Workforce Planning in Mental Health and Learning Disability: Implementation of Bamford Review Recommendations

FINAL REPORT

June 2009

Deloitte.

Deloitte.

Deloitte MCS Limited
Consulting
19 Bedford Street
Belfast
BT2 7EJ

Contents

Appendices

1 INTRODUCTION & CONTEXT

1.1 INTRODUCTION

Deloitte MCS Limited was commissioned by the Department of Health Social Services and Public Safety (DHSSPS) to undertake a workforce planning review to support the implementation of the recommendations of the Bamford Review of Mental Health and Learning Disability. There is a commitment at ministerial level to implement the findings of the Bamford Review in an effort to build on mental health and learning disability services in Northern Ireland. This report presents the findings from the review.

1.2 CONTEXT

The Bamford Review of Mental Health and Learning Disability (MHLD) services was the first ever comprehensive investigation of the services, policies and legislation for people with learning disabilities and mental health needs in Northern Ireland. The review was prompted by recent comparable reviews in neighbouring jurisdictions, the need to ensure that law, policy and practice meets human rights and equality laws, and the need to maintain services that meet good practice recommendations. The review was a huge undertaking, involving health and social care professionals, service users and carers, service providers and policy makers from across the MHLD spectrum. Ten reports were published that included examinations of the services available and life opportunities for people with mental health needs (adults, children and young people and older people) and people with learning disabilities. The review highlighted gaps in the current provision of services and the high incidences of mental ill-health experienced in Northern Ireland relative to other parts of the UK. The review envisaged the need for a comprehensive programme of reform and modernisation, and the various reports detail a wide range of recommendations for improving MHLD services and better meeting the needs of their users.

The review concluded formally in 2007 and DHSSPS is now addressing implementation of its recommendations. The successful implementation of the reform of MHLD services will rely on the development of an appropriately sized workforce with the necessary competencies to deliver the services required.

1.3 TERMS OF REFERENCE

The aim of this review was to conduct a workforce planning exercise to provide the Department with a comprehensive assessment of workforce needs to support implementation of the Bamford Review recommendations. The specific terms of reference for this review were as follows:

- To address the main domains in the Bamford review:
  - Adult mental health services;
  - Learning disability services;
  - Child and adolescent mental health services;
  - Dementia and mental health issues in older people;
- To provide detailed analysis of future demand based on provision of services as set out in the Bamford recommendations including:
  - Numbers of each professional group required to meet service demands including areas of new service provision;
  - Skill-mix options in the delivery of services;

- The context within which the skills of various professionals will be delivered and what impact this will have on the workforce;

- Areas of particular difficulty / need and those areas where service development is well underway;

- Provide an analysis of the current multi-disciplinary MHLD workforce in Northern Ireland including:

  - Size, composition, sectoral distribution, age and gender;

  - Working conditions and patterns;

  - Professional area;

  - Specialist service commitments;

- Provide an analysis of current and future recruitment and retention issues including:

  - The different issues applicable to the range of professionals required for the provision of these services;

  - Career development and specialisation issues;

  - Training and professional development issues;

  - Priority areas showing difficulties in recruitment and retention;

  - Geographical issues in supply and demand;

  - Initiatives underway in any professional area or programme of care that specifically relate to MHLD services;

  - Returners; and

  - Working arrangements.

1.4 METHODOLOGY

The approach to the assignment is summarised in the sections below.

Research and Literature Review

Relevant strategic documentation and literature was reviewed to identify the strategic priorities for MHLD and workforce development in health and social services, and current recruitment and retention issues facing the MHLD services / the professional groups that deliver them. This included review and analysis of:

- the reports produced by the Bamford Review;
- recent workforce planning reviews for the staff groups involved;
- the Autistic Spectrum Disorder (ASD) Action Plan;
- information on statutory MHLD workforce available from the Department's Human Resource Management System (HRMS);
- information on the non-statutory MHLD workforce from various sources; and

- documents setting out priorities for MHLD including Priorities for Action, Trust Development Plans and Health and Wellbeing Investment Plans.

Data Collection

A proforma was distributed to key contacts in each of the domain areas as outlined in the Bamford Review across the five Health and Social Care Trusts to gather information on:

- current service model;
- future service model planned;
- the workforce implications of the future service model;
- existing workforce challenges; and
- challenges expected in implementing the future service model.

Workshops

A workshop was undertaken for each of the four main domains of the Bamford review. The primary aim of the workshops was to discuss the recommended models set out in the Bamford reports, explore their workforce implications and gather information about current service development priorities. The workshops involved a range of policy, commissioning and provider representatives from the statutory and non-statutory sectors.

Analysis and Reporting

Information collated through desk research, the data collection exercise and the workshops was analysed to develop recommendations on the priority workforce actions needed to support the implementation of the Bamford recommendations.

1.5 STRUCTURE OF THIS DOCUMENT

This report sets out the findings of the review and is structured as follows:

- Section 2 – baseline analysis of the current MHLD workforce and its existing recruitment and retention challenges;
- Section 3 – description of the Bamford vision for each of the four main domains and analysis of the key workforce implications;
- Section 4 – estimates of the future workforce requirements to inform future resource planning; and
- Section 5 – recommendations for the future workforce actions required to support implementation of the Bamford review.

2 BASELINE WORKFORCE ANALYSIS

2.1 INTRODUCTION

This section presents an analysis of the current MHLD workforce in terms of its size, sectoral distribution, demographic trends and staff group. It also details the key recruitment and retention issues currently facing this workforce.

2.2 DATA SOURCES

The MHLD workforce is made up of a diverse range of staff groups, working across the statutory and independent sectors, in a variety of settings and with a range of client groups. In order to understand this large and diverse workforce, the baseline workforce analysis drew upon the following sources of information:

DHSSPS' Human Resources Management System (HRMS)

All Trusts provide a download of their combined payroll and personnel systems to the Department on a quarterly basis for addition to the HRMS. This download provides a snapshot of all people employed by the Trust at that point in time including information on department / specialty, trust, age, gender and part-time / full-time working.

For the purposes of this review, Departmental statisticians generated a dataset for MHLD staff in the following groups:

- Learning disability nurses and nursing support staff ;
- Learning disability social workers and social work support;
- Mental health nurses and nursing support staff;
- Mental Health social workers and social work support;
- Clinical psychologists and assistant / trainee psychologists;
- Allied health professionals (AHPs) who could be identified as working in MHLD; and
- Medical staff working in MHLD.

It was not possible to identify all of those staff working in MHLD services through HRMS. Where staff groups have been fully transferred over to the new grade titles created under Agenda for Change these codes identify MHLD specialties. This is the case for nursing, social work, clinical psychology and medicine. However where this transfer has not yet happened, specialties must be estimated using department code. For AHPs, only occupational therapy staff could be identified as working within MHLD and for psychologists none were identified on HRMS as working in learning disability. HRMS data did not enable disaggregation of staff into the four Bamford domains. In addition, it is likely that the figures understate the number providing care for older people with dementia and functional mental illness, as this part of the workforce is often managed through the Older People Programme of Care. The statutory dataset compiled from HRMS for this exercise in relation to the MH and LD workforces is described in Section 2.3 below.

Data Returns from Trusts

To support the review, Trusts were asked to complete a proforma for each Bamford domain. The primary objective of the data collection exercise was to inform the review on current service

configuration and planned developments for the future. However, Trusts also provided useful information on their current workforce. This included quantitative data on staff in post across MHLD services and descriptive detail as to the nature of services in place at the Trust and the staff groups involved in providing them. A summary of the information provided is included in Section 2.4.

NICVA Workforce Surveys

The Northern Ireland Council for Voluntary Action (NICVA) conducts annual surveys of the community and voluntary health and social care workforce. The output of the 2007/8 survey has been used as an information source for the current review. The survey is distributed to organisations which define their primary or secondary function as providing mental health or learning disability services. The surveys returned provide an indication of the scale of the voluntary and community sector MHLD workforce. The data is likely to underestimate workforce numbers (not all organisations invited to respond to the survey do so) and cannot be disaggregated into the four main Bamford domains. Workforce estimates from this source are detailed in Section 2.5.

2.3 Statutory Mental Health and Learning Disability Workforce - HRMS

Workforce Composition

Table 2.1 shows the total mental health workforce in the statutory sector based on estimates from HRMS. It indicates that there are approximately 3,461 people working in mental health equating to 3,256.22 Whole Time Equivalents (WTEs). Nursing staff make up the largest proportion of the workforce accounting for just less than three quarters of the mental health staff identified through HRMS. As regards skill-mix, there are large numbers of support staff in the mental health sector:

- in nursing the qualified to unqualified / support ratio is 69:31; and
- In social work the qualified to unqualified / support ratio is 70:30.

Table 2.1
HRMS MH Workforce Figures (Headcount and WTE)

Staff Group	Headcount	WTE
Mental Health Nurse	1,688	1,597.73
Mental Health Nurse Support	771	727.6
Total MH Nurse / Nurse Support	***2,459***	***2325.33***
Clinical Psychologist	214	202.09
Assistant / Trainee Psychologist	47	45.78
Total Psychologist	***261***	***247.87***
Mental Health Social Worker	280	260.89
Mental Health Social Work Support	118	105.1
Total MH Social Worker / Social Worker Support	***398***	***365.99***
Mental Health Occupational Therapist	24	21.5
Mental Health Occupational Therapy Support	16	12.9
Total MH Occupational Therapy	***40***	***34.4***
Consultant	119	106.91
Associate Specialist / Specialist Registrar	117	114.92
Staff Grade	33	28.4
Foundation Doctor	34	32.4
Total MH Medical	***303***	***282.63***
Total Workforce	**3,461**	**3,256.22**

Source: HRMS March 2008 Note: it was not possible to identify all AHPs working in mental health

Table 2.2 shows the total learning disability workforce in the statutory sector based on estimates from HRMS. It indicates that there are approximately 2,139 people working in learning disability or 1,881.71 WTEs. The majority of staff identified on HRMS are in nursing or social work – these groups account for just under 99 per cent of the identified learning disability workforce. The number of nursing and social work support staff outweighs the number of qualified learning disability nurses and social workers:

- in nursing, the qualified to unqualified / support ratio is 50:50; and
- in social work the qualified to unqualified / support ratio is 23:77.

