Muckamore Abbey Hospital Inquiry
Witness Statement

Second statement of Mark McGuicken, Director of Disability and Older People, Department of Health

Date: 26 May 2023

Further to my two evidence sessions at the Inquiry on Monday 3 April and Wednesday 19 April 2023, I, Mark McGuicken, make this Addendum statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry to provide the Panel with additional information on a number of the queries that arose during my evidence sessions. In addition, this statement also provides the first Departmental evidence on module 3 (f), 'Policies and procedures concerning patients' property and finances.'

In this statement I will continue to exhibit any documents using my initials "MMcG", and will number these sequentially to follow on from my first statement, so the first document exhibited in this addendum statement will be "MMcG/175".

During the course of my evidence sessions on 3 and 19 April, in response to a number of questions I undertook to provide further information or clarification. This statement provides the Department's response to these queries. For ease of reference, I have included the relevant page number where each of the queries arose in the transcript of my evidence session.

Queries from 3 April

What was the RQIA inspection report that led to the set up of MDAG? - exhibit a copy of the inspection report (p14)

1.1 I referred in my evidence to the Muckamore Departmental Assurance Group, and I indicated that this Group had been established in 2019 following a report of an RQIA inspection of the hospital. I also referred to a letter RQIA sent to the Department following that inspection report.

1.2 RQIA carried out an unannounced inspection of MAH on 26 – 28 February 2019, which raised a number of concerns about the operation of the hospital and recommended implementation of a special measure in relation to MAH, specifically the establishment of two taskforces; one to stabilise the hospital and one to manage, deliver and govern the resettlement of the remaining delayed discharge patients in the hospital.

1.3 I have included a copy of this report at MMcG/175, and copies of two letters under Article 4 of the HPSS (Quality, Improvement and Regulation (Northern Ireland) Order 2003 (Article 4 letter) which RQIA issued to the Department following this inspection at MMcG/176 and MMcG/177.

1.4 As a follow-up to this inspection, RQIA subsequently carried out a further unannounced inspection of MAH on 15 – 17 April 2019, and on foot of this issued a further Article 4 letter to the Department on 30 April, setting out the inspection findings and reiterating their previous recommendations that two taskforces be set up in order to address the issues. I have attached a copy of this report and follow-up letter at MMcG/178 and MMcG/179.

1.5 The Department subsequently established the Muckamore Departmental Assurance Group (MDAG) to reinforce and strengthen the existing governance arrangements, as well as giving the Department a direct line of sight on progress with the resettlement programme. MDAG was also intended to provide support to the BHSCT staff team at Muckamore and provide a mechanism for escalating any issues they may encounter. I have attached a copy of a letter to the RQIA in response to their inspection at MMcG/180 and a copy of a note of meeting with the RQIA, HSCB and the Belfast Trust at MMcG/181.

1.6 The Regional Learning Disability Operational Delivery Group was also established to provide the Department, through the Health and Social Care Board (HSCB), with assurance regarding the HSC response to the recommendations made in the 'A Way to Go' report (Review into Safeguarding at MAH) as well as to provide oversight regarding the commitments on resettlement made by the Department's Permanent Secretary in December 2018.

1.7 This Group was convened by the HSCB and was responsible to the Muckamore Departmental Assurance Group (MDAG) through the Mental Health and Learning Disability Improvement Board.

1.8 In addition, at the Department's request the HSCB identified a dedicated member of staff to work full time with the Trusts and the team on site in MAH to deliver on the resettlement commitments and the SAI report recommendations, as well as support the stabilisation of the hospital and contingency planning.

1.9 The Department also secured the input of an Ex Director of Nursing/Trust Chief Executive to work alongside the Belfast Trust to review and stabilise the nursing team at the hospital.

Which organisations assumed the functions/role of the HPSS Management Executive on its dissolution in 2000? (p25)

2.1 I understand the HPSS Management Executive was primarily established to act as the operational arm of the Department. It was intended to oversee and support the establishment and performance of the HSS Trusts. As such it was charged with ensuring that contemporaneous Government policies in relation to health and social care, such as the operation of the internal market in healthcare and the delivery of services, were properly implemented.

2.2 The Chief Executive of the Management Executive was responsible for overseeing the implementation of the health and social care policies which Ministers wished to pursue, and delivering on the Department's statutory duty to secure health and social care services for the population of Northern Ireland. This broad set of responsibilities included a number of key issues:

- the development of appropriate measures and programmes;
- dissemination of information and instructions;
- monitoring the delivery of objectives;
- interacting with the various health and social care bodies on their performance;
- securing and providing appropriate levels of funding;
- ensuring proper stewardship of public money;
- maintaining proper lines of governance and accountability; and
- keeping Ministers informed and briefed on significant issues.

2.3 The HPSS Management Executive ceased to exist on the creation of the Northern Ireland Executive in 2000. It was not replaced and its functions were reallocated within the Department.

2.4 With the increase around this time in the number of Departments to meet the requirements of the newly established Northern Ireland Executive, the Department relinquished responsibility for social security. The reduced scope of the Department meant that the Permanent Secretary could take on the former responsibilities of the HPSS Management Executive Chief Executive, including those of Accounting Officer for Health and Social Services expenditure. The Chief Executive became a Deputy Secretary within the Department with particular responsibility for policy and operational matters within the

HPSS, and the authority vested in the Management Executive Chief Executive role was absorbed in the role of the Department's Permanent Secretary.

Was the improvement of commissioning arrangements the key objective for the SPPG being integrated into the Department? (p28)

3.1 In 2014 the Department commissioned Sir Liam Donaldson to carry out a review of HSC governance arrangements. His report *"The Right Time, The Right Place*", is exhibited at MMcG/182.

3.2 The report was published in 2015 and recommended (at p44) a review of HSC commissioning arrangements. In response the then Minister initiated a review of HSC commissioning, and the report of the review was published in October 2015. A copy of the report is at MMcG/183.

3.3 Following this report, the then Minister Simon Hamilton MLA set out proposals to reform the administration arrangements for the HSC, including the closure of the HSCB.

3.4 A public consultation was carried out on the Minister's proposals and the consultation affirmed the need for change, highlighting that a full, competitive commissioning process is too complex and transactional for an area as small as Northern Ireland. Respondents felt that existing arrangements were not lean or agile enough to keep pace with changes in health and social care, and shift the focus towards public health.

3.5 The decision was re-affirmed by the then Minister Michelle O'Neill MLA with the launch of '*Health and Wellbeing 2026: Delivering Together*' (MMcG/5) in October 2016 which confirmed the closure of the Board as part of a wider transformation agenda, reducing bureaucracy to make the decision-making process more streamlined, and planning and managing services to promote collaboration, integration and improvement in service delivery.

Is there data or evidence to support the assertion that the integrated model HSC model used in NI is more effective than the England model? (p32)

4.1 There does not appear to be a significant body of research into the effectiveness of the integrated care model used in Northern Ireland judged against the delivery structures in England.

4.2 A report published in 2013 by the King's Fund (MMcG/184) examined the respective approaches taken to integrated care in each of the three devolved administrations with a view to drawing out any learning for England. The report noted that integration in health and social care *'has been an explicit policy goal of successive UK Governments over the last two decades'*, and also that *'There is widespread acceptance that an integrated system of health and social care can lead to better outcomes for service users, particularly for older people with complex needs.'* (p2).

4.3 However, the report goes on to note from the Northern Ireland perspective *'the lack of robust evidence to assess and evaluate the outcomes of this unique system. The effectiveness or otherwise of the integrated system is difficult to assess owing to the weakness of the existing data.'* (p21) and concludes that there were *'some local examples of innovation but little systematic evidence that integrated health and social care has demonstrated measurable improvements for the population.'* (p78).

4.4 The Health Foundation and Nuffield Trust jointly published a report in 2014 (MMcG/185) which sought to compare the performances of the four UK health systems and noted that *'it is becoming more difficult to compare the performance of the health service across the four countries because of differences in the way that data are collected.' (p8)* The report also concluded that *'there are few conclusive* *differences in satisfaction levels with health services between the populations of each country'.* (p7).

Who provides advice to the DoH on the level of funding necessary to maintain minimum standards for care? Do PHA have a role in this? (p37)

5.1 The required level of funding for HSC services is determined and allocated through the commissioning process, as set out in the HSC Framework Document (section 4, p32-37) which I exhibited at MMcG/31. This process requires service providers to ensure that the services they deliver comply with all the relevant standards of care set by the Department. These include minimum care standards for services regulated under the HPSS (Quality, Improvement and Regulation) (NI) Order 2003, as well as all relevant safety and quality standards and legislative requirements.

5.2 On an annual basis, the Department sets the strategic context for the commissioning of health and social care services through the Commissioning Plan Direction. Under section 8(3) of the 2009 Act, the HSCB was required to produce an annual commissioning plan which required agreement from the PHA (section 8(4)) before publication. This plan translated the strategic objectives, priorities and standards (including minimum care standards) set by the Department into a range of plans and associated investments for the delivery of high quality and accessible health and social care services.

5.3 HSC Trusts are the main providers of health and social care services, and they responded to the annual Commissioning Plan by preparing individual Trust Delivery Plans (TDPs). The HSCB, now SPPG, agrees Service and Budget Agreements (SBAs) with HSC Trusts, which detail the services to be provided and associated volumes, costs and outcomes, and the individual Trust Delivery Plans set out what Trusts will achieve, how they will meet Ministerial targets and standards, and the resources that they will use in delivering services. In addition to agreeing SBAs and TDPs, individual service developments may be subject to the completion of Investment Proposal Templates (IPTs).

5.4 The Department's budget allocation from the NI Executive budget settlement process at the start of the year dictates the funds available for commissioning services during each financial year. Where this was insufficient to meet service pressures (and taking account of any additional funding which might become available through the in-year Departmental monitoring round process), efficiency savings were required to achieve financial breakeven of the overall HSC system.

5.5 In developing the Commissioning Plan, SPPG is statutorily required to have regard to advice and information provided by the PHA and cannot publish the plan unless it has been approved by the PHA. SPPG and the PHA work together closely in supporting providers, through professional leadership and management collaboration, to improve performance and achieve desired outcomes.

Clarify dates of usage of Programme of Care (PoC) classification – earlier than 2008? (p39)

6.1 The PoC classification was first introduced for use by HPSS organisations in 1992.

6.2 Following the Korner review of health service statistical information in England in the 1980's, the Department led a review, guided by the 'Korner definitions' to produce guidance for Northern Ireland in 1992 to allow the capture of data by PoC.

6.3 The review was conducted with significant input from service and professional leads to ensure the required data definitions, data collation and reporting structures were reflected in the guidance. The data standards were designed to support the consistent capture and use of data across HPSS organisations. This was to allow both a consistent basis for management reporting information flows and it was considered that this would facilitate more accessible and understandable reporting to the public and users of the service.

6.4 Following the issue of the first version of the guidance in 1992, the Department designed some of their formal finance reports such as the Trust Financial Returns (TFRs) around these established categories. Whilst there has been some refinement to these reports over the years, they still largely follow the PoC structure.

Which PoC is used to record mental health care provided to people with a learning disability? (p42)

7.1 The PoC used to classify expenditure on individual patients care or treatment is determined by the consultant in charge of their care.

7.2 The Mental Health PoC includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties:

- Mental Illness;
- Child & Adolescent Psychiatry;
- Forensic Psychiatry; or
- Psychotherapy

7.3 It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, or day care. In addition, this programme includes all community contacts where the primary reason for the contact was due to a functional mental illness. If the reason for contact is that the patient has dementia, the activity is allocated to the Elderly Care programme of care.

7.4 The Learning Disability PoC includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in the Learning Disability specialty. It also includes all activity, and resources used, by a hospital consultant in this specialty, in relation to an outpatient episode, day case, or day care.

7.5 In addition, this programme includes all community contacts where the primary reason for the contact was due to learning disability. All community contacts with Down’s Syndrome patients who develop dementia, for any dementia related care or treatment are included, as are all contacts in learning disability homes and units.

Was spend on LD services treated as a special case and given protection in the budget? (p44)

8.1 In common with all other services, funding is allocated for the provision of Learning Disability services on the basis of assessed need, as identified through the established commissioning arrangements. No particular protection is given to the budget for Learning Disability services.

Does Community Services expenditure include community MDTs, day services and staff costs for community residential care? Are nursing care costs and social care costs in residential care classified separately? (p48)

9.1 The cost for Community Services within Trust Financial Returns (TFR) includes costs associated with Multi-disciplinary Teams (MDTs), however there is not an individual category of expenditure for MDTs. Instead, in the TFR the salary costs for members of MDTs are recorded in the total salary costs for the individual profession to which they belong (e.g. AHPs, Community Medical/ Dental, Nursing).

9.2 Day Opportunity and day-care costs are recorded separately within the Personal Social Services expenditure category, rather than in the Community Services expenditure category.

9.3 Total costs associated with community residential care are recorded with the Personal Social Services expenditure category rather than the Community Services expenditure category. The expenditure is not split between staff costs and goods and services costs. There is a split between Adult Residential Homes expenditure and Children's Residential Homes expenditure. Within these two categories, where relevant, there is a further split between Independent Sector expenditure and Statutory (HSC) Sector expenditure.

9.4 Nursing care costs and social care costs in residential care are not classified separately within the Personal Social Services category of expenditure. However, total costs associated with Nursing Care Homes are recorded separately to those of Residential Care Homes within the Personal Social Services category.

Can we explain the footnote to the funding table setting out PoC spend from 1999 - 2019, which refers to 'sub-commissioning spend'? (p52)

10.1 Sub-commissioning refers to the situation where one Trust may provide certain clinical services on behalf of another Trust and receive payment for doing so. The guidance on how Trusts should treat such items in their TFR returns was amended for 2003/04 to ensure consistency of treatment across Trusts and prevent double-counting of expenditure.

Can MAH running costs be provided for years prior to 2016-17? (p55)

11.1 The information provided on the running costs for MAH for the three years from 2016-17 to 2018-19 was collated by the then HSCB as a special exercise at the request of the Department and they are not therefore available in this form for other years. I attach at MMcG/186 the letter from the Department to the HSCB which commissioned this work. This was a one-off exercise to inform contingency planning for the future of MAH, and this information was not routinely produced in this form by the HSCB (or now SPPG). Should the Inquiry consider it necessary for a similar exercise to be repeated for other periods this would require the information to be commissioned from the Belfast Trust and is likely to take significant time and resource to produce.

The table shows £30 million Belfast trust expenditure on hospitals in the LD PoC – if £18m was spent on MAH where was the remaining £12 million spent - on other hospitals? (p56)

12.1 As the tables exhibited at MMcG/19 and MMcG/21 relate to Trust expenditure on services, the Department asked the Belfast Trust for further clarification on this query. The Department understands that the Trust consider that these two tables were produced for different purposes and therefore caution should be exercised in drawing direct comparisons between the two. Given this position the Inquiry is likely to obtain more comprehensive evidence from the Trust.

In relation to the 15% pay uplift for staff working at MAH, was the uplift pensionable? Was it consolidated? (p58)

13.1 This 15% uplift for staff is not consolidated, and as such does not form a permanent part of the staff members salary. The uplift is paid by submission. Staff are required to submit a time sheet every month to claim for the hours they work on site minus sick leave, annual leave, or shifts off site. A personalised specific time sheet for every staff member is submitted. This uplift is not pensionable.

13.2 For the Inquiry’s information, I have exhibited the relevant Directions made by the Department on the enhancement at MMcG/187, MMcG/188, MMcG/189 and MMcG/190.

There was an underspend on staffing from 2016, prior to the allegations of abuse coming to light, why was this? (p59)

14.1 As responsibility for staffing at the hospital rests with Belfast Trust as the service provider, the Department raised this query with the Trust, and it is likely to be the best source for evidence around this issue. The Department understand that the Trust's position is that while it is not possible to identify a single cause for the underspend in staff costs in 2016/17, the context in which it occurred is a key contributing factor.

14.2 The underspend occurred in a context of reducing levels of recurrent and non-recurrent funding year on year for the hospital, reflecting the strategic and operational emphasis on resettling patients into community settings and closing wards that were no longer occupied.

14.3 Over the period 2014/15 to 2016/17 actual staffing started to reduce as wards were closed.

14.4 At the same time, recruitment of staff required to provide care to patients at the hospital became increasingly difficult. Difficulty recruiting to this service area remains a persistent challenge.

Has there been an updated Framework Document since 2011? What is the review process for this document? (p64-65)

15.1 The Department published the Framework Document in September 2011 to meet the statutory requirement placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department.

15.2 The legislative position on review is as stated below:

5. (3) The Department–
(a) shall keep the framework document under review; and
(b) may from time to time revise it.

15.3 A review was undertaken in 2014 which did not result in any published changes to the Framework.

15.4 A Memorandum to the Framework Document setting out a temporary change for a period of two years with effect from 1 June 2020 was introduced to establish the Rebuild Management Board in response to the COVID pandemic. The addendum was in place from 1 June 2020 – 31 May 2022 and was revoked by former Minister Swann in August 2022, following a review and cessation of the Rebuild Management Board.

15.5 Due to the closure of the HSCB on 31 March 2022 and the transfer of functions to the Department, the Framework is currently being reviewed and updated to reflect this change.

What is the status of the Bamford Inter Departmental Ministerial Group? Does the Dept hold minutes of Group meetings and can these be provided to the Inquiry? (p67)

16.1 An inter-Ministerial group, chaired by the Minister for Health, Social Services and Public Safety was established in 2007 to oversee the work, drive forward the broad strategic changes required across Government and ensure that the issues requiring inter-Departmental co-operation were taken forward in a co-ordinated and coherent manner.

16.2 The Group had representation from all Departments charged with responsibility to deliver actions within the Bamford Action Plan. The Group was supported by the Inter-Departmental Senior Officials Group, and both Groups met to review progress on delivery of the overall

Bamford Vision and to consider ongoing delivery and implementation of Bamford related services.

16.3 By way of example, I include copies of the first and last minutes held by the Department from the Ministerial Group meetings at MMcG/191 and MMcG/192.

16.4 The Inter-Departmental Senior Officials Group is no longer active and there were no further meetings after 2015.

16.5 The Bamford Inter-Departmental Senior Officials Group was chaired by a senior Departmental official and supported the Ministerial Group. In addition to the Departments represented at Ministerial level, it also had representation from the Health and Social Care (HSC) Taskforce and the Bamford Monitoring Group which represented the views of service users and carers.

16.6 I have included a copy of the earliest and latest meeting minutes that have been identified by the Department within its records from the Bamford Inter-Departmental Officials Group at MMcG/193 and MMcG/194. A copy of the minutes pre 2009 have not been identified despite comprehensive searches. The early summer 2011 meeting was cancelled due to purdah and the later meeting in 2011 was deemed un-necessary by Inter-departmental Senior Officials Group as the publication of the Bamford 2012-2015 Action Plan had been delayed. No meetings were scheduled in 2012 as all Bamford business was forwarded directly to NI Executive.

16.7 Copies of all minutes of the Bamford Inter-Departmental Senior Officials Group and the Inter-Departmental Officials Group held by the Department can be uploaded to the Inquiry record platform if requested.

Can the evaluation of the 2nd Bamford Action plan be provided to the Inquiry? (p71)

17.1 I have exhibited a copy of the draft evaluation of the second Bamford action plan at MMcG/195 and the associated Annexes at MMcG/196, MMcG/197, MMcG/198 and MMcG/199.

17.2 The Department carried out an in-house evaluation of the second Bamford Action Plan (2012-2015) in 2016, in consultation with the other Departments and stakeholders responsible for its delivery. In general terms, the evaluation found that the Bamford Review and subsequent Action Plans had been a catalyst for the development of mental health and learning disability health and social care services in Northern Ireland.

17.3 The evaluation concluded that most of the actions contained within the Bamford Action Plans had either been completed or were being developed, subject to funding, and, in effect, mainstreamed into services and service development. For health and social care services, the Bamford principles are now embedded in policy and in service delivery and future service development.

17.4 In terms of the services which fall outside the remit of Department of Health, the actions committed to have largely been completed and there has been a mainstreaming of programmes of support for people with a learning disability or mental ill-health, to a greater or lesser degree, in services like employment services, further education and training, education, sports and leisure, transport and benefits.

17.5 The evaluation also recommended (p23-24) the formal accountability arrangements established to oversee the implementation of the Bamford recommendations should be stood down.

17.6 However, due to the collapse of the NI Executive in 2017, that evaluation report was not formally agreed by the Executive for publication at the time.

Clarify publication dates for LD Service Framework (p74)

18.1 The Learning Disability Service Framework was officially launched for implementation on 27 September 2012 at an event in Parliament Buildings. The launch was attended by officials from the Department, along with representatives from the Department of Justice and the Department for Social Development, NIPEC, the HSC Trusts, HSCB, RQIA, PCC, the Independent sector, the University of Ulster, MLAs, and also service users and their associated Groups.

18.2 The aim of the Learning Disability Service Framework was to improve the health and social wellbeing of people with a learning disability, their carers and families, through setting standards to promote social inclusion, reduce inequalities and improve the quality of care.

18.3 The Learning Disability Service Framework (2012), which I exhibit at MMcG/200, contained 34 standards and 85 associated Key Performance indicators which were evidence based and measurable. It included standards in relation to:

- Safeguarding and communication and involvement in the planning and delivery of services;
- Children and young people;
- Entering adulthood;
- Inclusion in community life;
- Meeting general physical and mental health needs;
- Meeting complex physical and mental health needs;
- At home in the community;
- Ageing well; and
- Palliative and end of life care.

18.4 The standards aimed to ensure that services were safe, effective and person centred. The HSCB and PHA identified an implementation lead for the project and an implementation plan was submitted to the

Department in April 2013.

18.5 The Service Framework closely aligned with the principles of Transforming Your Care. It did this through placing a key focus on person centred care which emphasised the importance of people with a learning disability being involved in their care needs while being treated fairly and with respect in the process.

18.6 The Service Framework was revised in January 2015 and a copy of this was provided in my previous statement at MMcG/33.

18.7 A further revision was published in October 2016, and I have included this at MMcG/201.

Who was responsible for oversight arrangements for implementation of the LD Service Framework, and assessing its impact? (p75)

19.1 In line with other established performance management arrangements, implementation and monitoring of progress towards delivery of the Learning Disability Service Framework was the joint responsibility of the HSCB and PHA. I have included at MMcG/202 a letter from the then Permanent Secretary of the Department formally requesting the HSCB and PHA to develop a plan for the phased implementation of the Learning Disability Service Framework.

19.2 A Service Framework Programme Board (SFPB), co-chaired by the Chief Medical Officer, was established in 2007 to oversee delivery of the programme of work to develop the suite of Service Frameworks, which included the LD Service Framework. In 2015 membership of the Service Framework Programme Board (SFPB) and its Terms of Reference (TOR) were redefined. Minutes of the Service Framework Programme Board can be uploaded to Inquiry record platform should the Inquiry wish to consider them.

19.3 The HSCB and PHA provided twice yearly progress updates on implementation of the LD Service Framework to the Programme Board. The SFPB last met on 6 December 2018.

19.4 In addition to this, the extant Accountability Review meetings and structures could also be used by policy leads to raise and address concerns should additional implementation assurance of this and other Service Frameworks by Trusts (other HSC Bodies) be deemed necessary by the Department.

19.5 A Regional Learning Disability Service Framework Implementation (LDSF) Group was established in 2014 to oversee the audit and implementation of the Framework. I attach a copy of their Terms of Reference at MMcG/203.

19.6 The Group was chaired by the HSCB and included a Project Coordinator from the HSCB and the Assistant Directors for Learning Disability from each of the five HSC Trusts.

19.7 The LDSF Group reported to an Agency Management Team (AMT) in the PHA and the Senior Management Team (SMT) in the HSCB. The AMT/SMT was chaired by the PHA/HSCB CEO.

19.8 The role of the Project Coordinator was to develop a range of data collection methods and audit tools to identify baseline information, which was used to develop indicators which were monitored and reviewed to measure improvement in standards over an agreed timescale.

19.9 Information was gathered from a number of sources, including existing datasets (such as for example, information gathered for Delegated Statutory Function Reports), an organisational audit of information held by Trusts, Case Note Review audits, and an on-line survey.

19.10 This information was used to inform RAG assessments of the LDSF standards as follows:

- Green - Standard achieved;
- Amber - Standard partially or almost achieved;
- Red - Standard not achieved;
- Black - Unable to make an assessment or issues with data collection;
- Purple - Awaiting data; or
- White - No target for this year

19.11 I have exhibited at MMcG/204 a copy of the 2017-18 end-year report on the implementation of the LD Service Framework which was prepared for the Service Framework Programme Board, and a copy of the accompanying RAG assessment of the standards and key performance indicators is exhibited at MMcG/205. This summarises the extent to which the standards set in the Framework were achieved.

Was the LD Service Framework published? (p77)

20.1 The Learning Disability Service Framework was published on the Department's website following its launch on 27 September 2012.

Was there a complaints mechanism for the LD Service Framework? (p77)

21.1 If a patient or a family member was not satisfied that the relevant standards in the Learning Disability Service Framework had been met, they could make a complaint to the providing Trust in line with that organisations Complaints Policy at the time.

What was the rationale for standing down the LD Service Framework? (p80)

22.1 The Service Framework Programme Board agreed in December 2018 that the Learning Disability Service Framework had come to the end of its lifecycle. The Department decided not to commission the then HSCB and the PHA to develop a new Service Framework in this area.

22.2 There was general consensus among Programme Board members that the value-added purpose and role of service frameworks more generally had become unclear, in particular given the range of other evidence-based practise and standards that existed and underpinned quality of care (for example, NICE standards).

22.3 In that context, it was determined that the RQIA would carry out a review of the Service Framework Programme and its continuing utility. However, due to competing priorities, this work was paused in September 2018 and has not yet since recommenced.

22.4 The safety and quality of services is not dependent on a relevant Service Framework being in place and there are many contributing factors which underpin clinical governance and protect and improve the quality of services. This includes the statutory duty of quality owed by Trusts. Service Frameworks were designed to build in quality indicators as an aid to commissioning and to supplement and build on extant arrangements for ensuring quality of services in the commissioning and delivery of services; not to replace or remove any of these extant arrangements or requirements.

22.5 Arrangements for ensuring safety, quality and improvement of services in general include but are not limited to the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 which established a statutory duty of quality on HSC Trusts under which they must have in place organisational arrangements to monitor and improve the quality of health and social services provided and the environment in which they provide them. The duty of quality extended at that time to the services commissioned by Trusts, by the former HSCB and by the Public Health Agency.

22.6 HSC Trusts must ensure that that they have appropriate organisational management, clinical governance and risk management arrangements in place to provide them with assurance and satisfy themselves in respect of services delivered to individuals. These arrangements will include for example an Executive/ Management Team led by the Chief Executive with responsibility including for assuring the quality of services delivered, and responsible to the Trust Board.

22.7 It is worth noting that National Service Framework programmes in England and Wales were also discontinued around the same time.

22.8 The intelligence developed through the LD Service Framework process informed the business case for a new Learning Disability Service Model (LDSM), and work to develop this new Service Model commenced in 2018.

22.9 In January 2023, the Department approved a strategic plan for Learning Disability, which aims to finalise the LDSM and ensure better integration with Children's Disability services. A task and finish group was established in March 2023 and an initial review of data has commenced to establish a baseline for Learning Disability services in NI. This work will draw on and be informed by learning from the Service Framework structures, and provide recommendations for how performance against relevant standards and indicators for Learning Disability services will be monitored in the future. It will also include a review of governance structures for Learning Disability services, with the aim of developing new overarching structures to oversee the implementation of the LDSM and ensure better accountability across HSC organisations.

Copy of the draft LD Service Model and LD Strategic Plan and its ToR to be exhibited (p82)

23.1 In 2018, the Department commissioned the HSCB to develop a new service model for adult learning disability services. The project aimed to provide a strategic response to the significant challenges across the programme of care, including health inequalities; growing complexity of need; transition from children's services, over-reliance on inpatient services and accompanying delayed discharges; accommodation gaps; a lack of meaningful day activity; insufficient short break provision and support for older carers. I have included a copy of the service model's Project Initiation Document, which includes the Terms of Reference at MMcG/206.

23.2 The draft service model was submitted to the Department in July 2021, and a copy of this was included in SPPG's statement to the Inquiry at BW/29.

23.3 The assessment of the draft model was significantly delayed by resources being diverted to dealing with the pandemic, with the result that the Department's evaluation was not finalised until March 2022.

23.4 The Independent Resettlement Review report (2022) that I have included at MMcG/207, noted at section 5.2.3, p25, that it remains important that the service model is brought to completion to underpin the delivery of an overarching strategy for learning disability. The progression of this work will inform the development of a commissioning plan for Learning Disability services going forward. In addition, implementing a consistent service model across Trusts will address the longstanding issue of regional variation in the provision of Learning Disability services.

23.5 Work to incorporate the Service Model into the wider Learning Disability Strategic Plan is underway. I have attached a copy of the draft Strategic Action Plan at MMcG/208. This document contains the draft Terms of Reference for the Task and Finish Group to progress work on the Strategic Plan at Appendix B.

In the absence of an LD Service Framework, what standards are currently being used? If there are none, how is the system held to account in the absence of standards? (p83)

24.1 The safety and quality of services is not dependent on a relevant Service Framework being in place and that there are many contributing factors which underpin clinical governance and protect and improve the quality of services. Service Frameworks were designed to build in quality indicators as an aid to commissioning and to supplement and build on extant arrangements for ensuring quality of services in the commissioning and delivery of services; not to replace or remove any of these extant arrangements or requirements.

24.2 Arrangements for ensuring safety, quality and improvement of services in general include but are not limited to:

- The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 which established a statutory duty of quality on HSC Trusts under which they must have in place organisational arrangements to monitor and improve the quality of health and social services provided and the environment in which they provide them. The duty of quality extended at that time to the services commissioned by Trusts, by the former HSCB and by the Public Health Agency.
- HSC Trusts must ensure that that they have appropriate organisational management, clinical governance and risk management arrangements in place to provide them with assurance and satisfy themselves in respect of services delivered to individuals. These arrangements will include for example an Executive/ Management Team led by the Chief Executive with responsibility including for assuring the quality of services delivered, and responsible to the Trust Board.

24.3 The RQIA was established under Article 3 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. The 2003 Order makes provision for the duties and responsibilities of the RQIA. These can be summarised as 3 main aims:

- Keeping the Department informed about the overall state and provision of health and social care services, and in particular, about their availability and their quality.
- Encouraging improvement in the quality of services by conducting reviews of health and social care organisations' clinical and social care governance arrangements against quality standards; and thematic and service reviews; and specific investigations as directed by the Department.
- Regulation of a range of establishments and agencies including but not limited to:
  - children’s homes;
  - day care settings;
  - nursing homes;
  - residential care homes;
  - domiciliary care agencies.

MDAG minutes from Aug 2019 to date (p89)

25.1 Copies of MDAG minutes from September 2020 onwards are available on the Departmental website. Minutes of these meetings have been exhibited at MMcG/209 to MMcG/228.

25.2 I have included a copy of the MDAG Terms of Reference at MMcG/229.

Does MDAG risk rate actions in the Action Plan? (p95)

26.1 Following a recommendation from the Department's internal audit team, a draft Risk Register was developed for the MAH HSC Action Plan and instigated in May 2021. I include a copy of this as at August 2022 at MMcG/230.

26.2 This has not been formally agreed by MDAG, pending the development of revised governance arrangements for oversight of the Action Plan and Learning Disability services more generally that I referenced above. Work on these changes is continuing.

26.3 At the August 2022 MDAG meeting, members were advised that the draft Risk Register would be re-evaluated in light of proposed changes to reporting arrangements. A move to a thematic reporting approach was agreed at the October 2022 MDAG meeting. A copy of the minutes from this meeting have been provided at MMcG/226 and this is the form the report has taken since that date. I include an example report at MMcG/231.

<u>Queries from 19 April</u>

Can you provide minutes from the Central Nursing and Midwifery Advisory Council meetings that specifically refer to learning disability? (p16)

27.1 The Department has reviewed minutes from these meetings over the period from December 2013 to date. I have included copies of minutes which include references to learning disability at MMcG/232, MMcG/233, MMcG/234, MMcG/235 and MMcG/236.

Have the recommendations on Agency and bank staff (p8, exhibit MMcG/53) from the Nursing and Midwifery Review Summary 2009 been implemented?(p18)

28.1 A search of Departmental records in respect of this review has been conducted, and this has identified that the Department has not retained records in relation to the implementation of the recommendations of the review. Since the report was published, the HRMS payroll system for HSC organisations was replaced by a new system, HRPTS, which is itself due to be replaced with a further new system, called EQUIP. The Department is unable to confirm if the HRPTS or EQUIP systems can identify where agency and/or bank staff are deployed as this is primarily an operational issue for the HSC Trusts.

28.2 In general terms however, the use of agency staff across HSC services is currently under review with a view to reducing the overall cost of agency staff and end the use of ‘off’ contract agency staff. The first part of this review will focus on nursing and midwifery agency use, with review of other professional disciplines being taken forward separately. As part of this work HSC Trusts are currently examining and reviewing the protocols and systems in place for commissioning the use of agency staff at an operational level. This work is due to be completed in line with the implementation of a new procurement framework for nurse & midwifery agency staff by June 2023.

In Exhibit MMcG/54, p52, there are a number of action recommendations relating to the area of supervision, including a number of timescales. Were these deadlines met? How are exercises of this kind filtered down to facilities such as Muckamore? (p21)

29.1 The Department has been unable to identify records relating to the implementation of these specific recommendations and has not to date identified anyone currently in post with the necessary corporate knowledge who can assist. In general terms however, good practice recommendations of this nature emerging from reviews or reports are taken account of through the commissioning arrangements, with service providers expected to deliver services in compliance with all relevant statutory obligations and in line with established evidence-based good practice guidance. Delivery of services is routinely monitored as part of the established HSC accountability and governance processes.

Has there been work undertaken between then and now to assess whether the supervision issue has been satisfactorily addressed? (p21)

30.1 In August 2022 NIPEC issued the Reflective Supervision Framework on behalf of the Chief Nursing Officer (CNO), Midwifery Officer and Executive Directors of Nursing, who endorsed the Framework for adoption and implementation by all organisations employing NMC Registered Nurses and Registered Midwives in Northern Ireland. Organisations were requested to share widely across their staff and to update existing policies, processes and procedures to reflect the new Frameworks which supersede the previous Supervision Guidance. The Executive Director of Nursing or Lead Nurse/Midwife of each organisation is responsible for the implementation and assurance within their organisations. The Framework also states that the Department will review the benefits and challenges of the implementation of Reflective Supervision and identify areas for further improvement.

Can a copy of the Review of Learning Disability Nursing Workforce that was initiated in 2021 be provided? (p27)

31.1 This report has not yet been completed, due to the impact of Covid and staff changes. The paper is currently in the final stages of completion, and a copy will be provided to the Inquiry once this is finalised.

Was the Northern Ireland Learning Disabilities Nursing Collaborative stood down in 2019 and re-established as the Registered Nurse Learning Disabilities Strategic Development Project Group? Why was the Northern Ireland Learning Disabilities Nursing Collaborative stood down in 2019? (p28)

32.1 In 2019 the CNOs across the UK noted the intention to stand down the four countries *Strengthening the Commitment* groups as it was felt they had achieved their objectives. *Living the Commitment* which was published in 2016, provided a summary of the activity linked to the Modernising Learning Disabilities Nursing Review Strengthening the Commitment across the four countries.

32.2 On 30 May 2019 the Department met with the Collaborative Co-Chairs and the NIPEC Project Lead to advise that the Department had commissioned a review of the role of registered nurses in the learning disability workforce in Northern Ireland. It was intended that the recommendations from this review would inform the workplan of the Collaborative going forward, and the NI Action Plan 2014 would no longer be the framework guiding the activity of the Collaborative. In the interim period, priorities and objectives for the Collaborative were identified and agreed with the Department. It was also noted that the PHA was leading a Learning Disabilities Service Model Review.

32.3 An annual report was submitted to the CNO on the 27 January 2020 providing an update on activity pending the publication and recommendations of the NI Review of Learning Disabilities Nursing.

32.4 During the pandemic, meetings and activity of the Collaborative was paused at the request of the HSC due to system pressures. It was agreed by the Co-Chairs of the Collaborative and the NIPEC Project Lead that the Collaborative members would reconvene as a means of keeping in contact and receiving updates from each organisation represented on the group. Two meetings were subsequently held by teleconference on 8 October 2020 and 15 June 2021. At the second meeting Collaborative members agreed that the NIPEC/RCN Professional Development Forum (PDF) should be reconvened.

32.5 NIPEC hosted an event on the 16 November 2021 by teleconference, which was attended by staff working in Learning Disabilities services including Registered Nurses Learning Disabilities, Learning Disabilities nursing students and medical staff. No further meetings of the PDF have been scheduled, pending the completion of the Departmental review.

32.6 The CNO commissioned NIPEC to establish a RNLD Strategic Workforce Development Project to oversee the implementation of the review.

32.7 It was recommended that the NI Collaborative be reconvened for a further meeting to:

- provide an overview of the Department's Review of RNLDs in NI including the findings and recommendations;
- update the Collaborative members regarding the work of the RNLD Strategic Workforce Development Project;
- formally stand-down the Collaborative in its current form and agree arrangements to establish an expert reference group aligned to the recommendations from the review;
- explore the establishment of a Community of Practice for RNLDs which it is anticipated will replace the NIPEC/RCN Professional Development Forum; and
- prepare and disseminate a NI Collaborative Communique detailing changes and plans for the future.

32.8 Accordingly on the 8 November 2022 an in-person meeting of the NI Collaborative was convened and the findings and recommendations of Review of RNLDs in NI were presented in draft form.

32.9 The RNLD Expert Reference Group (RNLD ERG) was established and met on the 19 December 2022. It meets monthly either virtually or face to face. The aim of the RNLD ERG is to act as a resource and an expert reference group for the various workstreams stemming from the Registered Nurse Learning Disabilities – Strategic Development Project Group.

32.10 The Department understands minutes of these meetings are held by NIPEC.

In Exhibit 59, p76 there is a recommendation at point 8 that states, 'Review and future-proof the mental health and learning disability nursing programs to ensure the workforce is equipped to fulfil an increasing public health role, manage and provide interventions to those with co-morbidities and/or complex physical and mental health needs." Was this recommendation acted on at the time? (p31)

33.1 All pre-registration nursing programmes in Northern Ireland were updated and revalidated to meet the Nursing and Midwifery Council Standards of proficiency for nurses (NMC 2018), widely known as the Future Nurse standards. These were exhibited in my previous statement at MMcG/50, 'Future nurse standard of proficiency for registered nurses (2018)'.

33.2 The relevant standards are in Platform 6: Improving safety and quality of care required quality improvement methodologies to be included in all pre-registration nursing programmes (see proficiencies 6.4, 6.5 and 6.7).

33.3 The need to consider the increasing public health role of nurses working with people with learning disabilities and people with mental ill health was also addressed with the implementation of standards required in Platform 2: Promoting health and preventing ill health.

33.4 All pre-registration nursing programmes in Northern Ireland were revalidated in 2020 / 2021.

A copy of the internal review for stopping the Professional Alert policy to be provided to the Inquiry (p 41)

34.1 I have included a copy of a submission to the then Minister, Robin Swann that provided different options for the future process of the Professional Alert policy. This is attached at MMcG/237.

34.2 A further submission is included at MMcG/238, seeking approval of a Direction to revoke the Alert Policy.

Exhibit the recently published Regional Restraint and Seclusion policy (p 47)

35.1 The public consultation on the draft Regional Policy on the use of Restrictive Practices in Health & Social Care Settings closed in October 2021. Following consideration of the consultation responses, the Permanent Secretary of the Department approved the publication of the consultation analysis report and the final regional policy on the use of restrictive practices. I have included a copy of the consultation analysis report at MMcG/239 and a copy of the new Regional policy at MMcG/240.

Did the Department have any system in place for auditing the use of restraint and seclusion at health care facilities? How would trends in inappropriate use of restraint and seclusion be reported to the Department? (p48)

36.1 The Department does not have a specific system in place to audit the use of restraint and seclusion at health care facilities and trends in appropriate use of restraint and seclusion are not routinely reported to the Department. However, as part of its oversight role for MAH, MDAG receives a Highlight report from the Belfast Trust which includes information on incidences of restrictive practices on the hospital site, and also provides data over time in order to identify trends. I have included an example of this report at MMcG/241.

36.2 In addition, RQIA may be alerted to concerns (which may include restrictive practices in certain circumstances) relating to services, including notification of safeguarding incidents, serious adverse incidents and direct contact from patients, families and members of staff. RQIA has various means of seeking assurances from HSC Trusts of the actions they have taken to address areas of risk or concern as a result of a restrictive practice.

Exhibit copy of Safeguarding guidance issued by Department in 1996 if able to locate (p 52)

37.1 Following a further search of records, a copy of the guidance from 1996 was located. I include a copy of this at MMcG/242. I also include at MMcG/243, a circular that was issued to the Boards, Trusts and Central Services Agency asking that the guidance is brought to the attention of all relevant staff and to advise of their course of action taken.

Was there any specific training given in respect of the operation of the Protocol for Joint Investigation of Adult Safeguarding Cases (2016)? (p 55)

38.1 HSC Trusts are responsible for proving this training (it is completed with PSNI colleagues) to their staff.

38.2 The training is available to social work staff who are Investigating Officers and Designated Adult Protection Officers, and some nursing staff who have been trained as investigating officers as per adult safeguarding procedures as well as their managers.

How and why safeguarding came to be included as a priority in the NI Executive’s Programme for Government 2011-2015? Was it as a result of RQIA’s review of the effectiveness of safeguarding arrangements in mental health and learning disability hospitals? (p57)

39.1 The NI Executive's Programme for Government (PfG) 2011-2015 which I exhibit at MMcG/244 was agreed by the Executive on 8 March 2012 and endorsed by the Assembly on 12 March 2012.

39.2 It included a commitment (p47) to 'introduce a package of measures aimed at improving Safeguarding Outcomes for Children and Vulnerable Adults.'

39.3 This commitment was in support of the wider Executive PfG Priority 3, which was focused on 'making real improvements to people's health and wellbeing, both physically and mentally, enhancing community safety, achieving improved safeguarding outcomes for children and adults most at risk of harm and protecting and improving the environment in which we live.'

39.4 The Department had lead responsibility (with support from a range of partner organisations) for implementation of this commitment, which also included a number of milestones/outputs. Details of these milestones are set out in the associated delivery plan for this commitment, which I attach at MMcG/245 (p1-2 refers).

39.5 The delivery plan also describes the strategic context for this commitment, identifying that 'awareness of the phenomenon of abuse of vulnerable adults; the scale and range of the problem; and the factors that leave adults at increased risk of harm is growing.'

39.6 I attach at MMcG/246 a copy of the updated delivery plan for this commitment which summarises progress towards delivery of each of the milestones at the end of March 2015.

39.7 The RQIA review of safeguarding which I referenced in para 8.14 of my statement was commissioned by the Department as a follow-up to an earlier RQIA review of safeguarding arrangements in mental health and Learning disability hospitals. I attach at MMcG/247 a letter from the Department commissioning this review.

39.8 I attach a copy of the original RQIA review from 2008 at MMcG/248.

39.9 This review was commissioned by the Department in 2006 in response to concerns raised about allegations of historic sexual abuse in Muckamore Abbey Hospital. From an examination of the records held by the Department in relation to this, I have been unable to establish definitively whether this report led to the inclusion of safeguarding as a priority in the NI Executive PfG 2011-15.

39.10 I attach at MMcG/249 a copy of a letter from the Department to Trust Chief Executives advising that RQIA had been asked to provide independent assurance that services were safe following these allegations.

Copy of Adult Protection Bill consultation responses and any other relevant documentation. A copy of documentation to include how it is hoped the new legislation from the Adult Safeguarding Bill will actually improve current safeguarding arrangements? (p59)

40.1 I have included a copy of the Adult Protection Bill consultation analysis report at MMcG/250 and a Draft Final Policy Proposals for Ministerial Consideration at MMcG/251.

Does the Department receive prescribing trend data? (p63)

41.1 The Department does not routinely receive prescribing trend data from HSC Trusts, but has access to primary care data managed by the Business Services Organisation (BSO). BSO data encompasses prescriptions dispensed in primary care and provides high level trends on number of prescription items, spend etc. The Department’s SPPG, formerly the HSC Board, have also developed a range of COMPASS prescribing indicators which track trends in primary care prescribing at several levels including Northern Ireland wide, Trust/Local Commissioning Group level and down to GP practice level which enables targeting of interventions by SPPG prescribing advisors. HSC Trusts will have their own pharmacy level data for medicines use at ward / clinic level which allows tracking of trends, but this is not routinely shared with the Department.

Does the Department have a policy on the auditing of medication? (p 65

42.1 The Departments Medicines Optimisation Quality Framework (MOQF) expressly supports quality improvement (of which audit is one approach) by setting standards for what patients should expect from the use of medicines in care settings, as well as quality standards – this supports quality improvement (of which audit is part) by setting standards against which current practice can be audited.

42.2 The Department also sets standards for medicines management and optimisation through successor arrangements introduced in 2018 following discontinuation of the Department's controls assurance process. This involves HSC Trusts providing annual assurance to the Department's medicines policy branch of compliance with Trust extant responsibilities to deliver safe and effective medicines management in compliance with legislative requirements, as codified in HSC Trust Medicines Codes. Again, these standards can support audit / quality improvement by setting standards against which current practice can be assessed, and the BSO have previously indicated to the Department that these standards will be incorporated into their audit processes for medicines management. The Department expects HSC Trusts to establish policies and procedures for the prescribing, administration, dispensing, monitoring, ordering and storage of medicines within the organisation in support of these standards and seeks annual assurance of compliance from Trusts. Audit against these standards may form part of the operational process undertaken by HSC Trusts to ascertain compliance with these standards or otherwise.

What is the role of the Chief Pharmaceutical Officer (CPO) and do they provide advice on the auditing of medication? (p 66)

43.1 The role of the CPO is to provide specialist advice on medicines and pharmaceutical issues to the Minister and Department and professional leadership to the pharmacy profession, including leading the development of pharmacy and medicines policy including in relation to professional standards and practice, quality and safety, legislation, workforce planning, professional development and research. As outlined above, this includes the development of standards for medicines management and optimisation based on current professional and legislative requirements which can form the basis for audit.

Module 3(f): Policies and procedures concerning patients' property and finances (p 66). Evidence in respect of this module having not been initially requested.

44.1 Legislative provision for the protection of patients' property is made in the Health and Personal Social Services (Northern Ireland) Order 1972 (the 1972 Order) under Article 38 'Protection for property of certain persons'. This states

(1) Where a person- (a) 'is admitted as a patient to any hospital or is admitted to other accommodation provided under this Order or the 2009 Act';…

(2) 'Paragraph (1) shall have effect in relation to persons suffering from mental disorder as if -
(a) the reference to 'hospital' included a reference to a private hospital within the meaning of the Mental Health Order; and (b) after sub-paragraph
(b) there were inserted the following words – "or
(c) is subject to guardianship under the Mental Health Order;"

Paragraphs (3) and (4) of Article 38 of the 1972 Order provide detail on how this duty should be discharged.

44.2 From the introduction of the 1972 Order until amended by the Health and Social Care Act (Northern Ireland) 2022, the duty under Article 38 sat with the ‘Ministry’ (the Department). However, over the duration of the period covered by the Muckamore Abbey Inquiry Terms of Reference this responsibility has been delegated to Trusts. The amending legislation enacted in 2022 explicitly amended this duty to formally move it to be the responsibility of the HSC Trusts.

44.3 Article 116 of the Mental Health (Northern Ireland) Order 1986 (the 1986 Order) set out specific expectations in relation to Health and Social Services Boards, as established under Article 16 of the 1972 Order, and subsequent to amending legislation in 2022, HSC Trusts’ handling of patients’ property. This is outlined in paragraphs 1 to 5 of Article 116 of the 1986 Order. Paragraph 1 places responsibility on a Trust to receive and hold money on behalf of any patient in any hospital or accommodation administered by it under the 1972 Order where the patient has been deemed incapable, by reason of mental disorder, of managing or administering their property or affairs.

44.4 Paragraphs 2 to 5 of Article 116 of the 1986 Order outline how the Trust must manage this responsibility in relation to receipts, the Trust’s ability to expend or dispose of money or valuables for the benefit of that person with due regard to its proper value, the need to have RQIA consent for the holding of money or valuables above an amount that may have been determined by the Department of Health, and impact of the appointment of a controller on the duty.

44.5 As part of the system of internal control that the Department’s Arms Length Bodies operate under, key minimum controls include that Standing Orders and Standing Financial Instructions are in place in organisations. In September 1999, the Department issued ‘HSS Trust Finance Manual – Model Standing Financial Instructions’ to Chief Executive/General Managers’ and Directors of Finance in each Health and Social Services Trust for incorporation into their Trust Finance Manuals. The detail within the new chapter, 3.2, included a section at paragraph 3.2.154 to 3.2.160 on Patients’ Private Property which set out the responsibilities of the organisation, its Chief Executive and Director of Finance on the management of patients’ property and money in line with Article 116 of the Mental Health (Northern Ireland) Order 1986. I attach a copy of the covering letter and Model Standing Financial Instructions from September 1999 at MMcG/252.

44.6 All Arms Length Bodies of the Department still maintain a Finance Manual, which includes a chapter on Model Standing Financial Instructions, and contains detail on Patients’ Private Property. The Arms Length Bodies are required to keep these up to date, for example when changes are made to delegated limits.

44.7 In April 2005 the Department introduced the Nursing Homes Regulations (Northern Ireland) 2005 and the Residential Care Homes Regulations (Northern Ireland) 2005. These Regulations include a requirement to *‘provide a place where the money and valuables of patients may be deposited for safe keeping, and make arrangements for patients to acknowledge in writing the return to them of any money or valuables so deposited’* at Article 18 (2) (l). Article 19 and Schedule 4 to both Regulations set out the requirements in relation to record keeping. Restrictions on financially acting for patients is detailed in Article 22 of the Regulations. This outlined the circumstances in which money belonging to any patient could be paid into a bank account.

44.8 In March 2007 the Department issued the circular HSS (F) 13/2007 Financial Governance Model Documents. The circular was produced by a finance group that had been set up to identify any issues to be addressed during the Reform of Public Administration (RPA) process to ensure that financial stability, propriety and continuity was maintained throughout and beyond the transition period for the new Trusts. Amongst the documents included and highlighted was the Standing Financial Instructions which contained a section on Patients Private Property outlining the responsibilities on Trusts to provide safe custody for money and other personal property of patients. I attach a copy of the circular at MMcG/253.

44.9 In the 2009 Northern Ireland Audit Office published the *'General Report on the Health and Social Care Sector by the Comptroller and Auditor General for Northern Ireland'.* HSC Trusts arrangements for the safeguarding of service users' monies, and the discharge of the Mental Health Commission's statutory duties in this regard, were criticised at paragraphs 5.3.1 to 5.3.5. A copy of the Report is attached at MMcG/254.

44.10 In July 2009 the Department issued the circular '*HSS (F) 45/2009 'Misappropriation of Resident's Monies – Implementation and Assurance of Controls in Statutory and Independent Homes'*. The circular was prompted following notification to the Department of two incidents where there had been misappropriation of patients' monies. One was in respect of Trust patients in a private care home and the other in respect of a Trust facility. The purpose of the circular was to remind relevant HSC bodies of their responsibilities in relation to ensuring that patients' interests are safeguarded, basic controls are operating successfully and that those controls are reviewed on a regular basis. Accountable Officers were also reminded of the essential need to ensure a range of controls, were operating in both care homes and Trust facilities and in compliance with extant Departmental guidance. A copy of the circular is attached at MMcG/255.

44.11 Circular HSS (F) 45/2009 was subsequently updated and reissued by the Department as '*HSS (F) 57/2009 Misappropriation of Residents'*

Monies – Implementation and Assurance of Controls in Statutory and Independent Homes' in December 2009. The circular reminded organisations of the mandatory controls that should be in place in respect of the handling of residents' monies in statutory homes and sought reassurance that residents' interests should be protected when placed in independent sector care homes. A copy of the circular is included at MMcG/256.

44.12 In June 2012 the Department, through the Director of Finance, wrote to Accounting Officers and Directors of Finance in HSC Trusts to remind them of their responsibilities in relation to the safeguarding of residents' interests under HSS (F) 57/2009. The reminder was prompted following reports from the RQIA and the 2009 NIAO General report on the Health and Social Care Sector by the Comptroller and Comptroller and Auditor General for Northern Ireland (MMcG/267), which raised concerns about the procedures used in dealing with patients' monies, and in particular, that no specific audits of Mental Health and Learning Disability inpatient wards were undertaken during the 2010/11 or 2011/12 financial years in any HSC Trust. In addition, the Department also advised in the letter that it was considering whether to increase the level of patients' funds that could be held without seeking the consent of the RQIA from £5,000, given the length of time that had passed since that limit was established. I attach a copy of the letter at MMcG/257.

44.13 The Department issued a letter to the Chief Executives of the then Health and Social Care Board (now SPPG), each HSC Trust, Chair of the RQIA and the Master of the Office of Care and Protection in September 2012, to advise of an increase of the maximum sum of patients' monies that trusts are not permitted to receive or hold balances in excess of, without the consent of the RQIA, in line with Article 116(4) of the Mental Health (Northern Ireland) Order 1986. The new sum was set at £20,000 for any single mental health or learning disability patient. A copy of the letter, including the Determination to increase the sum, is attached at MMcG/258.

44.14 The RQIA published the report *'Monitoring of Patient Finances Under Article 116 of the Mental Health (Northern Ireland) Order 1986 2012 – 13*'. The report concluded that subject to the findings from the inspections undertaken as detailed in the report, patients' monies and property in the mental health and learning disability wards inspected across four HSC Trusts (no Southern HSC Trust wards were included), had generally been managed appropriately and were being properly safeguarded. However, 13 control issues were identified and relevant recommendations made to the relevant trusts to address these issues. A copy of the report is attached at MMcG/259.

44.15 The RQIA published the report '*Monitoring of Patient Finances Under Article 116 of the Mental Health (Northern Ireland) Order 1986 2013 – 14'.* The report concluded that findings from the inspections undertaken had indicated that patients' monies and property in the mental health and learning disability wards inspected across the five HSC Trusts, including 10 wards at Muckamore Abbey (listed in Appendix 1 on page 13), had generally been managed appropriately and were being properly safeguarded. The report noted some areas of robust processes consistent with best practice and that these practices were to be commended. A copy of the report is attached at MMcG/260.

44.16 In June 2014 the RQIA also carried out a review of patients' finances *'Oversight of Service Users' Finances in Residential and Supported Living Settings'*. This review highlighted in particular the need to strengthen the level of assurances received, the need to extend these assurances to supported living settings, that Trusts should ensure that sufficient focus was placed on safeguarding service users' personal finances and that care managers are trained to deal with service users' financial matters. I attach a copy of the RQIA review at MMcG/261.

44.17 In February 2015, the Department issued guidance document *'HSC (F) 08-2015 Safeguarding of Service Users' Finances within Residential and Nursing Homes and Supported Living Settings'*. This guidance superseded HSS (F) 57/2009 and was produced following the 2014 RQIA review of patients' finances. The Departmental guidance outlined the responsibility of relevant HSC Trusts, the HSCB and the Business Services Organisation (BSO) to ensure that service users' finances were safeguarded within both the statutory and independent sectors. The guidance outlined accountability arrangements for each of the sectors and provided proforma templates to be used to aid demonstration of the controls applied in safeguarding of patients' finances. Controls included covered authorisation, procedures, clients' agreements & accounts, deposits and income, withdrawals and expenditure, monitoring, authorising signatures and property security. A copy of the guidance is attached at MMcG/262.

44.18 The RQIA published the report *'Monitoring of Patient Finances Under Article 116 of the Mental Health (Northern Ireland) Order 1986 2014 – 15'*. The report concluded that findings from the inspections undertaken had indicated that patients' monies and property in the mental health and learning disability wards inspected across the five HSC Trusts, including 8 wards at Muckamore Abbey (listed in Appendix 1 on page 6,) had generally been managed appropriately and were being properly safeguarded. The report noted that the majority of recommendations made in the previous report had been met, some recommendations were assessed as no longer applicable and that there were recommendations made in the previous report for wards that had since closed. A copy of the report is attached at MMcG/263.

44.19 In February 2016, '*HSC (F) 15-2016, Safeguarding of Service Users' Finances within Residential and Nursing Homes and Supported Living Settings'*, was issued by the Department. The guidance was an update to HSC (F) 08-2015 and reflected additional assurances and checks to be implemented to ensure that service users' finances are were safeguarded within both the statutory and independent sectors. A copy of the circular is attached at MMcG/264.

44.20 In May 2016 the Mental Capacity Act (Northern Ireland) 2016 (MCA) was enacted, with the intention to have full implementation of the Act by April 2020. The collapse of the Northern Ireland Assembly in January 2017 impacted on the planned full implementation of the Act by 2020. In the absence of an Assembly and a Health Minister, a decision was taken by the then Permanent Secretary to move to a phased implementation of the Act in order to bring a number of provisions into operation. Phase one implementation included provisions in relation to money and valuables, and section 276 of the MCA including regulation making powers in relation to same, which came into effect on 2 December 2019. This enabled the Department to make The Mental Capacity (Money and Valuables) Regulations (Northern Ireland) 2019. The Regulations made provision for the managing authority of hospitals and residential care and nursing homes to hold and manage money and valuables for a person who lacked capacity. They also prescribed details on considerations that must be had and the formalities when holding money and valuables. As the Mental Health (Northern Ireland) Order 1986 still remains extant, these Regulations mean that there is a dual system in operation for those aged 16 and over until the Mental Capacity Act is fully implemented.

44.21 The RQIA published the report *‘Monitoring of Patient Finances Under Article 116 of the Mental Health (Northern Ireland) Order 1986 2015 – 16’*. The report concluded that findings from the inspections undertaken had indicated that patients’ monies and property in the mental health and learning disability wards inspected across the five HSC Trusts, including Moylena Ward at Muckamore Abbey, had been properly safeguarded. A copy of the report is attached at MMcG/265.

Is the ‘Improving Health and Well-being through Positive Partnerships: A Strategy for the Allied Health Professions in Northern Ireland 2012-2017’ still operative or did the ‘UK Allied Health Professions Health Strategic Framework 2019-2024’ supersede this? (p 68)

45.1 A NI Population Health Strategy was developed in line with the UK AHP Population Health strategy, cognisant of supporting HCPC registration, and signed off by the Chief AHP Officer (CAHPO) and Head AHP, Deputy Director (Public Health Agency) in September 2022. This was not a replacement for the ‘Improving Health and Well-being through Positive Partnerships: A Strategy for the Allied Health Professions in Northern Ireland 2012-2017 as it was in relation to population health only. In the absence of a CAHPO in post at present, the 2012-17 strategy is still in place in NI as it was not replaced by the previous CAHPO.

Is there any other policy document that touches upon the number of psychologists required to deal with learning disability patients or the actual deployment of psychologists in the field of learning disability? (p 71)

46.1 The Department has not issued any such policy documents. Practitioners can draw upon guidance issued by their own regulatory bodies, I include five such documents at MMcG/266, MMcG/267, MMcG/268, MMcG/269 and MMcG/270 which outline good practice models for psychology services in Learning Disability settings.

Detail on the membership of the Regional Learning Disability Operational Delivery Group (p 88)

47.1 The membership of the Regional Learning Disability Operational Delivery Group included representatives from the Department, the Health and Social Care Board, the Public Health Agency, 5 Trusts and the Northern Ireland Housing Executive. The Group was chaired by the then Health and Social Care Board. I include a copy of the Governance Structure at MMcG/271.

Copy of Terms of Reference of Regional Learning Disability Operational Delivery Group and Regional Resettlement Taskforce to be exhibited (p 88)

48.1 I include a copy of the Terms of Reference of the Regional Learning Disability Operational Delivery Group ToR at MMcG/272 and the Regional Resettlement Oversight Board ToR at MMcG/273**.**

Exhibit the minutes of the Regional Learning Disability Operational Delivery Group (p 88)

49.1 I have exhibited a copy of the first and last meeting of Regional Learning Disability Operational Delivery Group (RLDODG) minutes at MMcG/274 and MMcG/275. Copies of all RLDODG minutes held by the Department can be uploaded to the Inquiry record platform if requested.

Do the Department hold copies of the Yearly 'Compliments and Complaints' reports for all trusts? (p 91)

50.1 Each HSC Trust publishes individual annual compliments and complaints reports on their website, and a link to the report is sent to the Department to provide confirmation of publication. These reports give an overview of complaints and other feedback received from patients, their carers and family members by the HSC Trust annually and include information such as how many complaints were received, the types of complaints, timeframes for response and learning from complaints. I include a copy of the Belfast Trust's Complaints and Compliments report from 2013-2014 at MMcG/276. This is the only report which includes reference to Muckamore Abbey Hospital.

50.2 The Department publishes an annual statistical publication detailing information on complaints and compliments received by all HSC Trusts and Family Practitioner Services (FPS) in Northern Ireland. This report includes information on the Programme of Care, category, subject and specialty of the complaint issue, as well as demographic information and the time taken to provide a substantive response to the complaint received. Data on complaints received by HSC Trusts has been published each year since 2011/12 and I have exhibited these at MMcG/277 – MMcG/286.

Who was responsible for the trend analysis of complaints? (p92)

51.1 The 'Guidance in relation to the Health and Social Care Complaints Procedure' (the Guidance) states that HSC organisations must have effective processes in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons from complaints are learnt and shared.

51.2 The Guidance also recommends that the management boards of the HSC Trusts should receive quarterly reports: summarising the categories, emerging trends and the actions taken in relation to complaints to help prevent recurrence; in order to monitor the arrangements for local complaints handling, consider trends in complaints; and consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

51.3 The Department of Health's SPPG Complaints Team (previously HSCB) maintain an oversight of all Family Practitioner Services and HSC Trust complaints received (including HSC prison healthcare) and analyse any patterns or trends of concern or clusters of complaints against individual clinicians/professionals, practices, or organisations.

51.4 The Department of Health's SPPG (previously HSCB) Complaints Team have procedures for collecting and disseminating the information, themes and good practice derived from complaints and area-wide procedures for collecting and disseminating learning and sharing intelligence.

Was complaints a standing agenda item at Trust board meetings? (p92)

52.1 The Department understands complaints are not a standing agenda item at Trust Board meetings. A Complaints Report is presented at the quarterly Assurance Committee meeting. The Assurance Committee is a standing committee of Trust Board which includes all Trust Board members.

Does the Department have Guidance relating to complaints from 2022? (p92)

53.1 The 'Guidance in relation to the Health and Social Care Complaints Procedure' was amended in 2022 to reflect the transfer of the former Health & Social care Board functions to the Strategic Planning and Performance Group in the Department. I attach a copy of this MMcG/287.

53.2 The guidance was further amended in April 2023 to reflect amendments made to the HSC Complaints Directions following that transfer of functions. A copy of the current guidance is provided at MMcG/288.

Were confidentiality gagging clauses and compromised agreements prohibited in any Trust?(p 96)

54.1 This is an employment matter for individual Trusts and therefore the Department does not routinely collect or hold information on this.

Did the Department check if the Trusts adopted a Whistleblowing policy? (p 101)

55.1 A Regional Task and Finish Group was established in August 2016 to take forward the recommendations made by RQIA in their Whistleblowing Report published in 2016. I include a copy of this report at MMcG/289.

55.2 The Task and Finish Group was chaired by the NHSCT Assistant Director, and contained representation from each of the five Trusts and the Department.

55.3 One significant area of work progressed by this group was the completion of Trust Whistleblowing Policies, which reflect the HSC Model Whistleblowing Policy, as launched by the Department in November 2016. A copy of this was included in my previous statement at MMcG/116.

55.4 Following this each Trust made a commitment that they would adopt the Model Policy by no later than 31st March 2018. I attach a copy of the HSC Whistleblowing Task and Finish Group sign off report at MMcG/290.

55.5 The Department’s Sponsor Branch checklist up until 2015-16 prompted ALBs to include Whistleblowing as part of their risk register process. A copy of this can be found at MMcG/291, at 2.13.

55.6 From 2016-2017 the Sponsorship checklist was updated and now asks Sponsor Teams to confirm that the ALB has a whistle blowing policy. This can be found at 4.6 in the attached exhibit MMcG/292.

Who in the Department is responsible for monitoring whistleblowing and trends?(p 102)

56.1 There is no formal process for the notification of whistleblowing instances in Trusts to the Department. Each individual Trust and its

Board has responsibility for monitoring whistleblowing trends in their own organisations. Given the confidential nature of whistleblowing cases limited information can be shared. The Department has initiated consideration of how to report on ALB whistleblowing cases, but this is at an early stage and work remains on-going to consider how this information can best be presented to DARAC and the Departmental Board.

What is the composition and working arrangements of the Regional Whistleblowing Working Group? (p 104)

57.1 The Regional Whistleblowing Working Group was formed and met with the intention of developing a new whistleblowing policy and framework in line with current guidance and consisted of representatives from Department of Health, the HSC Trusts, NIAS, BSO, DLS and TUS. This involved meetings throughout the year in consulting on successive drafts of the framework. Meetings were facilitated virtually 3-4 times in the year, chaired by the Northern Trust HR Director.

Can a copy of the HSC Whistleblowing Framework and Model Policy from 2022 be provided to the Inquiry? (p 104)

58.1 The new draft that the working group has been completing is currently in progress and has not been finalised.

Has consideration ever been given in Northern Ireland to an initiative such as the National Guardians Office and the Freedom to Speak Up Guardians? (p 104)

59.1 The use/collaboration with the National Guardians Office was raised in response to the consultation on the policy in 2022. Southern Trust had made enquiries about the Freedom to Speak Up Guardians and whilst they were happy to share documentation, the National Guardians

Office had stated they could be of no further assistance in Northern Ireland.

59.2 Belfast Trust has 52 Whistle Blowing advocates who are spread throughout the Directorates and who are available to support /guide/advise anyone considering raising concerns or indeed in the process of doing so. They have been trained by PROTECT (UK), who are a leading independent charity who can be contacted for whistleblowing advice.

Is the fit and proper person test as applied in the NHS under consideration in Northern Ireland? (p107)

60.1 The application of a fit and proper person test has currently no statutory under-pinning in Northern Ireland, and the Department has no present plans to introduce this test.

Is the Health and Social Services Improvement Authority actually the RQIA? (p 110)

61.1 *Best Practice, Best Care* (2001) (MMcG/117) proposed the introduction of a new independent body to monitor the delivery of services, to be called the Health and Social Services Improvement Authority. This body was named in the establishing legislation, the HPSS (Quality, Improvement and Regulation) Order (NI) Order 2003, as the Health and Personal Social Services Regulation and Improvement Authority, and was subsequently established as the RQIA in 2005.

What were the reporting and review mechanisms of the ‘Quality 2020- a 10 year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland? (p 118)

62.1 The Q2020 Strategy management structures comprised of a Quality 2020 Steering Group, which was supported by a Quality 2020 Implementation Team.

62.2 Reporting against implementation of Quality 2020 action was organised through a number of work-streams designed to manage projects, directed by the Steering Group. The Strategy had five strategic goals and ten key supporting objectives with indicators to measure improvement.

62.3 The Q2020 Steering Group, chaired by the CMO, was responsible for the strategic direction, oversight and reporting, as required, to the Permanent Secretary and Minister on Q2020 progress. The Steering Group was also responsible for reviewing and approving plans and the timetable for programme implementation.

62.4 The Q2020 Implementation Team was co-chaired by the Director of Public Health/Medical Director and the Director of Nursing and Allied Health Professionals in the Public Health Agency (PHA). The Implementation Team was responsible for ensuring that the Strategy was delivered in line with implementation plans approved by the Q2020 Steering Group.

62.5 The Implementation Team provided reports to the Q2020 Steering Group on implementation progress, including strategic and project planning updates, project outcomes as well as information on quality improvement initiatives across the HSC which aligned to the overall vision of Q2020.

62.6 The Q2020 Steering Group has not met since October 2019. HSC organisations through their Annual Quality Reports, which are published in November to coincide with World Quality Day, continue to report on activity under the Q2020 Strategic goals. These reports showcase the initiatives which improved quality and safety of care and ultimately the associated impact on Patient Safety under the Q2020 themes of transforming culture, strengthening the workforce, raising the standards, measuring the improvement and integrating the care.

62.7 The initial Q2020 Project Implementation Plan was published in May 2012. Q2020 implementation was to be subject to review on an ongoing basis every 3 years. The last review was undertaken in 2019. A post-implementation evaluation has not yet been undertaken.

62.8 It is important to note that the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 established a statutory duty of quality on HSC Trusts under which they must have in place organisational arrangements to monitor and improve the quality of health and social services they provide and the environment in which they provide them. The duty of quality extends to the services commissioned by Trusts, by SPPG and by the Public Health Agency.

62.9 HSC Trusts must ensure that there have appropriate organisational management, clinical governance and risk management arrangements in place to provide them with assurances and satisfy themselves in respect of services delivered to individuals. These arrangements will include for example an Executive/Management Team led by the Chief Executive with responsibility including for assuring the quality of services and responsible to the Trust Board.

What year did the accountability meetings start? (p124)

63.1 There is a long-standing convention across Government regarding safeguarding public funds and oversight of Arm’s Length Bodies. The Department of Finance are the lead Department and provide guidance for all Northern Ireland Departments and public bodies as currently detailed in Managing Public Money NI (MPMNI). Although processes will have changed over time, oversight of ALBs has always taken place, most likely via formal meetings. The Department has electronic records of accountability meetings with Belfast Trust back to June 2008. Previous records of earlier accountability meetings are no longer held by the Department in line with records management retention schedules.

Did any of the accountability meetings discuss issues relating specifically to learning disability or Muckamore? Can minutes from these meetings be provided to the Inquiry? (p 124)

64.1 Copies of accountability meetings which included discussion on issues relating to either 'learning disability' or 'Muckamore' are included at MMcG/293-MMcG/303.

Does the DSF report from 2017 to 2018 specifically address the revelations of Muckamore? (p 129)

65.1 The DSF report from 2017-2018 does not include any reference to MAH. I have included a copy of the of Chief Social Work Officer letter at MMcG/304, outlining the issues he wished to discuss following analysis of the 2017/18 DSF Report. Adult Safeguarding features but there is no direct reference to MAH in the letter.

Other DSF reports after 2017 that refer to Muckamore to be provided to the Inquiry (p 129)

66.1 I attach a copy of the 2017-2018 DSF report at MMcG/305. Muckamore is referred to in pages 118, 120, 125, 126, 128,129, 131, 132, 133, 138, 139, 150, 208 and 209.

66.2 Copies of all DSF reports from 2007 onwards which include references to Muckamore can be uploaded to the Inquiry record platform if requested.

Exhibit copy of reports that Owen Barr was involved in the production of in relation to Muckamore Abbey Hospital (query raised by Inquiry counsel following evidence session with Professor Owen Barr on 26 April).

67.1 I attach a copy of the report from the Independent Assurance Team at MMcG/306. This team was established following a range of actions that were put in place by the Belfast Health and Social Care Trust following safeguarding concerns that were identified at Muckamore Abbey Hospital in 2017.

67.2 I also include a copy of the Terms of Reference and the report from the Safeguarding Audit that took place in July 2021. These can be found at MMcG/307 and MMcG/308.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed:

Date: 6th June 2023

List of Exhibits - Addendum statement (Mark McGuicken)

MMcG/175 RQIA Unannounced Inspection report MAH Feb 2019

MMcG/176 RQIA Article 4 letter to DoH 6 March 2019

MMcG/177 RQIA Article 4 letter to DoH 14 March 2019

MMcG/178 RQIA Unannounced Inspection report MAH April 2019

MMcG/179 RQIA Article 4 letter to DoH April 2019

MMcG/180 RP3765 letter to Olive Macleod – Muckamore Abbey Hospital – Unannounced Inspection March 2019

MMCG/181 Muckamore Abbey Hospital Meeting with RQIA, HSCB, BHSCT 14 May 2019

MMcG/182 The Right Time The Right Place (2014)

MMcG/183 Review of HSC Commissioning Arrangements Final Report -October 2015

MMcG/184 Integrated care in Northern Ireland, Scotland and Wales - Lessons for England (2013)

MMcG/185 The four health systems of the United Kingdom - how do they compare (2014)

MMcG/186 letter to HSCB re MAH budget and running costs - November 2019

MMcG/187 Direction re MAH pay enhancement November 2019

MMcG/188 Direction re MAH pay enhancement February 2020

MMcG/189 Direction re MAH pay enhancement May 2020

MMcG/190 Direction re MAH pay enhancement August 2020

MMcG/191 Bamford Inter Departmental Ministerial Group January 2009 minutes

MMcG/192 Bamford Inter Departmental Ministerial Group May 2015 minutes

MMcG/193 Bamford Inter-Departmental Officials Group minutes October 2007

MMcG/194 Bamford Inter-Departmental Officials Group minutes April 2016

MMcG/195 - draft Evaluation of Second Bamford Action Plan (2016)

MMcG/196 - draft Evaluation of Second Bamford Action plan - Annex A - LD actions - detailed findings (2016)

MMcG/197 - draft Evaluation of Second Bamford Action plan - Annex B - MH actions - detailed findings (2016)

MMcG/198 - draft Evaluation of Second Bamford Action plan - Annex C - Mental Capacity Act (2016)

MMcG/199 - draft Evaluation of Second Bamford Action plan - Annex D - Terms of Reference - June 2015

MMcG/200 - Learning Disability Service Framework (2012)

MMcG/201 Learning Disability Service Framework October 2016

MMcG/202 Letter to HSCB and PHA re implementation of LD Service Framework (2012)

MMcG/203 Regional Learning Disability Service Framework Implementation (LDSF) Group ToR 2014

MMcG/204 SFPB LDSF end of year narrative report 2018

MMcG/205 SFPB LDSM RAG assessment ratings 2018

MMcG/206 Learning Disability Service Model Project Initiation Document - January 2019

MMcG/207 Independent Review of Learning Disability Resettlement July 2022

MMcG/208 Draft Disability Strategic Action Plan - January 2023

MMcG/209 MDAG minutes August 2019

MMcG/210 MDAG minutes October 2019

MMcG/211 MDAG minutes November 2019

MMcG/212 MDAG minutes December 2019

MMcG/213 MDAG minutes February 2020

MMcG/214 MDAG minutes June 2020

MMcG/215 MDAG minutes September 2020

MMcG/216 MDAG minutes October 2020

MMcG/217 MDAG minutes December 2020

MMcG/218 MDAG minutes February 2021

MMcC/219 MDAG minutes April 2021

MMcG/220 MDAG minutes June 2021

MMcG/221 MDAG minutes August 2021

MMcG/222 MDAG minutes December 2021

MMcG/223 MDAG minutes February 2022

MMcG/224 MDAG minutes April 2022

MMcG/225 MDAG minutes August 2022

MMcG/226 MDAG minutes October 2022

MMcG/227 MDAG minutes December 2022

MMcG/228 MDAG minutes February 2023

MMcG/229 MDAG ToR August 2019

MMcG/230 MDAG - DRAFT - Risk Register Template

MMcG/231 HSC MAH Action Plan - Revised Reporting Arrangements - October 2022

MMcG/232 Note from CNMAC Meeting 14 September 2015

MMcG/234 Notes from CNMAC meeting 8 September 2017

MMcG/235 Notes of CNMAC meeting 27 June 2019

MMcG/236 Note of CNMAC meeting 18 September 2020

MMcG/237 Updated Nursing Alerts Policy Submission to Minister - June 2022

MMcG/238 Submission for approval of Direction for the revocation of the Professional CNO Alert process

MMcG/239 Restrictive Practices in Health and Social Care Settings Consultation Analysis Report - March 2023

MMcG/240 Regional policy on practice restraint and seclusion March 2023

MMcG/241 MDAG 13 22 - Highlight Report - August 2022

MMcG/242 Guidance on Abuse of Vulnerable Adults 1996

MMcG/243 - Circular re Guidance on Abuse of Vulnerable Adults 1996

MMcG/244 Programme for Government 2011-2015

MMcG/245 Programme for Government 2011-15 DoH Commitment

MMcG/246 Programme for Government Updated Delivery Plan

MMcG/247 Letter to RQIA to commission Safeguarding Review - March 2011

MMcG/248 RQIA Review of the Safeguards in place for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals - Overview Report - June 2008

MMcG/249 Letter from DoH to Trust Chief Executives re RQIA providing assurance that services were safe (2006)

MMcG/250 Adult Protection Bill consultation document

MMcG/251 Adult Protection Bill final policy proposals 2021

MMcG/252 HSS Trust Finance Manual – Model Standing Financial Instructions September 1999

MMcG/253 HSS (F) 13 2007 - Financial Governance Model documents

MMcG/254 NIAO General Report on the Health and Social Care Sector by the Comptroller and Auditor General for Northern Ireland 2009

MMcG/255 HSS (F) 45 2009 – Misappropriation of Patients' Monies

MMcG/256 HSS (F) 57 2009 – Misappropriation of Patients' Monies - Implementation and Assurance of Controls in Statutory and Independent Homes

MMcG/257 Director of Finance letter – reminder re HSS (F) 57 2009

MMcG/258 Maximum Sum Determination signed and sealed with covering letter from DoH September 2012

MMcG/259 RQIA – Monitoring of Patient Finances under Article 116 of the Mental Health (Northern Ireland) Order 1986 2012-13

MMcG/260 RQIA – Monitoring of Patient Finances under Article 116 of the Mental Health (Northern Ireland) Order 1986 2013-14

MMcG/261 RQIA – Oversight of Service Users Finances in Residential and Supported Living Settings June 2014

MMcG/262 HSC (F) 08-2015 – Safeguarding of Service Users' Finances within Residential and Nursing Homes and Supported Living Settings

MMcG/263 RQIA – Monitoring of Patient Finances under Article 116 of the Mental Health (Northern Ireland) Order 1986 2014-15

MMcG/264 HSC (F) 15-2016 – Safeguarding of Service Users Finances within Residential and Nursing Homes and Supported Living Settings

MMcG/265 RQIA – Monitoring of Patient Finances under Article 116 of the Mental Health (Northern Ireland) Order 1986 2015-16

MMcG/266 Commissioning Clinical Psychology services for adults with learning disabilities 2011

MMcG/267 Delivering Effective Specialist Community LD Health Team Support to People with LD Disabilities and their Families or Carers 2019

MMcG/268 Guide for commissioners of services for people with LD who challenge services 2010

MMcG/269 Commissioning Specialist Adult LD Health Services Good Practice Guidance 2007

MMcG/270 Developing better commissioning for individuals with behaviour that challenges services - a scoping exercise 2010

MMcG/271 RLDODG -organisational structure chart 2019

MMcG/272 Regional LD Operational Delivery Group ToR October 2019

MMcG/273 Resettlement Oversight Board TOR Sept 2022

MMcG/274 Regional LD Operational Delivery Group action points September

2019

MMcG/275 Regional LD Operational Delivery Group action points February 2022

MMcG/276 Complaints-and-Compliments-Annual-Report-13-14

MMcG/277 Complaints received by HSC Trusts in NI 2011-12

MMcG/278 Complaints received by HSC Trusts HSC Board and Family Practitioner Services in NI 2012-13

MMcG/279 Complaints received by HSC Trusts HSC Board and Family Practitioner Services in NI 2013-14

MMcG/280 Complaints received by HSC Trusts HSC Board and Family Practitioner Services in NI 2014-15

MMcG/281 Complaints received by HSC Trusts HSC Board and Family Practitioner Services in NI 2015-16

MMcG/282 Complaints received by HSC Trusts HSC Board and Family Practitioner Services in NI 2016-17

MMcG/283 Complaints received by HSC Trusts HSC Board and Family Practitioner Services in NI 2017-18

MMcG/284 Complaints received by HSC Trusts HSC Board and Family Practitioner Services in NI 2018-19

MMcG/285 Complaints received by HSC Trusts HSC Board and Family Practitioner Services in NI 2019-20

MMcG/286 Complaints received by HSC Trusts in NI 2020-21

MMcG/287 Guidance in Relation to Health and Social Care Complaints Procedure April 2022

MMcG/288 Guidance in Relation to Health and Social Care Complaints Procedure April 2023

MMcG/289 - RQIA Whistleblowing Report 2016

MMcG/290 HSC Whistleblowing Task and Finish Group Sign off Report 2018

MMcG/291 2015 16 Sponsor Branch Checklist Template

MMcG/292 2016 17 Sponsor Branch Checklist Template

MMcG/293 BHSCT Accountability meeting minutes 2008-09

MMcG/294 BHSCT Year End Accountability meeting minutes 2009 10

MMcG/295 BHSCT Mid-Year Accountability meeting minutes 2011 12

MMcG/296 BHSCT Part B Mid Year Accountability meeting minutes 2012-13

MMcG/297 BHSCT End of Year Accountability meeting Part B minutes 2013 Part B

MMcG/298 BHSCT Mid Year Accountability meeting Part B minutes 2013-14

MMcG/299 BHSCT Part B End of Year Accountability meeting minutes 2013-14

MMcG/300 BHSCT Mid Year Accountability meeting minutes 2017-18

MMcG/301 BHSCT Mid Year Accountability meeting minutes 2018 19

MMcG/302 BHSCT End Year Accountability Minutes 2018-19

MMcG/303 BHSCT Mid-Year Accountability meeting minutes 2022-23

MMcG/304 letter from CSWO re DSF Overview Report 2017-18

MMcG/305 Belfast Trust DSF Report 2017-18

MMcG/306 Final Report of Independent Assurance Team (MAH) 2018

MMcG/307 Draft TOR Safeguarding Audit BHSCT 2021

MMcG/308 Muckamore Abbey Hospital Final Safeguarding File Review Report 2021

The Regulation and
Quality Improvement
Authority

Unannounced Inspection Report
26, 27 & 28 February 2019

Belfast Health and Social Care Trust

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Assurance, Challenge and Improvement in Health and Social Care

Membership of the Inspection Team

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Paulina Spychalska	Inspection Coordinator Regulation and Quality Improvement Authority
Claire McNicholl	Inspection Coordinator Regulation and Quality Improvement Authority

Abbreviations

AHP	**Allied Health Professionals**
BHSCT	Belfast Health and Social Care Trust
DoH	Department of Health
MAH	Muckamore Abbey Hospital
MDT	Multi-disciplinary Team
MHO	Mental Health(Northern Ireland) Order 1986
NHSCT	Northern Health and Social Care Trust
OCP	Office of Care and Protection
PICU	Psychiatric Intensive Care Unit
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

Is care safe?

Avoiding and preventing harm to service users from the care, treatment and support that is intended to help them.

Is care effective?

The right care, at the right time in the right place with the best outcome.

Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and the experiences of service users in order to deliver safe, effective and compassionate care.

Is Care Compassionate?

Service users are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

2.0 Profile of the service

Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability Hospital managed by Belfast Health and Social Care Trust (BHSCT). The hospital provides inpatient care to adults 18 years and over who have a learning disability and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986.

MAH provides a service to people with a Learning Disability from BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT). There were 83 beds in the hospital at the time of the inspection. The Psychiatric Intensive Care Unit (PICU) had temporarily closed on 21 December 2018 and has remained closed since.

At the time of the inspection there were five wards on the MAH site:

- Cranfield One (Male assessment)
- Cranfield Two (Male treatment)
- Ardmore (Female assessment and treatment)
- Six Mile (Forensic Male assessment and treatment)
- Erne (Long stay/re-settlement).

A hospital day care service was also available for patients.

On the days of the inspection there were 67 patients receiving care and treatment in MAH.

3.0 Service details

Responsible person: Mr Martin Dillon Belfast Health and Social Care Trust (BHSCT)	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 83
Person in charge at the time of inspection: Mairead Mitchell, Interim Co- Director, Learning Disability Services, Adult Social and Primary Care Directorate, BHSCT.	

4.0 Inspection summary

We undertook an unannounced inspection to MAH over three days commencing on 26 February 2019 and concluding on 28 February 2019. All five wards were visited over the course of the inspection.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).
We employed a multidisciplinary inspection methodology during this inspection. The multidisciplinary inspection team examined a number of aspects of the hospital, from front line care and practices, to management and oversight of governance across the organisation. We met with individual staff members and various staff groups, patients and a small number of relatives, observed care practice and reviewed relevant records and documentation to support the governance and assurance systems.

Key Findings

We noted some measures which had recently been introduced to improve staff well-being, additional pharmacist input to wards had been secured and day care staff were in reaching into the wards. We were unable to determine that these measures were having the desired impact on patient care and treatment.

We identified both a structural and a psychological disconnect in relation to communication between clinical/ward based staff and hospital management. We noted the significant impact the recent abuse allegations, the ongoing police investigation and staff suspensions were having on staff, leading to poor morale amongst the staff groups in each of the wards we visited.

Overall we observed a reactive and crisis approach to management. We did not find effective arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to patients and proactive identification of issues in relation to the safety and quality of some aspects of care.

Governance arrangements were found to be insufficiently developed to be capable of providing assurance to BHSCT that services in MAH are safe and well led. We suggested that additional resources and external support was required. This is necessary to provide robust assurance of the quality and safety of care provided in the hospital, to ensure appropriate planning for transition of identified patients from the hospital to suitable community placements and to define the hospital's overall purpose within the wider HSC system (current and future).

During this inspection we identified six areas of significant concern in relation to the following overarching themes emergent:

- Staffing;
- Patients' physical health care needs;
- Financial governance;
- Safeguarding;
- Restrictive practices (seclusion); and
- Hospital governance.

We provided feedback to BHSCT senior management team on 1 March 2019. At this meeting we informed BHSCT that RQIA had serious concerns in relation to the care, treatment and services as provided for patients in MAH in respect of the emergent themes.

In response to our ongoing concerns we invited the Chief Executive and up to four BHSCT colleagues to attend a meeting at RQIA on 7 March 2019 as it was our intention to serve six Improvement Notices to BHSCT in respect of MAH.

We also wrote to the Department of Health (DoH) in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. We advised the DoH of our serious concerns in relation to care, treatment and services provided for patients at MAH and recommended that the DoH agrees and implements a special measure for BHSCT in relation to MAH. The recommendation was made with a view to supporting BHSCT (and the other two HSC Trusts served by MAH), to improve care and treatment of patients currently in MAH, to ensure appropriate governance systems/arrangements are in place, and to ensure appropriate planning for patients who have completed their active assessment/treatment and who will relocate out of MAH to accommodation in the community over the coming months.

At our Intention to serve six Improvement Notices meeting on 7 March 2019, representatives from three of the HSC Trusts who have patients receiving care and treatment at MAH were provided with an opportunity to outline and discuss evidence/information relating to each of the six areas of concern identified. After thorough consideration of BHSCT representation at our meeting on 7 March 2019 and of the additional information provided by BHSCT to RQIA on 8 March 2019, we determined not to serve Improvement Notices to BHSCT at this point in time. We advised BHSCT that we will continue to closely monitor each of the six areas of concern and the quality of care and treatment delivered to patients in MAH. We advised that we will seek evidence of improvement resulting from the actions/measures BHSCT is now progressing as the main provider of care in MAH and/or in conjunction with other providers, in particular with NHSCT and SEHSCT.

Following our determination not to serve Improvement Notices to BHSCT we also wrote to the Department of Health (DoH) on 14 March 2019 in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to update them about our determination. At this time we advised that our recommendation that the DoH agrees and implements a special measure for BHSCT in relation to MAH remained valid.

4.1 Inspection outcome

Total number of areas for improvement	**11**

We identified 11 areas for improvement in relation to the six emergent themes arising from this inspection. These relate to:

- Staffing
- Safeguarding
- Close Circuit Television (CCTV)
- Restrictive practices (seclusion)
- Patient observations
- Management of medicines

- Patients' physical health care needs
- Discharge planning
- Strategic planning & communication
- Hospital governance
- Financial governance

Detailed findings of this unannounced inspection were shared with the BHSCT senior management team during a feedback session held on 1 March 2019. At this meeting we advised that RQIA had serious concerns in relation to care, treatment and services as provided for patients in MAH in respect of the emergent themes.

In response to our ongoing concerns we invited the Chief Executive and up to four BHSCT colleagues to attend an Intention to serve six Improvement Notices meeting at RQIA on 7 March 2019. We also wrote to DoH recommending the implementation of a special measure for BHSCT in respect of MAH.

After thorough consideration of BHSCT representation at our meeting on 7 March 2019 and of the additional information provided by the BHSCT to RQIA (8 March 2019), we determined not to serve Improvement Notices to BHSCT at this point in time. We advised BHSCT that we will continue to closely monitor each of the six areas of concern and the quality of care and treatment delivered to patients in MAH. We also wrote to the DoH to update them about our determination. At this time we advised that our recommendation that the DoH agrees and implements a special measure for BHSCT in relation to MAH remained valid.

The Quality Improvement Plan (QIP) should be completed and detail the actions taken to address the areas for improvement identified. The timescales for implementation of these improvements commence from the date of this inspection.

4.2 Action/enforcement taken following our most recent inspections

The most recent inspections of the wards were as detailed:

Erne Ward: No further actions were required following the most recent unannounced inspection on 24 October 2017.
Donegore: No further actions were required following the most recent unannounced inspection on 17 and 18 May 2017.
Killead: No further actions were required following the most recent unannounced inspection from 2 October to 4 October 2017.
Cranfield PICU: Cranfield PICU was closed temporarily on 21 December 2018 and has remained closed since.
Cranfield One: No further actions were required following the most recent inspection on 22 November 2018.
Cranfield Two: No further actions were required following the most recent inspection on 9 and 10 July 2018.

N.B. RQIA were notified on 7 December 2018 that the BHSCT had restructured Killead and Donegore wards and amalgamated the staff team into one ward. The new ward was renamed Ardmore.

Other than those actions detailed in the QIP's no further actions were required to be taken.

5.0 How we inspect

Prior to this inspection a range of information relevant to MAH was reviewed, including the following records:

- Previous inspection reports
- Serious Adverse Incident notifications
- Information on Concerns
- Information on Complaints
- Other relevant intelligence received by RQIA

Each ward is assessed using an inspection framework. The methodology underpinning our inspections includes; discussion with patients and relatives, observation of practice, focus groups with staff involved in all functions from across the hospital and review of documentation. Records examined during the inspection include; nursing records, medical records, senior management and governance reports, minutes of meetings, duty rotas and training records.

Questionnaires were provided to patients during the inspection by the lay assessor on behalf of RQIA. Returned completed patient questionnaires were analysed following the inspection.

We invited staff to complete an electronic questionnaire during this inspection. We did not receive any returned completed staff questionnaires following this inspection.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspections

Erne Ward: The most recent inspection was an unannounced inspection on 24 October 2017. There were no areas for improvement identified as a result of that inspection.

Donegore and Killead amalgamated on 7 December 2018 to become Ardmore ward. Prior to amalgamation they were inspected individually.

Donegore: The most recent inspection was an unannounced inspection on 17 and 18 May 2017. There were no areas for improvement identified as a result of that inspection.

Killead: The most recent inspection was an unannounced inspection from 2 October 2017 to 4 October 2017. Seven areas for improvement were identified as a result of that inspection. These areas related to speech & language therapy recommendations, ligature risk assessment, complaints management, fire safety, environment, care plan management and lack of clinical pharmacy support. These areas of improvement were reviewed as part of this inspection.

PICU: Was closed temporarily on 21 December 2018 and has remained closed since.

Cranfield One: The most recent inspection was an unannounced inspection on 22 November 2018. Four areas for improvement were identified as a result of that inspection. These areas related to the management of patient observations and the management of patients physical health care. These areas were reviewed as part of this inspection.

Cranfield Two: The most recent inspection was an unannounced inspection from 9 to 10 July 2018. Four areas for improvement were identified as a result of that inspection. These areas related to the management of patients physical health care and were reviewed as part of this inspection.

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

6.3.1 Staffing

We observed that nursing staff throughout the wards were responsive to patient requests and managed them in a caring manner. Staff described the multidisciplinary team (MDT) within each of the wards as being patient centred and safety focused.

We reviewed patient care records and evidenced that patient progress and safety was being monitored and regularly reviewed by nursing staff. It was noted that each patient's care pathway/plan was reviewed on a weekly basis.

Discussions with staff and a review of duty rotas evidenced that the nursing staff complement for MAH for the week commencing 26 February 2019 was subject to significant deficits. This was as a result of a combination of long-term sickness absence, precautionary suspensions, maternity leaves and unfilled vacant posts.

There was evidence of insufficient staffing at ward level to meet patients' prescribed level of observation, to implement and execute appropriate therapeutic care plans for patients, or to appropriately manage patients' physical health care needs. We evidenced insufficient staffing at ward level on each day of the three day inspection visit. Staff of all grades throughout the hospital site informed us there was insufficient staffing at ward level. Due to staff shortages at ward level, staff are at times unable to appropriately fulfil their responsibilities and this is impacting on the quality and assurance of care delivered and is in itself a source of anxiety for staff.

We noted good evidence of psychology assessments and positive behaviour support (PBS) plans for patients who presented with challenging behaviour. These plans were being regularly reviewed and adapted to meet patients' needs. However, there was limited evidence that PBS plans were being incorporated into care plans and interventions undertaken by nursing staff. Inspectors noted that specialist behavioural nurses were rostered to general duties on wards. This was having a significant impact upon the availability of support to implement patients' PBS plans. We noted that this was having a detrimental effect for patients and staff.

Staff informed us that they were unable to attend training due to low numbers of staff available at ward level.

We determined that staff morale was low and has been particularly impacted by events at MAH over the last 18 months. We highlighted that the impact of psychological trauma experienced by staff was significant.

We highlighted that the insufficient staffing at ward level had the potential to impact on patient safety and the safety of staff that are at risk from the challenging behaviour of patients who present as unwell. We noted from the minutes of a recent MAH live governance meeting that high levels of adverse incidents involving staff injuries in Ardmore and Cranfield One had been discussed.

We noted that almost all wards were in a cycle of continuous crisis management which was impacting on the quality, safety and effectiveness of care delivered.

We highlighted our concerns regarding the large number of vacancies that exist and which greatly exceed the number of additional staff recently recruited or in the process of being recruited. BHSCT Senior Management informed us of an on-going recruitment campaign for nurse staffing.

A day care coordinator had recently been appointed to support all wards and day care staff are now in-reaching to wards. Ward managers confirmed that this has been introduced as a measure to reduce the risk associated with staff having to leave a ward to support a patient attending MAH’s day care facility.

We highlighted that staff currently in the hospital (both front-line and managerial) have displayed enormous resilience, they are to be commended for their dedicated service to the patients in MAH, however they now require additional support and resources in order to continue to provide safe care.

An area for improvement in relation to staffing has been made.

6.3.2 Management of Incidents

Policies and procedures in relation to incident/risk management were reviewed and found to be up to date and incidents were being recorded, reviewed and approved on the Datix incident system.

We determined that incident reports were being completed in accordance to the required policies and staff were able to effectively describe the processes to report incidents. We could not evidence how the learning from incidents was shared or how it resulted in changes to practice. There was no evidence of analysis of incidents to determine patterns or trend data and information coming from incidents was not being shared with frontline ward staff.

Members of the senior management team informed us that incidents and risk management issues are being reviewed on a weekly basis at the recently established site situation report (SITREP) and MAH live governance meetings. Having reviewed the information feeding into the SITREP and MAH live governance meetings we were unable to determine that incident/risk management processes were sufficiently integrated within the overall MAH governance system or intelligent enough to consistently feed risk information to BHSCT management/Board. We highlighted that this was necessary in order to assure the safety and effectiveness of care.

We were concerned to find that a number of adverse incidents involving glass in Ardmore had been reported but that this issue or an action plan to address it was not detailed on the risk register.

An area for improvement in relation to strengthening of the governance arrangements, (into which management of incidents will feed), in MAH has been detailed under the “Is the service well led?” domain.

6.3.3 Safeguarding Practices

MAH adult safeguarding guidance was reviewed and found to be up to date and in accordance with the regional safeguarding policy.

We noted a high number of frequently reported safeguarding referrals for individual patients as a result of the same issue (physical abuse, assault or violence). We were unable to evidence any change in outcome or learning from these incidents and there was no evidence of how these incidents resulted in changes to practice.

Staff advised us that there was a process to review and screen incidents out of the safeguarding process at ward level. We were unable to evidence that incidents screened out at ward level were being audited to confirm and assure this screening process.

There was evidence that some information in relation to safeguarding referrals was being reported into governing arrangements for MAH but there was no evidence that learning was identified and shared back out to front line ward staff.

We highlighted the need for learning to be shared in a meaningful way with frontline ward staff. We acknowledged that this was also made difficult due to the challenges with staffing levels on wards.

We recommended that safeguarding incidents or allegations are assessed by a multidisciplinary team to determine the best action and outcome for the patient(s) and staff member(s). We advised that this approach would assist with addressing potential root causes giving rise to and/or influencing repeated referrals.

From an analysis of information provided our inspection team did not find evidence of effective deployment of safeguarding referrals, of implementation of learning arising through safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. A structural disconnect between various groups of professional staff was evident within the current safeguarding arrangements.

Close Circuit Television (CCTV)

The inspection team was clear that staff across the site were fearful. The inspection team found a number of examples where staff had allowed themselves to be struck by patients because they feared the consequences of using legitimate intervention techniques in which they had been trained, to support patient’s behaviour. The use of CCTV on site has contributed to this fear, with many staff unable to articulate to the inspection team their understanding of how and why CCTV was used. We determined that there was some confusion with respect to how CCTV is being used and the associated operational parameters of its use.

The Senior Management Team must develop policies and associated operational procedures to clearly define how CCTV is being used at the MAH site.

Once defined staff must be supported to develop their understanding of CCTV use and the MDT team must be utilised as a safe environment for staff to learn how CCTV use can assist them in their practice.

An area for improvement in relation to safeguarding has been made. An area for improvement regarding the management and monitoring of CCTV has also been made.

6.3.4 Restrictive Practices (Seclusion)

The only purpose built seclusion room, which meets with relevant best practice guidance in terms of a seclusion environment, on the MAH site, is located in the PICU. In December 2018, BHSCT made a decision to temporarily close PICU and relocate the six patients to other wards across the hospital site. Two patients had been relocated to Ardmore, one patient to Cranfield One, two patients to Cranfield Two and one patient to Six Mile. We reviewed the care and treatment of these patients as part of our inspection focus.

The use of seclusion across the MAH site was also reviewed. We found that seclusion of patients as an appropriate and managed therapeutic intervention was taking place across the hospital site. In the main staff were found to be managing the practice well with evidence of de-escalation measures in use and required documentation in place.

The MAH seclusion policy and procedure provided to the inspection team was dated November 2016 and did not reflect the changes which had been introduced following the temporary closure of the PICU in December 2018.

Cranfield Two which had previously been an open ward was found to be locked. We were unable to locate evidence of the decision making process with regards to this change. Staff told us that patients who had been risk assessed as being safe to leave the ward knew how to do so. We observed this to be the case but found no evidence that care plans of individual patients had been updated to reflect these risk assessments.

We highlighted concerns that following the closure of PICU, the physical environments utilised for seclusion across a number of wards in MAH do not meet best practice guidelines. We observed that ward MDTs were implementing local arrangements to facilitate seclusion for patients in the absence of a clearly defined policy and following the closure of PICU. These arrangements were being provided in rooms that did not meet best practice guidelines for seclusion. In addition, various practices such as; seclusion; self-seclusion; de-escalation or practice agreed as part of a patient’s management/care plan were being described across the wards. In the absence of a clearly defined policy it was difficult to determine what information was being reported into the SITREP or MAH’s weekly live governance meetings.

The inspection team highlighted the need for the use of restrictive practices (seclusion) to be closely monitored. We could not find evidence of seclusion practices being audited and trends monitored over time. There was no evidence of robust assurance arrangements with respect to restrictive practices (seclusion).

We recognised that this issue is complex and will be challenging to address and suggested the BHSCT obtain ongoing expert support to ensure clear definitions and practices in relation to use of seclusion, self-seclusion, de-escalation and patient care planning.

BHSCT senior managers advised that they have recently sought support from the East London and Mersey Care NHS Foundation Trusts to assist with a review of restrictive practices in general and seclusion specifically.

An area for improvement has been made to ensure that the use of restrictive practices (seclusion) is reviewed across the MAH site in line with the following best practice guidance:

- Challenging Behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges; NICE guideline NG11 (2015);
- Nice Clinical Guidance NG-54 Mental Health Problems in people with learning difficulties: prevention, assessment and management DoH (NI) (2016) and
- Guidance: Isolation in detention; National Preventive Mechanism (2017)

The review should include daily discussion and MDT review at ward level and as a core component of MAH's weekly live governance meeting.

The BHSCT seclusion policy should also be reviewed and updated in line with these best practice guidelines and should include involvement of patients' families, staff and advocacy organisations.

6.3.5 Patient Observations

We reviewed the arrangements in place for the management of prescribed patient observations. We reviewed patient numbers, supervision ratios and the number of patients receiving enhanced one to one care.

Samples of patient observation records were reviewed and we noted that patients' observations were prescribed as required but were not always completed. Staff informed us that due to current nurse staffing they were unable to meet patients prescribed observations levels.

We observed that nurse staffing shortages were having a detrimental impact on patient behaviour and ward routine.

There was no evidence of audits of observations being carried out at ward level. We recommended that there should be engagement with ward managers and frontline nursing staff to implement a regular programme of audits of patient observations across the wards in MAH. An area for improvement in relation to this has been made.

6.3.6 Management of Medicines

We reviewed the arrangements in place for the management of medicines within MAH to ensure that medicines are safely, securely and effectively managed in compliance with legislative requirements, professional standards and guidelines. We evidenced that an up to date Medicines Code was in place.

There was evidence of satisfactory systems in place for medicines management. Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were observed to be clean, tidy and organised.

Pharmacist input is provided across the hospital site for 18.75 hours each week. The pharmacist input includes provision of medicines reconciliation at admission and discharge, review of prescribing and monitoring of stock levels.

We found a number of examples of medicines which had been prescribed for on-going treatment for several long-stay patients as having been ordered "urgently" on supplementary requisition sheets. This evidenced that stock management and effective anticipatory ordering was not consistent.

There was no Pharmacy Technician support. We highlighted that this would be beneficial in supporting/reducing pressure on nursing staff, releasing the pharmacist time to concentrate upon patient facing activities and to support stock management and address deficiencies (stock levels/ordering/expiry date checking).

We reviewed patient kardexes and found that they were well maintained overall. We noted the good practice of highlighting dates for medicines prescribed at intervals.

A review of administration records highlighted a number of unexplained missing nursing staff signatures and we identified four examples of medicines being unavailable for administration. We did not see evidence of these areas being audited at ward level, except in Erne where some evidence of medication audit was found.

In relation to anxiolytic and antipsychotic medicines prescribed on a ‘when required’ basis e.g. to manage agitation, there were clear parameters to direct administration of these medicines on the patient’s kardex. This included the indication for the medicine, the minimum frequency intervals and the maximum daily dose. Details of first line and second line (and occasionally third line) treatment were clearly recorded.

Samples of case notes (on the PARIS system) were reviewed and the rationale for any administration within a strategy for de-escalation was detailed; however, the assessment of effectiveness of the administration of these medicines was not consistently recorded.
Staff advised us that the incidence of use was monitored and reviewed as part of patient reviews/ward rounds.

A range of audits should be completed to include: omitted doses, completion of administration records and effectiveness and appropriateness of ‘when required’ medicines be undertaken to improve medicines assurance.

Staff advised us of a regular review of stock to ensure that the medicine trolley only contained medicines for patients currently in the ward. However, we found some expired medicines including an anaphylaxis kit in Ardmore. We highlighted these to staff for removal (none of these medicines were in use) and advised that they ensure the immediate replacement of the anaphylaxis kit.

In relation to medicines requiring refrigeration we found a number of medicines which had expired or which did not require refrigeration. These were subsequently removed. We noted that refrigerator temperature was not being consistently recorded in Ardmore. The minimum and maximum medicine refrigerator temperatures should be recorded in all wards.

It was not always clear that therapeutic blood monitoring/other monitoring of physical health parameters associated with antipsychotic prescribing was being systematically undertaken or followed up to ensure that it was completed at required intervals (in accordance with the hospital’s antipsychotic monitoring protocol). To remind staff when these are due for completion staff advised us that the required intervals would be recorded in the nurse’s diary.

An area for improvement has been made regarding medication management.

6.3.7 Environment

Ardmore and Erne were the specific focus of the environmental inspection parameters; however, all five wards were visited over the course of the three day inspection.

Ardmore

The environment was observed to be clean and appropriately maintained.

We observed that when patients are in the dining room/communal area the noise echoes throughout both sides of the ward and creates a noise reverberation which can be very distracting and unpleasant.

Ward staff informed us that they have tried to encourage patients to access other parts of the ward. We found that there are a number of rooms in the ward which patients can avail of which are very pleasant.

We noted that patients tended to congregate in the large open dining room/communal area as the nurses' station is located there and it appears to be the hub of the ward.

Patients with hearing impairments, sensory problems and autism may find this area very distressing due to the high ceiling creating vibrating sounds. We suggested consideration of a possible review of furnishings/layout to try and absorb noise and reduce the echo effect.

Erne

The environment was observed to be clean, clutter free and well maintained.
There was good ventilation, large lounge areas and neutral odours.

We observed that the ward was undergoing renovation work. We noted that this was being well managed.

Ward furnishings were observed to be well maintained and comfortable.

The ward is of an older design and has a number of areas, annexes and rooms with some limitation to sight lines.

Cranfield One and Two

The Cranfield wards were observed to be similar in design to Ardmore.

Number of areas for improvement	**6**

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome

6.4.1 Care Pathways & Plans

There were 67 patients receiving care and treatment in MAH at the time of the inspection.

We reviewed a sample of patient care plans. There was evidence of an up to date mental health needs review of each patient, as well as records of decision making by the MDT involved in delivery of the patient's care.

We noted that MAH operates a dual records system. Patient care documentation was available on the PARIS electronic patient information system and in hard copy. Core care records were centrally located on the PARIS system and we observed that staff are familiar with the system. We found that continuing care records were difficult to track and locate.

Staff demonstrated good understanding of individual patient needs. We noted that nursing staff also demonstrated a high level of skill when supporting patients who presented with challenging behaviour. Effective use of de-escalation techniques with patients was observed throughout the duration of the inspection.

We found that there were good psychological formulations recommended for individual patients but they were not being fully implemented. Staff informed us that this was because they were complex in nature and staff did not have the time required to implement them. Staff reported that the deficit of positive intervention was impacting patient behaviour adversely.

BHSCT senior managers informed us that they were trying to resolve this issue by each ward having dedicated support from psychology staff to assist ward staff with the implementation of patients' positive behaviour support plans.

We found that the management and recovery of patients was being adversely affected by the mix of patients present in wards and delays in the discharge of patients who no longer required treatment. Acutely unwell patients were being admitted whilst patients' whose assessment and treatment had been completed were experiencing delays in their discharge. We were told that this combination was contributing to deterioration in patient behaviour.

We highlighted that other key expected activities including the audit of prescribed observations and the provision of nurse led ward based activities for patients were not being undertaken as nursing staff had prioritised the primary care needs of patients.

An area for improvement in relation to audit of patient observations has been detailed under the "Is care safe?" domain.

6.4.2 Physical Health Care Needs

We reviewed patient care records and ward procedures and processes for the management of patients' physical health care needs.

We found evidence of reactive measures for patients in respect of their physical health. No evidence of annual physical health checks or monitoring of co-existing physical health conditions was found.

Ward staff were observed to respond quickly to patients if they became ill or suffered injury as a result of a fall or from the effects of a seizure. We were told that patients could access out of hours general practitioner services as required.

Senior managers informed us that they had recently advertised for a general practitioner to facilitate in hours clinical sessions on the hospital site. They told us about the development of a physical health checklist which was to be piloted. Whilst we welcomed this development we highlighted that this approach may assist with addressing local ward arrangements but will not introduce a sustainable system level solution.

Reviews of patient care records evidenced that patients did not have their physical health appropriately monitored. We found they did not access health or population screening appropriate to their gender and/or age, and did not have appropriate access to primary care services. We noted that this placed them at a disadvantage when compared to their peers living in the community.

We found that there were no regular audits of patients' physical health care records being undertaken at ward level. We also found that some patients who were prescribed antipsychotic medications did not experience appropriate monitoring of related parameters of physical health as required in accordance to MAH's antipsychotic monitoring protocol.

Dental screening was in place but we found that this was not consistent across the hospital.

MAH must develop an appropriate system to ensure that the range of patients' physical health care needs are robustly addressed and monitored. An area for improvement has been made.

6.4.3 Discharge Planning

We did not find robust systems in place to ensure that agreed discharge arrangements are recorded and co-ordinated with all services that are involved in the patient's on-going care.

We were informed by BHSCT senior managers that they are continuing to progress a collaborative regional approach to ensure the hospital functions as an assessment and treatment hospital. They highlighted multi-agency involvement with all stakeholders including other Trusts, the Health and Social Care Board (HSCB), the Public Health Agency (PHA) and the Department of Health (DoH).

Discharge planning arrangements were reviewed. We found that 32 patients no longer required treatment and were experiencing a delay in their discharge from hospital.

During discussions with ward staff we were told that they often did not have up to date information about the plans for patients who have completed their active assessment and treatment and are awaiting discharge. Staff told us about the challenges that this presents as patients, family members/carers seek their advice in relation to possible discharge options. We did not find evidence of clear communication with families taking place. We could not find detailed or up to date information in relation to proactive discharge planning for patients who are delayed in leaving the hospital.

An area for improvement has been made to ensure that ward staff have access to the most up to date information regarding patients who are awaiting discharge from MAH.

We acknowledged that wider systemic issues were negatively impacting on the hospital's ability to discharge patients. We noted a lack of appropriate community infrastructure had resulted in the delayed discharge of a number of patients.

Senior managers advised they recognise that urgent action is needed to facilitate reintegration back into the community of those patients who no longer require hospital treatment. They told us that they had set a priority for all patients to have a discharge address and plan and for this to be developed using a co-production model.

6.4.4 Strategic Planning and Communication

Following discussions with senior managers and reviewing minutes of meetings we found that BHSCT had a number of priorities in relation to re-modelling services in MAH. These priorities include review of admission criteria so that admission to MAH will only be for mental ill health or severe behavioural concerns that require hospital intervention, development of a clinical assessment unit and a target that use of seclusion would be reduced to zero.

Discussions with a wide range of staff across the whole MAH site identified that a large number were not aware of the plans for the hospital. We highlighted an issue relating to how the hospital's management team communicated plans to staff.

Staff told us that they were unclear as to the role and function of the hospital's PICU. During discussions some staff advised us that they were in temporary positions whilst PICU was closed for a short time; whilst others who had been relocated from PICU believed that they had been moved permanently to other wards.

We advised that stated aims and objectives for the hospital's PICU should be developed and disseminated to frontline staff so that there is clarity regarding both the unit and staff aligned to this service.

We noted that the poor understanding of the of hospital plans was symptomatic of this disconnect between what the management team were trying to achieve and what staff actually understood.
We found that this disconnect was common across several areas

An area for improvement has been made regarding the provision of a forward plan for MAH to include stated aims and objectives for the PICU.

Number of areas for improvement	**3**

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

6.5.1 Person centred care

Compassionate and positive interactions between staff and patients were observed throughout the inspection.

We observed staff treating patients with dignity and respect and responding compassionately to patients presenting with physical and/or emotional distress.

We found that nursing staff had good knowledge and understanding of the specific needs of individual patients they were caring for.

All staff described the MDT teams within each ward as patient centred, inclusive and supportive. We noted that MDTs included the range of professionals necessary to provide the required care and treatment to patients.

6.5.2 Patient Engagement

We reviewed how MAH engages with patients and/or their representatives.

We found that when appropriate and in accordance with each individual's presenting needs and health, patients were given the opportunity to be involved in any meetings where decisions about their care and treatment were being made.

We evidenced that care and treatment options were discussed with patients and their relatives.

During the inspection the Lay Assessor met with five patients from three wards, namely, Ardmore, Erne and Cranfield One. Patient staff interactions observed by the Lay Assessor were positive. Patients remained relaxed and at ease throughout the inspection. The Lay Assessor noted that when a patient became unsettled or agitated staff intervened quickly in a sensitive, supportive and caring manner.

One patient reported that their relationship with staff was good and they knew who to talk to if they were unhappy or had a concern. The Lay Assessor observed that ward staff were familiar with this particular patient's care needs and that the patient and staff had a close informal relationship. Two patients described the ward they were on as being clean and tidy. Both patients stated that there were not always enough activities to keep them busy at nights and at weekends. Both patients stated that when they had a concern or difficulty regarding their care they could discuss this with their named nurse. Patients told inspectors that they knew who was involved in their care and who to talk to if they were not happy or they were upset.

The Lay Assessor was also provided with feedback in relation to the impact of delays in obtaining a suitable community placement. One patient stated that they had been on the ward for three years and there was no suitable community placement available for them. Another patient informed the Lay Assessor that they had no concerns regarding the care provided however, the patient expressed frustration at having to remain in hospital as they wanted to be in their own home. The Lay Assessor was informed that there was no community placement currently available for this patient.

A third patient discussed their concerns and frustrations in relation to their discharge from the ward being delayed. The patient explained that they understood why their discharge had been delayed and the reasons for this.

BHSCT senior management informed us that it plans to appoint a Carers' Consultant to enhance family/carer experience and to influence and shape services from a holistic perspective.

Number of areas for improvement	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

6.6.1 Planning and oversight of staffing levels

We reviewed the staffing arrangements in MAH. The multidisciplinary team (MDT) for each ward included nursing, occupational therapy, psychiatry, clinical psychology, behavioural support and social work professionals. In addition there is forensic psychology and specialist nurse practitioner support available. Independent advocacy services also visit the wards in MAH.

Senior managers told us that they had implemented nurse staffing planning measures and escalation arrangements to support ward managers. We were advised that bank and agency staff had been employed and that staffing levels on each ward were being monitored daily.

Wards were staffed using a mix of BHSCT, bank and agency staff. Staff told us that this mix did not always contain the required knowledge and skills to meet the complex needs of the patients currently receiving care and treatment in MAH. Staff told us that the BHSCT policy of agency staff not being permitted to take charge of the wards was creating difficulty in getting BHSCT only staff in charge to cover the wards.

Staff reported their experiences which indicated that morale was poor. Staff told us they had been significantly affected by the recent abuse allegations, the ongoing police investigation and staff suspensions. Staff told us that they could not complete the required level of observations, that they frequently had to cancel therapeutic and leisure activities and that they continually had to spend time inducting new members of agency staff. They informed us that this inability to fulfil their responsibilities is a further source of anxiety. We noted that it is impacting on the quality of care that staff are providing.

We were told that frequent changes of staff and increased use of agency staff was negatively impacting patients and their behaviour due to unfamiliarity. We highlighted the importance of continuity of staffing for patients with learning disabilities. Ward managers told us that they did not feel supported to address the daily workforce shortfall.

The monitoring and escalation arrangements in relation to staff shortages were reviewed. We found they did not accurately identify the impact the nurse staffing shortages were having on the care and treatment experienced by patients on some wards.

We found no evidence of an overarching forward plan for staffing in MAH which details how the BHSCT is going to find, retain and support staff.

The importance of the BHSCT engaging with colleagues from NHSCT and SEHSCT to seek necessary staff resources to facilitate adequate nurse staffing cover in MAH was discussed. It was noted that the BHSCT is experiencing difficulty in recruiting sufficient numbers of learning disability trained nurses because of the low numbers of nurses available within Northern Ireland.

An area for improvement in relation to planning arrangements for nurse staffing at MAH has previously been made in the “Is care safe?” domain.

This area of improvement has been made to ensure:

- A model to determine safe levels of ward staffing (including registrant and non-registrant staff) is defined. The model should be based on the assessed needs of the current patient population and incorporate flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements; and
- An effective process for oversight and escalation of challenges relating to staffing across the hospital site is implemented.

Senior managers informed us that they had recently introduced a number of arrangements to improve staff support. These included facilitating staff information/update sessions, access to one to one meetings with occupational health staff, information and support regarding the management of personal and professional issues, a keeping in touch system for absent staff and a Health and Wellbeing strategy.

Staff told us that they do not feel empowered, that they are fearful and that they are not engaged with the support measures.

We advised of the need for monitoring of the effectiveness of these arrangements after adequate time has been allowed for staff engagement and reflection. This is included in the area for improvement.

6.6.2 Hospital Governance

We reviewed the arrangements in place to support hospital governance.

MAH governance arrangements and documentation was discussed with senior managers, senior nursing managers, ward managers and members of the MDT.

We found that a BHSCT Assurance Committee covering the Learning Disability Division and chaired by the Chair of Division and Clinical Director has recently been established.

Hospital Services meetings were operating on a monthly basis. We found that they are chaired by the hospital services manager and are attended by ward managers and MDT staff. A review of sampled minutes illustrated that items discussed included staffing, patient discharges, site updates and Datix incidents.

MDT staff told us that weekly consultant led MDT meetings were taking place. We were told that Leadership Walk Arounds with a safety and quality focus are undertaken on a monthly basis by senior managers from both within and outside the division.

Staff informed us that they were unclear about the functions and operational purpose of the committees, meetings and walk arounds. Staff could not describe how these arrangements were supporting them to discharge their responsibilities. We highlighted that in view of psychological trauma experienced by staff it is important that there is clear communication about any new arrangements introduced. We also advised that the BHSCT should avoid implementing too many new arrangements at once so that staff do not feel overwhelmed.

We noted and welcomed that the BHSCT had introduced new approaches to review and strengthen governance arrangements including; introduction of a SITREP tool, weekly safety pause meeting and a weekly MAH live risk management/governance meeting. We observed both types of meetings during the inspection and found them to have been effectively chaired. There was limited evidence that the SITREP tool was used to escalate issues of concern to the service managers or BHSCT more widely. We highlighted that the tool may require some revision in order to be sensitive to pertinent issues, such as finance and pharmacy, and to be utilised to its’ full potential.

The benefit of the weekly safety pause meeting becoming embedded within the overall governance system was discussed.

Ward managers advised us that they meet on a weekly basis and that a ward based morning safety briefing (huddle) is being piloted in two wards (Cranfield One and Two). We observed briefings and noted that they were attended by the MDT. We found them to be open, inclusive and effective particularly with regard to the sharing of patient information and providing updates on patient progress. We noted that the outputs from these meetings would also help to improve decision making with respect to appropriate escalation of issues.

The benefit of the daily safety huddle becoming embedded across all the wards in MAH was discussed.

Erne was observed as being well led. Local governance arrangements and effective auditing were noted as having been implemented by the ward manager. Supervision and appraisals were evidenced as being up to date. We noted that a programme of audit of case records, safeguarding referrals and incident reports was being undertaken. Nursing staff were visible and approachable and there was evidence of effective leadership. Patients and relatives who met with inspectors reflected positive experiences and reported a good standard of care and treatment being provided by the ward’s MDT.

We acknowledged that the new governance system arrangements were at an early stage and would take time to become fully embedded throughout the hospital. Current arrangements were not sensitive enough to identify risks so as to consistently feed them to management. We highlighted that this development will be necessary in order to provide assurance to BHSCT that all operational aspects of MAH are robust.

We advised that the governance system requires further strengthening to ensure it is robust and supports collection and analysis of governance data at both ward and management level.

An area for improvement has been made relating to comprehensive implementation of robust governance arrangements at ward and hospital level.

6.6.3 Financial Governance

We assessed how the BHSCT discharged its' responsibilities in accordance with Articles 116 and 107 of the Mental Health (Northern Ireland) Order 1986 (MHO). This legislation sets outs the requirements for the Trust in managing monies and valuables on behalf of patients and the conditions for referring a patient to The Office of Care of Protection (OCP) to enable appropriate financial decisions to be made.

We noted a number of cases where monies was held in excess of 20K and where neither consent has been obtained by RQIA or referral had been made to The Office of Care and Protection to enable a controller to be appointed. We advised that the necessary steps should be taken to ensure that the Trust is compliant with its responsibilities.

We were informed that the MAH site manager acts as appointee for 13 patients but found related documentation for only six of these patients. We noted that none of the 13 patients' files were fully complete, entirely clear or contained evidence of an overarching financial plan. We were not assured that the designated appointee had sufficient knowledge and understanding of the individual patients for whom they had been appointed to enable fully informed best interest decisions to be made.

We noted that ward level ledgers, used for recording routine transitions were in place. However, we found these were sometimes inaccurately completed and that weekly checks by ward managers or monthly checks by senior managers were not being undertaken consistently.

We reviewed a sample of three sets of patient finance records. We found no evidence of discussions with patients regarding their choices or evidence of support being provided for decisions relating to spending. We found records of expenditure which were not supported by accompanying receipts. We identified a case where a safeguarding referral had not been made when there was some indication of potential financial abuse. Ward staff reviewed the patient's circumstances and a safeguarding referral was completed and forwarded to the responsible Adult Safeguarding Team.

We reviewed a sample of patients' property records and identified that three patients did not have an accurate record of their personal property and that one patient's record was last completed in June 2016.

The ward procedure for maintaining property records was discussed with two members of staff. We were informed by one member of staff that property records are not routinely maintained following a patient's admission to the ward and that items deposited for safekeeping were not recorded. We were advised by the second member of staff that property is recorded on admission and discharge only. We were told that items acquired and disposed of during the patient's stay are not recorded.

We determined these findings reflected a lack of understanding by ward managers and other ward staff, of their responsibilities for patient finances and we recommended this be urgently addressed. We also highlighted the need for improvement in the consistency and accuracy of completion of weekly and monthly ledger checks.

The BHSCT Patient Finances policy was reviewed and we noted it was only in draft form. We did not find evidence of regular financial audits being completed in MAH. An audit had been last completed in 2015. We recommended that the Patient Finances policy be updated and then an audit of its' operational use be undertaken to assure it full implementation.

We advised that there is a need for BHSCT to implement a programme of regular audits of compliance with its financial procedures across all wards in MAH to ensure a robust system approach to oversight and governance.

An area for improvement with respect to financial governance has been made and incorporates all of the concerns outlined.

6.6.4 Quality Assurance

We found evidence of active quality improvement initiatives with respect to violence reduction (Ardmore) and improving physical health (Cranfield Two).

Weekly incident audits and audits of the use and cost of bank and agency staff were evidenced as being undertaken and subsequently reviewed at the weekly SITREP meeting.

We were informed by BHSCT Senior Management Team that feedback and learning from a workshop undertaken on 30 January 2019 in relation to the purpose of MAH as an Assessment and Treatment unit, the patient pathway and desired outcomes would be utilised for future quality improvement initiatives. We were told that the learning would also be used for improving communication with frontline staff and remodelling of service provision.

BHSCT Senior Management Team informed us that they will be participating in NHS Benchmarking for Learning Disability Services. We recognised this was an opportunity for appropriate service data to be collected and analysed and also for local peer comparator review.

We welcomed these elements as signs of early development of an improvement culture in MAH and encouraged their progression moving forward.

Number of areas for improvement	**2**

6.7 Staff views

No staff questionnaires were received by RQIA.

Inspectors met formally and informally with staff from various professions during the inspection.

Structured staff interviews were undertaken with two members of junior medical staff, one member of agency nursing staff, one hospital social worker and a ward deputy manager. Focus groups with senior management staff, allied health professionals (social work, occupational therapy and psychology) and support staff were also held.

All staff interviewed highlighted issues with nurse staffing. The nursing staff who spoke with the inspection team told us about the impact of the increased use of agency staff and the challenge of seeking additional staff on a daily basis. They highlighted the impact of this upon the safety of staff and patients. Staff discussed the challenges of ensuring that there was an appropriate number of trained nursing staff available to cover each shift. This was noted as being particularly challenging during nightshifts.

All staff interviewed indicated that they felt patient care was compassionate. They highlighted an approach of continuous assessment and of patient focused MDT working.

We were told by staff that the effectiveness of care would be improved by appropriate placements being available in the community.

Staff experience of management support was mixed. One staff member described their manager as someone who was approachable and always listened. The staff member reflected that they felt valued. Another staff member told inspectors that staff job plans changed continually and there was uncertainty regarding the future and purpose of some wards.

A number of staff commented on the hospitals inconsistent approach and the completion of patient medical reviews. Staff stated that medical reviews were completed as required and that there was no system to ensure continuous routine patient medical reviews.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the Deputy Chief Executive & Medical Director, BHSCT Senior and Executive Management Team and ward staff as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

BHSCT should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of BHSCT to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified in which action is required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The BHSCT should confirm that these actions have been completed and return the completed QIP to bsu.admin@rqia.org.uk for assessment by the inspector by 5 March 2020.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">The Trust must ensure the following findings are addressed:</td></tr>
<tr><td colspan="2">Staffing</td></tr>
<tr><td rowspan="2">Area for improvement No. 1

Ref: Standards 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1, 5.3.3)

Stated: Second time

To be completed by:
Before 14 May 2019</td>
<td>The Belfast Health and Social Care Trust must:
1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH, which;
a) is based on the assessed needs of the current patient population <i>and</i>
b) Incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.
2. Implement an effective process for oversight and escalation to senior management and the executive team when challenges in nurse staffing arise.
3. Implement an effective assurance mechanism to provide oversight of the implementation of the model and escalation measures.
4. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing.</td></tr>
<tr><td>Response by the Trust detailing the actions taken:
1. a. Work progressed to determine safe staffing levels through an assessment of the current patient population’s acuity and dependency. Acuity and dependency was determined using the current level of observation employed by the staff to safely care for patients, and using Telford to determine the registrant levels. This triangulated approach has resulted in a nursing model, which is in use to describe safe staffing levels.
b. The model is in use by the ward managers and reviewed regularly to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.
2. Ward staffing levels are reviewed on a daily basis Monday to Friday and at the weekly Ward Managers meeting (Friday) for the weekend. ASMs are on site Monday to Friday and review the requirements daily. An OoH co-ordinator also reviews staffing levels on site in the OoH period. Any issues of concern are raised by the wards to the ASM/OoH Co-Ordinator to Service manager and then to Collective leadership team. In the OoH there is a senior manager on call rota in place to provide additional support to staff OoH.
3. The Model was developed with engagement from the ward managers and ASMs in the first instance to ensure buy in. the Divisional Nurse worked closely with the ward Managers and ASMS to determine the current patients’ needs on site in order to inform the model. Also a Telford exercise was undertaken with each of the ward managers.</td></tr>
</table>

	Once the model was developed the DN met with each of the Ward managers and ASMS to implement. Assurances are sought at the weekly ward managers meeting that the model is in use. When there are any issues Ward managers and ASMS are able to contact and talk it through with the DN if that support is required. The pathway used to escalate issues is Ward Manager to ASM to SM and then to the Collective Leadership team. 4. The nursing model has been developed by the senior team in MAH (in conjunction with the ward managers and ASMs) and approved by the Executive Director of Nursing and the Expert Nurse Advisor, DoH, and it has been presented to and supported by RQIA.
Safeguarding	
Area for improvement No. 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding at MAH and ensure: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations; b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care; d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved. 2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward sisters, hospital managers, BHSCT senior managers and / or the Executive team as appropriate. 3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.
	Response by the Trust detailing the actions taken: A detailed action plan was developed by the ASG and management team at MAH. There are 37 actions in place to ensure that the key 3 areas outlined in the QIP are achieved. At present 34 of these actions have been completed, the remaining 3 actions are currently on hold following advice from the PSNI not to proceed whilst the investigation is ongoing.

	There are plans in place to meet with the PSNI to discuss further. There are currently monthly ASG audits taking place on site to provide assurance that the changes implemented through the action planned are still in place and compliant.
CCTV	
Area for improvement No. 3 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.
	Response by the Trust detailing the actions taken: The CCTV policy has been reviewed, included update to forms included within the policy, the policy is currently with the Trust's Standard and Guidelines Committee for tabling. All staff have access to the initial policy approved in MAH. Further policy review and update is planned to improve the use of CCTV for safety monitoring. This is being progressed with the CCTV working Group and will be shared with staff when fully approved. There are agreed procedures within the hospital for monitoring and managing CCTV images, the template for requesting a download of footage has been updated. Work is required to improve the robustness, monitoring and functionality of the CCTV system on site. The Co-Director is awaiting quotes from Estate Services/ RadioContact and a business case will be developed. A CCTV working group has been set up (this includes a representation from ward staff, safeguarding staff, management, litigation and unions) to review the current use of use and the development of use within the hospital. Feedback surveys and processes have been developed to gather feedback on the current use and developed use of CCTV for safety monitoring within the hospital. Feedback is being sought from staff, families, carers, advocates and patients.

Restrictive Practices (Seclusion)	
Area for improvement No. 4 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Undertake an urgent review of the current and ongoing use of restrictive practices including seclusion at MAH whilst taking account of required standards and best practice guidance. 2. Develop and implement a restrictive practices strategy across MAH that meets the required best practice guidance. 3. Ensure that the use of restrictive practices is routinely audited and reported through the BHSCT assurance framework. 4. Review and update BHSCT restrictive practices policy and ensure the policy is in keeping with best practice guidelines.
	Response by the Trust detailing the actions taken: MAH have implemented a suite of reports including a weekly patient safety report and a monthly governance report to ensure a clear statistical position for the use of restrictive practice is available for each setting. Reports are shared at both Executive Team and Trust Board. To date the use of seclusion and physical intervention have greatly decreased in the hospital. Audits have been implemented for the use of seclusion and patient observations, they are carried out on a monthly basis. The finding and actions from the audits are discussed at Pipa meetings and at the monthly Governance Committee. Restrictive Practices usage is discussed at a range of meetings, a Live Governance Call takes place each week when ward staff discuss the use of seclusion, Physical Intervention and use of PRN medication at patient level. The use of restrictive practice is included in the weekly Patient Safety Report and reviewed at the monthly Governance Committee. A Restrictive Practice Working group has been set up to provide a strategic overview of the use of and future use of Restrictive Practices within the hospital. The group has presentation of medical staff, ward staff, management, Safeguarding Staff, Governance, PBS and pharmacy. The suite of Restrictive Practice policies have been reviewed by an MDT within the hospital, an overarching Restrictive Practice Policy has been developed in line with best practice across the UK. MAH have formed a ‘critical friend’ relationship East London NHS Foundation Trust to act as critical friend to provide support and challenge in respect of all restrictive practices

Patient Observations	
Area for improvement No. 5 **Ref:** Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must address the following matters in relation to patient observations: 1. Engage with ward managers and frontline nursing staff to ensure that a regular programme of audits of patient observations is completed at ward level. 2. Ensure that there is an effective system in place for assessing and managing patient observation practices, which is multi-disciplinary in nature and which enables staff to deliver effective care and learn collaboratively.
	Response by the Trust detailing the actions taken: A monthly audit process has been embedded across the hospital. The audit looks at the use of observations and reports compliance or non-compliance with the policy. The outcome of each audit is circulated to the management team, discussed at PiPa and reviewed at the Governance Committee meeting. Assessing and management of patient observation practices are reviewed through PiPa meeting with a MDT approach.
Management of Medicines	
Area for improvement No. 6 **Ref**: Standard 5.1 Criteria 5.3.1(f) **Stated:** First time **To be completed by:** 28 August 2019	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of “when required” medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.
	Response by the Trust detailing the actions taken: 1. The existing registered pharmacist has agreed to increase hours from 0.5wte to 0.8 wte from the beginning of April 2020. The pharmacy technician post is in the early stages of recruitment. 2. The pharmacist reviews the kardexes for omitted does and completion of administration records at the PIPA meetings and any omissions or areas of concern raised at that time. With the increase in the Pharmacy hours, a more formalised approach can now be developed.

	A POMH audit on antipsychotic prescribing in ID patients, led by the Trust Pharmacy team will commence by the end of March 2020. 3. Each ward sister is responsible to ensuring that refrigerator temperature monitoring recording (Actual/Minimum & Maximum) is in place on their ward. This will be placed on the safety brief for daily checking. In addition the Pharmacist will audit the temperature monitoring when the Controlled drug audits are being undertaken.
Physical Health Care Needs	
Area for improvement No. 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to: 1. Ensure that there is an appropriate number of suitability qualified staff to ensure that the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes. 2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy. 3. Ensure that specialist learning disability trained nursing staff understand and oversee management of the physical health care needs of patients in MAH. 4. A system of assurance in respect of delivery of physical healthcare.
	Response by the Trust detailing the actions taken: A GP role has been recruited to the hospital to focus on physical health checks for all patients. There are 3 SHO positions within the hospital which are made up of one GP trainee and 2 psychiatry trainees. There is an out of hours GP available on site from 7pm-11pm each day with all other hours are covered by the onsite GP, the 3 SHOs and the psychiatry team for physical health care and queries. A lookback exercise has taken place to gather all physical health information for each patient including family history were available. This information is now stored on one template which is available on the PARIS system and in a physical health folder kept on each ward. Patients who meet the guidelines set out by Northern Ireland screening programmes have had their screening completed and added to the registers to ensure they are called appropriately with the general population. (Cervical cancer, Bowel screening, mammograms, AAA and diabetic eye. Each relevant patient now has an annual Chronic Health Condition review (Eye exams, asthma review, epilepsy review, hypertension review, testicular exams, breast exams and cervical screening.

	A review of all patients' health checks in regards to antipsychotic medication has been carried out. Each patient has an anti-psychotic monitoring chart which is reviewed by both a medical professional and a pharmacist. Six monthly (March & September) checks in line with Maudsley Guidelines is carried out, this includes bloods, ECG and all other relevant physical checks. All patient physical check information is stored on one template providing assurance that historical check information, family history and planned checks are available to all relevant staff. This provides assurance that all relevant checks have taken place or planned within the required timeframe. 1. All patients receive a physical examination within 24 hours of admission (ward trainee/on call trainee and nursing staff observations). We have ECG machines, physical observation equipment and venepuncture facilities available on site. 2. Past medical history and medicines reconciliation are confirmed within the first week (ward trainee/pharmacist) 3. Any initial concerns about physical health are followed up accordingly (ward trainee) 4. Longer term conditions and screening are managed by or GP locum doctor who also offers advice to trainees where required 5. For non-urgent physical concerns on the ward, the ward trainee is called 6. For urgent physical concerns, we have a duty bleep system for our site doctors and staff are aware to also contact NIAS in emergencies (as we have limited resuscitation facilities on site). Mandatory training for staff includes Life Support Training (at various levels depending on the grade/role of staff) accessed via the Trust HRPTS system 7. PIpA Visual Control Boards on each ward include prompts regarding physical healthcare, screening and antipsychotic monitoring. 8. We operate daily ward rounds (PIpA model) with focus days, one of which per week is about health promotion 9. All material pertaining to physical healthcare concerns are kept in manual files on the wards for easy access at PIpA and for out of hours doctors 10. Antipsychotic monitoring is performed as required and routinely every six months (March and September) now by our GP locum doctor and ward nursing staff. An audit of this across the site was carried out in December

	11. Current completion of the POMH audit: Antipsychotic prescribing in people with a learning disability under the care of mental health services (4/2-27/3/20 period, all inpatients and a sample of community patients). To compare with previous audit findings 12. We have the facility to refer to podiatry, dietetics, SALT, physio, OT on site and to our visiting dentist. 13. We have close links with and advice from the lead AMH pharmacist. We also have a part time pharmacist on site. 14. Future plans to develop the role of our locum GP colleague in the 'ID Physician' model to bridge the knowledge gap between primary and secondary care and improve the quality of physical healthcare assessment for our patients with complex co morbidities
Discharge Planning	
Area for improvement No. 8 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3(b)) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must ensure that ward staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from MAH.
	Response by the Trust detailing the actions taken: Patient level assessment and discharge information and plans are discussed at weekly PiPa meetings at ward level. Information from these meetings is shared appropriately at ward level by the ward representatives at Pipa. Patient transition plans are shared at ward level and there is an MDT approach for transition planning. The Transition team attend the ward managers meetings and the ASM meetings when there are updates to patient resettlement plans. A Quality Improvement project has been initiated involving staff from across the hospital to focus on standardising and improving the transition processes for patients resettling from hospital.
Strategic Planning & Communication	
Area for improvement No. 9 **Ref**: Standards 4.1 & 8.1 Criteria 4.3 (b, d and e), 8.3 (b) **Stated:** Second time	The Belfast Health and Social Care Trust must address the following matters to strengthen hospital planning: 1. Ensure that a comprehensive forward plan for MAH is developed, communicated, disseminated and fully understood by staff. 2. Ensure that stated aims and objectives for the hospital's PICU are developed and disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.

To be completed by: 14 May 2019	**Response by the Trust detailing the actions taken:** A workshop (invite open to all MAH staff) is planned for the 26 Mar 2020 to discuss plans and development for the future of the hospital site. Monthly staff briefing meetings have been embedded within the hospital, these meetings aim to share information with staff across the site and respond to any questions. A weekly newsletter is distributed to all staff across the hospital, providing information updates and sharing news. The PICU is no longer in use and will not be restored to its previous function, this information has been communicated to staff. The workshop planned for March and future planning meetings will include discussion around the future use of the PICU space.
Hospital Governance	
Area for improvement No. 10 **Ref**: Standards 4.1 and 5.1 Criteria 4.3 (a) and 5.3.1.(f) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must review the governing arrangements in MAH and consider the following matters in order to strengthen the governance arrangements: 1. Enhance communication, staff knowledge and understanding of relevant committees and meetings to support local leadership and governance on the MAH site. 2. Embed the recently introduced Daily Safety Huddle (at ward level) and the Weekly Safety Pause (hospital level) meetings. 3. Implement an effective assurance framework.
	Response by the Trust detailing the actions taken: A governance framework has been developed within the hospital, this consists of a hierarchy of meetings which provide the space for discussion, challenge, review and assurance. There have been a suite of reports developed to provide statistics, analysis and oversight of key governance areas within the hospital. The governance meeting and reports framework has been illustrated in a flow chart and provided to staff to assist with understanding of the reports and meetings within / about the hospital. The daily safety huddle now takes place on a daily basis within each ward. A weekly live governance call has been embedded within the hospital, this meeting has multi-disciplinary representation and is led by ward level information. The assurance framework has been embedded, this has been built from ward level reports and meetings building into Hospital management meetings which feed into Executive and Trust Board level meetings.
Financial Governance	
Area for improvement No. 11	The Belfast Health and Social Care Trust must ensure: 1. That the BHSCT is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116

Ref: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	of The Mental Health (Northern Ireland) Order 1986. 2. In respect of those patients in receipt of benefits for whom BHSCT is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits. 3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and BHSCT policy and procedures; this includes: a) that appropriate records of patients' property are maintained; b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role; c) that audits by senior managers of records retained at ward level are completed in accordance with BHSCT policy; d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in MAH.
	Response by the Trust detailing the actions taken: A comprehensive action plan has been developed by the finance team and management team at MAH. The plan consists of 18 actions (8 completed, 9 in progress and 1 no longer applicable). The appointment of a Finance Liaison Officer has been very successful and enabled individual financial plans to be produced. The Trust has recently received a response from RQIA to our request to hold balances over £20k for 4 patients and we are currently addressing the questions raised and remain confident that the Trust is best placed to manage these monies on patient's behalf. The Trust has sought and received appropriate documentation including benefit entitlement for all patients we are appointee for with the exception of one patient that transferred to MAH from a Trust supported living accommodation – the documentation for this one patient is currently being followed up. The Trust Policy has been extensively reviewed and updated a number of times since the inspection and training has been delivered to all relevant staff. Although the current version of the Policy has been issued to staff it continues to be reviewed and updated in light of in-house monitoring findings. The BSO Internal Audit has now taken place and the Trust is due to meet with auditors on 25th March to discuss findings.

Name of person (s) completing the QIP	Gillian Traub		
Signature of person (s) completing the QIP	Gillian Traub	**Date completed**	12 March 2020
Name of Responsible Person approving the QIP	Gillian Traub		
Signature of Responsible Person approving the QIP	Gillian Traub	**Date approved**	18 September 2020
Name of RQIA Inspector assessing response	Wendy McGregor		
Signature of RQIA Inspector assessing response	Wendy McGregor	**Date approved**	18 September 2020

The Regulation and Quality Improvement Authority

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

Assurance, Challenge and Improvement in Health and Social Care

Our ref: 020426/IN033250

06 March 2019

Private and Confidential

Dr Michael McBride
Chief Medical Officer
Department of Health
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Dear Dr McBride

I write in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to advise you of serious concerns identified by the Regulation and Quality Improvement Authority (RQIA) in relation to care, treatment and services as currently provided for patients in Muckamore Abbey Hospital (MAH).

You will be aware that RQIA has responsibility to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention and/or loss or damage to property under the Mental Health (Northern Ireland) Order 1986 and the Health and Social Care Reform Act (Northern Ireland 2009). Under Article 35 (1) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, RQIA conducts inspections and makes reports on arrangements by statutory bodies for the purpose of monitoring and improving the quality of health and personal social services.

This correspondence follows RQIA's unannounced inspection undertaken last week, from 26 to 28 February 2019 (inclusive), during which our multidisciplinary inspection team assessed care and treatment provided to patients currently in MAH. Our inspection team also assessed risk management, oversight and governance arrangements within and across the hospital during last week's inspection. A number of important findings emerged from our unannounced inspection, as summarised below:

1. Staffing - there was evidence of insufficient staffing at ward level to meet patients' prescribed level of observation, to implement and execute appropriate therapeutic care plans for patients, or to appropriately manage patients' physical health care needs. Due to staff shortages at ward level, staff are at times unable to appropriately fulfil their responsibilities and this is impacting on the quality and assurance of care delivered and is in itself a source of anxiety for staff.

Staff morale has been particularly impacted by events of the last 18 months and this is a significant cause for concern. Staff currently in the hospital (both front-line and managerial) have displayed enormous resilience, they are to be commended for their dedicated service to the patients in MAH, however they now require additional support and resources in order to continue to provide safe care and to plan for transition of the hospital's overall function and operating model.

2. Patients' physical health care needs - evidence of an appropriate system to ensure that patient's physical health care needs were addressed was lacking. Patients did not have their physical health appropriately monitored, did not access health screening appropriate to gender and/or age, and did not have appropriate access to primary care services. Additionally, some patients prescribed antipsychotic medications did not experience appropriate monitoring of related parameters of physical health (per the hospital's antipsychotic monitoring protocol).

3. Financial governance - concerns were identified in relation to failure to refer patients appropriately to the Office of Care and Protection, lack of awareness of management responsibilities relating to finances for detained patients, non-completion of patient property records and variation in completion of ledgers at ward level. There was also an apparent omission to make a safeguarding referral in the context of financial arrangements for one detained patient.

4. Safeguarding practices - our inspection team did not find evidence of effective deployment of safeguarding referrals, of implementation of learning arising through safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. A structural disconnect between professional staff was evident within the current safeguarding arrangements.

5. Restrictive practices (seclusion) - there was evidence that current seclusion practices across the hospital site are not in line with best practice guidelines.

6. Hospital governance - although arrangements have been established with a view to strengthening governance and appropriately identifying and managing risks across the hospital, our inspection team could not evidence that these arrangements were having the required impact on safety and effectiveness of care for patients or on the health and well-being of staff.

7. Discharge/relocation planning – ward staff reported they do not have current information regarding planning for some patients who have completed their active assessment and treatment and are awaiting discharge from MAH, this is challenging as family members/carers contact ward staff to seek their advice in relation to potential discharge options for their relatives (this is to be expected as ward staff are likely to be most familiar with patients' care needs). Despite several requests we (RQIA) have not received robust information in relation to discharge planning for patients who are delayed leaving the hospital. We have discussed one potential option with Belfast HSC Trust for 9 patients, however we have yet to receive any paperwork to register this service – this in the context of the Trust advising they wish to commence this service in April 2019 and Trust staff reporting (during our inspection) that they were working closely with RQIA.

We consider that the governance and operational systems across MAH fall below that which is required as set out in the Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (DoH, March 2006):

1. Theme 1 - Corporate Leadership and Accountability of Organisations: The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

2. Theme 2 - Safe and Effective Care: Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

3. Theme 4 - Promoting, Protecting and Improving Health and Social Well-being: Has structures and processes in place to promote and implement effective partnership arrangements, to contribute to improvements in health and social well-being and promote social inclusion and a reduction in inequalities.

4. Theme 5 - Effective Communication and Information: The HPSS communicates and manages information effectively, to meet the needs of the public, service users and carers, the organisation and its staff, partner organisations and other agencies.

The current position is of concern. Upon completion of our unannounced inspection last week we held a detailed feedback session with senior Trust staff on the MAH site (8.30am to 10.30am Friday 1 March 2019).
This was a helpful meeting, Trust colleagues accepted our assessment of the current position and agreed that immediate action is required to address the findings outlined above.

We plan to meet with the Chief Executive and members of the Trust's Executive Management Team on Thursday of this week (Thursday 7 March 2019). This will be an 'Intention to Serve' meeting which will provide us and the Trust with an opportunity to discuss our intention to issue a number of Improvement Notices to the Trust to address 6 of the 7 areas outlined above.

Given the current position we are now recommending that DoH agrees and implements a special measure for Belfast Health and Social Care Trust in relation to MAH. The special measure we recommend is the establishment of two taskforces – (i) a taskforce to stabilise the hospital site, in support of patients currently receiving care and staff delivering that care, and (ii) a taskforce to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community.

This recommendation is made with a view to improving the care and treatment of patients currently in MAH, to ensuring appropriate governance systems/arrangements are in place, and to effecting appropriate planning for patients who have completed their active assessment/treatment and who will relocate out of MAH to the community in the coming months.

We would stress the importance of ensuring that MAH is recognised as a service providing for all HSC Trusts (not just Belfast HSC Trust), the hospital has in-patient beds for three Trusts (Belfast, Northern and South-Eastern), however we understand all Trusts may currently have patients in the hospital. Therefore all Trusts and the Commissioner will need to work earnestly together to effect the required improvements. Given the challenges described Trust and/or Commissioner colleagues may wish to seek expert advice from colleagues working in other parts of the UK and this may well be very beneficial to informing and assisting the work required.

You may wish to receive a more detailed update on the key themes emerging from our unannounced inspection last week (as set out above), to this end Dr Lourda Geoghegan and I will be happy to meet with you and DoH colleagues to discuss the relevant areas. We would not be available Friday (8 March) of this week or Thursday (14 March) or Friday (15 March) next week, otherwise we are happy to meet if this would be helpful.

We will continue to support improvement work in relation to care and services delivered to patients in MAH, and as always we will keep you informed of the outcome of any future work.

Yours sincerely

Olive

Mrs Olive Macleod
Chief Executive

Cc –

Dr Lourda Geoghegan, Director of Improvement and Medical Director, RQIA
Mrs Emer Hopkins, Deputy Director, RQIA
Mrs Lynn Long, Assistant Director (Acting), RQIA
Mr Alan Guthrie, Inspector, RQIA
Mr Malachy Finnegan, Communications Manager, RQIA
Mr Sean Holland, Chief Social Work Officer DoH
Mr Fergal Bradley, Director of Safety, Quality and Standards, RQIA Sponsor Branch DoH

The **Regulation** and **Quality Improvement Authority**

Assurance, Challenge and Improvement
in Health and Social Care

Our ref: 020426/IN033250

14 March 2019

Private and Confidential

Dr Paddy Woods
Deputy Chief Medical Officer
Department of Health
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Dear ~~Dr Woods~~ Paddy

I write in Dr McBride's absence and in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to update you on serious concerns identified by the Regulation and Quality Improvement Authority (RQIA) in relation to care, treatment and services as provided for patients in Muckamore Abbey Hospital (MAH).

This correspondence follows RQIA's unannounced inspection to MAH from 26 to 28 February 2019 inclusive, and our earlier correspondence to DoH in which we outlined six areas of serious concern which emerged during our inspection (6 March 2019).

You will be aware that we held an 'Intention to Serve Improvement Notices' meeting with Belfast HSC Trust on 7 March 2019. During that meeting Belfast Trust colleagues were provided with an opportunity to outline and discuss evidence/information relating to each of the six areas of concern identified. We subsequently received correspondence from the Trust's Chief Executive (8 March 2019) which set out in detail the work Belfast Trust is progressing in relation to improving care and treatment of patients currently in MAH. The Trust also forwarded a written outline of their response to feedback from our unannounced inspection and a copy of MAH Inter-Trust Safe Compassionate and Effective care Action Plan 2018/19, both documents setting out a range of actions currently in progress and/or planned for MAH.

After thorough consideration of Belfast Trust's representation at our meeting on 7 March 2019 and of the additional information provided by the Trust to RQIA, determinations have now been made in relation to each of the six areas of serious concern identified. I attach a detailed outline of our assessment of each of these areas and our determination in relation to each, as also advised to Belfast Trust's Chief Executive today (see Annexe 1).

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You will note that we have determined not to serve Improvement Notices to Belfast Trust at this point in time. You will also note that we have advised the Trust we will continue to closely monitor each of the six areas of concern and the quality of care and treatment delivered to patients in MAH. We will seek evidence of improvement resulting from the actions/measures Belfast Trust is now progressing either as the main provider of care in MAH and/or in conjunction with other providers, in particular with Northern and South-Eastern HSC Trusts.

In our correspondence of 6 March 2019, we recommended that DoH agrees and implements a special measure for Belfast HSC Trust in relation to MAH. Our assessment is that the above recommendation remains valid. The special measure we recommended is the establishment of two taskforces –

(i) *a taskforce to stabilise the hospital site, in support of patients currently receiving care and staff delivering that care in MAH* – Belfast Trust has refreshed its arrangements for oversight and governance of MAH (per Annexe 1) including securing active input from colleagues in Northern and South-Eastern Trusts (whom MAH also serves) and securing national expert advice and assistance from two NHS Foundation Trusts (East London and Mersey Care) – this work and these actions collectively could now be aligned under the auspices of one taskforce focusing on MAH site delivery;

(ii) *a taskforce to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community* – given the scale and complexity of work to be progressed in the coming months and to ensure delivery of the Permanent Secretary's commitment to family members of patients/residents in MAH (that the resettlement process will be completed by end of 2019) we would highlight the pressing need for focus and momentum in relation to resettlement work – this work is likely to require expertise and input from staff not only within DOH and HSC but from across other government departments and the public and independent sectors in Northern Ireland.

As previously advised, this recommendation is made with a view to supporting Belfast Trust (and the two other HSC Trusts served by MAH), to improving the care and treatment of patients currently in MAH, to ensuring appropriate governance systems/arrangements are in place, and to effecting appropriate planning for patients who have completed their active assessment/treatment and who will relocate out of MAH to accommodation in the community over the coming months.

You may wish to receive a more detailed update on the key themes emerging from our unannounced inspection to MAH and our work to date with Belfast Trust to address the serious concerns identified. To this end Mrs Olive Macleod and I will be happy to meet with you and DoH colleagues to discuss the relevant matters. Mrs Macleod is on leave today and tomorrow (14 and 15 March 2019) and I will be on leave for most of next week (w/c 18 March 2019). Otherwise we will be happy to review availability to meet during w/c 25 March 2019.

We will continue to support improvement work in relation to care and services delivered to patients in MAH, and as always we will keep you informed of the outcome of any future work.

Yours sincerely

Lourda Geoghegan

Dr Lourda Geoghegan
Covering Chief Executive
Medical Director & Director of Improvement

Cc –

Mrs Olive Macleod, Chief Executive, RQIA
Mrs Emer Hopkins, Deputy Director, RQIA
Mrs Lynn Long, Assistant Director, RQIA
Mr Alan Guthrie, Inspector, RQIA
Dr Michael McBride, Chief Medical Officer, DoH
Mr Sean Holland, Chief Social Work Officer DoH
Mr Fergal Bradley, Director of Safety, Quality and Standards, RQIA Sponsor Branch DoH
Mr Jerome Dawson, Acting Director Mental Health, Disability and Older People DoH

Enc

Annexe 1 – RQIA Determination in Relation to Areas of Serious Concern as Advised to Belfast HSC Trust on Thursday 14 March 2019

1. **Staffing**: *RQIA found evidence of insufficient staffing at ward level to meet patients' prescribed level of observation, to appropriately manage patients' physical health care needs and to implement and execute appropriate therapeutic care plans for patients.*

   (a) Belfast Trust has provided new information indicating that seven additional nursing professionals (learning disability) have been recruited and are commencing employment this week in MAH (w/c 11 March 2019).

   (b) Belfast Trust management has provided a robust assurance that ward staffing levels will be appropriate to ensure all patients will have their prescribed level of observations completed.

   (c) Belfast Trust management has confirmed that daily physical checks of ward staffing levels will be undertaken, clear escalation arrangements will be implemented and assured, and that the hospital's e-rostering system will be used to effectively deploy and monitor staffing levels.

   (d) Belfast Trust has sought co-operation and staff resources from other Trusts, specifically Northern Health and Social Care Trust (Northern Trust) and South Eastern Health and Social Care Trust (South Eastern Trust), to assist with providing adequate nursing cover for wards in the hospital. Representatives from Northern Trust and South Eastern Trust have confirmed their commitment to assisting Belfast Trust in this regard.

   (e) Belfast Trust has advised that improvement work has commenced to further develop the role of Allied Health Professionals and specialist behavioural nurses, to support meaningful activities for patients/residents in MAH.

RQIA remains concerned at the large number of vacancies that exist currently in the hospital, which greatly exceeds the number of additional staff recently recruited. RQIA would also highlight that the monitoring and escalation arrangements in relation to staff shortages, described as in place prior to our unannounced inspection, did not accurately identify the impact of these shortages on the care and treatment experienced by patients on some wards.

It is determined that collectively the above described actions/measures are a constructive response, which will improve the capacity of frontline staff and Trust management to immediately deliver safe and effective care to patients in MAH.

Determination - an Improvement Notice in relation to Staffing will not be served at this time. RQIA will continue to monitor this aspect of care closely and will seek evidence of improvement resulting from the above described actions/measures.

2. **Patients' physical health care needs**: *Evidence of an appropriate system to ensure that patient's physical health care needs were addressed was lacking. Patients did not have their physical health appropriately monitored, did not access health screening appropriate to gender and/or age, and did not have appropriate access to primary care services. Additionally, some patients prescribed antipsychotic medications did not experience appropriate monitoring of related parameters of physical health.*

   (a) Belfast Trust has advised of the imminent appointment of two medical physicians (staff grade doctors) and two nursing professionals to MAH, who will undertake the required work to ensure a plan is in place for each patient in respect of their physical healthcare needs, this work to be complete within four weeks.

   (b) Belfast Trust has confirmed that an alert has been issued to all medical and senior nursing staff in MAH regarding monitoring of patients in receipt of antipsychotic medication (per protocol), medical consultant staff have confirmed that monitoring is now in place, and an audit is planned for w/c 11 March 2019 and results will be shared with RQIA in due course.

   (c) Belfast Trust has recognised and acknowledges that, moving forward, all specialist nursing staff (learning disability) will need to understand and oversee management of the physical healthcare needs of patients receiving care in MAH.

It is determined that the above described actions measures are a constructive response which will improve the quality of provision in respect of the physical healthcare needs of patients currently in MAH.

Determination - an Improvement Notice in relation to Physical Healthcare Needs will not be served at this time. RQIA will continue to monitor this aspect of care closely and will seek evidence of improvement resulting from the above described actions/measures.

3. **Financial governance**: *Concerns were identified in relation to a failure to refer patients appropriately to the Office of Care and Protection, non-completion of patient property records and variation in completion of ledgers at ward level. There was also an apparent omission to make a safeguarding referral in the context of financial arrangements for one detained patient.*

(a) Belfast Trust has confirmed that outstanding referrals to the Office of Care and Protection have been made (referrals relate to seven patients).

(b) Belfast Trust has confirmed that the outstanding safeguarding referral (as referred above) has now been made.

(c) Belfast Trust has confirmed it will review its Patient Finances and Private Property Policy and will undertake an audit of its activity to assure appropriate implementation of this policy.

(d) Belfast Trust will undertake an audit of compliance with financial procedures across all wards to assure appropriate implementation of financial governance throughout the hospital.

RQIA notes the Trust's feedback in relation to the most recent internal audit assessment/report on patients' finances in MHLD (2015/16), which provided a satisfactory opinion. However, we would highlight that this opinion is now some three years old and the Trust requires appropriate assurance that arrangements relating to financial governance are sufficiently robust.
It is determined that the above described actions/measures are a constructive response which will improve the oversight and management of patient property and finances across the hospital site.

Determination - an Improvement Notice in relation to Financial Governance will not be served at this time. RQIA will continue to monitor this aspect of care closely and will seek evidence of improvement resulting from the above described actions/measures.

4. **Safeguarding practices**: *Our inspection team did not find evidence of effective deployment of safeguarding referrals, the team did not find evidence of the implementation of learning arising through safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. A structural disconnect between professional staff was also evident within the current safeguarding arrangements.*

(a) Belfast Trust has provided a firm commitment that following any potential safeguarding incident or allegation a multidisciplinary risk assessment will be completed to determine the best action and outcome for the patient(s) and staff member(s) in question.

(b) Belfast Trust recognises that work is needed to support staff to develop their understanding of risk assessment and protection, and to enable multi-disciplinary teams to provide a safe environment for staff to learn, to adapt to CCTV use and to improve confidence in their own practice.

(c) Belfast Trust has confirmed it has commenced planning for a practice development module, utilising input from an external critical friend, to support improvements in safeguarding practice across all staff groups in MAH (initial workshop held on 18 February 2019).

RQIA advises that in line with the anticipated improvements in staffing on individual wards and across the hospital site, the practice of deploying staff who have been subject of a safeguarding referral to work with patients involved in the same safeguarding referral should be reviewed. We would highlight that in circumstances which give rise to multiple and repeated safeguarding referrals for the same patient, it is essential that there is a team approach to addressing potential root causes giving rise to and/or influencing these repeated referrals (as distinct from focusing on the referral process and repeated investigations).

It is determined that the above described actions/measures are a constructive response which have potential to improve the Trust's position in relation to its safeguarding practices and local on-site implementation of the regional safeguarding policy.

Determination - an Improvement Notice in relation to Safeguarding Practices will not be served at this time. RQIA will continue to monitor this aspect of care closely and will seek evidence of improvement resulting from the above described actions/measures.

5. **Restrictive practices (seclusion):** *There was evidence that current seclusion practices across the hospital site were not in line with best practice guidelines.*

(a) Belfast Trust has advised that use of seclusion is currently monitored across all wards and is discussed on a weekly basis at a multi-disciplinary governance meeting, use of seclusion will form part of a core set of data for regular review at hospital live governance and assurance meetings.

(b) Belfast Trust has confirmed that it has undertaken a review of its seclusion policy (in line with Royal College of Psychiatry guidelines); the refreshed policy is to be available w/c 18 March 2019 and will now be subject of engagement with families, staff and advocacy organisations.

(c) Belfast Trust has asked East London NHS Foundation Trust to act as a critical friend to provide support and challenge as it works through its approach to and use of restrictive practices in general and seclusion specifically.

(d) Belfast Trust has confirmed it will approach Mersey Care NHS Foundation Trust to seek expert input and support in its work on use of restrictive practices in general and seclusion specifically.

RQIA remains concerned that following the closure of the PICU, the physical environments currently utilised for seclusion across a number of wards in MAH do not meet best practice guidelines. It is likely this issue will be particularly challenging for the trust to address and will require further detailed consideration with assistance from national experts (as referred above). We would recommend that as an early first step the Trust should agree and implement clear definitions in relation to various practices in this context (e.g. seclusion, de-escalation, practice agreed as part of management/care plan etc.).

It is determined that the above described actions/measures are a constructive response which have potential to improve the Trust's position in relation to its use of restrictive practices, in particular seclusion.

Determination - an Improvement Notice in relation to Restrictive Practices (seclusion) will not be served at this time. RQIA will continue to monitor this aspect of care closely and will seek evidence of improvement resulting from the above described actions/measures.

6. **Hospital governance**: *Although initial arrangements have been established with a view to strengthening governance and appropriately identifying risks across the hospital, the inspection team did not find evidence that these were having the required impact on the safety and effectiveness of care or on staff health, well-being and morale.*

   (a) Belfast Trust has outlined detailed arrangements to strengthen local governance on the MAH site using an evidence based safety measurement and monitoring framework. A core set of metrics to underpin this work is in development.

   (b) Refreshed arrangements include on-site presence and leadership from the Trust's Director of Adult, Social and Primary Care whom the Chief Executive has confirmed is now dedicated to work relating to MAH.

   (c) The two other Trusts served by MAH confirmed their support for strengthened governance arrangements (at meeting on 7 March 2019), through their Directors of Adult Services and Prison Health Care (South Eastern Trust) and of Mental Health and Learning Disability and Community Services (Northern Trust).

   (d) Belfast Trust has confirmed the introduction of a daily safety huddle (wards) and a weekly safety pause (hospital) across the MAH site.

   (e) Belfast Trust's Medical Director and Deputy Chief Executive will now chair a recently introduced weekly assurance meeting.

(f) Belfast Trust has advised a range of measures to support staff, these include; the presence of a counsellor on MAH site, the presence of Occupational Health on-site, a keeping in touch system for absent staff, the development of a psychological services strategy for staff and the introduction of a stress assessment tool.

It is determined that the above described actions/measures are a constructive response which have potential to improve the Trust's position in relation to its governance and oversight of MAH.

Determination - an Improvement Notice in relation to Hospital Governance will not be served at this time. RQIA will continue to monitor this aspect of care closely and will seek evidence of improvement resulting from the above described actions/measures.

