affected by the drug and alcohol use of parents, siblings, or others within their family. The presence of addiction in a family member can lead to faulty family communications, disruption of the family system and inappropriate role modelling. In extreme cases, there may be parental neglect or physical, mental or sexual abuse of children either as a direct result of parental or other family substance use or the chaotic lifestyle potentially associated with it.

Risk assessment in Addiction Services must take account of this issue and as part of every assessment procedure there should be an attempt to establish whether there are any children within the family or with significant exposure to influence from the person with an identified substance misuse problem. Trusts must have clear policies and procedures regarding referral to Child and Family Childcare Services of any identified risk.

There is increasing recognition that services should be provided for families of those with the more serious elements of addiction or existing inappropriate family functioning. Clear protocols and policies must be in place to ensure appropriate referral between agencies and acknowledgement of the different roles of the respective agencies. Liaison must also be encouraged at all levels of these processes.

Those with Co-existing Mental Illness

The co-occurrence of substance use problems and psychiatric illness is often referred to as “dual diagnosis”. Within this document, the more narrow definition of “dual diagnosis” has been adopted: that is, those with severe and enduring mental illness and a co-occurring substance use problem. The overlap between serious mental health problems and alcohol and drug use is significant. Half of all patients with Schizophrenia have substance missue disorder and 50 to 60% of people with Bipolar Disorder have substance use disorder. Such co-morbidity is associated with heavy use of psychiatric inpatient care, poor treatment compliance, poor prognosis and high offending rates.

Patients' needs may be multiple rather than "dual" and may include medical and social care needs in addition to straightforward psychiatric and substance use services.

Good risk management includes identification of the relevant risks presenting to either service and good liaison between the relevant services involved to develop the most appropriate care plan for the individual. Such patients frequently present to Psychiatric or Substance Misuse Services in an "emergency", with acute psychiatric disturbance made significantly worse by the presence of substance intoxication. Joint service involvement is appropriate to develop "longitudinal" treatment plans in order to best enable substance misuse interventions to be delivered at a time when the mental health problem is stable.

Some substances, particularly alcohol, Cannabinoids, hallucinogens and stimulants can produce psychotic symptoms directly without the presence of mental illness and without apparent vulnerability to these. The psychotic state may be sufficiently severe to warrant input from the Psychiatric Services if it persists beyond the spell of simple substance intoxication. The management of florid symptoms may, at times, require management through the Mental Health (Northern Ireland) Order 1986, if they are not simply the result of intoxication.

Primary Care Management of Psychiatric Conditions Within Addiction

Chronic heavy use of any addictive substance, including alcohol, may lead to neurotic conditions, including minor levels of depression, anxiety and other neurotic illneses. These are conditions, which are normally managed properly within Primary Care and for which the individual would not be expected to come into contact with the Secondary Care Psychiatric Services.

Workers within Substance Misuse Services should be capable of assessing, correctly identifying and managing these disorders, in partnership with the General Practitioner, at community level. They should also be able to adequately screen and identify more serious levels of depressive illness or other psychiatric illness, which may need referral to the Secondary Care Psychiatric Services for management.

The converse of this is that those working within the generic mental health services should be able to screen, identify and deliver brief interventions on addiction issues to those presenting with substance use problems as a manifestation of a psychiatric disorder requiring treatment. There should be policies and guidelines regarding referral in each case and regarding the liaison and communication between service personnel, when appropriate.

Those Who Self-harm

This group of people is "vulnerable" in terms of the relative risk of further self-harm or completed suicide in the 10 years after an episode of self-harm. The behaviour is frequently associated with substance use, which in itself, may be viewed by the patient as a form of self-harm. All Addiction Services staff should be able to carry out a screening risk assessment and should be able to carry out an assessment of risk of self-harm in individuals who have such a history.

The act of carrying out the risk assessment will, in many cases, be a useful piece of addiction work as it may help the individual to identify potential harms resulting from continued substance use. This may serve a “motivational” purpose and will enable the individual to become meaningfully involved in the development of plans to reduce his risk in the future. There are 2 significant management issues in this subgroup of patients.

a. Identification of Major Psychiatric Illness

Any person presenting to Addiction Services with a history of self-harm should have a full diagnostic screen to exclude the presence of depressive illness or other significant psychiatric illness. Any identified illness should be managed within Primary Care, but with the ability to refer for psychiatric opinion and management, if considered necessary. The identification and treatment of mental illness will reduce the risk of completed suicide.

b. Attention and Management of the Substance Misuse Issue

The act of addressing and managing a substance misuse issue will, in itself, reduce the likelihood of further self-harm regardless of the existence of other mental illness. There are various reasons for this, including the reduction in the depressed mood associated with chronic substance use, the positive attitude engendered by “dealing with” or undertaking to deal with a lifestyle issue and the associated social enhancement inherent in many addiction treatments. It should also be acknowledged that much self-harm behaviour is carried out while under the influence of alcohol or drugs so that the natural inhibitions are reduced.

Containment or amelioration of the addiction problem may lessen the likelihood of this. It should be borne in mind, however, that addiction is a chronic, relapsing condition. While some individuals can gain significant improvements (including cessation of substance use per se) of their illness during a spell of treatment, the risk of future relapse to substance use is very high and the risk appears to remain on a lifetime basis. Even with intensive, supportive management, only about 50% of the people attending services can expect significant amelioration of their substance use problem.

Pregnant Drug and Alcohol Users

In the case of pregnant women, risks to the mother and risks to the foetus must both be considered.

Risks to the mother include the normal sequelae of excessive drug or alcohol use, the unavailability of some of the normal pharmacological treatments because of the danger of teratogenicity, the potential for a difficult pregnancy and a difficult labour, risks of poor pregnancy outcome and the possibility of having to raise a child with significant disability.

Risks to the foetus include teratogenic affects from the drugs of misuse, potential teratogenic affects of treatments and substitute offered or prescribed (effects generally seen in the first 10 to 12 weeks of pregnancy), potential developmental delay and difficulty in assessing foetal dates (effects seen from substance use throughout pregnancy), potential for premature delivery and for complicated labour (during this last 12 weeks of pregnancy), the potential for withdrawal syndrome manifesting in the foetus in the neonatal period, risk of death at any time during pregnancy or the neonatal period and risks of severe developmental delay or organ malfunction during childhood.

Pregnant women who use substances should have easy access to services for drug and alcohol misuse. Access should be signposted from Primary Care, and from Maternity Services and Addiction Services should prioritise these cases so that they are assessed as soon as possible after referral.

A variety of agencies must be involved in every instance. These include the normal Maternity Services as well as the normal child health services available to all women. There should be protocols and policies in place across services to enable easy access across services and to enable consultation liaison interactions without barriers and without waiting lists. There should be protocols for full and open sharing of information between the Addictions Services, Obstetricians, Community Midwives and the Childcare Social Services, where appropriate.

As the majority of care during pregnancy takes place within Primary Care, it is essential that the General Practitioner and the Primary Care structures are similarly fully informed. This enables good planning during pregnancy by the individual services and enables early decisions about optimum timing of delivery and management of delivery. Good aftercare services are also essential for both mother and infant to ensure optimum outcome.

For most women, advice and information about substance use should be available within Primary Care and should be delivered at the point where pregnancy is considered or as soon as a pregnancy is identified. Primary Care Services will normally refer more complicated cases to Addiction Services if it is considered that dependence on a substance is present, if the mother shows significant resistance to drug reduction or if a complicated withdrawal is envisaged.

Multiple substance use would often also be referred to Addiction Services. A full assessment should be made of substance use of the mother and her goals and aims for the pregnancy. Her motivation should be assessed to manage her substance use and advice and motivational interviewing are appropriate at this point.

It is imperative that women with undisclosed pregnancies should be encouraged to access the Maternity Services in order to establish the maturity of the foetus as early as possible. All complicated cases should involve the multidisciplinary team and should have a full assessment of risk carried out on the various domains, which appear relevant. There will often be additional involvement of the criminal justice services and there may additionally be issues of domestic or partner violence.

Children's Addiction Services

Most children who take drugs do so in a limited way and most learn over time to control their drug use. There are 2 significant sub-groups who may be at risk of additional harm.

a. Those Who Have Significant Pre-existing Psychological Problems

These children will often use drugs or alcohol in larger quantities then their peers and may use in isolation to their peers. They may demonstrate other high-risk behaviour such as truancy, conduct disorder, self-harm or other psychiatric disorder.

These children should be identified and should properly be referred to the Child and Adolescent Mental Health Services for assessment and management. Such children should be identified through screening processes by specialist services dealing with substance misuse in children and young people. These must have clear internal protocols and policies and must have strong links with the Child and Adolescent Mental Health Services at local level. There should be clear protocols and clear referral pathways.

b. Children Who Develop Significant Substance Misuse Problems

Those under the age of 18 may develop physical or psychological addiction to a drug of misuse, including alcohol. The management of children with addiction or other serious substance use problems should take place within the context of “child-centred” treatment.

There should be a holistic model of management, which takes into account the child’s developmental level, other physical or psychiatric problems and should operate within the family environment and setting. Treatment models will normally include systemic family therapy and attention to education and all of the child’s needs. They should also include specialist addiction work input by competent, trained staff.

Trusts should have policies and procedures in place for referral of all such children and should ensure that there is access to service provision for this age group. Good liaison is essential across the family and childcare network to ensure good and appropriate communication between the various agencies, which may be involved. Such children should not be exposed to adult substance misuse populations because of the risk of initiation of more dangerous drug taking behaviours or sexual behaviours.

Screening and Assessment Tools

The risk screening tool is appropriate for addiction services.

Similarly, the comprehensive assessment tool is appropriate to use to identify the nature of risk in cases where the screening process identifies specific risk, and where this is applied in specific cases, with the decision to apply made on the key worker’s considered decision. It would not, for example, be appropriate to use automatically in all cases as most addiction cases are dealt with by a single case worker. Involvement of the multidisciplinary team in every case would require a staff resource which would be impossible to meet.

These more detailed instruments would be used as appropriate to describe and manage risk in cases that have been opened by the addiction services and which will require intensive support. All identified risk should be shared with the referrer, but it cannot all be managed from these low intensity, high volume services. The priority has to be to identify reversible risk, such as psychiatric disorder, and risks posed to children. Addiction services should identify (screening) and refer to appropriate services, where they exist, issues like personality disorder and self-harm.

Annex

Risks Associated with Substance Abuse

Accidents

Most morbidity and mortality associated with substance use is due directly to accidents associated with intoxication. Alcohol and drug use account for a high proportion of road traffic accidents and fatalities, domestic accidents and work-related accidents. Mortality is highest in young adults and naive substance users from direct intoxication. Accidental overdose is a further significant cause of morbidity and mortality in this group. Serious accidents of this sort frequently arise in those who are not addicted to substances and who do not present to Addiction Services. Public Health advice and opportunistic advice from Primary and Secondary Care staff is an important part of prevention of such untoward events.

High-risk Behaviours

Substance use is associated with high-risk behaviour such as joy-riding, sexual promiscuity and high-risk ingestion of substances such as cigarette smoking and intravenous injection of drugs. Those who use alcohol or drugs have higher rates of deliberate self-harm than the general population. Continued excessive substance use in itself may be regarded as a form of “self-harm” with significant mortality rates, particularly in the case of alcohol, and significant levels of physical, psychiatric, and social disability resulting directly from substance misuse. Social disability includes major domestic effects including domestic violence, employment loss and interaction with the criminal justice system.

Lifestyle Choice

Those who develop significant dependence on a substance may develop a chaotic lifestyle. This results directly from the addictive process as the person’s life becomes increasing focused around obtaining and taking the drug of choice. Commitments and responsibilities become increasingly neglected and there will be increased self-neglect. This includes neglect of nutrition, of sleep, of grooming and self-care and neglect of normal social interaction. The dependent person often becomes isolated as he or she seeks to avoid influences which might moderate use of the drug of choice. Interventions to decrease the risk include treatment of the addiction process or, in more severe cases, harm reduction as a means of reducing risk.

Intravenous Drug Use

Use of the intravenous route to administer drugs carries particular risks to well-being. These include direct injecting risks with a danger of ischemia or embolus, both of which may lead to limb loss or death. In the early stages of injecting drug use there is a particularly high risk of accidental overdose because of the rapid onset of the drug effect. Over time, veins become sclerosed and the intravenous drug user may start to use significantly more dangerous injection sites such as groin or neck injecting, either of which may lead to significant illness or death. Infection may be introduced to the body without the normal means of defences. In particular, sharing of injecting equipment may lead to transmission of viruses including HIV and the various forms of hepatitis.

Harm Reduction

Because of the significant risks associated with intravenous drug use, management of those who do inject drugs normally follows a “harm minimisation” route. Individuals are encouraged to move away from more risky injecting behaviour into slightly safer oral drug use. This is encouraged through the Substitute Prescribing Services, which deliver high quality, focused education and direct intervention to reduce these risks. At Public Health level, needle exchange schemes, operated through community pharmacies, provide geographic access to injecting equipment with education to reduce the likelihood of sharing equipment.

The harm minimisation interventions have been shown to have effectiveness in reducing the spread of viruses at population level and should be acknowledged as risk reduction within the population. Outreach Services may help reduce risk in those unwilling to engage with mainstream services.

Addendum on Adult Learning Disability Services

Introduction and Context

Within learning disability services, an integral component of sound, robust and safe care delivery is the consideration of risk, and how that risk is effectively assessed and managed, in whatever context it arises. Learning disability services (statutory and non-statutory) work with a heterogeneous, diverse and often vulnerable service user group, and consequently, the concept of risk often presents in a range of different contexts

This addendum, specific to the adult learning disability population, is focused on identifying a small but significant number of individuals who, alongside their learning disability, may also have substantial additional psychiatric, personality, forensic and/or behavioural needs, and who consequently may present with significant risks to self and/or others. Such circumstances require processes of risk screening to be in place, to identify those presenting with the most significant risks and then, for robust, collaborative, and comprehensive risk assessment and management processes to be established, where appropriate, in order to minimise the risk and reduce the potential of harm to self and/or to others.

This addendum only applies to adults. Children with a learning disability should be considered in the context of the CAMHS addendum.

It should be noted that the future direction of service delivery will result in more people with a learning disability (mostly mild to borderline learning disability) receiving services from mainstream mental health, CAMHS and other specialist services such as forensics. In these circumstances, the service in question should use the risk assessment processes that are used routinely with other service users who use that particular service.

The Main Guidance

The principles, fundamentals and processes of risk assessment and management outlined in the main guidance are equally applicable within the field of learning disability. However, a number of key principles and issues that have particular relevance to the field of learning disability include the need to:

- ensure that professionals completing risk assessment and management plans utilise a human rights-based approach (see section below);

- consider proactive/preventative risk reduction measures in the formulation of risk management strategies, including protective factors and individual wishes and strengths;

- involve people with a learning disability and/or their carers in the process of risk assessment and management. Outcomes are likely to be more positive for all concerned if staff optimise the participation of service users and carers in the processes and the decisions made (see section below);

- ensure implementation of the processes and systems across and within other services and agencies (considering the impact on service commissioning and contracts) involved in care delivery to the learning disabled population to whom this addendum applies;

- ensure that risk assessment and management processes utilise positive risk-taking strategies, where appropriate. Overstating risks and being overly risk-averse carry human rights implications for the service user and resource implications for services, and can also lead to unnecessary exclusion from services and stigmatisation;

- ensure shared, multi-professional, and multi-agency collaboration and accountability, with individual practitioners feeling confident and competent to make risk management decisions within a supportive organisational structure;

- promote consistency and standardisation of process and documentation across all care settings in Northern Ireland; and

- consider the impact of these developments from a resource, training and supervision perspective across all involved agencies.

A Human Rights Based Approach

All of the human rights protected by the European Convention belong to and may be relevant for learning disabled people. There are a range of issues that need to be carefully considered in the risk assessment and management process for people with learning disabilities. For example, the individual’s right to human rights such as freedom and choice may need to be balanced against the need to protect the individual and/or society’s right to protection. Therefore, professionals completing risk assessment and management plans must consider the impact on an individual’s human rights, particularly when they are considering interventions such as enhanced supervision, use of medication, or other restrictive practices such as physical restraint. In such circumstances, the least restrictive option needs to be carefully considered. In other circumstances, principles of choice and freedom (e.g. the right to have a sexual relationship) may override the need for protection, recognising that within the right circumstances, taking positive risks can be beneficial, yet still require to be carefully managed.

Consequently, the risk assessment and management process in this addendum places strong emphasis on a human rights-based approach, which means:

a) enabling meaningful involvement and participation of **all** key people, and, in particular, service users;
b) encouraging a positive and proactive approach to risk taking and risk management;
c) considering the least restrictive option(s); and
d) applying the principle of proportionality in all risk management strategies, whereby the management of the risk must match the gravity of potential harm.
(Mersey Care NHS Trust 2008)

Accessible information relating to Human Rights can be found on the Equality and Human Rights Commission website.

http://www.equalityhumanrights.com/pages/eocdrccre.aspx

Involving Service Users and Carers

One of the most fundamental components of any human rights-based approach is involvement of the person concerned and the people who care for him/her. Consequently, the principles stated within the main guidance (Sections 3.4 and 4.8) are fully applicable to the learning disability population.

It is particularly important that staff are open and honest about the purpose and process of risk assessment and management and facilitate service users' and family/carer participation in the process. Consequently, it is important that efforts are made to make the process and documentation amenable and accessible. For example, summary and easy-read versions of the decisions made may have to be developed for some service users.

Family members and carers know the service user best and will have first-hand information about his/her history, behaviours and situation. Involving all relevant stakeholders from the outset in gathering information, in generating ideas and solutions will ensure a positive risk-taking approach and will help in the understanding of risk from various perspectives. Most importantly, such an approach will clarify the responsibilities of each person involved in managing risks effectively.

Positive risk-taking may not be suitable for all service users, and it is likely that there will be occasions where the professional's views and those of the service user and or the family/carer will differ. These need to be discussed and worked through to reach agreement as to what are acceptable risks, recognising that it may not always be possible to achieve full agreement. In such circumstances, the key worker needs to ensure that consideration of consent guidance, mental health legislation and human rights law have been made to ensure that any agreements are within the appropriate and acceptable frameworks. It is essential to recognise the potential within services and family carers for risk aversion that leads to the significant limitation of the person's life experiences and personal development.

In such circumstances, advocacy services can play an important intermediary role, giving service users the opportunity to express their views and concerns, assisting them to make informed decisions, and encouraging their personal responsibility for their ongoing care and treatment.

Service users may also refuse permission for information to be shared with particular family members and relatives for a variety of reasons: such wishes should always be taken into account. Clarification of those who should and should not be communicated with should be clearly noted in the service user's Care Plan. Professionals will, of course, need to fulfil their legal obligations to contact the service user's next of kin, where appropriate, under the Mental Health (Northern Ireland) Order 1986.

The issue of consent needs to be very carefully considered within the learning disability arena. The DHSSPS provides informative guidance regarding consent in the document "Seeking consent: Working with people with learning disabilities" (DHSSPS, 2004). However, recognising and understanding the issues involved in informed consent is often challenging, specifically where the individual's judgement is at odds with that of the professionals/carers involved. Care needs to be taken that incapacity is not assumed relating to decision-making for people with learning disabilities, and shared discussion and decision-making should guard against such incidents in each case.

Further clarification around confidentiality, disclosure and consent can be found in the Code of Practice on Protecting the Confidentiality of Service User Information, http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf.

Risk Assessment and Management in Everyday Practice Within Learning Disability Services

The main guidance focuses on 4 distinct categories of risk:

- Risk of harm to self;
- Risk of harm to others;
- Risk of harm to children/vulnerable adults; and
- Risk of harm from others and individual vulnerability.

Considering the preference to have a common and shared framework/protocol across both mental health and learning disability services, these 4 categories will remain the predominant focus within the screening and comprehensive risk management processes.

Although the categories of risk will be universal across learning disability and mental health services, the specific sub-set of risks within each category will be different. An aide memoire (Appendix 1 to this addendum) has been developed to assist staff, users and carers to consider the nature of risk that may be relevant within each category. This aide memoire is however simply a guide to the processes of risk screening, and when completing the more comprehensive risk assessment and management plan. It does not provide a definitive or exhaustive list.

It is also known that people with learning disabilities are vulnerable to exploitation, coercion, harassment, abuse, intimidation and bullying. In this context, the risk assessment and management process will complement and support vulnerable adults' processes.

The Process of Risk Assessment and Management in Learning Disability Services

Considering that the majority of individuals with a learning disability who present to services will not require a risk assessment and management plan in this context, the process of risk assessment and management within learning disability services will follow a slightly different pathway from that outlined in Section 4 of the main guidance. Arrangements within learning disability services, will involve the following 4 stage process:

1. Routine initial assessment;
2. Risk Screen;
3. Comprehensive and/or Specialised Risk Assessment and Management Plan; and
4. Review.

Stage 1. Routine Initial Assessment

Routine initial assessment will take place as is currently the case for every individual who presents for community-based learning disability services. It is good practice for all types and levels of risk (where apparent) to be thoroughly explored at the initial assessment phase. Trusts should, therefore, satisfy themselves that the routine assessment processes utilised at various points of access to learning disability services will identify needs, in the context of additional behavioural, forensic, personality or psychiatric co-morbidity that may benefit from a risk screen.

It is anticipated that for the high majority of service users with a learning disability, there will be no need to move to the next stage of risk screening in the context of additional behavioural, forensic, personality or psychiatric needs.

Indicators of need to carry out a risk screen may include:

- A history of violence or harm to others;
- Involvement with the Criminal Justice System;
- Inappropriate sexualised behaviour;
- A history of being easily led/exploited by others;
- Any issues regarding access to children; and
- Behaviour change as a consequence of mental health deterioration.

NB. IN CIRCUMSTANCES OF ADMISSION TO HOSPITAL, THE RISK SCREEN SHOULD BE COMPLETED FOR ALL NEW ADMISSIONS.

Stage 2. Risk Screen

When it is decided to complete the risk screen (Appendix 2), this will be completed by the relevant named nurse and admitting doctor (hospital) or named/key worker (community). Clearly, other relevant members of the multi-disciplinary team will be involved in this process. As is stated within the main guidance, screening need not be time-consuming and formalised, but should be conducted as part of the overall assessment of need. This approach will encourage a therapeutic relationship and should be seen as part of good clinical practice.

Depending on the risk factors identified in the risk screen, a decision will need to be taken whether or not to progress to completion of the comprehensive risk assessment and management plan (Appendix 3) or, indeed, a specialised risk assessment process (see below).

There is no definitive threshold for such decisions. Clinical judgement, rather than specific scoring/rating systems, should inform decision-making through the stages of risk assessment and management. These decisions will be made by the relevant multidisciplinary team members involved in the service user's care, the line manager, and will include the service user and relevant carer(s).

This process should identify those individuals who have additional forensic, personality, psychiatric, and/or behavioural needs, **and** who present with significant risks to self and others, **and** who require a more comprehensive assessment and management plan to address the risks that present.

Although not a definitive or exhaustive list, possible triggers for completion of the comprehensive risk assessment and management plan will include a previous history of involvement by the service user in activity such as:

- Sexual assault (as victim or perpetrator)
- Arson
- Exploitation
- Violence
- Self-harm
- Concerns regarding access to children

At the routine assessment stage it may be immediately apparent that a comprehensive or specialised risk assessment will be required. However, in many circumstances, the comprehensive/specialised risk assessment process and management plan may not be able to be initiated immediately. Therefore the risk screen will still need to be completed in order to provide an immediate and interim risk management plan.

The risk screen should be used as an interim measure for no longer than **28 days**.

NB. The risk screen also prompts the assessor to identify risks relating to physical health, such as epilepsy, complex health needs, risk of aspiration etc. However, this tool is specifically designed to assess and manage risks related to additional forensic, personality, psychiatric and behavioural needs. Therefore, any physical health risks identified at screening should be addressed via alternative risk assessment and management pathways (e.g. manual handling risk assessment).

Stage 3. The Comprehensive Risk Assessment and Management Plan

If a decision is taken to complete the comprehensive (or specialised) risk assessment and management plan, a key worker and care coordinator (Section 4.5 of main guidance) should be identified.

The key worker should ensure that the process of risk assessment and the development of the risk management plan is completed within 28 days of the risk screen being completed.

From a community perspective, completion of the comprehensive risk assessment and management plan (Appendix 3) should be facilitated by the key/named worker, although it is essential that it is contributed to by relevant members of the multidisciplinary team. Within the hospital setting, a member of the hospital staff will be responsible for facilitating completion of the comprehensive assessment and management plan. The multi-disciplinary team will agree who is best placed to take on this role. The service user and family members/carer(s) should (where possible and appropriate) be fully involved in the risk assessment and management process.

Accurate history-taking plays an important role in the process of risk assessment. Relevant information should be obtained from health records and referral letters, as well as by asking service users themselves, carers, and other family members. It is important to obtain past records from other hospitals, districts, or social services departments and a history of criminal offences (where applicable).

Sometimes it may not be possible to obtain sufficient information to conduct a thorough and accurate assessment: immediately, in which case, this should be recorded and arrangements made to seek relevant information at a later stage. Self-reliance on information provided by service users should always be considered in the context of other available information.

The subsequent risk management plan must be based on the outcome of the above assessment, whereby the multidisciplinary team share responsibility for ensuring that risk is minimised, as far as possible, and managed effectively. The management plan should ensure that there is an appropriate balance between protection and ensuring that the service users psychological, physical and social needs are addressed, and that human rights are not compromised.

Within the risk management plan the following areas should be considered:

a) Triggers and warning signs;
b) Proactive and preventative strategies;
c) Reactive and emergency strategies; and
d) Human rights considerations.

Within risk assessment and management, proactive and preventative strategies, rather than simply reactive approaches are more likely to have long term impact and are more consistent with a human rights based approach. Such proactive strategies may include:

- Putting in place a suitable social activities programme to reduce boredom and social isolation
- Provision of sex education
- Referral for psychological therapy
- Skills teaching such as anger/stress management
- Managing the environment e.g. reduction in noise or activity
- Education and training of staff in relation to behaviour management, communication, mental health needs etc.
- Referral to the relevant behaviour support team
- Increasing the availability of appropriate support (e.g. family, carers, professionals, community workers, advocates, accommodation needs, day care needs, Probation Service etc);

Reactive strategies are an immediate or emergency response to the specific risks identified, and may include:

- Increasing the frequency of home visits
- Increasing the level of observation
- The use of prescribed medication
- The use of prescribed physical intervention

- The use of legal processes such as the Mental Health (Northern Ireland) Order 1986 or calling the police

Where the risk management plan identifies needs that cannot be met, these must be recorded in the “unmet needs” section and immediately brought to the attention of the relevant line manager. Any dispute or disagreement should also be recorded in the relevant section and immediately brought to the attention of the relevant line manager.

When completed, the risk assessment and management plan should be signed by the service user and/or his/her principal carer. Should either be unable or unwilling to sign the reason(s) should be clearly recorded. The risk assessment and management plan should also be signed by the key worker/caseload holder, and all who contributed to its completion and should be signed by the care co-ordinator/line manager.

In finalising and agreeing the risk management plan it is good practice to consult with and involve those people who will be expected to deliver and monitor it. Consultation, therefore, should also take place with relevant service providers and other carers. Care delivery can take place in a range of different environments, including inpatient settings, day care, residential care, and in the person’s home. The risk assessment and management plan should therefore be integrated with other support plans such as the person’s Essential Lifestyle Plan or Service Plan as a process of best practice. This information should be recorded in the section “Communication and information sharing process”

Specialised Risk Assessment

Although it is anticipated that in most circumstances the generic risk assessment process will suffice, there will be some occasions when an adult with a learning disability presents risks in areas such as extreme violence and aggression, sexual violence, offending behaviour and suicide. In these circumstances, the following considerations should be helpful in ensuring a robust approach to specialised risk assessment and management tools/processes.

Most of the research and evidence base around specialised risk assessment tools has taken place within mental health settings. However, the literature on the use of specialised risk assessment tools in the learning disability population reflects increased recent interest in exploring the validity of tools developed within forensic or general mental health practice for this population.

Evidence is now growing that the following tools are useful and valid for the assessment of people with a mild/moderate learning disability who present with significant risks in areas such as violence, arson, sexual violence or other inappropriate sexual behaviour:

- HCR-20 - (Historical, Clinical, Risk management–20, Webster et al., 1997)
- PCL-SV - (Hare Psychopathy Checklist: Screening Version (PCL:SV), Hart et al., 2004);
- VRAG - (Violence Risk Appraisal Guide, Quinsey, 2003);
- RRASOR - (Rapid Risk Assessment of sexual offence recidivism, Hanson, 1997);

- Static-99 - (Hanson and Thornton, 1999);
- RAMAS - (Risk assessment, audit and management systems, O'Rourke and Hammond, 2004);
- RSVP - (The Risk for Sexual Violence Protocol, Hart et al., 2003);
- SARN – (Structured Assessment of Risk and Need, Thornton, 2002).

The development of new tools for specialised risk assessment with people with a learning disability has also progressed in recent years. Validation work continues on DRAMS (Dynamic Risk Assessment and Management Systems, Lindsay et al., 2004) a tool for the assessment of dynamic risk factors that is designed to be used collaboratively and specifically with service users with a learning disability. It shows evidence of effectiveness for both risk assessment and therapeutic purposes.

The ARMIDILLO (Assessment, Risk Management of Intellectual, Developmental or Learning Disabled Offenders, Boer et al., 2007) is also currently undergoing validation and shows a high level of face validity in its consideration of both internal and environmental risk factors.

These specialised risk assessments are likely to be undertaken by a relatively small number of clinicians and efforts should be made to ensure a degree of consistency across the region. Further clarification on the range of tools appropriate and available for use with those service users with a learning disability who present risks in these specific areas should be sought from the responsible medical officer, and/or local/regional forensic leads within the Learning Disability Service.

It should be noted that the need to utilise a specialised risk assessment process may become apparent having gone through all the stages of risk assessment. Equally, the need for specialised risk assessment may become apparent at the screening stage.

Stage 4. The Review Process

The level of risk and success of the management plan will determine the frequency of review, but in general it is expected that reviews should take place at least 6-monthly for those who have had a comprehensive or specialised risk assessment completed. Section 4.3 of the main guidance provides clarity in respect of the review process, and similar approaches to review should take place within learning disability services.

At review, it is important that relevant information is brought to the table, including any incidents/near misses since previous review, any changes in unmet needs, any changes in personnel, and what worked and what didn't in managing the risk. A format to assist in the review process is provided in Appendix 4 of this addendum.

It is recognised that there may be regional variation in the use of routine assessment (stage 1) formats for individuals who present to learning disability services. However, the same processes and documentation formats for stages 2 and 3 should be used consistently across the region. The review process (Stage 4) and forms should also be used consistently across the region.

Hospital Admission and Discharge Planning

As outlined in the main guidance, the key to good risk assessment and management for service users admitted to any inpatient assessment and treatment facility is effective communication and liaison between community and hospital personnel. Most admissions of learning disability service users to hospital are as a consequence of risk to self/others, or significant vulnerability. Consequently, it is recommended that **all** new admissions to hospital have a risk screen carried out on admission (which may be a review of a previous risk screen that has already been completed). This is necessary to inform the decision regarding the need for further in depth comprehensive or specialised risk assessment.

As outlined earlier, there may be circumstances where it is immediately apparent that a comprehensive or specialised risk assessment will be required. Once again, in acknowledging that the comprehensive/specialised risk assessment process and management plan may not be able to be initiated immediately, the risk screen will need to be completed in order to provide an immediate and interim risk management plan.

The risk screen should be used as an interim measure for no longer than **28 days**.

As part of safe and effective care delivery and robust discharge planning, the multidisciplinary team (including hospital and community personnel), the service user and carer, should be involved in determining and agreeing whether the comprehensive or specialised risk assessment and management plan needs to be applied on discharge. This decision should be routinely documented as part of the discharge planning process. For further guidance on the process of discharge planning, please refer to Section 4.11 of the main guidance.
As already highlighted, a member of the hospital staff will be responsible for coordinating the comprehensive risk assessment and management plan. The multi-disciplinary team will agree who is best placed to take on this coordinating role.

Interface arrangements

Service users who have a learning disability will encounter a range of other transitions and interface arrangements: e.g. between children and adult services; within generic health and mental health settings; and with other agencies (housing and employment). To effectively manage such circumstances and maintain continuity of risk management, the same principles as outlined in the main guidance (Sections 4.9 and 4.10) should be applied.

Protocols governing the interests of service users between and within services/agencies need to be developed by learning disability service providers to ensure clear guidance for staff in maintaining and reviewing risk management plans at such times.

Co-ordination Responsibilities

Considering the wide range of services and agencies that may be involved in the delivery of care and support to adults with a learning disability, critical to the success of effective risk assessment and management is a coordinated approach.

As outlined in the main guidance, statutory agencies will have lead and coordinating responsibility. Therefore, this responsibility will either be held by community learning disability teams for community-based service users, or by the learning disability hospital if an individual is admitted to that setting (see above). Without a designated lead/coordinating agency, there is the potential for confusion, duplication and disjointed application.

As stated above, many non-statutory and other agencies may be involved in the delivery of care and support to individuals, and to assure effective risk communication, the lead individual/service must ensure that information available is documented and communicated to all those who need to have access to it, in order to effectively care for the service user and protect him/her/others from the risks identified within the risk assessment (see Section 3.5 of the main guidance).

References

Boer, D. et al. (2007) Contextualising Risk in the Assessment of intellectually disabled Individuals. Sex offender treatment, vol 2, issue 2

DHSSPS (2003) Seeking consent: Working with people with learning disabilities

DoH (2007) Independence, choice and risk: A guide to supported decision making

Hanson, R.K. (1997) The Development of a Brief Actuarial Risk Scale for Sexual Offence Recidivism. Anonymous. Ottawa: Department of the Solicitor General of Canada

Hanson, R.K. and Thornton, D.M. (1999) Static 99: Improving Actuarial Risk Assessments for Sex Offenders. Ottawa: Public Works and Government Services Canada

Hart, S., Cox, D. and Hare, R. (2004) Hare Psychopathy Checklist: Screening Version (PCL:SV), MHS, Toronto

Hart, S. D., Kropp, P. R., Laws, D. R., Klaver, J., Logan, C. and Watt, K. A. (2003) The Risk for Sexual Violence Protocol (RSVP)

Lindsay, W. R., Murphy, L., Smith, G., Murphy, D., Edwards, Z., Grieve, A., et al. (2004) The dynamic risk assessment and management system: An assessment of immediate risk of violence for individuals with offending and challenging behaviour. Journal of Applied Research in Intellectual Disabilities, 17(4), 267–274

Mersey Care NHS Trust (2008) Human Rights Joint Risk Assessment and Management Plan: A consultation document

O'Rourke and Hammond (2004) RAMAS: Risk Assessment, management and audit systems. Ramas Foundation, London

Quinsey, V.L.E., Harris, G.T., Rice, M.E. and Cormier, C.A. (2003) Violent Offenders: Appraising and Managing Risk

Thornton, D. (2002) Constructing and testing a framework for dynamic risk assessment. Sexual Abuse a Journal of Research and Treatment, 14, 139-154

Webster, C.D., Douglas, K., Eaves, D. and Hart, S.D. (1997) HCR-20 Assessing risk for violence (2nd ed.). Vancouver: Simon Fraser University

Appendix1

AIDE MEMOIRE FOR LEARNING DISABILITY SERVICES

NB, THIS IS AN AIDE TO BOTH THE SCREENING AND THE COMPREHENSIVE RISK ASSESMENT PROCESSES AND IS NOT AN EXHAUSTIVE LIST

RISK OF HARM TO SELF

- Previous history of suicide attempts / self harm
- Suicidal ideation / preoccupation
- Family history of suicide / or recent loss
- Alcohol/ substance misuse.
- History of self harm or self injurious behaviour.
- Reckless behaviour.
- Impulsive behaviour
- Sexualised behaviour causing concern such as, promiscuity/exploitation

RISK OF HARM TO OTHERS

- Previous violence, aggression or assault towards others including – other patients vulnerable people / staff / family / carers / general public
- Actual or suspected criminal history.
- History of violent/sexual offences or assaults
- Previously been a diagnosis made of psychopathy / antisocial personality disorder
- Talking of or threats to harm others
- Display high anger, hostility, threatening behaviour
- History of owning, carrying, using weapons
- History of property damage or arson

RISK FROM OTHERS AND VULNERABILITY

- Known history of abuse towards the individual (physical, financial, sexual).
- History of being targeted/bullied
- History of being easily led and exploited by others.
- Previous history of poor engagement with services/ treatment / medication
- Problems coping with severe stress (e.g. bereavement)
- Current/previous history of severe self neglect, inadequate housing, poor nutrition, poor hygiene

CHILDREN AND/OR VULNERABLE ADULTS AT RISK

- Previous concerns regarding access to children.
- Service user has been linked to formal vulnerable adult processes.
- Involvement of other services, eg, family and child care team, CAMHS, health visiting.
- Threats of previous harm to, or preying on any child / children or other person.
- Emotional abuse or neglect of children
- History of family or domestic violence
- History of volatile personal relationships

THE FOLLOWING AREAS SHOULD ALSO BE CONSIDERED TO INFORM THE SCREENING, RISK ASSESSMENT AND MANAGEMENT PLAN PROCESSES

MENTAL STATE (IF APPLICABLE)

- Previous history of mental illness and associated risk behaviour
- Delusions and/or hallucinations (command) associated with risk behaviour.
- History of emotional distress associated with risk behaviour
- Relapse indicators.
- Medication effects, side effects and concordance.
- Previous involvement in therapy for anger management..

ENVIRONMENTAL FACTORS

- Suitability of the living environment (e.g. in design, or proximity to potential victims, access to intoxicants)
- Staffing levels
- Staff skills , attitudes and competencies
- Communication systems
- Lack of purpose and structure to day to day life

OTHER POSSIBLE INDICATORS OF RISK

- Recent severe stress/loss.
- Concern expressed by others
- Impending stressors e.g. court appearance
- Lack of social or carer support system
- Difficulties managing or coping with social and personal relationships
- Nomadic lifestyle
- Housing problems
- Severe financial difficulties
- History of compulsory admission
- Social isolation.

HUMAN RIGHTS CONSIDERATIONS

- Involving service users and carers (where appropriate) throughout the process. Consent process followed
- Consider wishes of service user
- Consider skills and strengths of the individual
- Utilise the least restrictive option
- Consider what is important “to” the service user
- Consider communication needs
- Facilitate understanding of the process
- Provision of appropriate and accessible information
- Consider advocacy arrangements
- Proportionality should be considered
- Emphasis on proactive and preventative strategies

POTENTIAL PROTECTIVE FACTORS

- Willingness to engage with learning disability services
- Compliance with medication
- Abstinence from alcohol/ drugs
- Effective family/ social support networks
- Faith/ religion
- Financial security
- Having a job / constructive activity
- Ability to communicate
- Belief that change is possible
- Previous approaches used successfully to manage risk
- Positive risk taking

ADDITIONAL RISKS (REQUIRING ALTERNATIVE PATHWAYS OF REFERRAL OR INTERVENTION)

- Complex physical health needs
- Specific co-morbid conditions such as Epilepsy, Diabetes etc. and associated risks
- At risk of accidental wandering / falls / harm inside or outside the home.
- Risks associated with nutrition/swallowing/aspiration
- Risks associated with daily living (e.g. road safety, fire safety etc)

Appendix 2

RISK SCREENING TOOL FOR LEARNING DISABILITY SERVICES

NAME			**DOB**		**DATE**		**TIME**	
Outpatient/ community		**Inpatient (insert Hosp No.)**			*Voluntary*		**Detained**	

INFORMATION SOURCES AVAILABLE / ACCESSED FOR COMPLETING RISK SCREEN

Key Worker / Team Leader	Specify:	
Service user	Specify:	
Clinical notes	Specify:	
General Practitioner (GP) via referral	Specify:	
General Practitioner (GP) direct/ by telephone	Specify:	
Carer / relative	Specify:	
Police / Probation Services	Specify:	
Other (Please Specify)	Specify:	

PLEASE PROVIDE BRIEF DETAILS UNDER EACH HEADING ***(in particular, you should consider the likelihood and consequences of the risk behaviour taking place)***

RISK OF HARM TO SELF	**Yes** ☐ **No** ☐ **Unknown** ☐
RISK OF HARM TO OTHERS	**Yes** ☐ **No** ☐ **Unknown** ☐
RISK FROM OTHERS AND VULNERABILITY	**Yes** ☐ **No** ☐ **Unknown** ☐

CHILDREN AND/OR VULNERABLE ADULTS AT RISK	**Yes** □ **No** □ **Unknown** □
ASSESSMENT OF MENTAL STATE (IF APPLICABLE)	
ENVIRONMENTAL FACTORS THAT MAY BE ENHANCING THE RISK	
OTHER INDICATORS OF RISK	
CURRENT PROTECTIVE FACTORS	
OTHER RISKS HIGHLIGHTED DURING SCREENING *(NB: This section may highlight other risks such as risks associated with epilepsy, or risk of falls which will indicate the need for alternative pathways of risk assessment such as epilepsy risk assessment or manual handling risk assessment).*	
COLLATERAL HISTORY (INCL. RELATIONSHIP TO SERVICE USER)	

SUMMARY OF CURRENT RISKS:

(**NB.** *Should any risk issues have been identified in the above section, and the decision is* ***not to*** *proceed with the full risk assessment and management documentation, please specify reasons here).*

IMMEDIATE MANAGEMENT PLAN OF IDENTIFIED RISK

ACTION	**LEAD RESPONSIBILTY**	**Signed/Date**

Risk screen completed by:______________________ Designation: _______________

Date: __________________

Contact Tel. No. ___________________

Signature of Medical Officer *(for inpatient admissions only)* _____________________

Designation: ______________________ Date: ______________________________

Contact Tel. No. __________________________________

Service user signature: ___________________________ **Date:** ___________________

Unable/Refusal to sign ☐ Please explain:

Carer signature: __________________________________ **Date:** ___________________

Unable/Refusal to sign ☐ Please explain:

Is a comprehensive risk assessment and management plan indicated? Yes ☐ No ☐

Is a specialised risk assessment and management plan indicated? Yes ☐ No ☐

IF NO, PLEASE OUTLINE ACTION TAKEN____

Line Manager Signature: __________________________ **Designation:** __________________

Date: ___________________

Contact Tel. No. ___________________

DISTRIBUTION
Service user ☐ Carer/Family member ☐ Key Worker ☐ Other ☐ (specify)

IF COMPLETING COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT PLAN:

KEY WORKER WIL BE: ____

CARE CO-ORDINATOR WILL BE: _____________________________________.

Appendix 3

COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT TOOL
LEARNING DISABILITY SERVICES

NAME		**DOB**		**DATE COMPLETED**		**TIME**	
Outpatient/ community		**Inpatient (insert Hosp No.)**		***Voluntary***		**Detained**	

THOSE CONTRIBUTING TO COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT PLAN

NAME	**ORGANISATION/ RELATIONSHIP**	**COPY SUPPLIED**
OTHER INFORMATION SOURCES		

STATEMENT OF CURRENT CAUSE FOR CONCERN (including brief pen picture, background information, and why there is a need for comprehensive risk assessment)

MAHI - STM - 089 - 2137

CHRONOLOGY OF SIGNIFICANT EVENTS

EVENT (include date of event, if known)	Source of Information	Time/Date/Signature

HISTORICAL FACTORS: *(Consider an analysis of the significant events above. Assessors should look for patterns or trends in the service users behaviour. Analyse their frequency and severity and the context in which they took place (e.g. for aggressive or violent behaviour: has this been targeted at other service users, staff, children). Consider how these were managed previously. Other contextual issues such as exposure to institutional care, involvement with the criminal justice system, any history of drug/alcohol abuse)*

CLINICAL FACTORS: *(Consider the degree of learning disability, associated conditions (e.g. autism, epilepsy), physical and mental health factors that may affect the risks posed by or to the service user, previous clinical psychological or behavioural interventions associated with potential risks. Also consider the service users interpersonal style (traits such as impulsivity, hostility, anger, ability to self control will all affect how risk is managed):*

SOCIAL FACTORS: *(Consider previous and current social factors that may affect the risk behaviour, such as early childhood experiences, relationship stability, ethnicity, bullying, social isolation, finance, environmental factors(such as layout of environment, access to weapons) that may enhance or contribute to risk behaviour)*

HUMAN RIGHTS CONSIDERATIONS: *(What are the key human rights issues to consider in the formulation of this risk management plan. Consider the strengths and wishes of the service user, the need for advocacy, proactive/preventative strategies, positive risk taking, proportionality and least restrictive option).*

RISK MANAGEMENT PLAN FOR ……………………………………….

1. RISK OF HARM TO SELF

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour)*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

2. RISK OF HARM TO OTHERS

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential severity of consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour))*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

3. RISK FROM OTHERS AND VULNERABILITY

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour))*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

4. CHILDREN AND/OR VULNERABLE ADULTS AT RISK *(Specify arrangements for care of any dependent children)*

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour))*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

COMMUNICATION AND INFORMATION SHARING PROCESS: *(Specify who needs to receive a copy of this risk management plan, are there any confidentiality or consent issues in sharing information that need to be considered?)*

UNMET NEEDS IDENTIFIED: *(Please include any difficulties encountered in applying any of the preventative or control mechanisms to address the stated risks in any of the settings (including home) in which the individual receives care).*

Has this risk assessment and management plan been shared with the service user, and/or carers?

Service user: Yes ☐ No ☐ **Service user signature ....**

Refusal to sign ☐

Unable to sign ☐

Carer: Yes ☐ No ☐ **Carer signature ....**

Refusal to sign ☐

If not shared, please specify reasons.

Are there any disagreements with this risk assessment and management plan from the individual service user, main carers or relevant others? Yes ☐ No ☐

If yes, please specify nature of disagreement and outline action taken.

Signature of Key/Named Worker ______________________*Date:*________

Signature of Line Manager/Care Coordinator: ___________*Date:* ________

Signatures of all other professional/advocacy staff involved in the development of this comprehensive risk assessment and management plan

Name: ______________________ Designation: _________________ Date: _________

Name: ______________________ Designation: _________________ Date: _________

Name: ______________________ Designation: _________________ Date: _________

Name: ______________________ Designation: _________________ Date: _________

Name: ______________________ Designation: _________________ Date: _________

Name: ______________________ Designation: _________________ Date: _________

Name: ______________________ Designation: _________________ Date: _________

Date of Review: ______________________________

Appendix 4

Comprehensive Multidisciplinary Risk Assessment and Management Plan

Review Record

Service user name:____

Attended By **(Identify each person's role in the review)**	**Person's consulted** **Persons not in attendance**

Date of initial risk assessment:_________________ **Date of last review:** ___________________

Overview since previous risk assessment/management plan:(include any incidents/near misses, changes in unmet need or involved personnel, what worked and did not work, changes in service user's situation/understanding/co-operation levels/self management skills).

Action(s) required following this review

Key actions	**Responsible person**	**Target date**

Signature of service user ________________________Date ______________

Signature of Key/Named Worker ________________ Date: ______________

Signature of Carer ________________________ Date ________________

Signature of Line Manager __________________ Date ________________

Copies to: (please list all individuals/services who are provided with a copy of this form)

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Select Bibliography

Appleby. L., Shaw, J., Kapur, N., Windfuhr, K. *et al.* (2006) *Avoidable Deaths: Five Year Report by the National Confidential Inquiry into Suicide and Homicide By People with Mental Illness.* University of Manchester, published online 2006 (http://www.medicine.manchester.ac.uk/suicideprevention/nci/Useful/avoidable_deaths_full_report.pdf)

Clinical Resource Efficiency Support Team (2006) *Protocol for the Inter Hospital Transfer of Patients and Their Records.* CREST, August 2006. (http://www.crestni.org.uk/protocol.pdf)

DHSSPS (2009) Code of Practice on Protecting the Confidentiality of Service User Information

DHSSPS (2007a) *Supporting Safer Services*. DHSSPS, December 2007

DHSSPS (2007b) *Health and Social Care Regional Template and Guidance for Incident Investigation/Review Reports.* DHSSPS, September 2007

DHSSPS (2006) *Quality Standards for Health and Social Care*. DHSSPS, March 2006

DHSSPS (2004a) *Discharge From Hospital and The Continuing Care In The Community of People With a Mental Disorder Who Could Represent a Risk of Serious Physical Harm To Themselves or Others*. DHSSPS, 2004

DHSSPS (2004b) *Clinical Supervision For Mental Health Nurses In Northern Ireland: Best Practice Guidelines.* DHSSPS, August 2004

Department of Health (2007a) *Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services*. DH, London, June 2007

Department of Health (2007b) *Independence, choice and risk: a guide to best practice in supported decision making.* DH, London, May 2007

Department of Health (2002) *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide*. DH, London, May 2002

Department of Health (1999) *National Service Framework for Mental Health*. DH, London, September 1999

Department of Health (1998) *Crossing Bridges: Learning Materials to Support Mentally Ill Parents and Their Children.* DH, London, December 1998

Higgins et al. (2005) *Assessing Violence Risk In General Adult Psychiatry.* Psychiatric Bulletin, 29, pg 131 - 133

HSC (SQSD) 33/07 – *HSC Regional Template and Guidance for Incident Review Reports* (DHSSPS, September 2007)

Langan, J. and Lindow, V. (2004) *Living with Risk Mental health service user involvement in risk assessment and management.* Published for the Joseph Rowntree Foundation by the Policy Press, April 2004

Laurence, J. (2002) *Pure Madness: How Fear Drives The Mental Health System.* King's Fund Lecture. King's Fund and The Faculty of Public Health Medicine Annual Scientific Conference, 2002

Morgan, S. (2007) *Working with Risk Practitioner's Manual*. Practice Based-Evidence – A Practice Development Consultancy for Mental Health. Pavilion Publishing (Brighton) Limited, 2007

Morgan, S. (2004) *Positive risk-taking: an idea whose time has come.* Health Care Risk Report, October 2004: 18–19

Morgan, S. (2000) *Clinical Risk Management: A Clinical Tool and Practitioner Manual.* Sainsbury Centre for Mental Health

Morgan, J. F. (2007) *Giving up the Culture of Blame. Risk assessment and risk management in psychiatric practice.* Briefing Document for the Royal College of Psychiatrists, February 2007

NIMHE/SCMH Joint Workforce Support Unit (2004) *The Ten Essential Shared Capabilities A Framework for the Whole of the Mental Health Workforce.* NIMHS/SCMH, August 2004

NIMHE (2004) *NIMHE Guiding Statement on Recovery.* National Institute for Mental Health in England. Leeds, January 2005

NIMHE (2003) *Preventing Suicide: A Toolkit for Mental Health Services.* National Institute for Mental Health in England, Leeds, October 2003

Roberts et al. (2008) *Detained – What's My Choice Part 1: Discussion*. Advances in Psychiatric Treatment, Vol. 14, Pg. 172 - 180

Royal College of Psychiatrists (2008) *Rethinking Risk to Others in Mental Health Services, Final report of a scoping group.* College Report CR150. London: Royal College of Psychiatrists

Royal College of Psychiatrists (2003) *Good Psychiatric Practice: Confidentiality and information sharing.* Council Report CR133. London: Royal College of Psychiatrists

Royal College of Psychiatrists (2000) *Good Medical Practice in the Psychiatric Care of Potentially Violent Patients in the Community.* Council Report CR80. London: Royal College of Psychiatrists

Royal College of Psychiatrists (1996) *Assessment and clinical management of risk of harm to other people.* Council Report CR 53. London: Royal College of Psychiatrists

Royal College of Psychiatrists/Social Care Institute for Excellence/Care Services Improvement Partnership (2007) *A common purpose: Recovery in future mental health services.* Social Care Institute for Excellence: London. (www.scie.org.uk)

Royal College of Psychiatrists and The Princess Royal Trust for Carers (2004) *Carers and confidentiality in mental health: Issues involved in information sharing.* London: Royal College of Psychiatrists, August 2004

Ryan, T. (2006) Chapter 14 Risk *Management in Mental Health: People, Perceptions and Places* in Catherine Jackson, and Kathryn Hill (eds) Mental Health Today a handbook. Pavilion Publishing/Mental Health Foundation, 2006

Scottish Executive (2000) *Risk management*. Report of the Mental Health Reference Group. Edinburgh: Scottish Executive

Shepherd, G., Boardman, J. and Slade, M. (2008) *Policy Paper: Making Recovery A Reality.* Sainsbury Centre for Mental Health: London. (www.scmh.org.uk)

Taylor, P. J. and Gunn, J. (1999) *Homicides by people with mental illness: myth and reality*. British Journal of Psychiatry, vol 174, pp 9-14

University of Manchester (1996) *Learning Materials on Mental Health Risk Assessment.* Manchester, University of Manchester, School of Psychiatry and Behavioural Sciences

Further Reading and Additional Resources

Appleby, L., Shaw, J., Sherratt, J., Amos, T., Robinson, J., McDonnell, R. et al. (2001) *Safety First, Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.* London: Stationery Office

Doyle, M. and Dolan, M. (2002) *Violence risk assessment: combining actuarial and clinical information to structure clinical judgements for the formulation and management of risk*. Journal of Psychiatric and Mental Health Nursing, 9 (6), 2002: 649–57

Doyle et al. (2003) *Inter-professional clinical risk training.* Psychiatric Bulletin 2003, 27, 73-76

Holloway, F. (2004) *Risk: more questions than answers*. Advances in Psychiatric Treatment, 10, 273–274

Maden, T. (2006) *Review of Homicides by Patients with Severe Mental Illness.* National Institute for Mental Health in England, Leeds, 2006. Available from: www.nimhe.csip.org.uk

Mental Health Commission Ireland (2006) *Multidisciplinary Team Working: From Theory to Practice. Discussion Paper.* Mental Health Commission Ireland, January 2006. Available from: www.mhcirl.ie

Munro, E. and Rumgay, J. (2000) *Role of risk assessment in reducing homicides by people with mental illness.* British Journal of Psychiatry, 176, 116–120

National Assembly for Wales (2001) *Adult mental health services for Wales: Equity, empowerment, effectiveness, efficiency:* Strategy document. Cardiff: National Assembly for Wales

NICE (2005) *Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments*

Petch, E. (2001) *Risk management in the UK mental health services: An overvalued idea?* British Journal of Psychiatry, vol 25, pp 203-05

Pullen, I. and Loudon, J. (2006) *Improving standards in clinical record-keeping*. Advances in Psychiatric Treatment, 2006, vol. 12, 280–286

Rethink (2008) *A brief introduction to the recovery approach.*
(www.rethink.org/living_with_mental_
illness/recovery_and_self_management/recovery)
[Accessed May 2008]

Risk Management Authority (2007) *Risk Management Authority: Risk Assessment Tools Evaluation Directory*. RMA Scotland. Available online at http://www.rmascotland.gov.uk

Risk Management Authority (2006) *Risk Management Authority: Standards and Guidelines For Risk Assessment.* RMA Scotland. Available online at http://www.rmascotland.gov.uk

Szmukler (2003) *Risk assessment: 'numbers' and 'values'*. Psychiatric Bulletin, 2003, 27, 205-207

Websites

The website established to support and promote the Department of Health in England's guidance - Best Practice in Managing Risk guidance for mental health services across England:
http://www.merseycare.nhs.uk/managing_clinical_risk/default.asp

Annex A

Assessment and Management of Risk Regional Steering Group Members

Ms Linda Brown (Chair)	DHSSPS
Mr Martin Bradley	DHSSPS
Ms Maura Briscoe	DHSSPS
Mr Hugh Connor	Eastern Health and Social Services Board
Ms Marie Crossin	CAUSE
Dr Oscar Daly	South Eastern Health and Social Care Trust
Mr Martin Daly	LAMP
Mr Oscar Donnelly	Northern Health and Social Care Trust
Ms Norma Evans	Northern Health and Social Care Trust
Mr Roy Keenan	DHSSPS
Dr Paula Kilbane	Eastern Health and Social Services Board
Mr Paul Martin	DHSSPS
Mr Brendan Mullen	Belfast Health and Social Care Trust
Professor Roy McClelland	Board for Mental Health and Learning Disability
Mr Paul McFall	LAMP
Mr Noel McKenna	Mental Health Commission (Northern Ireland)
Dr Ian McMaster	DHSSPS
Mr Colin McMinn	DHSSPS
Miss Gillian McMullan	DHSSPS
Ms Heather O’Neill	DHSSPS
Mr Jude O’Neill	Regulation and Quality Improvement Authority
Dr John Simpson	Southern Health and Social Care Trust
Mr Phelim Quinn	Regulation and Quality Improvement Authority

Annex B

Background

Context

In May 2006, both in response to serious adverse incidents reported to the Department and to the publication of the McCleery Independent Inquiry Report, DHSSPS established a multi-agency Regional Steering Group to address the issues raised in relation to the assessment and management of risk within adult mental health and learning disability services.

To do this, a key objective of the Group was to develop regional guidance to ensure that mental health provider organisations have robust risk assessment and management processes embedded in their practice to minimise, as far as possible, the occurrence of adverse incidents.

The Steering Group was informed in the development of this guidance by:

- *A review of current practice in HSC Trusts;*
- *A review of currently available information on adverse incidents in general mental health and learning disability services; and*
- *Regional stakeholder workshops to identify good practice and challenges in risk assessment and management by mental health services.*

The publication of the O'Neill Independent Inquiry Report in March 2008 significantly reinforced the need to urgently address these issues and highlighted recurring systematic failures, e.g. poor communication between professionals, lack of collaboration and ineffective interfaces between services, and a failure to adequately address the holistic needs of the service user and his/her families/carers.

Review of Current Practice

During the Autumn of 2007 the RQIA carried out the first dedicated Clinical and Social Care Governance Review of general adult mental health within each of the five HSC Trusts in Northern Ireland. The review was commissioned by the Steering Group to provide independent assurance that the Trusts have appropriate policies and standard operating procedures in place for the assessment and management of risk, which are in keeping with the McCleery Report recommendations and the 2004 Departmental Discharge Guidance.

Each Trust completed a 'Self Assessment Proforma' supported by evidentiary documents. Visits to validate the information were then completed by multidisciplinary review teams, comprising Health and Social Care professionals (Peer reviewers) and members of the public (Lay reviewers).

Key findings from these review visits have been incorporated into this guidance and an overview report was published by the RQIA in March 2008.

Review of Local Adverse Incidents

This work was informed by *'Supporting Safer Services'*, the second annual DHSSPS report promoting safety and learning arising from serious adverse incidents[28]. It found that between 1st January 2006 and 31st March 2007, 43% of all incidents notified to the Department came from mental health services. Whilst the report acknowledges that mental health service users are vulnerable to a number of potential risks such as self-harm, violence and aggression, which may be linked to their mental illness, much can still be done to reduce their risk of harm.

The report highlighted learning for mental health services categorised by three themes: assessment and management of risk; Trust internal reviews; and suicide and self-harm. Several areas for improvement in relation to the assessment and management of risk were suggested, including:

- *Prompt and proactive follow-up following discharge from inpatient care;*
- *Management of disengagement from services;*
- *Management of alcohol misuse, especially with dual diagnosis;*
- *Improving compliance with medication;*
- *Preventing absconding, especially detained patients;*
- *Increased staff awareness/training to encourage identification and management of specific well known risk factors;*
- *Improving assessment and management of risk, both to self and others, with particular focus on risk factors sometimes being identified but not managed prior to "inevitable" incident; and*
- *The need to establish consistency across HSC units on risk assessment and subsequent management.*

Regional Stakeholder Workshops

The Department held a series of workshops in each of the five HSC Trust areas across Northern Ireland between January and March 2008. These were extremely well attended, with representation from user and carer organisations, each of the different mental health professional groups in HSC Trusts, HSS Boards and from the voluntary sector. During the workshops, the outcomes of the RQIA review visits were reported and views taken on key issues and good practice examples regarding risk assessment and management. Feedback from the workshops has been incorporated into this guidance.

The views of service users, their families and carers must be central to any decisions affecting the future planning and delivery of mental health and learning disability services[29]. Voluntary sector organisations representing both service users and their families and carers through real-life experiences, have made a valuable contribution to the development of risk assessment and management processes.

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[28] *An adverse incident is "any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation" (DHSSPS 2007a, 7)*

[29] *DHSSPS (2007a)*

Similarly, as regards identifying examples of good practice and understanding the challenges of risk assessment and management, mental health staff are key. Collaboration with professionals working throughout the service in Northern Ireland is essential to explore the potential opportunities for improvement.

At the workshops, there was some apprehension about using the word ‘risk’ in mental health services, as it was thought it might stigmatise service users and act as a barrier to involving them in a collaborative process. Whilst this concern is recognised, for the purposes of this guidance “risk” is being used as it represents a commonly understood term within mental health and learning disability services.

It is important to reinforce that risk assessment is only one component of the overall comprehensive assessment of a service user’s health and social care needs, which contribute to the development of an effective Care Plan. A balance must be maintained between the need of the service user to progress towards recovery and the responsibility of mental health professionals to ensure the safety of the service user and that of those around him/her.

Development of Guidance

On the basis of these strands of work, the Department prepared draft guidance and issued it for consultation over July and August 2008. This included hosting one further stakeholder consultation conference. The responses to this exercise informed the finalisation of this document for the Steering Group’s approval.

Supporting Tools

In addition, to support the implementation of this guidance, the Steering Group oversaw the development of new regionally-agreed risk screening and risk assessment and management tools. These were piloted over a 12 week period in adult mental health services in each HSC Trust at the beginning of 2009, in order to test their viability in day-to-day practice and to enable them to be finalised.

Tools for use in learning disability services are being similarly piloted in those services within each Trust and will be issued when finalised. Tools for use in CAMHS are also being developed.

Specialist Addenda

Another element of the work has been to develop specialist addenda to the main guidance, on specialist mental health services (CAMHS, forensic mental health services and addiction services) and on learning disability services, to provide advice on any specific issues and procedures within these areas of provision. A stakeholder consultation exercise on draft versions of these addenda was conducted in the Spring of 2009, as a result of which, they have been finalised and incorporated into the guidance document.

Annex C

What Is Meant by ‘Risk’?

Risk relates to the possibility that service users will cause harm to themselves or others, i.e. physical violence to self (self-harm/suicide/self neglect) or to others, and psychological harm.

When actively assessing risk, historical information should be considered according to[30,31,32]:

- ***Recency*** *– When was the last incident of harm to self or others?*
- ***Severity*** *– How serious have previous incidents been?*
- ***Frequency*** *– How frequently do incidents of harm to self or others occur?*
- ***Pattern*** *– Is there a common pattern to the type of incident or the context in which it occurs?*
- ***Likelihood*** *– How likely is it that the event will recur?*

Risk assessment involves working with a service user to determine each of these aspects of risk. The assessment requires consideration of a wide variety of risk factors that will be of different significance for each individual and will vary in importance as his/her circumstances change.

Risk factors are not static and can be increased or decreased.

Risk factors relate to issues both internal and external to the client. There can be significant impact from external factors, for example: staff factors (attitudes; knowledge; training etc.); and organisational factors (such as openness of communication systems; models of staff support deployed etc.).

Risk Factors – A Risk Factor is “a personal characteristic or circumstance that is linked to a negative event that either causes or facilitates the event to occur” (DH, 2007a, 13).

The assessment of risk requires consideration of a wide variety of risk factors that will be of different significance for each individual and will vary in importance as his/her circumstances change. It also requires professionals to make a judgement on the basis of the information available at the time. This is always difficult but it is a professionally-informed decision. Consider:

- *What are the factors which contribute to the risk for the individual service user?*
- *Is the risk factor <u>stable</u> (e.g. history of child abuse) or <u>dynamic</u> (e.g. drug and alcohol use, current mental state)?*
- *Is the risk specific (i.e. directed at an individual person) or general?*
- *How can risk factors be modified or managed?*

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[30] *University Of Manchester (1996)*
[31] *DH (2007a)*
[32] *Royal College of Psychiatrists (1996)*

The National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (Appleby L, Shaw J, Kapur N, Windfuhr K *et al.,* 2006) found risk factors for suicide to include: acute episodes of illness; recent hospital discharge; social factors such as living alone; and clinical features such as substance misuse and non-fatal self-harm.

Types of Risk Assessment

Risk assessment seeks to identify the specific risks in an individual service user. There are three main methods to predict risk outcomes.

The **unstructured clinical approach** is based on interviews with the service user and his/her family/carers. As it does not follow a structured format there is the potential that important risk factors will be missed (DH, 2007a). Also, the element of subjectivity in the approach makes it susceptible to bias on the part of the clinician (Ryan, 2006).

The **actuarial approach** measures levels of risk according to factors that have been shown as statistically associated with increased risk amongst a large population of people. An overall score is calculated as a predictor of future risk over a specified time period.

Actuarial tools have several weaknesses. They are only applicable and suitable for use with service users who come from the population for whom the tool was developed and they emphasise risk prediction rather than management (DH, 2007a). Also, they tend not to be sufficiently sensitive to the idiosyncrasies of every individual service user they are used to assess (Ryan, 2006).

- *Actuarial tools should only inform clinical judgement*
- *They are not a substitute for clinical judgement but an aid to it*

The structured clinical judgement approach combines the use of actuarial tools or evidence-based risk factors, clinical judgement and information from service users and their families/carers to assess risk. This is thought to be the best approach for risk assessment (Morgan J.F., 2007; Higgins *et al.,* 2005).

Transforming Your Care

A Review of Health and Social Care in Northern Ireland

Transforming Your Care

A Review of Health and Social Care in Northern Ireland

December 2011

The Review Team would like to thank the Project Team:

Pamela McCreedy – Project Leader
Angela Hodkinson, Elaine Hunter, Seamus Carey – Project Managers
Ffiona Dunbar, Maria Higgins, Jonathan Houston – Project Support

1. INTRODUCTION

The task faced by the Review was both challenging and daunting. Health and Social Care is of interest to everyone in Northern Ireland and the team approached their task fully aware of the responsibility it had been given.

It was also aware that whilst it was important to look to best practice and examine data from outside the province the deliberations had, in the end, to make sense for Northern Ireland. Many drivers exist in this context: the importance of health and social care to the economic wellbeing of NI; the contribution staff make; the shadow of our recent history in NI, particularly in the mental well being of the citizenry; and the very powerful affinity the NI society has to the core NHS principles.

The team approached its task with that knowledge and these matters were reflected exhaustively in their deliberations. However, the overriding desire of the team was to describe and build a system of health and social care which would place the individual, family and community that use it at the heart of how things are done. That meant using evidence to explain why there needs to be change and concentrate on the outcomes that individuals could reasonably expect in a modern system of care and treatment.

The Review is therefore about change; not careless or haphazard change but planned change over a 5 year period that can and should improve care. The report may be contentious to some, but the Review team saw clearly that there are no neutral decisions as it looks to the future. It has taken the view that a managed and transparent change is better than unplanned, disorganised change.

Finally on behalf of the team I should like to thank the very many people, citizens, professionals and representatives of interest groups who gave freely of their time to help the Review. I should also like to extend thanks to the independent panel members for their honesty, challenge and contribution to the Review.

John Compton
Chair of the Review Team
December 2011

EXECUTIVE SUMMARY

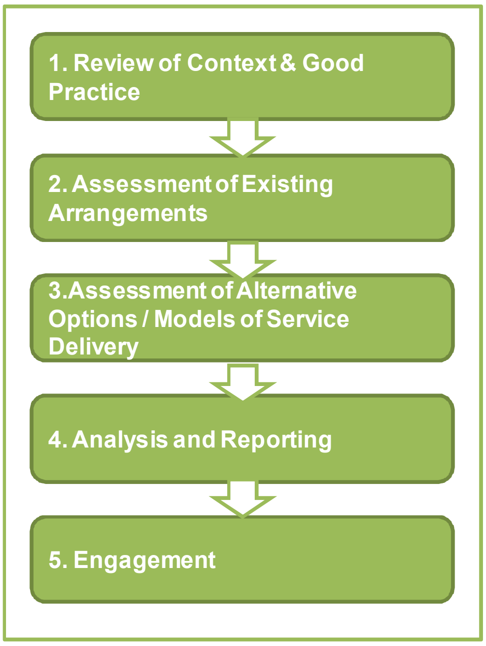
2. EXECUTIVE SUMMARY

In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, announced that a Review of the Provision of Health and Social Care (HSC) Services in Northern Ireland would be undertaken. The Review was to provide a strategic assessment across all aspects of health and social care services, examining the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and communities are being met. Crucially it was to bring forward recommendations for the future shape of services and provide an implementation plan. The Review team was not asked to bring forward proposals which reduced the budget published by the Northern Ireland Executive, but was asked to ensure that it was used to best effect.

The Minister judged that at a time of considerable flux within health and social care and the wider economy it was prudent not to disconnect the service from the Review process. Therefore, he appointed John Compton, Chief Executive of the Health and Social Care Board, to complete the task in an ex-officio capacity. However, the Minister did want a strong independent overview to the process, helping to shape and providing challenge to any proposals. Therefore he also appointed an independent panel comprising: Professor Chris Ham (Chief Executive of the King's Fund), Professor Deirdre Heenan (Provost and Dean of Academic Development at the Magee Campus), Dr Ian Rutter (General Practitioner), Mr Paul Simpson (retired senior civil servant), and Mr Mark Ennis (Executive Chair of SSE Ireland).

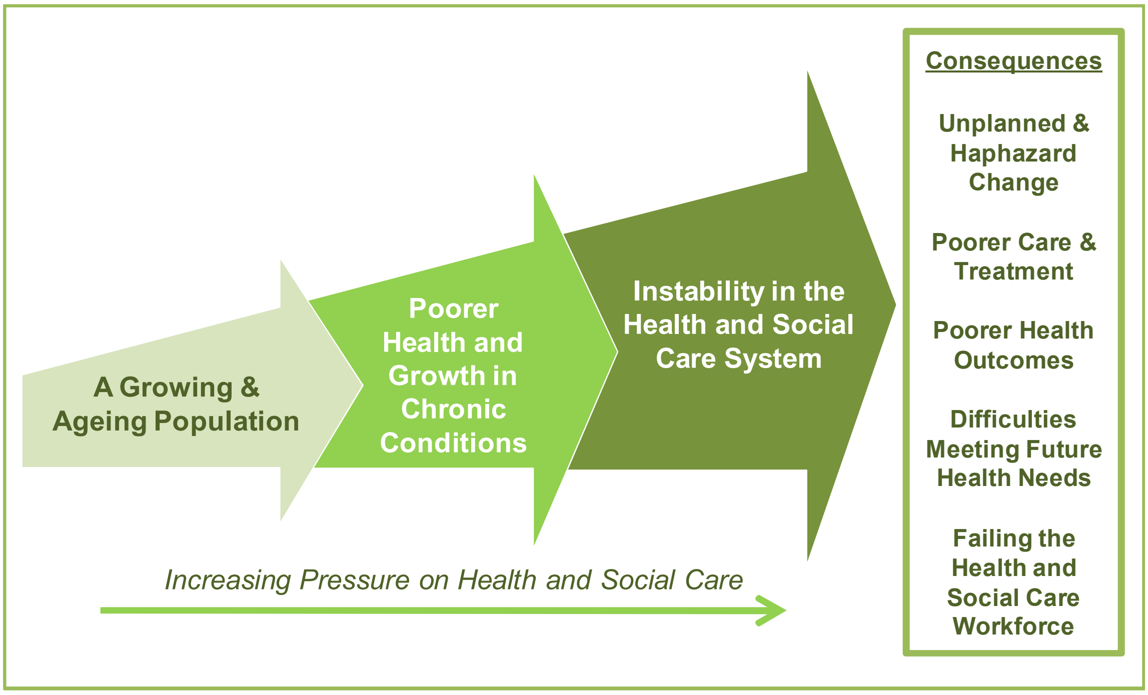
The Review was to complete by 30 November 2011. Within the timescale available, the Minister was keen to ensure maximum engagement with the public, clinical and professional leaders, health and social care organisations and stakeholders in the voluntary, community, private and independent sectors. In particular the Minister highlighted the importance of engaging with the health and social care workforce through the Partnership Forum. Following their appointment in August, the Review team designed its approach as shown below.