Table 2.2
HRMS LD Workforce Figures (Headcount and WTE)

Staff Group	Headcount	WTE
Learning Disability Nurse	455	416.15
Learning Disability Nurse Support	456	413.41
Total LD Nurse / Nurse Support	***911***	***829.56***
Learning Disability Social Worker	281	250.44
Learning Disability Social Work Support	920	776.72
Total LD Social Worker / Social Worker Support	***1,201***	***1,027.16***
Learning Disability Consultant	10	8.9
Learning Disability Associate Specialist / Specialist Registrar	17	16.09
Total LD Medical	***27***	***24.99***
Total Workforce	**2,139**	**1,881.71**

Source: HRMS March 2008 Note: it was not possible to identify AHPs working in learning disability

Table 2.3 overleaf provides a breakdown of the age, gender and working pattern (i.e. full / part-time) of the staff groups identified as working in statutory MHLD services. Key trends are as follows:

- Gender - across all staff groups, the workforce is predominantly (at least 70 per cent) female, with the exception of the medical workforce which is just under 60 per cent female. The proportion of female staff is particularly high in learning disability, with up to 85 per cent of social workers, social work support staff and nurses being female. In mental health, the assistant / trainee clinical psychology staff are almost entirely female (96 per cent). Of all of the staff groups identified, the medical staff in LD and the clinical psychology group are the youngest. Only 16 per cent of qualified psychologists are aged over 50 and more than half of the assistant / trainee psychology group is aged between 25 and 29;

- Age – many of those working in MHLD services are eligible to retire at age 55 and across all staff groups with exception of clinical psychology and medical staff, more than a fifth of each group is aged over 50. Within learning disability, 28 per cent of social work support staff are aged over 50 and 12 per cent are aged over 55. Within mental health, 22 per cent of social workers are aged over 50 and at least 7 per cent are aged over 55. Only 4 per cent of the medical workforce is aged over 55. Across the workforce, a considerable proportion of staff will become eligible to retire within the next five to ten years and many are already eligible to retire. This presents a significant risk in terms of succession planning and retention of knowledge and experience; and

- Working Pattern - the learning disability social work support staff group is the only group where the proportion of part-time workers (56 per cent) outweighs that of full-time workers (44 per cent). Part-time working is least common in mental health nursing and nursing support and medical staff working within learning disability, with fewer than one in five taking this option. In the other staff groups, between 19 and 32 per cent of staff work on a part-time basis.

Table 2.3
HRMS Workforce – MH and LD Staff Groups by Age, Gender and Working Pattern (Headcount)

		Mental Health (%)							Learning Disability (%)				
		Medical Staff (all grades)	Nurse	Nurse Support	Social Worker	Social Worker Support	Clinical Psychologist	Assistant / Trainee Psychologist	Medical Staff (all grades)	Nurse	Nurse Support	Social Worker	Social Worker Support
Age	25 and under	-	2	10	-	5	-	23	0	2	12	0	7
	25 - 29	28	8	11	8	7	16	51	22	12	9	7	13
	30 - 34	22	10	11	10	11	20	-	-	11	9	11	15
	35 - 39	13	13	15	22	14	21	--	26	14	11	16	16
	40 - 44	11	21	14	20	14	14	0	-	18	13	18	15
	45 - 49	11	22	18	15	8	9	-	-	20	18	19	13
	50 - 54	9	16	13	15	19	10	-	-	14	13	15	11
	55 - 59	4	6	5	7	15	6	-	-	7	9	8	7
	60 - 64	-	1	3	-	7	-	-	0	4	5	5	3
	65+	-	1	-	-	0	-	-	0	-	-	-	1
	Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Gender	Female	58	73	73	74	82	71	96	63	85	77	75	84
	Male	42	27	27	26	18	29	4	37	15	23	25	16
	Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Work Pattern	Part time	18	17	19	22	32	21	6	19	28	27	32	56
	Full time	82	83	81	78	68	79	94	81	72	73	68	44
	Total	**100**	**100**	**100**	**100**	**100**	**100**	**100-**	**100**	**100**	**100**	**100**	**100**
Total Headcount		**303**	**1,688**	**771**	**280**	**118**	**214**	**47**	**27**	**455**	**456**	**281**	**920**

Source HRMS March 2008.

Notes: Figures exclude bank staff and staff with a WTE of less than or equal to 0.03. A dash (-) represents percentages based on fewer than 6 people. Percentages may not sum to 100 due to rounding.

Workforce Distribution by Trust

Table 2.4 outlines the headcount information for those staff groups identified as working in statutory MHLD services across the five HSC Trusts. Information was not available at this level for AHPs working in MHLD. It illustrates that BHSCT has the biggest MHLD workforce and SEHSCT has the smallest. Tables detailing the age and gender breakdown of staff by Trust are included in Appendix I and II. Staff group totals in Table 2.4, and those in Appendices I and II differ due to cell counts of less than six (represented by a dash '-').

Table 2.4
HRMS Workforce – MH and LD Staff Groups by HSC Trust (Headcount)

	HSC Trust	Medical	Nurse	Nurse Support	Social Work	Social Work Support	Psychologist	Assistant Psychologist	Trainee	Total HSC Staff
Mental Health	BHSCT	100	431	223	63	36	76	13		942
	NHSCT	71	338	156	67	67	35	10		744
	WHSCT	47	427	183	56	-	22	7		742
	SHSCT	45	282	133	42	9	20	-		531
	SEHSCT	40	210	76	52	-	27	13		418
	Total	**303**	**1,688**	**771**	**280**	**118**	**180***	**47**		**3,387**
Learning Disability	BHSCT	17	202	243	54	308	*Data not available*			824
	NHSCT	0	20	0	34	298				352
	WHSCT	-	59	77	98	41				275
	SHSCT	6	125	115	38	167				451
	SEHSCT	0	49	21	57	106				233
	Total	**27**	**455**	**456**	**281**	**920**				**2,139**

Source HRMS March 2008

Notes: Figures exclude bank staff and staff with a WTE of less than or equal to 0.03. A dash (-) represents cell counts of fewer than 6 people. *An additional 34 Clinical Psychologists work in Regional Services.

Workforce Turnover

Tables 2.5, 2.6 and 2.7 detail information available from HRMS on MHLD staff who have joined, left or moved within the statutory health and social care system in 2007/8. Overall, the information indicates a relatively stable workforce, with areas of growth. This suggests that despite the aging population within the MHLD workforce, many are choosing not to take up the option of early retirement. Across the Northern Ireland Trusts in the period September 2007 to end of March 2008, turnover averaged 10.4 per cent (calculated on the basis of movers and leavers as a percentage of staff in post) and turnover rates for the various staff groups in MHLD services are considerably below this level based on the information available. It should be noted that this is inconsistent with the views of stakeholders consulting during the review (see Section 2.6) who reported a high degree of turnover in some areas.

The data captured from HMRS in relation to movers only records those individuals who move between trusts, not within, therefore those individuals who move post or are promoted to a new role within a trust are not recorded in HRMS. In addition, the total figures for leavers, movers and joiners are calculated by comparing staff level information from the same time of year, one year apart, and calculating the difference.

Table 2.5
Nursing Staff - Leavers, Movers, Joiners (Headcount)

	Leavers	Movers	Joiners	Staff Turnover (%)
Mental Health				
Nurse	83	17	91	**5.9**
Support Nurse	31	-	57	**4.3**
Learning Disability				
Nurse	25	-	17	**6.2**
Support Nurse	25	-	26	**5.9**

Source: HRMS March 2008

Table 2.5 shows a reasonable degree of movement in the mental health nursing workforce but net differences are small - at year end there were eight more mental health nurses in the system and fifteen more mental health support workers. In learning disability nursing there is also evidence of substantial movement, with an indication of a reduction in the workforce - there were 8 fewer learning disability nurses in the system at the end of the year than at the beginning. The data indicates that staff turnover across the nursing and nurse support workforces is below that of the Trust average of 10.5 per cent.

Table 2.6
Social Work Staff - Leavers, Movers, Joiners (Headcount)

	Leavers	Movers	Joiners	Staff Turnover
Mental Health				
Social Worker	9	0	14	**3.2**
Social Work Support	-	0	15	**-**
Learning Disability				
Social Worker	5	0	6	**1.8**
Social Work Support	12	-	73	**1.5**

Source: HRMS (March 2008)

Table 2.6 indicates there has been more limited movement within social work / social work support parts of the MHLD workforce compared with nursing – there were no recorded movements in three of the staff groups indicating a high degree of workforce stability. Across mental health and learning disability, the large social work support staff groups saw a net growth (by 15 and 61 people respectively). Staff turnover across the social work and social work support workforces is below that of the Trust average of 10.5 per cent.

Table 2.7
Clinical Psychology Staff - Leavers, Movers, Joiners (Headcount)

	Leavers	Movers	Joiners	Staff Turnover
Mental Health				
Clinical Psychologists	8	7	13	**7**
Trainee/Assistant Psychologist	12	22	7	**72.3**

Source: HRMS (March 2008)

Table 2.7 shows that slightly more clinical psychologists working in mental health joined than left in 2007/8 but there was limited movement within the staff group overall. There was greater movement in the trainee / assistant psychology group, probably reflecting movement into qualified posts among trainees and the often temporary nature of assistant posts. This is reflected in the turnover percentage of 72.3, which is significantly higher than that of the Trust average of 10.5 per cent. Staff turnover in relation to the clinical psychology workforce is below that of the Trust average of 10.5 per cent.