ENDS

The Regulation and Quality Improvement Authority

Unannounced Inspection Report
15 & 16 April 2019

Belfast Health and Social Care Trust

Muckamore Abbey Hospital

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Antrim
BT41 2RJ
Tel No: 028 9446 3333

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Assurance, Challenge and Improvement in Health and Social Care

Membership of the Inspection Team

Olive Macleod	**Chief Executive** **Regulation and Quality Improvement Authority**
Dr Lourda Geoghegan	Director of Improvement and Medical Director Regulation and Quality Improvement Authority
Emer Hopkins	Deputy Director Regulation and Quality Improvement Authority
Lynn Long	Assistant Director Regulation and Quality Improvement Authority
Fionnuala Breslin	Inspector, Mental and Learning Disability Team Regulation and Quality Improvement Authority
Alan Guthrie	Inspector, Mental Health and Learning Disability Team Regulation and Quality Improvement Authority
Cairn Magill	Inspector, Mental Health and Learning Disability Team Regulation and Quality Improvement Authority
Wendy McGregor	Inspector, Mental Health and Learning Disability Team Regulation and Quality Improvement Authority
Carmel Tracey	Inspector, Mental Health and Learning Disability Team Regulation and Quality Improvement Authority
Briege Ferris	Inspector, Finance Regulation and Quality Improvement Authority
Stephen O’Connor	Inspector, Independent Health Care Team Regulation and Quality Improvement Authority
Dr Gerry Lynch	Medical Peer Reviewer Regulation and Quality Improvement Authority
Dr John Simpson	Medical Peer Reviewer Regulation and Quality Improvement Authority
Dr Aimee Durkin	Medical Peer Reviewer Regulation and Quality Improvement Authority
Jennifer Lamont	Head of Business Support Unit Regulation and Quality Improvement Authority
Claire McNicholl	Inspection Coordinator Regulation and Quality Improvement Authority
Pauline Morris	Inspection Coordinator Regulation and Quality Improvement Authority

Abbreviations

AHP	Allied Health Professionals
BHSCT	Belfast Health and Social Care Trust
DoH	Department of Health
MAH	Muckamore Abbey Hospital
MDT	Multi-disciplinary Team
MHO	Mental Health(Northern Ireland) Order 1986
NHSCT	Northern Health and Social Care Trust
OCP	Office of Care and Protection
PICU	Psychiatric Intensive Care Unit
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation,

1.0 What we look for

Is care safe?

Avoiding and preventing harm to service users from the care, treatment and support that is intended to help them.

Is care effective?

The right care, at the right time in the right place with the best outcome.

Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and the experiences of service users in order to deliver safe, effective and compassionate care.

Is Care Compassionate?

Service users are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

2.0 Profile of the service

Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability Hospital managed by Belfast Health and Social Care Trust (BHSCT). The hospital provides inpatient care to adults 18 years and over who have a learning disability and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986.

MAH provides a service to people with a Learning Disability from BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT). There were 83 beds in the hospital at the time of the inspection. The Psychiatric Intensive Care Unit (PICU) had temporarily closed on 21 December 2018 and has remained closed since.

At the time of the inspection there were five wards on the MAH site:

- Cranfield One (Male assessment)
- Cranfield Two (Male treatment)
- Ardmore (Female assessment and treatment)
- Six Mile (Forensic Male assessment and treatment)
- Erne (Long stay/re-settlement).

A hospital day care service was also available for patients.

On the days of the inspection there were 63 patients receiving care and treatment in MAH.

3.0 Service details

Responsible person: Mr Martin Dillon Belfast Health and Social Care Trust (BHSCT)	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 83
Person in charge at the time of inspection: Mairead Mitchell, Interim Co- Director, Learning Disability Services, Adult Social and Primary Care Directorate, BHSCT.	

4.0 Inspection summary

We undertook an unannounced inspection to MAH over two days commencing on 15 April 2019 and concluding on 16 April 2019. All five wards were visited over the course of the inspection.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

The focus of this unannounced inspection was to assess the progress made by BHSCT to address the areas of significant concern in relation to six overarching themes emergent during our inspection to MAH from 26 to 28 February 2019:

- Staffing;
- Patients' physical health care needs;
- Financial governance;
- Safeguarding;
- Restrictive practices (seclusion); and
- Hospital governance.

We employed a multidisciplinary inspection methodology during this inspection. The multidisciplinary inspection team examined a number of aspects of the hospital, from front line care and practices, to management and oversight of governance across the organisation. We met with individual staff members and various staff groups, patients and a small number of relatives, observed care practice and reviewed relevant records and documentation to support the governance and assurance systems.

Key Findings

Overall we evidenced limited progress in relation to the 10 areas for improvement and the six areas of significant concern previously identified.

We identified that staffing levels had not improved and there continued to be a lack of support for ward managers when they experienced challenges in relation to staffing. We did not find effective escalation arrangements in relation to staffing and we remain concerned that there is a lack of evidence that staffing at ward level and across the site is managed and assured on the basis of assessed patient need.

We did not find evidence of any mechanisms/tools in use by the BHSCT to determine the staffing model required. We were not able to demonstrate that current planning arrangements were achieving consistency across the site and assurance in respect of the delivery of safe and effective care.

Staff morale was observed to still be significantly impacted. The staff well-being measures recently introduced were not found to have led to the desired improvements in staff health and well-being.

We again identified a structural disconnect between professional staff in relation to the current safeguarding arrangements for the hospital. We noted that the approach to safeguarding practices was process driven. There was no improvement in integration of social care staff and frontline nursing/ward staff. It was concerning to note that safeguarding incidents were being reviewed in isolation and ward(s) MDT's were not being appropriately utilised to improve debriefing and learning between staff groups.

We noted that the BHSCT CCTV policy was a generic BHSCT wide policy. The CCTV policy had not been updated to support the use of CCTV within the MAH site.

Improvements in appropriate recording and monitoring of restrictive practices (seclusion) were noted. We found that the overall use of seclusion had reduced since the February 2019 inspection but we remain concerned regarding the environments currently used for seclusion across the hospital site.

We found that patient observations were being carried out as required, however we found no evidence of a regular programme of audits of patient observations being completed at ward level.

We noted some improvements in relation to patients' physical health care needs including the completion of annual checks for most patients in the hospital. Appropriate monitoring of physical health parameters of patients receiving antipsychotic medications in accordance with the hospital protocol was evidenced. We did not, however, find effective arrangements in place to support robust assessment and/or planning to ensure patients are included in appropriate population screening programmes.

We found limited progress had been made to ensure that agreed discharge arrangements were recorded and co-ordinated with all services involved with patients' on-going care.

The inspection team determined that the governance systems were not working effectively to assure the Senior Management and Executive Teams that the care provided at MAH is safe, effective and compassionate. We did not find that arrangements to improve hospital governance were having the required impact on patient safety or improving integration and communication with staff groups.

Limited progress was evidenced in relation to financial governance. We did not find robust arrangements in place to monitor, audit and review the effectiveness of financial oversight or that the BHSCT was discharging its' responsibilities in accordance with Articles 116 and 107 of the MHO.

We provided feedback to BHSCT Senior and Executive Management Teams on 17 April 2019. At this meeting we informed BHSCT that RQIA continued to have significant concerns in relation to the care, treatment and services as provided for patients in MAH in respect of the emergent themes.

Following the inspection RQIA wrote to the Chief Medical Officer on 30 April 2019 in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inform him of RQIA's continuing serious concerns in relation to care, treatment and services as currently provided for patients in Muckamore Abbey Hospital. In this letter we recommended the establishment of two taskforces:

(i) a taskforce to stabilise the hospital site, in support of patients currently receiving care and of staff delivering that care and
(ii) a taskforce to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community.

We also wrote to the Department of Health (DoH) in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. We advised the DoH of RQIA's continuing serious concerns in relation to care, treatment and services as currently provided for patients in MAH. We recommended that the DoH agrees and implements a special measure for BHSCT in relation to MAH. The recommendation was made with a view to supporting BHSCT (and the other two HSC Trusts served by MAH), to improve care and treatment of patients currently in MAH, to ensure appropriate governance systems/arrangements are in place, and to ensure appropriate planning for patients who have completed their active assessment/treatment and who will relocate out of MAH to accommodation in the community over the coming months.

4.1 Inspection outcome

Total number of areas for improvement	**11**

As outlined previously the focus of this inspection was the six emergent themes and 11 areas for improvement arising from our inspection to MAH (26 to 28 February 2019). The area for improvement in relation to medications management identified during the last inspection was not reviewed during this inspection. This area will be carried forward for review at the next inspection

We identified ten areas for improvement from this inspection. These relate to:

- Staffing
- Safeguarding
- Close Circuit Television (CCTV)
- Restrictive practices (seclusion)
- Patient observations
- Patients' physical health care needs
- Discharge planning
- Strategic planning & communication
- Hospital governance
- Financial governance

Detailed findings of this unannounced inspection were shared with Dr Cathy Jack, Deputy Chief Executive & Medical Director, BHSCT Senior and Executive Management Teams and ward staff during the feedback session on 17 April 2019 held at the conclusion of the inspection.

4.2 Action/enforcement taken following our most recent inspections

The most recent inspection of MAH was an unannounced inspection commencing on 26 February 2019 and concluding on 28 February 2019. Following this inspection we continue to engage with BHSCT and the DoH to secure improvements across the hospital site.

Ongoing enforcement action resulted from the findings of this inspection.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.or.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

In response to our ongoing concerns we invited the Chief Executive and BHSCT colleagues to attend an Intention to Serve six Improvement Notices meeting at RQIA on 7 March 2019. We also wrote to DoH recommending the implementation of a special measure for BHSCT in respect of MAH.

After consideration of BHSCT representation at our meeting on 7 March 2019 and of the additional information provided by the BHSCT to RQIA (8 March 2019), we determined not to serve Improvement Notices to BHSCT at that point in time. We advised BHSCT that we will continue to closely monitor each of the six areas of concern and the quality of care and treatment delivered to patients in MAH. We also wrote to the DoH to update them about our determination.

5.0 How we inspect

Prior to this inspection a range of information relevant to MAH was reviewed, including the following records:

- Previous inspection reports
- Serious Adverse Incident notifications
- Information on Concerns
- Information on Complaints
- Other relevant intelligence received by RQIA
- BHSCT action plan for MAH received by RQIA on 8 March 2019

Each ward is assessed using an inspection framework. The methodology underpinning our inspections includes; discussion with patients and relatives, observation of practice, focus groups with staff involved in all functions from across the hospital and review of documentation. Records examined during the inspection include; nursing records, medical records, senior management and governance reports, minutes of meetings, duty rotas and training records.

We invited staff to complete an electronic questionnaire during this inspection.
We did not receive any returned completed staff questionnaires following this inspection.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection on 26, 27 & 28 February 2019

Areas for improvement		Validation of compliance
	Staffing	
Area for improvement No.1 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1, 5.3.3) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH, which; a) is based on the assessed needs of the current patient population; and a) incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Implement an effective process for oversight and escalation to senior management and the executive team when challenges in nurse staffing arise. 3. Implement an effective assurance mechanism to provide oversight of the implementation of the model and escalation measures. 4. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing.	**Not met**
	Action taken as confirmed during the inspection: Inspectors evidenced significant staffing deficits in each of the wards. Evidence of robust plans and allocation of nurse staffing, including registrant and non-registrant staff, on the basis of assessed patient need was not demonstrated. We could not accurately confirm nursing staff requirements as compared to nursing staff provision across the hospital. We were unable to evidence any mechanisms/tools in use by the BHSCT to determine the staffing	

	model required. Site managers described escalation arrangements in the context of staffing challenges. We found these arrangements were unclear and we were not assured that they were working effectively. Frontline staff told us they were not receiving adequate support from senior managers when they escalated staff shortages. We found that to date additional nursing staff had not been secured through collaborative working arrangements with the NHSCT and SEHSCT.	

Safeguarding		
Area for improvement No. 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding at MAH and ensure: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations; b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care; d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved. 2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward managers, hospital managers, BHSCT senior managers and / or the Executive team as appropriate. 3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.	**Not met**
	Action taken as confirmed during the inspection: As in our previous inspection, we did not find evidence of implementation of learning from safeguarding investigations or that he outcomes from safeguarding investigations were positively impacting patient well-being. Due to the complexity and mix of patients in some wards and staffing levels, we noted that	

	meaningful implementation of protection plans was a significant challenge. A structural disconnect between professional staff was again evident within the current safeguarding arrangements for the hospital.	
	CCTV	
Area for improvement No. 3 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.	**Not met**
	Action taken as confirmed during the inspection: We noted that the BHSCT CCTV policy was a generic BHSCT wide policy. The CCTV policy had not been updated to support the use of CCTV within the MAH site. Staff told us that they were not clear as to how and when CCTV was used. A MAH CCTV policy had not been implemented and that they had not received any further update since the February 2019 inspection. We found no evidence of a CCTV images monitoring system to support staff to deliver care and learn collaboratively.	

<table>
<tr><th colspan="3">Restrictive Practices</th></tr>
<tr><td rowspan="2">Area for improvement No. 4

Ref: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3)

Stated: First time</td><td>The Belfast Health and Social Care Trust must:
1. Undertake an urgent review of the current and ongoing use of restrictive practices including seclusion at MAH whilst taking account of required standards and best practice guidance.
2. Develop and implement a restrictive practices strategy across MAH that meets the required best practice guidance.
3. Ensure that the use of restrictive practices is routinely audited and reported through the BHSCT assurance framework.

Review and update BHSCT restrictive practices policy and ensure the policy is in keeping with best practice guidelines.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The overall use of seclusion had reduced. However we remained concerned about the environments being used for seclusion across the hospital site as they did not meet the required standards.

We remained concerned that MAH site managers did not appear to appreciate the considerable distance between arrangements and practices as outlined in the Trust's updated seclusion policy and practices as currently implemented in the hospital.

Our inspection team noted that staff involved in managing patients with challenging behaviours did not appear to be supported through structured debriefing and there were limited opportunities to identify and share learning in a meaningful way.</td></tr>
</table>

Patient Observations		
Area for improvement No. 5 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** First time	The Belfast Health and Social Care Trust must address the following matters in relation to patient observations: 1. Engage with ward managers and frontline nursing staff to ensure that a regular programme of audits of patient observations is completed at ward level. 2. Ensure that there is an effective system in place for assessing and managing patient observation practices, which is multi-disciplinary in nature and which enables staff to deliver effective care and learn collaboratively.	**Partially met**
	Action taken as confirmed during the inspection: We found that patient observations were being carried out as required. We found no evidence of a regular programme of audits of patient observations being completed at ward level. We found no evidence that an effective system was in place for assessing and managing patient observation practices, which is multi-disciplinary in nature.	

Management of Medicines		
Area for improvement No. 6 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1(f)) **Stated:** First time	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of “when required” medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.	**Not Reviewed**
	Action taken as confirmed during the inspection: This area for improvement was not reviewed during this inspection and will be carried forward for review during the next inspection.	

Physical Health Care Needs		
Area for improvement No. 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to: 1. Ensure that here is an appropriate number of suitability qualified staff to oversee that the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes. 2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy. 3. Ensure that specialist learning disability trained nursing staff understand and oversee management of the physical health care needs of patients in MAH. A system of assurance in respect of delivery of physical healthcare.	**Not met**
	Action taken as confirmed during the inspection: We noted improvements since our previous inspection in regards to annual physical health checks for patients and monitoring of physical health parameters of patients receiving antipsychotic medication. However we did not find evidence of robust assessment and/or planning to ensure patients were included in appropriate population screening programmes.	

Discharge Planning		
Area for improvement No. 8 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3(b)) **Stated:** First time	The Belfast Health and Social Care Trust must ensure that ward staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from MAH.	**Not met**
	Action taken as confirmed during the inspection: Ward staff told us that they did not have up to date information for all patients who had completed their active assessment and treatment and were awaiting discharge. We found limited progress had been made to ensure that agreed discharge arrangements were recorded and co-ordinated with all services involved in patients' on-going care.	
Strategic Planning & Communication		
Area for improvement No. 9 **Ref**: Standards 4.1 & 8.1 Criteria 4.3 (b, d and e), 8.3 (b) **Stated:** First time	The Belfast Health and Social Care Trust must address the following matters to strengthen hospital planning: 1. Ensure that a comprehensive forward plan for MAH is developed, communicated, disseminated and fully understood by staff. 2. Ensure that stated aims and objectives for the hospital's PICU are developed and disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.	**Not met**
	Action taken as confirmed during the inspection A forward plan for MAH had not been developed. We were unable evidence a clear strategic direction and robust planning regarding staffing, safeguarding, management of patients' physical health care, discharge planning and financial governance Staff were not clear about the plans for the future of the hospital. This was due to a combination of factors relating to a cessation of patient admissions, delayed discharges, the inability to safely staff the hospital, and uncertainty about the hospital's PICU.	

Hospital Governance		
Area for improvement No. 10 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 (a) and 5.3.1.(f) **Stated:** First time	The Belfast Health and Social Care Trust must review the governing arrangements in MAH and consider the following matters in order to strengthen the governance arrangements: 1. Enhance communication, staff knowledge and understanding of relevant committees and meetings to support local leadership and governance on the MAH site. 2. Embed the recently introduced Daily Safety Huddle (at ward level) and the Weekly Safety Pause (hospital level) meetings. 3. Implement an effective assurance framework.	**Not met**
	Action taken as confirmed during the inspection: Frontline staff informed us that they were unclear about the role and functions of the various meetings and arrangements. Our inspection team could not clearly determine the linkages between the constituent parts of the governance system. We noted discrepancies in information reported through various parts of the hospital's operating and governing systems. We could not evidence that the hospitals governance arrangements were having the required impact on safety and effectiveness of care for patients or on the health and well-being of staff.	
Financial Governance		
Area for improvement No. 11 **Ref**: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must ensure: 1. That the BHSCT is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986. 2. In respect of those patients in receipt of benefits for whom BHSCT is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits. 3. Implementation of a robust system to	

	evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and BHSCT policy and procedures; this includes: a) that appropriate records of patients' property are maintained; b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role; c) that audits by senior managers of records retained at ward level are completed in accordance with BHSCT policy; d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in MAH.	**Not met**
	Action taken as confirmed during the inspection: We could not evidence appropriate documentation relating to appointee-ship arrangements for six of 13 patients, we could not identify improvements in completion of patient property records or in completion of ledgers at ward level. Monthly monitoring of ward finances by senior site managers was inconsistently completed, and when completed lacked evidence of appropriate assurance. The inspection team could not evidence work relating to the Trust's planned audit of financial procedures across the site, to be undertaken during April 2019 as advised in the Trust's action plan.	

6.2 Inspection Findings

Staffing

We reviewed the staffing arrangements in MAH against the BHSCT action plan and new information/assurances provided to us on 7 March 2019. We found limited progress in relation to staffing. Significant deficits in staffing levels on all of the wards had continued since the previous inspection.

As part of the assurance provided to RQIA on the 7 March 2019 in respect of the safety of the site, the Trust Chief Executive had advised that seven additional nurse registrants had been recruited, inducted and would begin work on the site in the week commencing 11 March. The inspection team noted on this inspection that the seven additional nursing registrants had not in fact been in post since 11 March. Over the two days of the inspection, conflicting information in respect of the actual numbers of new staff recruited and in post was given to inspectors. However RQIA was eventually able to ascertain that four additional nursing registrants were in post and that these are all agency staff.

We were informed that five experienced Band 7 nurses and two other senior staff would move from their roles/posts in MAH in the near future.

We reviewed the data provided by the MAH senior nursing office and detailed in the minutes of hospital situation report (SITREP) meetings for numbers of staff in post, vacancies, sick or maternity leaves, precautionary suspensions and also the numbers of agency staff for each ward. We examined staff rotas and spoke to ward managers when reviewing staffing levels and applicable ward data.

There was evidence of insufficient staffing at ward level to meet patients' prescribed level of observation, to implement and execute appropriate therapeutic care plans for patients, or to appropriately manage patients' physical health care needs. We evidenced insufficient staffing at ward level on each day of the two day inspection visit. Staff of all grades throughout the hospital site informed us there was insufficient staffing at ward level. Due to staff shortages at ward level, staff are at times unable to appropriately fulfil their responsibilities and this is impacting on the quality and assurance of care delivered and is in itself a source of anxiety for staff. Frontline ward staff told us that activities are frequently cancelled or re-scheduled causing frustration for patients.

Considerable difficulty was experienced with regards to accurately confirming nursing staff requirements as compared to nursing staff provision across the hospital. We were unable to accurately confirm the BHSCT determination of this.

We found that checks of the numbers of nursing staff in the wards were being undertaken. We highlighted that the issue was not in relation to numbers of staff but rather the requirements to achieve consistency across the site. Evidence of robust planning and allocation of nurse staffing, including registrant and non-registrant staff, on the basis of assessed patient need was not demonstrated. We were unable to evidence any mechanisms/tools in use by the BHSCT to determine the staffing model required.

Site managers described escalation arrangements in the context of staffing challenges. We found these arrangements were unclear and we were not assured that they were working effectively so as to appropriately support frontline ward staff when they experience challenges in relation to staffing. Frontline staff told us they were receiving poor support from senior managers and that they could not escalate staff shortages as in practice the responsibility to address the staffing deficits is retained with them.

We noted a mismatch between information supplied by site managers and that supplied by ward staff/managers with regards to nursing staff provision across the site.

We found that to date additional nursing staff had not been secured through collaborative working arrangements with the NHSCT and SEHSCT. We could not evidence a plan for permanent recruitment.

Concerns regarding the skill mix and appropriate deployment of staff were shared with the inspection team.

Specialist behavioural nurses continued to be rostered to cover general duties on wards. We were unable to evidence the commencement of improvement work to develop the roles of AHPs in MAH.

We acknowledged that front line staff continue to display enormous resilience and they are to be commended for their dedicated service to the patients in MAH and their families.

Safeguarding Practices

We reviewed the safeguarding arrangements in MAH against the BHSCT action plan and new information/assurances provided to us on 7 March 2019.

From an analysis of information provided our inspection team did not find evidence of effective deployment of safeguarding referrals, of implementation of learning arising through safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. A continued structural disconnect between various groups of professional staff was evident within the current safeguarding arrangements

We noted that the approach to safeguarding practices was process driven. There was no improvement in integration of social care staff and frontline nursing/ward staff. We again evidenced that safeguarding incidents were being reviewed in isolation. We observed that MDTs were not being optimally utilised to improve debriefing, learning and connection between staff groups. We did not find evidence of any implementation of learning arising from safeguarding investigations. There was no evidence that outcomes from safeguarding investigations were positively impacting patients' care.

Figures for current adult safeguarding incidents and referrals, including the time period for referrals received by the designated adult protection officer (DAPO), were found to be collated by ward and type and reported at the weekly SITREP meetings.

Due to the complexity and mix of patients in some wards and with current staffing levels, it was again noted that meaningful implementation of protection plans was a significant challenge. We recommended that safeguarding incidents or allegations are assessed by a multidisciplinary team to determine the best action and outcome for the patient(s) and staff member(s). We advised that this approach would assist with addressing potential root causes giving rise to and/or influencing repeated referrals.

BHSCT senior managers informed us that the discharge of patients from MAH is a factor strongly influencing the implementation of effective safeguarding arrangements. We noted that the number of patients being looked after in MAH since the February 2019 inspection has largely remained static.

It was positive to note that following commencement of a recent Quality Improvement project there had been a 10% reduction in violence and that there were plans to introduce activity boxes to each ward.

Overall we found that arrangements for reviewing, risk assessing and recommending safeguarding measures were not robust.

CCTV

The inspection team was clear that staff across the site remained fearful of the use and implications of CCTV. The inspection team found a number of examples where staff had allowed themselves to be struck by patients because they feared the consequences of using legitimate intervention techniques in which they had been trained, to support patient's behaviour. The use of CCTV on site has contributed to this fear, with many staff unable to articulate to the inspection team their understanding of how and why CCTV was used. We determined that there was continued confusion with respect to how CCTV is being used and the associated operational parameters of its use.

Policies and associated operational procedures to clearly define how CCTV is being used at the MAH site were not in place. Staff told us that MAH did not have a CCTV policy and that they had not received any further update since the February 2019 inspection with regards to purpose and operational parameters of use.

Once defined staff must be supported to develop their understanding of CCTV use and the MDT team must be utilised as a safe environment for staff to learn how CCTV use can assist them in their practice. We again highlighted the impact upon staff and the importance of clear communication with them regarding this issue.

Restrictive Practices (Seclusion)

It was positive to note that overall use of seclusion had reduced since the February 2019 inspection. We evidenced that care staff were appropriately recording and monitoring when seclusion was used. We found that staff were trying to reduce the number of areas that patients were secluded to. Seclusion was evidenced as being discussed at patients' MDT meetings and during weekly MAH live governance meetings. We found that a report of contemporaneous CCTV viewing is also being produced and reported at governance meetings

We observed that staff involved in managing patients with challenging behaviour (in particular patients for whom restraint and/or seclusion may be required) did not appear to be supported through structured debriefing. Additionally, there appeared to be limited opportunities to identify and share learning in a meaningful way.

There was no change in respect of the environments used for seclusion since the February 2019 inspection. We again highlighted our concerns regarding patient safety and comfort.

We noted that the PICU remains closed with the consequence that the environments currently used for seclusion did not meet required standards.

We found that Site Managers did not appear to appreciate the considerable distance between arrangements and practices as outlined in the BHSCT updated Seclusion Policy and the actual operational practices implemented in the hospital.

We noted that the BHSCT had recently updated its' Seclusion Policy and that it was out for review/comment. However, we were unable to evidence any plan which the BHSCT had for implementation of its' refreshed Seclusion Policy. There were also no details regarding how the BHSCT intends to move from the current operational practices in relation to seclusion of patients in MAH to the position stated in the Policy.

Whilst we welcomed the stated commitment of the BHSCT to seek expert input/support from both East London and Mersey Care NHS Foundation Trusts, we were unable to evidence the level of engagement or the impact to date.

Patient Observations

We reviewed the arrangements in place for the management of prescribed patient observations in each ward. We noted patient numbers, supervision ratios and the number of patients receiving enhanced one to one care. Four of the five wards we visited continued to experience staffing shortages. Despite this inspectors found that patient observations were being carried out as required and that day care and in reach services were ongoing on the site. Staff were challenged in taking breaks and leaving on time after their shifts. It was noted that the Behaviour Nurses were not always operating in this capacity and that this was not helpful in respect of the therapeutic interventions that would improve patient outcomes.

Patient observation records reviewed by inspectors evidenced that patients' observations were prescribed as required. We observed that nurse staffing shortages in each ward, with the exception of Erne, continued to have a detrimental impact on patient behaviour and ward routine.

We found no evidence of audits of observations being carried out at ward level.

Physical Health Care Needs

The inspection team found evidence of appropriate monitoring of physical health parameters of patients receiving antipsychotic medications in accordance with MAH's protocol. Inspectors noted that an audit of antipsychotic monitoring had been completed since the previous inspection in February 2019.

We also evidenced that annual checks of physical health had been completed for most patients in the hospital (52 patients checks completed). We noted that eleven patients had not received a physical health check (3 patients on leave and 8 patients declined). Whilst we welcomed that this work had been undertaken we noted that the medical staff deployment was on a short-term basis. We did not find evidence of a plan to ensure the completion of checks for patients on leave or a rolling programme for managing patients' physical health checks going forward.

The hospital situation report (SITREP) dated 04 April, 2019 was reviewed and found to state that physical health checks for all patients were complete. We found that this was not an accurate reflection of our findings.

Arrangements to support robust assessment and/or planning to ensure patients are included in appropriate population screening programmes (breast, cervical, abdominal aortic aneurysm (AAA) and/or diabetic retinopathy screening) were not found to be in operation.

We found evidence of some consideration of how many patients might need a particular screening test ((eg) mammography) but we could not evidence a hospital-wide system to identify, arrange and assure appropriate participation of patients in population screening programmes relevant to their age and gender.

In hours general practitioner (GP) clinical sessions are not provided on the MAH site. We found that there was no local partnership/service level agreement arrangement in place with any of the local GP practices to address this requirement. We noted that this disadvantages patients in MAH when compared to their peers living in the community.

Discharge Planning

We found limited progress for those patients experiencing a delay in the discharge. Ward staff told us that they did not have up to date information for all patients who had completed their active assessment and treatment and were awaiting discharge. Inspectors met with several patients who were experiencing a delay in their discharge from MAH. Patients and staff discussed the challenges that this presents as patients, family members/carers continued to seek advice and support in relation to possible discharge options.

Staff of all grades and professions highlighted the ongoing difficult in securing appropriate community based resources to support patients upon their discharge from hospital. BHSCT continued to progress a collaborative regional approach to ensure the hospital functions as an assessment and treatment hospital. The MAH management team advised us that a Supported Living Service was being developed close to the hospital site. The service will provide accommodation for up to twelve individuals and was in the process of registering with RQIA.

It was positive to note continued multi-agency involvement with all stakeholders including other Trusts, the Health and Social Care Board (HSCB), the Public Health Agency (PHA) and the Department of Health (DoH). However, we found limited progress had been made to ensure that agreed discharge arrangements were recorded and co-ordinated with all services involved in patients' on-going care.

Discharge planning arrangements were reviewed. We found that a high percentage of patients no longer required treatment and were experiencing a delay in their discharge from hospital.

Strategic Planning and Communication

Following the most recent inspection of MAH BHSCT had introduced a number of priorities to support the re-modelling of services within MAH. At the time of the inspection the hospital was not accepting new admissions and patients requiring acute care were being redirected to facilities in other Trusts.

MAH admission criteria had been reviewed to ensure that only those patients presenting with mental ill health or severe behavioural concerns would be admitted to the hospital going forward.

Despite the introduction of new arrangements we remained concerned about the hospital's strategic planning. We did not evidence a clear strategic direction and robust planning regarding staffing, safeguarding, management of patients' physical health care, discharge planning and financial governance.

Discussions with a wide range of staff across the whole MAH site identified that a large number were not aware of the future plans for the hospital.

Staff told us that they were unclear as to the role and function of the hospital's PICU. During discussions some staff advised us that they were in temporary positions whilst PICU was closed for a short time; whilst others who had been relocated from PICU believed that they had been moved permanently to other wards.

Ward MDT's continued to implement local arrangements to facilitate seclusion for patients as they were unable to access the purpose built seclusion room located within the PICU. These arrangements were being provided in rooms that did not meet the required standards and best practice guidelines for seclusion.

Hospital Governance

MAH governance arrangements and documentation was discussed with BHSCT senior managers, senior nursing managers, ward managers and members of the MDT.

We welcomed that a BHSCT Assurance Committee has been established and that daily, weekly and monthly governance meetings were also occurring at ward/hospital level. We found that the Deputy Chief Executive/Medical Director chairs a weekly assurance meeting. We noted that SITREP meetings included a weekly governance review section during which staffing, service continuity, incidents, seclusion, complaints, risk register issues and updates regarding on-going CCTV monitoring are reported. Whilst these metrics are useful we highlighted that the tool may require some revision in order to be fully sensitive to all pertinent issues and to be utilised to its' full potential. We did not find that exploration of alternative safety measurement and monitoring frameworks had been undertaken.

Governance arrangements were found to be insufficiently developed to be capable of providing assurance to BHSCT that services in MAH are safe and well led. We suggested that additional resources and external support was required. This is necessary to provide robust assurance of the quality and safety of care provided in the hospital, to ensure appropriate planning for transition of identified patients from the hospital to suitable community placements and to define the hospital's overall purpose within the wider HSC system (current and future).

Frontline staff again informed us that they were unclear about the role and functions of the various meetings and arrangements. We were unable to clearly determine the linkages between the constituent parts of the governance system.

We noted discrepancies in information reported through various parts of the hospital's operating and governing systems.

We were concerned to find that incidents meeting the threshold for Serious Adverse Incident (SAI) review were not being robustly reviewed, assessed and progressed through the system. An incident in which a patient had threatened to self-harm using glass and then subsequently threatened staff was noted. We were concerned that it appeared that the categorisation of the incident had been on the basis of outcome (no significant injury occurred) rather than the potential for a catastrophic injury.

A review of the minutes of SITREP of 04 March 2019 indicated that a member of the medical staff team was "conducting serious event audit review". We found frontline staff were unclear whether this was focusing solely upon the incident in Ardmore or involved a review of a different incident/number of serious adverse incidents.

BHSCT senior managers informed us that on-site presence and leadership had been refreshed.

We spoke to a wide range of staff from across the hospital a large number of who told us that they did not feel appropriately supported. We were informed that there was only two middle management staff on site when the complement should be four. Staff told us that this was causing them significant pressure and contributing to them being unsupported. Staff experiences shared with us evidenced that morale continued to be poor. It remained a significant cause for concern. Staff told us that they were often subject to a lot of assaults by patients. They reported that there was no formal debrief following an incident but they instead accessed support from within the immediate team or their peers.

We were told that debriefs post incident usually only occur when staff who have been off sick return to work or when there is a serious incident. We observed that nursing staff continue to experience enormous challenges and may not be able to avail of comfort breaks or finish their working hours on time due to the demands of providing care in these complex and challenging circumstances. Staff also told us that they have had to carry over a lot of annual leave and feel at risk of burnout.

The inspection team noted that a BHSCT survey of MAH staff in relation to the question "How safe did you feel in work today?" was reported at the weekly SITREP meeting on 18 March 2019. The results indicated that 60% of (150 staff) reported that they felt very unsafe.

We again could not evidence that the local governance arrangements or the support measures were having the required impact on safety and effectiveness of care for patients or on the health and well-being of staff.

Financial Governance

We confirmed that the outstanding safeguarding referral in relation to one patient identified during the previous inspection had been completed. We were unable to evidence progress in relation to the other aspects of financial oversight and governance.

We reviewed a sample of patient property records and ward ledgers and were unable to identify improvements in the standard of their completion. The documentation and knowledge deficiencies with respect to the appointee-ship arrangements for 13 patients identified during the previous inspection in February 2019 were not found to have been comprehensively addressed.

We found that monthly monitoring of ward finances by senior site managers was inconsistently completed. The records we reviewed highlighted a lack of evidence of appropriate assurance.

The report of a previous financial audit undertaken in 2015 by the internal audit team was reviewed. We noted that many of the priority one and two recommendations in this report were similar to those identified during this inspection and also the previous inspection in February 2019. We highlighted the timeline of this audit report (>3 years old) in the context of a need for more recent audit and assurance. We were unable to evidence that BHSCT had undertaken an audit of its’ financial procedures across all wards in the MAH site during April 2019.

Overall we were not assured that implementation of and compliance with financial procedures was consistent across all wards in order to provide assurance of robust financial governance.

7.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the Deputy Chief Executive & Medical Director, BHSCT Senior and Executive Management Team and ward staff as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

BHSCT should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of BHSCT to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified in which action is required to ensure compliance with the Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The BHSCT should confirm that these actions have been completed and return the completed QIP to bsu.admin@rqia.org.uk for assessment by the inspector by 5 March 2020.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">The Trust must ensure the following findings are addressed:</td></tr>
<tr><td colspan="2">Staffing</td></tr>
<tr><td rowspan="2">Area for improvement No. 1
Ref: Standards 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1, 5.3.3)
Stated: Second time
To be completed by: Before 14 May 2019</td><td>The Belfast Health and Social Care Trust must:
1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH, which;
a) is based on the assessed needs of the current patient population <i>and</i>
b) Incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.
2. Implement an effective process for oversight and escalation to senior management and the executive team when challenges in nurse staffing arise.
3. Implement an effective assurance mechanism to provide oversight of the implementation of the model and escalation measures.
4. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing.</td></tr>
<tr><td>Response by the Trust detailing the actions taken:
1. a. Work progressed to determine safe staffing levels through an assessment of the current patient population’s acuity and dependency. Acuity and dependency was determined using the current level of observation employed by the staff to safely care for patients, and using Telford to determine the registrant levels. This triangulated approach has resulted in a nursing model, which is in use to describe safe staffing levels.
b. The model is in use by the ward managers and reviewed regularly to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.
2. Ward staffing levels are reviewed on a daily basis Monday to Friday and at the weekly Ward Managers meeting (Friday) for the weekend. ASMs are on site Monday to Friday and review the requirements daily. An OoH co-ordinator also reviews staffing levels on site in the OoH period. Any issues of concern are raised by the wards to the ASM/OoH Co-Ordinator to Service manager and then to Collective leadership team. In the OoH there is a senior manager on call rota in place to provide additional support to staff OoH.
3. The Model was developed with engagement from the ward managers and ASMs in the first instance to ensure buy in. the Divisional Nurse worked closely with the ward Managers and ASMS to determine the current patients’ needs on site in order to inform the model. Also a Telford</td></tr>
</table>

	exercise was undertaken with each of the ward managers. Once the model was developed the DN met with each of the Ward managers and ASMS to implement. Assurances are sought at the weekly ward managers meeting that the model is in use. When there are any issues Ward managers and ASMS are able to contact and talk it through with the DN if that support is required. The pathway used to escalate issues is Ward Manager to ASM to SM and then to the Collective Leadership team. 4. The nursing model has been developed by the senior team in MAH (in conjunction with the ward managers and ASMs) and approved by the Executive Director of Nursing and the Expert Nurse Advisor, DoH, and it has been presented to and supported by RQIA.
Safeguarding	
Area for improvement No. 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding at MAH and ensure: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations; b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care; d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved. 2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward sisters, hospital managers, BHSCT senior managers and / or the Executive team as appropriate. 3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.
	Response by the Trust detailing the actions taken: A detailed action plan was developed by the ASG and management team at MAH. There are 37 actions in place to ensure that the key 3 areas outlined in the QIP are

	achieved. At present 34 of these actions have been completed, the remaining 3 actions are currently on hold following advice from the PSNI not to proceed whilst the investigation is ongoing. There are plans in place to meet with the PSNI to discuss further. There are currently monthly ASG audits taking place on site to provide assurance that the changes implemented through the action planned are still in place and compliant.
CCTV	
Area for improvement No. 3 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.
	Response by the Trust detailing the actions taken: The CCTV policy has been reviewed, included update to forms included within the policy, the policy is currently with the Trust's Standard and Guidelines Committee for tabling. All staff have access to the initial policy approved in MAH. Further policy review and update is planned to improve the use of CCTV for safety monitoring. This is being progressed with the CCTV working Group and will be shared with staff when fully approved. There are agreed procedures within the hospital for monitoring and managing CCTV images, the template for requesting a download of footage has been updated. Work is required to improve the robustness, monitoring and functionality of the CCTV system on site. The Co-Director is awaiting quotes from Estate Services/ RadioContact and a business case will be developed. A CCTV working group has been set up (this includes a representation from ward staff, safeguarding staff, management, litigation and unions) to review the current use of use and the development of use within the hospital. Feedback surveys and processes have been developed to gather feedback on the current use and developed use of CCTV for safety monitoring within the hospital.

	Feedback is being sought from staff, families, carers, advocates and patients.
Restrictive Practices (Seclusion)	
Area for improvement No. 4 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Undertake an urgent review of the current and ongoing use of restrictive practices including seclusion at MAH whilst taking account of required standards and best practice guidance. 2. Develop and implement a restrictive practices strategy across MAH that meets the required best practice guidance. 3. Ensure that the use of restrictive practices is routinely audited and reported through the BHSCT assurance framework. 4. Review and update BHSCT restrictive practices policy and ensure the policy is in keeping with best practice guidelines.
	Response by the Trust detailing the actions taken: MAH have implemented a suite of reports including a weekly patient safety report and a monthly governance report to ensure a clear statistical position for the use of restrictive practice is available for each setting. Reports are shared at both Executive Team and Trust Board. To date the use of seclusion and physical intervention have greatly decreased in the hospital. Audits have been implemented for the use of seclusion and patient observations, they are carried out on a monthly basis. The finding and actions from the audits are discussed at Pipa meetings and at the monthly Governance Committee. Restrictive Practices usage is discussed at a range of meetings, a Live Governance Call takes place each week when ward staff discuss the use of seclusion, Physical Intervention and use of PRN medication at patient level. The use of restrictive practice is included in the weekly Patient Safety Report and reviewed at the monthly Governance Committee. A Restrictive Practice Working group has been set up to provide a strategic overview of the use of and future use of Restrictive Practices within the hospital. The group has presentation of medical staff, ward staff, management, Safeguarding Staff, Governance, PBS and pharmacy. The suite of Restrictive Practice policies have been reviewed by an MDT within the hospital, an overarching Restrictive Practice Policy has been developed in line with best practice across the UK.

	MAH have formed a 'critical friend' relationship East London NHS Foundation Trust to act as critical friend to provide support and challenge in respect of all restrictive practices
Patient Observations	
Area for improvement No. 5 **Ref:** Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must address the following matters in relation to patient observations: 1. Engage with ward managers and frontline nursing staff to ensure that a regular programme of audits of patient observations is completed at ward level. 2. Ensure that there is an effective system in place for assessing and managing patient observation practices, which is multi-disciplinary in nature and which enables staff to deliver effective care and learn collaboratively.
	Response by the Trust detailing the actions taken: A monthly audit process has been embedded across the hospital. The audit looks at the use of observations and reports compliance or non-compliance with the policy. The outcome of each audit is circulated to the management team, discussed at PiPa and reviewed at the Governance Committee meeting. Assessing and management of patient observation practices are reviewed through PiPa meeting with a MDT approach.
Management of Medicines	
Area for improvement No. 6 **Ref**: Standard 5.1 Criteria 5.3.1(f) **Stated:** First time **To be completed by:** 28 August 2019	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of "when required" medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.
	Response by the Trust detailing the actions taken: 1. The existing registered pharmacist has agreed to increase hours from 0.5wte to 0.8 wte from the beginning of April 2020. The pharmacy technician post is in the early stages of recruitment. 2. The pharmacist reviews the kardexes for omitted does and completion of administration records at the

	PIPA meetings and any omissions or areas of concern raised at that time. With the increase in the Pharmacy hours, a more formalised approach can now be developed. A POMH audit on antipsychotic prescribing in ID patients, led by the Trust Pharmacy team will commence by the end of March 2020. 3. Each ward sister is responsible to ensuring that refrigerator temperature monitoring recording (Actual/Minimum & Maximum) is in place on their ward. This will be placed on the safety brief for daily checking. In addition the Pharmacist will audit the temperature monitoring when the Controlled drug audits are being undertaken.
Physical Health Care Needs	
Area for improvement No. 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to: 1. Ensure that there is an appropriate number of suitability qualified staff to ensure that the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes. 2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy. 3. Ensure that specialist learning disability trained nursing staff understand and oversee management of the physical health care needs of patients in MAH. 4. A system of assurance in respect of delivery of physical healthcare.
	Response by the Trust detailing the actions taken: A GP role has been recruited to the hospital to focus on physical health checks for all patients. There are 3 SHO positions within the hospital which are made up of one GP trainee and 2 psychiatry trainees. There is an out of hours GP available on site from 7pm-11pm each day with all other hours are covered by the onsite GP, the 3 SHOs and the psychiatry team for physical health care and queries. A lookback exercise has taken place to gather all physical health information for each patient including family history were available. This information is now stored on one template which is available on the PARIS system and in a physical health folder kept on each ward. Patients who meet the guidelines set out by Northern Ireland screening programmes have had their screening completed and added to the registers to ensure they are called appropriately with the general population. (Cervical cancer,

	Bowel screening, mammograms, AAA and diabetic eye. Each relevant patient now has an annual Chronic Health Condition review (Eye exams, asthma review, epilepsy review, hypertension review, testicular exams, breast exams and cervical screening. A review of all patients' health checks in regards to antipsychotic medication has been carried out. Each patient has an anti-psychotic monitoring chart which is reviewed by both a medical professional and a pharmacist. Six monthly (March & September) checks in line with Maudsley Guidelines is carried out, this includes bloods, ECG and all other relevant physical checks. All patient physical check information is stored on one template providing assurance that historical check information, family history and planned checks are available to all relevant staff. This provides assurance that all relevant checks have taken place or planned within the required timeframe. 1. All patients receive a physical examination within 24 hours of admission (ward trainee/on call trainee and nursing staff observations). We have ECG machines, physical observation equipment and venepuncture facilities available on site. 2. Past medical history and medicines reconciliation are confirmed within the first week (ward trainee/pharmacist) 3. Any initial concerns about physical health are followed up accordingly (ward trainee) 4. Longer term conditions and screening are managed by or GP locum doctor who also offers advice to trainees where required 5. For non-urgent physical concerns on the ward, the ward trainee is called 6. For urgent physical concerns, we have a duty bleep system for our site doctors and staff are aware to also contact NIAS in emergencies (as we have limited resuscitation facilities on site). Mandatory training for staff includes Life Support Training (at various levels depending on the grade/role of staff) accessed via the Trust HRPTS system 7. PIpA Visual Control Boards on each ward include prompts regarding physical healthcare, screening and antipsychotic monitoring. 8. We operate daily ward rounds (PIpA model) with focus days, one of which per week is about health promotion 9. All material pertaining to physical healthcare concerns are kept in manual files on the wards for

	easy access at PIpA and for out of hours doctors 10. Antipsychotic monitoring is performed as required and routinely every six months (March and September) now by our GP locum doctor and ward nursing staff. An audit of this across the site was carried out in December 11. Current completion of the POMH audit: Antipsychotic prescribing in people with a learning disability under the care of mental health services (4/2-27/3/20 period, all inpatients and a sample of community patients). To compare with previous audit findings 12. We have the facility to refer to podiatry, dietetics, SALT, physio, OT on site and to our visiting dentist. 13. We have close links with and advice from the lead AMH pharmacist. We also have a part time pharmacist on site. 14. Future plans to develop the role of our locum GP colleague in the ‘ID Physician’ model to bridge the knowledge gap between primary and secondary care and improve the quality of physical healthcare assessment for our patients with complex co morbidities
Discharge Planning	
Area for improvement No. 8 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3(b)) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must ensure that ward staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from MAH.
	Response by the Trust detailing the actions taken: Patient level assessment and discharge information and plans are discussed at weekly PiPa meetings at ward level. Information from these meetings is shared appropriately at ward level by the ward representatives at Pipa. Patient transition plans are shared at ward level and there is an MDT approach for transition planning. The Transition team attend the ward managers meetings and the ASM meetings when there are updates to patient resettlement plans. A Quality Improvement project has been initiated involving staff from across the hospital to focus on standardising and improving the transition processes for patients resettling from hospital.

<table>
<tr><th colspan="2">Strategic Planning & Communication</th></tr>
<tr><td rowspan="2">Area for improvement No. 9
Ref: Standards 4.1 & 8.1 Criteria 4.3 (b, d and e), 8.3 (b)
Stated: Second time
To be completed by: 14 May 2019</td><td>The Belfast Health and Social Care Trust must address the following matters to strengthen hospital planning:
1. Ensure that a comprehensive forward plan for MAH is developed, communicated, disseminated and fully understood by staff.
2. Ensure that stated aims and objectives for the hospital's PICU are developed and disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.</td></tr>
<tr><td>Response by the Trust detailing the actions taken:
A workshop (invite open to all MAH staff) is planned for the 26 Mar 2020 to discuss plans and development for the future of the hospital site.
Monthly staff briefing meetings have been embedded within the hospital, these meetings aim to share information with staff across the site and respond to any questions.
A weekly newsletter is distributed to all staff across the hospital, providing information updates and sharing news.
The PICU is no longer in use and will not be restored to its previous function, this information has been communicated to staff. The workshop planned for March and future planning meetings will include discussion around the future use of the PICU space.</td></tr>
<tr><th colspan="2">Hospital Governance</th></tr>
<tr><td rowspan="2">Area for improvement No. 10
Ref: Standards 4.1 and 5.1 Criteria 4.3 (a) and 5.3.1.(f)
Stated: Second time
To be completed by: 14 May 2019</td><td>The Belfast Health and Social Care Trust must review the governing arrangements in MAH and consider the following matters in order to strengthen the governance arrangements:
1. Enhance communication, staff knowledge and understanding of relevant committees and meetings to support local leadership and governance on the MAH site.
2. Embed the recently introduced Daily Safety Huddle (at ward level) and the Weekly Safety Pause (hospital level) meetings.
3. Implement an effective assurance framework.</td></tr>
<tr><td>Response by the Trust detailing the actions taken:
A governance framework has been developed within the hospital, this consists of a hierarchy of meetings which provide the space for discussion, challenge, review and assurance. There have been a suite of reports developed to provide statistics, analysis and oversight of key governance areas within the hospital.
The governance meeting and reports framework has been illustrated in a flow chart and provided to staff to assist with understanding of the reports and meetings within / about the hospital.</td></tr>
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	The daily safety huddle now takes place on a daily basis within each ward. A weekly live governance call has been embedded within the hospital, this meeting has multi-disciplinary representation and is led by ward level information. The assurance framework has been embedded, this has been built from ward level reports and meetings building into Hospital management meetings which feed into Executive and Trust Board level meetings.
Financial Governance	
Area for improvement No. 11 **Ref**: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must ensure: 1. That the BHSCT is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986. 2. In respect of those patients in receipt of benefits for whom BHSCT is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits. 3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and BHSCT policy and procedures; this includes: a) that appropriate records of patients' property are maintained; b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role; c) that audits by senior managers of records retained at ward level are completed in accordance with BHSCT policy; d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in MAH.
	Response by the Trust detailing the actions taken: A comprehensive action plan has been developed by the finance team and management team at MAH. The plan consists of 18 actions (8 completed, 9 in progress and 1 no longer applicable). The appointment of a Finance Liaison Officer has been very successful and enabled individual financial plans to be produced. The Trust has recently received a response from RQIA to our request to hold balances over £20k for 4 patients and we are currently addressing the questions raised and remain confident that the Trust is best placed to manage these monies on patient's behalf. The Trust has sought and received appropriate documentation including benefit entitlement for all patients

	we are appointee for with the exception of one patient that transferred to MAH from a Trust supported living accommodation – the documentation for this one patient is currently being followed up. The Trust Policy has been extensively reviewed and updated a number of times since the inspection and training has been delivered to all relevant staff. Although the current version of the Policy has been issued to staff it continues to be reviewed and updated in light of in-house monitoring findings. The BSO Internal Audit has now taken place and the Trust is due to meet with auditors on 25th March to discuss findings.

Name of person (s) completing the QIP	Gillian Traub		
Signature of person (s) completing the QIP	Gillian Traub	**Date completed**	12 March 2020
Name of Responsible Person approving the QIP	Gillian Traub		
Signature of Responsible Person approving the QIP	Gillian Traub	**Date approved**	18 September 2020
Name of RQIA Inspector assessing response	Wendy McGregor		
Signature of RQIA Inspector assessing response	Wendy McGregor	**Date approved**	18 September 2020

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Assurance, Challenge and Improvement in Health and Social Care

The **Regulation** and
Quality Improvement
Authority

Assurance, Challenge and Improvement
in Health and Social Care

30 April 2019

Private and Confidential

Dr Michael McBride
Chief Medical Officer
Department of Health
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Dear Dr ~~McBride~~ Michael

I write in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and further to my earlier correspondences of 06 and 14 March 2019, to advise you of RQIA's continuing serious concerns in relation to care, treatment and services as currently provided for patients in Muckamore Abbey Hospital (MAH).

As you know we undertook an unannounced inspection of MAH two months ago (26 to 28 February 2019, inclusive), during which our multidisciplinary inspection team assessed care and treatment provided to patients as well as risk management, oversight and governance arrangements within and across the hospital. A number of areas of concern emerged from that inspection. These related to staffing, patients' physical healthcare, financial governance, safeguarding practices, restrictive practices (seclusion) and hospital governance.

You will be aware that RQIA held an 'Intention to Serve Improvement Notices' meeting with Belfast HSC Trust on 07 March 2019. During this meeting we discussed evidence/information relating to each of the six areas of concern with the Chief Executive and Executive Directors in the Trust. Belfast Trust subsequently forwarded a written outline of their work in relation to care and treatment provided in MAH and a copy of their MAH Inter-Trust Safe Compassionate and Effective Care Action Plan 2018/19 to the Permanent Secretary in DoH, this correspondence was copied to RQIA (dated 08 March 2019).

After thorough consideration of Belfast Trust's representation at our 'Intention to Serve' meeting on 07 March 2019 and of additional written information provided by the Trust to DOH, and copied to RQIA, we determined not to serve Improvement Notices at that point in time. Dr Geoghegan's correspondence of 14 March 2019 outlines the assurances provided by Belfast Trust in this context and the rationale informing our determinations in respect of each of the areas of concern. We shared a written summary of our

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determinations with Belfast Trust (dated 14 March 2019). In our correspondence we stressed the importance of robust implementation of the Trust's action plan/quality improvement plan (QIP) to ensure immediate improvements in the care and treatment delivered on the MAH site. We also indicated that, given the significant concerns identified, RQIA would monitor and assess progress over the subsequent weeks.

I can now advise that our team undertook a further unannounced inspection of MAH from 15 to 17 April (inclusive). The purpose of this second inspection was to assess progress regarding the Trust's action plan/QIP and to follow-up on assurances provided by the Trust during discussion at our 'Intention to Serve' meeting and in correspondence to DoH (copied to RQIA). I am disappointed to report that our inspection team evidenced limited progress in relation to the areas of concern previously identified. I have outlined some of the main findings from our second inspection below:

1. Staffing
   a. While the Trust advised during our 'Intention to Serve' meeting that seven Band 5 nursing professionals had been recruited, were undergoing induction and were due to commence in MAH w/c 11 March 2019, it is now apparent that this has not been the case. The seven Band 5 nurses were agency staff who did not commence working in MAH on the date advised, in fact seven agency nurses had various start dates between 25 Mar and 24 Apr 2019. We are now aware that up to five experienced Band 7 nurses will move from their current roles/posts in MAH in the near future and two other senior staff are also moving from their current roles/posts. To date no additional nurses have been secured through collaborative working arrangements with Northern and South-Eastern Trusts. Since our inspection in February a further four staff have been placed on precautionary suspension.

   b. During this inspection we experienced considerable difficulty with regard to accurately confirming nursing staff requirements as compared to nursing staff provision across the hospital. We could not evidence robust planning of nurse staffing on the basis of assessed patient need. We noted a mismatch between information supplied by site managers and that supplied by ward staff/ward managers. Although site managers described escalation arrangements in relation to staffing challenges we were not assured that these arrangements are working effectively, we remain concerned that ward staff/managers are not appropriately supported when they experience challenges in relation to staffing.

   c. Staff morale remains a significant cause for concern. As highlighted previously staff providing front-line care have displayed enormous resilience, they are to be commended for their dedicated service to patients and patients' families. We remain concerned for the health and wellbeing of staff, particularly nursing staff, who are experiencing enormous challenge and who may not be able to avail of comfort breaks or finish their working hours on time due to the demands of providing care in these complex and challenging circumstances. Staff have reported that they do not feel appropriately supported.

2. Patients' physical health care needs – we found evidence of completion of annual checks of physical health for most patients in the hospital (52 patients' checks completed, 3 patients on leave, 8 patients declined). We also found evidence of appropriate monitoring of physical health parameters of patients receiving antipsychotic medications (per protocol). These are improvements since our previous inspection in February. We did not find evidence of robust assessment and/or planning to ensure patients are included in appropriate population screening programmes (breast, cervical, AAA and/or diabetic retinopathy screening). While there was evidence of some consideration of how many patients might need a particular screening test (e.g. mammography), we could not evidence a hospital-wide system to identify, arrange and assure appropriate participation of patients in population screening programmes relevant to their age and gender.

3. Financial governance – during this inspection we confirmed that a safeguarding referral had been made in relation to the financial arrangements for one detained patient (lack of referral identified during our February inspection). We could not, however, evidence progress in relation to the other aspects of financial oversight and governance which remains a cause for significant concern. We could not evidence appropriate documentation relating to appointee-ship arrangements for 6 of 13 patients, we could not identify improvements in completion of patient property records or in completion of ledgers at ward level. Monthly monitoring of ward finances by senior site managers was inconsistently completed, and when completed lacked evidence of appropriate assurance. Inspectors reviewed the report of a previous financial audit undertaken the Trust's internal audit team (2015) and noted that many of the items leading to priority one and two recommendations in that report were similar to those identified in this and our previous inspection. We could not evidence work relating to the Trust's planned audit of financial procedures across the site, to be undertaken during April 2019 (as advised in the Trust's action plan/QIP).

4. Safeguarding practices – as in our previous inspection, we did not find evidence of implementation of learning arising from safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. Due to the complexity and mix of patients in some wards and with current staffing levels, we noted that meaningful implementation of protection plans is a significant challenge. A structural disconnect between professional staff was again evident within the current safeguarding arrangements for the hospital.

5. Restrictive practices (seclusion) – the Trust has recently updated its seclusion policy which is out for review/comment with staff and carer/family representatives. The overall use of seclusion is reducing and inspectors

noted that care staff are appropriately recording and monitoring seclusion when used, seclusion is discussed at MDT meetings and at weekly live governance meetings. However we remain concerned about the environments currently used for seclusion across the hospital site. While the seclusion suite remains unavailable and PICU remains closed, the environments used for seclusion will not meet required standards. While the Trust has indicated it is seeking expert assistance from two NHS Foundation Trusts with regard to the use of restrictive practices in general and seclusion specifically, we remain concerned that site managers do not appear to appreciate the considerable distance between arrangements and practices as outlined in the Trust's updated seclusion policy and practices as currently implemented in the hospital. Our inspection team was particularly concerned that staff involved in managing patients with challenging behaviour (in particular patients for whom restraint and/or seclusion may be required) do not appear to be supported through structured debriefing and there are limited/few opportunities to identify and share learning in a meaningful way.

6. Hospital governance – the Trust has established arrangements to strengthen governance and to identify and manage risks across the hospital. These arrangements include a weekly live governance meeting, a weekly safety pause and a ward-based safety huddle which is currently being piloted on two wards. A hospital SITREP has also been established and this is reported weekly. While these arrangements are to be welcomed, frontline staff indicated that they are not clear about the role and function(s) of the various meetings and arrangements. Our inspection team could not clearly determine the linkages between the constituent parts of the governance system. We noted discrepancies in information reported through various parts of the hospital's operating and governing systems. We could not evidence that these arrangements were having the required impact on safety and effectiveness of care for patients or on the health and well-being of staff.

Upon completion of this unannounced inspection we held a detailed feedback session with senior Trust staff (3.00pm to 5.30pm, Wednesday 17 April 2019).

This week we have been contacted by staff working in MAH, under our whistleblowing arrangements, to report concerns regarding current staffing levels and patient safety within the hospital. Staff have advised us of their perception that there are communication challenges between staff working in front line and management. This information aligns with findings identified during our inspection.

Given that we have been able to demonstrate limited progress only in relation to assurances previously provided and in light of recent contacts by staff to RQIA (as above), we are now recommending that DoH implements a special measure for Belfast Trust in relation to MAH.

We recommend the establishment of two taskforces – (i) a taskforce to stabilise the hospital site, in support of patients currently receiving care and of staff delivering that care, and (ii) a taskforce to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community.

I would highlight a pressing need to ensure that senior operational nursing leadership is provided in the hospital as soon as possible. It is essential that frontline nursing staff now receive appropriate support as they continue to deliver care in the most complex and challenging environments.

You may wish to receive a more detailed update on key findings of our inspection and the matters outlined above. Dr Geoghegan will be on leave from 04 to 13 May 2019, otherwise we are happy to confirm our availability to meet.

We will continue to support improvement in care and services delivered to patients in MAH, and as always we will keep you informed of our future work.

Yours sincerely

pp Dr Lourda Geoghegan

Mrs Olive Macleod OBE
Chief Executive

Copy to
Dr Lourda Geoghegan, Medical Director and Director of Improvement, RQIA
Ms Emer Hopkins, Deputy Director, RQIA
Mrs Lynn Long, Assistant Director, RQIA
Mr Alan Guthrie, Inspector, RQIA
Malachy Finnegan, Communications Manager, RQIA
Mr Sean Holland, Chief Social Work Officer, DoH
Mr Fergal Bradley, RQIA Sponsor Branch, DoH
Dr Paddy Woods, Deputy Chief Medical Officer, DOH

**From the Permanent Secretary
and HSC Chief Executive**

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Our ref: RP3765
SSUB-0183-2019

Date: 22 March 2019

Dear Olive

MUCKAMORE ABBEY HOSPITAL – UNANNOUNCED INSPECTION

Your letters of 6th and 14th March to the Chief Medical Officer and his deputy regarding the unannounced inspection of Muckamore Abbey Hospital on 26th-28th February refer.

Firstly, I am grateful to the RQIA for the work it has undertaken in relation to the unannounced inspection of Muckamore, and for the notification of the findings and the subsequent outcome of your meeting with Belfast Trust on 7th March. I note in particular your decision not to serve improvement notices at this time, and to continue to monitor the six areas of concern closely.

With regard to your recommendation to implement a special measure for the Trust, I note and take assurance from the measures in place across the HSC system to oversee the significant amount of joined up task force working already ongoing with the focused aim of stabilising MAH, and delivering on the discharge planning programme of work that now needs to done. It is my intention to ensure that this important work is fully supported by all parts of the HSC system, and in doing so to be mindful of the need not to overburden any one part of it, including the Belfast Trust, at this crucial time.

As you suggest, I would be very happy to meet to discuss this matter further.
Please contact Suzanne Ferris in my office ([redacted] to arrange a meeting as soon as possible.

Yours sincerely

RICHARD PENGELLY

MUCKAMORE ABBEY HOSPITAL: MEETING TO DISCUSS FINDINGS OF SECOND UNANNOUNCED INSPECTION

14th May 2019

D4.14 Castle Buildings

Attendees:

Sean Holland DoH (Chair)	Marie Roulston HSCB	Olive MacLeod RQIA
Charlotte McArdle DoH	Mary Hinds PHA	Lourda Geoghegan RQIA
Chris Matthews DoH	Marie Heaney BHSCT	
Jerome Dawson DoH	Moira Mannion BHSCT	
Mark Lee DoH		
Rodney Morton, DoH		
Alison McCaffrey DoH		

Summary of key points:

1. After a round of introductions, Sean welcomed everyone to the meeting and explained that the meeting had been convened at Richard Pengelly's request in response to the RQIA Article 4 letter of 30 April to Dr McBride which detailed the findings of the second unannounced inspection by RQIA. On the foot of the significant concerns raised by RQIA about a number of issues, the purpose of the meeting was to reach a common understanding of the safety of services at Muckamore to inform any decisions that may need to be taken by the Department in the immediate term.
2. Sean invited Olive to outline the inspection findings. At this point, Marie Roulston and Marie Heaney noted that they had not had sight of the letter. Olive explained the purpose of Article 4 letters: to advise the Department of serious concerns about a service; and that the letter of 30 April was to inform the Department of the outcomes of the second inspection following the original Article 4 letter of 6 March and subsequent correspondence to the Department on 14 March, both recommending a special measure in relation to Muckamore.
3. It was also noted that the RQIA letter of 30 April to the Department had been issued prior to factual accuracy checks being completed on the detail of the RQIA feedback sessions with the Trust following the inspection. This was queried by Sean Holland given the effect of the letter: to escalate issues to the Department on which potentially swift decisions would be required. He also noted that it would be important for Richard to be made aware of this. Lourda

Geoghegan explained that the feedback sessions were a new part of the inspection process designed to improve the process, but the point being made was accepted, and Olive MacLeod agreed that it would be addressed in future in respect of Article 4 letters.

4. The discussion returned to the pivotal issue raised in the 30 April letter: staffing – both numbers and morale. In relation to numbers of staff, Lourda Geoghegan explained RQIA concerns and clarified that these were based on staff feedback which had been triangulated with a range of sources at ward and senior management level. Reference was also made to the whistle-blower who had contacted RQIA a few days after the second inspection raising similar concerns. In response, Moira Mannion outlined the steps taken by the Trust to manage the ongoing challenges associated with current vacancy levels (25 in total), including e-rostering, recruitment of both agency (current total of 35 FTE) and permanent staff (additional 8 as of 11 May) and daily monitoring of staffing. In terms of the future, Charlotte McArdle noted that a review of LD nursing is underway, which will provide normative nursing standards for LD. Marie Heaney also noted that the net effect of the Trust's work was that there were now more staff and fewer patients in Muckamore than in the past. Further, there was also now a higher ratio of qualified staff relative to unqualified staff.
5. In view of the staffing position, there was some discussion as to the apparent disconnect between the high numbers of staff and the findings reported by RQIA. It was also noted that there were risks inherent in relying solely on the accounts of the staff on site; particularly as some of these staff might be the subject of future disciplinary or criminal proceedings.[1]
6. The focus of the remainder of the meeting therefore turned to other factors impacting on staff. These were summarised by Olive in terms of the complexity and fragility of the environment in which staff were working in Muckamore in the wake of the SAI report, and the ongoing PSNI investigation/CCTV viewing and monitoring. Both Marie and Moira acknowledged the pressures and challenges faced by frontline staff and senior management, and referred to the support now being provided to both, including Marie and Moira's presence on site, plans to appoint a new senior nurse manager and weekly ward sister meetings.
7. Some of the deeper cultural issues evident to RQIA during its inspections were also discussed, with some differing views being expressed as to the likelihood of these being addressed in the medium to longer term. This led to a discussion about the future of Muckamore, and the

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[1] To note: Although this was not done, one possible way of resolving the factual position would be to review the contemporaneous CCTV footage.

critical importance of addressing delayed discharges in the hospital. Both Lourda and Olive emphasised the regional dimension to this work. Again, this was acknowledged by all and Marie Roulston outlined the work underway and being overseen by the HSCB Mental Health and Learning Disability Improvement Board involving all 5 Trusts, to deliver on Richard's commitments around the resettlement/delayed discharge population, as well as the medium to longer term reviews of acute care/treatment and wider LD service model. The backdrop of the resettlement of around 270 learning disability patients in the last ten years was also noted.

8. In conclusion, Sean Holland summarised the discussion as highlighting a number of significant actions being taken across the system to both stabilise the hospital in the immediate term, and plan for the future. He noted the evolving nature of these actions and plans, and in light of this, asked the Trust to respond to the RQIA on the detail by **21 May**. On receipt of this, Olive confirmed that RQIA would write to the Department further to its letter of 30 April to inform further advice to Richard who would be informed of the agreed outcome of today's meeting that no immediate safety concerns were highlighted requiring immediate action by the Department at this point in time.

Alison McCaffrey

Learning Disability Unit

THE RIGHT TIME, THE RIGHT PLACE

An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland

DECEMBER 2014

Review Team | Sir Liam Donaldson | Dr Paul Rutter | Dr Michael Henderson

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1 CONTEXT

Throughout the developed world much healthcare is of a very high standard. The range of technologies and drugs available to diagnose and treat illness greatly increased during the second half of the 20th Century, and into the 21st, offering life and hope where patients' prospects were once bleak. As a consequence, the number of people living with disease and needing years or even decades of support from care systems has expanded enormously.

The ageing population of today is a central consideration in a way that was not foreseen when modern healthcare came into being in the aftermath of the Second World War. Today, people are living much longer and developing not just one disease but several that co-exist. In old age, the twin states of multi-morbidity and frailty are creating acute and long-term health and social care needs on an unprecedented scale.

Technology has continued its rapid and beneficial advance, opening up new opportunities for diagnosis and treatment but bringing even greater numbers through the doors of hospitals and health centres. Citizens experience the benefits of an advanced consumer society and when they encounter the health and social care system, they rightly expect it to be commensurate with this. Rising public expectations are a further driver of demand for healthcare. There are other, less predictable sources of pressure on services. For example, a change in the pattern of winter viruses can bring surges in demand that threaten to overwhelm emergency departments. In response to all of this, the size of budgets devoted to health and social care has had to expand dramatically.

At the epicentre of this complex, pressurised, fast-moving environment is the patient. The primary goal of the care provided must always be to make *their* experience, the outcome of *their* condition, *their* treatment, and *their* safety as good as it gets. Health and social care systems around the world struggle to meet this simple ideal. Evaluations repeatedly show that: variation in standards of care within countries is extensive; some of the basics such as cleanliness and infection are too often neglected; evidence-based best practice is adopted slowly and inconsistently; the avoidable risks of care are too high; there are periodic instances of serious failures in standards of care; and, many patients experience disrespect for them and their families, bad communication and poor coordination of care.

The health and social care system in Northern Ireland serves a population of 1.8 million. People live in urban, semi-rural or rural communities. Responsibility for population health and wellbeing, and the provision of health and social care, is devolved to the Northern Ireland Assembly from the United Kingdom government in Westminster. As in other parts of the United Kingdom, the Northern Ireland health service operates based on the founding principles of the National Health Service - the provision of care according to need, free at the point of access and beyond, funded from taxation. However, since the advent of devolved government, England, Scotland, Wales and Northern Ireland have adopted their own strategies for: promoting and protecting health; preventing disease; reducing health inequalities; and, planning and providing health and social care services. The countries have developed different structures and functions within their systems to meet these responsibilities. Thus, they vary in features such as: arrangements for planning and contracting of care; levels of investment in public health, primary and community care versus hospital provision; funding models; incentives; use of the independent sector; managerial structures; and, the role of the headquarters function.

Various agencies, groups and strategies populate the quality and safety landscape of Northern Ireland. Quality 2020 is the flagship ten-year strategy. Commissioned by the Minister of Health, Social Services and Public Safety in 2011, its vision is to make Northern Ireland an international leader in high quality, safe care. Quality 2020 is sponsored by the Chief Medical Officer and led by the Department of Health, Social Services and Public Safety. It has a steering group, a management group, an implementation team, project teams, and a stakeholder forum. These bring together representatives from across the statutory care bodies and beyond. Separately, a Health and Social Care Safety Forum convenes a similar group of stakeholders.

The Regulation and Quality Improvement Authority (RQIA) is the main regulator in Northern Ireland's care system. Many of the social care providers, and some healthcare providers, are registered with the Regulation and Quality Improvement Authority. However it does not register the Trusts, which provide the bulk of health and social care in Northern Ireland, or general practices. The Trusts' relationship with the regulator therefore has a somewhat softer edge than might be the case if they were formally registered, although an expanded role has been announced recently by the Minister.

Northern Ireland takes a keen interest in the work of quality and safety bodies elsewhere in the United Kingdom, and often implements their guidance and recommendations. The National Institute for Health and Care Excellence (NICE) and the former National Patient Safety Agency have been prominent in this regard.

Technical quality and safety expertise sits not in the Health and Social Care Board, but next door in the Public Health Agency. The Public Health Agency has a statutory role in approving the Health and Social Care Board's commissioning plans. Two executive directors are jointly appointed between the Public Health Agency and the Health and Social Care Board. There are therefore mechanisms through which quality and safety expertise should inform the Board's work. The Quality Safety Experience Group is jointly managed between these two agencies. It meets monthly and its primary focus is learning. It looks at patterns and trends in incidents and initiates thematic reviews.

In short, there is a good degree of activity in the sphere of quality and safety improvement. There are some unusual features of the landscape, which will emerge in some detail in this Review.

The way in which central bodies seek to achieve compliance with their policies and make broader improvement changes is based on a very traditional and quite bureaucratic management model. There is much detailed specification of what to do, how to do it, and then extensive and detailed checking of whether it has been done. This has strengths in enabling the central bodies and the government to demonstrate their accountability and give public assurances, but it can greatly disempower those at the local level. It can cause those managing locally to look up, rather than looking out to the needs of their populations.

The alternative is a style of leadership based on inspiration, motivation and trust that those closer to the front line will make good judgments and innovate if they are encouraged to do so. Perhaps the relationship needs a lighter touch, to liberate freer thinking on how to make services better for the future.

2 TERMS OF REFERENCE AND WORKING METHODS

The Review's formal Terms of Reference are available online[1]. The overall aim of the Review has been to examine the arrangements for assuring and improving the quality and safety of care in Northern Ireland, to assess their strengths and weaknesses, and to make proposals to strengthen them.

The analysis in this report is based on extensive input from, scrutiny of, and discussion with people across the health and social care system in Northern Ireland. Each of the main statutory organisations made formal submissions to the Review (including records of board meetings, policies, and plans). The Review put substantial emphasis on travelling around the system – both literally and figuratively – to see it from as many different angles as possible, and to come to a rounded view.

The Review Team visited the five Health and Social Care Trusts, the Northern Ireland Ambulance Service, the Department of Health, Social Services and Public Safety, the Health and Social Care Board (and its Local Commissioning Groups), the Public Health Agency, the Patient and Client Council, and the Regulation and Quality Improvement Authority. In each, the Review Team met with the executive team (Chief Executive and executive directors) and, in most cases, the Chair of the Board and other non-executive directors. The management team of each organisation gave a series of presentations covering the areas of interest to the Review, and Review Team members asked questions and led discussion.

During their visit to each Health and Social Care Trust and to the ambulance service, Review Team members also led focus groups discussions amongst frontline staff. In each of the five Health and Social Care Trusts, for example, the team met with separate groups of consultants, nurses, junior doctors, and other health and social care professionals. Senior managers were not present for these discussions. Participants were encouraged to speak openly, and generally did so. It was understood that no comments would be attributed to individuals. The focus groups centered on any concerns about quality and patient safety in their organisation and incident reporting, and other highly-related topics. The team also met with two groups of general practitioners.

The Review Team paid particular attention to the experiences of people who have come to harm within the Northern Ireland health and social care system. At each Trust, including the ambulance service, the team reviewed two recent Serious Adverse Incidents in detail, particularly considering the incident itself, the way in which patients and families were kept informed and involved, and the learning derived. The team later returned to two Trusts to review further incidents, this time selected by the Review Team from a list of all serious adverse incidents in the previous year. The Review Team met with people who have come to harm. Most of these meetings were in person; some were by telephone. In addition to people affected directly, the Review Team spoke to their family members and carers. We are particularly grateful to all of these individuals for giving of their time, and for graciously sharing their stories with us, which were often painful.

Finally, the Review Team met with a series of other individuals and groups that form part of the wider health and social care system in Northern Ireland, or have a strong interest in it. These were: the Attorney General, the British Medical Association, the Chest Heart and Stroke Association, the Commissioner for Older People for Northern Ireland, Diabetes UK, the General Medical Council, MacMillan Cancer Support, the Multiple Sclerosis Society, the Northern Ireland Association of Social Workers, the Northern Ireland Human Rights Commissioner, the Northern Ireland Medical & Dental Training Agency, The Honourable Mr Justice O'Hara,

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http://www.dhsspsni.gov.uk/tor-080414.pdf the Ombudsman for Northern Ireland, the Pain Alliance of Northern Ireland, Patients First Northern Ireland, the Royal College of Nursing, and the Voice of Young People in Care. Other patient and client representative groups were invited to meet with the Review Team, or to make written submissions.

To inform one aspect of the Review, the Regulation and Quality Improvement Authority oversaw a look-back exercise, reviewing the handling of all Serious Adverse Incidents in Northern Ireland between 2009 and 2013. Their report was received late in the Review process, but has been considered by the Review Team and reflected in this report.

Between starting and producing its final report, the Review Team has had a relatively short period of time. It has not been possible to undertake research, extensive data analysis, large-scale surveys of opinion, or formal evidence-taking sessions. However, the documents reviewed, the meetings held, the visits made, and the views heard have given a strikingly consistent picture of quality and safety in the Northern Ireland health and social care system. The Review Team is confident that a longer exercise would not have produced very different findings.

3 THE CHALLENGES OF DELIVERING HIGH QUALITY, SAFE CARE

Patients in hospitals and other health and social care services around the world die unnecessarily, and are avoidably injured and disabled. This sad fact has become well known since the turn of the 20th Century. Awareness of it has not been matched, unfortunately, by effective action to tackle it.

There is consistency in the types of harm that occur in high-income countries. In low-income countries, harm is mainly related to lack of infrastructure and facilities, as well as poor access to care. However, in North America, Europe, Australasia, and many parts of Asia and the Middle East, analysis of incident reports and the findings of patient safety research studies shows a different, strikingly consistent pattern. Between 3% and 25% of all hospital admissions result in an adverse incident, about half potentially avoidable. Within any health or social care service, there are many potential threats to the quality and safety of the care provided:

1. Weak infrastructure - the range and distribution of facilities, equipment and staff is inadequate to provide fair and timely access to required care.
2. Poor co-ordination - the components of care necessary to meet the needs of a patient, or group of patients, do not work well together to produce an effective outcome and to be convenient to patients and their families.
3. Low resilience - the defences in place, and the design of processes of care, are insufficient to reliably protect against harm such as that resulting from errors or from faulty and misused equipment.
4. Poor leadership and adverse culture - the organisation or service providing care does not have clear goals and a philosophy of care that it is embedded in the values of the organisation and visible in every operational activity.
5. Competence, attitudes, and behaviour - the practitioners and care-providers working within the service lack the appropriate skills to deal with the patients that they encounter, or they are unprofessional in their outlook and actions, or they do not respect other team members, nor work effectively with them.
6. Sub-optimal service performance - the way that the service is designed, organised and delivered means that it does not deliver processes of care to a consistently high standard so that over time it chronically under-performs often in a way that is not noticed until comparative performance is looked at.
7. Slow adoption of evidence-based practice - the service does not conform to international best practice in particular areas of care or overall.

The amount of each type of harm varies but the overall burden has changed little over the last decade despite the unprecedented priority that has been given to patient safety within these health systems. Little is known about the level and nature of harm in primary care, though more attention is now being given to it.

Although these threats are described in relation to health, they apply also to social care. Many are strongly related to the level of resources that is available to a health and social care system. The extent to which each problem is present varies hugely across the world, within countries, and even between different parts of the same service or area of care provision.

In some ways it is reassuring to believe that the problems of quality and safety of care are somehow universal, and that no country has the answers. This is dangerous thinking. The best services in the world show that even with the all the pressures of large numbers of patients, many with complex needs, excellence can be achieved consistently across all fields of care. The Northern Ireland health and social care service must not be satisfied with 'good enough.' With a clear recognition of the reasons for its current problems in quality and safety of care, and with everyone working together, it could be amongst the best in the world.

4 KEY THEMES ESTABLISHED BY THE REVIEW

The Review established six key themes. Each is set out in some detail below. Exploration of these themes provides the basis for the Review's conclusions (in section 5) and recommendations (section 6).

4.1 A SYSTEM UNDER THE MICROSCOPE

Northern Ireland's health and social care system is subject to a high, perhaps unrivalled, level of media coverage – much of it negative. Over recent years, it has also been the subject of a series of high profile inquiries. All have highlighted numerous failings in the leadership and governance of care. Many have made extensive recommendations and the extent to which these have been implemented has itself been controversial. The pressures of increasing demand for care have meant that access has been more difficult. There has been a focus on over-crowding and delays in emergency departments, the front door of the hospital service. All of this has meant that the last five years has been a period of unprecedented scrutiny of the way that health and social care in Northern Ireland is planned, provided and funded.

4.1.1 A stream of inquiries highlighting service failures

The number of recent major investigations and inquiries into shortfalls in standards of care in health and social care services in Northern Ireland is striking in relation to the size of its population. This does not necessarily mean that such occurrences are commoner than elsewhere in the United Kingdom. It may simply be that the level of public and media scrutiny is higher and the pressure from this triggers a statutory response by government ministers and officials. The end-result is that the profile of the service is more often one of failure rather than success.

In March 2011, Dame Deirdre Hine, a former Chief Medical Officer for Wales, issued the report of her inquiry into deaths from *Clostridium difficile* in hospitals in the Northern Trust area. She had been brought in to investigate 60 deaths that had been attributed to the organism. She found that the true figure was 31 deaths. She found management, organisational, clinical governance and communication failings. She made 12 recommendations. It took 23 months to complete.

In February 2011, the Belfast Trust recalled 117 dental patients following a review of the clinical performance of a senior consultant. An independent inquiry commissioned by the Minister was published in July 2013 and made 45 recommendations. An action plan developed by the Department of Health, Social Services and Public Safety identified 42 key actions including on staffing, training, supervision and clinical governance. In November 2013, the Regulation and Quality Improvement Authority conducted an assessment of implementation of those actions.

In December 2011, an independent report by the Regulation and Quality Improvement Authority examined delays in the reporting of plain X-rays in all Trusts after concerns were expressed about delays in two hospitals. The review found that serious delays had occurred and were caused by three main factors: a shortfall in consultant radiology staffing, a growth in numbers of x-rays to be reported after the introduction of digital imaging and the introduction of a new policy to report on all hospital chest x-rays because of worries about patient safety. The review found that there was little awareness at regional level that a serious backlog in reporting was developing with potential risks to patients due to delayed diagnosis. The review made 14 recommendations.

In May 2012, Doctor Pat Troop, former chief executive officer of the Health Protection Agency in England, issued her final report of the independent investigation into an outbreak of infections in neonatal units due to the organism *Pseudomonas aeruginosa*. Five babies had died in the outbreak and 32 recommendations were made covering technical matters, management, governance, communication, training, and outbreak management.

In April 2012, the Minister asked for special measures to be put in place to oversee the Belfast Trust because of major concerns about serious adverse incidents in the emergency department, recommendations from the Pseudomonas review, reviews of paediatric congenital cardiac surgery and recommendations of the dental inquiry.

In December 2012, the Minister appointed a Turnround and Support Team to go into the Northern Health and Social Care Trust because of concerns about the weakness of governance and quality assurance systems, the paucity of clinical leadership, and uncertainties about the reliability of mortality data. This particular Trust has had five chief executive officers in the last seven years.

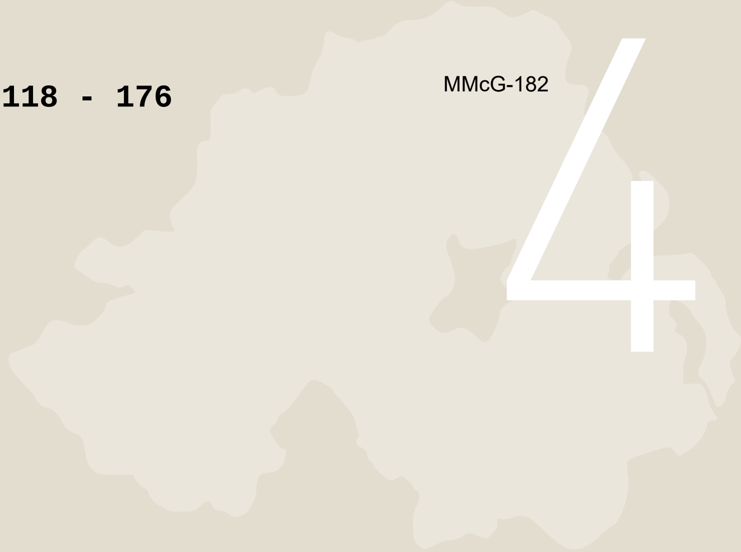
In June 2014, the Regulation and Quality Improvement Authority reported on its review of unscheduled care services in the Belfast Trust. The concerns that led to the review included: the declaration of a major incident, 12-hour waiting time breaches, dysfunctional patient flows and gross overcrowding of patient care areas. This triggered a fuller review that looked at matters region-wide. This produced 16 recommendations.

The dominant inquiry in recent times remains the *Independent Inquiry into Hyponatraemia–Related Deaths.* It is examining the deaths of children after being transfused in hospital with a fluid that was subsequently found to carry a significant risk. Concerns had been raised by the parents and others that this risk should have been identified much earlier, that action should have been taken to stop it being used, that there was a cover-up and that systems for monitoring safety were inadequate. It is being chaired by John O'Hara QC and was commissioned in 2003/4 but, because of other legal processes, was not able to hear full evidence until more recently. The report is expected in 2015.

The criticisms in inquiries like these have been largely justified and must be followed by action to improve the situations. Whether establishing formal, often lengthy, and costly inquiries is the right way to drive improvement is very debatable. Certainly doing so as the normative response to failure has important disadvantages. In particular, it often paralyses the organisation under scrutiny as its staff become pre-occupied with preparing evidence and supplying information. The learning is often put on hold - sometimes never to be returned to - until the inquiry is over. The burden of recommendations to be implemented and progress-checked can be overwhelming, so that the implementation becomes a bureaucratic exercise rather than a watershed moment for leadership, culture and the content of practice. It might be better to define a clear threshold for when a full-blown inquiry is initiated.

4.1.2 Intense political and media interest in service provision

Northern Ireland's health and social care system is subject to a high degree of political, as well as media, interest. This is a valid and expected feature of a publicly-funded system. Ironically, though, the way in which this interest becomes manifest often creates results that are counter to the true public interest. There have been many examples of local communities – and therefore their politicians – wanting to keep a local hospital open, contrary to the analysis of service planners. This has created



a situation in which Northern Ireland has more inpatient units than is really justified for the size of population, and the expense of maintaining them impedes provision of other services that would represent better value for money and more appropriately meet the needs of the population. Likewise, political pressure and media interest has prevented the salaries of top managers from being raised too substantially. However, senior executives in the Northern Ireland care system are now paid much less than their counterparts elsewhere in the United Kingdom. The public would be better served if their care system could compete to attract the very best managerial talent. The pressure to keep salaries down may be penny-wise and pound-foolish.

4.2 THE DESIGN OF THE SYSTEM HINDERS HIGH QUALITY, SAFE CARE

When a quality or safety problem arises somewhere within the Northern Ireland care system, the tendency is to point to the individuals or services involved, and to find fault there. As with so many other features identified in this report, this tendency is far from unique to Northern Ireland. But it represents, in the view of the Review Team, too narrow a focus. In reality, the greatest threats to the quality of care that patients receive, and to their safety, come from the way in which the system as a whole is designed and operates.

In short, the services that exist are not the services that the population truly requires. Political and media pressure acts to resist change, despite the fact that change is much needed. It is not clear who is in charge of the system, and the commissioning system is underpowered. All of this compounds the pressures, creating high intensity environments that are stressful for staff and unsafe for patients – particularly out of hours. These effects are explored further below.

The Northern Ireland care system has some elements in common with the other United Kingdom countries, and some that differ. Observers, asked to describe the Northern Ireland system, often point first to the integration of health and social care as its distinguishing feature. It is clear though from the findings of this Review that whilst the integrated design of the system has great advantages, it falls well short of perfection in promoting the highest standards of care and in preventing the dysfunctions in the co-ordination of care that are prevalent elsewhere.

4.2.1 Service configuration creates safety concerns

A striking feature of the provision of care in Northern Ireland is the wide distribution of hospital-type facilities outside the major city, Belfast, some serving relatively small populations by United Kingdom standards. This geographical pattern leads to specialist expertise being too thinly spread, and to the patchy availability of experienced and fully competent staff. It means that it is not possible everywhere to deliver the same quality of service for an acutely ill person at 4 a.m. on a Sunday as at 4 o'clock on a Wednesday afternoon. There is therefore a two-tier service operating in Northern Ireland - in-hours and out-of-hours - that is more pronounced in some places than in others. This is one of the biggest influences on the quality and safety of care. Delivery of services is too often higher risk than it should be in a 21st Century healthcare system because of the pattern of services.

Past analysts and observers have pointed to the current level and siting of provision not being in keeping with maintaining high standards of care. Some populations are just too small to warrant full-blown general hospital facilities yet they are kept in place because of public and political pressure. Amongst those who work within the system, there is deep frustration that the public are not properly informed about the higher risks of smaller hospitals and that the misapprehension that alternative forms of provision are in some way inferior to a hospital. These issues are illuminated by two wry comments made to the Review: “the word ‘hospital’ should be removed from the Oxford English Dictionary” and “ Northern Ireland needs more roads not more hospitals.”

Despite its small size, there is less co-operative working across Northern Ireland than might be expected. Silos reign supreme. The Health and Social Care Board runs regional commissioning teams, covering areas such as learning disability, mental health, prison health and a very broad category of 'hospital and related services'. However, particular scope exists to do more in improving standards in areas of clinical care where there is a strong evidence base for what is effective. In the cases where clinicians have worked together across organisational boundaries, remarkable transformations have occurred. This happened in cardiology where a regionally planned and coordinated service means that more patients with heart attacks get treated early, get less damage to their hearts, and more people live rather than die. The Ambulance Trust is the only one of the six Trusts organised on a regional basis. The Review Team was very struck by how much pressure this important service was under. This is consistent with the headline stories in other parts of the United Kingdom about ambulance services being unable to meet their service standards because of huge surges in demand. All parts of the service are taking the strain – from those in the control centre to those on the road. Yet when the detail of their situations is explored in depth, it is clear again that the problems stem from dysfunctional patient flows and pathways where different parts of the system are not working together.

4.2.2 Adverse consequences for primary and social care

The pressures on hospitals have consequences for primary and community services. There is a constant need for hospitals to discharge patients as soon as they possibly can to free-up beds for new admissions. Generally, this happens when an older person is judged medically fit for discharge. However, this does not necessarily mean that their physical and social functioning has reached a level where they can cope with a return to the community. The Review was told by general practitioners and social care staff that they often have to step in to provide unscheduled support in such circumstances and, because of inadequate communication at the time of discharge, they can be left in the dark about ongoing treatment plans and even be unclear about something as basic as a patient's medication regime. Some general practitioners spoke of spending long, frustrating hours trying to get to speak to a hospital doctor about their patient, without success.

Over the last decade, there has been a major increase in the dependency levels of people being cared for in the community. For example, the use of PEG feeding (directly into the stomach through a tube in the skin) is now commonplace in community settings, whereas it used to be a hospital treatment. As a result, community nursing staff have much more complex caseloads. There is also greater complexity in the other forms of disability, as well as in the treatments that people are receiving and other technologies that are supporting them.

The Review Team was very struck by the experience of one on-call pharmacist whom they talked to. He was responsible for preparing the discharge medication for patients leaving hospital on a particular Bank Holiday weekend. He reported filling a doctor's prescription for 20 different medications for each of four patients. This strongly illustrates several points. Firstly, it is not right that such an excessive amount of medication should be routinely prescribed. It should be rigorously reviewed and adjusted. Secondly, it again shows the complexity and multiple conditions affecting many patients, who move regularly between hospital and community. Thirdly, it highlights the opportunity for a much stronger role for under-appreciated disciplines like pharmacy on the boundary between hospital and population.

The integration of health and social care means that the Review Team's discussions within Trusts necessarily took account of the important role of social care staff, and particularly social workers. They are a vital part of the workforce and although under equal pressure to their healthcare counterparts, the Review was encouraged to hear about the strong emphasis on professional development in Northern Ireland and the particular expertise in specialist areas such as adult safeguarding.

The knock-on effects of pressures in the hospital system for community services are not restricted to post-discharge matters. Many hospital departments are so pre-occupied with urgent work and the high volume of patients that they do not have time to provide proper responses when patients or their doctors make contact to ask about progress with an outpatient appointment or test results.

4.2.3 High-pressure environments fuel risk to patients and sap morale

The demand from patients who need emergency care, as well as those who require planned investigations and treatments, is extremely high. The pressures on emergency departments and hospital wards are very great. Over-crowded emergency departments and overflowing hospital wards are high-risk environments in which patients are more likely to suffer harm. This is because delays in assessment and treatment occur but also because staff have to make too many important and difficult decisions in a short space of time - what psychologists call cognitive overload. That they will make mistakes and misjudgments is inevitable, and some of them will be in life-and-death areas. Experience in other safety-critical industries, and research, shows that high-pressure, complex, and fast-moving environments are dangerous. If inadequate staff levels are added to the mix, risks escalate further.

The Review met with many groups of health and social care staff, speaking on condition of anonymity. They are overwhelmingly conscientious people who feel deeply for their patients and want to excel in the care that they deliver. Yet, the workloads in some situations are unacceptably high; so too are stress levels. The stress comes not only from the large numbers of cases per se, but much more from the feeling of staff that they are not giving patients the quality of care they were trained to deliver. There is guilt too in knowing that they are forced to compromise their standards to levels that they would not accept for their own families. The phrase "doing just enough" was repeatedly used in the Review's meetings with front-line staff. There are extra pressures for some groups of staff. Doctors in training can find themselves in situations that are beyond their competence and experience. Sometimes they can call on back-up from senior staff, sometimes they have to do their best until the morning or Monday comes. Some nurses can find themselves dealing with an unacceptably large number of patients on a hospital ward at night. They too feel that they are having to lower their professional standards. This assessment is not based on isolated anecdotes but much more widespread and consistent accounts.

4.2.4 Transformation efforts are moving slowly

Transforming Your Care began as a substantial review of health and social care provision in Northern Ireland, commissioned in 2011. The review was led by the then-Chief Executive of the Health and Social Care Board, supported by an independent panel. It was a strong, forward-thinking piece of work.

The whole of the United Kingdom, like most developed countries, has a fundamental problem: the health and social care system that it has is not the health and social care system that it needs. The pattern of ill-health in the population has changed substantially since the systems were founded, and the systems have not changed to keep up. *The Transforming Your Care review* set out a convincing case for change. It described inequalities in health, rising demands, and a workforce under pressure. It particularly established that Northern Ireland has too many acute hospitals

- that elsewhere in the United Kingdom, a population of 1.8 million people would likely be served by four acute hospitals – not the 10 that Northern Ireland had.

Transforming Your Care set out a broad new model of care, which aimed to be tailored to today's needs and person-centered. In practical terms, its most substantial proposal was to move £83 million away from hospitals and give it to primary, community and social care services.

Those interviewed by this Review Team unanimously supported the need for this initiative. The widespread feeling, though, is that *Transforming Your Care* is simply not being implemented.

As a result of weak communication and little action, there is substantial skepticism about *Transforming Your Care*. The Review Team heard it variously referred to as "Transferring Your Care", "Postponing Your Care", and even "Taking Your Chances". One of its central concepts, 'shift left', is viewed particularly warily. Carers see it as a euphemism for dumping work onto them; general practitioners likewise. Those working in the community see their workload increasing, and worry that there is no clarity at all about what the overall care model is supposed to be.

The frustrations of the general practitioner community in Northern Ireland that *Transforming Your Care* has not worked, is not properly planned nor funded, has led them to take matters into their own hands and form federations. General practices themselves are financially contributing to these, in a move to establish community-centered care pathways.

The needs that *Transforming Your Care* sets out to address are becoming ever more pressing. Its implementation needs a major boost in scale and speed, and communication needs particular attention.

4.2.5 An under-powered system of commissioning

At 1.8 million, the population of Northern Ireland is relatively small to justify what is a quite intricately designed health and social care management structure. In addition to the Department of Health, Social Services and Public Safety, there are six Trusts, a Health and Social Care Board with five Local Commissioning Groups, a Public Health Agency, and several other statutory bodies.

A central feature is the split between care providers and commissioners, which increases the complexity of the system and its overhead costs. This began life as the so-called purchaser-provider split, introduced by Margaret Thatcher's government in the late-1980s. In various iterations, it has remained a feature of the NHS ever since. The introduction of a purchaser-provider split was originally intended to create a competitive 'internal market' to drive up quality and so increase value for money. However, the scope for genuine competition has always been very limited. The term 'commissioning' subsequently superseded 'purchasing'. Commissioning involves a wider set of functions – assessing need and planning services accordingly, and the use of financial incentives to intentionally drive the system's development relating to the type of services provided, their quality and their efficiency.

Within the United Kingdom, the English NHS has the most developed commissioning system. NHS England, the national commissioning board, is now separate from the central government Department of Health. It is a pure commissioning organisation, completely free from overseeing the performance of Trusts. Its only relationship with the provider side of the market is through the commissioning process. It devolves the vast majority of funds to local Clinical Commissioning Groups (of general practitioners) that make decisions about the allocation of money against a national framework of policies and goals. Services are priced under a tariff system. This tariff has become increasingly complex, to facilitate locally agreed variation and to incorporate pay-for-performance elements.

There are several contextual differences between England and Northern Ireland, of which the most obvious is population size. In England, the overhead costs associated with establishing and administering a complex tariff system are essentially divided between 53 million people. With a population one-thirtieth the size, the cost per head of running a similar system in Northern Ireland would be difficult to justify.

The problem for Northern Ireland is that it has gone just partially down the commissioning path. It does not have the benefits of a sophisticated commissioning system, yet has the downside of increased complexity and overhead costs. The worst of both worlds.

Northern Ireland has no service tariffs. The Health and Social Care Board allocates money by a process akin to block contracting. This approach was abolished years ago in England because it was considered old-fashioned, crude and not conducive to achieving value for money. Fully developed tariff systems reimburse providers on a case-by-case basis, with the amount paid dependent on the diagnosis or the procedure undertaken, the complexity of the patient and, in some cases, measures of the quality of care. In Northern Ireland, the funding system is far more basic. Staff the Review Team spoke to believed that it makes no distinction, for example, between a cystoscopy (a simple diagnostic procedure, usually a day case) and a cystectomy (a complex operation), a clear absurdity if true.

Northern Ireland's five Local Commissioning Groups are not like England's Clinical Commissioning Groups. The Local Commissioning Groups have a primary focus on identifying opportunities for local service improvement. They have very few resources and, in effect, are advisers and project managers rather than commissioners. England's Clinical Commissioning Groups, by stark contrast, have a high degree of control over resource allocation.

It is imperative, somewhere in the system, for needs to be assessed, services planned and funds allocated. Whichever part of the system is responsible for this must be sufficiently resourced to do it well – arguably, the Health and Social Care Board is currently not.

The Northern Ireland system would benefit from stronger thought- leadership from within. There is no established health and social care think-tank, and some key disciplines such as health economics are not strongly represented.

Northern Ireland could choose to go down any number of different routes. It could strengthen the current Health and Social Care Board, particularly to create a tariff that includes a strong quality component. Alternatively, it could devolve budgetary responsibility to the five Trusts, making them something akin to Accountable Care Organisations in other countries, responsible for meeting the health and social care needs of their local population. The Trusts would then buy in primary care services, and contract between themselves for tertiary care services.

Recommending a commissioning model is beyond the scope of this Review. It is clear, though, that the Northern Ireland approach to commissioning is not currently working well, and that this is surely affecting the quality of services that are being provided. For that reason, the Review Team must recommend that this issue be addressed.

4.2.6 Who runs the health and social care system in Northern Ireland?

It was instructive for the Review Team to have asked this question of many people. The question elicited a variety of answers, the common feature of which was that no one named a single individual or organisation. Indeed, most reflected their uncertainty with an initial general comment. Typical was a remark like: "The Minister has a high profile."
When pressed to directly answer the question: who runs the service? Their answers included: "The Minister", " The Permanent Secretary in the Department of Health", " The Chief Executive of the Health and Social Care Board", and " The Director of Commissioning of the Health and Social Care Board."

These responses reflect the complexity of the governance arrangements at the top of the health and social care system in Northern Ireland. They show that ambiguity has been created in the minds of people – both clinicians and managers – throughout the system.

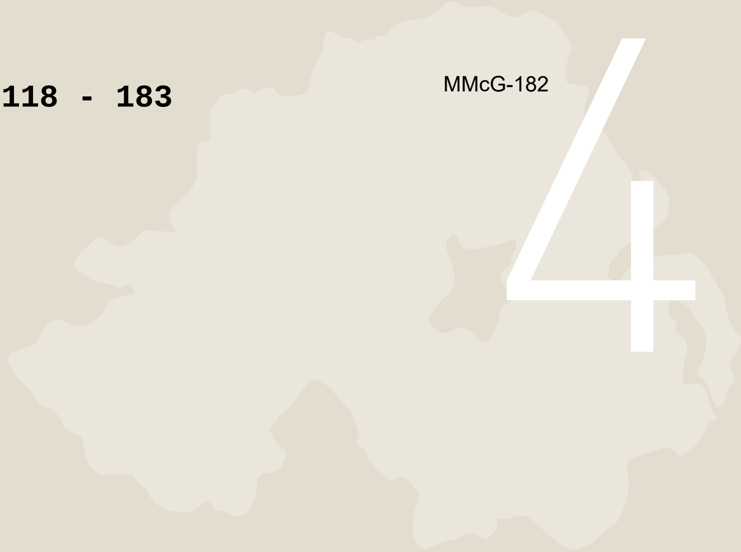
The question of who is in charge is both simple and subtle. Whilst overall accountability versus calling the shots versus making things happen are aspects of governance that would have a single leadership locus in many places, this is not the case in Northern Ireland. There is no single person or place in the organisational structure where these things come together in a way that everyone working in the service, the public and the media clearly understand.

The present arrangements have evolved over time but the Review of Public Administration in 2007 led to many of them. Prior to this the Department of Health, Social Services and Public Safety was larger and oversaw four Commissioning Boards and 18 Trusts. There were highly-centralised control mechanisms and the service was subjected to many and frequent circulars and directives. Since then there has been a smaller Department of Health, Social Services and Public Safety that is more focused on providing policy support to the Minister. A single Health and Social Care Board has been created from the previous four. The number of Trusts has been reduced from 18 to six, five organised to provide health and social care services by geographical area and the sixth an ambulance Trust for the whole region. Another important change has been the advent of a fully-devolved administration and the end of direct rule where power was in the hands of civil servants rather than elected local politicians. The lack of clarity about who is in charge is a major problem for Northern's Ireland care system. The difficulty is not that there is no figurehead, but that strategic leadership does not have the visibility of other systems. Without a clear leader, progress is piecemeal and change is hesitant and not driven through at scale – the Review Team was told "there are more pilots than in the RAF".

4.2.7 Clarifying the role of healthcare regulation

Aside from being commissioned by the Department of Health, Social Services and Public Safety to conduct occasional service-specific inspections, the Regulation and Quality Improvement Authority has until now conducted a program of thematic reviews driving more at quality improvement than at regulation.

From 2015, the Minister has decided that the regulator should undertake a rolling programme of unannounced inspections of the quality of services in all acute hospitals in Northern Ireland. The Regulation and Quality Improvement Authority is being directed in this task to examine selected quality indicators in relation to triage, assessment, care, monitoring and discharge. As a result of this change, the regulator will reduce its normal annual programme of thematic reviews.



These changes give the Regulation and Quality Improvement Authority a much stronger locus in the healthcare side of provision. However, this body has no real tradition of doing this kind of work, unlike its counterparts elsewhere in the United Kingdom. For example, in England, the various health regulators have evolved over a 15-year period with frameworks, methodologies, metrics and inspection regimes. For this reason, the Review is recommending that healthcare regulation in Northern Ireland is re-examined in the round, rather than approaching it piecemeal on an initiative basis.

4.3 INSUFFICIENT FOCUS ON THE KEY INGREDIENTS OF QUALITY AND SAFETY IMPROVEMENT

The recognition that quality and safety should be a priority in the planning and delivery of health and social care arrived late to this sector in developed nations. Until the early 1970s, services operated on the tacit understanding that doctors' and nurses' education, training, professional values and standards of practice ensured that most care was good care. It was not until measurement of quality became more commonplace that it was realised that faith in this ethos had been badly misplaced. A series of scandals blew apart public confidence in the NHS. There were many victims, and it became clear that trust alone was not sufficient. Often, such events depicted cultures in some health and social care organisations in the United Kingdom and other countries that had tolerated poor practice and even sought to actively conceal it.

Organised programmes to assure quality and improve it initially came into healthcare through approaches developed in the industrial sector, notably total quality management and continuous quality improvement. Until 1998, there had never been a framework to progress quality and patient safety in the United Kingdom's NHS. From that time, a comprehensive approach was introduced with: *standards* set by the National Institute for Clinical Excellence and in National Service Frameworks; a programme of *clinical governance* to deliver assurance and improvements at local level backed up by a statutory duty of quality; and, inspection of standards and *clinical governance* arrangements carried out by the Commission for Health Improvement. These roles have changed over time. Some still cover all, or most, of the United Kingdom, whilst others have been taken up differently in the four countries.

Much recent commentary on the NHS in the United Kingdom has focused on whether its leadership is really serious about quality and safety. There is a widespread view within the service that financial performance and productivity are what really matter to managers, despite what might be in the mission statements of their organisations. This came home to roost in the scandalous events at the Mid-Staffordshire NHS Trust in England where the Francis Inquiry heard that concerns about quality were down-played against financial viability in the pressure to gain Foundation Trust status.

A key consideration in quality and safety of healthcare is whether it is embedded in the mainstream at all levels. Up until the late-1990s, it was largely the domain of academics and enthusiasts. Since then, those who are fully committed to its underlying principles and goals have increased in number. However, it is still debatable what proportion of board members, management teams, and clinical leaders are 'card-carrying' quality and safety enthusiasts.

Prominent in international experience are four essential ingredients to improving the quality and safety of care. These are: clinical leadership, cultural change, data linked to goals, and standardisation. In Northern Ireland seeds of each can be found, but none is blossoming. This is substantially holding Northern Ireland's care system back from achieving its full potential.

4.3.1 Clinical leadership

A crucial test of the strength of the quality and safety system is the extent of clinical engagement. This is partly a question of hearts and minds but also a case of knowledge, skills and the philosophy of clinical practice.

The quality and safety of care will only get better if those who deliver the care are not only *involved* in improving it, but are *leading* the improvement effort. In the very best healthcare systems in the world, clinicians are in the driving seat, supported by skilled managers. Traditionally, doctors, nurses and other health professionals have seen their duty to the patient in front of them. Rightly, this remains the important primary requirement for establishing a culture of good clinical practice. However, this is not enough to enable consistently high standards of care, nor to make care better year-on-year. This requires a paradigm shift in clinical practice, a different mission of practice, so that all healthcare professionals see the essence of their work not just in the care of individual patients but in ensuring that the service for all their patients reaches a consistently high standard and that opportunities for improvement are identified and taken. Accomplishing this is not easy. Clinicians will point out that their workloads are too heavy to make time to reflect on these wider considerations or that they do not have access to reliable data to allow them to compare their service to best practice or that they have not had training in quality and safety improvement.

Clinicians need to step forward to lead. This involves expanding their sense of responsibility beyond the individual patient in front of them to the system as a whole. When clinicians do step forward, they need to be supported. They need to be given responsibility and resources. They need to be given training, because leading improvement is technically and emotionally difficult.

In Northern Ireland, the Review Team met a small number of talented clinicians who have decided to step forward, and who are succeeding in leading positive change. The Review Team met many more clinicians who have tried to engage with 'management' in the past, have been knocked back, and have given up trying. There are many great ideas lying latent in the heads and hearts of clinicians, untapped by the system. The Review Team saw some effort, particularly in the South Eastern Trust, to provide clinicians with the skills that they need to lead improvement projects. Across the system as a whole though, the scale and scope of these is nowhere near what is needed.

4.3.2 Cultural change

Culture determines how individuals and teams behave day to day. It determines how clinicians view and interact with patients; whether they consider harm to be "one of those things", "the cost of doing business", or a feature of healthcare that, with effort, can be banished; whether they react to seeing problems in the system by complaining, or by taking on responsibility for fixing them.

All healthcare systems in the world realise the importance of culture. The difference between the best and the rest is what they do about this. The very best do not hope that culture will change; they put major effort into actively changing it. Their approach is not light-touch or scattergun; they see changing culture as a central management aim.

The Cleveland Clinic in the United States of America, for example, set out to improve patient experience, most of which is determined by how staff behave towards patients. The Clinic's management wanted all staff to better work as a team, and to see their role as being important for patient care – from doctors and nurses, to cleaners, receptionists and electricians. They designated them all 'caregivers'. All 40,000 caregivers attended a series of half-day training sessions, designed to build their practical communication skills and their awareness of self, others and team. They made patient experience scores widely available – ranked by doctor, by hospital, and by department. These efforts have continued for several years. In 2013, the Chief Executive's annual address to all caregivers included a powerful video about empathy. It has since been viewed 1.8 million times on YouTube. In short, the Cleveland Clinic made a major concerted effort to make patient experience important to all who work there.

It has paid off. With staff now more engaged than ever, the Cleveland Clinic has been able to move on to making safety and other elements of quality a crucial part of the culture too.

In Northern Ireland, as in many places, no effort has been made to influence culture on anything like this scale. Many people in the system are able to describe the culture, and many cite it as important. Scattergun efforts are made – a speech here, an awards ceremony there – but shifting culture is hard, and scattergun will not do it. Culture is viewed with a degree of helplessness – but the evidence from elsewhere is that it can be changed, and that doing so is powerful.

4.3.3 Data linked to goals

The importance of data and goals are news to nobody. Yet in Northern Ireland, as in too many other healthcare systems, data systems are weak and proper goals are sorely lacking.

Improving healthcare requires clear and ambitious goals. It requires a statement that preventable harm will be reduced to zero, or that the occurrence of healthcare associated infections will be cut in half within a year. Management guru Jim Collins would call these BHAGs – Big Hairy Audacious Goals. They are goals that are at once exciting and scary. They get people interested and motivated. They are the kind of goals that Northern Ireland should be setting for its care system.

If the goal is the destination, strong data are the sat nav. They show the current position in a form that provides useful information for action. Too often, data show where the system was over the last three months, or what performance has been across large units. They need instead to show the situation in real-time, or as near to it as possible. And they need to show performance at the very local level.

As with culture and leadership, data capability is an area that the best care systems in the world have invested in heavily. They have online dashboards that enable all aspects of the system to be measured, understood, and therefore managed. In comparison, Northern Ireland (and many other places) has a care system that is being managed as if through a blindfold. Investment in information technology is crucial and, if done intelligently, will pay dividends.

4.3.4 Standardisation

Doctors generally dislike standardisation (nurses warm to it more), but it is a crucial part of improving the quality and safety of healthcare.

One healthcare standardisation tool is the World Health Organization's Safe Surgery Checklist. Modelled after the checklists that pilots use throughout every flight, it lists a series of simple actions that should be taken before the patient receives anaesthetic, before the operation starts, and before the patient is moved from the operating theatre. Each item on the list is something blatantly obvious – checking the patient's identity, confirming the type of operation that is planned, and so forth. Without the checklist, each of these things is done most of the time – but not all of the time. The checklist ensures that they are done all of the time – to avoid the occasional instance, as happens, in which nobody properly checks the operation type, and the patient has the wrong operation.

Care bundles are a concept that in recent years have brought higher quality to the areas of care where they have been used well. They help clinicians to reliably give every element of best practice treatment for common conditions such as pneumonia. The evidence is clear: they save lives. Without them, patients get best, safest practice only some of the time and those who do not are the unlucky ones who can suffer greatly as a consequence.

Checklists and care bundles are not widespread in healthcare primarily, because they are counter-cultural. Doctors' training, in particular, emphasises the importance of retaining knowledge, of autonomy, and of variation between patients. All of these go against the idea of standardisation.
The concept of standardisation does not just relate to novel methods like checklists or care bundles. It is also concerned with all patients with a particular disease receiving a consistent process of care based on best practice internationally. The idea that people with conditions like bowel or oesophageal cancer should be receiving different treatment based on clinical preference or where they live is a disgrace. Healthcare should not be a lottery.

The best healthcare systems in the world have a high degree of standardisation. Not for everything – but for the areas of care where the evidence shows that it makes a difference. They have a substantial number of care pathways, checklists, and care bundles. This does not leave the clinicians without a job – far from it. Their judgement is vital in deciding which pathway, checklist or care bundle to use, and in spotting the cases in which a standard approach is not appropriate. They still spend the majority of their time working without reference to any of these things, but use them whenever they are needed.

Northern Ireland has some good examples of work in this area, including the rollout of a National Early Warning System for acutely ill patients, a care bundle for sepsis, an insulin passport, and regional chest drain insertion training. However, the opportunity for standardisation is much greater and needs to be applied at a more fundamental level, which influences the model of practice beyond this series of individual initiatives. There is not yet a critical mass of clinicians clamouring for more standardisation. There are multiple examples of different Trusts approaching the same clinical scenario in different ways, and wanting to retain their autonomy to do so. If Northern Ireland wants to be anything like as good on safety, clinical effectiveness and patient experience as the Cleveland Clinic and other centres of excellence, it needs to be more open to big change.

4.3.5 The recipe for success

There is little doubt that quality and safety are not fully embedded in the planning, design and delivery of services in Northern Ireland. More sleep is lost over budgets than about whether patients are treated with dignity and respect, whether outcomes of care are genuinely world class and whether patients are properly protected from harm when they are being cared for.

Four vital, and often superficially treated, ingredients for quality and safety improvement are: clinical leadership, cultural change, data linked to goals, and standardisation. They are highly inter-linked.

The Northern Ireland care system is not seeing the wood for the trees on these ingredients. The *Quality 2020* strategy cites them (and does set some big goals), but they are not held as central and are therefore somewhat lost. They need to be given far more prominence, because they form the bedrock on which all quality and safety improvement is built.

With focused effort, Northern Ireland could: build a cadre of skilled clinical leaders; develop a culture in which quality improvement is second nature; set big goals; establish the information technology systems required to measure quality locally and in real-time; and standardise processes substantially. If the care system makes these activities central to its quality and safety efforts, improvement will follow and will flourish. Without building this bedrock, no other efforts to improve quality and safety will gain any significant purchase.

4.4 EXTRACTING FULL VALUE FROM INCIDENTS AND COMPLAINTS

Most patient safety programmes have at their core a process to capture and analyse errors and accidents that arise during the provision of care. This is based on the long-established premise that only by learning from things that go wrong can similar events be prevented in the future. To some extent, this draws on the experience of other industries that have successfully reduced accidents and risk year-on-year. This thinking has led to the establishment of incident reporting systems in health services across the world, some operating only at the level of healthcare organisations, some encompassing whole countries and some restricting reports to those within one field of medicine (e.g. surgery).

It is not always appreciated that reporting of incidents (which can be voluntary or mandatory) is only one way of assessing harm in the care of patients. Numerous other approaches have been used, including: prospective observation of care processes; trigger tools involving retrospective case note review; expert case note review; Hospital Standardised Mortality Ratios (and similar metrics); and mining electronic hospital databases.

Alongside Northern Ireland's incident reporting systems runs a complaints system. Globally, surveys have consistently shown that what patients want from a complaints system are: an explanation, an apology, and a reassurance that improvements to the service will be made based on their experience. Other jurisdictions have found that the features of a good complaints system are: satisfactory local resolution of the majority of complaints; speedy response times; excellent communication with patients; good record keeping; apologies made in-person by the senior staff involved not on their behalf; accurate monitoring of the numbers and categories of complaint; effective learning at the local and systemic level.

All these systems have a common primary purpose: to improve the quality of care, and to reduce avoidable harm.

4.4.1 Incident reporting elsewhere

Globally, incident reporting systems vary greatly in: the nature of the data captured, the extent of public release of information, whether reporting is voluntary or mandatory, and the depth of investigation undertaken.

Most reporting systems start by defining in general terms what should be reported. Terminology varies; *adverse event, incident, error, untoward incident* are all in common use internationally. The epithet serious can be applied to any of the terms. The largest national system in the world was established in the NHS in England and Wales as a result of the report *An Organisation with a Memory*. From 2004 until recently, it was run by an independent body, the National Patient Safety Agency, and is called the National Reporting and Learning System. NHS staff are encouraged to make an incident report of any situation in which they believe that a patient's safety was compromised.

In this system, a *"patient safety incident"* is defined as *"any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS care."* Reports are first made to a local NHS organisation and then sent in batch returns by the local risk manager to the national level. Staff make a small number of reports electronically directly to the National Reporting and Learning System. The information required covers: demographic and administrative data; the circumstances of occurrence; a categorisation of causation; an assessment of the degree of harm as "no", "low", "moderate", "severe", or "death"; and action taken or planned to investigate or prevent a recurrence. These data are captured in a structured reporting form, but there is also a section of free text where the reporter is asked to describe what happened and why they think it happened. Data are anonymised to remove the names of patients and staff members.

In just over a decade, covering the NHS in England and Wales, nearly 10 million patient safety incidents have accumulated in this database. Since 2012, it has been mandatory to report all cases of severe harm or death. It remains voluntary to report all other levels of harm.

During the period of its existence, the National Patient Safety Agency in England and Wales issued 77 alerts and many other notices about specific risks, most of which had been identified by analysis of patient safety incident reports. New arrangements for issuing alerts are in place following the abolition of the National Patient Safety Agency.

This system of incident reporting in England and Wales holds a huge amount of data but only a small proportion of it is effectively used. It is currently being reviewed and is unlikely to continue in exactly the same way.

Worldwide, the problems associated with incident reporting are remarkably consistent, whatever system design is adopted. Firstly, under-reporting is the norm, although its degree varies. This seems to depend on the prevailing culture and whether incidents are seen as an opportunity to learn or as a basis for enforcing individual accountability and apportioning blame. It also depends on staff perceptions about the difference their report will make and how easy it is for them to convey the information that they are required to. Reporting rates are much lower in primary care services than in hospitals. Secondly, given the volume of reports made, there is often insufficient time, resource and expertise to carry out the depth of analysis required to fully understand why the incident happened. Thirdly, the balance of activity within reporting systems goes on collecting, storing, and analysing data at the expense of using it for successful learning. Indeed, there are relatively few examples worldwide of major and sustained reductions in error and harm resulting because of lessons learnt from reporting.

4.4.2 Incident reporting in Northern Ireland

Incident reporting began in the Northern Ireland health and social care system in 2004. Two categories of incident were established: *an adverse incident and a serious adverse incident.* The former were reported and investigated locally within each Trust. The latter were documented and investigated locally but also had to be reported to the Department of Health, Social Services and Public Safety. Staff make 80,000 to 90,000 adverse incident reports each year. Over 400 Serious Adverse Incident reports were made in 2013. In the five-year period from 2009, the number of Serious Adverse Incidents related to Emergency Departments rose from 8 to 36.

An adverse incident is defined as:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation."

In 2010, major new guidance was issued passing responsibility for managing and further developing the serious adverse incident system to the Health and Social Care Board, where it remains to this day. Further guidance was issued in 2013 with new reporting rules.

To be regarded as a Serious Adverse Incident for reporting purposes, the incident must fall into one of the following categories: the serious injury or unexpected/unexplained death of a service user, staff member or visitor; the death of a child in health or social care; an unexpected serious risk to a service user and/or staff member and/or member of the public; an unexpected or significant threat to service delivery or business continuity; serious self-harm or assault by a service user, staff member, or member of the public within a healthcare facility; serious self-harm or serious assault by any person in the community who has a mental illness or disorder and is in receipt of mental health and/or learning disability services, or has been within the last twelve months; and, any serious incident of public interest.

Any staff member may report an adverse incident. The reporter is not asked to make a judgment about whether the incident meets the serious adverse incident criteria. A responsible manager makes it based on their reading of the incident and application of the guidelines. Any Serious Adverse Incident must be reported to the Health and Social Care Board within 72 hours. A subset of Serious Adverse Incidents must be simultaneously reported to the Health and Social Care Board and the Regulation and Quality Improvement Authority.

Trusts in Northern Ireland differ slightly in the procedure adopted for encouraging, receiving and investigating incident reports. Generally, all staff are encouraged to make reports as a way of making care safer. They complete an incident report and submit it to the Trust's risk management department so that it can be entered into the risk management database. Increasingly, more reports are being made on-line which cuts out the laborious form-filling which is an undoubted barrier to staff making a report and often leads to paper mountains in the risk management department. Trusts vary in the proportion of incidents that they investigate, the depth of that investigation and the extent to which action is agreed and implemented. Clinical governance committees (or their equivalents), sub-committees of the Trust board or the Board itself usually look at a selection of individual incident reports, at aggregated incident data or at both.

The number of Serious Adverse Incidents varies between Trusts (Figure 1). To some extent this reflects their differing number of patients. However, there is no way of knowing at present whether a higher level of incidents means that the organisation is less safe than others or that it is more safe and that its staff are more conscientious in making reports so that learning can improve patient safety. Whilst data are available on Serious Adverse Incident types, the categories and classifications used do not make it easy to aggregate data in a way that enables systemic weaknesses to be identified. Opportunities are therefore being lost for surveillance of patient safety across Northern Ireland.

The vast majority of Serious Adverse Incidents are reported by the five acute Trusts. Much smaller numbers are reported by the ambulance service and by primary care (Figure 2). The number of incidents reported has increased quite substantially from 2013 to 2014 (Figure 3). In part this is because of improved awareness of the reporting system. In part it is because the reporting criteria were changed – most notably, requiring that all child deaths be reported.

Figure 1. Serious Adverse Incident reports: by Trust

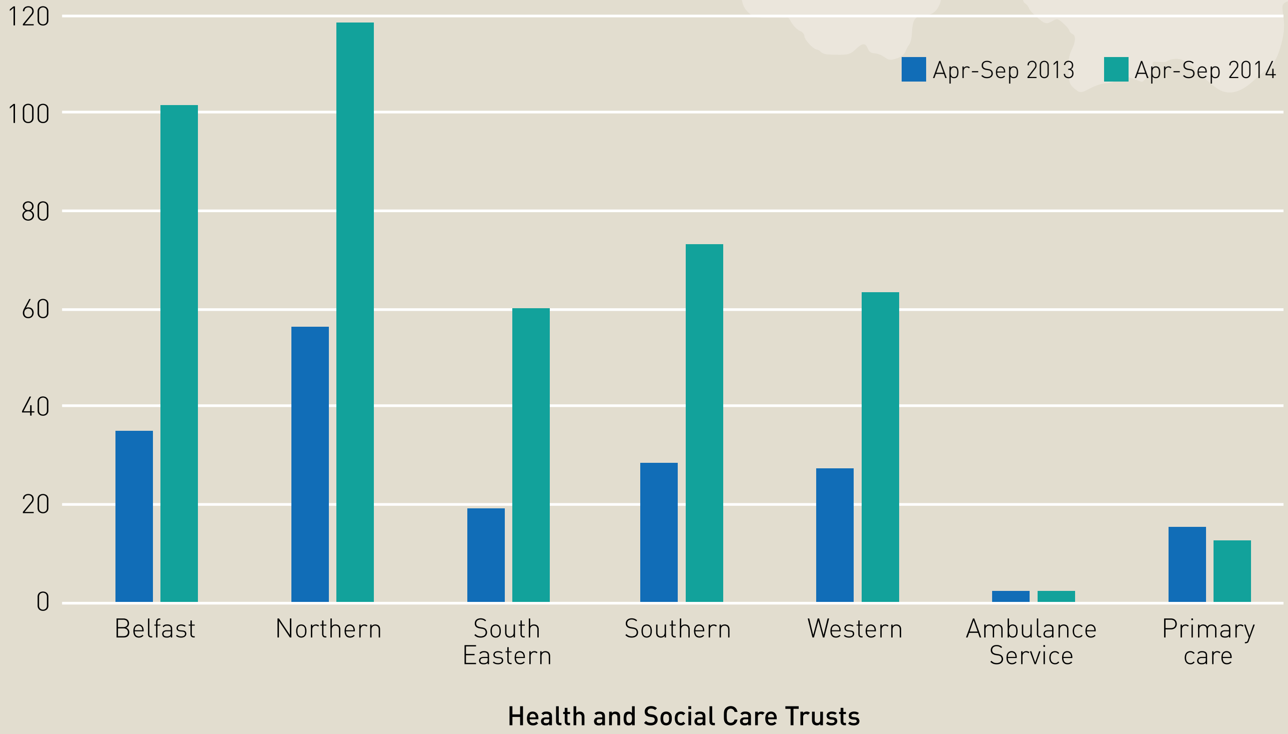
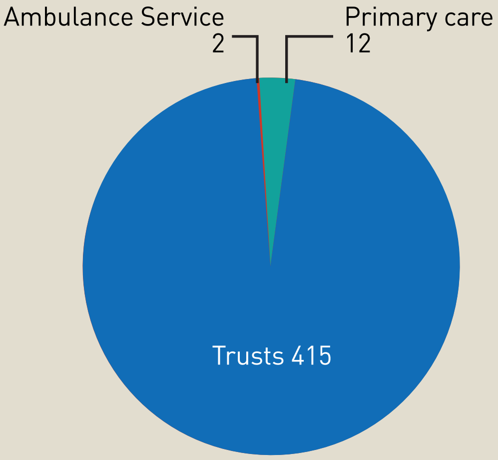
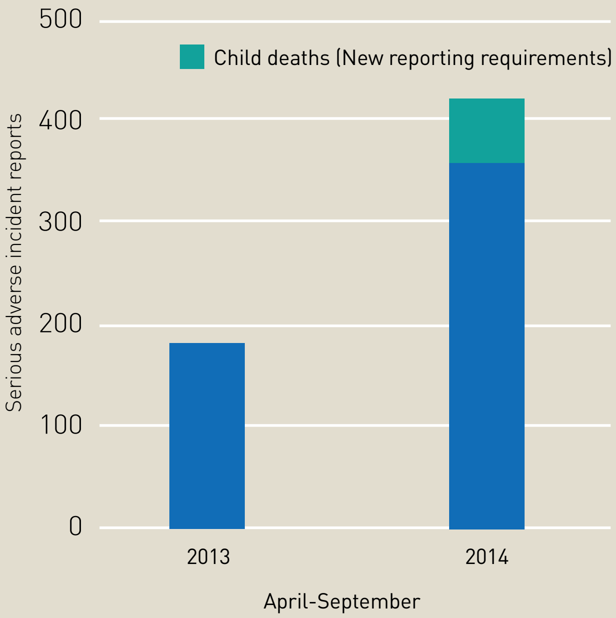


Figure 2. The great majority of Serious Adverse Incident reports are made by the Health & Social Care Trusts



Serious Adverse Incident Reports, Apr-Sept 2014

Figure 3. Serious Adverse Incident reporting increased between 2013 and 2014. Some of the increase was because reporting criteria changed, particularly introducing a requirement to report all child deaths.



All Serious Adverse Incidents are investigated. The type (and therefore intensity) of the investigation should depend on the severity of the incident, its complexity, and the potential to learn from it. Three levels of investigation are stipulated:

- *Level 1* involves a Significant Event Audit – a method of assessing what has happened and why, agreeing follow-up actions, and identifying learning.
- *Level 2* involves a Root Cause Analysis – a more detailed exercise to determine causation and learning, undertaken by a formal investigation team chaired by somebody not involved in the incident.
- *Level 3* involves a full-blown independent investigation.

Most Serious Adverse Incidents start at Level 1 investigation, and may proceed to Level 2 or 3 if the Level 1 investigation suggests that this is necessary or would be useful. A minority start at Level 2 or 3 immediately, bypassing Level 1.

A Designated Review Officer, assigned by the Health and Social Care Board and Public Health Agency, provides independent assurance that an appropriate level of investigation has been chosen, and that it is conducted appropriately.

The process of dealing with Serious Adverse Incidents at the operational level of the service is very involved and highly regulated with little room for flexibility. There are a number of decision-making points at which important judgments must be made by staff on matters such as what level the incident falls into and whether to refer an incident to the coroner.

4.4.3 Frustrations with the incident reporting system

The staff who use the incident reporting system have concerns and frustrations. Firstly, at the policy level, the requirements to report Serious Adverse Incidents places a considerable burden on them to complete forms and meet deadlines, with very little flexibility to deviate from the proscribed procedure. There is an acceptance by staff that it is important to document and investigate Serious Adverse Incidents but the pressure to complete all the steps of the process often means that there is no time to reflect on what can be learned so as to reduce risk for future patients. One of the Serious Adverse Incidents that the Review Team discussed with Trust staff had involved interviews with 34 different people. It was by no means the most complex incident that the Review Team heard about.

There is an almost universal view that the requirement to report and investigate all child deaths in hospital as Serious Adverse Incidents has been a retrograde and damaging policy decision. The consequence of it has been that, if a child dies from a cause such as terminal cancer or a congenital abnormality, a grieving family must be advised that there is to be an investigation. Inevitably, this strongly implies that the service has been at fault. Such an approach is not kind to such families, puts staff in a very difficult position, and diverts attention from the investigation of genuinely avoidable incidents involving the care of children. In a separate aspect of incident policy, many staff working within the mental health field have concerns about the inflexibility of the Serious Adverse Incident scheme as it applies to suicide of their patients. Whilst the time-scales for investigation impose a necessary discipline on the process generally, the range of factors, individuals and agencies that need to be part of the determination of the root causes of the suicide of a mental health patient are very great indeed. The pressure to adhere to statutory deadlines can mean that the work in such cases can sometimes be incomplete and so has limited value in preventing recurrences.

Secondly, at the cultural level, some medical, nursing and social care staff are concerned that, in reporting an adverse incident, they will expose themselves to blame and possible disciplinary action. Junior doctors told the Review Team that making too many reports draws suspicion that they are trouble-makers and that an active interest in patient safety could damage their career prospects. They prefer to make their views on patient safety known through the medical trainee annual survey (Figure 4), where they can remain anonymous.

Figure 4. Percentage of medical trainees reporting concerns about patient safety and the clinical environment

Trust:	Belfast	Northern	South Eastern	Southern	Western
Patient safety	6.5%	6.8%	3.0%	4.7%	3.2%
Clinical environment	2.8%	3.6%	0.8%	1.4%	0.4%
Total	9.3%	10.4%	3.8%	6.0%	3.7%

Source: General Medical Council National Training Survey 2013. Numbers are rounded.

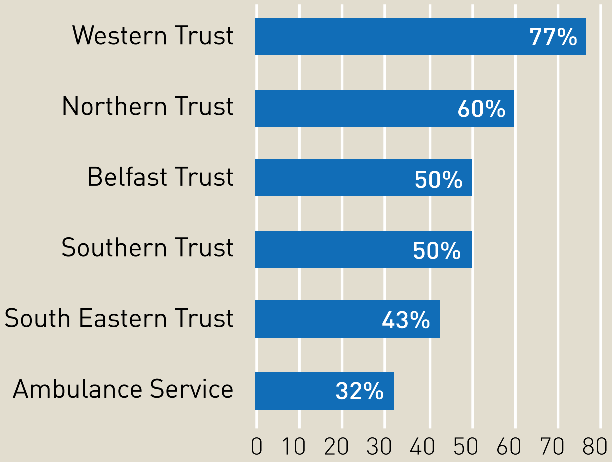
These cultural barriers to reporting and learning are not unique to Northern Ireland. Creating a culture where the normative behavior is learning, not judgment, is very much the responsibility of political leaders, policy-makers, managers and senior clinicians. This does not mean that no-one is ever accountable when something goes wrong but it does mean that a proper regard should be given to the overwhelming evidence that a climate of fear and retribution will cause deaths not prevent them.

Thirdly, at the operational level, staff frustrations with the incident reporting processes range from the very practical, such as not being able to find the form necessary to make the report, to the deeper de-motivating features of the system such as never receiving any feedback or information on the outcome of the report that they had made. Other weaknesses of the process perceived by staff include: having little training in how to investigate properly, reporting an incident then being asked to investigate it yourself, and a tendency for investigations to descend into silos even though there might have been a multi-specialty element to the patient's care.

4.4.4 The complaints system in Northern Ireland

Patients, their carers, and their families can make a complaint about the services received in person, by telephone or in writing. If the complaint concerns the health or social care services delivered by one of the six Trusts in Northern Ireland, a senior officer within the organisation will work with the staff involved in the person's care to investigate and produce a response. A letter from the chief executive officer of the Trust must go to the complainant within 20 working days. However, performance is suboptimal and very variable in this respect (figure 5).

Figure 5. All Trusts are failing to meet the standard 20-day substantive response time for complaints (% meeting standard shown; 2013-14)



The best outcome is for the complaint to be resolved locally to the complainant's complete satisfaction. This is not always possible and if the complainant is not satisfied with the response, the complaint can be re-opened and further investigation can be undertaken or external advice sought. If this still does not resolve the complaint, the complainant can make a submission to the Ombudsman. He will look at whether the process of responding to the complaint was undertaken appropriately. He can also investigate the substance of the complaint but under present legislation, he cannot make these reports public. This bizarre situation means that the public is unaware of where standards have fallen short and what the Ombudsman thinks should be done.

An increasing number of people who have complaints contact The Patient and Client Council asking for help. The Council does not have powers to investigate complaints, only to provide support. Nearly 2000 complainants contacted the Council last year. Many such contacts were from people who had tried to navigate the complaints system alone and had had difficulties. The Patient and Client Council's involvement often helps in facilitating resolution of the complaint, sometimes by arranging meetings of the two sides.

Complaints about primary care are handled somewhat differently. They are raised with the Health and Social Care Board directly. The number of complaints from primary care is lower than might be expected. This may reflect the reluctance of patients to complain about a service that they are totally reliant on.

4.4.5 Involvement of the coroner

Northern Ireland, like elsewhere, is still grappling with a difficult question: what is the appropriate role for the Coroner in the investigation of deaths that may have been caused, at least in part, by patient safety problems? This is not an easy question. It is difficult to create guidance that precisely defines which deaths should be investigated by the coroner and which should not. And Coroner's inquests have major pros and cons.

When somebody dies and their care may have been perceived as poor, some families call for a Coroner's inquest. The positive elements of this are that the Coroner is independent of the health and social care system, has clear legal powers, and is skilled in the investigation of deaths.

On the other hand, conducting an inquest into every Serious Adverse Incident that results in a death would be a resource-intensive undertaking. It also may not result in the most effective learning. Few could honestly say that the courtroom environment does not intimidate them. It is not the easiest place to build a constructive relationship between the clinicians involved in the care of the deceased and the deceased's family. It is not the most conducive environment to open, reflective learning.

In cases of negligence or gross breaches of standards of care, it is very clear that referral to the Coroner is the most appropriate course.

At the other end of the spectrum, in a few cases there is a Serious Adverse Incident at some point during a patient's care and this patient subsequently dies, but the death is entirely unrelated to the incident and so an inquest is really not warranted. In between these two extremes lies a substantial grey area, in which the relative merits of a Coroner's inquest and an internal Serious Adverse Incident investigation are debatable. This is not only the case in Northern Ireland, but across the United Kingdom as a whole (except that Scotland does not have a Coroner).

This is a complex issue. Currently only a subset of the deaths that could be the subject of a Coroner's inquest actually become so. Some are not reported to the coroner's office (largely appropriately, it seems) and some are discussed with the coroner's office but not listed for inquest. In other words, the judgments of clinicians and coroners' officers alike have a substantial bearing on which cases proceed to inquest. The subset of cases that end up in front of a coroner's inquest are also determined as much by family's wishes as by the content of the cases.

To some this may sound shocking but, given the complexity of the issues involved, the status quo is not entirely unreasonable and is in line with practice internationally. But the status quo is certainly not ideal. There is substantial room for improvement, so that the coroner can more optimally contribute to the system's learning.

4.4.6 Redress

The creation of financial, and other new, forms of redress would have to be linked to the handling of complaints, incidents and medical negligence claims in a whole systems manner. This is a highly complex area that was extensively examined in England in the report *Making Amends*. In the end, the central idea of introducing some payments for victims of harm and recipients of poor quality care, as well as potential litigants, was not taken forward. There were sound principles behind the proposals, but there was a leap-in-the-dark element too. Priority was given instead to action to improve the quality and safety of care and to improve responses to complaints. However, one of the other proposals of *Making Amends*, the introduction of a Duty of Candour, is finally being implemented in England. The Review Team considers that priority in Northern Ireland should be given to the areas covered by its recommendations, to making important changes to generate safer higher quality care, rather than embarking on new policies for redress, including financial compensation.

4.4.7 The nature of learning

The whole question of how *learning* takes place in healthcare through the scrutiny and analysis of incident reports or through their investigation has been little debated. Indeed, the term learning itself is very loosely applied in this context. Strictly applied, it would mean acquiring new knowledge from incidents about how harm happens. Yet, the way in which the word learning is repeatedly used in the context of patient safety is more than increasing understanding. It implies that behaviour will change or actions will be taken to prevent future harm. Unfortunately, although there are some exceptions, there is little evidence that major gains in the reduction of harm have been achieved in Northern Ireland or in many other jurisdictions through the so-called learning component of patient safety programmes.

In Northern Ireland, the main formally-identified processes for reducing risk or improving patient safety, aside from action plans derived at Trust level, are:

- the production of learning letters
- the bi-annual Serious Adverse Incident Learning Report
- the circulation of newsletters such as *Learning Matters*
- thematic reviews
- training and learning events

- implementing the recommendations of reviews and inquiries
- disseminating alerts and guidance imported from other parts of the United Kingdom or further afield.

On many, perhaps most, occasions when something goes wrong, the potential for learning from this is very rich indeed. This potential too often goes unrealised. This is a problem not just in Northern Ireland, but in care systems worldwide.

Three features determine the extent to which investigation of an adverse event results in risk being reduced:

- How deep the investigation gets, in understanding the true systemic issues that helped something go wrong
- How systemic the investigation's focus is, in considering where else a similar problem could have occurred beyond the local context in which it did occur
- How strong the corrective actions are in actually, and sustainably, reducing the risk of a repeat

The first of these, depth of investigation, is done reasonably well. A decade ago, harm was often put down to 'human error'. There is now far greater recognition that this is a superficial interpretation – that there are almost always problems within the system which not only allowed that harm to occur but made it more likely. The technique of root cause analysis is widely used in Northern Ireland, and helps to uncover some of the causal elements. Often, though, it does not find the deeper reasons. This is partly because of the time pressures to finish the investigation, partly because not all staff have had the necessary training to do this deeper analysis, and partly because of a lack of human factors expertise in the process. Also, many hospital incidents involve primary care in the chain of possible causation, yet primary care staff play a minor, or no, role in many investigations.

In relation to the systemic view, when a problem occurs, there is too great a tendency to investigate that specific problem, without looking for the broader systemic issues that it highlights. Problems are often addressed in the department where they occur, without asking whether they could have occurred in other departments, for example. Similarly, if a medication incident occurs, there is a tendency to fix the problem for that medication, without looking at whether there is a problem for similar medication or routes of administration.

This narrow, reactive approach fails to make full use of incident reports. In short, it reflects an erroneous assumption that the system as a whole is working fine, and that the problems that allowed the event to occur are specific, local ones. This is not the case. There are systemic problems through the health and social care system. Incidents of harm are distributed largely by chance – by location and by type. Fixing each specific problem is like playing "Whack-A-Mole" – it does not get to the nub of the issues.

The ultimate aim of investigation is to reduce the risk of harm, not simply to understand what went wrong. Corrective action is too often inadequate. There is no automatic link between understanding what went wrong and being able to reduce the risk of it happening again. Indeed, making the leap between investigation and risk reduction is really very challenging.

In Northern Ireland, the action lists that are generated by Serious Adverse Incident investigation commonly feature plans of the following kinds:

- Making staff aware that the incident took place
- Explaining to staff what went wrong
- Circulating a written description of the incident and actions taken to other parts of the health and social care system to share the learning

Such information sharing actions should form part of the plan but they do not amount to systemic measures that will reliably and significantly reduce the risk to patients.

Research and experience outside health care has shown that safety comes down to appreciating that big improvements are not made by telling people to take care but by understanding the conditions that provoke error.

Action plans often also feature some change to current paperwork or introduction of new documentation. This, too, is very reasonable but often has a weak impact on outcomes. It also has the important downside that mounting paperwork reduces the time for patient care and introduces complications of its own.

So what do strong corrective actions look like? Technological solutions have an important role to play. Electronic prescribing systems, patient monitoring systems, and shared care records can address multiple patient safety issues simultaneously (although their implementation and use is not without risk). Policies, rules, and checklists can also be useful, but are easy to implement badly and more difficult to implement well.

As discussed earlier in this Report, one area of high potential is the use of standardisation of procedure. It is underutilised in healthcare worldwide but where it is applied it has brought results. Standardisation of procedure is a mainstay of safety assurance and improvement in other sectors.

In large part, though, healthcare systems worldwide are not yet good at implementing solutions that will truly reduce risk. It is not the case that Northern Ireland is lagging behind – but that Northern Ireland is struggling with this problem alongside other countries.

Identifying the systemic issues and identifying strong corrective actions: each of these is tough; an art and a science in itself; an area in need of intense and rigorous study. Until these issues are tackled head on, in Northern Ireland and elsewhere, the system's learning when things go wrong will fall short.

When something goes wrong, patients and families ask for reassurance that it will not happen again. As it stands, nobody can honestly provide this reassurance. In fact, it is difficult even to say that the risk has been significantly reduced – let alone to zero. This needs to change.

4.4.8 Strengths and weaknesses of Northern Ireland's systems for incident reporting and learning

No system of reporting and analysing patient safety incidents is perfect. In an ideal world, all events and occurrences in a health service that caused harm or had the potential to cause harm would be quickly recognised by alert, knowledgeable front-line staff who would carefully document and communicate their concern. They would be enthusiastic about their involvement in this activity because they would have seen many examples of how such reports improved the safety of care. The resulting investigation would be impartial and multi-disciplinary, involving expertise from relevant clinical specialties but, crucially, also from other non-health disciplines that successfully contribute to accident reduction in other fields of safety. Investigation would be carried out in an atmosphere of trust where blame and retribution were absent, and disciplinary action or criminal sanctions would only be taken in appropriate and rare circumstances. Action resulting from investigation would lead to re-design of processes of care, products, procedures and changes to the working practices and styles of individuals and teams. Such actions would usually lead to measurable and sustained reduction of risk for future patients. Some types of harm would be eliminated entirely.

Very few, if any, health services in the world could come anywhere near to this ideal level of performance in capturing and learning from incidents of avoidable harm. This is so for all sorts of reasons ranging from an insufficiency of leaders skilled and passionate enough to engage their whole workforces on a quest to make care safer, through an inability to investigate properly the volume of reports generated, to the weak evidence-base on how to reduce harm.

The system of adverse incident reporting in Northern Ireland operates to highly-specified processes to which providers of health and social care must adhere. The main emphasis is on the Serious Adverse Incidents. The requirements laid down for reporting, documenting and investigating such incidents together with the rules for communicating about them and formulating action plans to prevent recurrence have created an approach that has strengths and weaknesses (Figure 6). In general, the mandatory nature of reporting means that there is likely to be less under-reporting than in many other jurisdictions. However, staff in Trusts must exercise judgment on whether to classify occurrences of harm as Serious Adverse Incidents. Whether they always make the right decision has not been formally evaluated. The Review did not find any evidence of suppression or cover-up of cases of serious harm.

Figure 6. Serious Adverse Incident reporting system in Northern Ireland: Strengths and weaknesses

Dimension	Strengths	Weaknesses
Accountability	Absolute requirement to report and investigate	Creates some fear and defensiveness
Coverage	Relatively high for serious outcomes	Less attention given to incidents with lower harm levels
Timescales	Clear deadlines for investigation and communication	Pressure to meet deadlines leaves little time for reflection
Investigation	Reasonable depth with frequent root cause analysis	Quality variable and little use of human factors expertise
Staff engagement	All appear to understand the importance of reporting	Do not often see the reports translating into safer care
Patient and family involvement	Requirement to communicate reinforced by checklist	Often creates tension and little ongoing engagement
Learning	Specified action plan required in every case	Not clear whether action is effective in reducing future risk

Tight time-scales are laid down for the various stages of handling a Serious Adverse Incident. These generally add a necessary discipline to a process that in other places can become protracted or drift off-track. There is a need, though, for some flexibility where an investigation requires more time. This is particularly so in the mental health field where the avoidable factors in a death can be very complex and are only discernible after interviewing very many people.

It is important to recognise that, whilst almost all of the experience and research literature is about patient safety, Northern Ireland has an integrated health and social care system. Social care in the United Kingdom has its own traditions in recognising, investigating and learning from episodes of serious harm involving those who use its services; the fields of child protection and mental health exemplify this. It is not entirely straightforward to integrate incidents in social care into the overall patient safety approach but the essential principles and concepts are little different.

The Northern Ireland health service falls short of the ideal just as do most other parts of the United Kingdom and many other places in the world. In all of these places, including Northern Ireland, patients are dying and suffering injuries and disabilities from poorly designed and executed care on a scale that would be totally unacceptable in any other high-risk industry.

The Northern Ireland approach to incident reporting and learning does not make its services any less safe than most of the rest of the United Kingdom or many other parts of the world. However, this should not be a reason for comfort, nor a cause for satisfaction.

The current requirement for all child deaths to be reported and managed as serious adverse incidents seems to be doing far more harm than good. It is distressing for families, burdensome for staff, and is not producing useful learning.

The ethos of improving safety by learning from incident investigations needs to shift:

- Away from actions that only make a difference in the particular unit where the incident occurred, towards actions that also make a difference across the whole of Northern Ireland
- Away from actions that only target that particular incident, towards actions that also reduce the risk of many related incidents occurring
- Away from weak actions such as informing staff, training staff and updating policies, towards stronger actions of improving systems and processes
- Away from long lists of actions, towards smaller numbers of high-impact actions

Less attention has been given in Northern Ireland to adverse incidents that do not meet the definition of a Serious Adverse Incident. They are reported, analysed and acted upon at Trust level. Only exceptionally are they considered centrally. The numbers are much greater so the logistics of analysing more would be considerable. However, there is much to be learned from situations when something went wrong in a patient's care but they did not die or suffer serious harm.

4.5 THE BENEFITS AND CHALLENGES OF BEING OPEN

The health and social care system aspires to a 'no blame' culture, or a 'just' culture, in which staff can be open without fear of inappropriate reprisal. In reality, this is not the culture that currently exists. This is not primarily the fault of those delivering health and social care.

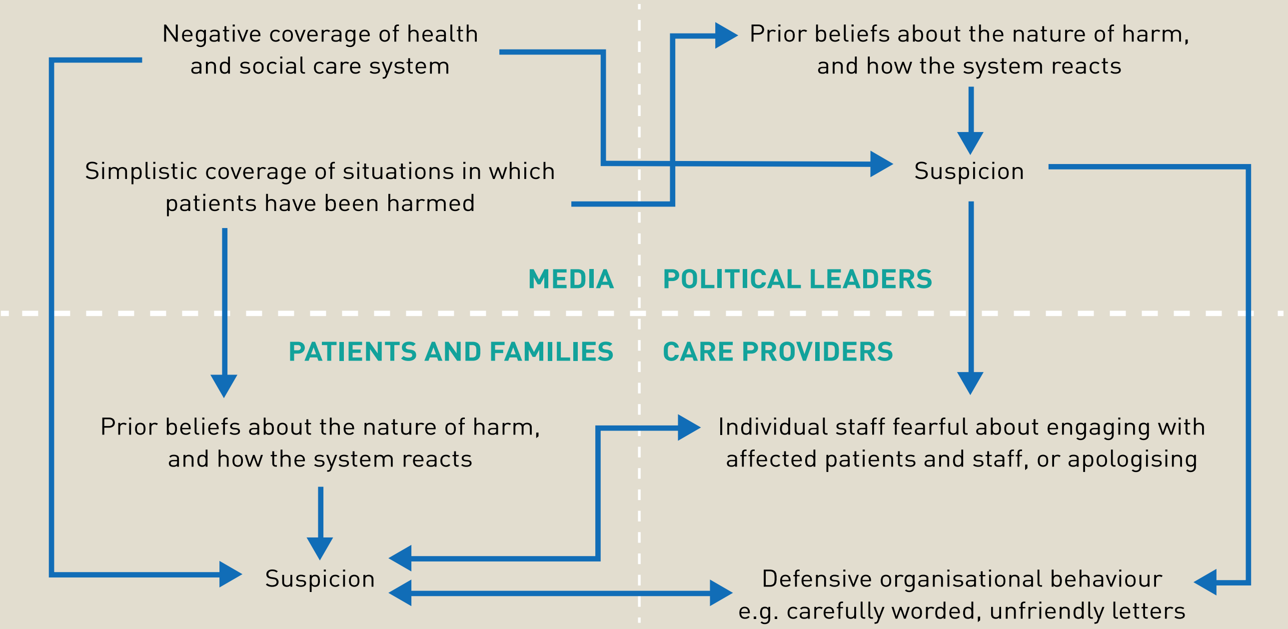
Openness is not something that can simply be demanded. It needs the right conditions in order to flourish. The enemy of openness is fear.

When something goes wrong, many patients' and families' first reaction is to want to know who is to blame. The situation often escalates, with the media coverage and political pressure that the detail of the story generates. In an ideal world, leaders of the system should be able to step in to paint a proper picture of the background to these complex events, and to build public understanding that few are a simple case of incompetence and carelessness. Instead, to remove the heat from the situation, approaches are announced that may not be the most effective way to achieve learning. On top of this, day-by-day the media portrays health and social care in a mainly negative light. There has been one inquiry after another. These are conditions conducive to blame and fear, not to transparency and openness.

Despite these adverse conditions, the Review Team found front-line staff willing to talk about problems, and to be open with families and patients when things go wrong. There is a willingness to be open – but there is blame, and there is fear.

Northern Ireland needs to increase the degree of openness and transparency in talking about harm, and decrease the degree of blame and fear. The responsibility cannot lie solely within the health and social care system. They are complex cycles.

Figure 7. The vicious cycle of suspicion and fear



Openness and transparency, blame and fear: these are multi-dimensional issues that cannot be improved directly by legislation, rules or procedures alone. As this Report has made clear, Northern Ireland is far from unique.

4.5.1 Governance arrangements to promote openness

Promoting openness and avoiding fear is about culture. Responsibility for this sits with many people, within and beyond the health and social care system. Governance may sound like a blunt tool and, used alone, it would be. But alongside other approaches, appropriate governance arrangements can promote openness and dispel fear.

The Serious Adverse Incident process currently requires Trusts to inform affected patients (or families) that their care is the subject of investigation. In general, they are invited to provide input and are provided with a copy of the investigation report. A checklist has been introduced to prompt investigators to take these steps. This is commendable, and represents a basic, but important, degree of openness with patients and families.

The nature of the involvement with patients and families in the aftermath of a Serious Adverse Incident cannot be shaped by a checklist alone. The Review Team heard from each of the Trusts how they handled this aspect of the policy. It is clear that this is a difficult area to get right. Early contact with the family in the event of a death is important but could come at a time when funeral arrangements are being made and perceived as intrusive or insensitive. The bureaucracy of the procedure can create an official feeling that opens up distance in the relationship with the family. It is important that staff in the Trust have the skill, experience and credibility to communicate with a family. It is helpful to have staff who deal with this situation regularly and have good inter-personal and counselling skills. They should be there with the clinical staff who may encounter the situation less frequently. Experience from elsewhere suggests that regular contact with the patient and family is important, not just a couple of one-off meetings with long silences in between. In the best services, the patient and family are fully involved in the process of learning and action-planning. Where this happens, it is empowering for everyone. This is only happening to a limited extent in Northern Ireland currently.

The Serious Adverse Incident process is also overseen by a Designated Review Officer within the Public Health Agency. This is also a welcome feature of the system although there is potential for these officers, or their function, to play a more substantial role.

Every Trust has appropriate arrangements for Serious Adverse Incidents to be discussed within the departments affected. The fact that these conversations are taking place usefully promotes a culture in which talking about harm becomes easier, and openness becomes the norm.

Every Trust also has arrangements for organisation-level oversight of this process. In most, this responsibility sits with a sub-committee of the Trust board. This too is good practice.

When something goes wrong, there is a tendency for the Department of Health, Social Services and Public Safety to deal directly with the Trust's Executive Team, bypassing the board. This happens partly from expediency – because the executive directors are present full-time, and are therefore available to take an urgent phone call from an official concerned about briefing the minister. But it serves to diminish the role of the board, and misses opportunities to build the board's familiarity with these issues and capability in dealing with them.

There is great concern and depth of feeling amongst staff in the system who have attempted to uncover poor standards of care and been denigrated. Their role as whistleblowers has placed them in an even more isolated position. This unsatisfactory situation needs to be resolved.

4.5.2 Perceptions of openness

The Serious Adverse Incident guidelines include some requirements intended to help openness and transparency. A recent look-back exercise, quality controlled by the Regulation and Quality Improvement Authority, suggests that patients and families are being appropriately informed when a Serious Adverse Incident occurs. This creates a substantially higher degree of openness than is the case in many countries worldwide. In the main, the Trust staff who are leading the investigation are willing to spend time meeting with patients and families.

However, several features of the investigation process too often give patients and families an adverse impression:

- The investigation process is frequently delayed beyond the stipulated timeline, and patients and families experience delays in getting responses to calls and emails. Such delays make people start to wonder, "what is going on?"
- When the investigation process starts, the degree of openness and transparency that the patient and/or family feel they are seeing is highly dependent on the communication skills of the Trust staff that they meet with. Some staff are highly skilled in these potentially difficult meetings; others are not.
- Standard practice is for patients and families to meet with the manager and/or clinician leading the investigation, and not to be asked whom else they would like to meet with. Many, for example, would find it helpful to meet with the staff directly involved in the incident, to put their questions directly, but this is not routinely offered. Such meetings have the potential to be intensely difficult; to be very useful if they go well, but harmful if they go badly.

4.5.3 Duty of candour

In 2003, the head of the Review Team (as Chief Medical Officer for England) issued a consultation paper, *Making Amends*, which set out proposals for reforming the approach to clinical negligence in the NHS. One key recommendation was that a duty of candour should be introduced.

As long ago as 1987 Sir John Donaldson (no relation), who was then Master of the Rolls, said "I personally think that in professional negligence cases, and in particular in medical negligence cases, there is a duty of candour resting on the professional man". There was, at the time of the *Making Amends* report, no binding decision of the courts on whether such a duty exists.

In November 2014, the General Medical Council and the Nursing & Midwifery Council issued a joint consultation document proposing the introduction of a professional duty of candour. Such a duty will give statutory force to the General Medical Council's Code of Good Medical Practice for doctors.

In the concomitant healthcare organisational measures introduced in England, a new "Duty of Candour" scheme will mean that hospitals are required to disclose information about incidents that caused harm to patients, and to provide an apology.

In Northern Ireland, it is already a requirement to disclose to patients if their care has been the subject of a Serious Adverse Incident report. There is no similar requirement for adverse incidents that do not cause the more severe degrees of harm. In promoting a culture of openness, there would be considerable advantages in Northern Ireland taking a lead and introducing an organisational duty of candour to match the duty that doctors and nurses are likely to come under from their professional regulators.

4.6 THE VOICES OF PATIENTS, CLIENTS AND FAMILIES ARE TOO MUTED

The best services in the world today give major priority to involving patients and families across the whole range of their activities, from board-level policy making, to design of care processes, to quality improvement efforts, to evaluation of services, to working on reducing risk to patients as part of patient safety programmes.

At the heart of the traditional approach to assessing whether a service is responsive to its patients and the public are surveys of patient experience and attitudes. This is still a very important part of modern health and social care. In many major centres whose services are highly rated, such surveys are regularly carried out and used to judge performance at the organisational, service and individual practitioner level, as well as, in some cases, being linked to financial incentives. Indeed, in the United States system, observers say that it was not until surveys of patient experience were linked to dollars that it was taken seriously. This is not a prominent feature of the Northern Ireland system, although there is some very good practice, for example the 10,000 Voices initiative, which has so far drawn on the experience of over 6,000 patients and led to new pathways of care in pain management, caring for children in Emergency Departments, and generally focusing on the areas of dignity and respect.

Looked at from first principles, the kind of questions a user, or potential user, of a service could legitimately require an answer to would include:

How quickly will I first be seen, how quickly will I get a diagnosis and how quickly will I receive definitive treatment?

If my condition is potentially life-threatening, will the local service give me the best odds of survival or could I do better elsewhere?

Will each member of staff I encounter be competent and up-to-date in treating my condition and how will I know that they are?

Does the service have a low level of complications for treatment like mine compared to other services?

How likely am I to be harmed by the care that I receive and what measures does the service take to prevent it?

If I am unhappy with a care-provider's response to a complaint about my care, will the substance of it be looked at by people who are genuinely independent?

Which particular service elsewhere in the United Kingdom, and other parts of the world, achieves the best outcome for someone like me with my condition? How close will my outcome be to that gold standard?

Very few of these questions could be answered reliably in Northern Ireland and other parts of the United Kingdom.

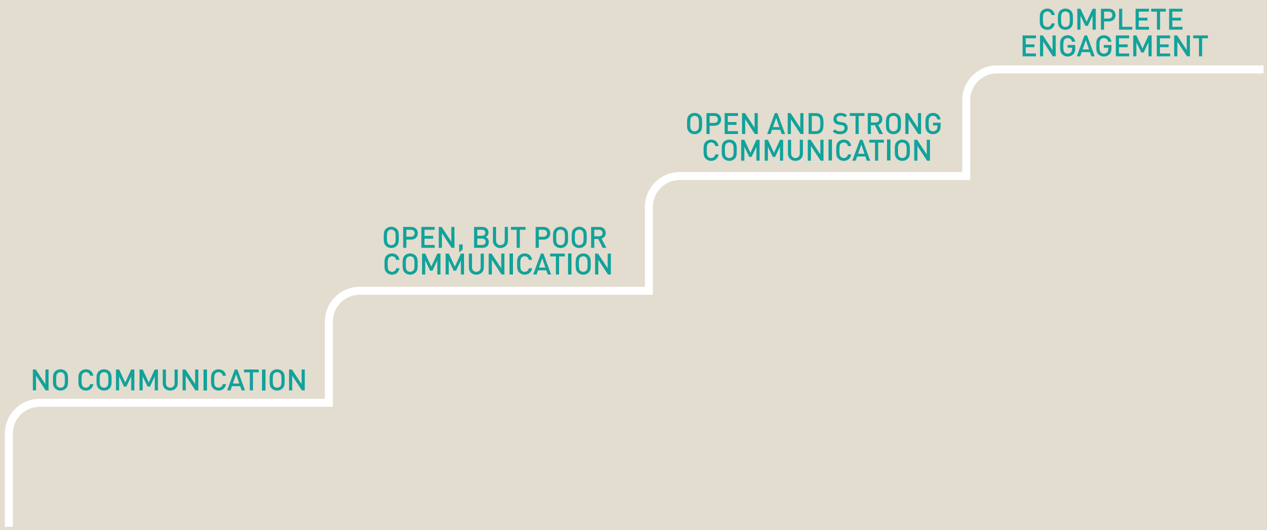
There are many potential themes for patient and family engagement in health and social care, for example:

- in shaping and designing services
- in measuring the quality of care
- in setting standards for consultation
- in shared decision-making
- in self-care of chronic diseases
- in preventing harm
- in giving feedback on practitioner performance

Few services do all of these, some only scratch the surface of genuine involvement, others do a few well. Overall, the Northern Ireland care system is engaged in some of these areas but certainly not in an organised and coherent way.

The terms of reference of the Review put particlar emphasis on harm. Globally, there is a spectrum in how well health and social care systems interact with patients, clients and families when things go wrong (figure 8). The ideal approach is to engage patients and families completely in the process of learning. They often find this hugely beneficial, because it allows them to play an active part in reducing the risk for future patients. It is also immensely powerful for staff, to hear patients' stories first-hand and to work with them to improve things.

Figure 8. Levels of engagement with patients and families when something goes wrong



Northern Ireland should aim for level three as an absolute minimum, but strive for level four.

The system is too often falling down to level two because:

- Staff who communicate with patients and families during the Serious Adverse Incident investigation process have variable communication skills – some are excellent, but some are less good. Little formal effort has been made to train staff to manage these difficult interactions well.
- Patients and families are often not offered the opportunity to meet with those who they would like to – the staff directly involved in the incident. Instead, they tend to meet with managers, and with clinicians who were not involved.
- There are frequently delays in the process of investigating a Serious Adverse Incident.
- Patients and families are too often sent letters filled with technical jargon and legalese.

When something goes wrong, the harm itself is intensely difficult for patients and families. Poor communication compounds this enormously.

5 CONCLUSIONS

5.1 RELATIVE SAFETY OF THE NORTHERN IRELAND CARE SYSTEM

5.1.1 There is some perception amongst politicians, the press and the public that Northern Ireland's health and social care system:

- Has fundamental safety problems that are not seen elsewhere
- Is less safe than other parts of the United Kingdom, or comparable countries
- Suffers from lack of transparency, a tendency to cover-up, and an adverse culture more broadly.

5.1.2 The Review found no evidence of deep-seated problems of this kind. Northern Ireland is likely to be no more or less safe than any other part of the United Kingdom, or indeed any comparable country globally.

5.1.3 This does not mean that safety can be disregarded, because it is clear from reading the incident reports and accounts of patients' experience that people are being harmed by unsafe care in Northern Ireland, as they are elsewhere. Northern Ireland, like every modern health and social care system, must do all it can to make its patients and clients safer.

5.2 PROBLEMS GENERATED BY THE DESIGN OF THE HEALTH AND SOCIAL CARE SYSTEM

5.2.1 There are longstanding, structural elements of the Northern Ireland care system that fundamentally damage its quality and safety. The present configuration of health facilities serving rural and semi-rural populations in Northern Ireland is not fit for purpose and those who resist change or campaign for the status quo are perpetuating an ossified model of care that acts against the interests of patients and denies many 21st Century standards of care. Many acutely-ill patients in Northern Ireland do not get the same standard of care on a Sunday at 4 am as they would receive on a Wednesday at 4 pm and, therefore, a two-tier service is operating. It may be that local politics means that there is no hope of more modern care for future patients and if so this is a very sad position.

5.2.2 The design of a system to provide comprehensive, high quality, safe, care to a relatively small population like Northern Ireland's needs much more careful thought. This applies to almost all aspects of design including: the role of commissioning, the structuring of provision, the relationship between primary, secondary and social care, the distribution of facilities geographically, the funding flows, the place of regulation, the monitoring of performance, and the use of incentives. Nowhere is the old adage: "I would not start from here" truer than in the Northern Ireland care system today.

5.2.3 There is widespread uncertainty about who is in overall charge of the system in Northern Ireland. In statutory terms, the Permanent Secretary in the Department of Health, Social Services and Public Safety is chief executive of the health and social care system but how this role is delivered from a policy-making position is not widely understood or visible enough.

5.2.4 In the specific domain of quality and safety itself, whilst it is reflected in the goals and activities of boards and senior management teams in Northern Ireland, it is not yet fully embedded with the commitment and purpose to make a real difference. The Review was most impressed with the work of the South Eastern Trust in this regard. The Review Team could not assess each Trust in depth, but its judgment on the South Eastern Trust is backed up, for example, by the national survey of trainee doctors.

5.3 FOCUS ON QUALITY AND SAFETY IMPROVEMENT

5.3.1 *Quality 2020* is a ten-year strategy with a bold vision – that the health and social care system should "be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care". Three years on, there is good evidence of the strategy being implemented. An influential steering group oversees the work.

5.3.2 The Review Team judged that *Quality 2020* represents a strong set of objectives, and that there is clear evidence of extensive work and of some successes in implementation. However, this does not amount to quality and safety improvement being given the primacy of focus that it needs, and Northern Ireland is not seeing the wood for the trees about the need to establish crucial aspects of quality and safety improvement which are not well represented at present: clinical leadership, cultural change, data linked to goals, and standardisation.

5.4 THE EXTENT TO WHICH SERIOUS ADVERSE INCIDENT REPORTING IMPROVES SAFETY

5.4.1 The system of Serious Adverse Incident reporting in Northern Ireland has been an important way to ensure that the most severe forms of harm that are inadvertently caused by care processes are recognised and investigated.

5.4.2 The Serious Adverse Incident process fulfils five main purposes:

- a public accountability function
- a response to the patients and families involved
- a communications alert route
- a barometer of risk within health and social care
- a foundation for learning and improvement

5.4.3 The kinds of incidents reported into this system appear little different to other parts of the United Kingdom and are similar to many other parts of Europe, North America and Australasia. Many harmful events are potentially avoidable and the human cost to patients and families in Northern Ireland is of grave concern, as it is in other jurisdictions.

5.4.4 Good practice elsewhere in the world suggests that patients who suffer harm and their families should be fully informed about what has happened, how it happened and what will be done to prevent another similar occurrence. More than this, they should be fully engaged in working with the organisation to make change. Patient and family engagement is a good and established feature of Serious Adverse Incident reporting in Northern Ireland but it often falls short of this fully engaged scenario. The extent to which it is valued and trusted by patients and families appears to vary, depending on the staff communicating with them.

5.4.5 The design for the specification, and recording, of information on each Serious Adverse Incident is sub-optimal particularly in gathering appropriate information on causation; this hinders aggregation of data to monitor trends and assess the impact of interventions.

5.4.6 The process for investigating Serious Adverse Incidents is clearly set out and involves root cause analysis-type methods. In many cases, it lacks sufficient depth in key areas such as human factors analysis. The degree of oversight by supervisory officials (the Designated Review Officers) is variable in extent and timeliness. Local health and social care staff generally approach the task of investigation conscientiously but many lack the training and experience to reach a standard of international best practice in unequivocally identifying the cause and specifying the actionable learning. They get little expert help and guidance in undertaking this activity.