Figure 1: Overview of Approach



The Review concluded that there was an unassailable case for change. The figure below illustrates the core of the argument.

Figure 2: Future Model for Integrated Health and Social Care



Responding to these pressures, the Review identified eleven key reasons which support the need for change (summarised in the adjacent box) along with a model of health and social care which would drive the future shape and direction of the service.

Figure 3: Reasons for Change

To be better at preventing ill health

To provide patient-centred care

To manage increasing demand across all programmes of care

To tackle health inequalities

To deliver a high-quality, evidence-based service

To support our workforce in delivering the necessary change

In developing a new model, the Review engaged with over 3000 members of the public, clinicians, providers and interest groups. It also reviewed evidence to ensure that any changes required had at their heart better outcomes for patients and clients and their families.

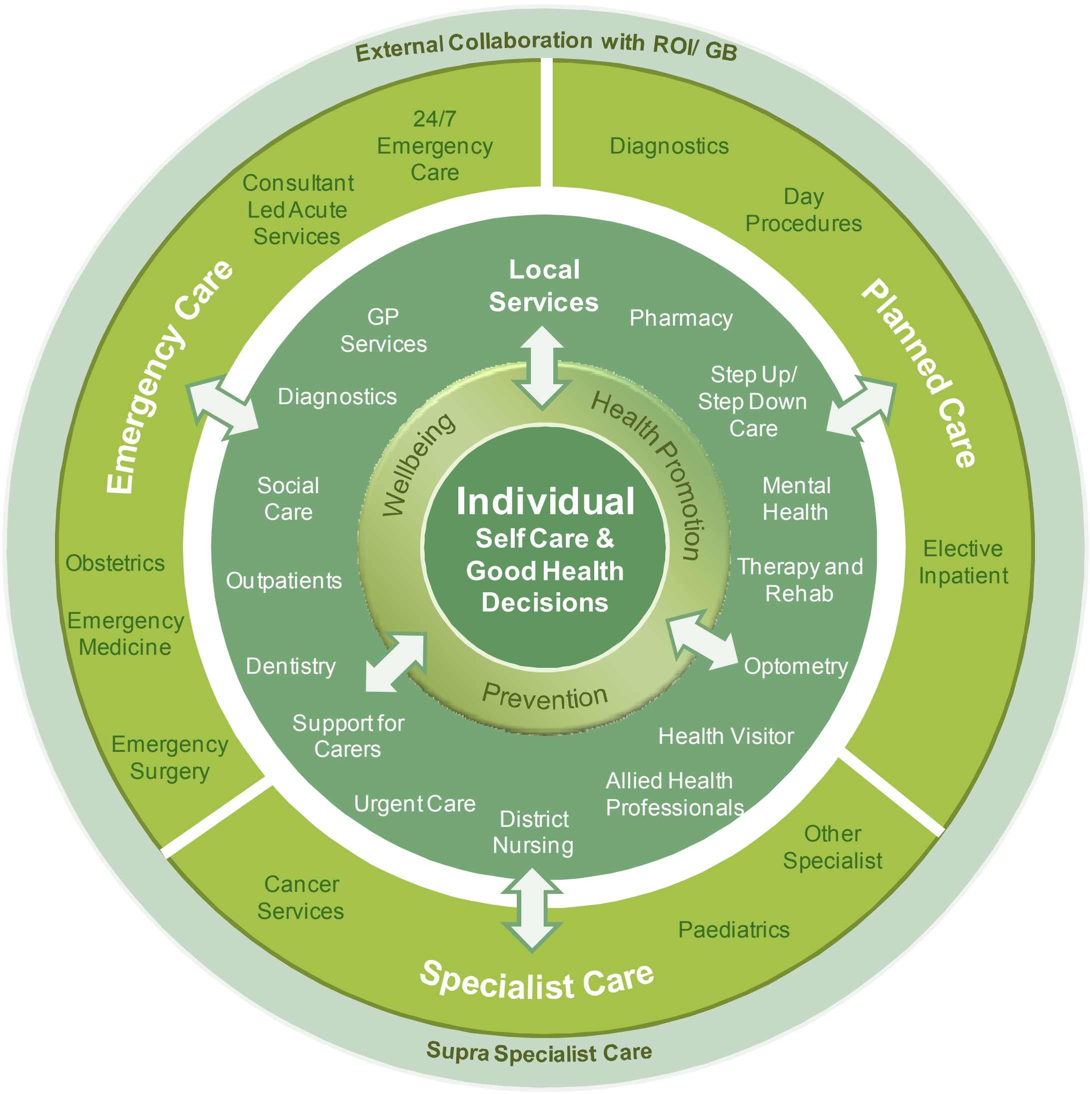
The Review was clear about the purpose of change namely, what changes would make the greatest difference to outcomes for patients, users and carers. In doing so the Review looked beyond the geographical boundaries of Northern Ireland.

The Review identified twelve major principles for change, which should underpin the shape of the future model proposed for health and social care.

1. Placing the individual at the centre of any model by promoting a better outcome for the service user, carer and their family.
2. Using outcomes and quality evidence to shape services.
3. Providing the right care in the right place at the right time.
4. Population-based planning of services.
5. A focus on prevention and tackling inequalities.
6. Integrated care – working together.
7. Promoting independence and personalisation of care.
8. Safeguarding the most vulnerable.
9. Ensuring sustainability of service provision.
10. Realising value for money.
11. Maximising the use of technology.
12. Incentivising innovation at a local level.

The model devised by the Review team is shown in the figure overleaf.

Figure 4: Future Model for Integrated Health and Social Care



Briefly described the model means:

- every individual will have the opportunity to make decisions that help maintain good health and wellbeing. Health and social care will provide the tools and support people need to do this;
- most services will be provided locally, for example diagnostics, outpatients and urgent care, and local services will be better joined up with specialist hospital services;
- services will regard home as the hub and be enabled to ensure people can

be cared for at home, including at the end of life;

- the professionals providing health and social care services will be required to work together in a much more integrated way to plan and deliver consistently high quality care for patients;
- where specialist hospital care is required it will be available, discharging patients into the care of local services as soon as their health and care needs permit; and
- some very specialist services needed by a small number of people will be provided on a planned basis in the ROI and other parts of the UK.

To help illustrate what this would mean, case studies were developed to explain the model. In essence they show it to be simpler to use, clearer about the key worker, and crucially providing an improved outcome for those who use the service.

Following on from this, the impact on ten major areas of care was examined:

Population Health and Wellbeing

Older People

People with Long-Term Conditions

People with a Physical Disability

Maternity and Child Health

Family and Child Care

People using Mental Health Services

People with a Learning Disability

Acute Care

Palliative and End of Life Care

The model was applied to these service areas and each has a series of recommendations. The full list of 99 proposals is provided Section 19 of the report.

The key themes in the recommendations are summarised below.

Quality and outcomes to be the determining factors in shaping services.

Prevention and enabling individual responsibility for health and wellbeing.

Care to be provided as close to home as practical.

Personalisation of care and more direct control, including financial control, over care for patients and carers.

Greater choice of service provision, particularly non-institutional services, using the independent sector, with consequent major changes in the residential sector.

New approach to pricing and regulation in the nursing home sector.

Development of a coherent 'Headstart' programme for 0-5 year old children, to include early years support for children with a disability.

A major review of inpatient paediatrics.

In GB a population of 1.8million might commonly have 4 acute hospitals. In NI there are 10. Following the Review, and over time, there are likely to be 5-7 major hospital networks.

Establishment of a clinical forum to ensure professionals are fully engaged in the implementation of the new model.

A changing role for general practice working in 17 Integrated Care Partnerships across Northern Ireland.

Recognising the valuable role the workforce will play in delivering the outcomes.

Confirming the closure of long-stay institutions in learning disability and mental health with more impetus into developing community services for these groups.

Population planning and local commissioning to be the central approach for organising services and delivering change.

Shifting resource from hospitals to enable investment in community health and social care services.

Modernising technological infrastructure and support for the system.

Following from this, the Review considered and presented the methodology to make the change over a 5 year period.

This initially describes a financial remodelling of how money is to be spent indicating a shift of £83million from current hospital spend and its reinvestment into primary, community and social care services. It goes on to describe as integral the need for transitional funding of £25million in the first year; £25million in the second year; and £20 million in the third year enable the new model of service to be implemented

In conclusion, the Review reiterates that change is not an option. It re-affirms there are no neutral decisions and there is a compelling need to make change. The choice is stark: managed change or unplanned, haphazard change. The Review team commends its report to the Minister.

BACKGROUND TO THE REVIEW

3. BACKGROUND TO THE REVIEW

This part of the report explains the nature and purpose of the Review. It sets out who was involved and why, then describes the objectives set for the Review, the scope of the task and the approach taken to complete it.

In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, announced that a Review of the Provision of Health and Social Care Services in Northern Ireland would be undertaken, asking how it should change and requesting an implementation plan to manage the change. The full terms of reference is included at Appendix 1.

The key objectives of the Review were to:

- undertake a strategic assessment across all aspects of health and social care services;
- undertake appropriate consultation and engagement on the way ahead;
- make recommendations to the Minister on the future configuration and delivery of services; and
- set out a specific implementation plan for the changes that need to be made in health and social care.

The Review was not to be fully independent and Mr John Compton, Chief Executive of the Health and Social Care Board, was invited to lead the process. The Minister judged that at a time of considerable flux within health and social care and the wider economy it was prudent not to disconnect the service from the Review process. However he did want a strong independent overview to the process providing challenge to any proposals. Accordingly he appointed five independent panel members:

- Professor Chris Ham (Chief Executive of the King’s Fund);
- Professor Deirdre Heenan (Provost and Dean of Academic Development at the Magee Campus, University of Ulster);
- Dr Ian Rutter (General Practitioner);
- Paul Simpson (retired senior civil servant); and
- Mark Ennis (Executive Chair of SSE Ireland).

The appointments reflected the desire to ensure proper scrutiny was applied to the process.

The Minister's over-riding concern is driving up the quality of care for clients and patients, improving outcomes and enhancing the patient experience. In initiating the Review, the Minister explained that he wanted it to ensure that health and social services are focused, shaped and equipped to improve the quality of care and outcomes for the population, and to provide value for money in financially challenging times. He wants to see a shift in care currently carried out in hospitals into the community with patients being treated in the right place, at the right time and by the right people.

The Minister also made it clear that in deciding to have a Review no criticism was implied about staff working in the current system. Quite the reverse, he concluded that the current model was unsustainable going forward and that he wanted to see a service which was developing not declining, a service which built upon the commitment and expertise of those working in health and social care.

OBJECTIVES

Accordingly the objectives of the Review were to:

- provide a strategic independent assessment across all aspects of health and social care services of the present quality and accessibility of services and the extent to which the needs of patients, clients, carers and communities are being met by existing arrangements in terms of outcomes, accessibility, safety, standards, quality of services and value for money;
- undertake appropriate consultation and engagement on the way ahead with the public, political representatives through the Assembly Health Committee, HSC organisations, clinical and professional leaders within the system, staff representatives through the Partnership Forum, and stakeholders in the voluntary, community, independent and private sectors;
- make recommendations to the Minister on the future configuration and delivery of services in hospital, primary care, community and other settings; and
- set out a specific implementation plan for the changes that need to be made in the HSC, including proposals in relation to major sites and specialities.

SCOPE

In delivering these objectives the Review was to take account of the following:

- extant policy and strategies approved by the Minister, in particular the aims of improving public health, the prevention of illness and of improving outcomes for patients and clients;
- statutory duties on the HSC to improve the quality of services provided, to improve the health and social wellbeing of the population and to reduce health inequalities; and

- primary care, community care, social care and hospital services.

Certain areas were deemed to be outside the scope of the Review:

- the new organisational structures created as a result of the RPA process within Health and Social Care; and
- the Review should work within the constraints of the current level of funding for the coming period. The current Performance and Efficiency Unit (PEDU) review of the scope to make savings in the health and social care sector is separate from the HSC Review and the development of an implementation plan to deliver savings will continue in parallel with this Review.

However, the Minister indicated that if the Review felt it should comment on any of these areas, it should not feel constrained in doing so.

Public health and social wellbeing is at the heart of health and social care. The Review team is aware that there is a separate piece of work being undertaken by the Department of Health Social Services and Public Safety (DHSSPS) and the Public Health Agency (PHA) to create a new public health strategy, as set by the Executive and Minister. Notwithstanding this, the Review considered it appropriate to look at public health and wellbeing in its work.

The Terms of Reference had asked the Review to make recommendation on the future configuration of hospital, primary care, community care and other settings. During the course of the Review, the team proposed to the Minister that it was better to describe a framework for the future of care rather than including specific proposals in relation to sites and specialties. The rationale for this presented to the Minister was the critical need to enable professionals and communities to devise local solutions within a very clear framework and criteria for success. The Minister agreed to this approach to applying the Terms of Reference.

APPROACH

Giving consideration to the Terms of Reference set by the Minister (Appendix 1), a project plan was developed. The approach to the Review involved five key strands of activity, as shown in the figure below.

Figure 5: Overview of Approach

In particular the Minister highlighted the importance of engagement with stakeholders and a comprehensive engagement plan was developed. The objective was to enable informed debate and to present information to the public.

This resulted in more than 3,000 people engaging directly with the Review, and many more being exposed to debate on the key issues affecting health and social care provision through media coverage of the Review on TV, radio, online and by the printed media.

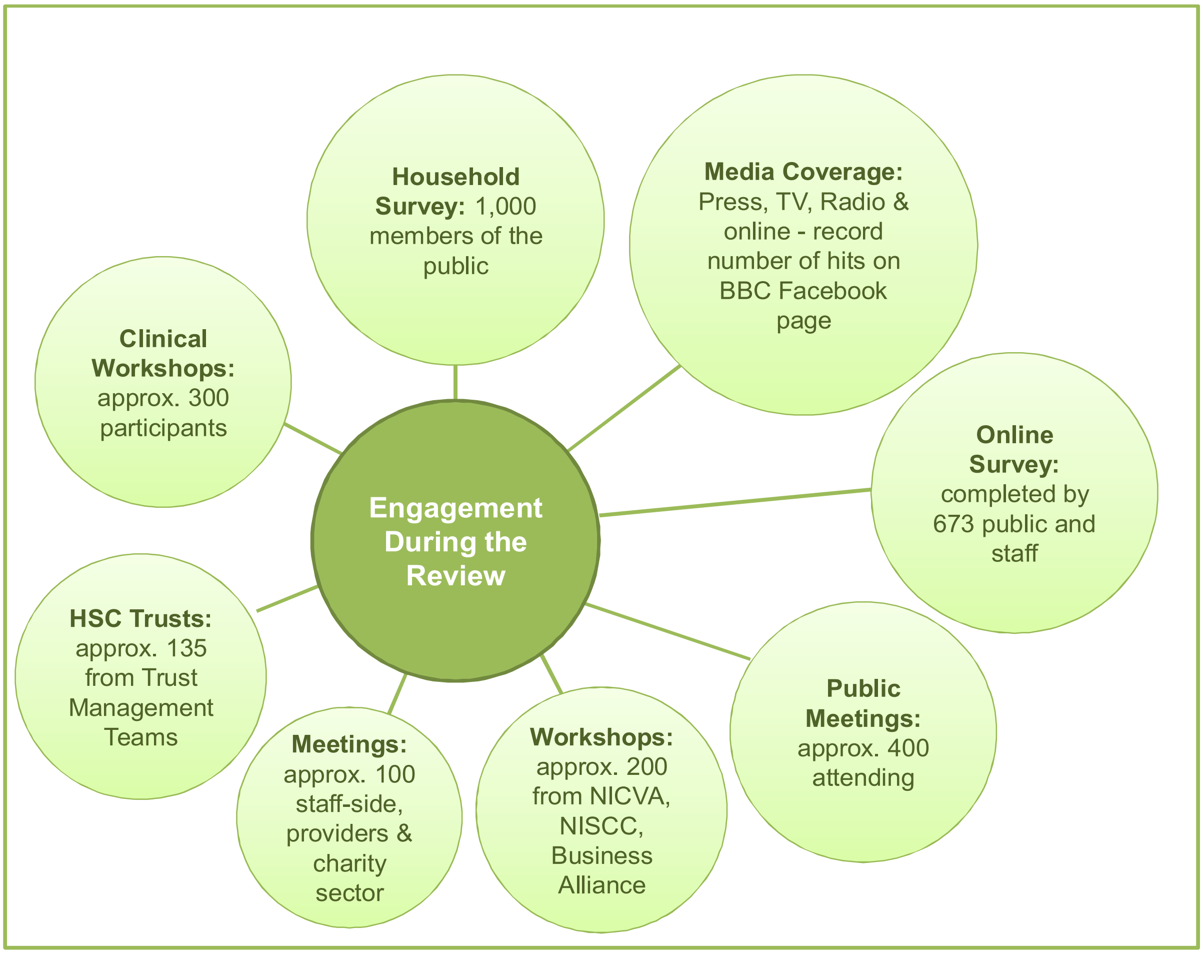
The engagement plan for the Review involved:

- An **online survey** completed by 673 individuals, of which 91% worked for an organisation providing health and social care (see Appendix 2 for a summary of results);
- Engagement with local **media** to promote press, television and radio features on the Review to raise public awareness of the issues involved and stimulate debate. The BBC e-panel received 641 views on aspects of the health and social care system;
- A **household survey** (completed by IpsosMORI) of 1,009 adults aged over 16, selected to be representative of the Northern Ireland population in terms of gender, age, social class and geography (see Appendix 3 for a summary of results);
- Six **public meetings** were held in Londonderry, Omagh, Ballymena, Belfast, Lisburn and Armagh. These were facilitated by the Patient and Client Council (PCC). (See Appendix 4 for details of the questions raised during the meetings);
- A series of **workshops with clinicians** from HSC Trusts, General Practitioners (GPs) and HSC managers to discuss current provision and future needs of specific service areas (see Appendix 5 for details of attendees and areas covered at each workshop);
- A series of **sector workshops**, with representatives from the voluntary and community sector (facilitated by the Northern Ireland Council for Voluntary Action), registered social care workforce (facilitated by the Northern Ireland Social Care Council), and private sector (facilitated by the Business Alliance) (see Appendix 6 for details of attendees);
- **Small group meetings** with a range of stakeholders including HSC arm's length bodies, trade unions (via the Partnership Forum), professional and regulatory bodies, voluntary and community sector organisations, political representatives, independent care providers, and colleagues within health and social care in other parts of the UK and the Republic of Ireland (see Appendix 7 for a full list of the stakeholders engaged with);
- Submission of **written responses** to the Review (see Appendix 8 for a list of written submissions); and
- Meetings with **HSC Trusts'** Senior Management Teams.

A Glossary is included in Appendix 9.

An overview of the stakeholders engaged with throughout the review is shown in the figure below.

Figure 6: Engagement during the Review



STRUCTURE OF REPORT

This report begins by outlining the reasons why our health and social care system needs to change, based upon the evidence that the Review has collected during the Review process. It then sets out the principles the Review considers should underpin this change.

A new model of care is described and contrasted with the existing model of care using case studies. The report details the impact of the new model across 10 areas of care.

- Population Health and Wellbeing
- Older People
- People with Long-Term Conditions
- People with a Physical Disability
- Maternity and Child Health
- Family and Child Care
- People using Mental Health Services
- People with a Learning Disability
- Acute Care
- Palliative and End of Life Care

It moves on to describe the implications for the health and social care system. This takes account of integrated working across health and social care, workforce issues and enhanced use of technology. Finally, an implementation roadmap outlines how this change will be implemented and delivered over a five year period.

THE CASE FOR CHANGE

4. THE CASE FOR CHANGE

Making the case for change is at the centre of this Review. It is not a critique of the current provision but rather a fundamental recognition that the existing model of care is not fit for purpose as one looks to the future.

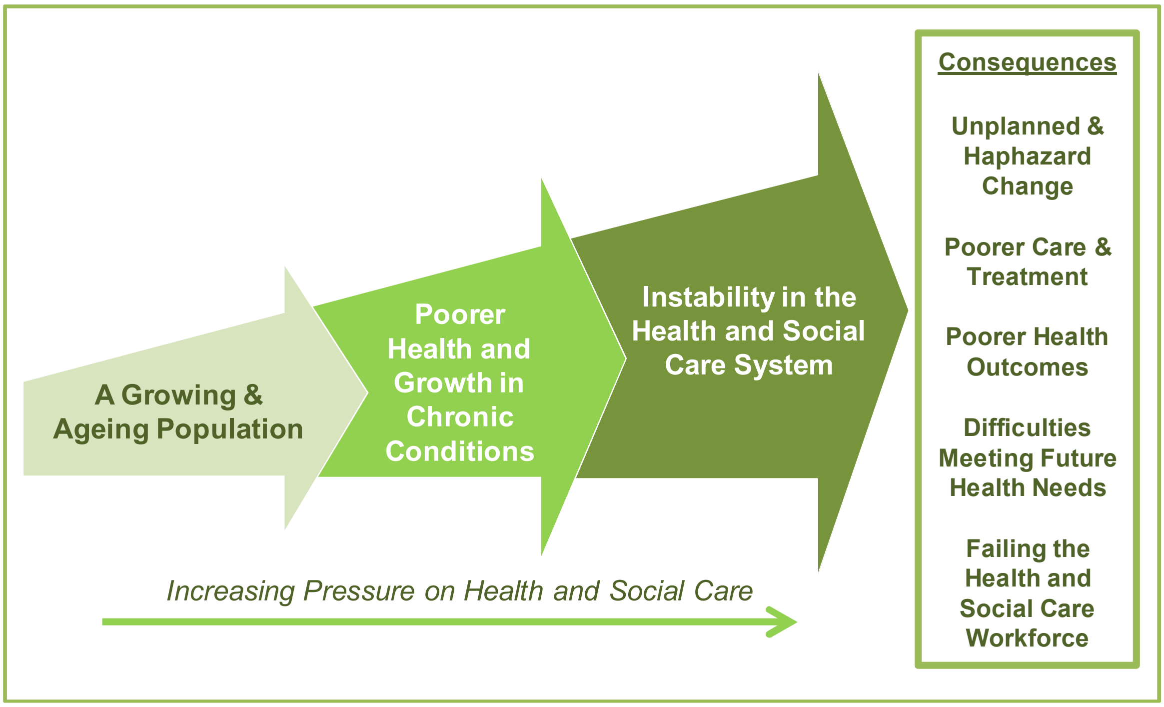
The figure below illustrates the pressures currently facing the system and the potential consequences of doing nothing.

There are no neutral decisions in this regard. If we do nothing, the system will not be able, in its current form, to continue to deliver a high quality service that will meet the needs of the population.

The fundamental changes to our population in terms of age and need are clear. We must design a model which acknowledges this and is based on the needs of this changing population rather than its historic configuration. If we do not plan to change the system we will continue to be faced with unplanned changes that will not be in the best interest of the patient. This will result in a prioritisation of who gets care and a reduction in access to many important services for a large proportion of our population.

We have a highly skilled and dedicated workforce who are being failed by a system which is no longer fit for purpose. This has resulted in staff working within a system which does not deliver the quality

Figure 7: Pressure facing the system



of service to which they strive.

The Review also acknowledges that throughout this process everyone spoken to has asked the Review to promote the **'making it better'** principle and has affirmed that it **can be better**.

WHY DO WE NEED CHANGE?

Despite the many positive aspects of the current model of health and social care, compelling factors reflect the need for change:

- a growing and ageing population;
- increased prevalence of long term conditions;
- increased demand and over reliance on hospital beds;
- clinical workforce supply difficulties which have put pressure on service resilience; and
- the need for greater productivity and value for money.

Against this backdrop, the Review identified 11 keys reasons supporting change. In a new model, how these are responded to will be key to shaping the decisions for the future configuration of specific services.

Reason 1 – The need to be better at preventing ill health

Reason 2 - The importance of patient centred care

Reason 3 – Increasing demand in all programmes of care

Reason 4 – Current inequalities in the health of the population

Reason 5 – Giving our children the best start in life

Reason 6 – Sustainability and quality of hospital services

Reason 7 – The need to deliver a high quality service based on evidence

Reason 8 – The need to meet the expectations of the people of NI

Reason 9 – Making best use of resources available

Reason 10 – Maximising the potential of technology

Reason 11 – Supporting our workforce

Reason 1 – The need to be better at preventing ill health

The population of Northern Ireland can become a healthier society through prevention of ill health and the promotion of health and wellbeing. People wish to be responsible in taking decisions to support better personal health. In this regard it is important to communicate evidence to enable people to choose a lifestyle where healthier outcomes can happen.

Smoking - In Northern Ireland around 340,000 people aged 16 and over smoke. Smoking contributes to not only many cancers, heart disease, bronchitis and asthma, but other illnesses including stroke, which causes around 2,400 deaths per year. These deaths are avoidable. Around 86% of lung cancer deaths in the UK are caused by tobacco smoking and, in addition, the International Agency for Research on Cancer states that tobacco smoking can also cause cancers of the following sites: upper aero-digestive tract (oral cavity, nasal cavity, nasal sinuses, pharynx, larynx and oesophagus), pancreas, stomach, liver, bladder, kidney, cervix, bowel, ovary (mucinous) and myeloid leukaemia. Overall tobacco smoking is estimated to be responsible for more than a quarter of cancer deaths in the UK, that is around 43,000 deaths in 2007.[1] Half of all smokers eventually die from cancer, or other smoking-related illnesses.[2] A quarter of smokers die in middle age, between 35 and 69.

Obesity – in the most recent survey of Northern Ireland's health and wellbeing, 59% of all adults measured were either overweight (35%) or obese (24%)[3]. The impact of this increase has resulted in complications in pregnancy, increase in type 2 diabetes, coronary heart disease, stroke and a number of cancers. It is also known that obese children are more likely to become obese adults. We face a significant challenge in halting the rise in the proportion of the population who are overweight or obese.

Alcohol and drug misuse cost our society hundreds of millions of pounds every year. However, this financial burden can never truly describe the full impact that substance misuse has on many vulnerable individuals including children and young people, families, and communities in Northern Ireland.

Not to act on these facts will condemn the population and the system to failure.

Reason 2 – The importance of patient centred care

Evidence suggests that people are best cared for as close to home as possible. It is also what people have told us through the Omnibus survey - 81% of people

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[1] Cancer Research UK

[2] Mortality in relation to smoking: 50 years' observations on male British doctors, Doll et al, 2004

[3] NI Health and Social Wellbeing Survey 2005/06, DHSSPS

surveyed said that more health and social care services should be delivered in GP surgeries, local centres and in people's homes.

Inpatient hospital care will always be an important part of how care is provided, but it is only best for a patient with acute medical needs. There are many benefits associated with delivering care within people's homes and in their local communities. Providing patient choice about where they are cared for is critical. Integrated teams working together in the community provide this opportunity and would deliver better quality.

A central theme of 'Quality 2020 - a 10 year Strategy to protect and improve Quality in Health and Social Care in NI[4]' is to ensure the patient and client receives the right care, at the right time in the right place, with the best outcome. The 'High Quality Care for all NHS: Next Stage Review Final Report' also identified the need to bring care closer to home, to ultimately deliver better care for patients. This was also a central focus of the 2006 White Paper 'Our health, our care, our say', and it has become clear that a health and care economy-wide approach is needed for an effective and sustainable model of care that is more convenient for patients.

A bed utilisation audit of 2011 showed that, on the day in question, up to 42% of the inpatients reviewed should not have been in hospital.[5] Furthermore in 2009/10, 28% of the deaths of people admitted from a nursing home, occurred within 2 days of admission into hospital[6].

The care closer to home approach is not about challenging hospital provision, but about defining the role of hospitals in meeting the needs of the population. The real prize is to provide community alternatives which improve patient/ client care and experience. The evidence again points to a need for change.

Reason 3 – Increasing Demand

The evidence of increasing demand is compelling whether from a population or disease perspective.

Demography

Northern Ireland has a population of approximately 1.8m people. It has the fastest growing population in the UK and it continues to grow. The number of people over 75 years will increase by 40% by 2020. The population of over 85 year olds in NI will increase by 19.6% by 2014, and by 58% by 2020 over the 2009 figure (see the figure below).

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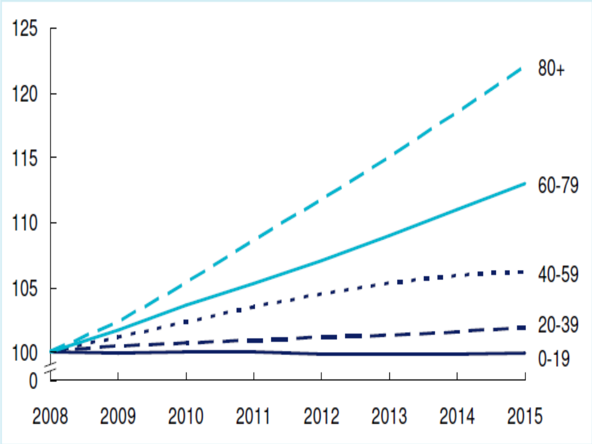
[4] Quality 2020, A 10-year Strategy to Protect and Improve Quality in Health and Social Care in NI, DHSSPS

[5] Bed Utilisation Audit of 8 acute hospitals in NI, April – September 2011

[6] HIB, DHSSPS, 2011

Figure 8: Northern Ireland Population Projections



Source: NI Neighbourhood Information Service

Longer life expectancy is something to celebrate. Many older people enjoy good health and continue to make a significant contribution to society as carers, learners, workers and volunteers. In particular, older people are identified as important social resources in rural areas, providing informal care and supporting the cultural and social lives of their communities.[7] The health and social care system has a role in enabling older people to live as full and healthy a life as possible and caring for the most vulnerable when needs change.

There is however, a high level of dependence on institutional and hospital care for older people, and inconsistencies in the quality and range of services provided across Northern Ireland. Services are not currently meeting expectations and, since they account for a large proportion of health and social care expenditure, defining a new model to successfully meet the needs of older people is an overwhelming priority. Older people have said they want care, support and treatment in or close to home. Services must therefore continue to reform and modernise to respond to growing demand with an increased emphasis on personal, community based services.

Disease Prevalence

There are increasing numbers of people with chronic conditions such as hypertension, diabetes, obesity and asthma. The disease prevalence levels reported via the Quality Outcomes Framework (QOF) are summarised below[8].

- QOF reported prevalence for hypertension has increased year on year across all UK regions, with the rates reported in NI lowest of the 4 UK countries at 12.54%, showing an absence of managing this condition.
- Diabetes is an increasingly common condition. Prevalence in the UK is rising. NI prevalence is 4%.

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[7] Commission for Rural Communities (2008) The Personalisation of Social Care

[8] Source: PHA Health Intelligence Briefing on QOF 2009/10).

- QOF reported prevalence of Atrial Fibrillation is increasing year on year across the whole of the UK. In NI, rates have increased from 1.25% in 2006/07 to 1.33% in 2009/10, equating to an additional 1,500 patients with AF.
- Stroke/ Transient Ischaemic Attack (TIA) reported prevalence has increased yearly across the UK. In NI prevalence has increased from 1.37% in 2004/05 to 1.71% in 2009/10, representing over 6,400 additional patients.
- NI has the lowest QOF reported prevalence of asthma at 5.86 per 1,000 patients compared to the rest of the UK. Notwithstanding this prevalence has increased in the last 5 years.
- QOF reported prevalence of Chronic Obstructive Pulmonary Disease has risen steadily since records began in 2004. The prevalence in NI was 1.63% for 2009/10.

All of this describes the unremitting increase in chronic conditions in NI. Individuals with long-term conditions very often have multiple conditions – around a quarter of those in the UK with a long-term condition have three or more conditions[9]. Our system often does not deal with multiple conditions in an integrated way, which for the individual can mean having to engage with multiple clinicians and services which are not well joined up. The consequent personal experience is often very frustrating.

Keeping Pace with Developments

Best practice in health and social care provision is developing all the time. There are new technologies, new care pathways, new partnerships, new drugs and new levels of regulation. Our population will expect access to these improvements. The need to understand demand patterns and work with providers in primary, community and secondary care to ensure more effective management of demand will be a central issue in the future.

It is estimated that the demand for services could grow by around 4% per year by 2015[10]. Examples of the potential consequences without change are listed below:[11]

- 23,000 extra hospital admissions;
- 48,000 extra outpatient appointments;
- 8,000 extra nursing home weeks; and
- 40,000 extra 999 ambulance responses.

If we were to continue to deliver services in the way that we do today, we would

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[9] NHS Scotland (2005) National Framework for Service Change. Long Term Conditions Action Team Report.

[10] Reshaping the System (2010) McKinsey

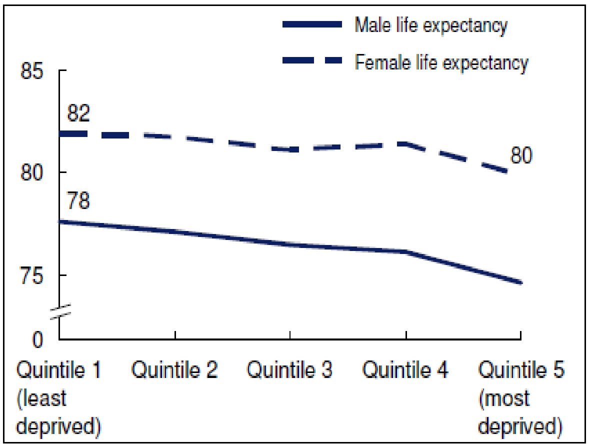
[11] NI Confederation for Health and Social Care: Areas for Action for Health and Social Care in Northern Ireland 2011-2015

quite simply fail the popula#tion as the system struggled to cope. The quality of outcome for the individual and their family would inevitably decline.

Reason 4 – Current inequalities in the health of the population

In Northern Ireland life expectancy increased between 2002-2009 from 74.5 years to 76.1 years for men and from 79.6 years to 81.1 years for women. However, against this positive overall trend, inequalities are evident when mortality rates are compared across geographical areas. People who live in the 20% most deprived areas are 40% more likely to die before 75 than the NI average. Life expectancy against deprivation level is shown in the figure below.

Figure 9: Life Expectancy and Deprivation in Northern Ireland



Source – NISRA: Independent Review of Health and Social Services Care in Northern Ireland

For example, along the bus route from Donegall Square to Finaghy Road South, there is an increase in life expectancy of 9 years, as shown in the figure overleaf. Similar patterns exist in rural areas.

Across NI there is also variability in the health of the public. Belfast had the highest rate of births to mothers aged 19 or under in 2004 (25.9 per 1000) compared to other Local Government Districts in Northern Ireland. Indeed there is considerable variation even within the Greater Belfast area. In 2009, of the 349 births to teenage mothers in Belfast Trust 37% were in west Belfast, 28% in north Belfast, 15% in east Belfast, 11% in south Belfast and 8% in Castlereagh.

The most deprived group of the population has an admission rate to Neonatal Intensive Care of 19% above the regional average for Northern Ireland.

Some of the most common characteristics associated with being born into poverty rather than more affluent circumstances are highlighted below:[12]

- lower life expectancy;
- 23% higher rates of emergency admission to hospital;
- 66% higher rates of respiratory mortality;
- 65% higher rates of lung cancer;
- 73% higher rates of suicide;

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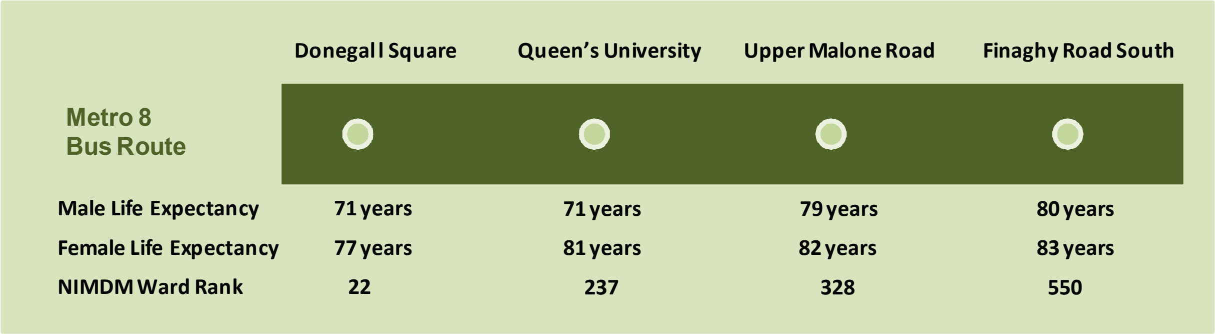
[12] NISRA Inequalities Monitoring Report 2010

Figure 10: Life Expectancy, Donegall Square to Finaghy Road South



	Donegall Square	Queen's University	Upper Malone Road	Finaghy Road South
Metro 8 Bus Route	●	●	●	●
Male Life Expectancy	71 years	71 years	79 years	80 years
Female Life Expectancy	77 years	81 years	82 years	83 years
NIMDM Ward Rank	22	237	328	550

- self harm admissions at twice the Northern Ireland average;
- 50% higher rates of smoking related deaths; and
- 120% higher rates of alcohol related deaths.

Health and Social Care alone cannot fully address the inequalities issue. If we are to deliver effectively on improving the health of our population, we need meaningful partnerships and a common agenda to be developed with local government, housing, education, the environment, and our local communities. Making joined up government more tangible is essential. However, it is incumbent on health and social care to look to change and how it can contribute to better outcomes for the citizen.

Reason 5 – Giving our children the best start in life

The 2007 Unicef review of Children and Wellbeing ranked the UK 21 out of 21 developed countries.[13]

There is growing evidence that a child's early years of development have a significant impact on their health in later life.

The Californian Adverse Childhood Experience study (1998) linked childhood maltreatment and later-life health and well-being.[14] The consequences for society include: adult mental health

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[13] UNICEF (2007) *Child Poverty in Perspective: An overview of child well-being in rich countries*, Innocenti Report Card 7, UNICEF Innocenti Research Centre, Florence.

[14] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS, 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med.;14(4):245-58

problems, poor physical health and high health expenditure.

Early Intervention: Good Parents, Great Kids, Better Citizens report argues 1 in 8 children are currently growing up in an environment of unacceptable risk.[15] Neglect and abuse in early years creates emotionally, mentally and physically damaged adults thus perpetuating problems into the next generation. An early intervention approach counteracts this outcome. The study identified the need to respond differently to the childhood years through structured early intervention.

The review of research found that targeted, intensive programmes such as the Family Nurse Partnership can help improve outcomes for vulnerable children and families, for example: reduced child abuse and neglect, reduced crime, reduced drug and alcohol abuse, and reduced school grade repetition.[16] These result in reduced victims' costs and increased earnings, highlighting a ratio of return of £3 for every £1 invested.

The Review noted that it has been acknowledged by several independent authors that the level of investment in Children and Families Services in NI is approximately 30% less than in other parts of the United Kingdom. It had been predicted that the number of births in Northern Ireland was to decline but in fact birth rates have remained broadly static. This overall position has led to an increased demand, particularly for family support services.

Given this evidence, failure to do better will prevent any opportunities to break the cycle of poor life outcomes for many in our society.

Reason 6 – Sustainability and quality of hospital services

Given the increasing and changing nature of the population, changing practices in medicine and increased expectations of the public, the gap between demand for services and current provision is widening. If we were to continue to provide services as they currently are, it would lead to unplanned and unmanaged collapse of key services. This would ultimately lead to detrimental impact on patients and clients. The choice is stark: it is not principally about money but about sustainability and clinical evidence. The conclusion is clear: plan and manage the transition or accept a more haphazard set of changes. In this regard there are no neutral decisions.

Historically, in Northern Ireland, there has been an over-reliance on hospital services. Given its rurality and based on recognised norms, a population the size of NI is likely to have between 5 and 7 major acute hospital networks, each

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[15] Good Parents, Great Kids, Better Citizens. Graham Allen MP and Rt Hon Iain Duncan Smith MP, Centre for Social Justice and Smith Institute 2008

[16] The Family Nurse Partnership Programme, Department of Health, http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128402.pdf

serving a population of some 250,000 to 350,000. Currently we have 10 hospitals for a population of 1.8million, in other words one per 180,000. The rurality of Northern Ireland has historically influenced the number of hospitals provided, and this must also be taken into consideration when developing a new model of care. There is however evidence to show that whilst important in a Northern Ireland context that travel per se does not create worse outcomes. For example the Rural Trauma Outcome Study in Scotland[17] showed that longer pre-hospital travel times did not increase mortality or length of stay.

The Royal College of Surgeons has stated that in a fragmented emergency surgical set-up a patient is four times more likely to have a poorer outcome than in a more organised model. It goes on to say that where the model is not organised, patients have prolonged hospital stays with significant cost implications, both physical and emotional to the patient and their family[18].

Trying to maintain acute services across the current number of sites has proved increasingly difficult. Scarce staffing and other resources are spread too thinly, making it impossible to ensure that permanent senior medical cover for emergencies is available at all sites, on a 24/7/365 basis (24 hours a day, seven days per week and 365 days per year). Currently, many sites rely on a combination of junior doctors and temporary locums to provide much of the cover required, particularly out of hours. This inevitably impacts on quality and cost. It also creates service fragility.

The Chairman of the British Medical Association’s Council in Northern Ireland stated that “the present situation is untenable: we cannot maintain top flight A&Es in every town. Reconfiguration... is currently happening by crisis rather than by taking difficult decisions”. He goes on to cite recent changes at the Mid-Ulster, Whiteabbey and Belfast City Hospital as examples of how reconfiguration is currently occurring by crisis rather than in a structured and planned approach.[19]

More people are admitted to our hospitals than in other areas of the UK and lengths of stay are significantly longer.

In simple terms, we know it is possible and better to provide services closer to home but we have continued to use hospitals. This is an unsustainable model which will deliver poorer outcomes for the patient in the future.

Reason 7 – The need to deliver a high quality service based on evidence

The responsibility of the HSC is to deliver a high quality, safe and accessible service

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[17] Scottish Urban v Rural Trauma Outcome Study, J Trauma September 2005

[18] The Higher Risk General Surgical Patient: Towards Improved Care for a Forgotten Group, Royal College of Surgeons of England and Department of Health

[19] News Letter, November 7 2011

to the population of Northern Ireland, with good outcomes. Currently there are indications that there is room for improvement in how things are done.

There are increasing numbers of people with chronic conditions such as hypertension, diabetes, obesity and asthma. Yet evidence suggests lower than appropriate access to general practice is achieved.

Although improving, daycase rates are lower when compared to England at 64.7% compared to the England average of 75.5%.

The number of registered suicides rose from 146 in 2005 to 313 in 2010. The rates per 100,000 of the population vary greatly across the region with a rate of 24.9 in the most deprived area compared to 7.6 in the least deprived area.

Treatment for cancer has been revolutionised over the past decade with survival rates improving across a range of cancers, but we still fall behind European survival rates in a number of cancers, so further work needs to be done. A study[20] funded by Cancer Research UK and the Department of Health, England was carried out by researchers from a number of institutions in Australia, Canada, Denmark, Norway and the UK that were the focus of the study. Survival rates were found to be “persistently lower” in Denmark, England, Northern Ireland and Wales.

In obstetric services, 55.6% of deliveries are normal, compared with 61.2% in England and 61% in ROI. Our caesarean section rate is high at 30.2% compared to 24.1% in England and 25% in ROI.

Investment in Mental Health, Learning Disability and Children and Family Services in NI is up to 30% less than in other parts of the UK because our model over consumes resource in hospital provision.

At March 2010 there were 2,606 looked after children in Northern Ireland, up by 6% (143) from 2009 (2,463). 11% (about 270) of these children were in residential care, where the outcomes are likely to be very poor, and 65% were foster care placements.[21] The recruitment of foster carers to meet rising demand continues to be a challenge to ensure choice and the matching of carer skill to the needs of the child.

Every year in Northern Ireland around 3,000 people suffer a stroke. Stroke is the third biggest killer and the leading cause of severe disability in Northern Ireland. Up to 40 per cent of strokes are preventable.[22]

The Royal College of Physicians, National Sentinel Audit 2010, found NI had a higher length of stay of 21.3 days (to

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[20] The study was published in the peer-reviewed medical journal The Lancet.

[21] Children Order Statistical Tables for NI 2009/10

[22] National Stroke Association 2005

discharge or death) compared to the National average of 19.5 days.[23]

Looking at general Surgery, the chance of a patient dying in a UK hospital is 10% higher if he or she is admitted at the weekend rather than during the week, where the service is not well organised. Provision of services, particularly of theatre access, critical care and interventional radiology, is often incomplete, and the correct location of patients after surgery is often not given sufficient priority. Furthermore, the clinical response for patients who deteriorate is often poorly thought through and, at times, ad hoc[24].

Dr Foster, a UK provider of comparative health and social care information, also reported that it found a worrying 10% spike in deaths at weekends compared with weekdays across 147 hospital trusts.[25] Too often our services do not respond to 7 day a week working.

PCI (Percutaneous Coronary Intervention) is a treatment to reduce or eliminate the symptoms of coronary artery disease including angina, dyspnea and congestive heart failure. A pilot carried out by the Belfast HSC Trust (Feb10 – Mar11) showed low mortality rates associated with PCI that were largely predictable and could be improved if PCI was better organised.

While significant improvements have been secured, NI continues to spend significantly more per head on prescription medicines than the rest of the UK at £232 per head of population, compared to Wales £194, Scotland £187 and England £165 (2009/10).

All this has informed the Review that the current model does not provide as high quality care as it could.

Reason 8 – The need to meet the expectations of the people of NI

Whilst the Review acknowledges it is difficult methodologically to get a full consensus on a population view, there are however factors which need taken into account.

A structured Omnibus survey to inform the Review was conducted in October 2011 in which 1009 people were surveyed from across Northern Ireland. This was supplemented by the online public survey. The online survey was completed by 673 persons, 91% of whom work for an organisation providing HSC services.

The high level results of the surveys are highlighted within this section with more detail throughout the body of this report and within Appendices 2 and 3.

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[23] RCP National Sentinel Clinical Audit of Stroke 2010

[24] Aylin P, Yunus A, Bottle A *et al*. Weekend mortality for emergency admissions. A large,multicentre study. Qual Saf Health Care 2010; 19: 213–217

[25] Dr Foster – Hospital patients ‘more likely to die at weekends’, November 2011

There were positive comments about the existing service, 22.6% of the people interviewed in the omnibus survey stated that they were very satisfied with health and social care provision in NI and 54.8% were fairly satisfied.

However, the Omnibus survey results went on to highlight dissatisfaction with:

- accessibility of services;
- the quality of services to older people; and
- the quality of services for people with mental health problems and learning disabilities.

A need for improvement was identified across each of these areas.

Access

- In regard to GP services: 65% felt that improvement is required including 23% who stated that a lot of improvement is required (22% in the online survey).
- Looking at assessment for home nursing or residential care: 79% felt that some improvement is required (including 21% who felt that a lot of improvement is required). This was supported by the online survey findings where 86% felt improvement is required (including 26% who felt that a lot of improvement was required).
- Appointment with a hospital consultant: 82% (and 91% in the online survey) felt some improvement is required, including 36% (30% in the online survey) who felt that a lot of improvement was required.
- Non emergency operations: 88% (91% in the online survey) felt some improvement was required including 36% (and 34% online) who felt that a lot of improvement is required.
- Time waiting in Accident and Emergency (A&E): 91% (96% online) felt improvement was needed, including 56% (and 47% online) who felt a lot of improvement was required.
- Access to Mental Health Services: 93% of people (online survey) stated that improvement was required to the availability of mental health services (43% stated that a lot of improvement was required).

Quality of Care for Specific Groups

- Older People: 89% (98% online) felt that improvement is required in the quality of care for older people, including 35% (35% online) who felt a lot of improvement is required.
- People with a Mental Health problem: 93% (88% online) felt improvement is required including 43% (28% online) who felt that a lot of improvement is required.
- People with learning disability: 70% (91% online) felt that improvement is required, including 30% (32% online) who felt a lot of improvement is required.

The online survey also highlighted the following:

- Quality of hospital services: this was not highlighted as an issue within the omnibus survey, but the online survey results showed that 92% felt there was some improvement required, with 18% feeling a lot of improvement is required; and
- Support for Carers: 97% of the online survey stated that improvement is required, including 45% who felt a lot of improvement is needed.

Further reinforcement of these results is expressed in the Patient and Client Council Priorities for HSC in Northern Ireland, November 2011. Some of the key priorities identified were:

- hospital care;
- care of the elderly (including domiciliary and community care);
- waiting times;
- cancer services;
- mental health and learning disability;
- health and social care staffing levels;
- access to GPs and primary care;
- children's services;
- reducing the costs of administration and management; and
- quality of care.

This evidence indicates strongly that the current system of health and social care is not meeting citizens' expectations.

Reason 9 – Making best use of resources available

This review is not about money per se and any discussion on resources produces strong views. It is, however, entirely valid to look at how we could use resources and the consequent productivity. In that regard it is difficult not to conclude that, with the overall level of resources available, we have the ability to provide a better service. The budget cycle has indicated annual expenditure of £4.65billion by the end of this Assembly period (2014/5). The Review was not asked to reduce this figure but knows that with annual pressure of 4% from residual demand and changing population,[26] change is non-negotiable. The challenge presented to the Review is simply how best to spend the resource to achieve maximum benefits.

Best Use of Estate: we currently have 10 acute hospitals, 5 local hospitals and 30 community hospital facilities, with 4,361 beds in acute and local hospitals, and 1,924 community beds. In addition there are 60 statutory residential and nursing homes for older people, 39 residential homes for children, as well as a range of daycare centres and health centres. There is an over reliance on buildings to

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[26] Reshaping the System (2010) McKinsey

provide care rather than support its delivery.

Any future models of care will have to take into consideration the best use of the estate that is currently available. It will not however concentrate on the preservation of the existing building stock but rather present a new service model which delivers care on a 24/7/365 basis.

Best Use of Staff: the HSC currently employs 78,000 people either full-time or part-time, which equates to 53,209[27] whole time equivalents across all specialties comprising:

- 33% nursing staff;
- 7% medical and dental;
- 12% social services;
- 5% Allied Health Professionals;
- 4% home helps;
- 2% ambulance services staff;
- 7% other professional and technical staff; and
- 26% admin and clerical staff (including medical secretaries ward clerks); and
- 4% managers (being Band 7 or above).

Our staff mix is primarily structured to support the existing care model which is institutionally based. For example, Northern Ireland has a higher proportion of qualified nursing staff (across all settings) compared with England, at 77% compared with 73%. Nursing care has 3.5 times the activity per weighted population than England and Wales. The driver appears to be elderly patients, with NI having 3 per 1000 weighted population compared to 0.16 per 1000 population in England.[28]

Appleby[29] stated that indicative data suggests Northern Ireland produces between 17% and 30% less inpatient, outpatient, day case and A&E activity per head of hospital and community staff than England and that hospital activity per member of staff is 19% lower than the UK average. These efficiency figures are very closely aligned to our current hospital model.

Best Use of Money: In the US, currently the care costs for 5% of the population account for 50% of health care spending.[30] This fact can be applied to any western health economy including Northern Ireland. Addressing the reason for this will require changes to be made which ensure resources are focused in the right areas.

If we were to continue providing health and social care in the same way as we do today, some suggest we would need £5.4

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[27] DHSSPS NI Health & Social Care Census, March 2011

[28] Reshaping the System, McKinsey 2010

[29] Independent Review of HSC Services in Northern Ireland, 2005

[30] Research in Action, Issue 19, 2006

billion of funding by 2014/15 to cope with this combination of growing demand for care and inflating costs. Given that this is unrealistic, from both an economic and delivery perspective, we need to reshape services. Adopting a new model which is efficient, patient centred and providing high quality evidence based services, would enable a legitimate debate in the future on how much funding health and social care should receive, compared with other public services.

Much of the significant management, administrative and overhead efficiency savings potential in health and social care has already been captured through the Review of Public Administration (RPA), and the potential for further savings is limited. Instead, fundamental change is required in how we deliver care in the future.

Reason 10 – Maximising the Potential of Technology

Technological change is both a driver and enabler for the future. The pace of change is incredible and our current model does not promote its absorption or benefit as it should. For example, NI has now one of the most sophisticated radiological systems anywhere but we need new ways of working to maximise the potential of this technology. The technology that enables 24/7 intervention in the care of strokes and coronary conditions can revolutionise the outcome for patients but to deliver it our current service pattern must change.

There is overwhelming evidence that organising emergency care separate from elective care makes better use of the infrastructure in hospitals. Information is key. As a system we have a huge amount of data but poor data analysis, preventing professionals from having the evidence that is central to their work. For example, information from patient records could be used more effectively to monitor our local health needs and to assess what treatments are working well. Data needs to be used in a more effective way to ensure it is translated into information that we can use to plan our services.

Communication with the public is not as modern as it should be, for example in arranging appointments, in explaining how to use the service and giving timely information. This leads at times to disorganisation in our response to the individual and inefficiency.

The technological infrastructure in NI is good and it can promote more care closer to home but our service has not yet fully embraced the opportunity that exists. Connected health projects exist but have emerged in an ad hoc manner. If the service is to derive maximum benefit in this regard, development of connected health needs to be more coherent. Changes therefore will need to build upon the existing Memorandum of Understanding between Invest NI and DHSSPS in relation to connected health. A clear commitment to maximising the technological potential to service provision will be essential.

Reason 11 – Supporting Our Workforce

Problems being experienced by staff trying to deliver services within the HSC were highlighted in the HSC Staff Survey carried out in 2009. Over 2 in 5 staff (43%) felt that they cannot meet all the conflicting demands on their time at work, and only 34% agreed that there are enough staff at their organisation to do their job properly. The most common reason stated for staff having been injured or feeling unwell in the last 12 months was work-related stress (31%). When the Review team met with staff to discuss the future there was not a single voice which argued for the preservation of the existing model of service.

The Review acknowledged the willingness of staff to make change and heard clearly that they wanted to be closely involved in how change should happen.

CONCLUSION

It is clear that we need to act now both to improve our system's quality and productivity, and to better manage the demand on our services. Fundamental change is required in how we deliver care in the future. There are no neutral decisions: every decision will have consequences and opportunity costs for patients and clients. More simply put, we need a new model of care.

We are not different. Whilst there are unique factors at play in Northern Ireland impacting on the demand for services, a number of the issues with the HSC in NI are common in other areas of the UK.

Healthcare for London, A Framework for Action was a review into the healthcare delivered to the population of London, led by Prof. Lord Ara Darzi. This review set out similar issues in terms of the need to focus on improving the quality of services delivered, meeting the expectations of the public, addressing the inequalities in the system, delivering the right care in the right place at the right time, issues with the configuration of specialist services and making better use of resources available, both in terms of the workforce, the infrastructure and taxpayers' money.

The Scottish Government's Shifting the Balance of Care framework set out a programme of changes across health and care systems intended to: bring about better health outcomes for people; provide services which reduce health inequalities; promote independence; and provide services that are quicker, more personal and closer to home.

NHS Wales also recently published a report setting out its 5 year vision for the NHS in Wales, Together for Health. This review identified largely common issues, including challenges with a rising elderly population, enduring inequalities in health, increasing numbers of patients with chronic conditions, rising obesity rates and a challenging financial climate.

Consequently NI cannot insulate itself from the need for change.

The Review presents an opportunity to consider a more integrated model for the HSC system that allows us to deliver an excellent health and social care service to the population of Northern Ireland.

THE PRINCIPLES FOR CHANGE

5. THE PRINCIPLES FOR CHANGE

The Review team has concluded that the Case for Change is unassailable. It highlights the pressures currently faced by our health and social care system and the demands that will be placed upon it in the future. If we continue to deliver services as we currently do, they will not meet the needs of our population and will not be sustainable for the years to come. Therefore, changes are needed to meet future health and social care needs.

In looking to recommend a new model, the Review has engaged widely with the public, clinicians, providers and interest groups, and reviewed research evidence to inform the changes that are required. It started with the 'user first' principle rather than considering the structures in our health and social care system. The aim throughout has been to consider what changes would make the greatest difference to outcomes for patients, users and carers.

The Review has developed a set of principles that will underpin the shape of the future model for health and social care. Later, in the document, when the implementation pathway is described, these principles will be important determinants in the change process. They build upon the three core objectives upon which the National Health Service (NHS) was founded:

- to meet the needs of everyone;
- to be free at the point of delivery; and
- to be based on clinical need, not ability to pay.

The Minister, in his statement on 27th September 2011, said that he believed the Assembly was fully committed to those principles, but had to recognise the fact that the rising level of need in health and social care services, the need to focus on outcomes and the constrained financial context made it increasingly difficult to hold onto those principles. The ability to continue to deliver these principles is only possible through the support of a radical programme of service change and reconfiguration.

The Review has concluded that there are twelve major principles that should guide changes to health and social care.

KEY PRINCIPLES

1. Placing the individual at the centre of any model by promoting a better outcome for the user, carer and their family.
2. Using outcomes and quality evidence to shape services.
3. Providing the right care in the right place at the right time.
4. Population-based planning of services.

5. A focus on prevention and tackling inequalities.
6. Integrated care – working together.
7. Promoting independence and personalisation of care.
8. Safeguarding the most vulnerable.
9. Ensuring sustainability of service provision.
10. Realising value for money.
11. Maximising the use of technology.
12. Incentivising innovation at a local level.

WHAT DO THE PRINCIPLES MEAN?

1. Placing the Individual at the Centre of any Model

The individual must be at the centre of the health and social care system. The model must be built around what will produce the best outcomes for individual users, carers and families. Clarity about communicating this principle is essential.

2. Using Outcomes and Quality Evidence to Shape Services

All services should demonstrate that they are able to meet well understood measures of quality. This must include taking account of an evidence base of existing and emerging research on what produces the best outcome, both within Northern Ireland and beyond.

In NI, Service Frameworks[31] have been developed for 4 service areas, and a further 3 are under development. The Frameworks promote and secure better integration of service delivery along the whole pathway of care from prevention, diagnosis, treatment and rehabilitation, and on to end of life care. These include:

- cardiovascular services;
- respiratory services;
- cancer prevention, treatment and care;
- mental health;
- learning disability (under development);
- older people's health and wellbeing (under development); and
- children and young people's health and wellbeing (under development).

This is the best way to ensure that our limited human, financial and physical resources are used in the most effective way to produce the best possible patient and client outcomes.

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[31] Service Frameworks, DHSSPS

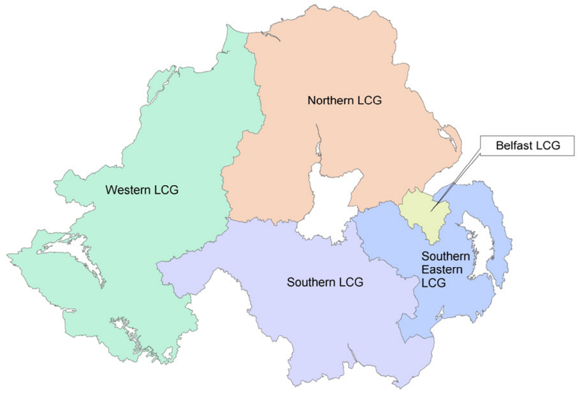
3. The Right Care in the Right Place at the Right Time

Care should be provided at home or as close to home as possible. Many of the services currently provided in an acute hospital or institutional setting should be provided in the community or in people's homes, making them more accessible. Where it is not safe and effective to provide services locally they should be provided more centrally or regionally. More simply put, the health and social care system should provide local services for local people, but safe, sustainable and accessible services for populations.

4. Population-Based Planning of Services

Services should be planned on the basis of the needs of a defined population or 'health and social care economy'. The Review team recognises population boundaries can be artificial but the starting point is to use the existing local health and social care economy populations, which are synonymous with the current Local Commissioning Areas (as in the figure below).

Figure 11: Local Commissioning Areas



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When necessary this should incorporate joint planning between these populations to deliver local or more central services. For some services this would require planning to take account of a NI wide perspective. However, with a population of 1.8million it is simply not feasible to provide every health and social care service that may be required, e.g. in these cases planning should be done jointly with other UK countries or the Republic of Ireland. The levels of planning are illustrated in the figure below.

Figure 12: Levels of Planning

5. A focus on Prevention and Tackling Inequalities

Prevention is always better than cure whether primary, that is avoiding the problem occurring, or secondary, that is arresting the problem. Such measures should be embedded into every service area. Services should support people to take good decisions about their health and wellbeing, with a particular focus on the needs of those groups that typically have poorest health outcomes. The factors impacting on health and wellbeing are diverse but well known and this will require partnership working across government and between the public and voluntary, community and independent sectors. Health economies will need to pay particular attention to achieving these outcomes demonstrating how in practice this approach expresses itself to the individual.

6. Integrated Care – Working Together

Services provided by different parts of the health and social care system should be better integrated to improve the quality of experience for patients and clients, safety and outcomes. This starts with making it simpler to use the system. It will require clinicians to organise care around the individual, with better communication and networking across primary, secondary and tertiary care, that is doctors talking to doctors, and professionals jointly reaching decisions about patients' and clients' care in partnership with them. Closer working together will be mandatory, illustrated by demonstration of full support of the various constituent parts of the service as to how services are organised. Underpinning this will be the requirement for improved technology and information sharing.

7. Promoting Independence and Personalisation of Care

Greater control by those in receipt of the service is a necessity. Flowing from this, as much diversity as practical should be available. To deliver this there should be a mixed economy of providers. In the majority of instances, this will be provided by statutory services but joint working with the independent sector will be expected. Services should aim to meet the needs of individuals, with care personalised in terms of their specific requirements. Patients, service users and their carers should be helped to take the important decisions about their own care, and importantly, enabled and empowered to take ownership of their own health. The vital contribution carers make to support the health and social care system should be recognised and carers' needs should be fully assessed and supported in this process.

8. Safeguarding the Most Vulnerable

Throughout the health and social care system, appropriate safeguards should be in place to protect the most vulnerable in society.

9. Ensuring Sustainability

Providing services requires significant attention to be spent in ensuring workforce sustainability. More simply put it means service models need to be robust. In this regard endorsement of regulatory and training bodies such as NIMDTA is essential. While locum and agency staff may be used to support a service where necessary and appropriate, they should not be inextricably linked to a service's ability to remain. Services organised this way are quite simply not sustainable.

10. Realising Value for Money

Any service models taken forward as a result of this Review must take cognisance of financial resources available to the HSC and secure value for money. Therefore there is a need for financial realism.

11. Maximising the Use of Technology

Changes should be supported by up to date technology to ensure vital information can be shared quickly among professional staff, duplication eliminated and that the latest diagnostic and treatment tools are available.

Changes should take account and build upon the Memorandum of Understanding between the DHSSPS and Invest NI on "Connected Health and Prosperity".

12. Incentivising Innovation at a Local Level

Making changes on the scale indicated in the following model will require devolved decision making and an incentive culture within health and social care, its workforce and the population. This is a direct response to the question 'why would I do it?'. Changes will need to show how they make things better, starting first with their positive impact on those using the service. The incentives of more local control in decision making, better training and development for the workforce and innovative ways of using resources will all be integral to the change process.

In this regard partnership working will be central, whether between populations in NI or with jurisdictions outwith NI. It will also be essential to explore in this context working with others, for example, the voluntary and independent sectors and the pharmacy industry to fully deliver the new model of care.

A FUTURE MODEL FOR INTEGRATED HEALTH AND SOCIAL CARE

6. A FUTURE MODEL FOR INTEGRATED HEALTH AND SOCIAL CARE

Following from the key principles outlined above and the Review's assessment of the opportunities that exist to do things better, a future model for integrated health and social care has been developed. This is illustrated in the figure below.

The future model is designed with the individual at the centre, with health and social care services built around them. Health and social care begins with the individual who is supported to care for themselves and make good health decisions.

Figure 13: Future Model for Integrated Health and Social Care

THE INDIVIDUAL

Every individual has a responsibility to make decisions that help maintain good health and wellbeing, prevent the onset of illness, and minimise deterioration as a result of any existing conditions they may have. People are supported to do this by health and social care professionals, their community, health and social care initiatives and regional health promotion, health protection and prevention initiatives. For example, this may include family support programmes run in community centres, smoking cessation programmes in pharmacies, screening in GP clinics (e.g. for cervical cancer), health visiting for newborns, healthy eating initiatives in community centres, and exercise programmes in local leisure centres. Fundamentally, people need to be supported to take responsibility.

LOCAL SERVICES

Integrated Local Services

For most people, much of what is needed from health and social care services will be increasingly accessible in their local area, either in their own home or in a local facility.

In many ways this may not seem much different to the way services are currently provided. The professionals providing local health and social care services, (for example GPs, district nurses, dentists and social workers) will continue to operate in local surgeries, health centres and high street practices, and to visit people's homes where needed. However, the way that they work with each other will be different.

GP practices will work together as federations of practices, enabling consistently high quality care for their patients. Additionally, Integrated Care Partnerships will be set up to join together the full range of health and social care services in each area including GPs, community health and social care providers, hospital specialists and representatives from the independent and voluntary sector. The Integrated Care Partnerships will have a role in determining the needs of local population and planning and delivering integrated services. Seventeen Integrated Care Partnerships will cover Northern Ireland.

For the individual, this will mean that GPs and all the other health and social care providers in an area, including from the voluntary and community sector, will be able to work together to deliver the services needed by their local population. As a consequence people will deal with fewer professionals and be at the centre of the decision making about their care and treatment.

Technology will support this integrated working. Electronic Care Records will allow health and social care teams to see patient records including details of medications, results of tests and any hospital treatment. This will help ensure that professionals have access to the information they need to treat a patient effectively, including in an urgent care situation. Patients will also have improved information on their personal circumstances.

More Services Provided In the Community

The public told the Review that there should be a greater range of services available in the community. Therefore, under the new model, more of the services that currently require a hospital visit will be available locally. This may include for example, X-rays and other diagnostic tests, and oral surgery. GPs will be enabled to undertake minor procedures in their surgeries. Outpatient appointments in many instances will be provided in the community rather than in hospital. In some specialties, care will be organised directly by the Integrated Care Partnership. New facilities will be developed to support this model, which may be similar to the health and care centres currently in some areas. This model will improve accessibility to health and social care services for the individual.

More specialist care will be provided in the community. Specialist hospital clinicians will support GPs and other community clinicians, working closely with them to plan how services are delivered. More specialists will also be employed in the community, for example, specialist nurses and GPs with a Special Interest. Providing outpatient appointments in the community will become the norm, with some of these being run by GPs and others by hospital specialists. This will reduce the number of follow-up visits to hospital required by patients.

These changes will be very important for people with long-term conditions, for example diabetes, cardiac illness or respiratory problems. For these patients, community-based support programmes will be put in place where multi-disciplinary teams work with patients to help them manage their condition. This will include:

- dedicated community-based clinics where patients can access a range of health and social care services, including inputs from community pharmacy, Allied Health Professionals such as podiatry and physiotherapy, nursing care and social work support as well as from GPs with a Special Interest and hospital specialists;
- better use of telehealth equipment to help people monitor their own conditions and alert health professionals when an individual’s condition deteriorates;
- a named contact person for patients to call when they need assistance – this may be the GP, a specialist nurse or another member of the integrated care team; and
- direct admission to hospital care when needed as agreed between the GP and hospital specialist, with no need to

pass through the hospital emergency department.

Working in this way will also benefit groups who can face barriers in accessing care. For example, the new model will support the provision of enhanced community health services for people with a learning disability.

There will be a consistent approach to the provision of mental health services through the stepped care model, with most services being provided in the community by community mental health teams and voluntary and community sector partners.

More Support Available at Home

Throughout the Review people expressed their preference for care at home or as close to home as possible. In response to this, the new model will provide more support to help people who are sick or frail to maintain their independence and stay in their own homes for as long as possible. This applies whether that home is the family home, supported housing, a nursing home or residential home. However, there will be much greater emphasis on enabling people to remain in their chosen home. Providing care, treatment and support in this way will change the current model, perhaps most noticeably in terms of the number of residential homes.

As part of this approach, more tailored support will be provided to meet people's needs. People will have access to specialist equipment, nursing care, telehealth and telemonitoring support, and other therapeutic support at home, e.g. physiotherapy, podiatry or occupational therapy.

Social care will also be a central part of the support provided to enable independent living. This will include access to a diverse range of provision to meet people's social and emotional needs and tackle social isolation. Voluntary and community sector organisations will provide this support as well as community health and social care teams.

Virtual wards will also be developed. Under this model, individuals are admitted into the care of specialist teams, and provided with similar care as would be available in a hospital ward, but remain in their own home. Mental health treatment services will also be available at home, provided by Crisis Response and Home Treatment teams. This will result in reductions in inpatient care.

Intermediate care will be an important component of the new model, with greater provision of step-up and step-down beds in the community for people needing extra care for a short period of time. Step-up beds provide locally-based short-term support to avoid the need for individuals to be admitted into an acute hospital. Those leaving hospital may spend time in a step-down bed for rehabilitation before returning home. A reablement model will be introduced to provide people with the support they need to return to their homes following a stay in hospital, an accident or other crisis.

There will be a need to provide more respite care and short breaks in the community, to support individuals and carers. This will include accommodation and other short break options. All of this intervention is designed to respond to the patient's and carer's needs.

How people are cared for at the end of life is a key indicator of the values expressed by the HSC. Under the new model, services for those approaching the end of life will be provided that enable people to die at home, where that is clinically appropriate and consistent with their wishes. GPs and other community health services will provide in-reach to support people at end of life. This will apply in nursing homes as well as family homes.

Urgent Care

An urgent care model will be implemented in every area to provide 24/7 access to urgent care services. These services will be planned in accordance with local need. Whilst the model will take account of local circumstances, the outcomes will be consistent. The system of urgent care will ensure each community has local access to urgent health and social care services, variously provided by GPs, urgent care specialist nurses, mental health crisis response teams and emergency social workers.

EMERGENCY, SPECIALIST CARE, AND PLANNED CARE

Emergency care, specialist care, and planned care services will be provided in hospitals for people whose health and care needs cannot be met in their own homes or their own communities.

People needing specialist and acute care will be admitted to hospital. This may be on a planned basis, for example, for a pre-arranged procedure or as a result of an emergency.

The model aims for those admitted to hospital to be discharged to home or a community facility as soon as their health and care needs can be met there. Once individuals are discharged, follow-up care will be provided by the integrated care teams in the community with support from hospital specialists as required. As well as meeting the needs of patients and their families more effectively, this is a more efficient approach which will result in greater productivity.

Triage services and patient transport will be critical to ensuring that individuals access the care appropriate to their needs on a timely basis.

EXTERNAL COLLABORATION AND SUPRA-SPECIALIST CARE

Some services that are only needed by a very small number of people will be provided outside of Northern Ireland. This is necessary to ensure the quality of provision. Networks will be set up between the HSC in Northern Ireland and health and care providers in the ROI and other parts of the UK.

CONCLUSIONS

The proposed model has been designed to address the challenges presented in the Case for Change and the concerns expressed by those engaged with throughout the Review, both clinicians and the public.

The key differences between the current model of care and that proposed by the Review will be:

- care will be organised around the individual and not the institution;
- greater involvement in decision making will be afforded for the patient / client;
- the model provides a new way to look at the traditional model of GP and community health and social care services;
- home or close to home will be the centre of health and social care provision;
- there will be responsible access to emergency and hospital care; and
- new arrangements will be put in place to support provision outside the jurisdictions.