2.4 Statutory Mental Health and Learning Disability Workforce - HSC Trust Data Returns

All five Trusts supported this review by providing information on their MHLD service provision. The primary aim of the data collection exercise was to collate information on current service configurations across the different Bamford domains. Trusts provided a variety of quantitative and descriptive information that adds value to the HRMS workforce data by providing information on the

various settings within which these staff work. Tables with full details of the information provided by the Trusts can be found in Appendix III and the sections below provide summaries by domain.

Learning Disability Service Provision

Trust returns indicated that a total of 2,259 WTE staff from across a range of disciplines work in learning disability services with the majority working as support workers in day care service provision. Approximately two-thirds work in hospital settings, with the remainder working in community teams.

Adult Mental Health Service Provision

Approximately 2,640 WTE staff from across a range of disciplines work in adult mental health (AMH) services. More than half of these staff work in hospital services with the remainder in community mental health teams.

Child and Adolescent Mental Health Service Provision

The CAMHS workforce is much smaller, with a total of 299 WTE staff reported by the Trusts. The majority of staff work within supported living services in the community or in hospital services, and a small number within community mental health teams.

Older People's Mental Health and Dementia Services

Three HSC Trusts completed a data return for this domain and in total the returns accounted for 330 WTE. It is possible that the low numbers of staff reported by the Trusts is due to some of the staff residing within the elderly programme of care rather than mental health. Based on this limited information, the majority of staff work in hospital services and residential accommodation.

2.5 THE NON-STATUTORY MHLD WORKFORCE

The 2007/8 NICVA survey of the community and voluntary health and social care workforce provides information on staff groups within the sector and broad service area.

Mental Health

The NICVA research highlights that there is an estimated MH workforce of 26,000 in the community and voluntary sector. In total, 80 organisations responding to the NICVA survey stated their primary or secondary beneficiaries to be people with mental health needs:

- The 80 organisations employ a total headcount of 1,685 staff;
- 78% of these staff are female; and
- 30% of all posts are part-time.

Learning Disability

Of the organisations responding to the NICVA survey, 64 stated their primary or secondary beneficiaries to be people with a learning disability:

- The 64 organisations employ a total headcount of 2,685 staff;
- 74% of these staff are female;
- 36% of all posts are part-time.

The workforce information supplied by NICVA indicates that a total number of 4,370 staff in the community and voluntary sector provide services to individuals with MH and LD needs.

Additional information from NICVA sources indicates that in the voluntary and community sector as a whole, the following professional HSC staff are employed:

- Nurses – 1,100;
- Health care assistants – 577;
- Doctors – 27;
- AHPs – 194; and
- Social workers – 1,500.

2.6 Recruitment and Retention Issues

Recruitment and retention are two of the main issues to be addressed as the transfer of MHLD services from hospitals to community based care is considered.

Key themes Identified by Trusts

- **Competing for Staff**
  - There is significant competition between Trusts to attract new graduates. In relation to nursing in 2008/9, there are 117 funded training places for MH nursing and 30 for LD nursing, and many of the Trusts involved in this review reported that the competition between Trusts to successfully attract these graduates often makes it difficult to ensure continued inflow into the workforce;
  - High average attrition rate for MH and LD pre-registration nursing courses of 25 per cent – this is some nine percentage points higher than the average for adult nursing (16%);
  - Competition with the voluntary, community and private sector for qualified and experienced MHLD staff;
  - Higher than average vacancy rates in MH and LD nursing. A research study completed for DHSSPS (by Moira Davren) compared nursing staff in post to funded establishment for MH and LD services. It found that approximately 13% of funded posts were vacant. The average vacancy rate for general nursing posts is 1.9%, substantially lower than MH and LD nursing; and
  - Competition for potential support staff - other employers offer job opportunities perceived to be less challenging and stressful than MHLD jobs, but with similar terms and conditions e.g. the retail sector.
- **Perception of MHLD Roles**
  - Attrition from pre-registration training and turnover among support staff is attributed to students and staff finding roles much more challenging than expected – there is a need to clearly illustrate to trainees and potential recruits what working in the MHLD sector involves; and
  - Scope for development of new services is also limited by difficulties in recruiting staff.
- **Career Pathways**
  - Lack of clear career pathway and commitment to continuing professional development impacts on recruitment and retention in the sector;

- **Challenging Nature of the Job**

  - Challenge of working with clients with challenging behaviour and working in small community-based units which do not have the same support structures for staff as hospital settings;

  - Professional isolation of staff working in smaller units in disparate locations across Trusts puts a large amount of pressure on these staff members; and

  - Long-term vacancies can pressurise existing staff and impact on retention.

- **Age of the Workforce**

  - A proportion of the workforce is eligible for retirement at 55 – loss of experience could lead to difficulties in service re-design and provision.

3 IMPLEMENTING THE BAMFORD VISION

3.1 INTRODUCTION

This section sets out the separate visions for each of Bamford's four main domains: adult mental health; older people; child and adolescent mental health; and learning disability. A summary of the key changes that will result from the implementation of the Bamford Review is outlined below. The analysis was informed by discussions with stakeholders from each domain through a series of workshops.

3.2 OVERARCHING BAMFORD VISION AND PRINCIPLES

The Bamford vision is for people with a learning disability or mental health need and their carers to have access to responsive services that respect their individual autonomy and that demonstrate justice and fairness. The key principles are set out below.

Key Principles of Bamford Review

Partnership with users and carers in the development, evaluation and monitoring of services;

Partnership with users in the individual assessment process, and in the development of their programme of treatment and care and support;

Delivery of high quality, effective treatment, care and support;

Provision of services which are readily accessible;

Delivery of continuity of care and support for as long as is needed;

Provision of a comprehensive and co-ordinated range of services and accommodation based on individual needs;

Take account of the needs and views of carers, where appropriate, in relation to assessment, treatment, care and support;

Provision of comprehensive and equitable advocacy support, where required or requested;

Promotion of independence, self-esteem and social interaction through choice of services and opportunities for meaningful employment;

Promotion of safety of service users, carers, providers and members of the public;

Staff are provided with the necessary education, training and support; and

Services are subject to quality control, informed by the evidence.

3.3 ADULT MENTAL HEALTH

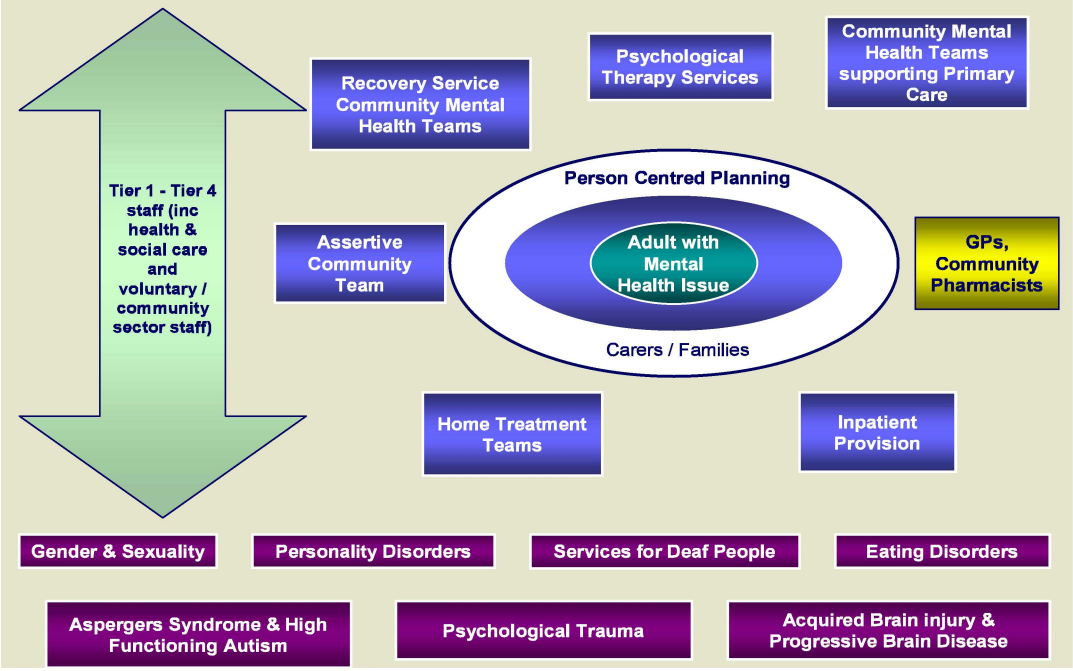
This section describes the vision for adult mental health (AMH) services and discusses the changes required and their workforce implications.

3.3.1 Vision for Adult Mental Health Services

Figure 3.1 illustrates the AMH service model set out in the Bamford Review. Key aspects of the model are:

- A person-centred approach;
- Provision of service in a variety of community and in-patient settings;
- Service provision by multi-disciplinary teams working effectively across tiers of service;
- Provision of service in conjunction with an individual's family and carers; and
- Service provision through the statutory, voluntary and community sectors working together.

Figure 3.1
Bamford's AMH Service Model



3.3.2 Workforce Implications

The workforce implications for AMH services can be separated into the following four areas:

1. New roles;
2. Model service configuration;
3. New / Extended Services; and
4. Specialist services.

1. New Roles

(i) Link Worker

Bamford recommended that all primary care teams should have access to a named mental health professional, a Link Worker. The Link Workers role would be to provide timely, appropriate and accessible assessment and management of people with mental health problems providing a link between primary care and secondary care for adults with mental health issues.

Key Points
Where the Link Worker role has been established it has been filled by a nurse or social worker, however it is apparent that other health care professionals could be appointed to this role. There is lack of consensus in terms of where this role should be located i.e. within primary care or within secondary care.