5.4.7 The most important test of the capability of a patient safety incident reporting system is its effectiveness in reducing future harm of the kind that is being reported to it. Unfortunately, there are few places around the world where there is a powerful flow of learning that moves from identifying instances of avoidable harm, through understanding why they did or could happen, to successful elimination of the risk for future patients. Northern Ireland is no exception to this regrettable state of affairs.

5.4.8 There are two main levels of learning from Serious Adverse Incidents in Northern Ireland. The first is local. The lack of a consistently high standard of investigation and action-planning are barriers to effective risk-reduction within health and social care organisations. Another barrier is the limited degree to which front-line staff are involved in discussing and seeking solutions to things that have gone wrong. Experience elsewhere suggests that this practical and intellectual engagement, if well-led, often sparks great interest and commitment to patient safety amongst front-line staff. This is not really happening in Northern Ireland at present, for a number of reasons. Firstly, staff do not have the time and space to do it and the leadership of Trusts is not consistently creating and facilitating such opportunities. The Regulation and Quality Improvement Authority has established training in Root Cause Analysis for front-line staff, and this will help. Secondly, the specified rules of the Serious Adverse Incident system mean that Trusts are under a great deal of pressure to meet the time-scales laid down and are often dealing with many such cases simultaneously. As a result, the activity is too often slipping into an incident management role or worse a necessary chore that 'feeds the beast'.

5.4.9 The second level of learning is across the Northern Ireland health and social care system as a whole. The main role is played by the Health and Social Care Board working with the Public Health Agency (and the Regulation and Quality Improvement Authority where appropriate). These bodies have established a multi-disciplinary Quality Safety and Experience Group that undertakes much of the work in assessing patterns, trends and concerns arising from the analysis of locally-generated Serious Adverse Incidents and deciding what action needs to be taken on a Northern Ireland-wide basis. It does so by issuing learning letters, reports, guidance, newsletters and other specified action that the service needs to take. This is a valuable function from which considerable action aimed at improvement has flowed. Experience of improving patient safety elsewhere has shown that specifying action on a particular safety problem is not the same thing as implementing the change required. The latter is often much more difficult and depends on factors such as the systems, culture, attitudes, local priorities and leadership in the organisation receiving the action note. In the Northern Ireland care system more skill needs to be added to the implementation process. This is closely linked to the difficulties that arise when local services feel overloaded with central guidance and requirements for action. They only have enough management and clinical leadership capacity to implement a small number of changes at a time.

5.4.10 General practitioners, and others in primary care, report their Serious Adverse Incidents directly to the Health and Social Care Board, not through any of the Trusts. Levels of reporting of patient safety incidents in primary care services around the world are very low and much less is known about the kinds of harm that arise in this setting compared to hospitals. It is not surprising that the same is so in Northern Ireland. Another aspect of the primary care dimension is that many of the incidents that the Review discussed with the Trusts in Northern Ireland had a primary care element in the key areas of the care processes that had failed, yet general practitioners seemed to be less frequently involved in the investigation and planning of remedial action.

5.4.11 There are two particular aspects of the criteria for Serious Adverse Incident reporting in Northern Ireland that are not working in the best interests of a successful system. Firstly, the requirement that every death of a child in receipt of health and social care should automatically become a Serious Adverse Incident is causing major problems. A proportion of such deaths every month are due to natural causes. Some of the conditions concerned - for example, terminal cancer and serious congenital abnormalities - are particularly harrowing for the parents. After the death of a child, in such circumstances, for a family to be told that their child's death has been categorised as a Serious Adverse Incident carries the clear implication that the quality or safety of care was poor and at fault or even that the death could have been avoided. This can be enormously distressing for families and is grueling for staff. It is cruel, unnecessary and liable to undermine public confidence in children's services.

5.4.12 Secondly, using the same time-scales for investigating Serious Adverse Incidents in mental health as in in other fields of care is also causing major problems. The complexity of many mental health cases, the long past history of many such patients and clients, and the number of people and organisations who may be able to contribute relevant information to the investigation mean that a longer period is necessarily required to get to the truth than is currently permitted.

5.4.13 Overall, the system of Serious Adverse Incident reporting in Northern Ireland, in comparison to best practice, scores highly on securing accountability, reasonably highly on the level of reporting, does moderately well on meaningful engagement with patients and families, and is weak in producing effective, sustained reduction in risk. Also, the climate of accountability and intense political and media scrutiny does not sit easily with what best practice has repeatedly shown is the key to making care safer: a climate of learning not judgment.

5.4.14 The Review concluded that front-line clinical staff are insufficiently supported to fulfill the role of assessing and improving the quality and safety of the care that they and their teams provide. The lack of time, the paucity of reliable, well-presented data, the absence of in-service training in quality improvement methods, and the patchiness of clinical leadership are all major barriers to achieving this vital shift to mass clinical engagement.

5.5 OPENNESS WITH PATIENTS AND FAMILIES

5.5.1 The Serious Adverse Incident investigation system contains, in the view of the Review Team, sufficient checks and balances to ensure that affected patients and families are informed that something went wrong, except in exceptional circumstances.

5.5.2 Such mechanisms are part of good governance, but alone are insufficient. It will be culture – not accountability – that increases the reporting of harm, and staff's comfort in talking openly about harm.

5.5.3 Those conducting investigations are committed to rigorous investigation, and to being open with patients and families about what is found. But whilst some communicate well in person and in writing, others are less strong. This can come across to families as a lack of openness.

5.5.4 High-profile inquiries and negative media coverage have led some to believe that there is widespread cover-up of harm in the health and social care system. This is simply inconsistent with what the Review Team observed, which was a system trying, as many others in the world are, to get to grips with the difficult problem of patient safety.

5.5.5 Fear and suspicion powerfully inhibit openness. The health and social care system needs to rise to the challenge of tackling these threats head on. Perception is important – even simple delays and communication weaknesses can fuel suspicion. And if staff hear more from the media than direct from their leaders, this does not dispel fear.

6 RECOMMENDATIONS

Recommendation 1:
Coming together for world-class care

A proportion of poor quality, unsafe care occurs because local hospital facilities in some parts of Northern Ireland cannot provide the level and standard of care required to meet patients' needs 24 hours a day, 7 days a week. Proposals to close local hospitals tend to be met with public outrage, but this would be turned on its head if it were properly explained that people were trading a degree of geographical inconvenience against life and death. Finding a solution should be above political self-interest.

We recommend that all political parties and the public accept in advance the recommendations of an impartial international panel of experts who should be commissioned to deliver to the Northern Ireland population the configuration of health and social care services commensurate with ensuring world-class standards of care.

Recommendation 2:
Strengthened commissioning

The provision of health and social care in Northern Ireland is planned and funded through a process of commissioning that is currently tightly centrally-controlled and based on a crude method of resource allocation. This seems to have evolved without proper thought as to what would be most effective and efficient for a population as small as Northern Ireland's. Although commissioning may seem like a behind-the-scenes management black box that the public do not need to know about, quality of the commissioning process is a major determinant of the quality of care that people ultimately receive.

We recommend that the commissioning system in Northern Ireland should be re-designed to make it simpler and more capable of reshaping services for the future. A choice must be made to adopt a more sophisticated tariff system, or to change the funding flow model altogether.

Recommendation 3:
Transforming Your Care – action not words

The demands on hospital services in Northern Ireland are excessive and not sustainable. This is a phenomenon that is occurring in other parts of the United Kingdom. Although triggered by multiple factors, much of it has to do with the increasing levels of frailty and multiple chronic diseases amongst older people together with too many people using the hospital emergency department as their first port of call for minor illness. High-pressure hospital environments are dangerous to patients and highly stressful for staff. The policy document Transforming Your Care contains many of the right ideas for developing high quality alternatives to hospital care but few believe it will ever be implemented or that the necessary funding will flow to it. Damaging cynicism is becoming widespread.

We recommend that a new costed, timetabled implementation plan for *Transforming Your Care* should be produced quickly. We further recommend that two projects with the potential to reduce the demand on hospital beds should be launched immediately: the first, to create a greatly expanded role for pharmacists; the second, to expand the role of paramedics in pre-hospital care. Good work has already taken place in these areas and more is planned, but both offer substantial untapped potential, particularly if front-line creativity can be harnessed. We hope that the initiatives would have high-level leadership to ensure that all elements of the system play their part.

Recommendation 4:
Self-management of chronic disease

Many people in Northern Ireland are spending years of their lives with one or more chronic diseases. How these are managed determines how long they will live, whether they will continue to work, what disabling complications they will develop, and the quality of their life. Too many such people are passive recipients of care. They are defined by their illness and not as people. Priority tends to go to some diseases, like cancer and diabetes, and not to others where provision remains inadequate and fragmented. Quality of care, outcome and patient experience vary greatly. Initiatives elsewhere show that if people are given the skills to manage their own condition they are empowered, feel in control and make much more effective use of services.

We recommend that a programme should be established to give people with long-term illnesses the skills to manage their own conditions. The programme should be properly organised with a small full-time coordinating staff. It should develop metrics to ensure that quality, outcomes and experience are properly monitored. It should be piloted in one disease area to begin with. It should be overseen by the Long Term Conditions Alliance.

Recommendation 5:
Better regulation

The regulation of care is a very important part of assuring standards, quality and safety in many other jurisdictions. For example, the Care Quality Commission has a very prominent role in the inspection and registration of healthcare providers in England. In the USA, the Joint Commission's role in accreditation means that no hospital wants to fall below the standards set or it will lose reputation and patients. The Review Team was puzzled that the regulator in Northern Ireland, the Regulation and Quality Improvement Authority, was not mentioned spontaneously in most of the discussions with other groups and organisations. The Authority has a greater role in social care than in health care. It does not register, or really regulate, the Trusts that provide the majority of healthcare and a lot of social care. This light-touch role seems very out of keeping with the positioning of health regulators elsewhere that play a much wider role and help support public accountability. The Minister for Health, Social Services and Patient Safety has already asked that the regulator start unannounced inspections of acute hospitals from 2015, but these plans are relatively limited in extent.

We recommend that the regulatory function is more fully developed on the healthcare side of services in Northern Ireland. Routine inspections, some unannounced, should take place focusing on the areas of patient safety, clinical effectiveness, patient experience, clinical governance arrangements, and leadership. We suggest that extending the role of the Regulation and Quality Improvement Authority is tested against the option of outsourcing this function (for example, to Healthcare Improvement Scotland, the Scottish regulator). The latter option would take account of the relatively small size of Northern Ireland and bring in good opportunities for benchmarking. We further recommend that the Regulation and Quality Improvement Authority should review the current policy on whistleblowing and provide advice to the Minister.

Recommendation 6: Making incident reports really count

The system of incident reporting within health and social care in Northern Ireland is an important element of the framework for assuring and improving the safety of care of patients and clients. The way in which it works is falling well below its potential for the many reasons explained in this report. Most importantly, the scale of successful reduction of risk flowing from analysis and investigation of incidents is too small.

We recommend that the system of Serious Adverse Incident and Adverse Incident reporting should be retained with the following modifications:

- **deaths of children from natural causes should not be classified as Serious Adverse Incidents;**
- **there should be consultation with those working in the mental health field to make sensible changes to the rules and time-scales for investigating incidents involving the care of mental health patients;**
- **a clear policy and some re-shaping of the system of Adverse Incident reporting should be introduced so that the lessons emanating from cases of less serious harm can be used for systemic strengthening (the Review Team strongly warns against uncritical adoption of the National Reporting and Learning System for England and Wales that has serious weaknesses);**
- **a duty of candour should be introduced in Northern Ireland consistent with similar action in other parts of the United Kingdom;**
- **a limited list of Never Events should be created**
- **a portal for patients to make incident reports should be created and publicised**
- **other proposed modifications and developments should be considered in the context of Recommendation 7.**

Recommendation 7: A beacon of excellence in patient safety

There is currently a complex interweaving of responsibilities for patient safety amongst the central bodies responsible for the health and social care system in Northern Ireland. The Department of Health, Social Services and Public Safety, the Health and Social Care Board, and the Regulation and Quality Improvement Authority all play a part in: receiving Serious Adverse Incident Reports, analysing them, over-riding local judgments on designation of incidents, requiring and overseeing investigation, auditing action, summarising learning, monitoring progress, issuing alerts, summoning-in outside experts, establishing inquiries, checking-up on implementation of inquiry reports, declaring priorities for action, and various other functions. The respective roles of the Health and Social Care Board and the Public Health Agency are clearly specified in legal regulations but seem very odd to the outsider. The Health and Social Care Board has no full-time officers of its own who lead on quality and safety and no in-house medical or nursing director. These functions are grafted on from the Public Health Agency. The individuals concerned have done some excellent work on quality and patient safety and carry out their roles very conscientiously. However, symbolically, and on grounds of organisational coherence, it appears strange that the main body responsible for planning and securing care does not hold these functions in the heart of its business. The Department of Health, Social Services and Public Safety's role on paper is limited to policy-making but, in practice, steps in regularly on various aspects of quality and safety. The Review Team thought long and hard before making a recommendation in this area. In the end, we believe action is imperative for two reasons: firstly, the present central arrangements are byzantine and confusing; secondly, the overwhelming need is for development of the present system to make it much more successful in bringing about improvement. Currently, almost all the activities *(including those listed above) are orientated to performance management not development. There is a big space for a creative, positive and enhancing role.*

We recommend the establishment of a Northern Ireland Institute for Patient Safety, whose functions would include:

- **carrying out analyses of reported incidents, in aggregate, to identify systemic weaknesses and scope for improvement;**
- **improving the reporting process to address under-reporting and introducing modern technology to make it easier for staff to report, and to facilitate analysis;**
- **instigating periodic audits of Serious Adverse Incidents to ensure that all appropriate cases are being referred to the Coroner;**
- **facilitating the investigation of Serious Adverse Incidents to enhance understanding of their causation;**
- **bringing wider scientific disciplines such as human factors, design and technology into the formulation of solutions to problems identified through analysis of incidents;**
- **developing valid metrics to monitor progress and compare performance in patient safety;**
- **analysing adverse incidents on a sampling basis to enhance learning from less severe events;**
- **giving front-line staff skills in recognising sources of unsafe care and the improvement tools to reduce risks;**
- **fully engaging with patients and families to involve them as champions in the Northern Ireland patient safety program, including curating a library of patient stories for use in educational and staff induction programmes;**
- **creating a cadre of leaders in patient safety across the whole health and social care system;**
- **initiating a major programme to build safety resilience into the health and social care system.**

Recommendation 8: System-wide data and goals

The Northern Ireland Health and Social Care system has no consistent method for the regular assessment of its performance on quality and safety at regional-level, Trust-level, clinical service-level, and individual doctor-level. This is in contrast to the best systems in the world. The Review Team is familiar with the Cleveland Clinic. That service operates by managing and rewarding performance based on clinically-relevant metrics covering areas of safety, quality and patient experience. This is strongly linked to standard pathways of care where outcome is variable or where there are high risks in a process.

We recommend the establishment of a small number of systems metrics that can be aggregated and disaggregated from the regional level down to individual service level for the Northern Ireland health and social care system. The measures should be those used in validated programmes in North America (where there is a much longer tradition of doing this) so that regular benchmarking can take place. We further recommend that a clinical leadership academy is established in Northern Ireland and that all clinical staff pass through it.

Recommendation 9:
Moving to the forefront of new technology

The potential for information and digital technology to revolutionise healthcare is enormous. Its impact on some of the long-standing quality and safety problems of health systems around the world is already becoming evident in leading edge organisations. These developments include: the electronic medical record, electronic prescribing systems for medication, automated monitoring of acutely-ill patients, robotic surgery, smartphone applications to manage workload in hospitals at night, near-patient diagnostics in primary care, simulation training, incident reporting and analysis on mobile devices, extraction of real-time information to assess and monitor service performance, advanced telemedicine, and even smart kitchens and talking walls in dwellings adapted for people with dementia. There is no organised approach to seeking out and making maximum use of technology in the Northern Ireland care system. It could make a big difference in resolving some of the problems described in this report. There is evidence of individual Trusts making their own way forward on some technological fronts, but this uncoordinated development is inappropriate - the size of Northern Ireland is such that there should be one clear, unified approach.

We recommend that a small Technology Hub is established to identify the best technological innovations that are enhancing the quality and safety of care around the world and to make proposals for adoption in Northern Ireland. It is important that this idea is developed carefully. The Technology Hub should not deal primarily with hardware and software companies that are selling products. The emphasis should be on identifying technologies that are in established use, delivering proven benefits, and are highly valued by management and clinical staff in the organisations concerned. They should be replicable at Northern Ireland-scale. The overall aim of this recommendation is to put the Northern Ireland health and social care system in a position where it has the best technology and innovation from all corners of the world and is recognised as the most advanced in Europe.

Recommendation 10: A much stronger patient voice

In the last decade, policy-makers in health and social care systems around the world have given increasing emphasis to the role of patients and family members in the wider aspects of planning and delivering services. External reviews – such as the Berwick Report in England - have expressed concern that patients and families are not empowered in the system. Various approaches have been taken worldwide to address concerns like these. Sometimes this has been through system features such as choice and personally-held budgets, sometimes through greater engagement in fields like incident investigation, sometimes through user experience surveys and focus groups, and sometimes through direct involvement in the governance structures of institutions. In the USA, patient experience data now forms part of the way that hospitals are paid and in some it determines part of the remuneration of individuals. This change catalysed the centrality of patients to the healthcare system in swathes of North America. Observers say that the big difference was when dollars were linked to the voice of patients. Northern Ireland has done some good work in the field of patient engagement, in particular the requirement to involve patients and families in Serious Adverse Incident investigation, the 10,000 voices initiative, in the field of mental health and in many aspects of social care. Looked at in the round, though patients and families have a much weaker voice in shaping the delivery and improvement of care than is the case in the best healthcare systems of the world.

We recommend a number of measures to strengthen the patient voice:

- **more independence should be introduced into the complaints process; whilst all efforts should be made to resolve a complaint locally, patients or their families should be able to refer their complaint to an independent service. This would look again at the substance of the complaint, and use its good offices to bring the parties together to seek resolution. The Ombudsman would be the third stage and it is hoped that changes to legislation would allow his reports to be made public;**
- **the board of the Patients and Client Council should be reconstituted to include a higher proportion of current or former patients or clients of the Northern Ireland health and social care system;**
- **the Patients and Client Council should have a revised constitution making it more independent;**
- **the organisations representing patients and clients with chronic diseases in Northern Ireland should be given a more powerful and formal role within the commissioning process, the precise mechanism to be determined by the Department of Health, Social Services and Public Safety;**
- **one of the validated patient experience surveys used by the Centers for Medicare and Medicaid Services in the USA (with minor modification to the Northern Ireland context) to rate hospitals and allocate resources should be carried out annually in Northern Ireland; the resulting data should be used to improve services, and assess progress. Finally and importantly, the survey results should be used in the funding formula for resource allocation to organisations and as part of the remuneration of staff (the mechanisms to be devised and piloted by the Department of Health, Social Services, and Public Safety).**

In implementing the above recommendations, the leaders of the Northern Ireland health and social care system should be clear in their ambition, which is in our view realistic, of making Northern Ireland a world leader in the quality and safety of its care. Northern Ireland is the right place for such a transformation, and now is the right time.

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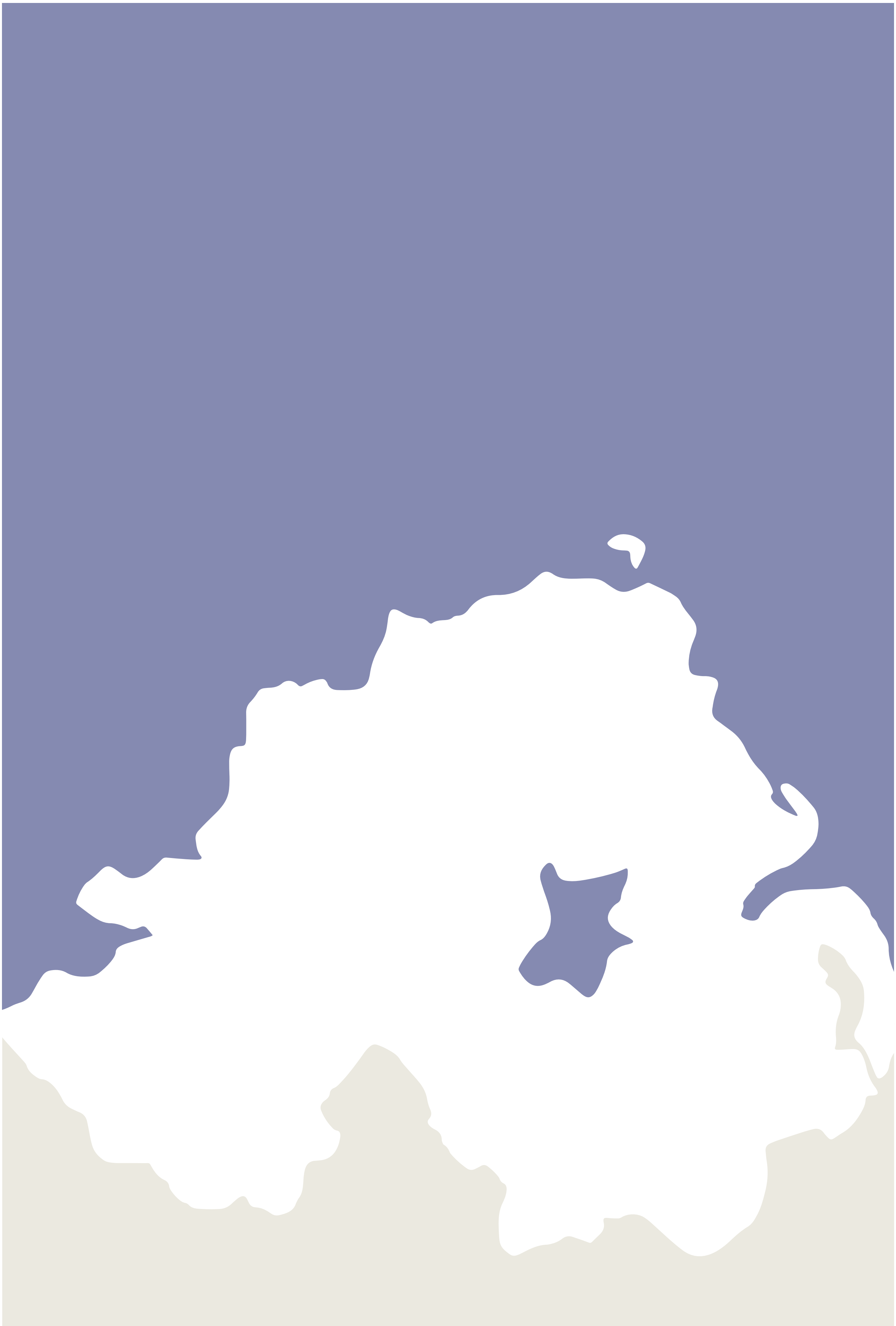

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REVIEW OF HSC COMMISSIONING ARRANGEMENTS

FINAL REPORT – OCTOBER 2015

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LIST OF ABBREVIATIONS

BSO	Business Services Organisation
CCGs	Clinical commissioning groups (NHS England)
DfP	Department for Finance and Personnel NI
DHSSPS	Department of Health, Social Services and Public Safety NI ('the Department')
FPS	Family Practitioner Services
HSC	Health and Social Care
HSCB	Health and Social Care Board
ICPs	Integrated Care Partnerships
IPTs	Investment Proposal Templates
LCGs	Local Commissioning Groups
NIGPC	Northern Ireland GP Committee (British Medical Association NI)
OECD	Organisation for Economic Cooperation and Development
PCTs	Primary Care Trusts (NHS England)
PHA	Public Health Agency
RPA	Review of Public Administration
RQIA	Regulation and Quality Improvement Authority
SBAs	Service and Budget Agreements
TDPs	Trust Delivery Plans
TYC	*Transforming Your Care*

CHAPTER 1 – INTRODUCTION AND CONTEXT

The Review of Commissioning

Commissioning in the context of health and social care can be defined as the process of securing the provision of services to meet the needs of a population. This encompasses assessing a population's health and social care needs, planning services to meet these needs, working with providers of services to agree the services to be delivered, monitoring delivery of services against agreed standards, and evaluating the impact of the services that have been commissioned (DHSSPS, 2011).

The current arrangements for Health and Social Care (HSC) commissioning in Northern Ireland were established in 2009, following the Review of Public Administration (RPA). Six years on from their establishment the Department of Health, Social Services and Public Safety (DHSSPS) has undertaken a review of the commissioning process.

This review was prompted by the need to assess whether the structures used to ensure the delivery of health and social care services in Northern Ireland remain the most appropriate ones. The review can be set in the context of:

- the need to ensure continued improvements in the health and wellbeing of the population and address health inequalities;
- the need to ensure continued improvements in the quality, safety and value of health and social care services;
- rising demand, resulting from an older population and the growth of chronic diseases;
- financial pressures set by both the constrained fiscal environment and rising demand;
- the increasing pace of technological change;
- as a result of these pressures, ongoing challenges in meeting key performance targets across the HSC.

Sir Liam Donaldson's review of the quality of health and social care provision in Northern Ireland also highlighted concerns about the effectiveness of the current arrangements in Northern Ireland. In response to the recommendation that the commissioning system should be redesigned, the then Minister initiated a review of commissioning arrangements in Northern Ireland. The Terms of Reference are included at Appendix 1. The review commenced in May 2015.

Review Arrangements

The review was led by DHSSPS. A project steering group was established to provide leadership and direction to the review. This group was chaired by the DHSSPS Permanent Secretary and included members of the Department's Top Management Group, the Chief Executive of the Health and Social Care Board (HSCB), the Chief Executive of the Public Health Agency (PHA) and a representative of the six HSC Trust Chief Executives. The review was carried out by a small project team, comprising Departmental officials and experienced commissioners from the HSCB and PHA.

Expert advice and guidance to the review was provided by Derek Feeley, Executive Vice President of the Institute for Healthcare Improvement, and Tony Hunter, Chief Executive of the Social Care Institute for Excellence.

Inputs to the review

In undertaking this review the project team carried out a series of interviews with a wide range of stakeholders. In all, more than 50 interviews were conducted including with senior officials in the Department, the HSCB and PHA; the Chair and a non-executive Director from both the HSCB and PHA; members of Local Commissioning Groups (LCGs) and Integrated Care Partnerships (ICPs); Chief Executives and senior executives from the HSC Trusts; the Patient and Client Council; professional bodies, including a number of Royal Colleges; and representatives from the voluntary and community sector. Written contributions to the review were invited from a number of other government departments, district councils, trade unions and other bodies that it was not possible for us to meet in the time available. A full list of meetings and written submissions is provided at Appendix 2.

Views in this report have not been attributed to individuals, given the importance of ensuring open and honest dialogue. Each meeting that we had and submission that we considered added value and helped to challenge our thinking – all those we met with were extremely generous with their time.

The review also considered a wide range of inputs, including:

- responses to the consultation on Sir Liam Donaldson's report;
- a stocktake undertaken by the HSCB, with support from Ernst and Young, of their commissioning approach;
- a draft case study on health and social care commissioning in Northern Ireland, produced by the OECD as part of its wider review of public sector reform;
- a literature review commissioned by DHSSPS from Ulster University, considering evidence for the effectiveness of alternative models for planning and resourcing health and social care services in other UK countries and internationally;
- input from the HSCB and PHA outlining their approaches to commissioning, providing case studies and key facts/ statistics; and
- relevant research papers and previous reviews, as detailed in the bibliography accompanying this report.

Review of Public Administration

Prior to RPA, health and social care services in Northern Ireland were commissioned by four Health and Social Services Boards and provided by 18 Health and Personal Social Services Trusts and one Ambulance Service Trust. The Northern Ireland Executive launched the RPA in June 2002 with a view to putting in place modern, accountable and effective arrangements for public service delivery. Within health and social care, there were two major phases for implementation of the RPA changes -

the establishment of the 5 new integrated HSC Trusts and the retention of the NI Ambulance Trust as providers of services, with effect from 1 April 2007; and the establishment of the HSCB and PHA on 1 April 2009.

In arriving at the final form of the current structures, various options were considered. One of these was to move away from separate commissioner and provider functions, and instead combine both functions in a number of sub-regional health agencies. However, this option was ultimately rejected on the basis that it may have lacked the tension that was perceived as necessary to bring about improvements in performance and productivity. Instead, a decision was taken to retain a commissioner/ provider split through the establishment of a regional commissioning function. It was initially proposed that a Strategic Health and Social Services Authority should be established that would have responsibility for commissioning, performance management and health promotion, along with five HSC Trusts and one Ambulance Service Trust as providers of services.

However, following the restoration of the devolved Assembly in 2007 the then Health Minister outlined concerns that the planned regional Authority would be too cumbersome and add unnecessary bureaucracy. Instead, in 2008 the Minister announced plans to establish a smaller regional HSC Board with no more than 400 staff, to focus on commissioning, financial management and performance management; five local commissioning groups (coterminous with HSC Trusts) to assess the needs of local populations and commission services to meet these needs; and the establishment of a new regional Public Health Agency to focus on health improvement, health protection, and to provide public health support to commissioning.

Aims and Goals of the NI Health and Social Care System

The Department’s statutory responsibility is to promote an integrated system of health and social care designed to secure improvement in:

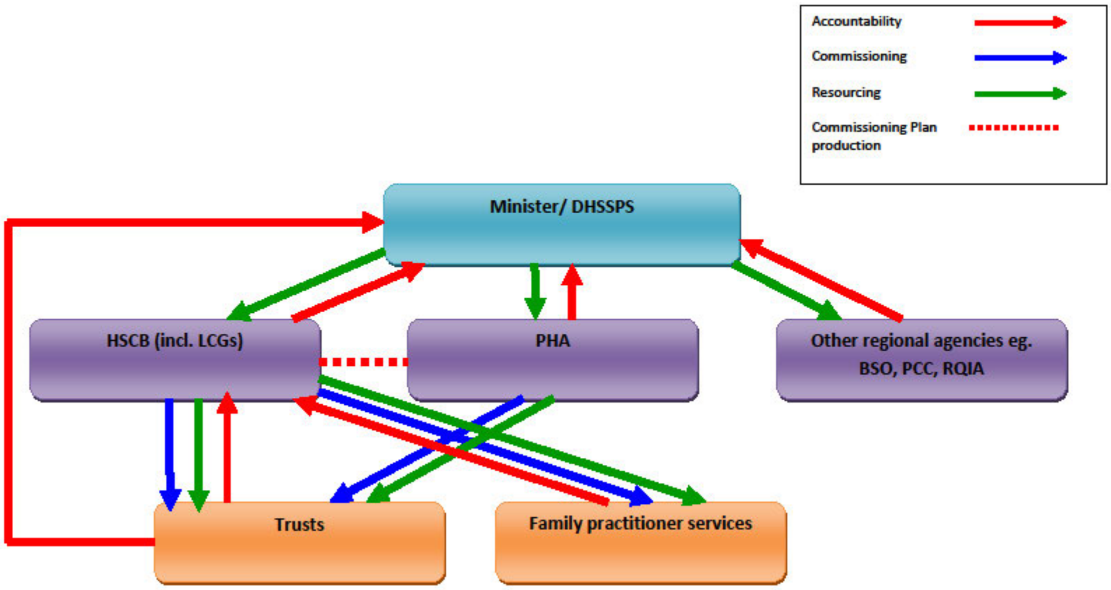
- the physical and mental health of people in Northern Ireland;
- the prevention, diagnosis and treatment of illness; and
- the social wellbeing of the people in Northern Ireland.

These responsibilities are carried out by direct departmental action and through the Department's arm's length bodies. The following are the Department's key strategic priorities:

- to improve and protect population health and wellbeing, and reduce health inequalities;
- to provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient satisfaction; and
- to ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.

Current Health and Social Care Structures

This current structure of the Northern Ireland HSC, along with the lines of accountability and funding flows between the different organisations, is represented in the following diagram:



The roles and responsibilities of the various HSC bodies, along with their relationships with each other and the Department, are set out in a Framework Document (DHSSPS, 2011) and are summarised below.

HSC Board

The HSCB, including five LCGs as sub-committees of the Board, is responsible for commissioning health and social care services to meet the needs of the population of Northern Ireland; managing the performance of HSC Trusts; acting as the named authority for the for the discharge of a range of delegated statutory functions including those specified under the Children (Northern Ireland) Order 1995; and ensuring the best possible use of resources of the health and social care system.

In discharging its commissioning function, the HSCB is required to produce an annual commissioning plan, in full consultation and agreement with the PHA, in response to a Commissioning Plan Direction issued by the Department. This process is intended to ensure the translation of the strategic objectives, priorities and standards set by the Department into a range of high quality, accessible health and social care services and general improvement in public health and wellbeing.

The Department has retained responsibilities for HSC pay, terms and conditions, workforce planning, estate management and asset management. This division of responsibilities requires the HSCB, PHA, Trusts and Department to work closely to ensure services which are to be commissioned can be delivered within the resources available.

Public Health Agency

The PHA - through its input to the commissioning process, by securing the provision of specific public health programmes, and by supporting research and development initiatives – is responsible for improving and protecting the health and social wellbeing of, and reducing health inequalities between, people in Northern Ireland.

The HSCB is required to consult with the PHA in the development of the annual commissioning plan and cannot publish the plan unless it has been approved by the PHA.

HSC Trusts

HSC Trusts are the main providers of the health and social care services commissioned by the HSCB. The HSCB agrees Service and Budget Agreements (SBAs) with HSC Trusts, which detail the services to be provided and associated volumes, costs and outcomes, and individual Trust Delivery Plans (TDPs) which set out what Trusts will achieve, how they will meet Ministerial targets and standards, and the resources that they will use in delivering services. In addition to agreeing SBAs and TDPs, individual service developments may be subject to the completion of Investment Proposal Templates (IPTs).

Monitoring Trust performance against the agreed objectives and targets, along with the financial break-even requirement, is the responsibility of the HSCB. In discharging this responsibility, the HSCB is required to work with the PHA, particularly where activity relates to the key priorities and targets of the PHA. In addition to performance monitoring, the HSCB and PHA will also work together to support Trusts on improving performance.

In addition to the lines of accountability between Trusts and the HSCB, Trust Chairs and Chief Executives are also accountable to the Minister and DHSSPS, reflecting the accountability arrangements between a parent Department and its arm’s length bodies.

Family Practitioner Services

Family Practitioner Services (FPS) – that is GPs, dentists, community pharmacists and opticians - are central to the health and social care system. Family practitioners and those who work with them in extended primary care teams act as the first point of contact for patients and service users and as a gateway to a wider variety of services across the HSC. The HSCB manages the various contracts with family practitioners, not only in terms of pay and performance monitoring but also in terms of quality improvement, adherence to standards and delivery of departmental policy. The HSCB is accountable to the Department for the proper management of FPS budgets. The PHA also commissions a range of health improvement services from FPS.

Commissioning Arrangements

As set out in the Department's 2011 Framework Document, the purpose of HSC commissioning is to improve and protect the health and social wellbeing of the people of Northern Ireland and reduce inequalities in access to good health and quality of life. Commissioning aims to achieve a progressive improvement in services through investment based on evidence of effectiveness, compliance with quality and efficiency standards and a focus on addressing the determinants of poor health and wellbeing. The involvement of public, patients, clients, carers and communities and engagement with other partners has a central role in the commissioning process.

The Department sets the policy and legislative context for health and social care in Northern Ireland. It also determines the standards and targets by which quality, access and outcomes should be measured and provides the strategic direction for the health and social care professions therefore ensuring that quality, safety and patient experience are considered the drivers in commissioning and service provision.

The commissioning process, which includes resource and performance management and is led by the HSCB working with the PHA, aims to translate the agenda set by the Department into a comprehensive, integrated commissioning plan for health and social care services.

The Commissioning Cycle

Commissioning includes the following activities:

i assessing the health and social wellbeing needs of groups, populations and communities of interest;

ii prioritising needs and investments within available resources;

iii building the capacity of the population to improve their own health and social wellbeing by partnership working on the determinants of health and social wellbeing in local areas;

iv engaging with the public/patients/clients/carers/families and other key stakeholders and service providers at local and regional level in planning health and social care services to meet current and emerging needs;

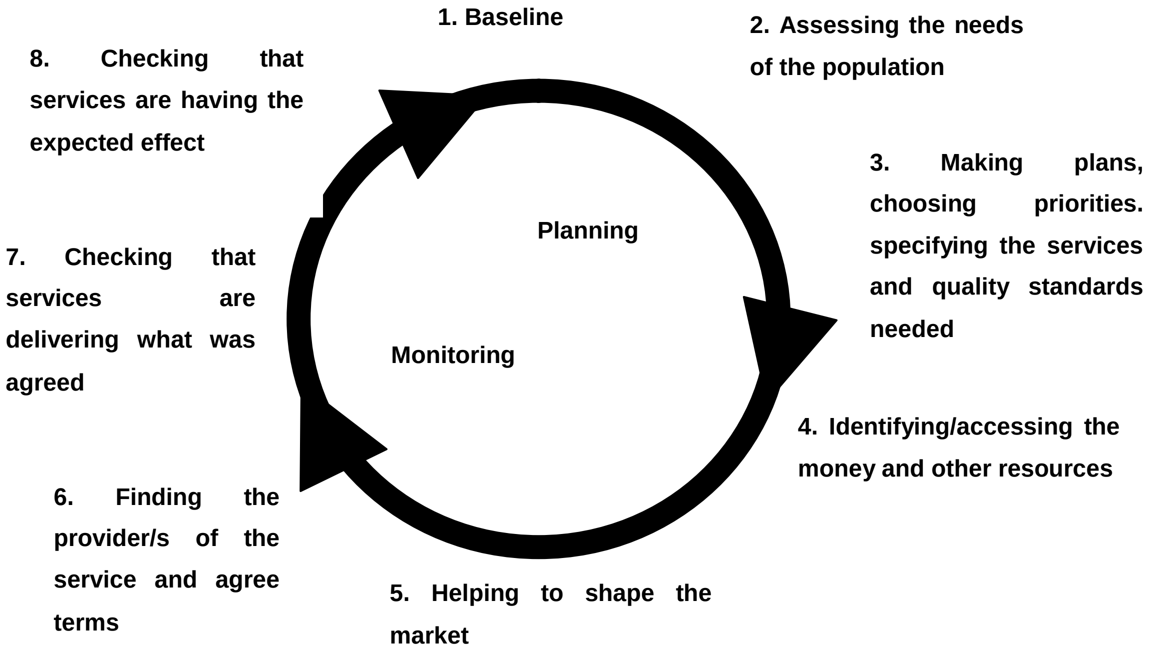
v engaging with clinical and social care staff, service managers and providers to design and reform services;

vi securing, through SBAs, the delivery of value for money services that meet standards and service frameworks for safe, effective, high quality care;

vii safeguarding the vulnerable; and

viii using investment, performance management and other initiatives to develop and reform services.

In the context of Northern Ireland's integrated health and social care system commissioning should be seen as a cyclical process involving the full range of health and care services and needs, as set out in the diagram below. Activities are organised around a commissioning cycle that moves through from assessing needs, strategic planning, priority setting, securing resources to address needs, agreeing with providers the delivery of appropriate services, monitoring that delivery, evaluating impact and feeding back that assessment into the new baseline position in terms of how needs have changed.



In delivering on its role as Commissioner the HSCB (and PHA) also needs to facilitate a more integrated provider system by managing the interfaces between providers (statutory, independent and voluntary), developing capacity in those provider networks and acting as 'guardians' of the care pathway. The range of providers in the marketplace varies and for social care provision is generally more developed than is the case for healthcare (for example, 100% of nursing home care is provided by independent and voluntary sector providers). The development of a social care market place was driven by the Griffith's report of 1988 and the subsequent community care reforms of the early 1990's which have resulted in a large proportion of adult social care services moving from in-house provision to third party providers.

Commissioning and Performance Management

As represented in the above diagram monitoring performance of providers against the agreements they make in relation to service delivery is a key part of the commissioning cycle and should be at the core of the interface between the Commissioner and the Provider. In this regard the HSCB (including LCGs) and PHA are required to maintain appropriate monitoring arrangements in respect of provider performance in relation to agreed objectives, targets, quality and contract volumes. In the case of social care there are an increasing number of contracts where service user outcomes form part of the contract.

Summary of health and social care systems in other UK regions

In developing the options and recommendations within this report, the review team has considered the current system in Northern Ireland and the different systems in place across the UK. It is therefore worth taking some time here to give a broad overview of these systems. In doing so, it should be noted that only Northern Ireland has an integrated system of health and social care. In England, Scotland and Wales responsibility for social care rests with local authorities, although it is clear that all UK regions currently recognise the need to better integrate the planning and provision of health and social care and are taking forward a number of initiatives with that aim.

The concept of “commissioning” in the healthcare context stems from the Conservative government’s NHS reforms of the early 1990s and efforts to introduce an internal market into the National Health Service with the aim of driving service efficiency. The idea of separating the purchasing of healthcare from the provision of healthcare – the purchaser provider split – was first proposed in the 1989 White Paper *Working For Patients*. These reforms were implemented from 1991 with separate purchasing and provider organisations established in all four UK regions. However, since devolution both Scotland and Wales have moved to reintegrate these functions, and only Northern Ireland and England have retained separate commissioning and provider organisations.

England

In England, the Department of Health is responsible for strategic leadership and funding of both health and social care in England. NHS England is an independent body, at arm’s length from government, with responsibility for providing leadership for improving outcomes and driving up the quality of care, overseeing the operation of clinical commissioning groups (CCGs), allocating resources to CCGs, and commissioning primary care and specialist services.

In March 2013, the implementation of the reforms set out in the 2012 Health and Social Care Act replaced Primary Care Trusts with 211 CCGs. CCGs are led by clinicians and have responsibility for planning and commissioning the majority of health services for their local area.

The main providers of health services in England are NHS Trusts, NHS Foundation Trusts and Family Practitioner Services such as GPs, dentists, opticians and pharmacists.

In addition to the main commissioner and provider organisations, there are a number of other NHS bodies. Public Health England was established in 2013, and has responsibility for protecting and improving health and wellbeing, and reducing health inequalities. Commissioning Support Units, Strategic Clinical Networks and clinical senates have been established to support CCGs in their work. Health and Wellbeing Boards bring together bodies from the NHS, public health and local government to plan how to meet local health and social care needs, and to commission services accordingly. A number of regulatory and monitoring organisations are also in place, including Monitor, the Trust Development Authority (currently being combined into NHS Improvement), the National Quality Board and the Care Quality Commission.

Scotland

The Scottish Government, through its Health and Social Care Directorate, sets the strategic direction and allocates resources for health and social care. Unlike England and Northern Ireland, the NHS in Scotland does not have separate commissioning and provider organisations. Instead, 14 regional NHS boards are responsible for planning and providing health services to meet the needs of their populations. Regional boards are also responsible for the protection and improvement of their populations' health.

In addition to the 14 regional boards, seven special NHS boards provide a range of specialist and national services for the whole of Scotland – these include NHS24 and the Scottish Ambulance Service. Healthcare Improvement Scotland is the national healthcare improvement organisation.

Whereas in England and Northern Ireland, responsibility for monitoring and managing performance against government health targets sits outside of central government, this function is retained by the Scottish Government.

Wales

Like Scotland, there is no separation of the commissioning and provider functions in NHS Wales. The majority of healthcare services in Wales are planned and delivered by seven local health boards. In addition, three NHS Trusts provide specialised services on a nationwide basis – these are the Welsh Ambulance Service Trust, the Velindre NHS Trust which provides specialist cancer services, and Public Health Wales.

Social Care Commissioning

Social Care is both funded and commissioned differently from healthcare in all administrations across the UK including Northern Ireland. Unlike healthcare personal social services are subject to assessment of need and means testing of the person’s capacity to pay. In England, Scotland and Wales Local Authorities are responsible for meeting the social care needs of their eligible populations which they do through a mixture of direct provision and services commissioned from third party providers. Since the introduction of the Health and Social Care Act 2012 Local Authorities in England have also been responsible for the provision Public Health Services.

In Northern Ireland social care is commissioned primarily by the HSCB and the HSC Trusts although in recent years there has been some limited commissioning of social care by the PHA in relation to family support services. This provides a combination of contracts for significant volumes of social care services and smaller locally based services. The social care market is, in general, more complex and diverse than the healthcare market: it spans a range of activities from setting regional tariffs to commissioning individual packages of care to meet the assessed needs of a single person.

Structure of the Report

Chapter 2 of this report provides an analysis of the current commissioning arrangements, drawing on the key findings from the stakeholder engagement conducted by the review team as well other materials. The analysis will be structured around a number of themes which reflect the agreed terms of reference:

- needs assessment, prioritisation and planning;
- quality, safety, patient experience and user engagement;
- funding mechanisms and market management;
- performance management and service evaluation;
- leadership, accountability and clinical/professional engagement;
- organisational structures and processes; and
- delivering reform and driving innovation.

Chapter 3 then considers the action that can be taken to strengthen the planning of health and social care services in Northern Ireland, including options for structural changes.

CHAPTER 2 - ANALYSIS OF CURRENT NI COMMISSIONING ARRANGEMENTS

Sir Liam Donaldson's review of health and social care governance arrangements in NI noted that the "quality of the commissioning process is a major determinant in the quality of care that people ultimately receive" (Donaldson, 2014: 44). However, before moving on to consider the strengths and weaknesses of the present commissioning system in NI, it is important to make the point that commissioning – and indeed the structures in place to perform that function – while a key component, is only one part of the wider health and social care system. A paper produced by the University of Birmingham's Health Services Management Centre in 2008 recognised the complexity of healthcare commissioning and noted that the impact of commissioning will be affected by the way in which other elements of reform of health and social care systems are taken forward – the additional factors identified included payment systems, market management and regulation, and the degree to which commissioners are given the authority to exercise leverage and make necessary, if at times politically difficult, decisions. The paper concluded that "even if world class commissioning is developed, it may fall short of its potential in the absence of other changes in system design" (Ham, 2008: 7).

Similarly, a recent study of integrated care in Northern Ireland, Scotland and Wales found that whatever structures are in place, the delivery of seamless integrated care is challenging (Ham et al, 2013). Another comparative study of the four UK regions suggests that the different health policies adopted since devolution have had little impact on performance against key indicators (Bevan, 2014: 8).

This point is reiterated in a recent comparison of the four UK health systems, which found that "despite hotly contested policy differences between the UK health systems since devolution on structure, competition, patient choice and the use of non-NHS providers, there is no evidence linking these policy differences to a matching divergence of performance". This might suggest that the quality of the people in the system and their relationships is the most important factor. The report also highlights improvements in population health and the increased resources available for health services across the four countries since the late 1990s, the study notes that the performance gap between England and the rest of the UK has narrowed in recent years and that Northern Ireland has improved performance against the majority of indicators assessed (Bevan et al, 2014: 1-2). Input provided by the HSCB to the review team also points to increased efficiencies in health and social care services in NI in the five years since 2009/10. For example, it notes that while spend on inpatient treatment has decreased by 2%, activity has increased by 11%. Overall, spend on hospital services decreased by 4% between 2009/10 and 2013/14, while the percentage of total spend on community and personal social services increased by 4%. The gap in reference costs between NI and England has also narrowed, from £152.5m in 2009/10 to £98m in 2013/14, a reduction of £67.4m (41% saving) in real terms.

However, despite these improvements, the Donaldson report concluded that the existing commissioning arrangements in NI are not operating as effectively as they could. Donaldson recommended that the NI commissioning system should be redesigned to make it simpler and more capable of reshaping services for the future, and that a choice must be made to adopt a more sophisticated tariff system or change the funding flow model altogether (Donaldson, 2014: 44). Respondents to the recent consultation on Donaldson's recommendations were overwhelmingly in agreement that the commissioning system should be redesigned – 92% of respondents either agreed or strongly agreed with this recommendation. These responses consistently emphasised the need to simplify the current process, make it more transparent, and ensure greater involvement from clinical/ professional staff as well as service users. Academic research has also questioned the effectiveness of commissioning in Northern Ireland (Birrell, 2015: 11-13).

During stakeholder interviews, and on considering the written inputs to the review, the review team encountered a number of differing views on the current commissioning arrangements. The team heard from some of those interviewed that a separate commissioning function provided the necessary tension and balance in the system, to ensure that the interests of one sector did not outweigh others and, where necessary, to take difficult decisions based on the best available evidence. Others considered that the separation of the commissioner/ provider function - and the bureaucracy perceived to surround it - hampered reform and innovation and reduced the autonomy and decision-making powers of providers.

However, despite the differing views on the effectiveness and impact of the commissioner/ provider split, some key messages emerged fairly consistently across all stakeholder groups regarding the current system:

- there is a lack of clarity regarding the chains of accountability and responsibility across the various HSC organisations;
- the current structures are overly complex and bureaucratic, and are disproportionate to size of NI population;
- the annual nature of the planning cycle has a negative impact on long-term, strategic planning;
- there is a need for greater stakeholder involvement in the planning and design of services – in particular clinical/ professional expertise, public/ service users, and the community and voluntary sector.

A more detailed summary of the key points made to the review team, and drawn from the additional inputs to the review, is set out below. These are organised under a number of broad headings, largely in line with the agreed terms of reference for the review.

Needs assessment, prioritisation and planning

The University of Birmingham’s 2008 study on *Healthcare Commissioning in the International Context* noted that “health needs assessment is not routinely carried out in many systems, and when it is it may not be incorporated into purchasing decisions” (Ham, 2008: 2). Similarly, the OECD case study contends that the health and wellbeing needs of the NI population are unevenly articulated to the commissioning process (OECD, 2015).

This statement reflects the views of many of those who were interviewed by the review team or who provided written inputs to the review. While some respondents suggested that the system was getting better at assessing and responding to need, the majority considered that there was scope to do more in this area. It was suggested that the role of LCGs in assessing local needs has not been realised, in part because of a perceived lack of data to support meaningful needs assessment. There was also a broad sense that commissioning teams do not always have access to – or do not fully utilise - the specialist skills and expertise required to adequately assess population health and care needs. For example, clinical and professional respondents to the review highlighted the knowledge among those engaged in delivering services regarding the specific health and care needs of patients and clients. There was also a clear message from voluntary and community sector respondents that they are uniquely placed to provide intelligence on need, but that this expertise is seldom sought – though we were also given details of an exception to this in the operation of and infrastructure for Children and Young People's Strategic Planning. In Children and Young People's Strategic Planning there are multi agency forums which seek to engage local people to identify and assess need and plan services. A number of district councils and the NI Local Government Association responded to the review, and all pointed to the role that new councils can play in assessing the health and care needs of local populations through the development of community plans. Finally, there was a sense that more could be done to engage the public and service users in determining health and care needs.

A common view expressed by stakeholders was that the priorities for health and social care services should be evidence-based, focused on outcomes across the entire patient pathway and developed in consultation with clinical/ professional staff, service users, and other stakeholder groups (for example, Royal Colleges). A number of respondents indicated that where the commissioning system has been most effective is when commissioning frameworks, service specifications and care pathways have been developed in partnership between clinicians, professionals and managers, based on evidence and in response to identified needs. For example, the screening programmes for abdominal aortic aneurysm and bowel cancer screening have been cited as responding to a clearly articulated need and having a robust evidence base drawn from both local and national intelligence. The review team was advised that the commissioning model employed by the HSCB's Social Care Directorate is outcome-focused and based on service improvement methodology. The model is framed around personalisation and user/ community engagement, and is aimed at improving outcomes and user experience through the application of evidence-based best practice. Work to establish a new radiotherapy service at the

Altnagelvin hospital site has also been cited as an example of a service developed through effective collaboration between all relevant parties, in response to a clearly identified need (i.e. growing demand for radiotherapy services provided at the regional Cancer Centre at Belfast City Hospital). The business case for this service has now been approved and the new facility, due to open in October 2016, is expected to enhance access to radiotherapy services and improve the patient experience.

There was a clear consensus across all inputs to the review that the annual nature of the planning cycle is problematic, resulting in a reactive system with a short-term focus. The OECD case study reports a view that "the commissioning process is poorly designed to deliver strategic planning that prioritises assessed needs within available resources" and notes an "almost universal consensus" that there is a need to shift to a longer term planning and commissioning horizon. Based on this, OECD proposes a move to a five to 15 year planning cycle (OECD, 2015). Certainly, among those interviewed by the review team, there was broad agreement that a three to five year planning cycle, perhaps accompanied by an underlying, longer-term strategic plan, would be more effective.

In this regard, it is worth noting recent developments in England, Wales and Scotland where there has been a move to three to five year planning processes, with plans reviewed and, if necessary, updated during that time:

- in England, commissioners are required to develop strategic plans covering a five year period, with the first two years being at an operational level (this reflects the fact that in December 2013, NHS England published CCG funding allocations for 2014/15 and 2015/16).
- in Wales, there is a new requirement that Health Boards (the planning and provider organisations in Wales) develop integrated medium term plans (IMTPs) covering a three year period. Subject to agreement of a satisfactory three year plan by DHSS Wales, Health Boards are given some flexibility over how they use resources over the period covered by the plan.
- in Scotland, legislation introduced in 2014 aimed at promoting greater integration between health and social care placed a duty on Health Boards

and Local Authorities to develop strategic plans. These plans can cover a longer period than three years, but must be reviewed and revised at least every three years.

A number of interviewees and respondents considered that there was a need for greater consultation on priorities and strategic plans, with stakeholders inside the HSC as well as with external parties such as district councils, community and voluntary sector organisations, and patients and service users.

There was also a clear view from respondents that there is a need for a whole systems plan incorporating workforce and capital planning. The OECD report notes anxieties expressed by interviewees regarding a potential “workforce crisis” and recommends that commissioning needs to be better joined up with other parts of the system, in particular with workforce planning.

Summary of key points

- need for longer term, strategic planning cycle.
- need for more effective collaboration between managerial, clinical and professional teams in assessing health and care needs; developing evidence-based, outcome-focused priorities that span the entire patient pathway; and contributing to the development of strategic plans.
- need for better integration of workforce and capital planning with broader strategic planning.
- scope for greater involvement of other stakeholders - including community and voluntary sector organisations, district councils, and service users – in assessing need, developing priorities and planning services.

Quality, safety, and patient/ service user experience and engagement

The Francis report into the events at Mid-Staffordshire was clear that commissioners of services have a duty to ensure that the services they commission are provided safely, and emphasised the importance of meaningful engagement with patients and service users throughout the commissioning process. There was a perception among some stakeholders consulted during the review that the focus of the commissioning process (and indeed the wider HSC system) is on finance, activity, performance targets and processes, rather than quality of services and patient outcomes. However, in its input to this review, the HSCB provided the review team with examples of service specifications and commissioning frameworks. These set out the aims and objectives of services to be commissioned, and showed a focus on the safety and quality of services and on improving patient/ service user outcomes and experience. In benchmarking services to inform future commissioning decisions, it is also clear that consideration is given to quality indicators, as well as to financial and access data. In addition, it is important to note that the Donaldson report found no evidence of fundamental safety problems within the HSC in Northern Ireland, and indeed it emphasised that services here are likely to be no more or less safe than in other part of the UK. Nonetheless, the clear perception among stakeholders is that too much emphasis is placed on monitoring activity.

The review team was provided with a number of examples of areas where patient and service user engagement has informed the commissioning process. For example, in commissioning the Lifeline service (a crisis response helpline), we understand the PHA consulted with a range of stakeholders including users of the existing service and families bereaved by suicide. Proposals to reconfigure inpatient addiction services were the subject of a programme of extensive public and service user consultation and were revised in response to the views expressed during this process. The development of the 2015/16 Commissioning Plan was informed by the views and opinions of service users and carers, facilitated by a workshop hosted by the HSCB and PHA, and commissioning intentions have been developed in response to issues identified by patients, in areas such as chronic pain and endometriosis. Nevertheless, there was a sense from some respondents to the commissioning review, as well as from the OECD study, that efforts to engage users in the planning of services are sometimes perceived as a “tick box” exercises, and that more could be done to engage more meaningfully with patients and service users.

In addition to the need for greater engagement with patients and service users in developing plans for specific services, a number of stakeholders suggested that there was scope for a more wide-ranging process of public engagement regarding the longer-term configuration of services and the prioritisation of health and social care needs within available resources.

Summary of key points

- need to address the perception that safety and quality of services and patient experience are not given sufficient priority in the commissioning process.
- potential for greater engagement with the public on the design and delivery of services, and on longer-term plans for the future of health and social care services.

Funding mechanisms and market management

In his 2005 review of the health and social care system in NI, Appleby suggested that further consideration should be given to the introduction of some form of activity-based reimbursement in NI, in order to drive increased efficiency and enhanced performance (Appleby, 2005: 172). Sir Liam Donaldson's report, while noting that the costs of running a tariff system would be difficult to justify in NI, recommended that a choice be made between a more sophisticated tariff system or to change the funding flow model altogether (Donaldson, 2014: 15, 44).

During the development and implementation phase of RPA, a programme of work was undertaken to explore the feasibility of implementing an activity-based funding model in NI. However, drawing on learning that had emerged from the operation of “payment by results” in the NHS in England and taking account of the integrated nature of Northern Ireland’s health and social care system, it was decided that such an approach would not be appropriate for full implementation in NI. It is important to note that the English commissioning model is not entirely tariff-based, with around 70% of NHS funding allocated via block contracts (NHS England, 2014: 10). Published information such as CHKS and HES which compare costs across the UK are used when setting block contracts in Northern Ireland. As elsewhere in the UK, the level of sophistication and specificity in the contracts tends to fall as you move away from acute procedures and into community based activity. It has been argued that public services in England are generally moving away from activity based funding to capitated models measured against outcomes (Jupp, 2015: 11) and the empirical evidence for the impact of payment by results is limited (Birrell, 2015: 29).

While interviewees recognised that the current funding mechanisms in NI are not ideal, and suggested that money tends to be allocated on the basis of historical activity rather than in line with assessed needs or agreed priorities, there was broad agreement that the introduction and operation of a tariff system here would result in high transactional costs that would outweigh any likely benefit. In addition, it was pointed out that such systems tend to incentivise hospital activity, rather than the necessary shift of services out of the hospital sector.

While there was little support for a move towards an activity-based funding model, there was a sense that more could be done to align financial pathways with care pathways and adopt payment mechanisms that would incentivise improved outcomes and patient experience across these pathways.

The short-term nature of the financial planning cycle was also reported as problematic, hindering long-term, strategic planning and reducing any flexibility for providers to innovate. Respondents noted the tendency of the HSC system to focus on the small amount of additional annual income, rather than a longer-term, strategic focus on the use of recurrent resources.

The concept of a commissioner/ provider split within Health and Social Care is associated with a desire to improve performance by increasing competition between providers. However it is clear that (at least with the health sector here) there is little competition between providers, with LCGs tending to commission services primarily from their local Trust (HSCB/PHA, 2015: 66). The OECD case study found that at present commissioning is neither geared towards lowest cost for delivery or best practice, that available data is poorly suited to identify and end inefficiencies and decommission redundant services, and that there is little competition between providers (OECD, 2015).

It is important to note that the review team heard evidence of the different landscape in both health improvement and social care where services are currently commissioned from a large field of potential providers. However, respondents to the review from the community, voluntary and independent sector were often negative about the commissioning and procurement processes, perceiving them to be overly bureaucratic, time-consuming, and not conducive to the development of innovative service models.

Summary of key points

- need for longer-term financial planning focusing on recurrent resources rather than non-recurrent annual allocations.
- lack of financial flexibility impacts on ability to make long-term investment decisions.
- no consensus as to whether commissioning is the right model for NI, given the size of its population and limited market of health service providers.
- broad agreement that an activity-based funding model is not right for NI, but that alternative approaches should be explored that would incentivise reform, innovation, more collaborative working and ultimately improved patient/ client outcomes.

Performance management and service evaluation

A number of interviewees expressed a view that performance management, rather than commissioning, is the primary focus of the current system. Some considered that the approach to performance management was adversarial and focused on numbers and activity rather than service improvement, quality of care, or patient outcomes. There was a sense that key stakeholders – in particular clinical and professional staff – are becoming increasingly disengaged from the process and that there was a need to secure greater "buy-in" from all stakeholders to the targets and priorities set for the HSC.

The lack of sanctions for poor performance and incentives for strong performance were also raised as issues. Although there was no clear view as to what form such sanctions or incentives might take, the onus on the HSCB to ensure financial breakeven means that imposing financial sanctions on providers is counter-productive. A number of stakeholders considered that the current performance management system was too hands-on and micro-managed, and that greater autonomy and flexibility could prove to be an incentive.

While it is clear that providers should be held to account for the services they provide, there may be lessons to be learnt from the model in place in Scotland where a robust performance management system is complemented by a separate service improvement function. In addition, the Scottish government has in place a clear "ladder of escalation" which sets out the specific circumstances when performance concerns about a provider would merit an intervention from government, and outlines the form such interventions take.

In relation to service evaluation, there was broad agreement that more could be done to routinely evaluate the effectiveness and impact of commissioned services. However the review team did also hear specific examples of formal evaluations that have taken place, and where new service models have been commissioned that have resulted in real improvements in patient experience and quality of care, as well as increased efficiency. For example:

- Transforming Cancer Follow Up programme – developed by the HSCB and PHA in partnership with Macmillan Cancer Support and HSC Trusts. An evaluation of the programme has recently been completed and the 2015/16 Commissioning Plan includes steps aimed at building on this evidence base and consolidating the approach for all eligible patients. Similarly the review team was provided with reports monitoring the impact and outcomes of the breast and bowel cancer screening programmes;
- Mental health and learning disability services – in addition to the regular feedback received from service user and carer representatives on the Bamford Monitoring Group, in 2012 the HSCB and PHA used the Sensemaker Audit tool to measure service user/ carer specific outcomes and experience of mental health services. It is intended to repeat this evaluation in 2015/16.

Summary of key points

- lack of sanctions and incentives to drive improvements in quality and performance – in particular, the use of financial sanctions has proved problematic because of the HSCB's overall responsibility for the financial breakeven of the HSC.
- need to strike a balance between accountability, responsibility and autonomy, and between performance management and service improvement.
- in terms of targets and priorities, a balance must be struck across the three key aims of the HSC – improving health and wellbeing; safety, quality and patient experience; and achieving value for money in terms of both resources and outcomes (the 'Triple Aim' approach).
- need to ensure that key stakeholders have a sense of ownership of performance targets – scope for greater engagement with clinical and professional staff, and with service users and their representatives, to develop a range of evidence-based and, where possible, outcome-focussed targets.

Leadership, accountability and clinical/ professional engagement

Sir Liam Donaldson's review pointed to a lack of clarity around who is ultimately in charge of health and social care in Northern Ireland (Donaldson, 2014: 11, 16). This point was also made to the review team on numerous occasions. Stakeholders considered that the lines of accountability across the various HSC bodies are blurred – for example, while the HSCB is accountable for performance and financial breakeven across the HSC, a number of stakeholders noted that Trusts are accountable to the Permanent Secretary of the Department, rather than the Chief Executive of the HSCB. There was a strong sense that the HSC needs to clarify roles and responsibilities and identify an individual leader of the system.

A number of stakeholders expressed a view that the level of political and media interest in the health and social care service here is more intense than in other parts of the UK. This point has not always been borne out in the review team's discussions with colleagues in other regions. Nevertheless, it is clear that implementing necessary reforms in the HSC is likely to generate intense public and political scrutiny. There was a strong sense from a number of stakeholders that there needs to be an element of freedom to make these decisions, where there is clear and demonstrable evidence that they are necessary for improved services.

In relation to clinical and professional engagement, a number of interviewees were of the view that the location of public health expertise in the PHA, separate from the main commissioning organisation, has not been helpful in this regard. While numerous stakeholders emphasised that public health, clinical and professional input is critical to the commissioning process, it was suggested that this is often not supported by the current structures. This point was reiterated to the OECD team (OECD, 2015).

The review team heard some examples where public health experts and clinical and professional teams have successfully been engaged in the commissioning process, from the assessment of need, through to service design and implementation. For example:

- expansion of radiotherapy services to the Altnagelvin site - plans developed through close working between the HSCB, PHA, the Western Trust and RoI colleagues. Clinical staff have led on the development of workforce, training and recruitment plans for the service as well as the development of a clinical service profile, detailing those radiotherapy components that can be delivered at the Altnagelvin site and those that will continue to be delivered at the cancer centre;
- stroke services – ongoing clinical engagement in the development of detailed service specifications;
- mental health and learning disability services – clinical and professional staff involved in the development of commissioning frameworks, service models and care pathways for each of the specialist areas in the Bamford Action Plans;
- drug and alcohol services – clinical staff were consulted on commissioning priorities and service models. In addition, drug and alcohol coordination

teams (multi agency partnerships at Trust level) were involved in the process of identifying local needs and gaps in service provision.

The commissioning of screening and immunisation programmes was also cited by a number of stakeholders as an example of when the commissioning process has worked well. Again, the reasons stated for this include a solid evidence base for a service, the input of public health expertise, and consultation with clinical staff and other stakeholders, including patients.

A number of interviewees expressed the view that the commissioning process operated more effectively in social care than in health. The reasons cited for this tended to include a clearer understanding of roles and responsibilities across the system, the involvement of professional teams in the commissioning process, the formalised arrangements and principles governing the delegation of statutory functions, and the use of evidence-based objectives to inform commissioning frameworks and service specifications. However, it should be noted that respondents to the review from the community and voluntary sector were particularly critical of the procurement and commissioning processes in the social care sector.

Previous reviews of the NI health and social care system (e.g. *Fit for the Future*, *Acute Hospitals Review*, Appleby report), and the RPA proposals, have recognised the need to secure the involvement of GPs and other primary care practitioners in planning and designing services that respond to local need. LCGs, and latterly ICPs, represent the outworking of this in the current system. However, some stakeholders interviewed during the review considered that the commissioning process, and the wider HSC system, remains too focused on acute services at the expense of both primary and community care – a point that was also made to the OECD team (OECD, 2015). A number of stakeholders emphasised the role of clinical networks - drawing on expertise from across health and social care, across the primary, secondary and community sectors, and across disciplines e.g. mental health as well as physical health - in planning and coordinating care across the whole patient pathway.

Summary of key points

- whatever option is agreed, strong sense from stakeholders that there is a need to identify a clear point of leadership within the system, and clarify roles and responsibilities of – and lines of accountability between - the various HSC bodies.
- greater autonomy and delegation of authority to reform and innovate. Strong sense that people want to get on with the job, but that they're being prevented from doing so.
- separation of HSCB and PHA has not been helpful in securing public health and clinical input to the commissioning process. Some good examples of when clinical and managerial teams have worked together with other stakeholders to develop commissioning frameworks and service specifications, but sense that this approach happens in spite of, rather than because of, structures.
- need for greater involvement of clinical and professional staff from beginning to end of commissioning process.

Organisational structures and processes

There was a strong sense from interviewees and respondents to the review that there is a need for leaner, simpler structures than exist in the current system. Stakeholders in general cited the separation of the HSCB and PHA, the five LCGs and 17 ICPs – as well as the duplication of some functions across the Department and HSC organisations - as creating a complex system, with too many layers of bureaucracy.

There is also a question as to whether the costs associated with the commissioning process represent value for money. Whereas the HSCB was limited to a maximum of 400 staff when it was established in 2009, it currently employs 584 staff with salary costs of £29m (this increase is in part due to additional functions that the HSCB has been tasked with since its establishment). The commissioning directorate within the HSCB accounts for £4.8m of this total, though staff across the organisation will also be involved in commissioning – for instance, those in the social services and finance directorates. The PHA currently employs 338 staff, at a cost of £16.9m.

In particular, interviewees expressed the view that there were too many layers of approval required before a decision to invest is taken. This point was echoed by respondents to the recently completed ICP evaluation survey, who expressed frustration that plans for innovative, multi-disciplinary care pathways have to go through multiple levels of approval before investment is confirmed. Respondents to the survey expressed the view that this approval process was impacting on the ability of ICPs to operate effectively.

Similarly, a number of respondents to the review from the community and voluntary sector expressed the view that the complexity of existing structures and processes made it difficult for them to engage with the system, despite being in a strong position to identify health and social care needs and contribute to the design of services and outcome measures.

Interviewees pointed to poor communication within and across organisations, and suggested that the complexity of existing structures does little to foster and support strong, collaborative working relationships across the health and social care system. The OECD team's case study adds an important corollary to this point – that in fact the size of the NI system has meant that good, productive working relationships have developed across a number of organisations. Importantly, some contributors to the OECD case study noted that "the quality of these relationships explained how the system continued to function despite resource constraints and organisational challenges" (OECD, 2015).

The OECD study notes that "support for the existing system of commissioning came from only a very small minority" (OECD, 2015). However, the Departmental-led review team heard from a number of interviewees that there was a need for some regional function to undertake the key elements of commissioning – assessing population need, planning and securing services to meet these needs, and evaluating the effectiveness of those services – and to ensure consistency of service models and standards across NI. While this could be undertaken at provider level for the majority of services, there are some services for which a regional approach is most appropriate. In addition, consideration would need to be given as to how to secure primary care involvement to any provider-led process, how to ensure that services are provided consistently across NI and to ensure the necessary shift from acute care.

Colleagues in Scotland have advised that these issues have been addressed by setting clear targets and outcomes, requiring Health Boards to develop plans outlining how these will be achieved, and holding Boards to account on performance against plans. In addition, a range of managed clinical networks have been developed to improve standards of patient care through integration of services and collaboration across professional and organisational boundaries.

A point made consistently by interviewees was that local commissioning was not operating as envisaged in the 2009 reforms. There was a strong sense that LCGs do not have the necessary information and autonomy to perform their function. While some stakeholders were of the view that some form of local function should remain to assess population need and secure input from local health economies (including primary care practitioners), others considered that for a country of NI's size all services could be planned on a regional basis.

Summary of key points

- need for leaner, simpler structures and processes.
- need to consider nature of regional and local structures.
- important to strike a balance between responding to local needs, while at the same time ensuring consistent standards and quality of service across NI.

Delivering reform and driving innovation

Some stakeholders considered that a regional commissioner provides the tension needed to implement reform and that recent changes to service models such as PPCI and paediatric cardiac surgery would not have been possible without a neutral, regional commissioning function. There was also a sense that the complexity and bureaucracy of the current structures stifle reform and innovation, and make it difficult to implement meaningful change. Certainly the empirical evidence for the impact made by commissioning seems limited (see Birrell, 2015: 11-13) with the suggestion that providers often defined the service they wanted to be commissioned. This idea of 'reverse commissioning' was also highlighted by stakeholders.

While much of the focus of discussions with stakeholders was on the way in which services are commissioned, there was also a recognition that de-commissioning is equally important to drive reform. However, there was a strong sense that the various issues identified above - the need for more meaningful engagement with the public on the future of health and social care services; the lack of long-term planning; the need for clarity on roles and responsibilities; and the complexity and bureaucracy of existing systems and processes - have impacted on the ability to take difficult decisions to reconfigure the way services are delivered.

The role and extent of localism in any future system will also have a bearing on the ability of the system to deliver reform and drive innovation. While there is an argument for a consistent service delivery model for a population of 1.8m people, the majority of stakeholders recognised the need to strike a balance in the system so that providers have flexibility to respond to local needs, but at the same time ensuring that innovative practices are evaluated and embedded consistently across the region as appropriate.

Summary of key points

- options for future systems will need to be assessed against their ability to facilitate sometimes difficult decisions necessary to deliver reform.
- the balance between local responsiveness and regional consistency will need to be a key consideration.

CHAPTER 3 - CONCLUSIONS AND RECOMMENDATIONS

In undertaking this review we have a heard a wide range of views and comments. There was a clear and consistent message that the system is not working as effectively as it should – and that it is not working as envisaged in 2009. While there were some issues that were cited frequently there is little consensus on how to make the current system work better nor on what the most effective model is for Northern Ireland. Despite this general view that the system was not working effectively, it is also clear there are some areas of good practice.

It is clear that we can improve the structure of the HSC and the way the functions work – but the pressures and challenges that the service faces will continue to remain and grow no matter what changes we make. Improvements to systems and structures will not reverse the growing challenge that we face in meeting demand.

There are also risks: changes to structures and functions create uncertainty and soak up time and energy; structural change could simply see problems which are behavioural moved rather than solved.

Despite this, the previous chapter of this review sets out a clear case for why avoiding change is not an option. In particular, it is clear that our current structures – with multiple layers – are simply not nimble enough to allow us to keep up with the increasing pace of change in health and social care.

Structure of the recommendations

Within the scope of this review there are a large number of issues and a plethora of options. We have sought to structure our conclusions in a way that allows people to navigate the various decision points, accepting that more detailed design work will need to follow.

We start by addressing the approaches that could be taken at a regional level – strengthening commissioning, moving away from the commissioner/ provider split or having a mixed model.

There are then a series of options for dealing with different elements of the system which could exist under any of the regional models. This includes an assessment of local approaches to commissioning or planning for services, approaches to family practitioner services and public health, different funding models and performance management. More effective performance management levers will be key to making whichever system we use work effectively.

There are some areas where action can be taken to improve the current system with or without structural change. We set out some principles and approaches that should be pursued within the current system, to make it work better.

The case for structural change

It is clear that the current structures provide for a complex decision making process (for instance, from ICP to LCG, with decisions then considered by HSCB and then PHA clinical staff, and sometimes by the Department). It is also clear that responsibility – and therefore risk – has not always been effectively shifted to provider organisations.

Maintaining a commissioning approach in Northern Ireland was intended to ensure there was appropriate challenge to providers. However, it is clear to us that we have a top down system without any teeth – and one in which the lack of clear lines of accountability make it easy for people to criticise and hard for people to take responsibility. It seems clear from consideration of the Scottish and Welsh models that effective challenge can be created – and change driven – without relying on a commissioner/provider split. It is also clear when we look at Scotland and Wales that we could design a simpler system of health and social care planning and management for Northern Ireland.

But the question of whether to maintain a ‘commissioning’ system is not one of clear contrast. Both the Scottish and Welsh systems have commissioning functions within them. In Wales the Specialised Services Committee commissions or plans more specialised services; while in Scotland the Joint Boards which will be responsible for both health and social care funds will explicitly employ a commissioning model. In making performance interventions, all systems need to be able to draw a distinction between services that are under-funded against genuine need and those which are under-performing.

Any change should be judged against some criteria to assess the likelihood of the making a positive impact. We suggest proposed changes should be considered against:

- How well they balance clear strategic direction at a regional level with operational independence
- Whether they improve accountability and responsiveness
- Whether they can deliver a focus on care delivery and reform, rather than oversight and process
- Whether they help to simplify and streamline the existing system
- Whether they allow us to build on our existing strengths
- How deliverable any changes would be.

The final section of this chapter draws on these criteria in coming to conclusions, though we have not sought to formally score options against them, given the possible variations within each option.

Changes to regional structures - options

Option 1 – strengthen the current commissioning process

There must be serious doubts about whether a full commissioning model is appropriate for Northern Ireland, given the overheads generated for a relatively small population group. However, we could seek to implement this model more effectively.

Assuming we are seeking a commissioning process that involves some element of competition, there is a choice about whether that competition should be internal between HSC organisations or include external competition from the private sector.

Competition

There seems to be a consensus that Northern Ireland is too small for there to be an effective private market in many areas of healthcare. We note some evidence from those involved in GP fundholding to suggest that some competitive tension can be created in elective care between HSC organisations where they are required to actively compete for work. Equally there is clear evidence from other countries in the UK that vibrant markets for social care can be built in relatively small constituencies – and there are good examples of this in Northern Ireland.

Generating effective competition across a reasonable range of services in Northern Ireland might necessitate a broader range of provider bodies. Returning to a greater number of Trusts in order to build competition is clearly not a wise option. However, the development of GP Federations (groupings of GP Practices) creates a body which could potentially provide an alternative to the Trust for the provision of a number of services.

More broadly, there could be a much stronger focus on building and managing private markets – as there currently is in England. This might involve more focus on encouraging new entrants to service provision and greater stability for third sector and private sector partners – potentially with multi-year agreements. Work with Federations and the private and third sectors could identify areas where greater competition to hold service delivery contracts could be built.

However, a stronger focus on creating competition, whether internal or external, would also mean the acceptance of the friction and waste that this can create, with effort expended on bidding for services. Some forms of competition and competitive tension may involve people having to travel further for their care – and as in England may involve staff being TUPE'd between employers when an incumbent service provider loses the contract for the service they are running. Thought would also need to go into planning for the failure of providers outside the state sector – though this would simply be an expansion of the risks that are already carried in areas like domiciliary care where there is a heavy reliance on private and third sector partners. It will also be challenging to ensure that service specifications drive quality as well as volume and cost. Nonetheless, there is likely to be learning from England and elsewhere that could be drawn on.

This approach would only be successful if there was a greater willingness to accept the financial impact on Trusts of losing service provision. The requirement on the commissioner to seek to achieve financial break-even would therefore need to be reconsidered.

This approach could involve:

- Holding competitive procurements for a far greater range of services.
- Creating a 'right' for community organisations to challenge provider organisations to outsource services for which they could bid.
- A stronger focus within the commissioning body on managing a market, alongside managing individual contracts (for instance, producing documents such as the Market Position Statement required by England's Health and Social Care Act 2014 and building relations with a wider range of providers). Different skills may be needed by the commissioner, if there is to be a greater focus on drafting and managing commercial contracts.
- Strengthening the 'choice' agenda to ensure patients can go to the provider who they see as likely to provide them with the best service.

- Policy changes may also be necessary, to ensure a greater proportion of services are competitively commissioned in order to help build markets.

Without some attempt to generate greater competitive tensions, we find it hard to see a compelling argument for the continuation of a commissioning model.

Pros	***Cons***
Could drive up quality and drive down cost	Could lead to a fragmentation and the loss of the integrated nature of our providers
	Greater risk of service failures, as organisations push down costs
	Difficult to maintain focus on quality as well as price
	Greater overheads from managing competitive procurements and regular engagement with a wider range of organisations
	Need to manage transition where services are taken over by different providers, including e.g. TUPE

Strengthening the Commissioner

Alongside, or instead of, focussing on introducing a stronger competitive element to our system we could focus on strengthening the commissioning function in other ways. This could allow the commissioning body/ies to drive better performance from Trusts and make it better able to plan on a system wide basis, taking difficult decisions where needed. This would also help to ensure there was a strong, independent voice in the system able to make the technical case for system-wide changes. To strengthen the current commissioning function a range of changes could be considered.

Greater influence in senior appointments:

- Give the commissioning body/ies a formal role in appointing members of Trust Boards and their Chief Executives. However, Trusts should not become directly managed units of the commissioning body/ies if we are to continue to attract the best talent to run our Trusts. This would need to be combined with changes to see the commissioning body/ies feeding into Trust governance reviews and a clearer regional approach to talent management.

Ensuring the right expertise exists:

- Providing the commissioning body/ies with its own dedicated clinical and public health expertise to improve clinical engagement and input.

Further simplifying the regional decision making structure:

- By either merging the HSCB and the PHA or separating their functions, so Northern Ireland has two distinct commissioners with separate responsibilities.
- Considering the role of LCGs and ICPs (see section below on local models).

Strengthening performance and financial levers:

- Commissioning is likely to be most effective where some form is tariff is implemented for at least some services.
- A broader range of performance levers is made available, with a clearer 'ladder' of intervention.

Putting all the relevant functions in one place:

- Transferring workforce planning and capital functions to the commissioning body/ies.

However, there is also an argument that the effectiveness of the commissioning function could be strengthened by stripping it back and ensuring it becomes more strategic in nature and focussed purely on the core commissioning process and the skills needed for this. This could still involve, for instance, merging the PHA and the

HSCB – but it could also involve moving some functions to other regional agencies or to the Department.

Strengthening the current commissioning arrangements may simply reinforce some of the weaknesses of the current system and potentially increase the costs of the commissioning function.

Pros	***Cons***
Provides a strong organisation to challenge Trusts and other providers, ensuring value for money	Uncertain whether enough competitive tension and challenge could be created to justify the overheads in this model
	Hard to reconcile collaborative approach with need to challenge and create competition
	Could add to uncertainty around system leadership

Option 2 – abolish regional healthcare commissioning, making Trusts responsible for assessing their population needs, planning to meet those needs and delivering appropriate services.

This option would broadly follow the model used in both Scotland and Wales, with local health boards (equivalent to our Trusts) responsible for planning their services against a capitated budget. Board plans are assessed and agreed by the Scottish and Welsh Governments. In both systems, it is recognised that some services need to be planned at a regional level – with a collaborative approach taken to identifying which services. In Scotland, managed clinical networks provide consistency in clinical approaches rather than a single central body.

This system avoids the transactional costs of seeking to track relatively small amounts of money through the system, which seems to be a characteristic of the

Northern Ireland system. This approach helps ensure delivery bodies take full responsibility for the delivery of care. We would also argue that this approach creates the space for a genuinely strategic regional function to have an impact in driving performance, delivering reform and ensuring consistency.

One decision in setting up this model is whether the capitated budget is top sliced for regional services – or whether the ‘whole’ budget for the population is given to the Trust who would then purchase services from other Trusts. The former approach would give the Trust body ownership for their population health – and inject the tension of a commissioner/provider function. However, it could lead to counter-strategic decisions (for instance different Trusts coming to different views on where and how specialist services should be commissioned) and the over-provision of specialist services.

As with Scotland and Wales there would need to be some planning, and in some instances procurement, of services that could only be considered at a regional level. This could include, for instance family and child protection services and those acute services currently dealt with by Specialist Service Commissioning Team – though a mechanism would need to be in place for deciding what should be planned at regional level (and what could be passed back to the local level, as technology develops to allow services to be delivered locally). As discussed below, there are choices about whether remaining regional functions sit independent of the Department or within its remit.

Mechanisms would also need to be in place to ensure consistency in approach to care pathways. In Scotland, this is done in a collaborative manner through Managed Clinical Networks. The HSCB and PHA currently oversee collaborative clinical networks in some areas and this approach could be expanded as part of a central regional function – as an alternative to an approach based around separate managed clinical networks. Performance management and service improvement would also need to be located at a regional level – with decisions to be made about public health and family practitioner functions (on which, see below).

One of the principle risks in this approach could be that central Government lacks the strong levers to drive reform. In particular, there is likely to be a concern that without a commissioning organisation Trusts' attention may be drawn to acute services (given the greater public profile these often hold). As well as strong performance management and service improvement functions, financial levers could be used to help achieve its aims (e.g. ring-fencing blocks of funding by programme of care).

Thought may also need to be given to whether internal governance arrangements for Trusts would need to change to reflect a broadened role – and what additional skills and knowledge senior managers would need.

Both the Scottish and Welsh systems demonstrate that strong levers can exist to drive performance and reform, even without a commissioning function. Indeed, it might be argued that without some of the transactional overheads associated with a commissioning regime, there could be a stronger central function. Well-defined performance criteria focussed on outcomes may be even more critical in models which devolve a lot of power to providers.

Both the Scottish and Welsh models are healthcare models. However, we see no reason why the approach could not apply as effectively to social care as to health.

Pros	***Cons***
Would remove some of the transactional overheads	Mechanisms would be needed to ensure Department could still deliver regional priorities, including reform
Should provide Trusts with more ownership and responsibility and emphasise collaboration	Would involve Trusts taking on a new function which would need to be resourced and properly overseen
Would simplify decision making structures	

Option 3 - take a split approach, commissioning some services and giving Trusts responsibility for planning in others.

It was clear through our engagement that some services in Northern Ireland are commissioned more effectively than others – and in some services there is more scope for competition than in others. As noted above, in any system some specialist acute and community services (such as statutory children's homes) will need to be planned at a regional level. A commissioning approach could be maintained for these services.

There may be other areas where the volume and transferability of services would enable a commissioning approach that could drive better value – for instance some elective procedures. There may be other services such as some community health services where the value added by a commissioning process is likely to be more limited.

We could therefore seek to pursue a mixed system – with some services planned by Trusts or a local body and others commissioned by a regional body/ies. A clear set of criteria would need to be developed against which to decide whether services were commissioned or locally planned.

Pros	***Cons***
May best enable us to build on what currently works well	Added complexity
Would ensure the most effective mechanism is applied to each service area, potentially helping to improve outcomes	Impossible to define the edges of some services
Would ensure limited commissioning resource was focussed where it could make most impact	Could create perverse incentives to deal with conditions through one route and not another

	Potential for confusion and difficulty reconciling different approaches within one relationship

Other structural considerations

Where should regional functions sit?

One of the key decisions on the structures we use is whether the system is managed from within DHSSPS or by an arms length body. A decision was made in 2009 to have separate functions in arms length bodies, with the HSCB and the PHA responsible for managing providers and ensuring delivery. England has a similar model – with NHS England working with other bodies to manage delivery. However, Scotland and Wales have incorporated the performance management function into their Departmental structures – with a role such as Chief Operating Officer in place.

A separate body

There are strong arguments for maintaining a separate function. Separation enables independence in operational decision making, helps draw a clear line between strategic decisions and the operation of the system, and may make it easier to draw in the specialist operational skills necessary by providing different terms and conditions.

An integrated body

There are equally strong, if not stronger, arguments for the incorporation of this management and performance function in the department. It would recognise that, ultimately, the Minister and the department are responsible for performance and delivery. It may also make it easier to ensure delivery informs policy and allow for better coordination of strategy and delivery. This system also has the benefit of simplicity and reduces the scope for friction between different bodies, different agendas or communication failures. It would also make it easier to pool some functions and create a bigger pool of clinical expertise to draw on. However, this approach would see a significant expansion in the Department’s headcount and could be seen to run counter to the broad approach pursued in 2009 and implemented by most other departments.

Many of those with the operational expertise necessary to undertake some of these functions would not view themselves as potential civil servants. Nevertheless, use of secondments and maximising the flexibility in civil service terms and conditions could address some of the potential challenges around terms and conditions.

Local models

Whether we have a system based on a commissioning approach, or one based on integrated local planning and delivery functions, there is still a question about how the need for local variances in care are identified and delivered.

We heard clear views that the current LCG model was not working effectively and that change is needed. At the minute we have not fully committed to a localised model and are carrying some of the costs with little of the benefit. We were impressed by the enthusiasm and dynamism of ICPs – but also heard questions about the need to put effort into varying care pathways for a population of 1.8m people.

If the commissioning based approach in Northern Ireland is to continue, there is an argument for strengthening local commissioning by devolving more power and resources to LCGs. However, this function could also be incorporated into the regional commissioning body and be administratively led. Either of these models could be combined with an approach which seeks to strengthen the local health and social care economy and drive greater cooperation amongst providers. Some funding could be offered on the basis of outcomes being achieved across a local 'health economy', with providers agreeing amongst themselves how best to deliver those outcomes.

If Northern Ireland moves away from a commissioning based model, the need for local variation and input could be reflected through the Trust's planning process. Further thought would need to be given to ensuring that primary care, third sector and other voices are fully reflected in a Trust-led local planning model.

Whichever approach is taken, care should be taken to pursue more effective coordination and collaboration between different partners involved health and social care delivery locally – whilst avoiding unnecessary administrative overheads and complex leadership structures.

Other regional functions – Public Health and Family Practitioner Services

These services are currently commissioned centrally by the Department and managed by the HSCB. Given the size of Northern Ireland, this makes sense and ensures there is no duplication in administrative function. However, in the other UK countries while contracts are centrally negotiated the management of those contracts and additional services agreed through, for instance, Local Enhanced Services with GPs, are negotiated and set at a local level. We can see some benefits in localising this function in Northern Ireland – principally it would give greater local ownership of primary care services as a whole and could help to address the join between primary and secondary care. It might also give a stronger voice to primary care services – with a Board-level executive in Trusts responsible for a broader range of primary care services.

Other parts of the UK devolve some of their health improvement functions to local units (such as the Health Boards in Scotland). England, Scotland and Wales also retain a regional/national public health body. A number of PHA functions – such as vaccination programmes – would only ever make sense being commissioned or planned on a regional basis but, as with family practitioner services, there is a case that could be made for devolving more responsibility for health improvement.

A decision on the approach to managing both family practitioner services and public health functions will need to weigh the potential for greater responsiveness and closer integration with other services from a devolved approach against the likely greater overheads and the loss of regional consistency.

Funding and performance management

As noted, a tariff based approach was carefully considered by the Department in 2007 as part of an exercise on payment mechanisms. It was decided at that time not to pursue activity based funding. While tariffs have driven up efficiency they have also encouraged hospital based procedures and driven a focus on activity rather than quality of outcome. In some cases they have also driven increased budgets, as hospitals have over-delivered against expected numbers. A tariff based system is also likely to increase the administrative costs for Northern Ireland, both in setting tariffs and tracking delivery.

What a tariff based system can bring is a greater discipline within hospitals for understanding their costs. Tariff systems continue to develop with results or outcome based tariffs being developed in some areas.

An integrated system without a central commissioner would necessarily rely on capitated budgets – but a proportion of funding could be retained to support innovative new schemes, with results based payments in some cases, until they become mainstream business. In particular, novel financial approaches could be explored to help drive collaboration and integration across bodies.

A capitated system may also be beneficial in helping Trusts plan for long term savings – provided there were clear multi-year financial planning assumptions. There was a general belief that savings from improvement and innovation were drawn back to the centre. This is not the case – but the setting of regionally defined efficiency targets has helped create this impression. Full ownership of their budgets by Trusts could help incentivise innovation and reform.

Overall we think a capitated approach is the right one for Northern Ireland – but with some constraints around how those funds are used in order to ensure that, for instance, funding is not switched from community to acute services. Oversight mechanisms to ensure the appropriate resourcing of delegated statutory functions discharged by Trusts will be required alongside this approach. There may also be scope for the deployment of payment by results agreements (including innovative new models such as ‘gainshare’ agreements and social impact bonds) in certain areas – for instance in some aspects of elective care. The use of these financial mechanisms needs to be more fully explored – with a judgement made about whether the additional complexity and overhead is justified.

Whatever structures are chosen going forward, stronger performance management levers are necessary. In particular, if we are to focus on devolving decision making, whether to Trusts or local commissioning mechanisms, increased accountability must follow that funding.

We heard that in other UK countries, there is a sense of earned autonomy: if the performance of your Trust or Board is generally good (both in clinical/social care and financial terms), then you are left to get on with the job. Where performance deteriorates there is a clear and tried and tested escalation process in place. We should look to create a similar system here – with freedoms and flexibilities as an incentive for performance.

More broadly, we should seek to create alternatives to the current process of withholding funds for poor performance. While that should remain as key lever, taking back funds where services have not been delivered only makes it more difficult to meet performance targets and could ultimately impact on the service provided to patients and clients. These alternatives could include focussing on greater transparency, greater choice and more rewards (both financial and non-financial – including ‘earned autonomy’).

Changes to begin work on immediately

Longer term strategic plans

Multi-year planning should free up effort that is currently trapped in an annual cycle, enabling a quicker and less resource intensive update process to take place each year. Multi-year planning will allow a stronger focus on long terms issues, such as population health, and should allow a better linkage with workforce planning and capital spend (which focus on longer time horizons). It should also create the capacity and the time to strengthen public engagement in the commissioning / planning process.

As noted, the Scottish Government require their Health Boards and Local Authorities to develop strategic plans covering at least a 3 year period, with a built in review every 3 years. Wales have attempted this approach but we understand not all of the Health Boards there have managed to develop and agree the 3 year plans required of them.

In Northern Ireland, the yearly budget cycle is likely to prove a constraint. Nonetheless:

- 3-year plans should form the basis for work across the HSC, driven by the objectives set in the Programme for Government.
- These 3-year plans should be underpinned by stronger and more robust assessments of need.
- The Department should consult more widely both within the HSC and outside it on the priorities and targets it sets, which should be more outcome focussed.
- The planning process should more effectively integrate priorities for primary and secondary care and priorities for workforce planning and capital investment.
- Working with DfP, the Department should provide a set of financial planning assumptions upon which these plans can be based.
- The scope for moving to multi-year negotiation processes with for e.g. GP contractual negotiations should also be explored.

- A sharper package of incentives and sanctions should be developed to incentivise the delivery of long term plans.

Leadership

In Scotland, there is a clear sense of 'NHS Scotland'. In Wales, we understand the Welsh Assembly Government is seeking to build further a similar sense of joint enterprise. In England, there is a strong focus on building 'systems leadership', focussed on collaboration to deliver transformation. While the core values of the NHS are strong across the HSC in Northern Ireland, more could be done to strengthen this sense of separate organisations but with a single purpose and ethos. The creation of a Strategic Leadership Group for the HSC in Northern Ireland is a positive step in this direction. In addition there should be:

- Continued operational independence for HSC bodies – but there must be greater clarity around lines of accountability.
- Greater collaboration amongst Trusts in delivering and developing services. In particular, more must be done to share and roll-out innovation from one Trust to another. We suggest that a repository of innovative change be developed to ensure that Trusts are, as a first step, able to check and identify what approaches have been tried and tested elsewhere – and that alongside this the scope for a regional hub to help drive a culture of quality improvement is considered.
- Trusts should expect that they will need to devote a proportion of their senior management time and energy to engaging with and leading regional projects and programmes in order to build collaboration and integration across organisations.
- Peer leadership should also be used more often when there are performance challenges. Failures in performance should be addressed collectively.
- Opportunities should be sought to bring clinical and professional staff together across specialities on a Northern Ireland basis more regularly, to build clinical and professional communities.

Delivering Transformation

One of the strong themes that came through in the review was the fact that the system focussed on the ‘fly not the elephant’, with significant energy expended every year on bidding for any additional funds that were allocated. This is not a challenge unique to Northern Ireland. We heard that the current system worked best when there was a multi-disciplinary team set-up, with a clear objective.

- The focus of the system should be on getting the best possible value from the £4.7bn we spend on health and social care. This could involve a programme of rolling thematic reviews across service areas to consider how services can be reconfigured and re-shaped to better meet demand within existing resources – and ensure the appropriate level of consistency in models of care across Northern Ireland.
- In-year funding should be allocated as far as possible against a list of agreed service priorities. Trusts should plan on the basis that additional funding will not become available in year.
- Any demography funds secured at the start of the year should be allocated where additional service capacity can be demonstrated through reform. Consideration should also be given to a dedicated reform fund.

Financial flexibility

If we are to move to a longer term planning horizon, we need to consider the financial flexibilities we give to provider bodies. Without some flexibility across years Trusts will not have the discretion to make longer term investment decisions. Northern Ireland seems unique in the UK in not providing this flexibility to its providers. Often this flexibility is used as a reward for good provider performance and / or is linked to the completion and sign off of longer term strategic plans. The Department will need to engage with DfP to make the case for any necessary changes.

Focussed on both service quality and access

There was a strong sense that the focus of performance management was heavily skewed to access targets for acute care, such as the 4 hour Emergency Department access target. There needs to be a better balance struck between ensuring access and driving quality.

- Performance management discussions with Trusts should encompass the whole range of Trust services.
- A clear ladder of intervention should be developed, so Trusts know in advance what response can be expected if and when performance starts to deteriorate.
- 'Earned autonomy' should be the key principle that underpins this approach.
- Greater emphasis should be placed on service improvement support.

Streamline decision making and strengthen accountability

Balancing coordinated decision making with devolved decision making is often a challenge. Without cutting across requirements to develop more consistent care pathways and ways of working across Northern Ireland, clearance processes need to be made clearer and slimmed down to allow for quicker decision making. Clarity on the roles and responsibilities of different decision makers is critical if we are to achieve this.

Community engagement

As well as creating the capacity for greater engagement with communities and service users by moving to a longer term planning horizon, new approaches are needed to gather views from the wider public around issues of relative prioritisation and forms of service delivery. Digital means of engagement provide new opportunities to engage more of the public in discussion.

Conclusions

It is clear that the current system of commissioning carries too much complexity and too many layers of authority, with too many interactions between different bodies slowing up decision making, blunting responsiveness and creating tensions as each organisational layer seeks to influence decisions. This has sapped the considerable energy and talents of those working in the system, with the focus on transactions rather than transformation.

This complexity has also meant that accountability is weaker than it should be, with a lack of clarity about where responsibility for decisions sit and a feeling of disempowerment at all levels. Instead of focussing on collaboration to drive change effort has been directed into transactional interactions. Moving forward we need to shift the balance between management and leadership. The current system is not uniform however – and as noted by this report there are some clear examples of good practice on which we should build.

While the scope for improvement is clear it is also transparent to us that it is impossible to build the perfect system. Conversations with Wales, England and Scotland confirm that they face many of the same challenges we do despite the differences between our systems. Nonetheless, there are clear lessons for us in the rest of the UK – particularly when it comes to both streamlined structures and collaborative cultures. The Scottish and Welsh systems also demonstrate that strong leadership and performance management is not synonymous with a commissioner/provider split.

Further detailed work will be needed to consider the finer details of how changes are implemented. Legislation will be necessary for some structural changes. Close engagement with HSC bodies and staff affected will be necessary to ensure the success of any changes. In particular we heard that the HSC was weakened by a loss of talent and experience when enacting previous structural reforms. Focussed efforts will need to be made to retain (and attract) talent as part of managing change. This is likely to be easier if there is a clear timeline for change, a commitment to moving swiftly and dedicated resource and oversight focussed on managing change.

At a regional level Northern Ireland should move away from a structure with a separate commissioning function. Instead, Trusts should take on responsibility for planning the bulk of services delivered in Northern Ireland. This should strengthen operational independence, shorten lines of accountability, simplify and streamline the existing system significantly and allow us to build on our existing strength – integration. It should also help create a stronger sense of a single HSC, working together and provide more scope for clinical engagement and leadership. Scotland and Wales provide templates from which to learn. This approach should increase the focus on care delivery and reform, rather than oversight and process, and should simplify and streamline the system. We would also argue that it builds on Northern Ireland's existing strength – the integrated nature of our health and social care system.

A stronger, more strategic core should be based within DHSSPS, again building on learning from Wales and Scotland. This should create a better balance between clear strategic direction and operational independence. This strategic core should have a clear focus on reducing unjustified variation, driving reform and overseeing financial management, performance management and the commissioning / planning of services that can only be effectively planned at regional level. The PHA should remain as a separate organisation, though the functions for which it is responsible must be considered further. Putting a clear focus on one regional body will address the core issue we heard – confused lines of accountability and leadership. Nonetheless, structural change will need to be accompanied with a focus on changing behaviours and ways of working.

Further thought should be given to how Family Practitioner Services are organised, given ongoing work to consider the delivery of GP services. There is merit, in our view of ensuring Trusts play a more active role in primary care – but adopting some of the approaches being trialled in England to bring together providers across an 'economy of care' should be considered alongside the devolution of greater responsibility to Trusts.

Moving away from a regional structure with a separate commissioning function to Trust-led planning for local services will necessitate changes at a local level, including ending the role of LCGs. But work will need to continue to better integrate services– including ensuring a strong voice for primary care, service users and the third sector. Further work is needed to define and refine how these structures will operate and how integration will be incentivised within the new structure.

This is a substantial set of changes for the HSC to make – which must be accompanied by a shift in culture and practice as we move to a system focussed on greater autonomy and accountability. Nonetheless, we believe the approach to be one that is deliverable.

While we heard arguments for changes to Trust boundaries and numbers we doubt that these changes would have a significant impact on the effectiveness of the system. Structural change should therefore be focussed on the areas where it is likely to have greatest impact.

The conclusions and recommendations set out above represent only a very broad framework for change, considered against the criteria set out at the beginning of this chapter. Further detailed work will need to be undertaken to refine the model, clarify structures, responsibilities and staffing issues.

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Appendix 1

Review of Health and Social Care Commissioning Arrangements in Northern Ireland

Terms of Reference

To ensure that the commissioning of health and social care services is fit for purpose to meet the changing and growing needs of the citizens of Northern Ireland into the future, the Department has instigated a review of commissioning to identify opportunities for improvement.

This review will:

1. Undertake an assessment of how the commissioning process facilitates the delivery of high quality and efficient health and social care services in Northern Ireland, with particular reference to:
    - **Assessing** the health and social wellbeing **needs** of the population of Northern Ireland.
    - **Strategic planning** to prioritise needs within available resources, including the use of financial and other levers, to reshape services to meet future needs.
    - **Engaging** patients, users, carers / families and other key stakeholders at a local level in the commissioning of health and social care services.
    - **Securing, procuring, incentivising and agreeing** high quality, value for money service provision to meet the assessed and prioritised needs of the population.
    - **Ensuring** the delivery and outcomes from services commissioned.
    - **Evaluating** impact of health and social care services and **feeding back** into the commissioning process in terms of how needs have changed.

2. Bring forward recommended options to improve the effectiveness of the delivery of health and social care services in Northern Ireland.

It is expected that the review will report in the summer of 2015.

Appendix 2

List of stakeholder meetings and written inputs

Meetings held:

Abigail Harris, Director of Planning, Cardiff and Vale University Health Board
Alex McMahon, Director of Strategic Planning, Performance and Information, NHS Lothian
Alex Morton, Director of Commissioning System Change and Public Health Transition, NHS England
Allied Health Professions Federation NI
Belfast HSC Trust Chief Executive and senior management team representatives
Belfast LCG representatives
Bernard Mitchell, Chair of the Northern Ireland Guardian Ad Litem Agency, former member of SMT at the HSCB and former senior civil servant DHSSPS
Brian Slater, Scottish Government policy lead, strategic commissioning policy for health and social care integration
British Medical Association, Chair, NI Council
British Medical Association, Chair, NI General Practitioners Committee
Bronagh Scott, Deputy Chief Nurse, NHS England, London Region and North-West London Director of Nursing, formerly Director of Nursing at the Northern Health and Social Care Trust
BSO Chief Executive
Catherine Underwood, Director of Integrated Commissioning for Adult Social Care Services, Norfolk County Council
Chair, Antrim and Ballymena ICP
Chair, Craigavon and Banbridge ICP
Chair, East Antrim ICP
Chair, Mid-Ulster ICP
Chair, North Down ICP
CO3 health and social care special interest group
Colm Donaghy, Chief Executive of Sussex Partnership NHS Foundation Trust and former Chief Executive of Belfast Health and Social Care Trust
Daniel Phillips, Director of Planning, Welsh Health Specialised Services Committee
David Geddes, Head of Primary Care Commissioning, NHS England
David Sissling, Chief Executive of Kettering General Hospital NHS Foundation Trust, former Chief Executive of NHS Wales, former Programme Director for Healthcare London and

former Chief Executive of the Northern Ireland Health and Social Care Authority
DHSSPS top management group
HSCB Chair and non-Executive Director
HSCB Executive Directors
Independent Health and Care Providers (IHCP)
Ivan Ellul, Director of Commissioning Policy and Planning, NHS England
John Compton, former Chief Executive of the Health and Social Care Board
John Connaghan, NHS Scotland Chief Operating Officer
Mairead McAlinden, Chief Executive of South Devon Healthcare NHS Foundation Trust and former Chief Executive of Southern Health and Social Care Trust
Martin Farran, Executive Director of Adult and Community Services, Barnsley Local Authority
NI Ambulance Service Trust Chief Executive
NI Association of Social Workers
NI Council for Voluntary Action
NI Faculty of Public Health
NI Practice and Education Council for nursing and midwifery
NI Social Care Council
Northern HSC Trust Chief Executive and senior management team representatives
Northern LCG representatives
PCC Chief Executive and Head of Operations
PHA Chair and non-Executive Director
PHA Executive Directors
Ray Martin, former DHSSPS civil servant
Rob Bellingham, Director of Commissioning (Greater Manchester), NHS England Lancashire and Greater Manchester
Robert Williams, Scottish Government policy lead, performance management
Royal College of GPs
Royal College of Midwives
Royal College of Nursing
RQIA Chief Executive and Executive Team representatives
South Eastern HSC Trust Chief Executive and senior management team representatives
South Eastern LCG representatives
Southern HSC Trust Chief Executive and senior management team representatives
Southern LCG representatives

Tim Davison, Chief Executive, NHS Lothian
Tom Coffey, Clinical Lead and Chair of Mental Health Clinical Commissioning Group, Wandsworth CCG.
Western HSC Trust Chief Executive and senior management team representatives
Western LCG representatives

Written submissions received

Action for Children
Antrim and Newtownabbey Borough Council
Association for Real Change
Brain Injury Matters
British Heart Foundation
CO3
College of Occupational Therapists
Craegmoor NI
Department for Social Development
Department of Agriculture and Rural Development
Derry City and Strabane District Council
Family Mediation NI
Homecare Independent Living
Lisburn and Castlereagh City Council
Mid and East Antrim Borough Council
Mid Ulster District Council
Newry, Mourne and Down District Council
NI Local Government Association
Office of the First Minister and Deputy First Minister
Praxis
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Surgeons
Triangle Housing Association

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The King's Fund

Ideas that change
health care

Integrated care in Northern Ireland, Scotland and Wales

Lessons for England

Authors
Chris Ham
Deirdre Heenan
Marcus Longley
David R Steel

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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About the authors

Chris Ham took up his post as Chief Executive of The King's Fund in April 2010.

He has been Professor of Health Policy and Management at the University of Birmingham, England since 1992. From 2000 to 2004 he was seconded to the Department of Health, where he was Director of the Strategy Unit, working with ministers on NHS reform. Chris is the author of 20 books and numerous articles about health policy and management. He was awarded a CBE in 2004 and an honorary doctorate by the University of Kent in 2012.

Chris has advised the World Health Organization (WHO) and the World Bank and has served as a consultant to governments in a number of countries. He is an honorary fellow of the Royal College of Physicians of London and of the Royal College of General Practitioners, an honorary professor at the London School of Hygiene & Tropical Medicine, and a companion of the Institute of Healthcare Management.

Chris was a governor and then a non-executive director of the Heart of England NHS Foundation Trust between 2007 and 2010. He has also served as a governor of the Canadian Health Services Research Foundation and The Health Foundation.

Deirdre Heenan is Pro-Vice-Chancellor (Communication) and Provost (Coleraine and Magee)of the University of Ulster.

A distinguished researcher, author and broadcaster, she is a member of the Institute for Research in Social Sciences and has published widely on health care, education policy, social care and devolution. She is a co-founder and former co-director of the Northern Ireland Life and Times Survey.

In 2001 she received a Distinguished Teaching Award and in 2006 a prestigious National Teaching Fellowship by the Higher Education Academy. In 2008 she secured an ESRC fellowship and spent nine months as policy adviser in the Office of the First Minister and Deputy First Minister. In 2011 she was appointed by the health minister to join a five-strong panel of experts to oversee a radical review of health and social care in Northern Ireland. In 2012 she was appointed to the Irish President's Council of State as one of the seven personal nominees of President Michael D Higgins.

David R Steel was Chief Executive of NHS Quality Improvement Scotland from its creation in 2003 until 2009 and played a major part in setting up the Scottish Patient Safety Programme. After 12 years as lecturer in public administration at the University of Exeter, he became Assistant Director of the National Association of Health Authorities in 1984. From 1986 he held various senior posts in NHSScotland and the Scottish Office Health Department. In retirement he has held an honorary senior research fellowship at the University of Aberdeen and chairs the Prioritisation Panel of the National Institute for Health Research Health Services and Delivery Research Programme. He is the author of the Scottish health system review published in 2012 as part of the European Observatory's *Health Systems in Transition* series. In 2008 he was awarded an OBE for services to health care.

Marcus Longley is Professor of Applied Health Policy and Director of the Welsh Institute for Health and Social Care, University of South Wales. He was educated at the universities of Oxford, Cardiff and Bristol, and worked in the NHS for 14 years, in a variety of managerial and planning posts, and for two years with the Welsh Health Planning Forum, before joining the university in 1995.

His current interests include public and client/patient involvement in shaping policy and service delivery; integrated working across public services; health care futures, particularly the development of the health professions in the future (with a particular interest in pharmacy and nursing); and the future impact of the new genetics on the organisation and management of health care. He is a specialist adviser to both the House of Commons Welsh Affairs Committee and the Welsh Local Government Association, is a board member of Consumer Focus Wales and two third sector organisations, and has served as an adviser to the Royal Pharmaceutical Society of Great Britain for many years. He is a member of the Welsh Assembly Government's Self Care Board, and was elected a Fellow of the Faculty of Public Health of the Royal Colleges of Physicians in 2008.

Introduction

Chris Ham, Chief Executive, The King's Fund

The aim of this report is to describe the approach taken to integrated care in Northern Ireland, Scotland and Wales with a view to drawing out the lessons for England. The report has been written at a time when policy-makers in England have made a commitment to bring about closer integration of care both within the NHS and between health and social care. This creates an opportunity to understand what has been done in the other countries of the United Kingdom to develop integrated care in order to inform policy and practice in England.

With this in mind, we commissioned authors in each of these countries to write a paper covering the following issues:

- the context in which health and social care is provided including the governance and planning of these services and organisational arrangements
- policy initiatives to promote integrated care pursued by the devolved governments, and the impact of these initiatives
- the barriers and challenges to achieving integrated care, and how these have been tackled and overcome.

We also invited the authors to reflect on what England could learn, drawing on their own experience and assessment of what has and has not been achieved in the country that they were asked to write about.

Early drafts of the papers were discussed at a seminar with the authors and this provided an opportunity to identify similarities and differences and emerging themes. Further drafts followed and these were then reviewed by experts in integrated care both within The King's Fund and outside. The papers published here have incorporated comments on these drafts, and provide comprehensive and up-to-date descriptions of the experience of Northern Ireland, Scotland and Wales and the lessons that can be drawn from this experience.

While the papers follow a broadly similar format, based on the brief given to the authors, there is some variation in the issues covered and the analysis offered by the authors. This reflects differences in the data sources that were drawn on in preparing the papers and in the availability of evidence in each country. The final section of this report offers an overview of the three countries and has been written to compare and contrast their experience and explicitly to identify lessons for policy-makers and practitioners in England.

This report was written in parallel with an analysis of health policy in the four countries of the UK written by my colleague, Nick Timmins. As Nick emphasises, there is enormous potential for countries to learn from each other but in practice this rarely happens. The natural experiments that have emerged since devolution have accentuated pre-existing variations between countries but policy-makers have shown little interest in studying these variations and learning from them. This report is a modest attempt to encourage greater curiosity and lesson learning in the hope that others may see its value and follow our example.

1 Northern Ireland

Deirdre Heenan, Pro-Vice-Chancellor (Communication)
and Provost (Coleraine and Magee), University of Ulster

Introduction

Integration in health and social care is not a new concept and has been an explicit policy goal of successive UK governments over the last two decades. A wide range of initiatives and strategies have been introduced to facilitate integrated working, including joint working, partnerships, pooled budgets and structural integration. The focus on integration has become a political preoccupation due to the growing pressure on the NHS, which has amplified the fragmentation and duplication that exist within the system and highlighted the need to ensure that a sustainable model of care is developed and implemented.

There is widespread acceptance that an integrated system of health and social care can lead to better outcomes for service users, particularly for older people with complex needs. Uniquely though, within the United Kingdom, Northern Ireland has had a structurally integrated system of health and social care since 1973. Significantly, the original decision was not informed by theoretical models of health care, but by an urgent need to reorganise the system of local government, which had become widely discredited. There was little awareness that this model of reorganisation, which was given a cautious, lukewarm welcome by health care professionals, would become viewed by many policy-makers, politicians and academics as the Holy Grail.

As this chapter will outline, policy developments in Northern Ireland from the late 1960s have taken place in a distinct context of 30 years of civil and political unrest and direct rule governance. Devolution was restored in 1998 to the locally elected Northern Ireland Assembly; however, following a political crisis it was suspended between 2002 and 2007 and direct rule was reinstated. While devolution has been in place continuously since 2007, this uncertain, volatile landscape has formed a challenging backdrop for the reform and modernisation of health and social care.

Context: the health and social care system

Social context

Northern Ireland has a population of approximately 1.8 million people, with two-thirds of these located around the capital city in the Greater Belfast area. Historically, the Northern Ireland economy has been dominated by manufacturing industry and agriculture, but there has been a shift over the last 30 years to a more service-based economy. The largest elements of the private sector in Northern Ireland are wholesale and retail, manufacturing, and business and professional services (real estate and renting, and business activities). Local and regional statistics have invariably confirmed that Northern Ireland is one of the most deprived regions of the United Kingdom, with relatively high levels of unemployment, disability and poverty. It has the lowest wages and one of the lowest labour productivity rates, and it is heavily reliant on the public sector, which is coupled with a weak private sector. These weaknesses reflect a number of unique, interrelated factors, not least the legacy of 30 years of conflict, the demographic structure and the peripheral location of Northern Ireland, as well as issues surrounding deprivation and rurality.

Northern Ireland is experiencing major demographic shifts: the Northern Ireland Statistics and Research Agency has projected the population to rise from 1.8 million in 2010 to nearly 2 million in 2025 (an increase of almost 8 per cent). They also project that over the same 15-year period, the number of people aged 65 and over will increase by 42 per cent, from 260,000 to 370,000. Significantly, though, the number of people of working age is projected to increase by only 1.4 per cent, from 1,109,000 to 1,124,000, by 2025. The projected figures for people aged 85 and over make dramatic reading: by 2025 the number will increase by 25,000 to 55,000 of whom 62 per cent will be women. The over-85 population will double by 2027 compared with 2010 (Department of Health, Social Services and Public Safety 2013).

Overall life expectancy in Northern Ireland has continued to increase over the period 1980–2009 (O'Neill *et al* 2012). However, there are increasing numbers of people with chronic conditions such as diabetes, respiratory problems, stroke and obesity. In Northern Ireland as in other parts of the United Kingdom, there are increasing expectations and rising demand for use of new drugs and technologies. Research has highlighted a predicted funding gap of £600 million by 2014/15 in a budget of about £4.5 billion, alongside a system of health and social care that over-invests in an inefficient hospital sector while under-investing in community, primary and mental health services (Department of Health, Social Services and Public Safety 2012).

Political context

The Northern Ireland Assembly was established as a result of the Belfast Agreement of 10 April 1998. The Agreement was the outcome of a long process of talks between the Northern Ireland political parties and the British and Irish governments. The Agreement was endorsed through a referendum held on 22 May 1998 and subsequently given legal force through the Northern Ireland Act 1998. The Northern Ireland Assembly has full legislative and executive authority for all matters that are the responsibility of the Northern Ireland government departments and which are known as transferred matters. Excepted matters remain the responsibility of the Westminster parliament. Reserved matters are also dealt with by Westminster, unless it is decided by the secretary of state that some of these should be devolved to the Assembly. Excepted and reserved matters are defined in the Schedules to the Northern Ireland Act. The Assembly was elected on 25 June 1998 under the terms of the Northern Ireland (Elections) Act 1998.

The Northern Ireland Assembly consists of 108 elected Members, six from each of the 18 Westminster constituencies. Its role is primarily to scrutinise and make decisions on the issues dealt with by government departments, and to consider and make legislation. The Assembly is a coalition government based on an agreed formula for power sharing. A First Minister and a Deputy First Minister lead an elected 11-person executive committee of ministers, each responsible for a separate government department.

Since its establishment in 1998, the Assembly has been suspended on four occasions; during these periods legislative power was returned to Westminster on all matters and, as previously, Northern Ireland was governed by the Secretary of State for Northern Ireland.

The United Kingdom's devolved administrations are, for the most part, financed by what is known as a block grant and formula system. The block grant is set by the UK government for multi-year periods. The current block grant covers the four years 2011/12 to 2014/15. The departmental expenditure limits are fixed for each year of the period. Due to HM Treasury rules, the Northern Ireland Executive cannot shift resources from one year into another. The money comes from general taxation across the United Kingdom. The size of the block grant is determined through a mechanism known as the Barnett Formula: as spending on a certain policy area in England goes up or down, Northern Ireland receives an equivalent population-based share of the funding.

Consequently, the amount of money that Northern Ireland receives through the block grant is a direct result of decisions to spend (or not to spend) on programmes that are comparable with England (but not, for example, defence spending, which is all controlled at the UK level). Ultimately, how the money is spent is a local issue depending on priorities. The Executive is not tied to spending it on any particular functions and does not have to mirror England. The block grant is distributed by the Executive among the various government programmes. The Department of Health, Social Services and Public Safety (DHSSPS) receives the largest single allocation of more than £3.8 billion each year, which accounts for almost 45 per cent of total public expenditure.

Historical context

Northern Ireland has had a long history of devolution within the United Kingdom, going back to 1921. The Northern Ireland parliament governed for 51 years, from the foundation of the state until the imposition of direct rule in 1972; it was the single longest-running scheme of governance in the province's history. In 1972, in response to a period of sustained violence and the apparent unwillingness of local politicians to share power, direct rule was introduced. This meant that public and social policy decisions were taken at Westminster and communicated through a secretary of state within the Northern Ireland Office, who answered directly to parliament. They in turn appointed a minister for health, who was responsible for health and social care.

The introduction of direct rule in 1972 coincided with the reorganisation of local government. The new structure was established under the Local Government Act (Northern Ireland) 1972 and became operational in 1973. It consisted of a single tier of 26 district councils based on the main population centres. A key feature of this reorganisation was that local government was divested of its key responsibilities such as health, personal social services, housing and youth education, which were transferred to statutory boards. Despite a number of reviews and reorganisations, local government functions have remained extremely limited (Birrell 2009).

Integrated health and social care

Northern Ireland has had an integrated structure of health and social services since 1973. The original decision owed more to a requirement to reorganise local government than any thought-out, evidenced-based strategy on integration. A radical restructuring of local administration in Northern Ireland was first mooted in a 1969 parliamentary Green Paper, *The Administrative Structure of Health and Personal Social Services in Northern Ireland* (Government of Northern Ireland 1969). A review body reported in June 1970, and in 1972 the shape of the new structure was outlined in a report by the appointed management consultants.

The rationale behind the restructuring was declared as being 'the improvement of the provision of health and social services to the community in Northern Ireland through establishing an integrated approach to the delivery of hospital and specialist services, local authority health and welfare services' (Government of Northern Ireland 1969). The changes would, it was hoped, provide a more rational and comprehensive structure in which to decide priorities, develop policies and 'work together toward a common goal of meeting the total needs of individuals, families and communities for health and social services' (Government of Northern Ireland 1969). These dramatic changes took place against a backdrop of social and political unrest. It has been contended that, rather than as a means of delivering more efficient and effective services, structural changes were introduced as a reaction to the political turmoil and were an attempt to exert control and stability by removing power from discredited elected representatives and placing it in the hands of appointed bodies (Birrell and Murie 1980).

The proposed integration under a structure of four area boards received 'remarkably little discussion' in the Green Paper apart from brief references to the need for co-operation and joint planning (Heenan and Birrell 2011, p 55). The Permanent Secretary of the Department of Health and Social Services, speaking in 1971, identified some of the main advantages of the new system as making possible comprehensive planning at every level, encompassing the totality of medical and social care, and ensuring public participation. Until reform in 2009, health and social services were delivered in Northern Ireland by four health and social services boards, organised on a geographical basis, and eighteen trusts. Of these, eleven were community health and social services trusts and seven hospital trusts based largely on acute general hospitals. A separate ambulance trust and 37 other quangos were involved in the delivery and administration of care.

During the period of direct rule (1972–99), reform and the development of policy and strategy in health and social services were virtually non-existent. The default position was to copy English policy changes, and the UK government appeared content to keep this unusual system of governance ticking over. Stability was the key priority, and social and public policy reform was generally sidestepped by direct rule politicians.

To some onlookers this may appear rather surprising. Direct rule health ministers were in a somewhat unique position in that they were not directly accountable to the local electorate and could have taken medically necessary but politically unpopular decisions. The absence of local political accountability, known as the 'democratic deficit', could have made Northern Ireland's health service a fertile ground for innovation and modernisation. Perhaps unsurprisingly, it was quickly apparent that direct rule ministers were unwilling to make politically contentious decisions.

Northern Ireland, it appeared, already had sufficient political controversy without adding health and social care reform to the mix. Importantly, direct rule was also largely viewed as a short-term stopgap with a devolved administration just around the corner, so it was considered best to leave the more controversial decisions to local politicians and pointless to embark on long-term projects. Consequently, health and social care in Northern Ireland largely stagnated under the period of direct rule, and there were few, if any, attempts to pursue distinctive policy approaches based on the needs of the local population.

The lack of progress with regard to social policy-making is clearly reflected in a number of key areas. In the area of social care, Northern Ireland continues to operate under the vision and principles set out in the 1990 White Paper, *People First: Community care in*

Northern Ireland. Community care has been neglected, under-developed and under-funded, and requires a radical review. The persisting levels of deprivation and the legacy of Northern Ireland's 30 years of social and political unrest, known as 'the troubles', have contributed to the significant mental health issues. In September 2005, *Equal Lives: Review of mental health and learning disability (Northern Ireland)* (known as the Bamford Review) set out proposals to reform services in this area. To date, however, progress has been slow and uneven. In 2011 it was reported that levels of mental health problems were 25 per cent higher in Northern Ireland than in Great Britain but funding was 25 per cent lower.

Amended mental health legislation and new mental health capacity legislation are still pending. Legislation has not been updated since 1986, a situation which contrasts sharply with the one in Scotland. The Bamford Review stressed the need to develop the advocacy role, but again little progress has been made in this area.

The resumption of devolution in 2007 initially delivered very little progress in the area of health and social care. Despite the unassailable case for substantial reform and reconfiguration, local ministers appeared unwilling or unable to grasp the nettle, sure in the knowledge that any proposed changes would be met by local opposition. The first Health Minister, Bairbre de Brún (Sinn Féin), seemed unwilling to accept that major reform was required, despite the historic over-reliance on hospital services and an under-developed system of community care. She was followed by Michael McGimpsey (Ulster Unionist Party), who was apparently aware that there were major problems but focused his attention on the implementation of the Review of Public Administration (RPA) and its accompanying restructuring.

Two substantial reviews of Northern Ireland's health and social care system (Appleby 2005, updated in 2011; Connolly *et al* 2010) have attempted to assess how the system compares with other countries of the United Kingdom. These reports and a recent National Audit Office report (NAO 2012) highlighted the difficulties of any attempt at cross-national comparisons due to the use of different indicators and changes over time. In his 2005 report, Appleby bemoaned the distinct absence of an explicit performance management system. He regarded it as pivotal to achieving improvements in efficiency, effectiveness and responsiveness. He was critical of the existing performance management structures and suggested (p 10) that they contributed to an impression of 'a system lacking urgency, of general drift, and a consequent frustration amongst many in the services – at all levels – with the relative lack of improvement in performance'. He contended that the current performance management system was devoid of the clear and effective structures, information and, most importantly, incentives – both rewards and sanctions – at individual, local and Northern Ireland organisational levels to encourage innovation and change.

Perhaps illustrative of the complexity and challenges inherent in the system, despite it being the largest portfolio in monetary terms, the health portfolio has not been viewed as a top priority for political parties. Edwin Poots (Democratic Unionist Party) became health minister in May 2011 and from the outset acknowledged the need for radical change in order to optimise outcomes. In June 2011, he announced that a major review of the provision of health and social care services would be undertaken. Making the case for change was at the centre of this review and a fundamental recognition that the existing model of care that had developed for the most part under direct rule was not fit for purpose (*see* p 9–10).

Organisation of health and social care in Northern Ireland

The Health and Social Care (Reform) Act (Northern Ireland) 2009 was introduced following the RPA to reduce the number of bodies involved in the administration, commissioning and delivery of health and social services. While Northern Ireland has had structural integration of health and social care since the early 1970s, this further major restructuring aimed to maximise economies of scale and improve outcomes. This Act created a single large commissioning body, the Health and Social Care Board, and five large health and social care trusts (HSC trusts) responsible for the delivery of primary, secondary and community health care. Co-terminous with the new trusts were five local commissioning groups (*see* Figure 1 below).

Figure 1 Structures for health and social care delivery, Northern Ireland

	Pre-2007	Post-2007
	Department of Health (DHSSPS)	Department of Health (DHSSPS)
Commissioning	4 health and social service boards	1 health and social care board 5 local commissioning groups
Delivery	11 community health and social services trusts 7 hospital trusts 1 ambulance trust	5 health and social care trusts 1 ambulance trust
Public involvement	10 specialist service bodies eg, Mental Health Commission 4 health and social service councils	8 special bodies Public Health Agency 1 patient and client council

Department of Health, Social Services and Public Safety

With overall authority and allocation of government funding, DHSSPS is one of 11 Northern Ireland government departments created in 1999 as part of the Northern Ireland Executive. Health and social care is one of the three main business responsibilities of the department, which are:

- health and social care, which includes policy and legislation for hospitals, family practitioner services and community health, and personal social services
- public health, which covers policy, legislation and administrative action to promote and protect the health and wellbeing of the population
- public safety, which covers policy and legislation for fire and rescue services.

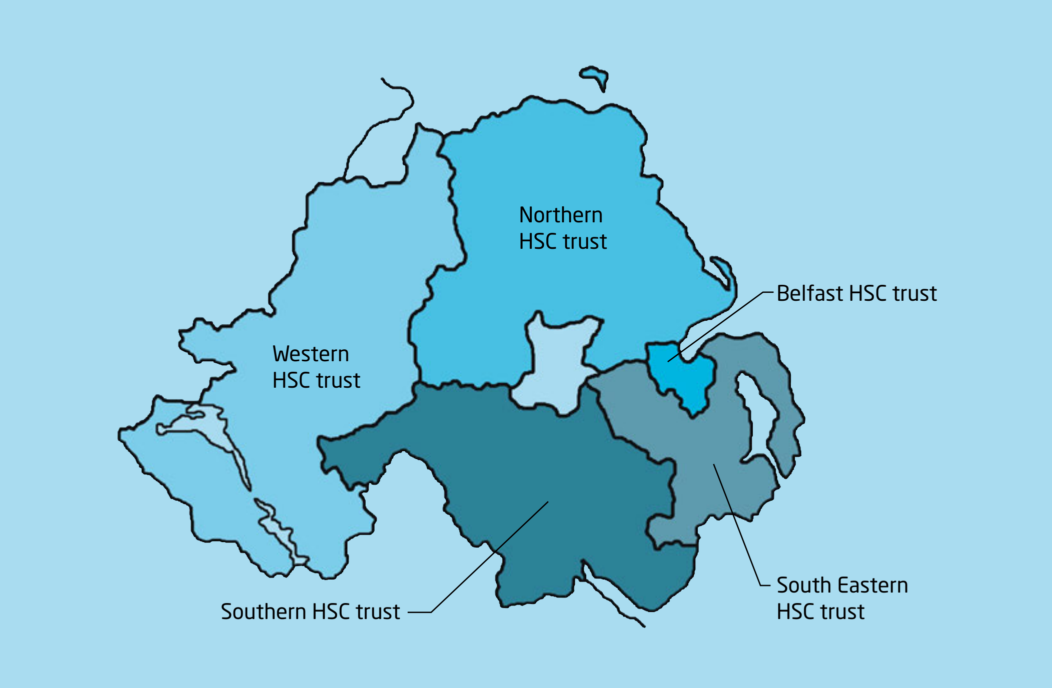
The department is responsible to the Minister for Health, who is one of the 11 departmental ministers in the Executive. A cross-party health committee performs a scrutiny role in terms of the decisions made by the minister, the operation of the department, and other health and social care bodies and functions.

Health and Social Care Board

The Health and Social Care Board (HSCB) sits between the department and the trusts and is responsible for commissioning services, managing resources and performance improvement. The board is also directly responsible for managing contracts for family health services provided by GPs, dentists, opticians and community pharmacists. These are all services not provided by HSC trusts.

Inside the board there are local commissioning groups focusing on the planning and resourcing of services. These groups cover the same geographical area as the HSC trusts, as shown in Figure 2 below. The structure of health and social care in Northern Ireland is shown in Figure 3 opposite.

Figure 2 Health and social care trusts, Northern Ireland



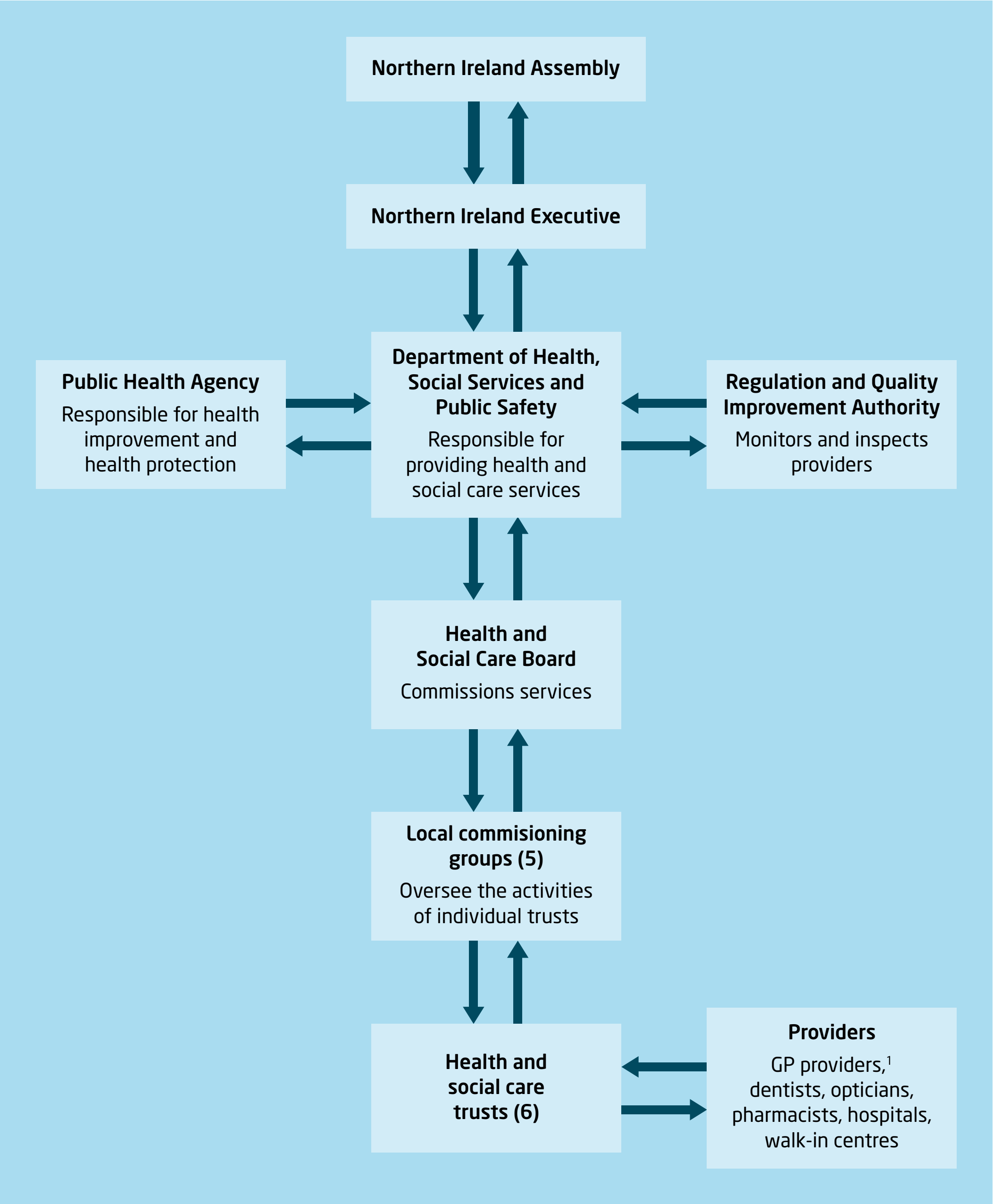
Source: Belfast Health and Social Care Trust

Health and social care trusts

The five HSC trusts provide health and social services across Northern Ireland on a geographical basis. A sixth trust, the Ambulance Service, serves a particular function and operates on a regional basis. While the HSCB commissions services, it is the trusts that actually provide them 'on the ground'. Each trust manages its own staff and services, and controls its own budget. The average population per trust is 359,878 (compared with 307,753 in England).

GPs play a key role in the system, as they are usually the first point of contact with service users and act as gatekeepers to other services. Usually GPs work in group practices, often in teams that include health visitors and nurses. The vast majority of health care services are available through the public sector, with just two small private hospitals. The majority of residential home places are provided by the private sector.

Figure 3 Structure of health and social care, Northern Ireland



[1] GPs in Northern Ireland are contracted directly by the Health and Social Care Board and so they receive funding from, and are directly accountable to, the board rather than the health and social care trusts.

Source: Northern Ireland Audit Office

Transforming Your Care

In 2011, Edwin Poots, Minister for Health, Social Services and Public Safety in Northern Ireland, launched a review of health and social care services, which was to undertake a strategic assessment of the system and bring forward recommendations for the future shape of services with an implementation plan. *Transforming Your Care: A review of health and social care in Northern Ireland* (the Compton Review) was published in December 2011 (Department of Health, Social Services and Public Safety 2011b). Described as the biggest shake-up of health care in the region's history, it concluded that doing nothing was not an option, as the current and future pressures on the health and social care system provided an unassailable case for change. It identified a clear mismatch between the needs of the population for proactive, integrated and preventive care for chronic conditions, and a health care system where the majority of resources are targeted at specialised, episodic care for acute conditions. The report set out a vision for the future of health and social care in Northern Ireland which ensured safe, sustainable, effective services for all. It advocated:

- a reduction in the number of acute hospitals from ten to between five and seven
- a shift of 5 per cent of hospital funding to primary and community care
- a shift of work from hospitals to community and primary care
- an increased role for GPs in the commissioning and provision of services
- an emphasis on prevention, focusing on obesity, smoking and alcohol
- a shift towards greater care at home
- a robust, bottom-up commissioning structure
- future planning for telemedicine
- the personalisation of care.

The Compton Review set out integrated care and working together as one of the key principles. This was justified in terms of a need for improvement, expressed as: 'different parts of the health and social care system should be better integrated to improve the quality of experience for patients and clients, safety and outcomes' (Department of Health, Social Services and Public Safety 2011b, p 40). There was little analysis or evaluation of the failings of existing integration, but there were implied criticisms in comments such as 'the professionals providing health and social care services will be required to work together in a much more integrated way to plan and deliver consistently high quality care' (Department of Health, Social Services and Public Safety 2011b, p 7), and an expression of concern at the slow implementation of new integrated services for learning disability (Department of Health, Social Services and Public Safety 2011b, p 94). It highlighted the over-reliance on hospitals and noted the need to deliver care closer to home; evidence for this included a bed utilisation audit of 2011 which showed that, on the day in question, up to 42 per cent of the inpatients reviewed should not have been in hospital.

Figure 4 Key trends in location of services, Northern Ireland

Source: Cole (2009)

The proposal for integrated care partnerships

As part of a future model for integrated health and social care, a key proposal is to establish integrated care partnerships (ICPs) to join together the full range of health and social care services in each of 17 areas, including GPs, community health and social care providers, hospital specialists, and representatives of the independent and voluntary sectors. It is envisaged that the ICPs will have a role in determining the needs of the local population, and planning and delivering integrated services. Crucially, it is suggested that these ICPs have the potential to make a positive contribution to the delivery of care closer to home, rather than in hospitals. It is stated that GPs will assume a critical leadership role in these groups (Department of Health, Social Services and Public Safety 2011b, p 123).

This proposal may seem surprising given the existing integrated structures, and it raises questions about the relationship of ICPs to integrated programmes of care, integrated teams, integrated budgets, decision-making powers, and the relationship with commissioning and provider arrangements. Following the publication of the Compton Review, detailed plans for the implementation of the Transforming Your Care agenda were drawn up by the five HSC trusts, which added some of their own interpretations to the proposals. Subsequently DHSSPS has published its own implementation paper, which provides some more detail about ICPs (Department of Health, Social Services and Public Safety 2012).

ICPs are described as a co-operative network between existing providers, that will design and deliver high-quality services and will be clinically led (Department of Health, Social Services and Public Safety 2012, p 22). It is expected that much of the initial focus of ICPs will be on improving key aspects of the way services are organised for frail older people and for those with specific long-term conditions such as diabetes. ICPs will prevent hospital admission by identifying patients most at risk, and will work proactively across the sector to develop strategies to manage health and social care needs. It is suggested that working in this 'more integrated way' will reduce or prevent hospital admissions.

Some trusts, however, have expressed their concerns over proposals to develop these ICPs. Particular issues raised included:

- that the creation of 17 new stand-alone bodies appears excessive and will lead to increased bureaucracy and overhead costs
- a scepticism about the resourcing of models of care in the community in the light of increasing demands
- that fixed professional membership could lead to a rigid approach and consequently membership should be fluid
- the possibility of creating new silos rather than facilitating more co-operation
- that the focus of these ICPs should be on patient pathways.

Implementing Transforming Your Care

In the implementation of Transforming Your Care, the focus on better integration between hospitals and GP practices tends to mean that little attention is paid to the continuing developments in integrated social and health care in Northern Ireland. There are numerous well-established examples of how a holistic approach providing care closer to home rather than in a hospital setting can improve service users' outcomes and reduce demand on the NHS. Policies to move resources from hospital care to home- and community-based care are being implemented throughout the United Kingdom. The Northern Ireland model of structural integration can be assessed for its potential and capacity to deliver on these goals and objectives. The need in Britain to bring those providing acute hospital services more into integrated working has been recognised (Ham 2009). The impact of different professional philosophies and cultures between the community and acute sectors has been a constant theme in research literature (Cameron *et al* 2012).

The Transforming Your Care implementation plans do carry with them risks for the successful and effective integration of social care with acute care. The Belfast HSC Trust (2012) has clearly identified a number of overall risks, including the assumptions about cash release from the acute sector and the change in demand for services not being realised, lack of financial resources, lack of capacity/capability in the workforce, lack of IT links and physical infrastructure, and lack of clinical engagement and commitment to deliver collectively on the implementation plans. The treatment of social care in the implementation plans can be seen as problematic. The plans may create a very unequal relationship between health and social care in terms of the composition of partnership committees and the leadership of partnerships. The planned shift from hospital care to health care in the community could undermine the position and role of adult social care and have adverse consequences on the allocation of resources.

There is a tendency in the implementation plans to define people's needs in terms of health attributes and the management of illness. It has been noted that a focus on re-ablement and getting people back on their feet can lead to a neglect of other social care support and measures to enhance wellbeing (Glendinning and Means 2004). The plans for the implementation of Transforming Your Care pay little attention to modernisation agendas for adult social care as developed in England, Scotland and Wales. The theme of user involvement and user control is largely ignored, despite its prominence in British narratives as a key to better quality and outcomes.

Personalisation was strongly advocated throughout the Compton Review, but is not discussed in detail in the Belfast HSC Trust's plans or the Department's implementation strategy, beyond the low-key definition of personalisation. It can be argued that if there is a shift from hospital care to a greater reliance on social care, more developed strategies would be needed relating to support for the enhanced role for carers, new workforce developments and specific outcome frameworks to measure transformation other than through changes in service provision. Overall there is also a need for new social services legislation, akin to the Bills for England and Wales, which builds on the knowledge that has been acquired since the inception of direct payments. This legislation would clarify and enshrine the rights of service users.

Critical to the success of the Transforming Your Care agenda is mobilisation of a cross-departmental policy network that supports the entire public policy agenda and ensures that there is joined-up thinking in the design and delivery of health care. Welfare payments, housing and transport are crucial elements of any comprehensive strategy, yet they sit within completely separate government departments. Previous research (Trench and Jeffrey 2007, p 24) noted that the extent to which responsibilities are spread across government departments means that Northern Ireland has 'the most disjointed and limited approach to ageing issues in the UK'. Clearly, this issue of a cross-departmental approach is one that must be afforded priority, yet it is one which has not yet been considered or discussed at Executive level.

Research on integration in Northern Ireland

A striking aspect of the system in Northern Ireland is the lack of rigorous evaluation and assessment, despite the fact that closer integration has been a key policy objective of successive British governments for decades. A range of methods and initiatives to facilitate closer working, including partnerships, have been introduced and piloted, yet scant attention has been paid to the system in Northern Ireland. Heenan and Birrell (2006, 2009) highlight this anomaly and noted the following.

> *Despite the uniqueness of the structure, it has received surprisingly little attention from policy analysts and academics. On the rare occasion where work on the integration of health and social services has referred to Northern Ireland, comments have tended to be somewhat dismissive of any beneficial achievements, without any substantial evidence to support this view.*
>
> (Heenan and Birrell 2006, p 49)

Policy documents from DHSSPS and sessions of the Northern Ireland Assembly Health Committee with senior civil servants pay little attention to the potential of integration. Among politicians, policy-makers and academics there continues to be a lack of understanding of the unique structures in Northern Ireland and the possibilities that they present. The challenge of achieving a holistic system of care across the spectrum of needs is an international one; this model of health care could provide important insights, but it requires robust evaluation and assessment. Despite the continuing support for integrated approaches, there is surprisingly little interest in strategic review.

Heenan and Birrell (2006, 2009, 2012) have published a number of small-scale reviews of the integrated system and highlighted the benefits and limitations of the system in Northern Ireland. The operation of the integrated structure has delivered benefits through programmes of care. The integrated management system allows for the cultural gap between health and social care to be effectively addressed. Reduced delays in hospital discharge have also been identified as a key advantage of this integrated system. In their research, Heenan and Birrell (2009) also identify a number of areas that continue to cause difficulty, including the dominance of health care over social care and the absence of inter-professional training. These advantages and disadvantages are now considered in more detail.

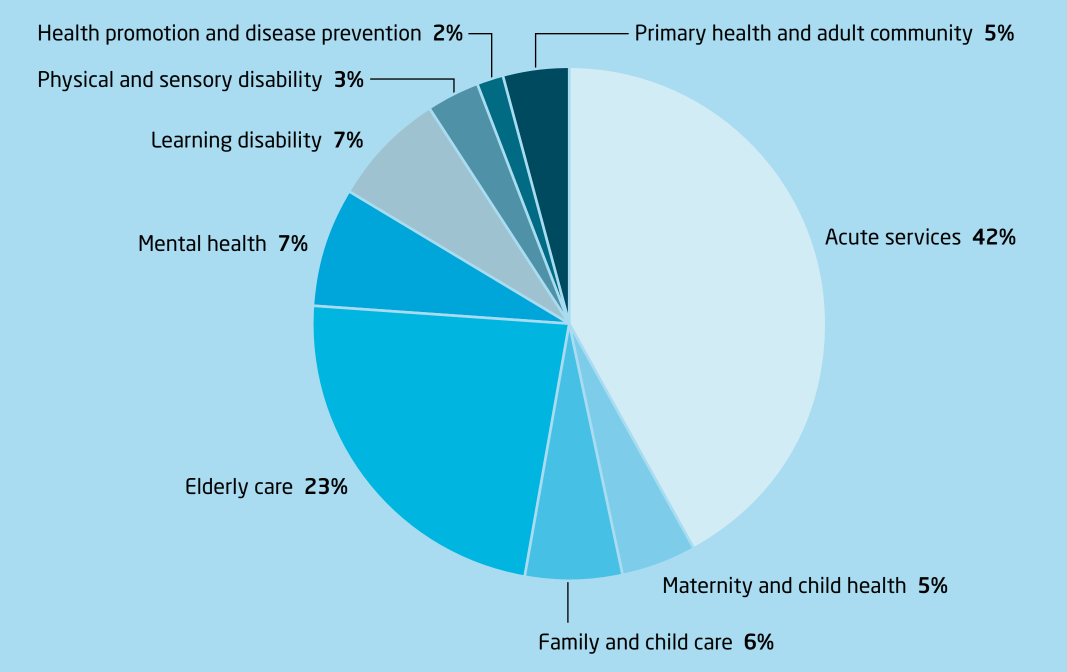
Achievements of structural integration

Delivery of integrated care

Integration in the delivery of services in Northern Ireland is mainly achieved through the division of health care into programmes of care to which resource procurement and finance are assigned (*see* Figure 5 overleaf), so as to provide a management framework. They are used to plan and monitor the health service by allowing performances to be measured, and targets set and managed on a comparative basis. They follow a similar pattern in all trusts. There are nine programmes of care: acute services; maternity and child health; family and child care; elderly care; mental health; learning disability; physical and sensory disability; health promotion and disease prevention; and primary health and adult community. The programme of care teams operate on an inter-disciplinary basis, but the degree of integration does vary between the programmes. Mental health and learning disability are the most fully integrated, with child care reflecting least integration, due largely to statutory commitments.

Heenan and Birrell (2009) highlighted extensive professional support for this method of working as it was claimed it ensures that resources are used to best effect and managers

Figure 5 Breakdown of HSC trust expenditure by programme of care, Northern Ireland, 2009/10



Notes: This figure shows that expenditure on acute services and elderly care accounted for about two-thirds (65 per cent) of the total expenditure recorded under the programme of care framework.

Expenditure on health promotion and disease prevention accounted for the smallest proportion (2 per cent) of the total expenditure recorded under the programme of care framework.

Source: Northern Ireland Assembly (2011)

are not constrained by artificial boundaries between health and social care. Programmes of care appear well placed to meet the increasingly complex needs of service users. Also, within this approach the individual has a named key worker and this makes access to services less complex and daunting. Care is co-ordinated and therefore duplication of services is avoided. This has been referred to as a ‘one-stop shop’ or ‘no wrong door’ approach. The fact that there is one point of entry for anyone wishing to access health and personal social services is considered to be a particular advantage of the system. The structural integration is thought to provide a seamless service which avoids fragmentation and duplication and ensures that service users do not slip through the net.

In Britain, the Care Programme Approach (CPA), which is similar to these programmes of care, was introduced in 1991 to improve collaboration and multidisciplinary working. The CPA has improved multidisciplinary working in services for older people and those with mental health problems but has not led to a fully integrated service (Snape 2003). In their discussions on modernising the NHS, Plamping et al (2000) claimed that many people shared the government’s aspiration for further co-operation but inter-agency tensions would not simply go away. Partnerships between organisations are difficult to achieve, as departmental, cultural and organisational differences are hard to overcome. The key difference in Northern Ireland is that there is one agency, one employer, one vision, shared aims and objectives, and one source of funding, and consequently many of the problems identified in Britain have been avoided.

Integrated management

Integrated management has been highlighted as a key achievement of the integrated health and social care structure. It is common in all programmes of care, with the exception of child care, for the position of programme manager or team leader to be open to a range of professions. Thus, a social worker may lead a team involving nurses on a mental health team, or a nurse may lead a team including social workers on an older person's care team. This approach is designed to ensure that all professions are equally valued and respected. It recognises the fact that each profession brings with it its own insights, traditions and values. A 'parity of esteem' model afforded to each profession gives everyone involved the opportunity to take the lead in management. Clearly, though, within this model it is essential that individual professional competencies are maintained and enhanced, and that all staff have a right to professional supervision.

This management structure enables and encourages health care professionals to move across to management roles, and a clear benefit of the integrated structure is that it widens the pool of potential managerial talent. Significantly, while there is integration in day-to-day service delivery, core professional training is still separate. This remains a significant weakness of the system in Northern Ireland. However, multi-professional training and staff development are a feature of work within the trusts, with courses offered on a range of subjects such as needs assessment, case planning, working with children who have been sexually abused, child protection training and courtroom skills.

Hospital discharges

An efficient and timely system of hospital discharge is perceived as one of the real benefits of the integrated structure. In integrated trusts a single body is responsible for discharge and arranging care outside the hospital. Rather than having two agencies debating over responsibilities and costs, a holistic response to individual needs is possible. This facilitates long-term strategic planning for the needs of service users. Systems have been designed to ensure a smooth interface between acute and community services. Strategic decisions are relatively straightforward. For example, when hundreds of long-stay patients with learning disabilities were transferred into the community, there was no need to set up joint management meetings with local authorities. The fact that the move was being overseen by one agency meant that it could happen relatively quickly.

Henwood and Wistow (1993) observed that in Britain there were inherent tensions between health and social care agencies and that this had a detrimental effect on hospital discharge. These conflicting perspectives about what constituted success could impact on patient care. Facilitating the move from institutional to community care, particularly in phasing out provision in relation to psychiatric hospitals and special care institutions, has been identified by those involved as a major achievement of integration in Northern Ireland. Integration has made it easier to close down such institutions, and to prepare for discharging patients into the community.

A social worker who had been appointed as a team leader in a community stroke rehabilitation team was in no doubt that the organisational arrangements were beneficial to the service user. The use of a single assessment system was also highlighted as a key to the successful transition from hospital to the community: care managers co-ordinate assessments involving multiple agencies and professionals. Information and expertise are shared in a way that is mutually beneficial. However, it should be noted that in the area of mental health and learning disabilities the targets set by DHSSPS for resettlement have not been achieved. Clearly, having structures in place to enable a smooth transition to community care and avoid conflict between health and social care agencies does not ensure that targets are met, and the area of mental health is often not viewed as a priority within trusts.

In 2012 an audit report on health care across the United Kingdom found limited availability and consistency of data across the four countries, restricting the extent to which meaningful comparisons can be made between the health services (National Audit Office 2012). Comparable data on the efficiency and quality of health care is patchy.

Consequently, without a single overarching measure of performance, the report was unable to draw firm conclusions about which health service is achieving the best value for money. Where comparative data is available, it found that no one country has been consistently more economic, efficient or effective across the indicators that were considered.

Research from Scotland on delayed discharge (Joint Improvement Team 2011) highlighted the difficulties of attempting to make comparisons across the countries of the United Kingdom. It noted that performance in Northern Ireland has often been held up as exemplary. A single, unified health and social care system might help to alleviate many of the issues, but it is difficult to make comparisons because of the different data collected. In Northern Ireland discharge delays are only counted from acute hospitals; mental health and learning disability discharges are excluded. However, there are very tight targets:

- 90 per cent of patients with ongoing complex care needs will be discharged from an acute setting within 48 hours of being medically fit, and no complex discharge will take longer than 7 days – in all cases with appropriate community support. (A complex discharge is one that can only take place following the implementation of significant (7 hours or more) home-based or other community-based services, including residential or nursing home services.)
- All other patients will be discharged from hospital within six hours of being declared medically fit, including all patients requiring reactivation of an existing care package, non-complex care packages or equipment provision.

These targets are generally achieved with a compliance rate of around 95 per cent.

However, most patients are transferred to intermediate care beds or post-acute settings, at which point there is no ongoing data collected on the patients. In other words, the vast majority of delays in Scotland would not be registered in Northern Ireland. In Northern Ireland, data is not collected for the complete patient journey and therefore some of the available statistics can be misleading. For example, in a number of trusts it is common practice for a patient to be moved from a bed in an acute hospital to a residential home while they are assessed. How long they stay in this setting and where they move on to is unknown.

There is some evidence to suggest that the larger, fully integrated HSC trusts in Northern Ireland have addressed some of the perennial issues around delayed discharges, and an efficient system is viewed by many as one of the real benefits of the integrated structure. The Southern HSC Trust reported that the number of delayed discharges has been significantly reduced, and in a similar vein the Belfast HSC Trust described improvements in discharge delay as very significant. The Northern HSC Trust has reported that it has been able to meet its target of effecting discharge from hospital within 48 hours for 90 per cent of people with complex needs and within 7 days for the remaining 10 per cent. It suggested that the success was largely attributable to the complete integration of care planning across the acute and community interface (Northern HSC Trust 2008).

Difficulties with the integrated system

The inequality of health care and social care

In Northern Ireland there is broad agreement among health and social care professions that integration has not been a marriage of equal partners. The health agenda has dominated from the outset and this disparity persists. This situation has a number of fundamental implications. First, in the context of resource allocation, frequently priority is given to the needs of health care, particularly acute health care, over those of social care. The total HSCB expenditure by programme of care for 2008/9 is given in Figure 5 (p 14): the programme of care for acute services dominates expenditure, with more than two-fifths of the total. Table 1, below, shows the per capita health and personal social services expenditure for Northern Ireland compared with that of England, Scotland and Wales. In 2010/11, health expenditure per capita was 10.8 per cent higher in Northern Ireland than in England, while personal social services expenditure was 5.1 per cent higher. Although health expenditure per capita in Northern Ireland was also higher than that in Scotland and Wales, the differential was smaller. Significantly, though, personal social services expenditure in Northern Ireland was appreciably less (O'Neill *et al* 2012).

Table 1 Government per capita expenditure on health and personal social services in Northern Ireland, Scotland, Wales and England, 2010/11

	Health (£)	Personal social services (£)	Health and personal social services (£)
Northern Ireland	2,106	512	**2,618**
Scotland	2,072	625	**2,697**
Wales	2,017	617	**2,634**
England	1,900	487	**2,387**

Source: O'Neill *et al* (2012)

Second, the medical model of need identification and response is highly influential. The integrated structure can easily be dominated by health agendas and priorities, such as the sustained focus on infection prevention and control. Performance targets set by the Department of Health relate almost entirely to health and include:

- outpatient waiting times
- inpatient and day care waiting times
- waiting times for diagnostic tests for cancer referrals
- beginning cancer treatment
- waiting times in accident and emergency (A&E) departments
- treatment in allied health profession areas
- first-year access targets for community mental health services.

Within the integrated system, social care values and priorities are overshadowed by a dominant health agenda, with social care relegated to the role of poor relation. The focus of public attention is on health. Adult social care failings and shortcomings do not have the same impact as hospital closures or stress on A&E departments. Significantly, the make-up of the executive teams of the HSC trusts reflects a health bias, with the majority of members from a health care background. In this context social care is afforded less priority and strategic influence. When compared with their health care counterparts, social care jobs tend to be poorly paid and have a low status, with few opportunities for progression.

All four of the UK countries are currently considering how they might best respond to growing and diversifying social care needs, but the Northern Ireland system is lagging behind, with community care policy operating under the vision and principles set out in *People First* (Department of Health, Social Services and Public Safety 2011a), which includes enabling individuals to remain in their own home or in suitable settings in the community. At the beginning of 2013, DHSSPS launched a consultation on social care (Department of Health, Social Services and Public Safety 2013). The document noted that it was a difficult area which would have to be tackled, but offered no recommendations or options for the way forward. Interestingly, the document stated explicitly that it did not deal with health care, that is, treatments offered by professionals such as doctors, nurses and dentists.

A recent report from the Patient and Client Council supported the view that care should be provided as close to home as possible, with a shift in resources from hospital to community enabling this transition. There is support for the concept of 'home as the hub of care'. However, the report suggested that it is evident that many people do not have full confidence in community-based services. Across a number of projects people have voiced concern about the quality, planning and delivery of community care, particularly for the most vulnerable in society. The *Care at Home* report into domiciliary care for older people (Patient and Client Council 2012) provides a good example of this dilemma: while most people said they would prefer to receive care at home where possible, many raised concerns about the inconsistent delivery and quality of home care. Age NI recently reported that evidence gathered through their discussions with older people suggested that the current model of social care is based on outdated ways of working, which results in poor value for money and does not always meet the outcomes that those in receipt of care expect (Age NI 2013).

Within social care there are some areas of work and services where integration is more prevalent. These include domiciliary services for the elderly, community services for mental health, learning disability and physical disability. This has led to integration being associated with these services and a reluctance to develop innovative approaches in other areas of social care where the benefits may be less obvious. Examples of areas where an integrated approach is less developed are direct payments, individual budgets, children's services, and early-years child care and welfare advice.

Following the RPA and full integration of the hospitals into five HSC trusts, Heenan and Birrell (2009) suggested that any achievement of the promised potential of full structural integration in Northern Ireland would require:

- a higher profile for social care in the modernisation initiative
- a joint initial training session for health and social care professionals to reinforce a culture of integration
- a focus on outcomes for service users
- a renewed debate on social models of care
- the composition of the new bodies to reflect a more equal status between health and social care
- a systematic programme of research and evaluation in integrated working to provide a robust evidence base.

While health and social care professionals work alongside one another in Northern Ireland and often share a base, education and training systems are marked by separation. Despite the obvious synergies between the groups, current training systems offer few, if any, opportunities to interact with other related professions. Given the emphasis on multidisciplinary working and co-operation, this system is hardly conducive to shared understanding and can hinder joint working between health and social care staff. Professional stereotypes and issues of status are significant, and joint training and education could enable the different professional groups to understand one another's roles, responsibilities and ways of working, and encourage mutual respect.

Case studies of good practice

While there is limited information and evaluation of integration in action, there is also a widespread recognition that there are many examples across Northern Ireland of innovative practice which aims to provide a seamless service of health and social care. The Southern HSC Trust, which covers the council areas of Armagh, Banbridge, Craigavon, Dungannon and South Tyrone, and Newry and Mourne – a population of some 358,650 – has been identified as an early innovator and an organisation committed to ensuring that their services are joined up and responsive. The reasons for this are manifold and may include leadership, vision and innovation, coupled with the absence of a dominant acute hospital.

Case study: Rapid access clinic in Lurgan Hospital

Within the Southern HSC Trust, Lurgan Hospital provides a consultant-led assessment clinic for rapid access for GP referral, and a community stroke rehabilitation service. The multidisciplinary team includes a consultant, an occupational therapist, a physiotherapist, a nurse and a social worker. Outcomes were audited for service users attending the clinic between 1 June 2010 and 27 May 2011. During the period, 300 people were seen; of these, 221 were discharged. The remaining 79 patients were admitted to hospital directly from the clinic. Thus for 74 per cent of service users, hospital admission was avoided on the day of the assessment. Of the discharged patients, just 8.6 per cent required an unscheduled admission via the A&E department. In 59 per cent of all service users, acute admission was completely avoided within 30 days. The facility provided a timely and comprehensive assessment of older people in a local setting and dramatically reduced the need for these older people to attend A&E.

The design of the service means that there is a single point of access for GPs and A&E. There is sharing of information and unified assessments, which are more cost-effective and efficient. Staff working in this team particularly valued its multidisciplinary nature and the fact that it was user-centred. The Director of Older People and Primary Care Services felt that this type of approach could ‘dissolve’ professional boundaries and ‘made sense at every level’. Feedback from service users and carers was described as overwhelmingly positive, as hospital admission was described as ‘traumatic’ for many older people. By providing accessible integrated health and care services within the community in facilities such as this, supported by multidisciplinary teams, an increasing number of people can be supported to live independently. This will, in turn, help to promote good health, improve management of long-term conditions, reduce unnecessary hospitalisation and length of stay in hospitals, and allow for early diagnosis and treatment.

Case study: Case management and pharmaceutical care of elderly patients in the intermediate care setting

Invest-to-save pharmaceutical care programme funding was provided by DHSSPS for service development in the provision of pharmaceutical care to older people in the intermediate/residential care setting. This funding was provided to the Western and Northern HSC Trusts in February 2012 for two years. The finance provided falls under the Regional Innovation in Medicines Management initiative, which aims to support and evaluate new ways of integrated working.

A consultant pharmacist in care of the elderly has been appointed at each trust to lead on this work, and two different models of care have now been implemented in the trusts. While the Northern HSC Trust has focused on medication review and case management of nursing home patients (in collaboration with a consultant geriatrician), the Western HSC Trust has adopted a 'virtual hospital', intermediate-care case management approach within the Waterside Hospital. In May 2012, service provision was scoped and mapped out in order to determine exactly where integration of the consultant pharmacist into the multidisciplinary team would have the most impact on the seamless care of elderly patients.

The Western HSC Trust project was implemented May 2012 and will require assessment of the impact of the consultant pharmacist on the care of elderly patients who have been, or will be, admitted to the Waterside Hospital. The consultant pharmacist case manages from acute care, through intermediate care and back out into primary/community care, and is central to facilitating communication between health care professionals, including the consultant geriatrician, the GP and the community pharmacist. Clinical interventions made by the consultant pharmacist are being measured, independently assessed and costed. Outcomes of the study will include: length of stay on baseline admission; readmission rates within 30 and 90 days post-discharge; length of time to readmission; length of stay on readmission; medication appropriateness; and drug costs.

Data for the first six months is presently being gathered and explored for interim reporting (February 2013). To date, pharmaceutical care plans have been prepared for 260 patients, with a demonstrated improvement in appropriateness of prescribing (as measured by the Medication Appropriateness Index). Initial calculations yield potential annual drug cost savings of £85,000 per annum for patients staying on the three wards included in the project. Implementation of a new assessment of medicines adherence in intermediate care has projected annual savings of approximately £10,000 per annum. Potential involvement with nursing homes with high numbers of presentations at the A&E departments of hospitals within the Western HSC Trust is also being explored.

Case study: Patient flow throughout Altnagelvin acute hospital

In May 2010, the Western HSC Trust embarked on a programme of acute reform in Altnagelvin Hospital. Previous to this, patient flow through the hospital was not smooth and it was not uncommon to have numerous patients awaiting admission to the main hospital from the A&E department each morning, some of whom had waited in excess of 12 hours. This resulted in poor patient experience and patients were often allocated beds outside of their specialty which, evidence shows, increases their length of stay in hospital.

Each specialty operated within its own silo, and there was poor understanding or recognition of the need for a whole system approach to finding solutions to the hospital's problems. There was a clear belief by the team that inpatient beds were easily allocated if they became available. In order to achieve this cultural shift in practice, new ways of working were required which involved all members of the hospital and community multidisciplinary teams working towards a common goal.

The programme was called 'Back to the floor' and involved all senior managers and clinical medical leads walking the floors of the hospital at 8.30 each morning and challenging medical and nursing staff in relation to inpatients, delays in patients accessing diagnostics and other relevant services. The purpose of this was to ensure that patient flow became everyone's business, not just that of the bed managers.

The programme focused on three key areas:

- supporting and enhancing patient flow – this involves senior management and clinicians walking each ward every day to show support for ward-based staff as they tackle patient flow issues; this unique programme allows bottlenecks in the system to be exposed, and real-time and lasting solutions to be found

- early discharge – ensuring that admitted patients who are well enough to leave the hospital are discharged earlier in the day
- length of stay review programme – every patient in the hospital who has been in the hospital in excess of 14 days is reviewed by the community team in conjunction with the ward-based staff, and an action plan to facilitate discharge as soon as appropriate is agreed.

Since its inception, the reform programme in acute and older people's services and community care has been underpinned by a collaborative approach between senior doctors, nurses, nurse managers, community colleagues, the Performance Management and Service Improvement Directorate (part of the HSCB) and allied health professionals to focus on improving the patient experience in the hospital setting. This process is dynamic, can be changed as needed, and seeks solutions to problems in real time.

Colleagues were consulted at the outset of the programme to ensure broad scanning of all the service needs and those of service users. This programme has also been formally evaluated using both qualitative and quantitative approaches. The quantitative data looked at length of stay and delivered significant improvements, as outlined previously. The qualitative evaluations took the form of questionnaires, and thematic analysis demonstrated key themes aligned to improving the services. Some trust staff described the process as 'Perception that patient flow is everyone's work', 'Now trust-wide approach with trust-wide solutions and shared ownership', 'Enhanced communication and understanding across hospital and with community' and 'Now aware of each other's pressure and realise the need for whole system approach'.