Overall, the model builds on evidence of what produces good outcomes, and supports the resilience and flexibility of the health and social care system for the future.

CASE STUDIES

The Review team considered it important to describe how it might be different for those using the service and offers the following examples to illustrate the change.

Older People	
Current Model	**Future Model**
Jean is a 79-year old woman, who lives alone in her house. She suffers from osteoarthritis, diabetes, bronchitis and heart disease. Because she is not as mobile she finds it difficult to get to hospital appointments. Jean was assessed on several occasions by various professionals, including a social worker, physiotherapist, occupational therapist, and a specialist diabetes nurse. She had to provide the same information each time she was assessed, which Jean found frustrating. The outcome of the assessments deemed that Jean required support from a range of professionals and adaptations to the steps up to her house. Jeans gets confused who is coming to her each day. Furthermore, no-one noticed that she might have a cataract. While Jean was waiting on the adaptations to her steps she fell and fractured her hip. She was taken to hospital and underwent emergency surgery. Jean had to stay in hospital while discharge planning was undertaken and a care package arranged. After some time, she was transferred to a rehabilitation ward where she underwent physiotherapy to assist her recovery, prior to returning home. Jean now worries that she will not be able to cope in the longer term and that she may need to begin thinking about residential care.	Jean's needs were assessed using the Northern Ireland Single Assessment Tool (NISAT), which allowed for all the information necessary to establish her health and social care needs to be collected in one assessment. All of those supporting Jean use this information so she doesn't have to provide the same information several times to various different professionals. Jean sees the specialist looking after her diabetes at her local which is more convenient. Further to the NISAT, the adaptations were made to Jean's steps. The assessment also identified that Jean required a cataract operation – both these interventions happened quickly preventing her fall. Jean was provided with details of the budget available to meet her care needs. The Trust explained that they could manage how this budget would be used or she could receive the budget via a Direct Payment and use it to purchase services herself. Jean chose not to take a Direct Payment, and instead to agree jointly with the Trust how her care budget would be used. They agreed that she would get support with going shopping and attending a local lunch club.

Case Study – Long Term Conditions	
Current Model	**Future Model**
Tom is a 75 year old man suffering with heart problems. He lives on his own but is visited regularly by his daughter. He experiences regular breathing difficulties and his condition is exacerbated by regular chest pains which results in recurring episodes. After waiting in A&E to see a junior doctor and explained his circumstances he has been admitted to a ward where he receives the appropriate treatment required to treat his condition and symptoms. He does not require a referral to see cardiologists. He is discharged when stable after 5 days with appropriate advice on medications and life style. The next time he experiences the same symptoms he is worried and he phones his GP. His GP recognises that this is an exacerbation of his heart failure and sends an ambulance to take him to A&E where he is admitted again. This cycle is repeated again and again and Tom visits A&E 10 times that year.	Tom's GP referred him directly to the community heart failure team who contact him the day following discharge. The nurse arranges to come out to see him in a few days and ensure he understands all the medication he has been prescribed. His daughter is included in these discussions. They are educated about his symptoms and lifestyle and left a number to phone if the symptoms get worse. Tom visits the nurse in two weeks while his medications are increased in line with his clinical presentation. The Heart Failure nurse in secondary care provides specialist telephone advice as necessary. A referral to cardiology will be made if deemed necessary. The nurse takes every opportunity to educate Tom on his condition in order to ensure he knows how to manage his condition. If Tom feels that his symptoms are getting worse he can phone the heart failure nurse help line number who arranges to see him quickly. This proactive contact continues as appropriate for four years during which time Tom only needs to be admitted once to hospital for stabilisation of treatment. This admission is planned by the specialist heart failure team and Tom does not have to present to A&E.

Case Study – People with a Physical Disability

Current Model	Future Model
Gary is a 23-year old man who has cerebral palsy. As a result of his condition, Gary has been in a wheelchair for most of his life. Gary spends most of his time at home or at the local day centre. He has a care worker who visits his home for 30 minutes each morning to assist his mother getting him out of bed and dressed. He then goes to the local day centre. Each evening, his care worker returns to assist his mother in putting Gary to bed. Gary is concerned that he does not receive enough stimulation at the day centre and the activities which he participates in are very limited. Gary would be keen to spend more time with people of his own age group and expand his social networks, as the only people he truly engages with at present are his close family members.	Gary is a 23-year old male with cerebral palsy. His care worker visits his home for thirty minutes every morning and evening to assist his mother with getting him in and out of bed and getting dressed. Gary would prefer to have more control over his daytime activities. He decides to receive some of the budget available for his care in the form of a Direct Payment from the HSC Trust. He uses the Direct Payment to buy the support of a care-worker two days per week. Gary now attends the local college one day per week, where he has joined a committee for students with a disability. On another day his support worker helps him with leisure activities such as swimming. Gary still spends three day per week at the day centre. To help manage his Direct Payment, he receives help from a voluntary sector organisation on being an employer, including how to recruit and pay someone.

Mental Health	
Current Model	**Future Model**
Joe is an unmarried, 25-year old man who lives at home with his mother. He worked for three years as an engineer in a production factory, but unfortunately one year ago he was made redundant from his job. Over the period since his redundancy, Joe has become increasingly depressed. He feels hopeless, experiences disturbed sleep, has lost interest in playing football and has become withdrawn from his friends. Joe's mother has encouraged him to visit his GP for some help, but Joe feels too embarrassed to do so. Joe has also started to drink heavily in an attempt to self-treat his depression. When his mother would encourage him to stop drinking, he would become aggressive towards her, which made him feel guilty. Joe has started to self-harm and have suicidal thoughts. The physical injuries caused by Joe's self-harming became so serious that he had to be admitted to hospital for treatment. Joe was also assessed by a psychiatrist at this time. Once the physical injuries had been dealt with, Joe was discharged from hospital and prescribed antidepressants to assist in the management of his illness.	Joe feels increasingly depressed having been made redundant from his job. He feels disconnected from his friends and experiences disturbed sleep. Joe picks up a booklet in a local takeaway produced by a local community organization. It encourages young men to look after their mental health and explains how to get help if necessary. Joe had been worried that there would be a social stigma attached to seeking help for mental health problems, but when he sees this advice he feels reassured that he could seek help. Joe went to his GP who listened to his problems and advised that he should attend cognitive-behavioural therapy sessions. Joe now meets his therapist once per week at the local health centre, and also has regular review appointments with his GP to monitor his progress. Joe was glad that he had heard the advice about seeking help with mental health problems at an early stage. He is now feeling much better and his illness is under control.

Case Study – Urgent Care	
Current Model	**Future Model**
Abby is 32 and is a keen cyclist. As she travelled home one afternoon, Abby was forced onto a curb by an oncoming car and crashed her bicycle which left her in considerable pain. On further inspection, Abby needed medical attention as her arm was bleeding badly and she was unable to move her wrist or put any pressure on it. Abby called her husband who took her to the nearest A&E department. She explained her situation and gave her details and waited to see a consultant. A serious traffic accident requiring urgent attention meant that Abby waited 4 hours for an assessment while continuing to be in distress. Eventually Abby saw a doctor where she was given stitches and some pain relief, as well as a splint to secure the arm and prevent any further damage. Abby was then referred for an X-ray to identify any fractures. After another lengthy wait of two hours for the X-ray and then the results, the X-ray showed that no major damage had been caused. Abby was free to return home and told to make an appointment with her GP to get her stitches removed.	When Abby called her husband to tell him what had happened, he remembered the new number to call for all urgent care enquiries which he had learnt from a leaflet which had come in the post. After ringing the helpline, he was advised to take Abby to the local Health and Care Centre. When Abby arrived at the Health and Care Centre she waited for a specialist nurse who saw her almost immediately. The nurse investigated the injury and identified that stitches were required but an X-ray would confirm whether further treatment was required. Abby received some pain relief and went for an X-ray which was taken in the same facility within half an hour. The X-ray showed no fracture and Abby was free to return home after the nurse applied some stitches. Abby was advised to make an appointment with her GP to organise the removal of her stitches.

7. POPULATION HEALTH AND WELLBEING

INTRODUCTION

Prevention is integral to the delivery of sustainable health and social care. It enables individuals to make better health and wellbeing decisions. Additionally it is an important determinant in optimising health outcomes for the citizen. Investment in prevention also makes economic sense, for example, inequalities have been estimated in England to cost £5.5billion to the NHS alone.[32]

Total annual inpatient costs to health and social services in Northern Ireland as a result of smoking were estimated at £119million in 2008/9.[33]

Loss to the local economy as a result of obesity is estimated at £500million, with 59% of the population being either overweight or obese. This includes, for example, some £24.5million spent on prescribed anti-diabetic medication alone.[34]

The impact of alcohol on the health and social care system is estimated at some £250million. The additional social costs are estimated at almost £900million. Furthermore, it is estimated that alcohol is a significant factor in 40% of all hospital admissions, rising to 70% of Accident and Emergency attendances at weekends.

Given the significant impact of these issues on the health of the population and the costs of care, strategic and bold action is required. No system can withstand the pressure of doing nothing, and the HSC has a duty to address the health inequalities in our population.

THE CHALLENGES

The starting point is to acknowledge that population health and wellbeing is not just a matter for the health and social care system. It begins with the individual and the choices they make, but improving health and reducing health inequalities also requires joint action across government and partnership working. One area brought to the Review's attention was rural isolation and transport. The Review would suggest this is an area in which joint working could be piloted, including joint sharing and control of resources.

No-one disagrees with the concept of health and wellbeing, the challenge is to deliver a programme of change. Financial pressures will undoubtedly increase within HSC budgets, and often there is

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[32] NICE (2009) Using NICE guidance to cut costs in the downturn.

[33] RCP (2000) Nicotine Addition in Britain: A report of the tobacco advisory group of the RCP applied to 2008/9 HRG costs. In: Ten Year Tobacco Control Strategy for Northern Ireland Consultation Document.

[34] N Gallagher, Presentation QUB Centre of Excellence 2011, Source BSO.

consequent pressure to defer investment in prevention.

LIFESTYLE CHOICES

Alcohol Consumption in Northern Ireland

Given the link between alcohol consumption and harm, and evidence that affordability is one of the drivers of increased consumption, price has become an important feature of prevention strategies. Alcohol is now 44% less expensive in the UK than it was in 1980. It is possible today to exceed the maximum weekly recommended intake of alcohol for men (21 units) for around £4.

A University of Sheffield report, used by the Scottish Government, suggests that a minimum price of 45p and a complete ban on promotions would save about 50 lives in year one, rising to 225 lives in year ten. Moreover, it has been estimated for Scotland that the 45p per unit minimum price would have a total value to health, crime and employment in year one of more than £50million and over ten years of more than £700million.

The submission to the Review from the Royal College of Psychiatrists in Northern Ireland also highlights its view that alcohol price control could be the single biggest act that Government could undertake to improve health and wellbeing in Northern Ireland.

As NICE states: “There is extensive international and national evidence (within the published literature and from economic analyses) to justify reviewing policies on pricing to reduce the affordability of alcohol".

Over the last ten years, it has become increasingly socially unacceptable to drink and drive. This has been via a mixture of enforcement, education and diversion. In this context, it is proposed that a reduction in hazardous and harmful drinking becomes a priority for Northern Ireland with associated targets such as a reduction in A&E attendances helping to drive performance. This could be supported by focused media campaigns to change behaviours/ culture along with evidence based interventions for reducing harmful and hazardous drinking across Northern Ireland.

Smoking

As detailed in the Case for Change, around 340,000 people aged 16 and over smoke in Northern Ireland. Half of all smokers eventually die from cancer, or other smoking-related illnesses.[35] A quarter of smokers die in middle age, between 35 and 69. These deaths could be avoidable.

Reducing smoking is a high priority for public health and there is an ongoing programme of action to encourage people who smoke to stop and discourage people from starting to smoke. This includes public information campaigns and

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[35] Mortality in relation to smoking: 50 years’ observations on male British doctors, Doll et al, 2004

smoking cessation services. The model of care proposed by the Review offers the opportunity to take an integrated, area-based approach to these actions, targeting groups facing particular risks, such as pregnant women, and locations where smoking rates are known to be higher, for example colleges.

Obesity

The Case for Change highlighted the rate of obesity in Northern Ireland and the challenges this presents. An estimated 59% of all adults are either overweight (35%) or obese (24%),[36] which has a very significant impact on our population's health and wellbeing. We face a significant challenge in halting the rise in the proportion of the population who are overweight or obese.

A regional Obesity Prevention Framework is being developed to set out the actions needed to reduce the rate of obesity. These include supporting the individual to take responsible decisions and helping to create an environment that supports healthy decisions about diet and physical activity.

In relation to the lifestyle factors of diet, physical activity, smoking and alcohol consumption, it is important that we provide citizens with good information and that we create environments which make it easier for people to make healthy choices.

To support this, the Review would encourage the Northern Ireland Executive to consider the wider role of the state in taking decisions impacting on health outcomes. In addition to considering the emerging evidence on the potential benefits of minimum pricing for alcohol (for example, taking account of the outcomes of the Scottish alcohol pricing initiative), the Executive may wish to consider the issue of pricing of alcohol and 'junk' food and further controls on tobacco usage.

SCREENING AND PREVENTION

Population screening programmes enable the early detection of disease. They involve testing people who do not have any particular symptoms of a disease to see if they have the disease or are at risk of getting it. Screening allows earlier intervention which contributes to improved outcomes for individuals. The current programmes include screening for breast, cervical and bowel cancers, diabetic retinopathy, antenatal infection screening and a programme of screening for newborns.

Immunisation is the most effective public health intervention for preventing ill health and saving lives. It provides people with vaccinations to protect them against serious infections. Many of these are provided in childhood, for example primary vaccinations for diseases including polio, whooping cough, diphtheria, and the MMR vaccine for measles, mumps and rubella. Uptake rates for childhood vaccination are very

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[36] NI Health and Social Wellbeing Survey 2005/06, DHSSPS

high in Northern Ireland and above the UK average. The uptake rates for the flu vaccination, which targets groups at risk of serious harm from the winter flu virus, are also higher than the UK average in Northern Ireland.

The Public Health Agency is responsible for screening and immunisation programmes. Key priorities are to maintain and expand existing programmes and to introduce new programmes where there is good evidence that they can be effective.

SOCIAL WELLBEING

The role of social support in preventing illness and enhancing individuals' quality of life is well recognised. For example, Section 8 which focuses on care for older people, describes how loneliness and social isolation have been proven to have a negative impact on physical health.

The voluntary and community sector plays a significant role in supporting the social needs of vulnerable groups, often working in partnership with health and social care, housing and other statutory services. This role should be expanded.

THE ROLE OF INTEGRATED CARE PARTNERSHIPS IN HEALTH PROMOTION

The Integrated Care Partnerships proposed under the new model, will have a leading role to play in promoting health and wellbeing. They should be incentivised to support evidence-based health and wellbeing promotion and embed prevention into health and social care services.

This should include:

- expansion of screening and immunisation programmes in the community where evidence exists to support them. Where possible, screening and immunisation should be provided in the community;
- an enhanced role for community pharmacists in health promotion, for example, in relation to information and advice around obesity and weight management, alcohol use and minor ailments;
- support for the role of Allied Health Professionals in secondary prevention, particularly as regards older people, for example, the role of podiatry care in falls prevention, and occupational therapy in rehabilitation;
- support from clinicians for community-based education programmes; and
- local community and voluntary organisations supporting the social and emotional needs of vulnerable groups.

SUMMARY OF KEY PROPOSALS

1. Renewed focus on health promotion and prevention to materially reduce demand for acute health services.
2. Production by PHA of an annual report communicating progress on population health and wellbeing to the public.
3. Maintenance of existing and implementation of new screening and immunisation programmes where supported by clinical evidence.
4. Consideration by the Northern Ireland Executive of the wider role of the state in taking decisions impacting on health outcomes, for example: in relation to pricing of alcohol and 'junk' food; and further controls on tobacco usage.
5. Incentivisation of Integrated Care Partnerships to support evidence-based health promotion, for example, clinician-led education programmes in the community.
6. Joint working pilot projects with other Government departments that enable resource sharing and control, for example in rural isolation and transport.
7. An expanded role for community pharmacy in the arena of health promotion both in pharmacies in the community.
8. Support for the health promotion and prevention role played by Allied Health Professionals, particularly with older people.

8. OLDER PEOPLE

INTRODUCTION

As highlighted in the Case for Change, Northern Ireland has the fastest growing population in the UK and it is an ageing population. By 2020, the number of people over 75 years is expected to increase by 40% from that in 2009, and the number of people aged over 85 is expected to increase by 58%.

Longer life expectancy is something to celebrate and many older people enjoy good health. However, among the 'older old', rates of ill health and disability increase dramatically. For example, dementia mostly affects people over the age of 70[37], and the rate of disability among those aged over 85 is 67% compared with only 5% among young adults[38]. The health and social care system cares for the most vulnerable when their needs change. Older people are significant users of health and social care services, and almost a fifth of the Health and Social Care budget (19% or £616million) is allocated to services for older people[39].

- Around 60% of acute hospital beds are typically occupied by people over 65.[40] Many arrive at hospital because there is no viable alternative in the community (more specific information on this follows later).
- Approximately 23,389 people receive domiciliary care, equating to some 233,273 hours of care each week.
- 9,677 people aged over 65 live in nursing or residential care.

Many excellent health and social care services are provided for older people by dedicated staff, volunteers and unpaid carers. But there is a high level of dependence on institutional and hospital care, and inconsistencies in the quality and range of services provided across Northern Ireland. Services are not currently meeting expectations in terms of quality and consistency. Too often they tend to focus on acute events and crises rather than providing the range of proactive and preventative support that can maintain the health and wellbeing of older people.

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[37] DHSSPS (2011) Improving Dementia Services in Northern Ireland. A Regional Strategy.

[38] DHSSPS (2010) Physical and Sensory Disability Strategy. A Consultation Document 2011-2015.

[39] HSCB Social Care Directorate Submission to the Review (October 2011)

[40] HSCB figures for 7/12/11 identified 60% of emergency and elective admissions excluding obstetrics, sick babies, the Children's Hospital and mental illness.

HOME AS THE HUB OF CARE FOR OLDER PEOPLE

Residential and Nursing Home Care

The proportion of older people in Northern Ireland living in nursing homes is 3.5 times higher than in England and Wales[41] and is increasing. Between 2007/8 and 2009/10, the number of nursing home places increased from 6,392 to 6,694. This reflects the growing complexity of needs and high dependency levels among some of the older population – for example the growth in cases of dementia where currently there are an estimated 19,000 cases. [42]

Meanwhile, the number of residential care places is slowly declining, reflecting the growth in supported housing schemes provided by Housing Associations which have replaced residential homes. Over the same period 2007/8 to 2009/10, the number of residential places fell from 3,096 to 2,983. Many of those using residential care are no longer permanent residents.

The policy aim for some time has been to shift care from institutional settings to home and community settings. The current Health and Social Care Board (HSCB) target (from April 2011) is for at least 48% of care management assessments to recommend a domiciliary care package rather than a nursing home or residential care. However, the majority of expenditure still relates to institutional care. In 2009/10 residential and nursing home provision accounted for £190million, with domiciliary care accounting for £138million and hospital care for £115million. Suggestions on how to improve care, from the online survey, included more community services, person centred care and in-reach services.

Following from the key principle that home should be the hub of care, the Review recommends that steps are taken to support greater provision of services for older people at home and in the community.

The Review supports the trend towards independent living – at home or in supported accommodation – and expects to see a very significant reduction in provision of long-term residential places in the next five years. This will inevitably

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[41] Reshaping the System, McKinsey 2010
[42] DHSSPS (2011) Improving Dementia Services in Northern Ireland. A Regional Strategy.

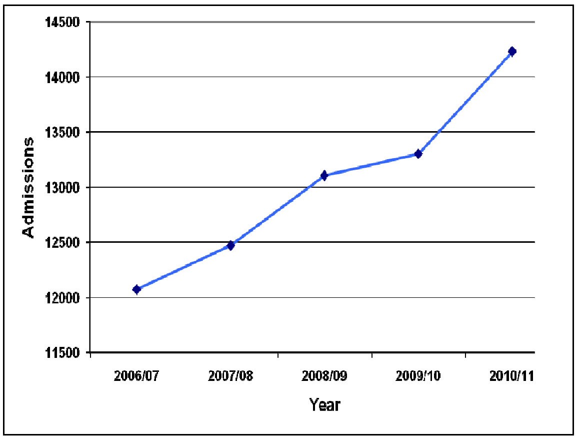
lead to the closure of existing facilities in a planned manner with resources transferred to home care or where appropriate to new models such as respite care.

Hospital Care

Increasing numbers of older people are being admitted to hospital on an unplanned basis and when they are admitted, older people tend to have longer stays and are more likely to face delays in waiting for discharge.

Over the five years to 2010/11, the number of admissions of older people into hospital increased by 18%, as shown below.

Figure 14: Total Admissions to HSC Hospitals in NI under the Elderly Care Programme of Care (2006/07 - 2010/11)



Source: NI Hospital Statistics: Inpatient Activity 2010/11

Many older people arrive at hospital because there is no viable alternative in the community, for example, due to lack of appropriate nursing and medical interventions available in nursing homes or at home.

Once admitted, older people tend to have longer stays in hospital. During 2010/11, the longest average length of stay across all specialties in Northern Ireland was under the rehabilitation specialty where admissions lasted for an average of 30.9 days. Longer lengths of stay for older people can be associated with cases involving a complex range of physical and mental health issues and therefore a requirement for a robust package of care to be agreed before discharge into the community.

Since April 2010, a target has been in place stating that the HSC Board and Trusts should ensure that 90% of complex discharges take place within 48 hours of the decision to discharge, with no discharge taking longer than seven days. As at the end of 2010/11, 86% (13,009) of complex discharges were within 48 hours regionally. The most common reasons for delay recorded were:

- no domiciliary package available;
- essential equipment / adaptations not available or assessment not completed; and
- no nursing home bed available in the chosen facility.

Research by the Alzheimer's Society found that people with dementia stay longer in hospital than other people undergoing the same procedure, and stays in an acute hospital environment can have a detrimental effect on the symptoms of dementia.[43] Admissions to hospital can also result in reduced confidence of older people and their families to live independently, and can lead to a move into residential and nursing care[44].

The Health and Social Care Board will begin to introduce a reablement model of care across Northern Ireland from 2012. This approach involves providing older people with intensive, time limited support with everyday tasks with the aim of enabling the individual to do the task as independently as possible at the end of the process. It has been shown to be an effective means by which to keep people independent for longer. The Southern HSC Trust has already begun implementing a streamlined assessment and care planning approach built around the reablement model.

It is also known that older people are often admitted to hospital at the end of life. A recent report by DHSSPS showed that 82% of people dying in hospital were over 65 years of age. Of these people, 18% (2010/11) had a length of stay of less than 2 days. The report also looked at the number of people dying in hospital within 2 days of admission who were admitted from a nursing home. In 2009/10, 28% of the deaths of people admitted from a nursing home occurred within 2 days of admission into hospital.[45]

Suggestions for improved care for people nearing the end of life, from the online survey, included more home support to allow people to die in their preferred location.

To help avoid unnecessary admissions of older people into hospital and encourage independence, the Review endorses the plan to introduce a reablement model across Northern Ireland. The Review also recommends that there should be better integration of hospital and community services. With the establishment of the 17 Integrated Care Partnerships there is a tremendous opportunity to:

- improve communication between GPs providing out of hours care and hospital specialists;
- provide in-reach into nursing homes by specialists and GPs;
- have clear specification of the care and interventions to be provided in a nursing home environment including, for example, administration of intravenous therapy and catheterisation;
- provide the management of end of life care in nursing homes – being transferred to hospital at the end of life can be distressing and the Review recommends that other than for sound

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[43] DHSSPS Dementia Strategy

[44] Stilwell and Kerslake (2003) What makes older people choose residential care, and are there alternatives?

[45] DHSSPS Hospital Information Branch (2011)

clinical reasons or family preference, nursing homes should manage end of life care;

- create greater provision of intermediate care, increasingly using the independent sector to provide:
    - step-down beds for short-term rehabilitation following a stay in hospital;
    - step-up beds that provide short-term support to prevent an admission into hospital; and
    - short-term reablement support to enable people to learn or relearn the skills necessary for independent living.

The Review suggests that whilst some intermediate care beds will be statutory, there will be an increased role for the independent sector in providing beds.

Patient and User Experience

The public place a high priority on the availability of good care for older people. In November 2011, the Patient and Client Council (PCC) engaged with its members on the future priorities for HSC in Northern Ireland. Of the top ten priorities identified, Care of the Elderly, including domiciliary care was second. Those consulted raised concerns about both the quality and quantity of social care provided, and the need for appropriate care in the community to help people live in their own homes. The need for better support for older people living in rural areas was identified.

Those consulted with by the PCC raised concerns with the PCC about the length of time that is allocated to those delivering domiciliary care.

Appropriate discharge planning for older people leaving hospital was also highlighted as a concern. Those consulted expressed a view that a holistic approach to discharge planning should be undertaken and that the patient, carers and community and primary care providers should all be involved in this process.

The quality and availability of respite care was highlighted as an issue, in particular for people with dementia. Consultees emphasised the importance of respite to support individuals and their families and carers.

The public survey conducted for this Review also found evidence of concerns with the quality and accessibility of care for older people:

- 35% of respondents felt that there was a ‘lot of improvement’ required in the health and social care services provided to older people overall;
- 24% of respondents stated that a ‘lot of improvement’ was needed in the quality of residential care for older people;
- 36% of respondents stated that ‘a fair amount of improvement’ or a ‘lot of

improvement' was required in home help or home nursing care; and

- strong concerns were expressed about the waiting time for an assessment for home help, nursing or residential care - 33% felt that a 'little improvement' was needed, with 24% and 21% respectively, stating that a 'fair amount' or a 'lot of improvement' was required.

Workshops with clinicians confirmed public concerns in relation to care for older people. Clinicians highlighted the increasing demand for nursing and residential care due to the ageing population. They expressed the view that the capacity and capability of staff within nursing and residential care settings to provide care to the increasing numbers of patients with complex care requirements needs to be addressed. Quality issues were identified including poor nutrition of older people in hospital, nursing and residential care.

A 2008 UK-wide nutrition screening survey in hospitals, nursing homes and mental health units found that people in these care settings had a higher risk of malnutrition on admission and that the risk was much higher again for older people being admitted to care. For example, it estimated the rate of malnutrition for those aged 65 in the community at 14% compared with 32% for those being admitted to hospital and 42% for those being admitted to care homes[46].

Clinicians also highlighted a perceived lack of continuity and integration between hospital care and community based care. The limitations of IT and communications systems to support sharing of information between hospitals, primary care settings and residential and nursing homes was noted.

They expressed the view that greater rehabilitation and intermediate care is needed to prevent hospital admissions and support timely discharge.

The Review was persuaded of the need for, and its new model supports, a shift in services from hospital settings to closer to home. This will require more personalised care and diversity of service provision. Advocacy will be important in providing safeguards to vulnerable individuals. Telecare support will enable the greater management of risk and improving personal confidence.

PROMOTING HEALTHY AGEING

Throughout the Review, the public and clinicians expressed a desire for a more preventative model of care and one which enables better quality of life for older people. This is supported by research that suggests that preventative approaches can deliver better outcomes

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[46] DHSSPS - Promoting Good Nutrition A strategy for good nutritional care for adults in all care settings in Northern Ireland.

for older people, with fewer hospital admissions, shorter lengths of stay and greater satisfaction with service provision.

Preventative approaches aim to take a more holistic view of older people's needs, by addressing issues other than health which impact on wellbeing but require intervention from other areas of public service. The Joseph Rowntree Foundation's Older People's Inquiry[47] identified the areas that are valued by and thus important for the wellbeing of older people as:

- comfortable and secure homes;
- an adequate income;
- safe neighbourhoods;
- getting out and about;
- friendships and opportunities for learning and leisure;
- keeping active and healthy; and
- access to good, relevant information.

This emphasises the need for a more joined-up approach to assessing the care needs of older people, recognising the role of multiple providers of health and other services across the public, voluntary and community, and private sectors. The Northern Ireland Single Assessment Tool (NISAT) aims to provide a joined-up approach to assessing the needs of older people and carers, but rollout of the tool is at an early stage and it is not yet in use in all HSC Trust areas.

The Partnerships for Older People Projects (2009) in England tested more integrated approaches to supporting older people. Its evaluation suggests that low intensity practical support services that

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[47] Raynes, N et al (2006) Evidence submitted to the Older People's Inquiry into 'That Bit of Help.' York, Joseph Rowntree Foundation.

help older people to live well in their own homes (e.g. cleaning, care of pets, gardening, befriending, help with managing bills and DIY) had by far the greatest impact on health-related quality of life[48].

There is also good evidence of the effectiveness of interventions to reduce loneliness and social isolation and improve health and wellbeing. Social exclusion is associated with poor physical and mental health outcomes for older people, and social isolation has been identified as a particular risk for older people in rural areas.[49] A review of a rural intervention to address social isolation among older people in Northern Ireland concluded that health and wellbeing of older people can be profoundly influenced by geographical location and that interventions informed by local needs are likely to be more successful.[50]

A recent report by the Social Care Institute for Excellence (SCIE) illustrates the emerging evidence that one to one interventions such as befriending and outreach can reduce loneliness and depression, and are cost effective[51]. Such initiatives are often provided by community organisations. In this regard care services are more important than health services.

Ultimately, older people want to stay at home, living independently for as long as possible, and the current model of care does not always provide the support needed to do so. Too often this results in reliance on institutional care with crisis intervention as the order of the day. This is not consistent with a shift to the wellbeing model the public expects.

Personalised budgets refer to the greater involvement of those qualifying for health and social care services in how they are provided. Needs assessment identifies the amount of care funding available for each individual and a joint decision is taken between the service user and the provider on how that funding will be used.

This includes the option to access a Direct Payment which involves the provision of funding directly to patients and clients who then purchase directly the services they feel best meet their needs. Direct Payments are available to older people who need support, individuals with physical disabilities, learning disabilities or mental health issues.

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[48] Windle, K et al (2009) National evaluation of Partnerships for Older People Projects: final report. Canterbury, Personal Social Services Research Unit.

49 Commission for Rural Communities (2008) The Personalisation of Adult Social Care in Rural Areas.

[50] Heenan (2009) How Local Interventions Can Build Capacity to Address Social Isolation in Dispersed Rural Communities: A Case Study from Northern Ireland. Aging International, vol 36, no 4, 475-491

[51] Windle, Francis and Coomber (2011) Preventing loneliness and social isolation: interventions and outcomes. Social Care Institute for Excellence.

When people are provided with information and advice on the services that are available to them, they are in a position to make an informed choice as to the most appropriate care delivery for their particular needs. Those choosing to take a Direct Payments are able to choose who provides their care, when they deliver it and what they do to meet their particular needs. This may mean reduced uptake of core social care services provided directly by the HSC Trusts and uptake of a more diverse range of provision including that of the voluntary sector. Direct Payments users may also employer support workers directly.

Promotion of personalised approaches and the uptake of Direct Payments has been Government policy across the UK for some time. However, research has shown that there may be variation in the benefits experienced by patients and clients receiving direct payments, especially for older people and those with mental health problems. The most recent figures indicate that a total of 687 older people are in receipt of Direct Payments and 34 carers receive Direct Payments on behalf of an older person[52].

During the Review, the Direct Payments process was highlighted as being bureaucratic and of limited appeal to older people and their families. The need for independent provision of advocacy and coordination was identified as a method to facilitate and support service users in using personalised budgets.

Where individuals do not wish to take financial control, they should be given the option of advocacy to act on their behalf or a financial statement of the cost of their assessed support to enable greater choice on their part.

The Review concludes that there should be a focus on promoting healthy ageing, individual resilience and independence among older people.

Care for older people should be underpinned by a consistent assessment process, and a more holistic approach to planning and delivering support taking account of physical, social and emotional needs. Budgets within health and social care should be pooled, with joined up assessment and planning of needs using NISAT. The Review would also recommend pilots to explore budgetary integration beyond health and social care so as over time, the support funding managed by other parts of the public sector e.g. for housing support, could be integrated into a single care budget.

Support planning should take account of a diverse range of health, social and other support services appropriate to the needs of the individual, whether provided by statutory health and social care providers, the independent sector or voluntary and community sector providers. Service user involvement models for adult social care are being developed in other parts of the

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[52] HSCB Statutory Monitoring Returns May 2011

UK as a basis for more collaborative 'co-production' of services.[53]

The role of care users and their families as partners in care should be recognised, and support should be personalised to deliver the outcomes care users and their families want to achieve. This should include control over and clear information about budgets, whether through Direct Payments or involvement in personalised budgets where HSC procures services on behalf of and as directed by the individual. Advocacy and support should be available if needed to help make this a reality.

A diverse choice of provision should be available to meet the individual health and social care needs of older people, with appropriate regulation and safeguards in place to protect the vulnerable. The Review recommends overhauling the current financial model to drive this objective within the statutory, voluntary and private sector.

SUPPORTING CARERS

Informal care from family and friends is vital to enabling a large number of older people to continue to live in the community. Across the UK, this informal care is estimated to equate to £87billion per year[54]. Carers UK estimate that there are 207,000 carers in Northern Ireland (a substantial increase from the DHSSPS figure of 185,000 quoted in 2006) and that the value of the care they provide is more than £4.4billion per year.

Carers can suffer poor physical and emotional health themselves, either directly because of the strains of their caring role or because their caring role restricts their ability to access health care. Carers UK report that carers are twice as likely to be permanently sick or disabled than the average person. The Princess Royal Trust for Carers research 'Always on Call, Always Concerned' found that 69% of carers surveyed reported a negative impact on their physical health from their caring role, and the same percentage reported that caring had a detrimental effect on their mental or emotional health.

Frequently the Review heard from carers the centrality of their role and their sense of being taken for granted.

The Caring for Carers Strategy (DHSSPS 2006) was designed to recognise, value and support the role of carers. Each HSC Trust has a nominated carer co-ordinator and is developing new ways of supporting the needs of carers. An assessment of carer needs is an integral part of the NISAT approach which is beginning to be rolled out across all HSC Trust areas.

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[53] Needham and Carr (2009) Queen Mary University of London, SCIE Research briefing 31: Co-production: an emerging evidence base for adult social care transformation Social Care Institute for Excellence.

[54] Valuing Carers – Calculating the Value of Unpaid Care, Carers UK 2007.

Different carers are likely to need different types of support and their needs will change over time. Carer support interventions may include:

- programmes designed to educate carers about the care-recipient's condition and treatment;
- peer or professionally led carer support groups;
- respite services to provide carers with 'time away' from their caring responsibilities, including within the home, daycare or residential / inpatient provision;
- psychological therapy for carers; and
- care recipient training to promote confidence, self management and empowerment.

Evidence indicates that carer interventions such as these are effective in reducing carer depression and in some cases can have a positive impact on the condition of the care-recipient. Interventions which exist over a longer period of time have been found to be more successful than short-term initiatives[55]

The Review recommends a policy review to improve the outworkings of the carer assessment to better respond to their needs. There should be better recognition of carers' roles as partners in planning and delivering care for older people, and more practical support including, in particular, improved access to respite provision.

THE COSTS OF CARE FOR OLDER PEOPLE

Those engaging with the Review raised the issue of funding for adult social care and the potential future mix of funding sources including health and social care funding, social security benefits, and the patient or user's income. Current legislation in Northern Ireland enables charging of those being admitted to institutional care or receiving home care, but at present charging is not enforced for home care. The Review's role is not one of recommending charging but suggests it is a debate in which Northern Ireland society must fully engage.

The Review acknowledges that the independent sector is a major local resource in providing care for older people. It recognises that the relationship with government, particularly over pricing can be difficult. Consequently, the Review recommends the DHSSPS undertakes a policy review to consider:

- the benefits or otherwise of independent price regulation within the sector;
- the feasibility of the introduction of a certificate of need scheme ahead of

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[55] Tommis, Zinovieff, Robinson and Morgan (2009) Carer Interventions Assessed Final Report. All Wales Alliance for Research and Development in Health and Social Care

the development of new premises with upper size limits;

- much more due diligence checking on any organisation entering the market, including exploring the concept of a financial bond for new entrants to minimise risk on all sides; and
- ongoing financial appraisal to ensure the robustness of facilities in the sector.

SUMMARY OF KEY PROPOSALS

9. Home as the hub of care for older people, with more services provided at home and in the community.
10. A major reduction in residential accommodation for older people, over the next five years.
11. Introduction of reablement to encourage independence and help avoid unnecessary admissions of older people into hospital.
12. A greater role for nursing home care in avoiding hospital admissions.
13. More community-based step-up/step-down and respite care, provided largely by the independent sector.
14. A focus on promoting healthy ageing, individual resilience and independence.
15. More integrated planning and delivery of support for older people, with joined up services and budgets in health and social care, and pilots to explore budgetary integration beyond health and social care.
16. A holistic and consistent approach to assessment of older people's needs across Northern Ireland and an equitable range of services.
17. A diverse choice of provision to meet the needs of older people, with appropriate regulation and safeguards to ensure quality and protect the vulnerable.
18. Personalised care designed to deliver the outcomes care users and their families want, with increasing control over budgets, and access to advocacy and support if needed.
19. A policy review of carers' assessments and more practical support for carers including improved access to respite provision.
20. An overhauled financial model for procuring independent and statutory care, including exploring the potential for a price regulator, a certificate of need scheme and financial bonds for new entrants.

9. LONG TERM CONDITIONS

INTRODUCTION

Long-term conditions (LTCs) refer to patients who have a condition that cannot, at present, be cured but can be controlled by medication and/or therapy for example diabetes, asthma or hypertension. These conditions affect both adults and children.

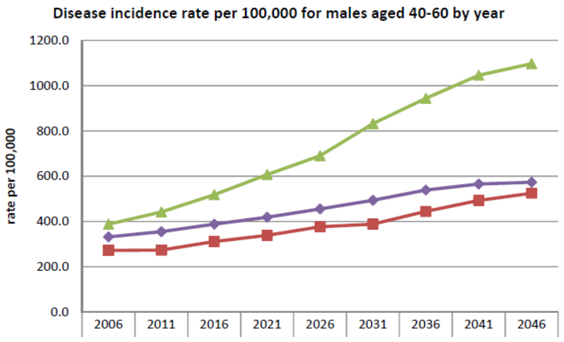
International studies have found that the cost of care for only 5% of the population makes up nearly 50% of the healthcare budget.[56] The majority of the 5% are made up of the elderly and people with long term conditions. Incidence of long-term conditions are on the rise.

A report[57] by the Royal College of GPs has identified that individuals with long term conditions account for more than 50% of all GP appointments, 65% of outpatient appointments and over 70% of in-patient beds in England. It also advocates that GPs are better placed to help individuals manage the issues associated with their condition.

It is clear that people with LTCs require high levels of care. It naturally follows that the health and social care system needs to focus its efforts on how to deliver high quality care to these individuals. The objective is to ensure better outcomes for patients. It is also important to understand that better organisation of care pathways will improve quality and value for money. The recent policy framework Living with Long-term Conditions[58] set out a number of principles and actions for the overall approach to the treatment and care of adults with LTCs.

The figure below illustrates the disease incidence rates for adult males.

Figure 15: Disease Incidence Rates



Source: National Heart Forum: Obesity Trends for Adults. Analysis from the Health Survey for England, (2010)

The Review recognises and celebrates advances made in modern treatments, but is also cognisant of the implications to future well-being. Major advancements in treatments for illnesses such as cancer have improved the life expectancy of sufferers. Increasingly cancers are becoming LTCs. Health and Social Care needs to ensure that it is ready to manage

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[56] Research In Action, Issue 19, 2006

[57] Care Planning: Improving the Lives of People with Long Term Conditions, 2011

[58] DHSSPS (2011) Living with Long-Term Conditions A Policy Framework Consultation Document

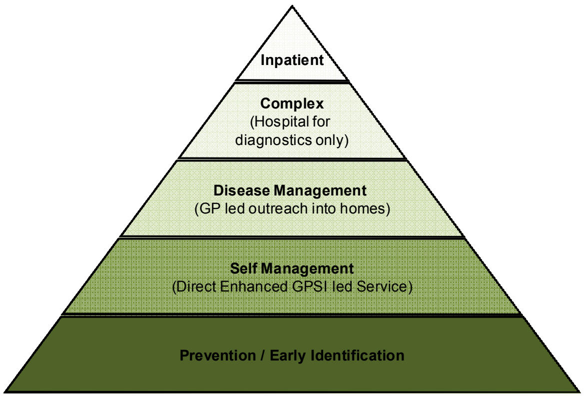
the LTCs that often develop as a result of progress in treatment.

The reality of the current system is that on many occasions individuals with a LTC are admitted to hospital after completing a complicated journey through A&E because there is no alternative.

In recent years, an emphasis has been placed on increasing the role of primary care and the community supporting LTCs. It is the Review's view that this current role can be expanded and based around the principle of 'home as the hub of care'.

The approach to the management of long term conditions should be based on the theory that the majority of effort is in prevention, early identification and self management with as little as possible care delivered within an inpatient setting, as shown in the following diagram.

Figure 16: Approach to management of Long Term Conditions



FOCUS ON PRIMARY AND SECONDARY PREVENTION

Whilst not all conditions are preventable, evidence indicates prevention has a key role in tackling:

- the increase in the percentage of children and adults who are overweight or obese;
- the increase in the number of people with long term conditions, such as diabetes;
- the higher frequency of risk factors for heart, stroke, vascular and respiratory diseases in more disadvantaged communities; and
- the higher death rates from conditions such as coronary heart disease, stroke, vascular and respiratory diseases in our society, particularly in more disadvantaged communities.

Although not all long term conditions are preventable, steps can be taken by individuals to decrease their chances of developing a condition. These include:

- promoting healthy lifestyles;
- reducing alcohol related problems;
- reducing overweight/ obesity levels;
- increasing a focus on psychological well-being; and
- decreasing incidences of falls among older people.

For many conditions, early case identification can be the key to limiting the effects of an illness.

There is a link between the prevalence of some conditions and deprivation, in particular for Chronic Obstructive Pulmonary Disease and asthma where rates are highest in the most deprived wards.[59]

The first focus is therefore to enable much greater self care to avoid chronicity. Integrated partnership working between clinicians in primary and secondary settings can produce real benefits for patients, for example in the treatment of diabetes. Support therefore begins with the GP, integrated community teams and community pharmacy.

The online survey included early intervention and use of community pharmacists as suggestions for better care for people with long term conditions and the Review supports this approach.

The Review considers Integrated Care Partnerships, that is professionals working together providing services for a population, as the way forward. In this regard the GP list acts as a building block for creating populations to enable this to happen. The data already known has the potential to be warehoused to inform best practice and intervention methods.

PERSONALISATION OF CARE PLANNING

At present personalised care planning is not practised in every area of NI. Consequently, care provision for people with a long term condition often lacks cohesion and consistency. This is a real source of frustration for the individual as they are managed simultaneously by a series of health professionals. This system results in the duplication of information reporting, which impedes analysis and treatment of the problem. All too frequently this results in overuse of hospitals.

Evidence shows that where information is readily available and accessible to all parties concerned with the treatment of LTCs, including the individual, patient experience outcomes are through a better managed system of delivery. This is enhanced even further if the individual has been involved in the planning of their care. Working in a more integrated system enables a more easily understood and straightforward care contract with individuals and their family to be created.

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[59] PHA Health Intelligence Briefing, QOF, 2011

Flexible care packages should make arrangements more responsive for individuals, particularly those with changing circumstances.

Evidence suggests that with the correct support, individuals suffering from a long term condition can have an important role in the management of their condition.[60]

Self management enables individuals to take control of their own care plan, acquiring the skills required to manage them through the education they have received.

The Stanford University Model designed by Professor Lorig, recognised that issues faced by individuals with chronic conditions were often exacerbated by a number of factors including pain management, stress, low self esteem and depression.

To tackle this, better planning of self-care management will need to be introduced and replicated across the region.

Social and emotional issues can be supported within the community by establishing links between the individual and clubs, societies, transport and other amenities which will have a direct impact to the overall well-being of the person.

The Expert Patient programme[61], led by fellow sufferers aims to empower people to:

- feel confident and in control of their life;
- manage their condition and its treatment in partnership with healthcare professionals;
- communicate effectively with professionals and be willing to share responsibility for treatment;
- understand how their condition affects them and their family; and
- use their skills and knowledge to lead a full life.

An important part of the individual’s ability to manage their LTC will be the strength of the support they receive from family and friends. Carers should be respected as partners in care in regard to the overall provision of services.

Working within Integrated Care Partnerships, community pharmacies have an important role in the support of individuals with a LTC, particularly in medicines management as discussed below.

Predominately referring to diabetes care, but applicable to the management of all long term conditions, a 2007 report described how organised and proactive

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[60] Patient and family participation – What difference should it make to the quality of care?

[61] NHS England

services in partnership with engaged, empowered patients would ultimately provide better outcomes.[62]

One example of this in action has been the introduction of insulin pumps. The Public Health Agency reports the case of a 14 year old girl who was previously admitted to hospital 99 times from 2001-2010, but since the introduction of an insulin pump has had no diabetic related admissions. As a result her attendance at school and level of academic achievement has increased.[63]

The North West London Integrated Care pilot introduced greater use of multidisciplinary teams working within the community as well as having a direct link into secondary care.[64]

In the new model of care recommended by the Review, multidisciplinary teams will form the essential nucleus of health care professionals supporting patients in their own homes and community.

The integrated team is likely to include:

- General Practitioner;
- General Practitioner with a Special Interest (GPSI);
- Specialist Nurse;
- Occupational Therapist;
- Physiotherapist;
- Dietician;
- Social Worker; and
- Support Care Workers.

The composition of these teams should reflect the needs of the local population and be flexible to adapt to the nature of individual cases. All GP surgeries should indicate the lead professional for that practice. It may not always be that individual who treats or supports but they should be the first point of reference for patient and colleague professionals.

MEDICINES MANAGEMENT

People with LTCs often have multiple medicines to help manage their symptoms. Pharmacy errors are a very common risk factor for these patients. Compliance with the directions for use is key to the successful use of the medicines. The community pharmacy plays a key role is assisting people with LTCs.

The community pharmacist will form part of the multi-disciplinary approach to the management of LTCs. Pharmacies are ideally placed within local communities to provide advice without appointment. [65]

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[62] Roberts S, Working together for better diabetes care: Clinical case for change, Department of Health, 2007

[63] PHA, 2011

[64] North West London Integrated Care Pilot : Business Case, 2010

[65] Supporting people with long term conditions to self care: A guide to PCTs in developing local

This new model seeks to keep the focus on the patient, providing alternative options to being admitted to hospital, and providing opportunity to prevent such occurrences wherever possible.

In the new model General Practitioners with a Special Interest (GPSI), will assess the individual to determine the correct treatment needed and where the most appropriate setting is. Where an individual requires secondary care, the GPSI will contact a specialist directly for admittance to hospital. Case records will be fully available to the hospital which will improve efficiency and reduce length of stay.

Making the home the hub of care, multi-disciplinary teams would provide the primary source of intervention. These health care professionals will be known to the individual, and likewise to each member of the team, allowing quick response and effective treatment delivered locally.

Community led teams should also be responsible for helping individuals to prevent their condition worsening. Regular contact with the individual is essential, along with practical support and education.

DIRECT ADMISSIONS TO HOSPITAL FOR PEOPLE WITH LTCS

Early prevention and self managed care supported by multidisciplinary teams will help stem the demand for hospital care. However, there is still a real need for high quality, responsible acute care for those who need hospital care.

In the event of an individual requiring emergency treatment, there should be greater integration between community teams and secondary care clinicians.

The GPSI will be able to contact the hospital directly once it has been determined that acute care is required. Direct admission will ensure a better experience for the patient and ultimately a better outcome.

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strategies and good practice, Department of Health, 2006

TECHNOLOGY

A key enabler in the introduction of the new model is technology. Greater support can be given to individuals and health care professional through telehealth monitoring.

An individual will have the ability to better manage their own condition through a combination of assistive technology and access to information.

The current duplication along with poor patient records slows down the system and causes frustration to the individual when forced to continually relay their particular situation and treatment. A solution to this would be the creation of a single Electronic Care Record (ECR) which follows the individual through different care settings and Trust boundaries.

SUMMARY OF KEY PROPOSALS

21. Partnership working with patients to enable greater self care and prevention.
22. Personalised care pathways enabling home based management of the LTC with expanded support from the independent sector.
23. Patients to have named contacts for the multi-disciplinary team in each GP surgery to enable more straightforward communication.
24. Improved data warehousing of existing information to support care pathways and enable better outcomes to be more closely monitored.
25. A stronger role for community pharmacy in medication management for LTCs.
26. Development of admission protocols between secondary care specialist staff and those in the community.
27. Maximising the opportunities provided by telehealth in regard to LTC patients.

10.PEOPLE WITH A PHYSICAL DISABILIITY

INTRODUCTION

Between 17-21% of the Northern Ireland population have a physical disability and around 37% of households include at least one person with a disability[66]. While many disabled people have no greater need for health and social care support than the rest of the adult population, some draw on specific support services provided by the statutory and voluntary and community sectors. At March 2010 there were 7,527 people with a physical or sensory disability (aged up to 65 years) in contact with HSC Trust disability services. In budgetary terms, adult disability services account for a small proportion of health and social care spend - 2.8% of the HSCB budget or £91million.

PERSONALISATION AND PROMOTING INDEPENDENCE

Personalisation, independence and control are at the heart of the Review and for those with a physical disability. A Physical and Sensory Disability Strategy for Northern Ireland is in the final stages of development. It will formalise in policy terms the changes to the model of support for disabled people. Traditionally, a limited range of support services such as daycare and residential care have been provided for people with a disability.

The current service-led approach should be replaced by a more person-centred model in which statutory health and social care acts as an enabler, working in partnership with the disabled person and their family / carers to help people access the support that meets their individual needs. This may include some of the traditional residential and daycare services, but will increasingly reflect a wider range of needs. For example, a personalised support package might include:

- personal care support at home;
- specialist equipment such as a wheelchair or adaptations to the home;
- occupational therapy, speech and language therapy and physiotherapy;
- assistive technology; and
- assistance with day to day activities such as cooking, travel or work.

Voluntary and community sector organisations play a vital role in providing this much wider range of support and in acting as advocates for disabled people, promoting the control and independence agenda. Other parts of government have an important role to play in promoting independence for people with a disability,

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[66] NISRA 2007, referenced in DHSSPS Physical and Sensory Disability Strategy A Consultation Document 2011-2015. December 2010.

notably housing, education, employment, and culture, arts and leisure.

This approach is supported by the findings of the online survey conducted by the Review which recommended a multi-disciplinary and person centred approach.

PROVIDING THE RIGHT CARE IN THE RIGHT PLACE AT THE RIGHT TIME

As independent living options become more readily available there has been a gradual decline in the number of people with a disability living in long-term residential care (from 92 in 2005 to 80 in 2010) and there are only three statutory residential homes solely for people with a disability. However, the number of disabled people living in nursing homes has increased over the same period, from 284 in 2005 to 319 in 2010, reflecting the complex support needed by some which is not currently being met in the community.

There continues to be around 400 people with a disability living in long-term care settings. Care could be provided closer to home with more intensive treatment and rehabilitation when needed. Despite the drive to provide more home-based support, the number of people receiving a home-help service actually decreased by 30% between 2004/5 and 2008/9. This may reflect higher thresholds to access services and a focus on providing services for those with the highest level of need or the increase in uptake of Direct Payments which allow individuals to purchase their own support.

There is an increasing population of young disabled people with complex needs who are surviving into adulthood because of improvements in therapies and medical care and who require more intricate and costly packages of care, particularly during the transition to adulthood.

Provision of equipment is vital to allow people with a disability to live well at home. A third of the respondents to the Review’s omnibus survey reported that ‘a lot of improvement’ was required to reduce waiting times for equipment such as wheelchairs and hoists. This issue was also raised at the clinical workshops where clinicians noted concerns surrounding the provision of adequate resources and equipment for patients and clients with physical disabilities. Clinicians also highlighted the need for inter-departmental working to address matters which patients and clients with physical disabilities experience, such as ensuring that housing is suitable for individual needs.

While it will be challenging to balance the increasing complexity of needs and requirement for significant nursing and personal care support, with more independent living, this is essential to promoting the rights of people with disabilities.

New service models will be needed to meet this challenge including continued development of respite and short break care to support disabled people and their families/carers. At present much of this continues to be provided in the traditional residential and daycare settings, but home-based respite services are beginning to be developed and should be further developed.

PERSONALISATION AND INDEPENDENCE

There has been little change in the number of people using statutory daycare facilities, although their role has changed somewhat, for example, provision of short-term respite support. Results from the omnibus survey indicated that 24% of respondents felt that ‘a fair amount of improvement’ was required with regard to the range of day provision for people with a disability, and a further 22% of respondents stated that ‘a lot of improvement’ was needed.

Participants at the clinical and voluntary sector workshops and many individuals engaging with the Review focused on the need to shift from a medical model of care and treatment for individuals with physical disabilities, towards a more user-centred care model, which delivers the right care to meet that patient or client’s needs. The potential of personalised budgets to improve choice and control was highlighted by many as a means to ensure that the care patients and clients receive meets their particular needs i.e. addresses the question “what would make my life better?”

Direct Payments have been embraced by many people with a physical disability who welcome the greater control they allow. Between September 2007 and September 2010 the number of Direct Payment recipients within the Physical Disability programme of care increased from 312 to 587. Encouraging uptake of Direct Payments has been a target for several years and mechanisms have been put in place to promote uptake and support people with managing their own budgets to purchase services or employ support directly.

While the uptake of Direct Payments is growing, in particular among people with a physical disability, there is potential to grow this and other self-directed support approaches considerably within this group. Feedback from some indicates that bureaucracy is a barrier to uptake of

Direct Payments and a regional approach is needed to tackle this issue and encourage greater uptake.

Set against the endorsement of the forthcoming Physical and Sensory Disability Strategy, the Review proposes the following:

SUMMARY OF KEY PROPOSALS

28. Promoting independence and control for people with a disability, enabling balanced risk-taking.

29. A shift in the role of the health and social care organisations towards being an enabler and information provider.

30. Joint planning of services for disabled people by the statutory, voluntary and community health and social care providers, and other relevant public services (e.g. housing) to ensure a wide range of services across NI.

31. Better recognition of carers' roles as partners in planning and delivering support, and more practical support for carers.

32. More control for service users over budgets, with continued promotion of Direct Payments, and a common approach to personalised budget with advocacy and brokerage support where required.

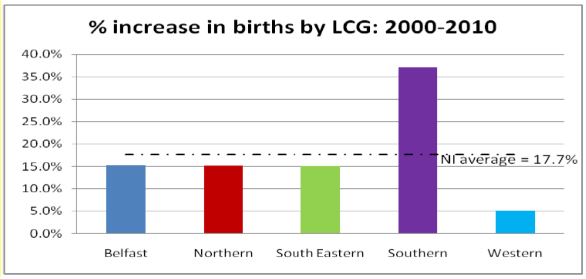
33. More respite and short breaks provision.

11.MATERNITY AND CHILD HEALTH

MATERNITY

The Review is cognisant of the current consultation on Maternity Services[67] and has factored that work into its thinking. In 2010 there were over 25,000 live births registered in Northern Ireland. During the last decade (2000-2010) the birth rate in Northern Ireland has increased by almost 18%. There are significant differences in birth rates across the province, as illustrated in the figure below.

Figure 17: Increase in births by LCG: 2000-2010[68]



Almost all births (99%) took place in hospital, and most mothers (91%) gave birth in their nearest consultant led unit.[69] Less than 1% of mothers are choosing to give birth at home. In recent years the proportion of births to teenage mothers has decreased (5.0% in 2010). Projections indicate that birth rates are likely to decrease over the next decade to approximately 23,500 by 2022/23.

There are a range of consultant led, co-located midwifery led, and freestanding midwifery units in NI. The capacity of the service to provide the recommended level of staffing cover for intra-partum care and to sustain inpatient paediatric services across all existing sites presents challenges, particularly for smaller units.[70]

Maternity care is of a high standard and according to recent surveys, women are happy with the standard of care they receive[71]. However there is increasing potential for variation in the provision of maternity care across Northern Ireland. In addition there are significant inequalities in maternal and infant outcomes, particularly amongst women from socio-economically deprived backgrounds.

The level of caesarean sections is generally higher than in the rest of the UK. There is increasing complexity arising from lifestyle for expectant mothers, most notably the increased rate of obesity, which provide both challenge and risk, across the population. Additionally many

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[67] Maternity Strategy for Northern Ireland, September 2011. DHSSPSNI, 2011

[68] NISRA in Health Intelligence briefing Trends in Northern Ireland Births and future projections, Public Health Agency 2011

[69] Births in Northern Ireland (2010), A Statistical Bulletin, Northern Ireland Statistics and Research Agency, March 2011

[70] Draft Commissioning Plan (Health and Social Care Board and the Public Health Agency – June 2011)

[71] Parental Views on Maternity Services. Parents' views on the Review of Maternity Services for Northern Ireland. Patient and Client Council, 2010.

women now choose to start their families later in life.

Challenges for maternity services into the future include:

- give a realistic choice of birth location for women;
- need for more continuity of care throughout pregnancy;
- reducing unnecessary interventions;
- dealing with the public health issues facing women of child bearing age to reduce ill-health and disability of mother and child; and
- supporting the expectant mother in her ante-natal care and connecting that support to the early years of parenthood.

The Review therefore expects change to follow the pattern set out in the forthcoming Maternity Strategy, from pre-conception, through pregnancy, birth and the post-natal period. In addition it recommends a specific regional plan for supporting the small number of mothers with serious psychiatric conditions.

CHILD HEALTH

Child health problems are often diverse in nature, severity and duration. The causes are often multi factorial and sometimes poorly understood. Effective interventions are often complex and time consuming, requiring a range of skills to be tailored to the needs of individual children.

Following the principle of care at or close to home, the Integrated Care Partnerships will be vital. However it was also clear to the Review that communities and the independent sector should be enabled to support families with ill children where appropriate.

When children need hospital care they need prompt access to skilled staff. There are challenges in providing a full range of paediatric sub specialties to a population of 1.8 million. Given this, there is a need to have clear pathways and consequent consistency of treatment.

In this field workforce issues and multiple service locations have the potential to threaten service resilience. Single handed specialties are difficult to sustain unless networked with other centres, whilst scarce skilled resources need carefully managed in the hospital setting. Notwithstanding this, community paediatrics should become a key resource working alongside integrated care partnerships enabling most care to be provided at or closer to home. The Review also saw potential for more formal links to larger centres in the UK or Republic of Ireland for this service area.

During its deliberations the Review team received a strong plea to examine, as a specific task, the nature, function and shape of in-patient paediatric services. The Review was persuaded this merited a separate piece of work. In this regard it also had drawn to its attention the very specific issue of palliative care for children.

Although there is a Children's Strategy for Northern Ireland there is no strategy for child health and no specific arrangements for palliative and end of life care for children. One of the Review proposals is that palliative and end of life care for children should be considered as part of the proposed review of Paediatric Services.

SUMMARY OF KEY PROPOSALS

Maternity

34. Written and oral information for women to enable an informed choice about place of birth.

35. Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy.

36. Services in consultant-led obstetric and midwife-led units available dependent on need.

37. Promotion of normalisation of birth, with midwives leading care for straightforward pregnancies and labour, and reduction over time of unnecessary interventions.

38. Continuity of care for women throughout the maternity pathway.

39. A regional plan for supporting mothers with serious psychiatric conditions.

Child Health

40. Further development of childhood screening programmes as referenced in the Health and Wellbeing section.

41. Child health included as a component of the Headstart programme referenced in the Family and Childcare section.

42. Promotion of partnership working on children's health and wellbeing matters with other government sectors.

43. Close working between hospital and community paediatricians through Integrated Care Partnerships.

44. Completion of a review of inpatient paediatric care to include palliative and end of life care.

45. Establishment of formal partnerships outside the jurisdiction for very specialist paediatric services.

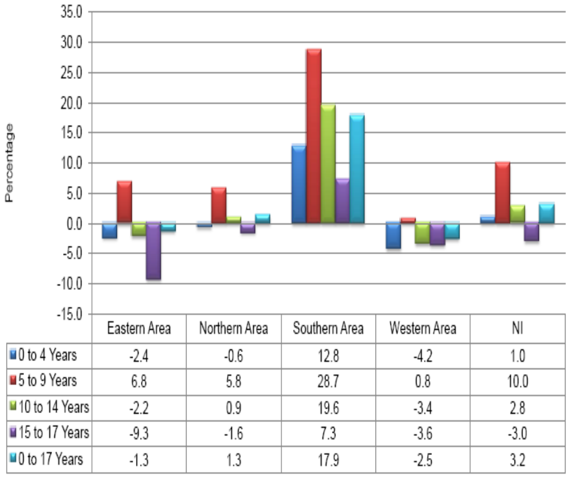
12.FAMILY AND CHILD CARE

INTRODUCTION

Approximately 24% of the Northern Ireland population is aged between 0 and 17 years. Population projections indicate this sector of the Northern Ireland population is set to increase by 3% by 2020. [72]

As the figure below illustrates, percentage increases between geographical areas is variable but the overall increase will bring increasing demands on family support services.

Figure 18: Percentage population change 2008-2023 by Area and Age Band



	Eastern Area	Northern Area	Southern Area	Western Area	NI
🟦 0 to 4 Years	-2.4	-0.6	12.8	-4.2	1.0
🟥 5 to 9 Years	6.8	5.8	28.7	0.8	10.0
🟩 10 to 14 Years	-2.2	0.9	19.6	-3.4	2.8
🟪 15 to 17 Years	-9.3	-1.6	7.3	-3.6	-3.0
🟦 0 to 17 Years	-1.3	1.3	17.9	-2.5	3.2

Source: NISRA 2008 Population Projections

Between 2005 and 2010 the number of Looked After Children per 1,000 children increased in Northern Ireland, England and Wales. The number of children on the child protection register per 10,000 children aged 0-18 is higher in Northern Ireland than in England, Scotland or Wales. Overall, the number of children on the child protection register has increased between 2006 and 2010 in all regions of the UK.

In 2010 there were 2,606 Looked After Children in Northern Ireland, up by 6% from 2009. The greatest proportion (65%) was in foster care. Between 2005 and 2008 the number of children in foster care decreased. Since then, this figure has increased by almost a quarter (23%) to 1,687. The total number of children on the child protection register has increased by almost 48% from 1,593 in 2005 to 2,357 in 2010.[73]

EARLY INTERVENTION

As discussed in Section 7, early intervention is an important focus in addressing population health and wellbeing.

It has been recognised by a number of independent reviews that, compared to other parts of the UK, there is a significant under investment in children's services

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[72] NISRA (2011) Population projections

[73] Social Briefing, Research and Information Service Briefing Paper, Northern Ireland Assembly, 83/11 NIAR 217/11, July 2011.

within Northern Ireland. Society will benefit from a coordinated effort to support and promote positive development of the intellectual, emotional and social skill of young children. There is a major incentive in getting this right. On a practical level, early engagement pays a very high rate of return. The dividend is 12%-16% per year for every £1 of investment – a payback of four or five times the original investment by the time the young person reaches their early twenties and the gains continue to flow throughout their life[74].

Key to this is promoting and supporting positive, engaged parenting particularly in those families where parenting skills are limited.

Children's services are heavily prescribed by legislation and associated guidance and regulations. These services operate within an infrastructure premised on the growth of partnerships which promote inclusivity and collaboration. These partnerships have enabled an increase in capacity and facilitated the improvement of outcomes.

The overarching principle set out within the Childrens (NI) Order 1995[75] that children are best cared for within the family of origin will continue to shape interventions and service delivery. The Review supports the development of advocacy, information services and training in the support of kinship care.

International best practice demonstrates that the health and social care needs of children and young people cannot be addressed by any single agency. A key example of this is the Children and Young People's Strategic partnership, which is a multi agency partnership whose purpose is to put in place integrated planning and commissioning aimed at improving the wellbeing of children in Northern Ireland.

The strategic direction over the past few years has recognised the importance of early intervention. The focus has been heightened through the publication of Families Matter[76], Healthy Child-Healthy Future[77] and the Family Nurse Partnership Initiative. The concept of Family Support Hubs is developing and the Family Support NI database provides an information and signposting resource for families, communities and professionals.

Child and Adolescent Mental Health Services (CAMHS)

The overall direction of Child and Adolescent Mental Health Services (CAHMS) will continue to be shaped by the Bamford Review of Mental Health and

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[74] (0-5): How small children make a big difference –The Work Foundation 2007

[75] The Children NI Order 1995, Legislation.gov.uk

[76] Families Matter: Supporting Families in Northern Ireland Regional Family and Parenting Strategy March 2009, DHSSPSNI

[77] Healthy Child, Healthy Future, A framework for the Universal Child Health Promotion Programme in Northern Ireland Pregnancy to 19 Years. DHSSPSNI, May 2010

Learning Disability. The needs of children with a disability remain a priority for commissioners and providers alike.

A Review of CAMHS in Northern Ireland was published in 2011 by the Regulation and Quality Improvement Authority[78]. A number of work streams are underway which will address many of that report's recommendations:

- progressing the Bamford Action Plan 2009;
- a review of Tier 4 services; and
- the appointment of a Commissioner for CAMHS.

Overall it is clear that child and adolescent services are continually improving and developing. However there is much work to do to develop and improve services further. It is estimated that to fully implement the RQIA recommendations may cost around £2million per annum. In the current financial climate this will require a prioritised approach.

Residential care

Approximately 11% of Looked After Children are in residential care. A number of issues have been identified:

- there is an increasing complexity of needs being presented by young people particularly in relation to mental health, drug and alcohol abuse, sexually harmful/vulnerable behaviours and criminality;
- it is difficult to provide flexible residential accommodation to meet the needs of a small number of young people; and
- young people aged 16+ are being excluded from their homes/ community as result of difficult behaviours.

Families

Families Matter: Supporting Families in Northern Ireland (Regional Family and Parenting Strategy 2009) moves parents into a central position in policy terms and strives to provide strategic direction on how best to assist parents in Northern Ireland to be confident and responsible in helping their children to reach their potential.

The wider vision of family support has been articulated in the Northern Ireland Family Support Model, which enables a 'whole system' approach to service planning. Its focus is on early intervention, ensuring that appropriate assistance is available to families at the earliest opportunity at all levels of need.

This model details four levels of need: all children and young people; children who are vulnerable; children who are in need and looked after children, illustrated in the figure below.

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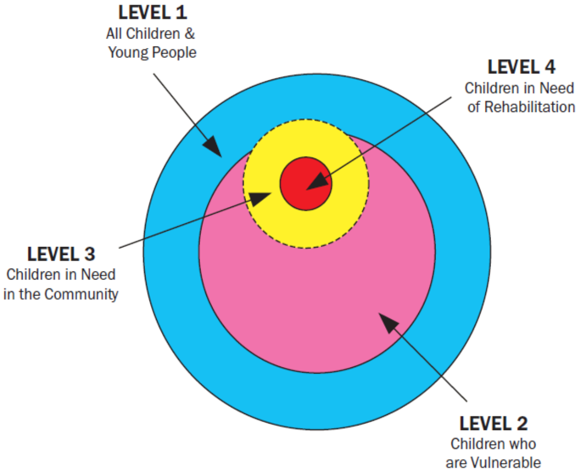
[78] RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland February 2011.

Figure 19: Northern Ireland Family Support Model[79]



It is widely acknowledged that early intervention produces positive dividends for children and families. The learning and experience from the Sure Start model which targets "children who will benefit most" and other similar initiatives here and elsewhere needs to be understood and extended where benefit can be demonstrated.

The Review acknowledges and endorses the streamlining and improving processes in regard to Children's Services as being taken forward through the Children's Services Improvement Board and Review on Co-operating to Safeguard Children. In addition the Review also makes the recommendations below.

SUMMARY OF KEY PROPOSALS

46. Re-structuring of existing services to develop a new 'Headstart' programme focusing on 0-5 year olds.

47. Exploration through pilot arrangements of budgetary integration for services to this group across Departments, under the auspices of the Child and Young People's Strategic partnership.

48. Completion of a review of residential care to minimise its necessity.

49. Promotion of foster care both within and outwith families.

50. Development of a professional foster scheme for those hardest to place.

51. Implementation of the RQIA recommendations in relation to CAMHS.

52. Exploration of joint working arrangements outside the jurisdiction, with particular regard to CAMHS services.

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[79] Families Matter: Supporting Families in Northern Ireland, Regional Family and Parenting Strategy. DHSSPS 2009

13. PEOPLE USING MENTAL HEALTH SERVICES

INTRODUCTION

Northern Ireland has higher mental health needs than other parts of the United Kingdom.[80] Based on the Northern Ireland Health and Social Wellbeing Survey (2001), 24% of women and 17% of men in Northern Ireland have a mental health problem – over 20% higher than the rates in England or Scotland.

Factors contributing to these rates include persistent levels of deprivation in some communities in Northern Ireland and the legacy of Northern Ireland's troubled history. For example, a recent study of the families of victims of Bloody Sunday found persistent effects of these traumatic events on the individuals concerned, with evidence of psychological distress still being found more than 30 years after the event.[81]

The incidence of suicide in Northern Ireland has been a particular concern in recent years. Suicide rates increased by 64% between 1999 and 2008, mostly as a result of the rise in suicides among young men. In 2008, 77% of all suicides were males and 72% were 15-34.

The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review) set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. The Bamford Review, which completed its work in 2007, has set the agenda for the transformation of these services. The Review heard nothing which challenged Bamford but did hear frustration at the speed of implementation.

Although there is frustration there is also progress with actions that lay the foundations for modernising and improving services, for example the development of new strategies and agreeing new models of care for particular conditions. However, it remains the case that tangible services on the ground are the touchstone by which those using the service judge its success.

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[80] DHSSPS (2004) The Review of Mental Health and Learning Disability (Northern Ireland). A Strategic Framework for Adult Mental Health Services. Consultation Report.

[81] McGuigan, K., & Shevlin, M. (2010). Longitudinal changes in posttraumatic stress in relation to political violence (Bloody Sunday). Traumatology, 16, 1–6

PROMOTION AND EARLY INTERVENTION

Raising awareness of mental health issues and reducing the stigma associated with mental ill-health continues to be a key objective of the reform and modernisation programme. In terms of primary prevention, a suicide prevention strategy Protect Life[82] was launched in 2006 and is currently being refreshed. A new five-year Mental Health and Wellbeing Strategy is being developed to support the whole population to maintain good mental health. The Review endorses these actions.

The Royal College of Psychiatrists' submission to the Review highlights that early intervention in psychoses can be effective and emerging evidence supports a similar approach for depression and anxiety. It therefore encourages development of a system capable of early intervention. The Stepped Care model (see figure below) promotes early intervention at the first stages of mental illness and the Psychological Therapies Strategy made recommendations as to how people with mild to moderate mental health problems could access psychological support. However, lack of investment has constrained the implementation of this strategy and feedback during the review suggested concern with the level of provision at Tiers 1 and 2.

Access to information about mental health services was raised by several of those with whom the Review engaged, including the Bamford Monitoring Group and registered social care workers. The Bamford Action Plan included plans to map available services and provide this information to service users, but progress has been slow in this regard. Users and carers told the Review how important it is to be able to easily access information on services that meet their particular needs.