(ii) Support, Time and Recovery Worker

It is anticipated that the new Support, Time and Recovery Worker (STRW) role will play a key part in recovery services. Developed by the NHS, responsibilities of the role include:

- promoting independent living;
- providing companionship and friendship;
- providing regular and practical support;
- providing support with daily living;
- facilitating people living "ordinary lives";
- helping the service user to gain access to resources;
- providing information on health promotion;
- helping to identify early signs of relapse; and
- supporting service users with involvement/participation with their treatment.

Key Points
The STRW role has mostly been developed in the independent sector in England, and is largely provided by existing and former service users. Clarification of the role, who might fill it, training requirements and career pathway have to be considered for NI. Current and former service users could be recruited into this role, and there is scope for it to be developed and managed within the voluntary and community sectors.

2. Model Service Configuration

(i) Community Mental Health Teams (CMHT) Supporting Primary Care

Bamford recommended that each HSCT should have a CMHT providing services for relatively short term mental health issues such as anxiety or trauma. These teams would require access to a comprehensive range of community resources, both statutory and independent sector. They should have a multidisciplinary mix of staff including nursing, social work, psychology, and medical to enable them to provide a broad range of skills and therapeutic interventions.

The introduction of the stepped care model will result in new ways of working for CMHTs and there will be an increased role for the independent sector and service users to support the delivery of services. CMHTs should operate across the Tiers. The points below summarise the four tiers in the stepped care model:

Tier One: Primary Care - *Services users with mild up to moderate mental health needs*. Services will be provided by local General Practice and or voluntary and community sector. This Tier includes early intervention, mental health promotion and screening for Tier two services.

Tier Two: Screening and Assessment Service – *Service users with moderate mental health needs.* The Gateway team will assess and either treat or signpost and refer to appropriate service.

Tier Three: Secondary Care – *Service users with moderate to severe, acute and chronic mental health needs*. This tier will provide acute services for in-patients, outpatients, day hospitals and home treatment.

Tier Four Specialist Services – *Service users with severe, complex. Atypical and recurrent mental health needs*. It involves referrals to specialist in-patient services, forensic, eating disorder, and addiction services.

A new Psychological Therapist role will be developed within CMHTs and Tier 2 services will be delivered to individuals with specific mental health issues in areas such as: psychological trauma; eating disorder; personality disorder; disorders of gender or sexuality; women with perinatal mental health problems; and deaf people with mental health problems. This will have a significant training implication.

Key Points

CMHTs operate in all Trusts but a consistent service model does not exist and they are each at various stages of developing the teams. CMHT resources are directed towards those with more complex mental health needs (Tier 3-4), as opposed to those with shorter-term mild to moderate needs (Tier 1-2).

In line with the PSA target to reduce hospital admissions, staff are being redeployed from acute to community settings. Stakeholders consider it unlikely that the redeployed staff will be sufficient to fulfil the Bamford vision and highlight the risk of attrition during the redeployment phase.

Key enablers for CMHTs to support Primary Care Services in line with Bamford's recommendation are: having sufficient community infrastructure; having regional direction regarding the CMHT model; reviewing the competencies required by staff to support Primary Care; and developing a learning and development framework to ensure that an effective skill mix is provided by the teams.

(ii) Recovery Service CMHTs

Bamford recommends that Recovery Service CMHTs are required by people with enduring and recurring mental disorder who require care in the longer term. Bamford recommended that these teams should be multidisciplinary and should include nursing, social work, occupational therapy, speech therapy, physiotherapy, medical and user participation. These teams should provide Tier 2 support for the mental health needs of people with brain disease and injury, Autistic Spectrum Disorder (ASD), also services for people with challenging behaviour, dual diagnosis, first episode of psychosis and mild learning disability. The teams should work closely with Home Treatment teams and Assertive Community Treatment teams (both of these teams are discussed at later stages in this section).

Demand for recovery services is increasing from Primary Care Teams and in supported living settings. Recovery should form a significant part of the CMHTs' role and is a key means of preventing admission to hospital. Mental health services are struggling to respond. In practice some but not all of the Trusts have established separate Recovery Service CMHTs, however, recovery services are being supported by Community and Project Workers operating in the voluntary and community sectors. Further development of this service will rely on the appropriate infrastructure being in place.

Key points:
- Separate Recovery Service CMHTs have not been established in all HSCTs but each Trust is delivering recovery services through their CMHT as opposed to a dedicated team;
- Demand for these services is increasing, particularly as a result of the resettlement of inpatients, reducing hospital admissions and the aim of delivering more mental health services in the community;
- Infrastructure will be required to support the delivery of recovery services;
- An increased number of staff from the following disciplines will be required to provide Recovery Services: Nursing, Social Work, Occupational Therapy, Speech Therapy, Physiotherapy, and Medical.

(iii) Home Treatment Teams

Home Treatment teams are designed to provide services on a 24/7 basis as an alternative to inpatient hospital treatment, enabling service users with the greatest vulnerability to be maintained more successfully in community settings. Bamford recommends that these teams have a gate-keeping function to other services, and ensure continuity of care between Recovery CMHTs and inpatient services, enabling a more home-based approach to community service provision.

Investment received by the Trusts to provide an out of hours service has been used in different ways with some having a Crisis Response Team to provide services when CMHTs are not working, and other Trusts having a dedicated Home Treatment Team. There was consensus that out of hours Crisis Response Teams are required but concerns were raised that establishing specific teams could result in staff leaving CMHTs to work in these teams.

Key points:
- The definition of "Home Treatment" and the relationship between Home Treatment, Crisis Response, and CMHTs requires clarification;
- Consistent services should be available within each Trust area appropriate to the population need;
- The service is envisaged to be provided by nurses and more nurses will be required to deliver out of hours services;
- There is potential to utilise the NVQ in "Direct Care" in relation to CMHT and an e-learning package already exists.

(iv) Psychological Therapy Services

Bamford recommended that a range of Psychological Therapy services should be developed in Northern Ireland. It further envisaged development of a single unit from which support, supervision and training can be provided for all CMHT staff.

The provision of a 'basket' of psychological therapy services is a priority for all Trusts as it forms one of their PSA targets.

The Department's draft Strategy for the Development of Psychological Therapy Services recommends

- the implementation of the recommendations set out in the Review of Psychology Workforce (2008);
- a consortium of stakeholders be commissioned to agree a regional approach to undergraduate and post graduate training to meet the needs of a stepped care model for the delivery of psychological therapy services;
- a supervisory framework be developed for the competencies and accreditation required by supervisors at the different level of intervention.

The emphasis is to deliver the majority of services at Primary Care level to provide prevention and early intervention thereby reducing demand for higher level specialist services. Psychological Therapists will also work in new ways and in new settings in support of the move to deliver services in community settings.

Key points:
- There is a need for additional staff to be recruited and trained as psychological therapists and for a supervision and career progression pathway to be defined;
- Roles need to be clearly defined in line with the Stepped Care Model / the regional working group's recommendations; and
- New ways of working will result from the increasing role that will be played by Psychological Therapists in the mental health area and this will impact a range of different mental health professionals working with Psychological Therapists.

3. New / Extended Services

(i) Out of Hours AMH Service

The Review recommended that access to out-of-hours mental health services should be prioritised according to clinical need and should comprise face-to-face contact and telephone advice.

Undoubtedly additional staff will be required to provide these services as flexible working practices are implemented (e.g. new rotas). Trusts are currently introducing out of hours working to some services. It is anticipated that in the future this service may be linked to the Crisis Response Service and Home Treatment Teams and although 24 / 7 cover will be provided it will not be a separate service in itself.

(ii) Liaison Mental Health Service

Bamford recommended development of an enhanced service providing access to mental health services for those people presenting in hospitals. This would be a multi-disciplinary team consisting of a liaison nurse, social worker, clinical psychologist, psychiatric trainee and consultant psychiatrist.

This service is being progressed to different degrees in the Trusts.

(iii) Assertive Community Treatment Teams

Bamford recommended that Assertive Community Treatment Teams should be established to maintain service users with the greatest vulnerability in community settings, as an alternative to inpatient hospital treatment. It was recommended that these teams should be linked closely to the Recovery Service Teams.

These are high cost low volume services and it is not believed to be economical to establish specific teams to deliver the services. Clarification is required on whether separate Assertive Community Treatment Teams will be established or alternatively, how this service could be provided through the Recovery Service, CMHTs or Home Treatment Teams.

(iv) For people with Challenging Behaviour

Within AMH, the term 'challenging behaviour' refers to "people who are suffering from a serious mental illness, for example schizophrenia or sequelae of head injury and who, in addition to severe and often persistent symptomatology, show a range of behavioural problems, such as aggression, violence, repeated self-harm, extreme self-neglect, fire-setting or inappropriate sexual behaviour". Bamford recommends that community mental health services should be equipped to support people with challenging behaviour, and that there should be specialist accommodation with appropriately skilled staff and local intensive care.

This service will require infrastructure within the community including accommodation and also appropriately trained staff to deliver services.

4. Specialist Services

Bamford made several recommendations regarding specialist services in the area of AMH, operating at Tier 3 and in some cases on a regional as opposed to on a local basis.

(i) For People with a Personality Disorder

Bamford recommended that residential and day treatment services for people with personality disorders should be established in Northern Ireland and that specialist multidisciplinary teams should be established to provide assessment, education and support to other services that may come into contact with people with personality disorders. The Review recommended that this service should co-ordinate with other mental health services such as forensic services, substance misuse and with learning disability services, and that awareness training of the needs of those with personality disorders should be provided for such services as primary care, A&E, and perinatal services, and to medical and surgical staff.

A regional group has developed proposals for mental health services for people with a personality disorder and the recommendations of this group will have workforce implications. The proposals, which are currently the subject of stakeholder consultation, are for the development of community-based teams along a hub and spoke model to provide psychotherapeutic care, supervision, liaison, training and support across all Trust areas.