Conclusions

Northern Ireland has had an integrated health and social care system for more than 40 years; however, for nearly three decades of direct rule the focus in this troubled region was on sustaining the delivery of services through the political and social unrest, rather than on policy innovation and future planning. Consequently, this integrated health and social care system has not realised its full potential and the opportunities provided by the structural organisation have not been fully exploited. Following the RPA, reorganisation in 2009 led to the creation of five fully integrated health and social care trusts covering primary, secondary and community care. This new, streamlined service was designed to produce economies of scale, simplify structures, reduce bureaucracy and promote further co-operation in order to maximise outcomes for service users. These new bodies are continuing to evolve and the extent to which they have met these aims is not yet evident.

A key issue in Northern Ireland is the lack of robust evidence to assess and evaluate the outcomes of this unique system. The effectiveness or otherwise of the integrated system is difficult to assess owing to the weakness of the existing data, which is particularly limited in terms of evidence of improved patient outcomes. To date, despite the fact that integration has been a key policy aim in the United Kingdom, no major study on the particular organisation of health and social care has been undertaken. The experience in Northern Ireland has usually been dismissed or overlooked, as Northern Ireland has its own peculiar context. Research in Scotland and Wales has highlighted the paucity of information from Northern Ireland and the difficulties associated with comparative study.

Despite this, a number of small-scale studies and policy overviews have identified key advantages and disadvantages of the system. Advantages include a single employing body, a single budget, and agreed strategies and plans on, for example, dementia care and mental health. Disadvantages include the continuing dominance of health care over social care, cultural differences between these areas, separate training systems, and GPs not being fully engaged in a whole system approach.

The Northern Ireland story demonstrates that structural integration can facilitate effective integrated working, but ultimately achieving a seamless service requires strong leadership underpinned by a clear vision, endorsed by the key stakeholders. There is no 'one size fits all' solution to meet the complex challenges but, as the case studies have shown, innovative local solutions can be found if senior staff share aspirations and space is given for innovative, creative ways of working.

The Transforming Your Care agenda, which aims to move care closer to home and tailor the care to the patients rather than deliver what suits clinicians, will increase the significance attached to social and community care. If this vision is to be realised, then it must be on the basis of equal weighting being afforded to both health and social care. Initial assessments of ICP membership and direction appear to suggest that, again, the focus is on herding GPs into further integration within the acute sector, with little consideration given to social care.

As this chapter has outlined, social care in Northern Ireland may need a package of extra support, including funding and legislation, to bring it up to a par with its health care partners. Shifting the focus of care provision away from acute hospitals towards a greater reliance on treating people in their own homes must be underpinned by a workforce development plan. Government must ensure that the social care workforce has access to relevant training and development opportunities, to ensure that individuals can be deployed in a range of roles. Improving the qualification base of the social care workforce is also a prerequisite to further professionalisation.

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2 Scotland

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Introduction

Closer integration of service planning and delivery is essential to ensure that service users can reliably access well co-ordinated, effective, safe and person-centred support and care that deliver value. This applies equally within the NHS, between primary, community and secondary care providers, and between health, social care, housing and other partners. Continuity and co-ordination of integrated care are of particular importance to frail older people and people with long-term conditions because the range and complexity of their needs require information, advice, support and care from multiple providers within health care and from other organisations across the statutory, independent and third sectors. This paper outlines the concerted efforts made in Scotland over the past decade to promote integrated care in order to improve the experience and outcomes for adults with long-term conditions and for their carers.

Context: the health and social care system

Political context

Scotland has a population of 5.2 million. Population density is low in comparison with the rest of the United Kingdom due to large remote and rural areas, notably in the Highlands. While the size of the population has remained relatively stable over the past 50 years, the proportion of people aged 65 and over has grown significantly and is projected to increase by around two-thirds over the next 20 years.

Following the passage of the Scotland Act 1998, the Scottish Parliament and the Scottish Executive (known as the Scottish Government since 2007) came into existence on 1 July 1999 and the powers relating to devolved matters were transferred to them from the Secretary of State for Scotland and other UK ministers. The Scottish Parliament has full legislative competence (ie, it can pass both primary and secondary legislation) across a wide range of devolved subjects. The Act lists the 'reserved matters' such as constitutional issues, foreign and defence policy, fiscal and monetary policy, and social security, for which the UK Parliament retains responsibility. Health and social care are devolved issues and represent the largest component of the budget that is provided as a block grant to Scotland by the UK Treasury (Keating 2010).

The Scottish Parliament has limited powers, to date unused, to vary the basic rate of income tax in Scotland by up to three percentage points. New powers set out in the Scotland Act 2012 to vary the rate by up to 10 percentage points will come into force in 2016.

Historical background

NHS Scotland

For much of the post-war period, the management, organisation and structure of the NHS in Scotland were broadly similar to elsewhere in the United Kingdom (Woods and Carter 2003). While there was some divergence in policy, there were limits on Scotland's autonomy (Hunter 1982; Keating and Midwinter 1983; Hunter and Wistow 1987). From 1974 until the early 1990s, 15 geographically based health boards had direct responsibility not only for hospital and community services but also for primary care contractor services within their areas. This differed from the arrangements in England, as did the absence of a regional tier of management.

In the early 1990s this model was replaced by one based on market principles, the so-called 'internal market'. Health boards became 'purchasers' of health care for their resident populations, and hospitals and community health services were established as separate NHS trusts which supplied services to the boards. Through fundholding arrangements, GPs could purchase a limited range of services from NHS trusts on behalf of their patients.

In 1997 broadly similar steps were taken across the United Kingdom to dismantle the internal market. From 2000, however, the NHS in Scotland has pursued an approach of increasing collaboration, partnership and integration, eschewing moves elsewhere to revert to a market in health care delivery. The unification of health boards and NHS trusts was completed by 2004.

The present government (in office since 2007) reaffirmed the commitment to a publicly provided service and announced a new focus on mutuality – involving patients, the public and NHS staff as 'owners' and partners rather than just users and providers – and on quality as a key organising principle for health care.

Local government

In 1996, local government on the mainland of Scotland was reorganised into 29 unitary authorities, replacing the regions and districts which had existed since 1975. The three existing island unitary authorities continued, making a total of 32 local authorities. As well as providing some services themselves, local authorities increasingly commission services from other providers such as the independent and third sectors.

The Local Government in Scotland Act 2003, designed to modernise local government, placed on local authorities a duty to secure best value and to initiate and facilitate community planning. In each local authority area a community planning partnership has been established to plan and oversee delivery of better public services and to co-ordinate other initiatives and partnerships. Led by local authorities, core community planning partners include the local NHS board, enterprise networks, police, fire and regional transport partnerships and other public, voluntary, community and private sector organisations.

Organisation of health and social care in Scotland

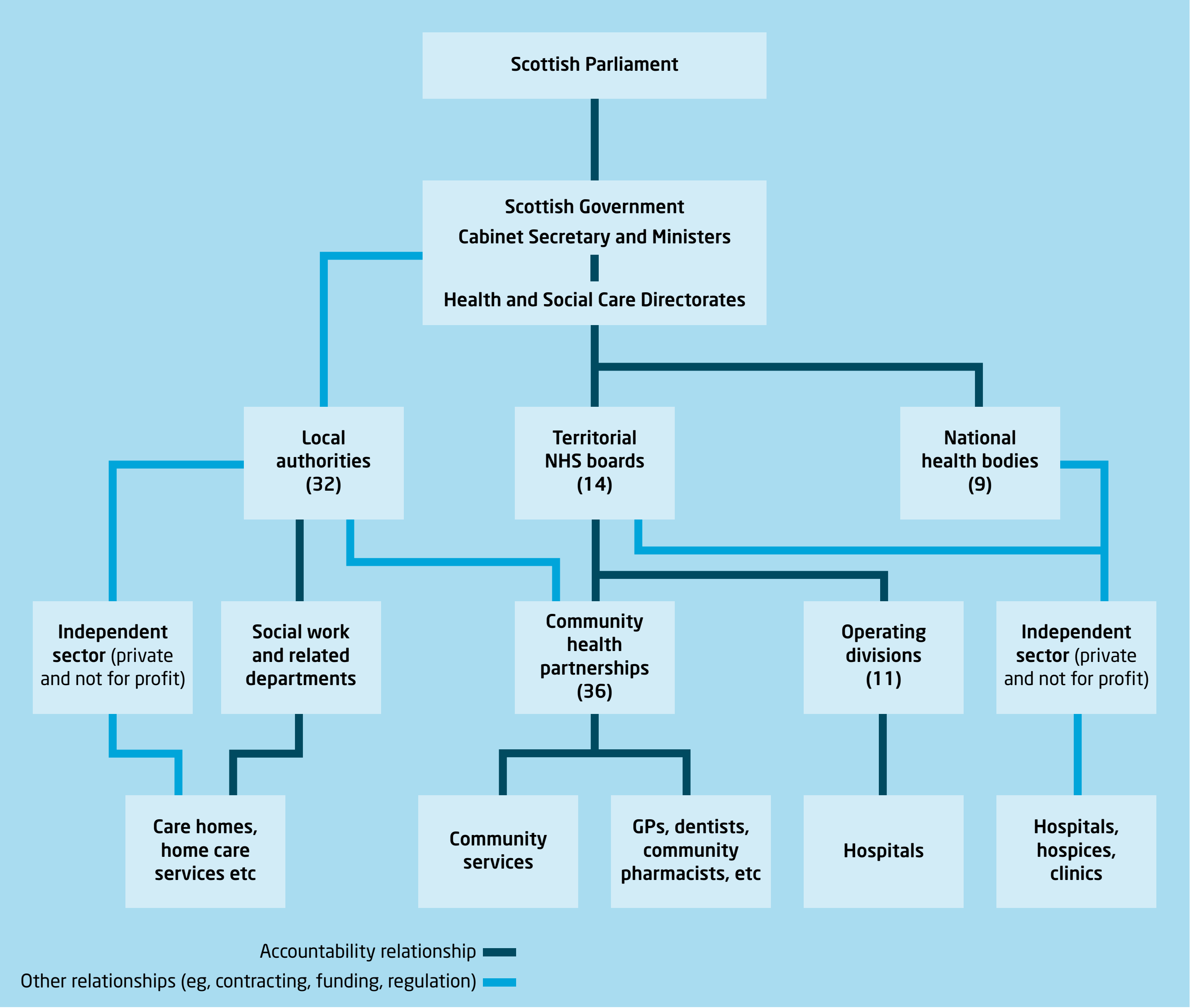
Scottish Government

Responsibility for health and adult social care was combined in 2000 when the work of the former Social Work Services Group was divided at ministerial and official levels between health (adults) and education (children). Since 2007, responsibility for health and social care policy, the management of the NHS and oversight of adult social care services has lain with the Cabinet Secretary for Health and Wellbeing (equivalent to the Secretary of State for Health in England) and the Scottish Government Health and Social Care Directorates, led by the Director-General for Health and Social Care, who is also Chief Executive of the NHS in Scotland.

A ministerial strategic group with responsibility to oversee health and social care reform is chaired by the Cabinet Secretary. It includes local government leaders, NHS board chairs and representatives from national, third and independent sector umbrella organisations. It is supported by a delivery group of officers chaired jointly by an NHS and a local authority chief executive and includes representatives from Scottish Government, the Convention of Scottish Local Authorities (COSLA), and the housing, third and independent sectors. Sub-groups on topics such as integrated resourcing, joint commissioning, outcomes, governance, improvement support and workforce report to the delivery group.

Figure 6, below, provides an overview of the structure of health and social care in 2011.

Figure 6 Health and social care system, Scotland



NHS Scotland

The key features of the health care system in Scotland are:

- integration of planning and delivery functions but with a high degree of operational delegation
- accountability of all parts of the NHS through NHS boards to the government and parliament
- co-operation and collaboration among all parts of the NHS and with other organisations
- partnership with staff and with patients and carers
- a focused performance management system designed to ensure that the NHS delivers its health improvement, health care and financial targets.

NHS boards

The majority of the health budget is provided to 14 geographically based NHS boards (reduced from 15 in 2006) which are responsible for planning and delivering services to meet the health care needs of their populations; these range on the mainland from 1.2 million (Greater Glasgow and Clyde) to 113,000 (Borders).

Each board comprises a non-executive chair, appointed by ministers after open competition, varying numbers (currently between 9 and 23) of non-executive directors (some lay members and others representing stakeholder interests such as the board's employees, the area clinical forum and each of the local authorities in the board's area), and normally around 6 executive directors. From 2010, a proportion of non-executive directors in two boards have been elected as a pilot to ascertain whether this improves public participation. An evaluation was published in 2012 (Greer *et al* 2012).

The focus of the boards is on strategic leadership and performance management of the entire local NHS system. Within each board responsibility for delivery is delegated to operating divisions for acute services and to community health partnerships (CHPs) for community and primary care services (discussed in more detail under 'Horizontal integration' on pages 34–36). Some boards have developed a model of a single operating system that combines both acute and community health functions.

In addition to the territorial boards, there are nine national bodies which are responsible, in partnership with the territorial boards, for services such as ambulance transport, education and training, and quality improvement, which are best provided on an all-Scotland basis. The composition and accountability of these bodies are broadly the same as for the territorial boards.

In 2011, the NHS workforce in Scotland comprised 161,369 people, of whom 154,340 (131,340 whole-time equivalents (WTE)) were employees of the NHS and the rest independent contractors (eg, general medical and general dental practitioners) providing services to the NHS.

Although not always co-terminous, NHS boards work closely with local authorities to ensure the effective delivery of a range of community health and social work services. This relationship is now formalised through representation of each local authority on the board of each relevant NHS board, through local authority membership of all CHPs and, in some cases, through joint accountability and joint appointments.

Local authorities

Since 1996 there have been 32 unitary local authorities with populations varying on the mainland from more than 600,000 (Glasgow City) to less than 51,000 (Clackmannanshire). Since 2007 councillors have been elected by single transferable vote, which ended one-party domination of most authorities.

In most respects the main features of the local government system in Scotland are broadly similar to those in the rest of the United Kingdom. Most operate through a structure of committees, with varying levels of delegated accountability.

Councils have a duty to provide social care for those who need it, whether they provide these services themselves, contract with voluntary or private organisations to provide them or give people a budget to arrange their own care. Increasingly, their role is to commission services from others, with councils themselves only providing around 12 per cent of care home places and 49 per cent of home care hours (Audit Scotland 2012).

Local authorities employed 244,500 (WTE) staff in 2010 of whom 41,100 worked in social work.

Independent (private) and third sectors

Scotland has a relatively small independent health sector, regulated from 2000 until 2011 by the Scottish Commission for the Regulation of Care (known as the Care Commission) and now by Healthcare Improvement Scotland. There are around 900 beds in 7 hospitals, 10 psychiatric hospitals and clinics and 15 hospices.

The independent health sector is funded mainly by voluntary health insurance or paid for directly by patients. The NHS contracts to a very limited extent with the independent sector for the provision of certain health care services. Hospices are charitable organisations and receive a substantial part of their funding from the NHS.

However, the independent and third sectors are important providers of care and support for older people, providing 88 per cent of care home places and 51 per cent of home care hours (Audit Scotland 2012), both registered with and regulated by the Care Inspectorate (which replaced the Care Commission in 2011).

Third sector organisations have always played a significant part in health and social care and continue to do so, frequently working in close partnership with statutory sectors to deliver services, funded by the NHS and local authorities and by charitable donations. They represent users of services, and lobby government on behalf of their members. Some are part of UK organisations, with varying degrees of autonomy, while others are separate Scottish organisations.

Funding

Public spending is mainly provided through the UK Treasury in the form of an overall block grant. In addition, funds are raised by local authorities by means of council tax and non-domestic rates; they also have borrowing powers.

Changes to the block grant are generally determined by the Barnett Formula, which is applied to all three devolved administrations. Under this formula, Scotland, Wales and Northern Ireland receive a population-based proportion of changes in planned spending on comparable services in England. Changes in each devolved administration's spending allocation are determined by the quantity of change in planned spending in departments in England of the UK government, the extent to which the relevant English programme is comparable with the services carried out by each devolved administration, and each country's population proportion (HM Treasury 2010).

The Scottish Government therefore receives its formula share of any increase in resources provided to the Department of Health in London. However, the allocation of public spending among the various services it controls is for the Scottish Government to decide, subject to the approval of the Scottish Parliament.

The Scottish Government provided £11.68 billion for health in 2011/12, which made up 34 per cent of its total budget. After a decade of sustained and substantial growth (around 40 per cent in real terms), the health budget has been constrained since 2009. It has continued to grow in cash terms but has been decreasing in real terms. It is projected to increase by just over 5 per cent between 2011/12 and 2014/15, which amounts to a real-terms reduction of 2.8 per cent. Spending on health per capita in Scotland is significantly higher than in the other countries of the United Kingdom (in 2010/11 £2,072 in Scotland in comparison with £1,900 in England). This differential has narrowed in recent years from 16.5 per cent in 2006/7 to 9 per cent in 2010/11 (HM Treasury 2011).

Spending by local authorities in 2010/11 amounted to £18.5 billion, of which 80 per cent was funded by Scottish Government grant and 20 per cent by council tax and other sources such as rents and charges. Since 2007 there has been a freeze on council tax.

Local authorities spent around £3 billion on social care services in 2010/11. The total cost of social care is greater as this figure excludes the contributions people make to their own care by paying providers directly, expenditure from other council departments such as housing, and the money transferred from the NHS to support patients discharged from long-stay hospitals. Councils' spending on social care increased by 46 per cent in real terms between 2002/3 and 2010/11 (Audit Scotland 2012).

Looking forward, social care budgets are under pressure as a result not only of constraints on local authority spending generally but also the escalating costs of providing free personal care for older people, a policy introduced in 2002 only in Scotland (Scottish Government 2012d).

Creating the conditions for integrated care in Scotland

There have been a very large number of initiatives taken, some specifically targeted on integration, others with integration as a by-product of other developments, and some aimed either at health care alone or at the interface between health and social care, but many addressing both dimensions of the integration agenda. The focus of these initiatives has been on achieving better outcomes through partnership working, service redesign and the development of integrated clinical and care pathways.

The range of initiatives to promote integrated care in Scotland has been categorised in the following way:

- system (eg, unified boards, no purchaser–provider separation, clear and consistent accountabilities, duty to collaborate)
- community (eg, community planning, CHPs, shared budgets, single outcome agreements, elected boards, participation standard)
- clinical (eg, managed clinical networks, community resource hubs, team-based care, eHealth, collaboratives)

- financial (eg, unhypothecated budgets, independent budget allocation formula, shared services, managed service networks)
- culture and ethos (eg, clear and shared vision, mutuality, partnership, clinical leadership) (Feeley 2008).

These are all set within a policy landscape that has provided a coherent context to support the development of integrated care.

Coherent policy landscape

Achieving the twin aims of integration within health care and between health and social care has long been an objective of government in Scotland. Its importance has grown significantly since 1997 and has been a major feature of all the strategic documents that have been published on the structure and functioning of the NHS, underpinning both the creation of unified NHS boards integrating planning and delivery of services, and the development of collaborative and partnership working.

Integrated care was a particularly prominent aspect of *Building a Health Service Fit for the Future* (the Kerr Report) (Scottish Executive 2005a) and the subsequent government response *Delivering for Health*, which asserted that 'Our objectives of high-quality services and better productivity will be achieved by promoting the integration of services' (Scottish Executive 2005b).

In 2007, *Better Health, Better Care* reaffirmed the commitment to 'strengthen the collaborative and integrated approach to service improvement that is the hallmark of Scotland's NHS' (Scottish Government 2007a). It stressed the importance of shifting the balance of care and made new commitments to introduce an integrated resource framework and strategic joint commissioning, and to strengthen the impact of managed clinical networks.

Integrated care is a key strand in *The Healthcare Quality Strategy for NHS Scotland* (Scottish Government 2010c). Within the context of Scotland's integrated delivery arrangements, it encouraged whole system improvement through mutually beneficial partnerships between clinical teams and the people in their care and collaboration with other bodies.

Nor has the focus on integration been confined to the NHS. It was also a major theme in the report of the Commission on the Future Delivery of Public Services (the Christie Commission), published in 2011, which called for substantial reform of how public services are delivered to make them 'outcome-focussed, integrated and collaborative' (Scottish Government 2011c). One of its key requirements was that public sector organisations should work together effectively to achieve outcomes.

Since the report of the Joint Future Group, established in 2000 to improve structures and processes associated with joint working between health and social care (Scottish Executive 2000), there has been steady progress in establishing formal health and social care partnerships between NHS boards and local authorities. Legislation was enacted in 2002 (Community Care and Health (Scotland) Act) to break down some of the perceived barriers to collaboration by conferring powers to transfer specific functions, without removing statutory responsibilities, and the associated powers to create pooled budgets between health and social care partners.

Health and social care partnerships in Scotland are at different points on the continuum of integration described by the World Health Organization, which passes from autonomy of individual organisations at one end, through linkage and co-ordination to full integration at the other. Arrangements have included:

- joint committees/planning forums
- shared performance management tools and reports to statutory bodies
- aligned budgets for community and social care
- joint appointments, in most cases managing joint funds as separate budgets for each partner
- some pooled budgets, generally for small stand-alone projects but in a few cases for services (eg, mental health services in Clackmannanshire)
- clinical and care networks that focus on pathway development (Scottish Government 2010a).

Aligned performance management

Delivering for Health (Scottish Executive 2005b) set out new arrangements for the management of performance in the NHS. This system has now been aligned to the National Performance Framework adopted by the Scottish Government in 2007 and replacing the proliferation of priorities that existed previously. Each part of this outcomes-based framework is directed towards a single overarching Purpose: 'To focus government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing economic sustainable growth' (Scottish Government 2007b).

Five strategic objectives support delivery of the Purpose (a Scotland that is wealthier and fairer; healthier; safer and stronger; smarter; and greener) and, in turn, these are supported by 16 national outcomes which describe in more detail what the government wants to achieve over a 10-year period. Progress towards delivering these outcomes is measured through 50 national indicators and targets. A significant number of these outcomes and indicators relate to health and social care. The NHS was the first public service to report its performance through the *Scotland Performs* system and website (Scottish Government 2012j).

An important part of the Performance Framework is the Single Outcome Agreement (SOA) between the government and each community planning partnership (CPP). SOAs are the means by which CPPs agree the strategic priorities for their local area and express them as outcomes to be delivered by the partners, individually and jointly; these contribute to the national outcomes. A Statement of Ambition agreed in 2012 between the Government and COSLA places community planning at the heart of public service reform and sees it as a key means of driving the pace of integration and encouraging a focus on prevention, integration and improving performance (Scottish Government 2012c).

Quality improvement and scrutiny

The *Healthcare Quality Strategy* published in 2010 aims to ensure that all work is integrated and aligned to deliver the highest quality health care services to people in Scotland and in doing so provide recognised world-leading quality health care services (Scottish Government 2010c). At its core are three Quality Ambitions:

- mutually beneficial partnerships between patients, their families and those delivering health services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making

- no avoidable injury or harm to people from the health care that they receive, and an appropriate, clean and safe environment to be provided for the delivery of health care services at all times
- the most appropriate treatments, interventions, support and services to be provided at the right time to everyone who will benefit, and wasteful or harmful variation to be eradicated.

In 2011 the Cabinet Secretary set out a strategic vision and a supporting narrative for achieving sustainable quality in the delivery of health care services.

> *Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting. We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.*
>
> (Scottish Government 2011a)

A Quality Measurement Framework provides a structure for understanding and aligning the wide range of measurement that goes on across the NHS, showing how it all leads towards the Quality Ambitions – which are illustrated by 12 quality outcome indicators. The three levels described by the framework are as follows:

- level 1 is for national reporting on long-term progress towards the Quality Ambitions
- level 2 contains the HEAT targets (*see* below), which are for shorter-term government performance management of NHS boards to implement key priorities
- level 3 is for all other measures required for quality improvement, either by national programmes or locally (Scottish Government 2010c).

NHS boards are required to produce annually a three-year Local Delivery Plan (LDP) which sets out specific actions, trajectories and risk management plans for achieving objectives and targets linked to the Scottish Government's overall Purpose and outcomes:

- **H**ealth improvement for the people of Scotland – improving life expectancy and healthy life expectancy
- **E**fficiency and governance improvements – continually improving the efficiency and effectiveness of the NHS
- **A**ccess to services – recognising patients' need for quicker and easier use of NHS services
- **T**reatment appropriate to individuals – ensuring that patients receive high-quality services which meet their needs.

LDPs and HEAT target performance are reviewed annually by the Scottish Government and the agreed LDP forms the annual 'performance contract' with the board.

Scrutiny and improvement

Unlike in England and Northern Ireland, responsibility for regulation and inspection of health and social care is divided between Healthcare Improvement Scotland (HIS), whose responsibilities since 2011 have included scrutiny and performance reporting on both the NHS and the independent health care sector (which it also regulates), and the

Care Inspectorate, which is responsible for regulation and inspection of social work, care and child protection services. The Care Inspectorate and HIS are testing a model for integrated inspections of services for older people, including those with dementia and who are residing at home or in a community setting.

HIS combines scrutiny with a strong focus on improvement support. In this respect its work is complemented by the Joint Improvement Team (JIT), established in 2004 to provide practical improvement support and additional capacity to local health, housing and social care partnerships. Itself a partnership between the Scottish Government, COSLA and the NHS, it has had a particular focus in recent years on the implementation of *Reshaping Care* and on the Change Fund (*see* 'Reshaping Care for Older People and the Change Fund' on pages 40–42), assets-based approaches and community capacity building, delayed discharge and intermediate care, joint commissioning and shared outcomes, and personalised outcomes-based approaches. The value of its work was endorsed by an independent review in 2011 (Petch 2011) and in the decision to establish a Joint Improvement Partnership Board, bringing together the JIT partners in a strategic partnership with the third and independent sectors. This arrangement will strengthen the position of the JIT, as the lead improvement partner in health, housing and care reform, to work with national partners to accelerate the pace of transformational change and to support and challenge improvement in the delivery of integrated health and care.

The only body with oversight of both health and social care services is Audit Scotland, which undertakes audit and value-for-money studies on behalf of the Auditor General for Scotland (health) and the Accounts Commission (local authority services including social work).

Horizontal integration

Both vertical and horizontal integration within health care have been taken forward since 1997 by progressive integration and unification of responsibility for hospital, primary care and community health alongside a range of specialist services for people with mental health problems, those with learning disabilities and older people.

Initially, voluntary combinations of GPs were encouraged to form local health care co-operatives (LHCCs), accountable to primary care trusts. From 2003 it was decided that LHCCs should evolve into community health partnerships (CHPs) to establish a substantive partnership with local authority services and to act as a focus for integrating health promotion, primary and specialist health services at a local level. The NHS Reform (Scotland) Act 2004 required boards to establish one or more CHPs in their area, albeit allowing differences in the size, role, function and governance arrangements for individual CHPs.

Broadly, two types of CHP evolved: health-only structures, known as CHPs, of which there were 29 in 2010; and integrated health and social care structures, known as community health and care partnerships (CHCPs) or community health and social care partnerships (CHSCPs), of which there were seven (the five integrated partnerships in Glasgow having been dissolved in 2010 and replaced by a single CHP for Glasgow). All are statutory committees or sub-committees of NHS boards and thus accountable to their respective board, although the integrated CHPs also have dual accountability to the relevant local authority (Audit Scotland 2011).

Membership of CHP committees was defined by the government and must include the CHP general manager, a GP, a nurse, a doctor who does not provide primary medical services, a councillor or an officer of the local authority, a staff representative, a member of the public partnership forum (which each CHP is required to establish to maintain dialogue with the local community), a community pharmacist, an allied health professional, a dentist, an optometrist and a member of a health-related voluntary sector organisation. A number of CHPs have sought to strengthen local authority involvement by including elected members.

Two reviews of CHPs have been undertaken. The first, commissioned in 2009, found examples of progress in shifting the balance of care, for example, in the development of long-term conditions strategies and anticipatory care initiatives; in improving health, for example, in smoking cessation; and in building working relationships across the health family (although many had found engagement with GPs challenging). Linking health and social care had proved even more challenging, reflecting the changing context and complex environment in which CHPs operated (Watt *et al* 2010).

In 2011 Audit Scotland published their review of effectiveness of CHPs. While the report highlighted examples of good practice in developing enhanced community services, it found only limited evidence of widespread and sustained improvement. This was attributed to:

- CHPs not having the necessary authority to implement the challenging integration agenda that they faced
- a lack of clarity about the role of CHPs resulting from a 'cluttered partnership landscape' with CHPs having been added to already existing health and social care partnership arrangements
- differences in organisational cultures, planning and performance and financial management in the NHS and local authorities
- few examples of good joint planning underpinned by a comprehensive understanding of the shared resources available (Audit Scotland 2011).

Proposals to legislate for integrating adult health and social care

The Audit Scotland analysis was one factor contributing to the government's decision to consult in 2012 on proposals to replace CHPs with health and social care partnerships (HSCPs) to secure greater integration between health and social care (Scottish Government 2012g). The proposals are based on four key principles.

- Health and social care services should be firmly integrated around the needs of individuals, their carers and other family members.
- There should be strong and consistent clinical and social care professional leadership in the planning and provision of services.
- The providers of services should be held to account jointly and effectively for delivering improved outcomes.
- Services should be underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve, rather than the organisations through which they are delivered.

The government's response to the consultation, issued in February 2013, promised draft legislation by summer 2013 with the following key features.

- NHS boards and local authorities will be required to integrate health and social care services for all adults (with freedom to extend the integrated arrangements to other areas of service by local agreement and with provision for extension to be made mandatory in future).

- HSCPs, which may be established either as a body corporate in law or through a delegation between partners arrangement, will be the joint and equal responsibility of NHS boards and local authorities, and will work in close partnership with the third and independent sectors and with carer representation.
- Nationally agreed outcomes will apply across adult health and social care. HSCPs will be jointly accountable to their NHS board and local authority for the delivery of those outcomes. Outcome measures will focus initially on adults with multiple and complex support needs, including frail older people.
- HSCPs will be required to integrate budgets for joint strategic commissioning and delivery of services to support the national outcomes. Integrated budgets will include, as a minimum, expenditure on community health and adult social care services and, importantly, aspects of acute secondary care spend on adults.
- A single point of senior oversight and accountability, either a jointly accountable officer or the chief executive of the host partner (depending upon which model above is adopted), will ensure that partners' joint objectives, including nationally agreed outcomes, are delivered within the integrated budget.
- The role of clinicians, social care professionals and the third and independent sectors in locality planning and the strategic commissioning of services will be strengthened (Scottish Government 2013).

In advance of the proposed legislation, a 'lead agency' model has been adopted in Highland with NHS Highland as the lead agency for adult community care and Highland Council the lead agency for children's services. In both cases the lead agency is responsible for delivery of services and for management of staff and budgets. Both bodies retain joint responsibility for specifying the outcomes to be achieved for service users. These new arrangements, implemented in April 2012, involved the transfer of 1,500 social care staff and £90 million to NHS Highland, and around 250 staff and £8 million to Highland Council (NHS Highland 2012).

Vertical integration through managed clinical networks

Managed clinical networks have been an enduring feature of the health care system in Scotland for the last 15 years. They originate from the Acute Services Review of 1998 which advocated the evolution of informal networks into managed clinical networks (MCNs) which it defined as 'linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and health board boundaries' (Scottish Office 1998). They have been described as a vehicle 'to broker care across providers for patients with a particular condition in a form of virtual integration' (Curry and Ham 2010).

Since then the importance of MCNs has been highlighted in every statement of government policy for the NHS and the guidance relating to their development and functioning has been updated on four occasions, most recently in 2012 (Scottish Government 2012h). The key principles have remained consistent:

- clear management arrangements, including designation of a lead clinician (or lead officer in the case of multi-agency networks)
- a defined structure that sets out the points at which the service is to be delivered, and the connections between them
- an annual plan setting out, with the agreement of those with statutory responsibility for the delivery of services, the relevant standards and the intended quality

improvements and, where possible, quantifying the outcomes and benefits for users and carers

- use of a documented evidence base, which should be developed through continuous quality improvement (CQI) and audit, which MCNs should undertake, and research and development
- multidisciplinary and multi-professional composition with clarity about the role of each member of the MCN
- meaningful involvement of those for whom services are provided and the voluntary sector
- full use of educational and training potential including participation in appropriate appraisal systems and continuing professional development
- scrutiny of opportunities to achieve better value for money through delivery of care that adds value from the patient's perspective, optimises productivity and reduces unwanted variation.

There are currently around 130 MCNs in existence. They vary in their coverage: 29 are Scotland-wide, 22 regional, and the remainder local; and in their scope: some cover particular conditions such as diabetes or epilepsy; others specialties such as neurological disease or palliative care. There is a concentration in five areas where coverage is universal: coronary heart disease, stroke, diabetes and respiratory (all with MCNs in each board area), and cancer where there are three long-established regional cancer networks (personal communication 2013). National MCNs have generally been created in response to concern about access to and sustainability and quality of particular specialist services. A few MCNs (eg, mental health and learning disability) fully involve local authorities as well as the NHS as managed care networks.

There has been only limited evaluation of the impact of MCNs: one of the pioneer local cardiac MCN (Hamilton *et al* 2005); the other of four MCNs (two cardiac, two diabetes, in each case one voluntary, one mandated) (Guthrie *et al* 2010). Their findings identified a positive impact on inter-professional and inter-organisational activity, especially in MCNs that had been created as a result of local enthusiasm. This had resulted in some changes in professional practice and service improvement; it had also facilitated implementation of national initiatives, such as clinical guidelines. There was limited evidence of a beneficial impact in reducing emergency admissions to hospital. There has also been a review of nine national MCNs (National Services Division 2010).

The longevity of MCNs – unusual in health care – is an indicator of support for the concept in government and in the clinical and managerial communities. Although the existence of an MCN is only one of a number of contributory factors, it is striking that they are clustered in areas, such as coronary heart disease, stroke and cancer, in which there have been significant improvements in outcomes and quality of care in recent years.

In reaffirming the role of MCNs in 2012 the government asserted that:

- MCNs are ideally suited to delivering service redesign, quality improvement, strategy and planning across pathways, and working across boundaries of departments, teams, units, sectors, agencies and boards
- they have the potential both to inform and to help to deliver the kind of prioritisation needed to ensure value in a context of strict financial limitations, increasing patient demand and rising public expectations
- they need to adapt and align with other partnership structures that support partnership working with local authorities and the third sector (Scottish Government 2012h).

Information technology

In 2005 the Scottish Executive placed 'increased sharing of information, with unified databases, effective communication links and standardised protocols' at the heart of its drive to promote integration of services and initiated a process of developing a comprehensive health information system, based around an electronic health record (Scottish Executive 2005b).

Progress in this direction has been a key feature of the two eHealth strategies produced covering the periods 2008 to 2011 and 2011 to 2017 (Scottish Government 2008b; Scottish Government 2011b). Two important milestones have been achieved: universal use of the unique patient identifier, the community health index number; and the introduction of the national emergency care summary, accessible to NHS staff in out-of-hours centres, NHS24 and accident and emergency (A&E) departments.

Increasingly, communications between different parts of the NHS, for example on referrals, laboratory tests and prescriptions, are conveyed electronically. The current eHealth strategy also commits the NHS to developing, in partnership with local authorities, a health and social care IT strategy which will enhance information-sharing across health, social work and the third sector to support the delivery of appropriate community-based services.

Integrated Resource Framework

The Integrated Resource Framework (IRF) is being developed jointly by the Scottish Government, NHS Scotland and COSLA to enable partners in NHS Scotland and local authorities to be clearer about the cost and quality implications of local decision-making about health and social care (NHS Scotland 2012a). The IRF helps partnerships to understand more clearly current resource use across health and social care, enabling better local understanding of costs, activity and variation across service planning and provision for different population groups, and contributing to the development of the integrated budgets that will be required under the proposed legislation.

By providing boards and their local authority partners with the information required to plan strategically and review services more effectively, and by developing financial relationships that integrate resources around populations instead of organisations, partners are able to realign their resources to support shifts in clinical and care activity within and across health and social care systems.

Central to the IRF is the explicit mapping of patient and locality-level cost and activity information for health and adult social care, to provide a detailed understanding of existing resource profiles for partnership populations. Most boards, some with their local authority partners, have completed a 'first cut' of their mapping and are currently working towards completing an improved 'second cut'.

From April 2011 four test sites (Ayrshire and Arran, Highland, Lothian and Tayside NHS boards, and their 12 partner local authorities) have been engaged in implementing agreed and transparent financial mechanisms that will allow resources to flow between partners, following the patient to the care setting that delivers the best outcomes. The report of an action research evaluation of the work under way in the test sites was published in July 2012 (Ferguson *et al* 2012). It found that:

- mapping of cost and activity data across health and social care for the first time had improved the evidence base on equity, efficiency, variation and quality on which planning decisions are made

- the IRF had enabled senior managers in boards and local authorities to co-ordinate joint working and had empowered staff to reflect on how to work together to improve care pathways but, within the timescale of the evaluation, had not resulted in the release of resources or of significant changes in fixed costs
- the success of new ways of integrated working was linked to the extent of stakeholder engagement. Particular problems had been experienced in engaging GPs and hospital clinicians in discussion of the data
- whereas hospital data on cost and activity is centrally gathered and well developed, more work is needed on social care and community care data.

Looking to the future, the report concluded that successful integration requires clarity of purpose and outcomes, strong leadership commitment, empowerment of staff, patients and carers, agreement on an appropriate scale and scope, and alignment of all available drivers (policy, legislation, structures, information, incentives and outcomes).

Specific programmes to improve integrated care

Improving care for people with long-term conditions

Around 2 million people in Scotland have at least one long-term condition, and one in four adults over 16 report some form of long-term illness, health problem or disability. By the age of 75, nearly two-thirds of people will have developed a long-term condition. Recent research has also demonstrated that most people with a long-term condition have more than one and that the prevalence of multi-morbidity increases with age and is associated with deprivation (Barnett et al 2012).

Delivering for Health sought to introduce a systematic approach to managing long-term conditions (Scottish Executive 2005b). Its priorities were, first, to identify those people at greatest risk of hospital admission and provide them with earlier care to prevent the deterioration of their health; and second, to equip people at all levels to manage their own health, enabling them to take greater control of their condition and of their life. On the first priority, SPARRA (Scottish Patients at Risk of Readmission and Admission) was developed in 2006 to predict a patient's risk of being admitted to hospital as an emergency in a particular year. Initially restricted to those aged 65 and over, it was extended in 2008 to all ages, and further extended in 2012 to include primary care prescribing information in order to increase the predictive power of the algorithm (Information Services Division 2012).

Better Health, Better Care (Scottish Government 2007a) committed the government to producing a delivery plan for the next stage of work on long-term conditions and this was published in 2009 as *Improving the Health and Wellbeing of People with Long Term Conditions in Scotland: A national action plan* (Scottish Government 2009). It set out an approach to the management of long-term conditions based on the Wagner Chronic Care Model (Wagner 1998), adapted to reflect NHS Scotland's integrated structures, and its focus on quality improvement and on a mutual care approach.

A Long-Term Conditions Collaborative between 2008 and 2011 was tasked with supporting NHS boards and their partner agencies to deliver sustainable improvements in the management of long-term conditions through three workstreams on self-management, condition management and complex case/care management (NHS Scotland 2012b). It encouraged the use of a variety of service improvement tools and techniques, and developed resources such as high-impact changes, improvement action bundles, a community of practice and guidance notes on key change areas:

- GP practice/community team-based risk prediction coupled with targeted anticipatory care planning and case management
- intermediate care and pull-through to early supported discharge using specialist nurses and co-ordinated inreach by community teams
- telecare and telehealth for chronic obstructive pulmonary disease and cardiology allied with increasing use of cardiac and pulmonary rehabilitation
- system-wide managed clinical networks adopting generic approaches
- local commissioning development, and provision of self-management training, supported by web-based service information directories and a national Self Management Impact Fund. A strategy for self-management, *'Gaun Yersel'*, was developed by the Long Term Conditions Alliance, an umbrella organisation of third sector bodies (now known as the Health and Social Care Alliance) (LTCAS 2008).

Results to date show:

- a rising profile for co-production and asset-based approaches and evidence of the impact of the Self Management Impact Fund
- whole-system targeting of anticipatory support for high-risk/high-resource-use individuals
- use of Releasing Time to Care and Lean to free up community team time for direct care and improve working lives
- a 13.5 per cent reduction between 2006/7 and 2010/11 in the rate of emergency bed days for long-term conditions.

Reshaping Care for Older People and the Change Fund

Approximately £4.5 billion of public funding is spent each year on health and social care for those aged over 65 (Scottish Government 2010b). Well over half (60 per cent) of this is spent on care in hospitals and care homes (and almost one-third on emergency admissions to hospital). Less than 7 per cent is spent on home care. Overall, emergency admissions of older people absorb £1.4 billion each year (more than the total spend on social care for older people) and are expected to continue to grow unless action is taken. To address these demographic and funding pressures, changes are needed in the way in which care is planned and delivered.

Reshaping Care for Older People: A programme for change 2011–2021 sets out an ambitious plan, developed by the government, the NHS and COSLA, for reshaping care for older people across Scotland, along with the first set of key actions required to deliver it (Scottish Government 2010b). It sets out the vision of older people 'valued as an asset, their voices are heard and [they] are supported to enjoy full and positive lives in their own home or in a homely setting' and a national framework within which local partnerships are developing joint strategic commissioning plans. A new Change Fund has been established as a catalyst to reshape care between 2011 and 2015.

The Reshaping Care programme is being taken forward under the supervision of the ministerial strategic group and comprises a number of primary workstreams including future funding of long-term care; building capacity in the community and promoting a co-production approach; promoting active and healthy ageing and developing preventive and anticipatory care; providing proactive and integrated care and support at home; and considering the future role of the care home sector, housing and communities.

A multi-agency improvement network has been established to share learning; spread local improvements; increase the pace of change; and maximise the impact of the range of local and national improvement support available for Reshaping Care and health and social care integration. Led by the JIT in collaboration with a range of stakeholder organisations across all sectors, the network provides support to partnerships through:

- a programme of regular WebEx virtual meetings and national and local events
- regular e-bulletins
- evidence, resources and improvement tools on the website
- use of measurement for improvement
- collaborating across programmes and workstreams
- integrating outcomes-based approaches across a range of activities (Joint Improvement Team 2012b).

The Change Fund

A key element of the Reshaping Care programme is the Change Fund which is to be used as a catalyst to rebalance care, support and service provision towards anticipatory care and preventive services that support older people to stay in their own homes. It aims to encourage more innovative use of care home placements alongside improvements in care-at-home provision and housing-related support, and support for unpaid carers. A total of £70 million in 2011/12, £80 million in each of 2012/13 and 2013/14 and £70 million in 2014/15 has been allocated to the fund (Scottish Government 2011d).

The fund is distributed to each of the 32 partnerships by formula but is released only on receipt of plans prepared, agreed and signed off by the NHS board, local authority, and third and independent sector partners, and with evidence of engagement of carers and the public. Partnerships are required to provide evidence of how the resources have been used to:

- meet nationally available outcome measures and indicators such as emergency inpatient bed day rates for people aged 75 and over (an NHS HEAT target), delayed discharges, prevalence rates for diagnosis of dementia (NHS Quality and Outcomes Framework), and percentage of people aged 65 and over who live in housing rather than a care home or a hospital setting
- improve performance against the targets for user and carer experience in the Community Care Outcomes Framework (*see* page 45) such as the percentage of community care service users feeling safe, of users and carers satisfied with their involvement in the design of their care package, and of carers who feel supported and capable to continue in their role as a carer
- shift the balance of spending along the Reshaping Care pathway with increases in the proportion allocated to preventive and anticipatory care and proactive care and support at home. A couple of examples are provided in the boxes on p 42.

From 2012/13 onwards at least 20 per cent of Change Fund spending is to be dedicated to direct and indirect support to enable carers for older people to continue in their role.

The fund is a transitional source of bridging and partnerships are required to plan how they will use their collective resources to sustain the new mix of services, care and support before it closes in 2015. Change plans are a stepping stone towards the development of longer-term joint commissioning strategies. In recognition of the complexity of this task,

Hospital at Home in North Lanarkshire

Age Specialist Service Emergency Team (ASSET), an inter-disciplinary, multi-agency team (including allied health professions, community psychiatric nurses, social work, consultant geriatricians and nursing), offers an urgent response to prevent avoidable emergency admission and deliver safe, effective and person-centred care at home.

A GP responding to a patient in crisis calls the emergency response centre and is offered ASSET as an alternative to admission. The ASSET team responds within one hour and provides assessment, diagnosis and management of the acute episode and communication/referral to community health and social care teams to continue support at home.

Key results to date: around 80 per cent of patients seen are kept at home; mortality and readmission rates compare favourably with those who are hospitalised; and acceptability with patients and carers is high.

Source: Joint Improvement Team website

partnerships were given until February 2013 to produce the first iteration of such joint commissioning plans, again developed and signed off by the NHS, local authority, and independent and third sector partners.

The proportion of the Change Fund allocated to upstream preventive and anticipatory care rose from 19 per cent in 2011/12 to 23 per cent in 2012/13, and a continued shift in 2013/14 (28 per cent) and 2014/15 (29 per cent) is estimated where partnerships have provided this information. Overall, in 2012/13, partnerships are allocating 48 per cent of the Change Fund to preventive, anticipatory and more responsive community-based services aimed at supporting people at home and in their communities, with this estimated to shift to almost 60 per cent in 2014/15. Change Fund investment in hospitals and long-stay care homes will decrease from 23 per cent to 16 per cent with a corresponding increase from 24 per cent to 28 per cent of funding spent on community care and support at times of transition (Joint Improvement Team 2012c).

Commissioning for better outcomes in Midlothian

Change funding has been utilised to accelerate the process by which more effective and efficient services are commissioned. As a result: rapid response is preventing 18 emergency admissions a month; care home placements have fallen by over 20 per cent from the level predicted; the number of long-stay hospital beds has been reduced by 53 and the resources reinvested in community services; and average expenditure per head on older people increased between 2006 and 2010 by only 6 per cent (compared with 19 per cent and 21 per cent in two benchmark authorities).

Source: Joint Improvement Team website

Intermediate care

Intermediate care encompasses a range of functions that focus on prevention, rehabilitation, re-ablement and recovery at times of transition so as to prevent unnecessary hospital admission, delayed discharge from hospital and premature admission to long-term care.

Maximising Recovery and Promoting Independence: Intermediate care's contribution to Rehaping Care – an intermediate care framework for Scotland, published in 2012, describes a continuum of integrated services to prevent unnecessary admission to acute hospital or long-term residential care, promote faster recovery from illness, support timely discharge from hospital and optimise return to independent living (Scottish Government 2012i). Intermediate care services can be provided in:

- individuals' own homes, sheltered and very sheltered housing complexes
- designated beds in local authority or independent provider care homes
- designated beds in community hospitals.

Most Reshaping Care partnerships are using their Change Fund to develop or enhance intermediate care services. Some are aligning their local menu of services to create a single point of contact while others are developing rapid response and 'hospital at home' services.

Although emergency bed day rates for over-75s are declining across Scotland, the rates for emergency admissions of older people continue to rise, particularly for short-stay admissions of less than two days (*see* page 48). Pathways that provide rapid access to short-term hospital at home alternatives to admission will have high impact on acute care. Partnerships with comprehensive intermediate care services are showing accelerated reductions in rates of emergency bed days and delayed discharge compared with those that have been slower to implement hospital at home and other models of community-based intermediate care (*see* box below).

Re-ablement in Stirling

Change funding has been used to accelerate implementation of re-ablement. This has led to a 30 per cent reduction in home care needs and fewer long-term care beds being purchased as more people return home after a period of intermediate care delivered jointly by an integrated health and social care team. The proportion of people with intensive support needs living in housing rather than a care home or hospital setting has increased from 18 per cent to 35 per cent; spending on home care is unchanged and on care homes has reduced by 24 per cent.

Source: Joint Improvement Team website

In 2006 a strategy was published setting out a new role for community hospitals (of which there are 58 in Scotland, mainly in small towns in rural areas) as part of an extended primary care system, providing local access to a wide range of services, wherever possible on a 24/7 basis, and promoting a multidisciplinary, multi-sectoral approach to health care (Scottish Executive 2006). CHPs were encouraged to use existing community hospitals as a platform to provide a bridge between home and specialist hospital care, through ambulatory and/or inpatient services, not only in rural areas but also in larger towns and cities (*see* box overleaf).

Working together in Invergordon

The community hospital in Invergordon is used as a hub to integrate primary, community and secondary care. The inpatient beds are co-run by the GPs and the consultant with a joint GP/consultant weekly ward round and a multi-disciplinary team meeting including social workers, home care organisers, community nurses and allied health professionals which also discusses patients on the community teams' caseload. A small budget has been created to allow community teams to spot-purchase home care directly.

Source: Joint Improvement Team website

A *Community Hospitals Strategy Refresh* was issued in 2012 setting out the vision for community hospital development in the context of quality and integrated care and a network was established to drive improvement within and across boards (Scottish Government 2012b).

Self-directed support

To deliver the aim of social care being based around the citizen rather than the service, the Social Care (Self-directed) Support (Scotland) Act 2013 requires local authorities to give people a range of options for how their social care is delivered, beyond just direct payments, so that they can decide how much ongoing control and responsibility they want over their support arrangements. The Act also confers on local authorities a power to support unpaid carers and a duty to provide information to help people to make an informed choice.

Telehealth and telecare

Another development with significant potential impact on integration and in which Scotland is recognised by the European Commission as a leader has been telehealth and telecare. A Scottish Centre for Telehealth and Telecare was established in 2003 and is

Lochalsh and Skye Housing Association's Care and Repair Service

Lochalsh and Skye Housing Association's Care and Repair Service is working in partnership with NHS Highland and Highland Council to deliver telecare and telehealth monitoring devices cost-effectively to older people and people with disabilities in their homes. Telehealth devices are used to monitor long-term conditions such as chronic obstructive pulmonary disease, heart disease and certain mental health conditions. Daily test results are automatically sent to the Highland Hub Call Monitoring Centre, which generates an alert if any abnormality is identified. This increased monitoring reduces travel time for people in remote rural areas to and from hospital and leads to a corresponding reduction in stress levels. A demo/assessment room within Portree Hospital acts as a training facility for home carers, clients and community nurses to better understand the use and benefits of the devices.

Source: Scottish Government 2012a

now part of NHS24; the JIT has led a Telecare Development Programme since 2006; and initial strategies for telecare and telehealth were issued in 2008 and 2010 respectively (Scottish Government 2008c; NHS24 2010). In recognition of the potential of these technologies to contribute to the achievement of the Scottish Government's 2020 Strategic Vision (*see* page 33), a national delivery plan to 2015 for telehealth and telecare was issued in December 2012; one of its workstreams relates to the integration of health and adult social care, for example, helping people with long-term conditions to live independently at home by supporting them to manage their own health and care (Scottish Government 2012a). An example is provided on p 44.

Anticipatory care planning

Following evaluation of a successful pilot in Nairn (Baker *et al* 2012), NHS Highland introduced a locally enhanced service in 2009 to provide anticipatory care plans for adults identified as being at higher than average risk of hospital admission. These were defined as residents in older adult care homes and the highest 1 per cent risk group in the remaining practice population. Aims were enhancement of quality of care, providing care as close to home as possible and reducing occupied bed days. Practices were paid £75 per initial plan and £25 for each annually reviewed plan.

The cohort was matched with a control group with similar SPARRA scores. Overall increases in emergency admissions and bed days for the control were 51 per cent and 49 per cent respectively, compared with reductions of 38 per cent and 49 per cent respectively in the anticipatory care plan cohort (Joint Improvement Team 2012a).

The Scottish Government and the British Medical Association's (BMA's) Scottish GP Committee have reached agreement over changes to the General Medical Services contract for 2013/14 (Scottish Government 2012e). These include a commitment to introduce anticipatory care planning and polypharmacy review to replace quality and productivity indicators within the Quality and Outcomes Framework on A&E and emergency pathways. These changes, agreed with BMA Scotland (in contrast with possible imposition elsewhere in the UK), were heralded not only to 'help to reduce length of stay and emergency admissions to hospital but also give fresh impetus to integrated working'.

Lessons learned

Assessment of progress

Integration is not an end in itself but a means towards providing seamless care and support that is responsive to the needs and wishes of patients. This has been a key policy goal in Scotland for many years and earlier sections of this chapter have outlined various initiatives to promote its achievement. What effect have they had?

A national outcomes framework for community care was produced in 2008 comprising four national outcomes (improved health, improved wellbeing, improved social inclusion, and improved independence and responsibility) and 16 performance measures across six themes (user satisfaction, faster access, support for carers, quality of assessment and care planning, identifying those at risk, and moving services closer to users/patients) (Scottish Government 2008a). This is widely used by CHPs and their parent bodies for performance management (*see* box overleaf).

User and carer-defined outcomes have been developed through a Talking Points Personal Outcomes approach which comprises three types of outcome: quality of life; process (how services are delivered, how people feel they have been treated); and change (removal

Table 2 Talking Points User Outcomes, Scotland

Quality of life	Process	Change
Feeling safe	Listened to	Improved confidence
Having things to do	Having a say	Improved skills
Seeing people	Treated with respect	Improved mobility
Being as well as you can	Treated as an individual	Reduced symptoms
Living where you want/as you want	Being responded to	
Dealing with stigma/discrimination	Reliability	

Source: Joint Improvement Team (2012d)

of short-term barriers to quality of life) (*see* Table 2 above). There are also outcomes for unpaid carers which emphasise the importance of carers being treated as partners in decisions (Joint Improvement Team 2012d).

Some of the measures in the framework have become official targets. Prominent among these has been tackling two of the challenges that reflect fragmentation of service planning and provision: reducing the rate of bed days as a result of emergency admission of older people to hospital and speeding up the discharge of patients from hospital to an appropriate setting.

On the former, as Figure 7, opposite, shows, there has been a reduction in the rate of emergency bed days in acute specialties for people aged 75 and over by 7.6 per cent between 2009/10 (the year in which the Reshaping Care and Long-term Conditions Programmes started) and 2011/12, an estimated saving of around 550 beds in the number of beds required. From April 2012, there is a new HEAT target to reduce emergency bed day rates for those aged 75 and over by at least 12 per cent nationally between 2009/10 and 2014/15.

Looking at the broader 65 and over population, the overall change from 2009/10 is even greater (saving an estimated 750 beds). Figure 8, opposite, compares the level of actual admissions with that which would have been expected on the basis of demographic trends and an unchanged pattern of service provision.

Performance management reporting in East Renfrewshire

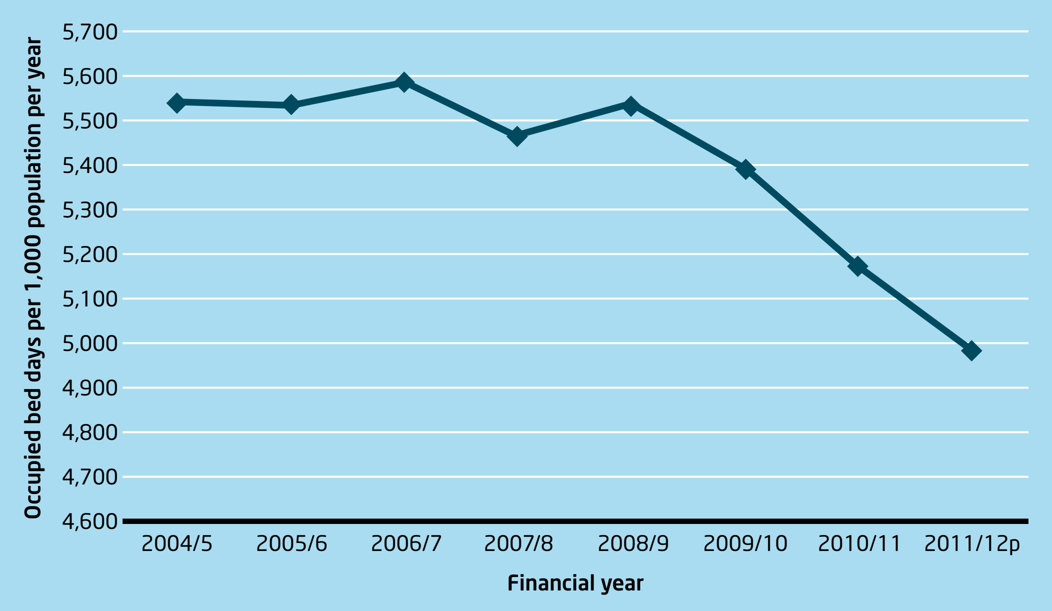
Performance is reported quarterly to the Community Health and Care Partnership (CHCP) Committee, using a traffic light system, on a wide range of measures:

- outcomes (19 measures including delayed discharges, hospital admission rates for long-term conditions, number of people receiving direct payments and percentage of home care clients receiving personal care payments)
- customer (10 measures including 7 drawn from Talking Points, mainly on quality of life issues)
- efficiency (6 measures relating to delivery of key assessments/services)
- people (10 measures mainly relating to staff absence and performance review).

The Talking Points Outcomes are woven into this process and have a major influence, for example, in the development of the Joint Commissioning Plan.

Source: East Renfrewshire CHCP (2012)

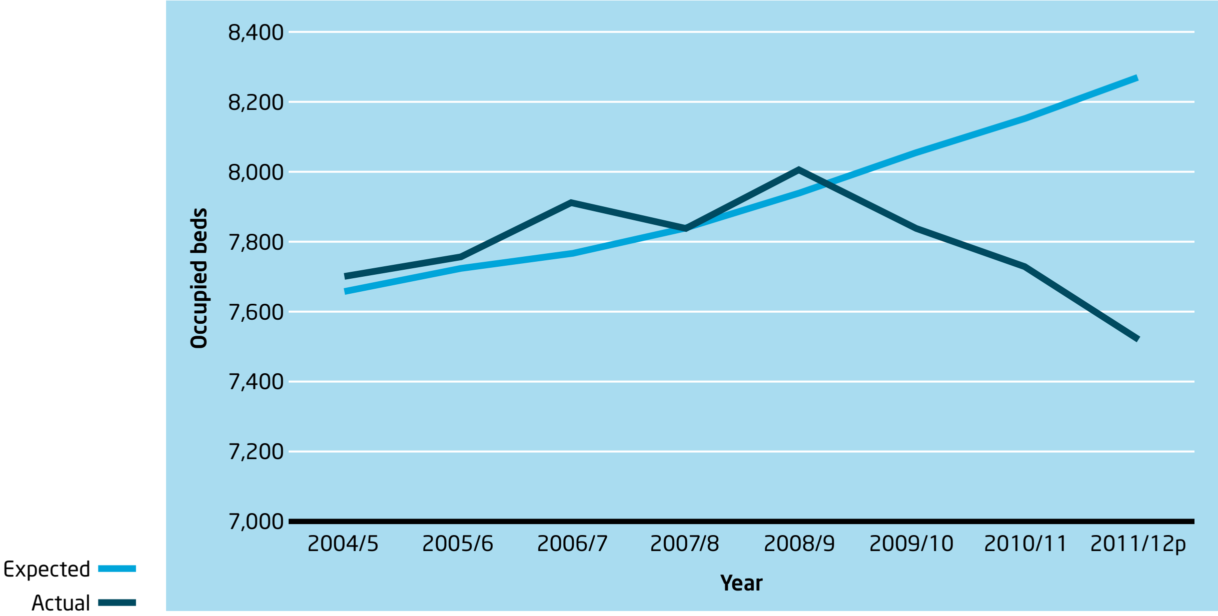
Figure 7 Rate of emergency bed days for patients aged 75+, Scotland



2011/12p: provisional

Source: Information Services Division Scotland (2013b)

Figure 8 Comparison of actual vs 'expected' trend in emergency bed use for patients aged 65+, 2007/8 rates, Scotland

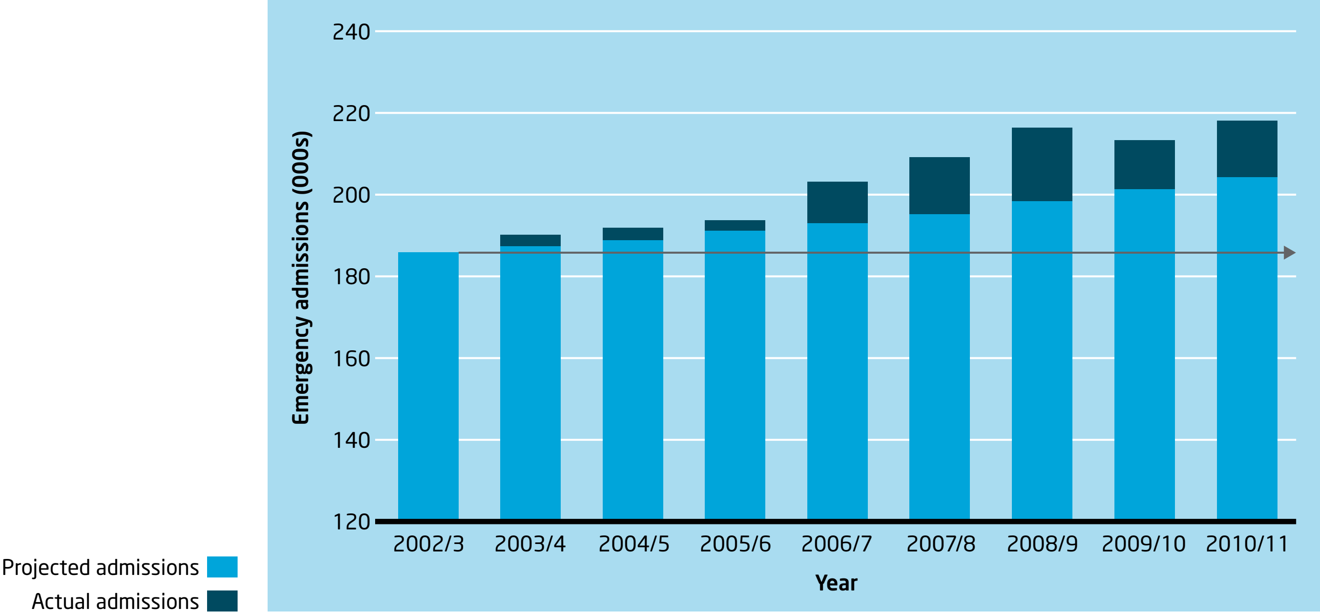


2011/12p: provisional

Source: Information Services Division Scotland (2013b). Analysis by Peter Knight, Lead on Partnership Information, Joint Improvement Team

However, challenges remain. As Figure 9, overleaf, demonstrates, the trend in the number of emergency admissions of people aged 65 and over continues to increase. The projected admission figures shown in the chart are estimated by multiplying the age-specific population size by the age-specific admission rates which applied in 2002/3. It shows that since 2002/3 actual admissions have risen faster than would be expected on the basis of the demographic changes occurring over this period.

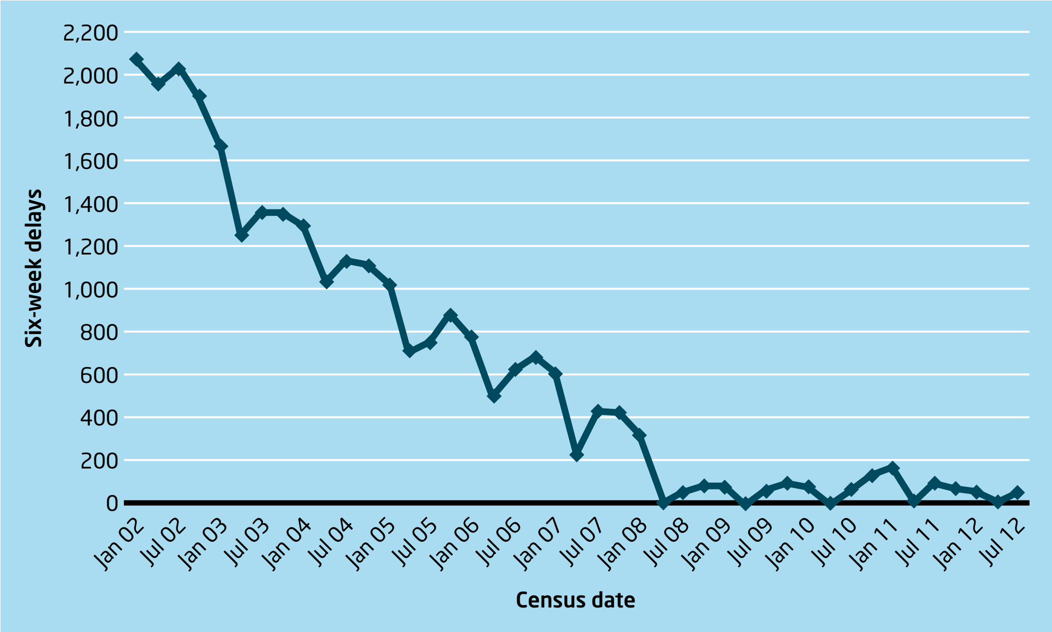
Figure 9 Hospital emergency admissions for patients aged 65+, actual vs projected numbers, Scotland



Source: Information Services Division Scotland (2013b). Analysis by Peter Knight, Lead on Partnership Information, Joint Improvement Team

On delayed discharge, there were more than 2,000 patient discharges delayed longer than six weeks in 2002; a target to reduce this number to zero by 2008 was achieved and subsequently numbers have generally remained below 100 (*see* Figure 10 below). However, delayed discharges still account for almost a quarter of a million bed days and cause considerable distress and anxiety. A new target was therefore set in October 2011 of reducing to zero the number of delayed discharges over four weeks by 2013 and over two weeks by 2015.

Figure 10 Levels of six-week delayed discharge, Scotland

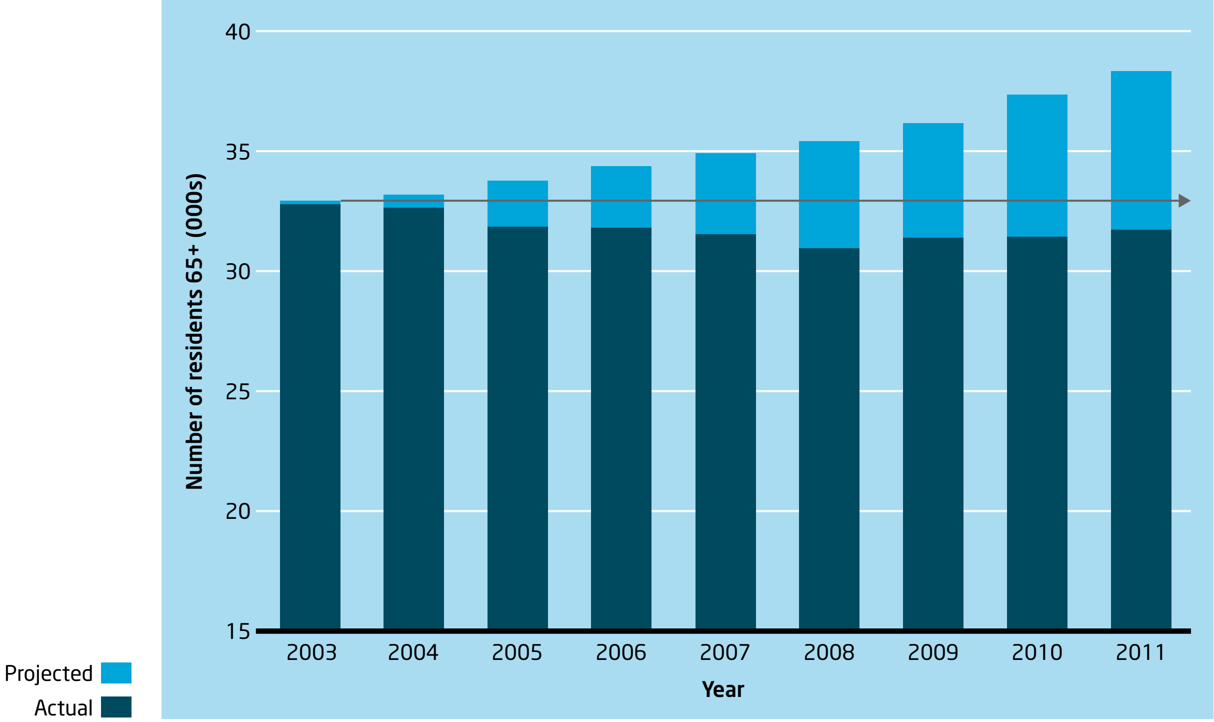


Source: Information Services Division Scotland (2013a)

The goal of shifting the balance of care for older people from institutional care to 'home-based' care can be tracked in two ways: by stemming the increase in the number of older people in care homes; and by increasing the number of those receiving intensive home care (defined as 10 or more hours a week).

In relation to the former, Figure 11, below, uses the same approach as in Figure 9 (*see* p 48) to compare the actual number of people aged 65 and over who are resident in care homes with projections based on demographic trends and an unchanged pattern of service provision, and shows that in 2011 there were around 6,500 fewer residents than the projection implies.

Figure 11 Long-stay care home residents aged 65+, actual vs projected numbers, Scotland

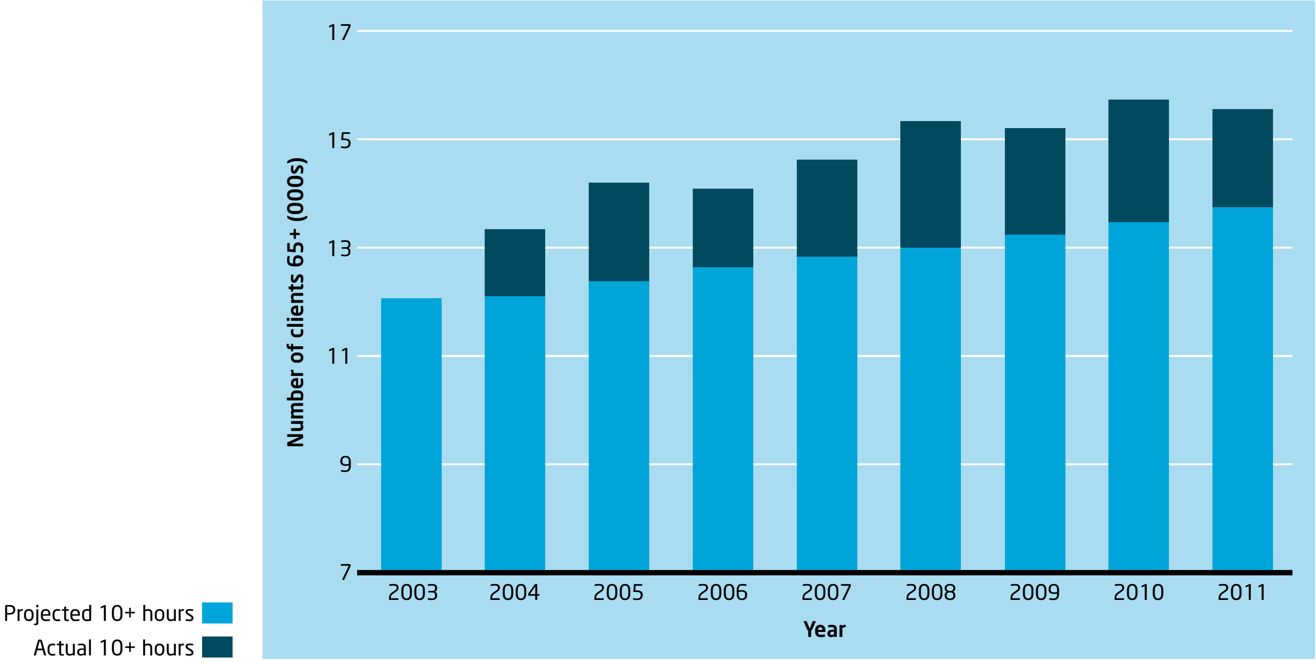


Source: Information Services Division Scotland (2013a). Analysis by Peter Knight, Lead on Partnership Information, Joint Improvement Team

Figure 12, overleaf, compares actual provision of intensive home care to people aged 65 and over with projections calculated on the same basis as in previous figures and shows that in each year more intensive home care has been provided than would have been expected on the basis of demographic change alone. By 2011 the difference between the actual and projected was about 1,800 people.

Sustaining any shift in the balance of care requires the transfer of resources from hospitals to primary care and community services and from the NHS to local authorities. CHPs were intended to have a key role in delivering such shifts in services and resources. As reported under 'Creating the conditions for integrated care in Scotland' (pp 30–39), work has been undertaken to obtain a clearer understanding of costs and activity across health and social care. However, Audit Scotland found in 2011 that there had only been a slight increase in the percentage of total NHS resources spent in the community between 2004/5 and 2009/10 and no change in the percentage of NHS resources transferred to local authorities during the same period (about £0.3 billion per annum or 3 per cent of the NHS budget) (Audit Scotland 2011).

Figure 12 Clients receiving intensive (10+ hours) home care, actual vs projected numbers, Scotland



Source: Scottish Government (2012f). Analysis by Peter Knight, Lead on Partnership Information, Joint Improvement Team

Enablers and barriers

This data provides evidence that, on the basis of what are widely regarded as output measures of integration, Scotland has in recent years made significant progress.

This reflects various factors that combine to make Scotland fertile territory in this respect. First, given that integrated service provision is not a quick fix but requires long-term sustained effort, its implementation has been facilitated by relative organisational stability, with no major structural change in the NHS for about 10 years and in local government for almost 17 years; and by political consensus, with all parties committed not only to integration but also to a partnership approach to achieving it. This has been bolstered by the strong personal commitment of successive ministers and leaders in the NHS and COSLA to the integration agenda and to an increasing focus across both the NHS and local authorities on implementation and improvement.

A second enabling factor has been the existence since 2004 of unified NHS boards, combining responsibility for planning and delivering acute, primary and community services and with strong local authority representation at board level and within each CHP to support better joint working between primary and secondary health care and between health and social care. This, coupled with the emphasis on collaboration rather than competition, has been of particular benefit for integration within the NHS.

Third, progress has been driven by a strong performance management culture within the NHS which since 2007 has been linked to the overarching national performance framework set by the government which also encompasses local government. This is underpinned by support and challenge for improvement across public services.

Fourth, Scotland's relatively small size – in this area as in many others – facilitates brokerage among the relatively small number of people occupying senior leadership positions in government, the NHS (both clinicians and managers), local government and the third and independent sectors.

Despite these enablers, significant barriers remain. Within the NHS, it has proved very difficult over the past 30 years to shift the balance of care. In the medical profession, acute specialties often have the loudest voice. Despite more than 30 years of promoting primary and community care, the public and even more the media still tend to equate the NHS with hospitals. Public pressure on politicians is also much more vociferous and sustained in relation to issues such as waiting times for elective procedures and access to new medicines. Public concern about the quality of care for older people or for people with mental health problems and learning disabilities hits the headlines from time to time but has not yet resulted in significant leverage on those responsible for decisions on the allocation of resources.

Even more intractable barriers stand in the way of achieving effective integration between health and social care. International evidence has identified three common and overlapping barriers:

- strong institutional and sectoral responsibilities expressed through vertical and organisationally discrete power structures
- funding streams, budgets and accountabilities remaining separate
- cultural, educational, professional and language differences and difficulties (Scottish Government 2010a).

These barriers apply in Scotland in spite of the enablers mentioned above. Despite the opportunities presented by unified NHS boards and by CHPs, there remain significant structural challenges resulting from what Audit Scotland described as a 'cluttered partnership landscape' (Audit Scotland 2011). The government's latest proposals are designed to mitigate these differences in the governance arrangements and financial management procedures relating to health and social care. NHS boards and local authorities also operate in significantly different environments, with separation of commissioning and provision increasingly the norm in local government whereas it has been largely abandoned in the NHS.

There are also tensions surrounding joint working. At organisational level it has been necessary to build relationships (helped by local authority membership of NHS boards) between elected members of local authorities and their appointed counterparts on NHS boards. Local authorities have also been wary of acute dominance within the NHS; and on both sides (particularly the NHS) there has been concern about 'losing control' of resources allocated to them. Similar problems have arisen in relation to information-sharing where the potential benefits of IT – managerially and in patient care – have proved difficult to realise within either the NHS or local government, quite apart from across the interface between them.

There have also been a number of professional tensions compounded by public perceptions of the differing roles of health and social work professionals, seen, for example, in hesitancy over the sharing of records. Training, including continuing professional development, of key professions such as nursing and social work continues to be mainly separate. Effective joint working also challenges conventional hierarchies and reporting lines; and there are difficult issues to be overcome in harmonising terms and conditions of employment, including the 'wicked issue' of equal pay.

In its 2012 consultation paper on the integration of health and social care, the government acknowledged that, while there had been 'very significant progress in improving pathways of care', there remained 'two disconnects in our system of health and social care' (between primary and secondary care in the NHS and between health and social care) which make it difficult to address people's needs holistically, and to ensure that resources follow patients', service users' and carers' needs (Scottish Government 2012g).

Strikingly, the problems it highlighted as requiring to be addressed were unchanged from those in earlier statements of government policy:

- inconsistency in the quality of care for people, and the support provided to carers, across Scotland, particularly for older people
- unnecessary delays in discharge from hospital when patients are clinically ready for discharge
- services required to enable people to stay safely at home not always being available quickly enough, leading to avoidable and undesirable admissions to hospital.

Conclusions

Over the next decade, health and social care organisations will have to respond to the challenges of an ageing population, increasing numbers of people with complex long-term conditions, increasingly sophisticated (and expensive) treatments, and rising expectations of what health and social care services should deliver. None of these is new but they now have to be addressed in a climate of significant budgetary constraint. This makes it even more essential that different parts of the NHS develop new ways of working and that the NHS and local authorities work even closer together and with the independent and third sectors if they are to sustain and improve services that are person centred, effective and safe. This makes the sharing of learning from other countries, to which this paper is intended to contribute, all the more important.

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3 Wales

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Introduction

Wales constitutes about 8 per cent of the land mass of the United Kingdom, and is home to just under 5 per cent of its population – currently 3.1 million. As elsewhere in the United Kingdom, this is an ageing and expanding population, with numbers projected to increase to just over 3.3 million by 2033, including a 90 per cent increase in the number of people aged 80 and over. Overall, Wales is the poorest region of the United Kingdom, with a Gross Value Added (GVA) per head in 2010 of 74 (against an index where UK = 100). The largest sectors of the economy are public administration, defence, education and health (27.4 per cent of GVA, higher than the UK figure of 20.3 per cent) and production (19.5 per cent, compared with a UK figure of 13.7 per cent).

The health of people in Wales reflects its post-industrial economy. Life expectancy overall has increased in recent years, rising by 4.4 years for males and 3.0 years for females since 1991–3, reflecting a substantial decrease in deaths from circulatory disease in men under 75. But there remain substantial geographical and socio-economic variations in all types of life expectancy (Public Health Wales Observatory 2011). For example, healthy life expectancy in males ranges from 57.1 in Blaenau Gwent to 68.2 years in Monmouthshire, and for females the largest difference is around 10 years. National inequalities are particularly wide in healthy life expectancy. The gap between the most and least deprived areas is 18.9 years for males and 17.8 years for females.

Context: the health and social care systems

Political context

Wales was united with England in the 16th century, and the constitutional settlement changed little (beyond the creation of the post of Welsh Secretary in the UK Cabinet in the 1960s) until a referendum in 1997 paved the way for the Government of Wales Act and the formal devolution of certain powers in 1999 to a newly created National Assembly of Wales. These powers included most aspects of domestic governance, including health, local government, transportation, and economic and other planning. Its responsibilities are funded almost entirely by the UK parliament through a sum of money based on Wales' population share of the corresponding English expenditure, to be spent in Wales as determined by the Assembly. There are 60 elected representatives, known as Assembly Members, comprising constituency (40) and regional (20) Members, the latter allocated according to a formula which aims to ensure that the overall balance of the Assembly broadly reflects the number of votes cast for different parties. In addition, Wales is represented in the UK parliament by 40 Members.

The process of devolution continued with a subsequent Government of Wales Act (2006), which extended the powers of the Assembly to seek from the UK parliament legislative competence within 20 specified fields (including health and health services). This competence would be granted for specific topics within the specified fields, a procedure now (following a referendum in 2011) replaced by a simpler approach, which allows the Assembly to legislate within its 20 fields without the prior approval of the UK parliament. The first Bills under this procedure are now in preparation.

There are up to 14 Welsh ministers who form the Cabinet and are accountable to the Assembly. The post-devolution governments in Wales have all been dominated by the Labour Party, either acting alone or in coalition with the Liberal Democrats or Plaid Cymru. The Labour Party currently governs alone, but with no overall majority. Given the electoral geography of Wales, it is likely that future governments will also be centre-left.

The Welsh Labour Party has followed quite different policies from its English counterpart, especially in health, and it rejects all notions of quasi-markets and competition in public services, seeking – in the words of its erstwhile leader and former First Minister, Rhodri Morgan – to create 'clear red water' between English ('New') Labour and Welsh Labour. In the NHS, this has resulted in very little engagement with private sector health providers, and a very cautious approach to the pharmaceutical industry. There is a determined attempt to get the various public services to work in partnership, using to the full the potential that comes from the fact that various public agencies, whether separately or as clusters, have common boundaries. Various mechanisms have been established to facilitate this, including local service boards (LSBs), which, led by local authorities, bring together local agencies in partnership to tackle issues that need a common approach.

The recent history of health and social care

Pre-devolution, health and social care policy in Wales closely followed that in England. Some small differences emerged over time, but these were confined to minor adaptations of policy to fit the particular circumstances of Wales (such as adjustments to the resource allocation formulae), or to small-scale initiatives which did not call into question national policy, such as the development of non-acute treatment centres in the 1980s, or the pioneering development of various public health initiatives in the 1980s and 1990s. Wales' adoption of the internal market was not as enthusiastic as that of England, even before devolution – GP fundholding did not achieve the same level of penetration as in England, for example – but the policy aims in key government priority areas were indistinguishable from those in Wales' eastern neighbour.

One area where policy implementation in Wales did diverge somewhat from that in England was in relation to local government reorganisation in the mid-1990s. The result across the whole of Wales was the replacement of the two-tier structure with 22, relatively small, unitary authorities, responsible for all local government services. They include just three with a population of more than 200,000, and seven with a population of fewer than 100,000. The intention was to simplify responsibilities and devolve accountability to smaller populations. The architects of this change hoped that authorities would choose to collaborate in the provision of services, appointing joint directors. But – perhaps not surprisingly – this did not happen, and Wales still has a relatively large number of small local government services, with the attendant difficulties in ensuring critical mass and avoiding inefficiency.

Since the devolution of powers in 1999, the gap between health and social care policy in Wales and England has steadily widened. Policy has been dominated by a desire to move Wales away from the quasi-market approach in England, reasserting an approach that prioritises public health and tackling health inequalities, and insists on the benefits of collaboration between public services – and especially the NHS and local government – in joint efforts to improve well-being and to deliver seamless services which place the citizen at their heart.

As a result, Wales followed the abolition of GP fundholding with the creation of local health boards (LHBs) that were co-terminous with their local authority partners. LHBs commissioned services from more than a dozen NHS trusts; but, with no national tariff and little encouragement for competition between providers, this was little more than an echo of the internal market. Until 2009, the emphasis on partnership working meant that Wales had to have 22 LHBs to match the 22 local authorities. This was increasingly recognised as untenable, as the difficulties in equipping the (often very small) LHBs to effect the major strategic shifts required of them defeated any attempts to do so. The analysis of the responses to the Welsh Government consultation on reorganisation suggested that many felt that the LHBs made good progress in establishing collaborative relationships with their local authority partners, and often enjoyed strong relationships with primary care, but their ability to engage effectively with the much larger trusts – which often served several LHBs – in order to increase their productivity and bring services into the community, was disappointing.

A further reorganisation of NHS services had therefore become inevitable, and the formal merger of the commissioning and providing functions into seven new LHBs was described by the Welsh Government as the removal of the final vestiges of the internal market. Local government reorganisation has also been mooted on several occasions, but the political opposition has so far been too strong.

Organisation of health and social care in Wales

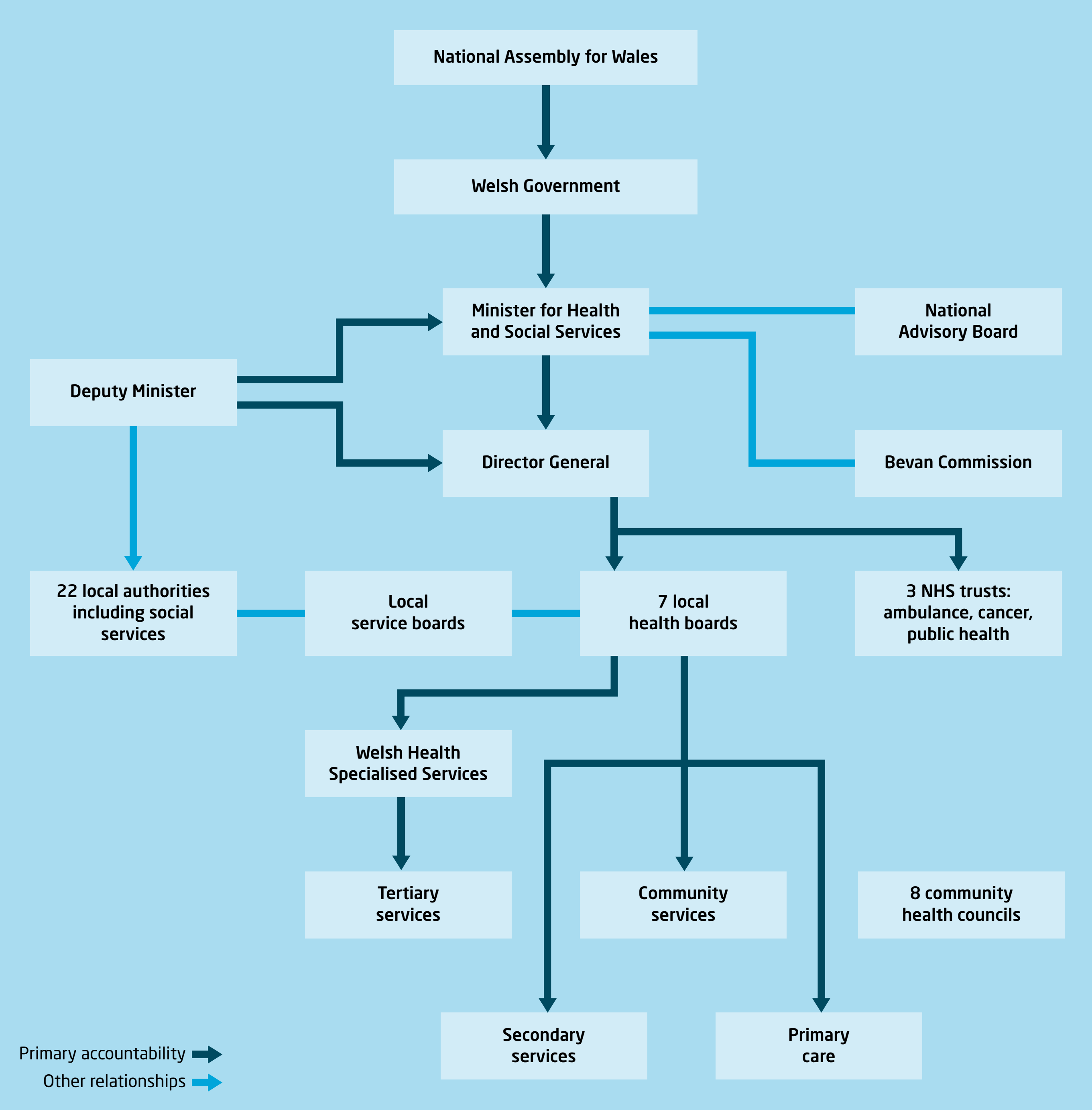
The post-2009 structure of the NHS in Wales unifies the planning and delivery functions of primary, secondary and tertiary care on a geographical basis, in seven LHBs: there is no purchaser–provider split. In addition, there are three NHS trusts – for the Welsh Ambulance Service, for public health and for specialist cancer services (the Velindre NHS Trust). Specialist care is now commissioned by the Welsh Health Specialised Services Committee, which is accountable to the seven LHBs. Public and patient input is the statutory responsibility of eight community health councils, the successors of the bodies originally established in 1974. Figure 13, overleaf, shows how the structure is organised.

The Minister for Health and Social Services is supported by the Department for Health and Social Services, the Director General of which is also the Chief Executive of the NHS in Wales. The Deputy Minister takes the lead on policy matters relating to social services and social care, the delivery of which remain largely a responsibility of local government.

The Welsh Government sets the framework for health and social care through national policy and strategy documents. The major strategic documents are *Our Healthy Future* (Welsh Assembly Government 2009b), *Together for Health* (Welsh Assembly Government 2011b) and *Sustainable Social Services for Wales: A framework for action* (Welsh Assembly Government 2011a). In addition, the Welsh Government sets out annual requirements in relation to NHS performance. The responsibility for local planning lies with the LHBs. They plan all services for their own resident population and work together through the Welsh Health Specialised Services Committee to make available national and highly specialised services for the whole of Wales. Those services include, for example, ambulance services, and highly specialised cancer and mental health services.

LHBs are also required to work with other public services locally through joint LSBs, whose role is to co-ordinate action in those priority areas where co-operation is most needed and can be expected to yield greatest results, and to produce integrated plans

Figure 13 The organisation of health and social care, Wales



for each local authority area. LSBs are not statutory bodies, but rather 'an expression of engaged public service leadership locally' (Welsh Government 2012b, p 7). Their role is to:

- agree the strategic priorities for multi-agency working
- ensure that arrangements are in place to deliver joint working as appropriate
- challenge local underperformance
- review and report progress annually.

Their core membership consists of the local authority (political and/or executive), police, health service, third sector parties and a senior representative of Welsh Government (the last, in part, to relay messages to central government about the changes required in their own ways of working).

To rebalance health services and develop more services closer to home, primary and community health care is being planned through approximately 60 locality networks, made up of clusters of GP practices working in partnership with other providers such as pharmacists.

The responsibility for standard setting, monitoring and enforcement is divided between several bodies, with professional regulation of the health care professions (although not of social workers) being vested in UK or British bodies. Table 3, below, shows this in more detail.

Table 3 Allocation of responsibility for health and social care, Wales

Function	Regulatory institution
Standard setting	**Welsh Government** – The Welsh Government issues health care standards. Clinical elements of the standards are underpinned by **National Institute for Health and Care Excellence (NICE)** guidance and by standards issued by professional bodies such as the **General Medical Council**.
Monitoring	**Healthcare Inspectorate Wales (HIW)** – HIW is the independent inspectorate and regulator of health care in Wales. The **Care and Social Services Inspectorate Wales (CSSIW)** has equivalent responsibilities for social care, and Estyn covers education and training. **Wales Audit Office (WAO)** – WAO is the public service watchdog for Wales. Bodies in England, such as the **Healthcare Quality Improvement Partnership**, NHS England and the Health Research Authority, also currently assist Wales in monitoring health care.
Enforcement	**HIW** and **CSSIW** – HIW will undertake special reviews and investigations where there appear to be systemic failures in delivering health care services. WAO audits the accounts of public bodies and publishes audit reports. If necessary, **WAO** will publish a 'Report in the Public Interest'. Professional bodies, such as the **General Medical Council**, also assist Wales in the enforcement of standards, and they may take action against members to protect patients from harm.

Wales currently has more than 120 hospitals as part of an overall estate valued at £2.3 billion. These include:

- 13 hospitals with major accident and emergency (A&E) units (approximately 2 per LHB area), and a wide variety of acute medical and surgical specialties. Two hospitals (Swansea and Cardiff) also provide specialist tertiary services for the south of Wales
- 15 hospitals with minor A&E units or minor injuries units
- 46 community hospitals (with the highest numbers in rural areas in north, central and west Wales), providing a mixture of rehabilitation, step-down and GP beds.

The NHS currently has approximately 72,000 directly employed full-time equivalent staff, reflecting an increase of almost a quarter in the first decade of the 21st century. Table 4, overleaf, gives a breakdown of this figure into staff groups.

In 2011, there were 2,022 GPs working in 483 GP practices in the NHS in Wales, of whom 43 per cent were women. Some 13 per cent of GPs work in single-handed practices, although they may employ a salaried GP or a GP trainee. The list size has fallen in Wales by 6 per cent (from 1,665 to 1,564) between 2001 and 2011 (6.5 GPs per 10,000 registered patients).

A new Mental Health Strategy for Wales is now in development and will cover the whole life course services for children, adolescents and older people. It aims to consolidate existing policy and address mental health and well-being as well as mental health problems, challenge stigma and discrimination, focus on the individual's care within a

Table 4 Breakdown of NHS staff numbers (full-time equivalent), Wales

Staff group	2001	2011	Percentage change in the last	
			10 years	1 year
Medical and dental	3,907	5,813	+48.8	+2.8
Nursing, midwifery and health visiting	24,751	27,999	+13.1	-0.6
Administration and estates	12,326	15,230	+23.6	-1.8
of which: managers	*1,339*	*2,092*	*+56.2*	*-10.7*
Scientific, therapeutic and technical	7,605	11,450	+50.6	-0.3
Health care assistants and other support	7,781	9,711	+24.8	-3.4
Ambulance	1,103	1,458	+32.2	+2.1
Other	121	157	+29.7	-0.9
TOTAL	**57,595**	**71,817**	**+24.7**	**-0.9**

Source: Statistics for Wales (2012)

recovery approach, and embed the Mental Health (Wales) Measure 2010. This Measure, a piece of law made by the National Assembly for Wales which has a similar effect to an Act of Parliament, makes several important changes to the current legislative arrangements in respect of the assessment and treatment of people with mental health problems in Wales, and is intended to expand primary care mental health services and the duties relating to the provision of statutory advocacy.

Performance management

All NHS bodies in Wales are accountable to the Welsh Government for their performance against government objectives and priorities. Local government accountability is more complex, being primarily to the local electorate, but with government having monitoring and other roles. Strategic health priorities (Welsh Assembly Government 2011b) currently include:

- service modernisation, including more care provided closer to home and specialist 'centres of excellence'
- addressing health inequalities
- better IT systems and an information strategy ensuring improved care for patients
- improving quality of care
- workforce development
- instigating a 'compact with the public'
- a changed financial regime to allow greater clinical involvement in financial decision-making.

Monitoring of health bodies' performance is set against a series of Tier 1 and Tier 2 targets. The former are 'key priorities where immediate improvement is necessary or where performance at defined target levels must be sustained' (NHS Wales 2012, p 1), and include 11 areas such as quality, mortality, access, and efficiency and productivity. The monitoring regime becomes progressively more intense as performance deviates from the specified level. Tier 2 targets are either longer term or subject to local monitoring, and include prevention and health promotion, primary care and clinical leadership. Both tiers are a mixture of nationally specified requirements (for example, on access or efficiency), those where LHBs are required to develop their own performance targets (such as for mortality rates) and those where the local partnership will agree targets (such as on child poverty or health promotion).

Funding

Overall expenditure on health services in Wales increased over the first decade of the 21st century broadly in line with that elsewhere in the United Kingdom (National Audit Office 2012). In 2010/11, spending per capita in Wales on health was £2,017, compared with £1,900 in England. Comparisons are often made between Wales and north-east England, the region most similar demographically to Wales: spending in that English region per capita was £2,091 in the same year. The NHS in Wales now faces a period of financial retrenchment greater than that elsewhere in the United Kingdom, as a consequence of the decision by the Welsh Government not to afford the same degree of protection to health spending as that granted elsewhere.

Wales has relatively little private financing of health care, and very little use is made of the private sector by the NHS. Budgets are allocated to the seven LHBs (three have allocations in excess of £1 billion a year); GPs and other private contractors are remunerated in similar ways to those elsewhere in the United Kingdom. Limited use is made of formal mechanisms to pool funding between NHS and other public bodies. Use of cost-sharing mechanisms was reduced when the Welsh Government was, in 2004, the first in the United Kingdom to announce its intention to abolish patients' contributions towards the cost of prescriptions; more recently the government has ended charges for parking on hospital premises (except where existing contractual arrangements preclude this).

Net expenditure on social services in Wales in 2011/12 was £1.4 billion, with services being delivered to more than 70,000 people. Some 24,700 people were directly employed by social services, with care being provided in 1,800 regulated care settings and more than 12 million hours of care being provided to older people each year (Welsh Government 2012c).

Funding for local government in Wales has been protected to a greater extent than in England (Crawford *et al* 2012). For example, between 2009/10 and 2012/13, local government expenditure in England (excluding education) decreased by 15.6 per cent, compared with 9.3 per cent over the same period in Wales. For social services, these reductions have taken away about £1 in every £8 gained between 2001/2 and 2009/10. During the past three years, expenditure on social services has decreased by 11.8 per cent in north-east England, compared with 3.8 per cent in Wales. Local government expenditure in Wales now exceeds that in all English regions bar London, with about half of the differences accountable to spending on social services. Nevertheless, social services budgets in Wales are experiencing acute pressure, with cash decreasing while demands have been rising.

Policy on integrated care

There is no single Welsh policy document on integrated care, but aspects of the concept appear in many policy documents. Indeed, the creation of the unified LHBs in 2009 was intended to provide a vehicle for bringing all elements of local health services into alignment. This was not only to end the inefficient transaction costs associated with the purchaser–provider split, but more importantly to incentivise the system locally to review all aspects of the patient pathway (including prevention and health promotion) to ensure that care and support were provided where they best met the needs of the citizen.

With sustainability now at the core of the current agenda for the NHS in Wales, making a reality of this unified system for health is identified as one of seven major areas requiring change.

> *The integrated NHS bodies will accelerate the development of new simplified, integrated services. Confusing, disconnected services fail people and do not make best use of scarce resources.*
>
> (Welsh Assembly Government 2011b)

The need for NHS bodies to work closely with the whole of the public sector, as well as the third sector, is stressed. In this five-year vision for the NHS, 'hospitals for the 21st century' form part of 'a well designed, fully integrated network of care' – with much care moving closer to home and GP teams doing more. In addition, patients will benefit from the planned 'clinical networks', which combine staff from different units, offering people over a wide area the best blend of skills and equipment.

Health improvement strategy

The current health improvement strategy, *Our Healthy Future* (Welsh Assembly Government 2009b), builds on a wide range of existing strategies and policies in Wales, aiming to ensure that health is embedded in all policies. A number of elements within the improvement strategy closely relate to an integrated care agenda. They include the rebalancing of services within the current financial pressures, with more emphasis on promoting, protecting, maintaining and restoring health and independence; and the notion of shared responsibility – between the NHS, its partners and citizens themselves. The statutory requirement for integrated plans at the local authority level is central to the service improvement agenda, with delivery plans reflecting the particular needs of local communities. They are aggregated at the local authority level and LHB level to inform overall development and performance management.

Primary and community health services

Setting the Direction (Welsh Assembly Government 2010) is a prime example of a policy document with integrated services at its core. The document is aimed at assisting the LHBs in the development and delivery of improved primary care and community-based services – particularly for those individuals who are frail or vulnerable, or have complex care needs. The proposed system of care – a 'pull system' – is said to deliver an easily recognisable, highly organised model of integrated community services that will act as a bridge between primary care and the acute hospital. It will move towards a more proactive and preventive agenda with a particular focus on high-risk patient groups and those with increasing frailty. It describes a 'locality'-based model, led by multi-sector locality leadership teams, with comprehensive community-based resources, and joint leadership to lower the boundaries between and within organisations and professional groups. Also central to this approach are shared, secure and robust information systems across health and social care to underpin the community services, with the Informing Healthcare programme playing a key role in ensuring that enhanced access is made available to the GP record, and work under way to develop integrated 'communications hubs'.

Chronic conditions

The Welsh chronic conditions management (CCM) model and framework, developed in 2007, sets out a proactive approach to the management of chronic conditions, based on early assessment, diagnosis, and appropriate treatment within the community (Welsh Assembly Government 2007). Findings from the CCM programme of work suggest that LHBs are improving community-based service provision, the establishment of cluster-based primary care and the formation of integrated teams working across health and social care. Implementation of the CCM programme of work between 2008 and 2011 has supported mainstream change in community service delivery and the introduction of the CCM core model of care co-ordination, integrated teams, GP clusters and locality working, as well as transferring appropriate services from secondary care settings into local community or primary care-based services. Further work is being undertaken to speed up and embed improvements more consistently across LHBs, focusing on high-risk and vulnerable groups, and to develop individual care plans for people with chronic conditions to improve the treatment, care and outcomes for these patients.

Supported self care

A key part of the chronic conditions work has been a growing recognition of the importance of self care, both in maintaining the health of those who are currently healthy and in maximising and preserving the health of those with diagnosed chronic conditions. The approach in Wales has been to develop the concept of supported self care – recognising the need for a partnership between services and citizens if the latter are to be able to sustain their own well-being equitably (Welsh Assembly Government 2009a). At the heart of the approach are four areas of such support, as shown in Table 5, below.

Table 5 Areas of support for self care, Wales

Area	Examples
1. Self-care information and signposting	Telephone advice Information prescriptions Awareness campaigns
2. Skills training – for patients, public and professionals	Disease-specific training Access to exercise Communication skills
3. Self-care support networks	Group interventions Forums/chat rooms Care/respite support
4. Assistive technologies	Home monitoring devices Computer-assisted treatment planner

Social care

The current key policy document for social services in Wales, *Sustainable Social Services for Wales* (Welsh Assembly Government 2011a), also refers to the principle of integration. In a push to renew, innovate and create sustainable services, the priority is to ensure that resources are used in a more joined-up way: 'Sustainability depends on picking up the pace of integration.' Social services will in future be better focused, with users and carers having a much stronger voice and greater control over their services. Renewed services will also be more efficient and effective through greater collaboration and integration of services. Social services in Wales will capitalise on the benefits of its innovative, integrated, family-based services approach. Three areas of work prioritised for much greater integration of delivery are: families with complex needs; transition to adulthood for disabled children; and frail older people. There are plans to develop an 'information hub', similar to that for primary health care.

Social Services and Well-being (Wales) Bill

One of the first new Bills that may gain legislative effect during 2013/14, as part of the recently acquired legislative competence of the Welsh Assembly, is the Social Services and Well-being (Wales) Bill (National Assembly for Wales 2013). Designed to provide the organisational architecture to deliver the government's policy intentions in social care, it will provide a single statutory framework covering local authorities' responsibilities in relation to all those who need care and support, of all ages, and including their carers.

As currently drafted, the Bill contains several significant features that bear upon the provision of integrated services in Wales. It is designed not only to maximise the response of services to the manifested needs of the 150,000–200,000 people in receipt of social services at any one time, but also to extend the regard of authorities to include anyone in the population of 3 million in Wales whose well-being might benefit from it. It will include a statutory framework for 'adults at risk', and will include rights for carers that are equivalent to the rights for those who are cared for. It will enshrine the notion of 'well-being' in law, and requires the government to establish a framework for the measurement of the performance of statutory authorities in improving well-being. It gives the government powers to speed up the provision of direct payment schemes.

It also addresses the question of the degree of co-operation between health and social care. As outlined above, LHBs, local authorities and others already have to co-operate in the production of a single plan for their shared populations; this Bill goes much further, by requiring local authorities to 'promote the integration of care and support with health and health-related provision, with a view to improving well-being, prevention and raising quality' (Welsh Government 2013b, para 84). The approach is to encourage such co-operation, but the Bill gives ministers the power to force the pace if they are not satisfied with the progress being made.

> *Provision is made for partnership arrangements to be prescribed through regulations both between local authorities and between local authorities and local health boards. The framework is sufficiently flexible to enable the Welsh Ministers to prescribe new integrated ways of working in particular areas or across services.*
>
> (Welsh Government 2013b, para 85)

Although this Bill may not become law until 2014, and even more time may elapse before government seeks to enforce greater integration, the effect of the new powers is already being felt. Senior figures in social services and health across Wales, recognising the direction of travel, have already begun to explore locally the sorts of client groups and the types of integration that might offer greatest mutual benefit.

Health care information

Many of the current policy documents in Wales highlight the importance of appropriate IT systems for the success of integrated health care. Informing Healthcare is the NHS programme to transform health care using information and IT. It recognises that delivering high-quality, rapid and integrated health care is often hindered by a legacy of fragmentation between health sectors, organisations and services. IT, however, provides an opportunity to support service improvement and integration around the patient by developing a seamless and shared information base.

Specific initiatives to promote integrated care

Wales' experience with some types of integration goes back many years. During much of the 1980s and 1990s, health services in many (but not all) parts of Wales were delivered by 'integrated' provider organisations (latterly, NHS trusts). These brought together hospital and community health services (district nursing, health visitors, all midwifery, community therapists, and so on) under one organisation. This mix of provision in Wales, with both combined and separate providers, offered an opportunity to compare the degree of service integration actually achieved under the two models (discussed later).

For much of the first decade of the 21st century, Wales carried forward the integrated secondary/community provider model, set alongside separate commissioning bodies, which also related to primary care. While some useful progress was made under this regime in the development of more integrated care pathways, the pace of change was limited, partly because the commissioning function was generally under-powered, with 22 small teams dealing with a dozen or so much larger trusts. What the commissioners gained in understanding and support from GPs, they lost in their lack of leverage with secondary/community services, which did not always perceive the advantage in designing more integrated care.

The creation of fully integrated health bodies in 2009 saw some specific attempts to take advantage of the new, simplified and unified structures. Government decided from the start that each LHB would give its vice chair lead responsibility for primary, community and mental health services within the board. They would work closely with an executive director with an equivalent brief to ensure that the needs of these strategically significant services were met. There was concern from chief executives and others at the time that this was not a satisfactory arrangement, because it would potentially divide the board, and might allow other board members to avoid their corporate responsibilities for *all* their services. After three years of experience with this arrangement, several boards have now sought to blur these separate responsibilities, and have found other ways to try to achieve strategic change. Some have sought to emulate elements of the commissioner–provider divide – albeit within a unified board – by restructuring their executive teams to include a chief operating officer (responsible for the current provision of the entire range of services) and a planning director (who focuses on designing the optimal balance of services).

While health bodies and local authorities have had the power in Wales to establish joint funding mechanisms, few have chosen to make much use of this power. A common perception is that the difficulties and time involved in agreeing how the funds should be established often outweigh the benefits to be gained; local bodies also often argue that the gains of joint working can be obtained in other (less inflexible) ways. The Welsh Government has not sought to force the pace on this issue, although this may change when the Social Services and Well-being (Wales) Bill becomes law.

There have been a few joint appointments between health and social care; for example, in Pembrokeshire, Carmarthenshire, Blaenau Gwent and the Vale of Glamorgan. The seniority and roles of each have varied, as have their impact. Many parts of Wales have not embarked on such joint appointments, while those that have would acknowledge that generally, while they may have achieved some valuable changes, much remains to be done to achieve optimal joint working.

In parallel, there has been some movement to increase the scale of operations in social services, including moves to commission and deliver some more specialised functions on a regional basis. In addition, a few neighbouring local authorities for example, Caerphilly and Blaenau Gwent, and Powys and Ceredigion, are exploring the possibility of bringing their respective social services departments together. The regionalisation agenda has developed some momentum, but covers relatively small elements of provision; the merger agenda has greater breadth, but progress is slow, and confined to few local authorities.

At the micro level, there are several examples of integrated teams across Wales, initiated by individual clinical and professional colleagues. One such example is in Anglesey, where a consultant physician has forged a very successful relationship between secondary and primary services, providing rapid and comprehensive support in the community for ill patients, thereby avoiding hospital admission.

These examples are usually led by a small number of individuals who – often serendipitously – link over a shared client group, spot opportunities for improving care by working more closely and work together to make such change possible. Table 6, below, based on unpublished work carried out for the Bevan Commission in 2012 (*see* http://wales.gov.uk/topics/health/nhswales/organisations/bevan/?lang=en), lists both the strengths and limitations of such projects.

Table 6 The strengths and limitations of integrated teams at micro level, Wales

Strengths	Limitations
Enthusiasm	Vulnerable to changes of personnel
Shared vision	Small scale
Undaunted by procedural rigidities	Constrained by inflexible systems
Direct observation of impact and feedback	Haphazard dissemination of results

There are also some larger-scale projects, which include those described below.

Gwent Frailty Programme

A different approach is being pioneered by the Aneurin Bevan Health Board and its five local authorities in south-east Wales, using a formal pooled budget arrangement, with close involvement by the third sector. This is the largest single exploration of integrated care delivery in Wales. Funded from April 2011 with approximately £7 million of 'invest-to-save' money from the Welsh Government, the aim of the Gwent Frailty Programme is to create a shared resource across health and social services for older people meeting specified criteria for 'frailty'. It is designed to:

- ensure that people have access to the right person at the right time
- focus on preventive care – wherever possible avoiding hospital admissions
- reduce the length of a hospital stay when admission is necessary
- reduce the need for complex care packages
- avert crises by providing the right amount of care when needed
- co-ordinate communication by providing a named person for all contact.

The programme began by focusing on earlier discharge of such patients and on providing alternatives to emergency hospital admission. It will also develop a hospital-at-home arm.

An assessment by WAO after 18 months of operation came to the following conclusion.

> *Partners are strongly committed to the Gwent Frailty vision... [It] is in the early stages of implementation and challenges remain to ensure it is sustainable, to change established behaviours and to demonstrate its impact.*
>
> (Wales Audit Office 2012a)

This was based on a sober assessment of the scale of the challenges faced by the programme, which inherited several quite different models of care across the LHB and the five local authorities. The project still struggles with some inconsistency in performance frameworks and referral criteria in practice. WAO detected some 'tensions' between some of the stakeholders, and some different approaches to scrutiny, and also identified the difficulties the programme may experience in establishing precisely what has been the contribution of the programme itself to the outcomes for frail people. The review also recommended a 'fundamental review of the IT programme' which supports Gwent Frailty. However, there is no denying the enthusiastic support of senior figures and many clinicians for what is Wales' cutting-edge programme in this area.

Further details of the programme are available at: www.gwentfrailty.org.uk/

Wyn Campaign, Cardiff and the Vale of Glamorgan

This is another invest-to-save scheme, serving a population of about half a million. Started in September 2011, it aims to provide wrap-around services for frail older people (the unisex name 'Wyn' representing everyman/woman), including facilitated discharge, an alternative falls pathway for ambulances, in-reach support to care homes to prevent admission, improved case management for people with long-term conditions, and targeted step-up responses for frail older people. Like the Gwent project, it builds on existing elements of service provision; it too is at a fairly early stage, and faces difficult challenges in expanding to provide comprehensive and uniform services.

Further details of the scheme are available at: www.cardiffandvaleuhb.wales.nhs.uk/the-wyn-campaign

Hywel Dda Health Board

Hywel Dda Health Board serves a largely rural population of just less than 400,000 in west Wales. It built on work to improve services for people with chronic conditions by developing joint health and social services provision for people in Carmarthenshire. Its focus has now broadened to embrace four elements of redesign for out-of-hospital care, including:

- population risk stratification using case finding (for frailty), GP practice lists and chronic disease registers, A&E attendance and direct ward admission data, and social care information
- surveillance and care co-ordination – including telephone case management, guided self-management and secondary prevention
- improved communication – including a new communications hub which schedules home visits, ambulance transport, and outpatient and GP appointments
- case management and navigation – including the development of a 'virtual ward', integrated community response teams (including multidisciplinary, multi-agency teams) and a needs-based, not criteria-restricted, approach.

Again, developments are at an early stage, and have yet to be evaluated.

Further details are available at: www.wales.nhs.uk/sitesplus/862/home

Lessons: barriers and enablers

Assessment of progress

Progress towards optimal integration of health and social care is probably best assessed in terms of beneficial outcomes, both subjective and objective. Although there is a wealth of evidence to support the beneficial impact on the patient experience of integrated care joint care workers, shared records, staff who are enabled to meet people's needs and a proactive approach to anticipating needs there is little data across Wales with which to systematically track progress over time or between settings, since there are no consistent and comprehensive assessments of the patient experience.

There is a little more evidence on potential objective outcomes, but there are substantial problems with attributing cause and effect. One interesting indicator is the level of unplanned admissions and emergency readmissions, especially for those chronic conditions where services have devoted considerable energy to being more integrated in recent years. As Table 7, below, shows, there is some data to suggest that, on both measures, service outcomes are improving, which is particularly impressive given the long-term trend of rising numbers of unscheduled admissions and attendances at A&E.

Table 7 Number of emergency admissions and readmissions, selected conditions, Wales, 2010/11–2011/12

	Type	2010/11	2011/12	Percentage reduction
Coronary heart disease	Emergency admission	16,805	15,243	9.3
	Emergency readmission	1,882	1,517	19.4
Chronic obstructive pulmonary disease	Emergency admission	6,835	5,708	16.5
	Emergency readmission	1,887	1,422	24.6
Diabetes	Emergency admission	2,209	1,886	14.6
	Emergency readmission	405	285	29.6

Source: Welsh Government (2012a)

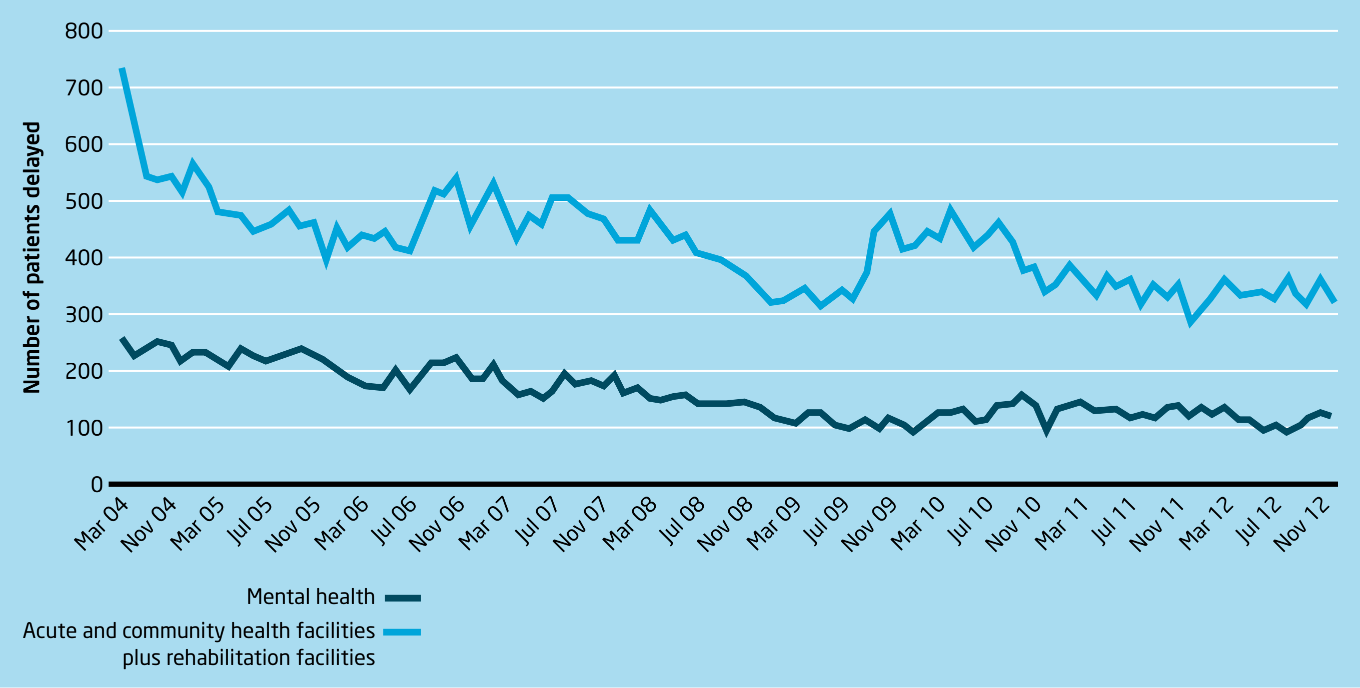
There has been some scepticism expressed (for example, by the British Medical Association in Wales) about the accuracy of the data, with concern that perhaps improvements in data coding may have created some of the change, rather than different service outcomes. Even if the figures are taken at face value, the extent to which this substantial improvement may reasonably be attributed to integration is difficult to ascertain. It seems unlikely that the integrated LHBs – which after all were only created in 2010 – could have effected change so quickly. Rather, it may well reflect the several years of focus on chronic disease management highlighted above; and it may also reflect the fact that the performance management regime has prioritised this issue more recently. In either case, it is an encouraging sign that local delivery of some aspects of care may be becoming better co-ordinated for patients at greatest risk, and that change is possible.

Another key test of the effectiveness of integrated working is the level of delayed transfers of care. Significant progress was made in this area in the period up to 2008, when the topic received considerable attention. Progress since then has been disappointing, with numbers of people being delayed remaining above 300 for most months (*see* Figure 14 opposite). (It should be noted that in Wales, all delayed transfers are counted, from the day the patient is deemed clinically ready for transfer.)

Another key challenge is the rebalancing of services between hospital and community. Government policy has long been to effect a strategic shift in the balance of resources between acute (mainly hospital) services and those services designed to support people at the pre- and post-acute stages. This led in 2010 to a performance target to shift 10 per cent of NHS human resources in this manner within three years. This sort of vertical integration between different elements of the health care system should be something which the integrated LHBs are well placed to deliver.

There is, as yet, no overall assessment of progress against this performance indicator, partly because of uncertainty over the appropriate definitions and comparability of the various measurements. However, WAO is currently conducting a series of local studies which include a consideration of this issue. To date, they have found no evidence that the required shift has been achieved. The comment from their report on Cwm Taf Health

Figure 14 Delayed transfers of care, Wales, 2004–12



Source: Welsh Government (2013a)

Board, for example, reveals the problems in both effective planning and the delivery of such a shift, even within an integrated board.

> *The rebalancing of the care system set out in Setting the Direction [Government policy] will require an increased capacity within the community. Workforce plans that consider the number and type of staff in the community will therefore be vital to success. The Health Board recognises that its workforce plans do not reflect the potential service changes expected in relation to the shift from secondary to primary and community care, in particular, the 10 per cent increase in the proportion of staff providing services in the community between 2010 and 2013. The Workforce Plan for 2011–2017 shows a forecast reduction of 1.5 per cent in the number of full-time equivalent (FTE) staff in the primary, community and mental health sector by 2017. However, no real change in FTE numbers is forecast over the same period for the acute sector. Since our fieldwork, the Health Board has carried out an exercise to reconcile the numbers of staff working in the community with information held by budget holders for acute and community services. The Health Board acknowledges that one of the challenges to compiling a robust workforce plan is the need to reconcile workforce numbers with the necessary skills and competencies to deliver different models of care in primary and community care settings.*
>
> (Wales Audit Office 2012b)

It is arguably too early for the structural integration of health care – still not three years old – to be yielding the anticipated benefits. Equally, many of the benefits will be serendipitous and unrecorded, the fruits of collaboration between different teams and individuals, and there may be no data sets that capture the outcomes of such changes at this stage. However, there is a certain unease that progress has not been as rapid or far-reaching as was hoped, or as is needed, given the pace and scale of change that services now face. The introduction of new powers in the Social Services and Well-being (Wales) Bill perhaps speaks to this unease, as does the quite demanding rhetoric from leaders in the system who are concerned about the slow pace and modest scale of progress in integration.

Six key challenges associated with integrating care are proving problematic in Wales, as elsewhere, and they are considered here.

Organisational alignment

One theoretical advantage enjoyed in Wales is the existence of integrated health bodies, having responsibility for the totality of health care provision for substantial populations. Each LHB receives a single allocation for primary, community, secondary and public health provision, and holds the contracts for all staff. It is therefore relatively unconstrained by external factors in its ability to shift or reshape services. Local authorities, however, remain separate, with different funding, accountability, eligibility and regulatory arrangements, albeit that they are required to plan jointly with their LHB.

Similarly, there is no separation into commissioners and providers within health care, and no formal power for GPs, for example, to reshape services in their own right. There is now some speculation in Wales as to whether it might be advantageous to create – albeit within the LHB – a capacity for objective and rigorous appraisal of the appropriateness and suitability of particular service configurations, independently of those staff directly involved in their provision ('commissioning' in a different form) and, if so, what shape that might usefully take.

At an operational level, co-location of staff is critical for integrated care delivery. This is often best achieved by having staff in the same offices and clinics, but 'virtual co-location' can also be an option, especially in rural areas where bringing staff together physically may not always be possible. There are some good examples of successful, virtually integrated teams in Wales, but they tend to require considerable investment in setting them up and maintaining them.

LHBs with several local authorities need to find effective ways of co-ordinating their planning and delivery. It is noticeably easier for LHBs with only two local authority partners to co-ordinate their services than for those with five or six, especially where the differences are compounded by different political allegiances.

Integration within health care remains difficult because of the persistence of cultural differences between primary, community and secondary care, lack of mutual understanding and the dominance of performance measures that are thought to relate exclusively to one sector or another. Although the LHBs have been in existence for three years, services often reflect the patterns developed by the previous trusts and smaller LHBs. The development of services for frail older people in Gwent (*see* case study example, p 68) has so far struggled to 'level' services across the areas that were previously commissioned by five LHBs.

Much of the ongoing support that people need is best provided by the third sector, and should generally be secured as a core part of the integrated service. Considerable effort has been expended in developing the third sector, and in improving relationships between health and third sector providers, but only a very small proportion of services is currently provided by the third sector.

Common IT platforms between agencies need to be adopted, but progress in this area has been slow. In the next two years, most people in Wales should have electronic personal health records, but in the meantime staff from different agencies usually do not have access to the patients' full records. There have been some attempts to share such access, but this often means staff have to 'double enter' data onto two systems.

Alignment of incentives

Individual citizens and service users should be empowered and supported to make real choices about what support they receive and how it is provided, and systems should be effectively incentivised to respond to service users' wishes and experience. To date, however, there is no common approach to eliciting patients' views, and most LHBs only collect such data for sub-sets of their patients. The Welsh Government is now committed to much greater consistency and transparency in this area, and it is likely that patient experience data will in future be more comprehensive and comparable.

The performance management of the different agencies should be aligned so that, for example, health and social services bodies are expected to aim for the same objectives. This requires not just formal alignment (the same written goals) but also that the 'organisational body language' is aligned – each chief officer having the same 'P45 issues'. Current performance management arrangements are frequently criticised for being inconsistent, as between health and social services, demanding performance across too many (and too crude) targets, and for being too dominated by financial performance targets. There are attempts to develop 'intelligent' targets, which may reduce some of the current perverse incentives and 'blindness' to the consequences of crude targets.

Practical ways must be found to circumvent the particular problems of 'cost shunting', which are significant in difficult financial times; this problem is often ignored or downplayed. Continuing health care, for example, is often very inflexible for people whose needs go beyond 'health'. Wales makes little use of formal arrangements for shared budgets, and there are few joint appointments. This may change in the near future, as the government gives greater priority to integration between health and social services agencies.

Private provision (for example, nursing homes) is not always matched to need or resourced realistically. Many nursing homes continue to struggle to meet rising standards, and to cross-subsidise provision at the expense of private payers.

Leadership

The integration of services is a change management task par excellence, demanding all the skills and resources of any major change. The impact of a leader who really 'believes' in the importance of integration, and is determined to see it through, is evident in many parts of Wales. Staff at different levels in the LHBs report the impact which this can have. Although no leaders would deny the importance of integrated care, some have clearly made it a higher priority than others. This is an inherently fragile arrangement, however, and progress on integration in parts of Wales would be jeopardised if a few key individuals were to change jobs.

Leadership from the bottom up is also important, and staff need to be empowered to integrate services where they see the need: the coincidence of a very small number of people in a locality who trust one another and are passionate about integrated care can be very powerful, and may even obviate the need for joint appointments. For example, in one locality serving a population of about 150,000, the director of social services and the most senior NHS manager have a good working relationship and share a passion for integration, which enables possible conflicts over issues such as cost shunting to be avoided. However, there are more examples where this is not the case.

The number of service providers potentially involved in integrated care in any locality is large, and the managerial task of ensuring their co-ordination is sometimes underestimated. As a result, managers and clinicians sometimes find it easier not to try to integrate services: 'You don't do integration if you want an easy life,' one senior manager commented to the author. Some leaders report the difficulty of persuading all the senior professionals in a service to make the sorts of changes to their professional practice that may be pre-conditions for greater integration. This sometimes takes the form of quiet resistance, and there appear to be few effective sanctions to address the issue in Wales.

Sufficient resources need to be allocated to integrated care – it is often not a cheap option, at least initially: 'You can't do Kaiser on a shoestring!' another senior joint manager commented. There is now some use of invest-to-save schemes, which not only make the initial investment available, but also help to keep the focus on assessing impact. None of these schemes in integrated care has yet reached the stage where the delivery of the original business plan can be assessed.

Giving control to patients/clients and carers

Successful integration of services usually begins with a thorough understanding of what patients/clients and their carers would find useful and acceptable. Although there are many impressive examples of such endeavours in Wales, they have tended to be isolated and sporadic, and there has perhaps been comparatively little investment in systematic efforts to ensure that services meet patients' needs and wishes.

Enabling patients/clients genuinely to be 'partners' in their care often requires support for the patient/client, and changes to staff attitudes and expectations, and to systems of care. This has not been an area of focus in Wales. Similarly, all services should routinely find out about the experiences of their patients/clients, should report them publicly, and should incorporate patients/clients in their performance management and continuous improvement. This has been a particularly under-developed aspect of health care in Wales, with no capacity to assess patients' experience of care on a comparable, comprehensive and consistent basis. This may now be about to change, as the Welsh Government is committed to greater consistency in the collection and publication of such data.

Carers are a major part of service provision, but sometimes report being disempowered and excluded by professional staff, in Wales as elsewhere. They need access to information about what services are available, influence over the care provided and support for their own needs. Carers' right to an assessment of their needs is enshrined in legislation, but receives comparatively little investment. The Social Services and Well-being (Wales) Bill is designed to ensure that carers' rights to support are set on the same legal basis as those of patients/clients.

Case management

Integrated care often depends on effective case finding, assessment for targeting of care, care planning and co-ordination. The first of these has been a significant challenge in Wales. Very few parts of the country have yet identified those individuals in their communities who are on the brink of becoming major service users (case finding) and for whom they could provide targeted support to maintain their well-being and independence. There has been sporadic adoption of clinical risk assessment tools such as PRISM to enable GPs to risk stratify their own populations, but none has met with universal support and as yet there is no generally accepted tool for the purpose. Individual LHBs are now starting to develop their own hybrid approaches, drawing on various data sets to provide some consistency of approach.

Having case managers who co-ordinate all the support for an individual can be a simple and effective way of integrating care, and patients and carers report positively on the immediate impact that one well placed and sensitive professional can have in co-ordinating otherwise disparate services, and ensuring that those services are delivered in a way that meets their needs. Case managers working across agency boundaries are found in some parts of Wales, but are not yet a normal and expected element in provision.

Telecare is currently under-utilised and its potential is unevenly understood across Wales. Given the rurality of much of Wales, and the significant difficulties in accessing hospitals experienced by isolated and deprived communities, telecare has particular salience. There is some evidence to suggest that further progress in the wider, appropriate adoption of these technologies now depends on tackling resistance from key staff groups who are not convinced of the merits of working differently.

Persistence

Integrated care typically takes five years or more to deliver its objectives and become self-sustaining. In some parts of Wales, services are reluctant to embrace integrated working, often either because they are nervous about the ability of other services to deliver for their clients or they are worried about the possible reduction in their own resources. Persuading them of the desirability of change takes a long time.

Medium-term planning is often undermined by staff turnover, short-termism from above or the overwhelming impact of annual financial targets. Brokerage, invest-to-save schemes and other mechanisms can help people to focus on the slightly longer term. Helpfully, there is no prospect of further structural reorganisation of health services in Wales, which avoids one major possible source of turbulence, although there is some exploration of mergers between social services departments.

Conclusions

Wales enjoys some considerable advantages in its journey towards optimising integrated care. The fact that almost all of the population is registered with a GP should make it easier to identify people at risk of becoming vulnerable; work on the management of chronic diseases leaves a legacy of joint working and understanding; and there is little prospect of forthcoming reorganisation of health bodies or (at least until after the 2015 Assembly election) of local government, providing a valuable element of consistency and longer-term planning. Each of these is an asset.

In addition, there are several potential strengths – opportunities – which have yet to be fully exploited. The greatest of these is the integrated LHBs, which have no financial or performance disincentives to ensuring that services best meet patients' current and future needs, and which are large organisations with access to specialist expertise and data in abundance. In addition, the NHS and social services are now focusing more seriously on capturing the patient's/client's experience, measuring outcomes and empowering service users to ensure that services meet their needs – all key elements in integrated care. The commitment of the government to this policy area, the availability of (limited) resources for invest-to-save schemes (essential if the initial costs of service redesign are to be met) and the encouraging development of locality networks, serving populations of about 50,000, are all further opportunities.

On the deficit side, there are several weaknesses. At present, seven LHBs are having to relate to 22 local authorities, have little experience in or appetite for pooled budgeting, and labour under multiple information systems, each serving elements of the integrated care package. There is currently little agreement on how to risk stratify the population, and areas within Wales have an often-remarked-on reluctance to adopt good practice from elsewhere. Progress to date in integration has often depended on the abilities of individual leaders and the coincidence of their shared workplace, criteria which are unpredictable and fragile.

Finally, two significant threats loom. First, the severe financial pressures, especially on health, may crowd integration off the NHS's agendas; and second, the managerial attention currently being given to controversial proposals for hospital reconfiguration may also divert attention elsewhere.

At the heart of this situation lies an old paradox. While most leaders in health and social care in Wales readily accept that greater integration would deliver better care for their patients and clients, and would be a key element in solving many of the other problems which currently confront them, it often seems just too difficult to make the initial step change that is required.

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4 Drawing out the lessons

Chris Ham, Chief Executive, The King's Fund

As this report shows, integrated care in the United Kingdom has developed in a variety of ways:

- Northern Ireland has had integrated health and social care since 1973 but there has always been a commissioner–provider separation throughout this period.
- Scotland has had an integrated NHS structure since 2004 when the commissioner–provider separation was ended and unified health boards created but local authorities continue to have responsibility for social care.
- Wales has followed the example of Scotland since 2009 with the creation of unified local health boards and again local authorities continue to have responsibility for social care.

One of the challenges facing the authors of the papers in this report is the lack of well-designed studies and evaluations of the impact of integrated care in all three countries. In the absence of such studies, it is necessary to rely on routinely available data, often collected in different ways in each country and therefore difficult to compare. As others have found before us (Connolly *et al* 2010; National Audit Office 2012), this presents formidable difficulties in making comparisons, let alone reaching consensus on how these should be interpreted.

The papers published here seek to assess impact by examining selected data on service use such as emergency bed use in hospitals and delayed transfers of care and how this has changed over time in different countries, where it is available. Yet even when changes in this data can be detected, there is the challenge of attributing them to progress on integrated care versus other developments, for example, in relevant policies, occurring at the same time. As well as statistical data, the papers provide examples of innovations in care in each country and draw on the assessment of the authors to reach conclusions on which this final chapter of the report is based.

Northern Ireland

Despite having the longest history of integrated care, Northern Ireland has been slowest to exploit the potential benefits. This reflects the fact that responsibility for social care was taken out of local authorities because of concerns about their capabilities rather than as a positive intention to promote integrated care; there was also a lengthy period of policy inactivity both before and after the creation of the Northern Ireland Assembly, with few examples of either direct rule or devolved governments seeking to use the integrated structures to develop integrated services. The political context of 'the troubles' and a focus on ending them and giving priority to other issues such as economic development meant that health and social care policy took a back seat until recently.

There are some local examples of innovation but little systematic evidence that integrated health and social care has demonstrated measurable improvements for the population.

Indeed, in some respects developments in policy and service change have lagged behind other parts of the United Kingdom, examples being care of people with mental health needs and learning disabilities, and care of children and young people. In many respects, therefore, Northern Ireland represents a missed opportunity to demonstrate on a system-wide basis what can be achieved when the organisational barriers to the integration of health and social care are removed.

Scotland

Scotland appears to have made the greatest progress and this can be attributed to: organisational stability since 2004; a political consensus on the importance of integrated care; the commitment of successive ministers and leaders in the NHS and local authorities; and the promulgation of a series of policies designed to promote and support integrated care. These policies include a national performance and outcome framework directed towards an explicit purpose for Scotland.

This is supported by 16 national outcomes and 50 national indicators and targets, a significant number of which relate to health and social care. At a local level the performance framework is translated into a Single Outcomes Agreement between the government and community planning partnerships. The latter are led by local authorities and involve a wide range of statutory partners and voluntary and private sector organisations.

Managed clinical networks are one of the means used to promote closer integration (mainly within the NHS) in Scotland. Despite this, it is clear that existing arrangements for joint working between the NHS and local authorities centred on community health partnerships are not working as well as desired, hence the development of plans to change the law to require the introduction of health and social care partnerships to bring together responsibility for health and social care services, initially for adults. It is also clear that health boards have struggled to bring about any significant shift in resources from hospitals to the community.

The impact of policies pursued in Scotland is evident in changes outlined in Chapter 2 on emergency bed day use and delayed transfers, increased use of home care, and lower than projected use of care homes. The extent to which these changes can be attributed to initiatives related to integrated care remains uncertain but they do indicate that benefits are being realised.

Wales

Wales is still at an early stage in the development of integrated care. As in Scotland, there is a supportive policy context and there are promising examples of local innovation. There is also some evidence that emergency admissions and readmissions from conditions such as chronic obstructive pulmonary disease and diabetes have started to decline substantially, although many factors lie behind this.

On the other hand, as in Scotland it has been difficult so far to shift resources within local health boards from hospitals to the community, let alone from health to social care. Lack of alignment between local health boards and local authorities (7 compared with 22), different funding streams and long-standing professional loyalties are some of the barriers that hinder more rapid progress in Wales, despite a strong political commitment and leadership from within the Assembly.

Unlike in Scotland, Wales does not have a single outcomes and performance management framework and this is a further obstacle to progress.

Implications

As this high-level summary suggests, it is important not to over-claim what has been achieved in these three countries. Even when some of the organisational obstacles have been removed, there remain formidable challenges in realising the anticipated benefits of integrated structures, including shifting resources from hospitals to the community. It is hard to exaggerate the power of acute hospitals within the NHS: structural change will do little to affect them unless politicians and health and social care leaders are prepared to manage the unpopularity that is often associated with plans to reduce reliance on hospitals and implement new models of care in the community.

The need for caution in interpreting the experiences of Northern Ireland, Scotland and Wales is underlined by studies comparing the performance of the NHS in these three countries with each other and with England. Although a matter of continuing and sometimes heated debate, it appears that on some key indicators the NHS in England outperforms the NHS in the rest of the United Kingdom, notwithstanding expenditure levels that have historically been lower than those in the other countries (Connolly *et al*, 2010). While the performance management regime developed in England, sometimes referred to as 'targets and terror', is often invoked to explain improvements in performance, it should be noted that similar regimes have been used in the other countries. The benefits of integrated care such as those that have been realised in Scotland therefore need to be weighed against what appears to be more limited progress in some other areas of care.

Lessons learned

An important lesson from this report is that structural integration either within the NHS or between health and social care is only one factor among many in facilitating the development of integrated care. It is also apparent from the experience of Northern Ireland that integrating health and social care within the same structures may have the unintended consequence of social care becoming subservient to health care. There is an obvious and important caution here for England at a time when debates about health and social care integration are gathering pace.

It is clear that structural integration in itself may bring few if any benefits unless it is accompanied by other changes. These include:

- coherent policies designed to promote and support integrated care, such as those developed in Scotland during the past decade – including a national performance framework and a single outcomes framework
- governance arrangements that enable different organisations (especially local authorities and NHS bodies) to work together to develop joint strategies in order to make a reality of integrated care
- political, managerial and clinical leadership at all levels that ensures a clear and consistent focus on integrated care
- organisational stability to avoid the distractions and delays that occur when structures are altered frequently
- a willingness to challenge and overcome professional, cultural and behavioural barriers to integrated care both within the NHS and between the NHS and social care
- a commitment to integrated care as a policy priority for government as a whole (as in Scotland and, to an extent, Wales)

- maintaining this commitment over a sufficiently long period to enable policies to have a measurable impact
- a willingness to provide financial support and flexibilities to enable the introduction of new models of care – examples being the Change Fund in Scotland and 'invest-to-save' schemes in Wales
- action to share information both within the NHS and between health and social care, an issue on which Scotland appears to have made more progress than other countries
- an ability to manage the differences and tensions that arise when different public services are organised differently, an example being the persistence of a commissioner–provider separation in local authorities but not in the NHS in Scotland and Wales.

It is clear that demonstrating the benefits of integrated care depends on action on most if not all of these issues. This is illustrated by the experience in Northern Ireland which has had a large measure of organisational stability and a long-term commitment to health and social care integration, but where the other factors we have identified have failed to be systematically addressed.

To these lessons we would add the importance of giving greater priority to evaluating the impact of structural and related changes to promote integrated care in order to assess what impact they are having. Although there is a growing body of evidence in this area (Curry and Ham 2010), we have been struck in bringing together these papers by the lack of well-designed studies of impact. In the absence of reliable evidence, debate about the relevance to England of experience in other parts of the United Kingdom will continue to be contested.

The question that arises is whether England would be better advised to promote and support integrated care not by further organisational change but by acting on the many other factors that are identified here as either facilitating or hindering progress. Readers will arrive at their own answers to this question but on the evidence presented in this report it is hard to argue persuasively that *restructuring* health and social care should be a high priority. Far more important is to address the myriad barriers (financial, cultural, and so on) that in most parts of England make integrated care the exception rather than the rule. The challenges in so doing should not be underestimated given the lessons enumerated above and the obvious difficulties in acting on these.

In this context, it can be argued that the most critical role of national policy-makers is to remove the barriers that inhibit progress, establish a policy context that is fully aligned with the aims of integrated care, and through their policies and actions demonstrate that integrated care is a core objective for government. A start has been made in this direction with the announcement in May 2013 by Norman Lamb, the Care and Support Minister, of the government's plans for integrated care supported by collaboration between 14 national partners. What now needs to happen is to convert the high-level vision and aspirations contained in these plans into specific changes that will enable integrated care in England to be taken forward at scale and pace.

As The King's Fund has argued in previous work (Goodwin *et al* 2012), this should include attaching the same priority to integrated care over the next decade as was given to the reduction in waiting times for treatment during the past decade. Setting a clear, ambitious and measurable goal to improve the experience of patients and service users should be an early priority, linked to goals relating to the outcomes of care and service utilisation. Also important is to put in place financial incentives that support integrated care by moving away from an over-reliance on payment by results and making use of capitated budgets and other forms of payment appropriate to this purpose (Appleby *et al* 2012). Ministers must also ensure that rules on procurement and regulation are applied in a way that balances the need to stimulate competition in some areas of care with the imperative to support collaboration and integration in other areas.

To use a medical analogy, the focus now needs to be on ensuring that the physiology of health and social care is fit for purpose rather than seeking to alter the anatomy. To be sure, anatomical changes may be needed at some point in the future but the clear message of this report is that on their own they are unlikely to be sufficient. Evidence from various studies underlines the fact that patients and service users benefit when the emphasis is on clinical and service integration rather than organisational integration (Curry and Ham 2010) and also that examples of successful clinical and service integration remain relatively rare. All the more important, therefore, that the pioneer communities to be established in England are given sufficient time and support to demonstrate what can be achieved in the next stage of health and social care reform. The lessons distilled in this final chapter offer both guidance and warnings as the pioneers embark on their journeys, illustrating both the opportunities on offer and the hurdles to be overcome.

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The Health Foundation

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The four health systems of the United Kingdom: how do they compare?

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Sheelah Connolly and Nicholas Mays

Source report

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About this research

This report is the fourth in a series dating back to 1999 which looks at how the publicly financed health care systems in the four countries of the UK have fared before and after devolution. The report was commissioned jointly by The Health Foundation and the Nuffield Trust. The research team was led by Nicholas Mays at the London School of Hygiene and Tropical Medicine.

The research looks at how the four national health systems compare and how they have performed in terms of quality and productivity before and after devolution. The research also examines performance in North East England, which is acknowledged to be the region that is most comparable to Wales, Scotland and Northern Ireland in terms of socioeconomic and other indicators.

This report, along with an accompanying summary report, data appendices, digital outputs and a short report on the history of devolution (to be published later in 2014), are available to download free of charge at
www.nuffieldtrust.org.uk/compare-uk-health
www.health.org.uk/compareUKhealth.

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Foreword

We stand on the verge of potentially fundamental constitutional changes in the UK, with the Referendum on Independence for Scotland in September 2014. Health has been a devolved matter since the late 1990s. Control over each country's health system has resided with each UK nation for 15 years. Against this backdrop, there is great interest in understanding how performance on quality and value for money compares across the UK.

Each country has a tax-funded service with universal coverage, similar values and similar operating principles, offering comprehensive benefits. Yet since devolution, there have been diverging policies for health care, with reorganisations taking place in each country at different times.

For example, in Scotland and Wales the division of purchasing from providing health care was abolished, in 2004 and 2009 respectively; competition between providers is discouraged; free prescription drugs are provided; purchase of NHS-funded care from private hospitals and clinics is discouraged; and, in Scotland only, there is free personal social care for the over-65s. The different countries have also made different choices about overall funding of the health service.

Central performance management occurs in all four countries but to varying strengths. In England there has also been a greater emphasis on developing patient choice, provider competition, and the use of private providers to deliver publicly funded health care; this has been underpinned by a system of regulated prices and a new set of regulatory bodies. The extensive reforms in England brought about by the contentious Health and Social Care Act 2012 were only implemented in April 2013, so it is too early to assess their impact. So too with the effects of any changes resulting from the Francis Reports into events at Mid Staffordshire NHS Foundation Trust.

In Northern Ireland, where the health service has been administratively integrated with social services since 1973, separation of purchasers and providers still exists, but without encouraging provider competition, patient choice or strong performance management.

Despite these differences, there have also been large similarities in goals across the four countries. For example, there has been growing attention given to patient safety, and involving patients and the public in decisions about care. All countries want to develop more coordinated care, and have made efforts to reduce waiting times.

Clearly there are many influences aside from devolution which can affect the overall performance of the UK's health services. These include levels of funding of other parts of the public sector, the quality of management inside key local organisations, wider determinants of health which affect the need for and use of care, and EU laws, for example on workforce matters.

However, it is clear that devolution has resulted in a set of policies for the health services of the four UK countries which are now quite different. A key question is: have these different approaches resulted in any demonstrable change in performance towards better quality and value for money in health care? If so, what might be the lessons?

This is the fourth in a series of reports since 1999 comparing aspects of performance of the health services across the four countries. Some of these were commissioned by the Nuffield Trust and the Health Foundation; the two health charities have commissioned this latest study, which is the only longitudinal analysis of its kind. Information is analysed from the 1990s up to at least 2010/11 (and in some cases to 2012/13). The latter half of this period saw significant growth in public funding of health services, which only ceased after 2009/10. The full impact of recent austerity and other reforms will need to wait for a future study.

To aid the comparability of Scotland, Wales and Northern Ireland to England, the analysis also includes the North East region of England – an area which is more comparable to Scotland, Wales and Northern Ireland than England, on a number of important characteristics. There is no perfect comparator, but the North East region is better than England as a whole.

While it has become more difficult to compare performance, because of differences in data collection and definitions across the four countries, there is much we can learn from this analysis. The key findings are:

First, there have been improvements across all four countries in population health, with reductions in amenable mortality (deaths which could have been prevented through better health care), which halved over the study period, and increases in life expectancy (adding between three and five years to people's lives). There are no appreciable differences between the four countries in the performance with respect to coverage of the population of breast screening, immunisation levels, and survival following renal replacement.

Second, in broad terms, the resources available – funding and key staff – to the health services in all four countries increased significantly over the period, although Scotland, Wales and Northern Ireland have made explicit choices to spend some of the money available for health care (under the formula for allocating money to them) on other services, such as social care in Scotland. While funds spent in England per head of population remained the lowest, spending per head in the North East rose to a similar level to that of Scotland and Northern Ireland.

Third, crude productivity (based on inpatient admissions per hospital and community health services doctor or dentist) has fallen in the 2000s, in part due to the numbers of these staff rising. However, this is a very crude measure; more sophisticated analyses, which so far have only been done for England and take into account a range of quality measures, suggest that productivity may have increased.

Fourth, there are few conclusive differences in satisfaction levels with health services between the populations of each country.

Finally, there are four differences between the UK countries that stand out:

- Average (median) **waiting times** for common elective procedures fell significantly in Scotland and England until 2009/10, which are now similar to each other, and shorter than in Northern Ireland and Wales; this reflected different centrally set targets. (After 2009/10, there are no data for Northern Ireland.) Waiting times in Wales have been increasing recently. For example, in 2012/13, patients in Wales waited on average about 170 days for a hip or knee replacement compared with about 70 days in England and Scotland. The reasons are unclear, although the decision to cut rather than maintain NHS spending in real terms may have affected them.
- All countries more than halved **amenable mortality** between 1990 and 2010 (the latest date for which comparable data are available). By 2010, the gaps between countries had narrowed in absolute but not relative terms: for example, amenable deaths remained about 20 per cent higher in Scotland than in England.
- In North East England, significant progress in **life expectancy and mortality** has been made. In 1990, overall mortality rates (both amenable and other deaths) were similar in the North East and Scotland, but by 2010 these rates

were 15 to 19 per cent higher in Scotland. In 1991, life expectancy in the North East was similar to Scotland, but by 2011 people in the North East were expected to live a full year longer than people in Scotland.

- Despite definitional differences and problems with comparability, it is clear that, over the period studied, **nurse staffing levels** have been lower in England than in the other three countries.

So, the main conclusions from this latest analysis are that, so far, the different policies adopted by each country appear to have made little difference to long-term national trends on most of the indicators that the authors were able to compare. Individual countries can point to marginal differences in performance in one or more areas. This lack of clear-cut differences in performance may be surprising given the extent of debate about differences in structure, provider competition, patient choice and use of non-NHS providers across the four countries.

However, comparing England, Scotland and Wales, in the period of austerity, waiting times for common procedures appear to be lengthening disproportionately in Wales. There was also slightly faster improvement in mortality and life expectancy in the North East of England, in particular relative to its near neighbour Scotland.

The authors' previously published analysis (using data from 1997 to 2006/07, and published by the Nuffield Trust in 2010) reported that the performance of the NHS in England was better than in the other countries across a range of, mostly efficiency, indicators. In this latest analysis, while there are few indicators on which a devolved country does better than England or its North East region, the gap has narrowed, with Scotland in particular improving its performance on waiting times. The previous analysis also showed marked differences in crude productivity between the countries, but much of this proved to be due to definitional differences in the data on staffing that had been supplied by each country and published by the Office for National Statistics (ONS). Further work by ONS and each country on these definitions resulted in adjustments to the data, which led to a revised report in 2011. The current analysis shows some differences in productivity using the data supplied to us by each country, but the comparisons of productivity in the current report, despite being based on the best data available, differ from those produced by the National Audit Office (for 2008/09) and so there are doubts as to whether the information available is adequate for the purpose of cross-country comparisons.

This analysis mainly shows nationally aggregated data. What is clear from the earlier analyses is that, except in relation to those areas covered by national targets, variations in performance of the health service within England are greater across many metrics than variations between England and the other three UK countries. Again, this suggests that, other than target setting, which all countries have adopted to a greater or lesser extent, underlying 'macro' policy shaping the health services is to date less influential on performance than local conditions such as quality of staff, funding, availability of facilities, health needs and historical legacies of inequalities.

Finally, it is disappointing that it is becoming more difficult to compare the performance of the health service across the four countries because of differences in the way that data are collected. We commend the authors for their ongoing efforts to shed light on this issue. After all, having comparable data is crucial to assessing changes in quality and value for money in health care across the UK.

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Summary

Purpose of the report

Following devolution, the four countries of the UK are now on such different policy paths that it no longer makes sense to talk of a UK National Health Service (NHS). The devolved governments have made different choices about the level of funding devoted to the publicly financed health system, the structure and governance of the system and the benefits available to their residents such as free general medical prescriptions and personal care in Scotland, but not in England. The principal aim of this report is thus to examine this changing 'natural experiment' of devolution between England, Scotland, Wales and Northern Ireland as it affects the health system in each country. This report compares the health outcomes and resources for, and the outputs and performance of, the countries before and after devolution; and also includes North East England (where data are available), which offers a better comparator with the devolved countries than England as a whole. There is no English region that offers a perfect benchmark for the three devolved countries, but the North East is similar to the three devolved countries socioeconomically, in terms of the level of health service spending and in the extent of reliance on non-publicly owned providers.

Policy context

These comparisons have been the subject of three previous studies involving some of the same authors: Dixon and others in 1999, Alvarez-Roseté and others in 2005 and Connolly and others in 2011. The outcomes of this natural experiment, over the period from 1996/97 to 2006/07, were reported in the second and third studies. These found that, with the limited data available, the English regime produced better performance with lower funding per head than the devolved countries in terms of waiting times, and the numbers of people treated as inpatients and outpatients by hospital doctors and nurses, and the response time by ambulances to category A calls.

Since 2006, the policy emphasis in England has shifted back towards the development of provider-based competition and individual patient choice, but with a continuing emphasis on strong performance management. England has seen the most organisational upheaval. In Scotland and Wales, the governments abolished the purchaser/provider split in 2004 and 2009, respectively, and each NHS has returned to an organisational model similar to that before the introduction of the first 'internal market'. In Northern Ireland, the complex and deep-seated structural, political and religious issues meant that devolution was suspended between 2002 and 2007. Its government was slowest to implement policies to end the idea of provider competition after 1997. The current policy seems to be one of retaining a purchaser/provider split, but without encouraging provider competition or emphasising strong performance management.

The three key questions to ask after the initial period of devolution are:

- First, has devolution had made any systematic differential impact on performance?
- Second, comparing England and Scotland, has the new system of performance management in Scotland since 2005 resulted in improved performance of the NHS in Scotland, and how does this compare with that of England?
- Third, have Wales or Northern Ireland been able to improve their performance since 2006 and how does their performance compare with that of England and Scotland?

In this report, we include more information on the quality of care than the three earlier studies. The requirement for indicators to be as comparable as possible over time and across countries limits the availabilty of data and hence the scope of this report. We have organised our principal findings in terms of the comparability and coverage of the data. We also give recommendations for improving data comparability across the four countries.

Principal findings

Where there are comparable data for the four countries

Life expectancy at birth
This has increased by between about five and three years for men and women, respectively, in each country from 1991–2011. In 2011, England had the highest life expectancy for males (78.9) and females (82.9), followed by Wales (77.5 and 82.2), Northern Ireland (77.0 and 81.4) and Scotland (76.1 and 80.6). At the start of that period, men and women in North East England had similar life expectancy to Scotland, but by the end of the period, men and women in North East England would have been expected to live about one year longer than men and women in Scotland.

Amenable mortality
Amenable mortality is defined as premature death (under age 75) from causes that should not occur in the presence of timely and effective health care, and is a good indicator of quality of care at the system level. Other mortality is based on deaths from other causes. Between 1990 and 2010 the principal changes were as follows.

- Rates of amenable mortality more than halved in both sexes and across all countries. These rates of decline were twice the rates of the decline of other mortality for men and three times the rates for women.
- For both amenable and other mortality for both sexes, England had the lowest rates and Scotland the highest. The amenable mortality rates per 100,000, in 2010, in Scotland and England were for men, 97 and 80; and for women 77 and 64.
- Comparing Scotland with North East England, the rates of decline of amenable mortality were similar for both sexes but the decline in other mortality was about 10 per cent greater for both sexes in North East England. By 2010, in Scotland, rates of amenable mortality for both sexes were about 10 per cent higher than in North East England, and for other mortality, were about 15 and 19 per cent higher for women and men.

Health spending per head

Health spending per head in 2000/01 was lower in England and North East England than any of the devolved countries; but, by 2012/13, North East England had similar spending to that of Scotland and Northern Ireland (about £2,100), which was 10 per cent higher than that of Wales (about £1,900). Increases in spending on each NHS over that period were: 115 per cent in England; 99 per cent in Scotland; 98 per cent in Wales and 92 per cent in Northern Ireland. The extra funding per head in North East England compared with the average for England increased from six per cent greater to 12 per cent more. Greer (2004, pp. 87–90) points out that Scotland funded the costs of free personal and nursing care for people aged 65 years and over from these sums. The recent cost of that policy (Timmins, 2013, p. 13) was estimated to be £450 million.

General practitioners (GPs) per 1,000 population

In headcount terms, the supply of GPs was highest in Scotland (0.9 in 2010); and in 2011, the rates were 0.8 in North East England, 0.7 in England, and 0.6 in Wales and Northern Ireland. There was no change in this rate for Wales and Northern Ireland from 1996 to 2011; but over that period there were increases in England and North East England (from 0.6) and Scotland (from 0.8). However, the data on whole-time equivalents (WTEs) show that in 2011 the rates for Scotland were similar to North East England (both about 0.7), with Wales having the lowest rate (0.6).

Screening

The rates for the uptake of screening for breast cancer between the ages of 50 and 70 for 2010/11 were about 70 per cent in the four countries and North East England.

Childhood rates of immunisation at age two

Childhood rates of immunisation for 2011/12 at age two were similar in the devolved countries and North East England, with England having lower rates. For the measles, mumps and rubella (MMR) vaccine, the rates were more than 90 per cent in all four countries and North East England (but below the 95 per cent recommended by the World Health Organization); and above 95 per cent in all devolved countries and North East England for the ‘5 in 1’ vaccine – also known as the DTaP/IPV/Hib vaccine. This is a single injection that protects against five serious childhood diseases: diphtheria, tetanus, whooping cough (pertussis), polio and Hib (Haemophilus influenzae type b). The rates were also over 95 per cent for the Meningitis C vaccine, except for England, where the rate was close to 95 per cent.

Rates of vaccination against influenza in the winter

Influenza vaccination rates varied widely over the two years 2011/12 and 2012/13. Northern Ireland had the highest rates for the general population at risk, but the lowest rate for health care workers.

Operation rates per 10,000 for seven common procedures

Common operation rates varied between 2005/06 and 2011/12, and across the four countries. There were increases in the rates for gall bladder excision, and hip and knee replacement; and decreases for coronary artery bypass grafts (CABGs), varicose veins (except for an increase in Northern Ireland in 2011/12) and hernia. There were diverging trends in cataract, as there was an increase in England and Scotland, but decreases in Wales and Northern Ireland. Compared to England statistically significant differences were as follows:

- Wales had a lower rate of varicose vein removal, hernia repair and hip replacement.
- Scotland had a higher rate of excision of gall bladder, and a lower rate of varicose vein removal, hernia repair and hip replacement.
- Northern Ireland had a higher rate of varicose vein removal, and a lower rate of hernia repair and hip and knee replacement.

Waiting times for common procedures

There are data on the 50th and 90th percentiles of the distributions of waiting times for six out of the seven common procedures (there are no data on excision of gall bladder). Between 2005/06 and 2009/10, all four countries achieved substantial reductions in median waiting times for most procedures, including a halving of the median wait for hip and knee replacement in England and Scotland. The 90th percentile decreased over the period from 2005/06 to 2012/13 for most of the procedures in England and Scotland (except for CABG surgery in England). In Wales and Northern Ireland, there were dramatic reductions in the 90th percentile from 2005/06 to 2009/10 for all procedures, except for cataract surgery in Wales, which increased. However, since 2009/10 in Wales there have been increases in the 90th percentile for all procedures. There are no data after 2009/10 for Northern Ireland.

Survival for patients on renal replacement therapy

The UK Renal Registry covers all four countries and reports one-year percentage rates of renal replacement survival, 90 days after the incident, by country from 2002–10 (the incident cohort years), adjusted to age 60. These rates have improved in all countries. For 2009/10, the mean rates were about 90 per cent; differences between the countries were not statistically significant.

Comparable data for England, Scotland and Wales

Satisfaction

Satisfaction (‘very satisfied’ or ‘quite satisfied’) is reported in the British Social Attitudes (BSA) survey for various aspects of health services, for 2011. The survey does not cover Northern Ireland. The rates of satisfaction for the two questions on the ‘the way in which the NHS runs’ and on ‘the way the NHS’s local doctors or GPs run nowadays’ were: North East England, 67 per cent and 80 per cent; Wales, 62 per cent and 78 per cent; England, 53 per cent and 76 per cent; and Scotland, 55 per cent and 68 per cent. The rates for two questions on satisfaction with ‘attending hospital as an outpatient’ and ‘being in hospital as inpatient’ were: Scotland, 70 per cent and 68 per cent; North East England, 69 and 63 per cent; England, 65 and 55 per cent; and Wales, 66 and 53 per cent.

Comparable data for England, Wales and Northern Ireland

Quality of stroke care

The stroke audit by the Royal College of Physicians of London covers all countries except Scotland. In 2006 and 2010, the percentages of patients who spent more than 90 per cent of their time in a stroke unit were: Northern Ireland, 60 per cent and 50 per cent; England, 51 per cent and 62 per cent; and Wales, 39 per cent and 37 per cent. There were, however, substantial improvements in the average achievement across nine key indicators of the quality of stroke care in all three countries: in England, from 60 per cent to 83 per cent; in Wales, from 52 per cent to 73 per cent; and in Northern Ireland, from 64 per cent to 74 per cent.

MRSA mortality rates

MRSA mortality rates are based on where Methicillin-Resistant Staphylococcus Aureus (MRSA) infection is mentioned on the death certificate. Data on these rates are available by sex for all countries except Scotland. The reduction in the rates for men (per million), which were about twice that for women, from their peak to 2012 were: in Wales, from 28 (in 2005) to 7.6; in England, from nearly 27 (in 2006) to 3.7; and in Northern Ireland, from 43 (in 2008) to 9.7.

Data where comparisons are problematic

Category A ambulance calls

Ambulance response rates within eight minutes to what may have been immediately life-threatening emergencies ('category A' calls) improved dramatically in the devolved countries between 2006/07 and 2011/12. In 2006/07, they were about 56 per cent; but by 2011/12 they were 73 per cent for Scotland and Northern Ireland, and 68 per cent for Wales. In England, the percentage was around 75 per cent throughout that period, and above 75 per cent in North East England.

Hospital and community health services (HCHS) medical and dental staff

This staff group showed the highest rates of increase (in WTEs per 1,000 population) of all staff groups in each country and North East England over the period 1996–2011: the increases were about 70 per cent in England and 50 per cent in the devolved countries. In 2011, the rates of HCHS doctors and dentists per 1,000 population were: England, 1.9; Wales, 1.9; Northern Ireland, 2.0; North East, 2.2; and Scotland, 2.3.

Rates of inpatient admissions per 1,000 population

We have data on the rates of inpatient admissions per 1,000 population to 2011/12, from 1998/99 for England and Scotland, from 2000/01 for Wales, and from 2005/06 for Northern Ireland. Inpatient admissions per 1,000 population increased in England from 119 in 1998/99 to 131 in 2011/12; were stable in Scotland at 139 in 1998/99 and 137 in 2011/12, with a peak of 143 in 2008/09; reduced slightly in Wales from 154 in 2000/01 to 144 in 2011/12; and also fell in Northern Ireland from 138 in 2005/06 to 131 in 2011/12. The data on inpatient admissions for North East England have not been included due to lack of the detailed information on the different types of admission required to ensure comparability and even the data we do report may not be fully comparable.

Inpatient admissions per hospital and community health services doctor/dentist

These rates decreased over various periods to 2011/12 as an inevitable outcome of rapid increases in the numbers of staff exceeding the increases in numbers of inpatient admissions. We have data to 2011/12, from 1998/99 for England and Scotland, from 2000/01 in Wales, and from 2005/06 in Northern Ireland. These rates decreased in England from 99 in 1998/99 to 70 in 2011/12; in Scotland from 89 in 1998/99 to 60 in 2011/12; in Wales from 115 in 2000/01 to 76 in 2011/12; and in Northern Ireland from 77 in 2005/06 to 65 in 2011/12. But, as mentioned above, there are questions over the reliability of these data in making cross-country comparisons and we lack comparable data for North East England.

Hospital waiting times

Changes over time in the targets or standards set by the different governments mean that it is not possible to examine past trends or compare countries. England, Scotland and Wales measure waiting times from referral to treatment (RTT). In Northern Ireland, there are separate targets for the first outpatient appointment and admission as an inpatient. In March 2013, performance, in each country's own terms, was as follows:

- In England, more than 92 per cent of patients who were admitted to hospital and more than 97 per cent of those who were seen as outpatients only, were admitted or seen within 18 weeks.
- In Scotland, more than 90 per cent of patients who were admitted to hospital, or seen as outpatients only, were admitted or seen within 18 weeks. In March 2013, the NHS in England and in Scotland met their different 18-week RTT targets.
- In Wales, 91.5 and 98.6 per cent were admitted to hospital or seen as outpatients within 26 and 36 weeks, respectively.
- In Northern Ireland, for the first outpatient appointment, 80 and 99 per cent were seen within nine and 21 weeks, respectively; and for inpatients, 69 and 97 per cent were admitted within 13 and 36 weeks, respectively.

Conclusions

Within the limitations of the performance information available across the four countries over time before and after devolution, it does not appear that the increasing divergence of policies since devolution has been associated with a matching divergence of performance. In addition, there is little sign that one country is consistently moving ahead of the others. In relation to measures such as amenable mortality, the pre-devolution differences seem to have changed relatively little while overall rates of amenable mortality have been falling. During the 2000s, the relative decline in amenable mortality was similar between the four countries. In some other aspects of performance, there are signs of a convergence in performance between the four UK countries, perhaps as a result of cross-border comparison and learning.

As the closest comparator to the four devolved countries, the North East of England is notable for the fact that by spending at Scottish levels it increased its staff and its admission rates while seeing increases in life expectancy and in amenable mortality. However, the North East had a larger improvement in amenable mortality than any of the devolved countries. This suggests greater health care system effectiveness in the North East both before and after devolution, but it is not possible to attribute this to specific English NHS policies.

Recommendations for improving availability of comparable data across the four countries

Our first recommendation is that there should be better comparative data. This is *not* about curbing the freedoms of governments to pursue different policies. However, it is right to require that data be collected to enable the impacts of different policies to be compared, particularly when these policies appear to be increasingly divergent. Expenditure on collecting data has the obvious opportunity cost of not being available for the care of patients; and this opportunity cost is felt more intensely in periods of austerity. On the other hand, the benefits of collecting data are that, through benchmarking, each country can learn how to both make changes that lead to care of higher quality without increasing costs, and enable savings to be made without impairing quality, for example, by better service integration. Within the devolved countries, unlike in England, the samples may frequently not be large enough for robust benchmarking of specialised services, with questions over their value and opportunity costs. We are not, however, recommending stopping the collection of these data, but rather increasing their value through making them comparable across the four countries.