PROVIDING THE RIGHT CARE IN THE RIGHT PLACE AT THE RIGHT TIME

The model of mental health care has evolved which promotes greater care at home and in the community rather than in hospital. A stepped care approach has been adopted, providing a graduated range of care to meet the patient's needs:

Figure 20: Stepped Care Model

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[82] Protect Life, A Shared Vision – The NI Suicide Prevention Strategy and Action Plan 2006-2011, DHSSPS

Each of the HSC Trusts has developed Crisis Response and Home Treatment models that provide services for acutely ill people at home and in the community rather than in psychiatric hospitals. The role, number and location of psychiatric inpatient units are also changing and Trusts are developing streamlined pathways for urgent mental health care.

However, these services have evolved differently in each area in terms of how people in crisis contact services, how they are triaged (by phone or in person at a hospital or other facility) and how they are treated in emergency departments. Whilst the Review acknowledges that there will be solutions for local areas, there is now a need to ensure that there is a consistent outcome for those who use the service. Additional home treatment services are still to be developed for particular client groups including children and young people, people with a learning disability and older people.

Despite the shift underway in care provision from the hospital to community setting, the Review noted that the objective to shift expenditure to a ratio of 60% community and 40% hospital has not yet been achieved.

PROMOTING INDEPENDENCE AND PERSONALISATION OF CARE

At the core of independence and personalisation is a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives. The Review strongly endorses this approach.

The voluntary and community sector plays a crucial role in providing the diverse range of support that may be needed. Recognising this, the Review recommends greater involvement of these organisations in planning provision for local populations. It also acknowledges this will be a challenge in some parts of the independent sector.

Provision of Direct Payments is one approach to support personalisation of care. However, among people with mental health issues, the uptake of Direct Payments has been lower than among other groups. At May 2011, a total of 81 people were in receipt of Direct Payments. The Review was told that perceived bureaucracy and inconsistent promotion of Direct Payments have been constraining factors.

A regional approach should be implemented to promote the uptake of Direct Payments among mental health service users including involvement of current recipients to share their experiences, and the provision of advocacy and support where needed should be considered. As a minimum, clear information on the financial package available should be given to those using the service.

INSTITUTIONAL CARE

A critical element in changing how things are done for this client group is to end long-term residency of people in mental health and learning disability hospitals. To date, 181 long-stay mental health patients have been discharged to the community. There are currently 150 long stay psychiatric inpatients who should be resettled into the community.

The model designed by the Review makes it clear that care should be provided at home or as close to home as possible. Fresh impetus into delivering the closure of long stay institutional care is required.

The Review urges an absolute commitment to completing the resettlement process by 2015 as planned, and ensuring that the required community services are in place to prevent the emergence of a new long-stay population. This should include developing models of treatment for children and young people, and those with specialist mental health needs, for example in the areas of learning disability and psychiatry of old age.

Attempts to shift the balance of spend between hospital and community expenditure should continue with reinvestment of any savings achieved in the hospital setting into community services.

The proposals below are set in the context of making tangible changes for mental health service users and their families and assessing the impact of that change on quality of life.

SUMMARY OF KEY PROPOSALS

53. Continued focus on promoting mental health and wellbeing with a particular emphasis on reducing the rates of suicide among young men.

54. Establishment of a programme of early intervention to promote mental health wellbeing.

55. Provision of clearer information on mental health services should be available to those using them and their families, making full use of modern technology resources.

56. A consistent, evidence-based pathway through the four step model provided across the region.

57. A consistent pathway for urgent mental health care including how people in crisis contact services, triage and facilities in emergency departments.

58. Review the approach to home treatment services for children and young people, learning disability and psychiatry of old age.

59. Further shift of the balance of spend between hospital and community, with reinvestment of any hospital savings into community services.

60. Greater involvement of voluntary and community sector mental health organisations in planning provision as part of Integrated Care Partnerships.

61. Promote personalised care promoting the uptake of Direct Payments among mental health service users with involvement of current recipients to share their experiences, and advocacy and support where needed.

62. Close long stay institutions and complete resettlement by 2015.

14.PEOPLE WITH A LEARNING DISABILITY

INTRODUCTION

A learning disability is a lifelong condition and requires long-term support. Provision of services for people with a learning disability requires a multi-agency and integrated approach – it is not solely a health issue. The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review) set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland.

In regards to this care programme the Review heard nothing which challenged Bamford, but as with mental health services, did hear frustration at the speed of implementation. Despite this frustration there is progress, with actions being completed that lay the foundations for further change, for example, the development of new strategies and agreeing new models of care. Ultimately though, those who are supported judge it by changes to services on the ground. In this regard the Review heard of the need for more rapid progress.

EARLY INTERVENTION AND PROMOTION

The importance of early years intervention to support positive life outcomes was highlighted throughout the Review's engagements with the public, clinicians and others. While children with a learning disability and their families may be able to avail of early years support this is variable across the region. Consistent with the proposals set out in Section 12 on Family and Childcare, the Review considers that early years support for children with a learning disability should be part of a coherent and consistent programme of support for 0-5 year olds.

Many learning disabilities have associated physical health conditions, for example complex mobility or personal care needs, whilst the rates of early onset dementia are much higher among those with Down's Syndrome than among the general population. Evidence was presented to the Review on the challenges for people with a learning disability in accessing the full range of healthcare provision enjoyed by the general population. In particular, accessing health services such as occupational therapy, physiotherapy and speech and language therapy was highlighted as being important. People with a learning disability also identified a need for disability awareness training for clinical staff in the community who do not always deal appropriately with them, for example, not providing enough time and not speaking directly to the disabled person. The Review considered improvement in this area as fundamental.

Programmes are in place in each population area to enhance access to primary healthcare services for people with a disability including annual healthchecks and employment of health facilitators in the community. The Review endorsed this approach but was clear that a consistent outcome for all is important. In this regard it was made aware of particular problems in accessing Dentistry.

As services are planned Integrated Care Partnerships should be asked to ensure that clinicians are facilitated to respond more appropriately to the needs of people with a learning disability.

PROMOTING INDEPENDENCE AND PERSONALISATION

Promoting independence and personalisation is a key principle underpinning the model proposed by the Review. Feedback provided to the Review indicates that achieving this objective for people with a learning disability will require particular focus on the following areas:

- Day services - the diversity and age-appropriate nature of day services remains an issue for people with a learning disability. While there has been progress made in reforming the day centre-based model and providing more community based options, there is further work to be done in this regard. A one size fits all service will be less relevant in the future;

- Respite and short breaks - provision has increased but service users and carers indicate that much remains to be done to meet current needs. Services are frequently accommodation based. While these are important more flexibility in the home or local day placement should be explored. Respite care is not always age appropriate, for example, respite provision in nursing homes primarily for older people has limits. New models need to be created;

- Direct Payments – the number of people with a learning disability taking up Direct Payments has increased from 218 in June 2008 to 561 at May 2011 but the Review heard that service users and carers need more information and support with Direct Payments. Sharing the experiences of current recipients is recommended, along with provision of advocacy and support where needed. As a minimum clarity about the financial commitment should be available;

- Information – in general, users and carers consider it remains difficult to access information on the services available for people with a learning disability. Information on housing options was highlighted as an issue. Many carers are also unaware of their right to a carer’s assessment and access to support to meet their physical and emotional needs; and

- Advocacy – people with a learning disability expressed the need for peer and independent advocacy to support them in making decisions and protecting their rights.

The Review considered voluntary and community sector organisations have a crucial role in providing support to people with a learning disability. In some instances these are organised and run by parent groups. This should be supported.

INSTITUTIONAL CARE

A critical element in changing the model of care and support for people with a learning disability is to end long-term residency in hospitals. Since 2008, 642 long-stay learning disability patients have been discharged to the community. There are currently around 200 long-stay inpatients in learning disability hospitals who should be resettled into the community.

The majority of learning disability services are already provided in the community as opposed to hospitals. The ratio of spend is 82% in the community to 18% in hospital. New community facilities are being developed for assessment and treatment for people with a learning disability which will support the resettlement programme. The Northern Ireland Housing Executive's Supporting People Programme also plays an essential role in developing a range of supported living options in the community for people with a learning disability. Supporting People has enabled 23,000 people (including both mental health and learning disability service users) to live independently.

The proposals below are set in the context of making tangible changes for people with a learning disability and their families and assessing the impact of that change on quality of life.

SUMMARY OF KEY PROPOSALS

63. Integration of early years support for children with a learning disability into a coherent 'Headstart' programme of services for 0-5 year olds as referenced in the Family and Childcare section (Section 12)

64. Further development of the current enhanced health services on a Northern Ireland basis.

65. Support from Integrated Care Partnerships to improve clinicians' awareness of the needs of individuals with a learning disability.

66. Better planning for dental services should be undertaken.

67. Further development of a more diverse range of age-appropriate day support and respite and short-break services.

68. Greater financial control in the organisation of services for individuals and carers, including promoting uptake of Direct Payments with involvement of current recipients to share their experiences, and advocacy and support where needed.

69. Development of information resources for people with a learning disability to support access to required services.

70. Advocacy and support for people with a learning disability, including peer and independent advocacy.

71. Commitment to closing long stay institutions and to completing the resettlement process by 2015.

15.ACUTE CARE

Acute care is often perceived as synonymous with hospitals. However it also includes elements of primary care such as Out of Hours. This part of the report comments upon:

- unscheduled care;
- planned care;
- ambulatory care and diagnostics; and
- regional services.

UNSCHEDULED CARE

Unscheduled care includes such services as accident and emergency, emergency surgery, intensive care, coronary care, stroke services, urgent care and medical admissions. Trauma and orthopaedic services are integral to emergency care.

Ambulatory care, where patients can walk in and walk out on the same day can also be unscheduled care.

The Review does not propose to extensively define each component of service but considers it prudent to share its thinking about urgent care, emergency departments or A&E services. Three broad levels exist:

- Major trauma, which is dealt with regionally;
- Emergency intervention most commonly associated with the 999 ambulance service; and
- Urgent care/ Out of Hours care where a difficulty exists but it does not initially present as life threatening and includes minor injuries.

Unscheduled care is currently delivered via 10 Accident and Emergency Departments (9 of which are 24/7 consultant led), 8 Minor Injuries Units and 19 GP Out of Hours facilities and supported by the NI Ambulance Service.

Evidence suggests the system is increasingly not fit for purpose in the 21st century.

For example the HSC is failing to deliver acceptable A&E waiting times of 95% of patients waiting no more than 4 hours and no patients waiting for more than 12 hours. Overall, performance against these standards has been poor other than in the Southern Trust, both in relation to the 12-hour and four hour standards. Regionally, there were 7,386 breaches of the 12-hour standard in 2010/11 (compared to 3,883 during 2009/10) and cumulatively only 82% of patients were treated and discharged, or admitted within 4 hours of their arrival in A&E during 2010/11.

As discussed in the Case for Change, the Royal College of Surgeons' evidence is that better organised care equals better outcomes for the patient.

New treatments and associated technology for stroke and coronary care are a challenge to deliver in the existing model. Maintaining the supporting infrastructure necessary for high dependency or intensive care in our current model also presents a challenge. Additionally difficulties in retaining appropriately trained staff creates sustainability issues and remains a frequent challenge.

Organisational resilience is a recurrent problem. Each year the current model cannot appropriately staff its A&E service with all of the quality and financial issues that flow from this.

The public in a different way expresses similar problems:

- 91% of the people involved in the omnibus survey felt that improvement was needed to the time spent waiting in A&E, of which 56% stated that a lot of improvement is needed.
- 68% of people surveyed in the Omnibus survey agreed or strongly agreed that they would be prepared to travel a further distance for hospital services if it means they don't have to wait as long. There was no significant difference in the response from people from an urban area (67%) compared to those in a rural area (70%).

EMERGENCY SERVICES

Proximity to acute facilities is often perceived as the determining factor as to whether the local health and social care service will adequately provide for their needs. Increasingly, however, it is not only the distance to the appropriate facility that may determine outcome for the patient, but also the timeliness of the initial intervention.

For example, a person with a stroke needs to get access to the staff and technology to diagnose the stroke as quickly as possible, as explained:

Best Practice Guidance - Stroke Care

Evidence shows that people with an ischaemic stroke who receive thrombolytic treatment within 3 hours of onset are more than twice as likely to have favourable outcomes (such as reduced disability and lower mortality rates) after three months.[83] However, this treatment would harm people with haemorrhagic stroke. Therefore, it is essential that suspected stroke patients are transferred directly to an acute setting with the staff with appropriate skills and access to diagnostics which will allow accurate diagnosis (and therefore appropriate treatment) as quickly as possible.

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[83] Best Practice in Stroke Care 2007, Buchan, A (sourced from Healthcare for London: A Framework for Action report

The Omnibus survey showed that 70% of people surveyed agreed or strongly agreed that they would be prepared to travel a further distance for hospital services if it means they get the best treatment and 71% agreed or strongly agreed that ambulance staff should take seriously ill people to a hospital with the specialist services they need even if it is not the closest hospital.

The Rural Trauma Outcome Study in Scotland[84] showed that longer pre-hospital travel times did not increase mortality or length of stay.

The omnibus survey also highlighted the fact that the majority of the public are aware of where to attend in a number of circumstances, for example 74% of people said that they would attend the GP Out of Hours service if they had a child with a high temperature after 10pm.

However, it appears that the public do not actually attend the most appropriate setting for their needs. Of the activity recorded within the accident and emergency departments across NI, 50% of these are for conditions rated as standard cases without immediate danger or distress (Category 4 based on the Manchester Triage Categories). It can be assumed that a large proportion of these cases could be cared for in an urgent care setting without the need to attend an accident and emergency department.

Furthermore, for less common emergencies it is essential to maintain the required skills to enable the best patient outcome.

A model of care has been set out which delivers best outcomes to patients with major trauma and ensures a resilient service for the population of NI.

Regional Trauma Service

Major Trauma is the single biggest potential cause of death of people under 35 years of age. Due to the relatively small population of Northern Ireland (circa 1.8m) and the low incidence of major trauma cases (approximately 0.02% of the total population per annum), it is impractical to equip and staff all hospitals to the required level to provide optimal care for patients with major trauma.

The DHSSPS has recommended that the Royal Victoria Hospital becomes a regional trauma centre acting as the hub of the NI trauma network. Protocol dictates that patients should be transferred to the Royal Victoria Hospital directly, provided they are able to withstand the journey. If a patient is not able, they will be taken to the nearest major acute hospital within the network with the intention of transferring them to the Royal Victoria Hospital when they are able. Staff employed at the acute hospitals within the network receive appropriate training to maintain their skills.

This Review concluded that a similar model could be considered for other

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[84] Scottish Urban v Rural Trauma Outcome Study, J Trauma September 2005

emergency conditions which do not present in sufficient numbers for services to be maintained at all acute sites.

The result of networking services will be a model which includes a major acute hospital supported by a network of hospitals providing services to meet the needs of the local population. There are ten acute hospitals in Northern Ireland. In Great Britain populations of 1.8million are supported by maybe only four large hospitals. The Review accepted that by 2016/7 the model of major acute hospitals for Northern Ireland's more dispersed population will reconfigure to a more appropriate scale.

This will mean change at several of the current acute hospital sites, and the Review recommends that the key test for any future service configuration must be that it is sustainable and resilient in clinical terms. We recommend that each Local Commissioning Group should draw up specific proposals, taking account of the potential to provide service to the ROI. The Review's view is that it is only likely to be possible to provide resilient sustainable major acute services on five to seven sites, assuming that the Belfast Trust hospitals are regarded as one network of major acute services.

The Role of the Northern Ireland Ambulance Service

The role of the NIAS will be key in ensuring that people are treated in the right place at the right time. Patients should be transferred to the correct location first time where possible, to avoid further transfers at a later stage. It will be important that the NIAS can transfer people not only to Accident and Emergency Departments but also to Urgent Care Centres, Minor Injuries Units or GP Out of Hours. Bypass protocols will be required which clearly define which location patients should be transferred to for each type of condition.

Better management of unscheduled care in partnership between the HSC Trusts and the NIAS offers potential for improving care, patient flows efficiency and patient satisfaction.

Alongside all of this, it will be essential that the public are provided with information about the correct procedures in an emergency.

Quality of Outcome

Quality of outcomes requires that senior clinical decision makers are available at all accident and emergency departments 24/7/365. The model will be capable of delivering this outcome.

For the model to be successful it will need the support of urgent care centres, minor injuries units and GP in and Out of Hours services.

Delivering this model will require clinicians to be networked as one workforce pool for its population to ensure that training and good organisational opportunities are available to deliver a safe, high quality service.

URGENT CARE SERVICES

The clinical advances that result in a more specialised workforce create tension between local accessibility of urgent care services and the need to provide high quality services in acute hospital settings.

The current model includes a small number of Minor Injuries Units and GP Out of Hours to support Accident and Emergency Departments. Given the high volume of attendances at A&E which are Category 4[85] and below, there is potential to do things differently and achieve consistent outcomes. Accident and Emergency Departments can and should be supported more locally through an integrated urgent care model.

The urgent care model is not a 'one size fits all' approach. It is an approach which looks at the needs of the local people and tailors the provision to meet their urgent care needs. This model could, for example, look very different for an urban area compared to a remote rural area. Urgent care should be available on a 24/7/365 basis, including some on-call arrangements where necessary. The services to be provided to a population would be minor injuries, specialist nurses trained in urgent care, urgent care GPs, specialist teams such as mental health crisis response teams and urgent care social workers. The key is that these services are delivered in an integrated fashion.

These services will be supported by diagnostics available in the local community and the ability for GPs to directly admit patients into beds where necessary. Many of these services, other than beds, could all be available within a health and care centre setting, like the Health and Care Centre at Holywood Arches for example.

GP Out of Hours services are currently available for urgent care outside of the normal GP practice opening hours.

GP Out of Hours services should work as an integrated model of care with other urgent care services. A good local example of this working in practice is Downpatrick Hospital. In the UK the Shropshire approach has merit, as outlined below.

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[85] Cases without immediate danger or distress, Manchester Triage

Good Practice Example

Shropshire Doctors Co-operative Ltd (Shropdoc) provides urgent medical services for patients when their own surgery is closed and whose needs cannot safely wait until the surgery is next open, i.e. evenings, weekends and bank holidays.

The service also supported Out of Hours nursing arrangements. Shropdoc doctors carried ‘Rapid Response Boxes’ for palliative care, catheterisation, resuscitation, syringe drivers and controlled drugs and therefore undertook much of the night-time care that might otherwise have been referred to district nurses or resulted in patients being admitted.

Shropdoc also ran the Care Coordination Centre. This provided a single point of access for GPs to other services between 8am and 6pm and included physiotherapy triage for some referrals.

This model has been working well and has the potential further to develop.

CLEAR PROTOCOLS FOR THE POINT OF CONTACT FOR EMERGENCY AND URGENT CARE

There is evidence that the options available to the public in dealing with emergency and urgent cases are limited or not well known. As outlined above, it is important that people are referred to the place that is best suited to meet their medical needs. This will require clear communication with the public as to the types of facilities available, where they are located and under what circumstances they should be used.

To allow this, it will be important that the public can get access to the right advice at the right time. At present this is through the 999 emergency telephone number. The introduction of an urgent number to work alongside the emergency 999 number would allow people to talk to a trained professional who will be able to advise them on the best route for them, be that to an Accident and Emergency Department, an Urgent Care Centre, Minor Injuries Unit, GP Out of Hours service or to wait for a GP appointment the following day. The NIAS will play a pivotal role in managing unscheduled care into the future.

Dedicated Care pathways should be developed for children and people with long term conditions that will allow direct contact with a trained team available to support them in an emergency or when requiring urgent care. This should involve the ability to directly admit these patients to beds hospitals.

PLANNED CARE

INTRODUCTION

Planned or Elective care includes inpatient admissions which happen with prior planning, sometimes at relatively short notice. Often these services cover major treatments or interventions, for example cancer surgery, diagnostics, testing to assist diagnosis, for example blood tests or X-ray and planned ambulatory care, where patients can walk in and walk out on the same day.

Planned care is currently delivered largely from our 10 acute hospitals, 5 local hospitals and a number of community hospitals. There are approximately 6,646 (average 2010/11) hospital inpatient beds in NI (3,683 acute beds and 2,963 non acute beds).

Increasing demand has evidenced itself through rising numbers of inpatient Finished Consultant Episodes. This reflects the increasing subspecialisation as well as absolute demand.

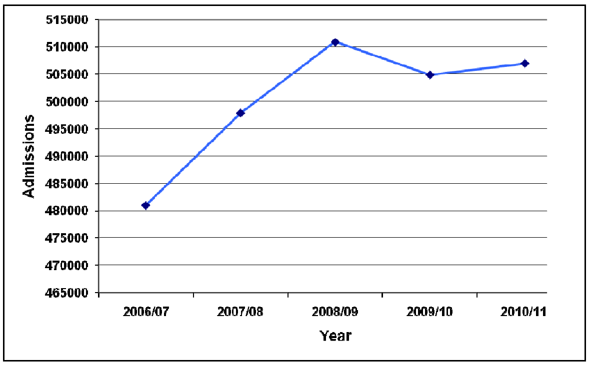
Some changes to service patterns have occurred, for example in cancer and urology, to improve outcomes. Whilst the role of some hospitals has also changed, more is required. However such change cannot happen without recognition of the impact on our current model. Partial change simply pressurises the existing system.

As stated in the Case for Change for both planned and emergency inpatient stays the length of stay is above UK levels.

During 2010/11, a total of 1,502,611 patients were seen at consultant led outpatient services within HSC hospitals in Northern Ireland.

The Total Admissions to HSC Hospitals in Northern Ireland under the Acute Programme of Care are shown in the figure below.

Figure 21: Acute Admissions



Source: DHSSPS Hospital Statistics

Our daycase rates are lower than they should be at 64% (2010/11) compared to the target of 75%. This means that the service is over reliant on inpatient beds when carrying out the procedures which could be carried out as a daycase.

The current target determines that at least 50% of inpatients and daycases are treated within 13 weeks and that all cases are treated within 36 weeks. At present, the current system is failing to meet these targets. Concern about increasing waiting times was highlighted as one of the

People's Priorities by the Patient and Client Council.

In the future planned care will be treating more older people. Planned care needs to be organised separately from emergency care. It gives better patient outcomes and enhances productivity. The Review therefore wishes to see better organisation of planned care.

Where there are planned specialist treatments, which are highly specialised, they will need to continue to be provided in one centre in Northern Ireland or via an agreement with a tertiary centre elsewhere (e.g. GB or ROI).

Diagnostics is an integral part of planned care. It assists the diagnosis of illness, for example blood tests, X-ray, MRI scans etc. These services are currently delivered within major acute hospitals and health and care centres. The review of Pathology Services in NI recommended there should be a managed clinical network for pathology. The Review strongly reinforces the expeditious implementation of this recommendation.

The current target determines that no patient waits longer than 9 weeks for a diagnostic test. In 2010/11 there were 23,518 breaches of this target.

Given all of this, it is impossible not to come to the conclusion that change needs to happen to improve outcomes for patients.

CARE CLOSER TO HOME

Evidence[86] shows that separating emergency and planned care improves outcomes in terms of continuity of care for patients, improved training for staff and faster access to senior opinion. The organisation of planned care should be clinically led and supported by the appropriate infrastructure.

Inpatient Activity

Key to the delivery of effective services is to ensure that people are given the right care in the right place at the right time. For planned care this means ensuring that people who need to be seen urgently are done so, that people who can wait do and that they are seen within a reasonable period of time.

Better organisation of planned services was supported by the Omnibus Survey which highlighted the following:

- waiting times for an appointment with hospital consultant: 82% felt some improvement is required, including 36% who felt that a lot of improvement was required; and

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[86] Separating Emergency and Elective Care: Recommendations for Practice, The Royal College of Surgeons of England, March 2007.

Delivering surgical services: Options for maximising resources. The Royal College of Surgeons of England, March 2007.

- waiting times for on emergency operations: 88% felt some improvement was required including 36% who felt that a lot of improvement is required.

In supporting the principle that care should be closer to home it will be important to ensure that referrals to acute hospitals and inpatient beds are for sound medical reasons.

Similarly when people are admitted as an inpatient, appropriate discharge protocols must be in place to ensure timely discharge.

This can be supported by multi-disciplinary teams in the community and the availability of intermediate care (care between home and hospital), including step-up and step-down facilities.

Outpatient and Diagnostics

Evidence suggests that GPs and nurses could carry out a proportion of outpatient appointments without the need for a consultant appointment. The location of these types of appointments does not need to be in an acute setting.

The National Primary Care Research and Development Centre[87] identified a number of approaches which resulted in effectively reducing demand for specialist outpatient treatment without impacting on quality or safety. These included primary care clinics for chronic diseases; discharging hospital outpatients to no follow up (patient initiated follow up only); and direct access by GPs to hospital-based diagnostic tests, investigations and treatments.

Case Study

In NHS Stracathro hospital in Scotland acute medical services are being concentrated in larger hospitals that have a full range of support services and technology. Smaller hospitals were reconfigured to provide a wider range of other services including: the management of chronic illness, community rehabilitation, provision of diagnostics and therapy and more local outpatient clinics delivered more locally than ever. The relatively small number of patients who require specialist inpatient treatment are managed in acute hospitals capable of meeting quality and safety standards.

A large proportion of diagnostics could be carried out within facilities closer to people's home. Diagnostics should be available alongside GP practices with the ability for GPs to directly refer patients.

Day cases where possible

Advances in surgical and medical techniques have meant that more procedures can be done as day cases. The Review recommends a better organised response to making sure the individual is referred to the most appropriate location for the best outcome.

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[87] Can Primary Care reform reduce demand on hospital outpatient departments? (March 2007)

The HSC should continue to work towards the 75% rates of day cases for surgical procedures for the basket of 24 procedures. This will assist the move away from inpatient care unless medically necessary.

While there is a strong argument for locally accessible services and care closer to home, this cannot be at the cost of quality and safety. There is recognition than any transfer of services must maintain the levels of both quality and safety.

HOSPITAL NETWORKS

To ensure good patient outcomes no hospital in the future can work other than as part of a network.

In order to provide complex healthcare safely and allow professionals to keep their skills and knowledge up to date they need to treat sufficient volumes of patients with particular conditions. Safe treatments are therefore difficult to deliver at every hospital because there are not enough patients to maintain the skills of the professionals.

Networks should be established to ensure that accessible and safe services are available to all citizens. For common conditions there will be sufficient demand to allow those services to be delivered as locally as possible, either through local hospitals or community facilities. For less common conditions, there will be a need to centralise services on major acute sites to ensure that a resilient workforce is available to support that service.

Planned services provided in hospitals should be organised to meet the needs of that population.

No facility or department should operate as a standalone unit. Professionals should work in networks across hospitals and Trusts to deliver the best care to the patient by working together. This can also help to sustain local services with staff in local hospitals networking with larger acute hospitals, or through provision of nurse-led facilities supported by appropriate medical backup and working with effective transfer protocols for patients requiring acute medical care.

Care Pathways

Care pathways are an important route map for how people will experience treatment and are clinically led.

While there has been some progress in developing tailored care pathways for specific conditions and to address the issue of resilience in the service, there needs to be more consistency of approach across the region to ensure the best quality care is provided, the service is resilient and sustainable and that people are treated in the right place at the right time.

Specialist Provision

The Review has already offered its thinking on the implications of the overall population size of 1.8million for sustaining the viability of specialist hospital services. Consequently this leads to vulnerable services which are difficult to attract staff to work in and if not effectively networked have the potential for poorer outcomes.

The sustainability of these services will best be delivered through networking with other tertiary centres, either in GB or ROI. This allows for consultants to gain the sufficient experience required and allows for multi-disciplinary team discussions on patients. Networks already exist for paediatric cardiac surgery (with the ROI), adult intensive care, cancer and pathology services.

The HSC sent 336 patients to hospitals in GB and ROI in the 6 months to September 2011 to be treated. Where services are so specialist the HSC cannot deliver these in NI, either in isolation or within a network. These types of specialist services will continue to be sent to specialist tertiary centres either in GB and ROI.

The Review recommends the development of joint planning arrangements with colleagues in the Republic of Ireland. In the first instance this would look at:

- shared opportunities in tertiary and specialist care,
- procurement,
- services in the New Hospital in the South West, and
- services which straddle the Border areas.

This would include a regular planning interface between the two jurisdictions to ensure areas of mutual interest are explored. These arrangements would be in addition to Co-operation and Working Together (CAWT), the existing partnership between the Health and Social Care Services in Northern Ireland and ROI, which facilitates cross border collaborative working in health and social care.

TECHNOLOGY

Technology will be a major enabler of networked working and care closer to home.

Investigations and treatment have become much more sophisticated requiring 24-hour access to increasingly complex technology – CT (Computerised Tomography) and MRI (Magnetic Resonance Imagery), sophisticated blood tests etc.

Technology will be required to support the changes in delivery of unscheduled care. Technology will allow all parts of the HSC to be linked in, allowing them to share live information on patients regardless of their location.

There is emerging evidence of the potential for telemedicine to support timely and appropriate inter-hospital transfer as well as better networking between hospitals. Some examples are shown below.

Example of Technology Working in the HSC

The Southern Trust currently operates a tele-dermatology service in which a specialist nurse sees the patient in an outreach clinic with a consultant remotely verifying the skin condition (via a high resolution photograph of the skin condition electronically sent to their location) and providing guidance on the most appropriate nurse or doctor-led pathway for the patient to follow.

The opportunities for technology to support the new model of care are explored further in the Implications section of this report.

CONCLUSION

All of this leads to a conclusion doing nothing is not an option and that planned and organised change is essential to achieve the following objectives:

- Right Care, Right Place, Right Time, Right Outcome;
- Organising Sustainable Inpatient Care;
- Improving Diagnostics;
- Engaging Primary Care;
- Creating a Sustainable Service;
- Being responsive to the public;
- Balancing local and central demand with quality and safety; and
- Providing clear information to the public about how to access services.

SUMMARY OF KEY PROPOSALS

72. Reinforce the full development of the Regional Trauma Network set out in the DHSSPS document.

73. Over time, move to a likely position of five to seven major acute hospital networks in Northern Ireland.

74. Ensure urgent care provision is locally available to each population.

75. Set targets for the reduction of hospital admissions for long-term admissions and end of life care.

76. Set targets for the reorganisation of outpatient and diagnostic services between hospitals and Integrated Care Partnerships.

77. Ensure the transition takes full account of Service Frameworks and clinical pathways.

78. Expeditious implementation of a managed clinical network for pathology.

79. Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements.

16. PALLIATIVE AND END OF LIFE CARE

INTRODUCTION

Palliative and end of life care is an important service in our system, expressing the essence of the values of the NHS. Palliative Care is defined as: "the active, holistic care of patients with advanced progressive illness". End of life care is a component of palliative care.

The Review heard no reason to challenge the Northern Ireland Palliative Care Strategy 'Living Matters, Dying Matters'[88], outlines an approach to improve the quality of palliative and end of life care for adults in Northern Ireland, irrespective of condition.

Approximately 15,000 people die in Northern Ireland each year. The main causes of death are circulatory diseases (35%), cancer related deaths (26%) and respiratory diseases (14%). Over two thirds of deaths occur in hospitals and nursing homes. The death rates in NI are falling and improving life expectancy means that the population of Northern Ireland is becoming 'older'. The profile of older people requiring care is becoming more complex, with many people now living with multiple chronic illnesses. Recent predictions suggest that one third of people over the age of 65 will be living alone by 2020.

Given that the prevalence of chronic conditions and dementia increases with age, demand for palliative and end of life care services is likely to increase.

As a society we need to have open and honest discussions with all age groups about the processes of dying, death and bereavement. We also need to understand the significance of planning ahead to avoid having to react in a crisis as well as planning for a death with dignity. Using some of the questions outlined in models such as in the Gold Standards model[89] can enable increased awareness and preparedness. We need to increase our understanding of when the palliative care phase ends and the end of life phase begins. These phases can move backwards and forwards and it may be difficult to determine when someone is dying. This can assist people in coming to terms with death and dying including the aspiration of planning for a good death.

Although the Palliative Care approach has traditionally been used for people mainly with a cancer diagnosis, it is applicable to other causes of death. The Review heard of a recognised inequity of access to palliative care for non cancer patients. General palliative care is delivered by a range of professional staff in primary, hospital and community settings.

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[88] Living Matters Dying Matters – A Palliative and End of Life Strategy for Adults in Northern Ireland - DHSSPS March 2010

[89] Gold Standards Framework

Specialist palliative care including complex psychosocial, end of life and bereavement issues is provided within HSC and by voluntary sector organisations that make a valuable contribution in this area of care.

It is estimated that two thirds of all deaths in Northern Ireland (9,570) would benefit from the palliative care approach in the last year of life, but do not receive it. 20,000 bed days are used in NI for people dying in hospital from cancer conditions alone. There is currently no strategy that directly addresses the palliative and end of life needs of children.

We correctly invest a large volume of resource in the last year of life, but often provide poor quality which does not meet patient and carer wishes. The Review concluded it can be improved with greater coordination of care in order to ensure that people die with dignity.

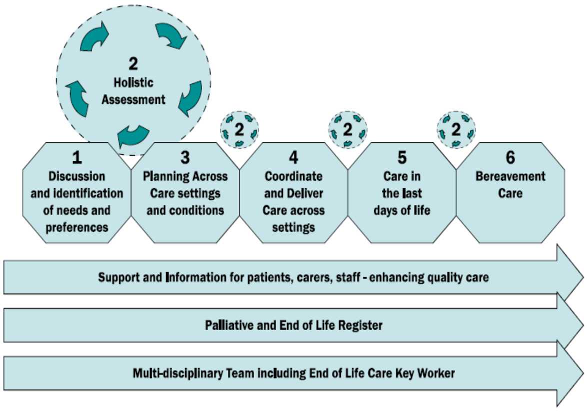
We also know that many more people than currently do would prefer to die at home. At the same time there are too many unnecessary, unwanted and costly end of life hospital admissions. We need to shift more care to the community where it can be more appropriately delivered.

Nursing homes are increasingly becoming the place where older people live and die with shorter average lengths of stay between 18-24 months. Complexity and higher dependency levels within nursing homes have implications for staff development to meet residents' end of life needs.

Frontline staff in general often lack training in delivering end of life care. There is a need to improve education and training for those providing palliative and end of life care.

The Review supports the model[90] below illustrating a continuous, holistic assessment of palliative and end of life care, co-ordinated by a key worker.

Figure 22: Palliative and End of Life Model



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[90] Living Matters, Dying Matters, An End of Life Care Strategy for Adults in Northern Ireland, DHSSPSNI, March 2010.

SUMMARY OF KEY PROPOSALS

80. Development of a palliative and end of life care register to enable speedy transfer of information required by those providing palliative and end of life care.

81. Enhanced support to the Nursing Home Sector for end of life care.

82. Individual assessment, planning, delivery and co-ordination of end of life care needs by a key worker.

83. Electronic patient records in place for the patient, their family and staff.

84. Targets to reduce the level of inappropriate hospital admissions for people in the dying phase of an illness.

85. Palliative and end of life care for children considered as part of the proposed review of Paediatric Services as referenced in the Maternity and Child Health section.

IMPLICATIONS FOR THE SERVICE

17.IMPLICATIONS FOR THE SERVICE

The changing model of care which moves care as close to home as possible, will only work if the way in which we deliver services also changes.

With a change in the model of care delivered by hospitals, the support required to deliver services in the community and at home, there will be a shift of services that will impact on the type of facilities which we require and the workforce that will deliver the service.

This section sets out an overview of the guiding criteria to be used when considering the new model of service delivery:

- infrastructure;
- technology;
- workforce; and
- resources.

INFRASTRUCTURE

CARE AT HOME

As has been outlined in the sections above, there will be a major shift to care delivered within people's homes, throughout people's lives, whether it be management of long term conditions, support to people with mental health or learning disabilities or end of life care.

In some cases people's homes are nursing homes or residential facilities. The care delivered to individuals in these facilities should enable residents to remain in the facility provided their needs can be met there. The package of care will be based on personal needs, not based on location.

Personalised budgets will encourage diversity of service. Where there is reluctance to take charge through personalised budgets, advocacy and clear information on the financial implications of any assessment will promote this outcome.

An overview of the services that will be delivered in the home, through Integrated Care Partnerships, is as follows.

Services in your home
Access to specialist teams for long term conditions will be developed
Support for Specialist care for cancer
Rehabilitation services
Domiciliary Care, including home nursing
End of Life Care
Access to a range of support services for example daycare or respite
Health and Wellbeing support for vulnerable groups
Enabling good outcomes for those using the service - for older people this is best described as the reablement model. In mental health, the recovery model and in child care, the rescue model.

CARE IN THE LOCAL COMMUNITY

People will have access to a greater package of services within the community.

Services will be focused on the needs of the local population. Local planning will ensure that services are delivered that meet their needs and work towards tackling health inequalities, for example multidisciplinary teams to deliver a package of care to someone with a long term condition or more than one condition.

The types of services that will be delivered within the community, through Integrated Care Partnerships, will include:

Services in your local community
GPs with enhanced services
Pharmacy
24/7 Urgent Care including GP, mental health crisis response and minor procedures
Outpatients
Diagnostics
Access to therapy and rehabilitation
Social support
Links to Voluntary and community organisations to support care
Advocacy services
Antenatal and postnatal care
Health and Wellbeing Advice
Optometry
Dentistry
Cross Departmental working groups to support social needs
Beds used for step-up/ step-down from hospital managed by GPs
Support to carers
Re-ablement

Our 353 GP practices will work within networks based on the already established 17 Primary Care Partnerships. These should be on a formal basis as ‘federations of practices’. This should result in GPs working together in a consistent manner.

The GPs currently within Primary Care Partnerships will form part of the Integrated Care Partnership along with representatives from other HSC bodies, as outlined above. Consideration should be given to the potential for these ICPs to form the basis for a multidisciplinary mutual organisation or to have social firm status.

Pharmacy will deliver an enhanced role in medicines management and health promotion to the local community and will be part of the multidisciplinary team supporting individuals with complex needs.

The ambulance service will have the ability to transfer patients to urgent care settings rather than defaulting to a major acute hospital if this is the most appropriate type of care required for the patient. The ambulance service will also be able to refer patients back to their GPs if they do not see the need to transfer the patient to other services such as urgent care or emergency care.

The focus of care will be reablement where possible. Support at home will be: increased availability of respite care; step up and step down beds between home and hospital; and rehabilitation beds. This will be supported by outpatients services, diagnostics and minor interventions being available closer to home.

The current decline in the demand for residential care homes will continue. In NI, we also have a higher use of supported accommodation than the rest of the UK. This trend is also likely to continue leading to a major reshape of this service.

People who require 24 hour nursing will be cared for within nursing homes.

The move away from residential care provision towards care at home will require a joined up approach to service delivery between the Department for Social Development and DHSSPS.

There will also be a move of dental services closer to home. For example, oral surgery can be carried out within the community at dental practices rather than within a hospital setting as is often the case.

The pathway for referral to hospital optometry services from practices has led to unintended high volumes of referrals. Clinical protocols for direct referral should be considered.

HOSPITAL SERVICES

Introduction

In the future hospitals will work as a system with each facility contributing to the provision of a total service to its population.

The Review is aware that there will be a considerable interest in the current hospital sites and their future role. However, as has been indicated early in the report, the final functionality of each of the facilities will be based on population need and the principles set out above.

The Review recommends that the commissioning system using its local communities should bring forward proposals for hospital services for each of the five populations by June 2012.

Evidence presented to the Review persuaded it that local populations and in particular professionals should design the way forward rather than impose a top down approach of specifying a function for each hospital.

In accepting this approach it wishes to make clear that there will be, as a consequence, change on all sites over a five year period. With change of this magnitude, the system and those working within it must enable, not disable, the change process. The following clearly articulates **what** should be provided. The **how** is for those working in the system.

Hospital Services

All current hospitals will have an integral role in the delivery of services to their localities. They will be essential in contributing to what a local population requires from a hospital service.

The Review is not prescriptive about the service configuration in these facilities but it is expected to include the following profile of services.

Services in your hospital
Urgent Care – doctor led assessment
Out of Hours – GP led
Elective Surgery – daycase and selective inpatient
Inpatient medical care on the basis of agreed pathways designed between primary and secondary doctors
Rehabilitation
Diagnostics
Midwife Led Obstetrics, where feasible based on demand

Hospitals will be networked with the GPs/ GPSIs and staff from the major acute centres. The preferred route for treatment is at home or within the community. Where people cannot be cared for in their own homes or within their community, they will be referred to hospital. Decisions on where to admit will be determined by clinical protocols and designed to ensure the best outcome for the patient.

Hospitals will be expected to separate elective surgical procedures from emergency procedures so that the system of care leads to better clinical outcomes and productivity, without one detrimentally affecting the other.

Patients may also be transferred within the network depending upon clinical need.

Major Acute Hospitals Services

Major acute hospitals provide care and treatment that requires centralisation to ensure that services are delivered by senior staff and that those services are resilient to demand pressures and provide the best outcomes for patients.

Each major acute hospital service must be capable of delivering and sustaining the following profile of services.

Services
24/7 Emergency Department
Emergency Surgery available 24/7
Complex Elective Surgery
Some non-complex elective surgery
Undifferentiated inpatient Medicine, e.g. coronary care and stroke
Paediatrics (Inpatient) available 24/7
Critical care available 24/7
Specialist Diagnostics available 24/7
Outpatients
Consultant led obstetrics
Midwife Led Unit, where appropriate

Since resilience is essential to the provision of hospital services, critical clinical staff will be employed to work in the hospital system and be a resource for each population working as necessary across hospital services and facilities.

Where inpatient provision is currently regional, such as cardiac surgery or sub regional, such as urology, clear clinical pathways which ensure equal access to populations will be required.

Specialist Services

Specialist hospitals will continue to deliver specialist services to the population of Northern Ireland including complex medicine, complex surgery and the associated outpatients service.

These services will be networked as necessary with ROI and GB to ensure that the highest quality services are delivered and that the staff are well trained and experienced.

Supra-Regional Services

Services which have such a low volume that they cannot be sustained to a high quality in NI, even without networking to other tertiary centres, should continue to be delivered outside of Northern Ireland. These include for example transplantations and rare disease management.

The Northern Ireland Perspective

The Review recognises that the future model must take into consideration the Northern Ireland dynamic. Given the rural nature of the West, and its close links to the ROI, the new model will require two major acute facilities in the West. The ROI has expressly indicated it wishes to maximise the opportunity for its population in the new hospital in the West.

Altnagelvin and Belfast hospitals have already well established working arrangements with ROI around some of its services which will continue.

There is currently a level of use of Daisy Hill Hospital by residents of the north east region of ROI. The future configuration of major acute services in Newry will be impacted upon by the potential demand for services from the ROI.

Conclusion

As a consequence of re-profiling services in this way there will be change on all existing sites.

The Review anticipates a major restructuring of how services are delivered by our current hospitals. As previously described, for NI this is likely to mean between five and seven major acute hospital facilities or networks.

The Review also wishes to make clear that maintaining an 'as is' model cannot be successful in delivering against the key principles or the guidelines already described. Furthermore, systems which are overly reliant on locum and agency staff are not acceptable.

Impact on the Northern Ireland Ambulance Service

The role of the NIAS is of central importance to the ability to deliver the new model of care. The NIAS has been going through some major changes in modernising its service to meet the needs of the HSC in the 21st century. This modernisation is planned to continue. The plans of the NIAS will support the implementation of the Review, in particular:

- supporting the new care pathways for unscheduled, in particular urgent care;
- training of NIAS paramedic staff to support the model;
- provision of an alternative to the 999 emergency number and availability of medically trained staff to triage patients to the most appropriate service;
- supporting the focus on prevention and wellbeing through information and advice; and
- continuing to support the move of care closer to home through diagnosis and treatment of minor illnesses and injuries in the community.

The NIAS will be involved in the planning and implementation process following the Review, alongside the representatives from across health and social care.

TECHNOLOGY

Technology is a key enabler of the delivery of the new model of care, in particular in supporting care closer to home and the ability of staff to work as an effective integrated multi-disciplinary team.

A forum should be established to take forward how technology will support the new model of care linking the service to industry and academia to ensure the optimum and best value for money solutions are taken forward and opportunities are identified and considered. Where appropriate, development of technological support will be through a collaboration approach with the Department of Enterprise, Trade and Investment (DETI) in line with the Memorandum of Understanding agreed between the Minister for Health, Social Services and Public Safety and the Minister for Enterprise, Trade and Investment.

The plans for technology to support the new model will come in the form of regional projects as well as technology solutions that will support the delivery of services to meet the specific needs of patients in a certain area. The population based planning approach will include plans for the use of technology to support how the model of care is delivered for that population.

Availability of Information at the Point of Care Delivery

Today, records are kept in all the places where you receive care. These places can usually only share information from your records by letter, email, fax or phone. At times, this can slow down treatment and sometimes information can be hard to access.

By making more health records electronic, there will be quicker ways to get important information to HSC healthcare staff treating patients, including in an emergency

Electronic Care Records (ECR) can be used to allow the sharing of information between the many systems currently used to store information across the HSC. This would result in all information held on each patient being available together through the use of the ECR platform.

An ECR pilot is currently underway. This has involved sharing of information within a Trust (i.e. acute, community and primary care information). The Review endorses the roll out of ECR across Northern Ireland with the ultimate aim of sharing information, not just within a Trust, but also across Trusts such that the service will provide an individual electronic care record for every patient in NI. Any patient could then attend any facility across NI and the health records and information will be available.

Information sources will include:

- GP records;
- Community Information Systems (also see below);
- pharmacy records (medicines management); and
- hospital records, including results of diagnostic tests.

Mobility of Staff

Mobile working by community staff allows for better use of resources.

With the shift of care into the community, consideration should be given to the merits of mobile technology to support staff working in the community.

The National Mobile Health Worker Project findings were that mobile devices loaded with office and clinical software allowed clinicians working within the community to make nearly 9% fewer referrals and avoid 21% of admissions.

GP Records

The Review also endorses the approach of developing a data warehouse for GP records in order to deliver information which is of a high quality and consistent across practices resulting in reduced variation and a safe and secure method of storing and sharing patient information.

The data warehouse will protect the confidentiality of patients and will provide timely, anonymised patient-based data and information for purposes other than direct clinical care, including:

- planning and commissioning;
- public health and research;
- clinical audit and governance;
- benchmarking; and
- performance improvement.

Data would be routinely extracted from GP systems and loaded into the data warehouse. The data warehouse would be used by staff at Trust, HSCB and DHSSPS levels. Access to the data would be strictly controlled and where necessary the data would be anonymised. Each "type" of user would have access only to the data for which they have authorised access.

Supporting People to Self-Manage their Care

Technology should be harnessed to support patients in managing their own care through, for example:

- supporting patient education;
- direct patient monitoring and support (telemedicine);
- clinical information and management systems; and
- promoting healthy living and disease prevention.

Telemedicine can be used to provide care closer to home such that the patient does not need to be in a hospital to receive care.

Connected Health

Connected Health is used to describe a model for healthcare delivery that uses technology to provide healthcare remotely. It provides a strategic opportunity for a different business model of procuring and delivering care around the needs of the patient. Through the use of technology patients are able to monitor their own condition, within the parameters set by their GP, thereby enabling them to take greater responsibility for managing their own health and well being. This should lead to a reduced need for patients to visit their GP Practices for monitoring of their condition. Variations to their clinical condition will be monitored remotely and they can be triaged to the relevant area of the health service as appropriate to their need at that time. This will result in patients visiting their GPs about their condition only when they need to and will lead to more appropriate and timely referrals to secondary care.

Connected Health sits well with government health strategies at many levels. It supports patient choice by allowing patients to remain within their own homes with effective self-management. It also supports the move of services from secondary to primary care settings and the ability to deliver a more cost effective, better quality service.

Supporting the principle of Right Care, Right Place, Right Time

One contact number for urgent care will allow triage of patients and ensure that they are directed to the best place of care as discussed in the NIAS section below.

A single robust community information system is required to support the increase in care to be delivered within the community.

WORKFORCE

The new model of service delivery requires a strong re-orientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated, integrated and at home or close to home.

New care model – Workforce implications

Some of the key implications include:

- more people will receive care in their own home, or close to home; which is more integrated with hospital clinicians working closely with GPs and other community staff to plan care delivery, along with increased clinical support provided in the home;
- multi professional community integrated teams will form the essential nucleus of health and social care professionals supporting patients in their own homes;
- increasing use of networks to coordinate care and share good practice and greater emphasis on partnership working within and across sectors; and
- the need to accelerate the pace of change.

The proposed changes will require staff to develop different skills and capacities. For example, GPs with Special Interests in emergency medicine or paediatrics, specialist long-term condition nurses and emergency care practitioners. It is likely that there will be more overlap and networking between services, and it is proposed that there will be an increase in outpatient follow-up appointments being carried out by GPs and nurses. Furthermore there is potential to explore new and extended roles as part of future care provision including the potential to introduce further multi-skilling alongside the use of assistive technologies to maintain older people in their homes.

Role change

Our expectations for what it means to be a health and social care professional are changing. They go beyond clinical practice itself, precisely because high quality care is delivered by a team in a system, not alone in a vacuum. To reach its full potential health and social care needs to harness the skills of professionals working together in making decisions in the clinical arena and bringing that expert judgement to bear on difficult resource and management decisions that impact on patients. Patients, the public and staff expect to see visible leaders making the case for those changes to services which evidence shows will improve patient care.

We need to be clear about what HSC organisations expect and need from tomorrow's clinicians and managers. Workforce planning and development is a critical building block in ensuring that staff are appropriately trained and confident in their roles. In light of the range of external factors likely to impact on health and social care our workforce planning needs to focus on demand signals from the local health economy and patients/ clients rather than just supply side inputs; linked to service planning and needs and underpinned by financial plans making it more robust and linked to patient needs. There needs to be close working between all education and training providers and the HSC to ensure continued high quality of education and training, based on service needs.

Extending GP leadership: Using the building block of Clinical Leads recently appointed to lead the recently formed PCPs, we need to identify and develop GPs will assume a critical leadership role in the new Integrated Care Partnerships. Clarity around roles and expectations will be critical to ensure they are able to engage with twin challenges of professional and management responsibilities.

Resilience

The ability to deliver good outcomes to patients is inextricably linked to workforce and in particular the medical workforce. In recent years the allocation of junior doctors has been problematic. Two matters are pertinent, access to good training and individual choice about workplace. Both will remain into the future. Failure to take full account of this has created many problems for the current model. It is likely that workforce availability over the next 3 years will be numerically less than required for the existing model but much more importantly the training experience that the current model provides, and ultimately the quality of outcome for patients, means that continuation of the current model is unsustainable. Any attempt to sustain the current model would simply flounder.

Engagement with staff organisations

Within the HSC a process of active engagement has been developed over a period of time, incorporating not only regular consultation on matters of concern to both HSC organisations and the staff representatives, but also partnership working on issues of joint concern to the service and the members they represent. It is vital that we remain committed to ongoing, close working with staff organisations and their representatives going forward.

NIAS

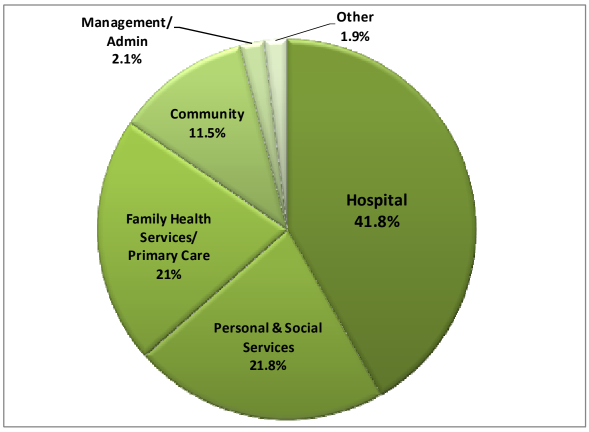
The Ambulance Service is a key part of the new service delivery model. Training of ambulance staff in the new model and best location of care will be required as well as ensuring that bypass protocols are in place.

RESOURCES

Revenue Budget

The current revenue budget for DHSSPS in 2011/12 is £4,383million. The Health and Social Care element is £3,904million and is split as follows:

Figure 23: Current HSC Revenue Budget, 2011/12

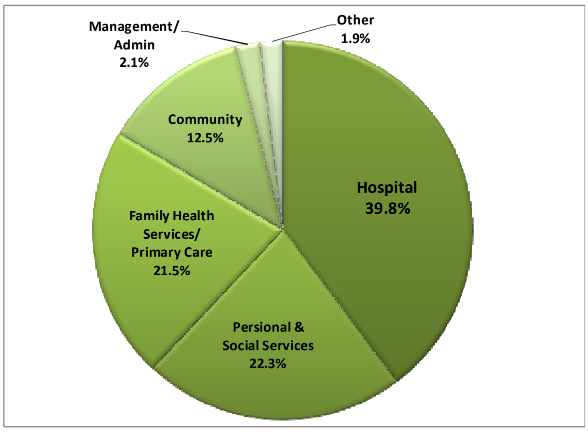


To allow the implementation of the new model of care the funding available for HSC services will be re-allocated. There will be a shift of care from hospital settings into the community. Some of the key changes that will be seen in the community will be:

- more care delivered in the home;
- changing care packages for people in nursing homes;
- increased role of the GP;
- increased role of Pharmacy in medicines management and prevention;
- a strong focus on prevention;
- increased use of community and social care services to meet people's needs; and
- outreach of acute services into the community.

The revenue budget for DHSSPS in 2014/15 is £4,659million. The Health and Social Care element is £4,150million. The projected allocation, applying the new model, is illustrated in the figure below.

Figure 24: Projected Allocation of HSC Revenue Budget, 2014/15

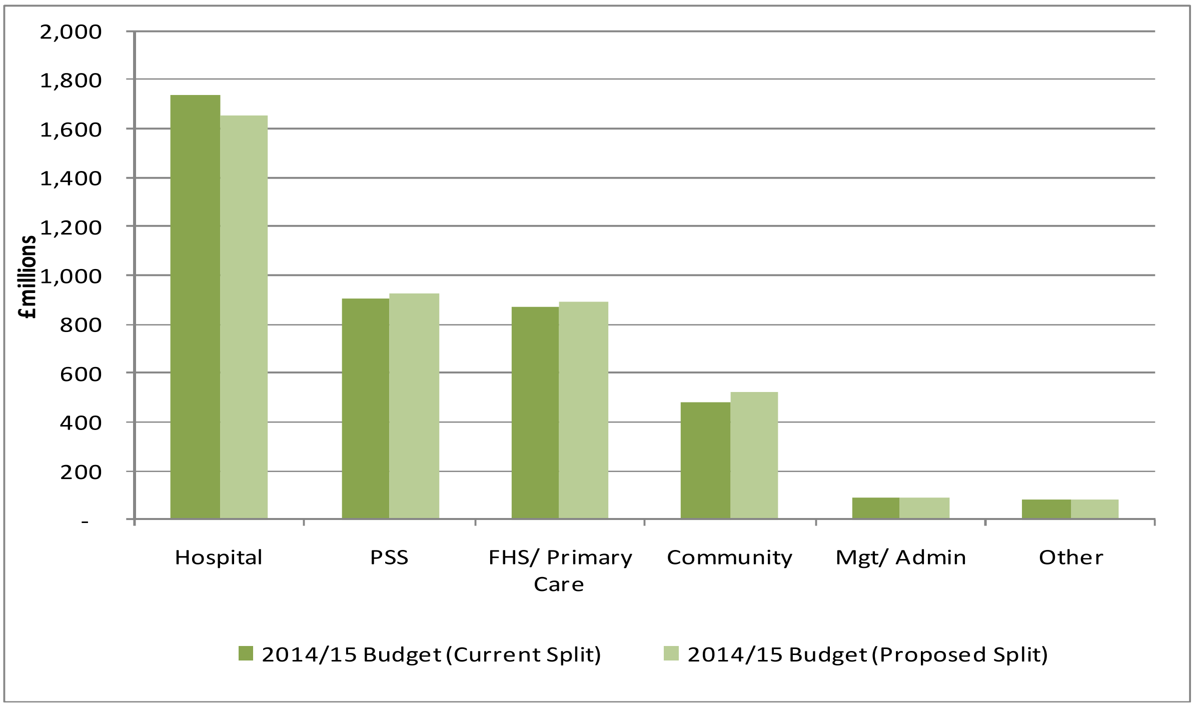


The impact on investment of the potential redistribution of the budget is illustrated in the figure overleaf and is as follows:

- reduction of the budget in hospital services, from £1,733million to £1,650million. This represents a £83million reduction, equating to 5% of the hospital services budget;

- increase in Personal and Social Services (PSS), from £903million to £924million. This represents a £21million increase, equating to a 2% increase in the PSS budget;
- increase in Family Health Services and Primary Care Services, from £871million to £892million. This represents a £21million increase, equating to a 3% increase in the FHS budget; and
- increase in Community Services, from £477million to £518million. This represents a £41million increase, equating to a 9% in the Community Services budget.

Figure 25: Projected Allocation of HSC Revenue Budget, 2014/15



A shift of care from hospital settings into the community reflects the principles, as outline in section 5, by which the Local Commissioning Groups will develop their population plans. The re-allocation of resource, illustrated in figures 23 and 24 is indicative; however it does reflect the anticipated level of change required to effect the change.

Consideration will also need to be given to the capital investment required to enable the change process to occur.

TRANSITION AND IMPLEMENTATION

This change will not be straight forward. It will require fundamental changes to the way we deliver services and will require substantial re-training of staff.

In addition it is estimated that transitional funding of approximately £25million in the first year; £25million in the second year; and £20 million in the third year will be required to enable the new model of service to be implemented.

We recommend this should be invested in:

- Integrated Care Partnerships, with a focus on older people and long term conditions;
- service changes; and
- voluntary early release scheme.

It is anticipated that after 2014/15 the model would be self-financing.

The principles for implementation are set out in section 18 overleaf. Detailed implementation plans will be developed following this review to reflect the complexity of changes required.

Income Generation

Often a parallel is drawn with other UK regions in regards to NI. Citizens contrast availability of services elsewhere with those that they have access to. This is sharply focused when there is discussion about income generation. Other regions have access to resources from charging which is not available in NI. The Review does not offer an opinion on how this should be addressed but would state there are no neutral decisions.

While income generation was not a matter for the Review, there needs to be a sensible debate about growing income within the spirit of the NHS principles. The Review recommends that this debate commences in NI in 4 areas:

- Non-emergency transport – for example car parking for visitors and staff and travel to day centres;
- Domiciliary care – DHSSPS has never applied the ability to charge for domiciliary care in the home;
- Prescriptions – consideration of a contribution towards the cost of prescriptions; and
- Social Bonds and their ability to support more diversity in community service provision.

The Review would wish to restate that it is not supportive of any move away from core NHS principles.

SUMMARY OF KEY PROPOSALS

86. Creation of 17 Integrated Care Partnerships across NI enabling closer working between and within hospital and community services.

87. Development of population plans for each of the five LCG populations by June 2012.

88. Establishment of a clinical forum to support the implementation of the new integrated care model, with sub-groups in medicine, nursing/AHPs, and social care.

89. Development of clear patient pathways for networked and regional services.

90. Establishment of a forum to take forward how technology will support the new model of care linking the service to industry and academia.

91. Full rollout of the Electronic Care Record programme.

92. Development of a data warehouse for GP records to high quality information on care across practices, resulting in reduced variation.

93. Introduction of a single telephone number for urgent care.

94. Introduction of a single robust community information system.

95. Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated and at home or close to home.

96. Development of GPs to assume a critical leadership role in the new integrated care teams.

97. More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.

98. Re-allocation of resources estimated to equate to a 4% shift of funds from hospitals into the community.

99. Initiation of a sensible debate about growing income within the spirit of the NHS principles.

ROADMAP FOR THE FUTURE

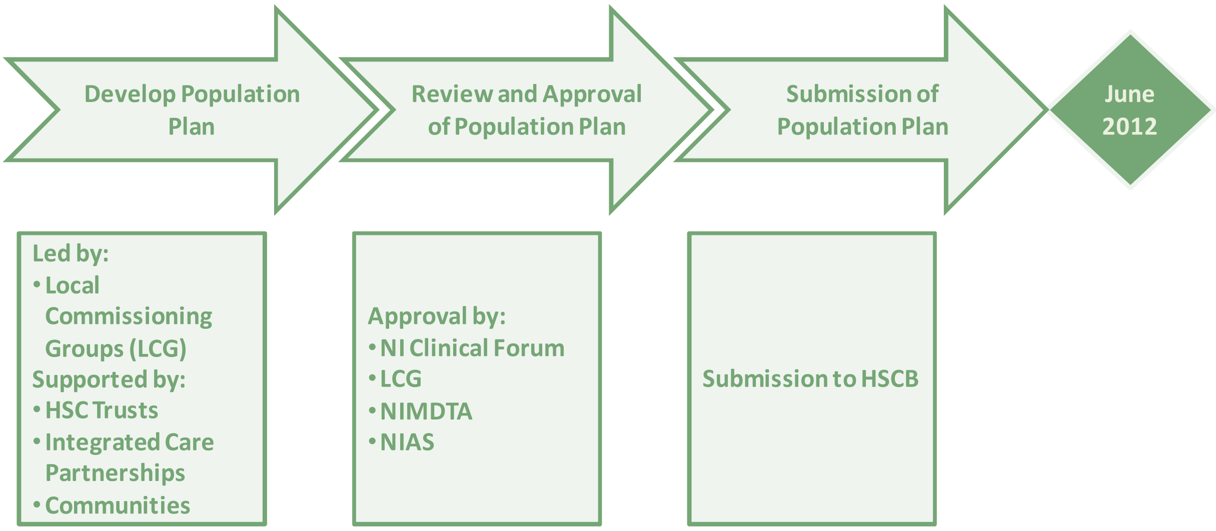
18.ROADMAP FOR THE FUTURE

Key to the successful delivery of the new model is a clearly defined roadmap for the future which sets out the steps needed to move from the current model of care to the new model of care. It is essential that a clear direction of travel is set out. This should be in the form of a clear implementation and engagement plan. The engagement plan will be an essential tool in setting out how the changes will affect users, families and staff. To support the implementation clear governance and reporting arrangements must be established. An answer to the 'who's in charge' question must be clear and accountabilities easily understood by all.

This section sets out a proposed response to this challenge. It comments upon governance arrangements for the programme, presents an approach to create an implementation plan and identifies the key actions and milestones for implementation of the recommendations of the Review. Additionally it describes a plan for engagement with staff and users. The Review recommends that detailed implementation and engagement plans are developed and published by June 2012 following this Review, as illustrated below.

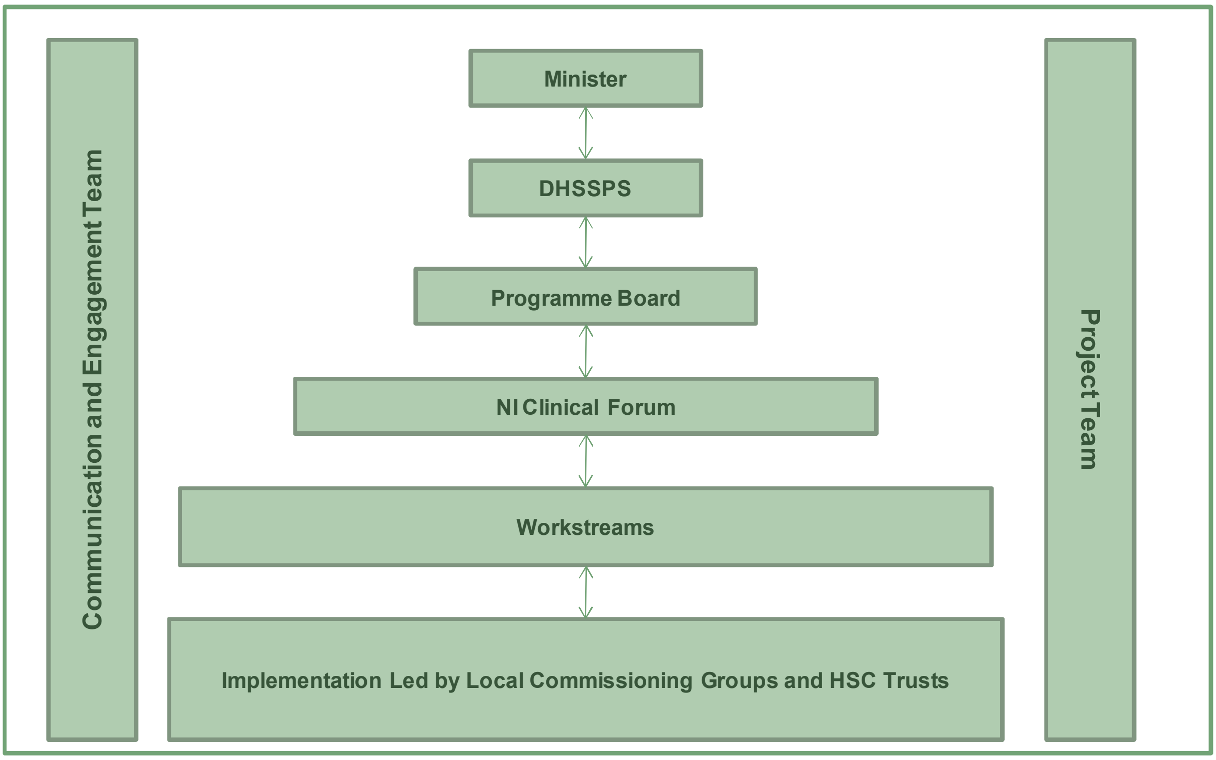
In addition, the Review recommends paying particular attention to achieving sign off from the 17 Integrated Care Partnerships, NIMDTA and the NI Ambulance Service when the Local Commissioning Groups put forward the models for their population.

Figure 26: Population Planning Process



PROGRAMME GOVERNANCE

Figure 27: Programme Structure



The programme of change will be led by the Minister for Health, Social Services and Public Safety. A Programme Board will be set up to report to the DHSSPS and Minister on the implementation of the Review. The Programme Board will be supported by the Northern Ireland Clinical Forum, a project team and workstream leads. The roles of each of the bodies included in the programme will be as follows.

Minister for Health, Social Services and Public Safety

The Minister is responsible for the roll out of the programme of change. The Minister will approve all major decisions about service changes, policy or legislation. The Programme Board will report to the Minister on progress of the implementation through the DHSSPS.

DHSSPS

The DHSSPS will advise the Minister on extant policy or new policy and will support the Minister in making decisions relating to the programme of change. In addition, the DHSSPS will ensure close collaboration with the Programme Board as it discharges its responsibilities.

Programme Board

The Programme Board will be chaired by the HSCB and made up of representatives from the HSCB and HSC Trusts. The Programme Board will be responsible for steering the implementation using the commissioning process. It will also be responsible for reporting to DHSSPS and the Minister on progress.

NI Clinical Forum

A NI Clinical Forum will be established in 2012 to provide strong professional advice to the Programme Board and give robust clinical advice in taking forward the changes. Additionally the Patient and Client Council will be invited to describe how best to ensure users and carers are engaged.

Workstreams

A number of workstreams will be set up for each area that is seen as key to leading the implementation. These workstreams will lead the implementation of the agreed plans for each population. They will report to the Programme Board on the progress under each workstream.

Delivery

The actual implementation of the changes agreed will be taken forward as a joint approach between commissioners and providers. The Local Commissioning Groups will work with the HSC Trusts and other providers in taking forward the plans. The LCGs will report to the Programme Board on the progress of the implementation.

Project Support

The Programme Board will be supported by a Project Team. The Project Team will use Project and Programme Management principles to monitor the progress of the implementation of the programme of change based on the plans approved by the Programme Board, the DHSSPS and the Minister. The Project Team will report directly to the Programme Board on the progress. The tools used to monitor progress will include:

- detailed Project Plan;
- key responsibilities for taking forward actions and associated timescales;
- actions and milestones;
- targets for measuring success; and
- development and management of project risks.

Communication and Engagement

The delivery of the programme will rely greatly on the ability to successfully communicate changes to the public and staff working in the HSC as well as successfully engaging with these groups and achieving their buy-in to the process. This will require communication and engagement support from a team with experience in taking forward major change programmes.

The suggested structure of the programme is shown in Figure 18 overleaf.

These arrangements should be in fully place by June 2012 to support the roll out of the population plans submitted at that time.

IMPLEMENTATION PLAN

A detailed implementation plan overleaf will be required to take forward the project. This will be based on population plans. Each of the population areas, led by Local Commissioning Groups, will be expected to produce population plans by the end of June 2012.

The figure overleaf sets out the high level actions associated with the recommendations of this Review.

The Review team acknowledge that many of the recommendations require policy change, as well as necessary equality, human rights and rurality impact assessments. In addition a number may also require legislative change to enable implementation. These will be taken forward in the implementation process.

ENGAGEMENT PLAN

The implementation of this programme of change is much more likely to deliver sustained transformational change through commitment than through compliance.

An engagement plan will be a key tool in taking forward the programme. The engagement plan will include:

- identification of the key stakeholders to be consulted with;
- how the stakeholders will be engaged with; and
- plan for engaging with stakeholders.

Stakeholders to be engaged with will include representatives from DHSSPS, HSC Board, HSC Trusts, Voluntary and Community Sector organisations, users and carers.

Stakeholders are expected to be engaged through a number of approaches, both targeted to specific stakeholders and those which are stakeholder wide. This will be via a number of methods which may include already established forums, workshops or one to one meetings.

Regular updates on engagement should be reported to the Programme Board.

COMMUNICATION PLAN

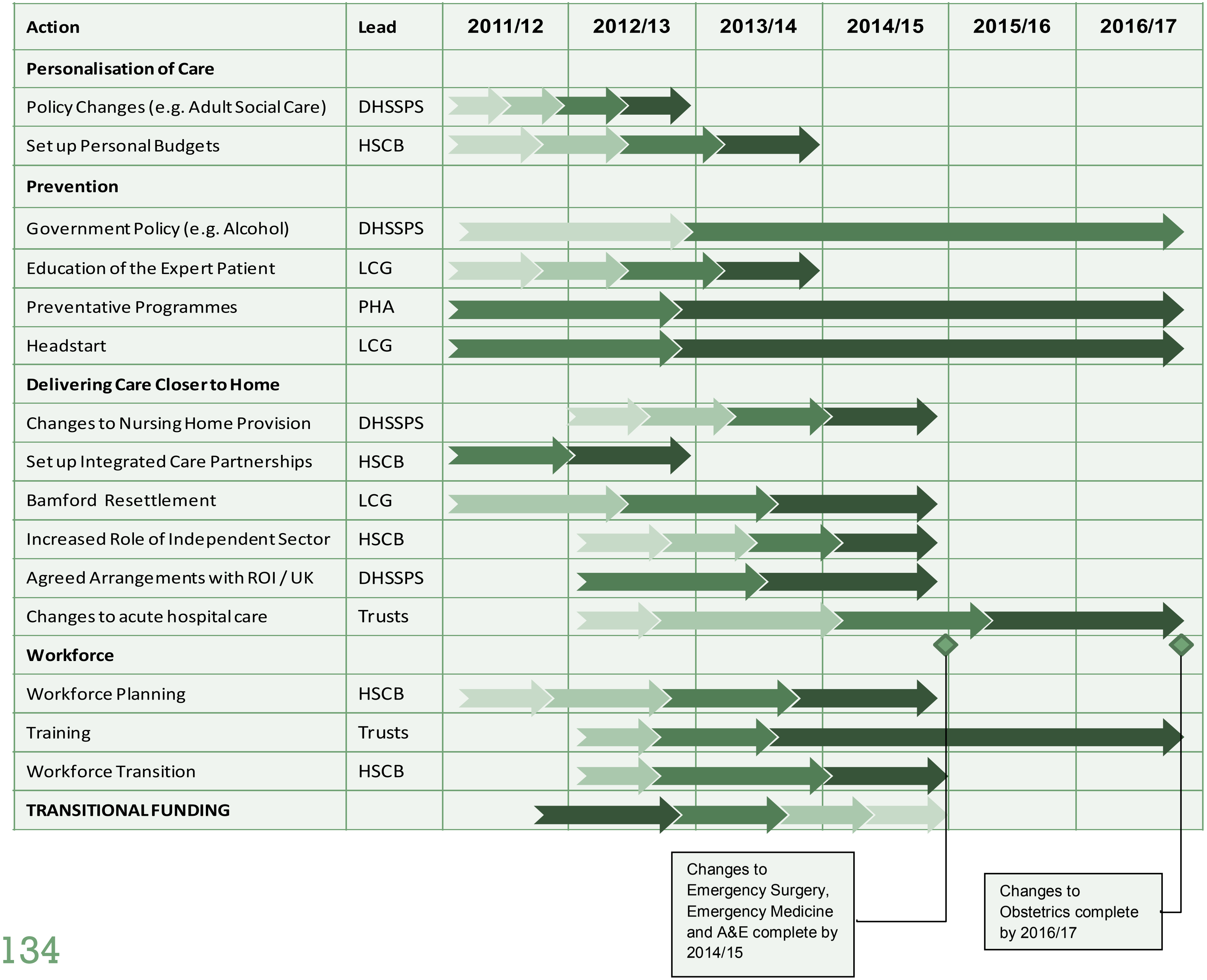
The major changes envisaged by this Review will impact on all residents of NI both those using the HSC service and those working in it.