Key Points:
Proposals for personality disorder services will necessitate:

- awareness training for HSC staff;
- further training for more specialist staff;
- approximately 50 additional staff in the short term; and
- development of role descriptions, management structures, and career pathways for the proposed new service.

(ii) For People with an Eating Disorder

Bamford recommended that a regional Tier 3 team should be developed in each Board area to deliver specialist services to people with an eating disorder. These Tier 3 professionals would support Tier 1 and Tier 2 through training, supervision and shared care arrangements. The Review also identified the potential for a Tier 4 service in the longer term at regional level (providing specialist day patient and inpatient services).

A regional strategy for the development of eating disorder services was agreed a few years ago and is broadly in line with Bamford. To date developments have focussed on establishing multidisciplinary (including Medical, Nursing and Psychological Therapy staff) community-based Tier 3 eating disorder services for both adults and younger people. Currently there are 18 WTE staff working in the adult teams, with the Belfast Trust team providing a regional service for more complex cases. Plans are now in place

to designate one medical inpatient bed in each Trust for treatment of those who need to be admitted for refeeding. 'In-reach' to these patients will be provided by the Tier 3 teams.

Key points:
- Recruitment of staff (including Psychotherapists) to provide day support and suitable training provided;
- Specialist training required for staff working in all settings; and
- Career plans and role descriptions developed for all staff in the service.

(iii) For People with Brain Injury

Bamford recommended that there should be development of Community Brain Injury Teams throughout Northern Ireland and identified the need for a specialist regional mental health team to offer expertise in the assessment, diagnosis, treatment and management of mental health problems in acquired brain injury and progressive brain disease.

The main Neurbehavioural Unit is located in BHSCT and provides short-term admissions for assessment, slow stream rehabilitation/recovery and long-term care for those whose behaviour cannot be met in other settings. A multidisciplinary approach is delivered in the Unit. Bamford recommended that this should be developed as a regional specialist service.

Key points
- Although this service does not sit within the mental health programme of care it is likely to require mental health professionals; and
- The workforce implications should be reviewed and addressed following the brain injury service review.

(iv) For Deaf People with Mental Health Needs

Bamford recommended that a new service be established for deaf people with mental health needs i.e. community mental health services linked to other agencies, day services, and out of hours services.

Demand for this service is small and work is being undertaken on an all Ireland basis to consider workforce requirements and delivering a cross border service.

(v) For People with Psychological Trauma

Bamford identified the need for training for primary care staff (and other front line services) in the detection, preliminary intervention and appropriate referral of people with trauma-related needs. The Review also recommended that pre professional training should be given to all HSC professions regarding the conceptualisation, recognition and treatment (including referral) of psychological trauma, with advanced training required for the treatment of Post Traumatic Stress Disorder.

Key points
- The workforce implications resulting from the provision of services to people with psychological trauma should be identified and addressed in line with the Psychological Therapies Strategy.

(vi) For Women with Perinatal Mental Health Problems

The Review recommended that a regional specialist mental health service for women with mental health problems occurring in the perinatal period be established and that all women with a past history of serious non-postpartum mental disorder should be offered assessment by a psychiatrist in the antenatal period.

Work on the development of a specialist regional service is progressing which will potentially identify further new roles to form part of a specialist multidisciplinary team.

The Department has endorsed 2007 NICE clinical guidance on antenatal and postnatal mental health.

Key points
- New dual qualified midwife and mental health nurse role has been developed;
- Career path for the role needs to be developed;
- Any further workforce implications should be identified following the completion of work to develop the regional service. This will include examining required competencies and appropriate training
- Development of a learning and development framework to ensure that an effective skill mix is provided by the team;

(vii) For people with Asperger's Syndrome or High Functioning Autism (AS / HFA)

Bamford recommended the development of multidisciplinary Asperger's Syndrome / High Functioning Autism Teams for each Trust area to deliver:

- specialist assessment services (Tier 3) providing clear pathways and access to services;
- clear referral pathways to mainstream services (Tiers 1 and 2); and
- appropriately trained specialists (Tier 3) to provide specialist interventions.

A review is currently being undertaken to examine where this service should be located. Workforce implications will result from the outputs of a separate ongoing review into the service.

(viii) For People with Disorders of Gender and Sexuality

Bamford recommended that local and community based services are required for People with Disorders of Gender and Sexuality, with appropriate access to regional specialist services, and that the workforce and training requirements should be analysed.

Key points
- It is anticipated that new roles and additional staff will be required to deliver this service; and
- The delivery of the service will have a training implication.

3.4 Older People's Mental Health

This section describes the Bamford vision for older people's MH services and discusses the workforce implications that will result from the implementation of Bamford's recommendations. Note that this covers functional mental illness (FMI) and dementia, and services are variously organised into Elderly and MH Programmes of Care.

3.4.1 Vision for Older People's Mental Health Services

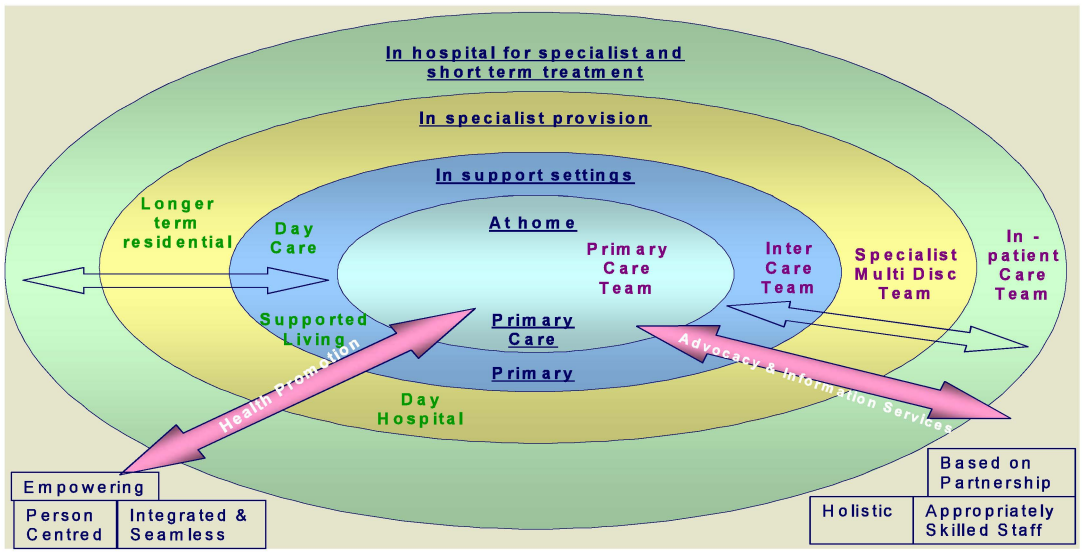
Figure 3.2 illustrates the older people's services model as set out in the Bamford Review. The vision for older people's mental health services depicts a model that operates in various settings and provides a range of services at varying degrees of specialism.

It has been developed based on a number of principles aimed to design services that:

- Respect individual autonomy and are person-centred;
- Demonstrate fairness and justice – transparent allocation and management of resources;
- Involve users and carers in their development, evaluation and monitoring;
- Provide high quality, effective treatment, care and support;
- Are readily accessible;
- Deliver continuity of care and support for as long as is needed;
- Are developed to provide a comprehensive and co-ordinated range of services and accommodation based on individual needs;
- Provide comprehensive and equitable advocacy support, where required or requested;
- Promote independence, self-esteem and social interaction through choice of services and opportunities for meaningful employment;
- Promote safety of service users, carers, providers and members of the public;
- Provide staff with the necessary education, training and support; and
- Are informed by best practice.

Figure 3.2

Bamford's Older People's Services Model



3.4.2 Workforce Implications

The workforce implications for Older People services relate to three main areas:

1. Primary Care and Community Care;
2. Intermediate, Specialist and In-Patient Care; and
3. Special Groups.

1. Primary Care and Community Care

(i) Support for people with acute mental health illness, Crisis Response and Home Treatment

Bamford recommended that support for older people with acute mental illness should be available 24 hours a day, 7 days a week, and that Crisis / Home Treatment Teams should be developed in a similar manner to that for younger people. The Review also recommended that crisis / rapid response services should be developed to include older people with functional mental illness and dementia and be sensitised to their needs.

The manner in which Crisis, Rapid Response, and Home Treatment Services have been configured varies considerably across the Trusts with some having developed a Crisis Response Service for all people with mental health issues, some having a home treatment service for people with FMI but not dementia (dementia cases are signposted elsewhere), some having a Crisis Response and Home Treatment Services combined, another using AMH out of hours service for older people, and another using its Older People Mental Health Team to deliver home treatment.

Key points:

- These services need to be considered on a Northern Ireland wide basis to produce consistencies in approaches and the terminology used. Following this the workforce implications need to be reviewed.

(ii) Specialist domiciliary care services

The Review recommended that Specialist Domiciliary Care Services should be developed for older people with mental health issues and that they should be available over a 24-hour period, assisted by multi-disciplinary Crisis/ Rapid Response.

With the increased focus on supporting people to live at home as opposed to entering residential care facilities an increased number of Domiciliary Care Staff will be required that have been trained in the mental health needs of older people.

(iii) Restraint free / minimal restraint care

Bamford recommended that restraint free / minimal restraint care should be built into organisational structures.

The fulfilment of this recommendation will require training across all grades of staff in the statutory and independent sectors.

(iv) Models of day-time support

Bamford recommended that models of day time support should be developed and particular attention paid to meeting the needs of people in rural settings.

Support may be provided in a variety of settings including day hospitals, day centres, and other community settings. It is anticipated this will require additional nursing and social care staff. Much of this support may be provided by the non-statutory sector and it is anticipated that additional volunteers will also be required.

2. Intermediate, Specialist and In-Patient Care

(i) Respite care

The Review recommended that a range of respite models should be delivered. These services should be provided locally, and be flexible, responsive and of benefit to older people with mental health issues and their carers.