Specifically, there should be a minimal set of data that is currently collected but defined so that it is comparable across the four countries, as follows:

- *Expenditure* – in total on health and social services, capable of being disaggregated by types of service (at least distinguishing between hospital and community health services, primary care and social care), and by the principal staff groups (as given below); and on public services by the devolved governments and England.
- *Staff* (in WTE) – hospital medical and dental staff; nursing, midwifery and health visiting staff; direct support to clinical staff; infrastructure staff; and GPs.
- *Hospital activity* – outpatients, day-cases and inpatient admissions.
- *Hospital waiting times* – the percentages waiting more than 18 weeks from referral by a GP to admission as an inpatient, or treatment as a day-case.
- *Ambulance services* – the percentage of category A ambulance calls met within eight minutes.
- *Satisfaction* – percentages reporting satisfaction with the general running of the NHS, inpatient care, outpatient care and GP care.

Second, we recommend that established systems of data collection ought to be extended across all four countries, as follows:

- Although Scotland does conduct its own stroke audit, coverage by the Royal College of Physicians of London (2011) could work towards harmonising the Scottish and the England, Wales and Northern Ireland audit, in order to show the way for other 'national' clinical audits which, over time, could report on a consistent UK-wide basis. This would be invaluable for the smaller specialties where the samples will be small in the devolved countries.
- Systems to provide Patient Reported Outcomes (PROMs) (Health & Social Care Information Centre, nd) collected in England to the other three countries. PROMs measure changes in a patient's health status or health-related quality of life through short, self-completed questionnaires before and after a procedure, and provide an indication of the outcomes or quality of care delivered to NHS patients.
- Surveys of the experiences of hospital and GP patients (NHS Surveys, nd) and staff (Picker Institute Europe, 2013), which have been run in England since the early 2000s.

We appreciate that the collection of data on PROMS and patient experience will entail extra costs in the devolved countries, but it seems increasingly untenable for modern health care systems to continue to run without routinely collecting such data. If these collections were available across the UK they would provide much greater scope for benchmarking than other systems that only routinely collect data to assess quality on whether patients have died or been re-admitted.

Third, as one of the main purposes of the governments in Belfast, Cardiff, Edinburgh and Westminister is the running of devolved services, it can legitimately be argued that proper electoral accountability ought to require data to be published on their comparative performance in running these services.

Our final recommendation relates to future research. While macro-level studies like the current one are important and valuable, and appear to have led to pressure to improve performance in the devolved countries, there is also a need for more granular and contextually relevant studies, for example, comparing similar areas with similar populations in the different countries (for example, on either side of the borders between England and Scotland, and Wales and England), and, in this way, identifying what the increasing differences in system policy mean for patients' and carers' experiences of health care. It should also be possible to shed some light on why health improved more quickly in the North East than in Scotland in the last decade, despite many population and contextual similarities. But, such detailed micro studies ought also to be informed by a larger set of more consistent data. We understand from feedback on an earlier version of this report that there is now some enthusiasm within the different countries for such developments.

A justification by governments in Scotland and Wales for abolishing the purchaser/provider split has been to enable better integrated care. That objective, particularly the integration of health and social services, is common to all four governments and seen as necessary for being better organised to care for an ageing population. However, there have been few controlled studies of integration in the devolved countries; and there are no cross-country studies. The recent review by the Nuffield Trust (2013) of controlled studies of pilots of recent attempts to develop integrated care in England found that none of the schemes had reduced rates of emergency hospital admission. This suggests a substantial agenda for future comparative research on developments in integrated care in England and Scotland, where policy objectives are the same, but the organisational forms and models of governance differ. This could include analyses of large linked individual level datasets for local areas within each country for the purposes of benchmarking, and detailed local studies of areas with similar demographics and socioeconomic circumstances that would include studies of patient experience and costs of specific services in the two countries.

1

Introduction

Comparing national health system performance across the United Kingdom before devolution

This report is the fourth study in a series comparing the funding and performance of the publicly financed systems of health care in the four countries of the UK. The first, by Dixon and others (1999), used data from 1995/96 before political devolution, when the governance of each system of health care was similar in each country, but there were marked differences in spending per head. The authors observed that in that year, “Scotland received 25 per cent more, Wales nearly 18 per cent extra and Northern Ireland 5 per cent more per head than England” (1999, p. 522). They observed that these differences offered a “natural experiment” to examine the impacts of different levels of funding on “inputs (such as number of staff, number of beds), activity (such as inpatient admission rates) and outcomes (such as waiting times, levels of public satisfaction and the extent of financial stress in hospitals)” (1999, p. 523).

There were two principal findings from this initial study. First, there were limitations in the availability and comparability of the data produced by each system. The authors observed:

> There has been no policy initiative to encourage consistent data recording across the NHS in the four countries – rather, diversity seems to have been championed. If national means the United Kingdom, there does not seem to be a national NHS. In many respects, therefore, devolution is a fact before the event. (Dixon and others, 1999, p. 524)

Second, given these limitations, the greatest pressure to be productive appeared to be being exerted on providers in England, and that “doctors and nurses in Scotland, Wales and Northern Ireland seem to be under less pressure (or are less productive) than their counterparts in England” (1999, p. 525).

Comparing national health system performance across the United Kingdom after devolution

The legislation that created the devolved governments in the countries of Scotland, Wales and Northern Ireland (which this report calls ‘the devolved countries’) took effect in 1999. Powers were transferred to the Scottish Parliament and Welsh Assembly on 1 July 1999, and to the Northern Ireland Assembly on 2 December 1999. The second and third studies (Alvarez-Roseté and others, 2005; Connolly and others, 2011) compared the funding and performance of the systems of health care in the four countries of the UK before and after devolution. The second study used data from 1995/96 and 2002/03; and the third added data for 2006/07 and reported comparisons of the four countries with North East England, which was argued to be a better comparator for the devolved countries than England as a whole. These later studies, like the study by Dixon and others (1999), found that the sets of data that were comparable were very limited

– and if anything, devolution seemed to have resulted in even fewer basic data being collected in a way that enabled meaningful comparisons to be made. There appeared to be no official body empowered to counter this trend. Furthermore, it seemed that no government organisation within the UK took a concerted interest in the comparative performance of the different systems of health care. It might have been expected that HM Treasury would use such data to make cross-country comparisons of the performance of public services, given its duty of oversight on the use of public expenditure in each country financed by taxation and borrowing on a UK basis, but this did not seem to be the case. A good example of this relative neglect of cross-country data was the discovery of:

> an error in the official statistics for hospital medical and dental staff for Scotland for 2006 as published by the Office for National Statistics (ONS) and checked by officials of the Information Services Division (ISD) of National Services NHS Scotland: the published statistic erroneously included general dental practitioners. (Connolly and others, 2011, p. xiii)

This error appeared in the first edition of our previous report on the four systems, but was corrected and a revised report published (Connolly and others, 2011), which had as its key message that:

> no one is responsible for ensuring that fundamental data on staff, activity and performance are collected on a consistent basis. This is because no one undertakes benchmarking of the use of UK taxpayers' money by the governments of the four countries. (2011, p. xiii)

A changing natural experiment

The three comparative studies also show a shift over time in the nature of the natural experiment taking place across the four countries of the UK. For the first study, systems of governance were similar prior to devolution, but there were substantial differences in funding per head in each country. Prior to devolution, the intended model of governance in all four countries had been one of provider competition. This was tried in each UK country, from 1991, in the form of an 'internal market' with each system organised into purchasers, which were to be funded equitably according to the relative need of their populations; and providers, which were to compete in a process of selective contracting driven by purchasers (Bevan and Skellern, 2011; Le Grand and others, 1998; Secretaries of State for Health, Wales, Northern Ireland and Scotland, 1989). Following devolution, these funding differences have narrowed (in part because Scotland has used its funding for other purposes, including free personal social care; see Chapter 2); but the system of governance in England has diverged from the systems in the other countries and, in particular, from Scotland and Wales. There was limited policy development in Northern Ireland, as devolution was largely stalled until 2007 (O'Neill and others, 2012).

The Labour Government elected in 1997 first abolished the goal of competition in England and Wales, but maintained the division between purchasers and providers (Secretary of State for Health, 1997). In 2000, the Prime Minister of the UK, Tony Blair, made a commitment to a period of unprecedented and sustained increases in funding of the NHS in England, in order to remedy a perceived crisis of underfunding, which had resulted in inadequate investment and staffing, and poor outcomes and quality of care, including long hospital waiting times (Smee, 2005, 2008). As a result, there were substantial increases in funding in England as well as the devolved countries (see Chapter 4). However, only the government in

England linked the increased funding to a radically novel system of performance management (the regime of annual 'star ratings' which applied from 2000/01 to 2004/05) (Secretary of State for Health, 2000). This regime was focused on penalising failure by providers to tackle what had been an endemic problem for each health service: namely, long waiting times for access to treatment (Bevan and Hood, 2006; Propper and others, 2008, 2010). Governments in the other countries, having just been empowered by devolution to develop policies that differed from England, did not follow that radical policy. Indeed, there is some evidence that their policies were perceived to reward failure by those working in the health service in Scotland (Farrar and others, 2004; Propper and others, 2008, 2010), Wales (Auditor General for Wales, 2005a, 2005b; Wanless, 2003) and Northern Ireland (Appleby, 2005) – which was exactly what the regime of star ratings had sought to end in the English NHS. From 2002, in England, the government's policy changed to reintroduce provider competition into its NHS (Mays and others, 2011; Secretary of State for Health, 2002). By 2006, all the main elements of this policy were in operation (after the end of the star ratings regime in 2005). Taken together, they introduced important structural differences compared with the previous internal market (for example, a much greater emphasis on provider autonomy and diversity; see Bevan and Skellern, 2011). In contrast, over the same period, the governments of Scotland and Wales abandoned the policy of provider competition and the purchaser/provider split (Longley and others, 2012; Steel and Cylus, 2012). Northern Ireland retained a purchaser/provider split, but without competition between providers.

Contribution of the current study

After 15 years of devolution, two distinctively different models of governance have been developed. In England, the policies of the Coalition Government (Secretary of State for Health, 2010; Timmins, 2012) imply that the NHS is acting increasingly as a public insurer, funding commissioners to contract with 'any qualified' provider, and with patients empowered to exercise choice in a system in which 'money follows the patient'. Nigel Edwards (then acting Chief Executive of the NHS Confederation) emphasised the intended shift from the state being responsible for "the day-to-day management of healthcare" to the NHS in England becoming " 'like a regulated industry' on the lines of telecommunications, water and the energy industries" (Timmins, 2012, p. 78). In contrast, the health services in Scotland and Wales have reverted to being traditional state monopolies run by organisations funded to deliver care to their local populations (Longley and others, 2012; Steel and Cylus, 2012); arguably, this also applies largely to the health care system in Northern Ireland (O'Neill and others, 2012). (This report elaborates on these policy differences in Chapter 2.)

The second (Alvarez-Roseté and others, 2005) and third (Connolly and others, 2011) comparative studies covered the initial period of devolution (up to 2002/03 and 2006/07, respectively), and offered an evaluation of different regimes of performance management: where failure to achieve government targets was penalised in the NHS in England, but not in the devolved countries. These studies found that the outcomes of this natural experiment, based on the limited data that were available, were that providers in the English NHS appeared to be more productive (as was shown in the study before devolution), and had shorter waiting times. As this report explains in Chapter 2, in Scotland, from 2005, following "unfavourable cross-border comparisons... about performance, particularly on waiting times", the government introduced a "tougher and more sophisticated approach to performance management in the system of HEAT [Health improvement, Efficiency, Access and Treatment] targets" (Steel and Cylus, 2012, p. 114). This fourth comparative study adds to these earlier studies by reporting data mostly up to 2011/12 – some analyses stop earlier, and others extend into 2013. Hence this new information is of great interest for two kinds of comparisons. First, between England and Scotland: has the new system of performance management resulted in improved performance of the NHS in Scotland, and how does this compare with that of England? Second, for Wales and Northern Ireland: have they been able to improve performance since 2006, and how does their performance compare with that of England and Scotland? This report also gives a stronger indication of changes over time, as it aims to report annual trends (where the data are available) for the four countries and the North East region of England; the three earlier studies reported data for snapshots (in 1995/96, 2002/03 and 2006/07).

A number of studies have examined the impact of devolution in terms of differences in policies, choice by patients, structures, values and accountability across the four systems of health care (Greer, 2004, 2008; Greer and Trench, 2008; Jervis, 2008; Jervis and Plowden, 2003; Peckham and others, 2012; Smith, 2007; Smith and others, 2009). This report draws on that literature to outline these differences, but its original contribution comes from reporting a set of indicators on populations and resourcing, and the performance of systems of health care measured over time, in order to raise questions about the funding, performance, governance and accountability of the governments of each country. The requirement for indicators to be as comparable as possible over time and across countries limits the number and time periods available, and hence the scope of this report, like the previous ones in the series.

Sutherland and Coyle (2009) reported cross-country comparisons at various times (mainly cross-sectionally) of a range of indicators of quality of care, using routinely collected data across six domains of quality:

- effectiveness
- access and timeliness
- capacity
- safety
- patient-centredness
- equity.

Some of these domains overlap with what was reported by Connolly and others (2011). Sutherland and Coyle (2009) also found the following:

- General practices in Scotland and Northern Ireland generally recorded the highest rates for providing care consistent with evidence-based practice.
- The lowest vaccination rates for two-year-olds were in England, and for influenza (for the over-65s) were in Wales.
- All countries faced problems with health care associated infections, in particular for MRSA and *Clostridium difficile* (*C. difficile*).
- Respondents in Scotland were most positive about their quality of care (based on surveys in 2005 and 2006 by the Commonwealth Fund).

Sutherland and Coyle found no systematic pattern across the various domains of quality of care such that one country consistently performed better than the others, except for hospital waiting times, where England performed best.

In this report, more information on the quality of care is included than in our earlier studies, namely on:

- rates of amenable mortality
- MRSA mortality
- survival from renal replacement therapy
- immunisation (of children and the over-75s)
- breast screening rates
- results from the Royal College of Physicians' stroke audit (which covers England, Wales and Northern Ireland).

Structure of this report

Chapter 2 of this report sets the context for the comparative analysis. It describes the background to, and the nature and arrangements for, political devolution. Chapter 3 outlines the methods of comparative analysis and problems in obtaining comparative data, especially over time, on even such basic measures of performance as outpatient attendances and hospital waiting times. That chapter also discusses the reasons for using North East England as a benchmark for comparison with the devolved countries in Chapters 4 and 5, where we have aimed, as far as possible, to report changes over time. Chapter 4 reports on the limited data that are comparable and collected routinely in each country and Chapter 5 focuses specifically on 'amenable mortality'. This is defined as premature death from causes that should not occur in the presence of timely and effective health care (Nolte and McKee, 2004), and is a widely accepted indicator of quality of care at the system level. Chapter 5 also compares 'other mortality' (derived by subtracting amenable mortality from total mortality), which is likely to be influenced by social and economic factors outside the health care system. The final chapter discusses the findings from these comparisons and their implications for policy and research. In addition, published separately from this report are a summary report (Bevan and others, 2014a); and appendices giving details of the sources of data for Chapter 4 (Bevan and others, 2014b) and additional information on the amenable mortality rates detailed in Chapter 5 (Bevan and others, 2014c). The political devolution context of this empirical study is presented in Bevan (forthcoming), which expands on the material presented in Chapter 2 of this report.

2

Devolution: background, arrangements and their implications

This chapter aims to set the context for the analyses of empirical data that follow. It gives a brief outline of the history behind, and the constitutional arrangements of, devolution. It also outlines, for each of the four countries of the UK, the predominant influences on the policies of their health care systems following devolution, and differences in models of governance. It discusses patient choice between providers, integration of services, funding and user charges. Most of the data in this report are from before the period of public spending austerity that began in 2010. This chapter concludes with a short overview of accounts of reported recent problems, as manifested in Accident & Emergency (A&E) services and quality of care.

There is a fuller account of this overview published separately alongside this report (Bevan, forthcoming), which makes fuller use of the rich source of work by others:

- for England, by Boyle (2011)
- for Scotland, by Steel and Cylus (2012)
- for Wales, by Longley and others (2012)
- for Northern Ireland, by O'Neill and others (2012)
- comparative analysis by Timmins (2013), which draws on those four reports
- by Greer (2004), who compares influences on policies and the policies that emerged in the early years of devolved government of health services in the UK
- by Bogdanor (1999), who analyses the political and constitutional aspects of devolution and shows how unresolved issues in Irish Home Rule have re-emerged decades later in the constitutional settlement of devolution, and
- by Davies (2000), who seeks to counter Anglocentric accounts of the histories of the countries that are part of the UK.

The four nations before devolution

Devolution followed a long and complicated historical development of conquest, unions and governance arrangements in the UK. The result is one set of policies for public services for the 50 million who live in England, and different policies in each country for the 10 million who live in Scotland, Wales and Northern Ireland. As Tuohy (1999) argued, in her development and application of the concept of 'path dependency' to analyse the systems of health care in Canada, the UK and the USA, the "accidental logics" of history "have shaped national systems at critical moments in time and in the distinctive 'logics' of the systems thus created" (1999, p. 6). Key developments in the formation of the current UK included historical defeats by the English of the Welsh, by the Scottish of the English and, in Northern Ireland, the plantation of Ulster in the 17th century and the movement against Irish Home Rule in the 1880s (Davies, 2000). Davies argues that the nature of the union of Scotland with England (and Wales) in 1707 prevented the UK from developing either a federal or unitary structure. Instead, the UK is “essentially a dynastic conglomerate, which could never equalise the functions of its four constituent parts” (2000, pp. 870–1) and lacks a unified legal system, centralised educational system, common cultural policy or history.

The different policies in each country, which have developed following devolution, reflect differences in scale, culture and history (Greer, 2004, 2008). England differs from the other countries in being so much larger, having a strong Conservative Party, significant independent sectors for health care (and schools), think-tanks across the political spectrum, advocates of market-based reforms and ideas of New Public Management, a large and critical press, and political debates that put “the operation and even the existence of the NHS in question” (Greer, 2004, p. 103). The massive scale of the NHS in England means that it is also more complicated to run than in the devolved countries. Greer (2004) argues that the consequences are that its “civil service policy and administrative capacity… far exceeds that of the devolved administrations” (2004, p. 96), and that “[t]he decisions of the government can be turned into policy and implemented far more quickly and with less hazard” (2004, p. 97).

Bogdanor (1999) uses a Marxist distinction to highlight a crucial difference between Scotland and Wales following their unions with England: Scotland remained a “historic” nation “which succeeded in retaining the institutions of statehood” (1999, p. 144), and Wales did not. Greer (2004, p. 131) argues that the geopolitics that made Scotland a separate successful Scottish state before its union with England (and Wales) in 1707 also allowed it to assemble and develop an imposing and distinctive civil society; and that the legacies of the distinctiveness of Scottish institutions prior to devolution meant that of the three devolved countries, Scotland had “the most complicated, competitive and well-worked out policies” (2004, p. 64). He argues that the major influence on policy for the NHS in Scotland is that of professionalism stemming from its powerful medical elite, with its own royal colleges and academic centres (2004, p. 68). In Wales, he argues that the most important political influence on the Welsh Assembly is local government (2004, p. 131). The devolved governments of Wales and Scotland have developed similar hierarchical models of governing health services that differ from the purchaser/provider spilt in England. In Northern Ireland, there has been relatively little distinctive policy development. Greer (2004, pp. 159–61) attributes this to its small size, history of direct rule and the nature and intensity of its political conflict. He describes its style of policy-making as that of “permissive managerialism”, which he defines as “a combination of minimal policy activity (such as quality improvement, new public health, or acute care redesign) and an emphasis on running services” (2004, p. 159).

Governance and funding of public services before devolution

Before political devolution in 1999, the administration of each health service in Scotland, Wales and Northern Ireland was the responsibility of the respective secretary of state. The Scottish Office was created in 1885, the Welsh Office in 1964 and the Northern Ireland Office in 1972 (Greer, 2004). Bogdanor (1999) argues that the convention of collective responsibility of the UK Cabinet meant that there was little scope for the Secretary of State for Scotland to pursue policies that diverged from those applied to England, except for matters “where English ministers did not particularly care what happened in Scotland and where there seemed to be no implication for policy across the border" (1999, p. 113). Greer argues that there was even less scope for policy divergence in Wales, where the Welsh Office, "[u]nlike its Scottish or Northern Ireland predecessors… had to hew a distinctive Welsh policy arena out of the unified England and Wales organisations, policy regimes and Whitehall departments responsible for policy until its creation" (2004, p. 133); and that Whitehall departments supervised the development of the NHS in England and Wales. Although Hunter and Wistow (1987) did identify some policy diversity in community-based care in the 1980s rather than uniformity across England, Scotland and Wales, they also highlighted two powerful constraints on Scotland and Wales developing distinctive policies: the relative lack of policy-making resources in Edinburgh and Cardiff; and the limited growth in public spending. Bogdanor (1999, p. 161) argues that in Scotland and Wales, the wide range of issues that their secretaries of state were responsible for meant that officials had a greater influence on policies than in England. The politics of Northern Ireland meant that "the Secretary of State and junior ministers were the executive and effective centres of power" (1999, p. 101) – and unlike their counterparts in Scotland and Wales, lacked political accountability. Greer describes this as "a type of vice-regal politics in which the separation of government and the vote was nearly total" (2004, p. 167).

The Secretaries of State for Scotland, Wales and Northern Ireland were accountable for expenditure on public services within each country. Although identifiable within each country, decisions on spending on social security, defence and foreign affairs were, and still are, made on a UK-wide basis. The problems of funding public services in the different countries have long been fraught because of political lobbying, the mismatch between countries' needs for these services and their tax base to pay for them (Bogdanor, 1999). The three Secretaries of State for Scotland, Wales and Northern Ireland were allocated a global sum for their public services, and were free to allocate money to their chosen spending priorities. The Barnett Formula used in making global allocations to the devolved countries began to operate in Scotland and Northern Ireland in 1979, and in Wales in 1980 (when political devolution was first being considered). This formula, in principle, uses data on crude populations to allocate increases in spending on public services in England to the devolved countries.[1] Before the formula was used, England had had the lowest per-head spending: in 1976/77, spending per head on public services was much higher in Northern Ireland than England (by 35 per cent) and Scotland (by 22 per cent) and a little higher in Wales (by six per cent) (Select Committee on the Barnett Formula, 2009, p. 21).[2] At the time of devolution to Scotland, Wales and Northern Ireland, Scottish public spending per head was around 25 per cent higher than in England.

The devolution settlement

Devolution took effect when powers were transferred from the Westminster Parliament to the Scottish Parliament and Welsh Assembly on 1 July 1999, and to the Northern Ireland Assembly on 2 December 1999. The constitutional arrangements for devolution are that the Westminster Parliament acts for the UK for non-devolved matters, and for devolved matters for England; also, in principle, as the body with oversight across the subordinate legislatures in the devolved countries. These arrangements lack three basic elements of a federal structure.

First, as Hazel argued, the "hole in the devolution settlement" (2000, p. 29) is the absence of an English parliament, which has the consequence of what has become known at Westminster as the 'West Lothian Question', after the former

MP for West Lothian, Tam Dalyell. That is, why should MPs from non-English constituencies be able to vote on policies for public services in England, when English MPs cannot vote on these policies for each devolved country, even though its finance comes from the budget for the UK?

Second, the UK lacks any constitutional basis for agreeing what should be the UK-wide elements of policy for public services (Greer, 2004), such as the Canada Health Act of 1984, which prohibits 'user charges' in the different provinces (Flood and Choudhry, 2004, pp. 10–11). In the UK, devolution has resulted in marked differences between countries in charges for health and social care (which are discussed below), and charges for tuition fees for undergraduate education: for example, students studying in their own country pay no fees in Scotland, pay annual fees (financed by income contingent loans) of up to £3,575 in Northern Ireland and Wales, and £9,000 in England (The Complete University Guide, nd).[3]

Third, there are no federal institutions in the UK which might negotiate the collection of minimum datasets on a comparable basis to be reported to federal ministries of health, unlike many federal systems such as Australia (Banks and McDonald, 2010).

The arrangements for devolution mean that, in effect, there have been two different systems for determining health service budgets over much of the period for which this study reports funding and performance: one system applied to England only; the other to the devolved countries. The NHS budget for England is the outcome of UK Cabinet agreements following negotiations between HM Treasury and the Department of Health for England. From 1998 to the end of the Labour Government in 2010, in principle, budgets for public services were contingent on each government department in England delivering performance that satisfied a set of targets agreed with HM Treasury and set out in Public Service Agreements (PSA targets) (HM Treasury, 1998, 2008). The global allocations for 'public services' in the devolved countries were determined largely by the Barnett Formula,[4] which has been criticised for various inadequacies (see below). Each devolved government decides how much of its global allocation ought to be allocated to the NHS. It has been argued that the lack of a constitutional framework for regulating the spending decisions of the devolved and UK governments allowed the government in Scotland to spend extra money directed at improving NHS performance in England to finance free personal social care in Scotland (see below). There are also differences in accountability for public services between the governments. The devolved countries have direct political accountability (to the assemblies in Wales and Northern Ireland and the Scottish Parliament); political accountability for these services in England is through elections to the Westminster Parliament, which hinge on a mix of English and UK-wide issues (such as the economy, social security and defence and foreign policy). Only in England are government departments accountable to HM Treasury for the performance of public services funded by UK taxpayers; in the case of the devolved governments, funding for these services is based on the Barnett Formula. Neither the NHS in Scotland nor Wales was subject to the Treasury's PSA targets (Connolly et al, 2011). Timmins (2013, p. 13) observes that, although the Department of Health, Social Services and Public Safety of Northern Ireland performed comparatively poorly against its PSA targets when these were reviewed in 2011, "it is not clear that any penalties were incurred, or indeed that much action followed, as a result of that poor performance".

Governance of health services before and after devolution

This section outlines four basic, conceptually distinct models of health care system governance, and uses these to analyse the trajectories of the four countries before and after devolution.

Models of governance

The four models of governance can be summarised as:

- trust and altruism
- choice and competition
- targets and terror
- naming and shaming.

These archetypes are similar to those described in books written, after serving in the Blair Government, by Professor Julian Le Grand (2007), as senior policy adviser to the Prime Minister from 2003–05, and Sir Michael Barber (2007), as head of the Prime Minister's Delivery Unit from 2001–05.

Trust and altruism

The model of *trust and altruism* assumes that providers of public services are 'knights' (Le Grand, 2003, 2007) and, as they are driven by altruism, they can be trusted to do the best that they can for those they serve within the available resources, without any need for external incentives – and indeed, poor performance should be taken to indicate a need for extra resources.

It is difficult to find any theoretical justification for this model, which can be criticised on two grounds. First, as Le Grand (2003) argued, those who deliver public services are not all driven purely by 'knightly' motives of altruism, but also by 'knavish' motives of self-interest. This mix cannot be guaranteed to provide the incentives necessary to overcome organisational inertia, in order to implement changes for quality improvement. This process requires using comparative information on performance to understand how performance needs to change to deliver better outcomes, and win support for implementing the necessary changes (Berwick and others, 2003).

Second, prospect theory, developed by Tversky and Kahneman (Kahneman, 2011), shows that people feel losses much more keenly than gains of equivalent magnitude. Thus, sanctions for failure can generate the high-powered incentives necessary to overcome organisational inertia, in order to improve quality. As the trust and altruism model eschews the use of sanctions, it removes these high-powered incentives and, of course, rewarding failure creates perverse incentives (Bevan and Fasolo, 2013). Nevertheless, this model has low monitoring costs, is popular with professionals, is common in public services (Le Grand, 2003, 2007) and, we assume, has been the default model for the governance of health services in the countries of the UK.

Choice and competition

Both Le Grand (2007) and Barber (2007) favour the model of *choice and competition* as having the greatest potential to deliver high performance in public services. This model assumes that users choose better performing providers, and that providers respond to the consequences of these choices for their market shares. This model creates external incentives through a quasi-market system in which there is patient choice of providers, and money follows the patient. However, it is difficult to design effective quasi-markets as they require good information, supply-side flexibility and freedom to manage. Quasi-markets have high transaction costs, but are increasingly popular with governments because pressure on poor performance is perceived to come from the 'invisible hand' of the market (Le Grand, 2007). They promise to have more potential to respond to users' needs than the two centrally driven models below.

Targets and terror

The model of *targets and terror* holds providers to account against a limited set of targets that clearly signal priorities to those responsible for running organisations, with clear threats of sanctions for failure and rewards for success (Barber, 2007 and Le Grand, 2007 describe this model as 'command and control'). The model assumes that providers will respond to clear economic incentives. Prospect theory tells us that of these incentives, sanctions will have a stronger impact than rewards. The targets and terror model imposes external incentives by strong performance management, has monitoring costs and is unpopular with professionals.

Naming and shaming

The model of *naming and shaming* assumes that providers respond to threats to their reputation, and is a system of performance measurement. Hibbard and others (2003) show that this model requires an ability to rank providers' performance, so that the public easily can see which providers are performing well or poorly on a regular basis, enabling change to be monitored. The classic model of naming and shaming is the publication of annual league tables of schools based on the performance of their pupils in examinations (Bevan and Wilson, 2013).

We conclude this outline of these models by making three points. First, elements of more than one model can coexist in a system, but they are conceptually distinct, as it is possible for any one model to be used alone.[5] Second, however convincing each model appears to be *a priori*, if it lacks effective sanctions for failure then it is, in effect, one of trust and altruism.[6] Third, models other than trust and altruism are vulnerable to 'gaming', because they create high-powered incentives in relation to inevitably imperfect measures of performance (Bevan and Hood, 2006; Holmstrom and Milgrom, 1991). Indeed, there is no perfect model, and it is a profound mistake to change policies in the belief that such a model is there to be discovered by trial and error.

Governance before devolution

The creation of the NHS in 1948 had established largely the same organisational forms and common policies across the whole of the UK: with access to the NHS being free at the point of delivery (except for the subsequent introduction of prescription charges), and typically via a GP, who acts as gatekeeper to specialist services (Webster, 1988). Initial arrangements illustrate how Wales was seen essentially as an English region, with Scotland and Northern Ireland seen as more distinct administratively: the regulation to control the distribution of GPs was implemented by three medical practice committees for England and Wales, Scotland and Northern Ireland. A hospital management committee governed each hospital, and was accountable to 14 regional hospital boards in England, one in Wales, five in Scotland (Levitt and Wall, 1984) and a hospitals authority in Northern Ireland (Leathard, 2000, p. 294).

The first major reorganisation of the NHS (implemented in 1973 in Northern Ireland, and 1974 in England, Wales and Scotland) aimed to shift the NHS from an organisation based on hospitals to one based on populations. This resulted in a regional structure in England of 14 regional health authorities; for the other countries, the government department responsible for health fulfilled both roles of region and department of state. Within English regional health authorities and Wales, there were area health authorities responsible for running hospital and community health services and planning for populations within each area (in England and Wales these were later reorganised into district health authorities), and family practitioner committees (later family health service authorities) for family practitioner services. In Scotland, health boards were created with equivalent responsibilities to both area health authorities and family health service authorities in England and Wales. In Northern Ireland, health and social services boards were created with responsibility for health and social services. The constitution of executive teams was similar in England, Wales and Scotland but differed in Northern Ireland, where the health and social services boards included the director of social services and excluded the treasurer (Levitt and Wall, 1984).

The dominant model of governance across each country for health services until 1991 was one of trust and altruism (Le Grand, 2003). From 1991, the model changed towards one of choice and competition, with the implementation of an internal market across the UK (Secretaries of State for Health, Wales, Northern Ireland and Scotland, 1989). This was based on a purchaser/provider split, with purchasers contracting with separate NHS providers on grounds of price and quality. District health authorities in England and Wales, health boards in Scotland and health and social services boards in Northern Ireland became purchasers, and their hierarchical role in governing providers was replaced with contractual arrangements, as providers became more autonomous NHS trusts. Another innovation of the internal market was the creation of new, small-scale purchasing by GPs who opted to become fundholders, of which various forms emerged over time (Mays and Dixon, 1996).

Differences in governance following devolution

Following the election of the Blair Government in 1997, the model of governance across UK health care systems largely moved back to that of trust and altruism. In England, this was described as the ‘third way’, compared with two ‘failed’ alternatives: the “divisive ‘internal market’ system of the 1990s” and the “old centralised command and control policies of the 1970s” (the last time there had been a Labour government) (Secretary of State for Health, 1997). The government in England retained the organisational separation of purchasers from providers created for the internal market, but abandoned the rhetoric of competition, so that purchasers became commissioners with the objective of fostering collaborative arrangements with providers. However, after 2000 in England, following the UK Government’s commitment to sustained increases in NHS funding, the model of trust and altruism was abandoned, and from 2000–05 the regime of star ratings combined the models of targets and terror with naming and shaming (Bevan and Hood, 2006). Over that period in Wales, the system of performance management for its NHS was criticised by the Wanless Report (Wanless, 2003) as lacking the “incentive systems to drive properly creation or imitation of best practice” (2003, pp. 1–2), and by the Auditor General for Wales (2005a, 2005b), who described the performance management arrangements to:

> have provided neither strong incentives nor sanctions to improve waiting time performance [and] Trust and Local Health Board chief executives consistently described their perception that the current waiting time performance management regime effectively ‘rewarded failure’ to deliver waiting time targets. (Auditor General for Wales, 2005b, p. 42)

Moreover, there was no system of "naming and shaming" (Auditor General for Wales 2005b, p. 40). In Scotland, Propper and others (2010) describe the regime for managing reduction of hospital waiting times from 2000 as one in which there was neither "naming and shaming" nor "the coupling of performance against targets and managerial sanctions that operated in England" (2010, p. 320). Farrar and others (2004) observe that in Scotland, there was the perception of "perverse incentives… where 'failing' Boards are 'bailed out' with extra cash and those managing their finances well are not incentivised" (2004, pp. 20–1). In his review of health and social services in Northern Ireland, Appleby (2005) criticises its system of performance management as lacking "appropriate performance structures, information and clear and effective incentives – rewards and sanctions – at individual, local and national organisational levels to encourage innovation and change" (2005, p. 162), and that there was also no system of naming and shaming.

In England, from 2005/06 to 2008/09, the annual Health Check replaced the regime of star ratings with elements of naming and shaming and targets and terror,[7] but the government emphasised the reintroduction of the model of choice and competition in the form of a revised internal market (Audit Commission and Healthcare Commission, 2008; Bevan and Skellern, 2011; Secretary of State for Health, 2002). From 2010, the Coalition Government stopped publication of the annual Health Check, and hence relied solely on the model of choice and competition (Secretary of State for Health, 2010; Timmins, 2012). The changes in policy announced in 1997, 2000 and 2002 in England have been compounded by the appetite of successive secretaries of state for structural reorganisation: Timmins rightly observes that this has reached the point at which "organisation, re-organisation and re-disorganisation" almost might be dubbed the English NHS "disease"' (2013, p. 6).

The governments in Scotland and Wales abandoned the purchaser/provider split in 2004 and 2009, and created health boards similar to those of the 1980s. In Scotland, Steel and Cylus state that "Unfavourable cross-border comparisons… about performance, particularly on waiting times" (2012, p. 113) led to two responses by the government from 2005. First, the primary change was "to shift the balance of care away from episodic, acute care in hospitals to a system that emphasises preventive medicine, support for self-care and greater targeting of resources on those at greatest risk through anticipatory medicine" (2012, p. 114). Second, "following a change in minister", the government introduced a "tougher and more sophisticated approach to performance management" (2012, p. 114) in the system of HEAT (Health improvement, Efficiency, Access and Treatment) targets, which is organised by a delivery group within the health department that agrees annual local delivery plans with each board and systematically monitors and supports improvements in performance and, where necessary, intervenes. In Wales, following the reorganisation of the NHS in 2009, the government developed the *Five-Year Service, Workforce and Financial Strategic Framework for NHS Wales* (NHS Wales, 2010, p. 7) in which the first of five guiding principles was: "Making LHB [Local Health Board] and Trust chief executives personally accountable for delivery with strong, transparent, specific performance management". The government in Wales has introduced a system of performance management around two sets of core delivery targets. Tier 1 targets are described as "key priorities where immediate improvement is necessary or where performance at defined target levels must be sustained" and are "subject to very close attention by health boards, trusts and Welsh Government (through national monitoring)" (NHS Wales, 2011, p. 1). However, Longley and others (2012) point out that in the absence of governance by the model of choice and competition:

> Wales has been less clear about enunciating its alternative set of metrics and levers for change. The dominant philosophy appears to rely on a combination of exhortation to do better plus performance management of the [local health boards] by the Welsh Government. (2012, p. 66)

Suspension of the Northern Ireland Assembly resulted in stasis in the development of health policy through much of the post-devolution period. The Health and Social Care (Reform) Act (NI) 2009 created one large commissioning body, the Health and Social Care Board, supported by five local commissioning groups organised geographically, and five coterminous health and social care trusts to provide care (O'Neill and others, 2012, pp. 9–14). Although that structure maintains a purchaser/provider split, the policy emphasis is on cooperation, and not provider competition, which is unlikely to be effective in Northern Ireland for structural reasons (O'Neill and others, 2012; Timmins, 2013). O'Neill and others (2012) argue that, as in Wales, there is no clear articulation of what will bring the discipline to improve provider performance and efficiency in the absence of competition. The chosen model of governance in Northern Ireland seems strikingly similar to the 'third way', which was tried and found wanting by the Blair Government in England between 1997 and 2000.

Differences between the four countries

This section outlines differences between the four countries in a range of specific policy areas that differ significantly across the UK:

- patient choice
- the approach to the common goal of integration
- charges
- funding in the period of austerity (and recent reports of financial pressures and concerns over quality).

Current policy differences in these areas are summarised in Table 2.1. As was explained above, prior to devolution, the policies for the NHS in England essentially applied throughout the UK. Table 2.1 shows how far the policies of the devolved governments currently differ from the English model of choice between competing providers, and how changes in user charges and entitlements have been made following devolution.

Table 2.1: Current differences in policy, organisational characteristics and charges and entitlements between the four countries

	England	Scotland	Wales	Northern Ireland
Population (m)	50	5	3	1.7
Organisational characteristics:				
Purchaser/provider split	Yes	Abolished 2004	Abolished 2009	Yes
Money follows the patient	Yes	No	No	No
Competition between public and private providers	Yes	No	No	No
Integration of health and social services	No	Various initiatives	No	Yes
Charges and entitlements:				
Free personal social care for the over-65s	No	Yes	No	No
Free prescriptions	No	Yes	Yes	Yes

Patient choice

As England alone has opted for the model of choice and competition, this raises the question of how choice varies across the four countries. Box 2.1 summarises a study across the four countries undertaken in 2008 and 2009 by Peckham and others (2012) on the development and implementation of policies related to patient choice. This showed that patient choice, as an aspect of responsiveness of the system to individual patients' needs, was apparent in the operation of all four countries. However, the only element of choice that *potentially* applied in each country was over the time and date of appointment and site within an NHS trust, and except in Northern Ireland, the choice of specialist, both at the discretion of the provider organisation. In practice, in each of the four countries, the study found that there was lack of clarity about both the options available and the way that choices were offered to patients, with limited discussion of choices between referrers and patients, and tension between offering choice and managing waiting lists. Only in England did patients have a guaranteed choice of provider organisation, with a system of funding in which money followed the patient (known misleadingly as 'Payment by Results') (Department of Health, 2002; Dixon, 2004).[8]

Box 2.1: A comparison of patient choices across the four countries, 2008–09

Choices	England	Scotland	Wales	Northern Ireland
Provider	Yes	No (exception basis only)	No (exception basis only)	No (exception basis only)
Consultant	At provider's discretion	At provider's discretion	At provider's discretion	No
Time/date	Yes	Yes	Yes	Yes
Site	At provider's discretion	At provider's discretion	At provider's discretion	At provider's discretion

Source: After Peckham and others, 2012

Integration

A justification used by governments in Scotland and Wales for abolishing the purchaser/provider split has been to enable the development of integrated care. However, the pursuit of better integrated care, particularly the integration of health and social services, is common to all four governments as being necessary for being better organised to care for an ageing population. Curry and Ham (2010) describe three levels at which integration may occur for providers, either together or with commissioners:

1. macro – at the level of populations; for example, as in the Kaiser Permanente health maintenance organisation (described as Kaiser) in the USA
2. meso – at the level of a particular care group or population with the same disease or condition; for example, managed clinical networks in Scotland
3. micro – at the level of individual service users and their carers.

Goodwin and others point out that integration at the macro level “appears to be neither necessary nor sufficient to deliver the benefits of integrated care” (2012, p. 2). Feachem and others (2002) compared the NHS in the UK (for about 60 million people) with Kaiser (for about six million Californians): they reported that the two systems used similar levels of resources per head, but Kaiser performed substantially better than the NHS with, for example, faster access to both primary- and secondary-care doctors. In a follow-up study, Ham and others (2003)[9] found that the use of hospital beds in the NHS for 11 leading causes of admission was three-and-a-half times that of Kaiser’s standardised rate, because of Kaiser’s combination of low admission rates and relatively short stays. They concluded that the NHS in England could learn in general from Kaiser’s integrated approach, which links funding with provision, inpatient with outpatient care and prevention, diagnosis and treatment (in particular for the effective management of chronic diseases).

Studies of integration suggest reductions in the use of hospital beds over time in England, in a pilot of integrated health and social care in Torbay (Thistlethwaite, 2011), and on a countrywide basis in Scotland and Wales (Ham and others, 2013). However, none of these developments has been subjected to a well-designed evaluation. Bardsley and others (2013) reviewed controlled studies of pilots of recent attempts to develop integrated care in England. They found that for none of these pilots was there good evidence of a reduction in rates of emergency hospital admissions. In contrast, they did find good evidence of the impact of the Marie Curie nursing service at the end of life: “a well-established and widely used model of care service delivered in a standard way” (2013, p. 12). Ham and others concluded that: “Despite having the longest history of administratively integrated care, Northern Ireland has been slowest to exploit the potential benefits” (2013, p. 78). Heenan explains this in terms of the distinctive problems of governing Northern Ireland, which “already had sufficient political controversy without adding reform of health and social care to the mix” (2013, p. 5). Indeed, the reason for moving social services out of local government in 1973 was not to achieve integration with health services, but because of “systematic discrimination by local governments, which was one of the factors causing the troubles. Northern Ireland’s social services, thoroughly politicised and sectarian, had to be changed – since they were a major cause of Catholic grievance” (Greer, 2004, p. 165). Although the organisational and policy environment in Scotland and Wales ought to enable integration, Ham and others point out that in each of these countries “it has been difficult so far to shift resources within local health boards from hospitals to the community, let alone from health to social care” (2013, p. 79).

Charges

The governments of the devolved countries abolished prescription charges in Wales in 2007, Northern Ireland in 2010 and Scotland in 2011. In England, about 90 per cent of the population are exempt from these charges, but for those who do have to pay, the charge is currently £7.85. Timmins (2013) points out that the governments of Wales and Scotland have also abolished the car parking charges at hospitals (unless these are required under contracts) (2013, p. 8), and he raises the question of whether at a time of austerity, prescription charges might be reintroduced (2013, p. 18). A striking example of what can happen from the combination of the Barnett Formula and the ability of UK governments – even from the same political party – to pursue radically different policies is Scotland’s policy implemented in 2002 of free, long-term personal and nursing care for people aged 65 years and over (Greer, 2004, pp. 87–90). When it was introduced, this policy was estimated to have had an annual cost of about £110 million for Scotland (Scott, 2000), and is said to have been funded in effect as a "Barnett consequential" from the massive increases in spending on the NHS in England (Greer, 2004, p. 89). Greer reports of one Scottish Labour politician being told "angrily" by English colleagues that the higher funding of public services was "because of the deprivation you have in Scotland, not so you can do things we can't do" (2004, p. 88). Timmins (2013, p. 13) points out that the costs of this 'free' care have more than doubled in cash terms in seven years, from £219 million to £450 million, and that there are now waiting lists for access to it (Scottish Government, 2012).

The pressures of austerity

The Organisation for Economic Co-operation and Development (OECD) (2013a) notes that health spending in the UK in 2011 was slightly above the OECD average in terms of percentage of gross domestic product (GDP), and also per head (adjusted for purchasing power parity). It points out that over the first decade of devolution:

> Health spending in the United Kingdom grew in real terms by 5.7% per year on average between 2000 and 2009. However, this came to an abrupt halt in 2010 as health spending dropped by 1.9%, in real terms, in 2010 with a further 0.4% fall in 2011. (OECD, 2013a, p. 2)

Appleby's (2011) analysis of governments' policies for expenditure on health services from 2010/11 identifies Wales as an outlier, with planned reductions in NHS spending of nearly 11 per cent by 2013/14. Timmins (2013) questions the Welsh Government's ability to achieve its planned reduction in spending, citing evidence from the House of Commons Health Committee that "no country has managed to keep spending on healthcare flat for four years, let alone cut it" (2013, p. 7). It is hard to see how such reductions could be achieved without rationalisation of acute hospital services, and Longley and others (2012) state that the NHS in Wales is embarking on proposals to do this – but as expected, it is proving controversial and facing vocal opposition. In October 2013, finance minister Jane Hutt announced an increase of nearly 3.6 per cent in cash terms (and 1.7 per cent in real terms) to "help the NHS in Wales to avoid a scandal such as the one in Stafford Hospital" (BBC News, 2013b).

This report looks back at how differences between countries have had an impact on funding, staffing and various measures of performance. Much of the data relate to the period when each country's health service was still experiencing growth in funding in real terms; hence, this report has no systematic basis for comparing how the different countries are managing their health systems in the period of austerity. However, this study does have reports that indicate pressures and concerns over meeting targets and quality of care.

Each country has experienced problems with A&E services. In England, the House of Commons Health Committee (2013) reported on "the failure of emergency departments to meet national waiting time targets in the early months of 2013", which was attributed to "a broader failure resulting from fragmented provision of emergency and urgent care and a structure that is confusing to patients". In Wales, the Health and Social Services Committee reported in December 2013 that: "Waiting times at hospital emergency departments have generally increased over recent years, with some patients, particularly older people, spending longer than 12 hours in these departments" (2013, p. 5). News reports suggest improvements in the second half of the winter in early 2014 in England (Triggle, 2014) and Scotland (Puttick, 2014), but serious problems have been reported at hospitals in Wales (BBC News, 2014a) and Northern Ireland (BBC News, 2014b).

There have been public concerns over quality of care and inspection regimes in England, Scotland and Wales.[10] In England, following publication of the report in February 2013 of the Second Francis Inquiry into the scandal at Mid-Staffordshire NHS Foundation Trust (Francis, 2013), Sir Bruce Keogh, medical director of the NHS, was asked by the Secretary of State for Health and the Prime Minister "to conduct a review into the quality of care and treatment provided by hospital trusts with persistently high mortality rates" (Keogh, 2013, p. 3). He selected 14 trusts with high rates following inspections, and 11 of these were placed in special measures. The new chief inspector of hospitals, Sir Mike Richards, recommended that two other NHS trusts be put into special measures in November and December 2013 (Care Quality Commission, 2013a, 2013b).

In Scotland, following higher than predicted hospital standardised mortality ratios in NHS Lanarkshire, the Cabinet Secretary for Health and Wellbeing commissioned Healthcare Improvement Scotland to undertake a rapid review of safety and quality of care for acute adult patients in its hospitals. The report from that review made 21 recommendations, including on better management of data, medical and nurse staffing levels and handling complaints (Healthcare Improvement Scotland, 2013).

In Wales, a review of 2013 by the BBC Wales health correspondent highlighted a series of concerns over poor care in various hospitals. These included cases of *C. difficile*, high death rates on cardiac waiting lists, and the avoidable deaths of eight patients with liver disease (Clarke, 2013). In a review by the Welsh Health and Social Services Committee of Healthcare Inspectorate Wales – the independent inspectorate and regulator of all health care in Wales – the chief executive of Healthcare Inspectorate Wales was unable to reassure the committee that there was no likelihood of a scandal in Wales like that of Mid-Staffordshire in England (BBC News, 2013c).

What this report adds

The initial period of devolution provided a 'natural experiment' because in each country there were substantial increases in health service funding, targets for waiting times for hospitals (Auditor General for Wales, 2005a, p. 16) and for response times to life-threatening emergency calls by ambulances (Bevan and Hamblin, 2009). However, as argued above, only in England did the government abandon the model of trust and altruism. Studies that have examined performance across the four countries over that period, in terms of hospital waiting times and ambulance response times, found that the NHS in England performed best (Bevan and Hood, 2006; Bevan and Hamblin, 2009; Connolly and others, 2011; Propper and others, 2010). This report gives information on performance after that initial period of devolution, the period from 2006, and is of great interest for two kinds of comparisons. The first is between England and Scotland, as these two countries now provide a stark contrast in models of governance. Since 1991, in the English NHS, the dominant model (except from 1997–2005) has been that of choice and competition. In Scotland, the hierarchical integrated model has been in place since 2004, with an organisational stability that is the envy of all who have suffered from the successive 're-disorganisations' of the English NHS. Scotland's emphasis since 2005 in terms of governance has been on a strong system of performance management. In Wales and Northern Ireland, there is neither the model of choice and competition and little compelling evidence of a sustained period of governance by a system of strong performance management (at least until 2010 in Wales). This suggests that, by default, the model of governance in Northern Ireland and in Wales (at least until 2010) had been one of trust and altruism. Therefore, the second comparative question of interest is: have Wales and Northern Ireland been able to improve their performance since 2006, and how does their performance compare with that of England and Scotland?

Notes

1. We point out in Chapter 6 that the Select Committee on the Barnett Formula (2009) reported that this formula had used crude, outdated population statistics (that benefited Scotland), with additional funding determined through bilateral negotiations (that benefited Scotland and Northern Ireland).
2. The formula did not determine all allocations of devolved public spending: there were extra allocations negotiated bilaterally with the Treasury outside the formula, in particular to cover public sector wage increases (which appear to have benefited Scotland and Northern Ireland).
3. These arrangements have become bizarre for students who are from one country and choose to study in another. Under European law, students from any European Union (EU) country are, like Scottish students, entitled to ‘free’ tuition at Scottish universities with three exceptions: students from England, Wales and Northern Ireland are required to pay annual fees, which at Edinburgh were £9,000 in 2013 (BBC News, 2013a).
4. There were also bilateral negotiations with the Treasury for allocations to Scotland and Northern Ireland.
5. For example, although the regime of star ratings combined the two models of targets and terror and naming and shaming, in schools and US health care the latter model is used alone, and there is no centralised system of accountability of providers to a government department. Although naming and shaming can lead to those responsible for running providers being sacked, this is the outcome of a local rather than a national decision.
6. For example, in the choice and competition model it has proved difficult for ministers to let ‘failing hospitals’ or services within hospitals exit the market. A system of targets without sanctions is one of ‘hope and exhortation’, rather than ‘targets and terror’ (or ‘command and control’).
7. See Bevan (2011).
8. Payment by Results creates financial incentives for hospitals to reduce costs and increase the numbers of cases that they treat, with concerns over incentives to skimp on quality or discharge patients too early. Farrar and others (2007; 2009) compared the efficiency of different types of hospitals in England with hospitals in Scotland over the period from 2003/04 to 2005/06. In Scotland, there was no tariff system for funding hospitals (other than for cross-boundary flows), and hence only weak financial incentives to reduce costs and treat more numbers. They estimated that efficiency had increased slightly faster in England than in Scotland. They tentatively concluded that reductions in hospital costs in England had been achieved by increases in efficiency, rather than reductions in quality.
9. This study standardised for age and sex, but did not take account of differences in morbidity (Talbot-Smith and others, 2004).
10. In Northern Ireland, there is little that is reported publicly over concerns over quality of care. The Inquiry into Hyponatraemia-Related Deaths after the deaths of five children in Northern Ireland hospitals between 1995 and 2003 is expected to report in 2014 (Inquiry into Hyponatraemia-Related Deaths, 2014).

3

Indicators and methods

The analyses presented in Chapters 4 and 5 compare a set of indicators relating to health, publicly financed inputs, activity and performance longitudinally across the four countries of the UK and England's North East region. In Chapter 4 this report aims mainly to update comparisons using the same data as Dixon and others (1999), Alvarez-Roseté and others (2005) and Connolly and others (2011). Like them, the authors of this report have faced the continuing problem of the extremely limited set of data that are reported for the four countries for which it is possible to make meaningful longitudinal comparisons. This study has tried to report full-time series for the selected indicators from 1996 up to the most recent available year, but often this was not possible. This chapter gives the bases of the indicators reported in Chapter 4, and of amenable and other mortality in Chapter 5. It also discusses the use of the North East region of England as a comparator for the devolved countries, and the distinction between statistical significance and materiality.

Indicators and data used in Chapter 4

The data for Chapter 4 have been obtained from a variety of sources, including routine and *ad hoc* publications from the Office for National Statistics, countries' statistical departments, national governments and health services and academic papers. Indicator definitions and sources are given in Appendix 1, which is published separately (Bevan and others, 2014b). We have been unable to report even the limited set of basic data that were reported by Connolly and others (2011) because of changes in data definitions across the four countries.

The comparisons in this report provide evidence of how differences in policy across the four countries since devolution have affected performance of their health systems. However, interpretation of this evidence is complicated by the fact that other factors shape the workings of those systems, regardless of the policy path pursued. The four countries differ in the following:

- size
- distribution of their populations between cities, towns and sparsely populated rural areas
- socioeconomic characteristics
- ethnic composition
- morbidity.

This study has tried to tackle this problem by including, where the data are available, statistics for the North East region of England which, as mentioned in Chapter 1, is a better comparator with the devolved countries than England as a whole (this is discussed below).

Most of the indicators selected were reported in the previous study by Connolly et al (2011). However, we have also tried to expand the range of data on quality of care beyond those on waiting times (for which it was not possible in the past to report comparative data for Scotland) that were reported in the earlier studies. In Chapter 4, we give comparisons using data from the UK Renal Registry and the stroke audit (except for Scotland); Methicillin-Resistant Staphylococcus Aureus (MRSA) mortality rates (where MRSA is mentioned on the death certificate); and rates of immunisation and vaccination. Sutherland and Coyle (2009) reported on rates of immunisation and vaccination and MRSA. They highlighted problems with MRSA in all countries. In 2013, as we discuss in Chapter 6, there were serious outbreaks of measles in England and Wales. The few national clinical audits that cover all four countries tend to be so highly specialised that patients often come from other countries. The UK Renal Registry is an exception. Although the stroke audit does not cover Scotland this merits inclusion given the importance of stroke care.

The indicators that are reported in Chapter 4 are as follows:

- life expectancy
- expenditure
- staffing levels (hospital doctors, GPs, nurses, non-clinical staff)
- activity (outpatient appointments, inpatient admissions and day-cases)
- crude productivity (inpatients per hospital doctor and nurse)[11]
- volumes of, and waiting times for, selected medical procedures
- waiting times and ambulance response times in relation to government targets
- satisfaction with health services
- quality of care (renal and stroke audits, MRSA mortality rates)
- immunisation and vaccination rates.

The indicators reported relate to publicly financed care only (patients treated by the independent sector, but paid for by the NHS, are included), and exclude privately financed activity. Appendix 1 of this report, published separately (Bevan and others, 2014b) highlights problems with data quality and comparability. The authors have devoted considerable effort to try to ensure that the indicators included in the analysis are defined and measured in the same way in each of the countries at each time point, and we are grateful to the data experts in each country for the assiduous way in which they have explained to us the many obstacles that stand in the way of achieving this objective (see Figures 4.1 to 4.37 and Table 4.1).

Table 3.1: Comparability of indicators across the four countries in the most recent years for which data are available

Indicator	England	Scotland	Wales	Northern Ireland
Life expectancy at birth	🟦	🟦	🟦	🟦
Public expenditure on health	🟦	🟦	🟦	🟦
Hospital doctors (WTE)	🟦	🟦	🟦	🟦
GPs (WTE headcount)	🟦	🟦	🟦	🟦
Nurses (WTE)	🟪	🟪	🟪	🟪
Non-clinical staff (WTE)	🟪	🟪	🟪	🟪
Outpatients	🟪	🟪	🟪	🟪
Inpatients	🟦	🟦	🟦	🟦
Day-cases	🟪	🟪	🟪	🟪
Selected procedures per 10,000 population*	🟦	🟦	🟦	🟦
Waiting time (RTT)	🟦	🟦	🟪	🟪
Waiting time (median and 90th percentile, selected procedures)	🟦	🟦	🟦	🟦
Ambulance response times	🟦	🟦	🟦	🟦
A comparison of patient choices available	🟦	🟦	🟦	🟦
Satisfaction with various aspects of the NHS	🟦	🟦	🟦	🟥
UK Renal Registry, survival	🟦	🟦	🟦	🟦
Stroke audit	🟦	🟪	🟦	🟦
Childhood immunisation 2011/12	🟦	🟦	🟦	🟦
Seasonal influenza vaccination uptake	🟦	🟦	🟦	🟦
Uptake of screening for breast cancer	🟦	🟦	🟦	🟦
Mortality rates for deaths with MRSA	🟦	🟪	🟦	🟦
Amenable mortality	🟦	🟦	🟦	🟦

🟦 Data comparable 🟪 Data available (but not comparable) 🟥 Data not available

Note: WTE = whole-time equivalent

RTT = Referral-to-treatment

*Comparable Northern Ireland data only available to 2009/10.

Table 3.1 shows for each indicator reported in Chapter 4 the extent of comparability of the most recent data across the four countries. Blue shading means that the data are broadly comparable; purple means that data are available, but pose serious problems in making comparisons; and red means that the data are not available. Over time, the comparability of data has changed with changes in definitions in the different countries.

The data in Chapter 4 are largely the most up to date available in autumn 2013, updated subsequently where new data became available that could be easily incorporated. Thus it was possible to, for example, include waiting times for selected procedures for 2012/13 and RTT times from March 2013. Inevitably, there is a longer lag in the availability of comparable data across the four countries than within each country.

Indicators and data used in Chapter 5

Chapter 5 gives comparative analyses of amenable mortality in the four countries and North East England. 'Amenable conditions' are defined in line with Nolte and McKee as "those from which it is reasonable to expect death to be averted even after the condition develops" (2004, p. 51). Age-standardised death rates are calculated by sex from selected single causes and cause groups, using the list of conditions applied in previous analyses.[12] The analysis was confined to deaths under 75 years, primarily because of the difficulty of reliably assigning a single cause of death to the often multiple conditions present among those dying at older ages (which includes almost 50 per cent of all mortality). In line with earlier work, ischaemic heart disease (IHD) is included in this report, but this cause is treated differently in that only 50 per cent of IHD deaths are considered as 'amenable'. This is based on a review of the evidence, which suggests that between 40 per cent and 50 per cent of the IHD decline in industrialised countries can be attributed to improvements in health care (Ford and others, 2007). Hotchkiss and others (2014) also reported that increases in medical treatments have accounted for almost half of the 40 per cent decline in mortality due to coronary heart disease in Scotland between 2000 and 2010. Throughout this report, the term 'amenable' mortality always includes 50 per cent of IHD deaths. Further, lower age limits have been applied for some causes, such as diabetes (<50 years). This analysis of amenable mortality builds on the work of Desai and others (2011).[13] The European standard population is used to calculate age-standardised mortality rates, and mortality rates for England and Wales are adjusted for known discontinuities related to the introduction of automated cause of death coding in 1993.[14] The change in age-standardised death rates in England as a whole, North East England, Wales, Northern Ireland and Scotland are reported in two time periods: 1990–2000 and 2000–10. The study also compares trends in amenable mortality and mortality from conditions other than those considered amenable to health care ('other' mortality).

Analysing aggregate changes among those under the age of 75 years provides important insight into understanding the potential impact of health care on population health. However, such aggregate figures are likely to conceal possible differential impacts by age group (Nolte and McKee, 2012). Therefore, this study analysed trends for men and women for three age ranges – under 75 years, under 65 years and 65–74 years – using relative (%) and absolute rates ('slope') of change in the two periods and in each of the countries, plus the North East. The absolute annual change ('slope') was estimated by fitting a linear regression function to each of the two time periods. The relative change was estimated as the average annual percentage change over the same time periods. For detailed results, see Bevan and others (2014c).

North East region of England as a comparator for the devolved countries

The third comparative study of the health care systems of the four UK countries (Connolly and others, 2011) argued that statistics for North East England are better benchmarks for comparison with the devolved countries than the statistics for England as a whole. The present report considers five criteria for benchmarking, as follows.

Scale

In terms of their populations (2010 estimates), England has 52.2 million people; Scotland, 5.2 million; Wales, 3 million; and Northern Ireland, 1.7 million (Office of Population Censuses and Surveys (OPCS), 2011). The North East region of England has a population of 2.6 million, which is much more comparable to the devolved countries.

Socioeconomic, demographic and morbidity characteristics

The Wanless Review of Health and Social Care in Wales chose the North East of England as its benchmark for comparisons with Wales because: "While there are some differences, the North East of England is very similar to Wales across a range of socio-economic indicators and expenditure on private healthcare" (Wanless, 2003, p. 31). The best choice of region in England as a benchmark with Wales was examined carefully by the First Report of the Independent Commission on Funding and Finance for Wales (Holtham, 2009, pp. 35–51). This also found Wales to be similar to the North East region of England in comparison with the average for England in terms of:

- low proportions of the population with a black and minority ethnic background
- low rates of economic activity – measured by gross value-added per head
- high percentages of adults with no qualifications
- percentages of the population with a limiting, long-term illness, and
- percentages of the working age population claiming social security benefits.

Wales differed from the North East region in that Wales has a higher dependency ratio (the ratio of the number of children and people above retirement age relative to the number of working age individuals), and higher rates of population sparsity (the percentage of people living in small settlements or isolated dwellings in sparsely populated areas). What is particularly striking in this analysis is that the Commission applied the formula used to determine target allocations of resources between NHS areas in England to the then English strategic health authorities and Wales. This formula aims to take account of geographical variations in the age distribution, additional needs and costs of delivering services to populations. The Commission found that the formula gave an estimate for the relative need for Wales that was "very close to the relative need in the North East of England" (2009, p. 48).

The Department of Health, Social Services and Public Safety of Northern Ireland (nd) also sought to identify the most appropriate English region as a benchmark for Northern Ireland. This analysis used data from around the 2000s, and so is now out of date. It suggested across a range of indicators that the region most similar to Northern Ireland was Yorkshire and the Humber. However, that analysis also found that the North East region was similar to Northern Ireland in terms of key measures of need for health care:

- dependency ratios
- standardised mortality ratios
- percentages of households with lone parents and dependent children
- older people living alone.

Bias

This regards avoiding the bias from London's high costs of labour and concentrations of staff involved in research, teaching and training. The 2011 Annual Survey of Hours and Earnings (OPCS, 2011, p. 21) showed again that there is little variation in earnings within the UK, except for London and the South East:

> In April 2011 median gross weekly earnings for full-time employees were highest in London at £651 (30 per cent higher than the national median) and lowest in Northern Ireland at £451 (10 per cent lower than the national median). (2011a, p. 20)

The weekly rates were £518 and £486 in the North East and Wales, respectively.

Data for numbers of medical clinical academics in 2009/10 show that there were nearly 1,000 in London, nearly 400 in Scotland, about 100 in the North East and Wales and about 50 in Northern Ireland (London Medicine, nd). These give rates per 100,000 of more than 11 in London, more than seven in Scotland, about four in the North East and about three in Wales and Northern Ireland.

Policy differences

This relates to accounting for differences in policies between the four countries that affect the comparability of statistics on staffing in relation to activity. England has had a different policy from the rest of the UK, which has encouraged NHS commissioners to contract with private providers. Arora and others (2013) have estimated the scale of these changes over time. They show that NHS spending on non-NHS providers increased from £5.6 billion in 2006/07 to £8.7 billion in 2011/12 (at 2011/12 prices). As these commissioners spent £91 billion in total on their populations, the non-NHS element accounted for about 10 per cent. However, this varied substantially within the regions of England and was lowest in the North East, where it was only 3.2 per cent in 2011/12. Hence, the use of non-NHS services is relatively unimportant in comparisons of the North East with the devolved countries.

Comparisons over time

This relates to being able to make comparisons over time, given the successive 're-disorganisations' of the English NHS. The North East region has been organisationally much the same over the period for which this study reports data.[15]

What this discussion shows is that comparisons between the three devolved countries and England as a whole are problematic, and that regions outside London and the South East generally offer better comparators than England as a whole. Detailed comparisons show that no English region is similar on all relevant criteria to Wales and Northern Ireland, also that the three devolved countries differ. Nevertheless, the North East region looks to be a good choice of comparator as it is similar in scale, morbidity and socioeconomic characteristics to the devolved countries. Scotland differs from the North East region, Wales and Northern Ireland in its concentrations of clinical academic staff, and in having slightly higher mean weekly incomes.

Statistical significance and materiality

In this report we give estimates of mean values of various indicators, which typically differ across the four countries and the North East region (data in the figures have been rounded so occasionally the bars in charts may appear slightly different from those reported in the text). The question then arises as to whether these differences in mean values are statistically significant: that is to say, are they within the range of what we would expect from sampling errors? In Chapter 4, the data are presented in a form that is available in the public domain, without undertaking further testing for statistical significance for changes in trends or in differences between the four countries and North East England. For a few indicators we have given 95 per cent confidence interval estimates around the mean values: if these intervals overlap then the differences in means are not statistically significant (at the five per cent level) and vice versa. In Chapter 5 we report trends in amenable and other mortality. We have undertaken further statistical analyses, which found that the declines in amenable mortality were statistically significant, but we did not formally test whether trends in countries differed because the relative changes between countries were so similar.

Another question is whether the differences reported are material – whether they are large enough to be of practical significance. Paradoxically, a material difference may not be statistically significant, and a statistically significant difference may not be material. As Lee and Tabak (2010) point out:

> Statistical significance sheds light on how unusual certain results or data are and specifically how unlikely it would be to see such results if there were no true causal effect or relationship present. Statistical significance, however, does not go to the magnitude of an effect, a concept referred to by terms such as practical, economic or clinical significance.

The question of materiality is a matter of judgement and we have aimed to present findings to inform such judgements.

Notes

11. This is a crude measure of productivity, as it captures neither costs in terms of use of resources, nor benefits in terms of gains in health.
12. Examples of cause groups are IHD, hypertension and stroke, colorectal and breast cancer, and diabetes.
13. We obtained data on deaths for each of the four countries with cause of death classified according to the ninth and 10th revisions of the International Classification of Diseases (ICD), by five-year age band and sex for 1990–2010 from the Office for National Statistics for England, England's regions and Wales, the General Register Office for Scotland and the Northern Ireland Statistics and Research Agency. Population data were obtained from the Office for National Statistics. Raw mortality and population data were collated into a single database in comparable format.
14. The introduction of automated cause of death coding resulted, among other things, in an overestimation of deaths assigned to pneumonia, and an underestimation of those assigned to cerebrovascular disease between 1993 and 1999. We used comparability ratios proposed by the Office for National Statistics for adjustment (see Brock and others, 2006; Griffiths and others, 2004).
15. We are grateful to Andy McKeon for pointing this out.

4

Cross-country comparisons

The aim of this report is to compare health and the resources for, and the outputs and performance of, each publicly financed health system in England, Scotland, Wales and Northern Ireland before and after devolution. As explained in Chapter 3, in order to inform comparisons with the devolved countries, we have tried to obtain data on the North East region of England. In common with all those who have tried to do this, we have found not only that limited data are available that could be used to make comparisons, but also that such comparisons can be problematic. This is because there are different definitions of what is and is not included in the data from each country, as well as differences in how performance is measured, in particular for hospital waiting times. The principal findings are reported in order of ease of comparison, and hence begin with data on life expectancy, where there are no doubts concerning comparability. As explained in Chapter 3, we present data in this chapter in a form that is available in the public domain, without undertaking further testing for statistical significance in changes in trends or in differences between the four countries and North East England. We have, however, given 95 per cent confidence intervals for some indicators. We have aimed to present data to inform judgements on the materiality of the differences shown.

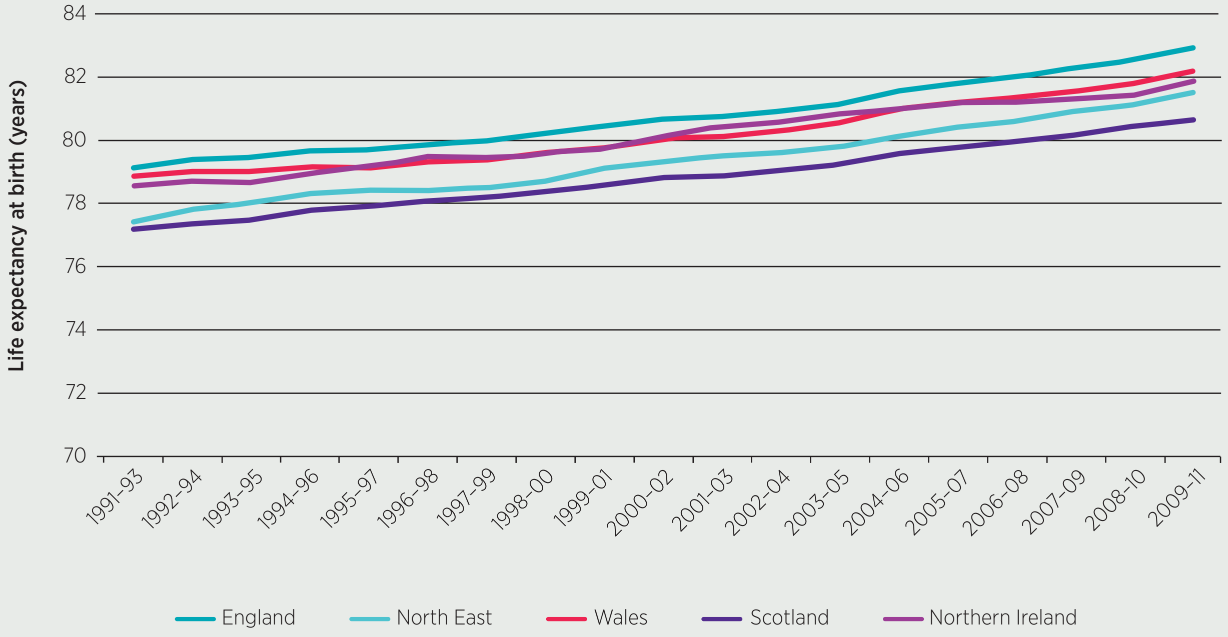
Performance comparisons where data allow good comparisons across all four countries

Life expectancy

In this report, life expectancy is used to provide a simple indicator of the relative health of the populations in the four countries of the UK, not as a measure of health system performance. Figures 4.1 and 4.2 (page 44) show that in the 21-year period between 1991–93 and 2009–11, life expectancy at birth increased by about five years for men, and three to four years for women in each country. The differences between the averages for each country were remarkably stable over time, with the ranking for men and women being consistently longest in England, and shortest in Wales, Northern Ireland and Scotland. Men and women in England would have been expected to live about two years longer than men and women in Scotland in the 1990s and 2000s, with the gap widening towards the end of the period. The interesting movement in relative rankings is shown in North East England, which in 1991–93 had similar life expectancy to Scotland, but, by 2009–11, both men and women in North East England would have expected to live about one year longer than in Scotland. Life expectancy (in years) in 2009–11 for women and men was 82.9 and 78.9 respectively in England, 82.2 and 78 in Wales, 81.8 and 77.4 in Northern Ireland, 81.5 and 77.5 in North East England and 80.6 and 76.1 in Scotland.

Figure 4.1: Male life expectancy in the UK countries and North East England, 1991–93 to 2009–11

Figure 4.2: Female life expectancy in the UK countries and North East England, 1991–93 to 2009–11



Health spending per head

The source of data on expenditure on public services is the Public Expenditure Statistical Analyses series produced by HM Treasury. These data are comparable across the different countries, but are unsatisfactory for this report's purposes for three reasons. First, the data available on health spending are for total expenditure only: it is possible to compare neither the components of expenditure across countries in terms of primary care versus hospital and community health services, nor by programmes of care, such as non-psychiatric acute and mental health services, nor still by types of staff. The totals include activities such as medical research so health services account for around 93 per cent of the total in England.

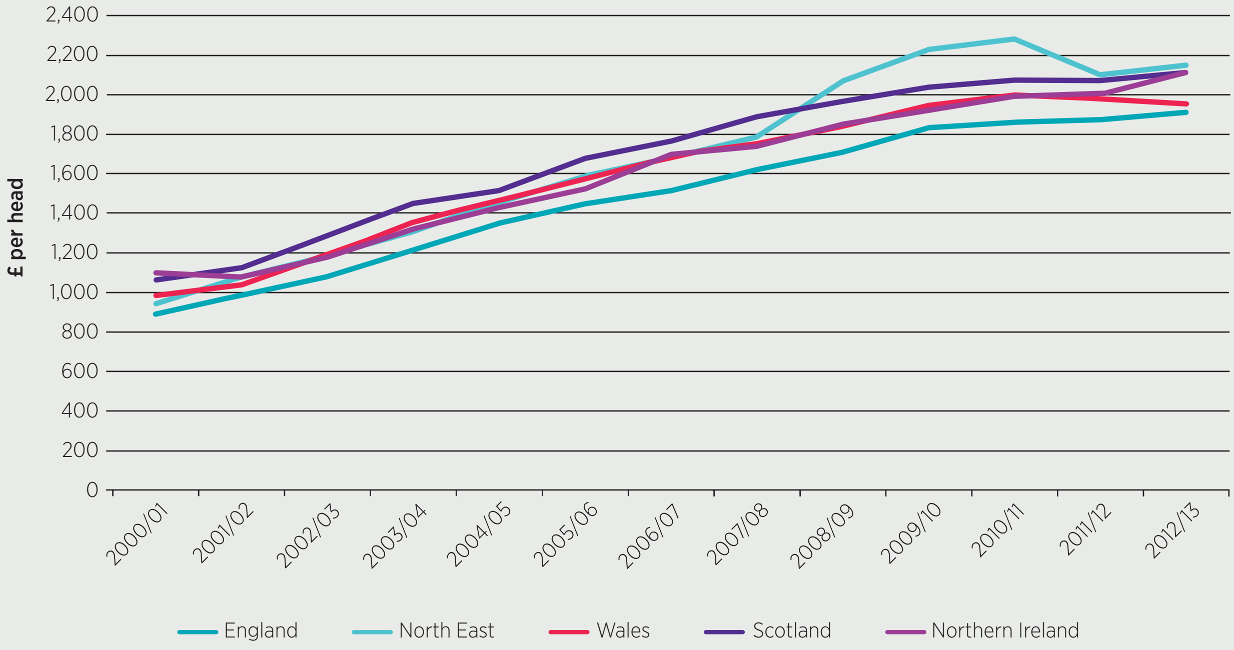
Second, HM Treasury reports total *identifiable* expenditure by country, which is different from the allocations made with reference to the Barnett Formula to the governments of the devolved countries. For example, the Independent Commission on Funding and Finance for Wales (Holtham, 2009) pointed out that in 2006/07, the block grant allocation made to Wales with reference to the Barnett Formula was £12.8 billion, but that this accounted for only 53 per cent of identifiable expenditure in Wales. The remaining 47 per cent of public spending was mainly from social security benefits and tax credits (managed by the Department for Work and Pensions and HM Revenue & Customs on a UK basis) (Holtham, 2009, pp. 14–19).

Third, there are potential problems in making comparisons over time because of frequent classification and transfer changes made by the Treasury between successive publications in the Public Expenditure Statistical Analyses series. These problems were investigated by the Holtham Commission in deriving its estimates of relative expenditure per head in Wales on programmes covered by the Barnett Formula from 1994/95 to 2010/11 (Holtham, 2009). The Commission was able to construct a robust single time series (from the Departmental Expenditure Limits for Wales of its block grants), which suggests that the classificatory changes over time have not been material, and that published data from different sets can be used to make meaningful comparisons over time. However, it remains problematic to derive comparable data on spending on public services by the devolved governments and England because HM Treasury publishes Departmental Expenditure Limits for the devolved countries only (and there is no comparable series for England). Hence, this report only gives data on total expenditure on health in each country and for North East England, and does not give estimates of the block grants to the devolved countries and their counterpart for England.

Figure 4.3 gives health expenditure per head in cash terms over the 13 years from 2000/01 to 2012/13 for the devolved countries and North East England. What is most striking about the Figure is the curious sharp increase in spending per head in North East England from 2007/08 to 2009/10, which diverges from the trend for North East England in the previous period from 2000/01, and from the four countries after 2007/08. There is then a sharp reduction in spending per head in North East England between 2010/11 and 2011/12. This odd pattern for the region appears in the latest data from HM Treasury, published in December 2013 (HM Treasury, 2013a). The previous publication of these data in July 2013 (HM Treasury, 2013b) showed no sharp rise and fall between 2007/08 and 2011/12 (see Bevan et al, 2014b, for further details on these sources). This latest revision of the data increased the Treasury's estimates of spend per head for North East England by five per cent in 2008/09, and eight per cent for 2009/10 and 2010/11. It is difficult to understand why such large changes were made in 2013 to data going back to 2007/08 and the odd pattern that results from these changes. There were also downward revisions in the estimates of spend per head for Northern Ireland of five per cent for 2010/11 and 2011/12. Such revisions weaken confidence in these data.

The estimates shown in Figure 4.3 of health expenditure per head show that this doubled in cash terms (that is, at current prices and not adjusted for inflation), and what follows is similarly based on changes in cash terms in 13 years. In 2000/01, the spending per head in each country was as follows: Northern Ireland, £1,099; Scotland, £1,064; Wales, £985; and England £891. In 2012/13, this was as follows: Scotland, £2,115; Northern Ireland, £2,109; Wales, £1,954; and England, £1,912. The total percentage increases over those 13 years were: England, 115 per cent; Scotland, 99 per cent; Wales, 98 per cent; and Northern Ireland, 92 per cent. The relative excess of spending in Northern Ireland over England reduced from 23 per cent in 2000/01 to 10 per cent in 2011/12.[16] Figure 4.3 shows the beginning of the period of public sector financial austerity. Over the 11 years from 2000/01 to 2010/11, the annual rates of growth were: England, ten per cent; Scotland and Wales, nine per cent; and Northern Ireland, seven per cent. Over the three years from 2010/11 to 2012/13, the annual rates of change were: growth in Northern Ireland of two per cent; growth in England and Scotland of one per cent; and a reduction in Wales of one per cent.[17]

Figure 4.3: Government expenditure on health, £ per head, UK countries and North East England, 2000/01 to 2012/13 (at current prices)



The estimates in Figure 4.3 also show how the formula used to allocate resources within England has directed more resources towards areas that were more materially deprived in 2012/13 than in 2000/01. Over the 13-year period, the total percentage increase in per-head spending was 128 per cent in North East

England, compared with 115 per cent for England as a whole, so the relative excess spending per head in North East England over the average for England increased from about six per cent in 2000/01 to about 12 per cent in 2012/13. This also meant that the relative spending per head in North East England as compared with the devolved countries changed over that period: in 2000/01, North East England had lower spending per head (£895) than the devolved countries, but by 2012/13 its spending per head (£2,150) was greater than the devolved countries.

Supply of general practitioners

We would like to be able to compare how spending on each NHS translates into staff. Data are presented for hospital doctors, nurses and support staff below, but there are considerable difficulties in interpreting these statistics across countries and over time. The only group of staff for whom this study has good comparable data are general medical practitioners (GPs). As many GPs work part time, comparisons ought to be based on WTEs (whole-time equivalents), but these data are consistently available only for England and Wales; for Scotland there are cross-sectional primary care workforce surveys for 2009 and 2013; and Northern Ireland stopped reporting WTE data for GPs in 2003. This report presents available data on both WTE and headcounts.

The data for GPs include GP providers (practitioners who have entered into a contract to provide services to patients – formally known as Contracted and Salaried GPs), and other GPs who work within partnerships (and were formerly known as 'GMS Other').[18] Figure 4.4 (page 48) gives the WTE rate of GPs per 1,000 population from 1996–2011, except for Scotland, where these data are only available for 2009–11 (estimated from the 2009 and 2013 primary care workforce surveys). Figure 4.4 shows that England, Wales and Northern Ireland had similar rates of about 0.6 per 1,000 population until the early 2000s, but between 2002 and 2009, there was an increase in England to almost 0.7 followed by a slight fall. In 2011, there were about 0.7 WTE GPs per 1,000 population in Scotland and England, and 0.6 in Wales; and North East England had the highest rate. The study has complete data for the headcount rate of GPs per 1,000 population from 1996–2011, which are given in Figure 4.5 (page 48). This shows Scotland to have had the highest rates throughout, reaching 0.95 in 2010. In 2011, the rates were 0.8 in North East England, 0.75 in England, 0.66 in Wales and 0.64 in Northern Ireland. Comparing Figures 4.4 and 4.5 shows that North East England (0.74) had a higher rate than Scotland (0.71) in WTEs, but Scotland (0.95) had a far higher rate than North East England (0.8) in headcount. Hence, data on headcount give misleading impressions of the supply of GPs as the ratio of headcount to WTEs varies between the countries.

Figure 4.4: General practitioners (whole-time equivalent) per 1,000 population, 1996–2011

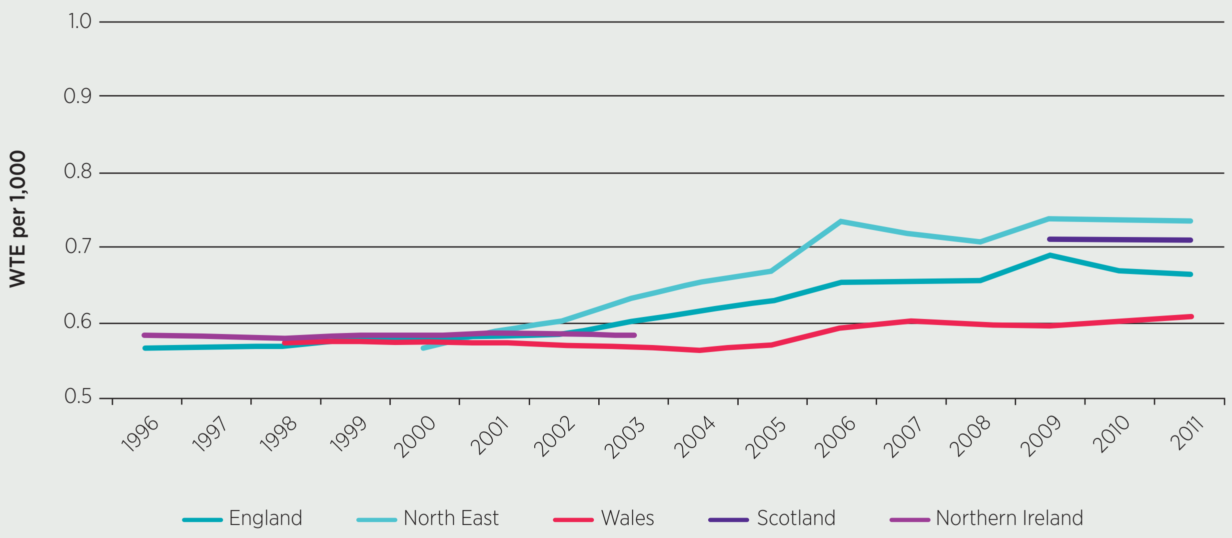
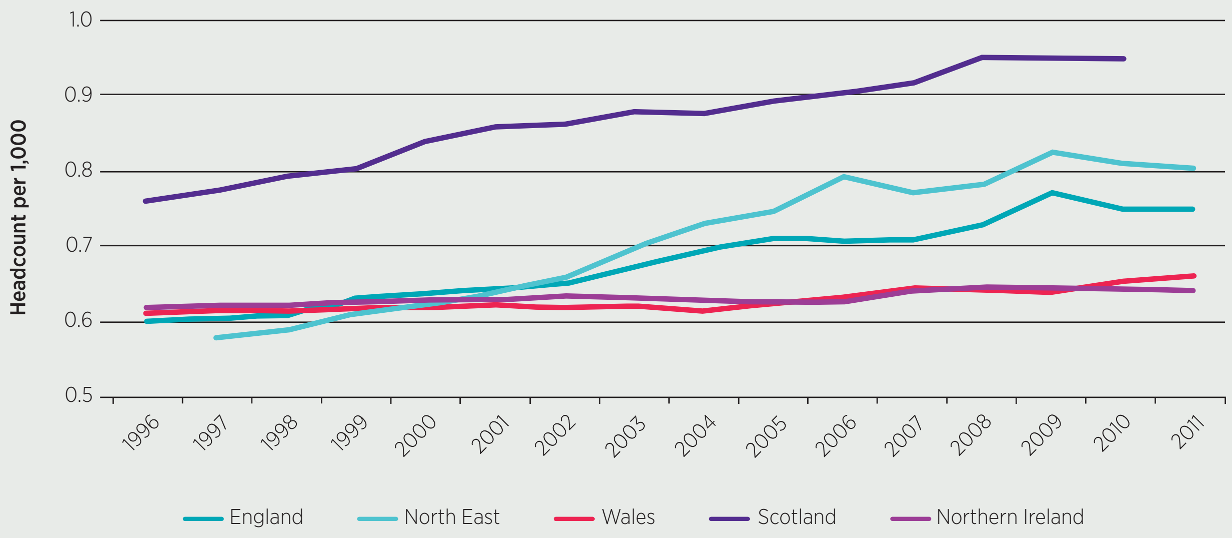


Figure 4.5: General practitioners (headcount) per 1,000 population, 1996–2011



Rates of treatment and waiting times for selected procedures

The three earlier studies (Dixon and others, 1999; Alvarez-Roseté and others, 2005; Connolly and others, 2011) compared how the inputs of spending and staff in the different countries translated into rates of treatment for outpatients, inpatients and day-cases. They also compared waiting times for the first outpatient appointment and elective admission (except for Scotland). Unfortunately, as explained below, it is now problematic to do so. However, this report does have broadly comparable data on rates of hospital treatment from 2007/08 to 2011/12 for the seven common procedures that were used to make cross-country comparisons in the earlier studies,[19] and for waiting times for six out of these seven procedures.[20]

Rates of treatment

Figures 4.6 to 4.12 give rates of hospital treatment (inpatients and day-cases) by procedure, by country. There were increases in the rates for gall bladder excision and hip and knee replacement; decreases for coronary artery bypass grafts (CABG), varicose vein removal (except for an increase in Northern Ireland in 2011/12) and inguinal hernia repair; and diverging trends in cataract removal, as there was an increase in England and Scotland, but a decrease in Wales and Northern Ireland. In 2011/12 the highest rates for cataract removal, excision of gall bladder and hip replacement were in Scotland; for CABG and hernia repair, in England; for varicose vein removal, in Northern Ireland; and for knee replacement in Wales.

Figure 4.6: Cataract, number of procedures (OPCS) per 10,000 population

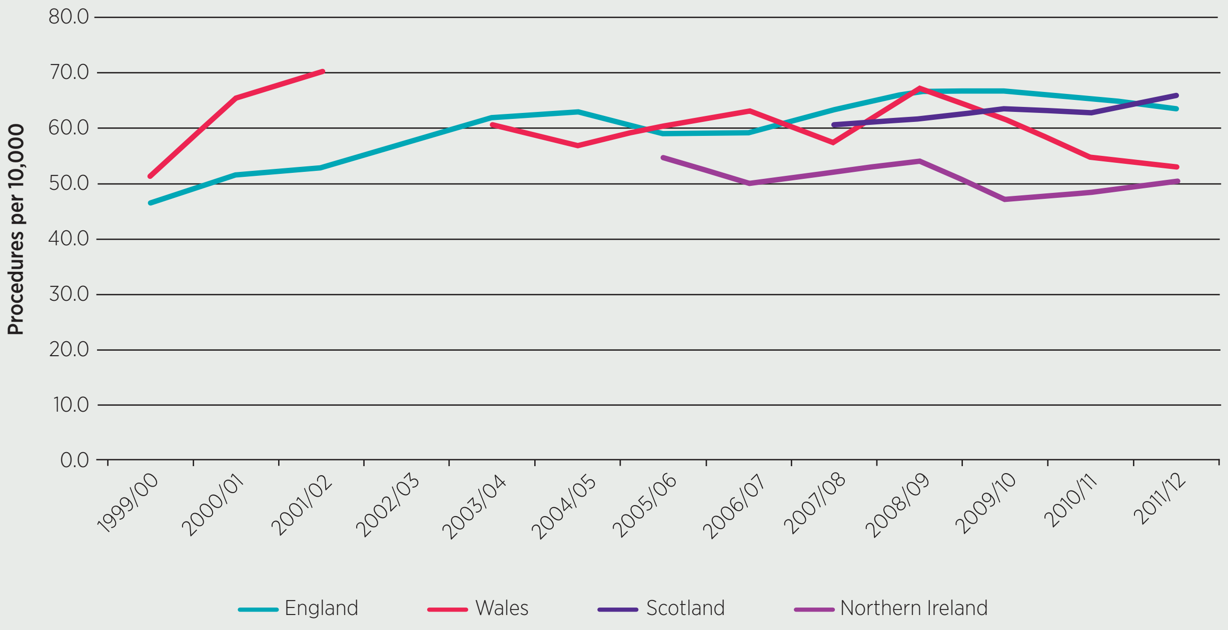


Figure 4.7: Coronary artery bypass grafts, number of procedures (OPCS) per 10,000 population

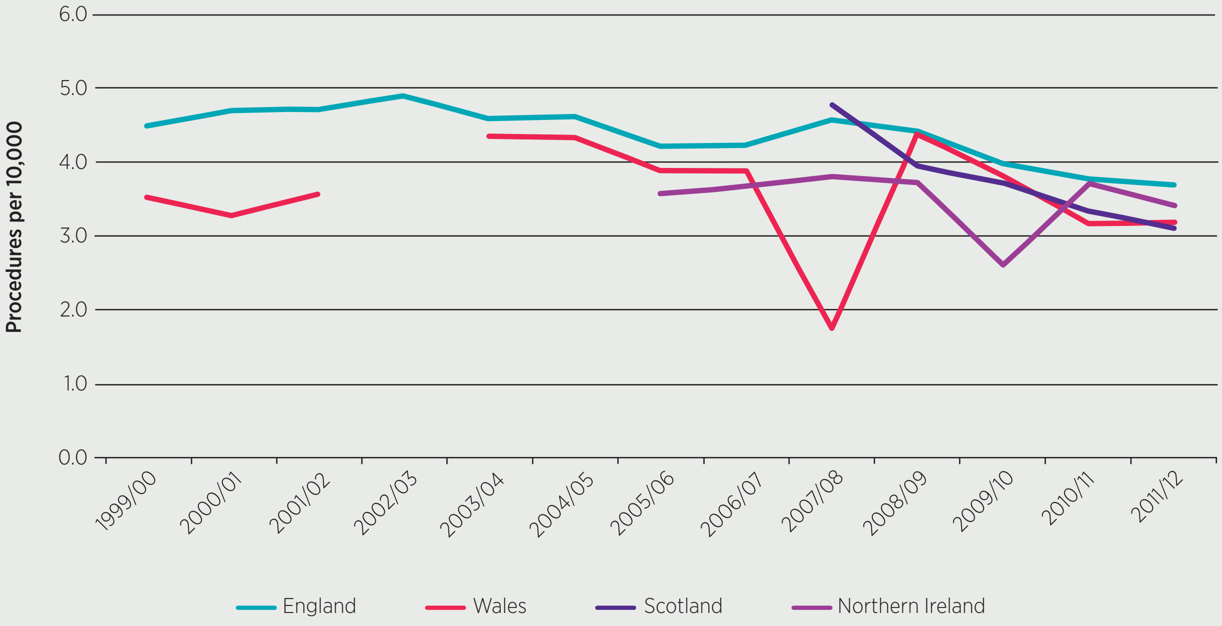


Figure 4.8: Hernia, number of procedures (OPCS) per 10,000 population

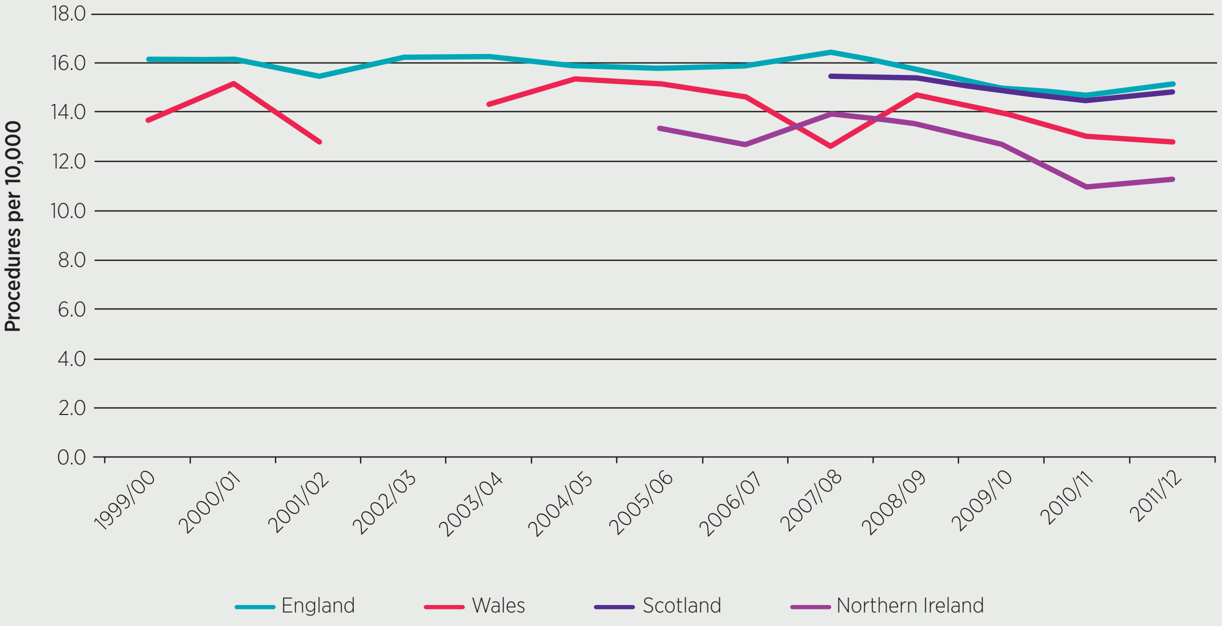


Figure 4.9: Hip replacement, number of procedures (OPCS) per 10,000 population

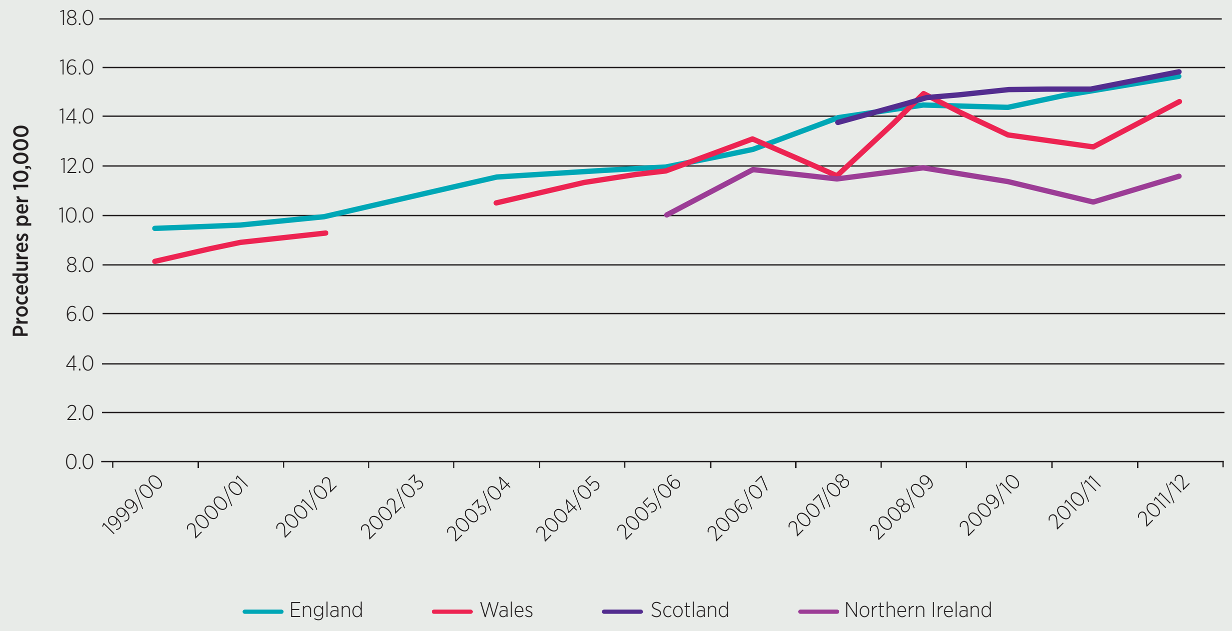


Figure 4.10: Knee replacement, number of procedures (OPCS) per 10,000 population

Figure 4.11: Varicose veins, number of procedures (OPCS) per 10,000 population

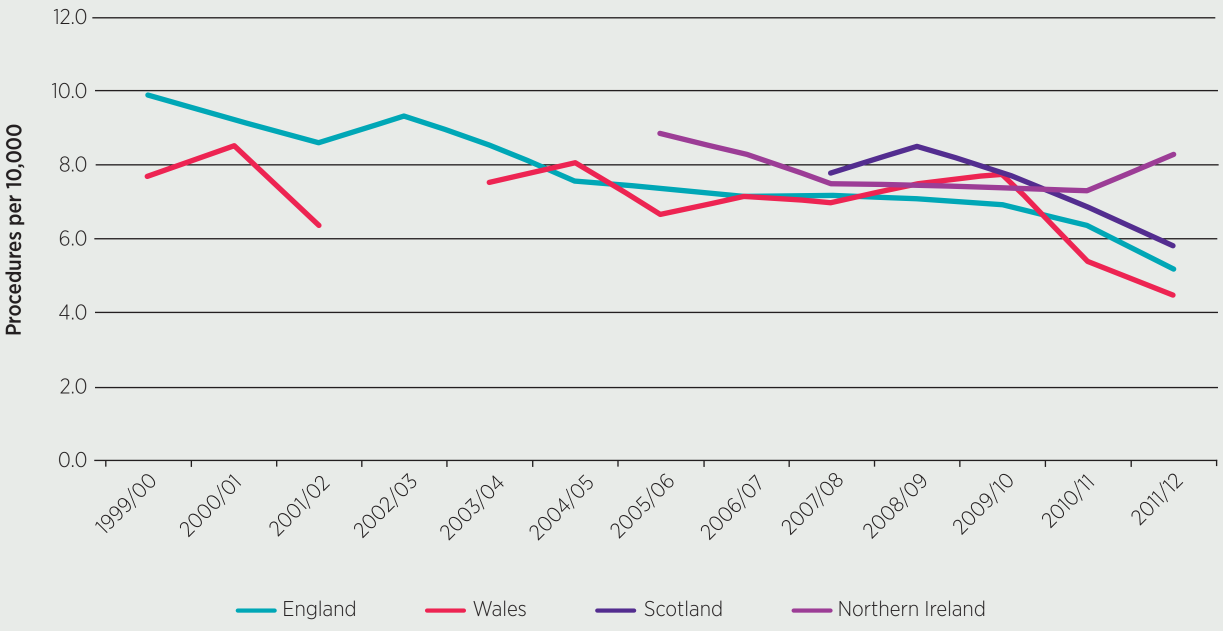
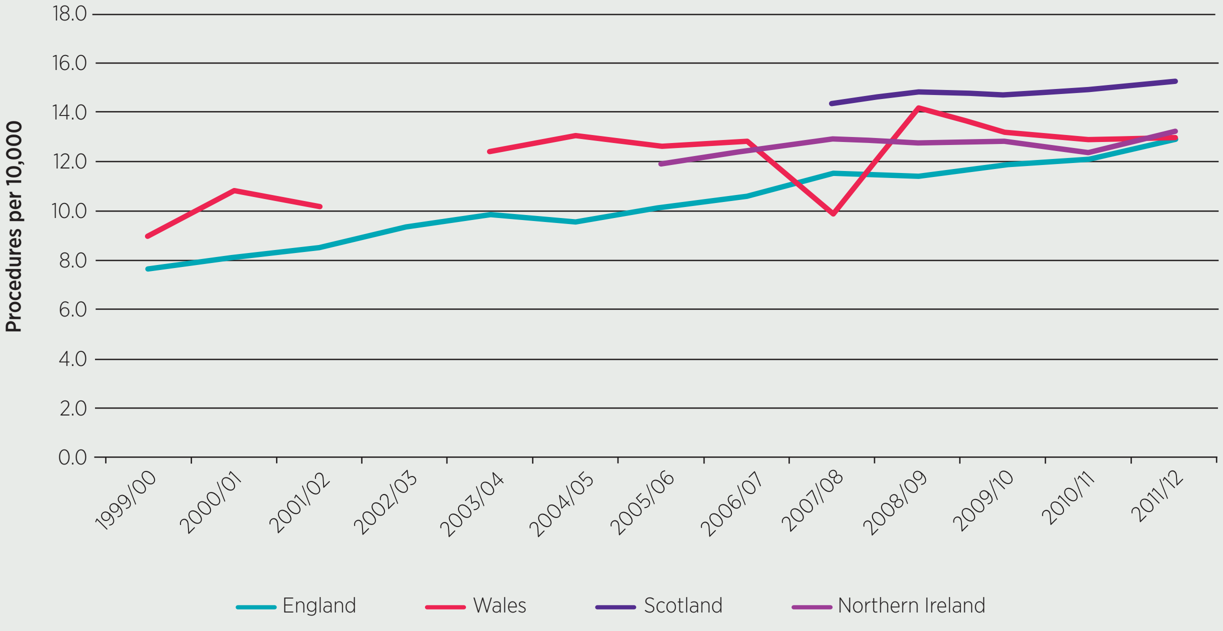
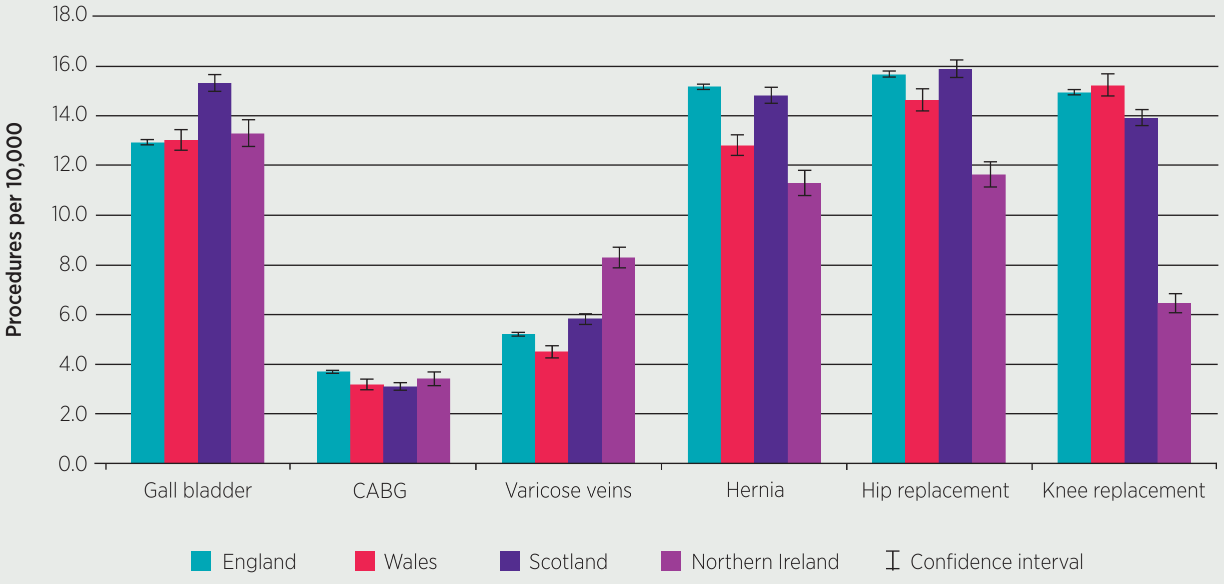


Figure 4.12: Excision of gall bladder, number of procedures (OPCS) per 10,000 population



In order to indicate whether there were statistically significant differences between the countries, Figure 4.13 gives, for 2011/12, 95 per cent confidence intervals for all procedures (meaning that one can be 95 per cent confident that the true value lies within the upper and lower bounds shown). The exception is cataract procedures, where all differences are significant due to the high volume performed (see Figure 4.6). Using England as a benchmark, Wales had significantly lower rates of varicose veins, hernia and hip replacement; Scotland had significantly higher rates of excision of gall bladder and varicose veins, and lower rates of CABG and knee replacement; and Northern Ireland had a significantly higher rate of varicose veins, and lower rates of hernia and hip and knee replacement. The rates of hernia and hip and knee replacement in Northern Ireland were also significantly lower than those in Wales and Scotland.

Figure 4.13: Differences in selected procedures (number of procedures per 10,000 population, with 95% confidence intervals), 2011/12, in UK countries



Waiting times for common procedures

Since 2005/06, the UK Comparative Waiting Times Group has developed comparable data for a list of 11 inpatient procedures on the length of time that a patient has waited for treatment (Office for National Statistics, 2010), and these include six of the seven procedures for which this study has reported rates of treatment above.[21] These data record waiting times from the initial decision to admit, to the date of admission for the procedure.[22] Figures 4.14 to 4.19 give the median and 90th percentile of the distributions of waiting times in days from 2005/06 to 2012/13, except for Northern Ireland, where data are only available until 2009/10. These figures show that substantial reductions in median waiting times have been achieved in most procedures across all four countries to 2009/10, including halving the median wait for hip and knee replacement in England and Scotland. The 90th percentile decreased over the period from 2005/06 to 2012/13 for most of the procedures in England and Scotland, except for CABG surgery in England. In Wales and Northern Ireland, there were dramatic reductions in the 90th percentile from 2005/06 to 2009/10 for all procedures, except in Wales for cataract surgery (which increased). However, in Wales since 2009/10, there have been increases in the 90th percentile for all procedures.

Figure 4.14: Median and 90th percentile of completed waiting time for cataract surgery

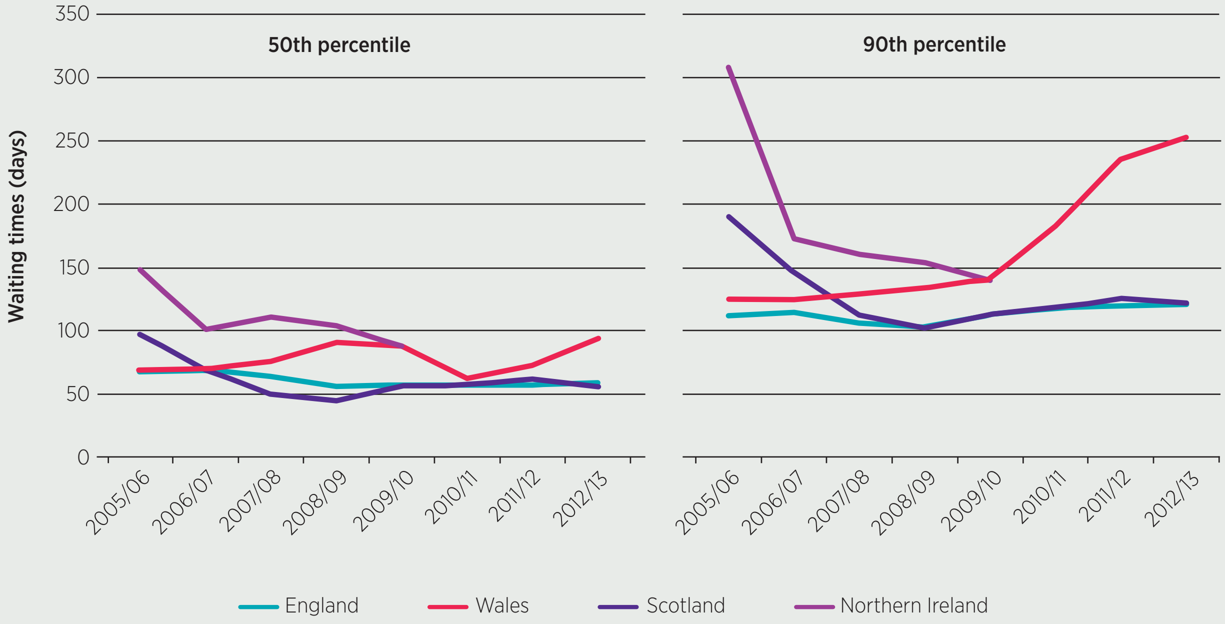


Figure 4.15: Median and 90th percentile of completed waiting time for coronary artery bypass grafts surgery

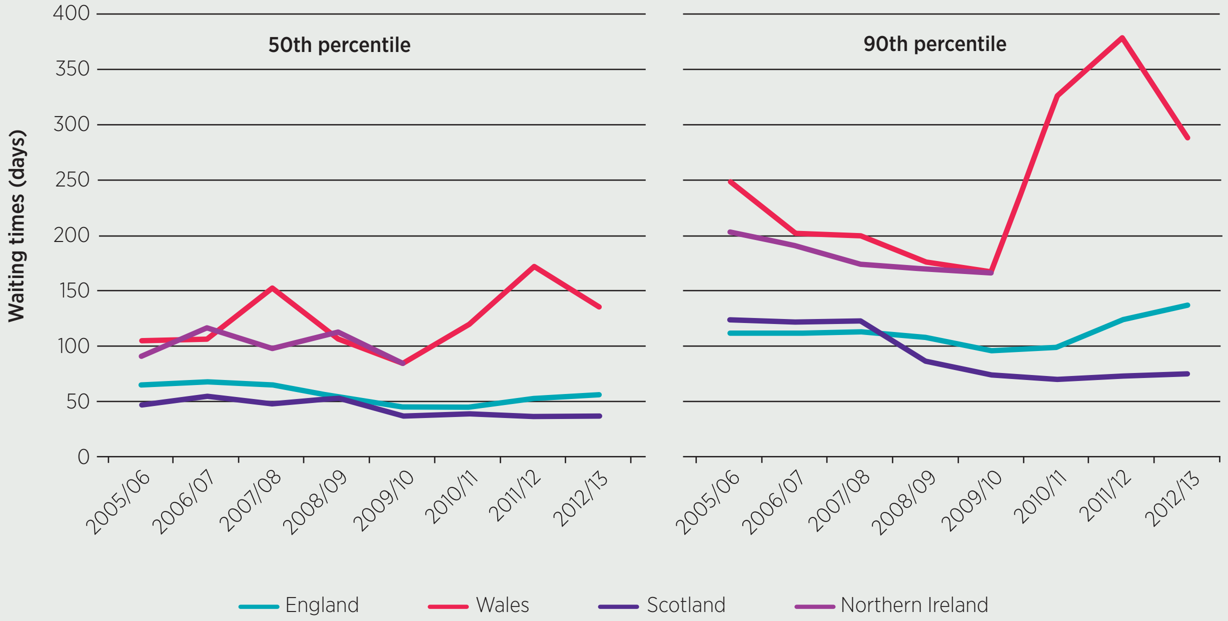


Figure 4.16: Median and 90th percentile of completed waiting time for varicose veins

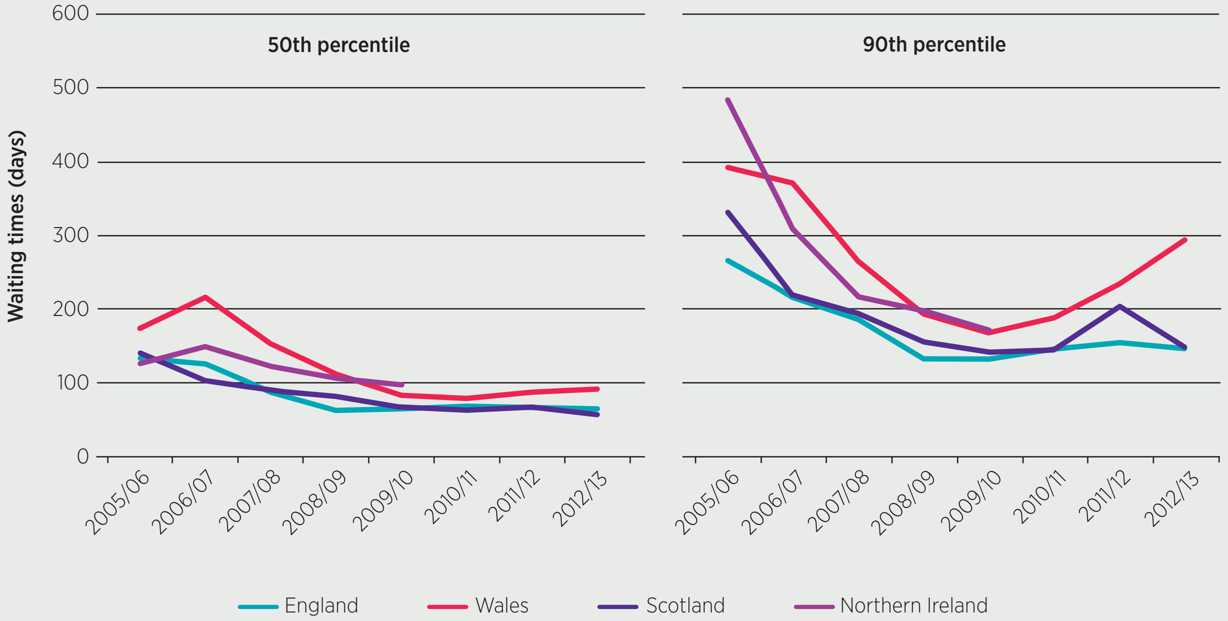


Figure 4.17: Median and 90th percentile of completed waiting time for inguinal hernia procedure

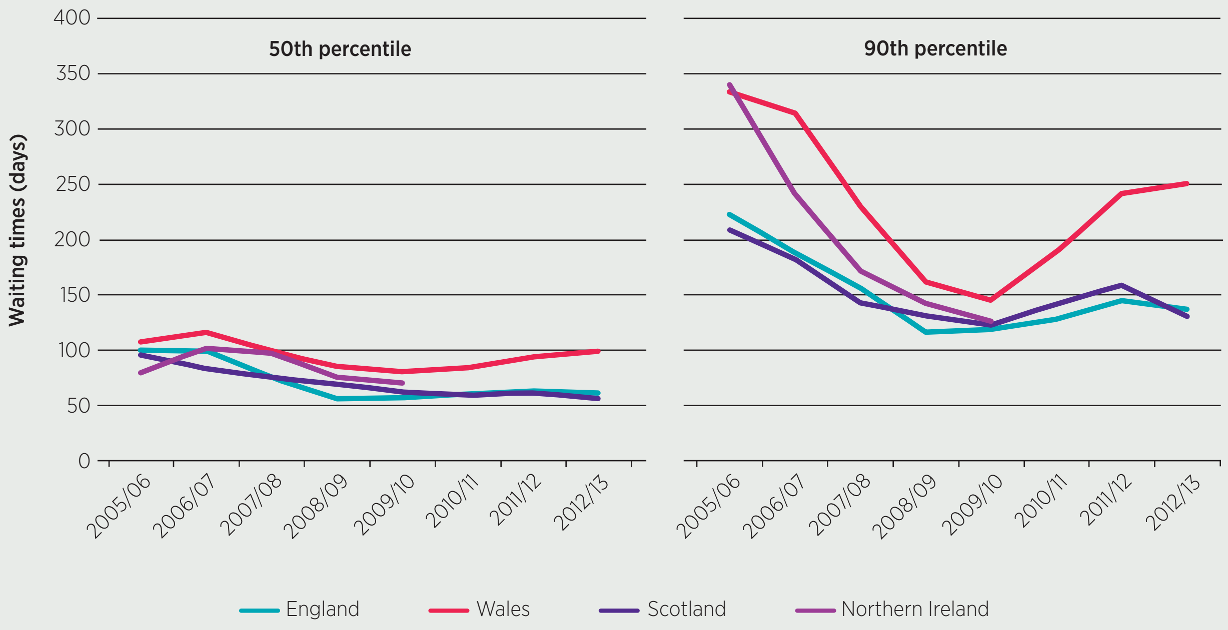


Figure 4.18: Median and 90th percentile of completed waiting time for hip replacement

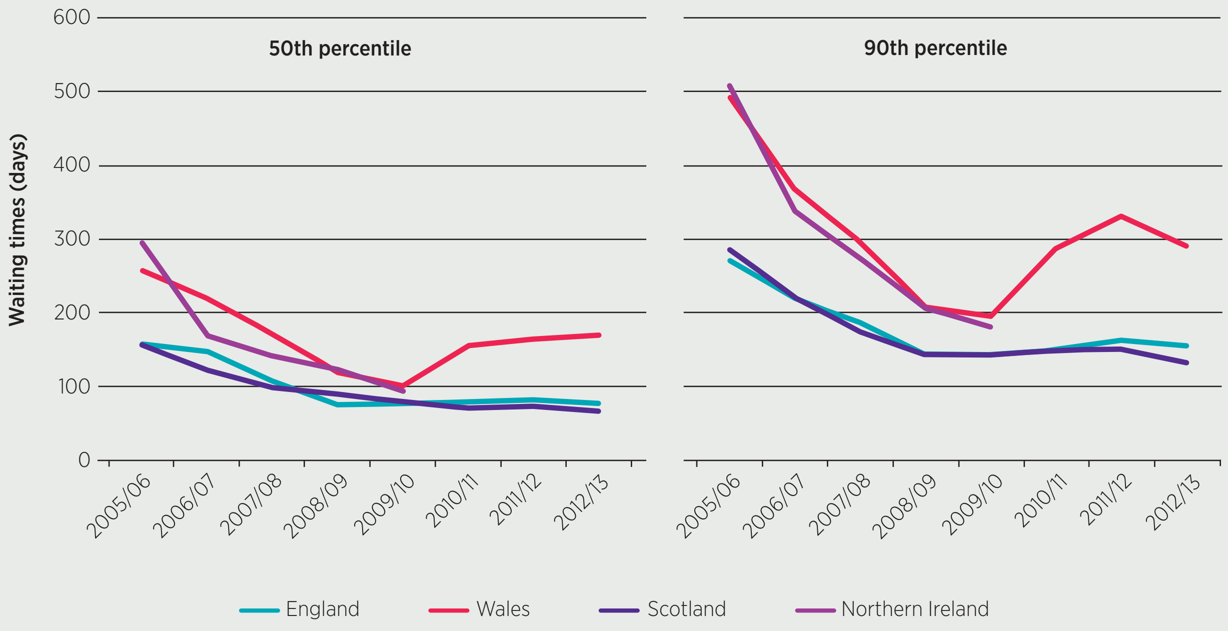
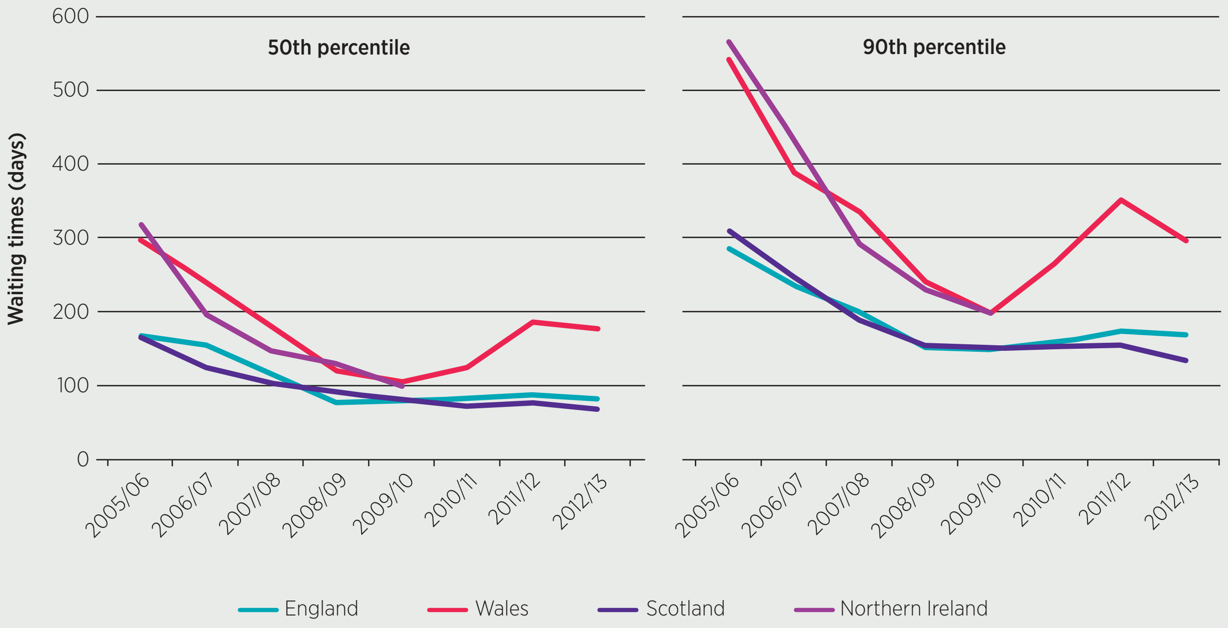


Figure 4.19: Median and 90th percentile of completed waiting time for knee replacement

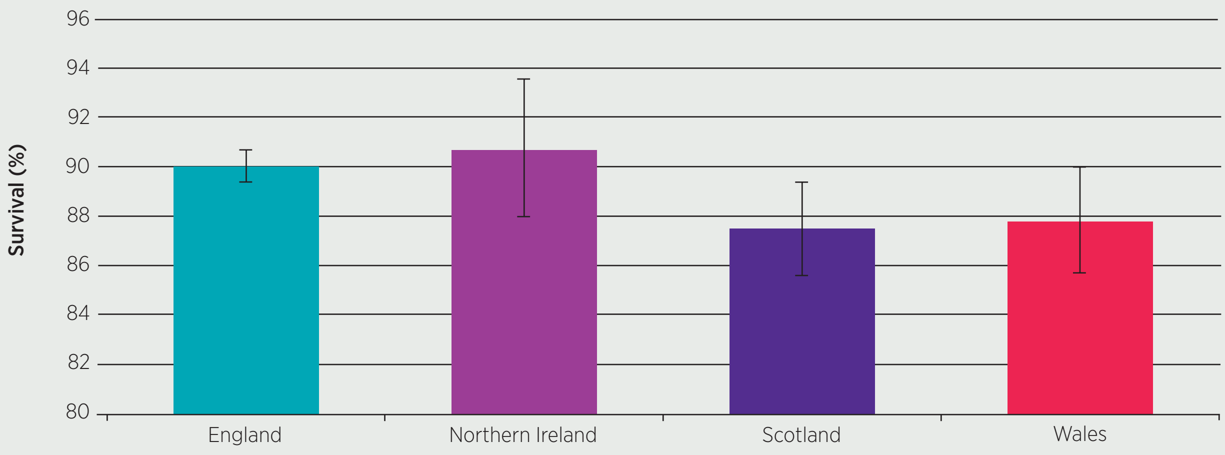


Survival after renal replacement therapy

In comparing the four countries, we would like to be able to compare dimensions of quality of care in addition to waiting times. The large number of national clinical audits is potentially a good source of these data, but few cover all four countries. Most of those that do are highly specialised (for example, paediatric intensive care, coronary angioplasty or cardiac surgery), with relatively small numbers of patients who often receive treatment outside their country of residence. This report gives results from the UK Renal Registry where patients are more likely to be treated closer to home. Figure 4.20 gives one-year percentage rates of survival for patients on renal replacement therapy, 90 days after the incident, by country, from 2002–2010 (the incident cohort years), adjusted to age 60. This shows that these rates have improved in all countries. Figure 4.21 gives mean survival rates and 95 per cent confidence intervals for 2009–2010. This shows that although the mean rates ranged between 87.5 per cent (Scotland) and 90.7 per cent (Northern Ireland), these differences were not statistically significant.

Figure 4.20: One year after 90-day incident survival (%) after renal replacement therapy, by country for incident cohort years 2002–10, adjusted to age 60

Figure 4.21: One year after 90-day incident survival (%) after renal replacement therapy, by country, combined two-year cohort (2009/10), adjusted to age 60, with 95% confidence intervals



Screening, vaccination and immunisation

The data for screening, vaccination and immunisation are comparable across the four countries as far as can be ascertained, and thus are included, though it was not possible to produce a time series.

Screening for breast cancer

Figure 4.22 gives rates for the uptake of screening for breast cancer between the ages of 50 and 70 years for 2010/11. This report has data for England, Scotland, Wales, Northern Ireland and North East England, and shows that the rate ranged from 69 per cent in England to 74 per cent in North East England.

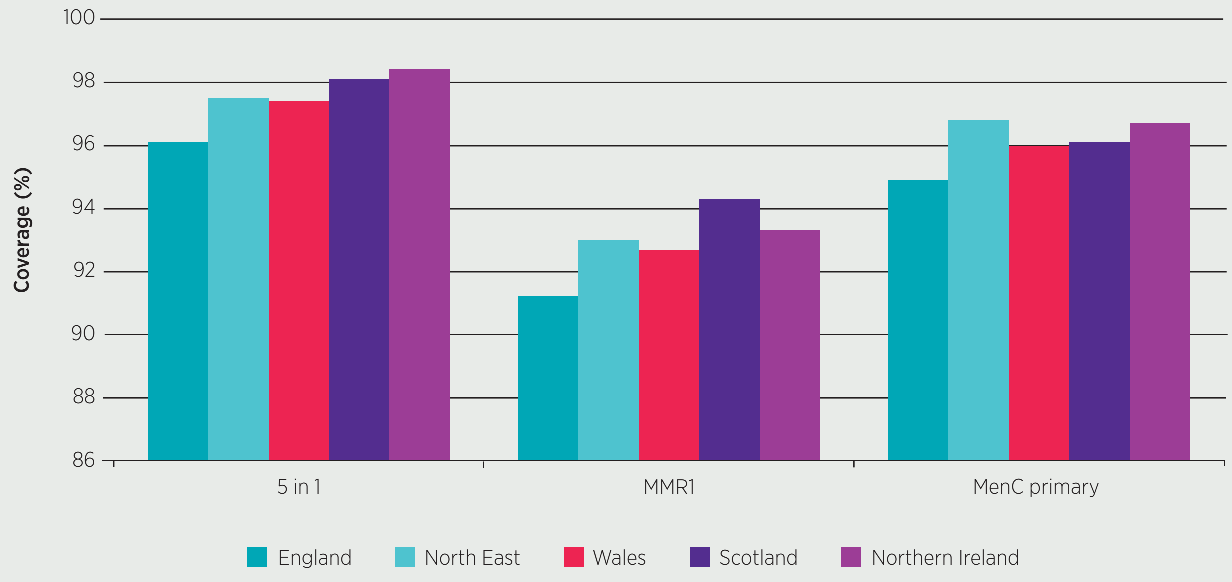
Figure 4.22: Uptake of screening for breast cancer (age 50–70), 2010/11

Childhood immunisation and vaccination

Immunisation and vaccination programmes provide protection against contagious diseases to vaccinated individuals and, through 'herd immunity', to a wider unvaccinated population. This study has comparable data for the four countries and North East England. It reports coverage for children reaching their second birthday for measles, mumps and rubella (MMR) vaccination, and the '5 in 1' (diphtheria, tetanus, whooping cough (pertussis), polio and Hib (Haemophilus influenzae type b))[23] and Meningitis C ('MenC') vaccines. Figure 4.23 shows that for all countries and North East England, the MMR rates for 2011/12 were below the 95 per cent rate recommended by the World Health Organization (Health and Social Care Information Centre, Screening and Immunisations Team, 2012, p. 30). For the other programmes, Figure 4.23 shows that the rates in children for 2011/12 were:

- for the '5 in 1' vaccine, from 98.4 per cent in Northern Ireland to 96.1 per cent in England
- for the MMR vaccine, from 94.3 per cent in Scotland to 91.2 per cent in England
- for the Meningitis C vaccine, from 96.8 per cent in the North East to 94.9 per cent in England.

Figure 4.23: Childhood immunisation and vaccination rates at 24 months, 2011/12

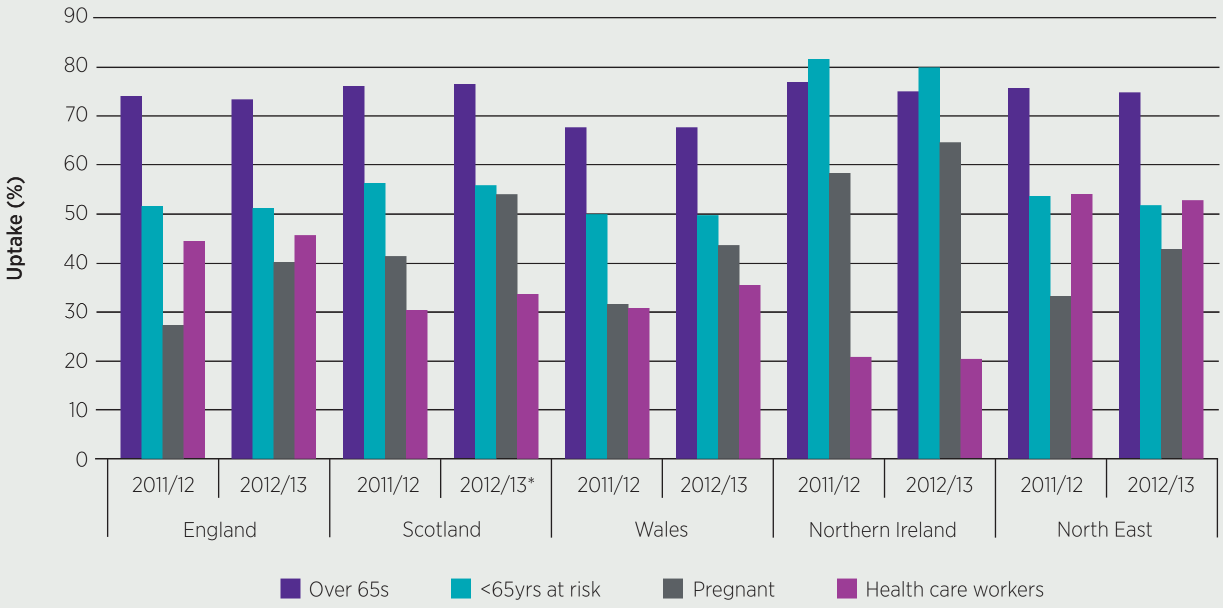


Winter influenza vaccination

The groups who are targeted for influenza vaccination in the winter are the over-65s, the under-65s who are at particular risk, pregnant women and health care workers. This report has data for rates of vaccination for the four countries and North East England. Figure 4.24 gives the coverage for these groups for 2011/12 and 2012/13 and shows that these rates were stable over those two years, except for increases in the coverage of pregnant women. Figure 4.24 shows that over those two years:

- for the over-65s, coverage was highest in Scotland and Northern Ireland (about 76 per cent) and lowest in Wales (about 68 per cent)
- for the under-65s at risk, coverage was highest in Northern Ireland (over 80 per cent) and lowest in Wales (about 50 per cent)
- in 2012/13 only, for pregnant women, coverage was highest in Northern Ireland (nearly 65 per cent) and lowest in England (40 per cent)
- for health care workers, coverage was highest in North East England (about 53 per cent) and lowest in Northern Ireland (about 20 per cent).

Figure 4.24: Seasonal influenza vaccination uptake (%) by target group, 2011/12 and 2012/13 seasons



* Provisional data

Ambulance response times

Governments in each country have set targets for their ambulance services for the percentage of ambulance responses in fewer than eight minutes to what may have been life-threatening emergencies (category A calls). Currently, these are 75 per cent in England and Scotland, 72.5 per cent in Northern Ireland and 65 per cent in Wales. This is the final indicator which, we believe, merits inclusion in the set of indicators that are relatively unproblematic for the purpose of making comparisons across the four countries; although we are aware of ambiguity over, and differences in, the definition of what is (and is not) a category A call (Auditor General for Wales, 2006; Bevan and Hamblin, 2009), as well as differences regarding when the clock starts recording the response time.[24]

Although all governments have introduced targets for ambulance response times to category A calls, there have been differences regarding when these targets were introduced, and changes in the percentages specified in targets. The governments in England (NHS Executive, 1996) and Wales (National Assembly for Wales, 2001) introduced a common target of 75 per cent of category A calls to be met within eight minutes, which was to have been achieved by 2001 and which has remained the target in England. However, in Wales, following failure to meet the 75 per cent target, from April 2004, this was reduced to 65 per cent, and, from April 2005, it was reduced further to 60 per cent (Auditor General for Wales, 2006, p. 28); then, from April 2008, it was increased back to 65 per cent (Auditor General for Wales, 2009). In Northern Ireland, the target was 65 per cent for 2007/08, 70 per cent for 2008/09, and has been 72.5 per cent since 2009/10 (see Northern Ireland Ambulance Service Health and Social Care Trust, nd, for the change in target).[25] In Scotland, the target of 75 per cent was to have been achieved by the fourth quarter of 2007/08 in mainland boards only, and from March 2009 across Scotland (Scottish Government, 2012).

Figure 4.25: Ambulance response times, % of category A calls within eight minutes

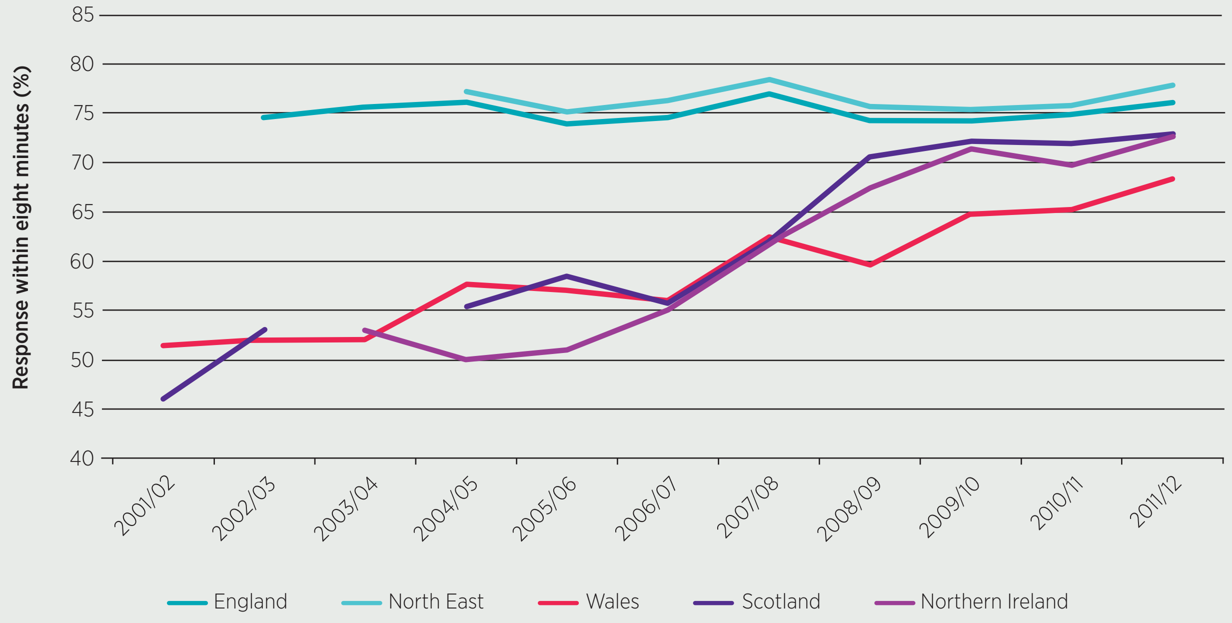


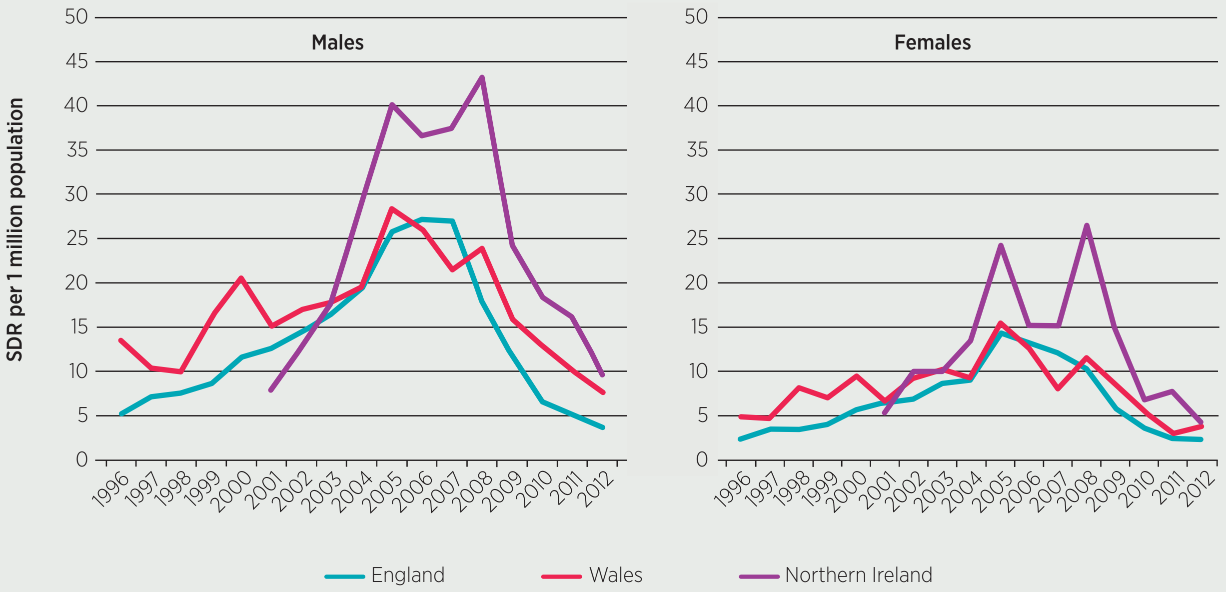
Figure 4.25 gives the performance of responses by the ambulance services of the four countries and North East England to category A calls from 2001/02 to 2011/12. Performance is measured by the percentages of responses in less than eight minutes. This shows that throughout the period, in England, the percentage was around 75 per cent, and in North East England, it was slightly higher than the average for England (and above the 75 per cent target from 2004/05 to 2011/12). Figure 4.25 shows dramatic improvements in the performance of the devolved countries between 2006/07 and 2011/12: in 2006/07, the percentage of responses to category A calls within eight minutes was about 56 per cent, and by 2011/12 this had risen to between 68 and 73 per cent. Performance in Wales improved from 58 per cent in 2004/05 to 68 per cent in 2011/12.[26] Performance in Northern Ireland increased from 50 per cent in 2004/05 to 73 per cent in 2011/12. Performance in Scotland improved from 55 per cent in 2004/05 to 73 per cent in 2011/12.

Performance comparisons across England, Wales and Northern Ireland where data are comparable

Methicillin-resistant staphylococcus aureus mortality rates

This study can compare mortality rates (per one million population) in which methicillin-resistant staphylococcus aureus (MRSA) is mentioned on death certificates (MRSA mortality rates), 1996–2012, for both sexes and for all countries except Scotland (for which data are not disaggregated by sex). This study does not have data for North East England. Figure 4.26 shows that MRSA mortality rates for men were about twice those for women. The rates for males in England fell from a peak of 27 in 2006 to 3.7 in 2012; in Wales, from a peak of 28 in 2005 to 7.6 in 2012; and in Northern Ireland, from a peak of 43 in 2008 to 9.7 in 2012.

Figure 4.26: Mortality rates for deaths with MRSA mentioned on the death certificate (per one million population), 1996–2012



Note: SDR = standardised death rate.

Quality of stroke care

The stroke audit by the Royal College of Physicians of London covers England, Wales and Northern Ireland (Royal College of Physicians, 2013), but not Scotland (see Scottish Stroke Care Audit, 2010).[27] Figure 4.27 shows how the percentage of patients who spent more than 90 per cent of their time in a stroke unit (generally regarded as strongly positive for patient survival and subsequent quality of life) changed, by country, between the stroke audits of 2006 and 2010.[28] In 2006, this percentage was highest in Northern Ireland (60 per cent) and lowest in Wales (39 per cent), with England in the middle (51 per cent). By 2010, the percentage had risen in England, with little change in Wales, but the percentage had fallen in Northern Ireland (to 50 per cent). However, Figure 4.27 also shows substantial improvements across nine key indicators of quality of stroke care in the three countries, with the average achievement increasing from: 60 per cent to 83 per cent in England; 52 per cent to 73 per cent in Wales; and 64 per cent to 74 per cent in Northern Ireland. Table 4.1 gives details for each indicator.

Figure 4.27: Percentages treated in stroke units and average performance across nine key indicators of the quality of stroke care in England, Wales and Northern Ireland, 2006 and 2010

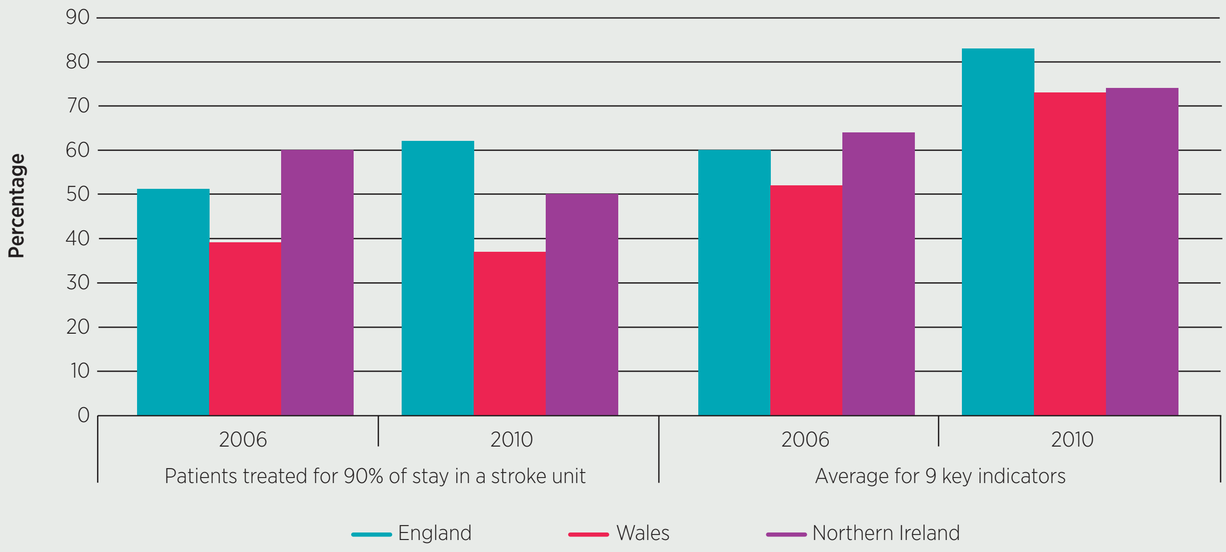


Table 4.1: Percentages treated in stroke units and performance on nine key indicators of quality of stroke care in England, Wales and Northern Ireland, 2006 and 2010

	England		Wales		Northern Ireland	
	2006	2010	2006	2010	2006	2010
Patients treated for 90% of stay in a stroke unit	51	62	39	37	60	50
Screened for swallowing disorders within first 24 hours of admission	67	85	55	76	62	67
Brain scan within 24 hours of stroke	43	71	38	60	40	57
Commenced aspirin by 48 hours after stroke	71	93	76	92	68	91
Physiotherapy assessment within the first 72 hours of admission	72	92	54	87	74	87
Assessment by an occupational therapist within four working days of admission	50	85	30	59	61	77
Weighed at least once during admission	57	86	54	81	50	73
Mood assessed by discharge	54	81	53	66	77	70
Rehabilitation goals agreed by the multidisciplinary team	76	95	70	95	88	92
Average for nine key indicators	60	83	52	73	64	74

Performance comparisons across England, Scotland and Wales where data are comparable

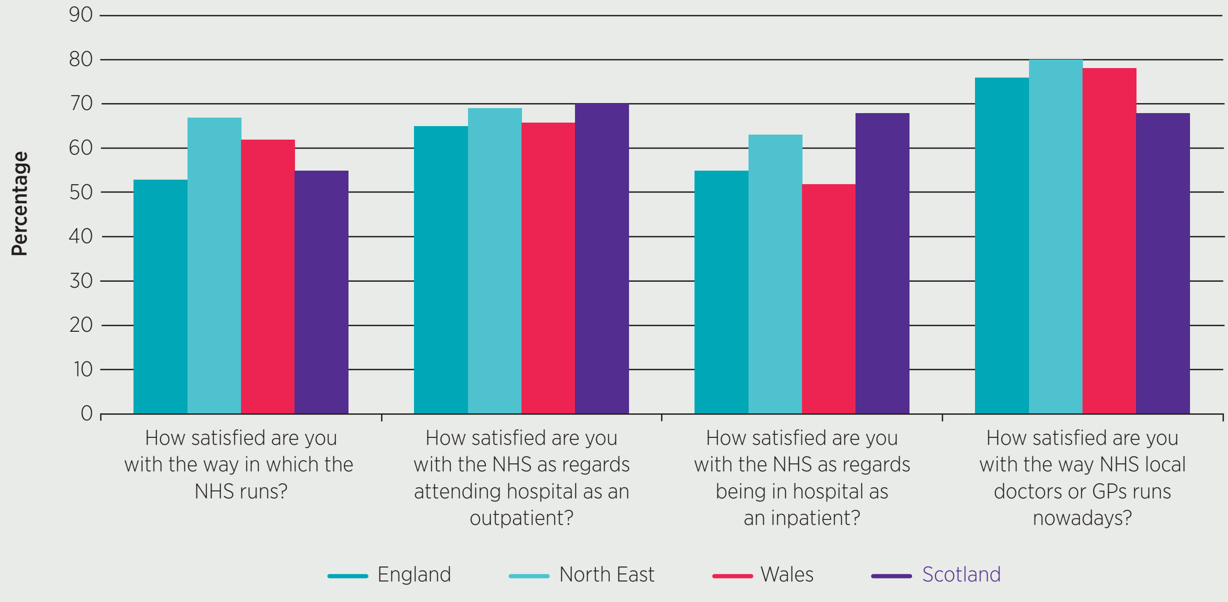
Patient satisfaction with various aspects of the NHS

The British Social Attitudes (BSA) survey (Park and others, 2012) produced comparable data on the population reporting satisfaction with various aspects of the NHS in 2011 for England, North East England, Scotland and Wales, but not for Northern Ireland. Figure 4.28 gives comparisons between England, North East England, Wales and Scotland of the percentages of people who reported that they were 'very satisfied' or 'quite satisfied' with:

- 'the way in which the NHS runs' – this ranged from 62 per cent in Wales to 53 per cent in England, but North East England (67 per cent) had a higher rate than any of the country averages
- 'attending hospital as an outpatient' – this ranged from 70 per cent in Scotland to 65 per cent in England, the rate for North East England being 69 per cent
- 'being in hospital as inpatient' – this ranged from 68 per cent in Scotland to 52 per cent in Wales, the rate for North East England being 63 per cent
- 'the way that NHS local doctors or GPs are run' – this ranged from 78 per cent in Wales to 68 per cent in Scotland, but North East England (80 per cent) had a higher rate than any of the country averages.

Apart from the BSA survey, there is no consistent public or patient survey across the different countries. Each system undertakes its own survey of the experience of care received in GPs' surgeries and, although the classifications used differ,[29] each survey reported high levels of satisfaction in 2011: 94 per cent in Northern Ireland, 92 per cent in Wales, 89 per cent in Scotland and 88 per cent in England. There is a lack of comparative data on patients' experience with hospital care (Park and others, 2012).[30]

Figure 4.28: Satisfaction with various aspects of the NHS – percentage reporting being 'very satisfied' or 'quite satisfied'



Source: Park and others, 2012

Performance comparisons with serious limitations in comparability of data

The available data on three broad categories of staff (excluding GPs, see above) and hospital activity provide blunt tools for analytic comparisons between the four countries, and in relation to each other. There always has been a particular difficulty in making comparisons with Northern Ireland, as its staffing data include those working in health and social services. It is has become much more problematic to make comparisons across the other three countries and over time because of changes in the definitions in categories of staff and activity. Moreover, it is not possible to compare performance across the four countries on hospital waiting times.

Staffing

This report uses shorthand to describe the three different principal groupings of staff (notes at the end of this chapter give details of their composition in England and we comment on differences between the four countries and changes over time below):

- *hospital doctors* – for hospital and community health services medical and dental staff
- *nurses* – for qualified nursing, midwifery and health visiting staff
- *infrastructure staff* – for NHS infrastructure support staff.

The massive increases in funding of all four countries from 2000 led to increases in staffing, and in particular, hospital doctors (ranging from more than 50 per cent to more than 70 per cent). In addition, there were increases in the other staff groups, but these were not so dramatic and varied between each country.

Hospital doctors

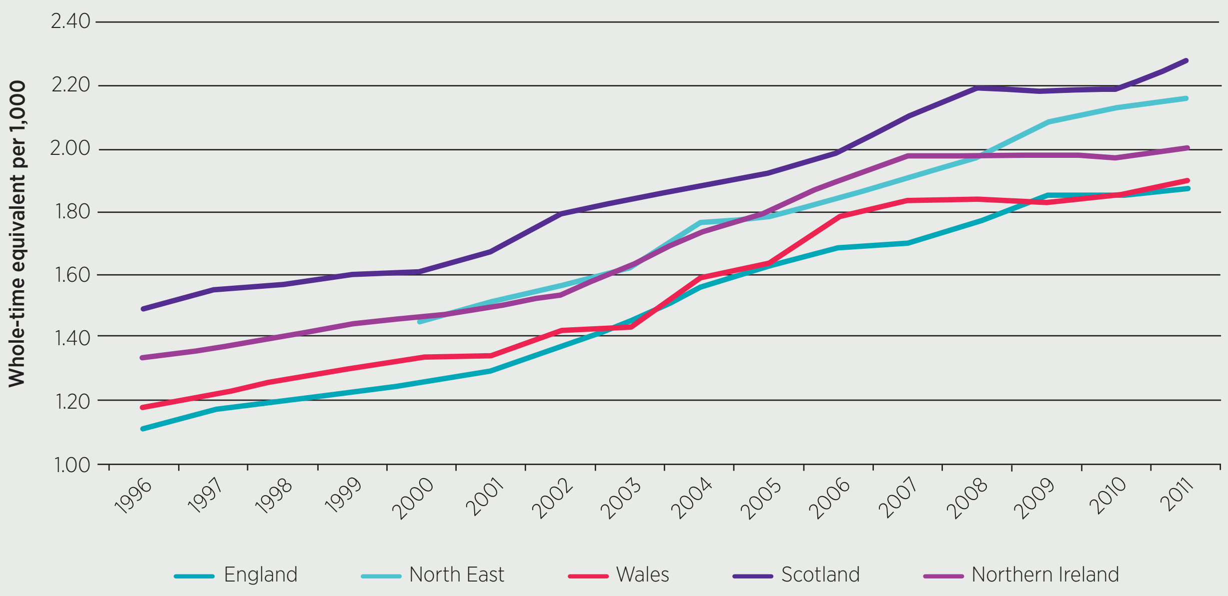
Hospital and community health services medical and dental staff include the following:

- consultants (including directors of public health)
- registrars
- other doctors in training and equivalents
- hospital practitioners and clinical assistants in non-dental specialties
- other medical and dental staff.

Data from the Health and Social Care Information Centre (2013a) show that at 30 September 2012 in England, of hospital and community health services medical and dental staff, only two per cent were dental, and only two per cent were in public health medicine and community health services. Hence, it is reasonable to describe these data as 'hospital doctors'. There are two principal definitional problems when comparing these data across the four countries. The first is whether these do or do not include public health medical and dental staff, but these numbers are unlikely to be material. The second is locum hospital doctors (staff on temporary or fixed-term contracts are included in all countries):[31] we know that directly employed locums are included in Northern Ireland, but we understand that these are excluded in Scotland, Wales and England.

Figure 4.29 gives the rates of hospital doctors, in WTEs per 1,000 population, 1996–2011. This shows that Scotland had the highest rates throughout; Northern Ireland was second; and England and Wales had similar rates. The magnitude of the excess of Scotland over England and Wales was remarkably consistent, at about 0.4 per 1,000 throughout the period. In 2011, the rates per 1,000 population were England and Wales, 1.9; Northern Ireland, 2.0; North East, almost 2.2; and Scotland, 2.3. Of all the staff groups, this group had the largest percentage increases – over the period 1996–2011, these were: Northern Ireland, 50 per cent; Scotland, 53 per cent; Wales, 60 per cent; and England, 67 per cent. Figure 4.29 shows a change in the relative rate of hospital doctors for North East England compared with Northern Ireland: the rates were similar from 2000–08; afterwards, the rate in Northern Ireland stayed the same, but increased in North East England to become close to that of Scotland by 2011.

Figure 4.29: Hospital doctors (whole-time equivalent) per 1,000 population, 1996–2011



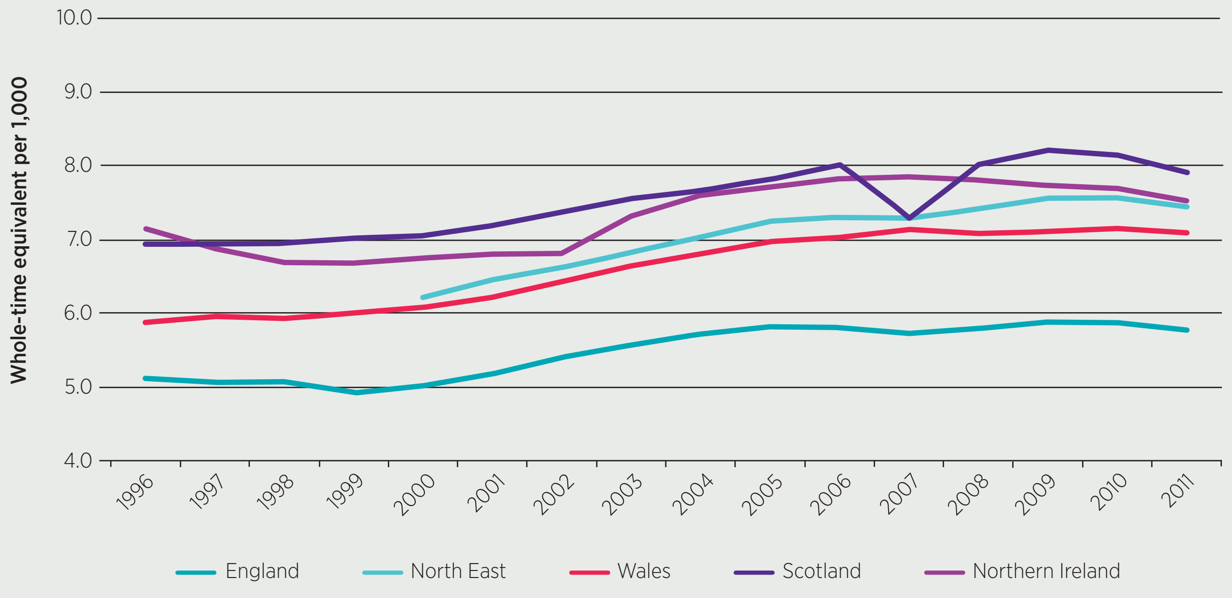
Note: ‘hospita l doctors’ refers to hospital and community health services’ (HCHS) medical and dental staff.

Nurses

This staff group includes three broad categories: qualified nursing, midwifery and health visiting staff.[32] In England in 2012, those working as health visitors and district and school nurses accounted for only five per cent of the total (Health and Social Care Information Centre, 2013b). These data ought to exclude students on training courses (leading to a first qualification as a nurse or midwife) and nurses working in general practices. However, there are problems in making comparisons over time because of the implementation of the *Agenda for Change* reforms[33] (which explains a sudden drop in Scotland in 2007, shown in Figure 4.30); and between countries because of differences in definitions of the grades included, and whether bank staff are (or are not) included. Furthermore, there are particular problems comparing the data from Northern Ireland, which include nurses working in social services and NHS trust-funded GP practices.

Figure 4.30 gives the rate of nurses in WTEs per 1,000 population, 1996–2011.[34] This shows England to be an outlier, with much lower rates (5.8 in 2011) than the other countries (Wales, 7.1; Northern Ireland, 7.5; and Scotland, 7.9 in 2011) and North East England (7.4), which means that England's low rate cannot be explained by definitional differences. The percentage increases in each country over the period 1996 to 2011 were Wales, 21 per cent; Scotland, 14 per cent; England, 13 per cent; and Northern Ireland five per cent.

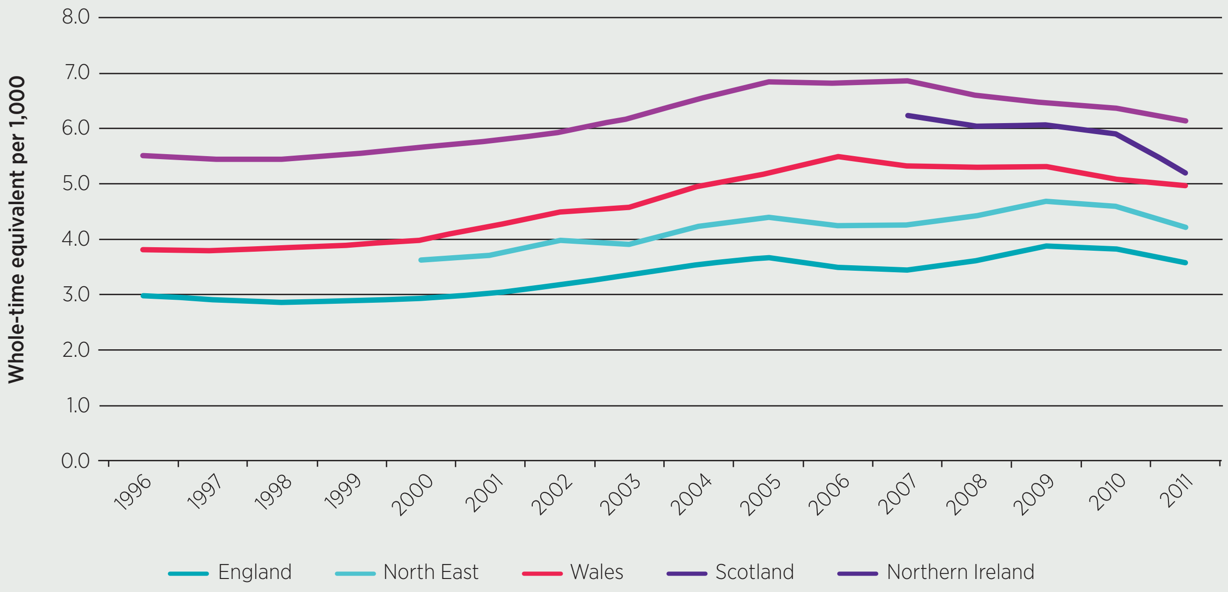
Figure 4.30: Nurses (whole-time equivalent) per 1,000 population, 1996–2011



Infrastructure staff

Infrastructure staff includes those who work in estates and facilities, central functions and managers. The differences in definitions of infrastructure staff mean that it is not possible to make any comparisons between countries;[35] and in particular, not for Northern Ireland, where the data are for health and social services combined. Staff in hotel services are included in the data for Scotland, but excluded in Northern Ireland; there are also questions over staff being excluded because the services they relate to have been contracted out to varying degrees across countries. In addition, it is problematic to compare changes over time in Scotland, following staff grouping changes under *Agenda for Change*, which is why this report gives Scottish data from 2007 only. Figure 4.31 shows the rates of NHS infrastructure staff in WTEs per 1,000 population. The percentage increases in the three countries over the period 1996–2011 were: England, 20 per cent; Wales, 30 per cent; and Northern Ireland 11 per cent.

Figure 4.31: Infrastructure staff (whole-time equivalent) per 1,000 population, 1996–2011



Activity

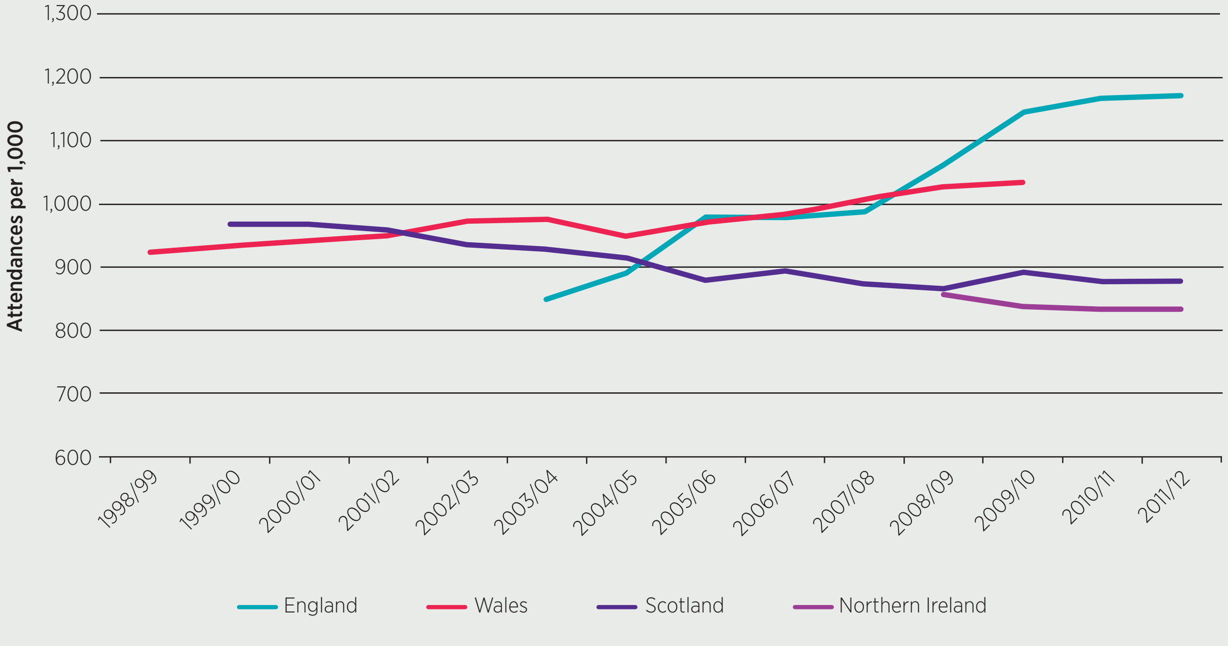
Reported here are rates per 1,000 population for outpatient appointments, inpatient admissions and day-cases. The data on inpatient admissions for North East England have not been included due to lack of detailed information on the different types of admission required to ensure comparability. There are also problems in estimating rates per head for Wales and Northern Ireland, because the data are for patients treated in hospitals in those countries, and do not take account of residents treated in England and the Republic of Ireland.