To manage the effective implementation of the programme it will be essential that the changes are communicated effectively to those who will be affected, both from the perspective of understanding how the changes will affect care, changes in how to access care and a clear understanding of what is expected from the public in delivering the programme of change.

The communication plan should include details of:

- the key messages to be communicated;
- the target audience for communication;
- the approach to communication; and
- the forum and tools to be used when communicating with the groups identified.

Figure 28: Timeline for Completing Key Actions



Action	Lead	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Personalisation of Care							
Policy Changes (e.g. Adult Social Care)	DHSSPS						
Set up Personal Budgets	HSCB						
Prevention							
Government Policy (e.g. Alcohol)	DHSSPS						
Education of the Expert Patient	LCG						
Preventative Programmes	PHA						
Headstart	LCG						
Delivering Care Closer to Home							
Changes to Nursing Home Provision	DHSSPS						
Set up Integrated Care Partnerships	HSCB						
Bamford Resettlement	LCG						
Increased Role of Independent Sector	HSCB						
Agreed Arrangements with ROI / UK	DHSSPS						
Changes to acute hospital care	Trusts						
Workforce							
Workforce Planning	HSCB						
Training	Trusts						
Workforce Transition	HSCB						
TRANSITIONAL FUNDING							

Changes to Emergency Surgery, Emergency Medicine and A&E complete by 2014/15

Changes to Obstetrics complete by 2016/17

19.SUMMARY OF PROPOSALS

POPULATION HEALTH AND WELLBEING

1. Renewed focus on health promotion and prevention to materially reduce demand for acute health services.
2. Production by PHA of an annual report communicating progress on population health and wellbeing to the public.
3. Maintenance of existing and implementation of new screening and immunisation programmes where supported by clinical evidence.
4. Consideration by the Northern Ireland Executive of the wider role of the state in taking decisions impacting on health outcomes, for example: in relation to pricing of alcohol and ‘junk’ food; and further controls on tobacco usage.
5. Incentivisation of Integrated Care Partnerships to support evidence-based health promotion, for example, clinician-led education programmes in the community.
6. Joint working pilot projects with other Government departments that enable resource sharing and control, for example in rural isolation and transport.
7. An expanded role for community pharmacy in the arena of health promotion both in pharmacies in the community.
8. Support for the health promotion and prevention role played by Allied Health Professionals, particularly with older people.

OLDER PEOPLE

9. Home as the hub of care for older people, with more services provided at home and in the community.
10. A major reduction in residential accommodation for older people, over the next five years.
11. Introduction of reablement to encourage independence and help avoid unnecessary admissions of older people into hospital.
12. A greater role for nursing home care in avoiding hospital admissions.
13. More community-based step-up/step-down and respite care, provided largely by the independent sector.

14. A focus on promoting healthy ageing, individual resilience and independence.
15. More integrated planning and delivery of support for older people, with joined up services and budgets in health and social care, and pilots to explore budgetary integration beyond health and social care.
16. A holistic and consistent approach to assessment of older people's needs across Northern Ireland and an equitable range of services.
17. A diverse choice of provision to meet the needs of older people, with appropriate regulation and safeguards to ensure quality and protect the vulnerable.
18. Personalised care designed to deliver the outcomes care users and their families want, with increasing control over budgets, and access to advocacy and support if needed.
19. A policy review of carers' assessments and more practical support for carers including improved access to respite provision.
20. An overhauled financial model for procuring independent and statutory care, including exploring the potential for a price regulator, a certificate of need scheme and financial bonds for new entrants.

LONG-TERM CONDITIONS

21. Partnership working with patients to enable greater self care and prevention.
22. Personalised care pathways enabling home based management of the LTC with expanded support from the independent sector.
23. Patients to have named contacts for the multi-disciplinary team in each GP surgery to enable more straightforward communication.
24. Improved data warehousing of existing information to support care pathways and enable better outcomes to be more closely monitored.
25. A stronger role for community pharmacy in medication management for LTCs.
26. Development of admission protocols between secondary care specialist staff and those in the community.

27. Maximising the opportunities provided by telehealth in regard to LTC patients.

PHYSICAL DISABILITY

28. Promoting independence and control for people with a disability, enabling balanced risk-taking.

29. A shift in the role of the health and social care organisations towards being an enabler and information provider.

30. Joint planning of services for disabled people by the statutory, voluntary and community health and social care providers, and other relevant public services (e.g. housing) to ensure a wide range of services across NI.

31. Better recognition of carers' roles as partners in planning and delivering support, and more practical support for carers.

32. More control for service users over budgets, with continued promotion of Direct Payments, and a common approach to personalised budget with advocacy and brokerage support where required.

33. More respite and short breaks provision.

MATERNITY AND CHILD HEALTH

Maternity

34. Written and oral information for women to enable an informed choice about place of birth.

35. Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy.

36. Services in consultant-led obstetric and midwife-led units available dependent on need.

37. Promotion of normalisation of birth, with midwives leading care for straightforward pregnancies and labour, and reduction over time of unnecessary interventions.

38. Continuity of care for women throughout the maternity pathway.

39. A regional plan for supporting mothers with serious psychiatric conditions.

Child Health

40. Further development of childhood screening programmes as referenced in the Health and Wellbeing section.

41. Child health included as a component of the Headstart programme referenced in the Family and Childcare section.

42. Promotion of partnership working on children's health and wellbeing matters with other government sectors.

43. Close working between hospital and community paediatricians through Integrated Care Partnerships.

44. Completion of a review of inpatient paediatric care to include palliative and end of life care.

45. Establishment of formal partnerships outside the jurisdiction for very specialist paediatric services.

FAMILY AND CHILD CARE

46. Re-structuring of existing services to develop a new 'Headstart' programme focusing on 0-5 year olds.

47. Exploration through pilot arrangements of budgetary integration for services to this group across Departments, under the auspices of the Child and Young People's Strategic partnership.

48. Completion of a review of residential care to minimise its necessity.

49. Promotion of foster care both within and outwith families.

50. Development of a professional foster scheme for those hardest to place.

51. Implementation of the RQIA recommendations in relation to CAMHS.

52. Exploration of joint working arrangements outside the jurisdiction, with particular regard to CAMHS services.

MENTAL HEALTH

53. Continued focus on promoting mental health and wellbeing with a particular emphasis on reducing the rates of suicide among young men.

54. Establishment of a programme of early intervention to promote mental health wellbeing.

55. Provision of clearer information on mental health services should be available to those using them and their families, making full use of modern technology resources.

56. A consistent, evidence-based pathway through the four step model provided across the region.

57. A consistent pathway for urgent mental health care including how people in crisis contact services, triage and facilities in emergency departments.

58. Review the approach to home treatment services for children and young people, learning disability and psychiatry of old age.

59. Further shift of the balance of spend between hospital and community, with reinvestment of any hospital savings into community services.

60. Greater involvement of voluntary and community sector mental health organisations in planning provision as part of Integrated Care Partnerships.

61. Promote personalised care promoting the uptake of Direct Payments among mental health service users with involvement of current recipients to share their experiences, and advocacy and support where needed.

62. Close long stay institutions and complete resettlement by 2015.

LEARNING DISABILITY

63. Integration of early years support for children with a learning disability into a coherent ‘Headstart’ programme of services for 0-5 year olds as referenced in the Family and Childcare section (Section 12)

64. Further development of the current enhanced health services on a Northern Ireland basis.

65. Support from Integrated Care Partnerships to improve clinicians’ awareness of the needs of individuals with a learning disability.

66. Better planning for dental services should be undertaken.

67. Further development of a more diverse range of age-appropriate day support and respite and short-break services.

68. Greater financial control in the organisation of services for individuals and carers, including promoting uptake of Direct Payments with involvement of current recipients to share their experiences, and advocacy and support where needed.

69. Development of information resources for people with a learning disability to support access to required services.

70. Advocacy and support for people with a learning disability, including peer and independent advocacy.

71. Commitment to closing long stay institutions and to completing the resettlement process by 2015.

ACUTE CARE

72. Reinforce the full development of the Regional Trauma Network set out in the DHSSPS document.

73. Over time, move to a likely position of five to seven major acute hospital networks in Northern Ireland.

74. Ensure urgent care provision is locally available to each population.

75. Set targets for the reduction of hospital admissions for long-term admissions and end of life care.

76. Set targets for the reorganisation of outpatient and diagnostic services between hospitals and Integrated Care Partnerships.

77. Ensure the transition takes full account of Service Frameworks and clinical pathways.

78. Expeditious implementation of a managed clinical network for pathology.

79. Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements.

PALLIATIVE AND END OF LIFE CARE

80. Development of a palliative and end of life care register to enable speedy transfer of information required by those providing palliative and end of life care.

81. Enhanced support to the Nursing Home Sector for end of life care.

82. Individual assessment, planning, delivery and co-ordination of end of life care needs by a key worker.

83. Electronic patient records in place for the patient, their family and staff.

84. Targets to reduce the level of inappropriate hospital admissions for people in the dying phase of an illness.

85. Palliative and end of life care for children considered as part of the proposed review of Paediatric Services as referenced in the Maternity and Child Health section.

IMPLICATIONS FOR THE SERVICE

86. Creation of 17 Integrated Care Partnerships across NI enabling closer working between and within hospital and community services.

87. Development of population plans for each of the five LCG populations by June 2012.

88. Establishment of a clinical forum to support the implementation of the new integrated care model, with sub-groups in medicine, nursing/AHPs, and social care.

89. Development of clear patient pathways for networked and regional services.

90. Establishment of a forum to take forward how technology will support the new model of care linking the service to industry and academia.

91. Full rollout of the Electronic Care Record programme.

92. Development of a data warehouse for GP records to high quality information on care across practices, resulting in reduced variation.

93. Introduction of a single telephone number for urgent care.

94. Introduction of a single robust community information system.

95. Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated and at home or close to home.

96. Development of GPs to assume a critical leadership role in the new integrated care teams.

97. More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.

98. Re-allocation of resources estimated to equate to a 4% shift of funds from hospitals into the community.

99. Initiation of a sensible debate about growing income within the spirit of the NHS principles.

20.CONCLUSION

The Review team was impressed and enthused by the opportunity offered by the Minister to bring forward coherent changes for HSC in NI. Change is always difficult, but in looking at change the Review was determined to keep the individual, their family and the evidence of what works at the fore-front of its deliberations.

Looking towards the next 5 years there is real potential with the implementation of the Review to see a service much improved and fit for the future. The Review cannot be impervious to the present wider economic climate and how that might impact on HSC. However the Review Team was firmly of the view that the best defence to such an eventuality was to be clear about the direction of travel, namely:

- starting with the individual;
- looking to a greater focus on prevention;
- maintaining care close to home;
- re-designing primary care; and
- re-shaping hospitals.

Planning for taking decisions and creating a new model for the future is at the core of the Review. The Review is convinced failure to plan will cause detriment to the health and wellbeing of the population

21.APPENDIX

1. Terms of Reference
2. Online survey summary of results
3. Household survey summary of results
4. Questions raised at public meetings
5. List of attendees at clinician workshops and areas covered at each event
6. List of attendees at sector workshops
7. List of stakeholders engaged with at small group meetings
8. List of written submissions
9. Glossary

Appendix 1
Terms of Reference

Review of the Provision of Health and Social Care services in Northern Ireland

1. The Review should take account of:

- the Minister's statement of vision and strategy for the HSC;
- the statutory duties on the HSC to improve the quality of services provided to individuals, and to seek to improve the health and social well-being of the population, and to reduce health inequalities;
- all extant statements of policy and strategy approved by the Minister, and in particular the aims of improving **public health**, the **prevention** of illness, and of improving **outcomes** for patients and clients. Other major themes of policy and strategy are the quest for better early intervention and chronic condition management, and the strategic shift of all suitable services towards a primary and community context;
- the organisational structure of the HSC as established in the 2009 Reform Act, and in particular the responsibility to secure a clear focus on public health, and increasingly effective local commissioning of services and to exercise good governance and provide clear accountability – the Review will need to ensure that its analysis and recommendations are practical and applicable within this statutory framework;
- the resources available in the Budget settlement for 2011-12 to 201415 approved by the Executive and the Assembly in March 2011, given the overriding obligation on all HSC bodies to manage services within the level of resources approved by the Assembly;
- best practice guidance of regulatory and advisory bodies affecting the provision of safe and effective services, notably the National Institute for Health and Clinical Excellence, the Social Care Institute for Excellence and the Royal Colleges;
- evidence of how arrangements for the delivery of health and social care in the Republic of Ireland and Great Britain and cooperation for mutual benefit with service providers there, might contribute to the objectives of the Review;
- the established framework of terms and conditions for HSC staff including Agenda for Change and the Consultants' Contract, and the contractual arrangements in respect of primary care;
- recent previous studies and analysis of the HSC including the Appleby Reports of 2005 and 2011, the McKinsey Report of 2010 and the forthcoming PEDU Review; and
- evidence-based good practice on the delivery of services from within Northern Ireland from elsewhere.

2. On that basis, the Review is asked to:

- Provide a strategic independent assessment across all aspects of health and social care services of the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and communities are being met by existing arrangements, taking account of the issues of outcomes, accessibility, safety, standards , quality of services and Value For Money;

- Undertake appropriate consultation and engagement on the way ahead with the public, political representatives (primarily through the Assembly Health Committee), HSC organisations, clinical and professional leaders within the HSC, staff representatives (through the Partnership Forum), and stakeholders in the voluntary, community, independent, private and local government sectors;
- Make recommendations to the Minister on the future configuration and delivery of services in hospital, primary care, community or other settings. The essential task of the Review is to set out a specific implementation plan for the changes that need to be made in the HSC in the context set out above, including proposals in relation to major sites and specialties;
- To identify, at an early stage, potential areas of concern, specific priorities for Ministerial focus and potential issues of public/political/media concern;
- To prepare a Report incorporating its analysis, findings and recommendations.

3. The new organisational structures within Health and Social Care have delivered major efficiencies already. They are currently the subject of a further review as part of a wide ranging review by the Executive of all Arm’s Length Bodies and are outside the scope of this Review.

4. The issue of overall funding levels available to meet the needs of Health and Social Care now and in the years ahead is also outside the scope of this Review as that is a matter for the Executive collectively drawing on the advice of DFP. The current PEDU review of the scope to make savings in the Health and Social Care sector is separate from the HSC Review and the development of an implementation plan to deliver savings will continue in parallel with this Review.

5. Where the Review finds major tension, or contradiction, between its emerging view of the best way ahead and the extant constraints listed at paragraph 1 above, this should be raised for consideration by the Department as soon as possible, so that the Minister can be advised of the issue and give a specific steer as to how the Review should proceed.

6. The Review should complete its Report by 30 November 2011.

Appendix 2
Online Survey Summary of Results

Online Survey Results

In total there were 1107 responses.

However many of the responses were incomplete and in many cases only demographic information was captured.

The final sample was **673** responses although for some of the 'Quality' questions the sample was reduced further.

Summary of findings:

Demographic Profile

- **91%** of respondents said they work for an organisation providing health or social care services in NI
- **81%** said they work for an HSC Trust
- **95%** were providing the response on their own behalf

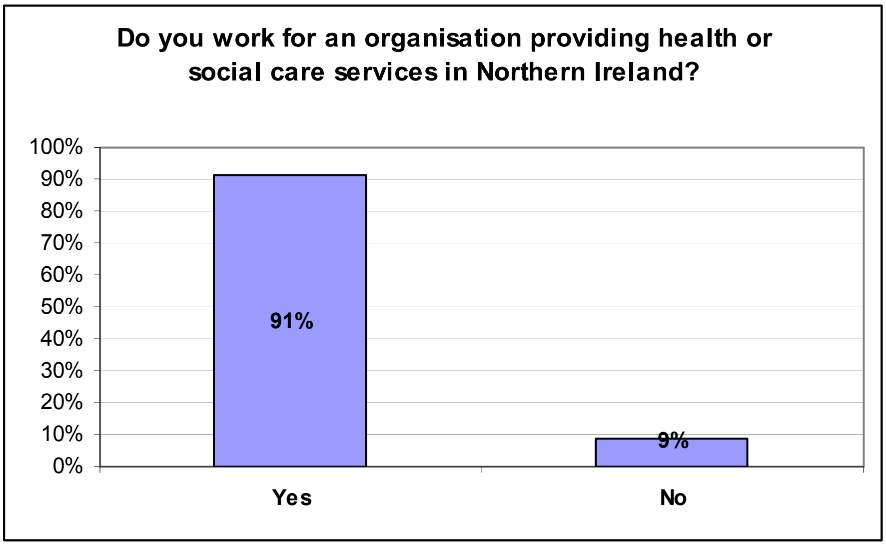
Service Usage in the last Year

Top 3 services reported by most respondents

- **94%** of respondents (or their families) have used GP services
- **54%** of respondents (or their families) have had an appointment with a hospital consultant
- **40%** of respondents (or their families) have used A&E services

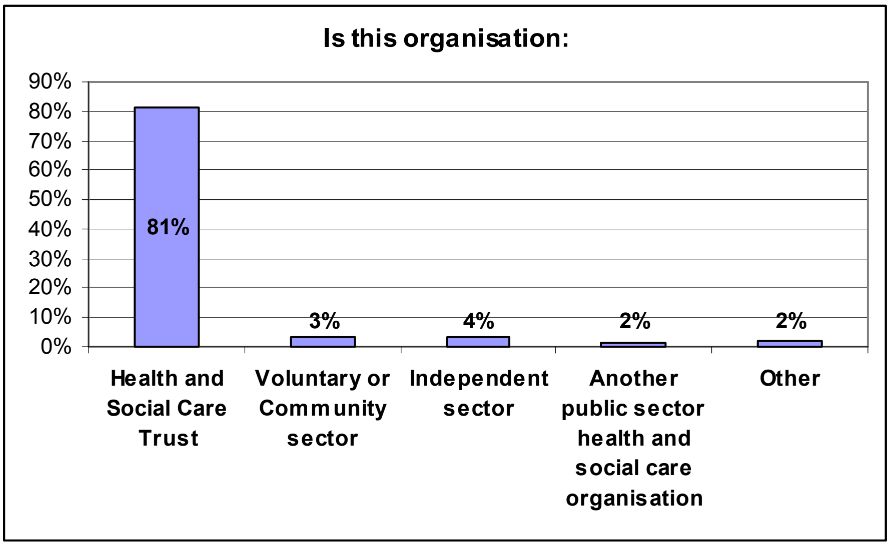
Profile

Do you work for an organisation providing health or social care services in Northern Ireland?

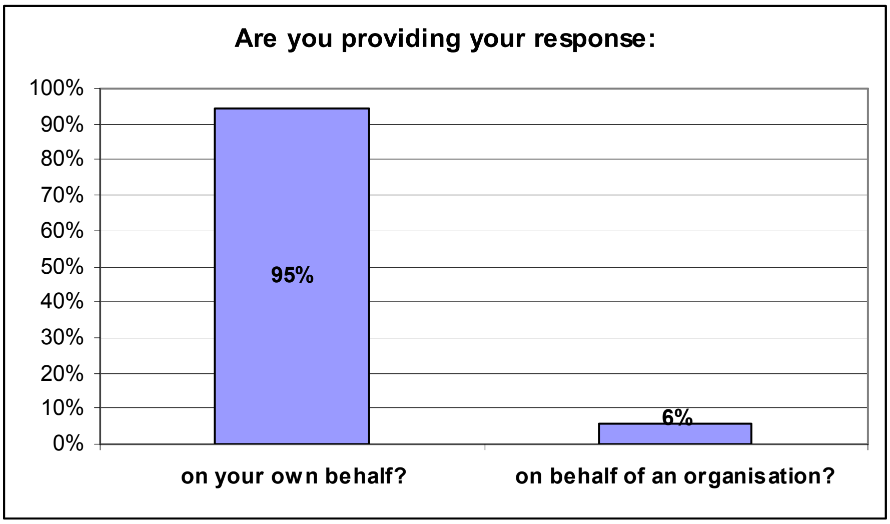


Is this organisation:

-A Health and Social Care Trust
-Another public sector health and social care organisation
-A voluntary or community sector organisation
-An independent sector organisation
-Other



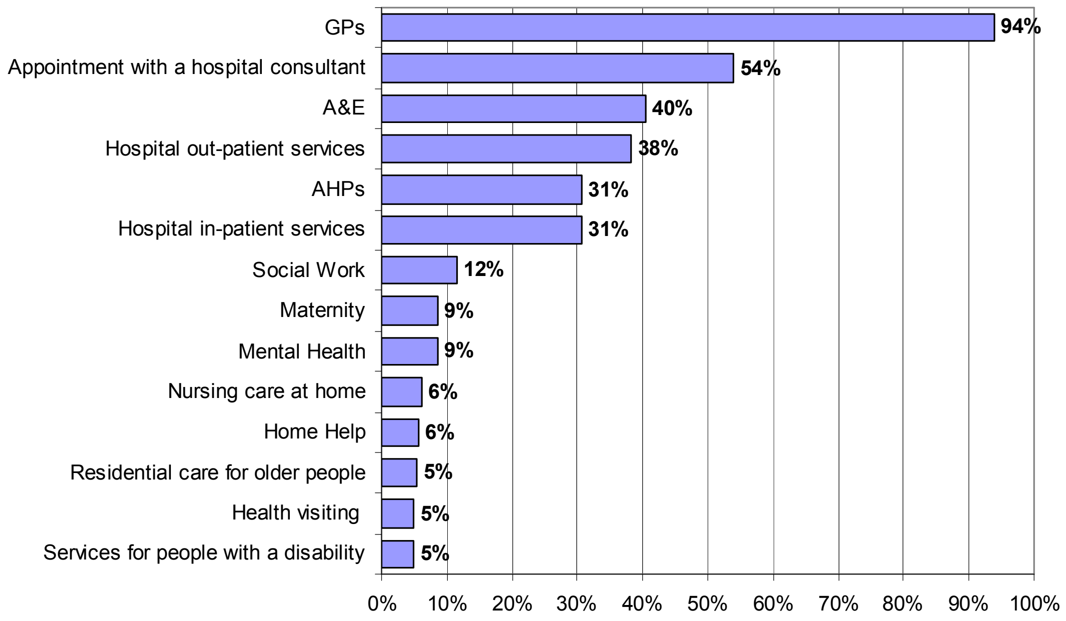
Are you providing your response
- On behalf of an organisation or
- On your own behalf?



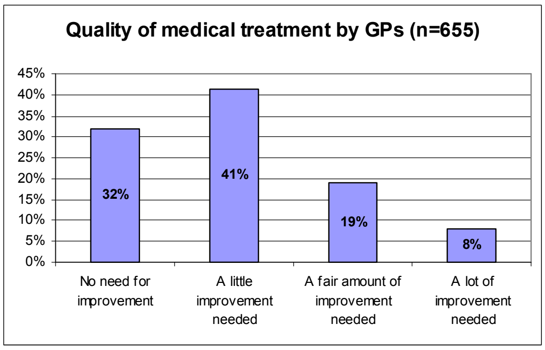
What is the name of the organisation you are sending your response on behalf of?

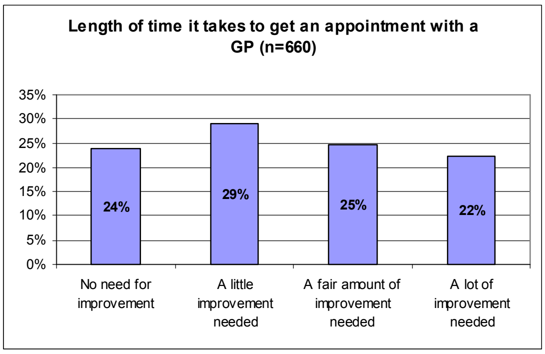
Action Mental Health
Autism NI (PAPA)
Bradleys Pharmacy
Castleview Private Nursing Home, Carrickfergus
Community Organisations of South Tyrone & Areas Ltd (COSTA)
Contact a Family
Dundela Pharmacy Ltd
FAITH HOUSE
Fermanagh Cardiac Support Group
Fold Housing Association
Foyle Parents and Friends Association
Home-Start Craigavon
Home-Start East Belfast
Home-Start In Northern Ireland
Kennedy's Pharmacy (Rasharkin and Dunloy)
Maria Mallaband Care Group Ltd
Mencap in Northern Ireland
MindWise New Vision for Mental Health
Newry & Mourne Carers Limited
Orchard House Private Nursing Home
Phoenix Healthcare
Shalom Care
Strandburn Pharmacy
The Dry Arch Children's Centre
The Stroke Association Northern Ireland
Wilson Group (Nursing Homes)

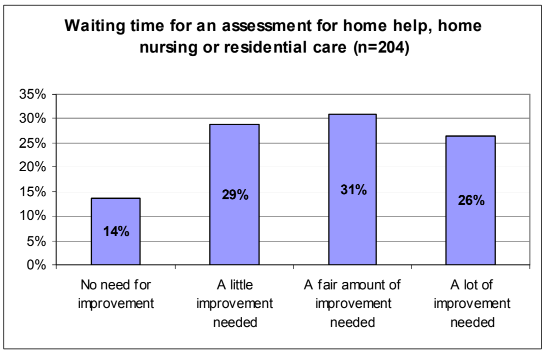
Have you or your family used any of these health and social care services in the last year?

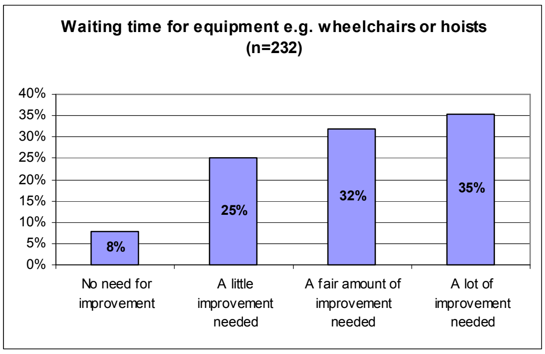


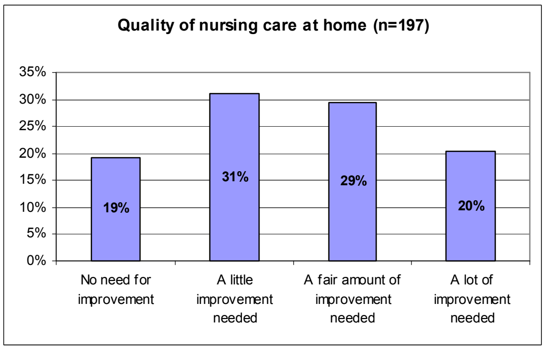
How would you rate the following aspects of Health and Social Care in Northern Ireland in terms of whether they require improvement or not?:

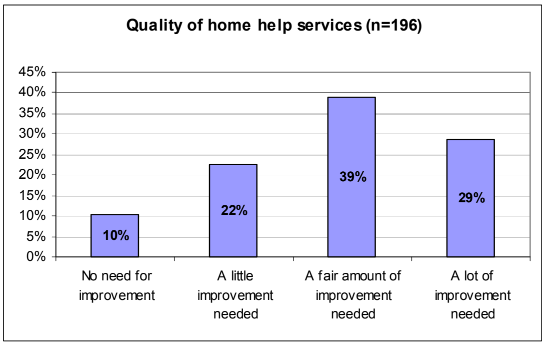

Quality of medical treatment by GPs (n=655)

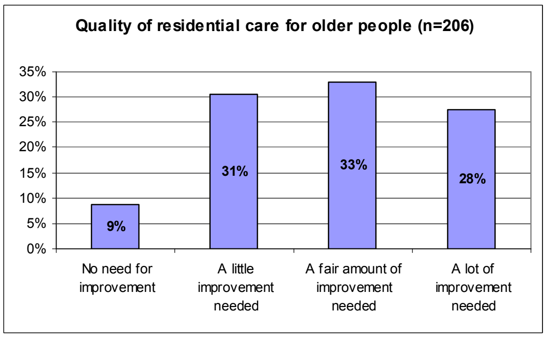

Length of time it takes to get an appointment with a GP (n=660)

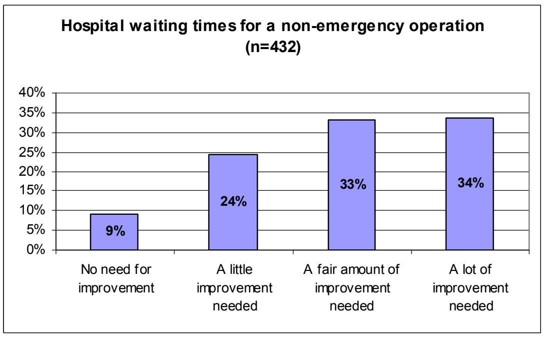

Waiting time for an assessment for home help, home nursing or residential care (n=204)

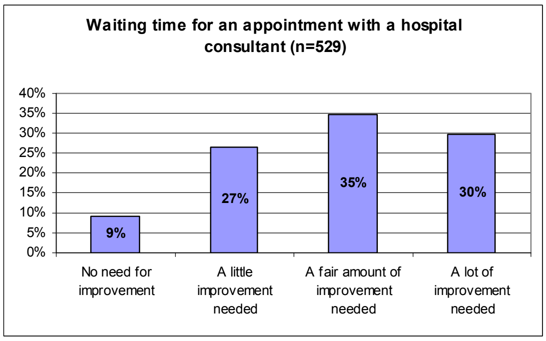

Waiting time for equipment e.g. wheelchairs or hoists (n=232)

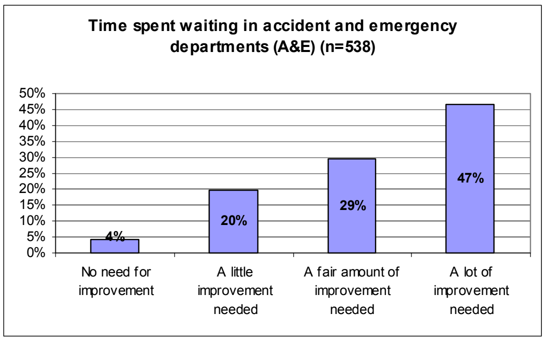

Quality of nursing care at home (n=197)

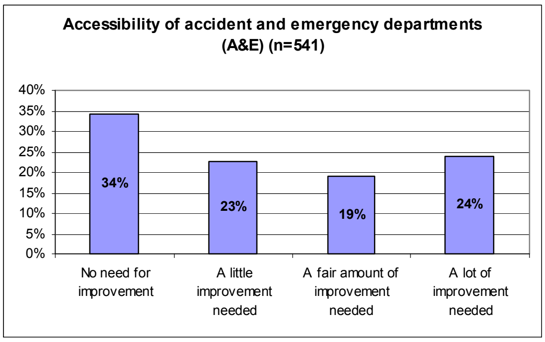

Quality of home help services (n=196)

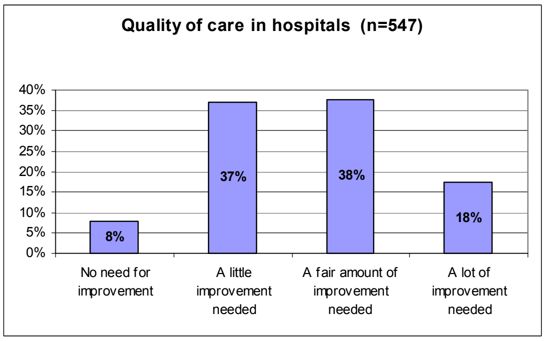

Quality of residential care for older people (n=206)

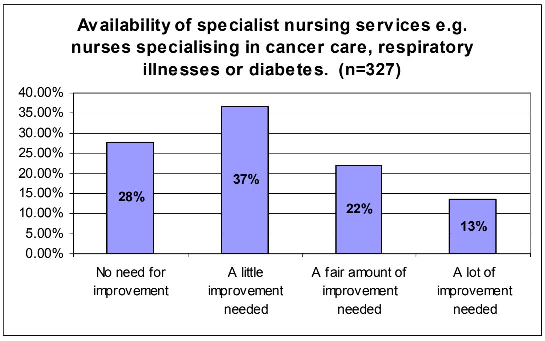

Hospital waiting times for a non-emergency operation (n=432)

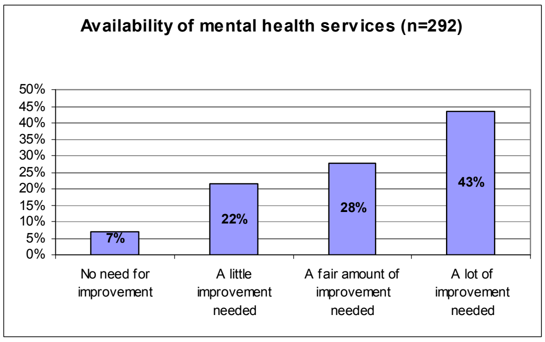

Waiting time for an appointment with a hospital consultant (n=529)

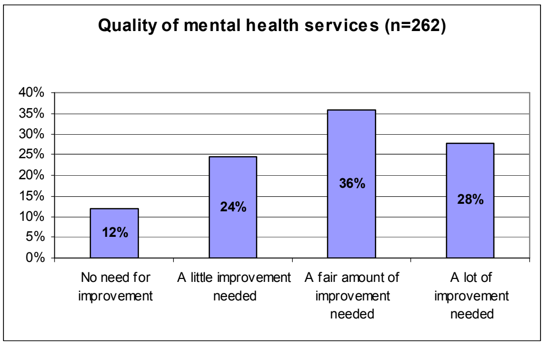

Time spent waiting in accident and emergency departments (A&E) (n=538)

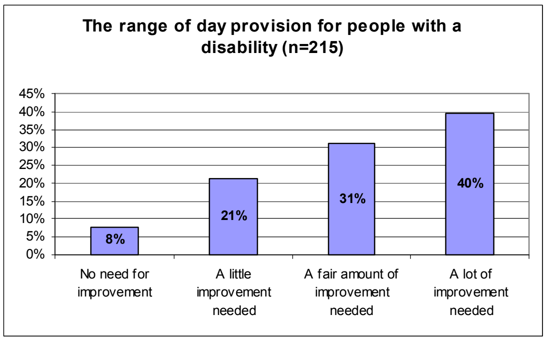

Accessibility of accident and emergency departments (A&E) (n=541)

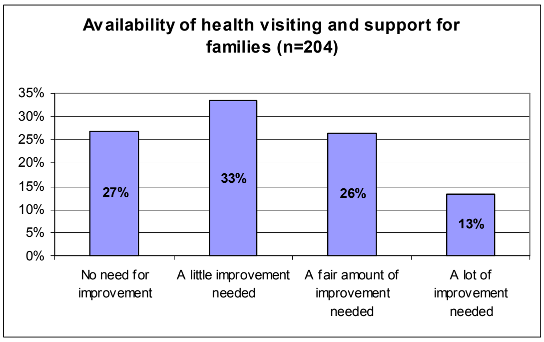

Quality of care in hospitals (n=547)

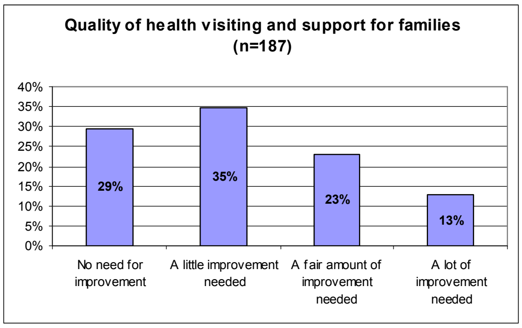

Availability of specialist nursing services e.g. nurses specialising in cancer care, respiratory illnesses or diabetes. (n=327)

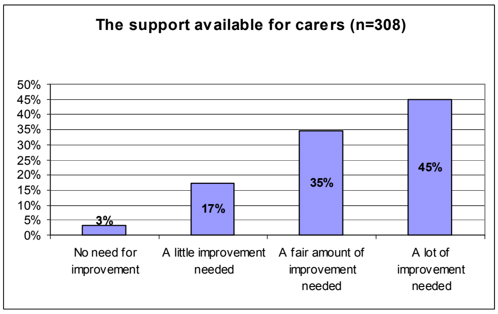

Availability of mental health services (n=292)

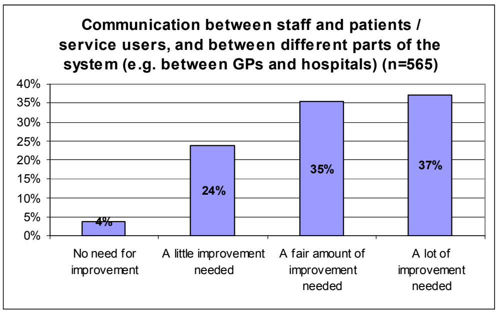

Quality of mental health services (n=262)

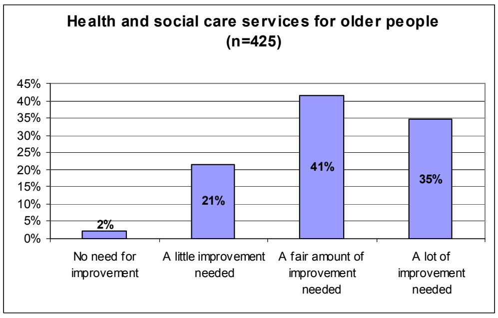

The range of day provision for people with a disability (n=215)

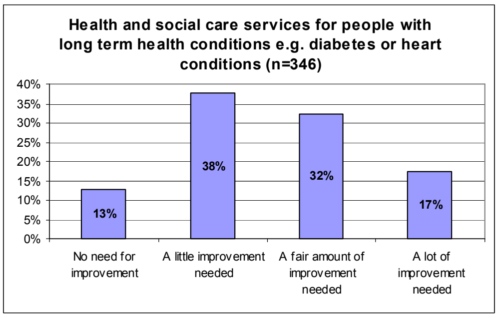

Availability of health visiting and support for families (n=204)

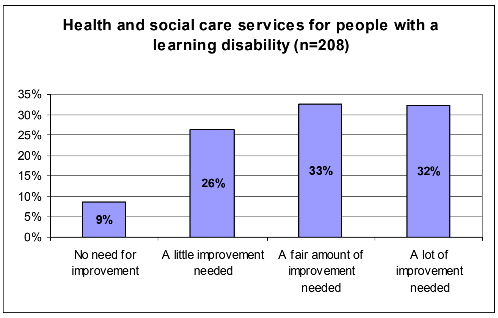

Quality of health visiting and support for families (n=187)

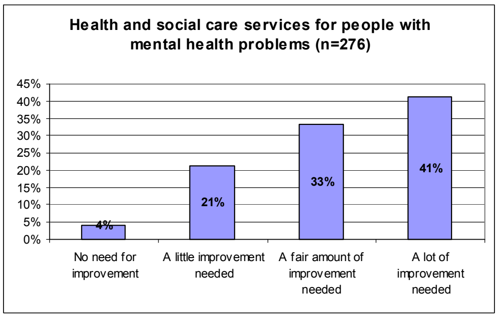

The support available for carers (n=308)

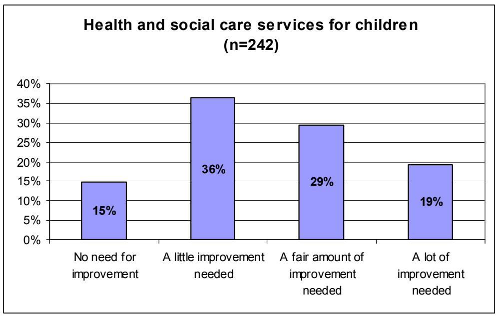

Communication between staff and patients / service users, and between different parts of the system (e.g. between GPs and hospitals) (n=565)

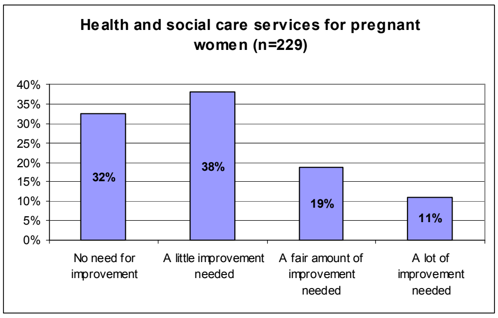

Health and social care services for older people (n=425)

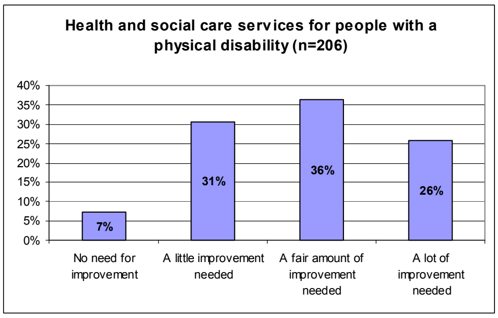

Health and social care services for people with long term health conditions e.g. diabetes or heart conditions (n=346)

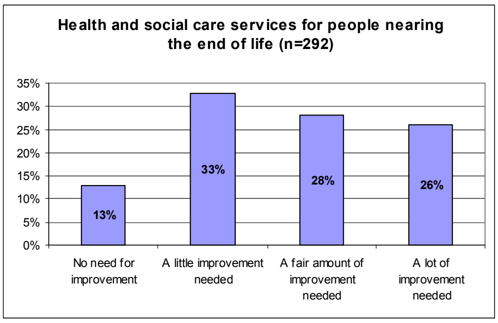

Health and social care services for people with a learning disability (n=208)


Health and social care services for people with mental health problems (n=276)


Health and social care services for children (n=242)


Health and social care services for pregnant women (n=229)


Health and social care services for people with a physical disability (n=206)


Health and social care services for people nearing the end of life (n=292)

Suggestions for Improvement

Quality of Medical Treatment by GPs

- Promote use of IT / access of information from other systems / electronic records for better decision making
- Improve communication across primary and secondary care / GP to GP / with patients & families
- Increase accessibility (extend opening hours) - evening and weekend clinics
- Training - skilling up especially in relation to Mental Health & Learning Disability, depression; keep skills up to date
- Improve interpersonal / customer care skills – especially listening skills, empathy
- More time for each appointment
- Continuity of GP
- More GPs
- Provide advice service - Use of other systems to provide advice e.g. telephone system, emails
- Use of Nurse to triage

Length of Time to get an appointment with a GP

- Increase accessibility (extend opening hours) - evening and weekend clinics
- Walk in Clinics (no appointments required)
- More GPs (and more Female GPs)
- Penalties for patients who ‘Did Not Attend’ (DNA) – use of reminder system
- Use of Community Pharmacist for minor ailments (German / Austrian Model)
- Provide help lines (may reduce demand for appointments)
- Increase role of the Practice Nurse / Triage Nurse / Triage service
- Improved system for making appointments (EMIS / online systems)
- Train receptionists re customer care skills
- Better sharing of information

Waiting time for assessment of home help home nursing or residential care

- Increase staff / resources / fill vacant posts
- More efficient use of resources
- Better process for assessment and implementation of services
- More funding
- Review ‘need’ – this may change / decrease
- Less bureaucracy
- Person centred / holistic approach

Waiting time for equipment

- Better procedures required for tracking and return of equipment e.g. central register of equipment; Trusts set target for return / recycling; patients pay deposit or application of financial sanctions for damage / non return (seems to be big issues with respect to trying to return equipment)
- More staff required particularly Occupational Therapists (OTs) and improved management of teams
- More resources for equipment purchase
- Faster appointment process

Quality of nursing care at home

- More time allocated per call
- More staff / resources
- Training of staff
- Increased use of Community Pharmacy
- Continuity
- Random audits / inspections and better regulation required
- Sign posting

Quality of home help services

- More time allocated per call – 15 minutes is not enough
- Training – a wider skills remit by staff and care plans to be held at home to indicate what carer has to do
- Increased use of Community Pharmacy
- Continuity
- More staff/ more resources / better pay = better service
- Increased funding – possibility of patient contribution
- Regulation
- Implement a register of carers - Trust service better than private.

Quality of Residential Care for Older People

- Improve regional standards of care especially for Dementia
- More staff
- Person-centred / holistic approach to provision including assessment on admission
- Random inspections
- More space / activities including crafts, stimulation to keep minds active etc
- Staff training especially re stroke
- More homes
- More money
- Better facilities including hygiene
- Direct payments – enable patient to make own decisions re care

Hospital waiting times for a non emergency operation

- Increased use of Community Pharmacy
- More staff (= more appointments) / more investment in staff to do scans etc
- Increased funding / use of Integrated Clinical Assessment and Treatment Services (ICATS)
- Prioritise waiting list using emergency and non emergency
- Up-skill staff
- Use/make better use of cancellation lists; deposit system (fines for DNAs)
- Improve, maximise theatre efficiency (including number of slots / evening and weekend appointments)
- NHS do NHS work - stop NHS consultants doing private work
- Employ Cardiac Paediatrician and stop sending to Birmingham and Dublin
- Improve communication
- Implement IEAP properly
- Bigger A&E departments and less of them
- St Thomas's

Waiting times for an appointment with a hospital consultant

- More consultants / specialists/ clear backlogs / increased training for these; more staff generally
- No private work
- More appointments (evening and weekends)
- Improved coding on new/review system / clarity on partial booking system
- Use of ICATS
- Expand Nurse led appointments /clinics
- Penalties for DNAs
- Improve communication
- Training for community specialists
- Telemedicine

Time spent waiting in A&E departments

- Reduce inappropriate referrals / attendances - educate public re appropriate use of A&E
- Use of specialist teams for improved triage – redirect to community as appropriate
- More staff and resources
- Improve communication re how long can expect to wait
- Long waiting times may be ameliorated through use of walk in centres / extended GP hours
- Use of a nurse led helpline to signpost public to correct department

Accessibility of A&E departments

- Improve local accessibility - stop closing local A&E Departments
- Address car parking including for disabled
- 24/7 opening hours including for Minor Injury Units
- Delivery of X-rays etc in other settings

Quality of care in Hospitals

- Improve hygiene
- Person centred care – more assistance with basic care e.g. eating, drinking, (dieticians), toileting
- Bring back matrons, senior nursing staff
- Address staffing shortages / more frontline staff doing the ‘nursing’
- Ensure all are treated with dignity and compassion – improve staff attitudes and morale
- Improve communication
- No mixed wards
- Look at OASIS system in South Australia for IT

Availability of specialist nursing services e.g. nurses specialising in cancer care, respiratory illness or diabetes

- More specialist nurse are required – more training
- Ensure equity of access geographically and for conditions – same as for cancer, and 24/7
- Roll out concept of Expert patient

Availability of Mental health Services

- Implement Bamford
- Investment needed for respite services
- Home treatment teams
- Improve access (for all age groups; 24/7; Learning Disabled) and signposting
- More resources (in the community) & staff
- Increased co-ordination
- Targeted resources
- Enhance understanding by GP

Quality of mental health services

- More investment & staff (Community Psychiatric Nurses (CPN), Cognitive Behavioural Therapists, Psychologists etc))
- Bamford
- Continued emphasis on recovery
- Holistic, multidisciplinary approach must be adopted
- Increased role of Community Pharmacy

- Improve Child and Adolescent Mental Health Services (CAMHS) and Older People's services
- More community initiatives
- Early intervention
- Reduce waiting times

The range of day provision for people with a disability

- Improve the range of activities including daily living skills / increased provision and more choice / appropriate activities
- Remove the age link with this service / increase the opportunity for younger people / for those aged over 65yrs
- Increase capacity provision and choice
- Person-centred
- More availability for brain injury
- Alternatives to daycare e.g. employment schemes; day therapy sessions / community development approaches
- Personalised budgets

Availability of health visiting and support for families

- Need for more health visitors
- Need for more resources
- Increase support provided by health visitors especially in first few weeks for new mums
- More links with Surestart
- Targeted approach for those in need (or at risk) of the service
- Health visitors directly employed by GPs

Quality of health visiting and support for families

- More staff, resources, training
- Provision of more support for families with young children and families, families with disabled children
- Improve communication

The support available for Carers

- More respite opportunities (more respite, regularly) / more funding for respite that is adequate and suited to needs
- Implement carers strategy
- Training for Carers
- Befriending schemes
- Financial reward
- Use of a key worker / advocate
- Use of voluntary sector to provide support
- Bank staff to cover illness
- Increase the awareness of support available to carers

Communication between staff and patients / service users, and between different parts of the system (e.g. between GPs and hospitals)

- Greater use of Technology and electronic methods for communication, prescribing etc
- Use of central information systems (1 system) / files / online patient notes
- Use of patient passports for some conditions
- Electronic Care Record
- Timely communication / openness and honesty
- System link up
- Proactive sharing of information
- User forums

Health and social care services for older people

- Increased use of private sector
- More community services
- Proactive in reach services
- More Nursing homes (to cope with changing demographics); more home help / care packages
- Explore cross border models
- More staff / more resources / more funding
- Person-centred care
- Community development / healthy lifestyles
- Right service, right time, right place

Health and social care services for people with long term health conditions e.g. diabetes or heart conditions

- Self management
- Education on risk management / healthy lifestyles and choices
- Early intervention
- Use of Community Pharmacists (for blood tests/fasting glucose etc)
- Specialist clinics, management by GPs, patients and Nurses in community / 24/7 availability
- Incentives such as paid gym memberships, slimming world etc
- Use of / explore alternative drugs
- Same level of services as for Cancer
- More community based rehab teams
- Rapid access to tests, treatments and surgery to prevent co-morbidities

Health and social care services for people with a learning disability

- Forward planning for individuals with a Learning Disability
- Use of Community Pharmacy

- Review of services for Learning Disability required including those provided by private sector
- More resources including rehabilitation, OT, and respite
- Improve communication and listening
- Multi-disciplinary and person-centred approach
- Implement Bamford
- Training for staff
- More community based services, including day care opportunities, befriending schemes, domiciliary care, training schemes and workshops.
- More support for families and carers
- Improved provision of supported housing for independent living

Health and social care services for people with mental health problems

- Improved access to services generally (24/7) and with respect to Clinical Psychology services
- Involve family
- Involve community services including Pharmacy and CPN
- Better training for mental health nurses
- More resources and staff (including specialists and CBT therapists), to aid early diagnosis and prevention, and continuity of care
- Better acute care provision
- Improved communication
- Implement Bamford – more funding
- More support for 18-25 year olds

Health and social care services for children

- Education / accessibility
- OT in CAMHS services
- Early intervention / prevention
- Inclusive policies /services
- Acknowledge extra support needed for disabled children /more services for Autistic children
- Listen to children and families / Involve parents
- More money/staff
- More school nurses
- More support through Allied Health Professionals (AHPs)
- Locally available services

Health and social care services for pregnant women

- Provide more comprehensive advice e.g. risk behaviour / health improvement / healthy choices – smoking cessation campaigns / alcohol / breast feeding etc
- Continuity of care for individual; consistency across region

- Support for women in general, and for those with mental illness
- More Midwives /direct access in community
- Targeted services for young expectant mothers
- Tailored accessible services for women with a learning disability
- Customer care training for Midwives
- Regular timely access to scanning throughout pregnancy – women should not be allowed to go over due dates
- Patient choice – but safety comes first.
- A little negativity re Midwife led units

Health and social care services for people with physical disability

- Multi-disciplinary and client-centred approach
- Care / Care teams should cater for individuals not age groups / consider children aged 14-18 who sits between paediatrics and adults
- Improved access to AHPS
- More resources / more respite services
- More accessible appointments
- Look at good practice / models e.g. Cedar Model

Health and social care services for people nearing the end of life

- More home support e.g. care packages to die at home or preferred place
- Open honest debate / listening to needs / wishes of patients / choice / allow patients to be part of the end of life plan
- More resources including hospice beds, District Nurses
- Use of Pharmacists
- Provision of Palliative Care teams to all people and allow to die with dignity
- Multidisciplinary approach /Specialist Nurses
- Palliative care for Learning disability
- Training for all involved
- More support for families / bereavement
- Same level of services as is for cancer
- Signposting – who to contact
- More staff –e.g. Palliative nurses
- More co-ordination –palliative nurses used as key workers

If you could make 3 changes to improve health and social care in Northern Ireland, what would they be?

Main themes

- More staff generally, more nurses and AHPs
- Reduce waiting times
- Improve communication
- Improve access to GPs
- Focus on health promotion / prevention; address alcohol as a public health issue
- Improve communication
- Increase local accessibility of services
- Improve hospital and community services for older people
- Reduce the number of managers and reduce paperwork
- Introduce charges for prescriptions, other services including meals in hospital, missed appointments,
- Improve services for learning disabled and their families carers including respite care
- Improve mental health services
- Staff training
- Better use of technology
- Bring back matrons
- Community Pharmacy
- Improve roads infrastructure
- More money
- Educate people to support themselves
- Fewer managers and less bureaucracy
- Decentralise where possible
- Enhance staff morale
- Interworking - enhance cross border working
- Increase involvement of community and voluntary sector
- Family support services
- More hospice and palliative care

Do you have any other suggestions for the future provision of health and social care services in Northern Ireland? For example this may relate to how accessible services are, the quality and safety of services, or the health outcomes achieved.

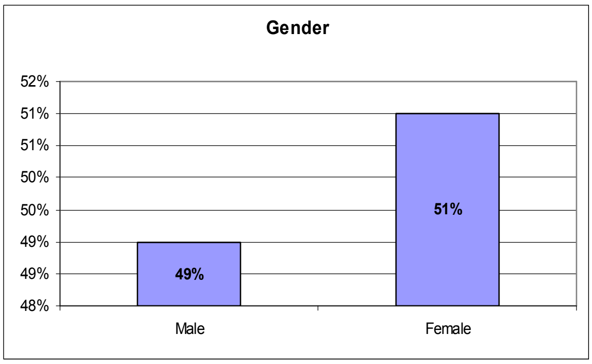
The responses given were variable and quite detailed. A very high level summary of some of the emerging themes are listed below:

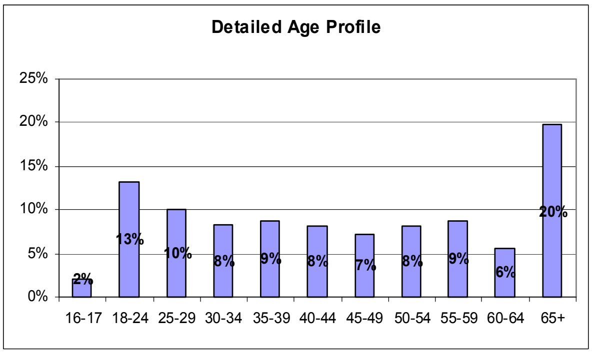
- Improve services for learning disabled and their families /carers
- Address alcohol as a public health issue
- Promote the use of Independent sector
- Reduce waiting lists
- Better use of Community Pharmacy services; more funding for Community Pharmacy services
- Better use of available services and facilities
- Promote / establish links within communities to combat loneliness
- Investment in resources / equipment
- More local services
- Introduction of charges (e.g. prescription charges)
- Equality of access for all in NI
- Invest in carers
- Invest in health promotion / prevention – make public responsible for their own health, start early; educate in schools to get public health message across
- Increase range of services offered by GPs / GP practice teams
- Stop closing A&E departments
- Reduce emphasis on targets and re focus on patient
- Fewer Managers
- Health care planning at local level
- Improve roads infrastructures thereby improve access to a range of services
- Enhance skills mix
- Improve GP accessibility
- Provision of quality training and communication
- More OTs
- Optimise use of technology
- Reconsider current location of some hospitals
- National health service for older people and those with disabilities
- Improve reporting times for diagnostic tests
- Less focus on waiting lists targets / find better ways to monitor waiting lists
- Reduce waste; reduce wastage with regard to pharmaceuticals
- Utilise skills in the community such as GPs, Pharmacists
- Better utilisation of AHPs
- More use of voluntary sector / community based services who can do the job for less
- Improve appointment systems
- More money needed

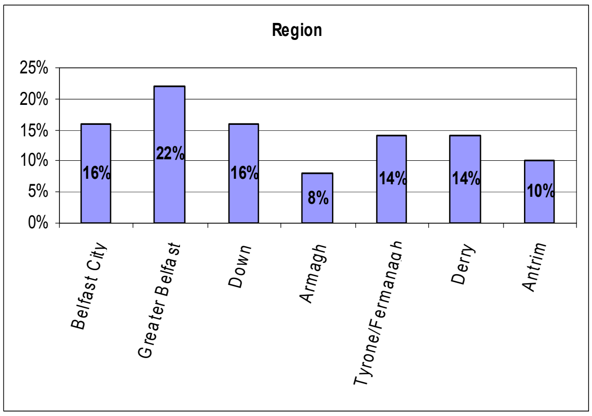
- Improve access to services for at risk youth
- Longer home help sessions
- Mobile clinics for hard to reach areas

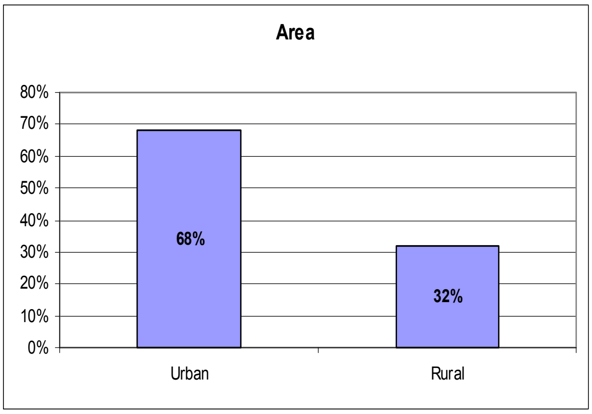
Appendix 3
Household Survey Summary of Results

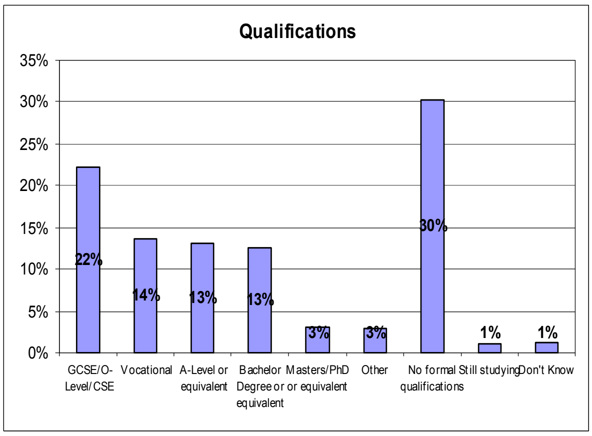
Profile Data

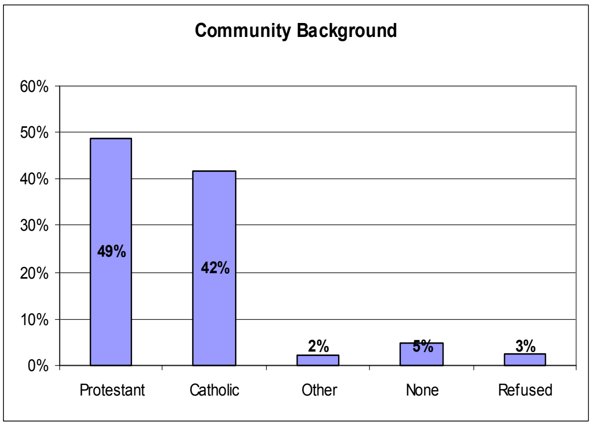


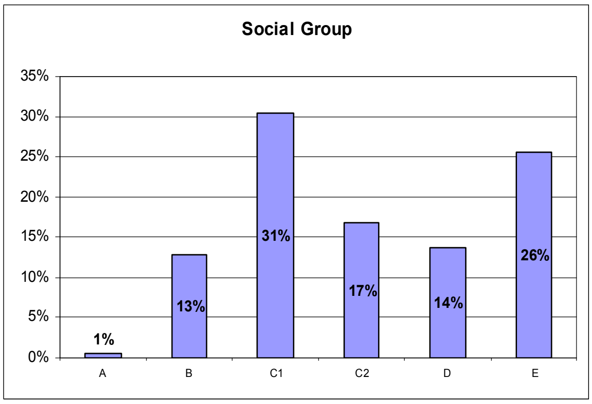


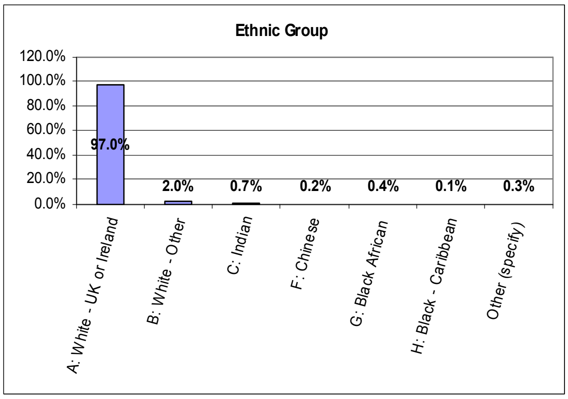






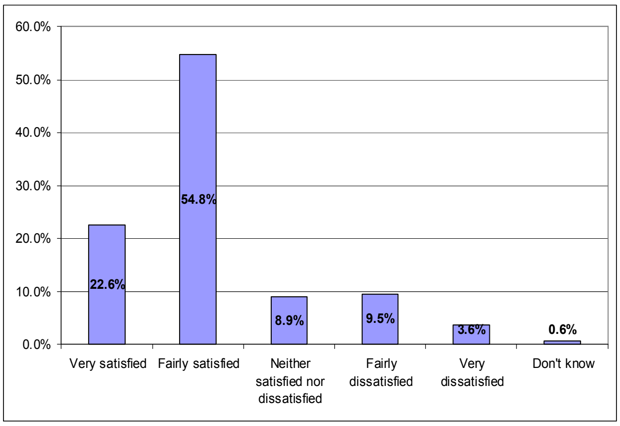


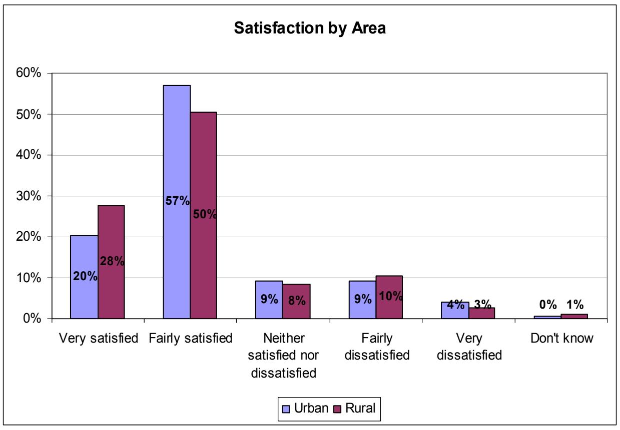


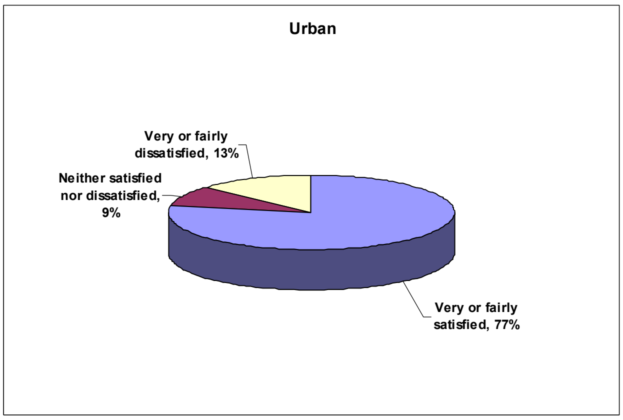


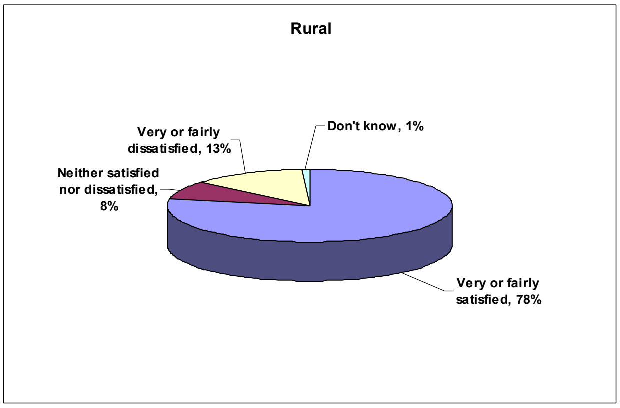
Question Responses

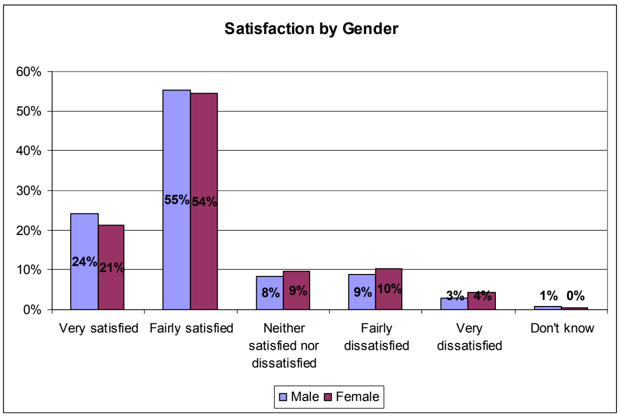
1. Overall, how satisfied or dissatisfied are you with health and social care provision in Northern Ireland at present?

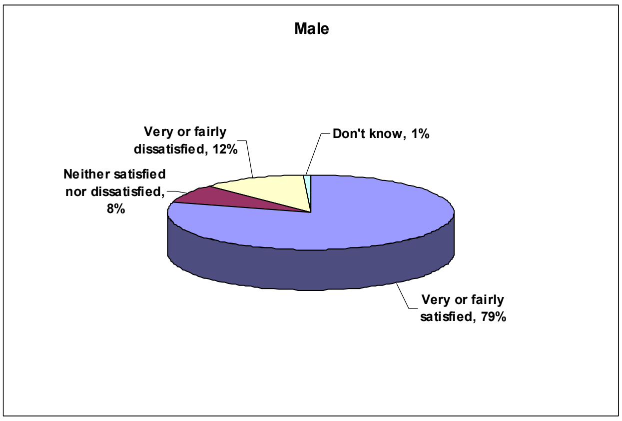


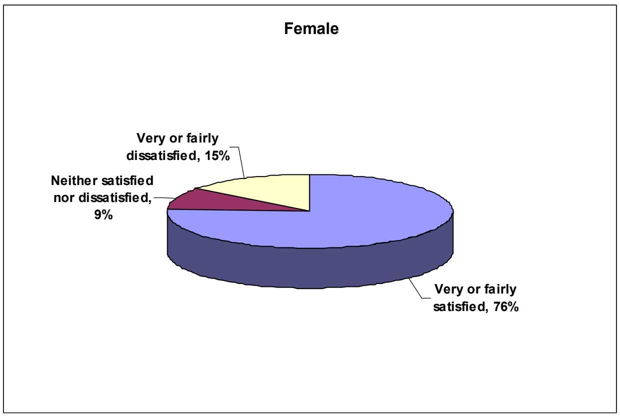


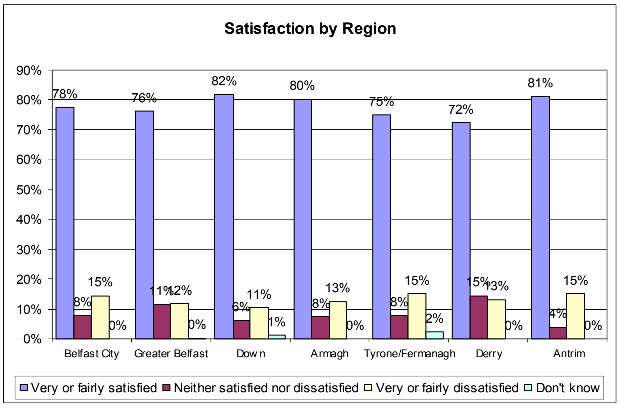




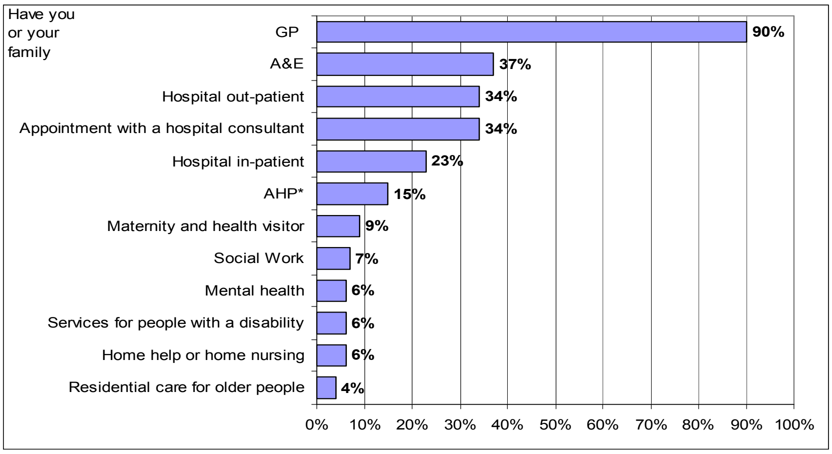




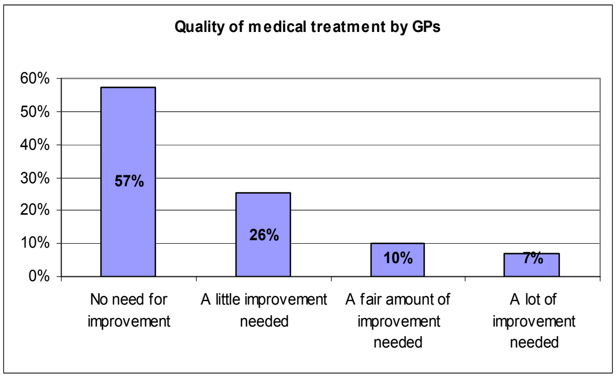


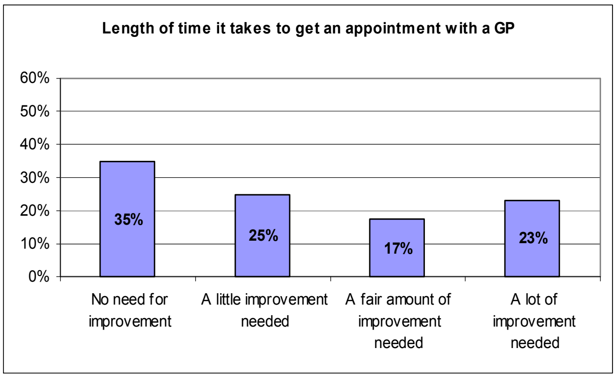


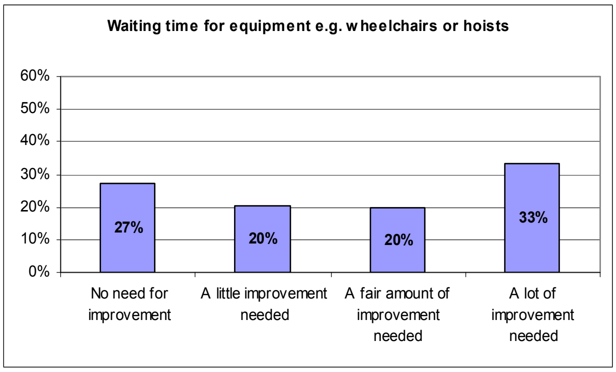
2. Have you or your family used any of these health and social care services in the last year?