Funding has been committed to develop respite services over the coming years and Trusts have included this within their Development Plans. It is anticipated that progress will be dependent on the availability of appropriate infrastructure. The Department is currently undertaking a piece of work to review respite services and the findings from the review should be taken into consideration before any firm conclusions are drawn on staffing implications.

(ii) Challenging behaviour

Bamford recommended that interim care facilities, that are appropriately staffed and funded, should be developed to provide support for older people with challenging behaviours.

Progress varies across Trusts and some are engaging private sector care homes as a means of providing this support. It is envisaged that this service will require additional specialist challenging behaviour nurses, psychologists, and nursing care staff. The workforce implications should be assessed once plans for service delivery are fully developed.

(iii) Palliative care

The review recommended that an approach for people with advanced dementia should be rolled out to all care settings.

Trusts are currently developing their own specific plans in this regard. One Trust is planning to implement the Liverpool Care Pathway for the Dying Patient (LCP). New approaches will have a training implication for staff working in care homes and palliative care teams. It is also expected that GPs and consultants will need to be educated in this area.

(iv) Intermediate Care

The Review recommended that older people with mental health needs should have access to suitable intermediate care services, and that specialist teams should provide the necessary support to staff working in mainstream intermediate care services.

Plans are at different stages of development across the Trusts but it is envisaged that there will be recruitment and training implications particularly involving dementia nurses, social workers, and AHPs.

(v) Psychotherapeutic services

Bamford identified that older people should have access to Psychotherapeutic Services and all evidence-based treatments according to need.

Currently CBT services treat approximately one older person with FMI each year. This low level of service provision is believed to be due to GPs' reluctance to refer older people with depression to Psychotherapeutic Services. The Advisory Group was however, of the opinion that prescribed medication should be a last resort and older people with mild to moderate depression should be referred to the service.

Development of this service will require GP support and will necessitate additional psychotherapeutic staff. No progress has been reported to date

(vi) Day Treatment Units

Bamford recommended that older people should have access to appropriately staffed Day Treatment Units. The units should have flexible opening hours and people with severe mental illness should be treated in the units as a priority.

Progress is varied across the Trusts but it was reported that additional suitably trained staff would be required in CMHTs to support the fulfilment of this recommendation. Stakeholders suggest that the units should not be restricted to hospital sites but should instead be located in the community. This was deemed to be particularly important in rural areas. This view supports Bamford's recommendation.

(vii) Enhanced Practitioner Roles

Bamford recommended development of the enhanced practitioner role responsible for developing closer links with primary care. These would provide health promotion, education, advice, and therapeutic input.

It is anticipated that additional nurses (including specialist dementia nurses, independent nurse prescribers) and social workers will be required to fulfil the enhanced practitioner role

(viii) Specialist Multi-disciplinary Teams

Bamford recommended that specialist multidisciplinary teams should be introduced for older people with mental health issues where they are not currently in place. These should include: Psychiatry, Nursing, Social Work, Occupational Therapy, Medicine, Occupational Therapy Technicians, Physiotherapy, Nursing Assistants and Mental Health Support Workers.

The skill mix within the teams should include: bereavement counselling, psychotherapeutic expertise or specialist training in management of behavioural problems in dementia. Furthermore, it was recommended that the teams should be further developed to include patient advocacy and input from physiotherapy, speech and language therapy, dietetics, podiatry, and community pharmacy.

Stakeholders reported that it is more important to ensure that the appropriate skills are available as opposed to how a team is structured. Therefore Trusts are reluctant to develop one type of team that is structured in the same way across all Trusts. Guidance from the Department is required to confirm whether Trusts will be required to each establish a specific Specialist Multi-Disciplinary Team.

The skill mix currently available should be reviewed to ensure all of the skills identified by Bamford exist. Ongoing training would be required regarding assessment.

(ix) Key Worker

The Review recommended that anyone with a diagnosis of dementia or long-term severe functional mental illness should be assigned a Key Worker throughout the duration of their illness.

It was reported that there would be no workforce implication resulting from this recommendation as a named contact could be allocated from members of existing Older People's Teams.

(x) Co-ordinating Discharges / Dementia Liaison Nurse

The Review recommended that all discharges for older people with mental health issues should have a dedicated discharge worker.

The majority of Trusts have a Discharge Co-ordinator who could undertake this responsibility would be undertaken by the Co-ordinator.

3. Special Groups

(i) Younger people with dementia

Bamford recommended that a service for younger people with dementia should be located within either the Mental Health Programme or Older People's Programme of Care. The review also recommended that there should be residential respite provision for these younger people for short breaks in a facility linked to an assessment / rehabilitation unit. Furthermore the Review identified potential for joint developments with the Brain Injury service for assessment facilities, respite care and specialist units for those younger people with extreme behavioural problems.

Work is required to establish the configuration of the service needed to support the estimated 450-500 younger people concerned. It is envisaged that additional social workers, community psychiatric nurses, and occupational therapists will be required to staff the service.

(ii) Learning Disability, Dementia and Functional Mental Illness

Bamford recommended that older people with learning disabilities (and who are already known to learning disability services) who develop dementia should remain within the learning disability programme of care for the purposes of continuity of care. The additional support should be delivered via "In-reach" expertise as required. The review also recommended that there should be the ability to care for people with mild learning disability who develop dementia within mainstream services if requested by the patient.

It was reported that learning disability services staff should be equipped with dementia skills via an appropriate dementia training course and that FMI and dementia should be developed as modules of core MH training.

3.5 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

This section describes the Bamford vision for CAMHS and discusses the reform required and its workforce implications.

3.5.1 Vision for Child and Adolescent Mental Health Services

Figure 3.3 illustrates the Bamford vision for CAMHS. The vision is based on a 4-Tier model that integrates the services of the statutory, voluntary and community services and involves collaborative working between a number of different departments, particularly health and education. The vision was informed by the following principles:

- Comprehensive services: addressing the child's physical, emotional, social and educational needs;
- Individualised services: taking a holistic view of the child including family and community contexts;
- Minimum restriction: least restrictive services & partnership approach;
- Family-focus: the child's family or surrogate family should be a full partner;
- Case management: case management or similar mechanisms used to ensure that the child can avail of multiple services in an effective, co-ordinated manner;
- Early intervention: systems and services to support the early identification and intervention;
- Service transition: smooth transition into the adult service system;
- Cultural competence: staff should respect diversity; and
- Inclusivity: all children who require mental health services should be able to access those services regardless of physical, mental or developmental ability.

Figure 3.3
Bamford's CAMHS Model

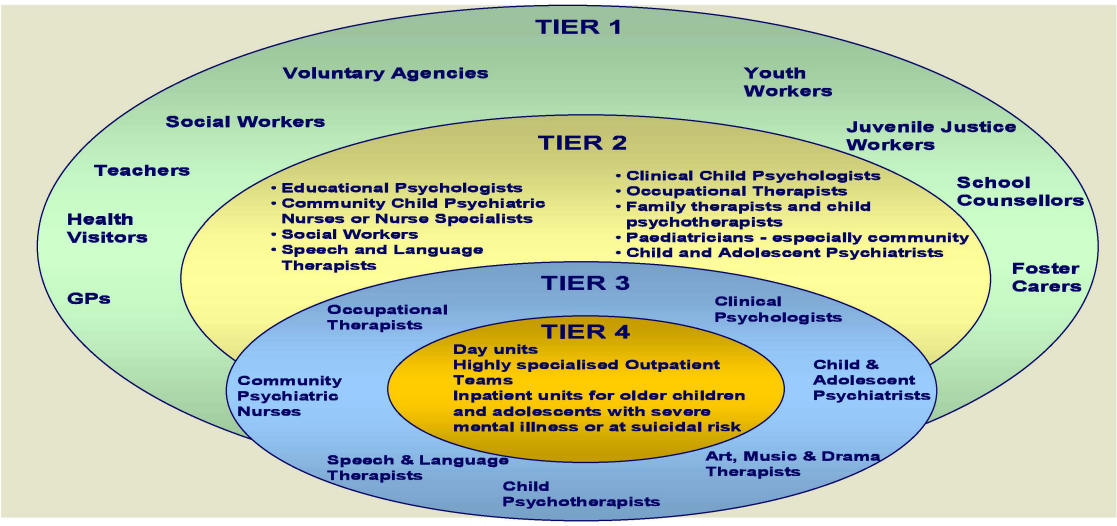


Figure 3.4 summarises how the stepped care model applies to CAMHS including the various staff groups delivering services at each tier.

Figure 3.4
Stepped Care Model for CAHMS

Tier 1	Tier 2
– Offers interventions to children with mild to moderate mental health problems. – many are self limiting but may cause distress in the child or family and disruption to the child's learning. – It is usually the first point of contact between a child and family with primary care, education and/or voluntary and community agencies.	– The first line of specialist services. – Workers need to have completed a dedicated training in the assessment and treatment of a range of mental health disorders. – Workers operate as individual practitioners, offering interventions for mental health problems and mental disorders.
Tier 3	**Tier 4**
– Staffed by specialist CAMHS professionals from Tier 2 who become Tier 3 workers when they function together as teams for particular children and families. – Interventions are offered by professionals working in specialist multidisciplinary teams. – Provision of specialist services for more severe, complex and persistent mental disorders and illness. – Require professional training and specialist training opportunities. – Service should be accessible across NI at a number of centralised sites.	– Delivers very specialised interventions and care for the most complex or uncommon disorders or illnesses. – Includes very specialised clinics that are only supportable on a regional or national basis, inpatient psychiatric services for children and adolescents, residential schools and very specialised residential social care. – Partnership working between education, youth justice, health and social services is essential at this level. – Requires specialist training. – Services will normally have the same profile of professionals as at Tier 3.