Outpatients

An outpatient is a non-resident of a hospital seen by a consultant for treatment or advice at a clinical outpatient department.[37] In capturing activity we would like to report and compare all outpatient attendances, but that is problematic. Data for England do include all consultant-led outpatient attendances, but this study has excluded North East England because its data also include outpatient sessions led by nurses and allied health professionals. In Scotland, it is mandatory to record only the first attendance and return appointments where a procedure has taken place.[38] In addition, there are problems in capturing data for NHS patients treated in non-NHS settings.[39] It looks as if in England there have been improvements in the coverage of outpatient activity in the statistics, including that in non-NHS settings.

Due to changes in definitions of outpatients, Figure 4.32 gives outpatient attendances per 1,000 for Wales from 1998/99 to 2009/10; for Scotland from 1999/2000 to 2011/12; for England from 2003/04 to 2011/12; and for Northern Ireland from 2008/09 to 2011/12.[40] From 1998/99 to 2006/07, these rates showed

Figure 4.32: Outpatient attendences – all attendances per 1,000 population, 1998/99 to 2011/12

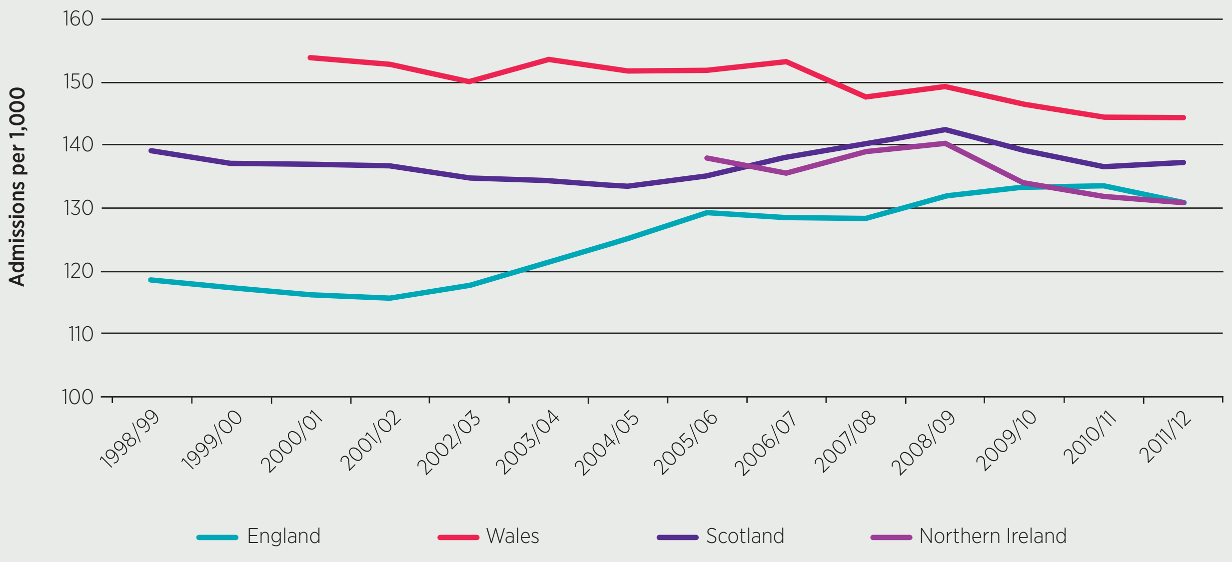


little change over time in each UK country, and were between 850 and 1,000 per 1,000 population; although, in 2006/07, the rates in England and Wales were a little higher than in Scotland (which was then about 900). However, from 2006/07, the rates in England increased rapidly, and in 2011/12 were 1,172. There was a slight decrease in Scotland to less than 900 in 2011/12. In Northern Ireland, the rates in 2011/12 were the lowest at 834 per 1,000 population.

Inpatients[41]

An inpatient admission is one where the patient is expected to remain in hospital for at least one night. The objective of this study is to capture ordinary inpatient admissions[42] separately from day cases and including NHS patients treated by non-NHS providers – which are reported for the NHS in England. The data for North East England are not included due to lack of details on types of inpatient admission and even the data we do report may not be fully comparable. For Northern Ireland, the change in definition means that data from before 2005/06 are not comparable with the earlier years, and so only the later data are given. Figure 4.33 shows the rate of inpatient admissions per 1,000 population to 2011/12, from 1998/99 for England and Scotland, from 2000/01 in Wales, and from 2005/06 in Northern Ireland. Inpatient admissions per 1,000 population increased in England from 119 in 1998/99 to 131 in 2011/12; were stable in Scotland at 139 in 1998/99 and 137 in 2011/12, with a peak of 143 in 2008/09; reduced slightly in Wales, from 154 in 2000/01 to 144 in 2011/12; and also fell in Northern Ireland from 138 in 2005/06 to 131 in 2011/12.

Figure 4.33: Inpatient admissions per 1,000 population, 1998/99 to 2011/12

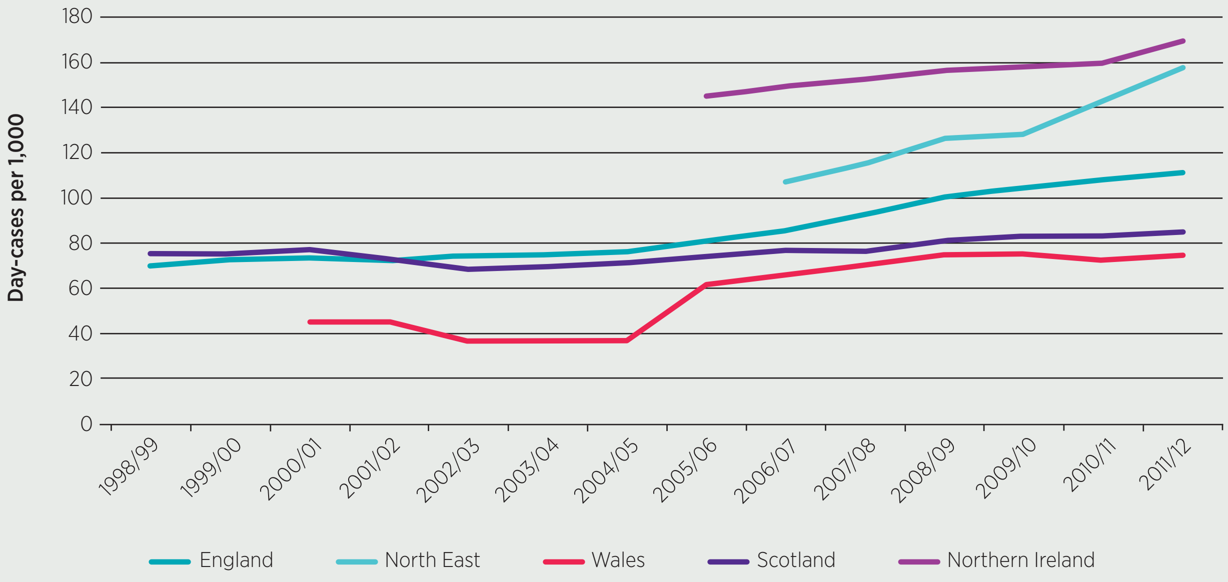


Day-cases

A day-case is a patient who comes for investigation, treatment or operation under clinical supervision on a planned non-resident basis, who occupies a bed for part or all of that day and returns home the same day.[43] There are problems in comparing rates of day-cases across the four countries because of differences in definitions, such as whether regular attenders are included or excluded, and coverage (of acute and non-acute specialties). In Wales, prior to April 2007, a set of 'cleansing rules' was applied to day-case activity, which resulted in under-reporting of day-case activity, but this stopped from 2007/08 onwards. Day-case activity information in Northern Ireland is not comparable to the other countries as it includes regular attenders; because of the change in definition, this study gives data for Northern Ireland from 2005/06 only.

Figure 4.34 gives day-cases per 1,000 from 1998/99 to 2011/12 (except for Northern Ireland and the North East of England). This shows little change in Scotland, a steep increase in these rates in Wales from 2005/06 (probably due to the ending of the 'cleansing' of these data), a small increase for England and Northern Ireland, and a substantial increase in North East England.

Figure 4.34: Day-cases per 1,000 population, 1998/99 to 2011/12



Inpatient rates per hospital doctor and nurse

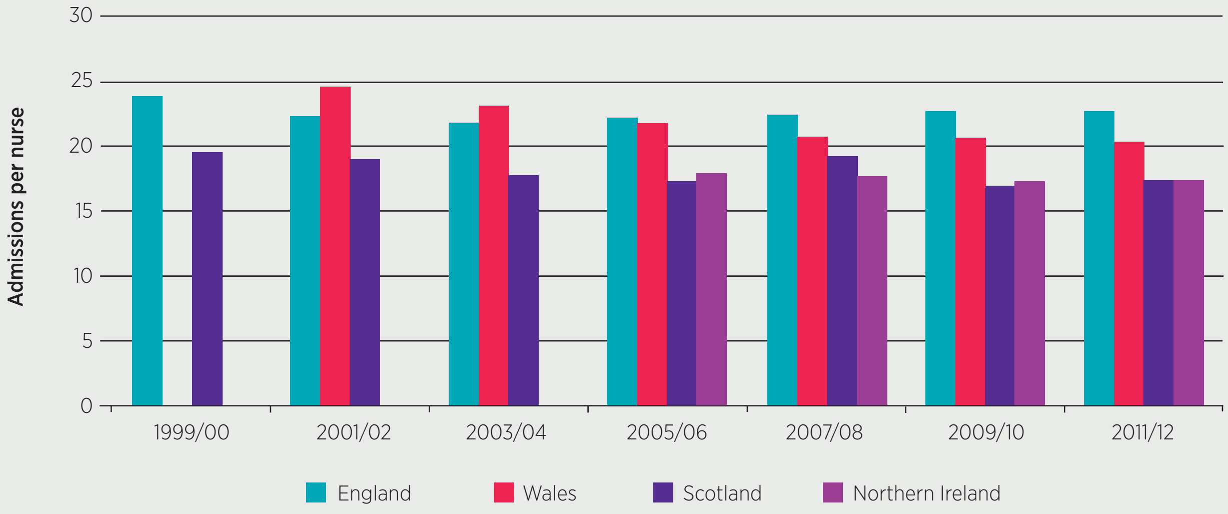
Problems over variations in definitions of hospital doctors (relating to locums) and inpatients complicate the interpretation of rates of inpatients per HCHS doctor/dentist between the four countries and over time. Figure 4.35 gives these rates to 2011/12 from 1998/99 for England and Scotland, from 2000/01 in Wales, and from 2005/06 in Northern Ireland. These rates decreased, in England from 99 in 1998/99 to 70 in 2011/12; in Scotland from 89 in 1998/99 to 60 in 2011/12; in Wales from 115 in 2000/01 to 76 in 2011/12; and in Northern Ireland from 77 in 2005/06 to 65 in 2011/12. The comparable data for North East England are not available.

Figure 4.35: Inpatient admissions per hospital doctor, 1999/00 to 2011/12

Note: 'hospital doctors' refers to hospital and community health services' (HCHS) medical and dental staff.

We mentioned above that there are problems with using data on nurses to make comparisons between Northern Ireland and the other three countries, and for Scotland for 2007. Figure 4.36 gives the number of inpatient admissions per nurse from 1999/2000 to 2011/12. Over that 13-year period, the reductions were, in Northern Ireland, by more than 40 per cent from 30 to 17; there were small reductions in Scotland, from 20 to 17 and in England from 24 to 23. In Wales, from 2001/02 to 2011/12, there was a 20 per cent reduction from 25 to 20.

Figure 4.36: Inpatient admissions per nurse, 1999/00 to 2011/12



Hospital waiting times

Although performance on hospital waiting times is a key indicator in each country, it is difficult to compare their performance over time for three reasons.

First, census data from Scotland on time spent on waiting lists before admission were not comparable with the other countries, due to the policy of excluding certain patients from the waiting list statistics. Godden and Pollock (2008[2007]) describe this as follows:

> Though waiting list statistics include all categories of patients, those with an Availability Status Code (ASC) are not subject to national waiting time guarantees. These include self-referrals, patients refusing a reasonable offer of admission, individual cases where treatment is judged as low clinical priority or deemed to be highly specialised, and patients who did not attend or who were unavailable for medical or social reasons.

In the other countries, these patients were added back to waiting lists once they became available for treatment. From January 2008, the policy of the Scottish Government brought practice in Scotland in measuring waiting times more into line with the other three countries.[44] However, the Auditor General for Scotland (Audit Scotland, 2013) found that the change in definition by the government does not seem to have been consistently implemented within Scotland, with concerns over inappropriate use of 'unavailability' codes to exclude patients from the waiting time calculations: the use of these codes had increased from 11 per cent in 2008 to more than 30 per cent in June 2011; there had been inadequate recording of the grounds for their use; and there were inconsistencies in waiting time guidance between health boards. In England, the comptroller and auditor general identified problems of "inconsistencies in the way trusts measure waiting time and errors in the waiting time recorded" (2013, p. 7), and the need for "independent validation of trusts' data" (2013, p. 8) (National Audit Office, 2014).

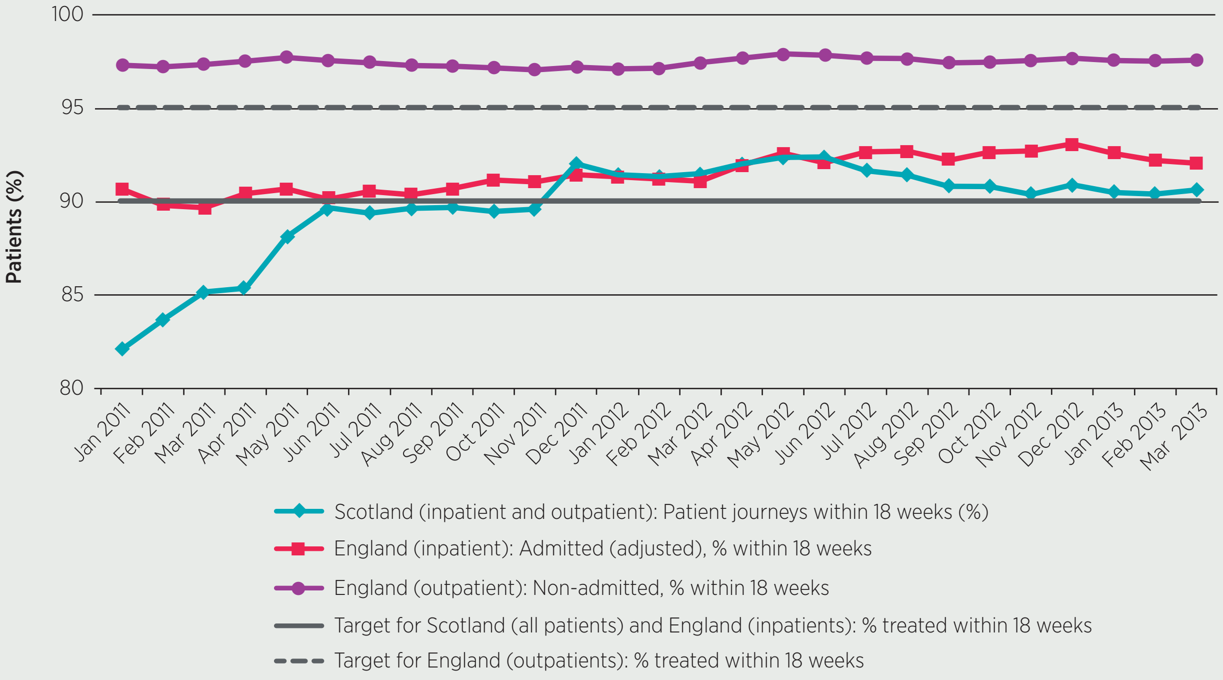
Second, although the governments in England, Scotland and Wales now measure performance in terms of the time from referral to treatment (RTT) for elective care,[45] which includes all stages between first referral and treatment (including, for example, diagnostics), there are differences in how this performance is measured. The RTT waiting time targets (or standards) in England, Scotland and Wales are as follows:

- England (from January 2009) – 95 per cent of outpatients to be seen, and 90 per cent of inpatients to be admitted, within 18 weeks
- Scotland (from December 2011) – 90 per cent of outpatients to be seen, and inpatients to be admitted, within 18 weeks
- Wales (for 2011/12) – 95 per cent of outpatients to be seen, and inpatients to be admitted, within 26 weeks; and 100 per cent within 36 weeks.

Third, the NHS in Northern Ireland has not yet moved to an RTT target, and still has separate targets for the time spent waiting for outpatient and inpatient attention. From April 2012, these were as follows:

- outpatients – at least 50 per cent of patients should be seen for a first outpatient appointment within nine weeks, and no one ought to wait for more than 21 weeks

Figure 4.37: Waiting time (referral to treatment, percentage of patients treated within 18 weeks), Scotland and England, January 2011 – March 2013



- inpatients – 50 per cent of patients should be seen within 13 weeks, and no one ought to wait for more than 36 weeks.

Given these differences in targets against which performance is measured, the closest, albeit complicated, comparison is between England[47] and Scotland, which is given in Figure 4.37. Since January 2011 in Scotland, the percentage of outpatients treated and inpatients admitted within 18 weeks increased from 82.1 to 90.6 per cent;[48] in England, the percentage of inpatients admitted within 18 weeks increased from 90.7 to 92.1 per cent and outpatients seen from 97 to 98 per cent. In Wales, in March 2013, 91.5 per cent of outpatients were seen and inpatients admitted within 26 weeks and all within 36 weeks; and in Northern Ireland, 80.1 per cent of outpatients were seen within nine weeks and 68.8 per cent of inpatients admitted within 13 weeks.

Notes

16. Under the Barnett Formula the increase in spending on the NHS in England feeds through into the global allocations for the devolved nations, and their governments can decide whether to use some of these increases on other services. We discussed above that the Scottish Government had used its growth money to finance free social care for older people, and return to this point in Chapter 6.
17. We mentioned in Chapter 2 that the government in Wales plans to cut spending on its NHS by about 10 per cent in real terms by 2014/15.
18. We assume that these data exclude GP registrars (practitioners employed for a maximum period of one year for the purpose of training in general practice, and in respect of whom a training grant is paid) and GP retainers (practitioners who provide service sessions in general practice as an assistant employed by the practice, and who are allowed to work a maximum of four sessions each week).
19. These were cataract, CABG, varicose vein operation, inguinal hernia, hip replacement, knee replacement and excision of gall bladder (there are questions over the exact coverage of diagnoses for cataracts and procedures included for knee replacements).
20. There are no data on excision of gall bladder.
21. This exercise did not include excision of gall bladder.
22. Hence includes time spent waiting in periods of suspension from the waiting list for medical and social reasons, which is excluded from the measure used in recording waiting times in relation to targets.
23. This is for diphtheria, tetanus, pertussis, polio and Haemophilus influenza type b (DTaP/IPV/Hib).
24. The timing of the start of the response time changed in England from April 2008 to the point where the call was received at the control room switchboard. Before that, response times were measured from the point where a series of details were recorded by the control room, such as exact location and nature of the incident. The end point remained when the response unit arrived on scene (see Health and Social Care Information Centre, 2012; for differences between the countries, see Appendix 1 of this report, published separately: Bevan and others, 2014b). The Auditor General for Wales (2006) investigated the definitional difference between England and Wales, as only in Wales from April 2005 have all calls for children under the age of two been classified as category A. The Auditor General found that in comparison with rural areas in England, in a “sample of 471,000 emergency calls during the period April 2005 to September 2006… there would have been only 0.6 per cent more Category ‘A’ calls in Wales, had it applied the same call categorisations as England” (2006, p. 35). From this, we conclude that the data on category A calls are comparable across the four countries.
25. The first mention of the target of 70 per cent is in Northern Ireland Ambulance Service Health and Social Care Trust (2008, p. 1).
26. However, the Welsh ambulance service has missed the 65 per cent target for 13 consecutive months (see BBC News, 2013c).
27. The Royal College of Physicians of Edinburgh organises a stroke audit in the NHS in Scotland that uses different categories, and so is not comparable with the other three countries.
28. Airoldi and others (2008) discuss the evidence of the comparative effectiveness of stroke units. The most recent report from the Royal College of Physicians of London (2011, p. 36) observes: The majority of patients (57%) are still initially admitted to general assessment units where stroke specialist care is often not delivered as effectively as on stroke units. It is very disappointing that only 36% of patients are admitted directly to an acute or combined stroke unit and only 38% within 4 hours of arrival in hospital despite the strong recommendations that this should occur in both the National Stroke Strategy and the NICE Guidelines on Acute Stroke and TIA… some of the key interventions such as provision of fluids, nutrition and brain scanning are performed as well for patients admitted to medical assessment units; it is concerning that swallow screening is less frequently performed. This screening is essential to lower the risk for respiratory infections.

29. The categories were Scotland, ‘excellent’ or ‘good’; England, ‘very good’ or ‘fairly good’; Northern Ireland and Wales, ‘very satisfied’ or ‘fairly satisfied’.
30. There were inpatient surveys of Scotland and England only with different categories of response options (see NHS Scotland, 2012). The recent UK inflammatory bowel disease audit did compare patient experience in hospitals across the four countries. This showed no significant differences between the four countries in comparisons of satisfaction rating across several care domains (see UK IBD Audit Steering Group, 2012).
31. Unfortunately this study has been unable to find good data to check the materiality of the numbers of locum hospital doctors. It can compare the total spend on NHS consultants, reported by the National Audit Office (2013) to be £5.6 billion in 2011–12, with spend on locum hospital doctors over the three years 2010–13, which was reported by the *Daily Telegraph* to be about £700 million (Donnelly, 2013). So the spend on locums was more than 12 per cent of the spend on NHS consultants.
32. This includes those who are employed as nurses and hold at least a second-level registration with the Nursing and Midwifery Council.
33. *Agenda for Change* was implemented across the UK on 1 December 2004, with pay terms and conditions backdated to 1 October 2004.
34. The drop in 2007 is due to disruption reporting following the introduction of *Agenda for Change*.
35. In Scotland, some administrative and other support are excluded, as they are included in direct care staff; in Northern Ireland, staff working within personal social services are included, as health and social services are integrated; and in England and Wales, this category includes directly employed NHS staff only.
36. In 2010/11 there were 467,000 inpatient admissions for Welsh residents in Wales, and further 50,000 were admitted to hospitals in England.
37. A new outpatient is one whose first attendance (or only attendance) is part of a continuous series for the same course of treatment falling within the period in question.
38. So this does not include all return attendances.
39. In Scotland the completeness of these data has varied across locations and time.
40. In Northern Ireland, from the beginning of 2008/09, the count changed from clinics and appointments.
41. Again, there are problems in making comparisons because of changes in definitions and shifts between inpatients and day cases. This study gives data for Northern Ireland after 2005/06 because the change in definition means that earlier data are not comparable. For all countries, inpatient admissions exclude births and maternity, mental health and regular attenders.
42. These are counts of admissions/discharges and effectively spells, not finished consultant episodes, where there are multiple finished consultant episodes for one spell. See note 41 on exclusion of certain specialties.
43. The definition of a day-case is as follows: a patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight, and who returns home as scheduled. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an inpatient. In England, where a day-case patient stays overnight, they become an ordinary admission.
44. This is known as ‘New Ways’, so that the time that patients were unavailable was not included in their overall waiting time against the guarantee, but they remained on the waiting list (with a waiting time guarantee), and were included in statistics on time spent waiting prior to admission.
45. The RTT for elective surgery does not apply to, for example, cancers where there are much shorter targets for treatment. For information on these targets for England see .
46. These targets were tightened in March 2013 for both outpatient and inpatient services, to

60 per cent for the minimal wait threshold, and reduction of longest wait to 18 and 30 weeks.

47. England provides two sets of rates (adjusted and unadjusted) for inpatient admission RTTs. The adjustment allows for patients to be excluded for clinical reasons, patient refusing treatment and patient non-attendance, provided that the appointment was clearly communicated. In Scotland, patients can be excluded for refusal to attend an appointment (even if outside the health board area), not being able to attend within seven days (compared with three weeks in England) and changing an appointment more than three times.

48. Scottish performance was based on 91 per cent of total records (the rest were coded as unfinished journeys, with no data on the outcome).

5

Trends in amenable and other mortality

It remains challenging directly to measure the contribution of health care to population health, given the often multi-causal nature of many outcomes. One approach that has been shown to provide a useful approximation is the concept of 'amenable mortality' (Nolte and McKee, 2004). It derives from work by the American Working Group on Preventable and Manageable Diseases which, in 1976, introduced the idea of measuring quality of care using the notion of 'unnecessary, untimely deaths' – that is, outcomes that ought not to occur, or that occur rarely in systems that deliver high-quality care (Rutstein and others, 1976). 'Amenable mortality' is defined as premature death from causes that should not occur in the presence of timely and effective health care. This has been applied widely as a means to assess quality of care in different systems across countries and over time (Charlton and others, 1983; Gay and others, 2011; Mackenbach and others, 1990; Nolte and McKee, 2003), and was recently adopted as one of the indicators in the NHS Outcomes Framework in England (Department of Health, 2010).

Desai and others (2011) used this approach to examine trends in amenable mortality in England and Wales in 1990–99 and 1999–2009, in comparison with Scotland and Northern Ireland. This showed that deaths from causes amenable to health care fell more slowly in England and Wales in 1990–99 than in Scotland and Northern Ireland, but that the rate of decline in England and Wales increased after 1999. Desai and others attributed this to a narrowing of the funding gap between England and Wales combined and the other two countries. However, as they also argued (and we shall see below), it is important to recognise that rates of amenable deaths were higher in Scotland and Northern Ireland in the 1990s than in England and Wales, and therefore the potential for improvement was greater in the former two countries. Furthermore, they observed that changes differed by cause of death: some improved uniformly, and others varied across countries.

This chapter updates this analysis for all four countries, examines England and Wales separately, and adds North East England which, as explained in Chapter 3, provides a more appropriate comparator with the devolved countries than England as a whole. It reports age-standardised death rates for men and women for amenable mortality and for other mortality, which are derived by subtracting amenable mortality from total mortality. For simplicity, we refer to these as 'amenable mortality' and 'other mortality'. The focus of this chapter is on understanding variation in amenable mortality that can be more closely related to changes in health services (Nolte and McKee, 2004); and variations in other mortality that are likely to be indicators of variations in the wider determinants of health. This chapter also examines trends over two decades: 1990–2000 and 2000–10. The figures that illustrate these changes are given in the body of this report, and Appendix 2, published separately (Bevan and others, 2014c), includes detailed tables of amenable mortality by age, sex and major cause of death for 1990, 2000 and 2010, as well as relative changes over time. As explained in Chapter 3, we report trends in mortality only. We have undertaken further statistical analyses, which found that the declines in amenable mortality were statistically significant, but we did not formally test whether trends differed across countries, because the relative changes between countries were so similar.

Trends in amenable and other mortality: under 75 years

Figures 5.1 and 5.2 show rates of amenable and other mortality for men and women under the age of 75 from 1990 to 2010. Amenable mortality forms an important contributor to total mortality under the age of 75 in all four countries, although this proportion has reduced over time. Thus, in 1990, deaths considered amenable to health care accounted for about 30 per cent of all deaths under age 75 in men, and about 40 per cent in women (data not shown). By 2010, these proportions had fallen to about 20 per cent in men, and about 30 per cent in women. This is mainly because, during the 20-year period, the rates of decline for amenable mortality were twice the rates of decline of other mortality for men, and three times the rates for women.

In 1990, across the four countries, rates of amenable mortality per 100,000 for both men and women under 75 were highest in Scotland (234 for men and 170 for women), and lowest in England (184 for men and 138 for women) (Appendix 2, Table 1). Between 1990 and 2010, amenable mortality rates more than halved in both sexes and across all countries, which meant that the relative gap between Scotland and England remained. Thus, amenable mortality rates in Scotland continued to exceed those in England by about 20 per cent for both men and women throughout the period. In Scotland, the rates per 100,000 in 2010 were for men, 97 compared with 80 in England. For women, rates in Scotland were 77 per 100,000 compared with 64 per 100,000 in England, respectively.

Figure 5.1: Trends in amenable mortality in the four countries of the UK and North East England, men and women, aged 0–74, 1990–2010

Similarly, Figure 5.2 shows that rates of other mortality were also highest in Scotland and lowest in England: the rates per 100,000 for men in Scotland were 477 compared with 396 in England; and for women, 249 and 198 respectively. By 2010, while falling everywhere, rates remained highest in Scotland and lowest in England. However, Scotland experienced a relatively smaller decline in other mortality compared with England over the entire period and, as a consequence, the relative mortality gap between the two countries increased from about 20–25 per cent higher in Scotland than in England in 1990, to more than 30 per cent higher in 2010.

Figure 5.2: Trends in other mortality in the four countries of the UK and North East England, men and women, aged 0–74, 1990–2010

Figures 5.1 and 5.2 show that in 1990, rates of amenable and other mortality for both men and women in North East England were most similar to those in Scotland. However, whereas between 1990 and 2010 amenable mortality declined at a similar pace in North East England and Scotland, at just under 60 per cent among men and 55 per cent among women, the decline in other mortality was much greater in North East England: this fell by just under 39 per cent for men and 28 per cent for women in North East England, compared with 28 per cent for men and 19 per cent for women in Scotland. As a consequence, by 2010, for both men and women, while rates of amenable mortality were only about 10 per cent higher in Scotland compared with North East England, for other mortality, rates in Scotland were about 15 per cent (women) to 19 per cent (men) higher than those in North East England.

This study has examined changes for the periods 1990–2000 and 2000–10 separately to explore how changes in mortality rates have differed pre- and post-devolution (as further illustrated in Appendix 2, Table 2 of this report, published separately (Bevan and others, 2014c)). Using the annual absolute change in amenable mortality, rates fell much more rapidly during the 1990s than they did during the 2000s among both men and women, and across all four countries. These declines were driven largely by a reduction in mortality from cardiovascular disease and treatable cancers during this period. However, there was variation in the pace of change across the four countries. Thus, among men during the 1990s and 2000s, the absolute reduction was greatest in Northern Ireland and in Scotland, and least in Wales and England. Among women during the 1990s, the absolute reduction was greatest in Scotland and lowest in Wales; however, during the 2000s there was little difference between the countries. The reductions in North East England were similar to Scotland in both decades for men and women.

In order to interpret trends more fully, it is important to analyse the observed absolute changes in mortality rates in the context of relative changes. There was acceleration in the decline in amenable mortality between the 1990s and 2000s for men in all four countries, and for women in all countries except in Scotland, where death rates fell consistently by about 30 per cent in each decade (see Appendix 2, Table 1 of this report, published separately (Bevan and others, 2014c)). Looking across the four countries, the largest declines in the 1990s were for men in Northern Ireland, and women in Scotland. In the 2000s, the largest declines were for men in Northern Ireland and Scotland, and for women in Northern Ireland. However, it is important to recognise that the differences in relative mortality reduction between countries were rather small. These observations suggest that health care had a stronger impact on mortality trends in the 2000s in all four countries compared with the 1990s, and also compared with the relatively smaller reductions in mortality from causes other than those considered amenable to health care (Appendix 2, Table 2: Bevan and others, 2014c). Analysis at the country level suggests that the diverging policies following devolution may not have had a measurable impact on health care outcomes in the four countries, as assessed by amenable mortality, but the greater progress in North East England suggests a slightly better performance in England than the other countries post-devolution given the socioeconomic similarity between the North East and the devolved countries.

The next two sections give results from analyses in which data were disaggregated into two broad age groups: the under-65s and 65- to 74-year-olds (see Chapter 3).

Trends in amenable and other mortality: 0–64 years

Figures 5.3 and 5.4 give rates of amenable and other mortality for men and women under 65 from 1990–2010. In 1990, across the four countries, rates of amenable mortality per 100,000, for both men and women under 65, were highest in Scotland (121 for men and 96 for women) and lowest in England (99 for men and 80 for women) (Appendix 2, Table 2: Bevan and others, 2014c). Between 1990 and 2010, amenable mortality rates approximately halved in both sexes and across all countries, which meant that the relative gap between Scotland and England remained. Thus, amenable mortality rates per 100,000 continued to be about 15 per cent higher in Scotland than England for both men and women throughout the period, and in 2010, were in Scotland, 55 for men and 48 for women; and in England, 48 for men and 42 for women. Although there was a downward trend in Northern Ireland, there were considerable fluctuations over the 20-year period, which is probably due to small numbers of amenable deaths in this age range and its relatively small population.

The pattern of change in other mortality, for both men and women under 65, was similar to that of the under-75s overall. Thus, in 1990, mortality rates per 100,000 were highest in Scotland (284 for men and 146 for women) and lowest in England (224 for men and 113 for women). As we have also seen for the 0–74 age group, the gap between Scotland and England increased over time during the 20-year period. Thus, in 1990, the other mortality rate per 100,000 in Scotland exceeded that in England by just under 30 per cent for men and women. However, by 2010, this had increased to 42 per cent for men and 35 per cent for women: the rates for Scotland were 222 for men and 118 for women, and for England were 156 for men and 88 for women.

Figure 5.3: Trends in amenable mortality in the four countries of the UK and North East England, men and women, aged 0–64, 1990–2010

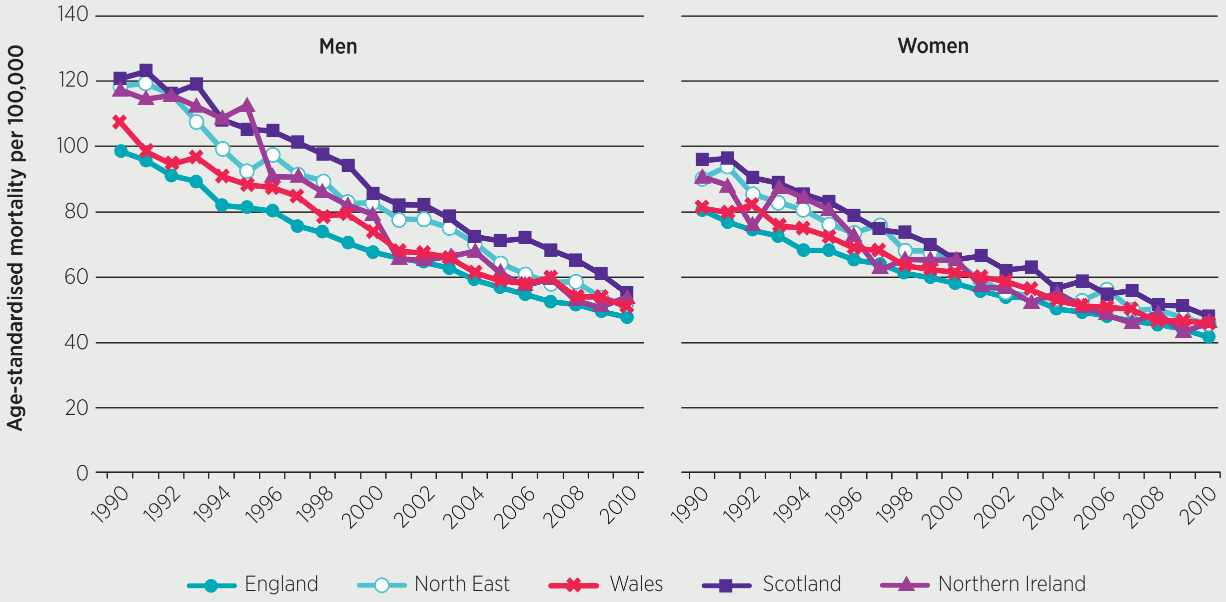
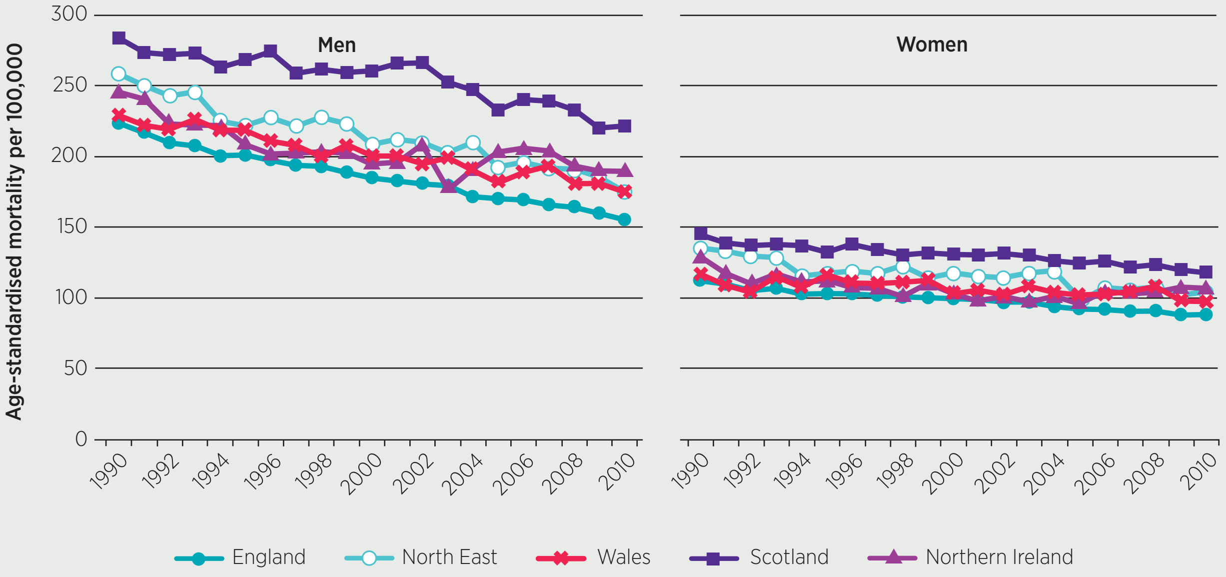


Figure 5.4: Trends in mortality from other causes in the four countries of the UK and North East England, men and women, aged 0–64, 1990–2010



In absolute terms, amenable mortality for the under-65s declined faster in the 1990s than the 2000s for both men and women in all countries, with rates declining faster among men than women. From 1990 to 2000, the greatest reductions in magnitude for men and women were in Northern Ireland and Scotland, and the smallest in Wales and England. From 2000 to 2010, the rates of absolute decline for men were greatest in Scotland and least in Wales; and for women, were greatest in Northern Ireland and least in England. The faster pace of decline in the 1990s was driven mainly by the larger reduction in that decade in premature deaths from ischaemic heart disease (IHD) among both sexes (this decline was greater in men) and from treatable cancers in women (see Appendix 2, Table 2: Bevan and others, 2014c).

In terms of relative change for the under 65s, during the 1990s, the decline in amenable mortality for men was greatest in Northern Ireland and least in Scotland; for women, it was greatest in Scotland and least in Wales (Appendix 2, Table 2: Bevan and others, 2014c). However, contrary to ages 0–74, the pace of decline in amenable mortality among those aged under-65 during the 2000s accelerated only for men in Scotland and in North East England; it decelerated in England as a whole, and stayed the same in Northern Ireland and Wales. For women, compared with the 1990s, the rate of reduction in amenable mortality accelerated in Northern Ireland, Wales and North East England, decelerated in Scotland and stayed the same in England. However, the differences in rates of decline among women in all countries were small.

Trends in amenable and other mortality: 65–74 years

Figures 5.5 and 5.6 give rates of amenable and other mortality for men and women aged 65–74 from 1990 to 2010, which reflect the pattern observed for the age group 0–74.

In 1990, rates of amenable mortality per 100,000 for both men and women aged 65 to 74 were highest in Scotland (1,682 for men and 1,114 for women) and lowest in England (1,266 for men and 867 for women) (Appendix 2, Table 3: Bevan and others, 2014c). Rates of amenable mortality fell across all countries for both sexes over the 20-year period. Although differences in rates between countries decreased between 1990 and 2010, rates per 100,000 remained highest in Scotland (630 for men and 445 for women) and lowest in England (491 for men and 352 for women). The greatest relative reduction of rates of amenable mortality per 100,000 from 1990 to 2010 was in Northern Ireland for men (from 1,630 to 556) and for women in North East England (from 1,033 to 373). However, differences in the relative decline between countries were comparatively small, ranging from 61 to 66 per cent in men and 57 to 64 per cent in women. We examine the reasons for these declines below.

Figure 5.6 shows that rates of other mortality per 100,000 in 1990 were highest in North East England (3,145 for men and 1,640 for women) and lowest in England (2,583 for men and 1,276 for women). However, rates in North East England fell more steeply than those in Scotland so that the relative mortality gap between Scotland and England rose from between 10 per cent (men) and 20 per cent (women) in 1990 to 25 per cent (men) and almost 40 per cent (women) in 2010.

Figure 5.5: Trends in amenable mortality in the four countries of the UK and North East England, men and women, aged 65–74, 1990–2010

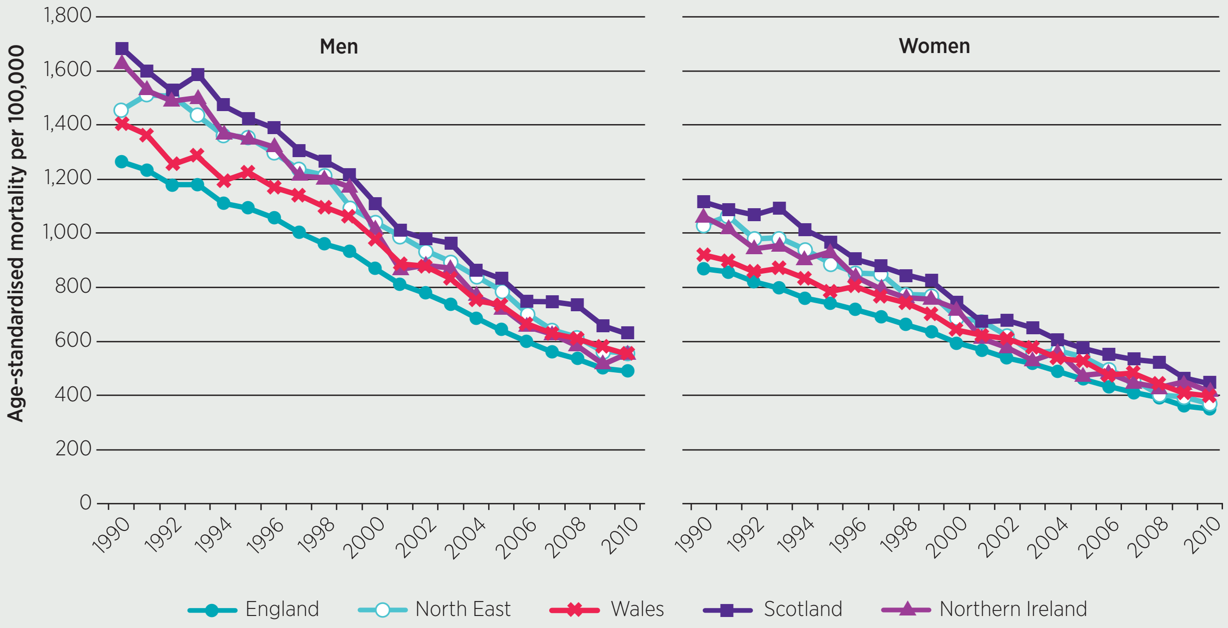
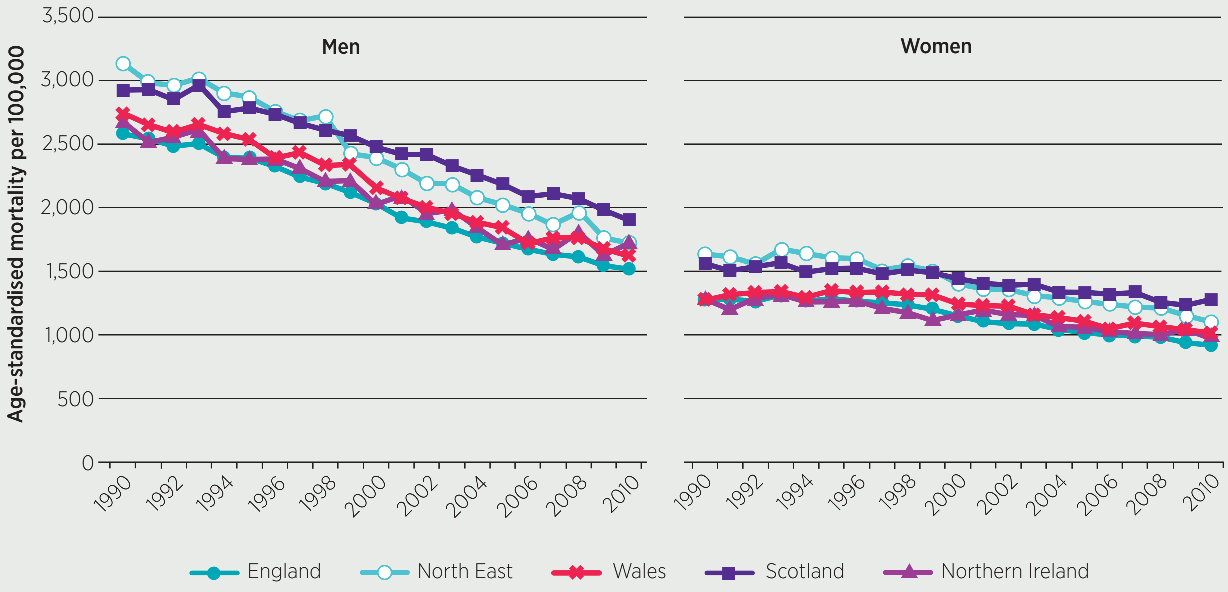


Figure 5.6: Trends in mortality from other causes in the four countries of the UK and North East England, men and women, aged 65–74, 1990–2010



The absolute reduction in the rates of amenable mortality in the two decades varied between the sexes across the four countries and North East England. For men, the absolute reduction was greater in the 1990s than in the 2000s in Northern Ireland and Scotland, but greater in the 2000s than the 1990s for England and Wales. For women, the absolute reduction was greater in the 1990s than the 2000s in all four countries, except Wales and North East England. The faster rate of decline in the 1990s for women was driven mainly by a reduction in deaths from treatable cancers and IHD. For men there was also a greater reduction of deaths from IHD in the 1990s.

Other drivers are less clear. For example, for stroke, there was a greater reduction in mortality in the 1990s in Scotland than in the 2000s, whereas in all other countries the rates of reduction were greater in the 2000s. For treatable cancers, there was a greater reduction in mortality rates in the 2000s for Wales and Scotland than in the 1990s; however, in Northern Ireland, the rate of reduction in the 2000s was much lower than in the 1990s.

The relative rate of decline in amenable mortality in each country and North East England was greater in the 2000s than the 1990s for both sexes, and there were only small differences in the rates of relative change. In the 1990s, for men the relative decline was greatest in Northern Ireland at 38 per cent, and smallest in Wales at 30 per cent. For women, the relative decline ranged from 30 to 33 per cent. Differences in the relative decline between countries became very small during the 2000s, at around 43 to 45 per cent among men and 38 to 42 per cent among women.

Changes in amenable mortality between 1990 and 2010

Figure 5.7 shows the relative change in amenable mortality between the 1990s and the 2000s for men and women for the two age groups 0–64 and 65–74. In general, the relative pace of decline was greater among men than women in both age groups. Only in North East England was the rate of decline in amenable mortality for both men and women of all ages greater in the 2000s than in the 1990s.

Figure 5.7: Relative decline in amenable mortality from 1990–2000 compared with 2000–2010, in the four countries of the UK and North East England, men and women, aged 0–64 and 65–74

Summary

Over the 20 years from 1990 to 2010, there was a marked decline in both amenable and other mortality in each country. Throughout both decades, Scotland had the highest rates of amenable mortality for both sexes. The pace of relative decline in amenable mortality in all four countries was faster in the 2000s than in the 1990s for all groups (except for women in Scotland, where it stayed the same), and exceeded the rate of decline for other mortality. This suggests that health care had a stronger impact on mortality in the 2000s than in the 1990s. During the 2000s, relative declines in amenable mortality were fairly similar between the four countries. The greatest decline was in North East England for both men and women. For other mortality, Scotland had the highest rates throughout both decades. In 1990, other mortality rates in North East England were comparable to Scotland. However, relative to the devolved countries, improvements made over the two decades were greatest in North East England, so that by 2010, rates in the region were similar to Northern Ireland and Wales. The comparison of amenable mortality at the country level suggests that the different NHS policies associated with political devolution may have had little measurable effect, but including a comparison of the devolved countries with North East England suggests that there may have been a greater beneficial impact in England over the other countries in reducing both amenable and other mortality.

6

Discussion

Introduction

Devolution coincided with a 'crisis' of underfunding of the NHS. Clive Smee, who was the chief economist at the Department of Health throughout the 1990s, shows how good comparative data on countries' performance helped to add to that sense of crisis:

> In 1994, in its regular survey of the UK economy, the Organisation for Economic Cooperation and Development (OECD, 1994) stated that the 'NHS was and is a remarkably cost-effective institution'. Most national and international policy analysts probably concurred. Analysts in the Department of Health certainly did (Smee, 2005). Six years later, in its next major review of UK health care, the OECD came to a radically different conclusion. The 2000 study highlighted poor cancer survival rates in the UK, suggested that other disease-specific outcomes were also poor, and noted the limited progress on waiting times and the apparent under-investment in both doctors and buildings. Instead of drawing attention to the efficiency of the NHS, it drew the conclusion that the NHS was underfunded. Many of the officials in the UK had reached a similar conclusion. On 16 January 2000, while the OECD report was still in draft, the prime minister made his seminal commitment to match the average health expenditure levels of the European Union by 2006/07. (Smee, 2008, p. 92)

Smee also points out in a footnote that: "In private the authors went further and indicated that they had been unable to identify any features of the NHS that were particularly commendable" (2008, p. 92). He attributes the change in the OECD's assessment of the NHS to four reasons. First, although the UK had looked to be efficient in 1994 on average lengths of stay for acute care, bed turnover rates and hospital doctors' caseloads, these comparisons were misleading and made the UK look better than it was because of differences in definition: the UK's data were based on finished consultant episodes, but other countries used data on hospital spells. When comparable data were used, the UK did not stand out. Second, in 1994, the UK had both a low level of spending on health care as a share of gross domestic product (GDP) and a level of health status in the middle of the OECD range, but by 2000, data on disease-specific outcomes and, in particular, cancer survival rates showed the NHS to be performing comparatively poorly. Third, the internal market reforms which had excited interest internationally in 1994 had "not produced the scale of benefits that many had anticipated" (2008, pp. 93–4), and there was less interest in the new policy emphasis on targets. Fourth, there was a mismatch between increases in public expectations and slowdown in the growth of NHS funding; the UK's long hospital waiting times were seen as a "clear sign of failed policies and particularly of underfunding" (2008, p. 94).

These observations help to set the context for the discussion of the comparisons in this report over time and across the four countries. They emphasise both the power of comparative data, and the importance of consistency in definitions. They also indicate ways of assessing health system performance: at the aggregate level in terms of spending and health status; by linking funding to staffing and numbers of cases treated; and how in Beveridge-type systems, long hospital waiting times are seen as a symptom of systemic failings. A recent analysis by the OECD (2013a) pointed out that over the first decade of devolution, UK health spending grew in real terms by nearly six per cent a year on average. This raises one set of questions about the data reported here in terms of accountability: is there evidence of such substantial improvements in performance that they justify the massive increases in NHS expenditure in the 2000s? Furthermore, which of the different policies pursued by the different countries has produced best value for money? A second set of questions looks forward: do the available data enable benchmarking to inform better practices and policies in future in the four countries?

Bogdanor (1999) and Greer (2004) saw the legacies of history as indicating that the Scottish Government should be better able to govern following devolution than the governments of Wales and Northern Ireland, but for different reasons. Given that Wales has been governed from England for so much of its history, one would expect there to be a period of learning how to govern, following recognition of its new, more independent status. Northern Ireland ought to have the advantage of having experienced devolution for much of its history, but the complex and deep-seated structural, political and religious issues confronted by government in Northern Ireland meant devolution was suspended between 2002 and 2007, and, as Greer (2004) argued, the normal processes of political accountability have not generally applied. Chapter 2 pointed out that studies that had examined performance across the four countries from devolution to 2006 in terms of hospital waiting times and ambulance response times found that the NHS in England performed best (Bevan and Hamblin, 2009; Bevan and Hood, 2006; Connolly and others, 2011; Propper and others, 2010). The later information reported here on performance after that initial period of devolution is of great interest for answering two kinds of comparative questions. First, has the new system of performance management since 2005 in Scotland resulted in improved performance, and how does this compare with that of England? Second, have Wales or Northern Ireland been able to improve their performance since 2006, and how does their performance compare with that of England and Scotland?

In the next five sections, the following are discussed: health care spending, health care need and health; health care productivity; health care quality; patient satisfaction; and related wider public policy issues posed by devolution.

Spending, need and health

Smee (2008) argues that one macro-level performance indicator of a country's system of health care is the relationship between its total spending on health care as a percentage of GDP and its population health status. However, the relationships between spending and health status are complex: poorer health creates a need for increased health care which, it is hoped, leads to better health and hence reduced need (Grossman, 1972). Here, this report considers spending in relation to need and health status.

One of the main findings of Dixon and others (1999) was that in 1995/96, health spending per head in Scotland was 25 per cent higher than in England. The first three columns of Table 6.1 give spending per head on health in the devolved countries, England and North East England for 2000/01 and 2012/13, as well as the percentage increases over those 13 years. Comparing the devolved countries with North East England, at the start of that period, North East England had lower spending per head than any of the devolved countries, but by the end, health spending per head was about £2,100 in North East England, Scotland and Northern Ireland; and in Wales was about 10 per cent lower (at about £1,900). This marked shift in relative spending is the outcome of two changes shown in Table 6.1. First, the government in England increased spending on health more than those in the devolved countries: the percentage increases were 115 per cent for England, 99 per cent for Scotland, 98 per cent for Wales and 92 per cent for Northern Ireland. The second change was that England increased the funding per head in regions such as North East England (128%) relative to the average for England (115%), because of changes in the formula used to allocate resources in England according to the relative needs of different areas (Bevan, 2009).

Table 6.1 gives estimates of differences (in £s per head) between their actual health spending in 2012/13, and what they would have been able to spend on health if they had increased spending at the same per capita rate as England: £249 in Northern Ireland; £168 in Scotland; and £160 in Wales. If the devolved governments had been able to match the growth rate in England, we estimate that the extra amount they would have spent on health care would have been about £900 million in Scotland, over £400 million in Wales and the same in Northern Ireland (the per-capita rates multiplied by their populations). Increases in the total funds actually available in Scotland, Wales and Northern Ireland are largely determined by the Barnett Formula, which gives each country a proportionate share according to population of the increase in planned spending in England on comparable services. Each devolved government then determines its spending priorities. For example, total public spending increased at broadly the same pace in Scotland as the rest of the UK between 2002/03 and 2011/12, and remained on average 14 to 19 per cent higher than in the UK as a whole (Deaner and Phillips, 2013). Chapter 2 mentioned how Scotland funded the costs of free long-term personal and nursing care for people aged 65 years and over from the 'Barnett consequentials' by not increasing spending on its health service at the rate implied by the Barnett Formula. The recent cost of that policy was estimated to be £450 million (Timmins, 2013, p. 13).

Table 6.1: Health spending per head – increases

	Actual per head	Actual per head	% increase	Projection for 2012/13 at rate of increase for England
	2000/01	2012/13	2012/13 over 2000/01	Per head
	£	£	%	£
North East	945	2,150	128	2,028
England	891	1,912	115	1,912
Scotland	1,064	2,115	99	2,283
Wales	985	1,954	98	2,114
Northern Ireland	1,099	2,109	92	2,358

An unresolved difficulty in making sense of differences in spending per head on health in the different countries, lies in accounting for differences in relative health care need in terms of morbidity, of which age is one indicator (Bevan, 2009). Each country has developed different formulas for estimating the relative needs of different areas within the country, but the Barnett Formula used for the devolved countries is designed to take account of population size only.[49] The National Audit Office (2012a, 2012b) has produced estimates of relative health care needs across the four countries. These are given in Table 6.2 with the present study's data on life expectancy, and rates of amenable and other mortality over the period 2007–10.

Table 6.2: Life expectancy, mortality and relative health care need, 2007–10

	England	North East	Wales	Scotland	Northern Ireland
Life expectancy at birth (2008–10)					
Males	78.50	77.1	77.62	75.9	76.96
Females	82.51	81.1	81.78	80.4	81.4
Amenable mortality under age 75; age-standardised mortality per 100,000 (2010)					
Males	80	89	87	97	90
Females	64	69	72	77	72
Other mortality under age 75; age-standardised mortality per 100,000 (2010)					
Males	255	289	281	344	302
Females	149	177	165	203	170
National Audit Office population relative needs weights (2007/08 to 2009/10)					
Mean	0.91		1.07	0.98	1.11
Range	0.63–1.27		0.92–1.24	0.8–1.16	1.00–1.26

The estimates of relative needs by the National Audit Office (2012a, 2012b) were based on data from 2007/08 to 2009/10, which included measures of population age, levels of disability and wealth (National Audit Office, 2012a, p. 18). The National Audit Office's weighting for the different measures was estimated by regression analysis on the Resource Allocation Formula used in England. The National Audit Office estimated that on this basis, relative need was as follows: England (0.91), Scotland (0.98), Wales (1.07) and Northern Ireland (1.11). More generally, on the basis of its analysis of indicators of relative need, using measures of age, income, morbidity and unemployment, the Select Committee on the Barnett Formula also concluded that "any well-based combination of the measures would show that England and Scotland have lower overall needs than Wales or Northern Ireland" (2009, p. 42).

Chapter 3 mentioned that in its examination of the Barnett Formula, the Holtham Commission also applied the formula used for the NHS in England, and estimated that the relative need for Wales was almost the same as for North East England, which was 14 per cent greater than that for England as a whole (Holtham, 2009, p. 48). This report now considers differences in health and life expectancy across the four countries, and how these do (and do not) relate to the National Audit Office's estimates of their relative needs.

The OECD (2013b) noted that in 2011, the life expectancy at birth in the UK of 81.1 years was a full year more than the OECD average (80.1 years). Table 6.2 shows Scotland to have the worst life expectancy and amenable and other mortality for both men and women of the four countries. Dixon and others (1999), Alvarez-Roseté and others (2005) and Connolly and others (2011) all found that in comparison with the other countries, the population of Scotland had the highest rates of standardised mortality and lowest life expectancy. The current study found that in 1991–93, men and women in North East England had a similar life expectancy to Scotland, but that by 2009–11, both would have been expected to live about one year longer in North East England than in Scotland.[50]

Over the 20 years from 1990–2010 there was a marked decline in both amenable and other mortality in each country. Throughout both decades, Scotland had the highest rates of amenable mortality for both sexes across the four countries and North East England for all the three age groups that this study examined (the under-75s, under-65s and those aged 65–74). The wide dispersal of rates for amenable mortality in 1990 between the devolved countries and North East England narrowed considerably, so that by 2010 there were only small differences between England, North East England and the devolved countries. For other mortality, in 1990 the rates in Scotland and North East England were higher than in Wales and Northern Ireland; however, by 2010, North East England had similar rates for men and women as Northern Ireland and Wales, and lower rates than Scotland. Scotland's relatively high mortality rates indicate a greater need for health care than in the other countries, which was not reflected in the National Audit Office's estimates of relative need.

Productivity

The dramatic increases in NHS funding from 2000 have been associated with low rates of NHS productivity, as increases in spending have outstripped increases in measured outputs. The problem of measuring productivity has been a focus of research since the Atkinson Review (Atkinson, 2005). The Office for National Statistics (2010) estimates that across the four countries, average productivity growth in publicly funded health care in the UK was 0.4 per cent a year between 1995 and 2010, but the growth in the rate of output began to exceed the rate of inputs from about 2005 (Massey, 2010). Looking at the end of the period studied by the Office for National Statistics, Bojke and others (2013) estimated that between 2004/05 and 2010/11 there had been an eight per cent increase in the productivity of the English NHS, which is almost three times greater than the Office for National Statistics' estimates over the period 1995 to 2010.

This section begins by considering what might be described as a reductionist approach to assessing productivity. It then considers another way of thinking about productivity, by benchmarking the NHS in each country against Kaiser

Permanente using estimates by Feachem and others (2002). This discussion of waiting times also refers to a study that sought to estimate the costs and benefits of the dramatic reductions in waiting times that have been achieved in England.

A reductionist approach

In a reductionist approach to measuring productivity, we would like to be able to:

- disaggregate total spending on health care into hospital and community health services and family health services
- see how funding on hospital and community health services translates into different types of staff
- relate staffing to activity in terms of outpatients, day-cases and inpatients.

Box 6.1 shows how the availability of these data has degenerated over the four studies, which means that it is not now possible to assess how spending translates into staff and their productivity.

Box 6.1: Availability of data on spending, staffing and activity

	Dixon and others (1999)	Alvarez-Roseté and others (2005)	Connolly and others (2011)	This study
Expenditure				
Hospital and community health services	✓	✗	✗	✗
Family health services	✓	✗	✗	✗
Staff				
Hospital doctors	✓	✓	✓	✓
Nurses	✓	✓	✓	✗
GPs	✓	✓	✓	✓
Activity				
Outpatients	✓	✓	✗	✗
Inpatients	✓	✓	✗	✓
Day-cases	✓	✓	✗	✗

The OECD (2013a) highlighted the large increase in practising doctors per 1,000 population in the UK, from 2.0 in 2000 to 2.8 in 2011, but showed that the rate was still below the OECD average of 3.2. The OECD rate is based on headcounts of practising doctors (including GPs and hospital doctors), and there are differences in definitions between countries over whether doctors in training are or are not included (OECD, 2013b, p. 64). The increase in the UK was driven by the increase in hospital doctors, which of all the staff groups had the largest percentage increases over the period 1996–2011. The rates of hospital doctors per 1,000 population (in whole-time equivalents; WTEs) in 2011 were 1.9 in England and Wales, 2.0 in Northern Ireland, 2.2 in the North East and 2.3 in Scotland. Staffing rates per 1,000 population for GPs are discussed below, which ranged from 0.6 to 0.7 in WTEs and from 0.6 to 0.9 in headcounts.

The OECD (2013b, p. 77) reported that in 2011 in the UK, there were 8.6 nurses per 1,000 population, which was similar to the OECD average of 8.7 (again, there are problems over differences in definition; OECD, 2013b, p. 64). The present report's comparisons of nurses in WTEs per 1,000 population in 2011 showed England to be an outlier with a much lower rate (5.8) than the other countries (Wales, 7.1; Northern Ireland, 7.5; and Scotland, 7.9). As the rate for the North East (7.4) was similar to that of the devolved countries, the low rate for England as a whole cannot be explained by definitional differences. This could be due to proportionately more NHS-funded care being provided by non-NHS staff in England than in the devolved countries and the North East,[51] given that only in England are NHS commissioners encouraged to contract with private providers. Chapter 3 mentioned that Arora and others (2013) showed that NHS spending on non-NHS providers in 2011/12 was about 10 per cent for England as a whole, but only 3.2 per cent in the North East. If this were the complete explanation, then it would imply that a nearly seven per cent increase in NHS spending on non-NHS providers in England as a whole over that of the North East had resulted in a reduction of nearly 30 per cent in rates of nurses. This is highly implausible.

Although the formula used to guide the allocation of health service resources aims to compensate for variations in labour markets by the Market Forces Factor, this is designed to cover costs of agency nursing staff in high-cost areas (Bevan, 2009). Buchan and Seccombe (2012) point out that temporary nurse staffing costs as percentages of permanent staff costs (including all staff groups and types of temporary staff) were 7.4 per cent in England, about 5.3 per cent in Scotland, 2.8 per cent in Northern Ireland and 2.3 per cent in Wales (p. 25). There are no recent data on the distribution across England, but it is likely that the North East of England will have low rates that are comparable with the devolved countries: the National Audit Office (2006) reported the percentage in the then Northern and Yorkshire region to be among the lowest in England and to be about 4 per cent (p. 14). Hall and others (2008) also showed the North East to have low rates of agency staff (p. 57). They also found that high use of temporary agency staff, was associated with worse health outcomes: a 10 per cent increase in the outside wage was associated with a 4 to 8 per cent increase in death rates for acute myocardial infarction within 30 days of emergency admission. The key points are that the gap in nursing supply per head between England, and the devolved countries and North East England, is likely to be explained by differences in the levels of employment of agency staff, and that low levels are likely to be associated with better quality of care.

This report has explained that it is not meaningful to make comparisons between countries in term of rates of infrastructure staff per 1,000 population. However, it is possible to compare England with North East England. The rates of infrastructure staff in England and North East England in 2011/12 were 3.6 and 4.2, respectively; so North East England had about 17 per cent more staff than the average for England. This may be due to North East England spending about seven per cent less than the average for England on independent providers.

This study has data on rates of hospital treatment per 1,000 population in England, Scotland and Wales from 1998/99 to 2011/12 for outpatient attendances, inpatient admissions and day-cases. For Northern Ireland, the study has data from 2006/07 or 2008/09 only. For North East England, the study has data on day-cases only from 2006/07. Rates of treatment per 1,000 population changed as follows:

- Outpatients – for England, Scotland and Wales, these showed little change from 1998/99 to 2006/07 and were between around 900 and 1,000. From 2006/07 to 2011/12 these rates increased in England (to 1,200), changed little in Wales, and slightly decreased in Scotland (to less than 900). In Northern Ireland, the rates in 2011/12 were the lowest (around 800).
- Inpatient admissions – between 1998/99 and 2011/12, showed little change in Scotland (from 139 to 137); with an increase in England (from 119 to 131); between 2000/01 and 2011/12; a small reduction in Wales (from 154 to 144); and, between 2005/06 and 2011/12, a modest change in Northern Ireland (from 138 to 131). We do not report data for North East England due to lack of details on inpatient admission type and even the data we do report may not be fully comparable.
- Rates of day-cases – between 1998/99 and 2011/12, showed an increase in Scotland (from 76 to 85) and a substantial increase in England (from 70 to 112); between 2000/01 and 2011/12 rates increased substantially in Wales (from 45 to 75), but that change also reflected the ending of the 'cleansing' of these data; between 2005/06 and 2011/12, rates increased in Northern Ireland (from 145 to 170), and between 2006/07 and 2011/12 strongly in the North East (from 107 to 158).

There are serious problems of comparability between countries and over time because of differences and changes in definitions of outpatient attendances, inpatient admissions and day-cases. One indicator of efficiency used by the National Audit Office (2013, p. 4) is that of day-cases as a percentage of all hospital admissions. The National Audit Office reports these percentages to have been, for 2008/09, 41.0 for England, 36.4 for Scotland, 36.8 for Wales and 41.8 for Northern Ireland. The present study's data for the same year suggest that these percentages were 43.3 for England, 36.3 for Scotland, 33.5 for Wales and 52.7 for Northern Ireland. However, we are aware that the differences in definition of what constitutes a day-case mean that cross-country comparisons are unlikely to be valid, as well as making it virtually impossible to use the data that are collected routinely to compare rates of hospital activity or crude productivity across the four countries.

A further complication in interpreting cross-country comparisons of rates of hospital activity is caused by another policy difference between England and the devolved countries. In England, some hospital procedures are reimbursed depending on their volume following the introduction of Payment by Results, which was fully in place from about 2006/07. This creates financial incentives in England, but not in the other countries, for both increasing volumes of activity and their more complete recording, but it is not possible to distinguish between these real and artefactual effects. Farrar and others (2007, Table 5.41, p. 128; 2009) evaluated the early impact of Payment by Results in England in comparison with Scotland, where there was no funding of hospitals by activity. By using difference-in-difference analysis, they found that between English and Scottish hospitals there was no statistically significant difference in rates of outpatient activity in 2006/07; there was a small increase in rates of inpatient admissions in England, but this may have been due to pressure to reduce waiting times and cash limits; and, consistent with the anticipated effects of Payment by Results, there was a greater increase in day-case rates in England (as well as a greater reduction in lengths of stay).

Dixon and others (1999) measured crude productivity in terms of rates of hospital admissions (inpatient and day-cases) and outpatients per HCHS doctor/dentist and nurse in 1995/96. They found that "doctors and nurses in Scotland, Wales and Northern Ireland seem to be under less pressure (or are less productive) than their counterparts in England" (p. 525). Alvarez-Roseté and others (2005) found that the increases in numbers of HCHS doctors/dentists and nurses between 1995/96 and 2002/03 meant reductions in crude productivity for all measures in all four countries; that Wales had the highest rates of outpatients and hospital admissions per HCHS doctor/dentist; and that England had the highest rates for nurses. Connolly and others (2010) encountered problems from definitional changes of inpatients, day-cases and outpatients. Where cross-country comparisons were possible, for 2006/07, England had the highest rates of crude productivity for outpatient appointments and day-cases per HCHS doctor/dentist, and outpatient appointments, day-cases and inpatient admissions per nurse; and Northern Ireland had the highest rate for inpatient admissions per HCHS doctor/dentist.

This report has shown that increases in the numbers of hospital doctors over the decade or so to 2011/12 have resulted in reductions of between 15 per cent and a third in crude productivity in terms of the rate of inpatient admissions per HCHS doctor/dentist. (This is the only available measure of activity with broadly consistent definitions across the four countries, although there are some questions over the staff data from Northern Ireland and even the hospital inpatient data we do report may not be fully comparable.) By 2011/12, our data show the rates of inpatient admissions per HCHS doctor/dentist were similar for England and Wales, at 70 and 76, respectively; and similar, but lower, for Scotland and Northern Ireland, at 60 and 65.

The National Audit Office (2012a) estimated comparative efficiency per HCHS doctor/dentist in each country in 2008/09 by weighting the numbers of inpatient and day-case admissions and outpatients by their estimated average costs. This estimate did not take account of the complexity, quality of care, or differences in the levels at which staff were employed. Their estimates of cost-weighted activity per HCHS doctor/dentist for inpatients, outpatients and day-cases were: in England, £238,000; Wales, £219,000; Northern Ireland, £189,000; and Scotland, £179,000. Table 6.3 gives the data reported for each country by the National Audit Office, as well as this study's estimates of inpatient and day-case

Table 6.3: Crude productivity and cost-weighted activity per HCHS doctor/dentist, 2008/09

	England	Wales	Scotland	Northern Ireland
Crude productivity per HCHS doctor/dentist				
Inpatients	75	81	65	71
Day-cases	57	41	36	79
Outpatients	662	558	394	433
Cost-weighted activity (£000s) (National Audit Office)				
Inpatients	144	136	115	117
Day-cases	35	28	23	30
Outpatients	59	55	40	42
Total	**238**	**219**	**179**	**189**

admissions and outpatients per HCHS doctor/dentist for the four countries for the same year. The problems of inconsistency of definitions across the four countries for day-case admissions and outpatients, mentioned above, may explain the variations between this study's estimates and those of the National Audit Office. However, even for inpatients, where it appears possible to make the data broadly comparable, there is no consistency in the rankings by country. Information experts in each country have checked the current study's estimates, but the National Audit Office report does not give the raw data on which its estimates were based, so it is not possible to identify how these divergences arise. Given the problems of comparability of basic data on staff and hospital activity, it is thus not currently possible to compare with confidence even the crude productivity of HCHS doctors/dentists and nurses across the four countries.

Benchmarking against Kaiser Permanente

The measures that this study has tried to estimate of crude productivity in terms of numbers of inpatients per hospital doctor are meaningful where these rates are low, but it cannot be assumed that high rates mean high productivity. The caveat that always applies to activity-based measures of productivity is that they do not distinguish between care that improves health, has little or no impact, or is unwanted or even harmful from the patient's viewpoint. There is evidence that unwarranted variations in hospital care are pervasive and material (Wennberg, 2011): these have been mapped for the NHS in England by Right Care for 2010 and 2011, and in a series of themed atlases of services for children and young people, diabetes, kidney disease, respiratory disease, liver disease and diagnostic services (Right Care, n.d.). Indeed, one widely sought indicator of the success of better integration across different services is reductions in rates of emergency admissions to hospital. In the discussion of integrated care in Chapter 2, we cited comparisons between Kaiser Permanente in the USA and the UK in 2000 by Feachem and others (2002), and between Kaiser Permanente and the English NHS by Ham and others (2003). The latter detailed study standardised for age, but did not take account of differences in morbidity (Talbot-Smith and others, 2004), and suggested that Kaiser Permanente's better-integrated provision of health care explained why its rate of acute admissions was about one-third that of the English NHS.

Table 6.4 compares data from Feachem and others from 2000 with data from 2008/09 for the four countries, using the present study's data for inpatient

Table 6.4: Rates of use of acute beds per 1,000 population

	Kaiser Permanente (2000)	UK NHS (2000)	England (2008/09)	Scotland (2008/09)	Wales (2008/09)	Northern Ireland (2008/09)
Mean length of stay	3.9	5.0	4.3	5.7	6.3	5.5
Inpatient admissions per 1,000	69	200	132	143	149	140
Acute bed days per 1,000	270	1,000	567	812	941	772

Sources: Feachem and others, 2002 for Kaiser Permanente, and UK, 2000; National Audit Office, 2012a for mean lengths of stay for 2008/09 (see Appendix 1 of this report for details of the present study's data on admissions in 2008/09: Bevan and others, 2014b).

admissions (excluding day-cases),[52] and estimates by the National Audit Office (2012a) for mean lengths of stay.[53] The National Audit Office observed that "even after adjusting for differences in patient characteristics and case-mix (such as the proportion of complicated procedures), there was significant variation in hospital lengths of stay within nations" (2012, p. 33), which suggests scope for greater efficiency in the use of acute beds in Wales, Scotland and Northern Ireland. However, the promise of integration is of much greater efficiency savings, by eliminating all admissions that can be substituted by more appropriate, cheaper care. The estimate by Feachem and others that the UK used acute beds at about a rate more than threefold that of Kaiser is consistent with the findings of the later study by Ham and others (2003). Although we do not have comparable data for 2000/01 for Northern Ireland, for that year, the rates of acute impatient admissions per 1,000 were 116 in England, 154 in Wales and 137 in Scotland. These suggest a rate for the UK of about 120, which would put the UK rate of acute bed use at about twice (rather than threefold) of Kaiser. Our data show an increase in admission rates for England to 132 in 2008/09, with a slight reduction in Wales (to 149) and slight increase in Scotland (to 143). Wales appears to have the greatest scope to reduce its use of acute beds as it had the highest rate of acute admissions and the longest length of stay in 2008/09. More generally, the comparison with Kaiser Permanente suggests that a well-designed system of integrated care could release substantial resources from the acute hospital sector in each country. This suggests a focus for future comparative research on developments of integrated care in England and Scotland (see the final section of this chapter), where policy objectives are the same, but the organisational forms and models of governance differ (for example, England has to develop integrated care in a system with a commissioner/provider split and subject to the overarching institutional logic of choice and competition; see Chapter 2). This comparison could include analyses of large, individual-level linked datasets for the purposes of benchmarking, complemented by detailed local studies of areas with similar demographics and socioeconomic circumstances that would include studies of patients' experiences of particular services, as well as qualitative research to attempt to explain any differences observed.

Quality

As Smee (2005) pointed out, one of the reasons for the increases in spending on the NHS in the UK was that quality of care seemed to be so poor in comparison with other countries. This report considers what evidence there is of changes in quality in the four countries, organised using Donabedian's (1966) categories of structure, process and outcomes.

Structure

A major research question is: which of the different organisational structures and models of governance in the four countries is best for improving quality of health care? The only data that this study has on structure, which are deemed to be a good measure of quality, are for stroke care. The stroke audits by the Royal College of Physicians of London for 2006 and 2010 cover all countries except Scotland, which carries out its own stroke audit. In 2006, the percentage of patients who spent more than 90 per cent of their time in a stroke unit was highest in Northern Ireland (60 per cent), and lowest in Wales (39 per cent), with England in the middle (51 per cent). By 2010, the percentage had risen in England, with little change in Wales, and had fallen in Northern Ireland (to 50 per cent).

Process

This study has measures of process for ambulance response times, hospital waiting times, stroke care and some public health services.

Ambulance response times

This study has data for North East England and all four countries on the percentages of ambulance response rates in fewer than eight minutes to what may have been life-threatening emergencies (category A calls).[54] There was a substantial improvement in performance in the devolved countries between 2006/07 and 2011/12. In 2006/07 these were about 56 per cent, but by 2011/12 they ranged from 68 per cent in Wales to 73 per cent in Scotland and Northern Ireland, and more than 75 per cent in England and North East England.

Hospital waiting times

Table 6.5 summarises the findings on performance on hospital waiting times from the three earlier studies (Dixon and others, 1999; Alvarez-Roseté and others, 2005; Connolly and others, 2011). The data for Scotland were not comparable with the other countries (because of the different rules for excluding suspended patients). There are few data for 1995/96, but there was only one case of improvement by 2002/03: in England, where there was a small improvement in those waiting less than six months for day-case or inpatient admission, from 75 to 81 per cent. The data for 2006/07 show improvements in all cases except for waiting less than three months for a first outpatient appointment in Northern Ireland. Across the three countries, the performance for England was clearly the best, with virtually everyone waiting less than three months for a first outpatient appointment, and less than six months for day-case or inpatient admission.

Table 6.5: Performance on hospital waiting times, 1995/96, 2002/03 and 2006/07

	England	Wales	Scotland	Northern Ireland
% population waiting less than:				
3 months for first outpatient appointment:				
1995/96	N/A	72	N/A	65
2002/03	80	46	N/A	42
2006/07	100	56	N/A	39
6 months for day-case or inpatient admission:				
1995/96	75	N/A	N/A	62
2002/03	81	63	N/A	60
2006/07	100	79	N/A	84

Since this time, the health service in Scotland has brought its practice for suspended patients into line with the other countries. However, it is unclear how consistently this change has been implemented. The government auditor in Scotland has raised concerns over health boards' inappropriate use of 'unavailability' codes to exclude patients from waiting time calculations (Audit Scotland, 2013). The government auditor in England has also identified different problems of inconsistencies and errors in the way that English NHS trusts measure waiting times (National Audit Office, 2014, p. 7). Waiting time performance is now measured for elective hospital admission in terms of referral to treatment (RTT) time, which includes diagnostic waits, in England, Scotland and Wales. In March 2013, the performance in the different countries was as follows:

- England – more than 97 per cent of those seen in outpatients only, and more than 92 per cent of those admitted to hospital, were dealt with within 18 weeks (the targets were 90 and 95 per cent).
- Scotland – more than 90 per cent of those seen in outpatients only or admitted to hospital were dealt with within 18 weeks (the standard was 90 per cent).
- Wales – 92 per cent of those seen in outpatients only or admitted to hospital were dealt with within 26 weeks (the target was 95 per cent); 99 per cent of those seen in outpatients only or admitted to hospital were dealt with within 36 weeks (the target was 100 per cent).
- Northern Ireland – for the first outpatient appointment, 80 and 99 per cent were seen within nine and 21 weeks, respectively (the targets were 50 and 100 per cent); and for inpatients, 69 and 97 per cent were admitted within 13 and 36 weeks, respectively (the targets were 50 and 100 per cent).

The data on performance against targets show both a transformation for each country since 2000, and remaining differences between them in March 2013. As the targets and standards differ, it is not possible to make direct comparisons between the countries, and there are questions over the reliability of the data.

In assessments of health service productivity, a value is placed on reductions in waiting times, but a problem in doing so is that as Wanless and others observed, “there is no readily available data on the costs and benefits of meeting successive waiting time targets” (2007, p. 193). Morton and Bevan (2012) sought to produce such estimates for England by making some heroic assumptions. They first estimated that over the five years from 2002/03 to 2007/08, the better performance resulted in a reduction in time spent waiting of more than a million years. They estimated the annual cost of resources consumed by this policy in 2007/08 to be £3 billion at most, and if the value of waiting a day less were £15, then the costs of the policy would be about equal to the benefits.[55] The current report pointed out earlier that in 2002/03 the waiting time performance of the health system in England appeared to be superior to that of Wales and Northern Ireland, and that the data show substantial improvements in these countries since then. It would be interesting to undertake a similar kind of analysis for those countries in order to give a sense of the scale of their achievement, even if it has lagged behind that of England.

This study does have broadly comparable data for all countries on rates of hospital treatment from 2007/08 to 2011/12, for the seven common procedures that were used to make cross-country comparisons in the earlier studies;[56] and the 50th and 90th percentiles of the distributions of waiting times[57] for six of the seven surgical procedures from 2005/06 to 2009/10. There is no consistent pattern of higher or lower procedure rates across countries. There were substantial reductions in median waiting times for most procedures across all four countries, including halving the median wait for hip and knee replacement in England and Scotland. The 90th percentile decreased over the period from 2005/06 to 2012/13 for most of the procedures in England and Scotland, except for coronary artery bypass graft (CABG) surgery in England. In Wales and Northern Ireland there were dramatic reductions in the 90th percentile from 2005/06 to 2009/10 for all procedures, except in Wales for cataract surgery (which increased). However, in Wales since 2009/10, there have been increases in the 90th percentile for all procedures. Although there is no simple relationship between the statistics on rates of treatment and on waiting times, since 2009/10 in Wales, there has been an increase in waiting times, and a reduction in surgical rates for these procedures.

Stroke care

For stroke care, there were substantial improvements across nine key indicators of the quality of the process in all three countries between the audits published in 2006 and 2011 by the Royal College of Physicians of London (2006, 2011). The average achievement increased from 60 per cent to 83 per cent in England, from 52 per cent to 73 per cent in Wales, and from 64 per cent to 74 per cent in Northern Ireland.

Preventive services

For preventive health services, this study has rates of vaccination, immunisation and screening. Of these, the most serious failing in the 2000s was that the average rate in England for measles, mumps and rubella (MMR) coverage of children reaching their second birthday had fallen below 80 per cent in 2003/04, against the World Health Organization’s recommended 95 per cent. The report from the Health and Social Care Information Centre (2012b) states that:

> The controversy and associated publicity around a potential link between the MMR vaccination and autism and Crohn’s disease, which started in the late 1990s and continued through the early 2000s, may have impacted on MMR coverage during that period. The study that initiated the controversy has since been discredited.[58]

Since then, the average rate for England has increased every year and, for all countries and North East England for 2011/12, was over 90 per cent, but still below the recommended 95 per cent. In 2013, there were measles outbreaks with more than 2,000 cases in England and Wales (BBC News, 2013a); there was also a particularly severe outbreak beginning in Swansea in 2012 (BBC News, 2013a). ‘Catch-up’ campaigns targeting specific age groups have been conducted in England and Wales to increase coverage in older children and adolescents.

Rates of immunisation for 2011/12 for the ‘5 in 1’ (diphtheria, tetanus, whooping cough (pertussis), polio and Hib (Haemophilus influenzae type b)) vaccine and the Meningitis C vaccine, by the first and second birthdays, were above 95 per cent in all countries except England, which had rates close to 95 per cent. However, there were wide variations in the rates of vaccination against influenza in the winter over the two years, 2011/12 and 2012/13. Northern Ireland had the highest uptake rates for the general population at risk, but the lowest rate for health care workers. Uptake of screening for breast cancer among women between the ages of 50 and 70 for 2010/11 was 69 per cent in England, and above 70 per cent in the North East of England and the devolved countries.

Outcomes

This study has reported data on three different kinds of outcomes. First, at the system level, it has compared amenable mortality across the four countries and North East England. This shows that over the 20 years, 1990–2010, there was a marked decline in amenable mortality in each country, which exceeded the rate of decline for other mortality. Throughout both decades, Scotland had the highest rates of amenable mortality for both sexes. At the country level, there was little difference in the rates of decline in amenable mortality; but North East England showed greater reductions in amenable and other mortality than Scotland.

Second, this study has compared one-year percentage rates of survival for patients on renal replacement therapy for one indicator from 2002 to 2010, which showed improvements in all countries with rates close to, or more than, 90 per cent. This shows that these rates have improved in all countries. In 2010, the survival rates were above or close to 90 per cent.

Third, this study has compared rates (per one million population) of deaths in which methicillin-resistant staphylococcus aureus (MRSA) is mentioned on death certificates, from 1996 to 2012, for both sexes, for all countries except Scotland, which show that the rates for men were about twice that for women. However, this study does not have data for North East England. The MSRA mortality rates peaked in Wales in 2005, in England in 2006 and in Northern Ireland in 2008. From then the rates for men fell from their peaks to the following in 2012: in England, from nearly 27 to 3.7; in Wales, from 28 to 7.6; and in Northern Ireland from 43 to 9.7. In 2011 in England and Wales, there were on average 170,000 hospital admissions for a million population in each country. MRSA would have been mentioned on the death certificates of six men and women in England, and more than 11 in Wales per million admissions, indicating MRSA mortality rates of about 0.4 and 0.6 per cent, respectively.

Performance and satisfaction

We can see how comparative performance relates to patient satisfaction (percentages who were ‘very satisfied’ or ‘quite satisfied’), by using the 2011 British Social Attitudes (BSA) survey (Park and others, 2012), which gave results for England, North East England, Scotland and Wales (but not Northern Ireland). One of the questions in the BSA survey was on ‘the way in which the NHS runs’. Answers to that question may reflect people’s general perceptions of the system which are influenced by reporting in the media, rather than their own direct experience of health care. The rates of satisfaction were: North East England, 67 per cent; Wales, 62 per cent; Scotland, 55 per cent; and England, 53 per cent. Hood and Dixon (2010) found that coverage of the demanding target regimes that applied in England from 2000 to 2005 was generally negative in London-based press articles, and became more so over time. They also sought to test the hypothesis that “changes in party preferences on health and education would be more favourable to the incumbent party in England than in Scotland and Wales over this period – given the more aggressive pursuit of health and education targets in England” (2010, p. i292), but found “no significant differences between England, Scotland and Wales in level of Labour support or rate of decline” (2010, p. i292). Their conclusion was that there is no obvious benefit in terms of media or public support accruing from tough regimes in which governments put pressure on providers to improve their performance. Indeed, the opposite is possible, since an absence of such pressure will tend to avoid negative press coverage, and hence could lead conceivably to higher levels of satisfaction with the way that the NHS runs – even if performance is not improving.

Two questions in the BSA survey asked directly about patient experience of ‘attending hospital as an outpatient’ and ‘being in hospital as an inpatient’. Across the three countries, Scotland had the highest rates of satisfaction (70 per cent and 68 per cent, respectively); with England (65 per cent and 55 per cent) and Wales (66 and 53 per cent) having similar rates. North East England had rates that were closer to those of Scotland than England (69 per cent and 63 per cent).

The fourth and final question in the BSA survey was on 'the way the NHS's local doctors or GPs run nowadays' (for being 'very satisfied' or 'quite satisfied'). Answers to this question also may be influenced by reporting in the media rather than people's own direct experience of health care. The rates of satisfaction were: North East England, 80 per cent; Wales, 78 per cent; England, 76 per cent; and Scotland 68 per cent. The National Audit Office (2012a) sought to examine the quality of primary care in the four countries across four disease areas (coronary heart disease, stroke, hypertension and diabetes) using results from 28 indicators in the general practice Quality and Outcomes Framework between 2009/10 and 2010/11. General practices can exclude patients in order to prevent being penalised in the Quality and Outcomes Framework assessment: for example those who do not attend for a review, or for whom a medication cannot be prescribed due to a contraindication. The National Audit Office found that the extent of so-called 'exception reporting' varied across the four countries, and was highest in Scotland. Without adjustment for exception reporting, GP practices in Scotland and Northern Ireland generally scored better across the 28 indicators and outperformed England across all four disease areas, with practices in Wales performing similarly to England. After adjustment, practices in Northern Ireland still performed better than those in England, but there were no consistent differences between the other three countries, which appears to be at variance with the differences in satisfaction in the BSA survey.

Wider policy issues posed by devolution

In this section three general issues which apply to public services and are posed by devolution are discussed: resource allocation, governance and developing comparable data.

Resource allocation

The failure to develop a fair system of allocation of resources for devolved services in the different UK countries has a long history. Bogdanor (1999, pp. 35–42) points out that the problem of deciding what spending ought to be in relation to need, and the capacity of each country to raise taxes to fund public services, arose in the period of Irish Home Rule and remained unresolved following devolution. The consequence is that the level of funding has been vulnerable to political lobbying which, Bogdanor (1999, pp. 112–13) and McLean (2000, p. 82) argue, is why Scotland has been so successful in securing higher levels of spending on public services than the other UK countries. Insofar as there is a formal basis for funding, this is still through the Barnett Formula which, as the Holtham Commission pointed out, was described by Lord Barnett himself as no more than:

> 'a temporary expedient not expected to last a year, or even twenty minutes'... politically it was not found possible to secure agreement on a formula that allocated resources on the basis of needs, although the Treasury had devoted time and effort to developing such a formula, the results of which were published in 1979. The outcome was simply to take expenditure per head as it was in Wales, Scotland and Northern Ireland as a baseline. (Holtham, 2009, p. 14)

Furthermore, the Select Committee on the Barnett Formula (2009) reported that this formula had used crude, outdated population statistics (that benefited Scotland), with additional funding determined through bilateral negotiations (that benefited Scotland and Northern Ireland). Paradoxically, for more than

30 years, each country has developed and implemented complex formulas to ensure that within its borders, resources for the health service have been allocated with the objective of securing equal opportunity of access for equal need (Bevan, 2009). The Select Committee on the Barnett Formula concluded that "the resulting per head allocations are arbitrary and unfair" (2009, p. 8) between countries, and recommended that:

> Public spending per head of population should be allocated across the United Kingdom on the basis of relative need, so that those parts of the United Kingdom which have a greater need receive more public funds to help them pay for the additional levels of public services they require as a result. (2009, p. 8)

The First Report from the Holtham Commission recognised that the Barnett Formula "must ultimately be superseded by a needs-based formula" (Holtham, 2009, p. 30), but recognised that such a change:

> will need to be accompanied by an adjustment mechanism since the formula may imply substantial changes to block grants and it would be both disruptive and politically difficult to introduce those rapidly… [it] would need to be seen to be equitable to all parties… [and] therefore be jointly agreed by Ministers from both the UK Government and all the devolved administrations concerned. (2009, p. 30)

The Report from the Holtham Commission recognised that "any significant changes to the status quo will require a process of consultation, which will take time and will inevitably induce political difficulties" (2009, p. 30). The Government's response to the Select Committee's report (HM Treasury, 2009) rejected the proposal to develop a needs-based weighting for the Barnett Formula, so the Barnett Formula still fails to take account of relative needs. Although measuring relative need is complex and contentious, there is obvious scope to introduce measures that would make the formula fairer.

We have yet to see how recent constitutional developments, which will enable Wales and Scotland to raise taxes to fund devolved services, will develop (these were recommended by the Calman Commission for Scotland and the Silk Commission for Wales: Calman, 2009; Silk, 2012). Although this has the obvious attraction of linking representation to taxation, these developments will also encounter the same problem that was faced by Northern Ireland under devolution from the 1920s, where the mismatch between its needs for services, and the tax base to pay for them, resulted in "stabilising its financial position… but at the cost of drastically undermining her financial autonomy and destroying the connection between expenditure and revenue" (Bogdanor, 1999, p. 89). Indeed, in health care, this problem of mismatch between need and capacity to raise revenue to meet that need was captured vividly by Tudor Hart's Inverse Care Law which, he argued, meant that: "The availability of good medical care tends to vary inversely with the need for it in the population served" (Tudor Hart, 1971, p. 405). The purpose of formula funding, which is based on the relative needs of populations, is precisely to remedy this Inverse Care Law (Bevan, 2009).

Governance

This report has referred to the old, unresolved constitutional problem of devolution now known as the "West Lothian question" (Bogdanor, 1999, p. 34). The Report of the Commission on the Consequences of Devolution for the House of Commons (McKay, 2013) recommended that henceforward, decisions that affect England should be normally taken only with the consent of a majority of Members of Parliament (MPs) for constituencies in England. This raises the issue of MPs at Westminster having different voting rights. More central to this report are the different arrangements for governance and accountability for the different countries. As pointed out in Chapter 2, the governments of the devolved countries are held to account by their electorates specifically for the performance of devolved services, but there is no equivalent specific electoral accountability for such services in England, as this is exercised only through general elections to the UK Parliament. Furthermore, although the UK taxpayer pays for health services in all four countries, only the NHS in England is held to account for its performance by the UK Treasury. Since HM Treasury is also responsible for the effective use of the taxes and borrowing that finance devolved services, it is legitimate to ask why it does not require, as a condition of funding each country, that data are collected in such a way that each government's auditors are able to make valid cross-country comparisons.

The three previous studies (Dixon and others, 1999; Alvarez-Roseté and others, 2005; Connolly and others, 2011), before and after devolution, suggested that the NHS in England was both more efficient in terms of crude productivity of its hospital doctors and nurses, and was performing better in terms of shorter waiting times for hospitals and ambulance response times to what could be life-threatening emergencies, than the devolved countries. However, the more recent data reported here suggest that expenditure and performance of the health system in Scotland on these measures – insofar as they can be compared – appear to be similar to that of North East England. As mentioned above, improvements in performance in Scotland appear to have come about because of a policy change in Scotland in response to unfavourable cross-country performance comparisons (Steel and Cylus, 2012, p. 113). Both wider electoral and executive accountability for specific public services ought to be informed and driven by the availability of comparable information on performance across the four countries, and its lack is the subject of the following subsection.

Developing comparable data

This report has already quoted the comments by Dixon and others (1999), in their first comparative study of the four countries, on the lack of a policy initiative to encourage consistent data recording across the health systems in the four countries – even before devolution. The next study by Alvarez-Roseté and others commented that: "We have been astonished at the difficulty and in some cases impossibility, of obtaining valid comparable basic statistics on the NHS in the four countries" (2005, p. 949). They found that it was not possible at the time to produce comparative data on hospital waiting times for Scotland, and pointed out that unlike Dixon and others (1999), they had been unable to report per-head spending on the NHS and on its component programmes of hospital and community health services and family practitioner services.

These problems of a lack of comparable data apply across all the devolved public services. A report from the Centre for Public Policy for Regions stressed:

> the difficulties inherent in trying to make comparisons, even across the four home nations of the United Kingdom... Indeed a recent report to the Northern Irish government avoided making such comparisons due to these potential inconsistencies. (2009, p. 2)

After having reported spending per pupil using the available data, the report pointed out that: "The scale of the differences between Scotland and Wales and Northern Ireland… are scarcely credible" (2009, p. 2). The Select Committee on the Barnett Formula similarly highlighted the problem of inadequate comparable data published by the Treasury:

> Despite its importance, the Treasury only publish limited data about devolved public spending and the published official data appear in a number of places – in the Statement of Funding Policy, the Public Expenditure Statistical Estimates and the annual reports of the Scotland and Wales Offices. Older published data do not distinguish clearly which level of government is responsible – United Kingdom or devolved – for particular spending in the breakdowns published in the Public Expenditure Statistical Estimates. There is no time series showing how expenditure has changed as a result of spending decisions made in previous years or spending reviews. It is difficult to establish comparable levels of spending in England for devolved functions as they are different in each part of the United Kingdom. (2009, p. 30)

The Select Committee called for greater transparency, and recommended that:

> the Treasury publish their statistics of the workings of the Barnett Formula, or its successor, in a single, coherent and consistent publication. This annual publication should contain all material data on devolved finance, showing the allocations of grant to the devolved administrations, changes from previous years and explanations for any changes made. We recommend that the statistics be monitored by the UK Statistics Authority. (2009, p. 30)

The Government's response to that report (HM Treasury, 2009) did accept that "the allocations of grant to the devolved administrations, changes from previous years and explanations for any changes made, as provided to the Committee, should be included in PESA [Public Expenditure Statistical Analysis] supplementary material" (2009, p. 6). However, we have been unable to find any such supplementary material. Furthermore, what would also be required are not just data for the devolved governments, but also comparable data on expenditure in England.

This report has mentioned problems of errors in the data published by the Office for National Statistics that led to a revision of the report by Connolly and others (2011). Their revised report also highlighted problems of lack of comparability of data, stating that: "The divergences in definitions of basic NHS data between the devolved countries and England, such as for staff, hospital activity and waiting times, increasingly restrict benchmarking of performance to comparisons within each country" (2011, p. 109). More recently, in its comparison of the four countries, the National Audit Office (2012a) concluded that the current state of data is inadequate both for the retrospective purpose of accountability at the level of each country, and for comparing value for money across the four countries:

> We found limited availability and consistency of data across the four nations, restricting the extent to which meaningful comparisons can be made between the health services of the UK. For this reason and without a single overarching measure of performance, we cannot draw conclusions about which health service is achieving the best value for money. (2012a, p. 10)

The National Audit Office also highlighted the potential for learning from the 'natural experiment' following devolution:

> The shared history and similarities between the four health services mean they offer a natural starting point to better understand the factors that affect value for money and the impact of divergent health policies and systems on performance. We consider there would be value in the four health departments carrying out further comparative work to evaluate the variation in, and understand the drivers of, value for money. (National Audit Office, 2012a, p. 10)

The National Audit Office made recommendations that the health departments should:

- confirm that there is a desire at a national level to compare performance with a view to learning lessons and identifying good practice
- agree the specific indicators that would provide the most insight
- establish what data would be required to make comparisons, and identify how to collect and collate these data proportionately and cost-effectively
- use the comparisons as a starting point to draw out key factors that drive performance and value for money (2012a, p. 10).

More specifically, Ham and others (2013) described the approaches taken to integrated care in the devolved countries with a view to drawing out lessons for England, and thus remedying the failure of governments in the different countries of the UK to realise the "enormous potential" (2013, p. 1) to learn from each other in the 'natural experiment' of diverging policies following devolution. However, Ham and others found it difficult to draw lessons from the experience of the different countries in the absence of well-designed comparative evaluations, and the "formidable difficulties in making comparisons" from routinely available data, "because often these are collected in different ways in different countries" (2013, p. 78). Recent evidence suggests that the Department of Health in England and its external research advisers disagree about the "enormous potential" (2013, p. 1) of such studies for comparing policies between the countries of the UK. The following appeared in a second call for proposals under the Department's Health Reform Evaluation Programme in November 2013:

> In some applications to the March 2013 call, the proposed approach to framing a counterfactual in order to determine the specific impact of the health reforms in England was to undertake comparisons with the UK devolved administrations. However, the Commissioning Panel and colleagues within the Department of Health have taken the view that such an approach would not be regarded as a convincing solution because of the considerable difficulty in controlling for all relevant variables that may confound such comparisons… given the concomitant reforms in Scotland and Wales, policy officials are not convinced that any significant differences in outcomes between England and the other devolved administrations could be attributed to a specific reform (such as changes to commissioning) in England. (Department of Health, 2013, pp. 4, 7)

From this, there does seem to be a risk that as the policies of the four countries continue to diverge, this will become the government orthodoxy. It has the advantage of enabling health departments to avoid any potentially uncomfortable comparisons by invoking technical objections to comparing different systems.

This sort of argument entirely fails to recognise that from an international vantage point, the four systems are highly comparable (that is, all are tax funded, universal, largely free at the point of use, committed to securing equity of access, and so on).

In his overview of policy in the four countries, Timmins (2013) makes the same points as the National Audit Office but in much stronger language, which seems to be driven by his frustration at trying to make comparisons using the separate reports on each country from the European Observatory on Health Systems and Policies (Boyle, 2011; Longley and others, 2012; O'Neill and others, 2012; Steel and Cylus, 2012). Timmins also emphasises the opportunity provided by the UK's 'natural experiment':

> From the point of view of anyone interested in policy – politician, civil servant, policy adviser, academic, member of the public – this should be a unique opportunity to compare, contrast and learn. It is an almost perfect test bed. (Timmins, 2013, p. v)

The central argument of his paper is that there is far too little comparative work taking place, and that: "Something needs to be done to change this" (2013, p. v). Timmins points out that it is difficult to do comparative work using the data that are collected routinely (although not impossible), and that when this was done by Connolly and others (2010), the response to their report:

> appeared to be a greater willingness to pick holes in the data, or seek reasons, even excuses, for less good performance rather than confront the fact that there might be a real message here, despite the problems.
> (Timmins, 2013, p. 1)

His concluding section pulls together what can be gleaned from comparative data across the four countries, and leads to what he sees as "the most striking conclusion", which is that the problems of doing so mean that "there is a huge opportunity going to waste" (2013, p. 22). His concluding statements are that:

> the four health departments are charged with securing value for public money... the four health services offer a natural starting point to better understand the factors that affect value and the impact of diverging health policies and systems on performance... their health departments need to agree the specific indicators that would provide the most insight, establish the data needed to make comparisons and identify how to collect and collate that data cost-effectively.
>
> This is a call to arms that should be answered. In the meantime academics, their funders and others should do whatever is possible with what is available. And they should do so without fear of the answers. It is a public duty. (Timmins, 2013, p. 23)

This report is our response to that call to arms. In preparing this report, our experience has been that there seems to be greater interest within each country, at least in the short term, in highlighting the problems of using the data to make comparisons than in seeking to make sense of these data or make improvements. Indeed, there is a view that the performance data collected in each country can and should relate only to the policies and procedures of each country's system. This overlooks the possibility of collecting data in such a way as to be useful for different purposes.

We do applaud two developments which run against the general trend of data becoming less comparable over time as the logic of devolution unfolds. First, the Scottish Government has changed its definitions of patients on waiting lists, so that these census data are now more comparable with those from the other countries. Second, the Office for National Statistics has led the development of comparative data on waiting times for selected procedures, so that the four countries can be compared with some confidence in at least one very specific way (despite having ceased publication of its UK-wide annual *Regional Trends* in 2010). In addition, we are encouraged by the recent establishment of a working group of statisticians across the four health departments on the comparability of indicators, although we do not know what the eventual goal is likely to be, and what progress has been made.

The call for comparative data is not about curbing the freedoms of governments to pursue different policies. Indeed, we welcome the divergence in policies as providing the opportunity for valuable comparative research. But it is right to demand that data be collected to enable the impacts of different policies to be compared, particularly when these policies appear to be increasingly divergent. As one of the purposes of the governments in Belfast, Cardiff, Edinburgh and Westminster is the running of health services, it can legitimately be argued that proper electoral accountability ought to require data to be published on their comparative performance in running these services.

We recognise that the collection of statistics is a costly exercise: expenditure on collecting data has the obvious opportunity cost of not being available for the care of patients; and this opportunity cost is felt more intensely in periods of austerity. The benefits of collecting more comparable data are that, through benchmarking, each country can learn how to both make changes that lead to care of higher quality without increasing costs, and enable savings to be made without impairing quality. Within the devolved countries, there are often too few units of observation or degrees of freedom when assessing specialised services to allow for the most robust comparison and benchmarking. This can be improved by taking part in UK-wide exercises.

We have two specific sets of recommendations for developing more comparable data across the four countries: for a minimal set of data that is currently collected to be defined so that the items are properly comparable; and for extending established systems of data collection across all four countries.

A minimal set of data that ought to be defined so as to be comparable across the four countries would cover the following:[59]

- Expenditure: in total on each NHS, disaggregated by types of service (at least distinguishing between hospital and community health services, primary care and social care) and by the principal staff groups (as given below); and on public services by the devolved countries and England.
- Staff (in whole-time equivalents): hospital medical and dental staff; nursing, midwifery and health visiting staff; direct support to clinical staff; infrastructure staff; and GPs.
- Hospital activity: outpatients, day-cases and inpatient admissions.
- Hospital waiting times: the percentages waiting more than 18 weeks from referral by a GP to admission as an inpatient or day-case.

- Ambulance services: the percentage of category A ambulance calls met within eight minutes.
- Satisfaction: percentages reporting satisfaction with the general running of the NHS, inpatient care, outpatient care and GP care.

Systems of data collection that we believe ought to be extended to cover all four countries include:

- The coverage of the stroke audit by the Royal College of Physicians of London (2011) to Scotland to show the way for other clinical audits, which could, over time, report on a consistent UK-wide basis. This would be invaluable for the smaller specialties where the samples will be small in the devolved countries. Even in the larger specialties, it would allow closer 'like with like' comparisons (for example, of GPs working in sparsely populated areas which by definition will not have many GPs, but where Welsh and Scottish GPs might benefit from benchmarking one another).
- Systems to report Patient Reported Outcomes (PROMs). These measure changes in a patient's health status or health-related quality of life through short, self-completed questionnaires before and after a procedure, and provide an indication of the outcomes or quality of care delivered to NHS patients. Such data have been collected in England since 2009.[60]
- Surveys of the experiences of hospital and GP patients, and staff. Such surveys have been run nationally in England since the early 2000s.[61]

We are not advocating that English practice is ideal, but that the areas covered by PROMs, and surveys of patients and staff, ought to be undertaken in all countries. We appreciate that the collection of these data will entail extra costs, but it seems increasingly untenable for modern health care systems to continue to run without routinely collecting such data. If these collections were available across the UK, they would provide much greater scope for benchmarking than is available in other systems that otherwise only routinely collect data to assess quality on whether patients have died or been re-admitted.

Concluding observations

Within the limitations of the performance information available across the four countries over time before and after devolution, it does not appear that the increasing divergence of policies since devolution has been associated with a matching divergence of performance. In addition, there is little sign that one country is consistently moving ahead of the others. Where we do have comparable data, there are no material differences in performance in terms of breast screening, immunisation and survival following renal replacement therapy. Where there were material differences in the past, improvements over time have narrowed differences so these are now relatively small: for example, in ambulance response times to immediately life-threatening emergencies; perhaps as a result of cross-border comparisons and learning. The data on hospital waiting times do suggest that England and Scotland now have similar performance and do better than Wales[62] and Northern Ireland. England performed better than Wales and Northern Ireland on the structure and process indicators from the stroke audit, and in reducing MRSA mortality rates. In relation to measures such as amenable mortality, the pre-devolution differences seem to have changed relatively little while overall rates of amenable mortality have been falling. During the 2000s, the relative decline in amenable mortality was similar between the four countries.

As the closest comparator to the four devolved countries, the North East of England is notable for the fact that by spending at Scottish levels in the later 2000s it increased its staff and admission rates while seeing increases in life expectancy and in amenable mortality. In fact, the North East had a larger improvement in amenable mortality than any of the devolved countries. This suggests greater health care system effectiveness in the North East, before and after devolution. It may be that the policies pursued in England played some part in this, though it is impossible to be definitive on this score.

Future research

Over the next few years, we should begin to have firmer evidence about the impact of different models of governance across the UK; most starkly between pluralistic provider competition and individual patient choice in England, and managing NHS performance against targets in Scotland. While macro-level studies such as the current one are important and valuable, and have the potential to improve performance across the four countries (Steel and Cylus, 2012), there is also a need for more granular and contextually relevant studies, for example, comparing similar areas with similar populations in the different countries (for example, comparing the same services on either side of the borders between England and Scotland, and Wales and England) and, in this way, identifing what the increasing differences in system policy mean for patients' and carers' experiences of health care. It should also be possible to shed light on why health has improved more quickly in North East England than in Scotland in the last two decades, despite many population, funding and contextual similarities. A key focus for such comparative work would be to see which of the four countries is the most successful in achieving important shared goals such as the better integration of health and social services, which is vital for providing high-quality care to an ageing population in the context of severe constraints on public funding. Another focus would be to look at the impact and costs of some of the most obvious policy differences such as the removal of prescription charges in Wales, Scotland and Northern Ireland over time against their retention in England.

Notes

49. We point out below that the formula was criticised by the Select Committee on the Barnett Formula (2009) for failing to use good data on the populations of the four countries.

50. Life expectancy for 2009–11 for women and men were in years, 82.2 and 80, respectively in Wales, 81.5 and 77.5 in North East England, 81.4 and 77.0 in Northern Ireland (for 2008–10) and 80.6 and 76.1 in Scotland.

51. We are grateful to Jim Buchan for this explanation.

52. In 2011/12, the rates per 1,000 were 215 in Scotland, 209 in North East England, 176 in England, 174 in Wales and 163 in Northern Ireland.

53. The National Audit Office reported that: "We used a consistent methodology for calculating lengths of stay in the four nations. As a result, the figures quoted in the report may differ from previous publications due to variations in how lengths of stay are usually calculated in each nation" (2012b, p 4).

54. As discussed in Chapter 4, there are differences in ambiguity over the definition of what is (and is not) a category A call, and differences as to when the clock starts in recording the response time.

55. Propper (1995) describes a study (conducted in 1987) which estimated a mean value of waiting of £37 a month. Dawson and others (2005) revalued that result to 2002/03 prices, which gave a value of £3.13, and also used values of £10 a day and £50 a day (described as "likely to be at the high end of any willingness to pay for a reduction in waiting time for most elective care").

56. These were cataract surgery, coronary artery bypass graft (CABG) surgery, varicose vein operation, inguinal hernia, hip replacement, knee replacement and excision of gall bladder (there are questions over the exact coverage of diagnoses for cataracts and procedures included for knee replacements).

57. These data record time spent waiting from the initial decision to admit to the date of admission for the procedure, and differs from waiting times recorded as performance in relation to targets, which exclude time spent waiting in periods of suspension from the waiting list for medical and social reasons. The selected procedures are bypass surgery, cataract surgery, hip replacement, knee replacement and varicose vein procedures.

58. The original study was published in *The Lancet* but later retracted (Wakefield and others, 1998).

59. We assume that vital statistics on populations and their mortality rates, and rates of screening and vaccination, are not subject to definitional problems across the different health systems of the UK.

60. These are available in England for four of the selected elective surgical procedures for which we have reported rates of treatment and waiting times across the four countries: hip replacements, knee replacements, groin hernia and varicose veins. See www.hscic.gov.uk/proms .

61. See www.nhsstaffsurveys.com/Page/1010/Home/Staff-Survey-2013/ and www.nhssurveys.org .

62. Hawkes points out that the failings of the NHS in Wales: "have given the Westminster government a stick to beat Labour with. In the House of Commons on 23 April, the Prime Minister, David Cameron, asserted that Labour had been in charge of the NHS in Wales for three years and it hadn't hit an emergency target during that period. 'Last time the urgent care cancer treatment target was met in Wales, anyone? 2008,' he taunted. 'Last time A&E targets were met? 2009.' The Welsh Ambulance Service has missed its call-out target for the last 10 months" (2013).

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Marina Karanikolos is a Research Fellow at the European Observatory on Health Systems and Policies at the London School of Hygiene and Tropical Medicine. She specialises in health systems performance assessment and in the impact of the financial crisis on public health.

Josephine Exley is an Associate Analyst with the Health and Healthcare team at RAND Europe. Prior to joining RAND, she worked in Tanzania for the London School of Hygiene and Tropical Medicine (LSHTM), on a project evaluating the WHO/UNICEF's Joint Monitoring Programme for Water Supply and Sanitation indicator for improved sanitation. Josephine holds a Masters degree in public health from LSHTM.

Ellen Nolte is Director of the Health and Healthcare Policy programme at RAND Europe. Her expertise is in health systems research, international health care comparisons and performance assessment. She combines this expertise with experience in the systematic analysis of population health indicators across European countries, including the application of demographic and epidemiological approaches to understanding factors contributing to population health outcomes. Before joining RAND, she was given a Career Scientist Award from the National Institute for Health Research at the London School of Hygiene and Tropical Medicine to undertake a five-year research programme into chronic diseases. She holds a PhD from London University and a Masters degree in public health (MPH) from the University of Bielefeld, Germany.

Sheelah Connolly is a Research Fellow within the Academic Unit of Neurology, Trinity College Dublin. She was awarded a PhD in Epidemiology from the Centre for Public Health at Queen's University Belfast. In addition, she holds an MSc in health economics from the University of York, England and a BA from the National University of Ireland Galway. Her research interests lie in the area of the social determinants of health and ageing. Currently, Sheelah is working on a project looking at the epidemiology and economics of motor neuron disease in Ireland.

Nicholas Mays is Professor of Health Policy in the Department of Health Services Research and Policy at the London School of Hygiene and Tropical Medicine where he has been since 2003. He also directs the Department of Health-funded Policy Research Unit in Policy Innovation Research. He first became interested in how the health services operate in the different countries of the United Kingdom while working at Queen's University Belfast in the early 1990s.

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From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

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Tel: [redacted]

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By Email

Mr Paul Cummings
Director of Finance
SCB

[redacted]

Our Ref: SH228

Date: 25 November 2019

Dear Paul

Muckamore Abbey Hospital budget and running costs

You will be aware that as part of the HSC response to the events at Muckamore and the concerns raised subsequently about the safety and sustainability of services at the site, the Department in conjunction with the HSCB, PHA and Trusts has been engaged in a process of contingency planning for a number of scenarios for the future role of the hospital. This contingency planning is taking place in the wider policy context of an ongoing Health Transformation project led by the Board and PHA to develop a new service delivery model for adult learning disability services, with an accompanying transfer of resources from existing hospital based models of care to facilitate the development of an enhanced community infrastructure.

To inform the contingency planning process, it would be helpful to have a common understanding of the current costs associated with maintaining services at the hospital, and I am writing to ask that you arrange to provide a breakdown of the annual budget allocation for commissioning delivery of services at the Muckamore site, to include an analysis of all relevant costs, including for example those associated with staffing, estates management and capital depreciation, consumables etc. The analysis should cover the last three financial years (ie 2016/17, 2017/18 and 2018/19) to enable an identification of cost trends and inform estimates of likely future costs as inpatient numbers reduce further.

Given the very significant and ongoing issues around the safe operation of the hospital, I would be grateful if you would prioritise this exercise and would ask for a report by **Thursday 12 December.**

Should you wish to discuss or clarify the detail required, either Mark Lee or Máire Redmond would be happy to act as an initial point of contact.

Yours sincerely

Seán Holland

Seán Holland

cc: Marie Roulston, HSCB
Deborah McNeilly, DOH
Mark Lee, DoH
Máire Redmond, DoH

DIRECTION

2019 No. 7

Muckamore Abbey Hospital

This Direction is made by the Department of Health ("the Department") in exercise of the powers conferred by Article 10 of, and Schedule 3 to the Health and Personal Social Services (Northern Ireland) Order 1991(**1**) ("the 1991 Order"), in relation to pay and other conditions of certain staff who are providing direct care at Muckamore Abbey Hospital ("MAH").

1. The Department acknowledges the seriousness of the unique situation that currently exists at MAH. In particular, the Department is aware of the high number of staff suspensions, resignations and other absences which are directly linked to the ongoing investigations into allegations of widespread abuse at MAH.

2. The Department is concerned to ensure that a safe level of staffing is in place at MAH. Having considered a number of options, and secured approval of a business case from the Department of Finance, the Department directs Trusts as follows:

(i) The wider HSC system needs to collectively assist with the stabilisation at MAH. It has therefore been agreed that each of the five area Health and Social Care Trusts will provide up to 6 whole time equivalent (or equivalent) Band 5/6/7 Registered Learning Disability nurses and/or Registered Mental Health Nurses to work in MAH for a period of 3 months initially, from 1 November 2019 to 31 January 2020.

(ii) All HSC registered nursing and nursing assistant staff up to and including Agenda for Change Band 7, and HSC social care staff in the Day Care service on the MAH site, providing direct care at MAH in accordance with this Direction, shall receive an enhancement of 15% in addition to their normal gross pay (ie. basic pay plus enhancements), plus travel expenses at normal rates for those eligible staff whose normal place of work is not MAH.

3. HSC area Trusts other than Belfast HSC Trust will be able to recoup additional costs from the Belfast HSC Trust. The additional costs are the 15% uplift plus travel expenses, plus salary backfill costs for staff from other HSC Trusts coming to work in MAH.

4. This Direction provides for additional payment(s) to be to eligible staff on the terms set out above. This Direction has no effect in respect of any right(s) set out in the Agenda for Change handbook.

Sealed with the Official Seal of the Department of Health on 13th December 2019

(L.S.)

Andrew Dawson
A senior officer of the
Department of Health

(**1**) S.I. 1991/194 (N.I. 1)

DIRECTION

2020 No. 1

Muckamore Abbey Hospital

This Direction is made by the Department of Health ("the Department") in exercise of the powers conferred by Article 10 of, and Schedule 3 to the Health and Personal Social Services (Northern Ireland) Order 1991(a) ("the 1991 Order"), in relation to pay and other conditions of certain staff who are providing direct care at Muckamore Abbey Hospital ("MAH"). This Direction succeeds Department of Health Direction 2019 No. 7 which applied for the period 1 November 2019 to 31 January 2020.

1. The Department acknowledges the seriousness of the unique situation that currently exists at MAH. In particular, the Department is aware of the high number of staff suspensions, resignations and other absences which are directly linked to the ongoing investigations into allegations of widespread abuse at MAH.

2. The Department is concerned to ensure that a safe level of staffing is in place at MAH. Having considered a number of options, and secured approval of a business case from the Department of Finance, the Department directs Trusts as follows:

(i) The wider HSC system needs to collectively assist with the stabilisation at MAH. It has therefore been agreed that each of the five area Health and Social Care Trusts will provide up to 6 whole time equivalent (or equivalent) Band 5/6/7 Registered Learning Disability nurses and/or Registered Mental Health Nurses to work in MAH for a further period of 3 months, from 1 February 2020 to 30 April 2020.

(ii) All HSC registered nursing and nursing assistant staff up to and including Agenda for Change Band 7, and HSC social care staff in the Day Care service on the MAH site, providing direct care at MAH in accordance with this Direction, shall receive an enhancement of 15% in addition to their normal gross pay (ie. basic pay plus enhancements), plus travel expenses at normal rates for those eligible staff whose normal place of work is not MAH.

3. HSC area Trusts other than Belfast HSC Trust will be able to recoup additional costs from the Belfast HSC Trust. The additional costs are the 15% uplift plus travel expenses, plus salary backfill costs for staff from other HSC Trusts coming to work in MAH.

4. This Direction provides for additional payment(s) to be to eligible staff on the terms set out above. This Direction has no effect in respect of any right(s) set out in the Agenda for Change handbook.

Sealed with the Official Seal of the Department of Health on 17th February 2020

A senior officer of the
Department of Health

(a) S.I. 1991/194 (N.I. 1)

MMcG-189

DIRECTION

2020 No. 7

Muckamore Abbey Hospital

This Direction is made by the Department of Health ("the Department") in exercise of the powers conferred by Article 10 of, and Schedule 3 to the Health and Personal Social Services (Northern Ireland) Order 1991(a) ("the 1991 Order"), in relation to pay and other conditions of certain staff who are providing direct care at Muckamore Abbey Hospital ("MAH"). This Direction succeeds Department of Health Direction 2020 No. 1 which applied for the period 1 February 2020 to 30 April 2020.

1. The Department acknowledges the seriousness of the unique situation that currently exists at MAH. In particular, the Department is aware of the high number of staff suspensions, resignations and other absences which are directly linked to the ongoing investigations into allegations of widespread abuse at MAH.

2. The Department is concerned to ensure that a safe level of staffing is in place at MAH. Having considered a number of options, and secured approval of a business case from the Department of Finance, the Department directs Trusts as follows:

(i) The wider HSC system needs to collectively assist with the stabilisation at MAH. It has therefore been agreed that each of the five area Health and Social Care Trusts will provide up to 6 whole time equivalent (or equivalent) Band 5/6/7 Registered Learning Disability nurses and/or Registered Mental Health Nurses to work in MAH for a further period of 3 months, from 1 May 2020 to 31 July 2020.

(ii) All HSC registered nursing and nursing assistant staff up to and including Agenda for Change Band 7, and HSC social care staff in the Day Care service on the MAH site, providing direct care at MAH in accordance with this Direction, shall receive an enhancement of 15% in addition to their normal gross pay (ie. basic pay plus enhancements), plus travel expenses at normal rates for those eligible staff whose normal place of work is not MAH.

3. HSC area Trusts other than Belfast HSC Trust will be able to recoup additional costs from the Belfast HSC Trust. The additional costs are the 15% uplift plus travel expenses, plus salary backfill costs for staff from other HSC Trusts coming to work in MAH.

4. This Direction provides for additional payment(s) to be to eligible staff on the terms set out above. This Direction has no effect in respect of any right(s) set out in the Agenda for Change handbook.

Sealed with the Official Seal of the Department of Health on 27th May 2020

A senior officer of the
Department of Health

(a) S.I. 1991/194 (N.I. 1)

DIRECTION

2020 No. 10

Muckamore Abbey Hospital

This Direction is made by the Department of Health ("the Department") in exercise of the powers conferred by Article 10 of, and Schedule 3 to the Health and Personal Social Services (Northern Ireland) Order 1991(**a**) ("the 1991 Order"), in relation to pay and other conditions of certain staff who are providing direct care at Muckamore Abbey Hospital ("MAH"). This Direction succeeds Department of Health Direction 2020 No. 7 which applied for the period 1 May 2020 to 31 July 2020.

1. The Department acknowledges the seriousness of the unique situation that currently exists at MAH. In particular, the Department is aware of the high number of staff suspensions, resignations and other absences which are directly linked to the ongoing investigations into allegations of widespread abuse at MAH.

2. The Department is concerned to ensure that a safe level of staffing is in place at MAH. Having considered a number of options, and secured approval of a business case from the Department of Finance, the Department directs Trusts as follows:

(i) The wider HSC system needs to collectively assist with the stabilisation at MAH. It has therefore been agreed that each of the five area Health and Social Care Trusts will provide up to 6 whole time equivalent (or equivalent) Band 5/6/7 Registered Learning Disability nurses and/or Registered Mental Health Nurses to work in MAH for a further period of 3 months, from 1 August 2020 to 31 October 2020.

(ii) All HSC registered nursing and nursing assistant staff up to and including Agenda for Change Band 7, and HSC social care staff in the Day Care service on the MAH site, providing direct care at MAH in accordance with this Direction, shall receive an enhancement of 15% in addition to their normal gross pay (ie. basic pay plus enhancements), plus travel expenses at normal rates for those eligible staff whose normal place of work is not MAH.

3. HSC area Trusts other than Belfast HSC Trust will be able to recoup additional costs from the Belfast HSC Trust. The additional costs are the 15% uplift plus travel expenses, plus salary backfill costs for staff from other HSC Trusts coming to work in MAH.

4. This Direction provides for additional payment(s) to be to eligible staff on the terms set out above. This Direction has no effect in respect of any right(s) set out in the Agenda for Change handbook.

Sealed with the Official Seal of the Department of Health on 31st July 2020

L.S.

Andrew Dawson

A senior officer of the
Department of Health

(**a**) S.I. 1991/194 (N.I. 1)

NOTE OF THE INTERMINISTERIAL GROUP ON MENTAL HEALTH AND LEARNING DISABILITY – 26 JANUARY 2009

Michael McGimpsey was delayed in attending the meeting and in his absence Linda Brown (DHSSPS) chaired the meeting.

Present:
Linda Brown, Deputy Secretary
Maura Briscoe, DHSSPS
Jeffery Donaldson
Declan McGeown, DCAL
Tony McConnell, DRD
June Ingram, DEL
Heather Cousins, DSD
Dorothy Angus, DE
Maureen McCartney, DHSSPS

At later stage:
Michael McGimpsey
Sir Reg Empey

1. Linda Brown gave the background to the meeting and indicated that Ministers Michael McGimpsey and Reg Empey were expected to join the meeting. She referred to previous discussions between officials about the need to ensure in the Action Plan that there is evidence of joined-up working between Departments. She recognised that the mismatch in Departmental budgets, for example, on supported housing, was causing particular problems in progressing the Bamford agenda. She also referred to the current consultation on mental health and mental capacity legislation, which had been changed significantly in the light of the consultation on the Bamford document.

2. Linda Brown stressed that the draft Action Plan which had been circulated for today's meeting was a working draft. The intention was that the first section would set out the long term vision with specific targets, with timescales mostly in the next 2-3 years, in the second section. The Action Plan would then be reviewed and rolled forward in 2011. The aim was to have the draft completed by mid-February in order to seek Executive clearance in March.

Each Department then gave a summary of their contribution.

DE

3. DE indicated that, subject to Ministerial clearance, further actions would be submitted to supplement the actions already in the Action Plan.

DSD

4. The current financial allocations restrict the potential for action from DSD. A recent meeting between DSD and DHSSPS officials in relation to supported housing had taken place and a further meeting was scheduled for 30 January. DHSSPS was exploring the possibility of making sites available to DSD where these could progress the business objectives of both Departments.

DEL

5. A meeting had taken place between DEL and DHSSPS officials and a further internal DEL meeting was scheduled for 27 January. Key issues to be tackled were;
   - the difficulty clients have in finding their way through the various DEL programmes and
   - supported employment.

6. When Sir Reg Empey joined the meeting, he added that the introduction of unit learning was one way of allowing students to participate in further education at a pace which suited them. He also said that while a range of support, including technological aids, was available to FE students who required additional help, there are difficulties where the student has a high level of physical needs. The current economic climate also creates additional pressures due to increased numbers seeking employment.

7. It was suggested that DE might be able to provide advice on approaches they have used within schools to provide support to those with complex needs.

8. Maura Briscoe added that while day centres in future were likely to concentrate on people with severe disabilities, there was a need to look creatively at other ways of providing day opportunities.

OFMDFM

9. Jeffrey Donaldson referred to the actions already contributed for the Action Plan in relation to promoting social inclusion. He agreed to pursue the possibility of additional actions in relation to general equality issues and to support for victims, since the impact of the troubles had been raised as an issue during consultation.

10. Michael McGimpsey joined the meeting at this stage.

DRD

11. A review of Accessible Transport strategy is under way and a committee (INTEC) representing the disability sector is involved in "disability proofing" schemes. Work is ongoing with DEL and DHSSPS in relation to transport to services such as day centres, and with DARD in relation to rural transport.

DCAL

12. DCAL indicated that some of the actions already submitted for the Action Plan may need fine tuning. Some actions depend on successful Big Lottery bids, the outcome of which will not be known until after the Action Plan is finalised.

Summary

13. In summing up, Minister asked for any further input from Departments to the Action Plan by Friday 6 February. He stressed the need to complete the Action Plan soon. Maura Briscoe said that the first section of the Plan would include recognition of actions already taken and that DHSSPS officials may be in contact with Departmental representatives about some of these.

14. Sir Reg Empey added that it was important not to raise expectations unduly in the current economic climate. The outcome of the next CSR could not be anticipated. In addition the economic downturn is likely to have an adverse impact on the mental wellbeing of the population.

Inter Departmental Ministerial Group on Mental Health and Learning Disability

13 May 2015 in Castle Buildings, Room C3.18

Minutes

Attendees

Minister Hamilton, DHSSPS (chair)
Minister O'Dowd, DE
Minister Farry, DEL
Minister Storey, DSD
Minister Ford, DOJ
Junior Minister McCann, OFMDFM
Tom Reid, DRD (on behalf of Minister Kennedy)
Nicola Monson, DETI (on behalf of Minister Bell)
Cynthia Smyth, DCAL (on behalf of Minister Ni Chuilin)

Apologies

Minister Kennedy, DRD
Minister Bell, DETI
Minister Ni Chuilin, DCAL
Junior Minister McIlveen, OFMDFM

In attendance

Philip Weir, SpAd DHSSPS
Chris Matthews, DHSSPS
Andrew Dawson, DHSSPS
Neil Magowan, DHSSPS
Lorraine Brown, DHSSPS (minutes)
Siobhan Tweedie, DHSSPS
Caroline Gillan, DE
Paul Sloan, DE
Joan Hardy, OFMDFM
Stephen Martin, DSD
Karen Pearson, DOJ
Bobby Killow, DEL

1. Introduction and Apologies

Minister Hamilton welcomed everyone to the meeting and thanked them for their attendance. He noted apologies from Minister Kennedy, Minister Bell, Minister Ni Chuilin and Junior Minister McIlveen.

Minister Hamilton outlined the four substantive items for discussion:

a. To consider the most recent monitoring round of the Bamford Action Plan;
b. To discuss the evaluation of the Bamford Action Plan 2012 – 2015;
c. To get an update on the issue of Transitions for young people with severe learning difficulties/disabilities to post 19 provision;
d. To consider the Education and Training Inspectorate report on Transitions to Post School Provision.

2. Minutes of last meeting and action points

The minutes from last meeting held on 20 November 2014 were agreed. All actions were cleared.

3. Bamford Monitoring Report February 2015

Minister Hamilton indicated that there had been good progress made on the Action Plan, and that the position at February 2015 indicated that out of the 76 actions, 66 are GREEN, 10 are AMBER and none of the actions are RED.

He confirmed that the DHSSPS/HSC Board has responsibility for all of the AMBER actions and invited comments from Members. There were no comments.

4. Evaluation of the Bamford Action Plan 2012 – 2015 (Annex D)

Minister Hamilton summarised the current position with respect to the Bamford Evaluation, confirming that the target date for completion of the Bamford evaluation is 31 March 2016. He advised that DHSSPS officials had drafted Terms of Reference and an Evaluation Framework, which were both discussed at the last meeting of the Bamford senior officials, and which have now been agreed in principle, subject to minor amendments. He commented that this would be an intensive piece of work and thanked Departments for their continued engagement and commitment to this process.

Minister O'Dowd highlighted that there may be issues with staffing resources to carry out the Bamford evaluation, due to reduced staffing levels. He added that he felt the literature review was unnecessary. Chris Matthews indicated that he understood the point made and that this could be discussed and agreed between officials.

ACTION POINT 1: Officials to discuss and agree the value of a literary review in the Bamford Evaluation

Minister Farry commented that he still was of the opinion that the evaluation should be outsourced, especially taking into account the scale of expenditure on mental health and learning disability, and that an independent evaluation may provide more of a challenge and lead to more efficient use of resources. He added that he also has concerns about resources and timescales to do this in-house. Chris Matthews responded that DHSSPS would also prefer to the do the evaluation independently, but that given the financial situation the money was not available, the evaluation in-house was a contingency. Minister Hamilton agreed that Minister Farry had made a good point, and that this would be the preferred approach if circumstances were different.

5. Education and Training Inspectorate report on Transitions to Post School Provision

Paul Sloan from the Special Education Team in Department of Education gave a presentation to the Group on the Education and Training Inspectorate (ETI) Report on Transition Arrangements from Special Schools and Mainstream Learning Support Centres to Post-School Provision.

He highlighted the following key points:

- In part the report stemmed from concerns raised by NICCY about consistency of transition planning and post-school provision across NI;

- Transition planning from the age of 14 is a statutory requirement;
- There are 2 Education Transition Co-ordinators in each Board area who provide support to pupils to help them make informed decisions and who liaise with DEL, FE Colleges and community providers on post-school placements;
- In the first 6 months of 2014/15, there were 6,329 young people with learning disabilities supported to transition from school;
- The report found improvements in the Transitions service and good collaborative working between Education and DEL / FE Colleges/ community providers;
- One of the main findings of the report was that there are poor choices post-19 for young people for whom training / employment is not an option; and
- Next steps are for DE to consider of the Education Authority's formal response to ETI report, which is awaited, and further engagement with Education Transition Service, and with DHSSPS and DEL, as necessary, to take forward the recommendations.

Paul added that while DE can improve linkages with post-school provided through the transitions process, education services finish when the young person leaves school.

Junior Minister McCann welcomed the improved communication with parents, but expressed concern about the lack of available post-school services and lack of employment opportunities for people with disabilities. She commented that this is a big concern for parents and needs to considered in a more joined-up way. Paul Sloan responded that Transitions Services work very hard with post-school agencies to secure places and the Education will be making efforts to strengthen links.

Minister Ford commented that the transitions planning process appears to be working well and queries whether linkages had been lost when special schools moved from Health to Education. He also questioned the proportion of young people with learning disabilities moving from school into Further Education, training or employment.

Caroline Gillan advised that the issue with lack of placements relates to a small minority of pupils with complex needs. She said for young people with moderate learning disabilities (MLD) 34& went to FE, and 50% to training, and for those with sever learning disabilities (SLD) 30% went to training, 42% to Day Centres and 16% to ‘other’.

Minister Storey commented on the importance of schools making young people aware of their benefit entitlement through the transitions process, and that some special schools hadn’t engaged with the Benefit Uptake Programme. He added that while this is a DSD responsibility, there is also an onus on schools to take a proactive approach in letting young people know what is available to them.

Minister Hamilton concluded that this is a complex issue, and that post-school provision which goes beyond the remit of Health and must included options for young people with learning disabilities to go into training and FE. He recognised that there are a cohort of young people with complex needs, for whom it is likely Health will continue to provide post-school provision. He added that the Regional Day Opportunities Model, developed by the HSC Board is a benchmark for driving improvements in post-school provision, and that some people in day care settings could benefit from moving to a different setting, which will in turn free up places in Day Centres.

6. Transitions for young people with severe learning difficulties/disabilities to post 19 provision

Minister Farry provided an update on the work on transitions for young people with severe learning difficulties/disabilities to post 19 provision. He advised that the Action Plan had been agreed at official level and that this should be regarded as a living document and may be added to if required. He confirmed that DEL is content to take the lead on monitoring progress against the Action Plan, which would be channelled through the Bamford Inter-Departmental Senior Officials Group.

Minister Farry added that DEL are considering doing a comprehensive mapping exercise to determine where young people go after school, not just immediately but perhaps 2-3 years after they leave school.

He commented that there are no additional resources available, and that action will be focussed on doing things better and more efficiently, and improved interactions between Departments.

Cynthia Smith commented that her Minister has given priority to mental health and learning disability, and access to activities such as sport, art and culture should be included within post-school provision for people with learning disabilities. She added that there is much enthusiasm in sporting and arts bodies in making services accessible.

Minister Storey advised that currently 20% of neighbourhood renewal and community planning funding is spent on health related projects, and that this function would transfer to the new local Councils in 2016. He stressed the importance of sharing this work with local Councils, for example through Partnership Panels and the need for better co-ordination between central and local authorities.

Minister Hamilton welcomed the proposed mapping exercise, in particular the idea of doing this 2-3 years post-school, as some young people may not sustain further education / training placements.

The Action Plan was agreed by the Group.

7. Any Other Business

There was no other business.

8. Date of Next Meeting

Minister Hamilton advised that the next meeting will likely take place in November 2015, date to be confirmed.

He thanked the Group for their attendance and contributions at the meeting, and for the supportive approach taken by Ministerial colleagues and officials in other Departments in the implementation and evaluation of the Bamford Action Plan.

Inter-Departmental Working Group on Bamford

Main Points from Meeting of 5th October 2007

- All major players were represented at the meeting (only the NIO were missing – a separate bi-lateral was being arranged) – this group could become an effective forum for enabling joined up action on Bamford between the relevant Departments.

- The CSR was expected to have a very restrictive outcome. It would be necessary to look towards smarter working, re-skilling and lower cost innovations as the main levers for service change in the short term.

- Joined up working should not, by itself, entail additional expenditure. There was substantial scope for building on existing established initiatives. Considerable cross-Departmental and cross-cutting activity was already being undertaken, especially in areas such as Suicide and Substance Abuse

- The numbers of people needing resettlement was not itself very large and the timing could be approached flexibly. The exact figures are being researched and, when available, would be very helpful in planning outcomes. Nonetheless, this was a very difficult area and prioritisation would be necessary.

- There had been very substantial improvements e.g., the development of Special Schools, but this was often not publicly appreciated. These achievements should be publicised much more.

- The CSR restrictions also highlighted the importance of mobilising community involvement to achieve results, as had been done with Homestart or Women's Aid.

- It should be remembered that 'a little goes a long way' - if effectively used as levers by Departments

- There was a need to concentrate on what is realistically achievable. The best approach in the circumstances might be to press on smaller issues, seeking to secure a drip feed of funding

MINUTES OF INTER-DEPARTMENTAL BAMFORD SENIOR OFFICIALS GROUP

22 April 2016

D2 Lecture Theatre , Castle Buildings, 10am

Attendees

Chris Matthews, DHSSPS (Chair)
Andrew Dawson, DHSSPS
Lorraine Brown, DHSSPS
Julie Stewart, DHSSPS
Aidan Murray, HSCB
Stephen Bergin, PHA
Robert Heyburn, DCAL
Alan Heron, DRD
Stephen Martin, DSD
Maeve Hully, PCC
Bobby Clulow, DEL
Paul Sloan, DE
Debbie Cowan, DE
Laurene McAlpine, DOJ
Cyril Anderson, HSE NI
John McKee, BMG
Rosalind Dempsey, OFMDFM
Karen Oldham, DHSSPS (Minutes)

Apologies

Maggie Smith, DCAL
Joan O'Hara DSD (Benefits)

1.	**Welcome and last minutes**
1.1	Chris Matthews welcomed everyone to the meeting.
1.2	**Minutes from the last meeting**
	The minutes of the last meeting (November 2015) had been distributed following that meeting. A further copy was presented and Lorraine Brown asked that any issues arising were brought to her attention by e-mail (otherwise it was assumed that they are agreed).
2	**Update on Bamford Action Plan Evaluation**
2.1	Lorraine Brown summarised the numbers (129 carers and 86 people), nature of focus groups and the numbers of questionnaires returned (252 carers and 163 service users).

A summary of the emerging themes was presented although, it was emphasised that the questionnaire data has still to be analysed and reflected. See paper at **Annex A** for full detail.

2.2 Emerging themes on Learning Disability included:

- Carer’s support – lack of information for those without a social worker, lack of respite and carer’s assessments raising expectations but no extra support being available. Short term day opportunities creating uncertainty.
- Older Carers- concerns about lack of future planning.
- Housing- positive stories about supported housing but also some feelings of isolation from those who have been resettled. Also lack of suitable housing near home was a problem for carers. Feeling that more residential accommodation was needed for those with complex needs for whom supported living was not suitable.
- Day Opportunities- General feeling that post-school opportunities have improved. High dependence on voluntary sector bodies and high praise for work of those groups. There is a need for more opportunities leading to paid employment or a qualification. Difficulty for those with mild/moderate learning disability in accessing vocational courses due to requirement for formal qualifications. Specific problems identified with; accessing supervisory support to attend FE, Transport to Day opportunities (particularly rural areas), lack of opportunities for over 24s, disruption and uncertainty caused by short terms opportunities and breakdown of placements (and the loss of a safety net of a day centre place). Need for consideration of people who have routinely been attending a Day Centre and the impact of losing that routine.
- Physical healthcare- Annual health checks generally being offered and most people had a positive experience of the service.
- Hospital Care- Some good and some bad reports. Planned admissions seem to go better than A and E. Use of hospital passports seems to work well but not used in all areas.
- Resettlement- Some very positive experiences. Some negative experiences where accommodation placements have broken down due to not getting on with housemates, stress of day opportunities, lack of support and have ended up back in hospital.

- Benefits- Potential barrier resulting from benefits being cut on entering employment and it often doesn't work out and they have to reapply for benefits. Also reports of having to re-apply for benefits when they have a lifelong learning disability.

- Social worker support- Many people expressed the benefits of having a good key worker. Others felt social worker were only available to deal with crisis situations.

- Social/recreational activities- General view that there needs to be more access to social activities. Often run by parents.

2.3 <u>Evidence gathered on Mental Health through a number of sources:</u>

- The HSC Board/PHA carried out an Audit of Mental Health Services. There were a total of 665 completed questionnaires. Report completed in April 2016 and broadly shows improvement to MH services. More work to draw out more detailed breakdown of responses by Trust areas.

- The HSC Board are carrying out an audit of Child and Adolescent Mental Health Services.

- RQIA review of Eating Disorders (December 2015).

- Range of reports/evaluations from professional bodies and 3rd sector organisations.

- 16 Mental Health Focus Groups (80 carers and 52 service users)

2.4 <u>Emerging themes on Mental Health included:</u>

- Positive feedback on Recovery approach, ImROC, Recovery Colleges and WRAP. Some areas where promotion of Recovery Colleges is an issue.

- Positive Feedback on You in Mind Care Pathway though some variance in awareness of the pathway.

- Lack of consistency regarding Care Plans.

- Carers not feeling supported and excluded from care. Need for a point of contact during crisis for carers.

	• In some areas concerns about discharge without intensive community care leading to relapse. • Out of hours support • Negative experiences of A&E and Acute wards- no training of staff • Personality Disorder services- positive but issues accessing. • Eating Disorder services- some issues with access and GP awareness. • Role of 3rd sector bodies and need for better signposting/referral to those services • High staff turnover- inconsistency. • Employment barriers following detainment • Benefits - difficult to access and don't take into account episodic nature of mental illness.
3	**Process/timescale for completion**
3.1	Lorraine Brown explained that she hoped to have a draft report of the evaluation to the IDSOG in June and to present the final version to the Executive in September. She explained that the Bamford structures would also need to be looked at in time for the draft report.
3.2	**Comments on Findings**
3.3	Aidan Murray commented that many of the themes were familiar but that would be a need to gauge the proportions involved eg it would be a very small number of those who has been resettled who return to hospital setting in comparison to the numbers who never go back. It was agreed that the scale elements could be considered further when the HSCB and DHSSPS meet.
3.4	John McKee noted that the abuse of substances and potential for people being left unsupported following encounters with the Police could be an area that required further exploration, ideally with some statistical information.
3.5	Andrew Dawson explained that there was a joint Healthcare & Criminal Justice Strategy out to consultation and that may result in some useful developments. DSD added that they were looking at

	similar issues around homelessness and where people go following release by the Police. There were questions about how to have a better service but also limitations as the Police's role was to deal with the justice issues and it was not their role to deal with medical or social care aspects. Chris Matthews added that there were also issues about liberty and the Police's rights to detain people longer than required.
3.6	Lorraine Brown added that the Department would also be looking at areas for development and would consider these as part of the Comprehensive Spending Review process.
4	**Initial Findings from Each Department**
4.1	Lorraine Brown explained that she has received initial findings from some Departments (though there were some aspects requiring clarification) and some Departments still had to provide input. Departments were invited to summarise their activities and current positions.
4.2	**HSENI (Cyril Anderson) -** outlined work on Mental Wellbeing and Advisory Services Work- report already submitted to Department.
4.3	**DEL (Bobby Clulow)** – outlined various schemes. Explained that the new strategy would connect more directly to schemes with a support worker who would look to find people a job. However a difficulty was that not all employers use the schemes. Report submitted to Department but Lorraine Brown explained that they need to clarify evidence sources. Lorraine also asked if there was any information available regarding how many participants go on to paid employment. DEL reported that case studies are available and they may have activity measures.
4.4	**DRD (Alan Heron)**: Two evaluations completed on Travel Safe Guide and Access Travel Wallet. The Accessible Transport Strategy was almost complete and an Action Plan would be developed. Libraries NI have agreed to take on the travel wallet guide and distribute through libraries. Lorraine Brown explained that in rural areas there had been some focus group feedback about lack of training for Translink staff. It was reported that training for Translink was a potential action though it was sometimes difficult to qualify the justification for this need. Work was also ongoing with the community transport sector. The HSCB welcomed this as there was a need for help with access to day opportunities that already exist but people couldn't access. Lorraine Brown reminded that she needed the summaries of the DRD activities to be in Bamford format.
4.5	**DCAL (Robert Heyburn)**: Full response still to be provided. Further work on Health and Mind to be weaved into evaluation.

Analysis on mindfulness programmes had shown levels of stress 3 times lower on completion of training courses. Identified need for continuing focus on sport and active living. John McKee asked if the role out of the super councils had factored in a facilities strategy for sport. DCAL reported that they were working to create that interface.

4.6 **OFMDFM (Rosalind Dempsey):** Bamford responsibilities moving to communities. Currently looking at a refresh of the Disability Strategy. Work on victims and survivors identified 7 areas of need with monitoring and evaluation across organisations. This work will not be complete until autumn which does not fit with Bamford timescales so nothing to report at present. OFMDFM had been feeding into the Mental Trauma service work but that would now be taken forward by Department of Health. Lorraine Brown asked if there were any initial outcomes from the Disability Strategy but it was reported that this has not progressed far enough yet.

4.7 **DOJ (Laurene McAlpine):** Only one joint action on mental health legislation for which Royal Assent is awaited. DHSSPS are the lead Department on this action.

4.8 **DE (Paul Sloan and Debbie Cowan):** Full update has been provided. Summarised 6 actions and explained that work was ongoing to evaluate the outcomes.

In terms of the Early Years framework, it was difficult to attribute outcomes directly to children with mental illness or learning disabilities because the framework applied to all. Implementation won't fall within the Bamford timescales.

In terms of emotional health and wellbeing, there has been positive feedback and extensive use in schools. Lorraine Brown pointed out that the Action Mental Health report recommended better education and resilience building in schools so may be a benefit in DE engaging with AMH.

In relation to counselling services, it was reported that the sessions had been a benefit to 100% of pupils receiving them. Lorraine also fed back focus group reports of a disjoin between individual counselling and referral to CAMHS.

John McKee commented that Board of Governor training was not all it could be. It was explained that it was the Principal's job to identify training needs and the Education Authority provides the training. It was expected that regionalisation of Education services should help aid consistency of training.

4.9 In addition, it was reported that the Special Educational Needs and Disability Bill received Royal Assent on 23 March 2016. Consultation on SEN Regulations will finish on 16 May and consultation on the Code of Practice will take place in September with the new Framework likely to be in place from September 2017.

 4.10	Challenging behaviours work was being undertaken by the Education Authority who had initiated an analysis of current services. The Education Authority was also taking forward work relating to transitions planning which could hopefully be fed into the evaluation. DEL explained that their Minister had written to the Executive and Ministers asking for comments on the Report of the Inquiry into Special Educational Need. It was clarified that there were two letters – one seeking to have the recommendations tabled at the Bamford Ministerial meeting and another seeking comments. DHSSPS representatives had not had sight of the one seeking comments but would check again with Private Office.
4.11	**DSD (Stephen Martin):** Explained that had completed phase 1 of report on supported housing. Questions had been raised regarding the costs and ethos of the model. A number of independent schemes have a very institutional feel so it is questionable as to whether the Bamford ethos is really being met. In addition the current model is very expensive and potentially over-engineered. There has been some difficulty in identifying a sample frame due to ethical issues in getting details from the HSC so housing information was being used. However it would still be useful to have HSC information in order to achieve a balance. Lorraine Brown added that she had sent comments to Conrad Murphy in December on the DSD input and she would chase him up on that. The HSC representative pointed out that they had commissioned a piece of work looking at quality of life pre-resettlement which would compliment this.
4.12	**PCC:** Maeve Hully noted that people will look for different things and the views will change over time as the last people are resettled. **AP1- Any outstanding updates from Departments to be in required format, include evidence sources, and forwarded to Lorraine Brown within next 2 weeks.**
5	**Cross-Departmental Post-19 Transitions Action Plan**
5.1	DEL noted that the monitoring report of the Transitions Action plan could be brought back to the Bamford Ministerial Group for approval prior to publishing. Lorraine Brown added that the next Ministerial group was likely to be September so it was agreed that this could be done by correspondence. **AP2- DEL to seek** approval, from Ministers who sit on the Bamford Group, for publication of the monitoring report of the Transitions Action plan
6	**Agree Process for making changes to the Cross-**

Departmental Post-19 Transitions Action Plan

6.1 It was agreed that any minor changes to the Action Plan could be made at IDSOG and any more substantial changes would be subject to Ministerial agreement.

7 Proposed amendment to Cross-Departmental Post-19 Transitions Action Plan

7.1 Paul Sloan explained that the Education Authority considered that it was not their role to provide advice/information or links to benefit and transport support, post-school. Rather, it would be for schools to signpost where such advice may be accessed in DSD and DRD. DE would be having discussions with DSD and DRD about the possibility of these Departments providing information leaflets for schools to hand out to parents during transition planning meetings. Lorraine Brown explained that because there was nobody in attendance from DSD Benefits she would e-mail them to check that they were content. DEL had also made minor proposed changes to the wording of this action. No other objections were raised.

AP3 – Lorraine Brown to e-mail DSD Benefits to seek agreement on the proposed amendments to Cross-Departmental Post-19 Transitions Action Plan

8 Best Practice literature review

8.1 DEL explained that they had circulated this and requested a written response by 24 June. DE stated that they had considered a lot of the information, particularly in the Base Report as irrelevant. They also had concerns about the focus on Autism.

AP4- All comments on Best Practice literature review to be sent to DEL by 24 June.

9 Recommendation 13 of the Report on the Employment and Learning Committee's Inquiry into Post Special Educational Needs (SEN) Provision for those with Learning Disabilities

9.1 DEL pointed out that one of the recommendations related to Ministers handing this work over to the Department of Communities in the next mandate and that this would have to be considered by the relevant Ministers. There was some discussion as to the current status of such a recommendation as the new Department doesn't yet exist and the recommending committee no longer exists. In addition John McKee expressed some concern about who would who would be the “watchdog” for ensuring the current programme is taken forward. Andrew Dawson explained that the Bamford report will make

	recommendations and there will potentially be bids for new funding once we know what the policy direction is, however we cannot impose the recommendations.
10	**Any Other Business**
10.1	DEL explained that NI Direct were working on a gateway page for learning disability services but the initial view was that there was insufficient evidence of content on Departmental websites. Departments/HSCB agreed to have a look at the content of their websites and documents and to report back to Owen Gillespie in DEL. DE reported that they were working on their own transitions planning Briefing Note for publication on NI Direct. Paul Sloan (DE) agreed to circulate. **AP5- Departments/HSCB to consider content of website information to establish if content was suitable (or can be tailored) for inclusion on gateway page- to report to Owen Gillespie.** **AP6- Paul Sloan to circulate draft DE Transitions Planning Briefing Note.**
11	**BMG**
11.1 11.2 11.3	John McKee indicated that there had been much discussion about what the Bamford structures would look like in the longer term. BMG had been looking at: • Future planning for elderly carers- trying to replicate work around LD • Carers assessments- how they are working, looking at what is available • Acute service shift to community- capturing people's experiences • Experience of people in A&E and mental health crisis Lorraine Brown asked if there was a report available relating to elderly care learning disability work done last year. Maeve Hully explained that there was no paper produced but PCC brought a paper to the Board about the work and she could share that. Lorraine replied that this paper would be useful as evidence for the Bamford evaluation. **AP- Maeve Hully to share PCC Board paper on elderly care/learning disability.**
12	**Next Steps**

12.1	Lorraine Brown explained that it was hoped to provide a draft report to IDSOG by June and the next Ministerial meeting would be in September.

ACTION POINTS – 22 April 2016

Action Point No.	**Action**	**Lead**	**Status**
AP1	Any outstanding updates from Departments to be in required format, include evidence sources, and forwarded to Lorraine Brown within next 2 weeks.	All Departmental representatives	
AP2	DEL to seek approval from Ministers who sit on the Bamford Group for publication of the monitoring report of the Transitions Action plan	Bobby Clulow	
AP3	Lorraine Brown to e-mail DSD Benefits to seek agreement on the proposed amendments to Cross-Departmental Post-19 Transitions Action Plan	Lorraine Brown Joan O'Hara	
AP4	All comments on Best Practice literature review to be sent to DEL by 24 June.	All	
AP5	Departments/HSCB to consider content of website information to establish if content was suitable (or can be tailored) for inclusion on gateway page- to report to Owen Gillespie.	All Departments	
AP6	Paul Sloan to circulate DE Transitions Planning Briefing Note.	Paul Sloan	

ANNEX A

Update on progress on the Evaluation of the Bamford Review

- An evaluation of the Bamford Action Plan 2012-15 is underway, led by DHSSPS. Terms of Reference and an Evaluation Framework have been agreed by the Bamford IDSOG. The Inter Ministerial Group on Mental Health and Learning Disability has agreed to extend the Bamford Action Plan until the end of March 2016 to allow time for completion of the evaluation.

- The evaluation will consider three specific aspects of the implementation of the Bamford Action Plan 2012-15:

    a. Outputs – i.e. the action which has been taken by Government Departments and their agencies, and the Bamford structures, to progress the Bamford vision, and the progress made.

    b. Outcomes – i.e. – the differences made for service users and carers; how services have improved / changed from the service user and carer experience, including what is better and what is worse.

    c. Structures – a critical review of the structures in place to deliver Bamford, in the context of the recent and emerging Government policy.

- It will also consider the necessary actions and structures to take forward the Bamford vision after March 2016.
- Each Department with responsibility for actions within the Bamford Action Plan 2012-15 has ownership of the evaluation of their own actions. DHSSPS will lead on the completion of the evaluation and collate input from other Departments.

DHSSPS Update

- Within the Bamford Action Plan 2012-15, 46 of the 76 actions are the responsibility of DHSSPS. 12 of these 46 Health actions relate to Learning Disability services, 19 Mental Health Services and 15 are joint Learning Disability / Mental Health actions.

LEARNING DISABILITY

- With regard to the Learning Disability actions, the following evidence has been gathered to evaluate the impact of Bamford, summarised as follows:
    - **Questionnaire** issued for carers of people with a learning disability, and distributed December through the Patient Client Council membership scheme; the HSCB and HSC Trust service user and carer forums; local Councils, relevant community and voluntary sector groups and schools. All Departments were invited to contribute questions to the questionnaire, and it includes questions from DE, DSD and DEL. 252 responses which are currently being analysed.
    - **Questionnaire (easy read)** issued to people with a learning disability in February 2016. 163 responses which are currently being analysed
    - The Department has held 19 LD **focus groups**, covering the following themes:
        - Learning Disability – Health Services for Children (October, Antrim)
        - Learning Disability – Living in the Community (October, Lurgan)
        - Learning Disability – Day Opportunities / Post-School Provision (October, Omagh)
        - Learning Disability – Health Services for Adults (October, Downpatrick)

- Learning Disability –Support for Carers (October, Belfast)
- ARC organised 3 focus groups in January in Ballymena, Omagh and Lisburn covering a wide range of LD services
- TILIS groups - focus groups at Muckamore, Bangor and Belfast which covered resettlement and wider issues
- Focus group with Positive Futures Older Carers group in Lisburn
- Trust-based focus groups in Belfast, Enniskillen, Gilford, Bangor, and Lisburn
- PCC Carers event in Antrim

129 carers and 86 people with a Learning Disability participated in these events, as well as a range of voluntary sector representatives and support workers.

Emerging themes on Learning Disability

- Carer's support: People who have a social worker seem to be generally content with the support they receive, although there are complaints about lack of respite availability. However, there does seem to be an issue with people knowing who to contact if they need some support, if they don't have a social worker - so there appears to be a need for more awareness-raising and information sharing. Some frustration was expressed about carer's assessments raising expectations of support, and then little support is available due to lack of respite etc. Some concern was also voiced by carers about the move towards Day Opportunities, in that these are generally not long-term and create uncertainty about what the person will do next and therefore puts additional pressure on them.

- Older Carers: Grave concerns raised about lack of future planning. There appears to be a cohort of people with a LD who have been largely cared for at home by parents, and stayed 'under the radar'. Parents are now elderly and need proactive support and assistance to plan for the future.

- Housing: Some real success stories from people who have moved from hospital or the family home to supported housing and have developed their independence. Others commented that some supported living schemes have no communal areas, so they can lead to isolation which is very difficult, especially for the resettled population.

  There have been comments about lack of appropriate supported-accommodation in some areas, which makes it difficult for people with a learning disability to live independently, and in turn creates difficulties for carers (especially older carers) in planning for the future. Some concerns have been expressed about poor quality of care in some supported living schemes.

  Some carers felt that there needs to be more residential accommodation for people with more complex needs as supported housing was not suitable for them and government is imposing supported living.

- Day Opportunities: There was a general feeling that post-school opportunities for people with a learning disability have improved, and that accessing day opportunities made them feel part of a community. There appears to be high dependence on voluntary sector bodies such as MENCAP and Positive Futures, and high praise for the work of these groups. There is a need for more day opportunities, and more meaningful opportunities which could lead to paid employment or a qualification.
  There seems to be a lack of suitable training courses available for people with mild/moderate learning disability and difficulty in accessing vocational courses without formal qualifications.
  There were views that support for people with a LD to attend FE is not sufficient and difficult to access eg, no supervisory support available.
  Transport to Day opportunities is a problem, particularly in rural areas.
  Concerns expressed about the lack of Day Opportunities for people over 24.

Concerns about the short-term nature of Day Opportunities and the increased likelihood of placements breaking down leading to uncertainty and disruption for the person and their family.
Concerns about people losing their place in their Day Centre and need for this to be maintained as a base or safety net.
Need for consideration of people with a LD who have been in a 'routine' attending a Day Centre for many years and the impact of losing this on them.

- Physical healthcare: Annual health checks or MOTs are generally being offered and most people have had a positive experience of this service.

- Hospital care: Varied experiences across the Region, some very good, some very bad. Planned admissions appear to be managed well. Attendance at A&E still seems to be problematic in some areas, and can be very stressful for people with a LD and their carers. Use of hospital passports in some areas seems to work well, but not used everywhere.

- Resettlement: Some very positive experiences and people whose quality of life has greatly improved. Others had negative experiences where accommodation placements have broken down – due to housemates, stress of day opportunities, lack of support and have ended up back in hospital.

- Benefits: Some people highlighted issues with benefits being cut when they enter paid employment and that often it doesn't work out, and they have to re-apply for benefits. This seemed to be a barrier to some people with a learning disability seeking employment. Issues also with having to re-apply for benefits eg DLA / PIP when they have a lifelong LD and the stress this causes to carers.

- Social worker support: Many people expressed the benefits of having a good key worker. Others felt that social workers were only available to deal with crisis situations.

- Social / recreational activities: General view was there needs to be more access to social activities. In some areas the only activities available were run by parents, and people felt the need for more public-run activities.

MENTAL HEALTH

- With regard to the Mental Health actions, the following evidence has been gathered to evaluate the impact of Bamford, summarised as follows:
  - The HSC Board / PHA carried out an audit of Adult Mental Health Services. There were a total of 665 completed questionnaires. Report completed in April 2016 and broadly shows improvement to MH services. More work to be draw out more detailed breakdown of responses by Trust area.
  - The HSC Board are carrying out an audit of Child and Adolescent Mental Health Services, the findings of which will inform the evaluation.
  - RQIA carried out a review of Eating Disorder Services, published in December 2015.
  - A range of other reports / evaluations from professional bodies and 3rd sector organisations.
  - The Department has held 16 MH **focus groups**, covering the following themes:

    - Mental Health – Recovery (October, Lurgan)
    - Mental Health – Personality Disorder Services (October, Belfast)
    - Mental Health – Eating Disorder Services (October, Belfast)
    - PCC Carers event in Antrim (January)
    - Trust-based Eating Disorder focus groups (Belfast, Derry/Londonderry, Banbridge, Antrim)
    - Trust-based Mental Health Services focus groups in Belfast, Ulster Hospital, Enniskillen, Antrim, Coleraine, Derry/Londonderry, Lurgan)

80 carers and 52 people who have used mental health services participated in these events, as well as a range of voluntary sector representatives and support workers.

Emerging themes on Mental Health

- In the main, feedback on the Recovery approach, ImROC and Recovery Colleges has been very positive, with people describing this as ‘life-changing’. There are pockets where Recovery Colleges do not appear to be being promoted effectively or just not working, and we need to investigate the reasons behind this. Very positive feedback on WRAP.
- Positive feedback on the You In Mind Care Pathway, although variance in awareness of the Care Pathway from both service users and clinicians.
- Some people had Care Plans and were involved in creating their Care Plan, but others did not – need for consistency;
- Strong views from carers that they did not feel supported in their caring role nor involved in the care of their loved ones. Concerns that the confidentiality issue is being over-used to exclude carers from any involvement in care. Need for a point of contact for carers in times of crisis
- Concerns raised in some areas about people being discharged from hospital without the required intensive community care, leading to relapse.
- Issues with accessing help and support out of hours
- Some very negative experiences in A&E and on acute hospital wards. Staff not trained in mental health and ‘don’t want to know’;
- Positive feedback on Personality Disorder services, but issues with accessing these;
- Very positive feedback on Eating Disorder services, but some issues with accessing these in particular in relation to GPs lack of knowledge / awareness;

- Role of 3rd sector bodies to complement MH services is very important and need for better signposting / referral mechanisms / formal arrangements with these services;
- Issues with inconsistency with staff due to high levels of staff turnover / leave etc. Negative impact on MH service users who stressed the need for consistency;
- Issues in gaining employment after being assessed / detained under the Mental Health Order;
- Benefits – forms are difficult to complete and do not allow for the episodic nature of mental illness ie it depends on the day.

NEXT STEPS

- Drafting to continue on the evaluation report. It is hoped to circulate a draft to Departmental contacts, the HSCB, PHA and Trusts, and selected voluntary and community groups by end of June for comments.
- Once comments have been received, an updated draft will be sent to the new Health Minister, and subsequently to the Executive, with a recommendation to publish.
- As well as reporting on outputs and outcomes, the report will outline the proposed future for the various Bamford structures, and provide an indication of the outline of mental health policy and learning disability policy direction for the new Assembly mandate.

EVALUATION OF THE BAMFORD ACTION PLAN 2012-15

Ministerial Foreword

(TO BE COMPLETED FOLLOWING EXECUTIVE APPROVAL)

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INTRODUCTION

The Bamford Review, an independent review of mental health and learning disability law, policy and service provision, produced a series of 10 reports between 2005 and 2007 and identified the need for major reform of mental health and learning disability services across the Executive and other statutory bodies. The Bamford reports contained over 300 recommendations, which reach into all aspects of the lives of people with a learning disability or mental illness. They covered health, education, employment, training, leisure, transport and housing.

The first Bamford Action Plan 2009-11 was the Executive's response to the Bamford Review. Responsibility for delivery of the Action Plan spanned 8 Executive Departments. The Plan contained a total of 147 actions, 80 in respect of mental health and 67 for learning disability, under five themes:

- Promoting positive health, wellbeing and early intervention
- Supporting people to lead independent lives
- Supporting carers and families
- Providing better services to meet individual needs
- Developing structures and a legislative framework

The then Department of Health, Social Services and Public Safety (DHSSPS) carried out an in-house evaluation report of the 2009-11 Action Plan, in consultation with the other Departments responsible for its delivery. This evaluation, published in January 2012, found that 80% of the actions were achieved. However, feedback from some service users and carers indicated that they did not experience significant change in service delivery on the ground, and that going forward, evaluation of policy/service developments should focus on outcomes, rather than outputs.

The follow-up Bamford Action Plan 2012-15 was published in March 2013, and extended to 31 March 2016. This action plan contained a total of 76 actions under the same five themes. Responsibility for delivery of the 2012-15 Action Plan spanned 8 Executive Departments.