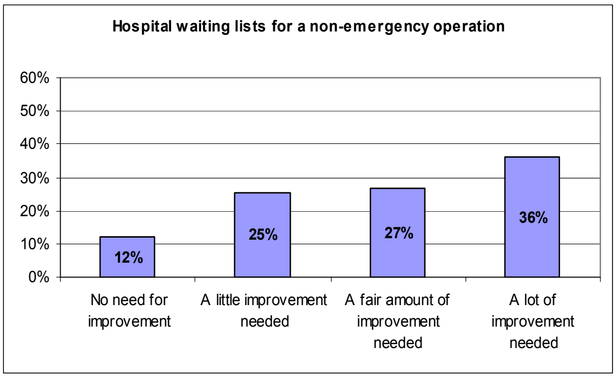


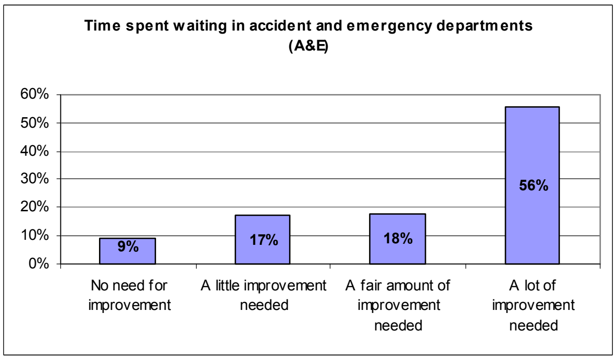
3. How would you rate the following aspects of Health and Social Care in Northern Ireland in terms of whether they require improvement or not?

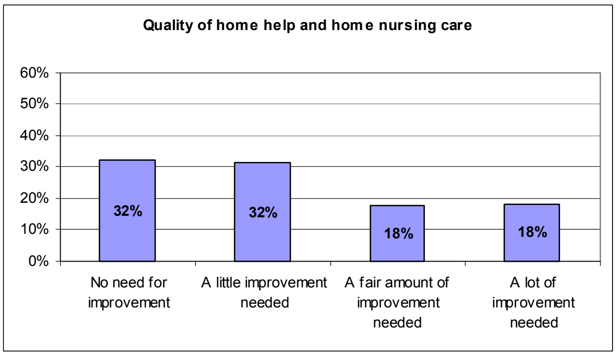


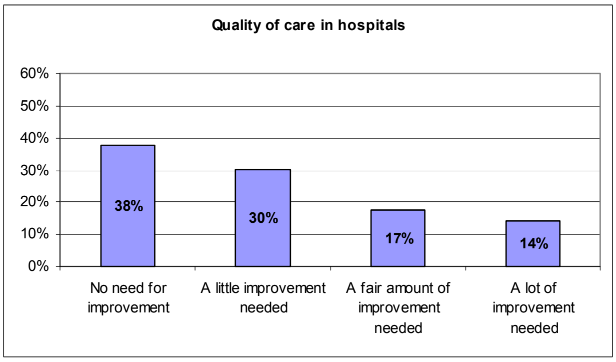


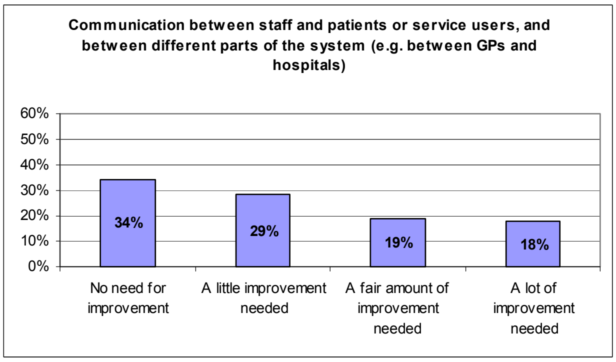


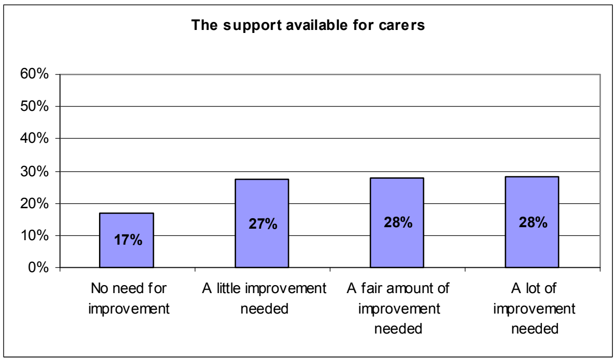




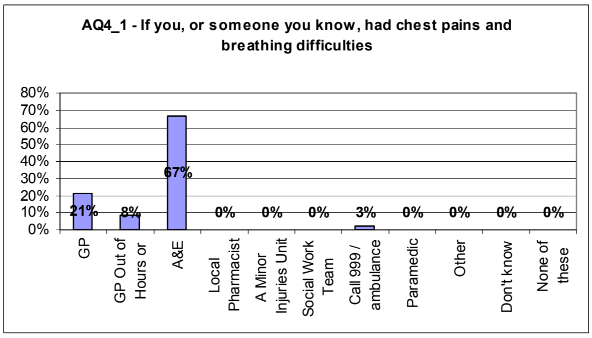


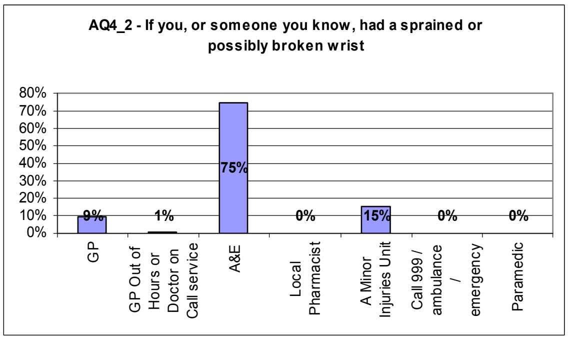

Quality of care in hospitals

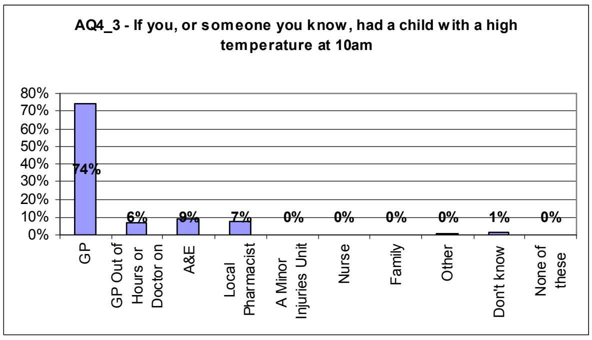

Communication between staff and patients or service users, and between different parts of the system (e.g. between GPs and hospitals)

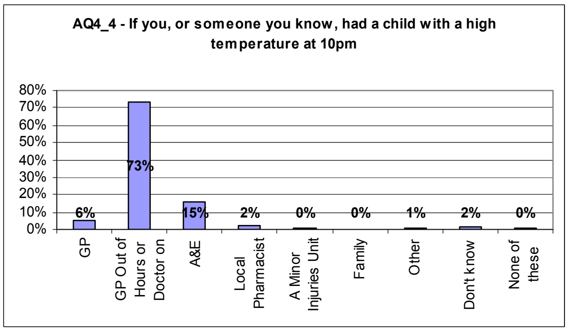

The support available for carers

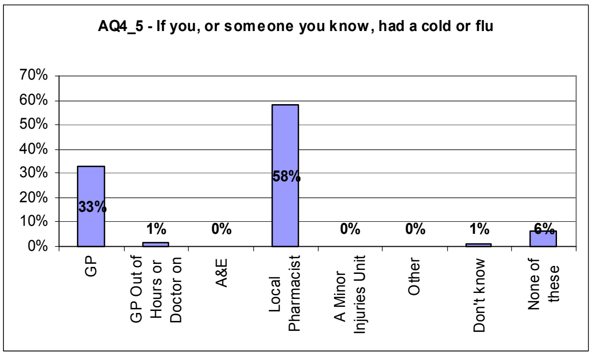
4. Which one of these services would you be most likely to go to in the following circumstances?

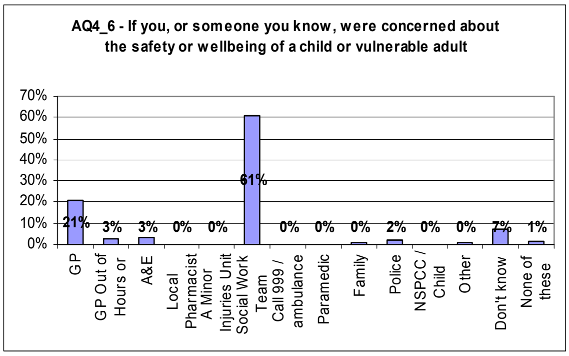

AQ4_1 - If you, or someone you know, had chest pains and breathing difficulties


AQ4_2 - If you, or someone you know, had a sprained or possibly broken wrist

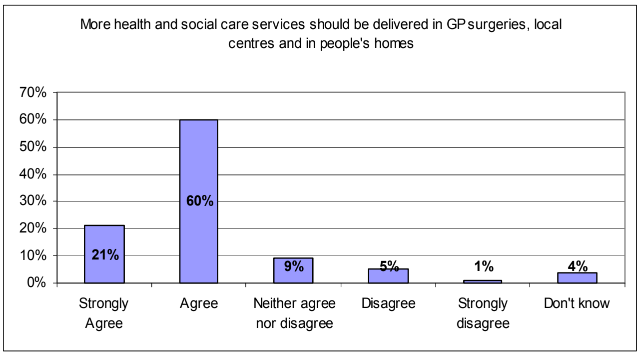

AQ4_3 - If you, or someone you know, had a child with a high temperature at 10am

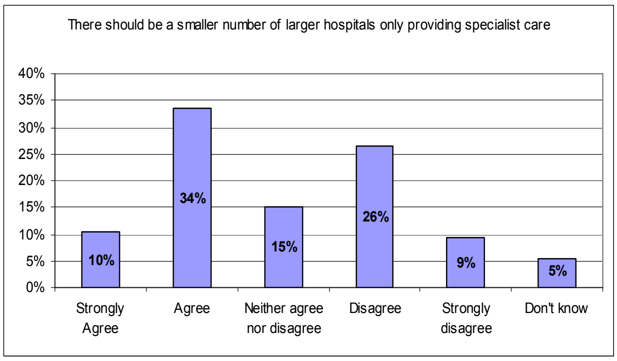

AQ4_4 - If you, or someone you know, had a child with a high temperature at 10pm

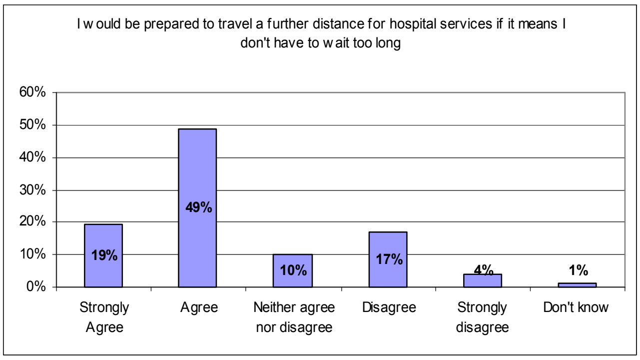

AQ4_5 - If you, or someone you know, had a cold or flu

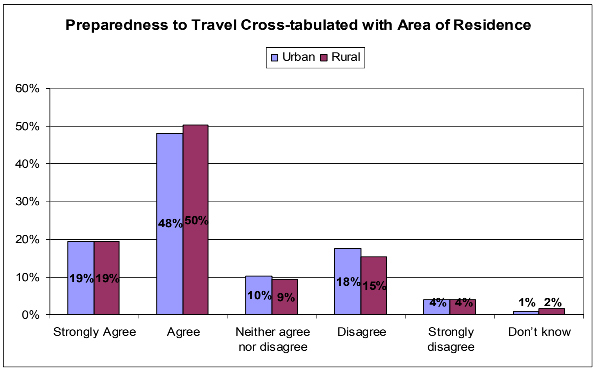

AQ4_6 - If you, or someone you know, were concerned about the safety or wellbeing of a child or vulnerable adult

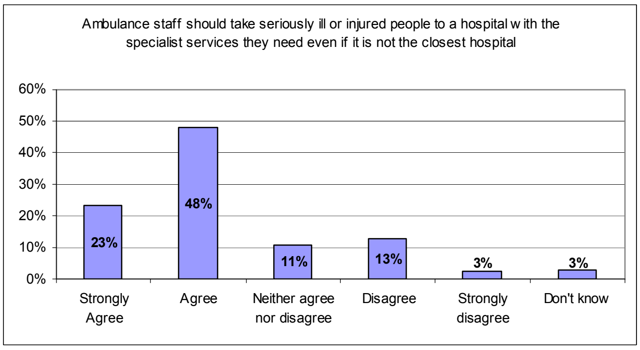
5. To what extent do you agree or disagree with the following statements?

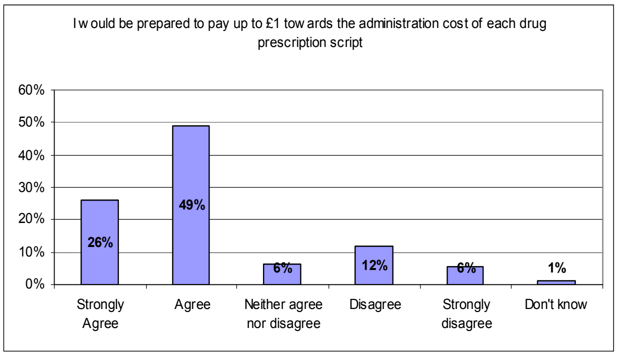




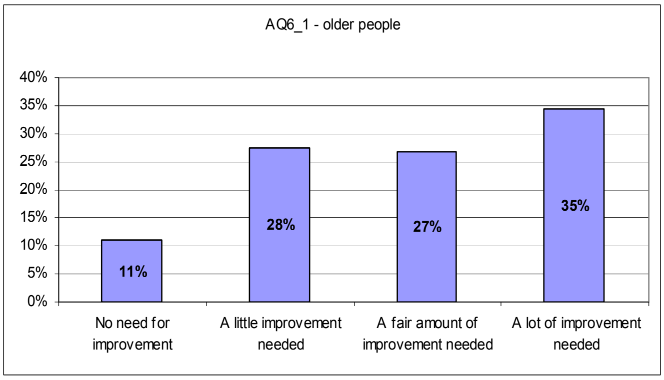


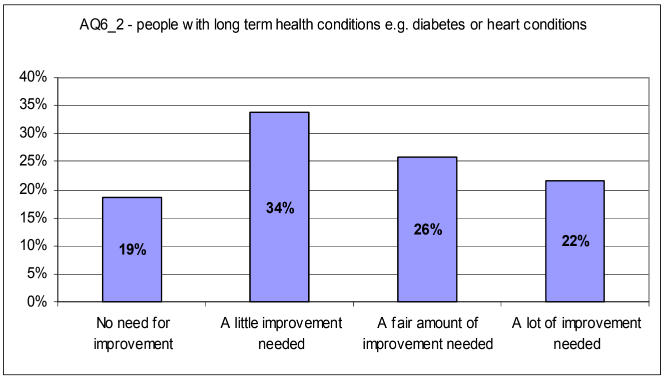


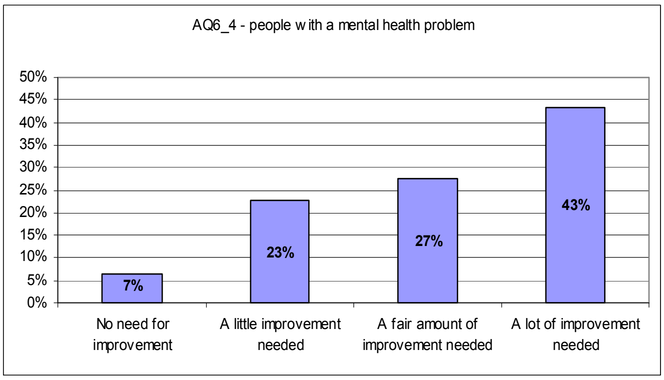


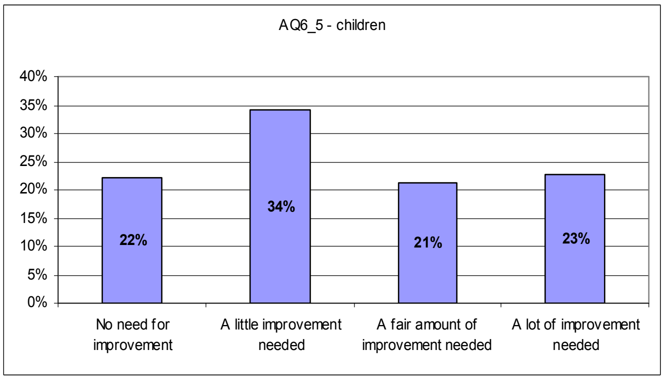


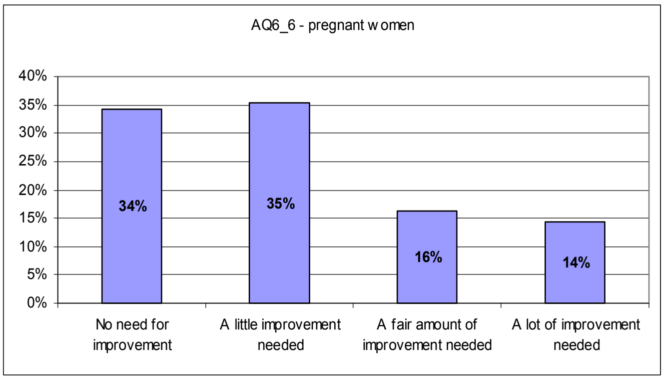
6. How would you rate the health and social care services provided for these groups in terms of whether they require improvement or not? Health and Social Care Services for:



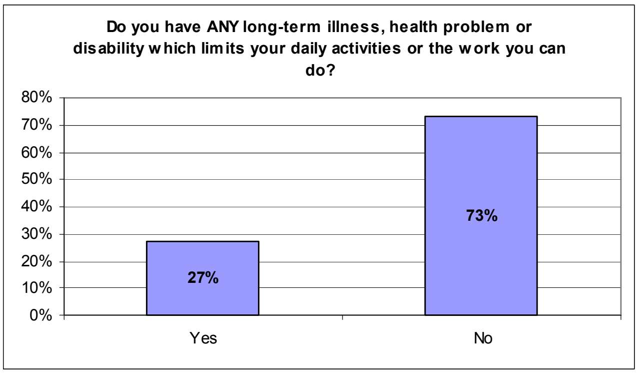


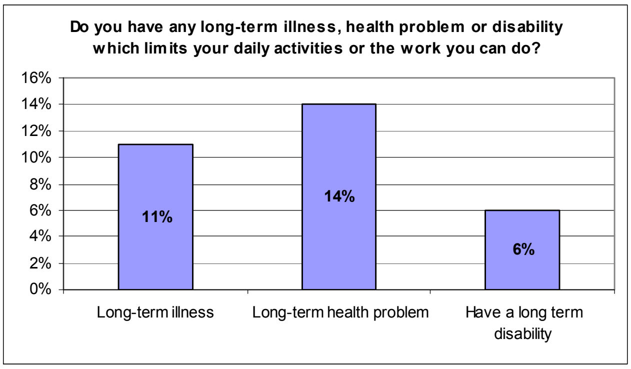




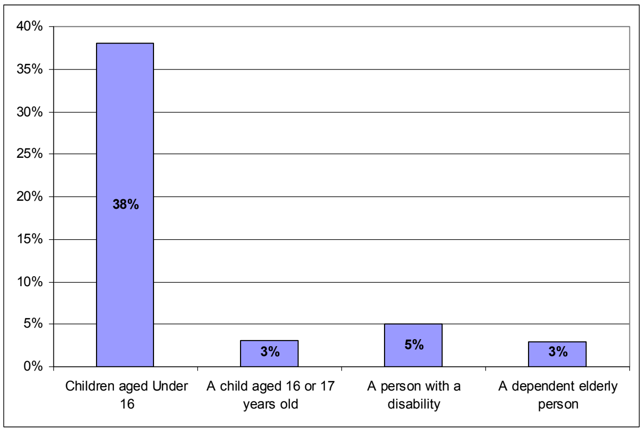


10. Do you have any long-term illness, health problem or disability which limits your daily activities or the work you can do?

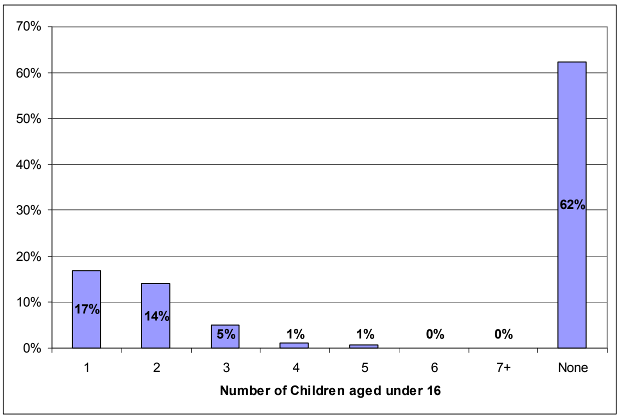

Do you have ANY long-term illness, health problem or disability which limits your daily activities or the work you can do?


Do you have any long-term illness, health problem or disability which limits your daily activities or the work you can do?

11. How many Children aged under 16 are there in your household, and do you have personal responsibility for the care of any of the following:



How many children aged under 16 are there in your household?



If you could do one thing to make health and social care services better what would it be?

Theme	No of responses	% of Total
More staff / no cutbacks on staff	126	11%
Don't know	120	11%
More money / spend money more wisely	81	7%
Shorter waiting times for GP / hospital appointments	77	7%
Reducing waiting times (general)	77	7%
Other	64	6%
Nothing	62	6%
Cut back on managers	41	4%
Keep services local / accessible	37	3%
Shorter waiting times at A&Es	34	3%
Better care for the elderly	29	3%
Improved care	24	2%
Cut down on bureaucracy / admin	23	2%
GP/doctor more accessible	23	2%
Better communication with patients / more information	22	2%
Better qualified staff / improve training	21	2%
Better mental health provision	17	2%
More flexible / longer opening hours for GPs	16	1%
More / better equipment / services	15	1%
Improve pay for nurses/doctors	14	1%
Improve A&E services	14	1%
Improve efficiency	14	1%
Keep hospitals open / more hospitals	13	1%
Bring back matrons	13	1%
Improve communication between GPs and other departments	11	1%
Cleanliness of facilities	11	1%
Making people more aware of services	10	1%
More services for children	10	1%
Keep A&Es open 24/7	9	1%
Longer opening hours for hospitals	8	1%
More beds in hospitals	7	1%
Access to specialists	7	1%
Penalties for missed appointments	6	1%
More community care / voluntary services	6	1%
Avoiding further cuts	6	1%
Consult with the public	5	0%
Fee for prescriptions / money wasted on prescriptions	5	0%
Open A&E at Lagan Valley	5	0%
More coverage in rural areas	4	0%
Improve follow-up care	4	0%
The way HSCNI is run	4	0%
Consistency of care	3	0%

Improve ambulance services	3	0%
Improving services for people with disabilities	3	0%
More time spent with patients	3	0%
More call outs	2	0%
Access to medical records	2	0%
Better working conditions	1	0%
Best practice in other countries	1	0%

Appendix 4
Questions Raised at Public Meetings

Questions Raised at Public Meetings

Tuesday 8th November 2011 at 7pm
Great Hall, Magee Campus, University of Ulster

- Mental health services have always been the "Cinderella" and are currently ten years behind UK funding levels. Will the Review Panel bring this to the notice of the Minister?

- How can the Review Team ensure relevant follow-up after care for services which take place elsewhere and are not sustainable in NI e.g. follow up for transgender people who have had surgery in other parts of the UK?

- The necessity for provision of respite care to go someway to alleviate massive carer stress and in order to allow carers to continue looking after loved ones in the community.

- How can you ensure quality of care with continual use of locum/agency staff when so many qualified practitioners/service providers are desperately seeking employment?

- Does the Panel feel that it may be time for a shift to a more social, rather than medical model of care, due to the ageing population?

- What consideration will the Health and Social Care Board be giving to building working relationships with the Health Service Executive in the Republic of Ireland in order to secure efficiencies in Service Delivery?

- Does the Panel have a view on the impact of the poor infrastructure in NI (i.e. lack of adequate rail link) on health care provision for people in the North West?

- How should the Department commission services for uncommon/rare conditions?

- Is there any recognition that we have just come out of 'conflict' and that health (especially mental health) is affected?

- Regarding mental health services, are there any plans to shift some of the budget to address the "Cinderella" service?

- Why do mental health patients go through A&E – why not have a mental health emergency room?

- How can commissioners support research to gauge the effectiveness of community interventions, which often do the most to promote inclusion but struggle to attract secure resources?

Wednesday 9th November 2011 at 7pm
Omagh Enterprise Centre, Omagh

- Why are there going to be hospital cut backs – particularly when new ones are being built but there is no money to run them?

- There is a growing emphasis on children's rights at the expense of the wishes and consent of parents. What protection will there be for the rights of parents?

- In the light of funding being withdrawn from the A5 (Derry – Aughnacloy Rd), can the Review Team use its influence to transfer the funding to the Omagh – Enniskillen (Hospital) Rd?

- Transport services to and from hospital is very poor. Older people refuse to go into hospital as they have no service to bring them home once discharged. Are there any plans to address this?

- What will the Review do to address Mental Health services as funding at present is inadequate?

- What are your greatest frustrations as a GP in a rural area (Dr. Gallagher) and what anxieties have you for our services over the next 5 years?

- The Review Team suggested a further shift of care from secondary into primary/ community care. How are planning to address the issue that primary care is already absorbing the bulk of care and there is no slack to be taken up?

- Why do we need a Board, and why do we need Trusts which have been allowed to become too powerful?

- Hospitals are not placed in the correct areas or take into account hospital across the border.

- How are hospitals going to be run? For example, the Erne has had its services cut back from what was promised.

- Communication is inefficient everywhere in the system. How does the Review plan to address this?

- Why are we not looking to innovation to reduce costs?

- Why don't the Patient and Client Council get a report from every patient after they visit a hospital?

- Can we have a nurse led midwifery stand alone unit at Enniskillen hospital?

- The Review should be carried out for the right reasons and not for an easy option. For example, safeguarding services to put another service in danger.

- Can the Review look at equity of service provision? For example, maternity services.

- Will the Review be based on an identified needs approach?

- Can we have assurances that our Health Service will remain public and free?

- Will all new initiatives be equality checked?

- Can we have assurances that the UK Health and Social care Bill will not be introduced?

- Will the Review look at statistics from the Trust Delivery Plans?

- How does the Review plan to reduce hospital bed waiting times at A&E?

Monday 14th November 2011 at 7pm
Ballymena Showgrounds, Ballymena

- There is a lack of good transport links for rural areas. How can equality be achieved for the socially poor who are left with no access to acute hospitals?

- How can HSC and society do more to protect the most vulnerable people e.g. victims of domestic violence, young and old?

- Has the Review looked at oral surgery services in primary and secondary care?

- Have there been any pilots set up to trial the emerging themes?

- How do you tackle resistance from consultants who use waiting lists to fund private practice?

- In the Northern Trust, the number of attendances and review attendances has dropped while there has been a massive increase in inpatients and daycases. We want to know what services are being given to us rather than taken away.

- The recommendations from the Comprehensive Spending Review were found to be untrue. How will you ensure this will not happen again?

- Has the Review Team engaged with community pharmacy and will it give a commitment to do so?

- With the planned closure of 100 pharmacies across the Province, how will this fit with the proposed move to primary care? What additional roles will community pharmacy have to take on?

- Will the Mid Ulster hospital receive the build and services it requires as stated in Developing Better Services?

- Are acute hospitals in the correct location to best serve patient need?

- Does the Review Team belie that a Rapid Response Vehicle is sufficient to fill the gap left by the closure of acute services in the Mid Ulster Hospital?
- Is it inevitable that fund shortages equal longer waiting times?

- What improvements can be made to case waiting times and welfare reports in relation to child abuse and acrimonious parental separation?

- Will the Review recommend making social workers give evidence under oath?

- Are there any plans to change the Dalriada Doctor on Call services within the Northern Trust i.e. move them to hospital sites?

Tuesday 15th November 2011 at 7pm
Assembly Buildings Conference Centre, Belfast

- What provision is in place in the Ulster Hospital, should it have to close, due to a super bug outbreak?

- What is the status of the McKinsey Report on/within the Review?

- Does the Panel see an expanded role for Multiple Sclerosis carers and would they be prepared to allocate some funding or shift in resources?

- The mandate is growth of domiciliary care. Is there any development in the funding?

- Do you feel that day care within the HSC Trusts is too cheap at £1.35 per day? Private day care is priced at £8 per hour.

- Out of 100 young people with severe learning disabilities leaving school each year in Northern Ireland, 20% with more complex needs have no choice but to attend a day centre – where is their choice for lifelong learning?

- Do the Panel feel that the cutting of jobs from Learning Disability services and not replacing day care workers is correct?

- Does the Review Team plan to address the short fall in Mental Health, as it is already underfunded by 44%?

- As an adult who has been diagnosed with a personality disorder, where is the promised help that the Bamford Report said was coming?

- During the Review is any thought given to the fact that we have 30% less cars here than the UK mainland and a transport system that stops at 9pm?

- What is the point in having a centre of excellence if it is located in an area unattainable to the public?

- What principles is the Review Team considering for the number of hospitals in Belfast and the services they provide? Will their funding be cut?

- What will be the acute status of all Belfast hospitals after the Review?

- Is the right to a second opinion still available?

- When one is a patient, can they be provided with a card that shows relevant standards for the service/treatment at issue? Patients don't generally know what they can expect.

- Pharmacy is not mentioned in the Review. Has the Panel considered the benefits and quality outcomes that could be achieved in Primary Care by fully engaging with Community Pharmacy?

- As the Minister has indicated he wants to close 100 Pharmacies, how will that impact on Community Pharmacy's ability to play its part in Primary Care?

- The Minister is on record of saying that there are 100 too many Pharmacies in NI. Has any consideration been given by this Review Team on the impact to the public if this was enacted?

- Why has Community Pharmacy not been covered by the Review?

- As Community Pharmacy is an integral part of the Primary Care team, has the Review Team any plans to engage with their representatives to obtain their view?

- Will the Review Team follow the Health Minister's stated intention of privatising social care services?

- You discussed 'evidence' of health inequalities in our society. Do you have plans as to how to address these in lower socio-economic groups with shorter life expectancy? What does that mean in relation to services?

- Does the panel believe in the principles of the NHS i.e. free at the point of need for all?

- What criteria is the there for the quality of care for the elderly in nursing homes where business people are requesting staff to cut incontinence pads?

- There is often mentioned 'interdepartmental working/interagency working'. Describe what that would look like if it were being done successfully across all government departments. What needs to change to make it happen?

- How innovative is this Review going to be e.g. in other parts of the UK there have been introductions for playgrounds for over 60s. Will this Review be as far ranging and looking at a whole systems approach to tackling health and social care?

- When you say the workforce needs to be 'less professionally driven' and be shaped more towards services, what do you mean?

- What are the plans to ensure that OT services should be developed as a core element of Child and Adolescent Mental Health provision as recommended by Bamford in 2006?

- Has the Review recognised the need to resource an already stretched frontline service with the means to treat individuals 'in the right place, at the right time and by the right people'?

Thursday 17th November 2011 at 7pm
Lagan View Enterprise Centre, Lisburn

- Who cares for the carers with health?

- How is the Downe A&E organised overnight? Is this a model that could be adopted for Lisburn?

- If the City hospital is going to become a specialist centre for chronic conditions within Belfast, could Lagan Valley become a specialist centre in the South Eastern Trust area in the same way?

- Do the panel agree that transparency is key to any planned changes and what is being done to ensure this takes place?

- What are the likely outcomes of the Review for (a) patients/users and (b) health care professionals?
- What preventative measures can be taken to reduce the obesogenic nature of our environment?
- Providing screening and enhanced services in community pharmacy can reduce NHS costs through early detection and treatment. This can remove pressure from our secondary care sector. Does the Review agree?
- Will the Review take account of the work of voluntary sector organisations and the value for money that these organisations provide?
- The N.I Assembly budget ensured that there would be no cut to Learning Disability budget. Can you confirm that this review completely safeguards this?
- Can the Review Team ensure that the recommendations made in the Bamford Review will be implemented?
- With nursing posts not being replaced and sick leave and maternity leave not being covered – how can we ensure delivery of patient-centred care?
- Why are hospitals still run on a Monday to Friday basis with skeleton staff working at weekends?
- In other parts of the UK (e.g. Scotland), community pharmacy plays a much greater role in the provision of both core and enhanced pharmaceutical services. Does the Review envisage this as the way forward in N.I?
- There is clear evidence that O.T. led reablement services deliver positive outcomes. Can the Review Team ensure that such services will be available to all service users in N.I?
- What is the potential for 24hr cover again in Lagan Valley A&E? Can local GPs help to ‘man’ the department?
- How is the RVH coping with the extra patients from LVH and BCH?
- With an annual intake of 135 medical students in QUB, where have all the doctors gone?
- Is it possible to use GP trainee doctors to staff local A&E departments as part of their training?

- There must be concern at the much lower resource spend on children in NI than elsewhere in the UK. Can the Review identify ways to increase the priority of services for children?

- How will the system deliver a more caring service to cancer patients who are terminally ill and at home? Will you work collaboratively with other depts. e.g. DSD for better housing conditions?

- What interventions can be made to ensure much needed improvements in the delivery of home care packages?

- Does the Lagan Valley hospital have a future?

Wednesday 23rd November 2011 at 7pm
St Patrick's Trian, Armagh

- How many more reports do we need? What are you going to do differently?

- The Department of Education is planning a 0-5 Early Years' Strategy – will the Review seek to link in the Department of Health, Social Services and Public Safety's pregnancy-5years provision with the Department of Education strategy?

- Are LCGs fit for purpose and how much money has been used to date? Are we getting Value for Money?

- Is there an assurance that Allied Health Professions staff will still be valued as integral to the process of effective/safe discharge planning from the acute setting into community care, as the focus appears primarily to be on community sector?

- There is a lot of talk on radio of proposed Pharmacy closures – what is the timescale for these closures?

- Would the Panel consider it a missed opportunity that the role Community Pharmacy could play in bringing health to the community is not mentioned in the Review?

- Will the Review recommend extended roles for Community Pharmacy in managing patients in the community, services to prevent ill health, health promotion etc?

- What plans are in place for more supported living accommodation in Newry? It is badly needed within the next two years.

- Are there any plans in place to build more long-term accommodation in the Newry area?

- Carers are for many the backbone of the health and social care system. In return the system has promised to deliver support to carers when it is needed. This is supposed to be achieved by offering each qualifying carer a Carers Assessment. This requirement is one of the statutory functions of the HSC Trusts. However, many Trusts do not fulfil this requirement and many carers continue to carry out their caring role without adequate support. How will the Review ensure that Trusts will no longer be able to neglect this statutory duty and how will the Board guarantee widespread compliance with this duty?

- Should service users, carers and members of the public have more say in how health and social care budgets are spent, via the use of scrutiny committees or citizen juries to ensure the public have real and meaningful input to service provision? The welcome initiative of Patient and Personal Involvement was introduced without direct funding for the development of this strategy. Will the initiative fail if health and social care fails to properly fund its development across the sector?

- What is your opinion of the proposals which include ‘older people’ receiving funds to pay their carers? Will this not further confuse the elderly?

- The BBC carried an article on the huge predicted increase in elderly population and the demand this will place on domiciliary care and social services. What is the Panel’s view on the impact this will have on acute services for hospital admissions?

- Following speculation in the press – do you plan to close Accident and Emergency and acute services in Daisy Hill Hospital?

- With less acute hospitals how will service users access treatment from rural areas with insufficient public transport?

- Where is the infrastructure that will support a reduced number of hospitals, which is widely rumoured to be the outcome of the Review? There is no use modelling ourselves on urban environments without appropriate support and access.

- What impact will this Review have on jobs within the HSC?

- In light of the recent publicity in the press, radio and TV, is there any point in this meeting as the Review has already been written?

- What would you do to encourage appropriate restructuring of resettlement teams to include Occupational Therapists with unique skills to assess and advise on support needs equipment and adaptations in line with a number of Bamford recommendations?

- Would the Panel agree that GPs should be left to treat their patients thus leaving the complex range of other care to Trusts and other staff?

- Do the Panel believe that the independent/private sector can run services better and/or cheaper than the Trusts currently do?

- The shift in community based care – is this not more idealistic than realistic? Are the people/relatives expected to do this because of economic resources?

- Can Mr Compton give an assurance that A&E and emergency surgical services will be maintained at Daisy Hill Hospital?

- Leaks about the downgrading of Daisy Hill Hospital have already affected staff morale – can you reassure us about the future of Daisy Hill Hospital and that the level of services will be maintained?

- Commenting on a leaked report of 29/06/2011, will the Review result in: 2000 jobs lost; £40 cut from locum doctors and doctors; £30million cut from Pharmacy budget; a recruitment freeze; and the number of acute hospitals cut by 50%?

Appendix 5

List of Attendees at Clinical Workshops & Areas Covered

Workshop 1: Unscheduled Care, Specialist Services (including Cancer), Elective Care
Wednesday 12th October 2011 at 4pm
Ballymena Showgrounds, Warden Street, Ballymena, BT43 7DR

Name	Organisation
Jennifer Welsh	BHSCT
Dr Patricia Donnelly	BHSCT
Dr Dermot Maguire	GP
Dr Garth Logan	GP
Dr Sloan Harper	HSCB
Beth Malloy	HSCB
Jeff Featherstone	HSCB
Louise McMahon	HSCB
Paul Leyden	NHSCT
Tom Morton	NHSCT
Margaret O'Hagan	NHSCT
Stephanie Greenwood	NHSCT
Dr Olivia Dornan	NHSCT
Joanne McKee	NHSCT
Sean Donaghy	NHSCT
Martin Sloan	NHSCT
Jackie Elliott	NHSCT
Brenda McConville	NHSCT
Denise Quinn	NHSCT
Valerie Jackson	NHSCT
Liam McIvor	NIAS
Dr David McManus	NIAS
Liz Henderson	NICAN
Eleanor Ross	PHA
Dr Miriam McCarthy	PHA
Paul Kavanagh	PHA
Kevin McMahon	PHA
Dr Janet Little	PHA
Chris Allam	SET
Joe Toner	SET
Sean McGovern	SET
Mark Armstrong	SET
Dr Tim Harding	SET
Stephen Hall	SHSCT
Dr John Simpson	SHSCT
Seamus O’Reilly	SHSCT
Robert Carlile	SHSCT
Gillian Rankin	SHSCT
Heather Trouton	SHSCT
Charlie McAllister	SHSCT
Dr Bassam Aljarad	SHSCT

Paula Clarke	SHSCT
Phillip Murphy	SHSCT
Robin Brown	SHSCT
Ron Thompson	WHSCT
Geraldine Hillick	WHSCT
Dr Padhraig Conneally	WHSCT
Dr Brendan Devlin	WHSCT
Dr Paul McSorley	WHSCT
Stephen Clanaghan	WHSCT
Dr Caroline Mason	WHSCT
Dr Fergal McNicholl	WHSCT
Gerard Daly	WHSCT
Michael Riley	
Gloria Mills	

Workshop 2: Long Term Conditions, Care for Older People, Physical Disability, End of Life Care

Thursday 13th October 2011 at 4pm

Lisburn Civic Centre, Lagan Valley Island, Lisburn, BT27 4LR

Name	Organisation
Dr Ken Lowry	BHSCT
Dr Alister Taggart	BHSCT
Dr John McCann	BHSCT
Denise Killough	BHSCT
Dr Bernie Corcoran	BHSCT
Una McAuley	BHSCT
Bernie Kelly	BHSCT
Dr Grainne Bonnar	GP
Dr Paul McGerrity	GP
Iain Deboys	HSCB
Dr Sloan Harper	HSCB
Margaret O'Brien	HSCB
Fiona Gilmour	NHSCT
Yvonne Duff	NHSCT
Wendy Longshawe	NHSCT
Ann Orr	NHSCT
Fergal Tracey	NHSCT
Patrick Graham	NHSCT
Wendy Magowan	NHSCT
Hazel Winning	NHSCT
Adele Kennedy	NHSCT
Sean Falls	NHSCT
Melanie Phillips	NHSCT
Brian Serplus	NHSCT
Debbie Gillespie,	NHSCT
Liz Knight	NHSCT
Liam McIvor	NIAS
Brid Farrell	PHA
Siobhan McIntyre	PHA
Dr Walter Boyd	SELCG
Charlotte McArdle	SET
Janice Colligan	SET
Sarah Browne	SET
Bridie McKeating	SET
Bria Mongan	SET
Ray Elder	SET
Dr Simon Coulter	SET
Paula Clarke	SHSCT
Angela McVeigh	SHSCT
Francis Rice	SHSCT
Pat McCaffrey	SHSCT

Miceal Crilly	SHSCT
Roisin Toner	SHSCT
Cynthia Cranston	SHSCT
Dr Angela Garvey	WHSCT
Mr John McGarvey	WHSCT
Mr Brendan McGrath	WHSCT
Mr Garry Hyde	WHSCT
Dr Joe McElroy	WHSCT
Alison Cook	

Workshop 3: Family and Child Care, Maternity and Child Health
Friday 14th October 2011 at 4pm
Malone House, Barnett Demesne, Belfast, BT9 5PB

Name	Organisation
Brian Barry	BHSCT
Ann Moffett	BHSCT
Liz Bannon	BHSCT
John Growcott	BHSCT
Lesley Walker	BHSCT
Clifford Mayes	BHSCT
Paul Jackson	BHSCT
Dr Brian Patterson	GP
Dr Reggie McAuley	GP
John Duffy	HSCB
Dr Ursula Brennan	HSCB
Louise McMahon	HSCB
Mary Maxwell	NHSCT
Brenda McConville	NHSCT
Dr Michael Ledwith	NHSCT
Ian Allen	NHSCT
Martin Sloan	NHSCT
Sean Donaghy	NHSCT
Grace Edge	NHSCT
Heather Reid	PHA
Denise Boulter	PHA
Deirdre Webb	PHA
Fiona Kennedy	PHA
Joanne McClean	PHA
David Glenn	SET
Marian Robertson	SET
Heather Crawford	SET
Jackie McGarvey	SET
Ian Sutherland	SET
Elaine Madden	SET
Zoe Boreland	SET
Marian Campbell	SET
Paul Morgan	SHSCT
Geraldine Maguire	SHSCT
Patricia McStay	SHSCT
Peadar White	SHSCT
Colm McCafferty	SHSCT
Julie McConville	SHSCT
Michael Hoy	SHSCT
Janet McConville	SHSCT

Appendix 6
List of Attendees at Sector Workshops

Review of Health & Social Care Services in Northern Ireland
Northern Ireland Council for Voluntary Action Workshop
Tuesday 1st November at 10am
NICVA, 61 Duncairn Gardens, Belfast, BT15 2GB

Name	Organisation
Claire Armstrong	Addiction NI
David Barnes	Royal National Institute for the Blind NI
Paula Beattie	Trauma Recovery Network
Bernadette Best	Action Mental Health Central Office
Patricia Boyd	Shankill Women's Centre
Myrna Brown	Northern Ireland ME Association
Pauline Brown	British Red Cross (NI) Belfast
Ann Cooney	Southern Area Hospice Services
Carmel Costello	Carers UK Belfast Central Branch - Newtownabbey
Judith Cross	Age NI
Chris Deconink	East Belfast Community Development Agency
Karen Diamond	NI Music Therapy Trust
Geraldine Fennell	Carers UK Belfast Central Branch – Newtownabbey
Helen Ferguson	Carers Northern Ireland
Pauline Ferguson	Positive Futures for People with A Learning Disability
Dolores Finnerty	Caring Breaks Limited
Kate Fleck	Arthritis Care Northern Ireland Regional Office
Nicola Gault	Compass Advocacy Network Limited
Nigel Hampton	Enable NI
Claire Anne Irvine	Stratagem (NI) Limited
Dympna Johnston	Greater Shankill Partnership
Neil Johnston	NI Chest Heart & Stroke
Tom McEneaney	Aware Defeat Depression Belfast Office
Joe McGrann	Bryson Charitable Group
Joseph McKane	Forum for Action on Substance Abuse – Belfast HQ
Linda McKendry	Compass Advocacy Network Limited
Esther McQuillan	Parkinson's UK
Brian Mullan	North Belfast Partnership
Iain Neill	MACS Supporting Young People
Mary O'Hagan	Community Development Health Network
Ronnie Orr	Public Health Agency
Caitlin Reid	TinyLife
Kirsty Richardson	Greenway Womens Centre
Eddie Rooney	Public Health Agency
Mark Shepherd	Stratagem (NI) Limited
Patricia Short	Open College Network Northern Ireland
Alicia Toal	Voice of Young People in Care Ltd HQ
Anne Townsend	CRUSE Bereavement Care NI
Clare Watson	MS Society NI
Heather Woods	Dundonald Family & Community Initiative
Trevor Wright	Extern

Review of Health and Social Care Services
Business Alliance Event
Thursday 3rd November 2011 at 3pm
Boardroom, Equality Commission, Equality House, 7-9 Shaftesbury Square, Belfast, BT2 7DP

Name	Organisation
Mr John Compton	Review HSCNI
Mr Mark Ennis	Review HSCNI
Mr Mark Gibson	BT
Mr Mark Hopkins	BT
Mr Alan Irwin	BT
Ms Anne McGregor	NICC
Mr Mark Regan	Kingsbridge Private Hospital
Mr Michael Caulfield	Connected Health
Mr Nevin Ringland	Praxis Care
Mr Roger McMillan	Carson McDowell
Ms Aoife Clarke	CBI NI
Mr Bob Barber	Centre for Competitiveness

Northern Ireland Social Care Council
Registrant Engagement Event
Tuesday 8th November at 2pm
The Pavilion, Stormont, Upper Newtownards Road, Belfast, BT4 3TA

Name	Organisation
Norma Blair	Ardmonagh Family & Community Group
Avery Bowser	Centre for Effective Services
Margaret Burke	BHSCT
Clare Burke	Care Circle
Veronica Callaghan	NHSCT
Lynne Calvert	BHSCT
Janet Carter Anand	Queen's University Belfast
Martin Creed	BHSCT
Julie Cunningham	Community Nurse
Patrick Curry	NHSCT
Sharron Cushley	Salvation Army
Martin Doran	Care Circle
Rosemary Edgar	
Lorraine Gibson	NHSCT
Nuala Gorman	SHSCT
Alan Hanna	Autism Initiatives NI
Michaela Herron	Salvation Army
Linda Hook	Salvation Army
Marita Magennis	SHSCT
Fiona McCartan	Youth Justice Agency
Valerie McConnell	HSCB
Siobhan McCormac	Ardmonagh Family & Community Group
Margaret McCrudden	Newington Day Centre
Gillian McGalliard	NHSCT
Ann McGlone	Willbank Community Resource Centre
Zara McIlmoyle	NHSCT
Mary McIntosh	SHSCT
Joyce McKee	HSCB
William McKnight	BHSCT
Kerry McTeague	NHSCT
Margaret Monaghan	BELB
Seaneen Pettigrew	NHSCT
Gail Saunders	Homecare Independent Living
Joan Scott	SEHSCT
Paula Smyth	Leonard Cheshire Disability
Janene Swain	Rodgers Community Care

Northern Ireland Social Care Council
Registrant Engagement Event
Thursday 10th November at 10.30am
MDEC Building, Altnagelvin Area Hospital, Glenshane Road,
Londonderry, BT47 6SB

Name	**Organisation**
Linda Beckett	Glen Caring Services
Fiona Devlin	NHSCT
Jean Doherty	WHSCT
Marian Doherty	WHSCT
Kitty Downey	Slievemore House
Sheena Funston	WHSCT
Vanessa Hegarty	WHSCT
Louise Horner	Leonard Cheshire Disability
Jonny Hoy	Simon Community NI
Moia Irvine	WHSCT
John Jackson	Slievemore House
Geraldine Jones	Limavady Community Development Initiative
Robin Kennedy	WHSCT
Bryan Leonard	Leonard Cheshire Disability
Elizabeth Logan	Partnership Care West
Martina McGuinness	Extra Care
Paul McLaughlin	WHSCT
Pat McMenamin	WHSCT
Dolores Moran	WHSCT
Rhonda Murphy	Action for Children
Sinead Murphy	Leonard Cheshire Disability
Stephen O’Connor	Seymour Gardens Residential Home
Michelle O’Neill	Praxis Care
Lorraine O’Kane	Slievemore House
Liam Quigley	Northern Ireland Association for Mental Health
Carol Scoltock	WHSCT
Paul Sweeney	Extern
Teresa Sweidan	WHSCT
Anne Weir	Probation Board for Northern Ireland

Appendix 7
List of Stakeholders Engaged with at Small Group Meetings

List of Stakeholders Engaged with at Small Group Meetings

Age NI
Alliance Party
Assistant Director of Allied Health Professions and Public Involvement, Public Health Agency (PHA)
Assistant Director of Human Resources, Business Services Organisation (BSO)
Assistant Director of ICT, Health and Social Care Board (HSCB)
Assistant Director of Integrated Care, Head of General Medical Services, HSCB
Assistant Director of Social Care and Children, Mental Health, HSCB
Assistant National Director for Disabilities, Health Service Executive (HSE), Republic of Ireland
Assistant National Director for Mental Health Services, HSE, Republic of Ireland
Assistant National Director for Older Persons, HSE, Republic of Ireland
Assistant National Director for Primary Care, HSE, Republic of Ireland
Bamford Monitoring Group
Belfast Health and Social Care Trust (BHSCT)
British Medical Association
Business Services Organisation
Department of Health, Social Services and Public Safety (DHSSPS)
Chair & Chief Executive, Patient and Client Council
Chairman, HSCB
Chartered Society of Physiotherapists
Chief Dental Officer, DHSSPS
Chief Economist, Health Policy, The King’s Fund
Chief Executive, BSO
Chief Executive, PHA
Chief Legal Adviser, BSO
Chief Medical Officer, DHSSPS
Chief Nursing Officer, DHSSPS
Chief Pharmaceutical Officer, DHSSPS
Chief Social Services Officer, DHSSPS
Chief Officers 3rd Sector
College of Occupational Therapists
Community Pharmacy Northern Ireland
Communications Manager, HSCB
Democratic Unionist Party
DHSSPS Partnership Forum
Bishop of Down and Connor, Diocese of Down and Connor
Director General, Department of Health and Children, Republic of Ireland
Director General, Department of Health, Social Services and Children, NHS Wales
Director of Cabinet Operations, Scottish Government
Director of Commissioning, HSCB
Director of Finance, HSCB
Director of Human Resources, DHSSPS

Director of Integrated Care, HSCB
Director of Nursing and Allied Health Professionals, PHA
Director of Performance Management and Service Improvement, HSCB
Director of Planning and Redevelopment Services, BHSCT
Director of Social Care and Children, HSCB
Disability Social Care Forum
Equality Commission for Northern Ireland
Equality Manger, Business Services Organisation
Four Seasons Health Care
Head of Corporate Services, HSCB
Head of Information and Analysis Directorate, DHSSPS
Health and Social Care Board Members
Health Service Executive, Republic of Ireland
Independent Health and Care Providers
Junior Ministers, Office of the First Minister and Deputy First Minister
Law Centre – Rights in Community Care Group
Medical Adviser, HSCB
Northern Health and Social Care Trust
Northern Ireland Ambulance Service
Northern Ireland Association for Mental Health
Northern Ireland Confederation for Health and Social Services
Northern Ireland General Practitioners Committee
Northern Ireland Human Rights Commission
Northern Ireland Social Care Council
Northern Ireland Practice and Education Council for Nursing and Midwifery
Northern Ireland Public Sector Alliance
Northern Ireland Medical and Dental Training Agency
Open University
Pharmaceutical Society of Northern Ireland
Professor the Lord Darzi of Denham PC
Programme Director, European Centre for Connected Health, PHA
Regional Director of Operations, HSE, Republic of Ireland
Regulation and Quality Improvement Authority
Royal College of General Practitioners
Royal College of Midwifery
Royal College of Nursing
Senior Adviser, Special Delivery Unit, Department of Health and Children, Republic of Ireland
Sinn Fein
Social Democratic and Labour Party
South Eastern Health and Social Care Trust
Southern Health and Social Care Trust
Trust Chief Executive Forum
Trust Directors of Social Work
Ulster Unionist Party
UNITE
Western Health and Social Care Trust

Appendix 8
List of Written Submissions

List of Written Submissions

Age NI
Aisling Centre
Alliance for Choice
Alzheimer's Society
Association of the British Pharmaceutical Industry
Belfast Health and Social Care Trust (BHSCT)
British Medical Association
British Red Cross
Business Services Organisation
CBI Northern Ireland
Centre for Effective Services
Centric Health
College of Occupational Therapists
Consultant Paediatric Surgeons, Royal Belfast Hospital for Sick Children, (BHSCT)
Co-operation and Working Together
Craigavon Lipreading Class
Cyclist Touring Club Right to Ride Network
Diabetes UK
Domestic Care
Dr Julian Kennedy
Fermanagh District Council
General Practitioners in Fermanagh (collective response)
Global Diagnostics Ireland and Ennis General Hospital
Health and Social Care Board
Independent Health and Care Providers
Intelesens Limited
Lisburn City Council
Macmillan Cancer Support
Mater Hospital Community Forum
Mencap
Mr Ian Houston
Mrs Valerie Rosenberg
National Confidential Enquiry into Patient Outcome and Death
Neurological Conditions Service User and Carer Reference Group
Northern Health and Social Care Trust
Northern Ireland Ambulance Service
Northern Ireland Confederation for Health and Social Services
Northern Ireland Hospice
Northern Ireland Practice and Education Council for Nursing and Midwifery
Omagh Hospital Campaign Group
Pharmaceutical Society for Northern Ireland Professional Forum
Princess Royal Trust for Carers
Professor AP Passmore, Professor of Ageing and Geriatric Medicine, Queen's University Belfast
Regulation and Quality Improvement Authority
Royal College of Nursing

Royal College of Psychiatrists
Save the Mid Campaign
South Eastern Health and Social Care Trust
Southern Health and Social Care Trust
Sustrans
TF3 Consortium
Trust Chief Executives Forum
United Kingdom Homecare Association
Volunteer Now
Western Health and Social Care Trust

Appendix 9
Glossary

Glossary

A&E – Accident and Emergency

CAMHS – Child and Adolescent Mental Health Services

DETI – Department of Enterprise, Trade and Investment

DHSSPS – Department of Health, Social Services and Public Safety

ECR – Electronic Care Record

GP – General Practitioner

GPSI – General Practitioner with Specialist Interest

HSC – Health and Social Care

HSCB – Health and Social Care Board

LTCs – Long-term conditions

MLA – Member of the Legislative Assembly

MRI – Magnetic Resonance Imaging

NHS – National Health Service

NIAS – Northern Ireland Ambulance Service

NICE – National Institute for Health and Clinical Excellence

NISAT – Northern Ireland Single Assessment Tool

PCC – Patient and Client Council

PCI – Percutaneous Coronary Intervention

PHA – Public Health Agency

QOF – Quality and Outcomes Framework

RQIA – Regulation and Quality Improvement Authority

MMcG- 42

HSC Health and Social Care

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

QUALITY 2020

A 10-YEAR STRATEGY TO PROTECT AND IMPROVE QUALITY IN HEALTH AND SOCIAL CARE IN NORTHERN IRELAND

November 2011

Minister’s Foreword

As Minister of Health, Social Services and Public Safety, the guiding principle for me, and I know for the vast majority of people working in health and social care, is to protect and improve the quality of our services. The strategy set out in this document is designed to provide a clear direction over the next 10 years to enable us to plan for the future while ensuring this principle is preserved, whatever the challenges we may encounter.

Clearly we face challenges in the immediate future on the financial front, but there are many other factors that we must also grapple with in the longer term which require that we plan now so as to be able to best address those challenges and maintain high quality services.

The people using Health and Social Care (HSC) services must be at the heart of everything we do. We will be measured by how we focus on their needs through delivering high quality as they deal with pain and distress. This means the services we provide must be safe, effective and focused on the patient.

HSC services in Northern Ireland are already internationally recognised for excellence in a number of areas, and these services are provided by thousands of staff who apply great skill with compassion to ensure the best possible outcomes and experiences of care for their patients and clients. Their continuing determination to deliver high quality care, whatever the constraints, is fundamental to achieving the right outcomes.

This strategy, therefore, has the great advantage of building on an already strong foundation. It gives a clear commitment to sustainable improvement and high standards, safe services and putting people first.

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

A VISION FOR QUALITY

Quality

Every day hundreds of thousands of people, old and young, are treated and cared for by highly skilled and dedicated professionals in our health and social care services. Some in their homes, some in hospitals, some in community settings, some because they are ill, some because they need care and support, some who need protection. Most of these people are in distress or pain. Some need urgent treatment. Some have to live with chronic conditions over many years. All of them deserve and seek one thing above all: to know that the service provided is of high quality.

But what is "*quality*", a word so often used but so little understood? The dictionary definition is "*degrees of excellence*". We know that quality can be high, low or somewhere in between. We also know that to make quality high normally requires a range of things to be present. Usually no one factor can define it. Whether it is holidays (facilities, food, comfort, service, etc) or cars (economy, power, safety, reliability, etc), the excellence is derived from how that product or service performs across a range of factors.

"No one wants luxury; people just want to be safe and given the proper care." - a carer

So how should we define quality for health and social care in Northern Ireland? One of the most widely influential definitions in healthcare was produced in the United States by the Institute of Medicine in 2001. It proposed six areas in which excellent results would lead to high quality or excellence overall: safety, timeliness, effectiveness, efficiency, equity, and patient-centredness.

The European Union describes high quality healthcare as care that is "*effective, safe and responds to the needs and preferences of patients*." Many other countries, including England, Scotland, Australia and the Republic of Ireland, have likewise focused on three key components, although not to the total exclusion of the others in the list of six above. Many countries have chosen to subsume those elements of timeliness, efficiency and equity under the heading of effectiveness. For Northern Ireland this 10-year quality strategy takes a similar approach defining quality under three main headings:

- **Safety** – avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

- **Effectiveness** – the degree to which each patient and client receives the right care (according to scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcome.

- **Patient and Client Focus** – all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Everyone expects the best care possible when they or a family member falls ill or needs social care support. In Northern Ireland this is provided by health and social care services, for the most part free at the point of use, and funded by the taxpayer at a cost of around £4 billion a year. It is different in one important aspect from the National Health Service (NHS) in Great Britain in that it provides integrated health and social care services.

It is a highly complex, sophisticated and increasingly technological service involving a wide diversity of some 70,000 people working together in multidisciplinary teams, providing services day and night, in all weathers, often dealing simultaneously with conditions that are very common as well as those that are very rare. They work in a compassionate and professional manner through more than 15 million engagements each year (hospital admissions, in-patient appointments, consultations, etc) with patients, clients, families and carers at times when they are suffering and vulnerable.

For all these people it is a fundamental expectation that the service provided will be as **safe** as possible. The fact is of course that in such a highly complex and stressful environment things will go wrong. The reasons are many and varied. Thankfully it is only in a tiny proportion of cases that things do go wrong. But a high quality healthcare service needs to protect and improve by learning from all such occasions and so minimising the chances of them happening again. There can never be room for complacency. Safety will always be an aspect of quality that needs to be guarded.

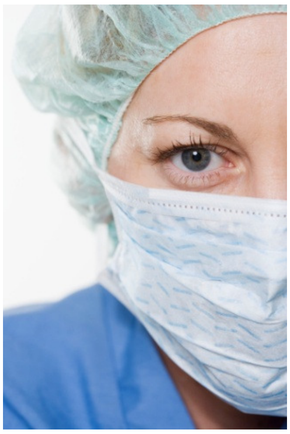
Equally, a high quality service should mean that the services provided are the right ones at the right time in the right place. In other words they are **effective** in dealing with the patient or client's clinical and social needs. Too often there is evidence that wasteful procedures or inefficient systems are being employed and internationally recognised best practice is not used where it can be.

Thirdly, and just as importantly, services must have a clear **patient and client focus**. People are not just an element in a production process. There is abundant evidence that such an approach delivers improved health and wellbeing outcomes. There is also more than enough evidence, particularly in recent reports within the UK alone (and internationally), that when the dignity of the person is not respected, or people are not effectively involved in decision making about their health and wellbeing, or indeed listened to when they complain or raise concerns, quality suffers and declines.

Undoubtedly the amount of money available for health and social care services affects the quality of care, but other factors such as behaviours, attitudes and the way services are designed, are also very relevant. There is much evidence to show that money is not the only determinant of high quality. When some say "*we cannot afford higher quality at this time*" they overlook the fact that low quality, so often the result of inappropriate behaviours and attitudes, costs more.

Over the last decade, health and social care services in Northern Ireland have taken important steps forward in improving quality. The consultation paper *Best Practice – Best Care* (April 2001) made proposals for setting standards, ensuring local accountability and improved monitoring and regulation. New legislation in 2003 introduced a statutory Duty of Quality for Boards and Trusts. This also led to the establishment of the Regulation and Quality Improvement Authority (RQIA) as an independent body, one of whose main functions is to promote improvement in the quality of health and social care services. *Safety First* (March 2006) produced a framework for sustainable improvement.

In 2009 the HSC Reform Act introduced a new statutory Duty of Involvement for all the main HSC bodies. This required them to involve people at a personal and public level in making decisions about service design and delivery. Together these initiatives have made a positive impact on safety, effectiveness and patient/client focus. The object of this strategy is to build on that foundation so as to widen and deepen the impact over the next decade in terms of protecting and improving quality in health and social care.



As we face the next 10 years, with all its challenges and uncertainties – not least funding – this is when we most need a strategy to protect and improve quality across all health and social care.

Purpose of a quality strategy

How will a new quality strategy help to protect and improve quality and achieve excellence in the three areas described above? Fundamentally a strategy is simply a plan to achieve a result over the long term. In this case a period of 10 years has been selected to deliver results for quality because much of what needs to be done simply cannot be achieved overnight but will take time, regardless of money. The strategy is intended to provide a clear direction for all of us, taking account of the strengths and weaknesses of the present system, so that we can better tackle the future challenges and opportunities faced.

It will provide a vision of what we can achieve, a mission statement of how to get there, and specific goals and objectives to make that vision become a reality over the 10 years. It will give us the long-term perspective needed to plan and design future services and deliver outcomes to the highest quality possible.

There are already many examples, often recognised internationally, of high quality or excellence within health and social care in Northern Ireland. Such examples, based on recent evidence, include the focus on early years and early interventions, the treatment of cancer and head injuries, neurosurgery, innovative mental health facilities, the new health and care centres with their one-stop approach to treatment and care, and many others. But even more importantly, there are also thousands of individual staff who apply great skill with compassion, giving patients and clients the best possible outcome and experience of care at times of personal crisis. They show an unshakeable determination to deliver high quality care, whatever the constraints.

Consequently, this strategy has the great advantage of building on an already very strong foundation, while still recognising that no system is beyond improvement. There is a clear imperative to remain committed to continuous improvement, to maintain high standards and to achieve even higher degrees of excellence – in other words, to protect and improve quality.

How the strategy was developed

This strategy was devised by a project team convened by the Department. Over 100 people, some employed in health and social care and some users of these services, came together at four workshops to discuss priorities for safety, effectiveness and patient/client focus. The outputs from each workshop were referred to an international reference group made up of 18 highly respected professionals and academics for quality assurance. The essence of what was discussed at the workshops was also brought by the Patient and Client Council (PCC) to a wider public cross-section of almost 100 people in the community for comment, and focus group meetings were held with over 150 frontline staff working in health and social care at 10 venues around Northern Ireland. In all, some 350 people, from many different backgrounds, have contributed significantly to the development of this quality strategy (quotations from some of them are included in this document).

"We are already world leaders in some areas but in Northern Ireland we never talk enough about our successes." – a community nurse

The strategy was then published for public consultation in January 2011 and attracted 46 responses from a wide range of health and social care, voluntary and charitable organisations, as well as individuals. There was very broad support for the strategy and many helpful comments and suggested amendments, many of which have since been incorporated in this final version of the strategy. This consultation process, building on the highly inclusive development process, has further strengthened the integrity, purpose and focus of the strategy, reinforcing the underlying support for its implementation. It has also fundamentally confirmed that protecting and improving quality really is the first priority for all those concerned with achieving the best health and wellbeing outcomes.

Principles, values and assumptions

The strategy identifies a number of **design principles** that should continue to inform planners and practitioners over the next 10 years. A high quality service should:

- be holistic in nature.

- focus on the needs of individuals, families and communities.
- be accessible, responsive, integrated, flexible and innovative.
- surmount real and perceived boundaries.
- promote wellbeing and disease prevention and safeguard the vulnerable.
- operate to high standards of safety, professionalism and accountability.
- be informed by the active involvement of individuals, families and communities, HSC staff and voluntary and community sectors.
- deliver value for money ensuring that all services are affordable, efficient and cost-effective.

In delivering high quality health and social care this strategy also identifies the need to promote the following **values**:

- **Empowerment** - supporting people to take greater responsibility for their own health and social wellbeing, and putting people at the centre of service provision.
- **Involvement** - ensuring that service users, their carers, service providers and the wider public are meaningfully involved, and if necessary supported, at all stages in the design, delivery and review of services at an operational and a strategic level so that, as far as possible, services are personalised.
- **Respect** – showing respect for the dignity of all people who use the service, their carers and families and for all staff and practitioners involved in service delivery.
- **Partnership** - engaging collaboratively across all disciplines, sectors and specialisms in health and social care, including the voluntary and independent sectors, to ensure an integrated team-based approach, and working with people in their local communities.
- **Learning** - promoting excellence in service delivery and founded on evidence-based best practice to achieve improvement and redress.
- **Community** - anchoring health and social care in a community context.
- **Continuity** - ensuring a co-ordinated and integrated approach to health and social care in all health and social care sectors, and ensuring continuity of care across the system.

- **Equity and Equality** - fairness and consistency in service development and delivery.

While it is impossible to predict exactly what will happen over the next 10 years, the strategy also identifies eight strategic **planning assumptions** (which will be adjusted as circumstances change). These are:

- **Political** - health, social services and public safety will continue to remain the responsibility of a devolved Administration.

- **Structural** - the present Departmental and HSC organisational structures will remain broadly unchanged but delivery structures will continue to evolve.

- **Economic** – very significant resource constraints and challenges will continue to impact on services requiring a robust focus on efficiency and effectiveness of service design.

- **Social** - an ageing society will have greater need for health and social care; general demands and expectations on quality including involvement will continue to rise; there will be an increased focus on safeguarding vulnerable people and groups; there will be continued challenges in addressing the impact of obesity, deprivation, drugs and alcohol.

- **Technology** - the effective use of information and technology in health and social care will increase in importance.

- **Rights** - the need to promote and protect human rights and equality will increase in a diverse society.

- **Environment** - the pressure to minimise waste of all kinds and maximise the use of sustainable resources will increase.

- **Service Delivery** - there will continue to be advances and changes in the science underpinning treatment and care, as well as emphasis on prevention and self-managed care and a continued move towards caring for people in their own homes.

A strategic Vision for quality

Ultimately every patient and client, and their families and carers, wants to receive the best care at the time they most need it to achieve the best outcome possible. In order for this to be a reality for all the people of Northern Ireland, the 10-year quality vision for health and social care is:

"To be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care."

This is a bold statement and will require continuous improvement, concerted effort, commitment and determination if it is to be achieved by 2020. It must be acknowledged that many aspects of current services and many of the people working in health and social care are already world-class and worthy of celebration. So the strategy starts from a strong position. But high quality cannot be assumed to remain constant against the challenges that inevitably lie ahead. There is always room for learning, innovation and improvement.

This vision statement is intended to inspire and motivate all of us and give a shared sense of purpose and direction. As Abraham Lincoln said "*Far better to aim high and just miss the target, than aim low and just reach it.*"

> *"We need to identify who is best at providing high quality and see what they are doing. It is not good enough to settle for second place; we must aspire to be the best."* - a GP

Mission statement

In terms of how the vision is to be achieved, the strategy mission statement is:

"In order to become an international leader for excellence in health and social care, the inherent motivation of staff to deliver high quality must be supported by strong leadership and direction at all levels, along with adequate resources, in order to:

- ***focus on improved health and social wellbeing for all;***
- ***provide the right services, in the right place, at the right time;***
- ***develop effective partnerships and communication between those who receive and those who provide services;***
- ***create a culture of learning and continuous improvement that is innovative and reinforced by both empirical and applied research;***
- ***devise better ways of measuring the quality of services; and***
- ***protect and enhance trust and confidence in the service provided."***

Succeeding in this mission will depend crucially on good leadership and partnership working. Excellence is something that should be obvious not only to professionals working within health and social care but to individual patients and clients and their families. There will be a need to embrace change positively and find innovative ways of dealing with problems with highly motivated, skilled and engaged staff and volunteers.

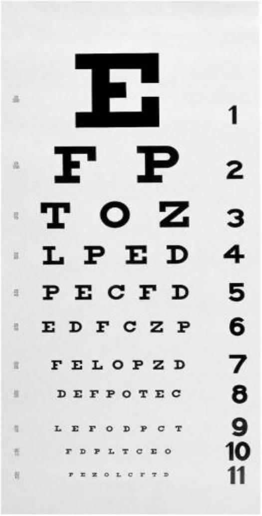
STRATEGIC GOALS AND OBJECTIVES

Setting strategic goals

The mission statement summarises how we can realise the vision of being an international leader in the excellence of health and social care. But it is the specific actions taken during the life of this 10-year strategy that will drive that positive change. To that end the strategy identifies five strategic goals to be achieved by 2020. Achieving them will help make the vision a reality.

1. **Transforming the Culture** - This means creating a new and dynamic culture that is even more willing to embrace change, innovation and new thinking that can contribute to a safer and more effective service. It will require strong leadership, widespread involvement and partnership-working by everyone.

2. **Strengthening the Workforce** - Without doubt the people who work in health and social care (including volunteers and carers) are its greatest asset. It is vital therefore that every effort is made to equip them with the skills and knowledge they will require, building on existing and emerging HR strategies, to deliver the highest quality.