3.5.2 Workforce Implications

The workforce implications for CAMHS relate to 3 main areas:

1. New and extended roles;
2. New and extended services; and
3. Specialist services.

1. New / Extended Roles

(i) CAMHS Managers

The Review recommended that managers are recruited to CAMHS services, each covering populations of approximately 250 - 300,000. The Review reported that the skills required for this role would not be found in any one profession.

This is a relatively new role and some of the Trusts have already employed a CAMHS Manager.

Key points
- A small number of posts will need to be recruited into and appropriate training will be required.

(ii) CAMHS Development Co-ordinator

Bamford recommended that a CAMHS Development Co-ordinator should be appointed by the Regional Health and Social Services Board (RHSCB) to facilitate the development of management structures relating to managed networks at local and regional levels across NI.

In England and Wales each region has a CAMHS Development Co-ordinator. The Regional CAMHS Advisory Group (Northern Ireland) is currently developing a job description for this role and there are plans for DE and DHSSPS to jointly fund one of these posts in each Board area. It is expected that these post holders will develop links with those in England and Wales performing a similar job.

(iii) Primary Mental Health (PMH) Workers

Bamford recommends that the role and complement of PMH workers within Northern Ireland should be expanded and that this role could be undertaken by professionals from any discipline with training and expertise in CAMHS. The expanded role should include:

- supporting education regarding CAMH services;
- aiding recognition of CAMH disorders and referral on; and
- assessing and treating some individuals with mental health problems at Tier 1 and Tier 2.

Key points
- The PMH Worker post does not operate consistently across all of the Trusts and is used in different Tiers of services; and
- Expanding the number and role of this post is not an immediate priority for Trusts but one that they may develop in the future.

(iv) Family Therapist and Child Psychotherapist Posts

The Review recommended that Family Therapist and Child Psychotherapist posts and their roles should be enhanced and developed in CAMHS.

The family therapist role is not new and Trusts agreed that more of these posts are required with some estimating that the current number should be doubled. Professionals filling these posts need to be trained in family therapy, family trauma, and psychotherapy. All CAMHS practitioners receive some family therapy training as part of their core training; however, it

takes four years to fully train family therapists whilst they are in service. Ideally family therapists will be in a position to act as consultants to other members of the CAMHS team.

The Family Therapist role does not sit within CAMHS in all Trusts; in some the role sits in the Women and Family Directorate and some stakeholders argued that the role should service more than one Directorate.

The Child Psychotherapist post is not new and is fulfilled by trained nurses or social workers who completed a final specialist year to become a child psychotherapist. This final element of training is not available locally with courses available in Ireland, Scotland and England. In total it takes between four and six years to become a Child Psychotherapist. The Child Psychotherapy Tier 3 service is managed in the EHSSB area by BHSCT, which also manages the regional clinical service. Local service in Northern Ireland does not currently meet demand.

Expansion of the inpatient provision for children is a priority to prevent some children being placed in adult inpatient settings and some being placed in England. Recruitment into posts is difficult and some Trusts are targeting students in their final year at university to help address this.

Key points:
- More family therapists and child psychotherapists need to be trained and recruited;
- Due to the length of time it takes to train personnel in either post plans need to be made now to ensure that appropriate numbers of both posts are developed in the future;
- Additional social workers and nurses will need to be trained to become family therapists and child psychotherapists;
- Clarification is required regarding whether the family therapist role should sit within CAMHS in all Trusts; and
- Tier 4 services are not resourced by the most experienced staff in the service.

2. New / Extended Services

(i) Increased age limit of service

Bamford recommended that CAMHS should be provided to children and young people up to their 18th birthday.

There is a lack of a regional and co-ordinated approach regarding the upper age limit for CAMHS and some Trusts are restricted in terms of delivering the service to children and young people up to their 18th birthday because Clinical Psychologists in the service cannot treat those over the age of 16 due to capacity issues.

Key points:
- There is a lack of a regional and co-ordinated approach regarding the upper age limit for CAMHS; and
- Potentially additional Clinical Psychologists may be required to support service delivery.

(ii) Infants and Early Intervention

The Review recommended that a strategy for infant mental health and early intervention services should be developed.

Key points:
- There is a lack of consistent approach across the trusts regarding the extent to which infant mental health and early intervention services have been developed; and
- Potential that as these services develop further additional health visitors and social services staff will be required.

(iii) Learning Disability

Bamford recommended that severe learning disability inpatient provision should be provided for children and adolescents in a community based specific unit.

A business case for an 8-bed purpose built unit has been approved and the number of beds allocated in the unit to each Board has been split as follows: six for EHSSB, none for WHSSB, one for SHSSB and one for NHSSB. It is planned that the unit will be operational by the end of 2009. The unit will be used to place children and adolescents from Muckamore and concerns have been raised that there will be insufficient beds in it.

It is anticipated that the staff for the unit will be redeployed from Muckamore and will include Psychotherapists, family therapists, nurses trained in psychotherapy and children's LD nurses.

Bamford also recommended that specialist mental health services for children and adolescents with learning disabilities should be commissioned as part of specialist mental health services for all children. The Review also highlighted the need for a small number of key staff to be trained in both learning disability and mental health disciplines to lead development of the service.

This has not to date been taken forward.

Key points:
- It is anticipated that the community based inpatient provision for children and adolescents with a severe learning disability will be delivered by redeployed staff from Muckamore; and
- Potentially a small number of staff will require training in learning disability and mental health disciplines to deliver specialist mental health services for children and adolescents with learning disabilities.

(iv) Autistic Spectrum Disorder

The Review recommended that an ASD assessment service should be established.

Currently each Board / Trust has its developed ASD services and there is no uniformity across Northern Ireland. An ASD Strategy and Action Plan has been developed which aims to introduce a more regional, consistent and streamlined care pathway for those with ASD in Northern Ireland. The Plan also aims to support Trusts' practitioners to share knowledge and working practices. It is anticipated that the finalised Strategy will be published in early 2009.

Key points:
- Full workforce implications should be addressed in support of the finalised Strategy.

(v) Physical and sensory disabilities

The Review recommended that there should be delivery of mental health services to children with physical and sensory disabilities and illnesses.

Currently Clinical Psychologists from England visit Northern Ireland once a month to deliver this service. The National Deaf Children's Society undertook a review which recommended that 2 workers should be employed locally to support the delivery of this service

Key points:
- A small number of additional clinical psychologists are required to deliver this service.

(vi) Occupational therapy

Bamford recommended that Occupational Therapy services should be developed as a core element of CAMH provision.

It was reported that this is a lower priority action for Trusts.

Key points:
- More occupational therapists will need to be trained and recruited for this service but it is anticipated that numbers required will be low and it is not an area that Trusts will develop in the near future.

(vii) European Working Time Directive (EWTD)

Bamford recommended that CAMHS out of hours services should be developed to meet the directive.

This will have a resource implication within CAMHS teams with general agreement that it will not require more medical staff but that Consultants will need to be accessible if required. Fulfilling this recommendation is deemed to be a medium term priority.

Key points:
- As a medium term priority, additional staff will be required to deliver out of hours services in line with the EWTD.

3. Specialist Services

(i) Specialist mental health services for children and adolescents with a learning disability

Bamford recommended that there should be a specialist mental health service for children and adolescents with LD and small number of staff trained in LD and MH to lead this.

Key points:
- There is an aspiration that in the longer term CAMHS would have staff trained in LD and MH;
- This would require an interagency approach with Youth Justice and the voluntary sector;
- In the shorter term there is a need for professional staff to have placements in LD settings during their core training.

(ii) CAMH Community Psychology Service

The Review recommended that there should be a CAMH Community Psychology Service delivered regionally through the CAMHS network. This would result in Psychologists working as part of Community Development Teams in a new way of working.

Key points:
- Identification of appropriate skill-mix and recruitment will be required to support this service.

(iii) Abuse and Sexually Harmful Behaviour

Bamford recommended the development of intervention services for children and young people that have suffered abuse and that display sexually harmful behaviour.

Key points:
- Currently the service delivered across Trusts is inconsistent;
- The voluntary and community sector play a key role in service delivery; and
- Development of the service will require additional Tier 2 and Tier 3 staff (most likely to be social workers).

(iv) Eating Disorders

The development of specialist child and adolescent outpatient services for feeding and eating disorders was recommended in the Bamford Review.

There has been a £1 million investment in these services during the past few years; as a consequence CAMHS teams have been augmented by an additional 11 WTE across the Trusts with working links established with the adult eating disorder teams.

The need to develop an in-patient service has also been identified given the current cost and acceptability of sending patients to the mainland UK for treatment. A Team has been developed to deliver the service which has access to sessions with a consultant psychologist, dietician, nurse and social worker. The outputs of this approach are currently being reviewed

Key points:
- Review of CAMHS eating disorder staffing requirement to take place once both the adult and CAMHS teams have been in operation for a time and in the light of other inpatient developments for eating disorders (as described in the adult eating disorder section).

(v) Psychological trauma

Bamford states that development and expansion of evidence based services to address psychological trauma in children should be taken forward. There is potential to expand core CAMHS teams in order to deliver the service locally.

Key points:
- The Northern Ireland Centre for Trauma and Transformation (NICTT) is currently being evaluated. It is likely that Psychiatrists, Psychologists, and Psychological Therapists would be involved in any local service delivery;
- It is considered that the voluntary and community sector could play a key role;
- Workforce implications to be further considered following the evaluation of the NICTT

(vi) Challenging behaviours

Bamford recommended that community based teams focusing on outreach, service flexibility and community development should be developed for young people with perceived challenging behaviours.

Key points:
- Currently this service is delivered through social work teams. There is a need for these teams and CAMHS to develop their Tier 2 and Tier 3 services which will require new ways of working;
- No additional workforce implication identified.

(vii) Complex Needs

Bamford recommended that models for assertive outreach / intensive treatment / day unit treatment for complex needs should be developed.

Funding of approximately £1 million was invested in the development of such services in recent years and each Trust has developed its own service.