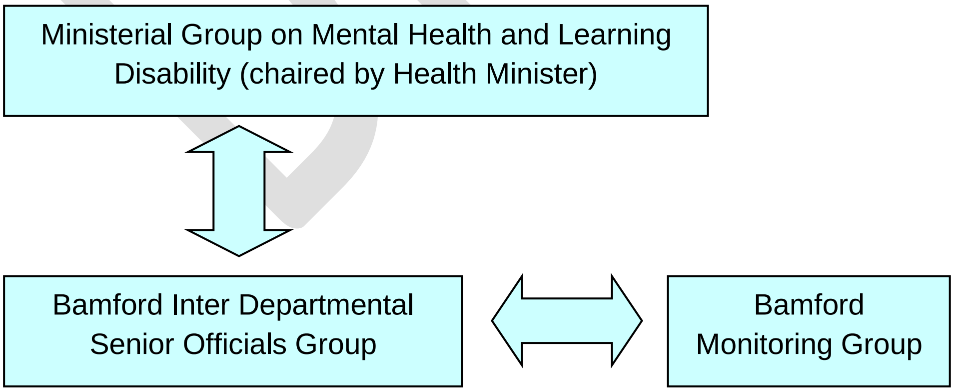
The number of actions per Department is summarised below:

Department (when Action Plan published)	Department (with responsibility as of May 2016)	No of actions
Department of Health, Social Services and Public Safety (DHSSPS)	Department of Health (DoH)	46
Department of Education (DE)	Department of Education (DE)	6
Department of Enterprise,	Department for the Economy	1

Trade and Investment (DETI)	(DfE)	
Department for Employment and Learning (DEL)	Department for Communities (DfC) (employment services) Department for the Economy (DfE) (further / higher education and training)	11
Department of Culture, Arts and Leisure (DCAL)	Department for Communities (DfC)	2
Department for Regional Department (DRD)	Department for Infrastructure (DfI)	3
Department for Social Development (DSD)	Department for Communities (DfC)	5
Office of the First Minister and Deputy First Minister (OFMDFM)	The Executive Office (TEO) (victims) Department for Communities (DfC) (disability)	2
TOTAL		**76**

Structures

The breadth of the Bamford agenda required an integrated approach to drive it forward. The structures established to deliver the Bamford agenda are illustrated below:



The role of the Inter-Departmental Ministerial Group on Mental Health and Learning Disability was to oversee and drive forward change across Departments and their agencies in a co-ordinated way.

The role of the Inter-Departmental Senior Officials Group (IDSOG) was to ensure that all Departments and HSC sectors worked together to deliver targets in the Action Plan and to support the Ministerial Group on Mental Health and Learning Disability.

The Bamford Monitoring Group (BMG) is a group of service users and carers, established and supported by the Patient and Client Council, to provide an independent challenge function on the extent to which the changes being put in place align with the Bamford vision. The chair of the BMG is a member of the IDSOG.

Scope of this Evaluation

With the publication of the follow-up Bamford Action Plan 2012-15 in March 2013, the Executive committed to a more outcome-focussed evaluation, which would focus primarily on outcomes that matter to service users and their families, i.e. not just quantitative outputs, but more importantly, qualitative inputs too. Whilst the Executive's original preference was for an **independent** evaluation of the Bamford Action Plan 2012-15, given the exceptionally challenging financial environment, it was decided that the evaluation would be undertaken in house, led by the then Department of Health, Social Services and Public Safety.

The scope of the Evaluation was set out in the Terms of Reference (Annex D) agreed by the Bamford IDSOG as follows:

The evaluation will consider three specific aspects of the implementation of the Bamford Action Plan 2012-15:

- Outputs – i.e. the action which has been taken by Government Departments and their agencies, and the Bamford structures, to progress the Bamford vision, and the progress made.
- Outcomes – i.e. – the differences made for service users and carers; how services have improved / changed from the service user and carer experience, including what is better and what is worse.
- Structures – a critical review of the structures in place to deliver Bamford, in the context of the recent and emerging Government policy.

It was also to consider the necessary actions and structures to take forward the Bamford vision after March 2016.

METHODOLOGY

It was agreed by the Bamford IDSOG that each Department with responsibility for actions within the Bamford Action Plan 2012-15 would take ownership of the evaluation of their own actions. DHSSPS led on the completion of the evaluation and collated input from other Departments.

The agreed methodology for carrying out the Bamford Evaluation is set out below:

- **Develop and agree Evaluation Framework:** DHSSPS drafted an Evaluation Framework (included in Annex D) which set out what would be evaluated, and was agreed by the Bamford Inter Departmental Senior Officials Group (IDSOG) and Bamford Monitoring Group;
- **Evaluation of Outputs:** Each Department with responsibility for actions in the Bamford Action Plan 2012-15 gathered information, including quantitative and statistical data, on what action has been taken to implement their actions;
- **Evaluation of Outcomes**: Each Department with responsibility for actions in the Bamford Action Plan 2012-15 was required to gather the experiences of service users and carers across the region and across the mental health and learning disability sectors on how services have changed. The most appropriate approach(es) were to be agreed by Departments;
- **Evaluation of Bamford Structures:** DHSSPS led on examining the functions and effectiveness of the Ministerial Group, the Inter Departmental Senior Officials Group and the Bamford Monitoring Group, with input from other Departments. All Departments will consider the delivery mechanisms for the Bamford actions and how effective these are.

Evidence gathering by Departments

Department of Health (DoH)

<u>Learning Disability</u>

With regard to the Learning Disability actions, the following evidence has been gathered to evaluate the impact of Bamford, summarised as follows:

- A range of data and statistics provided by the Health & Social Care Board (HSCB) and DoH's Information Analysis Directorate;
- A range of relevant reports completed by the Health & Social Care sector, including the HSCB, Patient Client Council (PCC) and the Regulation and Quality Improvement Authority (RQIA);
- **Questionnaire** issued for carers of people with a learning disability, and distributed in December 2015 through the Patient Client Council membership scheme; the HSCB and HSC Trust service user and carer forums; local Councils, relevant community and voluntary sector groups and schools. 252 responses received.
- **Questionnaire (easy read)** issued to people with a learning disability in February 2016. 163 responses received.

- 19 **focus groups** were held by the Department, covering the following themes:
  - Learning Disability – Health Services for Children (October, Antrim) (facilitated by Patient & Client Council);
  - Learning Disability – Living in the Community (October, Lurgan (facilitated by Patient & Client Council);
  - Learning Disability – Day Opportunities / Post-School Provision (October, Omagh) ;
  - Learning Disability – Health Services for Adults (October, Downpatrick) (facilitated by Patient & Client Council);
  - Learning Disability –Support for Carers (October, Belfast) (facilitated by Patient & Client Council);
  - ARC organised 3 focus groups in January in Ballymena, Omagh and Lisburn covering a wide range of LD services;
  - TILIS groups - focus groups at Muckamore, Bangor and Belfast which covered resettlement and wider issues;
  - Focus group with Positive Futures Older Carers group in Lisburn;
  - Trust-based focus groups in Belfast, Enniskillen, Gilford, Bangor, and Lisburn;
  - PCC Carers event in Antrim.

129 carers and 86 people with a Learning Disability participated in these events, as well as a range of voluntary sector representatives and support workers.

<u>Mental Health</u>

With regard to the Mental Health actions, the following evidence has been gathered to evaluate the impact of Bamford, summarised as follows:

- A range of data and statistics provided by the Health & Social Care Board (HSCB) and DoH's Information Analysis Directorate.

- A range of relevant reports completed by the Health & Social Care sector, including the HSCB, Patient Client Council (PCC) and the Regulation and Quality Improvement Authority (RQIA).

- The HSC Board / PHA carried out an audit of Adult Mental Health Services. There were a total of 665 completed questionnaires. Report completed in April 2016 and broadly shows improvement to MH services.

- The HSC Board are carrying out an audit of Child and Adolescent Mental Health Services, the findings of which will inform the evaluation.

- A range of other reports / evaluations from professional bodies and 3rd sector organisations.

- 16 MH **focus groups** were held, covering the following themes:
  - Mental Health – Recovery (October, Lurgan) (facilitated by Patient & Client Council);
  - Mental Health – Personality Disorder Services (October, Belfast) (facilitated by Patient & Client Council);

- Mental Health – Eating Disorder Services (October, Belfast) (facilitated by Patient & Client Council);
- PCC Carers event in Antrim (January);
- Trust-based Eating Disorder focus groups (Belfast, Derry/Londonderry, Banbridge, Antrim);
- Trust-based Mental Health Services focus groups in Belfast, Ulster Hospital, Enniskillen, Antrim, Coleraine, Derry/Londonderry, Lurgan).

80 carers and 52 people who have used mental health services participated in these events, as well as a range of voluntary sector representatives and support workers.

Department of Education (DE)

DE used the following evidence in evaluating their actions within the Bamford Action Plan:

- A number of reports for Education Training Inspectorate (ETI) including:
  Evaluation of Extended Services Funding Sep 2016;

  An Evaluation of the Special Educational Needs Capacity Building Pilot A: Early Years setting;

  A Survey Report on Transition Arrangements from Special Schools and Mainstream Learning Support Centres to Post-School Provision;

  An Evaluation of the Provision to meet the Needs of Pupils with Persistent and Challenging Behaviour in Special Schools;

  Interim findings from the Early Years SEN Inclusion Service Pilot.

- Ongoing evaluation of the ‘Team Teach’ training (for behaviour management);
- Feedback from schools on the self-assessment audit tool;
- Evaluation and feedback on the ‘Optimising Achievement’ Resource,
- Feedback from school staff on the Keeping Safe Programme;
- “**A Survey of Young People’s Views on Accessing Counselling in Schools**”, carried out by youth@clc at the Children’s Law Centre in 2012;
- A range of statistics and information from DE and the Education Authority (EA).

Department for the Economy (DfE) (previously DETI)

DfE used the following evidence in evaluating their actions within the Bamford Action Plan:

- An evaluation of the HSENI Mental Well-being at Work Advisory Service;
- A range of statistics on the enrolments of students with disabilities at Further Education Colleges and Higher Education Institutions.

In addition, there was feedback from people with a learning disability or mental ill-health and their families / carers on further / higher education and training given through the DoH focus groups and questionnaires, linked to discussions on the Day Opportunities model and Transitions, which provided some experience-based evidence.

Department for Communities (DfC) (previously DSD, DCAL, DEL, OFMDFM)

DfE used the following evidence in evaluating their actions within the Bamford Action Plan:

- an Interim Report of the housing element of Bamford (the first element of a 2 part bespoke evaluation) commissioned by the Northern Ireland Housing Executive, which gathered evidence from the professionals involved in delivering Bamford;
- the "Review of Supporting People" (November 2015);
- Progress reports on the Disability Strategy;
- Statistics and information on the Special Olympics programme;
- Ulster University Review of Mental Health & Wellbeing in Sport;
- Activity information and evaluation of the 'Health In Mind' libraries programme;
- Research report : Disability Living Allowance and Attendance Allowance: The Impact of the benefits and an exploration of Disability Living Allowance and Work;
- Statistics and information on benefits uptake.

There was also experience-based evidence shared with DOH via focus groups and questionnaires on housing, sports and benefits.

Department for Infrastructure (DfI) (previously DRD)

DfI used the following evidence in evaluating their actions within the Bamford Action Plan:

- evaluation of the Travel Safe Guide;
- evaluation of the Access Travel Wallet;
- statistics and feedback on disability training for drivers.

There was also experience-based evidence shared with DOH via focus groups and questionnaires on transport.

The Executive Office (previously OFMDFM)

As discussions in relation to a cross Departmental Mental Trauma Service Partnership agreement are currently ongoing, and the service has not yet been established, there was no evidence for the TEO action in relation to the mental health needs of victims and survivors of the Conflict.

SUMMARY OF KEY FINDINGS

The detailed findings for the Learning Disability actions and Mental Health actions are reported in Annexes A and B of this document. A separate section on the Legislative Framework (Annex C) is also included.

On balance, our assessment is that the actions within the Bamford Action Plan are largely complete, and that life is better for many people with learning disabilities and mental health issues, as a result of implementing the Bamford Action Plan 2012-15.

However, there is much more to do, and the evaluation has been extremely useful in identifying the needs and gaps that need to be addressed so that we can continue to work towards having first class provision, right across the region.

A summary of the findings for learning disability and mental health services are indicated below.

Learning Disability

Key Achievements

The Evaluation found that there had been many achievements in the development of learning disability services since the Bamford Review, including the resettlement of the majority of people living in long-stay hospitals into the community, improved physical healthcare and dental services, the commencement of the shift towards a Day Opportunities model, more short breaks / respite for carers, improved participation in sport and the introduction of new Special Educational Needs legislation.

LEARNING DISABILITY SERVICES: KEY ACHIEVEMENTS

Health & Social Care Services

- Improved physical healthcare for people with a learning disability. 95% of GP practices are now offering annual health checks to people with a learning disability under the Directed Enhanced Service. The number of annual health checks completed in 2015/16 was just over 6,000 in 2015/16;
- Learning Disability Crisis Response Services are being established in each Trust to provide short term assessment, support and treatment for individuals and their families so as to avoid admission to hospital where possible;
- The uptake of Self-Directed Support and Direct Payments by people with a learning disability has increased and work continues to remove barriers and promote SDS;
- Support for children with challenging behaviours has been enhanced;
- A revised Service Framework for learning disability services was published in January 2015, setting out standards of care that services users and their carers can expect;
- Expenditure on learning disability health and social care services has increased from £228M in 2009/10 to £276M in 2014/15, with 88% of expenditure now on community-based services;
- Measures to improve nursing practice for people with a learning disability have been taken through the Strengthening the Commitment Action Plan, and experiences of people with a learning disability indicate that most people have a positive experience with nursing staff;

- There are improved dental services, and in 2014/15, more than 6,500 people with a learning disability participated in Oral Health Promotion and Improvement programmes;
- The GAIN guidelines "Caring for people with a learning disability in general hospital settings" are being implemented, and the majority of people we engaged with had positive hospital experiences, apart from in Emergency Departments.
- We have invested almost £6.7M in learning disability facilities since 2011. Key developments include the development of the Dorsey Learning Disability Assessment and Treatment Unit at Bluestone hospital in Craigavon, and extensions and improvement works to a number of Day Centres.

Resettlement / Housing

- The majority of the 347 long-stay hospital patients have been resettled into the community. 25 patients remain to be resettled. Evidence indicates that the quality of life for the resettled people has much improved.

Support for Carers

- The uptake of Self-Directed Support and Direct Payments by people with a learning disability has increased and work continues to remove barriers and promote SDS;
- More short breaks / respite are being provided, and there is an increase in the completion of carer's assessments, to support carers in their caring role;
- £2M has been secured to provide services to meet the needs of people with a learning disability living with older carers who can no longer care for them or to manage crisis situations, including domiciliary care, respite, day care, supported living/nursing/residential placements;
- Training has been provided to key staff in future planning for older carers.

Education

- The new Special Educational Needs and Disability (SEND) Act received Royal Assent on 23 March 2016;
- The Education Authority (EA) has a well-embedded statutory transition planning process in all schools, which continues to support education transition co-ordination across the Authority;
- There are improved services and training to help schools to manage challenging behaviour.

Post –School Opportunities

- The implementation of the HSC Board's Day Opportunities Model (2014) has commenced, with the aim of ensuring that people with a learning disability can participate in meaningful day opportunities which will fulfil their potential such as employment, training and further education and sports and recreational activities;
- A number of initiatives are ongoing to increase the participation of people with disabilities in further and higher education and training. However, there is limited information on the numbers of people with a learning disability accessing these programmes or the outcomes of participation;
- Around 600 people with a learning disability have been supported through a range of DfC sponsored employment support programmes.

Sport and Leisure

- Sport opportunities for people with a learning disability are being provided through the Special Olympics programme with over 1,500 participants and 1,300 active coaches.

Transport

- There is better information available for people with a learning disability on using public transport through the revised Travel Safe Guide;
- Over 500 drivers within Translink and Community Transport have been trained in meeting the needs of people with disabilities.

Benefits

- Research into benefits has informed and supported the development of policy and strategy relating to disabled customers and measures to increase the uptake of benefits have resulted in a substantial increase.

Identified Needs

Whilst much has been achieved in the development of learning disability services, the Evaluation found that significant gaps remain in services to support people with a learning disability to live full and independent lives in the community.

LEARNING DISABILITY SERVICES: IDENTIFIED NEEDS
(IN NO PARTICULAR ORDER)

Health & Social Care Services

- Need to improve transitions from children’s health & social care learning disability services to adult services;
- Need to enhance Community Learning Disability Teams and infrastructure, including crisis and forensic support in the community, to meet growing demand and complexity of needs;
- Need to improve the experience of people with a learning disability in Emergency Departments;
- Capital investment is required to modernise a number of adult centres / day centres;
- Need to improve information on and signposting to support services to people with a learning disability and their families, recognising that many older carers in particular do not have access to technology;
- Need for a formal mechanism for people with a learning disability and families/ carers to engage with HSC Trusts, so that ideas and experiences can be shared and inform the design and delivery of service development;
- Develop further the role of 3rd sector organisations in providing support and information to people with a LD and their families.

Resettlement / Housing

- Need to complete the resettlement programme, to include those people whose discharge from hospital has been delayed since the resettlement programme began;

- Need to address the housing needs of the learning disability population provide more choice for those living in their family home who want to become more independent but remain close to support networks. Particular need in this area has been identified for people with a learning disability living with older parents / carers;
- Need for strategic needs assessment of supported living, improved commissioning arrangements and better regulation, as recognised in the Review of Supporting People.

Support for Carers

- Need for further investment in short breaks / respite and the promotion of carer's assessments and Self-Direct Support to help support carers to continue in their caring role to meet increasing demand;
- Need for provide better information and support, including better future planning to proactively address the needs of people with a learning disability who are living in the family home with older carers, in particular housing needs and support during a crisis.

Education

- Need for better forward planning of transitions from school and more options for young people with a learning disability leaving school.

Post –School Opportunities

- Continue the roll-out of the Regional Day Opportunities Model and manage the shift to this new model carefully, respecting the difficulties that the change may cause for people who have attended a day centre for many years. The short-term and part-time nature of many Day Opportunities is an issue, and impacts on the carer's role;
- Aligned to this, need to develop more supported employment opportunities for people with a learning disability;
- Need to review and increase Further / Higher Education and Training opportunities for people with a learning disability and the support available to enable them to participate.

Transport

- Need to address the lack of transport, particularly in rural areas, to Further Education Colleges and other existing or potential day opportunity services;
- Need to provide training for people with a learning disability to empower them to use public transport. The cessation of the travel training scheme should be reviewed.

Benefits

- There is a need to review the frequency with which benefits are reviewed for people with life-long learning disabilities, to reduce unnecessary burden of form-filling for families and carers.

It is clear that addressing the range of gaps identified in this evaluation will require a coordinated response from the Executive under the auspices of the Programme for Government. It is also imperative that people with a learning disability and their families/carers are at the very centre of developing that response and in particular service planning and delivery going forward.

Mental Health

Key achievements

Generally, the evaluation found that there had been much progress in the development of mental health services since the Bamford Review, with key achievements including the resettlement of the majority of people out of long-stay hospitals, the establishment of recovery-orientated practice, the development of crisis response services and specialist mental health services for people with a Personality Disorder or an Eating Disorder, investment in psychological therapies and improved mental health awareness and suicide prevention measures.

MENTAL HEALTH SERVICES: KEY ACHIEVEMENTS

Mental Health & Wellbeing

- Good progress on promotion of mental health & wellbeing with positive indications on awareness rates and an increase in the number of people seeking help;
- The establishment of a number of suicide prevention measures. While still too high, the suicide rate has remained stable in the last few years;
- Positive indications on reduction of binge drinking, illegal drugs misuse has plateaued and more people are accessing drugs and alcohol services;
- Mental health promotion is embedded through schools with the establishment of the I-Matter programme, Independent Counselling Services in Schools and introduction of anti-bullying legislation;
- Mental health awareness training is being widely delivered to sports organisations;
- Health & Safety Executive NI have provided advice and training to over 70 organisations through Mental Health & Wellbeing at Work Advisory Service, with evidence of reduced work-related stress and associated absenteeism.

Health & Social Care Services

- There was very positive experience of people with mental health problems being involved in the design and delivery of services through the Mental Health Service User Forums and through employment in Recovery Colleges. ;
- Expenditure on mental health services has increased by 44% in 10 years, with almost 60% of this being spent on community-based services;
- Recovery-orientated practice is well embedded in mental health services with the launch of the Regional Care Pathway 'You In Mind', the delivery of recovery training to mental health practitioners and the establishment of Recovery Colleges. Over 150 people with lived experience of mental ill-health are employed as peer support workers and other posts. There is some work to do to ensure this is consistent across the Region, but many people who engaged in the evaluation process spoke of their positive experiences and how they now had hope for the future;
- Implementation of a Regional Child & Adolescent Mental Health Service Model, including the establishment of Primary Mental Health teams and Crisis resolution teams in each Trust, investment in forensic services and the development of a Regional Gender Identity Service;
- Significant progress has been made in establishing psychological therapy services.

We currently invest more than £10M per year in Psychological Therapy services and have 294 (WTE) psychologists employed across the Region. Primary Talking Therapy Hubs are now established in each Trust area;

- Specialist Personality Disorder services have been established in each Trust and feedback from service users is that this is working very well in some areas;
- Establishment of Eating Disorder teams in each Trust;
- Community mental health forensic teams are in place and 3 newly refurbished low secure facilities are now in use at Holywell, Clare Villa Knockbracken and Gransha;
- New purpose-built inpatient facilities have been opened at Bluestone and Grangewood, and a new build has commenced at the Belfast City Hospital site.

Resettlement / Housing

- Resettlement is almost complete – out of the original 472 long-stay hospital patients, only 18 remain in hospital and 8 of these continue to require hospital care. There is evidence of much improved quality of life for those resettled.

Further / Higher Education and Training

- A number of initiatives are ongoing to increase the participation of people with disabilities, including mental ill-health, in further and higher education and training. However, there is limited information on the numbers of people with mental health needs accessing these programmes or the outcomes of participation.

Employment services

- An estimated 1,500 people with mental health problems participated in the DfC sponsored programmes Work Connect, Workable (NI) and Condition Management Programme, to support them back into the workplace.

Dementia

- Dementia Services are being improved through the Executive's Delivering Social Change Programme (Dementia).

Identified Needs

There were other areas in which services have not developed fully, which include a shortage of supported housing for those not being resettled out of hospital, trauma services, perinatal mental health services, treatment for people with severe and enduring mental illness and support for mental health carers.

MENTAL HEALTH SERVICES: IDENTIFIED NEEDS / GAPS

Health & Social Care Services

- The development of a Co-Production Mental Health Framework to create a formal mechanism for people with lived experience of mental illness to champion the rights and interests of people with mental health problems, take the role of independent advocates, ensure that mental health services continue to be developed in a way that effectively meets the needs of service users and carers and engage with senior Departmental mental health policy officials, commissioners and Trust mental health managers;

- Continue the implementation of the You In Mind care pathway to ensure consistency across all mental health services;
- Develop a new standard operating model for mental health delivery which will further support the integration of psychological therapies and recovery practice into the role and function of community mental health teams and services, and address the variance across the HSC in the use of recovery-orientated practice;
- Better promotion of and referral to Recovery Colleges, including by GPs;
- Consider what services need to be developed so that recovery-orientated practice outreaches to treat those patients with severe and enduring mental illness;
- The development of a Regional Mental Health Trauma Service;
- Improve signposting for people with mental ill-health and families / carers to support organisations;
- Improve acute Child & Adolescent Mental Health Services;
- Improve mental health services for young people with learning disabilities;
- Improve CAMHS primary mental health services;
- Further development of psychological therapy services is needed to address the increasing demand and improve waiting times. This will require substantial targeted investment – the shortfall is estimated to be in the region of £12M;
- Need to review workforce skills of core Community Mental Health Teams and develop solutions to address skills gaps to optimise the use of available resources and develop the capacity of these teams to deliver psychological interventions which are patient-centred, evidence based, cost-effective, and appropriately supervised;
- Need to develop tools to routinely measure the outcomes of mental health care and treatment, including psychological interventions;
- Need to develop further Personality Disorder services to ensure that a choice of treatment modalities to meet demand, and family carer and peers support services, are available consistently across the Region;
- Secure funding to invest further in the development of Specialist Eating Disorders in the North, in accordance with the findings of the DoH / HSCB review which is due to report by the end of 2016;
- Estimated further investment of £1.5M is required to fully establish community forensic mental health services;
- Need to develop specialist Perinatal mental health services in line with NICE guideline CG192;
- Continue to modernise mental health inpatient units to replace out-dated mental health units in the South Eastern, Northern and (southern sector of the) Western Trusts in line with capital budget Capital;

An additional urgent need has been identified, not through this evaluation, but through an emerging issue identified by the HSC Board and Trusts:

- Establish services to ensure the physical healthcare needs of people with mental ill-health are being met to ensure that they can be cared for in the community safely. This requires investment of an estimated £1M annually to fully implement.

Resettlement / Housing

- Need to complete the resettlement programme;
- Need to improve measurement of betterment as a result of resettlement;
- Need to address housing needs of people with mental ill-health, other than those in long-stay hospitals;
- Need for strategic needs assessment for supported living, improved commissioning arrangements and better regulation.

Support for Carers

- The need for better support to carers of people with mental ill-health through the full implementation of the You In Mind Care Pathway which requires the full and active participation of carers and families in the assessment, treatment and discharge of people with mental illness.
- Ensure carers have easy access to 24/7 mental health crisis contact so that they can seek appropriate guidance or professional help quickly in a crisis situation.
- Provide support for future planning for carers of people with severe and enduring mental illness, to include addressing housing needs.

The majority of the identified needs are within the responsibility of Department of Health, and priorities going forward are set out later in this report.

In addition to the evidence gathered to evaluate the actions within the Bamford Action Plan, a number of key reports have been published recently and have informed consideration on the way forward in respect of mental health services here.

Sensemaker Audit: You In Mind – Your Experience Matters

In 2012 the Public Health Agency and Health and Social Care Board surveyed people, including families and carers, who had experience of mental health services across the Region to gain insight into their experience of mental health services. The survey was based upon 9 questions developed by people who use services and carers from each Trust area and in addition, individual respondents could *tell their story* and describe their personal experience of using services. Trusts engaged in service improvement activities to address the issues highlighted in the 2012 survey.

In 2015 a re-audit was carried out by the Public Health Agency and Health and Social Care Board, which provided an analysis of regional survey data collected and (where applicable) a comparison was made with data from 2012. 3 questions were added to the 2015 re audit to cover the developments in recovery-orientated practice. 655 responses were received, and the report findings have informed the Bamford evaluation.

Overall, the data suggests that service users (& carers) perceive their experience of mental health services has improved.

For example when compared to the 2012 results, in 2015:

- There was an increase in the proportion of respondents who felt they had received the right services at the right time;
- A greater proportion of respondents reported that they found information provided by staff in mental health services useful;
- The proportion of users of services considered staff to be respectful and considerate increased;
- There was an indication that more people felt they were fully involved and respected in planning their care and treatment;
- A greater proportion of respondents reported that they felt stronger after their experience of mental health services;
- More respondents reported that they had made positive progress;
- Fewer people said that there was no change after using mental health services, that they were struggling to cope or both; and
- More respondents in the current period said that their journey within mental health services was smooth running
- the overall number of people reporting that their journeys within mental health services was confusing decreased.

Importantly over a third of respondents in 2015, felt that they were hopeful for the future and the majority reported that recovery had become an important part of their treatment and support. More than two-thirds of respondents said their physical health care needs were discussed in detail by their mental health team/practitioners.

These indications of general improvements in mental health services since 2012 provide helpful balance and context to the specific themes that emerged from the Departmental focus groups.

QUB / AMH report ‘An evaluation of mental health service provision in Northern Ireland’

AMH commissioned Queens University to conduct a study into mental health provision in NI. The study explored possible gaps, limitations, inconsistencies and strengths in services across Northern Ireland through research and interviews with staff, service users and carers. The final report was issued on 5 October 2015.

The report acknowledged that there has been considerable progress in realising the Bamford Vision for improving mental health service provision. It also highlights significant limitations in current services and makes ten recommendations for improvement, most notably in the areas of improving funding, addressing fragmentation and gaps in services, and in the provision of a new vision and leadership in mental health.

It is recognised in this evaluation that work must continue to ensure resources are directed appropriately, fragmentation of services is reduced and the views and experiences of service users and carers inform the future direction of mental health provision in Northern Ireland.

Mental Health Champion

One of the key recommendations in the AMH/QUB report was that an independent need for Mental Health Champion . The Together for You partnership provided a paper to the Department of Health which examines the possible role, remit, aims and objectives of a Mental health Champion. The paper suggests that the role would exist to:

(i) work across government in order to lever the significant public resource relevant to mental health and wellbeing across the Executive, Assembly, public bodies (including Commissioners and academia) and public services;
(ii) build the capability of public sector leaders in order to ensure that mental health is a core consideration in all decision making in legislation, policy, provision, research and data;
(iii) work closely with the voluntary, community and private sectors in order to identify, support and enhance their contributions to public mental health;
(iv) develop an evidence-based change agenda around mental health;
(v) develop a data system that will ensure data-informed decision making to maximize the benefit and minimize the harm to mental health; and
(vi) develop strong relationships with mental health leaders across the UK, in Europe and globally in order to ensure that the people living here have access to public mental health, therapeutic and technological innovation.

Having given this suggestion due consideration, we have reservations about the appointment, by the Minister or the Department of Health, of a Mental Health Champion. We have communicated these to the Together for You partnership. Our reservations relate to the independence of such a post, the appointments process, and whether this would duplicate efforts being made across the Executive, under the new Programme for Government arrangements.

Such a post should be credible when it criticises the Department of Health, and indeed when it considers that services are improving. However, the very fact that a Mental Health Champion has been selected by the Minister could call this independence into question. Further, there could be difficulties in ensuring that proper governance and accountability arrangements are in place. Appointment by a Minister or Department would engage the Public Appointments process which can be lengthy in itself, in the event that the post fell vacant.

An alternative to a champion appointed by the Minister or Department might be that relevant mental health voluntary and community organisations would come together, perhaps under the Together for You banner, to appoint a champion who would then be truly independent and authoritative. They could perform the functions outlined above, with a guaranteed direct line into the Department, but without any question mark over independence.

We have agreed with Together for You that there will be further exploration the role and remit of a mental health champion to protect and promote the interests of those suffering poor mental health and well-being

The proposed development of a Co-Production Mental Health Service Framework will ensure that people with lived experience are formally and actively involved in the development of mental health policy and the design and delivery of mental health services.

Royal College of Psychiatrists (RCPsych) Report 'Building on Progress: Achieving Parity for mental health in Northern Ireland'

The Commission on Acute Adult Psychiatric Care, chaired by Lord Crisp, former head of NHS England, was set up by RCPsych in early 2015 in response to widespread concerns about the provision of acute inpatient psychiatric care and availability of alternatives to admission in England, Wales and the North of Ireland. It was asked to review the situation, examine the causes of these pressures and make recommendations for improvement.

The local report was published on 17 June 2016. The Commission made eight recommendations, outlined below:

1. **Parity of esteem**: Equal priority for mental health with physical health.
2. **A single mental health service for the North of Ireland:** A single service would reduce fragmentation, allow common systems and standards to be adopted and provide for cross-boundary working.
3. **Improved functioning of the whole system**: Planners and providers need to undertake a service capacity assessment and improvement review.
4. **Quality improvement and standards for acute adult wards:** Current work to develop capacity and capability for quality improvement needs to be strengthened, and linked to a set of easy to understand and measurable quality standards.
5. **Support for patients and carers**: Need for greater emphasis on early involvement of carers, as well as peer-led and advocacy services.
6. **Investment for better value and improved quality:** Further investment in community and specialist services is required to remove pressure on inpatient care and improve efficiency.
7. **Commissioning**: Need a simpler and more evidence-based approach, and better financial mechanisms.
8. **Improved data:** Collection, quality and use of clinical, financial, patient and carer experience and organisational data needs to be radically improved, with introduction of a minimum data set.

Most of these recommendations reflect the findings of this evaluation, and are covered above and in Annex B as identified needs

In terms of parity of esteem, the Department is committed to progressing mental health services to the point where mental health gets its fair share of time, effort, attention and resources.

While a single mental health service is not planned, we are moving towards a managed care network approach which could provide for better uses of Trust expertise across the region. A single mental health service could affect links with physical health colleagues.

With regard to improving data, the HSC Board is leading on an Informatics Project to address data collection issues.

MENTAL CAPACITY LEGISLATION

The Mental Capacity Act (NI) 2016 achieved Royal Assent on 9th May 2016. The Act delivers on a major recommendation of the Bamford Review, to develop a comprehensive legislative framework that introduces mental capacity legislation and reforms mental health law here. A date for commencement has yet to be agreed. It is anticipated that implementation will take a number of years, dependent upon the availability of funding and resources in DOH and DOJ. However, with the right resources in place, the Act could be commenced within the current Assembly mandate.

REVIEW OF BAMFORD STRUCTURES

There were three structures established to oversee the delivery of the Bamford Action Plans:

- *Inter-Departmental Ministerial Group on Mental Health and Learning Disability*
  Ministers from the Departments with responsibility for actions in the Bamford Action Plan, chaired by the Health Minister. The main aim of the Group is to oversee and drive forward the Government response to the recommendations arising from the Bamford Review.

- *Bamford Inter-Departmental Senior Officials Group (IDSOG)*
  Members are senior officials from Departments with responsibility for actions in the Bamford Action Plan, HSCB, PHA, Patient Client Council (PCC) and the chair of the Bamford Monitoring Group; chaired by the Director of Mental Health, Disability and Older People in DoH. The Inter-departmental Group's focus is to ensure all Departments and HSC sectors work together to deliver targets in the Action Plan and to support the Ministerial Group.

- *Bamford Monitoring Group (BMG*)
  Membership is made up of service users of Learning Disability and Mental Health services and their carers. Its purpose is to provide feedback from the public, service user, family and carer perspective, on service improvement in relation to implementation of Bamford and to provide an independent challenge function on the extent to which the changes being put in place align with the Bamford vision. A Project Manager from within the staff of PCC supports the BMG. DoH provided recurrent ring-fenced funding of £125K to PCC to fund the work of the BMG.

In terms of the Ministerial Group and the Bamford IDSOG, the evaluation found that these groups have been effective structures in ensuring delivery of the Bamford Action Plans, and monitoring and reporting on progress. However, in recent years, representation at the Bamford IDSOG has generally not been at senior official level. In addition, where inter-Departmental working is required on cross-cutting issues, there are a number of inter-agency / inter-Departmental working groups set up to deliver on these specific issues – eg supported living, Day Opportunities, Post-19 Transitions, forensic mental health services. As the evaluation found that the development of mental health and learning disability services had now been mainstreamed in general, and that any identified gaps be addressed under the Programme for Government, it is recommended that both the Ministerial Group and the Bamford IDSOG be stood down.

In terms of the Bamford Monitoring Group, they have made an important contribution in terms of providing experience-based feedback to the Department and HSC more generally. This evaluation makes recommendations, for both the mental health and learning disability sectors, for the reform of structures for involving and engaging with people with lived experience of services and their families / carers in the development of policy and the design and delivery of services.

For the mental health sector, this will involve building on the success of the Mental Health Service User Forums in each Trust area, and evolving the structures into a Co-Production Framework.

For the learning disability sector, it is recommended that the HSC Board considers a more effective mechanism for engaging with people with lived experience of services, and suggests consideration should be given to the Mental Health Service User Forums and the proposed Co-Production framework as a model which could be replicated, recognising that this may need to be modified to suit this different client group.

On this basis, it is recommended that the Bamford Monitoring Group is also stood down. The dedication of the members of the BMG is recognised, and there may a role for BMG members within the proposed new structures, if they wish to be involved.

CONCLUSIONS

In general terms, the evaluation has found that the Bamford Review and subsequent Action Plans have been a catalyst for the development of mental health and learning disability health and social care services in the North of Ireland.

The evaluation concludes that most of the actions contained within the Bamford Action Plans have either been completed or are being developed, subject to funding, and in effect mainstreamed into services and service development. The evaluation finds that the Bamford Action Plans have run their course, and that there would be little value in developing a further Bamford Action Plan. For health and social care services, the Bamford principles are now embedded in policy and in service delivery and future service development. Improvements in mental health and learning disability health and social care services will continue the delivery of the Bamford Vision, and necessarily will be prioritised in line with resource availability.

In terms of the services which fall outside the remit of Department of Health, the actions committed to have largely been completed and we have seen mainstreaming of programme of support for people with a learning disability or mental ill-health, to a greater or lesser degree, in services like employment services, further education and training, education, sports and leisure, transport and benefits

The majority of the identified gaps in mental health services, fall to the Department of Health, with collaborative working required in a number of areas with Department of Justice and Department for Communities, which is already ongoing. Work to ensure the remainder of those people still in long-stay hospital placement who are deemed fit for discharge are provided with appropriate accommodation and support to live in the community will continue between Health and Housing. An addition priority will be to ensure appropriate accommodation is available for people with mental health needs other than those in long-stay hospitals. This needs to be considered within the context of the new Programme for Government.

In relation to the gaps identified in learning disability services however, the evaluation found that the onus for the development of wider services has largely defaulted to the Department of Health. This is particularly evident in the implementation of the Day Opportunities Model, the success of which going forward will very much depend on other Departments and in particular the creation of more employment opportunities and appropriate and varied further education / training opportunities for people with a learning disability.

A core principle underpinning Bamford is that we should move to a more social model to meet the needs of people with a learning disability, and away from a model based on healthcare where there is a risk of pathologising disability. The evaluation recommends that these gaps should continue to be developed by the Executive Departments with responsibility for them, working together collaboratively within the context of the new Programme for Government.

The enactment of the Mental Capacity Act (NI) 2016 is a major achievement which stemmed from the Bamford Review, and its implementation will provide a comprehensive legislative framework that introduces mental capacity legislation and reforms mental health law.

In terms of structures, this evaluation concludes that the Inter Departmental Ministerial Group on Mental Health & Learning Disability, the Bamford Inter-Departmental Senior Officials Group and the Bamford Monitoring Group have served a useful purpose in driving forward the Bamford agenda, but that these have lost focus in recent years, as mental health and learning disability policies have become embedded and service development mainstreamed. Cross-departmental groups exist for those areas which require collaborative working, on a focussed basis. The involvement of and engagement with people using services and their families / carers has evolved and future proposals for working on a co-productive basis will ensure proactive and meaningful engagement going forward.

It is therefore recommended that all three groups are stood down, and that the future drive and monitoring of services for people with mental ill-health or a learning disability is done through the new population-based, outcomes-focussed Programme for Government. The Ministerial commitment to co-production of service design and delivery is also a key element for future development.

WAY FORWARD

Addressing these gaps requires a co-ordinated response from the Executive, and there should not be an automatic default to health and social care. Indeed, a core principle underpinning Bamford is that we should move to a more social model to meet the needs of people with a learning disability, and away from a model based on healthcare where there is a risk of pathologising disability.

In terms of the way forward, the evaluation concludes that the Bamford Action Plans have run their course, and it is proposed that there is little benefit in developing a further Bamford Action Plan. For health and social care services, the Bamford principles are now embedded in policy and in service delivery and future service development. Improvements in mental health and learning disability health and social care services will continue the delivery of the Bamford Vision, and necessarily will be prioritised in line with resource availability.

It is recommended that the new population health and outcome-focused Programme for Government is the appropriate mechanism for taking forward priority service developments and addressing deficits in services.

IMPROVING LEARNING DISABILITY SERVICES IN THE FUTURE

Under the auspices of the Bamford Review, we have made some real improvements in the lives of people with learning disabilities and their families in the North of Ireland. Hundreds of people have been moved from hospital and supported to live in the community. We have improved physical healthcare and dental care. We have started to create new opportunities and activities for people to develop their skills and participate more fully in their communities. More support in the form of short breaks has also been made available to carers.

However, this evaluation highlights that there is much more we need to do to secure the best possible outcomes for people with learning disabilities. It has identified wide-ranging gaps in services and problems that need to be addressed across the health and social care, housing, education, employment, further education and transport sectors.

Many of these are also reflected in the RQIA Report on the Review of Adult Learning Disability Community Services Phase II published on 18th October 2016. That report contains 25 recommendations geared towards improving services in the community for people with learning disabilities.

We also know that demographic changes are likely to have a significant impact on future service provision. People with learning disabilities are living longer, many with more complex needs, and this means that there are more older carers.

Addressing the future needs of this growing population will undoubtedly require us look within and beyond the North for examples of best practice and new ways of doing things.

It will also require us, even more than before, to work across Departmental boundaries. The forthcoming Programme for Government provides us with a real opportunity to do just that.

However, we recognise that, in order to make progress, there is a need for a clear statement now of what we think we need to focus on to secure the best possible outcomes for people with learning disabilities in light of the outcomes of this evaluation.

Within health and social care, we see the need to improve the transitioning process from children’s to adult learning disability services and support for carers, in particular older carers, as our immediate priorities going forward. Related to these are the continued implementation of the Regional Day Opportunities model, the development of short breaks provision and the enhancement of community learning disability teams to manage and better support the increasing numbers of people with learning disabilities coming through requiring health and social care services. We also need to consider the further development of crisis support to work with those now being supported in the community and avoid re-admissions to hospital. Gaps in community forensic services also need to be addressed.

Addressing these gaps will take time and further investment. It will also require reform to make sure we are making the best use of our existing resources. We will therefore consider together with people with learning disabilities and their carers the development of a new service model for learning disability that will focus on:

1. Providing more choice for people with learning disabilities and more say in their care;
2. Providing more person centred care in the community, with support from multi-disciplinary teams;
3. Providing more innovative services to give people a range of care options that meet their individual needs, with self-directed support;

4. Providing early and more intensive support for those who need it so that people can stay in their community close to home; and
5. For those who need in-patient care, ensuring it is only for as long as they need it.

The aim of this new model would be to ensure that we have the right health and social care services in place to secure better outcomes for people with a learning disability. This will of course depend to a significant extent on other key gaps identified in the evaluation around housing, employment, higher/further educations and transport being addressed.

Proposed Structures to improve Learning Disability services

The evaluation recommends that specific actions to address the gaps in Learning Disability services are considered under the appropriate indicators in the forthcoming Programme for Government.

Instrumental to this will be the delivery of Indicator 42 within the draft Programme for Goverment which is ‘Improving the Quality of Life for People with Disabilities and their Families’. Responsibility for Indicator 42 falls to DfC. Delivery Plans for each indicator within PfG will issue in October 2016 for public consultation. In addition to the broader consultation, DfC will consult specifically with the Disability sector and people with disabilities on Indicator 42.

DfC will use co-design, co-implementation and co-delivery to take forward PfG Indicator 42, and will work with other Departments to ensure a co-ordinated and integrated approach.

Some of the emerging themes in the draft Indicator 42 Delivery Plan are:
- Raising awareness and changing attitudes towards disability.
- Addressing the needs of children and young people including improving transition.
- Enhancing opportunities for employment and/or lifelong learning.
- Improving independent living and the provision of suitable homes.
- Improving participation in public and community life.
- Improving access to information and better data collection.

It is reassuring to see that the emerging themes very much mirror the gaps in services the identified through this evaluation process.

IMPROVING MENTAL HEALTH SERVICES IN THE FUTURE

In carrying out this evaluation, the Department has gained a detailed understanding of the needs and gaps in services, the issues and problems that need to be addressed, and the areas where services are working and which could form the basis for future improvement.

We have also benefitted from the recommendations in the Royal College of Psychiatrists Commission on Acute Inpatient Care’s report, *Building on Progress*; and the work done by the Together for You partnership under the *Regress, React, Resolve* project.

The forthcoming Programme for Government will be outcomes-focused, with an indicator to improve mental health. The draft delivery plan for this indicator will be subject to public consultation before the end of 2016.

In working to improve mental health, the Department has identified six guiding principles for the future:

1. A move towards parity of esteem for mental health.
2. A focus on recovery.
3. Genuine involvement of experts by experience in the design, delivery and evaluation of mental health services.
4. Service development where resources allow.
5. Structural reform and performance management.
6. The potential for all-island collaboration.

We consider that everything we do on mental health over the next 5-10 years can fit within one of these principles, as **Figure 1** below shows. This is not exhaustive, but it hopefully provides an outline of how we will organise our work.

At all times, we will work together with experts by experience, and there will be formal public consultation when a new service or policy is being developed. We will assess the impacts on equality, human rights, regulation and rural communities.

Within the Department of Health, we will ensure that mental health services are properly linked with primary and secondary care and public health, particularly with regard to anti-stigma, health promotion, suicide and self-harm prevention, dealing with addictions and substance misuse, and reducing health inequalities.

We also need to contribute to improvements in areas where other Departments lead, for example, targeted early intervention for children and young people, services for homeless people, provision for those in the criminal justice system, and recognising that good mental health is good for the local economy.

We will need to take account of the Executive's budgetary situation, pressures across the Health and Social Care service, and practical issues such as recruitment.

Achieving everything will be a long-term process, and there will be a need to prioritise.

SIX PRINCIPLES TO IMPROVE MENTAL HEALTH					
MOVING TOWARDS PARITY OF ESTEEM FOR MENTAL HEALTH ***Making progress to the point where mental health gets its fair share of time, effort, attention and resources.***	**A FOCUS ON RECOVERY** ***A good life, with or without symptoms. Focused on what you can do, not what you can't.***	**INVOLVEMENT OF EXPERTS BY EXPERIENCE** ***People who have, or have recovered from, a mental health condition, carers, and voluntary and community sector experts, working with the HSC to design, deliver and evaluate services.***	**SERVICE DEVELOPMENT WHERE RESOURCES ALLOW** ***Filling the gaps in services as funding becomes available.***	**STRUCTURAL REFORM AND PERFORMANCE MANAGEMENT** ***Making the very best use of available resources.***	**ALL-ISLAND COLLABORATION** ***Sharing resources and expertise across the island of Ireland.***
Parity of esteem is the principle by which mental health is given equal priority to physical health. It is not a call for 50-50 funding between physical and mental health, rather, according to the Royal College of Psychiatrists, it would ensure that there would be: o equal access to the safest and most effective care and treatment; o equal efforts to improve the quality of care; o the allocation of time, effort and resources on a basis commensurate with need; o equal status within healthcare education and practice; o equally high aspirations for service users; and o equal status in the measurement of health outcomes. A move towards parity of esteem would be a major help in achieving improvements in mental health provision.	Recovery involves making sense of and finding meaning in, what has happened: becoming an expert in self-care: building a new sense of purpose in life: discovering resourcefulness and possibilities and using these and the resources available pursue aspirations and goals. This would be a common theme running throughout the development of mental health services in the future. Continuing the rollout of Recovery Colleges across the region will be a very high priority.	Mental health is leading the way in terms of developing co-production: collaboration between people who provide care, and people with lived experience. This has resulted in the development of networks and the employment of people with lived experience as recovery consultants, peer support workers, educators and advocates. This will be essential to improving mental health in the future and will be integral to all aspects of service development and delivery. We will also continue to draw on the expertise of the voluntary and community sector.	**We are working on a range of proposed service developments in relation to:** - physical monitoring of people with mental illness; - a regional perinatal service; - CAMHS services; - eating disorders services; - psychological therapies; - mental trauma; - personality disorders; - provision in the justice system; - safe places for people suffering from dual diagnoses; and - implementation of the Mental Capacity Act. **We will need to consider what we might do to:** - help and support carers; - enhance crisis support; and - improve acute provision across the region. **Service developments must be:** - affordable and sustainable; - evidence-based; and - focused on clinical governance.	**Structures** The Board's proposal for an **integrated services model** would see services reorganised into a more coherent way to enable more effective integration of care across primary, secondary and specialist mental health and psychological services. The intention would be to promote earlier intervention, streamlined access points, and co-working across Trust areas. **Service standards** The current Service Framework (December 2010) aims to set out clear standards of mental healthcare that are measurable. The Department is working on a revised version which will be issued for consultation in due course. **Finance** We will improve our financial monitoring so that we know for certain how every current and additional pound is spent on mental health and psychological therapies services, and that this spending is effective. **Workforce** The Department is at an early stage in considering a review of the workforce right across the HSC, to ensure that services are appropriately staffed. **Information and technology** The HSC Board is leading an Informatics Project to address issues in relation to availability, management and analysis of data.	The opportunity exists for mental health service development on a North-South basis in a number of areas, such as perinatal mental health services, eating disorder services, and child and adolescent mental health services. There may be the potential to look at joint staff training initiatives. This will require discussion and agreement North and South, and we will explore the potential with our counterparts in the South of Ireland.

How will we enhance the role of people who use our services

The Bamford Monitoring Group has played a key role in advancing the interests of people with mental health needs or a learning disability. The progress in the last decade would not have been made without the benefit of the experience of service users, families and carers.

The structure of the HSC is under review. When the new structures are being designed, we will ensure that effective, streamlined processes exist, which will allow experts by experience to work with the HSC to:

- very frequently review progress on our priorities;
- very frequently review current learning disability and mental health and psychological therapies services and standards and agree on remedial action where necessary;
- discuss and agree policy plans and proposed service developments;
- work across Trust boundaries to ensure that services are provided uniformly across the region; and
- have a direct link to the Minister of Health on an ongoing basis, in relation to learning disability and mental health services.

In championing mental health and improving service provision, service users, families, carers and mental health organisations will play a role right through the policy-making, commissioning and service delivery process. Genuine involvement by in the design, delivery and evaluation of mental health services will be essential.

The Department sees this as an opportunity to establish a forum to engage directly with people with lived experience on the development of mental health policy. In addition to significant ongoing engagement on policy and service issues, co-production representatives will have a scheduled meeting with senior Departmental mental health policy officials, commissioners and Trust mental health managers twice a year, to be briefed on and to ask questions about current services and forthcoming plans. A readout of these meetings will be sent to the Minister of Health.

The HSC Board has made proposals to develop a ‘Co-Production Mental Health Infrastructure’, with the aim of strengthening the influence and role of people with lived experience both locally and regionally in the delivery, development and design of mental health services.

This would create a formal mechanism for people with lived experience of mental illness to represent the rights and interests of people with mental health problem, take the role of independent advocates, and ensure that mental health services continue to be developed in a way that effectively meets the needs of service users and carers.

How this will work in practice is still to be determined, and no decisions will be made without the involvement of experts by experience.

In terms of championing learning disability and involving people with a learning disability and their families / carers in the development of policy and the design and delivery of services, this evaluation recommends that a formal mechanism is established by the HSC Board and

Trusts to provide a model for effective engagement. Consideration will be given to how the co-production model could be adapted and utilised in learning disability services.

ACKNOWLEDGEMENTS

The participation of people with a mental health need or a learning disability, and their families / carers in informing this evaluation report has been invaluable, and we would like to extend special thanks to them for taking the time to share their experiences with us.

Recognition also needs to be made to colleagues in the HSC Board, PHA, , HSC Trusts, PCC, BMG and all of the other Executive Departments who have provided valuable contributions to this evaluation.

Finally, a number of 3rd sector organisations, most notably Association of Real Change (ARC), have been instrumental in facilitating our focus groups with people with a mental health need or a learning disability, and ensuring that we got the right people round the table.

CLOSING REMARKS

The Bamford Vision was a 10-15 year vision, and the principles set out in Bamford largely remain valid today. Much has been achieved, and much remains to be done. The Bamford principles are embedded in service development and practice. Full development of services has been frustrated by the difficult financial climate.

But things have moved on. This evaluation report sets the scene for the future development of service priorities set out in the Bamford Review of Mental Health and Learning Disability Services, within the context of the new population-based Programme for Government.

The essential role of the Bamford structures, and in particular the Bamford Monitoring Group must be acknowledged in driving the Bamford Vision. We are now moving towards a refreshed model of co-production at local, regional and Departmental level.

We look forward to the continuing development of services and a better future for people with a mental health need or a learning disability,

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ANNEX A

EVALUATION OF THE BAMFORD ACTION PLAN 2012-15

LEARNING DISABILITY ACTIONS - DETAILED FINDINGS

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INTRODUCTION

Within the Bamford Action Plan 2012-15, there are 16 learning disability actions and 34 joint mental health / learning disability actions, under the following 5 themes:

- Promoting positive health, wellbeing and early intervention
- Supporting people to lead independent lives
- Supporting carers and families
- Providing better services to meet individual needs
- Developing structures and a legislative framework

This report contains the detailed findings of the mental health and relevant joint actions under the themes 1-4. Evaluation of theme 5 is covered in Annex C and in the main evaluation report.

KEY FINDINGS

THEME 1: Promoting Positive Health, Wellbeing and Early Intervention

The Bamford Action Plan 2012-15 contains a new of commitments in relation to promoting positive health, wellbeing and early intervention for people with a learning disability.

Mental Health & Wellbeing

What did we say we would do?

We said we would promote better mental wellbeing through the publication and implementation of a Promoting Mental Health Strategy.

Publish and Implement a revised cross-sectoral Promoting Mental Health Strategy (*Action 1 – Department of Health*)

What did we do?

'Making Life Better', the strategic framework for public health, was approved by the Executive and published in June 2014. Following this, so as to avoid duplication, a decision was made (subject to Ministerial approval) to progress mental health promotion through an action plan underpinning 'Making Life Better' rather than as a separate strategy. The promoting mental health action plan is under development and will issue in 2017.

Within Making Life Better, there are a number of specific references to people with a learning disability, including:

- Ensure high quality public health and social care services are provided for all children and young people, from ante natal care onwards to include additional and tailored support to those who need it, *for example families with children with a learning or physical disability and young children with speech, language and communication needs;*

- Assist people with mental and physical health and disability related barriers to employment to improve their chances of finding and sustaining employment through the provision of appropriate services and programmes;
- Strengthen the focus on improving the mental and physical health and wellbeing of those in contact with mental health services or with a learning disability;
- Work on addressing social exclusion should aim to bring together and maximise the resources invested in an area to ensure people of all ages have access to support networks and opportunities to participate, and to build individual and community resilience, capacity and social capital. This could be taken forward for example through targeted support for particularly vulnerable population groups locally, befriending schemes, schemes to promote access to services and advice, assisted transport, arts and cultural programmes, reading schemes etc. Key features would include securing the participation of the individuals/groups at risk of exclusion, building individual and community resilience, building on and linking community assets.

Did it make things better for people with a Learning Disability and their families?

The first update report for Making Life better was published in 2015.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/making-life-better-1st-progress-report-2014-15.pdf

It is too early in the Framework's implementation to determine impact but it will be subject to review and evaluation and will be refreshed in line with the new Programme for Government.

Current policy / service development

A Regional Learning Disability Health Care and Improvement Steering Group has been established, led by the Public Health Agency. The purpose of this group is to improve the health care and health and social wellbeing, and to reduce health inequalities, of adults with a learning disability. This group is focussing on the following priorities:

- Implementation of a Health & Wellbeing Action Plan for people with a learning disability, including the improvement of physical healthcare of patients in Muckamore Abbey Hospital;
- Development and roll out of a Regional Hospital Passport for people with a learning disability. This has been piloted and official launch is expected in Autumn 2016;
- Improvement of the transition for people with a learning disability from children's to adult HSC services;
- Promotion of healthy eating within Day Centres for adults with a learning disability;
- Measures to promote healthy personal and sexual relationships for adults with a learning disability;
- Promotion of physical activity for people with a learning disability and their families/ carers.

Health Improvement

What did we say we would do?

We said we would improve the health of people with a learning disability in key areas such as nutrition, obesity, exercise and mental health by ensuring that people with a learning disability have equal access to the full range of primary health care services.

Ensure that persons with a learning disability have equal access to the full range of primary health care services (*Action 5 – Department of Health*)

What did we do?

Learning Disability Directed Enhanced Services (DES) has been implemented. DES aims to ensure that all adults with a Learning Disability have annual physical and mental health checks and follow up by a health promotion nurse if required.

Each of the 5 Trusts now have HealthCare Facilitators who are located in the Adult Learning Disability Teams and are linked with GP practices. 95% of GP practices across the North of Ireland are offering annual health checks to people with a learning disability. The number of annual health checks completed through this service has risen steadily to just over 6,000 in 2015/16. Annual investment in these health checks was £427K in 2014/15.

An Evaluation report of the DES completed earlier in October 2013 found that 69% of people with a learning disability had been screened in the 2 years previous, so we have seen a substantial increase in the offer of annual health checks in the last 3 years.

Did it make things better for people with a Learning Disability and their families?

The DES Evaluation report found that there was a high rate of patient satisfaction with the service. There were almost 2,800 referrals made by GPs following health checks in 2012/13, including referrals for thyroid function testing, consultant, vision, hearing and cervical. The report noted that the focus to date had been on the establishment of the service, and highlighted a need for greater focus on health improvement outcomes.

The evaluation report makes 17 recommendations for improvement of the health checks and health promotion for people with a learning disability, which are being taken forward by the HSC Board-led Regional Learning Disability Health Care and Improvement Steering Group.

Feedback from the questionnaires issued to people with a learning disability and their carers, was in the main very positive about physical healthcare services. The questionnaire responses indicated that 91% of people with a learning disability were aware of the annual GP health check, 86% availed of the service and 92% felt it led to health improvements. The percentages for carers were less, 69% said the person they care for was offered an annual health check with the GP, 96% of these availed of the service and 76% said it led to health improvements. Discussions at the learning disability focus groups were again mainly positive about annual health checks, and most people were offered them and availed of them.

I have found my GP not always confident in treating my daughter and asking me to describe my daughter's symptoms rather than speaking to her direct.

I think it is very important to have health checks especially in my son's case as he cannot talk so is unable to tell you if something is not right

Detected a heart murmur at his annual check up and now takes medication to help

Comments about patient experience included that their experience depended on the doctor or nurse and how well they were trained in communicating with people with a learning disability, that timing of appointments was important so they don't upset the routine of day opportunities / day centre and that some doctors / nurses speak to the carer rather than the person with a learning disability.

A number of carers of children with a learning disability expressed concern that some nurses in special school do not appear to have been trained in learning disabilities.

Current policy / service development

The provision of annual health checks to adults with a learning disability is generally working well and the majority of people are happy with the service. Improvements will continue to be made to the service through the implementation of the recommendations made in the DES Evaluation report.

Improvements to the DES include: the development of a patient pathway which aims to ensure that every adult with a learning disability has a Health & Wellbeing Plan; standardisation of the health check across the Region to ensure all new screening programmes are included, including bowel screening and dementia; improved data collection systems which will provide better information to inform service development; and the production of a number easy read health booklets.

In addition, a Health & Wellbeing Action Plan for people with a learning disability is being implemented through the Regional Learning Disability Health Care and Improvement Steering Group, which includes the improvement of physical healthcare of patients in Muckamore Abbey Hospital.

Early Years Education

What did we say we would do?

We said we would develop an Early Years Strategy to ensure children ensure a high quality pre-school educational experience that promotes healthy development and lays the foundations for the achievement of good outcomes in the longer term.

Develop final proposals for Early Years Strategy (*Action 2 – Department of Education*)

What did we do?

'Learning to Learn – A Framework for Early Years Education and Learning' was published in October 2013.

https://www.education-ni.gov.uk/sites/default/files/publications/de/a-framework-for-ey-education-and-learning-2013.pdf

The overall policy aim of the Learning to Learn framework is that all children have equal opportunities to achieve their potential through high quality early years education and learning experiences. In support of that policy aim, the framework outlines 12 key actions supported by 34 further actions.

'Learning to Learn' included as a key action:

1.4 The Department will review how early years education and learning services are effectively targeted to address barriers to learning and enhance access and equity.

Within this context, the Department of Education (DE) has taken forward a number of further actions to:

- Carry out a review of Sure Start to assess the extent to which the investment is helping to secure improved well-being and development outcomes for children and families in the most disadvantaged areas; and
- Introduce Extended Services funding for eligible voluntary/private pre-schools and refocus the use of Extended Schools funding for Nursery Schools and Nursery Units to help identify and address underdeveloped social, emotional, communication and language skills of young children.

The Key action also included a further action that DE would:

"Subject to recommendations emerging from the evaluation of the current pilots in early years settings initiated by the Review of SEN and Inclusion, consider the need for extension of these pilots which are aimed at improving the access to specialist support and building capacity across pre-school settings".

Key action 1.5 in the Learning to Learn framework commits DE to collaboration '*with other departments to work towards a common goal of improving outcomes for children'* with a further action to actively seek opportunities for investing jointly with a number of other departments '*under the Delivering Social Change (DSC) framework in evidence based family intervention/parenting programmes planned, commissioned and evaluated through appropriate delivery structures*'.

The Department of Health (DoH) leads on the Delivering Social Change (DSC) – Early Intervention Transformation Programme (EITP) Workstream 1. EITP is a Northern Ireland Executive / Atlantic Philanthropies DSC Signature Programme. Workstream 1 aims to equip all parents with the skills needed to give their child the best start in life. It focuses on three inter-related parenting stages and DE and DoH are working collaboratively to deliver a range of projects namely, Getting Ready for Baby, Getting Ready for Toddler and Getting Ready to Learn.

- Getting Ready for Toddler is focused on embedding early intervention in core health visiting and introducing two key universal changes relating to the delivery of services for children aged 3+ in their pre-school year. Firstly, a named Health Visitor is now aligned to pre-school education settings with DE funded places and works in partnership with education colleagues to support and promote healthy child development and learning. Secondly, the 3+ Health Review is currently being piloted in pre-school education settings with DE funded places and will introduce the 3+ health review (using the Ages & Stages Questionnaire: Social-Emotional) into the pre-school setting where Health Visitors will work in partnership with children, parents and education colleagues to promote children's social, emotional and behavioural development, providing them with information and signposting to other services where appropriate.

- Getting Ready to Learn (GRtL) is focused on improving outcomes for children in pre-school by engaging and empowering parents to help them create and sustain positive home learning environments. It is an application based programme and settings can choose to implement any or all of four themes: Big Bedtime Read, Education Works in Pre-School, Happy Healthy Kids, Ages & Stages 3-4.
    - Big Bedtime Read – Activities to promote bedtime reading, support improved early attachment and bonding, improve speech and language development;
    - Education Works in Pre-School – delivering key messages about the home learning environment so that parents understand more about what they can do to support learning at home;
    - Happy Healthy Kids – about introducing parents to activities to promote the importance of providing their children with opportunities to develop and improve gross and fine motor skills;
    - Ages & Stages 3-4 – help parents understand progression and development and the developmental milestones for 3-4 year olds.

- The implementation of GRtL begins in pre-school settings in 2016/17 and runs to the end of the 2018/19 school year.

- A key element of the Getting Ready to suite of programmes is that they should be transformational and sustainable; ensuring that the benefits of the programmes continue after funding has ended.

Did it make things better for people with a Learning Disability and their families?

It is difficult to attribute outcomes from the Learning to Learn Framework directly to their impact on children with mental illness or learning disabilities and their families. The overall policy aim of the Framework is that all children have equal opportunities to achieve their potential through high quality early years education and learning experiences.

Implementation of the Learning to Learn Framework is still at an early stage and it is too early to undertake a full, informed evaluation at this time. However, there have been evaluations of specific elements and this is detailed below.

The Early Years SEN Inclusion Service Pilot aimed to improve early identification, assessment and intervention for children with SEN and / or disability in statutory nursery settings and in their immediate pre-school year in non-statutory pre-school education settings with DE funded places. The Education and Training Inspectorate (ETI) provided interim findings on the pilot which indicated that good progress was being made in the settings.

Following the success of the pilot scheme. and the positive comments in the ETI Evaluation Report of April 2015, the Education Authority (EA) has been operating an Early Years SEN Inclusion Service in statutory nursery settings and for children in their immediate pre-school year in non-statutory pre-school education settings with DE funded places since September 2015.

The SEN EY's inclusion programme includes the provision of a network of SEN support to sustain and build upon the good work the pilot as outlined in the programme including-

- To ensure uniformity of approach across the EA in respect of SEN Early Years provision;
- Capacity building for early years practitioners to be delivered by specialist teams;
- Further development of links between education professionals and health and care agencies involved with supporting SEN children.

The Education and Training Inspectorate (ETI) recently published an evaluation on the Extended Services Funding based on a sample of settings and found that the additional resources 'are enhancing the learning environment and providing better opportunities to develop the children's language and communication, social skills and sensory experiences'. It was also noted that "parents are being equipped through workshops and resources to build on the work within the pre-school and support further their child's learning and development at home'.

The Getting Ready suite of programmes is in the initial stages of implementation and therefore an evaluation is not yet available. The Getting Ready programmes use an outcomes based approach (OBA) for monitoring and evaluation. The focus of this is to consider if anyone is better off as well as reporting on what was done. All of the programmes have incorporated this methodology from the start of the programme to ensure the measurement tools are in place to assess the outcomes for children and families as the programmes are implemented.

Current policy / service development

The SEN Early Years Inclusion Programme will involve ensuring continued early identification and assessment of SEN and appropriate interventions for children in statutory and non statutory pre-school settings.

In addition, the HSC Board has secured funding to run an early years training and inclusion programme with Children and Young People's Strategic Partnership (CYPSP) and Child care partnerships, which will focus on the early years sector such as child-minders,play groups and community & voluntary groups.

Anti-Bullying

What did we say we would do?

We said we would promote an anti-bullying culture in schools so that bullying in school is dealt with in an appropriate and timely manner.

Promote an anti-bullying culture within schools in partnership with the Anti-Bullying Forum (*Action 4 – Department of Education*)

What did we do?

The Department of Education continues to fund the Northern Ireland Anti Bullying Forum (NIABF) which aims to ensure teachers and other educators working with children and young people are equipped with the tools necessary to effectively tackle bullying amongst young people this include making arrangements to promote an annual Anti-Bullying Week.

The Forum has recently published updated guidance on cyber bullying and bullying of Looked After Children (LAC) and sits on the Safeguarding Board Northern Ireland (SBNI) safety forum. In the coming months, the forum will work with the Department of Education, schools and other stakeholders in the development of guidance and training to support the proposed new Anti-Bullying Legislation.

Anti-Bullying Legislation

The Addressing Bullying in Schools Act (Northern Ireland) 2016 was enacted in May 2016. The Act provides a common definition of bullying; requires all schools to centrally record incidents of bullying, their motivation and their outcome; and requires the Board of Governors collectively to take responsibility for the development, implementation, monitoring and periodic review of the school's anti-bullying policies and procedures. It is hoped to commence all provisions of the Act by the start of the 2017-18 academic year.

Did it make things better for people with a Learning Disability and their families?

The Addressing Bullying in Schools Act (NI) 2016 received Royal Assent on 12 May 2016. It is anticipated its provisions will come into effect in time for the start of the 2017-18 academic year. Any possible evaluation of its impact will therefore only be possible several years after that. This is clearly outside the timing of the Bamford evaluation.

Current policy / service development

The immediate priority in relation to the Addressing Bullying in Schools Act (NI) 2016 is to work towards the commencement of the new provisions set out in the legislation in time for the start of the 2017/18 school year. This will require the development of guidance for schools, Boards of Governors, parent and pupils; a new C2k based recording system; and appropriate training for schools and governors in both their new duties and the operation of the new recording system.

Sport & Physical Recreation

What did we say we would do?

We said we would implement a 10 year strategy for Sport and Physical Recreation to provide improved opportunities for people to gain mental wellbeing benefits of participation in sports and physical recreation.

Implement a 10 year Strategy for Sport and Physical Recreation (*Action 3 – Department for Communities*)

What did we do?

Sport Matters': The Northern Ireland Strategy for Sport and Physical Recreation, 2009-2019' contains 11 high level Participation targets designed to achieve improvements in sports participation rates.

The main vehicle for the provision of sport and physical recreational activities for people with a Learning Disability is through the Special Olympics, which provides year round sports training and competition to people with an intellectual disability**.** Special Olympics Ulster, between 2012 and 2016, has been core-funded by 5 Executive Departments. For the period 2011-2015 the total funding was £2.3 million. An additional £0.545 million was provided for the period 2015/16.

Funding for the period from 2016 to 2020 is under consideration within the new Departmental structures in the Northern Ireland Executive.

Did it make things better for people with a Learning Disability and their families?

Over the period 2012 – 2016 Special Olympics has:

- Facilitated annual athlete participation rates of between 1500 and 1766, including registering approx. 100 new athletes per year;
- Had approximately 1300 active coaches per year;
- Increased the number of regular coaches from 458 (2011/12 baseline) to 1013;
- Enabled 145 individuals to gain over 300 coaching / leadership qualifications;
- Had a minimum of 1700 active volunteers annually and increased the number of regular volunteers by 253;
- Supported 12 Clubs to achieve the Clubmark standard; and,
- Established a further 6 Special Olympics Clubs within education settings.

14 athletes represented Team Ireland in the 2013 Special Olympics World Winter Games in PyeongChang, Korea. In total Team Ireland won 12 medals 3 gold, 6 silver 3 bronze and 6 place ribbons.

128 athletes and coaches, including 12 athletes from Special Olympics Ulster, participated in the 2015 Special Olympics World Summer Games in Los Angeles. In total Team Ireland won 82 medals: 26 Gold, 28 Silver and 28 Bronze and 43 placing ribbons. The Ulster athletes won 19 of these: 5 Gold, 9 Silver, 5 Bronze and 9 Place Ribbons.

The promotion of Special Olympics here in recent years has led to the following benefits:

- Establishment of new Special Olympics clubs across Northern Ireland.

- Establishment of a full club management structure within Special Olympics clubs and support to Clubs to achieve Clubmark accreditation.
- Increase in the numbers of athletes taking part in Special Olympics.
- Increase in the number of volunteers to assist athletes to take part in Special Olympics and improved capacity of volunteers through qualifications gained.
- Promoting integration of people with an intellectual disability into local communities through inclusive community sports activity.
- Improved active citizenship for people with intellectual disability through, for example, Athlete Leadership development opportunities.
- Increasing the hours per week that athletes are involved in sports training.
- Strengthening relationships with primary, secondary and third level educational establishments.
- Promoting the Special Olympics Health Promotion Programme.
- Improving public understanding of the Special Olympics – Awareness of Special Olympics raised from a baseline of 6% in 2011 to 13% in 2015.

Other groups such as sports governing bodies have run bespoke events for people with Learning Disability, for example:-

- Ulster Rugby:- introduced STAG rugby (Special Needs Tag Rugby Advisory Group). This is a group made up of representatives of the rugby clubs who have established sections for children and young adults with a Learning Disability. Their role is to co-ordinate activity amongst the clubs and to provide support and guidance to groups who are looking to establish similar sections within their own clubs.

- Irish Football Association (IFA):- 5,550 participants are involved in IFA disability programmes in the last 12 months including participants with Autism, Down's Syndrome and Cerebral Palsy. This includes all disability international squads, schools programme and club coaching programmes.

- GAA:- development of a family based programme for people with learning and other disabilities – to allow young siblings to participate in meaningful competition with their family members. GAA has also provided training opportunities for people through the GAA 4 ALL programme and delivery of programmes within the relevant special needs schools.

- Belfast Giants: organised special closed training sessions to facilitate young people with ASD and their families to experience Ice Hockey and the stadia experience without the pressure of noise and crowds; these families also received full match evening experience in terms of aiding respite arrangements for carers; and

- District Councils have run a wide range of programmes under the Active Community Programme including special needs initiatives such as Active Wildcats, 'Swimmability' and 'Visuability' initiatives.

Feedback from the people who participated in the focus groups was positive in terms of those who participated in Special Olympics clubs. Many people however still feel that there is a lack of social activities, including sport and physical recreation, for people with a learning disability, especially in rural areas and commented that often any social activities are run by parents, which does not provide people with a learning disability with a sense of independence, and is demanding on parents' time.

__Current policy / service development__

DfC's current priorities for improving the opportunities for people with disabilities to participate in Sport are set out below:

- To secure funding for a 4 year business plan for Special Olympics;
- To implement the actions set in the 'Active Living-No Limits Disability Sport Action Plan 2016 -2021', launched in October 2016 http://www.sportni.net/sportni/wp-content/uploads/2016/10/Active-Living-No-Limits-Action-Plan-2016-2021.pdf**;**
- The continued implementation of the HSC Board's Day Opportunities Model will enable people to access mainstream Leisure Centres.

THEME 2: Supporting People to Lead Independent Lives

The Bamford Action Plan 2012-15 contains a number of commitments in relation to supporting people with a learning disability to lead independent lives, covering the areas of housing, employment services, further education and training, self-directed support and transport.

Disability Strategy

What did we say we would do?

We said we would publish a Disability Strategy to improve the social inclusion of people with disabilities.

Publish a strategy for the implementation of recommendations arising from the PSI (Promoting Social Inclusion) report on Disability (*Action 12 – Department for Communities*)

What did we do?

The Disability Strategy, published in 2013, aims to raise awareness and improve opportunities and services for people with disabilities by addressing inequalities and tackling the barriers they face in their daily lives.
http://www.ofmdfmni.gov.uk/disability-strategy-2012-2015-revised-010313.pdf

The Strategy was extended by OFMDFM in May 2015 to 31 March 2017 to allow further time for its recommendations to be delivered and for a new Strategy to be considered.

Did it make things better for people with a Learning Disability and their families?

Policy responsibility for the Disability Strategy transferred into DfC from OFMDFM under Departmental restructuring on 9 May 2016. Progress reports for the 2014/15 and 2015/2016 years have been provided by The Executive Office (TEO) and are being analysed. At transfer, work to develop a new strategy had not begun.

Current policy / service developments

The Executive acknowledges the obstacles and challenges faced by people with disabilities in their daily lives. The draft PfG contains 14 strategic outcomes supported by 42 indicators, one of which is '*Improving the Quality of Life for People with Disabilities and their Families'*. DfC have responsibility for Indicator 42 and its draft Delivery Plan is currently with the TEO. The Delivery Plan will be part of the broader consultation on PfG in October 2016. In addition, DfC will consult specifically with the Disability sector and people with disabilities on Indicator 42. DfC will use co-design, co-implementation and co-delivery to take forward PfG Indicator 42, and will work with other departments to ensure a co-ordinated and integrated approach.

Some of the emerging themes in the draft Indicator 42 Delivery Plan are:
- Raising awareness and changing attitudes towards disability.

- Addressing the needs of children and young people including improving transition.
- Enhancing opportunities for employment and/or lifelong learning.
- Improving independent living and the provision of suitable homes.
- Improving participation in public and community life.
- Improving access to information and better data collection.

Identified Need

That the delivery plan for PfG indicator 42 '*Improving the Quality of Life for People with Disabilities and their Families' addresses the key gaps identified in this evaluation in services for people with disabilities, including people with a learning disability*

Resettlement

What did we say we would do?

We said that all long stay patients from learning disability hospitals would be resettled to enable them to live independently and safely in the community.

Resettle long stay patients from learning disability and mental health hospitals (*Action 13 - Department of Health / Department for Communities*)

What did we do?

Since 2007, the majority of the long-stay Primary Target List (PTL) patients have been resettled into the community (long-stay refers to patients who have been in hospital for 12 months or more).

In 2007, the number of people with a Learning Disability who were long-term patients in Learning Disability hospitals was 347. During the period 2007-2016, 279 of these people were resettled to new homes in the community. Sadly, 43 patients were deceased over this period.

At 31st March 2016, 25 long stay patients remained in Learning Disability Hospitals. Plans are currently in place to resettle 11 of these during 2016/17 and the Trusts are working on plans for a further 13 to be resettled in late 2017. One patient currently requires inpatient treatment.

These remaining patients are individuals with more complex conditions and behaviours, and the delay in resettling is due to the completion of specialist placements being customised to the patients' individual needs, predominantly within new supported living and nursing/residential developments. They all have an identified home to move into, and the delays are due to the timescales for planning / building. A great deal of work is required to establish the most suitable placement with the right level of support to suit their specific individual needs. The emphasis is on getting it right for the patient and ensuring their safety and care, and this must be the key priority.

In addition to the patients above, there are also a further 48 patients who have had a decision to discharge taken, but are still in Muckamore Abbey hospital more than 7 days later. The HSC Board and Trusts are making every effort to resettle these patients. Funding is allocated to resettle these patients, and most have plans. However, many need specialist / bespoke services designed and accommodation built, many of which are single dwellings with complex support packages. The HSC Trusts are working hard to plan for the procurements of these services.

Did it make things better for people with a Learning Disability and their families?

The experiences of people with a Learning Disability and their families on moving from a long-stay hospital to a community-based setting were shared in the learning disability questionnaires, in focus groups (and in particular the ‘Telling It Like It Is (TILII) groups), and through the HSC Boards Quality of Life questionnaires. General consensus amongst people who had resettled from hospital was that living in a supported community setting is a positive experience, which has greatly improved their quality of life. Benefits included having dedicated staff who provide good support and care, opportunities to do things such as go on outings, shopping, or to the cinema, having more freedom and independence, having privacy, visiting relatives and having friends round. Many told us about their increased independence and that they had learned valuable life and social skills – cooking, housework, shopping, socialising and having a choice about what they do.

We heard many times that having a good key worker is essential in providing the support needed to live in the community.

A small number of people reported feeling lonely and isolated since moving into the community and that they would like communal areas within supported accommodation.

The majority of people indicated that they had the appropriate support services to live in the community and that family, 3rd sector and statutory services are involved in providing that support.

Most people we met who had been resettled from hospital indicated that they had little choice in where they lived and who they lived with, and that choices were based on where places were available. There were a number of experiences of people having difficulty with the other people they lived with and some reports of this being difficult to resolve.

A number of carers of those who have been resettled in the community, indicated that for those who have more complex needs, life in the community was not necessarily any better that in residential care and that they felt there was a reduction in appropriate stimulation due to lack of support available to take them out, swimming etc.

The HSC Board has taken the ‘betterment’ approach to monitoring the resettlement of people with a learning disability through ‘Quality of Life’ (QoL) questionnaires (completed with the assistance of commissioned independent advocates), which are completed pre-discharge from hospital, and repeated at 3 months, 6 months and 12 months after they move to the community. To date (May 2016), 52 people have completed 6 month review questionnaires, and 46 have completed 12 month review questionnaires. The overall picture is that betterment has been achieved for the vast majority of individuals. Reasons for betterment include more choice for individuals, more opportunities to socialise and go on outings, improved communication skills and that they enjoy more privacy and freedom.

It is worth noting that initially almost all individuals, families and carers who completed the QoL questionnaires felt negative and anxious about the move into the community from hospital, and these attitudes and concerns changed dramatically in the follow up questionnaires as they started to experience an improved quality of life.

Through the focus groups, a number of carers indicated that in addition to supported living accommodation, there is a need for more residential places for those people with a learning disability with more complex needs, who they feel are unable to live independently or semi-independently.

The responses to both questionnaires indicated that of the most of the respondents (or carers representing people with a learning disability) lived in the family home.

It was evident from general comments that there were some concerns about availability of suitable/local supported living accommodation and a clear need to improve future planning for those currently living at home.

> *“She would like to live in a supported living complex, where she would have her own apartment, and have social interaction of people her own age, eg. 34. In the area where we live there is no such accommodation*

> *I love it. I do my own ironing and cooking and have my friends round for a cup of tea*

> *Because I was told to go there by Muckamore Hospital*

In conclusion, the resettlement programme has largely been completed, and there is evidence that the majority of people with a learning disability who have been resettled from hospital into community settings appear to have a much improved quality of life.

There were issues identified by a small number of people around the quality of life for those with more complex needs, the feeling of isolation for some and the perception that people do not have a choice about where the live and who they live with.

Current policy / service development

The current priorities with regards to the resettlement of people from long-term hospital stays are:

- To complete the resettlement programme;
- To continue to collect date and monitor the quality of life of the resettled population.

Identified Need

- To complete the resettlement programme

In addition, to support people with a learning disability living in the community, **Learning Disability Crisis Response Services** are established in the Southern HSC Trust and are being implemented in the other 4 HSC Trusts. These will provide short term assessment, support and treatment for individuals and their families in an effort to avoid admission to hospital where possible. This service is delivered by a small team of professional staff as a part of community based specialist services for learning disability. It aims to: provide a systematic community based specialist service to individuals who have a learning disability and who present with significant acute behavioural problems, emotional and/or coping disorders; to plan and provide support and formalised treatment/therapeutic interventions to assist people to reduce the frequency and intensity of presenting behaviours; facilitate and assist clients to develop alternative adaptive skills necessary to improve their independence, integration and quality of life. Evidence is that the establishment of this service in the Southern HSC Trust has reduced presentation to hospital. A formal evaluation is due in 2016/17.

Housing

What did we say we would do?

We said that suitable, safe and supported housing would be available for people with a learning disability who require it.

Scope existing supported housing capacity / suitability to maximise resources (*Action 14 – Department for Communities*)

Ensure new build supported housing programmes are 'future proofed' to ensure longevity / sustainability in terms of the tenants (*Action 15 – Department for Communities / Department of Health*)

What did we do?

The Northern Ireland Housing Executive (NIHE) has played a significant role in helping to deliver the post-Bamford resettlement programme. The Housing Executive has worked alongside the Health and Social Care Board and Trusts in commissioning new services for people with a learning disability and mental health needs to be resettled. Over the 2012-16 period a significant proportion of the social housing new build programme was dedicated to the provision of housing for people who have additional support needs or who need to live in supported housing, with the housing support element in these schemes is funded through the Supporting People Programme.

Review of Resettlement Programme

DSD through the Northern Ireland Housing Executive (NIHE) commissioned a review of the Resettlement programme in January 2014. Phase I of the review (an Interim Report) was designed to research and report on the institutional delivery of the resettlement programme and the role played by agencies involved in the planning and provision of housing, support and care services for learning disabled people and was completed in October 2014. The evidence base for the Phase 1 Interim Report was primarily interviews with 13 key policymakers, commissioners and service delivery providers.

Phase II is currently being commissioned and is intended to report on the experiences of people with a learning disability who have been resettled from hospital to the community, and will look at the effectiveness of the process from their perspective, their levels of satisfaction with the outcome, and the impact on their lives that living in the community has had.

In the period 2012-16 the then Department for Social Development (DSD), through the Supporting People (SP) Programme administered by the Northern Ireland Housing Executive, provided supported accommodation for 160 resettled clients. This amounts to an annual SP commitment of circa £3 million. The corresponding total capital investment associated with these 160 clients was circa £12 million.

The Interim Report raises some initial observations about the appropriateness of placements in a supported living environment for some people with a learning disability, in particular those with complex needs or challenging behaviours, and whether placements in residential care or a nursing home might be more appropriate. A number of people interviewed indicated that the presence of funding for resettlement in the Supporting People programme may have been significant in influencing Trusts to move people into supported housing rather than residential care. This suggestion is based on the views of a small number of people and requires further probing to determine if there is any evidence to substantiate it.

The Phase I Interim Report indicates that SP-funded services that have been identified as specifically for resettled people with a learning disability are considerably more expensive than the generality of SP-funded services for people with a learning disability. The mean contract value is £186,000 (1.7 times the mean value of all SP-funded services for people with a learning disability). The mean weekly price per bed space is £293 (2.7 times the mean weekly cost per bed space in all SP-funded services for people with a learning disability (this figure is just the SP housing cost and does not include the cost of support services). This may simply be because the SP services for learning disabled people in other SP funded schemes are focussed on the housing support needs required to assist low to moderate levels of this client group to live independently, as opposed to some of those resettled from long-stay hospitals who have more complex needs. Phase II of the Report and the implementation of the Supporting People Review (see below) may provide further clarity.

Review of Supporting People

In addition, the then Department for Social Development published a Review of the Supporting People programme in November 2015.

https://www.communities-ni.gov.uk/sites/default/files/publications/dsd/review-of-supporting-people-report.PDF

This review considered the whole of the SP programme, including people with mental health problems or a learning disability. It found that a variety of different types of housing, care and support services have been developed for the resettlement of people with a learning disability leaving long-stay hospitals.

The Supporting People Review contains a number of findings and recommendations which are of particular relevance to this Evaluation report:

- **Strategic Needs Assessment**: There is a need to introduce a new strategic, intelligence led approach to needs assessment across all client groups, which takes proper account of demographic trends and other social factors to identify current and future patterns of need. As with this evaluation, there was evidence of emerging of latent demand for housing support from people with learning disabilities living with older carers. The current needs assessment process does not articulate emerging housing support needs and there needs to be a more robust approach to needs assessment;
- **Cost**: Supporting People services for the resettled population are significantly more expensive than similar services offered to other clients with learning disabilities or mental health issues through the Supporting People programme. It will be difficult to sustain this higher cost in the medium and longer-term and all partners in such schemes (Health and Social Care, providers and NIHE) need to work together to develop a more viable service delivery model which meets need in the most cost-effective way possible. It also found that there are significant variations in costs within client groups - most marked for learning disability services. The Review recommends the introduction of standardised regional payment rates;
- **Specialist, bespoke accommodation:** The Review has found that there has been a move away from building generic models of supported housing towards more specialist, bespoke accommodation specifically designed for individual clients, often commissioned through Supporting People by Health and Social Care. This presents a number of challenges in term of risk, cost (current and potential future ‘sunk’ costs for modifications to meet the needs of future client groups). A number of housing professionals made a case for moving away from these higher-risk solutions towards the development of more generic models of supported housing, which can be adapted to meet a range of needs more flexibly over the expected lifespan of the building. The Review recommends that the relationships and funding responsibilities of the various statutory partners within the Supporting People programme should be clarified to ensure costs and risks are shared appropriately;
- **Commissioning process:** The Review found that the commissioning process for the SP programme was complex and confusing, and there was lack of a clear line of sight between commissioning decisions and strategic priorities. It recommends that the existing commissioning structure should be revised to improve its transparency, to increase representation from Supporting People service users and providers, and to ensure an appropriate role for both housing and health and social care professionals;
- **Regulation:** There is no bespoke regulatory system for Supporting People services *per se* - rather there are a number of existing regulatory systems which cover aspects of service delivered within Supporting People funded schemes. The Review identified a need to harmonise and streamline regulatory and administrative activity. The Housing Executive and the Regulatory and Quality Improvement Authority (RQIA) are well-advanced on the production of a draft memorandum of understanding which will go a considerable way to address these issues. The need for a longer-term, a more focused and tailored system of regulation for Supporting

People services was identified. This may required new legislation and therefore could take some time to deliver.

The recommendations of the Supporting People Review are being implemented by a cross-Departmental Implementation steering group, led by Department for Communities with representation from Departments of Health and Justice. Implementation of these recommendations will address many of the difficulties identified in the Interim Review of the Resettlement Programme.

Did it make things better for people with a Learning Disability and their families?

Phase II of DfC's review of the resettlement programme will consider the experiences of people with a learning disability who have been resettled from hospital to the community and the impact on their lives that living in the community has had.

The Department of Health and HSC Board have gathered some experience-based evidence from people with a learning disability and their families (see section above on Resettlement) which indicates that the majority of people who have moved from long-stay hospitals to the community have a much improved quality of life. However, there is a need to put in place a more robust method for measuring the outcomes associated with resettlement.

Another finding was that the delays in the resettlement programme have had a detrimental effect on those still living in hospital.

The review indicated that there continue to be concerns from some families of people with a learning disability in a long-stay hospital that a move towards the community would not be in their best interests and that their quality of life and level of care would diminish. However, more recent evidence from the HSC Board's Quality of Life assessments has noted changing attitudes by people who had concerns about resettlement, based on positive experiences.

In terms of the suitability and safety of housing for people with a learning disability, this is difficult to regulate due to the different agencies involved in the provision of housing, care and the fact that in supported housing schemes the person has their own home, and there are issues with rights to access to inspect. The intention is to address regulation issues through Recommendations 12 and 13 of the SP Review.

Phase I of the Supporting People review found that there are many good accommodation-based services which fully meet the needs of people living there. However, it notes that not all of these services are of this standard. This is consistent with some of the feedback from the focus groups with people with a learning disability and their families – where some were very happy with where they live and felt it met their needs and that they had good support, while others felt that it didn't meet their needs, particularly with regard to level of care.

Current policy / service development

Implementation of the 13 recommendations of the Supporting People Review will bring further improvements in SP generally which will impact on any remaining patients on the resettlement programme or any future resettlement programme. These include setting priorities, assessing need, commissioning, decommissioning, base lining and comparable funding and regulation and inspection.

As indicated above, the second phase of the NIHE research will provide a view on the extent of their betterment from those resettled through Bamford, which may complement and add detail to the evidence gathered by DoH in the Bamford evaluation.

The new NI Executive acknowledges the obstacles and challenges faced by people with disabilities in their daily lives. The draft PfG contains 14 strategic outcomes supported by 42 indicators, of which indicators on “Improving the supply of suitable housing” and ‘Improving the Quality of Life for People with Disabilities and their Families’ will determine government priorities for the future.

Identified Need

There is a need to ensure that there is appropriate housing, close to their support networks, for those people with a learning disability living at home who want to become more independent and move out of the family home. Work needs to continue between the Departments of Health and Communities, in partnership with housing providers and 3rd sector support organisations to determine the demand for appropriate housing for those with learning disabilities and develop services accordingly.

Employment Services

What did we say we would do?

We said employment services and support would be available to help people with a learning disability get into work.

To support and develop the Employment Advisor Teams to deliver services to people with mental ill-health or a learning disability (*Action 16 – Department for Communities*)

Incorporate provision within the design of the new Work Connect Programme to meet the employment needs of those who are claiming Employment Support Allowance and who have mental ill-health and learning disability (*Action 24 - Department for Communities*)

What did we do?

In 2015-16, there were 4 main services commissioned by Department for Communities which were supporting people with mental health problems or a learning disability into employment:

- ***Work Connect:*** Work Connect aims to improve client employability and assist appropriate clients to find and keep work. This offers quality pre-employment and employment provision to clients in receipt of Employment and Support Allowance, who have health conditions and / or disabilities but who are capable of and wish to play a full and active role in society. Work Connect provides a range of tailored support to clients for up to 26 or 39 week to help them overcome their employment barriers and help enhance their employability skills. Work Connect is delivered by contracted providers Supported Employment Solutions (SES), a strong consortium which brings together seven local disability organisations including a number who specialise in their support for people with mental ill-health and/or learning disabilities.

- ***Access to Work:*** Access to Work is a flexible individually assessed programme providing financial assistance to help overcome barriers faced by disabled people in accessing employment. Support can include Special Aids and Equipment, Adaptations, Support Worker and Travel to Work;

- ***Workable (NI)****:* Workable (NI) provides a flexible range of support to assist people with significant disability related employment barriers, move into and stay in work. It is delivered through a number of provider organisations, contracted by the Department. These organisations have extensive experience of meeting the vocational needs of disabled people. Workable (NI) provides the support and opportunity for people to progress into unsupported employment where this is the right option for the individual. Longer term support is available where appropriate.

- ***Condition Management Programme (CMP):*** CMP is delivered by multi-disciplinary health professional teams from across the five H&SC Trusts to help people to improve their health and their employability. The teams primarily consist of mental health nurses, Occupational Therapists, physiotherapists, and this enables them to support people with a number of health problems, many of whom present with more than one. Mental ill-heath would be the most prevalent health condition amongst CMP clients.

Work First Project

In addition to the four programmes, the Disability Employment Service (DES) has deployed a Specialist Transitions and Placement Officer (SFTP) who works with students and their tutors within the Colleges to obtain work experience placements by using local employer networks and knowledge. By working closely with these employers and promoting the DES programmes these opportunities are then converted into paid employment where possible. Support by the SFTP is available for students in the Northern and Southern Colleges DES are currently working with the College Co-ordinators in the all of the FE Colleges to ensure that this service is available to students, regardless of their location. The vast majority of these students have a learning disability or are on the autism spectrum.

Parkanaur College

DfC funds students with learning disabilities to attend Parkanaur College, a residential vocational training college providing training for people with disabilities whose disability prevents them from accessing mainstream training provision.

Did it make things better for people with a learning disability and their families?

- ***Work Connect***: The programme commenced on 1 September 2012 and has supported 1,328 clients with a range of health conditions and/or disabilities. 89 clients presenting with a learning disability, 54 with ASD and 594 with mental health issues have participated on Work Connect. This represents 737 (55%) of programme participants. Work Connect recently closed to new entrants on 31 August 2016.
  From client progress *reports a*nd data received to date, 49% of clients have increased employability after 13 weeks on the programme. Remaining clients are still being supported and this will continue until their individual support period ends. The programme has supported 169 clients with mental health issues, 16 with Learning disability and 11 with ASD into employment.

- ***Access To Work***: As at 31 March 2016, 9 people with mental ill health and 176 people with a learning disability are being assisted to stay in work through Access to Work NI. Support from the programme promotes independence, social inclusion, increases confidence and empowers these clients to reach their full potential in the workplace. For those with mental ill health support from the programme improves mental health and well being and helps them to sustain employment particularly those that have reoccurring mental health issues.

- ***Workable (NI)***: There are currently 288 people with a learning disability, 41 with ASD and 145 with mental ill health participating on the Workable (NI) programme.

- ***Condition Management Programme (CMP):***
  The new model of CMP has been introduced since 1 April 2016 and currently enables both Workable (NI) clients and those in receipt of Access to Work (AtW) to avail of provision to help them retain and sustain employment. Following a pilot the programme has now extended to allow for all suitable JSA clients to be referred for the specific period of 12 weeks support and intervention to help progress them towards employment, Since April 2016, CMP has assisted 16 clients with a Learning disability and 582 clients with mental ill health issues.

- ***Work First Project***: Since September 2015, there have been 34 students referred to the DES Work First project form the Northern and Southern Regional Colleges. The majority of students involved have learning disabilities with others having an Autistic Spectrum Disorder and other health conditions. At present 27 students are participating in work experience placements and 5 others have secured permanent part-time paid employment which will continue after they have completed their college course in June 2016.

- ***Parkanaur College***: The Disability Employment Service (DES) currently funds 8 students with severe learning disabilities to access residential training at Parkanaur College. Each student completes OCN qualifications in relation to their preferred vocational area and will embark on a period of work experience during the training to enhance their skills. A student with a severe learning disability recently obtained a permanent catering job using the skills which he had obtained during his training at

Parkanaur College. He is being supported in this job through the Workable programme.

There was varied feedback from the participants in the questionnaire about employment for people with learning disability. Of the 348 people (both those with a learning disability and carers) who answered the question about employment, 104 (30%) had a job in the last 4 years. It is not clear if these jobs were paid or unpaid or full-time /part-time, or if they were short-term or long-term. Some people felt that access to employment for people with a learning disability had improved, while other felt that there were very few employment opportunities. There were some very positive experiences shared by people who had received support from 3rd sector organisations.

> *Yes there are a lot more opportunities to access further education and more employment opportunities relevant to needs.*

> *Post school opportunities needs to be a marriage of Education and valuable work opportunities not short term placements. Our young adults need to have their abilities challenged and stretched*

> *Paid employment seems an unrealistic goal. Either employers should be encouraged, paid or coerced to offer real work- or abandon the idea*

> *Excellent support to gain employment by MENCAP*

Feedback from the learning disability focus groups was similarly varied. There was evidence that people were involved in a range of work placements including gardening, maintenance work, housekeeping, office work, catering and childcare. The key points made in the focus groups about employment are summarised below:

- In some places there was support for people with a learning disability to gain and maintain employment, but this varied greatly by geographic location, funding, existence of support organisations in the area and the ability of the individual;
- There is a need to develop more social enterprises who will provide employment opportunities for people with a learning disability in a supported environment;
- The vast majority of people who engaged in the focus groups and were in employment, were unpaid, and the importance of ‘feeling valued’ as a paid employee was raised a number of times;
- However, there was a concern, primarily from carers, about the impact paid employment may have on benefits, given that often job opportunities for people with a learning disability are on a short-term basis and the perceived likelihood of it breaking down;
- The short-term and part-time nature of job opportunities for people with a learning disability was raised a number of times;
- Many carers felt that they had to ‘work hard’ to identify opportunities, and identified a need for better information, promotion and co-ordination;

- The need for academic qualifications was identified as a barrier to gaining employment, and some felt there was a need to consider different pathways into employment and training for people with a learning disability, other than academic qualifications;
- The role of 3rd sector support organisations is very important in supporting people into and in employment, and needs to be extended.

> *It's frustrating that endless years of volunteering for people with a learning disability doesn't develop into anything*

> *I enjoy my work and would like more days*

Current policy / service development

The Department for Communities (DfC) Employment Strategy for People with Disabilities was launched in March 2016.

https://www.communities-ni.gov.uk/sites/default/files/consultations/del/Disability%20Strategy%20report%20%28Web%29.pdf

The Strategy focuses on supporting those people with the most significant disability related barriers to work, and who want to work, are motivated, and who, with the right type and level of support, will secure and sustain paid employment opportunities across every employment sector.

The Strategy also makes a clear statement to society that goes beyond finding a job – people with disabilities share the same ambitions and aspirations as everyone else, and are dedicated to realising their full career potential. The Strategy is about enabling and empowering those aspirations, and in doing so, disabled people will make a significant contribution to the economy.

The Disability Employment Service's main employment programmes – Workable (NI) and Access to Work (NI) - are clearly linked to the purpose and objectives of the Employment Strategy for People with Disabilities. The Strategic purpose is: *To improve the job prospects and working careers of people with disabilities;* The Key Objective is: *To directly assist disabled people to find, sustain and progress within paid employment; or to start up a business.*

The target client group for the Strategy is clearly stated throughout, and this includes people with learning disabilities, people on the autistic spectrum and those with mental ill-health.

This Strategy aims to build on existing disability services, delivered through mainstream and community and voluntary sector programmes and also presents a great opportunity to improve partnership working at all levels. The new Disability Employment Stakeholder Forum, established through the strategy brings together key officials from a number of

Executive departments, representatives from the disability sector, employers and most importantly, people with a range of disabilities, who will monitor and positively influence the implementation of the Strategy.

One of the Actions in the First Year of implementation is to roll out the Work First project, with the FE Colleges to ensure that all colleges throughout Northern Ireland have a pathway created for students with a learning disability or autism, when they complete their course of study or vocational training qualification. This will result in positive outcomes, including part-time and full-time employment for many.

This Strategy has been developed around five key themes, with a number of supporting proposals within each theme. The key themes are: Empowering and supporting people to secure paid employment; Job retention and career development; Working with employers; Research and development; and Strategic partnership and engagement.

The key proposals contained within the Strategy which aim to improve employment services for people with a disability are:

- Introduction of the Supported Employment Model;
- Introducing flexibilities to existing disability programmes to support people in employment of more than 10 hours (enables more people with mental ill-health or a learning disability to move into work, knowing they have in-work support, with a view to extending their hours over time;
- Extend the employment support partnership with Discrete Learning Units to all FE Colleges throughout NI;
- Introduce specialist recruitment support model for people with disabilities;
- Employer Education and Awareness;
- Work with Equality Commission and others to promote positive action;
- Disability Employment stakeholder Forum to include people with mental ill health and learning disability.

Identified Need

There is a need for investment in the creation of more employment opportunities for people with a learning disability, with the support required for them to access and maintain employment. This could include more opportunities available in Executive Departments and an increase in the development of social enterprises. This is crucial to the successful move towards a Day Opportunities Model.

Further / Higher Education and Training

What did we say we would do?

We said we would develop programmes and partnerships to support people with disabilities to access and participate in training and higher education.

Maintain support arrangements and extended eligibility for participants on the Training for Success Programme (*Action 17 – Department for the Economy*)

Widen Participation in Higher Education Strategy (*Action 18 – Department for the Economy*)

Establish and progress effective Partnership agreements and joint working arrangements with post-primary schools, further education, training and apprenticeship providers, HSC Trusts and organisations who act as advocates for young people with a variety of barriers, including disabilities (*Action 19 – Department for the Economy*)

Lead on the implementation of the cross-departmental strategy 'Pathways to Success' for those people not in Education, Employment or Training (NEET) (*Action 20 – Department for the Economy*)

Develop Careers Service delivery to support the 'Pathways to Success' Strategy (NEETs) (*Action 21 – Department for the Economy*)

Continue to work in partnership with DE to increase the level of information sharing in respect of relevant pupil data being shared with DfC's Careers Service including electronic sharing of pupil data via C2K (Action 22 – *Department for the Economy / Department of Education*)

Continue to provide specialist support , as appropriate for young people considering participating in Training for Success (TfS) (*Action 23 – Department for the Economy*)

What did we do?

One of DfE's key strategic goals is Widening Participation in higher education by students from groups who are currently under-represented, in particular students from disadvantaged backgrounds and those with disabilities and learning difficulties.

"Access to Success" the widening participation strategy was published in September 2012. It contains 11 Key Actions to improve accessibility and participation in higher education, including among students with disabilities. DfE (previously DEL) is working with Higher Education institutions and other key stakeholders to develop implementation plans for each of the Key Actions.

Actions include:

- the launch in March 2014 of “Reach Higher”, a single centralised and co-ordinated higher education awareness and aspiration raising campaign to communicate the benefits of Higher Education to disadvantaged groups, including students with disabilities;
- the introduction of the “REACH” programme which aims to expand the range of aspiration and educational attainment raising programmes; and
- the introduction of Widening Access and Participation Plans in which institutions detail their Widening Participation (WP) strategy, provide a review of their past achievement against regional benchmarks and provide a detailed programme of anticipated progress towards the institution's own targets.

DfE’s widening participation strategy, “Access to Success”, requires that the recruitment, retention and achievement of disabled students is monitored by all Higher Education providers. However, the definitions of disability differ slightly for each provider.

DfE publishes Widening Participation Performance Indicators in Higher Education annually by academic year (which covers the proportion of students in receipt of Disabled Students Allowance (DSA)), and also publishes statistical factsheets covering enrolments in NI Higher Education Institutions (HEIs) by equality categories, including disability status of the students.

DfE assists students with learning disabilities access the range of mainstream and discrete educational provision delivered by FE colleges through the Additional Support Fund. This fund provides £4.5 million per annum to help colleges to put in place the necessary technical and personal support required by an individual to attend further education.

The Community Family Support Programme (CFSP) has been designed to help families (some of whom may have learning disabilities) make life changing decisions to enhance their prospects and to become full participants in society, including breaking the cycle of inter-generational unemployment and associated poverty in communities. During the 26 week programme families receive help to address the health, social, economic, educational, employment and training issues that impact on their daily lives.

CFSP will be funded through the new NI European Social Fund (ESF) from 1 April 2015 – 31 March 2018 and aims to support 2,340 families over the 3 years of the programme.

During the period November 2013 to March 2015 a total of 720 families completed participation on the CFSP. A total of 2,694 family members received help and support on the programme, including: 795 aged over 25; 527 young people aged 16-24 years; and 1,372 children under 15 years of age.

Did it make things better for people with a learning disability and their families?

Disabled students are not broken down into categories that would allow us to provide this information specifically for students with learning disabilities. However, across the institutions, there are various outreach programmes aimed at students with disabilities including learning disabilities and once enrolled, various support measures are in place to aid retention of students.

There were 11,502 students self-reporting a disability (including learning difficulties) who were enrolled in Further Education Colleges in 2014/15.

In 2014/15, there were 4,550 students self reporting as having a disability or learning difficulty enrolled at NI's Higher Education Institutions.

Of the 346 people (both those with a learning disability and carers) who answered the question about training and further education, 74 people (21%) were currently availing of training and further education, and 56% of people with a learning disability who responded said they have participated in training or further education in the last 4 years. About 74% of these felt they received the support they needed to remain on the course or achieve a qualification. In focus group discussions a variety of courses were mentioned including childcare, ICT, hairdressing, numeracy, literacy, catering and independent living.

While an average of 65% of the respondents to the questionnaire stated that they had transport to get them to their training course, many of these stated that it was family transport.

The main themes emerging from the feedback from both the questionnaires and the focus groups are summarised below:

- There is variance geographically in the availability of training and further education for people with a learning disability;
- There is a lack of opportunities or support for people with a learning disability who are over the age of 24;
- Many tutors do not understand the needs of people with a learning disability;
- It can be difficult to access support in Further Education colleges, particularly at break times;
- Anecdotal evidence of funding cuts which have led to a reduction in courses available for people with a learning disability;
- There are limited courses available for people with a learning disability, and a need to develop more suitable courses that will lead to employment opportunities. Some people commented that they had repeated courses because there was no other courses on offer;
- There was frustration from many people about lack of progression in terms of improving the employability of individuals with a learning disability and suggestions that training courses could include work experience / apprenticeships / link with employers;
- Many carers felt that they had to 'work hard' to identify training / further education opportunities, and identified a need for better information, promotion and co-ordination;
- The need for academic qualifications was identified as a barrier to accessing training / further education, and some felt there was a need to consider different pathways into training for people with a learning disability, other than academic qualifications;
- Transport to attend training / further education was identified as an issue, particularly in rural areas. There were comments about difficulties in accessing transport across Council boundaries. This was seen as a barrier in some cases to the individual

attending training courses. A need was identified for more independent travel training for people with a learning disability to enable them to use public transport.

- The need to ensure smooth transition from school to training / further education is important so that the individual has certainty about what they will be doing.

> *They should be given the opportunity to continue with education and skills training. Adult training centres need to be developed to be just that - they need to be trained and taught."*

> *There are a lot more opportunities to access further education*

> *As soon as they turn 24 there is a black hole – there is nothing for them*

> *I really wanted to do hairdressing at Tech, but I couldn't get the GCSEs to get in. So I'm doing a computer course I don't really like. I think there should be another way for people with disability to get in to courses*

Current policy / service development

- Outcomes measurement: One of the projects within "Graduating to Success", the higher education strategy, is seeking to standardise the returns across all higher education providers to allow more consistent measurement of progress. The Department is working in conjunction with DE and the Higher Education Institutions (HEIs) to review and bring forward recommendations to improve the mechanisms used to gather comprehensive and reliable data pertaining to access to, and participation in, higher education by disabled students, including those with mental health issues and learning difficulties.

- The Social Inclusion project within the new Further Education Strategy, "Further Education Means Success" will identify the barriers that inhibit different groups of learners, including those with learning disabilities, from participating in FE provision and explore ways in which to overcome these barriers.

Identified Needs

There is a need to review and increase the offer of Further / Higher Education and Training open to people with a learning disability and the support available to enable them to participate to address the gaps and barriers identified including a lack of suitable courses (particularly for those aged 24+), part-time nature of courses, lack of transport, lack of understanding by tutors of the needs of people with a learning disability, barriers created by academic criteria and lack of progression for people with a learning disability.

Self Directed Support

What did we say we would do?

We said we would promote Self-Directed Support so people with disabilities can choose the health and social care services which best meet their needs.

To support the uptake of self-directed support and individual budgets in line with Transforming Your Care (*Action 25 – Department of Health*)

What did we do?

Self Directed Support (SDS) empowers service users and carers to exercise more control over their social care services, offering greater flexibility, promoting independence, and assisting individuals to make informed choices about how and when services are provided, enabling them to tailor their support package to fit their specific needs.

The SDS initiative commenced in March 2014 and represents a major change to the way people with social care needs are assessed and supported. SDS is based on the human rights principles of fairness, respect, equality, dignity and autonomy for all. Personalisation and Co-Production are key tenets of SDS promoting independence, and assisting individuals to make informed choices.

SDS aims to improve the impact that care and support has on people's lives, it is a strength based approach to assessment and support planning, focussing on the outcomes people identify as important to them. It means that people are equal partners with the relevant professional in determining their social care needs and controlling how their needs are met.

SDS affords the individual choice and the combination of a number of support options through a personal budget namely:

- Direct Payment (a cash payment in lieu of services)
- Managed budgets (where the Trust holds the budget, but the person is in control of how it is spent)
- Trust Arranges Support on behalf of the service users.

The HSC Board, and HSC Trusts in partnership with a wide range of stakeholders, is currently implementing the SDS initiative across the Region. This initiative is working towards the indicator (included in the Commissioning Plan Direction 2016/17) that by March 2019, all Service Users and Carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access Direct Payments, a Managed Budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.

In addition to the above indicator, it is intended that by March 2019, 1 in 3 eligible Service Users will avail of either a SDS Direct Payment or Managed Budget option. The Commissioning Plan Direction 2016/17 also has a target referring specifically to Direct Payments which will help drive improved performance on SDS; by March 2017, Trusts must secure a 10% increased in number of Direct Payments to all Service Users.

The implementation of SDS is currently underway and progressing steadily. Across the five HSC Trusts there are differing approaches to operationalization of SDS, currently two Trusts are approaching full implementation and the other three have well-constructed plans outlining an implementation timetable; for example SEHSCT have implemented SDS Trust–wide and across all POC on April 1st 2016, while other Trusts have implemented by individual POC's or Geographically.

Data collection within this initiative is developing along both qualitative and quantitative lines. The SDS activity data return is currently in trial with the five Trusts, it is our expectation that more reliable figures will result from this approach.

SDS has introduced the Adult Social Care Outcomes Toolkit (ASCOT) in partnership with Kent University. Initial trials are taking place with SEHSCT and all Trusts will introduce ASCOT in the coming months.

ASCOT is an integral part of the SDS initiative it enables an outcomes focus and helps evaluate the effectiveness of social care services on an individual's quality of life. In the future review and analysis of this outcome data will inform local and regional planning.

Through the implementation of SDS, funding issues have been raised at high level by a number of Trusts, SDS is a strategic initiative requiring fundamental transformation in how finance is directed to support change within Trusts

As well as changes for people who need support, SDS brings significant challenges for HSC Trusts and third and private sector social care providers. HSC Trusts need to transform the way they deliver social care by changing many of their processes and procedures, the way they plan and manage their budgets, and how they work with external providers to ensure a balance of flexible, responsive, quality services.

Did it make things better for people with a learning disability and their families?

The uptake of direct payments for clients with a learning disability increased by 50% from June 2012 to June 2015 – see regional figures below.

Number of Direct Payments Paid During Quarter for Learning Disability Clients

June 2012	June 2013	June 2014	June 2015	June 2016
662	727	852	994	1426*

Source: CIB

**due to a change in the data collection system, from March 2015 figures include adults with a learning disability and children with a disability, which includes learning, physical and sensory disabilities, so the June 2016 figure is not directly comparable with previous years.*

Access to Direct Payments has been available in Northern Ireland for many years but there has been limited uptake, particularly among older people, with many individuals being put off by the additional responsibilities that accessing direct payments can entail, for example, the management of the payments and the duties resulting from becoming the official employer of support staff. The ongoing rollout of *managed budgets* will benefit individuals who want to exercise more choice and control over their own support but are reluctant to take on a role in the management of their care services and how they are purchased.

In the response to the carer's questionnaire responses, 24% of carers indicated that they receive direct payments. Feedback from the learning disability focus groups identified a perception that information on Direct Payments is not widely available and that they need to be better promoted. Many carers commented that they had never heard of Direct Payments or Self Directed Support. Others commented that they were 'put off' Direct Payments as they thought they were too complicated or because they did not want to have the responsibility of being an employer. This was particularly prevalent in the case of older carers.

One family who participated in a focus group for older carers of people with a learning disability shared their experience of setting up a 'Micro-Board', to manage their daughter's care *(a model which is popular in other countries)*. They said arrangements are now in place and they are able to manage their personal budget effectively which has ensured their daughter is getting personalised care at home.

Current policy / service development

- The promotion of Self-Directed Support as a means of improving the quality of life of people with disabilities will be included as a priority within the Programme for Government.

- Self-Directed Support (SDS) will form part of the Department of Health's vision for social care within the Reform of Adult Social Care.

- To continue to increase the uptake of Self Directed Support including Direct Payments. There needs to be more information on Self Directed Support, better promotion and more assistance with the management of Self Directed Support, so as to break down perceived barriers. The HSC Board should consider different models for the promotion / delivery of Self-Directed Support to encourage people with a learning disability and their families to consider this as an option.

- Operationalization of SDS will continue, and progress will be monitored and reported under Programme for Government.

- As part of the SDS Equality Impact Assessment (EQIA) the need for a specific information resource for individuals with a Learning disability was identified, to address this need an Easy Read version of the service user guide is currently being developed in partnership with Service Users.

- HSC Trusts need effective leadership from Directors and Senior Management across Programmes of Care and support directorates (ie Finance, Planning & Contracts and Information) and continued support from the HSCB and DoH through detailed guidance and regular communication via existing SDS project structures.

- In parallel with regional work aimed at streamlining information gathering, SDS is working with Trusts developing and refining the regional SDS activity toolkit. There is no single activity gathering information system in operation across Trusts and plans to homogenise a regional system is some years away. As a consequence adaptations to the different systems currently in use will require additional financial resources.

- It is important that the HSC Trusts, HSCB and DoH can demonstrate the impact of the SDS Initiative, including the intended improvements to the quality of people's lives the importance of having timely information and validated data can't be over emphasised.

- The Mental Capacity Act (Northern Ireland) 2016, once commenced, will amend Section 8 of the *Carers and Direct Payments Act (Northern Ireland) 2002*, to extend the direct payments scheme to include those who lack capacity to provide this initial consent, by enabling a statutory duty to be imposed on Trusts to offer direct payments to such individuals, in situations where there is an appropriate person to consent to receive direct payments on behalf of the service user, and to manage such payments, with involvement from the service user, to the extent that this is possible.

Education

What did we say we would do?

The Bamford Action Plan 2012-15 included a commitment to take forward and implement a Review of Special Educational Needs and Inclusion, so that pupils with special educational needs are supported to achieve their full potential through the early identification of need and early intervention.

Take forward and implement Review of Special Educational Needs and Inclusion (*Action 26 –Department of Education*)

What did we do?

The Special Educational Needs Review proposals relate to all children and young people with special educational needs, as defined in the 1996 Order, regardless of the particular need. If a child, up to age 19, has special educational needs, then the new framework will include them.

The Department of Education is working to deliver a more responsive SEN Framework by 2017/18. The new Framework will focus on inclusion, early identification, assessment and intervention for children with SEN, whereby a child or young person with SEN should receive the support they need when they need it.

The SEN Framework is made up of three main elements, namely the Special Educational Needs and Disability (SEND) Act, SEN Regulations and a Code of Practice. The SEND Act, which includes cooperation duties between the Education Authority and health and social service authorities, received Royal Assent on 23 March 2016. Consultation on the draft SEN Regulations finished on 16 May and responses are currently being analysed. A new Code of Practice is currently being drafted and it is envisaged that it will be ready for consultation in early 2017.

Linked to the cooperation duties in the SEND Act 2016, the Departments of Education and Health have initiated a SEN Education and Health Interface Project. This will focus on improving the interfaces within the SEN framework.

Did it make things better for people with a Learning Disability and their families?

It is too early to measure the outcomes associated with the SEN Review. The new SEN Framework needs to be in place 2017/18, namely the SEND Act 2016 commenced, the Regulations commenced and the new Code of Practice in place, before we can begin to look at the outcomes.

Success will be measured through improved outcomes for children including faster timeframes for statutory assessment.

Current policy / service development

Progress each of the elements required for the new SEN framework including:

- Commencement of the SEND Act 2016 provisions, this will include the co-operation duties placed on EA and health and social services authorities.
- Finalise the draft SEN regulations and the draft supporting Code of Practice.
- Commence the new SEN Framework in 2017/18.
- EA to ensure that the capacity building training will have taken place before the new Framework is in place

<u>Advocacy</u>

What did we say we would do?

We said we would improve advocacy services, through the development of a policy guide for commissioners.

Implement 'Developing Advocacy Services – A Policy Guide for Commissioners' (*Action 27 – Department of Health*)

What did we do?

An Independent Advocacy Code of Practice and Standards Framework was launched in June 2014. Members of the Advocacy Network NI have committed to the code of practice and are using it as part of their induction and training programmes for new staff and volunteers.

RQIA carried out a review of Advocacy Services in 2015. The review team's overall findings indicate that the DHSSPS policy guide and associated action plan has helped HSC commissioning organisations to better understand and develop independent advocacy services in Northern Ireland. Advocacy is now regarded as a core element of provision for some services and is recognised to be valuable when service changes are being considered or implemented.

All Trusts now have Advocacy services in place, however the extent of this varies from Trust to Trust.

There has been investment in Advocacy services to ensure that all individuals bening re-settled from hospital to the community have access to advocacy. The Association for Real Change (ARC) has also provided advocacy support through the Telling It Like It Is (TILII) groups.

Did it make things better for people with a learning disability and their families?

RQIA found that the provision of advocacy services varies across geographical areas and HSC trust programmes of care.

The RQIA Review of Advocacy Services identified three main constraints that impact on the optimal delivery of advocacy services in Northern Ireland.

- At present there is no clear statutory duty or strategic framework to provide independent advocacy services in Northern Ireland;
- Lack of resources has impacted on investing in advocacy services across all programmes of care; and
- There is no process for regulation of providers of advocacy services or for individuals undertaking advocacy.

Feedback from the TILII members who engaged in the focus groups indicated that they found the support of these groups invaluable.

Current policy / service development

RQIA made 8 recommendations (6 for the HSCB, 2 for DoH) for improvements in the commissioning process and quality of advocacy services for children and adults which focused on: an assessment to determine future capacity requirements, and to improve access to advocacy; cross-agency working; evaluation of services and to inform future commissioning; consideration of a regulatory framework. The HSCB has developed an action plan for the recommendations that is feasible within current resources.

The future direction of advocacy services will be impacted by the commencement of the Mental Capacity Act (MCA) which includes the provision of a statutory advocacy service for people with impaired capacity in circumstances where serious health and social care interventions, or an intervention which may restrict their liberty, are being considered (Further detail on the implementation of the MCA is included in Annex C).

Involvement in Service Design and Delivery

What did we say we would do?

We said we would involve people with a learning disability in the commissioning and delivery of health services for people with a learning disability so that services meet the needs of those of use them.

To support the employment of experts by experience in the commissioning and delivery of mental health and learning disability services (*Action 28 – Department of Health*)

To ensure Personal and Public Involvement (PPI) in planning, commissioning, delivery and evaluation of services in line with guidance (*Action 42 – Department of Health*)

What did we do?

Under the current Bamford Structures, including the Programme Board and the Learning Disability sub group, there is representation from parents and carers, who contribute to commissioning decisions as follows:

- People with a learning disability and/or their families/carers represented at Bamford Monitoring Group, supported by the Patient Client Council, whose role it is to provide feedback from the public, service user, family and carer perspective in relation to implementation of 'Delivering the Bamford Vision';
- People with a learning disability and/or their families/carers represented at Commissioning HSCB/PHA group;
- People with a learning disability and/or their families/carers represented at Bamford Task Force. However, this is not working very well due to the complexities to the discussions;
- All Trusts have Carers Groups;
- Some Trusts use their Advocacy Service to ensure user engagement;
- HSC Board Local Commissioning Groups have regular engagement events with carers and users.

Did it make things better for people with a Learning Disability and their families?

18% of the carers who responded to the carer's questionnaire said they had been involved in the development of learning disability services. There were several expressions of frustration at lack of change as a result of such involvement, and lack of engagement by Trusts with people with a learning disability and their carers.

60% of the respondents to the questionnaire for people with a learning disability felt it was easy to get involved in changing services.

Feedback from focus groups was generally that there was a need for a formal mechanism for people with a learning disability and families/ carers to engage with HSC Trusts, so that ideas and experiences can be shared on a formal footing.

Have set up a carers/parents support group in our local area. Trusts do not make a good enough effort to connect with or really listen to carers/ parents.

We have as a group met with service providers and Trust managers. We are never told what you ask for is not achievable, however we are continually told - no financial budget at present ie your problems are not high priority

There was a comment that the Bamford Monitoring Group mainly focussed on mental health services, and that as a result the interests of the learning disability community were not being heard.

It is recognised that within the mental health sector it is much easier for individuals with lived experience of services to engage when they are well, and disengage when unwell. This is more complex with the learning disability sector, and there is a need to review the approach to and the infrastructure for engagement of people with a learning disability and their families / carers in the planning and delivery of services at regional and local level.

Current policy / service development

There is no current policy / service development in this area.

Identified Need

There is a need for a formal mechanism for HSC Trusts and the HSC Board to engage with people with a learning disability and their families / carers should be developed in each Trust area, so that the experiences of these people will influence service design and delivery.

The model adopted by the Mental Health Service User Forums is working very effectively in some Trust areas, and could be considered as a model that could be replicated in the learning disability sector. Another model for consideration might be through the commissioned advocacy organisations within each Trust area.

Transport

What did we say we would do?

We said we would improve access to public transport for people with a learning disability by providing better information, provide travel training schemes and training staff.

Investigate how information provision on transportation issues can be improved for people with learning disabilities (*Action 29 – Department for Infrastructure*)

Examine options for improving the provision of travel training schemes (*Action 30 – Department for Infrastructure*)

Review the training of staff to ensure that its content covers the needs of people with a learning disability (*Action 31 – Department for Infrastructure*)

What did we do?

Information: The refreshed Travel Safe Guide was published in June 2014 and distributed to voluntary groups, learning disability groups and schools. DfI has completed an evaluation on the Travel Safe Guide. Translink have reviewed their access guide which is available on the Translink website http://www.translink.co.uk/accessibility/translink-access-guide/ and at Translink Stations.

Travel training: The Transport Buddy pilot scheme has been evaluated and recommendations have been made for a future roll-out of the scheme if additional resources can be provided from Delivering Social Change Funds. There is no funding currently available through the Department for Infrastructure.

Staff training: Translink continues to provide training to its drivers covering passengers with hidden and learning disabilities and dementia suffering passengers in conjunction with its charity partners, the Alzheimer Society.

Training has also been delivered to Rural Community Transport Partnership, Bridge Transport and Disability Action drivers. All drivers undergo MiDAS training (Minibus Driver Awareness Scheme) which covers issues around people with a disability. A driver's MiDAS certificate is revisited every 4 years.

Bridge Transport participate on the Derry City and Strabane District Council Access and Inclusion Forum which brings together and encourages the pan- disability community in that area by improving access to participation, information facilities and events. Membership of this Forum includes Mencap, Disability Action, Cedar Foundation, Autism NI and Arts and Disability Forum.

In addition to its membership of the above Access and Inclusion Forum, Disability Action also engages with Mencap, Orchardville Society, NOW and Stepping Stones through a range of programmes that impact on people with a learning disability.

Did it make things better for people with a Learning Disability and their families?

There are currently 290 drivers/staff within Community Transport who have received disability awareness training.

Translink has advised that since 2012 there have been 245 new entrants to the bus driving grade who have all received a disability awareness presentation.

The following courses have been also been delivered to Translink drivers/staff as part of the Certificate of Professional Competence (CPC). There are currently a total of 3,790 staff within Translink and of these, circa 2000 staff have attended at least one of these courses

- Customer Care (Dealing with the Elderly)
- Customer Care
- Disability (Alzheimer's, Hearing/Vision Impaired, Learning Disability (JAM))
- Integrity - Visual, hearing and mobility impairment awareness including tips in how we can improve current service levels.

Furthermore, Employers for Disability NI (EFDNI) conducted a session earlier this year on general disability awareness for managers and supervisors. This was attended by 12 staff.

At the conclusion of the driver training programme participants complete an evaluation form by way of feedback on the overall programme content. This input is reviewed by Translink training staff.

The Department for Infrastructure will seek to encourage Translink to include evaluation analysis of this training through actions that will fall out from the new Accessible Transport Strategy 2025.

Translink can confirm that it is currently reviewing the initial training that bus drivers receive and are already in talks with various stakeholders such as the RNIB to discuss how to improve our initial training.

In discussions at focus groups, and in response to the learning disability questionnaires, concerns were raised about lack of transport to Further Education colleges and the cessation of Travel Training for people with a learning disability in some areas.

Current policy / service development

The Accessible Transport Strategy 2025 is currently scheduled to be published during 2016/17. The associated delivery plan will include actions intended to improve transport accessibility for people with a learning disability.

The Integrated Passenger Transport Project has been developed to combine the Translink and Education Authority large and medium bus fleet and establish a new demand responsive rural and urban disabled service incorporating the health trust day centre transport and special needs/mini-bus school transport services. A cross organisational steering group has approved the establishment of two projects:

Strand 1: Translink and Education Authority reviewing the scope for integration of large/medium sized buses in two areas; and

Strand 2: Department for Infrastructure coordinating work on integrating specialist Health and Social Care clients, Education Authority pupils and demand-responsive (community) transport (minibuses and specially adapted buses).

Identified Need

There is a need to address the lack of transport especially in rural areas to Further Education Colleges and other Day Opportunities.

There is a need to provide travel training to people with a learning disability to empower them to used public transport.

THEME 3: SUPPORTING CARERS AND FAMILIES

The Bamford Action Plan 2012-15 contains a number of commitments in relation to supporting carers of people with a learning disability.

- That we would identify the needs of people with a learning disability living with older carers to plan for their future care arrangements;

Respite and Short Breaks

What did we say we would do?

We said there would be more provision of respite and short breaks for carers.

Enhance the arrangements to meet demand for respite including emergency respite and short break care (*Action 37 – Department of Health*)

What did we do?

Provision of respite is based on a carer's assessment, the range and choice of respite has been extended and improved. The number of hours available for carers of people with a learning disability has increased by 11,000 hours since 2012. Demand for respite / short breaks is increasing and the HSC Board is aiming to offer as many flexible breaks for families as often as possible.

Did it make things better for people with a Learning Disability and their families?

Feedback from the learning disability questionnaires and the focus groups with regards to short breaks / respite was broadly positive for those who avail of this service.

Respite is a lifeline to enable me to have a break/holiday

Could not do without respite it is a lifeline to the family and one that makes my son's life better

However, there were many comments about lack of respite, and a general perception that respite provision had reduced in some areas due to funding cuts.

I do not get enough respite, just a short break a few days every few months. It is good to get a break from caring, when the carer is an older person

3 years ago we were getting 5-6 weeks per year respite. Now with our son becoming more difficult and we as parents ageing, we can only get 3-4 weeks per year!"

A number of carers raised issues with poor planning of respite provision and frequent changes, and indicated that often they were not given enough notice of their respite time to allow them to plan in advance for holidays etc.

Short breaks provision is increasing, and are moving towards regular 'short breaks' rather than less frequent but longer periods of respite, in line with families have told us is more beneficial to them.

However, demand is increasing due to people with a learning disability living longer and an increase in people with very complex needs coming through from Children's services. More respite is available in children's services than in adult services.

Carer's assessments

What did we say we would do?

We said that all carers would be offered a carer's assessment so they can be supported in their caring role.

To provide support to all carers in order that they may continue in their caring role (*Action 38 – Department of Health*)

What did we do?

The number of carer's assessments completed for carers of people with a learning disability has increased substantially since 2012 – see table below.

No of Carer's assessments completed			
	Learning Disability	Children with Disabilities	Total Learning Disability*
Apr 12 - Mar 13	401		401
Apr 13 - Mar 14	570		570
Apr 14 - Mar 15	487	156	643
Apr 15 - Mar 16	410	623	1033

Source: CIB

**note due to change in data collection system, from March 2015 figures include all children with disabilities, not just learning disability so figures are not comparable year on year*

The uptake of carer's assessments continus to be a challenge. Carers are being offered assessments, but the uptake does not match the offer numbers. Some of the reasons given for not accepting the offer of a carers assessment include that carers have no time to do this, it doesn't give them any services or they have been put off by other carers. However, many carers who have a carer's assessment completed find it very beneficial.

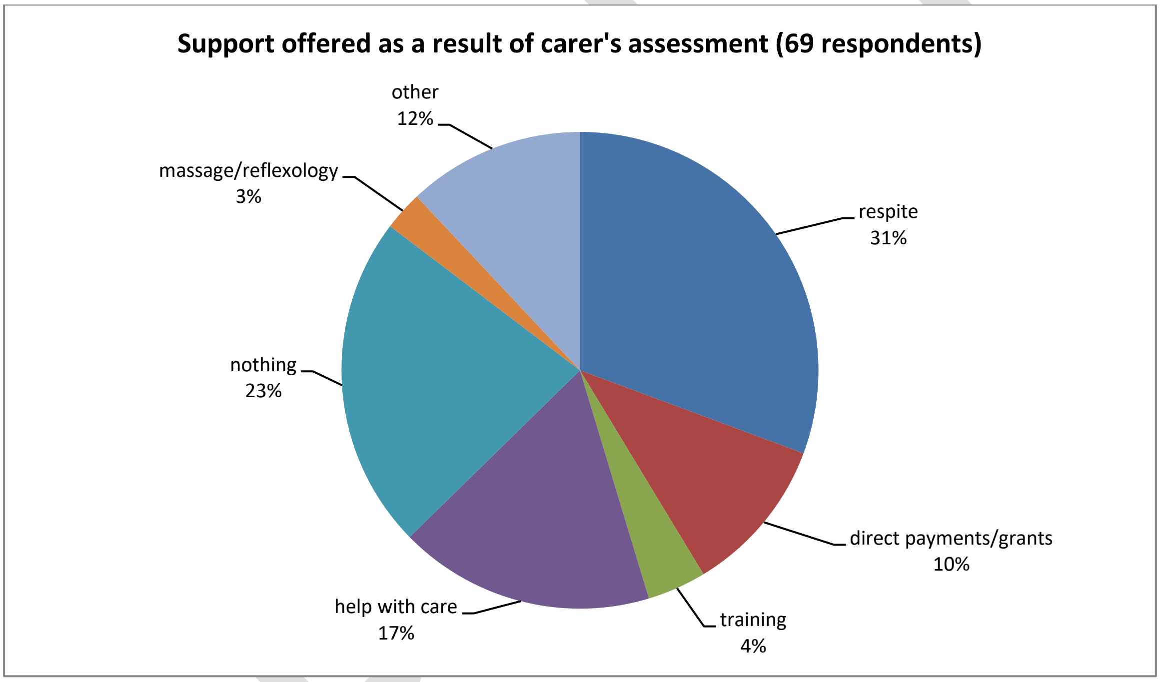
Did it make things better for people with a Learning Disability and their families?

Less than half of the respondents to the carer's questionnaire who answered the question about carer's assessments (161 responses) had been offered a carer's assessment. 83% of those who were offered accepted the carer's assessment. Several reasons were given for not taking up the offer of a carer's assessment including that carers were managing without any additional support and some who felt it would be of no benefit. There was also some frustration at the difficulty in accessing a social worker to seek help and support.

Nothing. They said we might qualify for £50; then said no, we weren't awarded it. I wanted offers of help and respite.

I have had a carers assessment done with our social worker about 2 years ago. I have asked for another one soon as our situation has become more difficult of late. No support

The types of support offered to those carer's who had a carer's assessment completed are set out in the chart below.



It is concerning that 23% of carers indicated that they has received no support as result of their carer's assessment, but it is not possible to assess if this is as a result of them being assessed as not requiring support, or there being no support available.

Feedback from those who did access support as a result of their carer's assessment was generally very positive.

Respite care six hours per week which helps as we are getting older and find times difficult as out child needs 24/7 care

I've got respite and 2 sits (nights) that let me get to my own bed

Yes it has been brilliant. A total life saver for my sanity

Could not lead a normal life at home without direct payment worker who makes my son's life better

Planning for the Future / Older Carers

What did we say we would do?

We said we would identify the needs of people with a learning disability living with older carers to plan for their future care arrangements;

Carry out a scoping exercise to ascertain future caring requirements for people with a learning disability living with elderly carers where there is a risk of breakdown in caring arrangements (*Action 39A – Department of Health*)

Develop a rolling, costed plan to support those with a learning disability living with elderly carers where there is a risk of breakdown in caring arrangements (*Action 39B – Department of Health*)

What did we do?

The HSC Board has completed research into the future care needs of older people with a learning disability and their families and carers. A plan which will consider both housing and care elements will be developed in conjunction with DfC.

A scoping exercise for those carers of people with learning disabilities who are 55 years old and above was completed. A second scoping exercise has been completed by the 5 HSC Trusts looking at carers of individuals who are 35 - 54 years. A costed plan for Phase One has been completed and a bid made for funding.

£2M recurrent funding (£1M part year funding in 2015/16) has been secured to develop services to meet this need. This investment will provide much needed domiciliary care, respite / short breaks, day care, supported living/nursing/residential placements for people with a learning disability living with older carers who are no longer able to care of them, and for crisis situations.

The University of Ulster developed and piloted a stand-alone training manual that focused on improving staffs' knowledge about the barriers and enablers to future planning and the additional information staff need regarding housing, direct payments and financial security to support them to signpost carers onto the appropriate professionals. Alongside the training manual, a two-day training programme was developed and delivered across the North to 215 staff from both the statutory and voluntary sectors. The majority of staff reported that the two-day training programme increased their knowledge, confidence and skills, however organisational barriers were reported in terms of putting the training into practice.

Did it make things better for people with a Learning Disability and their families?

The funding to develop services to address the future care needs of older people was secured in 2015/16, and these services are not yet fully developed. It is therefore not possible at this point to assess what impact these services will have on people with a learning disability and their families.

With regards to the future planning training, no formal evaluation in terms of the difference it made to carers has been carried out. However 215 staff from the statutory and voluntary sectors completed the 2 day training.

Many older carers participated in the learning disability focus groups. 31% (56/182) of the respondents to the carer's questionnaire were over 65, and 48% (88/182) were aged 45-64. We held a specific focus group to hear the experiences of an older carer's group involved with Positive Futures. A number of older carers also attended and spoke at the All Party Group for Learning Disability in December 2015 about their concerns for the future of their loved ones. In summary, we have heard from many older carers.

Only 22% of respondents to the carer's questionnaire indicated that they had received help to plan for the future.

It was very clear that the needs of many older carers are not currently being met. Many of these people have cared for their loved ones in the family home, and have not sought help from services, and therefore to a degree they have been 'under the radar'. There are issues around future planning, provision of respite / short breaks, provision of appropriate housing for people with a learning disability, lack of information about support services and lack of access to a social worker / key worker. We have a generation of older carers now, who have a genuine fear about the future of their adult sons/daughters.

People with a learning disability are considered of lesser importance than other members of society, they come after the elderly, after young people coming out of care, the drug/alcohol rehabilitated, the mental health people, and at the bottom of the barrel, learning disability. It appears the idea is that they can be 'put' somewhere that suits the 'putter' without consideration that they too have feelings, aspirations and views.

I go to bed at night praying that she goes before I do

We would like to see our daughter settled in comfortable supported living accommodation before we pass on

This is just a sample of some of the many experiences of older carers caring for a person with a learning disability – there were many more.

Current policy / service development

The development of domiciliary care, respite / short breaks, day care, supported living/nursing/residential placements for people with a learning disability living with older carers continues with the recent funding of £2M allocated, and will go some way to improve the support provided to carers.

Identified Needs

Support for carers generally:

- there is a need to continue to increase access to short breaks / respite to ensure carers are supported in their caring role;
- the HSC Board and Trusts should review planning of respite so that carers can forward plan;
- there is a need for better, co-ordinated information on support available;
- the HSC Board should ensure carer's assessments are proactively promoted and identify and address barriers to the completion of carer's assessment.

Identified Needs

There is an urgent need to develop solutions and further invest in services to proactively address the needs people with a learning disability who are living in the family home with **older carers.** Some of the measures that need to be taken include:

- That older carers have a point of contact in their local HSC Trusts to enable them to access information and support, including carer's assessments and short breaks;
- That all older carers are provided with support to help them plan for the future of their loved ones;
- That appropriate accommodation is developed to ensure that people with a learning disability living at home with older carers have access to housing which meets their needs and is close to their support networks.

These needs will require additional investment, and bids are currently under consideration.

THEME 4: PROVIDING BETTER SERVICES TO MEET INDIVIDUAL NEEDS

The Bamford Action Plan 2012-15 contained a number of commitments in relation to improving services for people with a learning disability:

HEALTH SERVICES

Information on Health Services

What did we say we would do?

We said we would compile information on all learning disability services provided.

Complete and maintain a map of learning disability services across Northern Ireland (*Action 51 – Department of Health*)

What did we do?

Following the launch of the Mental Health web portal by NI Direct in April 2015, a Learning Disability web portal is next to be developed, but this has not yet been completed. NI Direct is being used as a platform for information on learning disability services, and information on services is provided by the 5 Trusts. However, this is an area that requires further development.

Did it make things better for people with a Learning Disability and their families?

We asked in the learning disability questionnaire if people found it easy to access information about learning disability services. 65% of the carers who responded and 85% of the people with a learning disability indicated that it was easy to access information. There were positive comments about the helpfulness of day centre staff and social workers, and from 3rd sector organisations such as MENCAP and Positive Futures.

I am able to access information easily as I have particularly good social worker who provides very specific information and calls me with any changes to services or new services. He has been a lifeline and has made the transition from children's services to adult services very easy

If I want information I would go to MENCAP

33% of carers and 15% of people with a learning disability found it difficult to access information on learning disability services. Some of the reasons given were that they had no social worker to help them seek information on services, that the social worker was unhelpful and that they didn't know where to go for information. The issue of lack of information was re-iterated during focus groups, in discussions about carer's support and training and employment opportunities. There were suggestions for a directory of support services for each HSC Trust area or an information hub for each Trust.

Don't know how to access information and don't have a social worker and haven't for years.

Being a full time carer for a severely disabled child does not leave much time for research into available services- would be much more convenient to be presented with a list of support services

Social Worker not forthcoming with information- always have to go looking for information-very stressful

Current policy / service development

Information on learning disability services is available on the NI Direct website, but this is recognised as an area that needs further development.

Identified Need

There is a need for the HSC Board and Trusts to review the information available to people with a learning disability and their families / carers, and consider options like the development of an information hub or a directory of support services which includes information on how to access services and who to contact. These options should consider people who may not have access to the internet or are not computer literate.

Challenging Behaviours

What did we say we would do?

We said we would improve services for children with challenging behaviours and their families.

Improve services for children with challenging behaviours and their carers (*Action 47 – Department of Health / Department of Education*)

What did we do?

The HSC Board in 2012-13 committed £1m regionally to support development of services within Trusts for Children with Disability who display challenging behaviours. This initial allocation was to support developments of services at level 3 of the NI family support model and was in addition to additional funds provided to the regional unit at Iveagh to enhance the tier 4 service. In 2015-16, the HSC Board committed an additional £1.2m to enhance supports at level 2-3 for with a clear emphasis on early intervention and reducing the number of Children requiring placements outside of NI.

Education services also provide support with the management of challenging behaviours in school. These include:

- Pupils in mainstream schools displaying challenging behaviours (and their teachers) should initially receive in-house support determined by the school's Special Educational Needs Coordinator (SENCO). If internal supports in schools are insufficient, support and advice can be provided by the Education Authority's Behaviour Support Teams.

- The Behaviour Support Teams (BSTs) provide advice, support and training at various levels within the education system to promote positive outcomes for those children and young people with social, emotional and behavioural difficulties (SEBD), challenging behaviour, poor mental health and suicidal ideation.

- From their creation, the BSTs have tried to use available funding to undertake new pieces of work which are aimed at improving the capacity of schools to deal with a range of SEBD and Challenging Behaviour issues.

- These initiatives include a Behaviour clinic in Special Schools, Applied Suicide Intervention Training (ASIST), SafeTalk, Mind Out Programme and Time Out for Positive Steps (TOPS).

- The EA, between 2012-2015, provided a number of training courses and workshops to schools in relation to supporting pupils with challenging behaviour. These included training for teachers, classroom assistants, anger management, reasonable force /safe handling, anxiety based school refusal and many more.

- Team Teach, a training programme for behaviour support and management including physical interventions continues to be delivered to staff working in special schools; Advanced Team Teach is delivered in schools for pupils with Severe Learning Difficulties and Extreme Challenging Behaviour.

- In October 2014, DE held a workshop for Special School Principals to consider the recommendations in the Education and Training Inspectorate's report on challenging behaviour and to identify what could potentially be achieved in both the short term and longer term.

- The consensus of opinion was that a more structured consistent regional approach would be required to ensure the needs of all pupils with challenging behaviour are met and that consideration should be given to the needs of the staff supporting these pupils, particularly in relation to the impact it has on staff well-being.

Did it make things better for people with a Learning Disability and their families?

Only 44% of the 70 carers who responded to this question in the carer's questionnaire indicated that they had received help with managing their child's challenging behaviour. There were mixed experiences of the service, with some positive outcomes and some negative. Concerns were also raised about the waiting time for access to the service.

Making managing the behaviour less difficult. Ideas and strategies put into place to help the person with the difficulties. Using this at home, school and passing it on to respite carers

Difficult to say- prolonged observation and questioning/history taking and eventually a written plan materialised. But took so long from the time we asked for help, we had already addressed behaviours ourselves as so often before

Help given was very minimal and did raise our understanding but was not enough to alleviate or support us

With regards to the measures to enhance services for the management of challenging behaviours in schools:

- The EA has initiated an analysis of services offered with a view to bringing enhanced consistency to the provision for children and young people. Challenging Behaviour will be considered in the wider regionalisation of EA services.

- BSTs are able to send in behavioural specialists to observe the child in their classroom setting and recommend additional resources or strategies for the teacher to use to engage the child and reduce their negative behaviours.

- All of the EA's courses and workshops are evaluated by those who attend. The majority of responses, between 83% and 93%, rated the training as excellent

Current policy / service development

Enhanced support services for children with challenging behaviours continue to be developed by the HSC Board and it is anticipated that this service will reduce the number of children requiring placements outside of the North of Ireland.

The introduction of the EA provides an opportunity to draw together elements of best practice from across the former education & Library Boards into a regional approach that will address the needs of the pupils presenting with persistent and challenging behaviour and the staff supporting these pupils. The information gathered at the DE workshop has been shared with the EA and they have been asked to consider, in its wider regionalisation of services, a regional approach that will address the needs of the pupils presenting with challenging behaviour and the staff supporting these pupils.

Standards of Care

What did we say we would do?

We said we would implement a Service Framework for learning disability health services to improve the standards of care

Develop and implement a Service Framework for learning disability services (Action 48 – *Department of Health*)

What did we do?

A Service Framework for learning disability services was launched in September 2012, and a revised version was published in January 2015. This document sets out standard of care that services users and their carers can expect.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/service-framework-for-learning-disability-full-document.pdf

The service framework contains 34 standards and aims to improve a wide range of service issues such as better communication, support and advice on healthy living. Timely access to services and health action plans and greater support for carers is another important feature of this service framework.

Did it make things better for people with a Learning Disability and their families?

In terms of infrastructure Trusts are reporting that stronger links have been developed with GP practices, delivery partners and carers; staff training has been developed and rolled out across the HSC to help better support clients and their families, and record keeping has been improved through case note reviews and audits and GPs have been supported in identifying those on their registers with a learning disability.

Communication has also been improved through better signposting, clearer public health messages and support for those who do not use speech as their main form of communication.

Enhanced support for parents with a learning disability, help with finding employment opportunities, annual health checks and referrals to dentists, screening services and optometrists; consideration of age issues and accommodation needs all show that services to this client group and their carers have also been improved.

Current policy / service development

The service framework is now in its second year (2016/17) of implementation. It is expected that the service framework will undergo a thorough review after year 3 before a new one is developed and launched.

Funding

What did we say we would do?

We said we would increase funding in community based learning disability services to at least 80% of the HSC spend on learning disability services.

Maintain direction of HSC funding towards community based services *(Action 49 – Department of Health*)

What did we do?

The Bamford Action Plan 2012-15 commits to maintain the shift in funding within Learning Disability Services from hospital-based services to community based-services, with a target of at least 80% of funding on community services.

This has been achieved – in 2014/15 88% of the total expenditure on learning disability services was on services in the community and personal social services, as set out in the table below:

HSC Trusts expenditure on Learning Disability Services 2014/15		
Hospital Services	£33 M	12%
Community Services	£28M	10%
Personal & Social Services	£215M	78%
TOTAL	**£276M**	**100%**

In terms of Learning Disability expenditure generally on health and social care, there has been an increase in expenditure from £228M in 2009/10 to £276M in 2014/15.

HSC Trust Expenditure on Learning Disability Services from 2009/10 – 2014/15	
Year	**£M**
2009/10	£228
2010/11	£240
2011/12	£248
2012/13	£255
2013/14	£267
2014/15	£276

Did it make things better for people with a Learning Disability and their families?

The increased expenditure on learning disability services has mainly been on the following service developments:

- Day Opportunities / Day Care
- Crisis Response / Home Treatment
- Transition Teams
- Enhanced Community Infrastructure
- Satellite Units for Older People with a Learning Disability
- Health & Wellbeing / Healthcare Facilitators / Personal and Sexual Relationships

Feedback from people with a learning disability and their carers in the questionnaires and focus groups was generally that they felt there was little additional investment in learning disability services, and that in many areas there had been cuts to services like respite and day centres.

Current policy / service development

It is recognised that there is a need to further improve and develop learning disability health & social care services to ensure that they are effective in securing the best possible outcomes for people with a learning disability and their carers in the future. Areas for development include:

- improve the transitioning process from children's to adult learning disability services and support for carers, in particular older carers;
- the further roll out of the Regional Day Opportunities model;
- the development of short breaks provision;
- the enhancement of community learning disability teams to better manage and support the increasing numbers coming through requiring health and social care services system;
- provision for those whose discharge is delayed from hospital;
- the development of crisis support in the community to avoid unnecessary admissions or re-admissions to hospital also need addressed;
- the development of community forensic services to address the gaps identified.

To be effective, we will need to prioritise developments across the system and ensure that we configure our services in ways that target these needs and deliver for people with learning disability and their carers.

Nursing

What did we say we would do?

We said that learning disability nurses would develop their skills to improve the quality of care provided to people with a learning disability.

Development of UK wide framework for learning disability nurses (*Action 53 – Department of Health*)

What did we do?

A Northern Ireland action plan to implement the UK wide framework for learning disability nurses "Strengthening the Commitment" was launched in July 2014.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/learning-disability-action-plan.pdf

The action plan aims to improve services to people with a learning disability through the following:

- Providing awareness and encouraging participation across all specific and specialist areas relating to learning disability nursing;
- Providing a regional resource through the sharing of knowledge, expertise, service development, and innovation that will promote, influence and enhance best practice and consistency in learning disability nursing practice within services across the North of Ireland;
- Providing strategic direction and leadership for all of the nursing fields of practice and specialisms who work with people with learning disabilities here.

The action plan will be implemented and monitored by a regional implementation group who will report to the office of the Chief Nursing Officer on an annual basis.

Did it make things better for people with a Learning Disability and their families?

The collaborative have progressed and reported to Chief Nursing Officer a number of key initiatives that is promoting best practice in learning disability nursing to service users and carers. For example:

- During 2015, the Collaborative initiated work to undertake a review of the learning disabilities nursing workforce, across NI to include all sectors. This significant piece of work sought to establish where Learning Disabilities nurses are employed; line management and professional supervision arrangements; implications of anticipated service developments at local level and indications of associated educational/development needs;

- The sharing and profile of good practice initiatives in learning disability nursing. These included; a specialist community nurse led Learning Disability/CAMHS service, the use of Adapted Dialectical Behaviour Therapy (DBT), reducing restraint in acute in-patient settings and the development of an out of hours crisis response service;

- The establishment of a regional learning disabilities nursing network.

- A range of endeavours to strengthen leadership within the profession.

Feedback from people with a learning disability and carers through the learning disability focus groups was generally positive with regards to nursing staff. There was a suggestion that nurses working in schools should be trained in caring for people with a learning disability.

Current policy / service development

Current priorities for 2016/17, key priorities include:

- Agree key actions to address the messages arising from the Learning Disabilities nursing workforce review;
- Raise awareness of the NIPEC Careers Pathway with Learning Disabilities Nurses;
- Agree a Key Performance Indicator (KPI) specific to Learning Disabilities Nursing;
- Develop an Outcomes Measurement/Framework for Learning Disabilities Nursing within the 5 HSC Trusts in the first instance;
- Work to support development of leadership potential in Learning Disabilities nurses in practice.

Forensic Services

What did we say we would do?

We said we would improve forensic services for people with a learning disability.

Develop a plan for community forensic learning disability services taking account of services to be provided with available resources and which makes full use of other forensic arrangements in place (*Action 54 – Department of Health*)

What did we do?

A model for community forensic learning disability services was developed and £550K invested in 2015/16 to take this forward. Community Forensic Learning Disability teams have been established to varying degrees in all HSC Trusts. However, these teams are small and substantial additional funding is required to expand these teams, to provide medium secure beds and specialist community high support places, in order to meet need for this service.

Did it make things better for people with a Learning Disability and their families?

(DN: HSCB to provide stats on number of people who have accessed the community forensic service and outcomes?)

Representation from people with a learning disability and / or their families in the questionnaire respondents and in focus groups was very low, and therefore it is difficult to draw conclusions on how this service has impacted on their lives.

Of the very small numbers who responded to this question in the questionnaire who indicated that they had been known to the criminal justice system, most of these confirmed they got help to understand the process and to manage their behaviours. There was also very positive feedback from a focus group in the Southern Trust area on the support provided to young people and adults with a learning disability.

Current policy / service development

A model for community forensic learning disability services has been established and will continue to be developed, subject to availability of additional funding. The HSCB is developing a paper to outline the current gaps in forensic learning disability services.

Identified Need

There is a need to expand community forensic learning disability services, and this requires investment of around £3.3M. The expansion of these teams would provide the support needed to discharge of some of the people still in Muckamore Hospital.

Dental Care

What did we say we would do?

We said we would improve dental care for people with a learning disability.

Community Dental Service to undertake an annual oral health assessment for each learning disability client and produce an individual oral health plan, referring as appropriate for care (*Action 55 – Department of Health*)

Community Dental Service to provide training / training materials for staff in day care facilities re significance of oral health issues (*Action 56 – Department of Health*)

What did we do?

Annual dental checks for people with a learning disability were offered and in conjunction with other access to services oral health needs were addressed and preventative measures implemented.

Regular training is being provided for staff as and when required.

Did it make things better for people with a Learning Disability and their families?

In 2014/15, more than 6,500 people with a learning disability participated in Oral Health Promotion and Improvement programmes in the North of Ireland (this figure only includes those attending Trust Community Dental Teams and does not include those attending private dental practices).

Feedback from people with a learning disability and their families on dental services was in the main very positive. 96% of people with a learning disability and 87% of carers of people with a learning disability indicated that they attended the dentist annually. Most found this to be a very positive experience.

> *The dental team members all provide an excellent service. They have an excellent approach towards people with Disability and actively promote flexible options to promoting excellent dental care*

There were very few negative comments on dental services.

Current policy / service developments

Annual dental checks will continue to be offered to people with a learning disability and efforts to maximise participation to encourage access to dental services and the maintenance and promotion of good oral health will continue.

A current priority is to enable timely access to services when urgent or emergency situations arise.

<u>Hospital Experience</u>

What did we say we would do?

We said we would improve hospital experience for people with a learning disability.

Improve the experience of people with a Learning Disability using acute general hospitals based on the GAIN Guidelines ‘Caring for people with a learning disability in general hospital settings’ (*Action 57 – Department of Health*)

Implement a regional bed management protocol for those with a learning disability (*Action 58 – Department of Health*)

What did we do?

The GAIN Guidelines "Caring for people with a learning disability in general hospital settings" was issued in 2010 which set out 12 best practice statements related to such things as; education and training of staff who work in general hospitals, providing respectful and dignified care, the legal context when working with people with learning disabilities, effective communication and the provision of appropriate information.

RQIA completed a review of the implementation of the GAIN Guidelines in Dec 2014. https://www.rqia.org.uk/RQIA/files/69/6992f0a9-b602-4832-ace7-e505d6dc1125.pdf

This review made 19 recommendations for improvement, including the need for a regional hospital passport, that all staff understand the legal requirements related to reasonable adjustments, that at key points of access (for example, on arrival at the emergency department and/or on admission to a ward) staff are prompted to ask whether an individual has a learning disability, that Commissioners and HSC trusts should assess and consider the benefit of investing in the appointment of acute liaison nurses to support people with learning disabilities using their general hospital services and that all HSC trusts should establish appropriate, accessible mechanisms whereby people with a learning disability and their families and carers are able to comment (positively and negatively), on their experience of care, when using general hospital settings.

The HSC Board also completed a learning disability bed management protocol to govern how beds are allocated in the event of a bed shortage, which is a rare occurrence in the learning disability sector.

Did it make things better for people with a Learning Disability and their families?

Following engagement with people with a learning disability, carers and other stakeholders, it was agreed that the recommendations adequately captured the key priority areas that needed to be addressed, to ensure that hospital care for people with learning disabilities was of the highest possible standard.

83 people with a learning disability and 109 carers confirmed that they had had a hospital admission in the last 4 years. There was generally a high degree of satisfaction with hospital experience.

In some areas, the use of 'hospital passports' were used – a document which summarises the individual's condition / disability, their medical history, anxieties, likes / dislikes etc. A number of people commented on how useful this document was in helping staff to understand the needs of the individual. This was not promoted in all areas.

Above and beyond in care and compassion. Some staff demonstrate better knowledge and understanding of LD

Son attended A and E and after 6 hours hadn't been seen- only seen after I complained. Son distressed about wait, not being in own bed and whether he was getting better.

Most negative experiences shared about the experience of people with a learning disability occurred in Emergency Departments. This is a stressful environment generally for people with a learning disability, and many carers felt there is a need to 'fast-track' people with a learning disability so as to minimum their anxiety and ensure they are not kept waiting in noisy, busy waiting rooms for hours.

Current policy / service developments

Following an RQIA review of the care of people with a learning disability in acute hospitals in 2014, the HSCB and PHA are implementing the findings. A forum has been established to prioritise and take forward this work. Key activities undertaken to date include a scoping exercise across HSC Trusts to establish progress against the recommendations within the GAIN Guidelines and the development of a draft Regional Hospital Passport.

The Rapid Assessment Intervention Diagnosis (RAID) service in Emergency Departments is being piloted in the Northern HSC Trust, and has been very successful. Funding is due to come to an end March 2017. The other four HSC Trusts are keen to take this forward, subject to funding.

Research

What did we say we would do?

We said research would be carried out to improve services in priority areas.

Complete research into priorities highlighted by Bamford rapid reviews (*Action 41 – Department of Health)*

What did we do?

The Bamford Review identified a considerable number of areas of research need. The Review's recommendations for research were further developed in the Bamford Action Plan.

HSC Research & Development commissioned and published (30 November 2011) a series of Rapid Reviews in each of the agreed priority areas of: Children and Young People; Primary Care; Patient outcomes; Advancing Psychological Therapies; Intellectual Disability; Personality Disorders. These reviews aimed to: consider the available literature; identify policy implications; examine specified sub-themes; and determine the key research questions to inform the current call. The Rapid Reviews also provide immediate outputs for use by policy-makers, practitioners and commissioners. Bamford Rapid Review Summary

The Rapid Reviews were peer reviewed by an external panel of international experts who then identified eight priority research questions which formed the call for research within a Northern Ireland Context in the fields of intellectual disability and mental health.

5 research projects were selected and funded under Bamford to address questions highlighted in the Rapid Reviews carried out previously, as follows. The cost of these 5 research projects was £1.44M:

Study Title	Status	Dates	End Date
A natural experiment investigating differences in how residential facilities support people with intellectual disabilities with challenging behaviour and/or mental health problems	Active	2013-2016	April 2016
Effective family support models during the transition of adults with intellectual disabilities (ID) into old age	Active	2013-2016	June 2016
Transitions & outcomes for care leavers with mental health and/or intellectual disabilities	Active	2013-2016	Complete
Parental Alcohol Use and Resilience in Young People in Northern Ireland: A study of Family, Peer & School Processes	Research Complete	2013-2016	Complete
Improving pathways and care for young people in NI with mental health problems in the transition from CAMHS to adult services (IMPACT)	Active	2013-2016	November 2016

Did it make things better for people with a learning disability and their families?

It is difficult to measure the impact of research projects on people and their families. The research is used and will continue to be used to inform policy and service development to improve services available to people with mental health problems or a learning disability.

Current policy / service developments

A number of the research studies are still to report and will be used to inform policy and service development.

Buildings

What did we say we would do?

We said we would monitor the capital programme to ensure services would be provided in appropriate and fit for purpose buildings.

Monitor / review departmental capital budget (*Action 40 – Department of Health*)

What did we do?

We have invested almost £6.7M in learning disability facilities since 2011. Key developments include the development of the Dorsey Learning Disability Assessment and Treatment Unit at Bluestone hospital in Craigavon, and extensions and improvement works to a number of Day Centres.

Did it make things better for people with a learning disability and their families?

There has been some improvement to a number of facilities for people with a learning disability, mainly through the extension and modernisation of Day Centres. The development of the Dorsey Unit was essential to enable the closure of the Longstone hospital in Armagh.

However, it is recognised that a number of adult centres / day centres are in need of modernisation.

Current policy / service developments

There is an identified need for replacement facilities for Oakridge and Crossmaglen Social Education Centres in the Southern HSC Trust area, and a number of other Trusts have proposals for the modernisation of buildings-based Day Care Services. Any further developments are subject to availability of capital.

Identified Needs

To continue to modernise day centres / Social Education centres in line with capital budget.

EDUCATION SERVICES

What did we say we would do?

We said we would improve the transition from school to post-school.

Improve transitions planning for all children with statement of special educational needs (*Action 52 – Department of Education / Department of Health*)

What did we do?

The Education Authority (EA) has a well-embedded statutory transition planning process in all schools, and continues to support education transition co-ordinators across the Authority.

In line with legislation and the SEN Code of Practice, the young person, as appropriate, and their parents/carers are actively involved in the Education Transition process, and a Transition Plan must be prepared and maintained for all statemented pupils from age 14.

For those young people with SEN who do not have a statement, but who are nevertheless likely to require some support if they go on to further or higher education or training, schools should provide appropriate help and guidance. In some cases, schools may wish to prepare their own Transition Plans for such pupils.

Did it make things better for people with a Learning Disability and their families?

The EA reports that it has received positive evidence from previous questionnaires about the experiences of young people and their parents/carers during the education transition process.

The ETI Transitions report highlights that the majority of parents are content with the current transition arrangements and the efforts of schools to ensure that post-school placement is secured at an early stage and is appropriate. Although, it also reported that a small minority of parents of pupils with complex needs are concerned about the lack of post-school provision for their children transferring to adult health and social services provision.

There are, however, some good collaboration and working practices between the EA and HSCTs, particularly where the Trusts have Transition Co-ordinators. Consultation meetings between the EA and Health Transition Co-ordinators make provision for parent(s) / carer(s) to be introduced to the Health Transition Team in order for them to decide whether or not they wish to avail of their service. The EA Transition Co-ordinators will then work closely with Health Transition Team and DfE Careers Service in planning an appropriate transition from school to adult life. The Children with Disabilities Transition Planning Co-ordinator will continue to be involved with the young person up to the age of 25. Provision is made to handover to Adult Social Services, where appropriate, after their 18th birthday.

While the issue of transitions planning was not addressed specifically through the learning disability questionnaires and focus groups, there was some feedback indicating some difficulties with the transitions process. This was linked to limited post-school opportunities and delays in confirming placements at these and Day Centres, rather than the Transitions process per se.

Current policy / service development

The EA's Education Transition Service is taking actions to improve the education transition process on foot of the recommendations in an Education and Training Inspectorate's (ETI) report on transitions. This includes sharing of best practice across the EA and independent travel training. The EA is also represented on the HSCTs' project teams, established to develop and plan DoH's Regional Model for Day Opportunities.

DE is making good progress, in consultation with the EA and other relevant Departments, on revisions to the SEN Code of Practice that aim to provide improved information and guidance on the transition planning process.

DE is also working with the EA to progress the education actions in the cross-departmental Post-19 Transitions Action Plan and will liaise with other Departments as necessary.

The issue of post-school opportunities for people with learning disabilities was discussed by the Inter-Ministerial Group on Mental Health and Learning Disability. This has resulted in the establishment of a cross-Departmental working group who have developed an action plan to address the gaps in service provision. This is being taken forward on a cross-Departmental basis, led by Department for the Economy (previously DEL).

Arising from the post-19 Transitions Action Plan (see below under Post School Opportunities), DE will undertake a cross-Departmental data collection/analysis regarding the experiences of young people and their parents/carers during the transition process when moving from school to adult services.

POST SCHOOL OPPORTUNITIES

What did we say we would do?

The Bamford Action Plan 2012-15 committed that we would enhance the provision of day opportunities for people with a learning disability.

Enhance provision of person-centred day opportunities (including employment provision) for people with a learning disability that facilitates integration into the community (*Action 50 – Department of Health / Department for Communities*)

What did we do?

The HSC Board published a Regional Day Opportunities Model in April 2014. In essence, the Day Opportunities Model aims to move towards a model where people with a learning disability are encouraged to participate in day opportunities such as employment, training and further education and sports and recreational activities, which will fulfil their potential. A Regional Implementation Team and Local Implementation teams in each Trust are in place. The HSC Board is working closely with the Departments of Health, Agriculture and Communities and with local Councils to take the model forward.

All HSC Trusts are progressing well, but the lack of recurrent monies has not enabled them to invest in the development of services. Full implementation is dependent on additional resources of an estimated £1.5M recurrently.

The issue of post-school opportunities for people with learning disabilities was discussed by the Inter-Ministerial Group on Mental Health and Learning Disability. This has resulted in the establishment of a cross-Departmental working group who have developed an action plan to address the gaps in service provision. This is being taken forward on a cross-Departmental basis, and was previously led by Department for Employment and Learning. A decision on which Department will now lead on this work – Department for Communities or Department for the Economy – has not yet been reached.

Did it make things better for people with a Learning Disability and their families?

The implementation of the Day Opportunities Model has not yet been completed, and therefore we can only reflect on where we are at present.

It is difficult to measure the number of people who have moved from traditional Day Centres to accessing Day Opportunities, as some people are accessing more than one Day Opportunity, and others are attending Day Centres some days and accessing Day Opportunities on other days. In addition, data collection methods vary from Trust to Trust.

Figures provided by the HSC Trusts in October 2016 indicate that over 2,500 Day Opportunities are now being provided across the Region.

Experiences of people with a Learning Disability and their carers are varied. Some conclusions from the engagement with them are summarised below*:*

- Most people are in favour of the move towards Day Opportunities as a means of providing people with a learning disability with meaningful jobs, training and activities and providing social opportunities;
- 92% of people responding to the carer's questionnaire indicated that the person they care for takes part on some form of day opportunity, with the majority being involved in more than one activity.
- There is concern about the move away from Day Centres, and how this impacts on people who have been there for many years, or on those people who are not 'ready' to move to Day Opportunities and require development of skills to prepare them to do that. Carers are also concerned about the individual losing their place at the Day Centre if the Day Opportunities fall through, and the impact on both the person with a learning disability and them as carers;
- There are not enough Day Opportunities in terms of training / education and employment opportunities – there needs to be investment in the development of these, including more social enterprises and more further education courses for people with a learning disability. These points have been covered under Employment and Training and Higher Education under Theme 2;
- A big concern for carers in the short-term and part-time nature of Day Opportunities, which creates additional pressure on them in their caring role;
- Information on day opportunities is difficult to access and 3rd sector bodies such as Positive Futures appear to have important role in the provision of information;
- Some concern expressed about transport provision particularly in rural areas and a reliance on parents to provide transport was reported in many instances;
- There is a lack of social activities in the evenings and a reliance on parents to organise social activities; and
- There is a general feeling that opportunities vary across the region and that there is sometimes a lack of appropriate and varied opportunities.

Positive experience, more choices and more independence

Too much emphasis on independence even when this is not appropriate- need opportunities tailored to individuals

Current policy / service developments

The Regional Day Opportunities Model for Learning Disability is aimed at improving the availability of activities across all Trust areas, in a fair and equitable manner. The full roll out of this model is a key priority. Dependent on additional resources for the 2015-18 investment plan; it is envisaged that the whole programme of change, may take three to five years to complete.