3. **Measuring the Improvement** - The delivery of continuous improvement lies at the heart of any system that aspires to excellence, particularly in the rapidly changing world of health and social care. In order to confirm that improvement is taking place we will need more reliable and accurate means to measure, value and report on quality improvement and outcomes.

4. **Raising the Standards** - The service requires a coherent framework of robust and meaningful standards against which performance can be assessed. These already exist in some parts, but much more needs to be done, particularly involving service users, carers and families in the development, monitoring and reviewing of standards.

5. **Integrating the Care** - Northern Ireland offers excellent opportunities to provide fully integrated services because of the organisational structure that combines health and social care and the relatively small population that it serves. However, integrated care should cross all sectoral and professional boundaries to benefit patients, clients and families.

These five goals are developed in more detail below. Pairs of objectives for each goal are described in terms of why they are important, the actions to be taken, who might take the lead in each case, and, crucially, what will be the expected outcomes. Fundamentally, this sets out the difference this strategy can make for the future quality of health and social care.

TRANSFORMING THE CULTURE

Objective 1: We will make achieving high quality the top priority at all levels in health and social care.

Why is it important?

An emphasis on high quality will improve the experience of all those who use and work in health and social care services. It will also make those services safer for all.

What will be done?

- The delivery of high quality services will be central to the commissioning process.
- A consistent regional definition of what constitutes high quality in every service will be established and accountability for its delivery made part of governance arrangements.
- The use of best practice and improvement methods will be promoted and adopted across the health and social care system.
- Staff and service users' awareness of their individual roles and responsibilities in ensuring high quality outcomes for health and social care will be maximised.
- A culture of innovation and learning that creates more quality-focused attitudes and behaviours among HSC staff will be promoted.

"Often it's the little things that make a big difference to people's lives and make our own job worthwhile." – a social worker

How will we know it is working?

- The number of adverse incidents and near misses reported will increase steadily reflecting a stronger reporting and learning culture – serious adverse incidents will decline in number.
- Increased evidence of more effective complaints resolution and learning.
- Improved levels of satisfaction by both staff and the public.
- Quality, embracing safety, effectiveness and patient/client experience, will be a standing top item on the agenda of all boards and top management teams within the health and social care system.
- Waste caused by inappropriate variations in treatment or care will reduce.

Objective 2: We will promote and encourage partnerships between staff, patients, clients and carers to support decision making.

Why is it important?

There is already a body of evidence from around the world that involving patients and clients in decisions about their care and treatment improves the outcome and their satisfaction with the services they receive and at the same time reduces demands on services. Workshops conducted in the preparation of this strategy also confirmed that this is an important issue for a wide range of service users.

What will be done?

- Best practice standards will be established for informing patients, clients and carers based on what has been successful elsewhere.

- Regular patient and client surveys as well as other creative approaches to getting feedback, such as ‘patient/client narratives’ will be conducted in collaboration with the PCC.

- Effective and meaningful partnerships to support shared decision-making for HSC staff, patients, clients and carers will be created, including the voluntary and independent sectors.

- Patients, clients and carers will be involved in the design and delivery of education and training to all staff working in health and social care.

- The needs and values of individuals and their families will always be taken into account.

How will we know it is working?

- There will be clear evidence of user involvement arising from effective implementation of Public and Personal Involvement (PPI) Consultation Schemes at all levels of decision making in health and social care from individual care to corporate management.

- There will be baseline information and regular monitoring on how involvement changes over time.

- Evidence on compliance by HSC bodies with all relevant equality and involvement standards.

STRENGTHENING THE WORKFORCE

Objective 3: We will provide the right education, training and support to deliver high quality service.

Why is it important?

No matter how good our systems and procedures are, they all rely on staff who are motivated, skilled and trained to implement them. This is fundamental to the delivery of safe and effective services. Increasingly these systems and procedures must include personal and public involvement in their design and operation.

What will be done?

- Opportunities for continuous learning by staff will be resourced and planned in order to continuously improve quality.
- Increased knowledge and skills in the principles of PPI will be promoted among all HSC staff.
- Arrangements will be made to involve service users and carers more effectively in the training and development of staff.
- A customised Healthcare Quality training package for all staff working in health and social care (with mandatory levels of attainment dependent on job responsibilities) will be developed, with possible links to regulation and dovetailed with existing and emerging training and development strategies across HSC.

> *"We need constantly to look for simpler and faster ways of disseminating learning to staff who need to know, to improve quality."* - a hospital doctor

- Better use will be made of multidisciplinary team working and shared opportunities for learning and development in the HSC.
- Regular feedback from staff and service users and carers will be sought alongside commissioned research on quality improvement.

How will we know it is working?

- HSC service organisations will be recognised as employers of choice.
- Evidence for improved outcomes for patients and clients will be published.
- Increasing levels of competence among HSC professionals will be evidenced through professional revalidation and appraisal.
- There will be evidence from research of reducing errors in service delivery arising from "human factors".

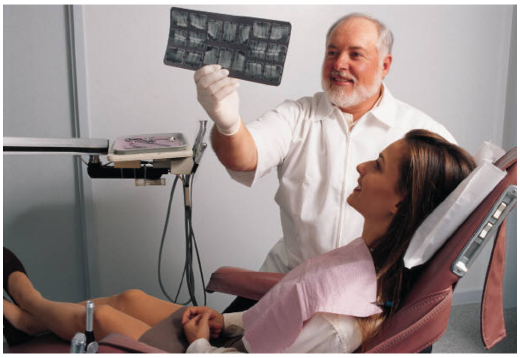
Objective 4: We will develop leadership skills at all levels and empower staff to take decisions and make changes.

Why is it important?

Strong leadership is the key to effecting change and we believe that giving frontline staff autonomy to take more decisions locally, provided this is balanced with clear accountability, is the best way to secure improved quality and productivity.

What will be done?

- Top management teams will be expressly accountable for quality improvement within their organisations.
- Each HSC organisation will produce an annual quality report and be responsible for making improvements year-on-year.
- Staff will be actively supported through service change programmes.
- Change champions will be trained and supported in the latest improvement techniques.
- A renewed emphasis will be placed on generating robust and relevant research to support innovation and quality improvement, building on links with local research organisations.



How will we know it is working?

- Evidence of increased authority being delegated to frontline decision makers wherever practical.
- Evidence of health and social care staff at all levels driving quality improvements.
- Every organisation or team will be involved in making their work safer, more effective and patient/client centred.

MEASURING THE IMPROVEMENT

Objective 5: We will improve outcome measurement and report on progress for safety effectiveness and the patient/client experience.

Why is it important?

Safety, effective treatment and a good experience of the care received, whether in hospital or the community, and whether provided by the public, voluntary or independent sectors, lies at the heart of a high quality service. We need to compile good baseline data and be able to measure that this is happening and let everyone have this information in as accessible a way as possible.

What will be done?

The HSC Board, Public Health Agency and Trusts will work with the RQIA, PCC and others to:

- Devise a set of outcome measures, with quality indicators, focused on safety, effectiveness and patient/client experience.

- Agree a set of effective quality performance targets, involving service users to drive improvement.

- Monitor quality improvement year-on-year and compare our performance with the rest of the UK, the Republic of Ireland and internationally.

- Publish a regional annual quality report that is widely available.

> *"We expect healthcare leaders and healthcare professionals to be intolerant of defects or errors in care and constantly seeking to improve, regardless of their current levels of safety and reliability."* - a doctor

How will we know it is working?

- There will be a set of effective and measurable quality targets agreed within the first year of the strategy implementation.

- All HSC organisations will meet quality performance targets.

- There will be evidence of steady improvement in the public's reported experience of health and social care.

Objective 6: We will promote the use of accredited improvement techniques and ensure that there is sufficient capacity and capability within the HSC to use them effectively.

Why is it important?

Within the large and complex health and social care system there is always scope for improvement. To achieve best outcomes it is important to review what happens and look for improvements with the aid of skilfully applied accredited techniques.

What will be done?

- A set of improvement methods and techniques for use in the HSC will be agreed and HSC staff will be trained and resourced to use them.
- Capacity and capability will be built up within the HSC to achieve the desired results.
- Audit techniques to measure how standards are being met will be further developed.
- Research and innovation will be encouraged.
- Benchmarking with other health and social care organisations outside Northern Ireland will be conducted to ensure that there is up-to-date information available on best practice.

How will we know it is working?*

- The number of avoidable deaths will decrease steadily.
- The number of healthcare associated infections will be reduced year-on-year.
- All HSC facilities will meet established standards for cleanliness.
- There will be 95% or higher satisfaction ratings from the public with the safety of care in the HSC.
- There will be 95% or higher satisfaction ratings from staff with the safety of care in the HSC.

(* These indicators will be further refined and developed during the implementation planning process.)

RAISING THE STANDARDS

Objective 7: We will establish a framework of clear evidence-based standards and best practice guidance.

Why is it important?

It is essential that we work to agreed standards that represent best practice and are clearly understood by staff, users and relatives alike. Standards should be authoritative and concise and help achieve high quality in the most cost effective way.

What will be done?

- Information on national and international standards will be gathered and standards developed, where necessary, to deliver best practice.
- A coherent regional framework for standards and guidelines will be established.
- A Web-based system will be established to allow easy access to the framework of standards and related information.

"Even though there is always change I think it is important that we ensure we are not seen to be stagnant, but an evolving organisation, always striving for the best." – a public health consultant

How will we know it is working?

- Standards will be evidence-based and effectively applied.
- Standards will be kept up-to-date and easily accessible to all.
- The meeting of standards will demonstrate measurable improvements in the quality of services, becoming safer, more effective and more patient/client-centred.

Objective 8: We will establish dynamic partnerships between service users, commissioners and providers to develop, monitor and review standards.

Why is it important?

Increasingly standards should span both health and social care sectors and be developed by partnerships that include all those involved in providing and receiving a service. They should also be monitored periodically and reviewed if they are to continue to be fit for the purpose they were designed.

What will be done?

- An advisory group, representative of HSC organisations and including service user and carer representation, will be set up to harmonise processes in relation to the application of standards.

- A new structure will be created for drafting and agreeing standards and guidelines that gives meaningful inclusion to those affected by them.
- A performance management mechanism will be put in place to ensure standards are achieved by means of audit and compliance measurement within set timescales.
- An incentives mechanism will be created to better ensure compliance with quality standards in all health and social care settings.
- The use of Service Frameworks will be extended.
- Surveys of the public will be conducted to seek feedback on compliance with standards.

How will we know it is working?

- Quality targets published in Priorities for Action will be met.
- All parts of health and social care will be able to demonstrate compliance with the standards.
- Information on standards, and associated compliance information, will be easily accessible on-line.
- New standards will only be introduced after full and effective consultation.

INTEGRATING THE CARE

Objective 9: We will develop integrated pathways of care for individuals.

Why is it important?

Northern Ireland already has an integrated health and social care system, but in order to be truly effective there should be seamless movement across all professional boundaries and sectors of care. This has implications for the timely transfer of information and how data is held. Improvements in this area will make a significant contribution to raising the quality of care and outcomes experienced by patients, clients and their families.

What will be done?

- More effective and secure information systems will be established to record and share information across HSC structural and professional boundaries (and with other relevant Departments and agencies as appropriate).
- Service users will be given a greater role in, and responsibility for, information transfer (e.g. patient held records, patient smart cards, etc).
- Barriers to integrated multidisciplinary and multisectoral working will be identified and removed.
- Annual targets for use of personal care plans will be established.

> *"The first premise, indeed the whole point of a health service, is to deliver what its customer needs. In other words – put the patient first."*
> – a service user

How will we know it is working?

- Patients, clients, carers and HSC staff will collaborate in developing individual care pathways.
- Patients and clients will be able to move between different sectors and specialties within health and social care without undue delay or the transfer resulting in avoidable information errors or resultant harm.
- Patient and client information will be available to staff and carers when it is required.
- There will be evidence of consistent quality of care experienced by patients and clients across all settings.

Objective 10: We will make better use of multidisciplinary team working and shared opportunities for learning and development in the HSC and with external partners.

Why is it important?

It is increasingly recognised that the effectiveness of treatment and care given to patients and clients is enhanced by a holistic approach that encourages co-operation between all those involved at every stage. Failure to address this can produce an "us" and "them" mentality, which has the potential to be detrimental to outcomes and wasteful of resources.

What will be done?

- All disciplines should contribute to a single assessment through a shared assessment framework – NI Single Assessment Tool, and for children, Understanding the Needs of Children in Northern Ireland (UNOCINI).
- More integrated treatment and care teams will be established with innovative management approaches.
- Universities will further develop inter-professional education at undergraduate and postgraduate levels in health and social care.
- Pre-registration and post-registration training will be reviewed to enhance the use of multidisciplinary teams.

How will we know it is working?

- There will be a significantly more effective skills mix on teams.
- There will be increasing evidence of joint working across professional disciplines to improve quality.
- In-house organisational training will give primacy to multidisciplinary learning.

MAKING IT HAPPEN

Managing, advising and reporting

Implementing any new strategy requires good governance arrangements and structures to deliver results at every stage of the process. This is especially true of any strategy that covers a period as long as 10 years.

There are three important elements to implementing this strategy.

The first is **management**. A programme board, chaired by the Chief Medical Officer, will be responsible for overall control and will report on progress on the implementation of the strategy to the Minister. The board will include senior Departmental policy and professional representatives, senior executives from health and social care organisations, including the voluntary and independent sectors, and people who use health and social care services. Many others will be involved in working on individual projects reporting to the programme board in order to meet the objectives set out under each of the five goals. A senior official within the Department will be responsible for co-ordinating and overseeing the work of these project teams and will report to the programme board.

"We need to involve patients and their carers in both the design and implementation of the quality strategy." - a patients' representative

The second is **advice**. A Quality Advisory Forum will meet twice a year and include a wide range of "stakeholders", e.g. patients, clients, carers, trade unionists, relevant professional bodies, academics and HSC frontline staff (not senior executives) and representatives from the voluntary and independent sectors. The Forum will facilitate comment on regular six-monthly reports provided by the programme board and comment on progress against the objectives set. It will be able to suggest changes, voice concerns to the programme board and thus provide transparent accountability. This will help to reinforce the consensual and inclusive approach that has characterised the development of the strategy.

The third is **reporting**. It is proposed that each health and social care organisation will publish a freestanding Quality Report every year. These reports will state clearly the progress made in each organisation towards meeting the goals of the strategy and also comment on the improvement made to the quality of services commissioned, delivered or promoted within the previous 12 months by that organisation. The reports will make use of new "quality indicators" to be developed by the quality programme. The purpose of this report is to increase accountability against the Duty of Quality that health and social care organisations are required by law to meet. Furthermore, quality should be given the top position on the agenda for meetings of all senior management teams and boards within these organisations.

Engagement and Involvement

The relationship and exchange of information between the Department and health and social care organisations and the wider public will be important in driving this strategy forward. A new Quality Interface Group will be established with representation from all HSC bodies, and patient/client representation, to consider all proposals for new best-practice guidance, guidance under development and the dissemination and evaluation of guidance on all quality issues concerning safety, effectiveness and patient/client focus.

The Department will set up and manage a dedicated Quality Website to provide access to all relevant policy documents and guidance circulars. While this will be provided primarily for health and social care services, it would be available to everyone and the Department would take active steps to bring such guidance to the notice of a wide range of interests, including patient, client and carers' groups and the independent sector. The object would be to make information easily accessible and include links to related websites nationally and internationally.

The Implementation process

This strategy provides a clear vision of **where** we want to get to over the next 10 years in terms of quality healthcare; a high-level mission statement of **how** we plan to get there; and, most importantly, **what** we need to achieve in concrete terms to deliver that vision - the strategic goals.

Achieving those goals will require a detailed, rigorous and inclusive implementation planning process which is to be carried out over the next six months. We have established an implementation planning team drawing on a diverse range of interests including service users, commissioners, providers and led by a senior official in the Department. That team will finalise an implementation plan and submit it for Ministerial approval by February 2012 to enable the detailed work to follow that will secure those strategic goals, and thus our strategic vision.

It will obviously be necessary to keep the strategy under review so that it remains fit for purpose, not least because the nature and scale of challenges to be faced in the future are always subject to change. If we are not ready to adjust our plans to deal with changing circumstances, then we are likely to be blown off course and fail to realise our objectives.

It will also be essential that the people served by health and social care services, and those who work in the system, are kept fully informed of progress being made. Annual reports on progress in protecting and improving quality in health and social care will be widely accessible.

CONCLUSION

The 10-year Quality Strategy

This strategy is designed to protect and improve quality in health and social care over the next 10 years. During this period, services will undoubtedly face many great challenges. Some of those are already clear, such as funding for health and social care services, but some will only become clear as time passes.

In any event, there is a clear need to be prepared and ready to tackle those challenges strategically and effectively if the quality of services, so important to peoples' lives and wellbeing, are to be protected and improved. This is especially so because health and social care services are large and complex and can take time to change in ways that are safe and effective.

This strategy will aid our preparedness and readiness and provide an enduring framework within which policy and service design can better develop.

> *"The quality of services is inextricably linked to raising awareness and earning commitment."* - a hospital doctor

The Department will give leadership in its implementation. But leadership will also be required in all parts, and at all levels, of the Health and Social Care service, as well as through partnership with patients, clients, carers and communities.

Produced by:
Department of Health, Social Services
and Public Safety,
Castle Buildings, Belfast BT4 3SQ
Telephone: (028) 9052 8321
Textphone: (028) 9052 7668
www.dhsspsni.gov.uk
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Evaluation Of the 2009-2011 Bamford Action Plan

As at December 2011

Integrated Projects Unit

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Department of
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and Public Safety
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ANNEXES

1 BACKGROUND

1.1 Background

Bamford Review of Mental Health and Learning Disability

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

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

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

1.2 Bamford Action Plan

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

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

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

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

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

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

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

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

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

1.3 Aims of Evaluation

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

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

1.3.3 It was envisaged that this evaluation would

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

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

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

1.3.6 The evaluation is informed by:

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

2009-2011 Plan have been achieved;

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

1.3.7 The following sections of this document consider:

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

Editors Note

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

2 Key Challenges faced in 2009

2.1 Background

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

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

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

2.2 Mental Health

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

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

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

2.3 Learning Disability

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

2.3.2 The Action Plan embraced a life long approach encompassing:

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

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

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

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

3 INPUTS

3.1 Financial resources

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

Health and Social Care Funding

Baseline

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

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

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

2008-2011 Comprehensive Spending Review

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

DHSSPS mental health and learning disability proposed allocation breakdown

3.1.6

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

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

from DHSSPS

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

Efficiencies

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

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

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

Overall Health and Social Care Service Expenditure

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

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

3.1.12 Mental Health Expenditure (£m)

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

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

3.1.14 Learning Disability Expenditure (£m)

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

3.1.15 A wide range of Departments and agencies fund programmes and services which benefit people with mental ill-health or a learning disability. Most of these benefit a wider range of people; it is not therefore possible to identify how much of this funding directly impacts Bamford services.

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

3.2 Staffing

Workforce Review

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

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

Mental health workforce

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

Learning disability workforce

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

Non-statutory support

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

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

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

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

Workforce Review recommendations

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

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

4 STRUCTURES

4.1 Bamford Vision

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

4.2 Ministerial Level

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

4.2.2 The Group has representation from 10 Departments:

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

Departmental breakdown

4.2.3 Mental Health

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

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

4.2.4 Learning Disability

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

4.3 Bamford Inter-Departmental Officials Group

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

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

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

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

4.4 Health and Social Care Sector

HSC Taskforce on Mental Health and Learning disability

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

4.4.2 Main duties of the HSC Taskforce are to:

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

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

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

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

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

HSC Taskforce Work Plan

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

4.5 Bamford Monitoring Group

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

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

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

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

Patient and Client Council Membership scheme

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

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

5 OUTPUTS

5.1 Summary of Progress on Actions

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

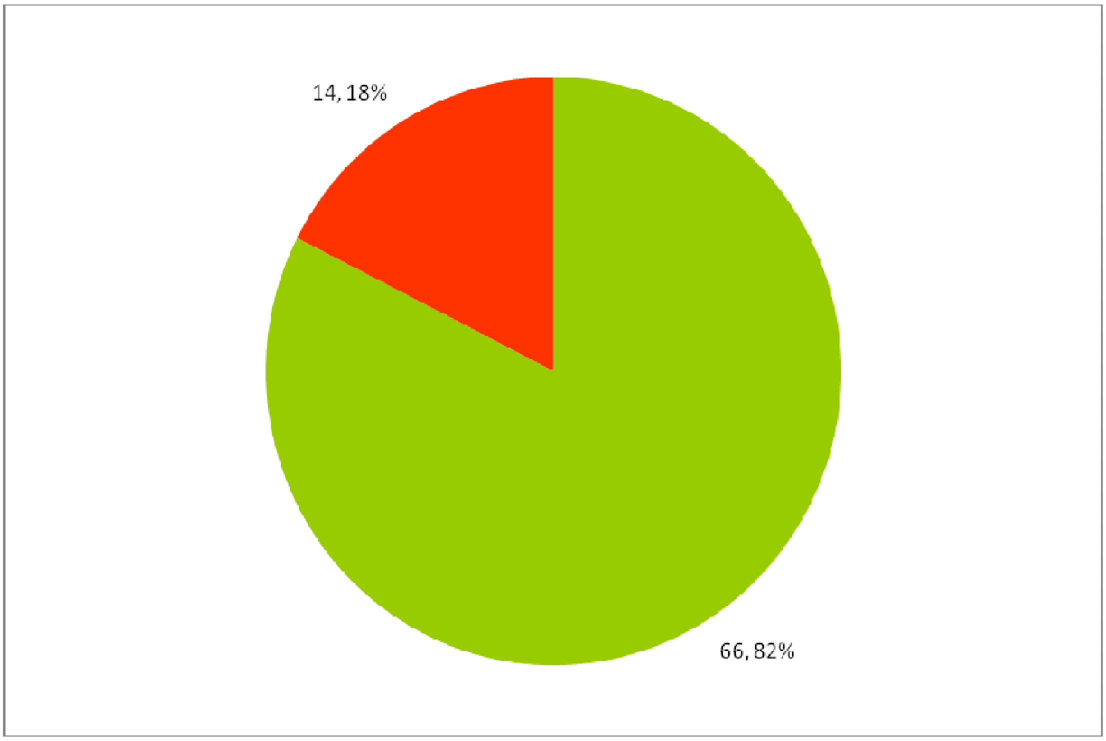
5.1.2 Each action in the Action Plan identified the Department(s) or agency(ies) responsible for delivery, the output required and the timetable for delivery. In order to report to the inter-Ministerial group on progress, monitoring arrangements have tracked the implementation of actions every six months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

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

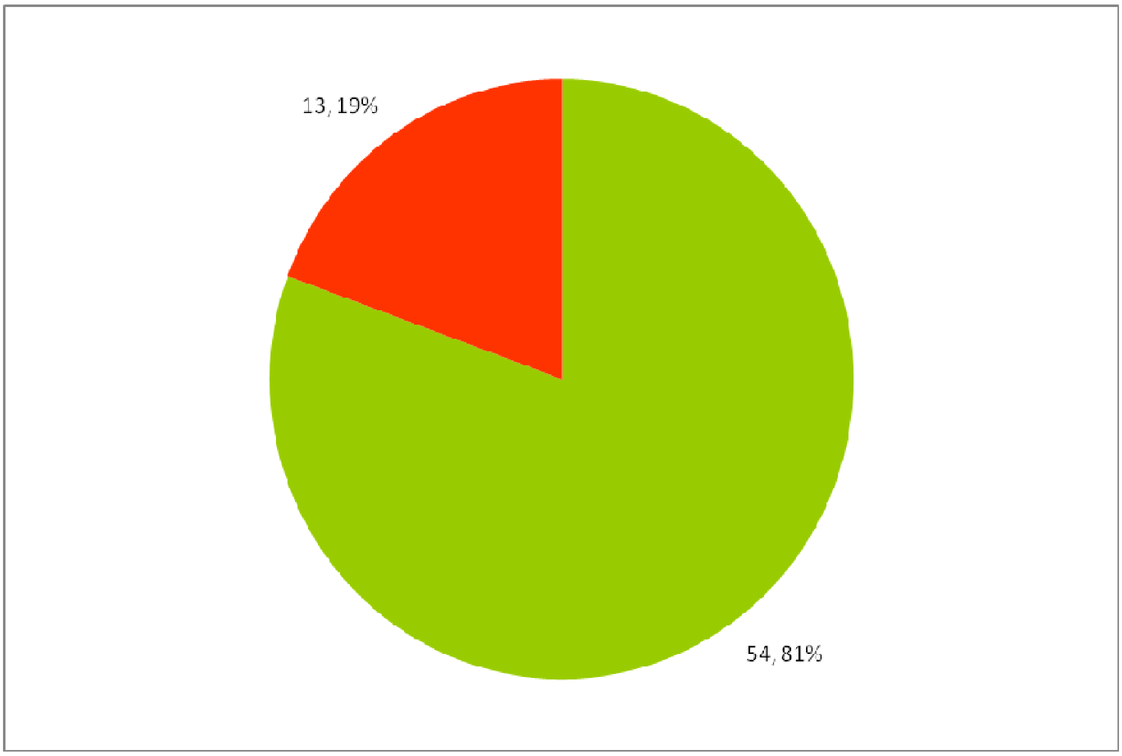
	GREEN	**RED**
Mental Health	82%	18%
Learning Disability	81%	19%

5.1.4

Mental health



Learning disability



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

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

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

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

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

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

5.2 Quantifiable Targets

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

5.2.2 Learning Disability

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

5.2.3 Mental Health

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

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

Consideration of five Themes of Action Plan

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

5.3 Promoting positive health and wellbeing

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

Mental Health and Well-being Strategy

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

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

Protect Life

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

5.3.6 The Protect Life strategy set a target to reduce the overall suicide rate by 15% by 2011. This however has not been achieved. 2010 witnessed the highest ever recorded suicide rate in Northern Ireland (20% increase on 2009), and there is concern that the ongoing economic downturn could further negatively impact on our ability to deliver on the future reduction of local suicide rates. Tackling suicide is a complex matter which is influenced by a wide range of societal issues, and enhanced cross-Departmental and cross-sectoral efforts will therefore be required to address the social, cultural, and economic determinants of health and wellbeing. Progress against the cross-Departmental actions in the refreshed Protect Life strategy will be monitored by the Ministerial Co-ordination Group on Suicide Prevention, and DHSSPS will continue to ensure identification and implementation of the latest international evidence-based interventions on suicide prevention.

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

Early Years

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

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

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

Schools and Colleges

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

5.3.12 The Action Plan recognised the DE's proactive measures to support pupils throughout their educational lives through a revised curriculum, M5, a new programme of pastoral care and counselling, M6, M7 and M8, guidance and support materials to tackle bullying, M9, and identification of those at risk, M10. Five work streams are currently taking forward different aspects of the development of the Pupils Emotional Health and Wellbeing Programme. Each Work Stream includes representatives from DE, DHSSPS, Education and Library Boards and the Voluntary and Community Sectors.

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

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

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

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

Workplace

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

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

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

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

Sport and Physical Recreation Strategy

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

Special Olympics

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

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

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

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

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

Drugs and Alcohol

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

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

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

Domestic and sexual violence

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

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

Equal Access to Health Services

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

5.3.31 The Plan also had a number of actions in relation to improving access to dental services for people with a learning disability, L49, 50 and 51. The pivotal action related to the appointment of a consultant in Specialist Care Dentistry. While attempts were made to fill the consultant post, this was successful only for a limited period. It has not been possible therefore to progress the related actions to training pathways and to training primary care dental care professionals. The need to further enhance oral health services for people with an learning disability will be actioned in the follow-on plan.

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

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

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

5.4 Supporting carers

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

Carer Support Review

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

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

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

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

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

- During 2010 some 30,000 copies of the revised A-Z guide for Carers have been distributed to all health and social care bodies and voluntary & community organisations working in support of carers;

  http://www.nidirect.gov.uk/a-z_guide_for_carers.pdf

- The Carers Support and Needs Assessment component of Northern Ireland Single Assessment Tool, NISAT, was issued to Trusts in December 2009 along with guidance indicating that it is the "tool of choice" for use in assessing the needs of carers in all programmes of care, thus ensuring a standardised approach to assessment.

5.4.5 Bamford Monitoring Group reports, Section 6, highlight that only 58% of those surveyed had heard of a carer's assessment, therefore more work is required to deliver outcomes.

5.4.6 Since there have been a number of policy documents in recent years focusing on support for carers, DHSSPS developed a 'self-audit tool' for Trusts which amalgamated all of the recommendations from the various documents since, and including, Valuing Carers in 2002 – some 170 in total. Within the last year all Trusts completed this self-assessment and submitted their returns. DHSSPS analysed these, identified gaps or weaknesses in provision and earlier this year forwarded the results to the HSCB, as commissioner for services, for appropriate action.

5.4.7 Generally speaking, the results showed that in most cases Trusts were working hard to provide a comprehensive service for carers and ensure that carers' needs featured strongly in their planning; but improvement could be made in areas such as the promotion of Direct Payments, the engagement with General Practitioners (GPs) with respect to the needs of carers, and the involvement of carers in service planning.

Respite provision

5.4.8 Recognising the value of respite provision in supporting informal carers to continue in their role, the Action Plan set targets for increased respite provision of 200 learning disability packages and 2000 dementia packages, L37/M41. It was feared that reductions in funding in 2010/11 would impact on this provision and these targets were reduced to 125 and 1200 respectively.

5.4.9 Early monitoring of these respite targets highlighted difficulties in defining and measuring what exactly respite provision is. The HSCB has carried out substantial work to agree definitions and measurement of respite provision and is leading on further work to progress respite support and standardise service provision.

5.4.10 Recent published data suggests that these early fears for delivery were not justified and the Action Plan targets for package delivery were surpassed. As of 31 March 2011 225 additional learning disability packages and 4585 dementia packages were delivered across Northern Ireland.

5.4.11 An example of improved provision is Omagh Beltany Disability Respite Unit. This £2.2m development opened in Jan 2011 is a state of the art facility with eight residential places which will offer short term breaks for children with a learning disability. The new facility will enable children with complex needs and their families to avail of short term breaks which will provide a positive experience for both the children and families. This form of respite care will also involve community and voluntary organisations as well as local employers.

5.4.12 Although the data would suggest that the targets have been achieved for respite provision, the views of those who use these services, outlined in Section 6, clearly indicate that more work is needed on outcomes.

5.4.13 The Bamford Monitoring Group reports reveal that people are aware that respite allocation is limited because demand is high and resources are stretched. Contributors noted that the level of respite provision generally had stayed the same although a variation in the service is apparent across the Trusts.

5.4.14 The carers and families of those using these services indicated that respite is an essential service and they would value more respite and short break provision.

5.4.15 The Bamford Monitoring Group has commenced a programme of work to identify the experiences of carers and families of people with dementia. Initial findings from the survey group indicate most people have reservations about the respite provision they receive and also have concerns regarding the availability of facilities suitable to meet the needs of someone with dementia.

5.4.16 The Group believes that in addition to learning disability and dementia mental health respite should also be recognised and further work is needed regarding definitions to ensure that the complexity of real lives, e.g. a service user who is also a carer, can be accommodated.

Family Support Pathways

5.4.17 Following the implementation of the DHSSPS/HSCB Reform Implementation Team process and launch of the NI family support model all children in need and their carers are entitled to an assessment of need. A full needs assessment considers what is required by the family as a whole. Where necessary support is provided via the family support pathway as set out in Understanding The Needs of Children in Northern Ireland (UNOCINI). This pathway establishes key roles and responsibilities within the provision of support.

Direct payments

5.4.18 Direct Payments, actions L38 and M43, allow individuals to decide when and in what form services are provided and who provides them, who comes into their home, and who becomes involved in very personal aspects of their lives. They put real power into the hands of service users and carers and allow them to take control over their lives. DHSSPS is committed to the wider roll-out of Direct Payments and as of May 2011, some 642 people associated with learning disability and mental health services were in receipt of a Direct Payment. Section 5.5 provides a further break down of this figure.

5.4.19 The Bamford Monitoring Group accepts that the targets have been achieved but point out that these targets were set against a very low baseline. The Group also highlights the considerable variation in availability of Direct Payments across Trust areas and the need for more progress towards self-directed support and personal budgets.

5.4.20 The recent Girvan judgement clarified that people who lack capacity to consent to their receipt cannot receive Direct Payments. As a result the Carers and Direct Payments Act (Northern Ireland) 2002 will need to be amended and this could take up to 2 years. Interim arrangements which make use of referral to the Office of Care and Protection will be published shortly. New cases where consent is an issue will make use of these arrangements; existing cases will be covered by Extra Statutory Authority until they can be migrated to the interim arrangements. DHSSPS will be asking the HSC Board, with HSC Trusts, to project manage this process.

Young Carers

5.4.21 DHSSPS in conjunction with Barnardos and DE has produced a DVD on the needs of young carers which is designed as a learning tool for those working with young people.

Provision of Information

5.4.22 Bamford also indicated that carers must be appropriately supported through the provision of information as well as practical and financial assistance.

5.4.23 A large resource of information for carers has been added to the central NIdirect website detailing available support from both DHSSPS and DSD.

http://www.nidirect.gov.uk/index/information-and-services/caring-for-someone.htm

The targeted material covers support services for carers, information on benefits, carers' rights, caring for a disabled child, respite, and employment issues with signposting to appropriate organisations.

5.4.24 The quality and availability of information to carers and families is raised throughout the recent Bamford Monitoring Group reports, Section 6. These reports highlight a continuing perceived major deficit in the provision of advice and information for those who use and rely upon mental health and learning disability services.

5.5 Supporting people to lead independent lives

Promoting Social Inclusion (PSI) report and action plan

5.5.1 Reflecting the strong theme of social inclusion in the Bamford Review, L15/M20, the PSI Working Group on Disability, which had cross Departmental and cross-sectoral membership including representation from Equality, Human Rights and the Children's Commission, reported in late 2009 on:

- Children, Young people and their Families;
- Housing, Transport, Information and Access;
- Access to Employment;
- Lifelong Learning, Sports, Arts and Culture: and
- Legislations, Citizenship, Language and Attitudes

5.5.2 However work to develop the associated Action Plan, L16/M21, has not been completed in the timescale envisaged. Work on this is being taken forward alongside work to publish the Executive's response to the PSI working group's report on Disability.

5.5.3 OFMDFM is working to develop a new strategy to sit alongside the Action Plan and to give effect to the recommendations included in the PSI report. It is anticipated that the Action Plan will also be subject to public consultation and will issue for comments early in 2012

Victims and survivors

5.5.4 OFMDFM was tasked with providing an assessment on the impact of the Troubles on the mental health needs of victims and survivors, M22. The Commission for Victims and Survivors has submitted a plan to OFMDFM for completion of the Comprehensive Needs Assessment (CNA). An initial interim report was submitted to OFMDFM in October 2010, with a second interim report in March 2011. The final CNA is expected in 2012.

School and Colleges

5.5.5 It is recognised that children and young people with disabilities must be offered the same opportunities as other young people in respect of education and training and their needs for specific support, flexible delivery and additional time to achieve these benefits should be recognised. To make certain that the full range of education and vocational provisions are available to disabled young people aged 14-25 years old, DE in collaboration with DEL and DHSSPS completed an action plan with appropriate performance measures to ensure:

- Continuation of support for learning and personal development
- Maintenance of a high standard of learning experience
- Achievement of the highest possible education and vocational

qualifications

- The provision of sufficient and appropriate educational, vocational and occupational services
- That young people are equipped with the necessary social and life skills for adult life
- Maximum use of the opportunities for collaborative working between different types of schools and colleges presented by the Entitlement Framework
- Guidance is available for extended schools to specifically encourage greater inclusion of young people with disabilities in activities through outreach and in-reach activities and afterschool provision.
- Performance measures are developed to ensure new opportunities are created and used
- Parents and young people are aware of their right to appeal to the Special Educational Needs & Disability Tribunal should a Board cease to maintain a statement
- That information will be made available for all young people, their families and relevant professionals in relation to transition procedures, services and opportunities in their local and regional areas taking care to ensure that those who fall outside statementing have access to this advice and guidance

Transition to Adult Life

In Schools

5.5.6 The Ministerial Sub Committee on Children and Young People, L18, identified transition of young people from school to post school placements as one of six key priorities to be addressed in a cross-Departmental approach. DE chair a sub-group on this issue with representatives from DHSSPS, DEL, DCAL DSD and DoJ.

5.5.7 The Key Priority/Outcome for this sub-group is:-

"Provision for children with special educational needs in mainstream and special schools, including transitions to adulthood and the provision of appropriate health and social care interventions"

5.5.8 A draft Action Plan has been developed by the sub-group to be implemented by all participating Departments and contains 19 actions to further strengthen policy delivery and post school provision. A draft flowchart detailing the transition from school to post school destinations has also been prepared.

In Health and Social Care Services

5.5.9 In relation to transition from children's to adult health and care services for children with a disability or special needs, L61, this work is being progressed through the new regional Children and Young People's Strategic Partnership (CYPSP).

5.5.10 CYPSP has replaced the children's services planning structures previously located within the 4 Legacy Health and Social Care Boards and was launched in February 2011.

5.5.11 This new regional group is a cross sectoral, strategic partnership, consisting of all key stakeholders who have responsibility for improving outcomes for all children and young people in Northern Ireland including health, social services, education, policing and housing as well as representatives from the voluntary and community sectors.

5.5.12 The key principles will be that transition should be person centred, needs led and will be outcomes focused in seeking to provide choice within a service reform model.

5.5.13 In conjunction with this there are a number of other processes occurring which will have relevance particularly in areas such as Personalisation, Direct Payments and currently a self directed support model is running in the Southern HSC Trust. This pilot is currently operational and will assist in looking how personalisation self directed support will become main stream in areas such as transition.

5.5.14 The CYPSP will lead to integrated planning and commissioning of supports and services aimed at improving outcomes for children and young people across the province.

5.5.15 In Section 6 people with a learning disability and their parents highlight the lack of appropriate information with regard to the options available in their local area. In addition they want access to real day opportunities and choice with support and guidance to decide on what to do during the day.

Further Education, Training and Employment

5.5.16 DEL have completed the Education and Training Inspectorate Evaluation, L17, that considered a range of documents including previous reports on Further Education and Training For Success and also carried out a range of interviews and site visits to Colleges and training providers.

5.5.17 Overall the findings of the Evaluation were quite positive, albeit highlighting some areas for improvement. The key priorities for development that will require cross-Departmental working are:

(a) The need for improved transfer of data between schools, further education (FE) and training providers in relation to the specific support needs of individual learners to allow for planning and scheduling of provision.

(b) Work with other organisations, including DHSSPS, to raise awareness of and develop roles needed to support learners with learning needs, ensuring that FE and Training For Success (TfS) complements the work in day care provision.

5.5.18 Regarding (a), work is ongoing between DEL and DE to find a means of sharing available information. The sharing of this information would provide DEL with essential information to assist in the planning and design of future services in relation to employment programmes, training, further and higher education.

5.5.19 The Careers Service is the interface between the school and FE/training providers. Careers Advisers encourage young people/parents to share information to ensure that the young person can avail of effective support and advisers will share appropriate information with their permission. However, further work will be required by a number of parties and progress is being made through the Children and Young People's Ministerial Sub Group on Transitions, referred to above.

5.5.20 In relation to (b) above, it is recognised that cross-sectoral work is required to resolve all the issues pertaining to the needs of this group. For some individuals the severity of their disability is such that it renders it unsuitable for them to be accommodated in mainstream provision. There are already good examples of collaborative working between Health Trusts and DEL. Under the College Development Planning process, FE colleges are required to provide DEL annually details of collaborative arrangements they have established with local Health Trusts, special schools, voluntary groups and other key stakeholders.

5.5.21 DEL has developed, and implemented, an action plan arising from the Education and Training Inspectorate (ETI) evaluation. The recommendations relating to the Further Education sector have been implemented, as appropriate, in partnership with the Colleges.

5.5.22 In 2009 DEL took the lead in completing a Scoping Study of those young people who are Not in Education, Employment or Training (NEET), M27, in Northern Ireland. The Study was submitted to the Executive in July 2010 and a cross-Departmental mechanism was put in place.

5.5.23 Considerable work has been undertaken by the Department with the principal service delivery Departments to elicit their initial views on the mechanism and development of a strategy and action plan. Work is also ongoing with the voluntary and community sector through and important working relationships have been developed.

5.5.24 The DEL Assembly Committee also undertook an Inquiry into the NEET group. A formal consultation document is being developed drawing on all of the work to date with the sector and Departments, supported by the evidence from the Scoping Study and Committee enquiry Report.

5.5.25 The consultation along with the pertinent findings from the DEL Assembly Committee Enquiry, will inform the final development of a strategy and related action plan. Proposals to develop partnership working guidance are currently being prepared and a draft will be issued to the relevant Departments, Health and Social Care and community and voluntary sector for comments and advice in the near future.

5.5.26 The Bamford Monitoring Group reports, Section 6, set out perceptions that there is a lack of new courses and a limited variety of existing courses. The group also believe that more input is needed from people with a learning disability in order to identify perceived barriers to change.

Evaluation of Supporting People Programme

5.5.27 The DSD's policy evaluation of the administration of the Supporting People Programme by the Northern Ireland Housing Executive (NIHE), L26, was completed in October 2009,.

5.5.28 The purpose of the evaluation of the Supporting People programme was to provide DSD with an assurance that the administration of the programme by the NIHE met both the policy intent and the programme's strategic objectives. It examined the NIHE current funding, governance and accounting arrangements for Supporting People and made recommendations for the future delivery of the programme which are currently being progressed.

5.5.29 The aim of Supporting People in Northern Ireland is to improve the quality and effectiveness of housing related support services. The Department has overall responsibility for the Supporting People programme in Northern Ireland. The intention of the Supporting People programme is to provide:

- a better quality of life for vulnerable people to live more independently and maintain their tenancies.
- housing related support to prevent problems that can often lead to hospitalisation, institutional care or homelessness, and
- help to smooth the transition to independent living for those leaving an institutionalised environment.

5.5.30 The Supporting People programme has made a significant and valuable contribution in assisting vulnerable people to live independently in the community. This has been evidenced in visits to various schemes across a range of client groups as part of the evaluation process. Very positive feedback was received from service users in relation to the benefits of being able to live independently and the value of the schemes and services that were provided.

5.5.31 DSD has committed substantial funding to the programme and this is making a difference to and improving the lives of vulnerable people. The programme has now been running for 6 years with a current annual budget of £63.8m being paid to 110 providers delivering 808 schemes. Currently the Supporting People programme is assisting approximately 23,000 vulnerable people to live independently, exceeding the Public Service Agreement target of assisting 17,000.

5.5.32 The Bamford Monitoring Group believe more input from service users and their carers is necessary within the evaluation process and more focus is required on the needs of people who currently live at home with their families but want to move and need housing support.

The Health in Mind project

5.5.33 To date the DCAL's Health in Mind project, M24, which runs through to 2014, has delivered 268 programmes, 5 courses, 5 high profile events and facilitated approximately 900 people including carers to enjoy enhanced opportunities for social interaction, and enabled people to have a better understanding of mental illness. Also enabling people with mental illness to acquire some self help skills to assist in their recovery and social inclusion, making people aware of the importance of positive mental health, facilitating people in accessing quality assured mental health information and wider information for life skills to facilitate tolerance and social inclusion.

5.5.34 Frontline library staff have been trained to be aware of customers with mental health issues and carers under stress. Relevant resource materials were researched, produced and disseminated. Thematic book and information displays and bibliotherapy exhibitions were held in libraries.

Equality and diversity awareness

5.5.35 The latest Northern Ireland Civil Service (NICS) Employment Equality and Diversity Plan, M33/L28, has been published by DFP and is available for download at:

http://www.dfpni.gov.uk/nics-employment-equality-and-diversity-report-2010.pdf.

5.5.36 It identifies the key equality and diversity issues facing the NICS, as an employer, and reports on the achievement of actions set out in previous plans.

5.5.37 The NICS equal opportunities and diversity training, M34/L29, continues to be made available to staff via a classroom based course for all new entrants and an e-learning package for all other staff. This is a mandatory training requirement for all NICS staff and over 12,000 civil servants have completed the training.

Transport accessibility

5.5.38 DRD was tasked to undertake research into the transport needs of people with a learning disability, L20. This research was carried out by the Inclusive Mobility Transport Advisory Committee (Imtac) and was completed in June 2010.

http://www.imtac.org.uk/publications/2learningdisabilityrpt(finalversion).pdf

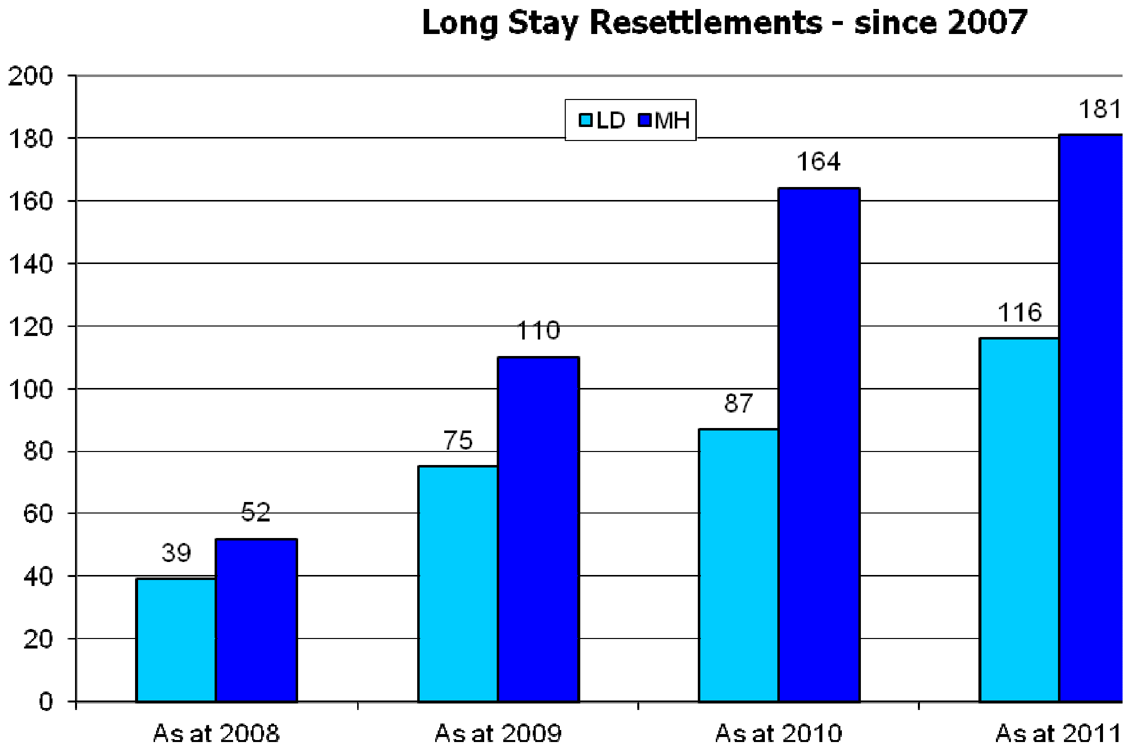
5.5.39 The research examined all aspects of transport accessibility through undertaking a literature review, assessing the current policies and transport opportunities available and also by talking to groups of people with learning disabilities. The report recommends 7 areas in which improvements could be made to increase the travel opportunity. These include: developing travel training programmes, improving provision of travel information, providing improved disability awareness training for staff involved in transport, raising awareness of current travel opportunities available, exploring taxi card schemes, reviewing the eligibility criteria for the concessionary fares scheme and engaging people with learning disabilities when making changes.

5.5.40 DRD is currently in discussion with Imtac regarding the outcomes of the report and how the recommendations can be implemented.

Resettlement of long stay Inpatients

5.5.41 For many years the policy aim in both mental health and learning disability services has been resettlement to enable people to live as far as possible in the community. The resettlement programme was supported by the Bamford review, which recommended challenging timescales for completing the resettlement programme. This was reflected in the targets set in the Action Plan, M37/L32.

5.5.42


Long Stay Resettlements - since 2007

5.5.43 Since 2007/08 the emphasis of the resettlement programme has been on people who had been admitted to hospital prior to 1 April 2006 and had been in hospital for 12 months or more at 31 March 2007. At the same time work continues to ensure that people who are admitted to hospital for assessment and treatment are discharged as soon as they no longer need to be in hospital, thus avoiding "delayed discharges".

5.5.44 The associated target of a 25% reduction in the number of long-stay patients in learning disability hospitals (baseline 2007/08) has also been achieved. While the resettlement target attracts specific funding it is assumed that other patients can be discharged to the community without additional specific funding for individual packages.

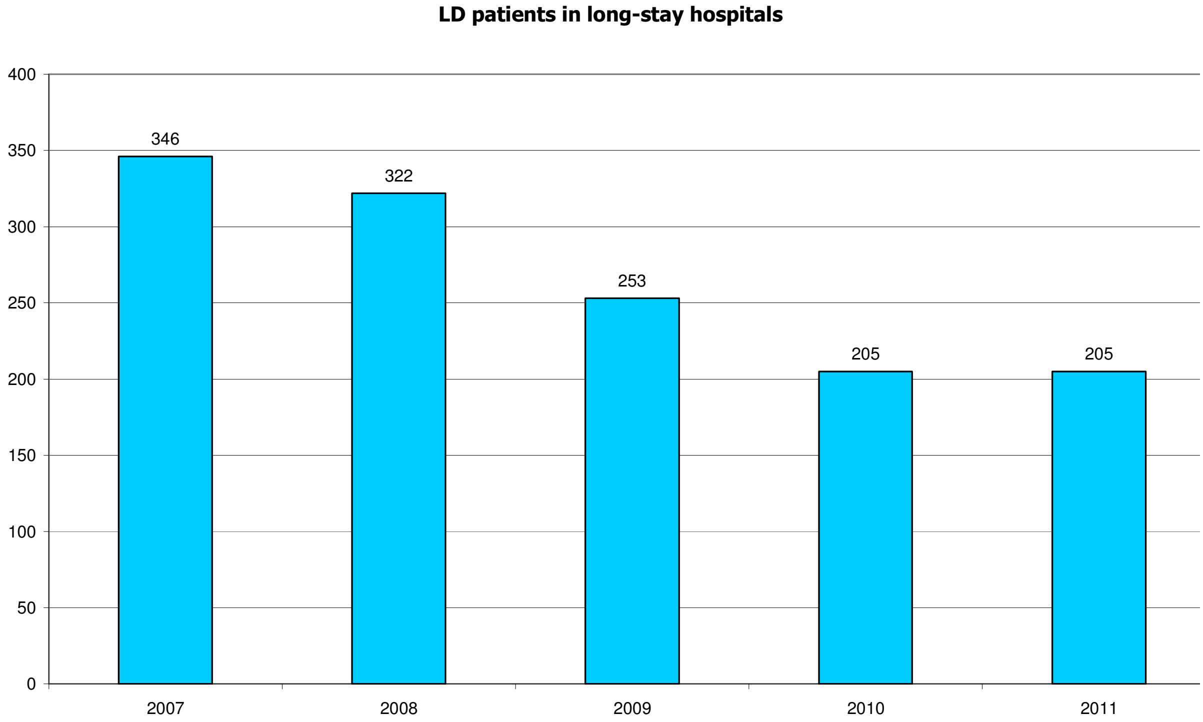
5.5.45 In most patients' cases this is what happens; however, there are a smaller number of patients who remain in hospital beyond the 90 days target who do require a newly funded package of care in the community to permit their discharge. In order to address the potential growth of a new long stay population the Department has set a target for 2011-12 specifying that the additional funding of £6.4m for learning disability is targeted on the resettlement of 45 long stay patients and a reduction of 15 in delayed discharges. It is the intention to continue to address both issues in parallel as the resettlement programme progresses.

5.5.46 The HSC Board has established a Community Integration Project to take a more managed, organised and structured approach to the resettlement process including the examination of all of the housing and care options which are available. The principle of "betterment" remains the key consideration for Trusts in the resettlement of individuals in the community. Considerations also include full discussion with the individual, family and carers on accommodation arrangements, support for independent living and the range of health and social care services which are required. Work has commenced on carrying out detailed individual assessments of those remaining in Muckamore and Trusts continue to work closely with NIHE and other providers to identify accommodation solutions to meet individual need.

5.5.47 The Bamford Monitoring Group is currently working on a project to capture the views and experiences of people with a learning disability who have moved from living in a hospital to a home in the community.

5.5.48 Another associated action was to improve inpatient assessment and treatment services for children with a learning disability. The Iveagh unit is a £4m investment providing a completely new eight-bedded children's treatment and assessment unit. The unit opened in April 2010.

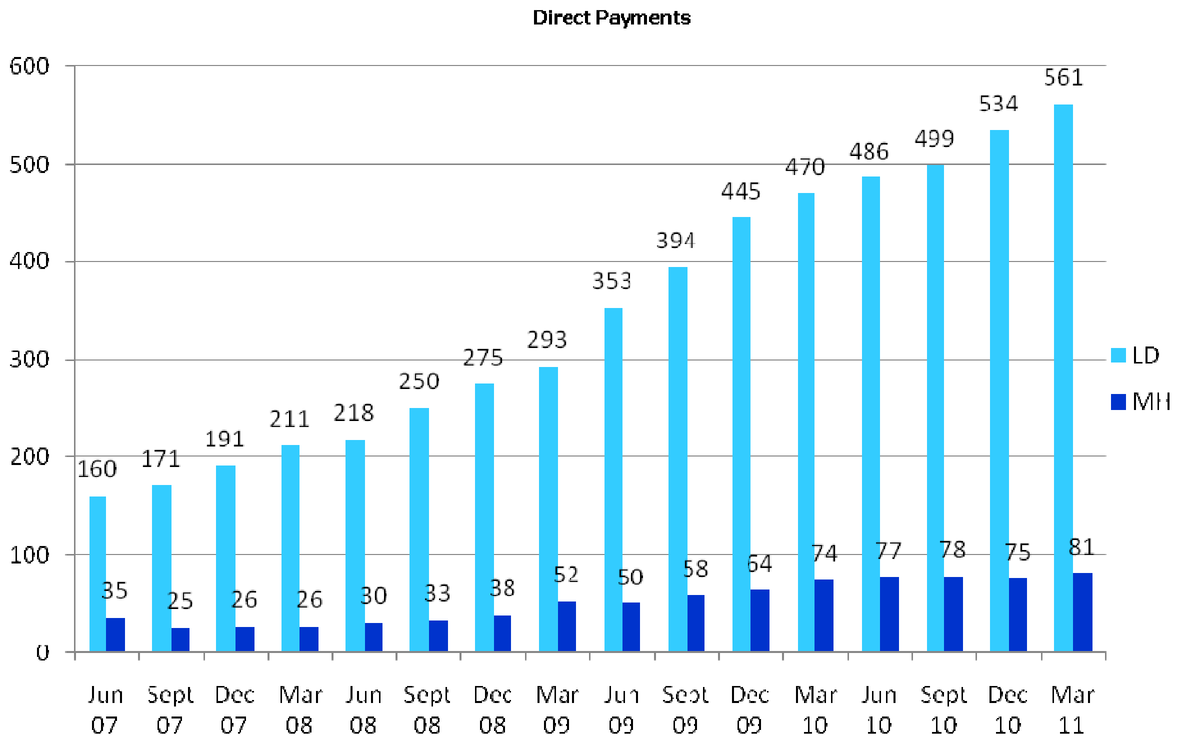
5.5.49



Direct Payments

5.5.50 In 2009 the HSCB were tasked to double the uptake of Direct Payments in order to give service users and their carers greater choice in the support they receive, M36/L38. Through active promotion and background support to those choosing this option the number of Direct Payments in effect has risen from 38 at the start of 2009 to 81 in May 2011 for mental health service users and from 218 in June 2008 to 561 in May 2011 for people with a learning disability. In addition a duty has been placed on Trusts to offer Direct Payments to those assessed as needing services and to whom they had agreed to provide services. Although the targets set in the Action Plan have been achieved, there is still considerable scope to further promote uptake of Direct Payments as a means of ensuring that people can access the support that best suits their needs.

5.5.51



Access to information

5.5.52 The Bamford Vision recognised the benefits deliverable by ensuring better support for service users and carers in understanding the services and making their views heard. The Action Plan tasked stakeholders with improving communication methods and access to information for people with a learning disability, L30, L31, L35, L43 and L58.

5.5.53 The Bamford Monitoring Group in conducting evaluation work for their 2011 reports captured the perceptions of service users and their carers on the availability of information. (see Section 6) Service users and their carers believe that relevant information is difficult to access, more dedicated local service information is required and that generally much more work is needed on this work stream.

Advocacy

5.5.54 Reflecting the Bamford Review’s recognition of the important role of advocacy in a health and social care context and informed by the outcomes of stakeholder workshops in September 2010 and May 2011, a draft policy was published for consultation in June 2011. Consultation responses are currently being analysed. The draft policy seeks to clarify what advocacy is and set out some key principles and standards for the future commissioning and delivery of advocacy services. Further more detailed guidance for commissioners will be prepared once the detail of the new statutory right (under the new Mental Capacity legislation, section 5.6) to an independent advocate has been fully developed. It is expected that the final policy will be published in March 2012.

5.6 Developing structures and legislative framework

Development of Mental Capacity Legislation

Background

5.6.1 One of the key Bamford reports A Comprehensive Legislative Framework (Bamford 2007) recommended new mental capacity and mental health legislation for Northern Ireland based on agreed principles. Work to develop the new legislation was therefore a key action within the Action Plan, M78/L65.

Progress to Date

5.6.2 In September 2009, the Health Minister took the decision to prepare new mental capacity legislation which would include, for the first time in any jurisdiction, mental health provisions. Since then the Department has developed policy proposals which give effect to the single Bill approach. This has been a complex project, as there is no template to follow. It has required developing innovate solutions. To this end the Department has worked closely with the major stakeholders, including other involved Government Departments.

5.6.3 As part of that process the DHSSPS on 30 July 2010 published an equality impact assessment for consultation. Many respondents felt that the impact on section 75 groups would be positive and there was a broad measure of support for the Department’s core proposals, in particular that:

- there should be a single Bill.
- the Bill should be principles based.
- there should be a presumption of capacity in all, and
- there should be a hierarchical approach to providing protections to those subject to interventions under the Bill.

5.6.4 Some concern was expressed that some areas of policy were insufficiently developed to enable respondents to express a view on these issues; that the legislation was not being applied to those under 16 years of age; and that DHSSPS did not propose extending roles traditionally undertaken by doctors and social workers to other professions. The DHSSPS does propose taking an enabling power to widen professional roles should the need arise at a future date.

5.6.5 In January 2011 DHSSPS sought the agreement of the NI Executive to the preparation of a draft Bill which would apply to civil society. It had previously been agreed with the Department of Justice that policy in relation to a separate Mental Capacity Bill will be prepared for those subject to the criminal justice system although if timings permitted the aim would be to bring criminal justice provisions back within a single Bill. The Executive has subsequently agreed to the overall policy content of the Bill and to moving to the drafting stage of the Bill. However the Executive has made it clear that the Bill when drafted should come back to the

Executive in due course for fuller consideration of the policy content and the estimated costs.

Next Steps

5.6.6 The next steps in relation to the Bill are :-

- Preparation of a draft Bill
  This will require the Bill Team to complete a comprehensive set of instructions for the Office of the Legislative Counsel which give effect to the agreed policy content of the Bill. However this will be dependent on the Counsel achieving the policy intent of what will be a complex piece of legislation and on the other legislative workload of the Counsel.

- Consultation on the Draft Bill
  While it is not essential to undertake consultation at this point, it would seem prudent to do so. This is an important piece of social legislation and it will give the minister and the Executive the opportunity to consider the Bill again before its introduction into the Assembly. Consultation should be complete by end of Summer 2012.*

- New Minister and Executive clearance of draft Bill
  Following consultation the minster and the Executive will have to provide final clearance of the Bill prior to its introduction into the Assembly in Autumn 2012.*

- Introduction to Assembly
  It is anticipated this will in late 2012.*

- Enactment
  This will be dependent on the time it takes progressing through the Assembly but should be achieved in 2014.*

** In relation to the timetable for the introduction and enactment of the proposed Mental Capacity Bill, the information provided in paragraph 5.6.6 was an accurate reflection of the position at 31 December 2011. However there has been a significant development since then which has altered that timetable considerably. Pressure from stakeholders and from the Health and Justice Assembly Committees led to a reconsideration of the original Executive proposal to apply the Bill only to those in civil society and for separate consideration of the application of the Bill approach to those subject to the criminal justice system. In February 2012 the Health and Justice Ministers jointly agreed that the scope of the Bill should be extended to include those subject to the criminal justice system. It is now proposed that, subject to Executive agreement, consultation on the draft Bill will occur in the Summer of 2013, with the Bill introduced into the Assembly towards the end of 2013 and its enactment in March 2015.*

Deprivation of Liberty Safeguards guidance.

5.6.7 The Department issued revised Deprivation of Liberty Safeguards (DOLS) guidance in October 2010 to provide interim guidance on the principles to be applied by those involved in taking decisions about an individual's care or treatment that may result in the deprivation of that individual's liberty, M80/L67.

http://www.dhsspsni.gov.uk/revised-circular-deprivation-of-liberty-safeguards-october-2010.pdf

5.6.8 The guidance was issued as result of the European Court of Human Rights (ECtHR) judgement in 2004 in the "Bournewood" case and is therefore an important element in the protection of human rights of patients as required under the European Convention of Human Rights.

5.6.9 The guidance is intended as an interim solution based on the current legislative framework, the Mental Health (Northern Ireland) Order 1986 and best practice, pending the introduction of the new Mental Capacity (Health, Welfare and Finance) Bill.

Nearest Relative Guidelines

5.6.10 Arising out of a ECtHR case has been a need to amend the Mental Health (NI) Order 1986 to provide patients with the right to challenge the appointment of their nearest relatives and have a county court appoint an alternative nearest relative, M79/L66. Rather than considering an amendment to the 1986 Order at this stage, however, consideration is being given to give effect to this through the introduction of nominated persons in the proposed Mental Capacity Bill.

Impact of management structures.

5.6.11 The structures put in place to drive forward the Action plan have been described in section 3. This section considers the impact the Bamford management structures have had on the delivery of the Bamford Vision.

5.6.12 The strong cross-sectoral working established at Departmental level is evident with the management structures under the Action Plan. Departmental, HSCB and Bamford Monitoring Group representatives cross-populate management groups and programmed meetings. Where beneficial, these structures have embedded the ethos of Personal and Public Involvement, PPI, as part of the organisational activity. The extent of direct user/carer involvement within these structures is increasing, however an ongoing focus on this work stream will be require to maintain momentum.

Inter-Departmental Group Monitoring

5.6.13 The Inter-Departmental Group's (IDG) monitoring has established a firm grounding for this first phase of the Bamford Vision. The chosen Traffic light system has provided a useful guide on specific action milestones and achievements. The current monitoring reports are supplied to the Ministerial Group, IDG, HSC Taskforce and Bamford Monitoring Group. The Bamford Monitoring Group outcome reports, Section 6, raise concerns that the quantity of interdepartmental and cross sectoral working evident at IDG level may not be as apparent or productive at local level. The issue of local level cooperation will be actioned in the follow-on Action Plan.

HSC Taskforce

5.6.14 The Taskforce Work Plan sets out the HSC/PHA workstreams necessary to make delivery of the Bamford Vision for people who use Mental Health Services and for people with a Learning Disability and their families a reality in future years. Many of the workstreams are taken forward within specific sub-groups.

5.6.15 The sub-groups further allow issues raised by service users and carers to be brought to the attention of the main Taskforce. The structure of the Taskforce has also ensured that actual Bamford targets for mental health and learning disability services are reflected in the HSCB's overall commissioning priorities.

5.6.18 The Taskforce is also undertaking work to develop a set of high level outcome indicators. The establishment of the indicator set will provide a solid foundation for longer-term evaluation of the Bamford programme of work.

Bamford Monitoring Group

5.6.19 The wider Patient and Client Council membership network currently includes 2,279 contacts under mental health and 2,132 contacts under learning disability. These include individual service users, carers, family members and interested members of the public together with organisational mental health and learning disability groups. These members have been engaged by the Bamford Monitoring Group to assist with the user and carer portion of this evaluation, Section 6. As this scheme develops further it may be possible for other groups within the management structure to get immediate feedback on focused queries through the Bamford Monitoring Group from this network.

5.6.20 The Bamford Monitoring Group reports précised in Section 6 are a good example of how this network can be utilised to focus in on specific work streams. These reports set out the outcomes and impacts of the 2009-2011 Action Plan from a user and carer perspective. They have been extremely useful not only in balancing the quantifiable outputs in this Evaluation but also through informing development of the follow-on Plan.

5.7 Developing better services to meet people's needs

Personal and Public Involvement

5.7.1 The Bamford Review of Mental Health and Learning Disability set a strong example of involving service users and carers in their deliberations. This has been sustained in the structures and processes set in place since then. The Bamford HSC Task force and its supporting subgroups, established within the last 18 months, have included service user and carer representation. In addition the Bamford Monitoring Group, established through the Patient and Client Council, has a remit to ensure that service users and carers have an opportunity to feed back their views to the Minister on how services are meeting their needs. The Bamford Monitoring Group reports annually to the Minister. "Easy read" versions of documents are also produced where appropriate.

Service Frameworks

5.7.2 Service Frameworks set out the standards of care that people who use services, their family and carers can expect to receive. Consultation on the Mental Health Service Framework finished in March 2011 and the final paper was published in autumn 2011.

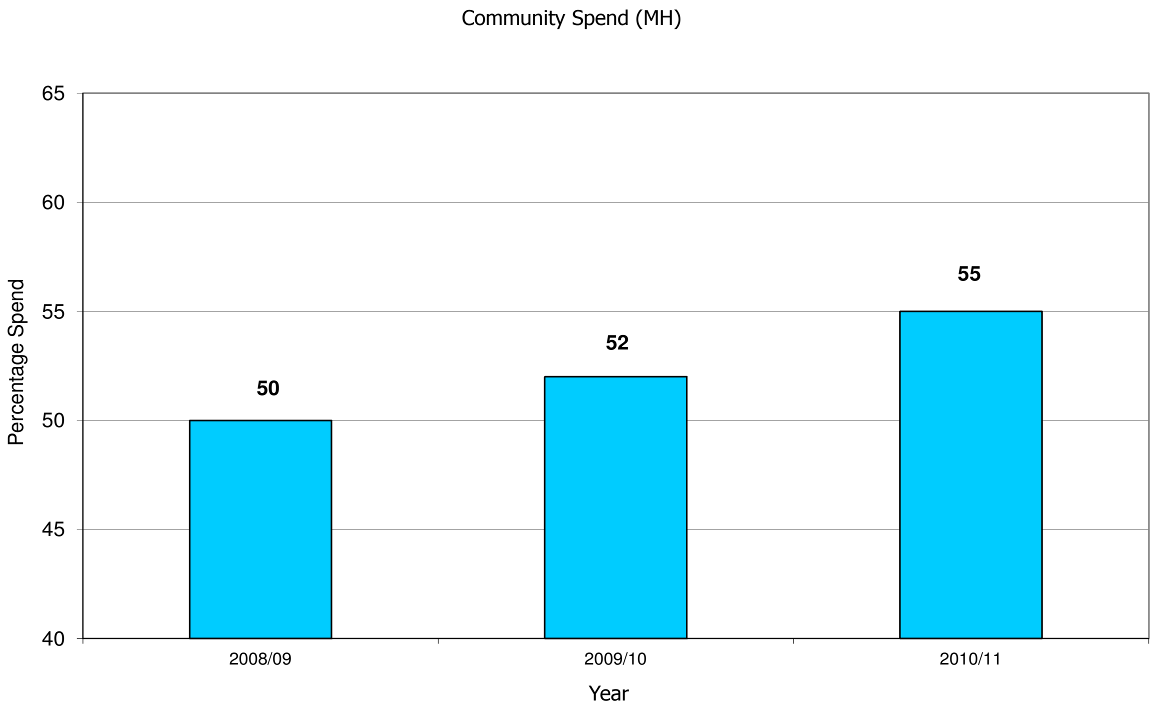
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-standards-service-frameworks/sqsd_service_frameworks_mental_health.htm

5.7.3 The Service Framework for Mental Health and Wellbeing, M47, sets a range of standards in relation to the prevention, assessment, diagnosis, treatment, care and rehabilitation of individuals and communities who currently have or are at greater risk of developing mental ill-health. These standards have been developed in partnership with a wide range of stakeholders with representation from all aspects of health and social care as well as service users and carers. They are aimed at improving areas such as mental health promotion and user and carer experience. They also set out the standards of care and treatment that patients can expect to receive.

Shift resources to community

5.7.4 The Bamford vision is to expand community based services and prevent inappropriate admission to inpatient services. The Action Plan targeted that 60% of HSC spend on mental health services, M46 , and 80% of HSC spend on learning disability services should be on community services. While the balance of spend in learning disability services has been maintained at above 80% (82% in 2010/2011), the target has not been achieved in mental health services, where spend on community services was 53% in 2010/11. However notwithstanding the efficiencies imposed on all spending in recent years the trend remains positive. The Bamford Monitoring Group's Is Bamford Making a Difference report stressed the need to focus on recovery within mental health; more support for carers in the community; the importance of mental health community groups in supporting people and the lack of appropriate information regarding the options for referral to voluntary and community groups.

5.7.5



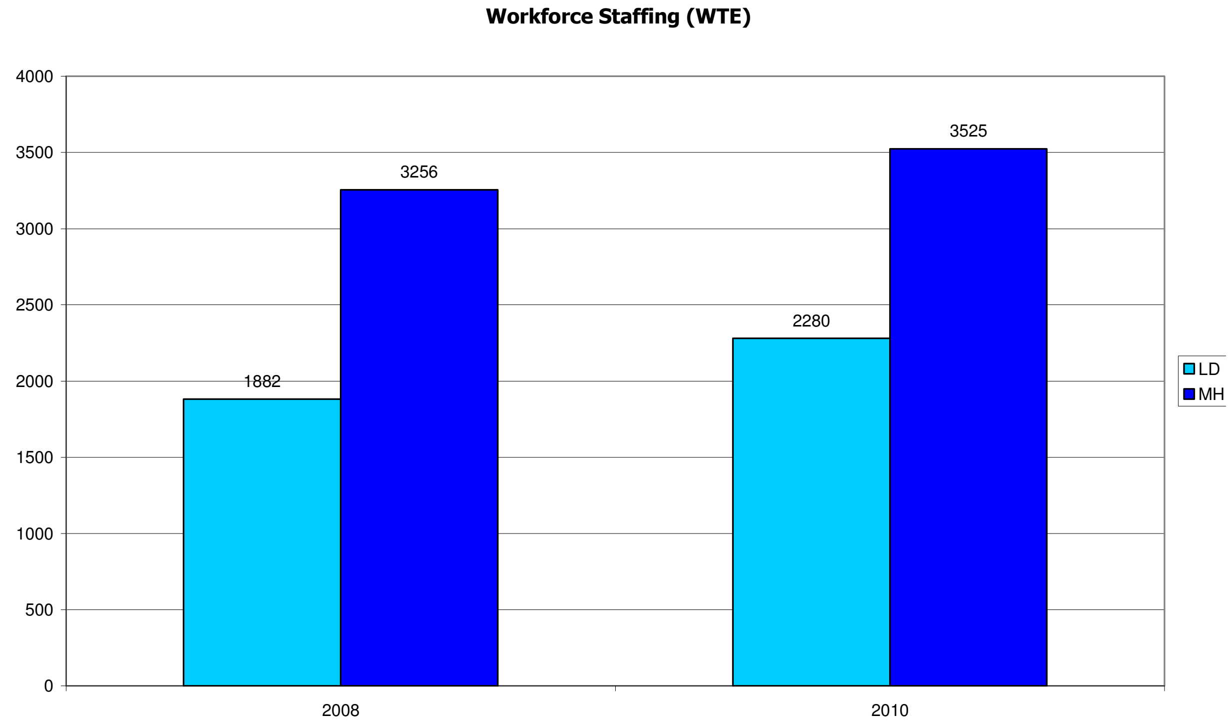
Workforce

5.7.6 The Action Plan sought an additional 240 staff in community mental health services from the 07/08 baseline, M54. The learning disability Action Plan also called for an increase in community staffing, L42, but set no target for the amount.