Key points:
- there is not a consistent approach across all trusts;
- the highest priority development is the provision of day care services;
- the biggest pressures the service faces are from waiting lists (the waiting list agenda came after Bamford and therefore the Review did not account for the agenda's waiting list targets), delayed discharges, and inappropriate inpatient facilities;
- it is anticipated that independent providers will enter the Northern Ireland market and that this will automatically change the shape of service provision, although it is impossible to predict this in the absence of any firm plans;
- need for additional appropriately trained nursing staff and social workers to deliver day care services.

3.6 LEARNING DISABILITY SERVICES

This section describes the vision for LD services and discusses the changes required and their workforce implications.

3.6.1 Vision for Learning Disability Services

The vision for LD services depicts a multi-agency and multi-sector model that operates across various settings, and provides a comprehensive range of services for people with a learning disability that aim to maximise social inclusion and improve quality of life. The service model includes a range of ongoing supports to maintain people with a learning disability in the community and specialist diagnostic, assessment and treatment services (community and hospital based) when required. It is underpinned by the following principles:

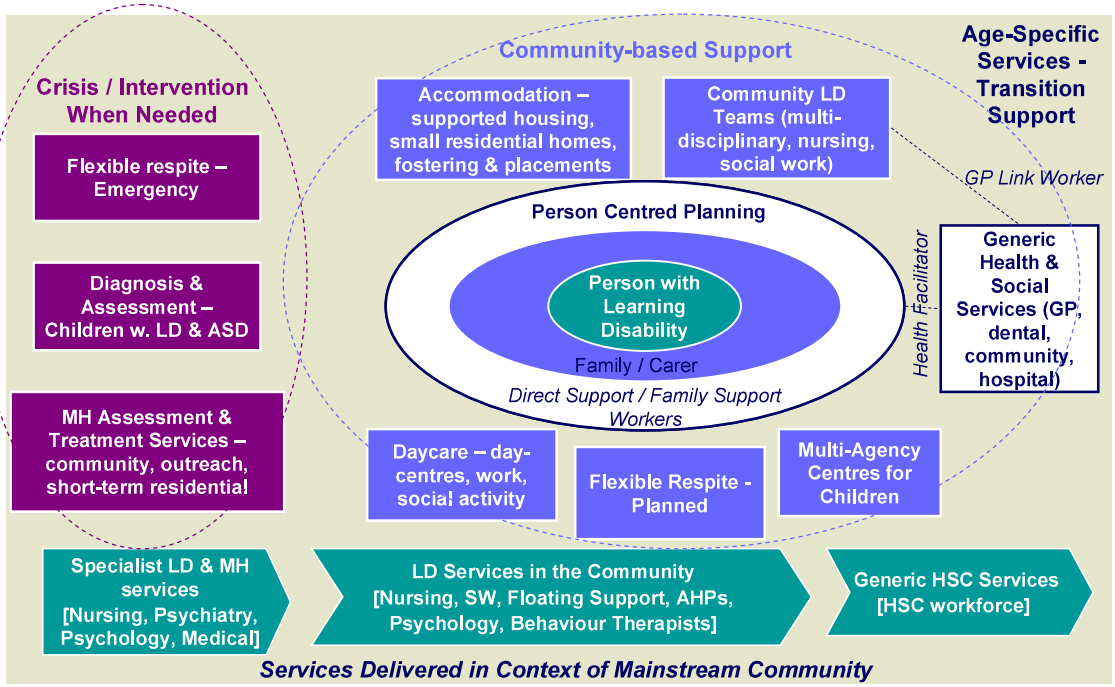
- ensuring that people with a learning disability:
  - have access to mainstream services;
  - participate in decisions affecting their lives;
  - have equal access to opportunities as they move into adulthood;
  - be supported to age well in their neighbourhoods;
  - be supported to enable them to live in the community;
- supporting families and carers of people with a learning disability;
- accessibility of high quality, locally based, health services;
- ensuring that health and social care staff are confident and competent in working with people with a learning disability; and
- joint working across sectors and settings to improve the quality of life of people with a learning disability.

The support model should operate in the context of mainstream services rather than as a discrete, segregated system. Services should be age-specific, reflecting the different needs of a person with a learning disability over the course of their lives and providing particular support at transition points, e.g. at first diagnosis, starting and finishing school, entering employment and vocational training, and moving between children's, adults and older people's services. The model involves co-ordination of services across several interfaces:

- the statutory and independent sectors;
- other Bamford domains, for example, in respect of people with a learning disability who also have mental health problems as children, adults or older people;
- mainstream health and social care services, for example, GP, dental, primary care and hospital services; and
- non-health and social care services, for example, education, employment and training, housing and community development.

Figure 3.3 illustrates the model for LD services described in the Bamford Review.

Figure 3.3
Bamford's Learning Disability Model



3.6.2 Workforce Implications

The workforce implications for LD services relate to 3 main areas:

1. New and extended roles;
2. New and extended services; and
3. Specialist services.

1. New / Extended Roles

(i) Key Worker

Bamford recommended that Key Workers should be available for all people with a learning disability using services. They would assume the primary responsibility for co-ordinating service intervention and delivery and lead on the production of Family Support Plans.

Key points:
- A Key Worker role is already provided by professionals in multi-disciplinary Community Learning Disability Teams (CLDTs);
- Nurses and social workers perform this role but it could be carried out by other appropriately trained professionals;
- Current CLDT resources do not support the level of Key Worker contact envisaged by Bamford;
- Services are not currently age-differentiated and specific needs exist for early years and transitions;
- Additional staff resource is required to fulfil this role fully.

(ii) Family Support Worker

The Review recommended that a Family Support Worker role be introduced to provide practical support to families of people with learning disability.

Key points:
- The Family Support Worker role does not currently exist in any of the Trusts, although all have plans to provide a family support model and the WHSCT will be introducing a Family Support Worker role;
- Role description, career pathway and appropriate training needs to be identified.

(iii) Health Facilitator

Bamford recommended that a Health Facilitator role be introduced to assist a person with a learning disability to achieve and maintain good physical and mental health by facilitating access to primary care and acute hospital services. It was recommended that one facilitator is available for every 110-120,000 population (i.e. 15-16 for the region).

Key points:
- Several of the Trusts are developing health promotion services for LD including role similar to the Health Facilitator role but a common approach does not exist across the region;
- The health facilitator role is anticipated to be taken up by LD nurses.

(iv) GP Link Worker

A further new role in the health promotion field was identified by Bamford. The GP Link Worker would act as a link between CLDTs and GP practices, provide staff training in health centres on learning disability and physical/mental illness, develop effective partnership work between primary care and LD services, and assist in health promotion for people with a learning disability.

Key points:
- The GP Link Worker role is a new role and not currently being developed in any of the Trusts
- The role should be planned in the context of a range of roles, training and other services to promote good physical health among people with a learning disability

(v) Direct Support Workers

The Bamford Review recommended that work continue to make people with a learning disability aware of the availability of Direct Payments as an alternative to support packages provided directly by Trusts. An increase in the uptake of Direct Payments would result in an increase in the number of Direct Support Workers employed by people with a learning disability, and expansion of the range of roles they undertake. Bamford recommended that that Direct Support Workers complete standard induction and foundation training (as per NISCC requirements) and that support is provided for their employers (i.e. people with a learning disability in receipt of Direct Payments).

Key points:
- Direct Support Worker roles are seen as an important element of a tailored service for people with a learning disability;
- Induction training is required for Direct Support Workers as well as promotion of Direct Payments uptake.

2. New and Extended Services

(i) Community based mental health assessment and treatment services

The Review recommended that services should be developed to support people with a learning disability who have specific mental health needs and / or challenging behaviours. They should include outreach to individuals, families and community services and short-term intensive treatment for those within a residential facility which may be approved to treat people under mental health legislation. Services should also target those with severe mental health problems including children and young people (with appropriate interface with CAMHS).

Key points:
- community based assessment and treatment services have been or are due to be developed in each of the Trusts;
- additional behaviour support and forensic services are required to support resettlement in the community;
- there is some opportunity for redeployment of hospital staff into these services but additional staff will also be required (professional and support staff specialists in nursing, social work, psychology and psychiatry);
- significant training needs have been identified for new / redeployed staff providing these services in challenging behaviours, forensics, therapies and community treatment, and community based practice.

(ii) Flexible respite – emergency and planned support and accommodation

The Review recommended that a much improved range of respite options be developed for people with a learning disability to provide home based support, community based activities, family placements, and residential respite.

PfA sets outs a target for the provision of an additional 200 respite places by 2011. In order to meet this target, all Trusts are expanding their respite care through development of community based respite facilities.

These will require experienced LD nursing, social work, and support staff who can provide respite care for people with complex physical and psychological needs. They will be required to operate at weekends and out of hours. Both these factors may make these positions difficult to recruit into.

The development of family based respite options is also a priority for those people with less complex needs. Recruitment of families who would provide these services is proving difficult and stakeholders suggested the need for regional coordination of recruitment and training.

Key points:
- Additional staff will be required to provide services in community based respite facilities being developed in each Trust;
- Regional coordination is required to develop family based respite care.

(iii) Community-based accommodation (for adults)

The Review recommended that accommodation for people with a learning disability be in community based supported housing and residential settings. PfA targets have been set to support the resettlement of people from hospitals into community accommodation.

Key points:
- All Trusts are increasing the number of supported living places available;
- New statutory provision is being developed but most supported living is provided by the independent sector;
- Domiciliary care support is also provided to maintain people with a learning disability at home with their families;
- Additional professional nursing and social work staff will be required as well as a range of support staff (Band 3 and 4) to provide these services;
- Increasingly complex needs will be supported in supported living facilities and at home as the resettlement programme progresses – this will challenge efforts to recruit, particularly into support roles;
- New roles were also identified for brokers, managers and team leaders.