5.7.7 The Human Resources Management System which was used by the Deloitte Workforce Review as a data source, identified 3256 Whole Time Equivalent (WTE) staff in mental health services in 2008, and of 3,525 WTE staff working within mental health services in 2010. For learning disability, the baseline identified 1882 WTE with an increase to 2280 WTE in 2010 using like-for-like comparators.

5.7.8 It is not possible to separate community staffing because of role descriptor indicators within the database. The ongoing commitment to community services should have channelled the majority of these additional staff – 269 in mental health and 398 in learning disability - into community services, although the existing database descriptors cannot substantiate this.

5.7.9



Service mapping

5.7.10 The Action Plan included actions to complete and maintain a map of mental health, M52, and learning disability services, L44, across Northern Ireland, so that new services can be better targeted and gaps in existing services can be filled. Information from this could also be made available to GPs and to members of the public, who may be seeking to access services. Progress on this action has been slower than anticipated. Some resources have now been identified jointly between the HSCB and the DHSSPS to take forward the mapping of services. It is anticipated that the mental health map will be completed early in 2012, and the learning disability map within the following 12-18 months.

Mental health service enhancement

Stepped Care Model

5.7.11 The Bamford Action Plan 2009-2011 envisaged a stepped care model for future service provision in Northern Ireland. The model aims to provide a graduated range of care options including self-help and the provision of support and treatment within primary care before referral to more specialist services.

Stepped Care Model

5.7.12

Step1
Recognition, Assessment and Support

Step 2
Treatment for Mild Disorders

Step 3
Treatment for Moderate Disorders

Steps 4 - 5
Treatment for Severe/Complex Disorders

5.7.13 The HSCB developed a Mental Health Elective Access Protocol in May 2010. This protocol requires Trusts to develop stepped care approaches as a means of streamlining care pathways. The HSCB continues to work with Trusts on the design of an agreed Stepped Care Service model. This work is currently being progressed through the Regional Psychological Therapies Network. Specific sub-streams are currently refining the required service elements necessary to provide a robust Stepped Care service model. A consensus position will be established encompassing the 5 Trusts regarding the elements of service provision required. This is being underpinned by the development of regional threshold criteria which will match need with intervention and decisions on who should provide this care. Beyond the consensus model Trusts are also required to review how their existing resources may be realigned/re-shaped to map into the Stepped Care model. Those using these services maintain that there are still difficulties in accessing services in times of crisis and uncertainty regarding the application of assessment criteria.

Psychological Therapies

5.7.14 Recognising the evidence base for psychological therapies and as recommended by the Bamford review, the Psychological Therapies strategy was published in June 2010, M55, to inform the development of these services in line with the Bamford Vision.

http://www.dhsspsni.gov.uk/show_publications?txtid=42865

5.7.15 A Regional Psychological Therapies Implementation Plan will ensure the provision of psychological therapies will be a core component of mental health and learning disability services. Services will be delivered by staff with the skills and competence appropriate to the level of interventions required, and to national and regionally agreed standards and guidelines. Future work streams will:

- Profile Services.
- Produce an Integrated Care Pathway.
- Develop Matched Care Threshold Criteria.
- Produce Workforce/Skills/Outcomes Frameworks, and
- Produce Regional Guides to Psychological Therapies.

Beating the Blues

5.7.16 Beating the Blues (BTB) a computerised Cognitive Behavioural Therapy programme, M56, is recommended by NICE for use in primary care for the treatment of mild/moderate depression. The programme is designed to provide feedback to the GP after a patient has completed each of the eight sessions, in order to monitor progress. The service has been available to all Northern Ireland GP practices from December 2010 but uptake has been slower than expected. Access to BTB has recently been extended to include prisons and Trusts' Occupational Health Departments and regional voluntary and community organisations. Up-take of the programme is steadily increasing, by September 2011 2,782 people had made use of the service.

5.7.17 The Bamford Monitoring Group is currently conducting a survey of users and carers asking them about their experiences of using the BTB programme. A report on the findings will be published in 2012. The Group have also raised concerns regarding the ease of use for those with a learning disability.

Crisis Response Home Treatment

5.7.18 The Action Plan sought an improved and harmonised model for crisis intervention Services, M64. Mental health services in all HSC Trusts are repositioning to the preferred model of treating people with acute mental illness within the community thus decreasing reliance on, and numbers of, acute inpatient beds. The 269 additional mental health staff outlined in section 5.7.8 are enabling the ongoing deployment of this vision.

5.7.19 Crisis Response Home Treatment (CRHT) teams and service models are being developed within Trusts to support people, who previously would have been admitted to acute units, in their community on a 24/7 basis.

5.7.20 Audits have been conducted on all Trust services and a process is in place to fully harmonise services with a further potential for implementation of a CRHT regional specification.

5.7.21 Service users and carers stressed that support for individuals and families in times of crisis were very important. They believed though that there was a lack of these support mechanisms in place and access to services was not easy. They also called for a place of safety particularly in relation to suicide and self harm. The ongoing need for education and strong therapeutic relationships were also emphasised.

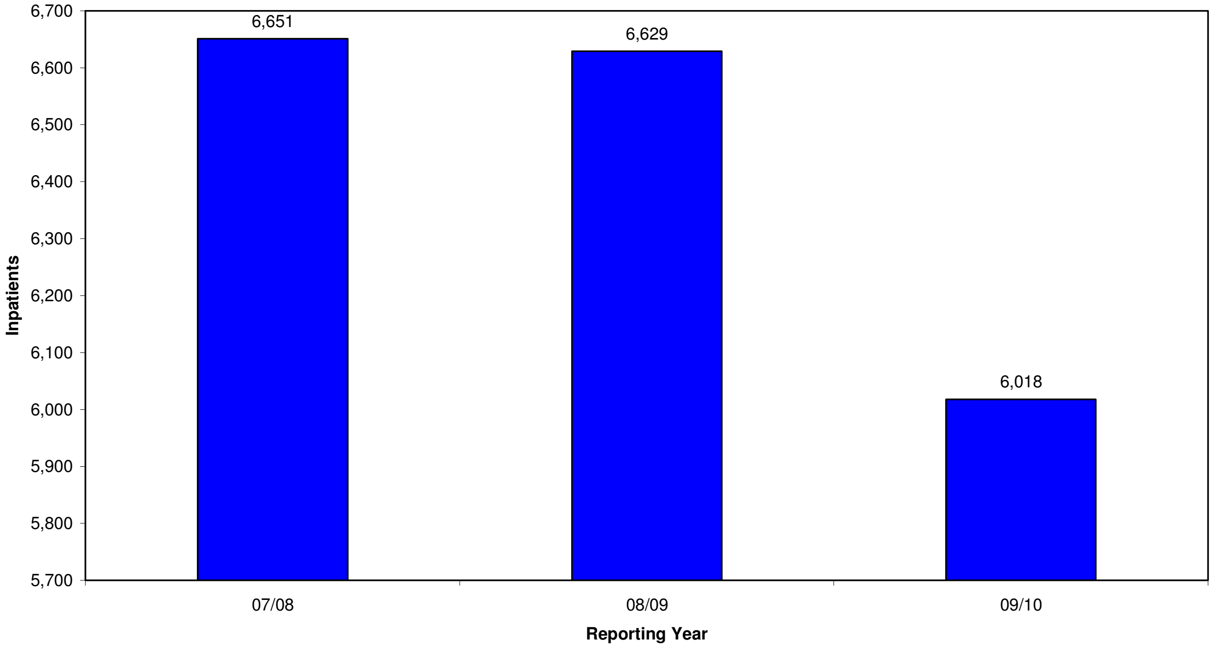
Admissions to Hospital

5.7.22 Linked to the development of crisis response services was an objective to see a 10% reduction in admissions to mental health hospitals (baseline 2007/08), M54.

5.7.23 While there have been increasing numbers of day cases in hospitals over recent years due to changes in working practice, the number of admissions spending at least 1 night in a mental health hospital has decreased by 10% (633).

5.7.24

Mental health inpatient admissions



Source ….http://www.dhsspsni.gov.uk/hosp_stats_2010_mhld.pdf

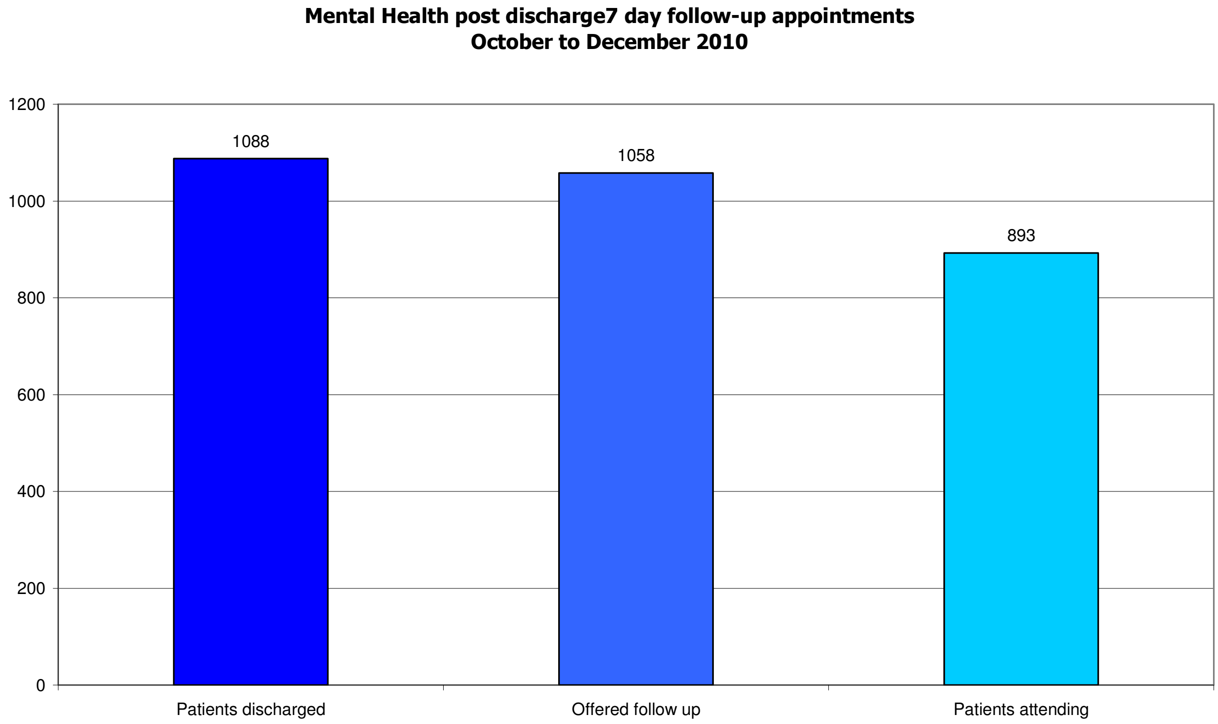
Access to Mental Health Services for those leaving hospital or A&E departments

5.7.25 The Card Before You Leave protocol is in operation in each Trust area. The programme was launched in January 2010 in order to ensure that patients at risk of self-harm or suicide receive ongoing care in the community following their discharge from A&E or an acute inpatient setting.

5.7.26 Those patients presenting at A&E, who are assessed to be at low risk of self-harm or suicide, are given a card detailing useful contact numbers within adult Mental Health Services. This card will also have a fixed-time appointment for a follow-up assessment in five Trust areas. The same system operates within Child and Adolescent Mental Health Services in all Trust areas.

5.7.27 In addition each Trust has procedures in place to ensure that mental health patients who need continuing care have a follow up contact with mental health services within 7 days of discharge from hospital, M62.

5.7.28



Mental Health post discharge7 day follow-up appointments
October to December 2010

5.7.29 The Bamford Monitoring Group is currently asking people to share their experiences of Card Before You Leave and follow-up appointments. The findings from this work will assist future evaluation of the schemes. Regular feedback is also being given to the Regional Card Before You Leave Steering Group.

Promoting Quality Care

5.7.30 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. The DHSSPS issued the Promoting Quality Care Guidance to Trusts in May 2010 in response to an Action Plan objective, M57.

http://www.dhsspsni.gov.uk/show_publications?txtid=42473

Meeting Specialist Needs

Child and Adolescent Mental Health Services (CAMHS)

5.7.31 The HSCB has recently reported to the Department that there is continued emphasis on the key areas of communication, interface and collaborative working which are being driven by the "Think Child, Think Parent, Think Family" regional project. Work reported as taken forward by this project includes:

- The Draft Joint Working Agreement consultation which finished in January 2010.
- UNOCINI guidance has been strengthened to reflect mental health needs. Further work will be developed on the UNOCINI Threshold of Need.
- 2 online surveys have been developed to capture the views of service users and carers and staff on a regional basis; these are expected to help shape and influence services through to the future.
- The development of the Social Care Institute for Excellence (SCIE) recommendations are being progressed by all 5 Trust locality teams.
- The 'Champions' model is being developed further in the Southern and South Eastern Trust areas which is expected to enrich the key areas of communication and collaborative working.

5.7.32 The Regulatory Quality Improvement Authority (RQIA) completed an independent review of CAMHS in Northern Ireland in 2010 their report dated February 2011 has been published.

http://www.rqia.org.uk/cms_resources/RQIA%20CAMHS%20Report%2022%20Feb%2011.pdf

5.7.33 A number of work streams are already currently underway which will address many of the recommendations outlined in this report. These include:

- The Bamford CAMHS sub-group which is taking forward actions from the Bamford Action Plan 2009;
- A review of Tier 4 services; and
- The recent appointment, by the HSCB, of a commissioner for CAMHS.

5.7.34 Overall it is clear that child and adolescent mental health services are continually improving and developing. However, there is still much work to do to develop and improve services further. Unfortunately, this cannot be achieved without additional investment. To fully implement the RQIA recommendations may cost around £2m per annum – in the current financial climate, clearly not all recommendations can be implemented in the short-term; therefore, it will require a prioritised approach to implementation.

5.7.35 A new combined child and adolescent mental health inpatient facility - a £15m investment at Foster Green opened in 2010, M70. These units provide a total of 33 inpatient beds and a further five day case beds for children and adolescents with mental health problems, along with parents' overnight stay accommodation and a family flat.

Dementia

5.7.36 The Northern Ireland Dementia Strategy was consulted on in 2010 and the final strategy and supporting action plan was published in November 2011, M71, albeit after the cut-off date for monitoring for the Action Plan. Key messages in the strategy are:

- Prevention
- Raising awareness and addressing stigma
- Access to early diagnosis
- Staged approach to care and support
- Improving staff awareness and skills, and
- Redesign of services

http://www.dhsspsni.gov.uk/show_publications?txtid=53089

5.7.37 DHSSPS has also funded the NI Dementia Services Development Centre for a 3 year period up to March 2012 to support dementia service providers in both the statutory and non-statutory sectors, M72. A separate evaluation of this work was completed in 2011.

Personality Disorder

5.7.38 The Personality Disorder strategy was published in June 2010, M61.

http://www.dhsspsni.gov.uk/show_publications?txtid=43090

5.7.39 New funding, (£600k 09/10 and £574k in 20/11), has been allocated and staff recruitment has commenced. Of the £574k, £100k is being provided to SET specifically to develop services within prisons. The main emphasis on moving forward will now be the development of a Personality Disorder care pathway, raising awareness across all professions, training of staff at steps 2 and 3, and engagement with the voluntary and community sectors.

Forensic Services

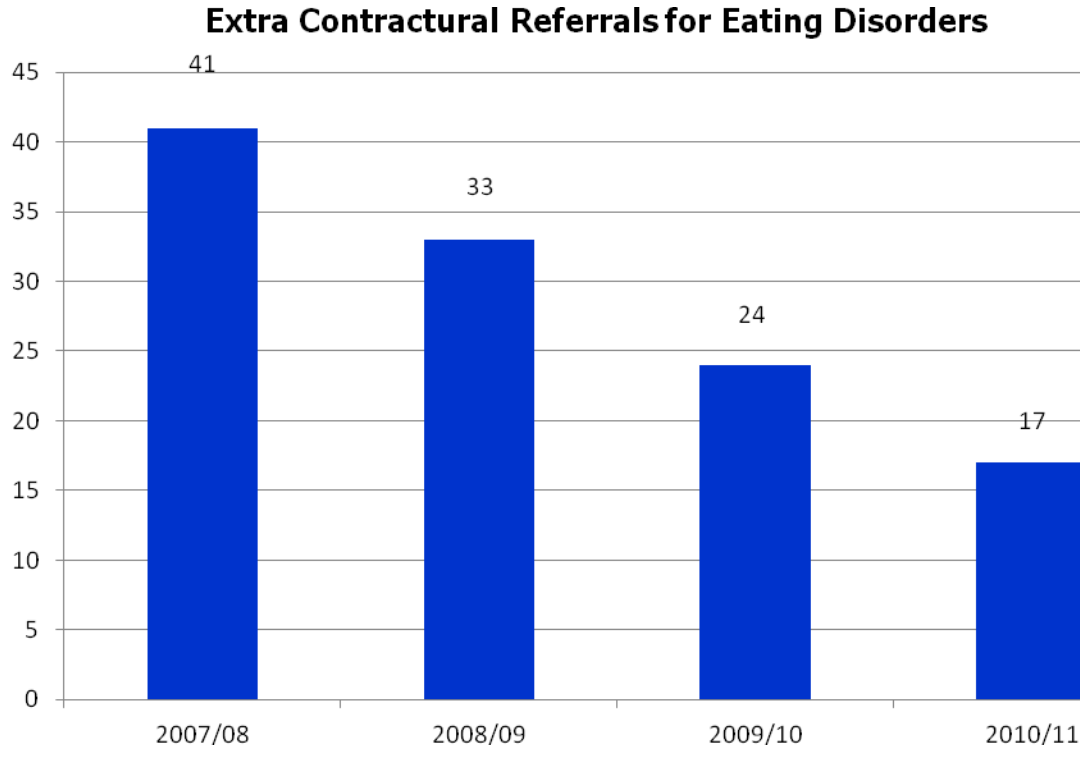
5.7.40 A multi agency Specialist High Support Bamford Subgroup has been established, M73. A work plan has been developed and its actions are being taken forward by the Group. This Group is also looking to see how existing services could be developed further and how best to share information. The Community Forensic Care Pathway has been reviewed and updated and has been issued for stakeholder consultation.

Eating disorders

5.7.41 The Action Plan aimed to establish an inpatient service for eating disorders to complement existing community based services, M66. The Regional Eating Disorders Network group is working towards implementation of a regionally agreed service model. This aims to enhance community provision allied to specific inpatient service capacity in each Trust's acute hospitals and also to reduce the number of people who require placement outside NI for specialist care. However Trusts are working together to progress the development of local in-patient service capacity in terms of sharing knowledge and skills. These beds (1-2 per Trust) are managed by specially trained medical/psychiatric staff, supported in an in-reach basis by staff from community based eating disorder teams. This provides a seamless service which is key to achieving the best long-term outcomes.

5.7.42 The absence of investment during 2010/11 has meant it is no longer possible to develop the model in full, limiting the scope to prevent placements outside NI. Although the development of the local in-patient service is at a relatively early stage figures show a significant reduction in referrals in recent years and this trend is expected to continue as local expertise in the management of complex conditions continues to develop.

5.7.43



5.7.44 The Bamford Monitoring Group's Open Dialogue Mental Health Conference report, Section 6, expressed criticism that people who battle with eating disorders are still sent to England; the lack of therapy, the types of therapy available for people and, as eating disorders impact the whole family, the need for therapy to be open to all family members.

Low secure provision

5.7.45 The Low Secure Sub Group of the HSC Taskforce has developed a referral care pathway for low secure services, M74. Consideration is now being given to the link between forensic and prison services to streamline that pathway. A new model of therapeutic interventions considering good practice guidance on therapeutic interventions and services elsewhere informed recommendations within this care pathway.

5.7.46 The Group also completed a Low Secure Services Report to look at the projected service need and identify a preferred model for future low secure provision.

5.7.47 Capital funding to enable implementation of the preferred service model was identified. This issue will now be taken forward by the HSCB in discussion with the Health & Social Care Trusts.

5.7.48 In April 2011 operational implementation of the low secure service was handed over to the HSCB for discussion and implementation with the five Health & Social Care Trusts.

Learning disability service enhancement

Day opportunities

5.7.49 To support people with a learning disability who want to have a job, DEL's Disability Employment Service (DES) provides a range of vocational and pre-vocational programmes to meet the needs of disabled people whatever their age, L60. The particular programme that is appropriate for each individual is discussed and agreed with an Adviser based in Jobs and Benefits Offices/Jobcentres. DES has a team of Occupational Psychologists to assist Advisers provide their services. The programmes are demand-led and much of the DES provision is individually assessed. Programmes include:

- Job introduction scheme
- Access to Work NI
- Workable NI
- Ulster Supported Employment Ltd
- Residential Training
- Steps to Work
- Local Employment Intermediary Service, and
- The European Social Fund (ESF) programme.

5.7.50 DEL is responsible for the implementation of the Northern Ireland ESF programme 2007-2013. Priority 1 of the programme , entitled ' Helping people into sustainable employment', provides support for projects that offer training to people disadvantaged from entering the labour market and those seeking further skills. Some of these projects focus exclusively upon participants with a disability. Currently, there are 17 projects in receipt of assistance in relation to participants with a mental health difficulty, learning disability or physical disability.

5.7.51 The HSC sector also continues to provide a range of day opportunities, often in partnership with voluntary and community organisations.

5.7.52 The Bamford Monitoring Group reports referenced in Section 6 reveal that people with a learning disability need real day opportunities, real choice and real decision making on what they can do during the day. These principles will be carried forward into the follow-on Action Plan.

People with challenging behaviours and profound and multiple learning disabilities

5.7.53 The Bamford Review of Mental Health and Learning Disability recognised children's services as a key area where Departments and their agencies must work together to most effectively meet assessed needs. This was particularly emphasised in relation to services for children with a learning disability who present with challenging behaviours, L47.

5.7.54 Departments gave priority to improving children's services through the establishment of separate sub groups and the development of specific action plans, these were given the full endorsement of the NI Executive.

5.7.55 The Bamford Action Plan carries 2 actions in relation to children with learning disability and challenging behaviours. These are:

- Improve services for people with challenging behaviours and their carers, and
- Improve collaboration between education and health sectors in meeting the educational needs of children and young people with significant challenging behaviours

5.7.56 A cross sectoral protocol has been developed to clearly set out the requirement for health and social care services and education services to collaborate closely in assessing and meeting the needs of those children with learning disability and challenging behaviour. This work will be progressed with a wider consultation and a follow-on Action Plan.

5.7.57 The Bamford Monitoring Group have decided to do a further piece of work to specifically focus on gathering the views and experiences of individuals, parents, carers and family members regarding the provision for and needs of this group.

Autism Spectrum Disorder (ASD) Action Plan - Implementation

5.7.58 The Bamford Action Plan recognised ASD as a related issue which needed to be progressed and some of the additional Bamford funding was directed towards services for people with ASD. The Regional ASD Network (RASDN), established in March 2009, comprises input from the 5 HSC Trusts (both children's and adult services) and the Education Sector. Parents, carers, service users and the voluntary sector are represented across the RASDN project structure via the 50 strong Regional ASD Reference Group.

5.7.59 Implementation of the Action Plan and improvement of actual services is taken forward via each Trust ASD forum and a lead director has been identified to oversee the improvement of services across service programmes and across the child/adolescent/adult age range.

5.7.60 The Education sector is also represented in each of regional sub-groups and also each Trust implementation group. Important links have therefore been established between Health and Social Care and the Education sector right across N.Ireland at both strategic and local operational level. RASDN is also forging links with other Departments and agencies, including Youth Justice and District Councils.

5.7.61 Parents, carers, service users and voluntary sector representatives from the Reference Group are full members of Trust ASD fora. For the first time parents, carers and service users therefore have a direct consultative role regarding the development of ASD services locally in each Trust area. Reference Group members are also assisting the Regional sub groups in their work to identify evidence based and consensus approaches to the key issues identified within the Action Plan.

5.7.62 A significant proportion of the available investment over the 2008-10 period has been directed towards improving the capacity of each Trust's children's service directorate, specifically to increase diagnostic/assessment and also intervention/support service capacity.

5.7.63 A single agreed diagnosis/assessment process is now being rolled out across N.Ireland. The Pathway document will further assist in addressing the previous lengthy waiting list position regionally. In addition, the inherent quality of service provision will be improved as the Care Pathway is incorporated into day-to-day practice by practitioners within Trusts. Implementation of the pathway will be accompanied by regional training.

Actions to Support Service Improvement

Research

5.7.64 The Bamford Review indicated a considerable number of areas of research need, L20/M50. The Action Plan sought to establish a prioritised plan for research with a timetable for delivery. In order to take this forward, the Health & Social Care

Research and Development Division of the Public Health Agency (HSC R&D Division) worked with users of research (policy-makers, practitioners and commissioners), service users and carers and researchers to determine the main priority areas. A series of Rapid Reviews was then commissioned to help refine the scope of subsequent research. The priority areas for rapid reviews were:

- Children & Young People
- Learning Disabilities
- Patient Outcomes
- Primary Mental Health Care
- Psychological Therapies, and
- Personality disorder

These reviews have been completed and will inform the future research programme.

Information systems

5.7.65 To ensure that mental health and learning disability services can be better planned to meet needs and monitored to ensure service improvement, an action was proposed, L43, to establish a regional anonymised database on inpatients in mental health and learning disability facilities and make it available at regional level for use by DHSSPS and HSC bodies. The action also proposed to extend the database to include users of community based services as a second phase. Phase One of this work is nearing completion, but Phase Two cannot be implemented at present due to the current resource position.

Bed Management Protocol

5.7.66 A draft Bed Management Protocol for learning disability hospitals has been developed, L57. It is expected that the final agreed Protocol will be implemented across all Trusts in 2012, this action has been carried forward into the 2012-2015 Action Plan.

Learning Disability Service Framework

5.7.67 Although indicating RED on the monitoring return, L41, the DHSSPS in association with other Departments has recently announced a public consultation on the Learning Disability Service Framework. The Framework recognises that improving the health and wellbeing of the population requires action right across society and acknowledges that health and wellbeing is influenced by many other factors such as poverty, housing, education and employment. The Framework reflects the full range of public service requirements for people with a learning disability and highlights the need for effective collaboration across sectors to meet these needs.

5.7.68 For people with a learning disability, the Framework details what they can expect in terms of care and support to meet their individual needs in ways that they understand and are accessible. For carers and families of people with a learning disability, it outlines what it is they can expect in terms of access to services for their family member and of their involvement as partners in the planning processes.

Summary

5.7.69 In the two years since the Plan's inception in 2009 the extent of services and programmes available has increased through the focus of the Bamford Vision; many of the outputs detailed in this section may not have been possible without this Vision. There are however areas where progress has not been sufficient, in some cases related to reduced funding levels. Consideration will be given to progressing these actions in the next phase of implementation.

6 OUTCOMES

6.1 Introduction

6.1.1 The previous section considers the substantial progress made in relation to progressing the actions in the 2009-2011 Action Plan over the last two years. It would however be unacceptable to reflect on these developments as the only measures of how effective, and reflective of the Bamford Vision, this Action Plan has been.

6.1.2 This section will consider the impact on service users, their carers and families. While it would be impossible to reflect the views of every stakeholder, the BMG has played a vital role over the past two years in representing the views of service users and carers and carrying out a number of studies on the effects of some of the key Bamford work areas. Studies completed in time to be reflected in this report are considered in the rest of this section.

6.2 Bamford Monitoring Group Reports

Is Bamford Making a Difference? - 23 June 2011

6.2.1 Hosted jointly with Mental Health Trialogue Network Ireland, this Bamford Monitoring Group day conference brought together 145 stakeholders - service users, carers, clinicians, service managers and policy developers. As well as a choice of focused workshops, delegates participated in a trialogue discussion on a key question – "How we will know if Bamford is making a difference?"

6.2.3 Participants acknowledged that the Bamford Review has initiated a change process and that significant seeds of change have been planted but that this process will take time to yield tangible outcomes. They acknowledged the longer timescale for delivery of the substantial change required to fulfil the Bamford Vision. In noting the achievements of the 2009-2011 Action Plan they also outlined their expectation to see more meaningful changes over the next few years.

6.2.4 Some frustration was expressed by delegates on the apparent emphasis on reviews and reports rather than using resources to improve services. Delegates agreed that service user and carer voices must continue to be heard in the decision making processes.

6.2.5 People said they would like more information on the range of services and alternative therapies available to them locally, including those offered by community and voluntary organisations. Community based and voluntary mental health services play an important role and it was suggested that statutory services should work with these organisations to support those affected by mental health issues. This is particularly significant because accessing mental health services, especially in times of crisis, remains an issue for some people.

6.2.6 People agreed that education and open discussion about mental health have an important role to play in decreasing stigma and discrimination around mental illness and in creating more compassionate communities

6.2.7 Delegates at this conference were able to identify positive changes within some mental health services over that last two years. Even though many did not readily link these improvements to the Bamford tag and others had not even heard of the Action Plan

Respite (Short Breaks)

6.2.8 The August 2011 Short Breaks Report from the Bamford Monitoring Group gave people with a learning disability or dementia, their carers and family members the opportunity to reflect on their experiences of respite provision. The views of over 700 people were gathered, either through a questionnaire or the Our Stories respite workshops.

6.2.9 The clear message from parents, carers and family members was that respite is an essential service. It was observed however that over the last 5 years regionally things have 'stayed the same' without any major enhancements to the provision of short breaks. Contributors to the report were however pragmatic, noting that respite allocation is limited while demand is high and resources are therefore stretched. This is however disappointing when over £3.8m has been allocated for increased respite provision for learning disability and dementia in the last 3 years.

6.2.10 There were gaps in provision noted; some local concerns were noted in the Northern and Western Trust where contributors believed that they have not received sufficient respite over the past 12 months and that respite services could be further improved.

6.2.11 The report observed that people would like more respite options and more alternatives to residential or nursing home accommodation. Provision of local information on what is available and how to access could also be improved.

6.2.12 Concerning Carer's Assessment and Direct Payments, carers and family members said that more advice and support was needed and that overall the benefit of a Carer's Assessment was questionable.

6.2.13 Further concerns were noted in relation to the flexibility of the service, advance bookings, confirmation of dates, respite for emergency or short-term breaks and transport to and from respite.

6.2.14 The provision of short breaks to people with dementia and their carers was perceived as being more problematic with concerns particularly noted regarding the general availability and the range and quality of facilities designed specifically to meet the needs of those with dementia.

6.2.15 This report reaffirms the importance of short breaks to services users, their carers and families. It is therefore essential that the services provided are fit for purpose and continue to be person centred. The areas for improvement highlighted within this report will assist in developing and reshaping future provision.

My Day My Way

6.2.16 This report gave people with a learning disability the chance to voice their opinions on the ways in which they spend their day and on the range of day services and opportunities available to them. Twelve hundred people with a learning disability, their parents, carers and family members took part in this process.

6.2.17 The report reveals that the majority of people with a learning disability were happy with how they spent their day and had many positive things to say about both day care services and day opportunities.

6.2.18 Contributors strongly expressed their belief that variety in their weekly activities and a balance between work, college, social enterprise, work skills training, drop-in or day centres was vital. However while many believed they had choice in the particular activities within their day centres, they had much less say in where they actually spent their day or in the range of activities provided. There was a sense amongst many that services are sometimes based on what is available rather than on the needs of the individual, and parents and carers highlighted the need for person-centred planning.

6.2.19 Some parents and carers also felt that there is a distinct lack of opportunities for people with more severe and complex disabilities and they highlighted the need for properly equipped and staffed centres to provide the necessary care and stimulation.

6.2.20 Most people in employment or education responded positively, valuing their jobs or courses, but issues were raised regarding impact of any earning on benefits and the diversity of courses available.

6.2.21 Contributors stated that more information and support was needed about the options available to advise them on the most appropriate service to meet their needs. Early planning for transition from children's to adult services was also seen important.

6.2.22 The report stresses the importance of continuing development of day opportunities to enable people with a learning disability to realise their full potential and support must be provided to enable people with a learning disability to understand the options available to them, and to help them make their own choices.

Online Mental Health Information for Young people

6.2.23 During the summer of 2011 20 young people with mental ill health in two focus groups carried out a "mystery shopper" evaluation of the five Health and Social Care Trust websites. The groups were tasked to investigate the ease of access to and the quality of information available on the Trust websites.

6.2.24 The young people identified a number of positive aspects of the information provided. One group found the 'CAMHS IN BRIEF' leaflet extremely useful. Others singled out the facility to enlarge text as a helpful feature.

6.2.25 The report identifies some difficulties young people had in locating relevant information on mental health services for young people when visiting websites for the first time. A considerable amount of guidance was necessary for people to find what they were looking for. Without this assistance many believed that the time spent locating it greatly outweighed the value of the information provided.

6.2.26 Most young people in the groups were not familiar with the terminology 'Child and Adolescent Mental Health Services' or the acronym CAMHS, so when these links came up they were not always recognised as relevant.

6.2.27 In summary, the report recommends that information on mental health services for young people on Health and Social Care websites must be:

- Easy to understand and relevant to young people
- Written using terms young people recognise
- Accessible within a few quick clicks, and
- Written by and for young people

Further Education

6.2.28 The views of 88 people with a learning disability contributed to the 2011 Bamford Monitoring Group report on Further Education.

6.2.29 The majority of contributors had positive things to say about the student experience. The report notes their experiences of learning new things, developing a greater sense of independence, working towards a goal and the feeling of achievement that comes from gaining qualifications.

6.2.30 Contributors also expressed their desire to see a more diverse range of courses available to people with a learning disability at college. Many felt that they were not involved enough when making the decision as to which course they take.

6.2.31 The report identified that going to college is clearly a valuable experience for many people with a learning disability and a significant step towards greater independence and progression into the workplace.

Summary

6.2.32 These Bamford Monitoring Group reports highlight many areas where existing services can be enhanced and where gaps in service provision exists. The wider recommendations and personal reflections have assisted in consideration of how the 2009-2011 Action Plan has progressed the Bamford Vision and will assist to inform the development of the follow-on Action Plan.

6.2.33 The full text of all these reports can be accessed at:
http://www.patientclientcouncil.hscni.net/bamford-monitoring-group

6.3 User and carer Overview

6.3.1 The second annual report from the Bamford Monitoring Group published in September 2011 summarises the work of the Group from September 2010 to August 2011 and reflects the findings from the reports detailed above in section 6.2.

6.3.2 On a wider scoping across these projects a number of themes and messages recur, including the following:

- Generally, people recognise that the Bamford Vision is beginning to make a positive difference to their lives; however, 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 interdepartmental working on realising the Bamford Vision. This has the potential to be a major detriment in the delivery of essential services and cause stress to individuals, families and carers.

7 LEARNING

7.1 Background

7.1.1 The aims of this evaluation as set out in Section 1.3 are:

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

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

7.1.3 We have been able to set out the key achievements in earlier sections of this document. These include:

- service enhancements and improved facilities;
- development of new regional policies and guidance;
- establishment of new monitoring, commissioning and implementation structures; and
- substantial progress towards the longer-term aim of legislation reform.

7.1.4 Much of this has been achieved through increased funding for mental health and learning disability services. We have been able to validate, through the monitoring process and via the feedback from service users, their carers and families, health and social care professionals and the voluntary and community sectors that change is happening, albeit slowly.

7.1.5 We must however balance these achievements against the challenges that still remain as we seek to improve the experiences of those who use and contact mental health and learning disability services. Additionally we must also reflect on those actions where we, as yet, have been unable to deliver all we set out to do in 2009 or where there were difficulties in verifying achievements. Much remains to be done. As we move forward with development of a further Action Plan, there are lessons to be drawn from the work on the 2009-211 Plan.

7.2 Key learning experiences

Monitoring and measurement

7.2.1 The regular cross-Departmental monitoring of progress on the Action Plan allowed all stakeholders including the representatives of service users and carers to readily identify those actions falling behind on delivery expectations and take remedial action where possible. Use of the same system at the end of the Action Plan period gave a clear indication of those actions completed and those, as yet, not achieved.

7.2.2 A number of quantified targets were set with the baseline period indicated in the Action Plan. The substantive data to back up these targets proved difficult to obtain for some quantifiable actions. The respite actions were a case in point where clarity on definitions and measures has been reached only recently.

7.2.3 In some instances however the outputs specified in actions have not yet been fully evaluated or the programme has a longer running term than the two years of the Action Plan.

7.2.4 The monitoring and measurement of the proposed 2012-2015 Bamford Action Plan must therefore be robust enough to give clarity and assurance with regard to achievements.

7.2.5 Stakeholders should consider:

- A Specific Measurable Achievable Realistic Time bound (SMART) template for all actions.
- Clarity on service and outcome definitions.
- Specific in-house measurement systems, where necessary, for each action, and
- The system for overall monitoring .

7.2.6 HSC Taskforce Outcome Indicators

The HSC Taskforce is developing a set of high level outcome indicators for both mental health and learning disability. Indicators include deaths from suicide, numbers on GP depression registers, survey data on numbers of people with potential psychiatric disorder, resettlement and day opportunities etc. The nature of these outcome measures means that any measureable change is likely to some time away, but the establishment of the indicator set will provide a solid foundation for longer-term evaluation of the Bamford programme of work.

Responsibility

7.2.7 The 2009-2011 Action Plan tables indicated the Department or agency with lead responsibility for taking forward each action. Many of the actions in the 2009-2011 Action Plan, particularly those in the health and social care sector, were directed to developing guidance/policies/action plans with a longer-term objective that existing services would be enhanced or new services put in place to progress the Bamford Vision. While DHSSPS was the lead body for the initial phase of the action, responsibility for implementation then moved to the HSC. This was not always adequately reflected in the Action Plan and in the monitoring systems. Also when the 2009-2011 Action Plan was being developed, the HSB Taskforce had not been established and ownership of some of the actions attributed to the HSC was unclear.

7.2.8 The HSC Taskforce is now well established with a number of working groups addressing specific service developments. This structure will help to clarify where lead responsibility lies for individual action in the next Action Plan.

7.2.9 Consideration should be given to

- Identification of a lead body/ individual for each action, and
- Tracking of that lead role throughout the life of the follow-on Plan.

Cross-sectoral working

7.2.10 The endorsement and support from the Northern Ireland Executive from an early stage in the Bamford processes has resulted in Ministerial and senior official level commitment of all the Departments with responsibility for delivery of the Bamford Vision.

7.2.11 This high level commitment has achieved much; cross-Departmental funding on housing and education issues, bi-lateral working on many mental health and learning disability issues.

7.2.12 In the course of stakeholder engagement for this evaluation some issues were raised concerning the resolution of some more practical issues around interdepartmental engagement. These tend to be at operational level and illustrate the need for collaboration at both strategic and operational level.

7.2.13 Stakeholders should consider:

- How best to structure future cross-sectoral interfaces particularly at local level.

Access to information

7.2.14 Continuing difficulties in obtaining local relevant up-to-date information on services have been highlighted in several of the recent Bamford Monitoring Group reports. While work was undertaken over the period 2009-2011 to improve information systems in both mental health and learning disability, we must accept that these systems are not yet fully meeting the needs of service users and carers.

7.2.15 There were three main areas for improvement flagged during the collation of evidence for this evaluation:

- the need for the information to be current;
- the requirement that information should be as local as possible, and
- the ease of accessibility.

7.2.16 Further work will be needed in the next Action Plan with regard to future provision, taking advantage where possible of new and emerging technologies.

7.3 The Bamford Vision in 2011

7.3.1 From the first Bamford Adult Mental Health Report published in 2005 to the end of the first Bamford Action Plan in 2011, servicer users, their carers, families, clinicians, health and social care professionals, and the voluntary and community sectors have experienced a process of change impacting on many areas and levels of mental health and learning disability services.

7.3.2 Over and above the Bamford Review's 700 published recommendations, the actions in the 2009-2011 Action Plan or even what actions may be within the next Plan, the Bamford Vision has in some ways had a much deeper impact than even the Review team could have envisaged. The thinking of many stakeholders has changed from a begrudging acceptance of what needs to be done to deliver the Bamford Vision, to an embedding of the Bamford ethos at all levels of government and administration. This deep rooted cultural change is in some ways a much stronger and more lasting testament of the achievements of the Bamford Review, than delivering a distinct number of actions or recommendations. It is perhaps this rather than any present structure or action plan that will carry the Bamford Vision into the future and well past the original 10-15 year lifespan.

7.3.3 The ongoing use of the Bamford title has been a topic for discussion as this 2009-2011 Action Plan draws to a close. During the course of this evaluation some stakeholders have expressed the view that the Bamford title has been superseded and should be replaced since some of the Review recommendations have been overtaken by more recent developments. Others want to see the Bamford title retained as a link back to the original Bamford Review.

7.3.4 It would be difficult to create a new title that invokes the same passion, and covers the whole range of mental health and learning disability services as the term "Bamford" achieves. We are now at a point where the Bamford ethos has been embedded in stakeholder culture.

7.3.5 It is fitting therefore, both for reasons of practicality and to maintain the ethos of the Review, that the follow-on Action Plan should still bear the Bamford title.

7.3.6 The 10 to 15 year programme of reform envisaged by the Bamford Review for service development has commenced and much has been achieved, there is still much to do.

Annex A

Quantifiable Targets

Learning Disability Actions

DEPT	KEY ACTIONS	OUTPUT REQUIRED	OUTPUT ACHIEVED
HSC	Resettlement of long stay patients from learning disability hospitals	a) 25% reduction in the number of long-stay patients in learning disability hospitals (baseline 2007/08) b) Anyone who has a learning disability is promptly and suitably treated in the community and no-one remains unnecessarily in hospital	a) Numbers in long stay LD hospitals 2007 – 346 2008 – 322 2009 – 253 2010 – 205 2011 - 205 41% reduction **ACHIEVED** resettled numbers 07/08 – 39 08/09 – 75 09/10 – 87 10/11 – 116
HSC	Support for individuals with a learning disability and their carers and families by the provision of short breaks and respite opportunities	The provision of 200 additional respite packages benefitting 800 people (baseline 2007/08)	Original target of 200 packages reduced to 125 as a result of CSR budgetary cuts announced in 2010/2011. Latest PFA data indicates 225 packages delivered. **ACHIEVED**
HSC	Increase uptake of Direct Payments	Double the number of recipients of Direct Payments in learning disability programme of care (baseline June 2007)	DHSSPS figures At 30/6/2007 **160** At 31/03/2011 **561** **ACHIEVED**

HSC	Maintain direction of HSC funding towards community based services	At least 80% of HSC spend on learning disability services should be on community services	LD community funding 82% 2010/2011 **ACHIEVED**

Mental Health Actions

DEPT	KEY ACTIONS	OUTPUT REQUIRED	OUTPUT ACHIEVED
DHSSPS	Implementation of the Protect Life Action Plan	Reduce overall suicide rate by 15% by 2011 (baseline: 2004-06)	rate per 100,000 of population 04/06 - 12.6 05/07 - 14.3 06/08 – 15.5 07/09 – 14.7 08/10(p) – 15.9 **NOT ACHIEVED**
DHSSPS	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	a) 5% reduction in the proportion of adults who binge drink (baseline - Adult Drink Patterns Survey 2005) b) 10% reduction in the proportion of young people who report getting drunk (baseline - Young People's Behaviour and Attitudes Survey 2003) c) 5% reduction in the proportion of young adults taking illegal drugs (baseline – Drug Prevalence Survey in Ireland and Northern Ireland 2002/3)	**a)** Baseline - 38% March 2005 Target - 36% March 2010 Latest position - 32% 2008 **ACHIEVED** **b)** Baseline - 33% March 2003 Target - 30% March 2010 Latest position - 23% 2010 **ACHIEVED** **c)** Baseline - 6.1% March 2003 Target – 5.8% March 2010 Latest position - 5.7% 2010/11 **ACHIEVED**
HSC	Increase uptake of Direct Payments	Double the number of recipients of Direct Payments in mental health programme of care (baseline June 2007)	DHSSPS figures At 30/6/2007 **35** At 31/03/2010 **81** **ACHIEVED**

HSC	Resettlement of long stay patients from mental health hospitals	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	resettled numbers 07/08 – 52 08/09 – 110 09/10 – 164 10/11 – 181 **ACHIEVED** For the period 1 April 2007 to 31st January 2011, 181 long-stay patients in mental health hospitals were resettled against a PfA target to resettle 90 patients by 31 March 2011. This in excess of 10% of the long stay patients at 07/08.
HSC	Improve respite care for people with dementia	Additional 2000 places per year (baseline 2007/08)	Original target of 2000 packages reduced to 1200 as a result of CSR budgetary cuts announced in 2010/2011. The latest data from PfA returns indicates 4858 additional places provided. **ACHIEVED**
DHSSPS PHA	Implementation of Hidden Harm Action Plan – supporting the needs of children and young people born to or living with substance misusing parents or carers	10% reduction in the number of children at risk from parental alcohol and/or drug dependency (baseline under development)	Proxy measures show no change **NOT ACHIEVED**
HSC	Re-direction of HSC funding towards community based services	60% of HSC spend on mental health services should be on community services.	MH community funding 53% 2010/2011 **NOT ACHIEVED**

HSC	Increase levels of community mental health services	a) 240 additional staff in community mental health services (baseline 2007/08) b) 10% reduction in admissions to mental health hospitals (baseline 2007/08)	a) 269 additional staff in MH Services. b) 07/08 6651 09/10 6018 633 reduction – 10% **ACHIEVED**
DHSSPS HSC	Establish procedures to ensure people leaving hospital who need continuing mental health care receive it	From April 2009, all mental health patients discharged from hospital who are to receive a continuing care plan in the community should receive follow-up within 7 days of discharge	For the period 1 April 2010 to 31st January 2011, **95%** of patients discharged from hospital who were to receive a continuing care plan received follow-up within 7 days of discharge **ACHIEVED**

Annex B

Learning disability Actions

L1	HSC	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 mu	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 • 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	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	GREEN
L2	DHSSPS	Publish a revised cross-sectoral Promoting Mental Health Strategy	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	RED **Strategy re-prioritised and carried forward to Follow-on Action Plan.**

L3	HSC	Increase oral health promotion programmes aimed at clients with a Learning Disability and their families	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 re	**RED** **The inability to fill a consultant's post, L50, had a impact on all actions relating to oral health provision.**
L4	DE	Develop, consult and implement a 10 year Early Years Strategy.	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	**GREEN**
L5	DE	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 e	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	**GREEN**

L6	DE	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	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	**GREEN**
L7	DE	Develop proposals for developing resilience among primary aged pupils and those in special schools for consultation; to implement agreed new services		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	**GREEN**
L8	DE	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	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	**GREEN**

L9	DCAL	Implement a 10 year Strategy for Sport and Physical Recreation	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	**GREEN**
L10	DHSSPS	Progress the Tackling Sexual Violence and Abuse Strategy 2008-2013	Annual action plans implemented to achieve strategic objectives	Ongoing	Reduce levels of mental trauma as result of sexual violence and abuse	**GREEN**
L11	DHSSPS	Implement the domestic violence strategy Tackling Violence at Home	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.	**GREEN**
L12	DEL	Commission a scoping study of Pastoral Care arrangements in FE	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	**GREEN**

L13	DHSSPS	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	Redesign of Child Health Promotion Programme to ensure best practice is being delivered	Implementation from 1 January 2010 ***** REVISED 1 MAY 2010*****	Early identification of disability to secure early intervention and support	**GREEN**
L14	HSC	Increase access to dental hygienists for education and regular appointments	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	**RED** **The inability to fill a consultant's post, L50, had a impact on all actions relating to oral health provision.**
L15	OFMDFM	Publish a report on the 'Promoting Social Inclusion' work led by OFMDFM 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	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; • Le	**GREEN**

L16	OFMDFM	Publish an action plan for the implementation of recommendations arising from the PSI report (above)	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	**RED** **Work to develop the associated Action Plan has not been completed in the timescale envisaged. Work on this is being taken forward alongside work to publish the Executive's response to the PSI working group's report on Disability**
L17	DE	Mainstream the funding of 5 Education and Library Board Transition Service Pilot Project, subject to positive outcome of ETI Inspection Report	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	**GREEN**

L18	DE	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 ed	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	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	**GREEN**
L19	DE	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	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 pos	**GREEN**
L20	DRD	Commission research to ascertain the impact on people with learning difficulties of the policies and actions contained in the Accessible Transport Strategy	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	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	**GREEN**

L21	DEL	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	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	**GREEN**
L22	DEL	Consider the findings of the overarching review and any strategic implications for DEL and develop an action plan	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	**GREEN**
L23	DEL	Undertake scoping study of provision for those not in education, training or employment (NEET), including those with mental ill-health and/or learning disability	Determination of available provision	Scoping study completed by Autumn 2009	Improved information to enable consideration of need for cross-Departmental strategic approach/ further actions	**GREEN**

L24	DEL	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 add	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 asses	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	**GREEN**
L25	W5	Develop new exhibitions / exhibits to include provision for those with learning difficulties	Include exhibits/Exhibitions with sensory experiences, graphics and limited text to be inclusive to those with learning difficulties.	Ongoing	Inclusion and enjoyment in exhibition	**GREEN**

L26	DSD	Carry out a policy evaluation of the Supporting People programme	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	Mar-10	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it	**GREEN**
L27	DSD	Collaborative work between DSD, NIHE, DHSSPS and HSC	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	**GREEN**

L28	CHR	Publish action plan of how NICS will promote diversity	Equal opportunities monitoring of the NICS workforce. Review the 2008 – 2011 NICS Employment, Equality and Diversity Plan	Dec-09	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 pos	**GREEN**
L29	CHR	To develop mandatory equal opportunities and diversity awareness training to all staff at all levels within the NICS	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	**GREEN**

L30	PHA	Improve communication methods and access to information for people with a learning disability	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	Ongoing	Better support for service users and carers in understanding the services and making their views heard	**GREEN**
L31	DE	Education and Library Boards to continue to develop their information and advice service	Improvement of statutory information and advice service	Ongoing	Better support and advice for parents, pupils and schools in understanding the services available	**GREEN**

L32	HSC	Resettlement of long stay patients from learning disability hospitals	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	**GREEN**

L33	HSC	Development of a plan by Local Commissioning Groups demonstrating what advocacy services are currently in place and the vision for the future	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	**RED** **Work was not completed in line with target and is carried forward to follow-on Plan**
L34	DHSSPS	Complete a joint Review of Support Provision for Carers	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	**GREEN**

L35	DHSSPS HSC	Improve regional information on provision of respite care	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	**GREEN**
L36	HSC	Support to families with a child with a learning disability	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	Mar-11	Families will be provided with more co-ordinated support at an earlier stage	**GREEN**
L37	HSC	Support for individuals with a learning disability and their carers and families by the provision of short breaks and respite opportunities	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-di	Mar-11	People will be afforded more flexible respite options which will help maintain their care settings by supporting their carers.	**GREEN**
L38	HSC	Increase uptake of Direct Payments	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	**GREEN**

L39	DHSSPS HSC	Provide a service wide, supportive, quality driven environment to promote Personal and Public Involvement, (PPI), in planning, commissioning, delivery and evaluation of services	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	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	**RED** **A number of Working Groups have been established to progress this action. It will be carried forward to the follow-on Plan.**
L40	HSC	Maintain direction of HSC funding towards community based services	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	**GREEN**

L41	DHSSPS	Develop a Service Framework for learning disability services	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	**RED** **Resource allocations delayed development. To be published at the end of 2011.**
L42	HSC	Increase levels of community learning disability services	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	**GREEN**
L43	HSC	Improve information systems on provision and use of mental health and learning disability services	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	**RED** **Phase one completed, resourcing restrictions impacted second phase of programme.**

L44	PHA HSC	Complete and maintain a map of learning disability services across Northern Ireland	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	**RED** **Resources not available to carry out. Carried forward to follow-on plan**
L45	DHSSPS HSC	Review range of facilities used to provide both inpatient and community based mental health and learning disability services and agree future pattern of provision	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	**GREEN**

L46	DHSSPS	Complete a workforce planning study for mental health and learning disability health and social care services	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	**GREEN**
L47	DHSSPS	Improve services for people with challenging behaviours and their carers	Production of agreed regional guidelines in partnership with service providers and the voluntary sector on the management of challenging behaviours within services	Mar-11	Assist carers in managing challenging behaviours e.g. by directing to appropriate "behaviour services"	**GREEN**
L48	DHSSPS DE	Improve collaboration between education and health sectors in meeting the educational needs of children and young people with significant challenging behaviours	Production of agreed protocols	Mar-10	Smooth transition between health and education services to appropriate placements	**GREEN**
L49	DHSSPS HSC	Training of primary dental care professionals to improve quality of care provided to patients with a Learning Disability	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	**RED** **The inability to fill a consultant's post, L50, had a impact on all actions relating to oral health provision.**

L50	DHSSPS HSC	Establish consultants in Specialist Care Dentistry (SCD)	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	RED **Consultant's post was filled for only a short time. Difficulty in recruiting to fill the post.**
L51	DHSSPS HSC	Establish training pathways in Specialist Care Dentistry (SCD)	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	RED **The inability to fill a consultant's post, L50, had a impact on all oral health provision.**

L52	HSC	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	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	**GREEN**
L53	HSC	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	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	**GREEN**
L54	HSC	Develop a plan for a community LD Forensic Service	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	**GREEN**

L55	DHSSPS	Inclusion of learning disability in all service frameworks.	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 disa	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	**GREEN**
L56	DHSSPS	Completion of a needs assessment to inform the future need for and provision of learning disability services.	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.	**GREEN**
L57	DHSSPS	Improve the experience of those with a Learning Disability accessing the HSC in all care settings	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.	**GREEN**

L58	DHSSPS HSC	Improve the information provided to people with a learning disability to ensure appropriate health and social care is given where needed.	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 o	Ongoing	Enhanced exchange of information between individuals, their families and carers and HSC Services.	**GREEN**
L59	HSC	Develop a Regional Bed Management Protocol for those with a learning disability.	A bed management protocol which will cover the 5 Trusts and 3 hospitals	Dec-09	Safer and more effective access to care for those with a learning disability	**GREEN**
L60	DHSSPS HSC	Increase the provision of person – centred day opportunities (including employment provision) for people with a learning disability that facilitate integration into the community	Provide better day support opportunities, including employment opportunities, recognising the impact of demographic changes	Mar-11	Opportunities tailored to the needs of people with a learning disability promoting their inclusion in society	**GREEN**
L61	DE	Improve transitions planning for all children with statements of special educational needs	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	**GREEN**

L62	HSC	Establish Health and Social Care Mental Health and Learning Disability Task Force	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	**GREEN**
L63	PCC	Establish Bamford Monitoring Group	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	**GREEN**
L64	DHSSPS	Inter-Departmental Ministerial and Implementation groups to continue	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	**GREEN**
L65	DHSSPS	Introduce new mental capacity and mental health legislation	Commence new mental capacity and mental health legislation	Post 2011, exact timing depending on legislative programme Initial objective is to have Ministerial and Executive clearance to policy proposals by Spring 2010.	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	**GREEN**

L66	DHSSPS	Introduce a small amendment to the Mental Health (NI) Order to enable patients to apply to the court to replace their nearest relative	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	**RED** **Instructions completed and amendments drafted, awaiting clearance to proceed.**
L67	DHSSPS	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	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	**GREEN**

Mental Health Actions

M1	DHSSPS	Publish a revised cross-sectoral Promoting Mental Health and Wellbeing Strategy	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	**RED** **Strategy re-prioritised and carried forward to Follow-on Action Plan.**

M2	DHSSPS	Implementation of the Protect Life action plan	Reduce overall suicide rate by 15% by 2011 (baseline: 2004-06)	Ongoing	Decrease risk of people taking their own lives	**RED** **Bamford sub-group established local regional and all island actions plans have been implemented. Outcome target not achieved. Carried forward to follow-on Plan.**
M3	DHSSPS	Implementation of Health Committee recommendations on the prevention of suicide and self harm	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	**GREEN** **(recommendations actioned)**
M4	DE	Develop, consult and implement a 10 year Early Years Strategy	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	**GREEN**

M5	DE	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 e	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.	**GREEN**
M6	DE	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	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	**GREEN**
M7	DE	Sustain the Independent counselling support service for pupils in post primary schools	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	**GREEN**
M8	DE	Develop proposals for developing resilience among primary aged pupils and those in special schools for consultation; to implement agreed new services	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	**GREEN**

M9	DE	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	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	**GREEN**
M10	DE	Progress ongoing work of the DE Safeguarding Co-ordination Group	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	**GREEN**

M11	TNC	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) • Centralisation of counselling services for	Reduction in incidence of bullying and harassment Improved level of support available to teachers Greater clarity for schools in dealing with and preventing this problem For issue to schools during 2010-11 year.	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 Ongoing from 1 April 2009 A workshop to consider revised guidance was h	Potential benefits to all teachers Benefits to teachers who have been bullied or have other mental health issues Will benefit schools whose staff have been abused. Includes a Desk Aid to help all teachers prevent incidents of abuse and deal with them when they do occur.	**GREEN**
M12	DEL	Commission a scoping study of Pastoral Care arrangements in FE	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	**GREEN**

M13	DCAL	Implement a 10 year Strategy for Sport and Physical Recreation	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	**GREEN**
M14	HSENI	Publish guidance for employers in general on "Creating a working environment that encourages Mental Wellbeing"	All employers will be better equipped to address workplace mental wellbeing issues.	Dec-09	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	**GREEN**
M15	HSENI	Set up a Stress and Mental Wellbeing Unit comprising health and safety inspectors and business advisors to focus on high stress risk work sectors	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 system	Dec-09	In high stress risk work sectors see, as a result of reduced stress related ill health and associated absenteeism, increased productivity	**GREEN**

M16	DHSSPS	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	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% red	By 2011	Reduce levels of harm related to alcohol and drug misuse	**GREEN**
M17	DHSSPS	Progress the Tackling Sexual Violence and Abuse Strategy 2008-2013	Annual action plans implemented to achieve strategic objectives	Ongoing	Reduce levels of mental trauma as result of sexual violence and abuse	**GREEN**
M18	DHSSPS	Implement the domestic violence strategy Tackling Violence at Home	Annual action plans implemented to achieve strategic objectives	Ongoing	Reduce levels of mental trauma as result of domestic violence and abuse	**GREEN**
M19	HSC	Implement the recommendations and associated actions arising from the Review of School Nursing and Health Visiting, once agreed post-consultation	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	**GREEN**

M20	OFMDFM	Publish a report on the 'Promoting Social Inclusion' work	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	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; • Le	**GREEN**
M21	OFMDFM	Publish an action plan for the implementation of recommendations arising from the PSI report (above)	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	**RED** **Work to develop the associated Action Plan has not been completed in the timescale envisaged. Work on this is being taken forward alongside work to publish the Executive's response to the PSI working group's report on Disability. Carried forward to follow-on plan**
M22	OFMDFM	Establish an initial assessment of the mental health needs of victims and survivors through a Comprehensive Needs Assessment	Better information on the extent of the impact of the Troubles on the mental health needs of victims and survivors	Sep-09	Better planning of services for victims and survivors	**GREEN**

M23	OFMDFM	Bring forward primary legislation to establish the Office of Commissioner for Older People	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	**GREEN**
M24	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	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	5 years from October 2009	People affected by mental ill health and their families have improved access to information and support	**GREEN**
M25	DEL	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 Learn	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	**GREEN**

M26	DEL	Consider the findings of the overarching review (above) and any strategic implications for DEL and develop an action plan	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	**GREEN**
M27	DEL	Undertake scoping study of provision for those not in education, training or employment (NEET), including those with mental ill-health or learning disability	Determination of available provision	Scoping study completed by Autumn 2009	Improved information to enable consideration of need for cross-Departmental strategic approach/ further actions	**GREEN**
M28	DEL	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	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	**GREEN**

M29	DEL	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 an	A range of clear and accessible information resources	Summer 2010	Better informed decision making in terms of future education, employment and training options available	**GREEN**

M30	DEL	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 add	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 asses	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	**GREEN**
M31	DSD	Carry out a policy evaluation of the Supporting People programme	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	Mar-10	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it	**GREEN**

M32	DSD	Collaborative work between DSD, NIHE, DHSSPS and HSC	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	**GREEN**
M33	CHR	Publish action plan of how NICS will promote diversity	Equal opportunities monitoring of the NICS workforce. Review the 2008 – 2011 NICS Employment, Equality and Diversity Plan.	Dec-09	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 pos	**GREEN**
M34	CHR	Develop mandatory equal opportunities and diversity awareness training to all staff at all levels within the NICS	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	**GREEN**
M35	HSC	Additional information and advice services for mental health service users and their carers	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	**RED** **Resources not available to complete. To be carried forward to follow-on Plan**
M36	HSC	Increase uptake of Direct Payments	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	**GREEN**

M37	HSC	Resettlement of long stay patients from mental health hospitals	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.	**GREEN**
M38	DHSSPS	Implementation of harm reduction strategies, including needle and syringe exchange and substitute prescribing	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	**GREEN**
M39	DHSSPS DSD	Complete a joint Review of Support Provision for Carers	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	**GREEN**
M40	DHSSPS	Improve regional information on provision of respite care	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	**GREEN**

M41	HSC	Improve respite care for people with dementia	Additional 2000 places per year (baseline 2007/08)	By March 2011	Improve access to respite care	**GREEN**
M42	HSC	Additional information and advice services for mental health service users and their carers	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	**RED** **Resources not available to complete. To be carried forward to follow-on Plan**
M43	HSC	Increase uptake of Direct Payments	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	**GREEN**
M44	DHSSPS PHA	Implementation of Hidden Harm Action Plan – supporting the needs of children and young people born to or living with substance misusing parents or carers	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	**RED** **Action progressing at regional and local level however outcome target not achieved.**

M45	DHSSPS HSC	Provide a service wide, supportive, quality driven environment to promote Personal and Public Involvement, (PPI), in planning, commissioning, delivery and evaluation of services	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. Mon	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	**RED** **A number of Working Groups have been established to progress this action. It will be carried forward to the follow-on Plan.**
M46	HSC	Re-direction of HSC funding towards community based services	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	**RED** **Work progressing. However outcome target not achieved. Carried forward to follow-on Plan,**

M47	DHSSPS HSC	Develop a Service Framework for mental health services and commence implementation	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	**GREEN**
M48	DHSSPS HSC	Review range of facilities used to provide both inpatient and community based mental health and learning disability services and agree future pattern of provision	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	**GREEN**

M49	DHSSPS HSC	Complete a workforce planning study for mental health and learning disability health and social care services	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	**GREEN**
M50	DHSSPS PHA	Develop and take forward a prioritised plan for research on mental health and learning disability issues	Plan agreed with a timetable	Jun-10	Service provision informed by local research on needs and on evidence of what works	**GREEN**
M51	HSC	Improve information systems on provision and use of mental health and learning disability services	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.	**RED** **Phase one completed, resourcing restrictions impacted full programme.**
M52	PHA	Complete and maintain a map of mental health services across Northern Ireland	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	**RED** **It is anticipated that work will be completed within 12 months.**

M53	HSC	Develop a stepped care model for mental health services	A regionally agreed model across all HSC services	By March 2010	People should be able to access mental health services appropriate to their needs	**GREEN**
M54	HSC	Increase levels of community mental health services	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	**GREEN**
M55	DHSSPS	Develop a strategy for improving access to psychological therapies	Strategy to be agreed	By October 2009	Improved access to psychological therapies	**GREEN**
M56	HSC	Introduce a computerised Cognitive Behavioural Therapy programme	Introduce programme and monitor uptake and patient outcomes	Ongoing	Improved support for those with mild to moderate depression	**GREEN**

M57	DHSSPS HSC	Develop regional guidance on assessment and management of risk in mental health and learning disability services	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.	**GREEN**
M58	DHSSPS HSC	Develop regional prescribing guidance on anti-psychotic medicines for primary and secondary care sectors	Provide regional guidance to those prescribing anti-psychotic medicines	Mar-10	Ensure that anti-psychotic medicines are prescribed and managed appropriately	**GREEN**
M59	DHSSPS HSC	Develop pilot of community pharmacy medicines management initiative for people with mental health needs	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	**GREEN**
M60	DHSSPS HSC	Establish specialist medicines management clinics for people who have been prescribed benzodiazepines	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	**GREEN**

M61	DHSSPS	Develop a strategy for services for people with a personality disorder	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	**GREEN**
M62	DHSSPS HSC	Establish procedures to ensure people leaving hospital who need continuing mental health care receive it	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	**GREEN**
M63	DHSSPS HSC	Establish procedures to ensure people presenting at A&E departments who need continuing mental health care receive it	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	**GREEN**

M64	DHSSPS HSC	Improve and harmonise model for crisis intervention services	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	**GREEN**
M65	HSC	Appoint a Service Improvement lead for mental health and learning disability in each HSC Trust	Ensure that service improvement in mental health and learning disability services is given sufficient focus	Apr-10	People using mental health and learning disability services have access to high quality, efficient and effective care and treatment	**GREEN**

M66	HSC	Introduce inpatient services for eating disorders	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	**RED** **Trusts are working together to progress the development of local in-patient service capacity in terms of sharing knowledge and skills.**
M67	DHSSPS HSC	Improve Perinatal mental health services	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	**GREEN**

M68	HSC	Improve interface between adult mental health services and child care services.	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.	**GREEN**
M69	PHA	Provide a mental health information resource for young people and their families	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	**RED** **Resources not available to carry out. This will be carried forward through future service mapping.**
M70	HSC	New facilities with 33 mental health inpatient beds provided for children and young people up to the age of 18	New linked units for children and young people who require inpatient mental health treatment	By 2010	Increased inpatient provision in new purpose-built facilities	**GREEN**
M71	DHSSPS HSC	Develop a strategy for dementia services, including the needs of younger adults.	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	**RED** **Strategy to be published later in 2011.**

M72	DHSSPS HSC	Support the Northern Ireland Dementia Services Development Centre	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	**GREEN**
M73	HSC	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.	A co-ordinated approach across HSC and criminal justice agencies to improve forensic services	Sep-09	Better joined up services for people who need forensic services	**GREEN**
M74	DHSSPS HSC	Conduct a review and produce a strategy to increase the provision of low secure and community forensic placements	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	**GREEN**
M75	HSC	Establish Health and Social Care Mental Health and Learning Disability Task Force	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	**GREEN**

M76	PCC	Establish Bamford Monitoring Group	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	**GREEN**
M77	DHSSPS	Inter-Departmental Ministerial and Implementation groups to continue	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	**GREEN**
M78	DHSSPS	Introduce new mental capacity and mental health legislation	Commence new mental capacity and mental health legislation	Post 2011, exact timing depending on legislative programme Initial objective is to have Ministerial and Executive clearance to policy proposals by Spring 2010.	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	**GREEN**
M79	DHSSPS	Introduce a small amendment to the Mental Health (NI) Order to enable patients to apply to the court to replace their nearest relative.	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	**RED** **Instructions completed and amendments drafted, awaiting clearance to proceed.**

M80	DHSSPS	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	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	**GREEN**

ANNEX C

Glossary of abbreviations

ASD	Autism Spectrum Disorder
BTB	Beating the Blues
CAMHS	Child and Adolescent Mental Health Services
CAN	Comprehensive Needs Assessment
CRHT	Crisis Response Home Treatment
CSIG	Carers' Strategy Implementation Group
CSR	Comprehensive Spending Review
CYPSP	Children and Young People's Strategic Partnership
DCAL	Department of Culture, Arts and Leisure
DE	Department of Education
DEL	Department of Employment and Learning
DES	Directed Enhanced Service
DETI	Department of Enterprise, Trade and Investment
DFP	Department of Finance and Personnel
DHSSP	Department of Health and Social Services and Public Safety
DOJ	Department of Justice
DOLS	Deprivation of Liberty Safeguards
DRD	Department of Regional Development
DSD	Department of Social Development
ECrHR	European Court of Human Rights
ESF	European Social Fund
ETI	Education and Training Inspectorate
FE	Further Education
GP	General Practitioner
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSENI	Health and Safety Executive Northern Ireland
IDG	Inter-Departmental Group
IMTAC	Inclusive Mobility Transport Advisory Committee
LD	Learning Disability
MH	Mental Health
NEET	Not in Education, Employment or Training
NICS	Northern Ireland Civil Service
NICVA	Northern Ireland Council for Voluntary Action
NIHE	Northern Ireland Housing Executive
OFMDFM	Office of the First Minister and Deputy First Minister
PCC	Patient and Client Council
PEHAW	Pupils Emotion Health and Well-being
PHA	Public Health Agency

PSI	Promoting Social Inclusion
RQIA	Regulatory Quality Improvement Authority
SCIE	Social Care Institute for Excellence
SOU	Special Olympics Ulster
TfS	Training For Success
UNOCINI	Understanding The Needs of Children in Northern Ireland
WTE	Whole Time Equivalents

From the Chief Medical Officer
Dr Michael McBride

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

BY EMAIL

Mrs Valerie Watts
Chief Executive
HSCB/PHA

Castle Buildings
Upper Newtownards Road
Belfast BT4 3SQ
Tel: [redacted]
Email:
[redacted]

Our Ref: HE3-19-395
Your Ref:
Date: 22 March 2019

Dear Valerie

SERVICE FRAMEWORK PROGRAMME

The Service Framework Programme Board met in December and discussed the current position of the Programme and what should be done next. I have been briefed on the conversation at SFPB and the decisions taken and felt it was best to formally communicate the Department's position to you and the wider HSC.

RQIA was asked to carry out a review of the Service Framework Programme but due to competing priorities this work has been paused. It is not clear at this time when the review will recommence. In the meantime a number of service frameworks (Respiratory, Learning Disability and Cardiovascular) have come to the end of their lifecycle with another (Older People) due to end this year.

The SFPB is content that under the circumstances these service frameworks will conclude and I am not going to commission the HSCB/PHA to develop new service frameworks in these areas. In addition, I am not proposing RQIA conduct a formal review of each framework as has been the case up to now.

I would ask that any KPIs rated as either amber or red will continue to be worked on by the Trusts in collaboration with the Service Framework lead to address the deficiencies identified.

With regards to the three service frameworks in development the SFPB is content that the Children's and Young People and the Mental Health Service Frameworks are processed to the point of being ready for launch but that any further work will be paused until the SFPB make a decision on the future of the Programme.

The Cancer SF can also be progressed, subject to available resources within PHA/NICaN and I understand that Departmental colleagues will be seeking a meeting with Hugh McCaughey and Louise Herron to discuss this in the near future.

I was sorry to have missed the SFPB meeting but was encouraged to hear that a full and frank exchange of views took place. I would like to be able to continue these discussions at our next meeting with a view to coming to some decisions on the future of the Programme.

Yours sincerely

DR MICHAEL McBRIDE
Chief Medical Officer

cc Chief Executive, HSC Trusts
Adrian Mairs
Miriam McCarthy
Marie Roulston
Service Framework Leads
SFPB members