An additional £810k was also allocated to learning disability services as part of the June Monitoring process, which deals with in-year budget reallocations. This will be used to specifically target day opportunities and transitions from child to adult services.

The successful move towards a Day Opportunities Model depends greatly on the development of more employment, further /higher education and training, leisure opportunities and the provision of transport for people with a learning disability, all of which fall outside of the remit of DoH. Investment is needed to increase opportunities for people with a learning disability, and this needs to be reflected in the new PfG.

Identified Needs

There needs to be investment in the development of more employment, further /higher education and training and leisure opportunities for people with a learning disability to enable them to move away from traditional Day Centre-based provision and towards Day Opportunities which will fulfil their potential. This needs to be reflected in the new PfG.

BENEFITS

What did we say we would do?

We said we would gain an insight into people with a disability and the impact of disability benefits to inform policy development, implement a strategy to increase the uptake of benefits and that we would work in partnership to share information and seek input on Universal Credit.

To carry out a qualitative research study into our customers who have a disability to allow us to obtain an insight into the thoughts and behaviours of this specific group of customers (*Action 43 – Department for Communities*)

To develop and implement a strategy for increasing the uptake of benefits (*Action 44 – Department for Communities*)

To work in partnership with organisations and government departments which are impacted by Universal Credit (*Action 45 – Department for Communities*)

What did we do?

A research study into clients with disabilities was completed by the then Department for Social Development (DSD) in December 2013 (responsibility transferred to the new Department for Communities in May 2016).

https://www.communities-ni.gov.uk/sites/default/files/dla-and-aa-the-impact-of-the-benefits-and-an-exploration-of-dla-and-work.pdf

In terms of increasing the uptake of benefits, a 3 year plan for improving the uptake of benefits - was launched by the DSD Minister on 3 July 2013.

Various governance structures have been established to include all organisations impacted by Universal Credit in the development of customer journeys, planning and communications. There is also ongoing consultation between relevant Departments to define eligibility for other benefits that are available to those in receipt of Social Security benefit, for example, free school meals. These are known as ‘passported’ benefits. Work is on-going but has been delayed due to uncertainty around the Welfare Reform Bill.

Did it make things better for people with a Learning Disability and their families?

The Research study has:

- Contributed to a greater understanding of the use and impact of disability benefits;
- Increased the understanding of the difference made to people’s lives by receipt of disability benefits;
- Informed and supported the development of policy and strategy relating to disabled customers.

Maximising Incomes and Outcomes - a 3 year plan for improving the uptake of benefits:

A 3 year plan “Maximising Incomes & Outcomes” commenced in 2013. Results are available for years 1 & 2. The final year’s results will be published in Autumn 2016.

Key findings:

- In 2013, Department for Social Development set a three year target to ensure that £30million in additional benefits is claimed by March 2016. This has already been exceeded with £30.1million being claimed by 8,968 people since the programme began in 2013;
- The Department’s Benefit Uptake Programme in 2014/15 saw 4,702 people gain £15.9million in new and additional benefits.;
- Since 2005, benefit uptake work has generated over £96million in additional income for people in Northern Ireland;
- In 14/15, the average additional amount of benefit received by people benefiting from the uptake campaign is £65 per week;

- For every £1 invested in the plan by the Department, £12 was generated in return; and

- The Department for Social Development remains committed to ensuring that everyone in Northern Ireland receives the benefits to which they are entitled; once the new Department for Communities Minister is appointed a new 3 year plan “Supporting People – Maximising Income through the Uptake of Benefits” will be submitted for approval.

Working in partnership to share information and seek input on Universal Credit.

- All impacted organisations attend various Universal Credit governance e.g. Programme Board, Steering Groups, Checkpoint meetings etc;

- Impacted organisations are also involved in the development of customer journeys, migration planning, staff communications etc and are embedded into the programme team working in the Design Centre.

Some of the experiences of the people with a learning disability and their carers who engaged in the questionnaires and focus groups are reflected below:

- Some concern about engaging in paid employment due to the potential negative impact on benefits;
- Frustration about benefits reassessments when people have a lifelong condition;
- 45% of carers reported that they were in receipt of Carer’s Allowance. Those who were not had not applied or considered that they would not be entitled; and
- A low number of carers reported having had a benefit entitlement check (25%). Those who had not commonly reported that they were either unaware that they could have such a check, were not sure how to go about this, did not require it, or considered that they would not be entitled to anything more.

Not sure how to access this

Never have, I’m a parent not a carer.

Current policy / service development

The Department for Communities remains committed to ensuring that every individual and household in Northern Ireland receives all the benefits, supports and services to which they are entitled. In September 2016, Communities Minister Paul Givan officially launched the Department’s new 3 year plan entitled “Supporting People – Maximising Income through the Uptake of Benefits”. Under the new plan, the Department aims to target a minimum of 100,000 people with the offer of a full Benefit Entitlement Check and secure at least £40 million in additional benefits by 2019.

The SSA is working with other Departments who are likely to be impacted by the introduction of Universal Credit e.g. developing new eligibility criteria for passported benefits.

Identified Needs

SSA to consider if improvements can be made to the benefits process for people with a learning disability to avoid unnecessary reassessments for people with a lifelong condition

CONCLUSIONS

Generally, the evaluation found that the actions within the Bamford Action Plan are largely complete, and that life is better for many people with a learning disability as a result of implementing the Bamford Action Plan 2012-15.

The Evaluation found that there had been many achievements in terms of the resettlement of the majority of people living in long-stay hospitals into the community, improved physical healthcare and dental services, the commencement of the shift towards a Day Opportunities model, more short breaks / respite for carers, improved participation in sport and the introduction of new Special Educational Needs legislation.

LEARNING DISABILITY SERVICES: KEY ACHIEVEMENTS

Health & Social Care Services

- Improved physical healthcare for people with a learning disability. 95% of GP practices are now offering annual health checks to people with a learning disability under the Directed Enhanced Service. The number of annual health checks completed in 2015/16 was just over 6,000 in 2015/16;
- Learning Disability Crisis Response Services are in place in each Trust to provide short term assessment, support and treatment for individuals and their families so as to avoid admission to hospital where possible;
- The uptake of Self-Directed Support and Direct Payments by people with a learning disability has increased and work continues to remove barriers and promote SDS;
- Support for children with challenging behaviours has been enhanced;
- A revised Service Framework for learning disability services was published in January 2015, setting out standard of care that services users and their carers can expect;
- Expenditure on learning disability health and social care services has increased from £228M in 2009/10 to £276M in 2014/15, with 88% of expenditure now on community-based services;
- Measures to improve nursing practice for people with a learning disability have been taken through the Strengthening the Commitment Action Plan, and experiences from people with a learning disability indicate that most people have a positive experience with nursing staff;
- There are improved dental services, and in 2014/15, more than 6,500 people with a learning disability participated in Oral Health Promotion and Improvement programmes;
- The GAIN guidelines "Caring for people with a learning disability in general hospital settings" are being implemented, and the majority of people we engaged with had positive hospital experiences, apart from in Emergency Departments.
- We have invested almost £6.7M in learning disability facilities since 2011. Key developments include the development of the Dorsey Learning Disability Assessment and Treatment Unit at Bluestone hospital in Craigavon, and extensions and improvement works to a number of Day Centres.

Resettlement / Housing

- The majority of the 347 long-stay hospital patients have been resettled into the community. 25 patients remain to be resettled. Evidence indicates that the quality of life for the resettled people has much improved.

Support for Carers

- The uptake of Self-Directed Support and Direct Payments by people with a learning disability has increased and work continues to remove barriers and promote SDS;
- More short breaks / respite are being provided, and there is an increase in the completion of carer's assessments, to support carers in their caring role;
- £2M has been secured to provide services to meet the needs of people with a learning disability living with older carers who can no longer care for them or to manage crisis situations, including domiciliary care, respite, day care, supported living/nursing/residential placements;
- Training has been provided to key staff in future planning for older carers.

Education

- New legislation the Special Educational Needs and Disability (SEND) Act received Royal Assent on 23 March 2016;
- The Education Authority (EA) has a well-embedded statutory transition planning process in all schools, which continues to support education transition co-ordination across the Authority;
- There are improved services and training to help schools to manage challenging behaviour.

Post –School Opportunities

- The implementation of the HSC Board's Day Opportunities Model (2014) has commenced, with the aim of ensuring people with a learning disability can participate in meaningful day opportunities which will fulfil their potential such as employment, training and further education and sports and recreational activities;
- A number of initiatives are ongoing to increase the participation of people with disabilities in further and higher education and training. However, there is limited information on the numbers of people with a learning disability accessing these programmes or the outcomes of participation;
- Around 600 people with a learning disability have been supported through a range of DfC sponsored employment support programmes.

Sport and Leisure

- Sport opportunities for people with a learning disability are being provided through the Special Olympics programme with over 1,500 participants and 1,300 active coaches.

Transport

- There is better information available for people with a learning disability on using public transport through the revised Travel Safe Guide;
- Over 500 drivers within Translink and Community Transport have been trained in meeting the needs of people with disabilities.

Benefits

- Research into benefits has informed and supported the development of policy and strategy relating to disabled customers and measures to increase the uptake of benefits have resulted in a substantial increase.

Whilst much has been achieved in the development of learning disability services, the Evaluation found that significant gaps remain in services to support people with a learning disability to live full and independent lives in the community.

LEARNING DISABILITY SERVICES: IDENTIFIED NEEDS

Health & Social Care Services

- Need to improve transitions from children's health & social care learning disability services to adult services;
- Need to enhance Community Learning Disability Teams and infrastructure, including crisis and forensic support in the community, to meet growing demand and complexity of needs;
- Need to improve the experience of people with a learning disability in Emergency Departments;
- Capital investment is required to modernise a number of adult centres / day centres;
- Need to improve information on and signposting to support services to people with a learning disability and their families, recognising that many older carers in particular do not have access to technology;
- Need for a formal mechanism for people with a learning disability and families/ carers to engage with HSC Trusts, so that ideas and experiences can be shared and inform the design and delivery of service development;
- Develop further the role of 3rd sector organisations in providing support and information to people with a LD and their families.

Resettlement / Housing

- Need to complete the resettlement programme, to include those people whose discharge from hospital has been delayed since the resettlement programme began;
- Need to address the housing needs of the learning disability population provide more choice for those living in their family home who want to become more independent but remain close to support networks. Particular need in this area has been identified for people with a learning disability living with older parents / carers;
- Need for strategic needs assessment of supported living, improved commissioning arrangements and better regulation, as recognised in the Review of Supporting People.

Support for Carers

- Need for further investment in short breaks / respite and the promotion of carer's assessments and Self-Direct Support to help support carers to continue in their caring role to meet increasing demand;
- Need for provide better information and support, including better future planning to proactively address the needs of people with a learning disability who are living in the family home with older carers, in particular housing needs and support during a crisis.

Education

- Need for better forward planning of transitions from school and more options for young people with a learning disability leaving school.

Post –School Opportunities

- Continue the roll-out of the Regional Day Opportunities Model and manage the shift to this new model carefully, respecting the difficulties that the change may cause for people who have attended a day centre for many years. The short-term and part-time nature of many Day Opportunities is an issue, and impacts on the carer's role;
- Aligned to this, need to develop more supported employment opportunities for people with a learning disability;
- Need to review and increase Further / Higher Education and Training opportunities for people with a learning disability and the support available to enable them to participate.

Transport

- Need to address the lack of transport, particularly in rural areas, to Further Education Colleges and other existing or potential day opportunity services;
- Need to provide training for people with a learning disability to empower them to use public transport. The cessation of the travel training scheme should be reviewed.

Benefits

- There is a need to review the frequency with which benefits are reviewed for people with life-long learning disabilities, to reduce unnecessary burden of form-filling for families and carers.

WAY FORWARD

Addressing these gaps will require a coordinated response from the Executive. It is imperative that people with a learning disability are at the very centre of developing that response and in particular service planning and delivery going forward.

For health and social care services, the Bamford principles are now embedded in policy and in service delivery and future service development. Improvements in learning disability health and social care services will continue the delivery of the Bamford Vision, and necessarily will be prioritised in line with resource availability.

Within health and social care, we see the need to improve the transitioning process from children's to adult learning disability services and support for carers, in particular older carers, as our immediate priorities going forward. Related to these are the continued implementation of the Regional Day Opportunities model, the development of short breaks provision and the enhancement of community learning disability teams to better manage and support the increasing numbers and the needs of people with learning disabilities coming through requiring health and social care services. We also need to consider provision for those whose discharge is delayed from hospital as well as the further development of crisis support to work with those now being supported in the community and avoid re-admissions to hospital. Gaps in community forensic services also need to be addressed.

Addressing these gaps will take time and further investment. It will also require us to prioritise and reform to make sure we are making the best use of our existing resources. We will therefore consider together with people with learning disabilities and their carers the development of a new service model for learning disability that will focus on:

1. Providing more choice for people with learning disabilities and more say in their care;
2. Providing more person centred care in the community, with support from multi-disciplinary teams;
3. Providing more innovative services to give people a range of care options that meet their individual needs, with self-directed support;
4. Providing early and more intensive support for those who need it so that people can stay in their community close to home; and
5. For those who need in-patient care, ensuring it is only for as long as they need it.

The aim of this new model would be to ensure that we have the right health and social care services in place to secure better outcomes for people with a learning disability. This will of course depend to a significant extent on other key gaps identified in the evaluation around housing, employment, higher/further educations and transport being addressed.

In terms of the services which fall outside the remit of Department of Health, the actions committed to have largely been completed and we have seen mainstreaming of programme of support for people with a learning disability, to a greater or lesser degree, in services like employment services, further education and training, education, sports and leisure, transport and benefits.

The evaluation found that in some cases the onus for the development of wider services is still on Department of Health. This is particularly evident in the implementation of the Day Opportunities Model, the success of which will depend on the creation of more employment opportunities, appropriate and varied further education / training opportunities for people with a learning disability, leisure opportunities and the provision of suitable transport. While there is good collaborative working between Department currently, roll-out of the Regional Day Opportunities Model very much depends on the availability of resources within health & social care.

A core principle underpinning Bamford is that we should move to a more social model to meet the needs of people with a learning disability, and away from a model based on healthcare where there is a risk of pathologising disability. The evaluation recommends that these gaps should continue to be developed by the Executive Departments with responsibility for them, working together collaboratively within the context of the new Programme for Government.

It is recommended that the new population health and outcome-focused Programme for Government is the appropriate mechanism for taking forward priority service developments and addressing deficits in services.

These will require collaborative working across a number of Departments under the auspices of the Programme for Government. The evaluation therefore recommends that specific actions to address these gaps are considered under the appropriate indicators in the forthcoming Programme for Government.

Instrumental to this will be the delivery of Indicator 42 within the draft Programme for Goverment which is ‘Improving the Quality of Life for People with Disabilities and their Families’. Responsibility for Indicator 42 falls to DfC. Delivery Plans for each indicator within PfG will issue in October 2016 for public consultation. In addition to the broader consultation, DfC will consult specifically with the Disability sector and people with disabilities on Indicator 42.

DfC will use co-design, co-implementation and co-delivery to take forward PfG Indicator 42, and will work with other Departments to ensure a co-ordinated and integrated approach.

Some of the emerging themes in the draft Indicator 42 Delivery Plan are:
- Raising awareness and changing attitudes towards disability.
- Addressing the needs of children and young people including improving transition.
- Enhancing opportunities for employment and/or lifelong learning.
- Improving independent living and the provision of suitable homes.
- Improving participation in public and community life.
- Improving access to information and better data collection.

It is reassuring to see that the emerging themes very much mirror the gaps in services the identified through this evaluation process.

In conclusion, much has been done to improve learning disability services in the North of Ireland. There is however much more to do, as identified in this evaluation report. It will take time, extra resource and prioritisation but there is a commitment to improving the lives of people with a learning disability here and we look forward to seeing a clear reflection of this in the new Programme for Government.

BIBLIOGRAPHY

(TO BE COMPLETED)

ANNEX B

EVALUATION OF THE BAMFORD ACTION PLAN 2012-15

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INTRODUCTION

Within the Bamford Action Plan 2012-15, there are 26 mental health actions and 34 joint mental health / learning disability actions, under the following 5 themes:

- Promoting positive health, wellbeing and early intervention
- Supporting people to lead independent lives
- Supporting carers and families
- Providing better services to meet individual needs
- Developing structures and a legislative framework

This report contains the detailed findings of the mental health and relevant joint actions under the themes 1-4. Evaluation of theme 5 is covered in Annex C and in the main evaluation report.

KEY FINDINGS

THEME 1: Promoting Positive Health, Wellbeing and Early Intervention

The Bamford Action Plan 2012-15 contains a number of commitments in relation to promoting positive health, wellbeing and early intervention for people with mental health issues.

Mental Health & Wellbeing

What did we say we would do?

We said we would promote better mental wellbeing through the publication and implementation of a Promoting Mental Health Strategy.

Publish and Implement a revised cross-sectoral Promoting Mental Health Strategy (*Action 1 – Department of Health*)

What did we do?

In 2014, the Department of Health published a Public Health Strategic Framework ‘Making Life Better’. Following this, so as to avoid duplication, a decision was made to progress mental health promotion through an action plan under ‘Making Life Better’ rather than as a separate strategy. This promoting mental health action plan is under development and will issue under the Making Life Better Public Health Strategy in 2017.

The first update report for Making Life better was published in 2015 (https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/making-life-better-1st-progress-report-2014-15.pdf). It is too early in the Framework’s implementation to determine the impact it has had yet, but it will be subject to review and evaluation and will be refreshed in line with the new Programme for Government.

A significant programme of work has been taken forward by the PHA through the Protect Life Strategy (with investment of £7M per annum) and other initiatives to improve mental health and wellbeing, outlined below:

- funding for counselling, bereavement support, and Lifeline;
- the roll out of the Take 5 steps to wellbeing programme;
- community based promoting mental health and suicide prevention small grants schemes support initiatives in local communities;
- the delivery of training programmes to first responders, ‘community gatekeepers’ which include teachers; sports coaches; and clergy;
- such as - ‘Mood Matters’; ‘Beating the Blues’; Depression Awareness”; “Roots of Empathy”; and “Safe Talk” - which aim to improve understanding of mental health issues;
- The continued development of the “Minding Your Head” website;
- widely disseminated self help guides and educational resources;
- opportunistic use of the media; and public information campaigns including the launch of a new 3 year anti-stigma campaign titled Change Your Mind.

Mental health awareness is an important issue for other Government Departments. The Ministerial Coordination Group on Suicide Prevention has expanded its remit to cover a broader range of activities to promote positive mental health in a cross-Departmental way. Examples of activities taken forward include: DE I-Matter programme to safeguard pupil emotional health and wellbeing; DfC Neighbourhood Renewal projects that promote good mental health and wellbeing; DfC mental health awareness training for sports clubs and work with the Arts Council to develop a Young People and Wellbeing Programme; and DAERA’s support for Farm Families Health checks programme.

Did it make things better for people with mental ill health and their families?

It is difficult to measure outcomes associated with mental health promotion generally. There is however evidence of the success of some of the initiatives undertaken by the PHA.

Mental health public information campaigns are undertaken by the Public Health Agency each winter. The Fog campaign is aimed at those most at risk of attempting suicide, particularly males and those from deprived areas. The secondary target audience for the Fog is anyone who may be contemplating suicide or self-harm. The Boxer campaign is aimed at the general public in the North of Ireland, in particular those who are most at risk of suicide or self-harm i.e. males and those from deprived areas.

Information from the Public Health Agency indicates that amongst those who had seen either advertising campaign 35% were encouraged to think about their mental health, 24% would discuss a mental health issue with someone they trust and 44% would do nothing. Overall, 57% were encouraged to do something to promote their mental health and/or emotional wellbeing.

There has been extensive awareness raising of the Lifeline service. In 2016, public awareness of a crisis helpline to call if in distress or despair was the highest recorded at 73%. This is a significant increase from 56% when the service first launched in 2008. Over 700,000 people have contacted the Lifeline helpline since its inception. Around 1,700 clients are engaged with Lifeline services each month.

In 2015/16, 78% of clients who commenced packages of Lifeline counselling were moderately to severely distressed. At the end of counselling 68% were recorded as being healthy or having low to mild levels of distress. 70% of clients reported an improvement in the level of distress experienced following Lifeline counselling. (Source: PHA)

In the Western Trust area, a pilot community-based service known as the Self-Harm Interagency Network (SHINE) addressed the issue of self-harm. SHINE has proved to be an effective community based self-harm intervention integrated into the referral pathways of statutory services. 83% of referrals take up counselling and 84% achieved a significant improvement in wellbeing. The new Self-harm Intervention Programme builds on this success delivering a similar service across the North of Ireland. (Source: SHINE evaluation).

Current policy / service development

A promoting mental health action plan is under development and will issue under the Making Life Better Public Health Strategy in 2017.

Suicide Prevention

What did we say we would do?

We said we would take forward the next phase of the suicide prevention strategy to reduce suicide rates.

Progress the next phase of the suicide prevention strategy (Action 6)

What did we do?

A wide range of suicide prevention services are now in place in Northern Ireland to help identify and support people who are in distress. These include bereavement support, Lifeline, community-based counselling, access to psychological therapies, mental health services, suicide awareness and intervention training, addiction service, self-harm prevention services, and public information campaigns.

There have also been significant new developments over the past year:

- Consultation on a new model for the Lifeline service;
- Self-harm Registry annual reports have helped to inform policy and service delivery. The World Health Organisation has commended the Self-harm Registry as a model of best practice.
- The Self-harm Intervention programme is being delivered by voluntary and community organisations in each of the five HSC Trust areas

- The sudden death notification system, the SD1 process, has been refined to provide virtually real time information on suspected deaths by suicide. This helps to identify emerging clusters of suicide and ensure prompt support for bereaved families. Other jurisdictions have expressed an interest in establishing a similar notification system such as the SD1 system currently in place in the North of Ireland.
- The four larger Christian churches are providing suicide prevention training to clergy and church members under the Flourish programme; and
- Cross government work continues led by the Ministerial coordination group on suicide prevention.

An evaluation of the Protect Life strategy was published in October 2012, and recommended the following:

- Need to build a strong collaborative approach to the continued development and delivery of Protect Life;
- Oversight and implementation structures should build in arrangements for ensuring representation from primary care and secondary care and greater partnership working with these sectors;
- Need to maintain an effective voice for families within Protect Life;
- Need for more specific focus on suicide and self-harm in Programme for Government;
- Actions to address suicide prevention should be cross-government; and
- Suicide prevention to remain a focus for North-South Ministerial Council.

Did it make things better for people with mental ill health and their families?

The suicide rate has remained stable in Northern Ireland over the last 10 years since Protect Life was launched in 2006 ((SOURCE: NISRA). The rate had increased significantly prior to 2006. While the rate is still much too high this is a positive sign against the background of increasing suicide rates in many other jurisdictions; high levels of mental health problems; high levels of deprivation; difficult economic situation and the legacy of the conflict.

Bereaved families are involved in all suicide prevention implementation bodies and their input is greatly valued. This has contributed to policy and service design and delivery. It is estimated that around six people are intensely affected by every suicide death and a further 60 people are deeply affected. On this basis, an estimated 16,500 people in the North of Ireland have been intensely affected by suicide over the 10 year period 2005-2014 and around 165,000 have been deeply affected. Given these statistics the draft Protect Life 2 Strategy has a particular focus on the needs of those who have been bereaved.

The Families Voices Forum have advocated for the wellbeing hubs model of care to be rolled out and evaluated to ensure its effectiveness in supporting GPs to deal with self-harm and suicidal ideation in a more holistic manner. The Families Voices Forum have also advocated for greater standardisation of the SD1 process across the North of Ireland.

Current policy / service development

The new draft Protect Life 2 Strategy was issued for consultation in September, with the expectation that the final strategy will be published in March 2017. Extensive pre-consultation engagement was undertaken with suicide prevention stakeholders to inform the document. The purpose of the Strategy is to reduce the suicide rate in the North of Ireland and reduce the differential in the suicide rate between deprived areas and the least deprived areas.

There are 10 key objectives:

- Fewer people who are in contact with mental health services, die by suicide;
- Reduce the incidence of repeat self-harm presentation to hospital emergency departments;
- Improve the understanding and identification of suicidal and self-harming behaviour, awareness of self-harm and suicide prevention services, and the uptake of these services by people who need them;
- Enhance the initial response to, and care and recovery of people who are experiencing suicidal behaviour and to those who self-harm;
- Restrict access to the means of suicide, particularly for people known to be self-harming or vulnerable to suicidal thoughts;
- Ensure the provision of effective and timely information and support for individuals and families bereaved by suicide;
- Provide effective support for “self care” in voluntary, community, and statutory sector staff providing suicide prevention services;
- Enhance responsible media reporting on suicide;
- Identify emerging suicide clusters and act promptly to reduce the risk of further associated suicides in the community; and
- Strengthen the local evidence base on suicide patterns, trends and risks, and on effective interventions to prevent suicide and self-harm.

A 3 day Future Search event was held in September 2016 to consider improvements to suicide prevention in the Belfast area where rates are highest. A new anti stigma campaign is also being aired to tackle this barrier which often prevents help seeking behaviour.

Drugs and Alcohol Services

What did we say we would do?

We said we would improve Drugs and Alcohol services through the implementation of the NEW Strategic Direction for Alcohol and Drugs strategy.

Develop and implement New Strategic Direction on Drugs and Alcohol Phase 2, and Strategy Evaluation (Action 7)

What did we do?

The cross-departmental strategy to reduce the harm related to substance misuse, known as the New Strategic Direction for Alcohol and Drugs (NSD) Phase 2, was launched in 2012. NSD Phase 2 sets out outcomes across five main areas: prevention and early intervention; harm reduction; treatment and support; law and criminal justice; and monitoring, evaluation and research. The Department allocates approximately £8 million each year to its implementation, and a further £8 million is invested each year through the mental health budget for the provision of treatment services.

Good progress has been made on the delivery of NSD. The main developments to date include:

- a review of alcohol and drug services, with new services (including education and prevention, early intervention, harm reduction, and treatment and support) in place from July 2015 and revised care pathways are now available;
- legislation banning the sale, supply and import/export of Psychoactive Substances has been enacted;
- following a review of Tier 4 (inpatient) services, a new regional network model has been put in place and is being embedded across the HSC Trusts, in partnership with the appropriate independent sector providers;
- a prescription drug misuse action plan is being implemented;
- legislation is in place to allow the lowering of drink-driving limits in the near future;
- Community support and awareness raising services are now in place in all HSC Trust areas;
- work has been undertaken to put in place a programme of brief interventions in primary care and secondary care with over 80,000 screenings having taken place over the last 2 years;

- a drug and alcohol monitoring and information system has been put in place to identify and provide public and targeted information on new substances or trends causing harm;

- work has been undertaken with the Department of Justice through the organised crime taskforce to reduce the supply of drugs;

- a regional "take home naloxone" scheme has been put in place to increase access to this life saving drug for those at risk of opioid overdose;

- the Needle and Syringe Exchange Scheme has been extended and now also provides foil to encourage people to smoke rather than inject certain drugs;

- eight one-stop-shops for young people have been put in place to address a range of issues, including providing diversionary activities, and information, advice and signposting in relation to substance misuse;

- a regional hidden harm action plan is being implemented to support and provide services for those children or young people living with substance misusing parents or carers;

- guidance for workplaces to put appropriate alcohol and drug policies in place has been refreshed and widely disseminated;

- work has been undertaken to improve the links between alcohol and drug services in the community and the criminal justice sector; and

- new alcohol guidelines have been published by the Chief Medical Officer.

Did it make things better for people with mental ill health and their families?

Overall, progress has been made in the implementation of the NSD Phase 2. There have been encouraging signs in relation to reductions in the levels of binge drinking and the percentage of young people who drink and get drunk. Prevalence of illegal drug misuse has largely plateaued and we are seeing more people accessing treatment and support services for alcohol and drug misuse.

However, levels of alcohol and drug related hospital admissions and deaths are still high (although both have slightly fallen in the last 2 years), and concerns remain about prescription drug misuse and the harms caused by New Psychoactive Substances. As noted above, a prescription drug misuse action plan has been developed to help address the first issue, and the Department successfully lobbied the Government at Westminster for new legislation to ban the sale, supply, manufacture and import/export of New Psychoactive Substances

The Impact Measurement Tool (IMT) – which monitors outcomes across a range of domains (alcohol and drug misuse, mental and physical health, family relationships, housing, etc) – is now a mandatory part of all services commissioned by the Public Health Agency and should in future provide a much better indication of outcomes for individual clients, services, and the Strategy.

Current policy / service development

A review of statutory Tier 3 service provision in line with the Commissioning Framework has been completed, with a view to improving consistency across NI and highlighting any gaps.

The Commissioning Framework, and the reviews of Tiers 3 and 4 addiction services, all identify and seek to put in place best practice for preventing and addressing alcohol and drug misuse – and highlight gaps that need to be addressed, either by reconfiguring services or helping to make the case for additional resources.

We are working with the Department of Justice to pilot a substance misuse court.

The NSD Phase 2 will be reviewed following its 5 years of implementation.

Suicides and Homicides by People with Mental Illness

What did we say we would do?

We said we would minimise the occurrence of suicide and homicide by people with mental illness through the implementation of the recommendations from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in Northern Ireland 2011.

Respond to the National Confidential Inquiry into Suicide and Homicide By People with Mental Illness in Northern Ireland 2011 (Action 8)

What did we do?

The annual UK-wide National Confidential Inquiry into Suicide and Homicide (NCISH) by People with Mental Illness aims to improve mental health services and to help reduce the risk of suicide or homicide by people with mental illness. NCISH collates data on all suicides and homicides nationally and produces an annual report, including a section for each of the UK jurisdictions, using clinical information on patients who had contact with specialist mental health services in the year before completing suicide or committing homicide which is sent by clinicians, including from our 5 HSC Trusts, to NCISH for analysis and identification of trends leading to evidence based recommendations to reduce patient suicide and homicide rates.

The DHSSPS also specifically commissioned a report for NI in 2011 which made 16 recommendations covering a wide range of issues including monitoring of suicide rates and causes of suicide, risk management, improvement in Child and Adolescent Mental Health

Services (CAMHS) and substance misuse services, discharge planning and follow-up care, de-stigmatisation of mental illness and the treatment of people who are mentally ill within the criminal justice system.

Following each annual NCISH report the HSCB and PHA draw up a combined action plan and work through the recommendations. Much progress has been made and work continues in all of the recommendations through the suicide prevention and drugs and alcohol services work, and the improvements to mental health services outlined later in this report, particularly in respect of risk management. This will continue through the delivery of the new Protect Life Strategy when published.

Did it make things better for people with mental ill health and their families?

The suicide rate has remained stable in the North of Ireland over the last 10 years since Protect Life was launched in 2006 ((SOURCE: NISRA). The rate had increased significantly prior to 2006. While the rate is still much too high this is a positive sign against the background of increasing suicide rates in many other jurisdictions; high levels of mental health problems; high levels of deprivation; difficult economic situation and the legacy of the conflict.

The numbers of mental health patients who commit homicides in Northern Ireland remain very low and therefore no trend analysis is available.

Current policy / service development

Work continues in all of the recommendations through the suicide prevention and drugs and alcohol services work, and the improvements to mental health services outlined later in this report, particularly in respect of risk management. This will continue through the delivery of the new Protect Life Strategy when published. The current priorities focus on addressing risk factors for males eg drugs/alcohol and poverty, improving access to psychological therapies, medicines management, involving families, ensuring the physical health care needs of people with mental health problems are met, improving discharge planning and follow-up care.

Emotional Health and Wellbeing in Schools

What did we say we would do?

We said we would promote an anti-bullying culture in schools, promote a focus on pupils' emotional health and wellbeing in schools, and provide counselling support in all post-primary schools.

Promote an anti-bullying culture within schools in partnership with the NI Anti-Bullying Forum (*Action 4 – Department of Education*)

Promote a focus on pupils' emotional health and wellbeing through a programme of awareness raising and staff capacity building for all schools (*Action 10 - Department of Education*)

Maintain access to counselling support which is independent of the school for all pupils of post primary age (*Action 11 - Department of Education*)

What did we do?

Anti-bullying

The Department of Education has taken a number of measures to tackle bullying in schools:

- It funds the Northern Ireland Anti Bullying Forum (NIABF) which aims to ensure teachers and other educators working with children and young people are equipped with the tools necessary to effectively tackle bullying amongst young people. This includes making arrangements to promote an annual Anti-Bullying Week;

- The NIABF has recently published updated guidance on cyber bullying and bullying of Looked After Children (LAC) and sits on the Safeguarding Board Northern Ireland (SBNI) safety forum; and

- The Addressing Bullying in Schools Act (NI) 2016, was passed by the Assembly and received Royal Assent in May 2016. The NIABF will now work with the Department of Education, schools and other stakeholders in the development of guidance and training to support the commencement of the new Act.

I-Matter

The DE 'i-Matter' programme (formerly known as Pupils' Emotional Health and Wellbeing (PEHAW) programme) continues to be the overarching vehicle for promoting pupils emotional health and wellbeing. The Programme addresses how the entire school community should be engaged in promoting resilient emotional health for all pupils, what support systems are available for vulnerable pupils, and what support is available to schools in the event of a crisis. The main activities delivered under the I-Matter programme are:

- A range of posters, leaflets and diary inserts have been produced for use by schools, which provide information, advice and signposting on a range of 20 subjects of concern to young people including bullying and keeping yourself safe. The materials produced to date under the Programme are widely used by schools, across the youth sector, local libraries, GP surgeries and parent organisations;

- The C2k System is used to deliver a 'message of the month' relating to emotional wellbeing. Topics have included 'being different' and 'stress and anxiety'**;**
- A Guide to Managing Critical Incidents in Schools was published in February 2014 by DE to ensure a regional approach to dealing with critical incidents, help schools be prepared for a critical incident and to ensure effective management before, during and after the event. Feedback from schools who have used the Guide to address a critical incident has been positive. The Education Authority has a Critical Incident Response

Team which provides direct support to schools during and after a critical incident. The Guide has been distributed to all grant-aided schools and available on the Department's website; https://www.education-ni.gov.uk/sites/default/files/publications/de/guide-to-managing-critical-incidents-in-schools.pdf

- **'Protecting Life in Schools: Helping Protect Against Suicide by Supporting Pupils' Emotional Health and Wellbeing'** was published in March 2016. This document has been issued to all schools and it includes a section to assist schools to understand self-harming behaviour and suicide; warning signs of potential suicidal thoughts or behaviour and possible school based strategies in order to respond to a distressed pupil and to safeguard them. Additional resources on suicide prevention and self-harm flowing from the main guidance document have also been developed for schools and parents. The guidance and resources are available on the Department's website: https://www.education-ni.gov.uk/articles/suicide-prevention-guidance

- A Self-assessment audit tool for schools has been developed to assist them in assessing their progress on promoting and supporting the emotional health and wellbeing of their pupils and comprises a series of questionnaires for staff, pupils and parents. The results of this assessment in turn informs the development of a Whole School Approach to emotional health and wellbeing, focusing on the entire school community rather than individual pupils with identified needs alone. The audit tool has been piloted with schools and feedback has been very positive about the benefit of such as resource. It is intended to upload the audit tool onto C2K for the schools to access towards the end of 2016. Once rolled out, support will be provided to schools through C2K to ensure they get the best from this resource.

- The Keeping Safe Programme being undertaken by NSPCC on behalf of the Department is a whole school preventative education programme that aims to teach every child from P1-P7 how to keep safe from all forms of bullying and abuse. The schools' pilot was launched in September 2016 and all school staff will receive a package of e-learning, face-to-face training and school-based support to teach and embed the programme in all aspects of school life. Also included is a comprehensive suite of teaching and learning resources to assist school staff. The project concludes in 2018 and will inform the Department's future strategic direction in this area; and

- The 'Optimising Achievement' Resource and limited pilot programme was developed through a partnership between the Regional Training Unit (RTU) and Barnardo's with funding from DE and the Public Health Agency. The overall objective is to ensure that the importance of pupil wellbeing is understood and given appropriate emphasis in school development planning to create a whole school approach to positive emotional health.

Independent Counselling Service for Schools (ICSS)

Counselling in schools can make an important contribution to supporting the emotional health and wellbeing of young people. There is considerable evidential and research information to confirm the position that counselling in schools supports the emotional health and wellbeing of young people. Pupils experiencing stress or emotional problems find it difficult to reach their potential. Where staff can recognise and respond appropriately to their needs, the educational outcome is maximised.

The Independent Counselling Service for Schools (ICSS), funded by the Department, has successfully been in place in the post-primary sector since 2007 and in special schools with a post-primary cohort since 2011.

The ICSS is there to provide a ‘listening ear’ and works as an integral part of a schools pastoral care system to help provide this support to pupils. This is primarily provided through the Personal Development and Mutual Understanding (Primary) and Learning for Life and Work (Post-Primary) areas of learning within the curriculum.

The support provided conforms to high professional standards and current best practice for school based counselling. All counsellors have at least a Diploma in Counselling and are experienced in working with young people.

Did it make things better for people with mental ill health and their families?

Anti-bullying

Addressing Bullying in Schools Act (NI) 2016 received Royal Assent on 12 May 2016. It is anticipated its provisions will come into effect in time for the start of the 2017-18 academic year. Any possible evaluation of its impact will therefore only be possible several years after that. As previously noted, this is clearly outside the timing of the Bamford evaluation and it is not appropriate to include this in the draft evaluation framework

I-Matter

The materials produced to date under the I-Matter Programme are widely used by schools, across the youth sector, local libraries, GP surgeries and parent organisations. Schools have advised that the diary inserts are particularly useful. The material ensures that pupils have access to contact details for organisations that can offer additional help and support to them. The Department is currently considering what additional subject matter could be added to ensure the material remains relevant for pupils.

Feedback from schools on the self-assessment audit tool has been very positive about the benefit of such a resource as it enables schools to assess their progress on promoting and supporting the emotional health and wellbeing of their pupils and identify areas for improvement.

The evaluation and additional feedback indicate that the ‘Optimising Achievement’ Resource, and suitable support, can equip schools’ leadership with the tools to begin the process of promoting pupils’ emotional health and wellbeing. However a number of issues and lines for further development around the Resource and related training have been identified.

Early feedback from school staff on the Keeping Safe Programme has been extremely positive, in particular in equipping them to incorporate the more sensitive issues linked to abuse into their teaching through the formal and informal curriculum. Whilst the pilot has a couple of years to run, these early indications are nonetheless encouraging as the impact on pupils' emotional health and wellbeing will be tangible.

Independent Counselling Service for Schools (ICSS)

As part of ICSS audit arrangements, a questionnaire was issued to schools for the 2012/13 school year. There was a 65% response rate with feedback from school staff very supportive of the service provided and 100% stating that the service has been of benefit to their pupils.

Approximately 98% of schools avail of the service with around 28,000 sessions delivered annually to approximately 5,500 pupils. An additional weekly 'Drop-in' service has been available to all mainstream post-primary schools from January 2015.

"**A Survey of Young People's Views on Accessing Counselling in Schools**", carried out by youth@clc at the Children's Law Centre in 2012, showed "*students surveyed thought the provision of counselling in schools was a necessary and important service which should continue to be available. Of those who had used it, the majority found it to be beneficial in helping them to cope with a range of issues impacting on their mental and emotional well being".*

Current policy / service development

- Anti-bullying: New Anti-Bullying Legislation has been introduced and was enacted in May 2016. In the coming months, the forum will work with the Department of Education, schools and other stakeholders in the development of guidance and training to support the implementation of the legislation;
- I-Matter: The DE 'i-Matter' programme (formerly known as Pupils' Emotional Health and Wellbeing (PEHAW) programme) will continue to be the overarching vehicle for promoting pupils emotional health and wellbeing. The Department of Education is currently considering what additional subject matter could be added to ensure the material remains relevant for pupils. The Department has been engaged with the Education Authority/RTU to explore how the Resources might be made available to all schools and to consider how emotional health and well-being can be integrated into mainstream leadership development provision. The EA is expected to submit a business case for the roll-out of the programme in the next business year;
- ICSS: The Independent Counselling Service for Schools (ICSS) will continue to operate in the post-primary sector since 2007 and in special schools with a post-primary.

Sport and Physical Recreation

What did we say we would do?

We said we would implement a 10 year strategy for Sport and Physical Recreation, to improve the opportunities for people to gain mental wellbeing benefits of participation in sport and physical recreation.

Implement a 10 year strategy for Sport and Physical Recreation (*Action 3 – Department for Communities*)

What did we do?

Sport Matters': The Northern Ireland Strategy for Sport and Physical Recreation, 2009-2019' contains 11 high level Participation targets designed to achieve improvements in sports participation rates.

Sport NI (SNI) are committed to further developing mental health and well-being within sport and a number of initiatives have been delivered as follows:

- 75 mental health awareness training sessions (with funding from Public Health Agency) to sports clubs, groups and community sport organisations in partnership with Mindwise and Aware Defeat Depression.;

- A Mental Health and Wellbeing In and Through Sport steering group was established in January 2016 to develop a strategy to encourage all sports clubs to embrace mental health and well-being;

- In November 2015, Sport NI appointed a lead officer [Dr Paul Donnelly] who is responsible for both the strategic and operational aspects associated with Mental Health and Wellbeing In and Through Sport;

- A pilot programme was conducted in the Downpatrick area with ten local sporting clubs. The programme was aimed at raising awareness of Mental Health issues, including suicide awareness, and to promote good health and wellbeing using local sporting clubs. Clubs appointed Mental Health First Aiders and then participated in Resilience training and worked with SNI to establish how to build mental health and well-being into their Clubs' strategy alongside Safeguarding and First Aid; and

- Ulster University was contracted in February 2016 to undertake a review of Mental Health and Wellbeing In and Through Sport. The aims of objectives of the research were to conduct a review of relevant policies, strategies and interventions that have used sport as a tool for promoting Mental Health and Wellbeing In and Through Sport in the North of Ireland. It is anticipated that the research report will be finalised and launched in the autumn 2016.

Did it make things better for people with mental ill health and their families?

A review of Mental Health and Well Being in Sport carried out by Sport NI in conjunction with the University of Ulster in 2015, concluded that:-

- participants in mental health and well being activities and training experienced a positive effect on their understanding and awareness of contributory factors, knowledge of conditions and attitudes towards mental health issues;
- participants experienced a positive influence on mental health and well being issues relative to the wider community;
- training delivered in a club or community context encourages group consideration of issues and a common purpose;
- Group training generated support group activity;

- Team environments encourage support mechanisms;
- Actively signposting help and support routes;
- Addressing mental health and well being issues in a sports and recreational environment offers a safe and supportive environment to step aside from the pressures of work and home stressors;
- Teenagers can access peer support in the sporting scenario;
- Those involved in organised sport and recreational activities have an increased likelihood of seeking and obtaining effective support.

Current service / policy development

DfC have identified the following recommendations to continue the development of mental health awareness through sport by:

- A need for continued roll out of training and awareness workshops in Sports Club settings;
- A need to tailor workshops for parents, teenagers and the Sports Governing Bodies;
- A need to embed mental health and well being into levels 1 & 2 Coaching Awards;
- Taking the example of Safeguarding Children and Vulnerable Adults, encourage clubs to skill and appoint Health and Well Being Officers for each Club.

Sport NI and its partners have a key role in improving Mental Health and Wellbeing and greater efforts should be made by all key stakeholders to realise this potential. On the basis of this agreed position, the following actions will be taken forward by Sport NI in the short to medium term:

- Establishing and maintaining a Mental Health and Well Being in Sport Project Board (drawn from the sports and health sectors);
- To conduct a *Review of Mental Health and Wellbeing in Sport Project (academic research piece);*
- To develop a *Mental Health and Wellbeing in Sport S*trategy/action plan for the North of Ireland; and
- To implement the actions set in the ‘Active Living- No Limits’ Disability Sport Action Plan 2016 -2021 (to be launched 15 October).

Reducing work-related stress and absenteeism

What did we say we would do?

We said we would reduce work-related stress and absenteeism by providing support to high stress risk work sectors.

Specialist health and safety inspectors and business advisors to provide advice and, where necessary, enforcement in high stress risk work sectors (*Action 9 – Department for the Economy*)

What did we do?

The Health & Safety Executive NI (HSENI) set up a Mental Well-being at Work Advisory Service(MWWAS) to carry out mental well-being/stress risk assessments for organisations and to provide advice and guidance on workplace stress at a corporate/organisational level. HSENI has worked with 71 organisations including high risk sectors such as local and central government and education. HSENI has also worked with a wide range of private industry organisations and third sector organisations. The Mental Well-being at Work Advisory Services include:-

- Facilitating stress/mental well-being risk assessments in organisations;
- Helping organisations with the analysis of their own survey;
- Facilitating organisations to carry out their own risk assessment;
- Delivering awareness seminars which provide advice, guidance and templates on how to effectively use the HSE Management Standards; and
- Attending events and delivering presentations on the use of the HSE Management Standards, in order to publicise best practice in promoting mental well-being in the workplace.

Did it make things better for people with mental ill health and their families?

An evaluation of the HSENI Mental Well-being at Work Advisory Service was carried out on the 71 organisations, with a 48% response rate. Analysis of those participating in the survey indicated that their interaction with the service had a number of benefits, which all contribute towards the agreed outcome in the Bamford Action Plan ie to reduce stress related ill-health and associated absenteeism in high stress risk work sectors and increase productivity. The survey also showed a number of other positive benefits through uptake of the service, resulting in the embedding well-being related policies such as a mental well-being action plan.

Key outcomes are summarised below:

- 97% of those participating in the survey indicated that they found the service useful;
- over 67% of the participants indicating that they found the service interaction to have made a positive impact on their business;
- 9% of participants indicated that they had already seen a direct impact on improved sickness rates and others stated that it was too early from the intervention to determine this outcome. It appears that further time for fruition is needed for a direct measure in this regard;
- 87% of participants stated that there had been some or much improvement in their understanding of stress/mental well-being;
- 48% reported improved communication as a result of the intervention; and
- 37% indicated better employee engagement.

The evaluation exercise has also shown the importance of how increased stress prevention awareness has helped reduce stress related ill-health and associated absenteeism in high stress risk work sectors, and in doing this, has allowed organisations to benefits in many different ways.

The results of the survey clearly indicate that HSENI's Mental Well-being at Work Advisory Service is very well received across all sectors of the workforce and making a positive impact on creating awareness and providing the practical tools for managing stress in the workplace. This is achieved through giving organisations a competent and manageable approach to tackling stress/mental well-being in the workplace.

HSENI is helping organisations make a positive impact on their staff and helping embed well-being policies into organisations large and small and those perceived to be at high risk of workplace stress. The biggest benefit of organisations availing of HSENI's services is that of gaining a better understanding of stress/mental well-being.

Current service / policy development

HSENI will take on board all of the feedback received from the survey to continue to improve the services it provides to employers.

HSENI are seeing an increase in demand for its services with more risk assessments being completed (12 in 2015 compared to 7 in 2012) as well as the introduction of its new awareness seminar in 2014, while still delivering numerous presentations and attending events throughout the North of Ireland.

The Mental Wellbeing at Work Advisory Service will continue to deliver awareness training sessions targeted at public, private and third sector organisations. The objective of the training sessions is to promote stress prevention and to deliver on the "Stress Management Standards". The focus of future training sessions is to enable organisations to carry out mental well-being risk assessments at both an organisational and individual level as well as develop their own local policies for workplace stress. The MWWAS will continue to promote stress prevention through primary interventions and will continue to work with local mental health organisations to ensure primary intervention is factored into future training programs.

THEME 2: Supporting People to Lead Independent Lives

The Bamford Action Plan 2012-15 contains the following commitments in relation to promoting supporting people with mental ill health.

Resettlement

What did we say we would do?

We said that that all long stay patients from mental health hospitals, who did not require inpatient hospital treatment, would be resettled to enable them to live independently and safely in the community.

Resettle long stay patients from learning disability and mental health hospitals (*Action 13 – Department of Health*)

What did we do?

Since 2007, the majority of the long-stay Primary Target List (PTL) patients have been resettled into the community (long-stay refers to patients who have been in hospital for 12 months or more).

In 2007, the number of people who were long-stay patients in psychiatric hospitals was 472. During the period 2007-2016, 293 of these people were resettled to new homes in the community.

Sadly, 161 (34%) patients were deceased over this period. This is considered, in part, to be reflective of the higher age profile of this group. In addition, it is recognised (by the World Health Organisation, among others) that there is a 10-25 year life expectancy reduction in people with severe mental disorders. This is due to a range of factors including a higher prevalence of chronic physical conditions or infection, and harmful lifestyle behaviours such as high smoking rates or a lack of exercise.

At 31st March 2016, 18 long stay patients remained in mental health hospitals. Plans are currently in place to resettle 10 of these during 2016/17. The remaining 8 patients currently require inpatient treatment.

Many of the remaining patients (PTL patients) are individuals with more complex conditions and behaviours. A great deal of work is required to establish the most suitable placement with the right level of support to suit their specific individual needs. The emphasis is on getting it right for the patient and ensuring their safety and care and this must be the key priority.

Delayed discharges

In addition to the patients above, there are also a further 14 patients (at March 2016) who have in subsequent years have become ready for discharge from hospital and where this has not occurred, they have become “delayed discharge”. The reason for the delay in discharge is that they are waiting on suitable placements. The HSC Board and Trusts are making every effort to resettle these patients.

Investment in Resettlement

Cumulatively to the end of March 2015 a total of £27.53m has been invested recurrently by the Health and Social Care Board on resettlement - £16.45m on learning disability resettlement and £11.08m on mental health resettlement.

Did it make things better for people with mental ill health and their families?

Through the mental health focus groups, we heard from a small number of people who had been resettled from hospital into supported living accommodation. Experiences were generally positive and participants praised support workers and commented on their ability to now engage in many activities that they couldn't have done while in hospital.

There is currently no regional 'Quality of Life' assessment of people with mental health problems who have been resettled from hospitals. It is proposed that outcomes measurement for this group of people be developed.

One peer advocate Kenny Ramsey, who is employed by the Irish Advocacy Network in the Belfast Trust area, shared with us a report that he had completed *'A Return to Community: A report on the closure of a psychiatric ward from a Peer Advocacy perspective'*, which gives an account of his involvement, observations and engagement with around 20 people who moved from a psychiatric ward in Knockbracken to the Millbrook Reablement Unit in the period 2012-2015. The report reflects a 'hugely positive experience' in the main for those people that had moved out of the Continuing Rehabilitation Unit in Knockbracken. It indicated that the transition was fairly smooth, with a few issues emerging as people learnt to cope with the changes, but that staff responded well to these. The report comments that people were starting to take outings into the community with support staff and is hopeful that they will eventually gain the confidence to lead fuller lives. The importance of the role of peer advocates in supporting people to adjust to life outside of hospital is emphasised in the report, as well as the value of collaborative working among staff, service users and peer advocacy.

A number of carers commented that as the focus has been on resettling people from hospitals, there have been limited places within supported living settings for people with mental ill-health who are not currently in hospital.

Current service / policy development

Every effort is being made to resettle the remaining 24 patients who are fit for discharge.

Identified Need

There is a need for the HSC Board to develop measures to assess the betterment for people with mental health needs who have been resettled from long-stay hospital placements.

Identified Need

There is a need to assess the housing needs, included supported living, of those people with mental health needs, who are not being resettled from hospital.

Housing

What did we say we would do?

We said that that suitable, safe and supported housing would be available for people with a mental health need who require it.

Scope existing supported housing capacity / suitability to maximise resources (Action 14)

Ensure new build supported housing programmes are 'future proofed' to ensure longevity / sustainability in terms of the tenants (Action 15)

What did we do?

The Northern Ireland Housing Executive (NIHE) has played a significant role in helping to deliver the post-Bamford resettlement programme. The Housing Executive has worked alongside the Health and Social Care Board and Trusts in commissioning new services for people with a learning disability and mental health needs to be resettled. Over the 2012-16 period a significant proportion of the social housing new build programme was dedicated to the provision of housing for people who have additional support needs or who need to live in supported housing, with the housing support element in these schemes is funded through the Supporting People Programme.

In the period 2012-16 the then Department for Social Development (DSD), through the Supporting People (SP) Programme administered by the Northern Ireland Housing Executive, provided supported accommodation for 160 resettled clients. This amounts to an annual SP commitment of circa £3 million. The corresponding total capital investment associated with these 160 clients was circa £12 million.

Review of Supporting People

The then Department for Social Development published a Review of the Supporting People programme in November 2015.

https://www.communities-ni.gov.uk/sites/default/files/publications/dsd/review-of-supporting-people-report.PDF

This review considered the whole of the SP programme, including people with mental health problems or a learning disability. It found that a variety of different types of housing, care and support services have been developed for the resettlement of people with a learning disability leaving long-stay hospitals.

The Supporting People Review contains a number of findings and recommendations which are of particular relevance to this Evaluation report:

- **Strategic Needs Assessment**: There is a need to introduce a new strategic, intelligence led approach to needs assessment across all client groups, which takes proper account of demographic trends and other social factors to identify current and future patterns of need. As with this evaluation, there was evidence of emerging of latent demand for housing support from people with learning disabilities living with older carers. The current needs assessment process does not articulate emerging housing support needs and there needs to be a more robust approach to needs assessment;
- **Cost**: Supporting People services for the resettled population are significantly more expensive than similar services offered to other clients with learning disabilities or mental health issues through the Supporting People programme. It will be difficult to sustain this higher cost in the medium and longer-term and all partners in such schemes (Health and Social Care, providers and NIHE) need to work together to develop a more viable service delivery model which meets need in the most cost-effective way possible. It also found that there are significant variations in costs within client groups - most marked for learning disability services. The Review recommends the introduction of standardised regional payment rates;
- **Specialist, bespoke accommodation:** The Review has found that there has been a move away from building generic models of supported housing towards more specialist, bespoke accommodation specifically designed for individual clients, often commissioned through Supporting People by Health and Social Care. This presents a number of challenges in term of risk, cost (current and potential future ‘sunk’ costs for modifications to meet the needs of future client groups). A number of housing professionals made a case for moving away from these higher-risk solutions towards the development of more generic models of supported housing, which can be adapted to meet a range of needs more flexibly over the expected lifespan of the building. The Review recommends that the relationships and funding responsibilities of the various statutory partners within the Supporting People programme should be clarified to ensure costs and risks are shared appropriately;
- **Commissioning process:** The Review found that the commissioning process for the SP programme was complex and confusing, and there was lack of a clear line of sight between commissioning decisions and strategic priorities. It recommends that the existing commissioning structure should be revised to improve its transparency, to increase representation from Supporting People service users and providers, and to ensure an appropriate role for both housing and health and social care professionals; and
- **Regulation:** There is no bespoke regulatory system for Supporting People services *per se* - rather there are a number of existing regulatory systems which cover aspects of service delivered within Supporting People funded schemes. The Review identified a need to harmonise and streamline regulatory and administrative activity. The Housing Executive and the Regulatory and Quality Improvement Authority (RQIA) are well-advanced on the production of a draft memorandum of understanding which will go a

considerable way to address these issues. The need for a longer-term, a more focused and tailored system of regulation for Supporting People services was identified. This may required new legislation and therefore could take some time to deliver.

The recommendations of the Supporting People Review are being implemented by a cross-Departmental Implementation steering group, led by Department for Communities with representation from Departments of Health and Justice. Implementation of these recommendations will address many of the difficulties identified in the Interim Review of the Resettlement Programme.

Did it make things better for people with mental ill health and their families?

As stated in the 'resettlement' section above, the experiences of people with mental health problems who have moved from hospital to the community were generally positive and people felt that they had more independence to engage in social activities that they couldn't have done while in hospital.

In terms of the suitability and safety of housing for people with mental ill-health, this is difficult to regulate due to the different agencies involved in the provision of housing, care and the fact that in supported housing schemes the person has their own home, and there are issues with rights to access to inspect. The Supporting People review found that there are many good accommodation-based services which fully meet the needs of people living there. However, it notes that not all of these services are of this standard.

Current policy / service development

Implementation of the 13 recommendations of the Supporting People Review will bring further improvements in SP generally which will impact on any remaining patients on the resettlement programme or any future resettlement programme. These include setting priorities, assessing need, commissioning, decommissioning, base lining and comparable funding and regulation and inspection.

The new NI Executive acknowledges the obstacles and challenges faced by people with disabilities in their daily lives. The draft PfG contains 14 strategic outcomes supported by 42 indicators, of which indicators on "Improving the supply of suitable housing" and 'Improving the Quality of Life for People with Disabilities and their Families' will determine government priorities for the future.

Employment Services

What did we say we would do?

We said employment services and support would be available to help people with mental ill health get into work.

To support and develop the Employment Advisor Teams to deliver services to people with mental ill-health or a learning disability (Action 16)

Incorporate provision within the design of the new Work Connect Programme to meet the employment needs of those who are claiming Employment Support Allowance and who have mental ill-health and learning disability (Action 24)

What did we do?

In 2015-16, there were 4 main services commissioned by Department for Communities which were supporting people with mental health problems or a learning disability into employment:

- ***Work Connect:*** Work Connect aims to improve client employability and assist appropriate clients to find and keep work. This offers quality pre-employment and employment provision to clients in receipt of Employment and Support Allowance, who have health conditions and / or disabilities but who are capable of and wish to play a full and active role in society. Work Connect provides a range of tailored support to clients for up to 26 or 39 weeks to help them overcome their employment barriers and help enhance their employability skills. Work Connect is delivered by contracted providers Supported Employment Solutions (SES), a strong consortium which brings together seven local disability organisations including a number who specialise in their support for people with mental ill-health and/or learning disabilities.

- ***Access to Work:*** Access to Work is a flexible individually assessed programme providing financial assistance to help overcome barriers faced by disabled people in accessing employment. Support can include Special Aids and Equipment, Adaptations, Support Worker and Travel to Work;

- ***Workable (NI)****:* Workable (NI) provides a flexible range of support to assist people with significant disability related employment barriers, move into and stay in work. It is delivered through a number of provider organisations, contracted by the Department. These organisations have extensive experience of meeting the vocational needs of disabled people. Workable (NI) provides the support and opportunity for people to progress into unsupported employment where this is the right option for the individual. Longer term support is available where appropriate.

- ***Condition Management Programme (CMP):*** CMP is delivered by multi-disciplinary health professional teams from across the five H&SC Trusts to help people to improve their health and their employability. The teams primarily consist of mental health nurses, Occupational Therapists, physiotherapists, and this enables them to support people with a number of health problems, many of whom present with more than one. Mental ill-heath would be the most prevalent health condition amongst CMP clients.

Did it make things better for people with mental ill health and their families?

- ***Work Connect***: The programme commenced on 1 September 2012 and has supported 1328 clients with a range of health conditions and/or disabilities. 89 clients presenting with a learning disability, 54 with ASC and 594 with mental health issues have participated on Work Connect. This represents 737 (55%) of programme participants.

From client progress reports and data received to date, 49% of clients have increased employability after 13 weeks on the programme. Remaining clients are still being supported and this will continue until their individual support period ends. The programme has supported 169 clients with mental health issues, 16 with Learning disability and 11 with ASD into employment.

Work Connect recently closed to new entrants on 31 August 2016, as the four year contract came to an end. A review of all programmes and services is underway, aimed at helping and supporting JSA and ESA clients, and those with additional barriers to overcome. This will result in proposals for a new menu of provision, some of which will be aimed specifically at supporting people on ESA, the majority of whom have mental ill-health as their primary barrier to work.

- ***Access To Work***: As at 31 March 2016, 9 people with mental ill health and 176 people with a learning disability are being assisted to stay in work through Access to Work NI. Support from the programme promotes independence, social inclusion, increases confidence and empowers these clients to reach their full potential in the workplace. For those with mental ill health support from the programme improves mental health and well being and helps them to sustain employment particularly those that have reoccurring mental health issues.

- ***Workable (NI)***: This is a specialist supported employment service is delivered by Employment Officers, delivered by a number of local disability organisations on behalf of the Disability Employment Service (DES). Support includes the identification of job opportunities, development of a support plan, dedicated job coach attendance for the employee, ongoing communication and contact with the employee and the employer, disability awareness training, as well as more tailored training to immediate colleagues of the Workable client, depending on their disability, help with identifying and sourcing external specialist training, and an advocacy role for the employee, similar to a staff representative. The majority of the 670 clients on Workable are being supported by organisations who specialise in their services to people who have a learning disability, mental ill-health or may be on the autistic spectrum.

- ***Condition Management Programme (CMP):*** The new model of CMP has been introduced since 1 April 2016 and currently enables both Workable (NI) clients and those in receipt of Access to Work (AtW) to avail of provision to help them retain and sustain employment. Following a pilot, the programme has now extended to allow for all suitable JSA clients to be referred for the specific period of 12 weeks support and intervention to help progress them towards employment, Since April 2016, CMP has assisted 16 clients with a Learning disability and 582 clients with mental ill health issues.

Case Study: Work Connect Client - Joan

I have found my experience with Work Connect to be nothing but helpful and positive experience in helping me make a return to work. I was made aware of work connect during my participation with the Condition Management Programme and my counsellors felt that I would benefit greatly from the support Work Connect could provide, in helping me deal with the trauma of returning to work, having been off some 16 months.

I was introduced to Robert from AMH (Action Mental Health) and from day one he was fantastic, informing me about the process of returning to work, explaining the benefits available to me, making it worthwhile to return to work and the support regarding the filling in of forms and accessing financial support for both myself and my employer, was invaluable. Now 6 months into my job I am enjoying my return to the workplace, at my pace and cannot thank Work Connect (AMH) enough for their support.

People with mental health problems are at greater risk of unemployment, job insecurity, absenteeism and lower salaries. The HSC Board carried out some research in 2014 to try to quantify the cost of mental illness here, and found that it costs the local economy an estimated £3.5 billion per annum. The research also found that almost half of people who claim illness-related out-of-work benefits do so because of mental ill-health.

Conversely, the report estimates that within two years of recovery following successful treatment for mental ill health, the employment rate for those with moderate/severe mental health problems is increased by 11.4%, and by 4.3% for those with mild mental health problems. In terms of addressing the high unemployment rates amongst people with mental illness, there is significant evidence of the effectiveness of psychological therapies on creating the right conditions for them to resume or regain employment. The HSC Board report found that for every £1 invested in psychological therapy services, there is a saving of £1.75 to the public sector

It is therefore important, not only from a health perspective, but also from an economic perspective, that people with mental health problems can access the right treatment at the right time. .

Current policy / service development

The Department for Communities (DfC) Employment Strategy for People with Disabilities was launched in March 2016.

https://www.communities-ni.gov.uk/sites/default/files/consultations/del/Disability%20Strategy%20report%20%28Web%29.pdf

The strategy focuses on supporting those people with the most significant disability related barriers to work, and who want to work, are motivated and with the right type and level of support, will secure and sustain paid employment opportunities across every employment sector.

The Strategy also makes a clear statement to society that goes beyond finding a job – people with disabilities share the same ambitions and aspirations as everyone else, and are dedicated to realising their full career potential. The Strategy is about enabling and empowering those aspirations, and in doing so, disabled people will make a significant contribution to the economy.

The Disability Employment Service's main employment programmes – Workable (NI) and Access to Work (NI) - are clearly linked to the purpose and objectives of the Employment Strategy for People with Disabilities. The Strategic purpose is: ***To improve the job prospects and working careers of people with disabilities;*** The Key Objective is: ***To directly assist disabled people to find, sustain and progress within paid employment; or to start up a business.***

The target client group for the strategy is clearly stated throughout, and this includes people with learning disabilities, people on the autistic spectrum and those with mental ill-health.

This Strategy aims to build on existing disability services, delivered through mainstream and community and voluntary sector programmes and also presents a great opportunity to improve partnership working at all levels. The new Disability Employment Stakeholder Forum, established through the strategy brings together key officials from a number of Executive departments, representatives from the disability sector, employers and most importantly, people with a range of disabilities, who will monitor and positively influence the implementation of the Strategy.

This Strategy has been developed around five key themes, with a number of supporting proposals within each theme. The key themes are: Empowering and supporting people to secure paid employment; Job retention and career development; Working with employers; Research and development; and Strategic partnership and engagement.

The key proposals contained within the Strategy which aim to improve employment services for people with a disability are:

- Introduction of the Supported Employment Model;
- Introducing flexibilities to existing disability programmes to support people in employment of more than 10 hours (enables more people with mental ill-health or a learning disability to move into work, knowing they have in-work support, with a view to extending their hours over time;
- Extend the employment support partnership with Discrete Learning Units to all FE Colleges throughout NI;
- Introduce specialist recruitment support model for people with disabilities;
- Employer Education and Awareness;
- Work with Equality Commission and others to promote positive action;
- Disability Employment stakeholder Forum to include people with mental ill health and learning disability.

Further/Higher Education and Training

What did we say we would do?

We said we would develop programmes and partnerships to support people with mental ill health to access and participate in training and higher education.

Maintain support arrangements and extended eligibility for participants on the Training for Success Programme (*Action 17 - Department for the Economy*)

Widen Participation in Higher Education Strategy (*Action 18 - Department for the Economy*)

Establish and progress effective Partnership agreements and joint working arrangements with post-primary schools, further education, training and apprenticeship providers, HSC Trusts and organisations who act as advocates for young people with a variety of barriers, including disabilities (*Action 19 - Department for the Economy*)

Lead on the implementation of the cross-departmental strategy 'Pathways to Success' for those people not in Education, Employment or Training (NEET) (*Action 20 - Department for the Economy*)

Develop Careers Service delivery to support the 'Pathways to Success' Strategy (NEETs) (*Action 21 - Department for the Economy*)

Continue to work in partnership with DE to increase the level of information sharing in respect of relevant pupil data being shared with DfC's Careers Service including electronic sharing of pupil data via C2K (*Action 22 - Department for the Economy / Department of Education*)

Continue to provide specialist support , as appropriate for young people considering participating in Training for Success (TfS) (*Action 23 – Department for the Economy*)

What did we do?

One of DfE's key strategic goals is Widening Participation in higher education by students from groups who are currently under-represented, in particular students from disadvantaged backgrounds and those with disabilities and learning difficulties.

"Access to Success" the widening participation strategy was published in September 2012. It contains 11 Key Actions to improve accessibility and participation in higher education, including among students with disabilities. DfE (previously DEL) is working with Higher Education institutions and other key stakeholders to develop implementation plans for each of the Key Actions.

Actions include:

- the launch in March 2014 of "Reach Higher", a single centralised and co-ordinated higher education awareness and aspiration raising campaign to communicate the benefits of Higher Education to disadvantaged groups, including students with disabilities;

- the introduction of the "REACH" programme which aims to expand the range of aspiration and educational attainment raising programmes; and

- the introduction of Widening Access and Participation Plans in which institutions detail their Widening Participation (WP) strategy, provide a review of their past achievement against regional benchmarks and provide a detailed programme of anticipated progress towards the institution's own targets.

DfE's widening participation strategy, "Access to Success", requires that the recruitment, retention and achievement of disabled students is monitored by all Higher Education providers. However, the definitions of disability differ slightly for each provider.

DfE publishes Widening Participation Performance Indicators in Higher Education annually by academic year (which covers the proportion of students in receipt of Disabled Students Allowance (DSA)), and also publishes statistical factsheets covering enrolments in NI Higher Education Institutions (HEIs) by equality categories, including disability status of the students.

DfE assists students with learning difficulties and disabilities, including those with mental ill health, access the range of mainstream and discrete educational provision delivered by all FE colleges through the Additional Support Fund. This fund provides £4.5 million per annum to enable colleges to put in place the necessary technical and/or personal support required by an individual to attend further education.

The Community Family Support Programme (CFSP) has been designed to help families (some of whom may have mental health issues) make life changing decisions to enhance their prospects and to become full participants in society, including breaking the cycle of inter-generational unemployment and associated poverty in communities. During the 26 week programme families receive help to address the health, social, economic, educational, employment and training issues that impact on their daily lives.

CFSP will be funded through the new NI European Social Fund (ESF) from 1 April 2015 – 31 March 2018 and aims to support 2,340 families over the 3 years of the programme.

During the period November 2013 to March 2015, a total of 720 families completed participation on the CFSP. A total of 2,694 family members received help and support on the programme, including: 795 aged over 25; 527 young people aged 16-24 years; and 1,372 children under 15 years of age.

Did it make things better for people with mental ill health and their families?

Disabled students are not broken down into categories that allows for specific information for students with mental health issues or learning disabilities. However, there are various outreach programmes aimed at students with disabilities including learning disabilities and once enrolled, various support measures are in place to aid retention of students.

Current policy / service development

- Outcomes measurement: One of the projects within "Graduating to Success", the higher education strategy, is seeking to standardise the returns across all higher education providers to allow more consistent measurement of progress. The Department is working in conjunction with DE and the Higher Education Institutions (HEIs) to review and bring forward recommendations to improve the mechanisms used to gather comprehensive and reliable data pertaining to access to, and participation in, higher education by disabled students, including those with mental health issues and learning difficulties.

- The Social Inclusion project within the new Further Education Strategy, "Further Education Means Success" will identify the barriers that inhibit different groups of learners, including those with mental ill health, from participating in FE provision and explore ways in which to overcome these barriers.

Self-Directed Support

What did we say we would do?

We said we would promote Self-Directed Support so people with disabilities can choose the health and social care services which best meet their needs;

To support the uptake of self-directed support and individual budgets in line with Transforming Your Care (*Action 25 – Department of Health*)

Self Directed Support empowers service users and carers to exercise more control over their social care services, offering greater flexibility, promoting independence, and assisting individuals to make informed choices about how and when services are provided, enabling them to tailor their support package to fit their specific needs.

What did we do?

The Self Directed Support initiative (SDS) commenced in March 2014 and represents a major change to the way people with social care needs are assessed and supported. SDS is based on the human rights principles of fairness, respect, equality, dignity and autonomy for all. Personalisation and Co-Production are key tenets of SDS promoting independence, and assisting individuals to make informed choices.

SDS aims to improve the impact that care and support has on people's lives, it is a strength based approach to assessment and support planning, focussing on the outcomes people identify as important to them. It means that people are equal partners with the relevant professional in determining their social care needs and controlling how their needs are met.

SDS affords the individual choice and the combination of a number of support options through a personal budget namely:

- Direct Payment (a cash payment in lieu of services)
- Managed budgets (where the Trust holds the budget, but the person is in control of how it is spent)
- Trust Arranges Support on behalf of the service users.

The HSC Board, and HSC Trusts in partnership with a wide range of stakeholders, is currently implementing the SDS initiative across the Region. This initiative is working towards the indicator (included in the Commissioning Plan Direction 2016/17) that by March 2019, all Service Users and Carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access Direct Payments, a Managed Budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.

In addition to the above indicator, it is intended that by March 2019, 1 in 3 eligible Service Users will avail of either a SDS Direct Payment or Managed Budget option. The Commissioning Plan Direction 2016/17 also has a target referring specifically to Direct Payments which will help drive improved performance on SDS; by March 2017, Trusts must secure a 10% increase in number of Direct Payments to all Service Users.

The implementation of SDS is currently underway and progressing steadily. Across the five HSC Trusts there are differing approaches to the operation of SDS, currently two Trusts are approaching full implementation and the other three have well-constructed plans outlining an implementation timetable..

Data collection within this initiative is developing along both qualitative and quantitative lines. The SDS activity data return is currently in trial with the five Trusts, it is our expectation that more reliable figures will result from this approach.

SDS has introduced the Adult Social Care Outcomes Toolkit (ASCOT) in partnership with Kent University. Initial trials are taking place with SEHSCT and all Trusts will introduce ASCOT in the coming months.

ASCOT is an integral part of the SDS initiative it enables an outcomes focus and helps evaluate the effectiveness of social care services on an individual's quality of life. In the future review and analysis of this outcome data will inform local and regional planning

Did it make things better for people with mental ill health and their families?

The uptake of direct payments for clients with mental ill health has increased by 33% from June 2013 to June 2016 – see regional figures below. However, the uptake remains low in comparison to the uptake of people with a learning disability.

Number of Direct Payments Paid During Quarter for Mental Health Clients

June 2013	June 2014	June 2015	June 2016
107	105	124	160

Source: HIB

There are a number of possible reasons why the uptake is low amongst people with mental health problems. The issue of capacity to consent to direct payments is a contributory factor, as well as the perceived burden of managing direct payments and becoming an employer.

Current arrangements permit an individual to avail of assistance in managing their direct payment, where they do not feel that they could manage on their own, but the individual must have the capacity to consent to enter into the direct payment arrangement at the outset.

It is proposed that the current primary and subordinate legislation be amended to extend the scheme to include those who lack capacity to provide this initial consent. There is an interim solution to ensure that those who lack the capacity to consent can continue to be offered a Direct Payment.

Current policy / service development

Work to promote and increase the use of Self Directed Support continues to be taken forward with the following priorities:

- The promotion of Self-Directed Support as a means of improving the quality of life of people with disabilities will be a priority within the Programme for Government.
- Self-Directed Support (SDS) will form part of the Department of Health's vision for social care within the Reform of Adult Social Care.
- Operationalisation of SDS will continue, and progress will be monitored and reported under Programme for Government.
- HSC Trusts need effective leadership from Directors and Senior Management across Programmes of Care and support directorates (ie Finance, Planning & Contracts and Information) and continued support from the HSCB and DoH through detailed guidance and regular communication via existing SDS project structures.
- In parallel with regional work aimed at streamlining information gathering, SDS is working with Trusts developing and refining the regional SDS activity toolkit. There is no single activity gathering information system in operation across Trusts and plans to homogenise a regional system is some years away. As a consequence adaptations to the different systems currently in use will require additional financial resources.
- It is important that the HSC Trusts, HSCB and DoH can demonstrate the impact of the SDS Initiative, including the intended improvements to the quality of people's lives the importance of having timely information and validated data can't be over emphasised; and

- The Mental Capacity Act (Northern Ireland) 2016, once commenced, will amend Section 8 of the *Carers and Direct Payments Act (Northern Ireland) 2002*, to extend the direct payments scheme to include those who lack capacity to provide this initial consent, by enabling a statutory duty to be imposed on Trusts to offer direct payments to such individuals, in situations where there is an appropriate person to consent to receive direct payments on behalf of the service user, and to manage such payments, with involvement from the service user, to the extent that this is possible.

Advocacy

What did we say we would do?

We said we would improve advocacy services, through the development of a policy guide for commissioners.

Implement 'Developing Advocacy Services – A Policy Guide for Commissioners' (*Action 27 – Department of Health*)

What did we do?

An Independent Advocacy Code of Practice and Standards Framework was launched in June 2014. Members of the Advocacy Network NI have committed to the code of practice and are using it as part of their induction and training programmes for new staff and volunteers.

RQIA carried out a review of Advocacy Services in 2015. The review team's overall findings indicate that the DHSSPS policy guide and associated action plan has helped HSC commissioning organisations to better understand and develop independent advocacy services in the North of Ireland. Advocacy is now regarded as a core element of provision for some services and is recognised to be valuable when service changes are being considered or implemented.

Did it make things better for people with mental ill health and their families?

RQIA found that the provision of advocacy services varies across geographical areas and HSC trust programmes of care.

Current policy / service development

The RQIA Review of Advocacy Services identified three main constraints that impact on the optimal delivery of advocacy services in the North of Ireland.

- At present there is no clear statutory duty or strategic framework to provide independent advocacy services in Northern Ireland;
- Lack of resources has impacted on investing in advocacy services across all programmes of care; and

- There is no process for regulation of providers of advocacy services or for individuals undertaking advocacy.

RQIA made 8 recommendations (6 for the HSCB, 2 for DoH) for improvements in the commissioning process and quality of advocacy services for children and adults which focused on: an assessment to determine future capacity requirements, and to improve access to advocacy; cross-agency working; evaluation of services and to inform future commissioning; consideration of a regulatory framework. The HSCB has developed an action plan for the recommendations that is feasible within current resources.

The future direction of advocacy services will be impacted by the commencement of the Mental Capacity Act (MCA) which includes the provision of a statutory advocacy service for people with impaired capacity in circumstances where serious health and social care interventions, or an intervention which may restrict their liberty, are being considered (Further detail on the implementation of the MCA is included in Annex C).

Involving People with Lived Experience

What did we say we would do?

We said we would involve people with lived experience of mental ill health in the commissioning and delivery of mental health services.

To support the employment of experts by experience in the commissioning and delivery of mental health and disability services (*Action 28 – Department of Health*)

What did we do?

People with lived experience of mental illness are now actively involved in the commissioning and delivery of mental health services through a number of fora:

- Each HSC Trust has a 15 person steering group to implement the Implementing Recovery through Organisational Change (ImROC) Programme – one third of these are service users/carers;

- Current Bamford Structures, including the Bamford Programme Board, have service user representation, who contribute to commissioning decisions;

- Recovery Colleges are now established in all 5 Trust areas, with more than 150 people with lived experience employed in a range of posts including peer support workers, trainers, peer advocates and service user consultants. All vacant posts within Mental Health services are now screened for peer suitability, and so this number will continue to grow; and

- Mental Health Service User Forums are established in a number of Trust areas, and are working very effectively. These Forums provide a mechanism for service users to provide feedback to Trusts on services and be involved in service development and delivery.

Did it make things better for people with mental ill health and their families?

There were very positive experiences of people's involvement, in particular with relation to Recovery Colleges in most areas. A number of people spoke of the 'sense of value' being employed in Recovery Colleges gave them.

Those involved in the well established Mental Health Service User Forums were generally enthusiastic that these provided a formalised mechanism for working with the Trusts and for their experiences and views to be listened to. There is however a need to ensure that such a Forum is available in every Trust area.

Current policy / service development

We want to enhance the role of people with lived experience of mental illness and ensure that they and their families/ carers and mental health organisations play a role right through the policy-making, commissioning and service delivery process.

The Recovery agenda will continue to be developed and provide more opportunities for the employment of people with lived experience in the delivery of mental health services.

In terms of involvement in policy-making and service delivery process, we recognise the success that some of the more established Mental Health Service User Forums have had, and that model should be replicated across all Trust areas.

The HSC Board has proposals to develop a 'Co-Production Mental Health Infrastructure' with the aim of strengthening the influence and role of people with lived experience both locally and regionally in the delivery, development and design of mental health services. This might include a Regional Peer Consultant Coordinator to lead the development of the network, and also include locally appointed peer consultants in each Trust area. Proposals are at an early stage and will require detailed development and costings.

The proposal for the appointment of a 'mental health champion' is a popular suggestion in the mental health sector generally, and a number of mental health organisations have supported the appointment of a mental health champion in recent months. This is discussed at some length in the main evaluation report.

It is suggested that co-production representatives on the proposed Co-Production Mental Health Infrastructure will have scheduled meetings with senior Departmental mental health policy officials, commissioners and Trust mental health managers twice a year, to be briefed on and to ask questions about current services and forthcoming plans. This would create a formal mechanism for people with lived experience of mental illness to represent the rights and interests of people with mental health problem, take the role of independent advocates, and ensure that mental health services continue to be developed in a way that effectively meets the needs of service users and carers. It would also provide the Department with a forum to engage directly with people with lived experience on the development of mental health policy. In effect, the co-production representatives would be 'mental health champions' for their local Trust areas, involved at both policy and commissioning levels. The Minister of Health would be briefed on the bi-annual meetings.

Identified Need

To create a formal mechanism for people with lived experience of mental illness to champion the rights and interests of people with mental health problems, take the role of independent advocates, ensure that mental health services continue to be developed in a way that effectively meets the needs of service users and carers and engage with senior Departmental mental health policy officials, commissioners and Trust mental health managers, through the development of a Co-Production Mental Health Framework.

Recovery-orientated Practice

What did we say we would do?

We said we would promote recovery orientated practice throughout all mental health services.

Promote recovery orientated practice throughout all mental health services (*Action 32 – Department of Health*)

What did we do?

Since 2012, mental health services in Northern Ireland have been formally commissioned and delivered to promote recovery approaches in partnership with people who use services and their carers.

The HSCB / PHA and Trusts have taken a number of measures to embed recovery-orientated practice in mental health services:

- Establishing of 'Implementing Recovery through Organisational Change' (ImROC) groups in each Trust area;

- Training for Trust staff on "Promoting Recovery" and WRAP (Wellness & Recovery Action Plan);

- Establishment of Recovery Colleges in each Trust, offering a curriculum of co-produced and co-taught courses and greater numbers of peer support workers;

- Launch of the new mental health care pathway ‘You in Mind’ which has the ethos of Recovery at its core; and
- Partnerships of people who use services, people who provide services (statutory and non-statutory) and carers have designed new person centred services in each Trust area.

Did it make things better for people with mental ill health and their families?

This is perhaps the most positive change in all of the mental health service development that has taken place in recent years, in terms of the impact the ‘recovery’ approach has had on the lives of people with mental ill health and their experience of mental health services.

Many people told us of their positive experience of Recovery Colleges. Key benefits of their involvement were that they helped them understand and take control of their mental health, build self-confidence, provide peer support, and remove isolation.

In terms of recovery-orientated practice, many people felt that how well this was embedded depended on their mental health team and in particular who was leading the teams. It appears to be well embedded in some areas, and not so much in others.

The use of the Wellbeing and Recovery Action Plan (WRAP) tool was described as ‘instrumental’.

There were some suggestions for improvement. While Recovery colleges offer good support, there appears to be lack of information/promotion/signposting in some areas. The need to inform GPs about Recovery Colleges, and for them to refer / signpost was highlighted. It was also noted that the provision of Recovery Colleges seems to vary across Trust areas, and that in some areas few courses were available and people felt that service users were not involved. Almost 1,400 people had attended courses in Recovery Colleges up to December 2015. Attendance was particularly good in the South Eastern and Northern Trust areas, with lower attendance in the Belfast, Southern and Western Trust areas.

We want to build on the success of those well established Recovery colleges, and ensure that these are available across the whole of the North of Ireland.

There was positive feedback on the You In Mind Care Pathway. The Care pathway was launched in 2014 and is being incrementally implemented across all Trusts. The You in Mind Pathway is the operational blue print for mental health services development. Implementation of the care pathway is a still work in progress and staff training continues. This was reflected in feedback from people using mental health services, who indicated that there was variance across Trust areas on the knowledge and use of the Care Pathway.

‘Your Experience Matters’ found that two-thirds of respondents in the 2015 survey reported that discussing their recovery has become an important part of their treatment and support. For 26% of respondents, their recovery was not discussed at all or was only briefly mentioned – again reiterating the issue with variance within the service.

“....the recovery college has been positive, enriching and informative both for my own mental well-being and for teaching me new skills to help support my son.”

An issue raised by carers / families of people with mental illness was that the Recovery Colleges were not appropriate or available for all people, in particular those with severe and enduring mental illness, and that they felt little had been done to develop services for those people. They identified a need for positive outreach to people with severe and enduring mental illness to encourage them to access courses within Recovery Colleges.

Current policy / service development

There is evidence that recovery-based practice is now well embedded within mental health services generally, and work to develop this continues in line with the Regional Mental Health Care Pathway 'You in Mind'.

Identified Needs

With regard to recovery-based practice, there are a number of gaps in service provision:

- **Continue the implementation of the You In Mind care pathway to ensure consistency across all mental health services;**

- **Develop a new standard operating model for mental health delivery which will further support the integration of psychological therapies and recovery practice into the role and function of community mental health teams and services, and address the variance across the HSC in the use of recovery-orientated practice;**

- **Better promotion of and referral to Recovery Colleges, including by GPs;**

  and

- **Consider what services need to be developed so that recovery-orientated practice outreaches to treat those patients with severe and enduring mental illness.**

Victims and Survivors of the Conflict

What did we say we would do?

We said we would complete a Comprehensive Needs Assessment of the mental health needs of victims and survivors of the Conflict.

Establish an initial assessment of the mental health needs of victims and survivors through a Comprehensive Needs Assessment (*Action 33 – The Executive Office*)

What did we do?

A Comprehensive Assessment of the needs of victims and survivors of the Northern Ireland conflict was published on 23rd November 2012 and can be accessed on the Commission for Victims and Survivors website.

http://www.cvsni.org/images/policy-research/pubs/CNA-Final-Feb-2012.pdf

The main development which is being taken forward following this Comprehensive Needs Assessment is the development of a Regional Mental Health Trauma Service. Discussion in relation to a cross Departmental Mental Trauma Service Partnership agreement is currently ongoing.

Did it make things better for people with mental ill health and their families?

As the Regional Trauma Service is still in development, there are no outcomes at this point.

Current policy / service developments

A Regional Mental Trauma Service Model has been developed by the HSC Board, in partnership with DoH and TEO. The service is based on the internationally recognised Psychological Therapies Stepped Care model, and will range from low-to-moderate intensity treatment provided by the voluntary and community sector, to high intensity treatment provided within the Health and Social Care system.

Initial funding of £180K has been secured. An implementation team and a Trauma Network (an expert advisory panel drawn from leading academics and clinicians based in Britain and the South of Ireland), to ensure that development and implementation of the service reflect clinical evidence and best practice, have been established. 13 staff are currently undertaking masters in Trauma Care in order to build the expertise required to implement the service. Full development of the Trauma Service will require funding of approximately £3.2M on an annual basis, which will be subject to a bid in 2017/18.

An application for a Victims and Survivors project has been submitted to the PEACE IV Programme by The Executive Office. It is proposed that PEACE IV funding will be utilised to build capacity within the voluntary/community sector, provide advocacy and assessor services and to fund research into mental health provision for victims and survivors.

Issues remain to be settled in relation to finance, recruitment and partnership working.

Identified Needs

To secure £3.2M recurrent funding to fully develop a Regional Mental Trauma Service

To secure Peace IV finding to build capacity within the voluntary/community sector, provide advocacy and assessor services and to fund research into mental health provision for victims and survivors

Health In Mind – Libraries project

What did we say we would do?

We said we would improve access to information and support on mental health through the implementation of the 'Health in Mind' programme.

'Health in Mind' programme to improve the quality of life of 25,000 adults affected by mental ill-health through the provision of information, learning and reading activities (*Action 36 – Department for Communities*)

What did we do?

'Health in Mind' has been led by Libraries NI in partnership with four mental health charities, namely Action Mental Health, Aware, CAUSE and MindWise. It was a library programme which promotes positive mental health. The aim of the project was to improve the quality of life of adults and young people affected by poor mental health through the provision of information, learning and reading activities and to reduce the stigma attached to mental illness. It also aimed to raise general awareness about mental health issues, including coping strategies and suicide prevention for people affected by mental ill health and their families, friends and carers.

The main Health in Mind project was funded by the Big Lottery Fund; approximately £1m over 6 years. This funding and the programme ended in January 2016. The 'Health in Mind' programme achieved a Highly Commended Award within the Community Impact Category at DCAL's Learning & Innovation Awards event held in Derry on 17th June 2015. It was also the winner of Claire's Award in 2014 in the Individual Impact category.

Did it make things better for people with mental ill health and their families?

Health in Mind has proven extremely successful and has exceeded all of its original targets. The project ran from 1 November 2009 and ended on 31 January 2016 and over 200,000 people were reached through the activities, events and resources provided, and outputs (figures provided by Libraries NI) *to January 2016*:-

- Over **90,000** people have accessed up-to-date and relevant information to enable to them to improve their mental health. *Target was 40,000*
- **12,000** people affected by mental illness have acquired the self-help skills and knowledge necessary to access and use relevant information to assist their recovery process. *Target was 2,000*
- **30,000** people affected by mental illness, their families and carers, have enhanced opportunities for social interaction through reading and learning activities enabling them to play a fuller role in community life and to access further training and potential employment. *Target was 3,000*
- **Nearly 90,000** people have now a better understanding of mental illness and awareness of the importance of positive mental health thereby improving their own

mental health as well as contributing to tolerance and social inclusion. *Target was 15,000*

- **41** volunteers have improved skills and confidence to participate in local community activity and be a long term resource for partner organisations. *Met target of 40.*

Current policy / service development

Health in Mind has ended, however the project has provided a number of lessons for Libraries NI which will shape its work into the future. Libraries NI has included in its draft Corporate Plan 2016 – 20 and its Business Plan 2016/17 activities and targets in relation to the promotion of health and wellbeing, in partnership with others, where appropriate.

THEME 3: SUPPORTING CARERS AND FAMILIES

What did we say we would do?

The Bamford Action Plan 2012-15 contains a number of following commitments in relation to supporting carers of people with mental ill health

- That there would be more provision of respite and short breaks;
- That all carers would be offered a carer’s assessment so they can be supported in their caring role.

What did we do?

Respite / Short breaks

What did we say we would do?

We said there would be more provision of respite and short breaks for carers.

Enhance the arrangements to meet demand for respite including emergency respite and short break care (*Action 37 – Department of Health*)

Mental Health Short Break provision increased from 110,003 hours to 146,737 hours from 2014 to 2015.

Carer’s Assessments

What did we say we would do?

We said that carers would be supported in their caring role by offering all carers a carer’s assessment so they can be supported in their caring role.

To provide support to all carers in order that they may continue in their caring role (*Action 38 – Department of Health*)

The number of carer’s assessments completed for carers of people with a mental ill-health has increased substantially since 2012 – see table below.

	Mental Health (adults)	CAMHS	Total Mental Health
Apr 12 - Mar 13	523		523
Apr 13 - Mar 14	608		608
Apr 14 - Mar 15	751	523	773
Apr 15 - Mar 16	827	608	901

Source: CIB

Information is available for the number of carer's assessments offered to carers of people with mental ill-health for the year April 2015-March 2016. A total of 2,887 carer's assessments were offered to this group, and only 901 were accepted / completed. We need to understand the reasons why carers are not participating in carer's assessments.

Did it make things better for people with mental ill health and their families?

Generally, the carers of people with mental illness who participated in the focus groups felt that there was a lack of support for them in their caring role.

Those involved with 3rd sector organisations, CAUSE in particular, spoke highly of the support provided by them and through interacting with other carers. CAUSE provide specialist carer advocate support to carers of people with a personality disorder or who are involved with forensic mental health services.

Carers found it difficult to specify what support in terms of respite would be needed, due to the episodic nature of many mental illnesses and also due to the fact that many were not full time carers and their loved ones did not live with them.

In terms of carer's assessments, while there has been an increase in the uptake of mental health carer's assessments, the majority of carers we engaged with felt that these were a waste of time, and little support was provided as a result of a carer's assessment.

The 3 main issues raised by carers of people with mental illness, and not covered in the Bamford Action Plan, were:

(i) **Lack of involvement in care**: The majority felt that they were not involved in the assessment or care of their loved ones. Many voiced concerns that the issue of patient confidentiality was 'overused', and that mental health practitioners could listen and involve them without breaching patient confidentiality. There were concerns that sometimes mentally ill people are unwilling or unable to share information, and that involving carers might provide additional information in terms of how the person is on a day-to-day basis. Carers also felt that they did not know their rights with regards to their involvement in treatment. Concerns were raised about patients being discharged home with no involvement with families / carers, and particularly issues around the management of medication, which often falls to the carer;

(ii) **No support in crisis**: Carers generally felt they had no one to contact in a crisis situation, in particular out of hours. Carers described this as 'frightening';

(iii) **Future planning for people with severe and enduring mental illness**: The work carried out by PCC on the future planning needs for people with mental illness, identified concerns by mental health carers, particularly of those with severe and enduring mental illness, about the future, and who would take on the caring role if they were no longer able to carry it on, what would happen to inheritance, where they would live. There is a need to provide support to carers of people with severe and enduring mental illness to plan for the future.

There is some support for implementing the 'Triangle of Care' (developed by the Carers Trust), as referenced in the Commission on Acute Adult Psychiatric Care's report ***'Building on Progress: Achieving Parity for mental health in Northern Ireland'.***

https://professionals.carers.org/sites/default/files/triangle_of_care_2016_latest_version.pdf

Current policy / service developments

Caring for someone with mental illness can have a significant impact on the carer's own mental health. While work continues to increase short breaks / respite, and to increase the uptake of carer's assessments, it is clear that the caring role of carers of people with mental illness differs substantially from carers of people with a learning disability, and that a different approach needs to be considered.

The Patient & Client Council is completing its study into needs of carers, including mental health carers.

The You In Mind Mental Health Care Pathway

Identified Needs

The following priorities have been identified in terms of supporting mental health carers:

- Determine what kind of support carers of people with mental illness need to help them continue with their caring role;
- Promote peer carer support through 3rd sector organisation and carer forums;
- Provide information/training to carers of people with mental illness on how to help / manage mental health conditions, identify signs of relapse and on their rights as a carer;
- To continue to implement the You In Mind Care Pathway which requires the full and active participation of carers and families in the assessment, treatment and discharge of people with mental illness. The development of the Care Pathway has been influenced by the principles and practices of the Triangle of Care;
- To ensure carers have easy access to 24/7 mental health crisis contact so that they can seek appropriate guidance or professional help quickly in a crisis situation.
- Proactively promote and identify and address barriers to the completion of carer's assessment by carers of people with mental ill-health.
- Provide support for future planning for carers of people with severe and enduring mental illness, to include addressing housing needs.

THEME 4: PROVIDING BETTER SERVICES TO MEET INDIVIDUAL NEEDS

The Bamford Action Plan 2012-15 contained a number of commitments in relation to improving services for people with mental ill health.

Information on Mental Health Services

What did we say we would do?

We said we would improve information on mental health services.

Provide information on child & adolescent and adult mental health services for use by the public, GPs and other clinicians (*Action 61 – Department of Health*)

What did we do?

A new mental health services information hub, hosted on the NI Direct Website, was launched in April 2015. http://mentalhealthservices.nidirect.gov.uk/

Work is also underway on creating a web page for the new Mental Health Care Pathway. This will be linked to the NI Direct Page.

In addition a new Children and Adolescent Mental Health services web page has been developed on the Family Support Network. http://www.familysupportni.gov.uk/

Did it make things better for people with mental ill health and their families?

'Your Experience Matters' reported more people found the information provided by staff in mental health services useful and relevant (64% in 2015 compared to 52% in 2012). There had been no change in the proportion of people who felt they received no information which remained at 14%. There was a slight reduction in the number of people who reported to not know what services were available from 14% in 2012 to 12% in 2015.

Comments made by people who attended the mental health focus groups include the following:

- *Recovery colleges offer good support but some lack of information/promotion. Need for referral / signposting. GPs need to be informed. Advertising in GPs;*
- *Variance in awareness of care pathway; and*
- *High praise of 3rd sector organisations inc AMH, New Horizons, Praxis, Mindwise – people linked in with these organisations had access to information - but need for better signposting to these groups.*

Current policy / service development

The mental health services information hub is regularly updated by the HSC Board.

The need to address issues around the variance in the awareness of the care pathway and the promotion of Recovery Colleges is addressed in the 'Recovery-orientated practice' under Theme 2 above.

There is a need to improve signposting to 3rd sector organisations and support organisations, both for service users and for carers.

Identified Need

There is a need to improve information about and signposting to 3rd sector organisations and support organisations, both for service users and for carers.

Funding

What did we say we would do?

We said we would increase funding in community based mental health services, to provide better services in the community.

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Re-direct HSC funding towards community based services (*Action 59 – Department of Health)*

What did we do?

Health expenditure on Mental Health has increased by 44% (and 17% over inflation) since 2004/05, as set out in the table below. Trust expenditure in 2014/15 was £243.7M, compared to £169.4M in 2004/05. This does not include direct expenditure by the HSC Board, PHA or GP practices in mental health.

In terms of the hospital / community split, mental health expenditure is now 57% in the community, 43% in hospital care, compared to 2004/05 when we spent 46% on mental health community based services and 54% in hospital services. The target of 60% expenditure in community services has not quite been achieved, but we are almost there and we have seen a gradual year-on-year shift in this direction.

Table: Expenditure in Mental Health Services

	2014/15 (£M)	2013/14 (£M)	2012/13 (£M)	2011/12 (£M)	2010/11 (£M)		2004/05 (£M)
Community	£73	£69	£67	£65	£64		£34
Hospital	£105	£104	£105	£102	£104		£91
PSS	£66	£60	£58	£60	£61		£45

Total	**£244**	**£234**	**£230**	**£228**	**£228**		**£169**

(*Note figures rounded to nearest £M*)

Some of the key areas of development in community based mental services are as follows:

- Development of crisis resolution and home treatment teams in each Trust;
- Establishment of Recovery Colleges;
- Establishment of Primary Mental Health Talking Therapy Hubs;
- Development Gender Identity Services
- Development of Community Forensic Teams
- Development of Community Eating Disorder Teams
- Development of Personality Disorders Teams
- Increased access to psychological therapies.

Did it make things better for people with mental ill health and their families?

The audit carried out by the PHA / HSCB in December 2015 'Your Experience Matters' captured the experiences of 720 people who have accessed mental health services and carers indicated a general improvement in mental health services. The key outcomes include:

- More people felt they received the right service at the right time (55% compared to 47% in 2012);

- The number of people who felt they were unable to access services reduced (14% compared to 20% in 2012);

- More people felt stronger after their experience of mental health services – 57% compared to 45% in 2012;

  Fewer people felt stressed, anxious, setback or frustrated after their experience of mental health services – 34% compared to 43% in 2012. (Carers numbers were higher than service users in this area);

- 56% of respondents reported that they had made positive progress compared with 47% in 2012; and

- The proportion of people who are still struggling to cope after accessing mental health services has reduced from 27% to 20%.

There has been a 27% decrease in the number of people being treated in hospital for mental illness since 2012.

Table: Mental Illness Inpatients Resident at 17 February 2016 by Year, 2012 - 2016 (including patients on Home Leave)

Year	**2012**	**2013**	**2014**	**2015**	**2016**	**Change 2012 - 2016**
No of Inpatients	893	840	765	683	651	-242 (27.1%)

Source: Mental Illness and Learning Disability Census 2012 - 2016

Current policy / service development

The focus for mental health service development continues to be on community-based services.

A number of funding bids are being considered including in the areas of physical healthcare for people with mental ill-health, the development of a Regional Mental Trauma Service, the development of a specialist Perinatal Mental Health service and the further enhancement of psychological therapy services.

Mental Health Service Framework

What did we say we would do?

We said we would implement a Mental Health Service Framework (MHSF) to improve standards of care.

Implement the Mental Health Service Framework across HSC (*Action 60 - Department of Health*)

What did we do?

A Mental Health Service Framework was published in August 2012, containing 58 standards. Some were generic standards across all service frameworks and relate to healthy lifestyles eg smoking cessation and the remaining standards covered a diversity of mental health conditions.

There were problems in capturing data for developing benchmarks from which to measure outcomes for the standards and as there was no progress in establishing a mechanism to collate the necessary data, the Department requested that the HSCB carry out a fundamental review of the MHSF in 2014.

A fundamental review of the Mental Health Framework has been carried out and a revised framework is being drafted and we hope to launch it for consultation in December 2016.

Did it make things better for people with mental ill health and their families?

As the new Mental Health Service Framework has not yet been finalised, it is not possible to evaluate the outcomes.

Current policy / service development

A revised Mental Health Service Framework is being drafted and we hope to launch it for consultation in December 2016.

Child and Adolescent Mental Health Services (CAMHS)

What did we say we would do?

We said we would implement a Regional Service Model for Child and Adolescent Mental Health Services (CAMHS) to ensure consistent services across NI.

Implement service model for CAMHS services (*Action 62 – Department of Health*)

What did we do?

The Regional Service Model for Child and Adolescent Mental Health Services (CAMHS) was published in July 2012, and has largely been implemented in the HSCB through a Regional Steering Group and Local Implementation Teams in each Trust.

Key service developments:

- All Trusts now have established Primary Mental Health Care (Step 2) teams (investment of £940K). The HSCB is working with Trusts to expand these teams to support children and young people with autism;
- 29 Family Support Hubs are fully established, which provide a collaborative family support network across community, voluntary and statutory services, with a Primary Mental Health worker linked to each Hub;
- All Trusts have established a Crisis Resolution Intensive Support Team to response to children and young people who have a mental health emergency (additional investment of £1M – total investment £2.5M);
- A Forensic CAMHS team has been established in partnership with Youth Justice Agency (investment of £177K);
- A Regional Gender Identity Service has been developed (Knowing Our Identity (KOI)) (investment of £111K);
- Investment of £340K in the development of Drug and Alcohol services for young people who have substance misuse and mental health needs;;
- ‘Mind Matters’ – an online regional guide to CAMHS services has been developed, as well as the HSCB’s Family Support NI website; www.familysupportni.gov.uk
- The PHA has developed an Infant Mental Health plan, and invested £244K in the provision of training to 367 practitioners;

- Young People and Parent Forums have been / are being established in each Trust; and

- A ‘Working Together, Learning Together’ framework has been developed to guide continued professional development, with investment to date of £85K to support training and development.

Did it make things better for people with mental ill health and their families?

The HSCB / PHA carried out a survey of CAMHS and Autism services in 2016. There were 183 responses on CAMHS, most of these (82%) from parents/ carers. Analysis of the results is underway, but emerging findings indicate that the experience of CAMHS reported by respondents was on the whole very positive. 66% rated their experience good –or very good. Most people said there was good communication, that they found support easily and they felt better after receiving care from CAMHS. There were mixed views about how well staff worked together. The main criticism is around waiting times and difficulty accessing the service.

The full results of the CAMHS audit are due in the coming months and will be used to enhance services in the future.

Current policy / service development

Implementation of the Regional CAMHS Model continues. The immediate priorities for service development include:.

- Integration of CAMHS with wider children services –primary care, child health, social care and specialist CAMHS.
- Early Intervention based on stronger partnership and collaborative working across and between sectors.
- Improve access – SPoE (Single Point of Entry) and to identified vulnerable groups – LAC, Learning Disability.
- Improve and capture service user experience.
- Streamlining and consistency in provision and practice (e.g. Managed Care Network for Acute CAMHS (Regional in-patient Unit, Trusts Crisis resolution & Home Treatment Teams (CRHT); links with secure care and youth justice; interventions that are evidenced based)
- Transitions to adult Services
- Early intervention teams to support adolescents and young adults with psychosis are being developed;
- An Integrated Care Pathway for CAMHS is being developed and will be completed by end of summer 2016;
- Advocacy services for young people are being strengthened;
- Development of workforce plan to address skills gaps and ensure interventions are in line with NICE guidance.

Identified Needs

The following priority needs have been identified in terms of Child & Adolescent Mental Health Services:

- **Improvement of Acute CAMHS through the implementation of the recommendations of the Review of Acute CAMHS (2014)**
- **Enhance the mental health service response for children and young people with a learning disability and mental health needs**
- **Extend CAMHS primary mental health and early intervention services**

Additional investment is required to deliver all of these priorities.

Whilst CAMHS funding has increased over the last few years to the current level of £20M, it is estimated that the shortfall to fully implement the Regional CAMHS Model is around £5M. Current bids for additional funding including the development of a CAMHS Managed Care Network, enhancement of therapeutic provision in inpatient services and development of an enhanced CAMHS service for people with a Learning Disability.

Mental Health Crisis Services

What did we say we would do?

We said we would improve services for people in mental health crisis so that people in crisis will be able to receive appropriate care and support to a consistent standard.

Improve and harmonise model for crisis resolution and home treatment services (*Action 63 - Department of Health*)

What did we do?

Crisis resolution Home Treatment provides assessment and treatment to people who are experiencing a mental health emergency of a nature or severity that would otherwise require admission to hospital.

Approximately £10million is currently invested in crisis resolution and home treatment (CRHT) care. There is a dedicated CRHT team in each Trust, which include consultant psychiatrists, nurses, social workers and step up care services. Each Trust has developed care arrangements for 24/7 Crisis and Urgent Care Services, including approved social work services.

Did it make things better for people with mental ill health and their families?

In 2015, the Health and Social Care Board undertook a review of the Development and Implementation of Crisis Resolution and Home Treatment Teams across the North of Ireland. The establishment of crisis resolution and home treatment services has made a significant difference to the lives of people who present with a mental health emergency. In 2015/16 there were over 20,000 unscheduled care contacts which demonstrate the important role CRHT services. The service has provided a real alternative to inpatient care and has enabled people to remain at home and maintained connection to their families and communities.

Of the 53 individuals from across the Trusts who participated in the review, 91% recorded a positive rate for their experience of Mental Health services.

There were mixed experiences of CRHT services reported in the focus groups held. Some people, particularly those using WRAP and involved in Recovery Colleges appeared to be well informed about crisis services and knew who to contact. Others criticised crisis provision, and there were a number of very negative comments

Another issue which came up consistently was that of carers not knowing who to contact in a crisis situation or out of hours. This will be addressed through the full implementation of the You In Mind which is discussed under Theme 3. Another issue raised by carers is the lack of continuity of care within the CRHT teams, from one day to another.

The Patient & Client Council are finalising a piece of research ' People's experience of the Home Treatment Crisis Resolution Service in Northern Ireland'. This involved 37 participants in discussion groups – 19 service users, 4 carers. Some of the emerging findings are outlined below.

Benefits:

- not having to go to hospital;
- confidence-building after hospital discharge;
- it enabled them to stay at home with family support and with their children;
- it enhanced carers understanding of illness / treatment.

Improvements needed:

- The CRHT is not consistent – in some areas there is a 24 hr service, but not all;
- Issues about lack of continuity of care and difficulties in building therapeutic relationship with staff changes;
- There should be alternative methods for access CRHT services other than through EDs;
- Some people felt staff did not give them enough time due to pressures of the job;
- Some people felt the CRHT teams are gatekeepers to hospital beds and felt they were trying to keep them out of hospital;
- Treating people at home creates pressure on family and carers, and sometimes they are not consulted or involved in care planning;
- Need for better communication with service user / carer.

Current policy / service development

HSC Board is developing a new high intensity acute care model. This will ensure that inpatient services and acute day services will be managed as one service, and aims to improve co-ordination, crisis management and therapeutic support available. This work is expected to be completed by April 2017.

The CHRT review indicated further work was needed to develop the model and to reduce the level of variation across Trusts. It also recommended that the HSC Board and PHA should consider the development of a data set for quality, activity and outcome measures to include patient experience.

The various reviews undertaken have highlighted that further work is needed to support carers when their partners and /or family members are experiencing a mental health crisis. The need for the full involvement and participation of families and carers is covered in the You In Mind Care Pathway, and the development of the new Acute Mental Health Care Pathway will reinforce this.

Psychological Therapies

What did we say we would do?

We said we would improve access to psychological therapies.

Enhance availability of psychological therapies (*Action 64 – Department of Health*)

What did we do?

Further to the publication of the Psychological Therapies Strategy (2010) and in response to the increasing demand for psychological therapies, significant progress has been made in establishing psychological therapy services here. All the 13 recommendations within the strategy have been actioned. The key developments are summarised below:

- Currently more than £10M per year is invested in Psychological Therapy services;
- We now have 294 (WTE) psychologists employed across the Region This includes therapist working in Mental Health, Learning Disability, Children's Adult Health Care and Trauma Services;
- To date the HSCB has invested over £2milion in the establishment of Primary Care Talking Therapy Hubs. Primary Care Hubs have now been established in each Trust locality for treatment of common mental health needs. These Hubs provide a wide range of low intensity talking therapies (Counselling, Interpersonal Therapy, Cognitive Behavioural Therapy etc.) and lifestyle coaching. This service continues to be developed and it will take about 5 years and a further £3M to fully implement the service which would then provide care for up to 20,000 people. These Hubs offer a real alternative to drug therapy, and early indications show improving access to the hubs, with an average waiting time of only four weeks . In the long term, it is anticipated that the establishment of this early intervention service will reduce demand on secondary care;
- The HSCB developed a new Psychological Therapies Mental Health Continuing Professional Development Framework. An additional £300,000 was invested to

support this framework and as a result over 300 staff have benefited from further training in Cognitive Behavioural Therapy Psychotherapy, Family Therapy Interpersonal Therapies, Counselling and Dual Diagnosis Training etc;

- The HSCB developed a new "You in Mind Mental Health Guide to Psychological Therapies. This set out the key evidence based therapies and provides guidance to Trust and provide on the types of therapies which should be provided as part of mental health care and treatment ;
- A computerised Cognitive Behavioural Therapy programme 'Beating the Blues' is available through GPs for the treatment of anxiety and mild-moderate depression. Usage of BtB has increased to over 6000 people. This programme is now linked into Primary Care Hubs and a contract is in place until March 2018 for unlimited use of licenses in NI;
- A Regional Mental Health Care Pathway 'You in Mind' was launched in 2014, which promotes the integration of psychological therapies within mental health care and ensures that people using services have information about what treatment options are available to them; and
- Initial work has taken place on the development of a Regional Mental Trauma Service, and subject to funding, this service, which targets people suffering from Post Traumatic Stress Disorder (PTSD) including those impacted by the Troubles, will be fully developed in the coming years.

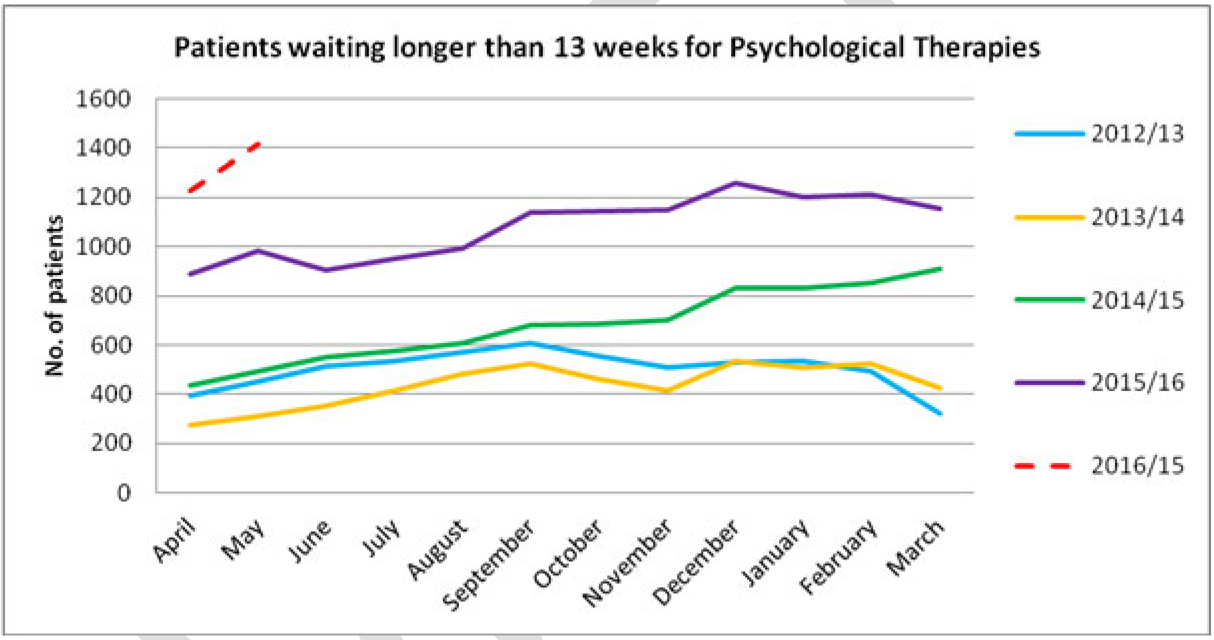
Did it make things better for people with mental ill health and their families?

Despite the development of additional psychological therapy services here, the demand for this service continues to spiral. We currently have almost 4,000 people (June 2016) across the North of Ireland waiting to access psychological therapy services.

It is important to note that not all these people are within Mental Health services. Other people who are referred for psychological therapy services are within Learning Disability, Paediatric, General Health and Older people services. Almost half of those people waiting for psychological therapy services are within Mental Health services, and around a quarter are from Health Psychology (when a physical health condition has a significant effect on a person's life; physically, emotionally, psychologically and socially).

The target waiting time to received psychological therapies is 13 weeks. This target is not being met, and in fact the breaches have increased dramatically over the last 4 years.

At 31 May 2016, 1,413 patients had been waiting longer than 13 weeks to access psychological therapies in the North of Ireland. This was an increase of 15% on the previous month (1,226) and of 44% on May 2015 (983). This upward trend is very concerning. Trust delivery plans for 2016/17 indicate that this position is a significant risk and pressure for the future if additional investment is not made.



Why?

There are a number of factors which contribute to the continuing increasing unmet need for psychological therapy services:

- **Demand**: It is well documented that mental ill health and psychological distress is 25% higher in the North of Ireland compared with the rest of the UK. Around 1 in 4 adults and 1 in 9 children in the North of Ireland will experience mental health problems during their lives. The impact of the Troubles is a contributory factor;
- **Under-investment**: Only 7.5% of the Health Budget is spent on mental health and psychological therapy services. £10.4M is spent on dedicated psychological services. An estimated £2.5M is required to address the current 13-week wait breach. When compared with the rest of the UK, the current gap in funding for

psychological therapies continues to widen and now estimated to be in the region of £12M;

- **Structure and Capacity of Mental Health Teams**: At present there is much variance across mental health teams in terms of the staff mix and skills base. There is a need to review the role and function of core community mental health teams to build expertise and capacity in the provision of psychological therapies within these teams, so that the needs of patients can be met effectively and the resources available are optimised.

An issue raised by carers was that referrals to psychological therapies are seldom made for patients with severe and enduring mental illness, and that if this were offered it could make a serious improvement in quality of life.

Current policy / service development

The development of psychological therapies continues to be a priority. This will require substantial additional investment – the estimated funding shortfall is in the region of £12M, compared to the Improving Access to Psychological Therapies model currently employed in England. Proposals as to how to close this gap will be taken forward during future budgetary rounds.

The HSCB continues to promote Beating the Blues as an alternative pathway for accessing psychological therapies.

Identified Needs

- Need to secure substantial additional targeted investment in Psychological Therapies to fully establish this service, including for people with severe and enduring mental illness;

- Need to review workforce skills of core Community Mental Health Teams and develop solutions to address skills gaps to optimise the use of available resources and develop the capacity of these teams to deliver psychological interventions which are patient-centred, evidence based, cost-effective, and appropriately supervised; and

- Need to develop tools to routinely measure the outcomes of mental health care and treatment, including psychological interventions.

Risk assessment and management

What did we say we would do?

We said we would review the guidance on assessment and management of risk, so that people who may pose a risk to themselves or others, or may be at risk from other people, will have these risks assessed and managed in an appropriate way as part of their treatment and care plan.

Evaluate implementation of regional guidance on assessment and management of risk in mental health and learning disability services (Action 67)

What did we do?

RQIA published a Review of the implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services in October 2012, and recommended that the guidance be reviewed to address issues including of risk tools, positive risk-taking, risk training and the management of Serious Adverse Incidents.

The Regional Mental Health Care Pathway was launched in October 2014. The focus of the new care pathway is on recovery oriented practice and co-production of care plans which include personal safety. It was agreed that guidance on risk assessment and management / safety planning would be developed as part of the supporting documentation for the Mental Health Care Pathway. This guidance has been drafted and is currently being piloted, with an expectation that it will be finalised by early 2017.

Did it make things better for people with mental ill health and their families?

As the new risk management / safety planning guidance is still in development, there are no outcomes as yet.

Current policy / service development

The Promoting Quality Care guidance remains extant until the new guidance is developed. The development of a personal safety plan is a key component of the 'You In Mind' Mental Health Care Pathway.

<u>Medicine Management Services</u>

What did we say we would do?

We said we would improve medicine management services of people with mental ill health living in the community.

Enhance medicine management services for vulnerable patients with mental illness living in the community (Action 68)

What did we do?

- A specialist mental health medicines information website ‘Choice and Medication’ has been launched for use of all community pharmacists, mental health staff and all NI citizens, hosted on HSCB and CPNI websites; http://www.choiceandmedication.org/hscni/

- A dedicated SHSCT pharmacist has been working with the lead Consultant and home treatment team to establish the role of a specialist community mental health pharmacist within the home treatment team.

- Reviews of nursing home patients taking mental health medication have been commissioned involving pharmacist prescribing; and

- A service specification for community pharmacists is under development.

Did it make things better for people with mental ill health and their families?

Information on mental health medicines is now available online for service users and carers. The continued developments of mental health medicines management, including the roll-out of specialist pharmacists within mental health home treatment teams, will continue to improve this service.

Current policy / service developments

Following the conclusion of pilots of mental health pharmacy services in Southern and Belfast Trust areas, specialist pharmacist posts will be introduced across all Trusts during 2016/17.

Personality Disorder Services

What did we say we would do?

We said we would improve services for people with a personality disorder, so they have access to appropriate services.

Enhance services for people with a personality disorder (Action 69)

What did we do?

Progress on the development of Personality Disorder Services here, following the publication of the ‘Personality Disorders Strategy: Diagnosis for Inclusion’ in June 2010, has been made as follows:

- 6 small community-based Personality Disorder teams in place, one in each Trust and one in Prison Health;

- A regional clinical network to share services, skills and expertise, including PBNI and Prison Health, has been developed;

- A training strategy has been developed and is being delivered, with a particular focus on raising the capacity of primary care and other mainstream services to meet the needs of the Personality Disorder population;

- Recovery principles have been adopted, which allow service users and carers to protect their own mental health and offer peer support, education and training;

- Joint training with Forensic services has taken place, where appropriate; and

- An Integrated Care Pathway based on NICE Guidelines has been developed.

Due to budgetary pressures resulting from the Comprehensive Spending Review, the funding initially earmarked for the Personality Disorders Strategy was substantially reduced. The initial focus for the delivery of the Strategy has been on the development of community Personality Disorder services, which are now in place.

Whilst the Strategy recommended a residential unit for adults with a personality disorder, due to the reduced budget for the delivery of the Personality Disorder Strategy, there are currently no plans for a residential unit for those with a Personality Disorder, not in contact with the Criminal Justice System.

General mental health services in all Trusts continue to directly provide case management and the majority of care and treatment interventions and carer support.

Within the current funding envelope the specialist PD services have attempted to fulfil most of the functions ascribed to specialist teams as identified in NICE Guideline 78, however none have been able to fully meet all of the demand in each of the areas. This has led to some variance / difference in emphasis across Trusts. All five HSC Trusts provide consultation, clinical and management advice and training, however in some areas this is restricted to other mental health teams, whilst others have been able to provide this service to Family & Child Care and Criminal Justice colleagues as well. The BHSCT provides specialist self-harm services associated with PD and have a contract with CAUSE for carer support for families of people with PD.

Knowledge and Understanding Framework (KUF) Personality Disorders training is being delivered through the Clinical Education Centre, with staff and service users from BHSCT, NHSCT and WHSCT co-delivering the training programmes; and WHSCT, NHSCT and BHSCT teams have been delivering bespoke co-delivered programmes through their respective Recovery Colleges.

All five Trusts provide at least one modality of specialist therapy.. SEHSCT and the WHSCT have focused on Dialectical Behavioural Therapy (DBT) as their main modality for treating people with high levels of emotional dysregulation and self-harming behaviour due to Borderline Personality Disorder; whilst NHSCT, SHSCT and BHSCT have concentrated on Metallisation Based Therapy (MBT). Only BHSCT have been able to provide a choice of treatment modality and move towards some case management function.

The BHSCT has a contract with CAUSE for PD carer support for families of people with PD; and a dedicated Peer Support Worker. NHSCT have commissioned specialist peer support groups from NIAMH, and WHSCT have provided DBT skills training for NIAMH staff who provide mental health day care; and have developed a post therapy graduate peer support group for relapse prevention.

Only the Trusts with a Consultant Psychiatrist or Consultant Psychologist are able to provide diagnostic advice.

Did it make things better for people with mental ill health and their families?

Feedback from service users at focus groups who had accessed specialist PD services was generally positive, although there were a number of issues highlighted around lack of awareness of the service and difficulties in accessing it:

- Positive about the Personality Disorder Service
- It can be difficult to access services, people don't know where to get help, "post-code lottery"
- lack of knowledge of PD services amongst GPs
- group sessions difficult for some people but positive reports of service where people persevere
- Positive reports on the support from CAUSE and FASA
- Need to be ready to engage in the service.

'the service was second to none when I eventually got to the right service'

The group sessions focus on personal relationships and mentalisation'

There is growing evidence to indicate that DBT is effective in the treatment of Personality Disorders and that it has reduced inpatient days, A&E and Crisis Contacts along with a reduction in onward referrals to Psychiatry and Community Mental Health Teams.

Current policy / service development

The 2010 Personality Disorder Strategy is still extant, and the full development of Personality Disorder services in line with the Strategy remains a priority. This will require additional funding.

Identified Needs

- The continued development of Personality Disorder services in line with the 2010 Personality Disorder Strategy: A Diagnosis for Inclusion. This will require additional funding;
- That outcomes data is developed to measure the most effective modality of treatment for Personality Disorders, with the aim of ensuring a consistent effective approach across the Region;
- That each Trust is able to offer a choice of treatment modalities and in sufficient quantities to meet demand;
- Ensure that specialist family carer and peers support services are available in all areas.

Eating Disorder Services

What did we say we would do?

We said we would provide inpatient services for people with an eating disorder, to ensure continuity of care from community services and so that fewer people would require admission to an inpatient facility outside of the North of Ireland.

Maintain the provision of specific eating disorders inpatient service capacity within each Trust (Action 70)

What did we do?

There have been significant advances in the development of specialist Eating Disorder Services here since the publication of the Bamford Review. A total of £2million is allocated to specialist eating disorder services every year and this has been the case since 2008/09. This figure does not include inpatient care or the cost of treatment for eating disorders provided outside Northern Ireland. Across the North of Ireland there are now over 40 (whole time equivalent) funded specialist eating disorders practitioners, covering children's and adult services. These include consultant psychiatrists, eating therapists and dieticians. This compares with a figure of less than one (whole time equivalent) practitioner in 2005.

The Bamford Action Plan 2012-15 committed us to maintaining inpatient provision for people with an Eating Disorder. This is currently provided mostly in psychiatric wards with input from Community Eating Disorder teams, and this provision has been maintained.

However, there has been some local support for the establishment of a local specialist unit. One key factor in considering the feasibility of a specialist regional eating disorder unit has been the appreciable number of patients who are transferred to facilities outside of the North of Ireland for specialist eating disorders treatment, and the associated cost. A study which commenced in late 2015 reported in March 2016 and it while it did make a case for the possibility of a specialist unit, it also makes a good outline case for prioritising early intervention care in community-based settings, or intensive day support, whilst continuing to treat the most serious cases in existing inpatient facilities, with specialist in-reach as at present. The second phase of the study is underway and will review and assess the most recent policy, medical and service developments, cases, reasons for transfer to Great Britain, local best practice, and gaps in current service, to determine whether the landscape is such that a specialist unit is necessary. Serious consideration will be given to the comparative benefits of enhancing community-based services, such as increasing the number of specially-trained primary care eating disorders therapists.

In addition, the Regulation Quality and Improvement Authority (RQIA) published its report Review of Eating Disorder Services in Northern Ireland in December 2015. The report highlights a number of positive features of current provision. It notes the good partnership working in all Trusts with the community and voluntary sector. It also makes reference to the good leadership in eating disorder teams with motivated, dedicated and compassionate staff with high levels of training. The report goes on to identify a number of areas for improvement and sets out 11 key recommendations. An action plan is currently being developed to take forward the recommendations contained within the report.

Did it make things better for people with mental ill health and their families?

We met with people with an Eating Disorder in a range of locations across the Region. The general feedback on Eating Disorder services here was very positive, with high praise for the local Eating Disorder teams. The importance of the role of support organisations such as Eating Disorders Association, ADAPT-NI, CARED and STAMP-ED was highlighted in providing peer support to sufferers and their families. It was noted that 3rd sector support is not currently available in the Western Trust area, and this needs addressed.

A number of suggestions by service users and carers for improving the service are summarised below. Many of these are reflected in the RQIA Review:

- Variance in the level of understanding of Eating Disorders by GPs. Need for more training;
- More support and information for carers needed. Knowing how to manage the illness while waiting for services is important Need for improved signposting to support organisations, in particular by GPs;
- More awareness raising needed in schools;
- The waiting time for specialist Eating Disorder services is too long, and people with an Eating Disorder can deteriorate very quickly, both physically and mentally;
- There is inconsistence monitoring of bloods by GPs – this is crucial to monitoring the physical condition of Eating Disorder patients in the community and needs to be addressed;
- Alternative softer therapies such as Arts Therapies are useful in helping people to engage in treatment;
- Need for more Family therapy here, with support for the Maudsley approach in particular;
- Transition from CAMHS to Adult Services needs to be gentler. It is difficult to engage with new people and change of approach. Move to adult services problematic for carers in terms of confidentiality and parental involvement;
- There was a general view that staff in medical wards here are inadequately trained in the treatment of Eating Disorders. Some service users described very negative experiences about their time on both mental health and general hospital wards which they felt was due to lack of awareness, understanding and adequate training of staff. This was the case for both children's and adult services;

- When patients are treated outside of NI, there needs to be better communication on return to NI to avoid danger of relapse; and

- Extra-Contractual Referrals: Some service users and carers spoke of very negative experiences when referred outside of the North of Ireland for specialist treatment. Service users reported feeling isolated and lack of communication with their team at home and lack of follow-up on their return. Carers talked about how stressful it was for the whole family having their loved one in hospital in England or Scotland. Some support for a specialist inpatient unit here.

Current policy / service development

The HSC Board and Trusts have agreed an action plan to take forward the recommendations from the RQIA Review of Eating Disorder Services 2015, many of which will address the concerns raised by people with an Eating Disorder and their carers.

The second phase of a DoH / HSCB scoping exercise into the need for a specialist eating disorder unit here is due to report by the end of 2016. This will examine the best options for strengthening eating disorder services to reduce the number of people being sent outside of the Region for specialist inpatient treatment. Further development in this area will require additional investment.

Identified Needs

- To secure funding to invest further in the development of Specialist Eating Disorders in the North, in accordance with the findings of the DoH / HSCB review which is due to report by the end of 2016

Forensic Mental Health Services

What did we say we would do?

We said we would provide low secure and community forensic mental health services, to offer more appropriate levels of therapeutic support and rehabilitation in the least restrictive conditions for those who need forensic services.

Ensure provision of appropriate low secure and community forensic services in line with 2011 review (Action 71)

What did we do?

- Small community mental health forensic teams are now in place and a centrally funded training programme continues; and

- 3 newly refurbished low secure facilities are now in use. A bid for additional funding of £1.5M recurrently has been submitted to fully resource these. Further development is subject to successful bid.

Did it make things better for people with mental ill health and their families?

No evidence of outcomes for people. None of this client group attended the focus groups and 'Your Experience Matters' is not divided into specific MH services.

Current policy / service development

Work continues to develop forensic mental health services under the HSCB's Forensic workplan which includes:

- Training for Forensic staff (multi-disciplinary and interagency) relating to Specialist Risk assessment and Therapeutic programmes;
- A 'New 2 Forensic Programme' (N2F)for new and existing staff has been developed and implemented across 5 Trust areas, Prison Healthcare and PBNI;
- A bespoke programme for PSNI is under development;
- The N2Fprogramme has been evaluated and findings will be out shortly'
- Service user and carer focus groups (Mental Health & Learning Disability) have occurred in Prison healthcare, Southern Trust, Northern Trust and Shannon clinic.
- A GAIN Audit of the Forensic Care Pathway and service user and carer experience underway over 1 year.

We will also be contributing to the implementation of the Health in Criminal Justice Strategy, being jointly developed between the Departments of Health and Justice.

Identified Needs

Estimated further investment of £1.5M is required to fully establish community forensic mental health services.

Perinatal Mental Health Services

What did we say we would do?

We said we would improve the detection and treatment of mental illness during pregnancy and the postnatal period, through improved perinatal mental health services.

Improve Perinatal mental health services (Action 73)

What did we do?

There are currently no specialist Perinatal Mental Health Services in the North of Ireland. Mental health services for expectant or new mothers are currently provided within community mental health teams. Where inpatient care is required, this is provided within existing general adult mental health facilities.

Current services are not in lines with NICE Guideline CG192

In terms of action to improve mental health services to expectant and new mothers, an Integrated Perinatal Mental Health Care Pathway was published in December 2012, by the Public Health Agency, providing regional guidance for all health care professionals who come into contact with pregnant women, to ensure that any mental health problems are identified early and women are directed to the appropriate mental health services. It is currently being updated.

Did it make things better for people with mental ill health and their families?

Anecdotal evidence on the mental health services provided to women during and after pregnancy indicates are that services are not meeting the needs of those woman and that there is a need for specialist perinatal mental health services to be developed.

The RQIA Review of Perinatal Mental Health Services is expected in the coming months, and will provide some insight into patient experience.

Current policy / service development

Following a study into the demand for perinatal mental health inpatient beds here, and the endorsement of NICE guideline CG192 in 2015, the Health and Social Care Board has developed outline proposals for the future development of specialist perinatal mental health services. These proposals include specialist community based services and a regional mother and baby unit. The estimated cost of developing these specialist services is £1.9 million. Future development of these services is subject to additional resources being secured.

RQIA will be carrying out a review of perinatal mental health services in 2016/17 and the recommendations from that review will help inform future development of this service.

Identified Needs

That Specialist Perinatal Mental Health Services, both community and inpatient, are established in the North of Ireland, in line with NICE guideline CG192, and that funding is secure d to develop this service

Dementia Services

What did we say we would do?

We said we would improve services for people with dementia, their families and carers.

Take forward action plan to improve dementia services in line with NI strategy (Action 72)

What did we do?

A number of measures have been taken to improve Dementia Services through the Executive's Delivering Social Change Programme (Dementia), funded by TEO/Atlantic Philanthropies/DoH:

- *Awareness Raising, Information and Support*: dementia website has been launched www.nidirect.gov.uk/dementia; information Guides on different stages of the dementia journey have been published; 10 Dementia Navigators (2 per Trust) are being recruited, with some of these staff are already in place;

- *Training*: a Dementia Learning and Development Framework was been developed which will help close a major gap that exists currently within dementia training and contribute to the creation to an informed, responsive HSC workforce with the knowledge and skills required to meet the needs of persons living with a dementia and their carers. Training commenced in May 2016 to deliver (i) training to support carers and (ii) training that will lead to the creation of 300 Dementia Champions across the H&SC sector;

- *Delirium:* A 'delirium bundle' bundle has been developed which includes an assessment tool (which is being piloted in 10 wards) and a range of recording and training materials. More than 500 staff have been trained in delirium awareness / treatment and training is on-going. The programme will be expanded to include the care home sector; and

- *Short-breaks, Information and Support to Carers: A* range of innovative, person-centred supports (pilots) are being delivered including Emergency Support Services, Enhanced Day Opportunities, Extended Domiciliary Care and Extended Home Support Services The project lead for this element of the programme has been actively working with Trusts, Hospitals and Care Homes to promote 'John's Campaign' for the right of a person with a dementia to have a family care / friend present throughout their stay in hospital / care home

In addition to the above, other elements of the Dementia strategy are being implemented as follows:

- *Research*: 7 research projects to be developed;

- *Mental Capacity Act*: Once commenced, the Act will govern situations where a decision needs to be made in relation to the care, treatment (for a physical or mental illness) or personal welfare of a person aged 16 and over who lacks capacity to make the decision for themselves, regardless of the underlying cause of the lack of capacity;

- *Memory Services (Collaborative)*: The regional Memory Services Collaborative is expected to report in October 2016 and make recommendations for the future design and operation of services;

- *Hospital Audit*: An audit of dementia care in acute hospitals reported in June 2015 and made a number of recommendations across a range of care and practice areas for improvement. Work has begun within Trusts to address these recommendations and arrangements are in place so that the HSCB / PHA have oversight of any developments / implementation arrangements;

- *Learning Disability and Dementia*: A regional care pathway has been developed linked to the Memory Services Collaborative work (referred to above). Staff training and development programmes are being developed / purchased and work is on-going to identify people with a learning disability and dementia;

- *Occupational Therapy*: An OT Memory Rehabilitation programme is being piloted by PHA lead and plans are in place to roll this model out across all 5 HSC Trust areas. Training and staff resources are being developed;

- *Assistive Technology*: A small scale regional pilot is being carried out across all 5 HSC Trusts. Further developments are expected in this area in Phase 2 of the Delivering Social Change Programme; and

- *Palliative Care*: Dementia Strategy Leads have been working with regional palliative care group (Living Matters, Dying Matters) to agree prognostic indicators for people with dementia as they reach the palliative care stage of their life. These indicators are currently with the Living Matters, Dying Matters implementation group awaiting endorsement for use in NI

Did it make things better for people with mental ill health and their families?

All of the workstreams listed under the Delivering Social Change Programme will have external evaluation in line with the agreement between the various funders. OBA Scorecards have been developed and approved by funders.

There are no outcome measures available as yet on the Programme.

Current policy / service developments

Work continues to improve Dementia services through the Delivering Social Change Programme.

The HSC Board is in the process of developing a new integrated service model for Dementia care, which will be supported by a regional care pathway. This will ensure consistent care across primary care and specialist dementia services. It is anticipated that these, subject to approval, will be implemented over a 3-5 year timeframe.

Private Hospitals legislation

What did we say we would do?

We said we would amend legislation so that people detained under the Mental Health Order (NI) 1986 could be treated in private hospitals.

Introduce legislation to extend the provisions of the Mental Health (NI) Order 1986 to private hospitals (Action 66)

What did we do?

The Private Hospitals (Mental Health) Regulations (Northern Ireland) 2013 came into operation on 31 March 2013, which means that people detained under the Mental Health Order (NI) can now be treated in private hospitals.

Did it make things better for people with mental ill health and their families?

At the time a private sector provider had plans to build a private mental health facility near Ballyclare. However these plans have not materialised, and therefore the amendment to the legislation has not been required to date.

Current policy / service developments

This action is complete and the legislation is in operation if required.

Research

What did we say we would do?

We said research would be carried out to improve services in priority areas.

Complete research into priorities highlighted by Bamford rapid reviews (Action 41)

What did we do?

The Bamford Review identified a considerable number of areas of research need. The Review's recommendations for research were further developed in the Bamford Action Plan.

HSC Research & Development commissioned and published (30 November 2011) a series of Rapid Reviews in each of the agreed priority areas of: Children and Young People; Primary Care; Patient outcomes; Advancing Psychological Therapies; Intellectual Disability; Personality Disorders. These reviews aimed to: consider the available literature; identify policy implications; examine specified sub-themes; and determine the key research questions to inform the current call. The Rapid Reviews also provide immediate outputs for use by policy-makers, practitioners and commissioners. Bamford Rapid Review Summary

The Rapid Reviews were peer reviewed by an external panel of international experts who then identified eight priority research questions which formed the call for research within a Northern Ireland Context in the fields of intellectual disability and mental health.

5 research projects were selected and funded under Bamford (total cost £1.44M) to address questions highlighted in the Rapid Reviews carried out previously, as follows:

Study Title	Status	Dates	End Date
A natural experiment investigating differences in how residential facilities support people with intellectual disabilities with challenging behaviour and/or mental health problems	Active	2013-2016	April 2016
Effective family support models during the transition of adults with intellectual disabilities (ID) into old age	Active	2013-2016	June 2016
Transitions & outcomes for care leavers with mental health and/or intellectual disabilities	Active	2013-2016	Complete
Parental Alcohol Use and Resilience in Young People in Northern Ireland: A study of Family, Peer & School Processes	Research Complete	2013-2016	Complete
Improving pathways and care for young people in NI with mental health problems in the transition from CAMHS to adult services (IMPACT)	Active	2013-2016	November 2016

Did it make things better for people with mental ill health and their families?

It is difficult to measure the impact of research projects on people and their families. The research is used and will continue to be used to inform policy and service development to improve services available to people with mental health problems or a learning disability.

Current policy / service developments

A number of the research studies are still to report and will be used to inform policy and service development.

Buildings

What did we say we would do?

We said we would monitor the capital programme to ensure services would be provided in appropriate and fit for purpose buildings.

Monitor / review departmental capital budget (Action 40)

What did we do?

We have invested almost £23M in mental health facilities since 2011. Key developments include the completion of Grangewood, the new Mental Health Unit in Derry, an extension to the Bluestone Unit in Craigavon, commencement of the new Mental Health Unit on the Belfast City Hospital site, and investment in 3 interim secure facilities at Holywell, Clare Villa Knockbracken and Gransha.

Did it make things better for people with mental ill health and their families?

People requiring mental health inpatient care are now being treated in modernised mental health units in Craigavon, Derry and one is being built in Belfast, as well as a regional 33-bed inpatient unit for young people at Beechcroft in Belfast.

Current policy / service developments

Future plans include the provision of modern mental health units in the South Eastern Trust (likely on the Tor Bank school site adjacent to the Ulster hospital), replacement of Holywell in Antrim, and a 2nd mental health unit in the Western Trust (Omagh). Any further developments are subject to availability of capital and an exercise is underway to prioritise these capital schemes.

Identified Needs

To continue to modernise mental health inpatient units, in line with the capital budget.

CONCLUSIONS

Generally, the evaluation found that there had been much progress in the development of mental health services since the Bamford Review, with key achievements including the resettlement of the majority of people out of long-stay hospitals, the establishment of recovery-orientated practice, the development of crisis resolution services and specialist mental health services for people with a Personality Disorder or an Eating Disorder, investment in psychological therapies and improved mental health awareness and suicide prevention measures.

MENTAL HEALTH SERVICES: KEY ACHIEVEMENTS

Mental Health & Wellbeing

- Good progress on promotion of mental health & wellbeing with positive indications on awareness rates and an increase in the number of people seeking help;
- The establishment of a number of suicide prevention measures. While still too high, the suicide rate has remained stable in the last few years;
- Positive indications on reduction of binge drinking, illegal drugs misuse has plateaued and more people are accessing drugs and alcohol services;
- Mental health promotion is embedded through schools with the establishment of the I-Matter programme, Independent Counselling Services in Schools and introduction of anti-bullying legislation;

- Mental health awareness training is being widely delivered to sports organisations;
- Health & Safety Executive NI have provided advice and training to over 70 organisations through Mental Health & Wellbeing at Work Advisory Service, with evidence of reduced work-related stress and associated absenteeism.

Health & Social Care Services

- There was very positive experience of people with mental health problems being involved in the design and delivery of services through the Mental Health Service User Forums and through employment in Recovery Colleges. ;
- Expenditure on mental health services has increased by 44% in 10 years, with almost 60% of this being spent on community-based services;
- Recovery-orientated practice is well embedded in mental health services with the launch of the Regional Care Pathway 'You In Mind', the delivery of recovery training to mental health practitioners and the establishment of Recovery Colleges. Over 150 people with lived experience of mental ill-health are employed as peer support workers and other posts. There is some work to do to ensure this is consistent across the Region, but many people who engaged in the evaluation process spoke of their positive experiences and how they now had hope for the future;
- Implementation of a Regional Child & Adolescent Mental Health Service Model, including the establishment of Primary Mental Health teams and Crisis resolution teams in each Trust, investment in forensic services and the development of a Regional Gender Identity Service;
- Significant progress has been made in establishing psychological therapy services. We currently invest more than £10M per year in Psychological Therapy services and have 294 (WTE) psychologists employed across the Region. Primary Talking Therapy Hubs are now established in each Trust area;
- Specialist Personality Disorder services have been established in each Trust and feedback from service users is that this is working very well in some areas;
- Establishment of Eating Disorder teams in each Trust;
- Community mental health forensic teams are in place and 3 newly refurbished low secure facilities are now in use at Holywell, Clare Villa Knockbracken and Gransha;
- New purpose-built inpatient facilities have been opened at Bluestone and Grangewood, and a new build has commenced at the Belfast City Hospital site.

Resettlement / Housing

- Resettlement is almost complete – out of the original 472 long-stay hospital patients, only 18 remain in hospital and 8 of these continue to require hospital care. There is evidence of much improved quality of life for those resettled.

Further / Higher Education and Training

- A number of initiatives are ongoing to increase the participation of people with disabilities, including mental ill-health, in further and higher education and training. However, there is limited information on the numbers of people with mental health needs accessing these programmes or the outcomes of participation.

Employment services

- An estimated 1,500 people with mental health problems participated in the DfC sponsored programmes Work Connect, Workable (NI) and Condition Management Programme, to support them back into the workplace.

Dementia

- Dementia Services are being improved through the Executive's Delivering Social Change Programme (Dementia).

Identified Needs

There were other areas in which services have not developed fully, which include a shortage of supported housing for those not being resettled out of hospital, trauma services, perinatal mental health services, treatment for people with severe and enduring mental illness and support for mental health carers.

MENTAL HEALTH SERVICES: IDENTIFIED NEEDS / GAPS

Health & Social Care Services

- The development of a Co-Production Mental Health Framework to create a formal mechanism for people with lived experience of mental illness to champion the rights and interests of people with mental health problems, take the role of independent advocates, ensure that mental health services continue to be developed in a way that effectively meets the needs of service users and carers and engage with senior Departmental mental health policy officials, commissioners and Trust mental health managers;
- Continue the implementation of the You In Mind care pathway to ensure consistency across all mental health services;
- Develop a new standard operating model for mental health delivery which will further support the integration of psychological therapies and recovery practice into the role and function of community mental health teams and services, and address the variance across the HSC in the use of recovery-orientated practice;
- Better promotion of and referral to Recovery Colleges, including by GPs;
- Consider what services need to be developed so that recovery-orientated practice outreaches to treat those patients with severe and enduring mental illness;
- The development of a Regional Mental Health Trauma Service;
- Improve signposting for people with mental ill-health and families / carers to support organisations;
- Improve acute Child & Adolescent Mental Health Services;
- Improve mental health services for young people with learning disabilities;
- Improve CAMHS primary mental health services;
- Further development of psychological therapy services is needed to address the increasing demand and improve waiting times. This will require substantial targeted investment – the shortfall is estimated to be in the region of £12M;
- Need to review workforce skills of core Community Mental Health Teams and develop solutions to address skills gaps to optimise the use of available resources and develop the capacity of these teams to deliver psychological interventions which are patient-centred, evidence based, cost-effective, and appropriately supervised;

- Need to develop tools to routinely measure the outcomes of mental health care and treatment, including psychological interventions;
- Need to develop further Personality Disorder services to ensure that a choice of treatment modalities to meet demand, and family carer and peers support services, are available consistently across the Region;
- Secure funding to invest further in the development of Specialist Eating Disorders in the North, in accordance with the findings of the DoH / HSCB review which is due to report by the end of 2016;
- Estimated further investment of £1.5M is required to fully establish community forensic mental health services;
- Need to develop specialist Perinatal mental health services in line with NICE guideline CG192;
- Continue to modernise mental health inpatient units to replace out-dated mental health units in the South Eastern, Northern and (southern sector of the) Western Trusts in line with capital budget Capital;

An additional urgent need has been identified, not through this evaluation, but through an emerging issue identified by the HSC Board and Trusts:

- Establish services to ensure the physical healthcare needs of people with mental ill-health are being met to ensure that they can be cared for in the community safely. This requires investment of an estimated £1M annually to fully implement.

Resettlement / Housing

- Need to complete the resettlement programme;
- Need to improve measurement of betterment as a result of resettlement;
- Need to address housing needs of people with mental ill-health, other than those in long-stay hospitals;
- Need for strategic needs assessment for supported living, improved commissioning arrangements and better regulation.

Support for Carers

- The need for better support to carers of people with mental ill-health through the full implementation of the You In Mind Care Pathway which requires the full and active participation of carers and families in the assessment, treatment and discharge of people with mental illness.
- Ensure carers have easy access to 24/7 mental health crisis contact so that they can seek appropriate guidance or professional help quickly in a crisis situation.
- Provide support for future planning for carers of people with severe and enduring mental illness, to include addressing housing needs.

The majority of the identified needs are within the responsibility of Department of Health, and priorities going forward are set out in the main evaluation report.

In carrying out this evaluation, the Department has gained a detailed understanding of the needs and gaps in services, the issues and problems that need to be addressed, and the areas where services are working and which could form the basis for future improvement. In working to improve mental health, the Department has identified six guiding principles for the future:

1. A move towards parity of esteem for mental health.
2. A focus on recovery.
3. Genuine involvement of experts by experience in the design, delivery and evaluation of mental health services.
4. Service development where resources allow.
5. Structural reform and performance management.
6. The potential for all-island collaboration.

Everything we do on mental health over the next 5-10 years can fit within one of these principles, as **Figure 1** below shows. This is not exhaustive, but it hopefully provides an outline of how we will organise our work.

At all times, we will work together with experts by experience, and there will be formal public consultation when a new service or policy is being developed. We will assess the impacts on equality, human rights, regulation and rural communities.

Within the Department of Health, we will ensure that mental health services are properly linked with primary and secondary care and public health, particularly with regard to anti-stigma, health promotion, suicide and self-harm prevention, dealing with addictions and substance misuse, and reducing health inequalities.

We also need to contribute to improvements in areas where other Departments lead, for example, targeted early intervention for children and young people, services for homeless people, provision for those in the criminal justice system, and recognising that good mental health is good for the local economy.

We will need to take account of the Executive’s budgetary situation, pressures across the Health and Social Care service, and practical issues such as recruitment.

Achieving everything will be a long-term process, and there will be a need to prioritise.

FIGURE1

SIX PRINCIPLES TO IMPROVE MENTAL HEALTH					
MOVING TOWARDS PARITY OF ESTEEM FOR MENTAL HEALTH ***Making progress to the point where mental health gets its fair share of time, effort, attention and resources.***	**A FOCUS ON RECOVERY** ***A good life, with or without symptoms. Focused on what you can do, not what you can't.***	**INVOLVEMENT OF EXPERTS BY EXPERIENCE** ***People who have, or have recovered from, a mental health condition, carers, and voluntary and community sector experts, working with the HSC to design, deliver and evaluate services.***	**SERVICE DEVELOPMENT WHERE RESOURCES ALLOW** ***Filling the gaps in services as funding becomes available.***	**STRUCTURAL REFORM AND PERFORMANCE MANAGEMENT** ***Making the very best use of available resources.***	**ALL-ISLAND COLLABORATION** ***Sharing resources and expertise across the island of Ireland.***
Parity of esteem is the principle by which mental health is given equal priority to physical health. It is not a call for 50-50 funding between physical and mental health, rather, according to the Royal College of Psychiatrists, it would ensure that there would be: o equal access to the safest and most effective care and treatment; o equal efforts to improve the quality of care; o the allocation of time, effort and resources on a basis commensurate	Recovery involves making sense of and finding meaning in, what has happened: becoming an expert in self-care: building a new sense of purpose in life: discovering resourcefulness and possibilities and using these and the resources available pursue aspirations and goals. This would be a common theme running throughout the development of mental health services in the future. Continuing the rollout of Recovery Colleges across the region will be a very	Mental health is leading the way in terms of developing co-production: collaboration between people who provide care, and people with lived experience. This has resulted in the development of networks and the employment of people with lived experience as recovery consultants, peer support workers, educators and advocates. This will be essential to improving mental health in the future and will be integral to all aspects of service development and	**We are working on a range of proposed service developments in relation to:** - physical monitoring of people with mental illness; - a regional perinatal service; - CAMHS services; - eating disorders services; - psychological therapies; - mental trauma;	**Structures** The Board's proposal for an **integrated services model** would see services reorganised into a more coherent way to enable more effective integration of care across primary, secondary and specialist mental health and psychological services. The intention would be to promote earlier intervention, streamlined access points, and co-working across Trust areas. **Service standards** The current Service Framework (December 2010) aims to set out clear standards of mental	The opportunity exists for mental health service development on a North-South basis in a number of areas, such as perinatal mental health services, eating disorder services, and child and adolescent mental health services. There may be the potential to look at joint staff training initiatives. This will require discussion and agreement North and South, and we will explore the potential with our counterparts in the South of Ireland.

with need; o equal status within healthcare education and practice; o equally high aspirations for service users; and o equal status in the measurement of health outcomes. A move towards parity of esteem would be a major help in achieving improvements in mental health provision.	high priority.	delivery. We will also continue to draw on the expertise of the voluntary and community sector.	- personality disorders; - provision in the justice system; - safe places for people suffering from dual diagnoses; and - implementation of the Mental Capacity Act. **We will need to consider what we might do to:** - help and support carers; - enhance crisis support; and - improve acute provision across the region. **Service developments must be:** - affordable and sustainable; - evidence-based; and - focused on clinical governance.	healthcare that are measurable. The Department is working on a revised version which will be issued for consultation in due course. **Finance** We will improve our financial monitoring so that we know for certain how every current and additional pound is spent on mental health and psychological therapies services, and that this spending is effective. **Workforce** The Department is at an early stage in considering a review of the workforce right across the HSC, to ensure that services are appropriately staffed. **Information and technology** The HSC Board is leading an Informatics Project to address issues in relation to availability, management and analysis of data.	

In conclusion, much has been done to improve mental health services in the North of Ireland, and we are in a very different place compared to where we were 10 years ago. There is however much more to do, as identified in this evaluation report. It will take time, extra resource and prioritisation but there is a commitment to improving mental health here and this will be reflected in the new Programme for Government.

ANNEX C: MENTAL CAPACITY ACT

New Mental Capacity Legislation (Action 76)

The Bamford Review of Mental Health & Learning Disability in 2007 recommended a new comprehensive legislative framework for new mental capacity legislation and reformed mental health legislation for Northern Ireland. This recommendation came in the wake of new mental capacity law in both England/Wales and Scotland; and reformed mental health law in both jurisdictions.

In January 2009, the Department published for consultation its policy intention to introduce separate mental capacity and mental health legislation for NI, in line with that in England/Wales and Scotland. The public consultation ran for 3 months; and the responses received overwhelmingly called for a combined piece of legislation encompassing both mental capacity and mental health law. As a result, the then Minister took the decision to proceed with a single Bill in summer 2009, a ground-breaking approach which had not been attempted in any other jurisdiction.

Due to the novel nature of such an approach, extensive and ongoing stakeholder engagement was a key feature of the Bill's development. A project management structure was set up in 2009 and a Stakeholder Reference group was established, the latter of which was particularly important in assisting and informing policy throughout the development phase of the Bill, drafting period and right up until the Bill's introduction to the NI Assembly.

Further public consultations were undertaken on the equality impact assessment of the key policy proposals from July through to October 2010; and the Department of Justice (DoJ) consulted on the criminal justice policy proposals, in July through to October 2012.

Finally, a joint DHSSPS/DoJ public consultation on the draft civil provisions of the Bill; and the policy proposals on the criminal justice aspects of the Bill, was launched on 27 May 2014, closing on 2 September 2014; the responses from which helped shape the final drafts of the Bill.

On the 8th June 2015, the Bill was introduced into the NI Assembly. A chronological summary of the Bill's passage through the Assembly is provided below:

Introduction: 8/6/15

Second Stage: 16/6/15

Committee Stage: 17/6/15 – 25/1/15

Consideration Stage: 16/2/16

Further Consideration Stage: 7/3/16

Final Stage: 15/3/16

The Bill achieved Royal Assent on 9th May 2016, becoming the Mental Capacity Act (Northern Ireland) 2016.

The Act can be viewed at the this link: http://www.legislation.gov.uk/nia/2016/18/contents

Future Priorities

We will fully implement the Mental Capacity Act.

Why?

The Act delivers on a major recommendation of the Bamford Review, to develop a comprehensive legislative framework that introduces mental capacity legislation and reforms mental health law in Northern Ireland.

The Act is intended to protect the human rights and interests of the most vulnerable people in society who may be unable to make decisions for themselves. The Act will help reduce the stigma associated with mental health; and offer enhanced protections for people lacking capacity.

The Act is principles-based and sets out in statute that it must be established that a person lacks capacity before a decision can be taken on their behalf. It emphasises the need to support people to exercise their capacity to make decisions where they can; and allows people to put in place decision-making arrangements (Lasting Powers of Attorney) for a time in the future when they might lack capacity.

If it is established that a person lacks capacity to make a specific decision at a particular time, and no formal decision-making arrangements have been made, the Act puts in place a new, alternative decision-making regime that provides important additional safeguards for the person who lacks capacity, including for example, the requirement that for all interventions there must be a reasonable belief that the person lacks capacity and that what is being proposed is in the person's best interests.

For all serious interventions a formal assessment of capacity must be carried out and a Nominated Person must be put in place and consulted. For some serious interventions further additional safeguards may also apply, such as:

- a second opinion for certain serious treatments;
- appointing and consulting an Independent Mental Capacity Advocate;
- authorisation by an HSC Trust panel; and
- the right to challenge any authorisation by having it reviewed by a Tribunal.

As part of this fused framework, the Act covers decisions which are currently dealt with under the Mental Health (NI) Order 1986 (the Mental Health Order). Once the Act is commenced, the Mental Health Order will no longer apply to persons aged 16 and over.

What will we do?

We will work towards the Act's commencement by progressing work streams essential for full and thorough implementation, including:

- securing the provision of finance;
- drafting and enactment of at least 80 pieces of subordinate legislation;
- drafting and enactment of over 150 consequential amendments;
- drafting of a code of practice;
- addressing jurisdictional issues, including patient transfers;
- design and delivery of training for the health and justice workforces; and
- other delivery issues, such as awareness raising, development of IT solutions and establishment of Trust Panels and the Office of the Public Guardian.

Since Royal Assent in May, the Department has begun work in earnest on the Act's implementation. Preparation of draft regulations and a code of practice is well underway. A virtual reference group consisting of upwards of 120 stakeholders and professionals has been established; and engagement with this group on draft material will continue well into 2017, as we work towards preparing drafts of the Code of Practice and Regulations for public consultation.

Much work is still required to allow for full and effective implementation. In particular there is a need to work with DoJ to implement the Act as it relates to the criminal justice system and, to a lesser extent, the Department of Finance in relation to some financial matters.

A date for commencement has yet to be agreed. Due to the scale of the task ahead it is anticipated that implementation will take a number of years, dependent upon the availability of funding and resources. However, with the right resources in place, the Department is optimistic that the Act could be commenced within the current Assembly mandate.

ANNEX D

EVALUATION OF BAMFORD ACTION PLAN 2012-15
TERMS OF REFERENCE
June 2015

INTRODUCTION

The Bamford Review, an independent review of mental health and learning disability law, policy and service provision, produced a series of 10 reports between 2005 and 2007 and identified the need for major reform of mental health and learning disability services across Government. The Bamford reports contained over 300 recommendations.

The first Bamford Action Plan 2009-11 was Government's response to the Bamford Review. Responsibility for delivery of the Action Plan spanned 8 Government Departments. The Plan contained a total of 147 actions, 80 in respect of mental health and 67 for learning disability, under five themes:

- Promoting positive health, wellbeing and early intervention
- Supporting people to lead independent lives
- Supporting carers and families
- Providing better services to meet individual needs
- Developing structures and a legislative framework

DHSSPS carried out an in-house evaluation report of the 2009-11 Action Plan, in consultation with the other Departments responsible for its delivery. This evaluation found that 80% of the actions were achieved.

http://www.dhsspsni.gov.uk/bamford-evaluation-action-plan2009-2011.pdf

However, feedback from some service users and carers indicated that they did not experience significant change in service delivery on the ground, and that going forward, evaluation of policy/service developments should be outcome-focussed, rather than output-focussed.

The follow-up Bamford Action Plan 2012-15 was published in March 2013. This current action plan contains a total of 76 actions under the same five themes. Responsibility for delivery of the 2012-15 Action Plan spans 8 Government Departments.

http://www.dhsspsni.gov.uk/2012-2015-bamford-action-plan.pdf

The Bamford Action Plan 2012-15 states that evaluation of the Plan should focus primarily on user outcomes that matter to service users and their families, over quantitative outputs.

The Northern Ireland Executive's original intention had been for the evaluation to be taken forward by an independent body. However, pressure on the public finances means that this would not now be the best use of resources. It is therefore being conducted by officials in the Department of Health, Social Services and Public Safety (DHSSPS). Minister Wells advised members of the Ministerial Group on Mental Health and Learning Disability of this decision on 13 January 2015. He advised the NI Executive Ministers and the Bamford Monitoring Group on 3 February 2015.

AIM OF EVALUATION

The aim of this evaluation is to evaluate the impact of the Bamford Action Plan 2012-15 on the lives of people with mental ill health or a learning disability which covers all aspects of their lives, including health, education, employment, training, leisure, housing and transport. This will be a comprehensive, inter-Departmental evaluation, facilitated and led by DHSSPS, which will consider fully the outputs of the Action Plan, i.e. what Government has done and the outcomes, what difference this has made to people's lives, etc. It will also consider: the effectiveness of the current Bamford structures; whether or not the aims of Bamford have been mainstreamed within the ordinary course of business; and make recommendations on the way forward.

SCOPE OF THE EVALUATION

The evaluation will consider three specific aspects of the implementation of the Bamford Action Plan 2012-15:

a. Outputs – i.e. the action which has been taken by Government Departments and their agencies, and the Bamford structures, to progress the Bamford vision, and the progress made.

b. Outcomes – i.e. – the differences made for service users and carers; how services have improved / changed from the service user and carer experience, including what is better and what is worse.

c. Structures – a critical review of the structures in place to deliver Bamford, in the context of the recent and emerging Government policy.

It will also consider the necessary actions and structures to take forward the Bamford vision after March 2016.

TIMING OF ASSIGNMENT

The target date for completion of the Bamford Evaluation is 31 March 2016.

The current Bamford Action Plan 2012-15 expires on 31 March 2015. It has been agreed by the Ministerial Group on Mental Health and Learning Disability that the current Action Plan will be extended until 31 March 2016. This will allow time for the evaluation to be completed without creating a policy vacuum.

METHODOLOGY

Each Department with responsibility for actions within the Bamford Action Plan 2012-15 will take ownership of the evaluation of their own actions. DHSSPS will lead on the completion of the evaluation and collate input from other Departments.

The methodology for carrying out this evaluation is as follows:

	Action	Detail
1	**Develop and agree Evaluation Framework**	DHSSPS will draft an Evaluation Framework for discussion and agreement by the Bamford Inter Departmental Senior Officials Group (IDSOG) and Bamford Monitoring Group. This will set out what will be evaluated.
2	**Evaluation of Outputs**	The evaluation of outputs can be evaluated primarily using quantitative analysis. This will involve each Department with responsibility for actions in the Bamford Action Plan 2012-15 gathering information on what action has been taken to implement their actions. DHSSPS gathers monitoring information on the progress of the actions on a 6 monthly basis. This will be used as a basis for evaluating the outputs, however Departments will add to this with statistical information etc where this is available. As part of this exercise, Departments should cross- reference any reviews or evaluations completed by their Department or by Arms Lengths Bodies, community & voluntary sector etc, in the period 2012-2016, which are linked to their actions in the Bamford Action Plan, highlighting any relevant information or findings therein. DHSSPS will collate the output analysis.
3	**Evaluation of Outcomes**	The evaluation of outcomes requires gathering of qualitative information. Work is required to gather the views of service users and carers across the region and across the mental health and learning disability sectors on how services have changed.

		As part of this exercise, Departments should cross- reference any reviews or evaluations completed by their Department or by Arms Lengths Bodies, community & voluntary sector , in the period 2012-2016, which are linked to their actions in the Bamford Action Plan, highlighting any relevant information or findings therein. Departments will carry out further research on the experiences of people with mental illness or learning disability, and to assess what impact their actions have had on their lives. This might include focus groups, interviews, questionnaires, surveys, liaison with service user groups, community & voluntary sector bodies, professionals working in the field eg clinicians, teachers. The most appropriate approach(es) will be agreed by Departments. Departments will also need to agree how best to build in a degree of independence to the evaluation. There may be opportunities for Departments to work together in carrying out this research, ie where issues / actions are inter-linked. DHSSPS will collate the outcome analysis.
5	**Evaluation of Bamford Structures**	DHSSPS will lead on examining the functions and effectiveness of the Ministerial Group, the Inter Departmental Senior Officials Group and the Bamford Monitoring Group, with input from other Departments. In addition, all Departments will consider the delivery mechanisms for the Bamford actions and how effective these are.

ROLES AND RESPONSIBILITIES

The evaluation will be led by DHSSPS with input from the other Departments with responsibility for actions in the Bamford Action Plan 2012-15.

The Bamford Inter Departmental Senior Officials Group will act as the steering group for the evaluation. Quarterly meetings will be held to update on progress.

The Bamford Monitoring Group will provide support to Departments in engaging with service users and carers and will assist with the research into patient experience.

The Ministerial Group on Mental Health and Learning Disability will receive updates on progress at their 6-monthly meetings, and will consider and, if content, approve the final evaluation report.

OUTPUTS AND TIMETABLE

Target date for completion of the evaluation is March 2016. An indicative timetable for the various phases of the evaluation is set out below.

OUTPUT	TARGET DATE
1. Agree Terms of Reference	End May 2015
2. Develop and agree Evaluation Framework	End May 2015
3. Evaluation of Outputs and Outcomes of Bamford actions	End October 2015
4. Analysis of effectiveness of Bamford structures	End November 2015
5. Gap Analysis	End November 2015
6. Develop options for way forward	End December 2015
7. Finalise report	End January 2016
8. Ministerial group sign-off	End March 2016

BAMFORD EVALUATION: EVALUATION FRAMEWORK

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
HEALTH & SOCIAL CARE	Has Learning Disability Directed Enhanced Services been implemented across the Region?	Action 5 (DHSSPS)	Do people with a Learning Disability have equal access to the full range of primary health care services? What difference has DES made to them? Is the general health of adults with LD better as a result?	Is this service available across all Trusts? How many people using service? Are people healthier as a result? Are illnesses being picked up earlier / referred to services earlier?
	Have all long stay patients in learning disability and mental health hospitals been resettled in the community? How many?	Action 13 (DHSSPS)	Do people with a mental health problem or learning disability have a choice about where they live, who with? Are people happier in current setting? Do you feel supported? What do they do now that they couldn't do in the hospital setting?	How many people have been resettled? Where have they been resettled to? Are people who have been resettled happy in their new homes?
	What actions have been taken to facilitate a culture of recovery across all mental	Action 32 (DHSSPS)	Is a recovery based approach to mental health now embedded in services? Is your life better as a result? Eg job, social activities,	HSCB – is there data on outcomes of mental health service users? Any comparison from pre-

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
	health services?		friends	recovery approach? Are people living better lives?
	What actions have been taken to enhance day opportunities for people with a learning disability?	Action 50 (DHSSPS)	Is there improvement in day opportunities for people with a learning disability? Is there a wider range of opportunities? Are these person-centred? Have people's lives improved as a result?	Eg Statistics on what people with a learning disability do after school? Is there reduced reliance on day centres? How many people are eg in supported employment, further education.
	What action has been taken to develop community forensic learning disability services? Has this resulted in people being resettled from long stay hospitals who otherwise would have remained there?	Action 54 (DHSSPS)	Have community forensic services for those with a learning disability improved? How have their lives improved as a result?	Eg how many people living in the community are supported by community forensic LD services? Are there comparative figures? How many people have been able to be resettled from hospital as a result of community forensic LD services being in place?

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
	What action has been taken to improve the experience of people with a learning disability in acute general hospitals?	Action 57 (DHSSPS)	Has the experience of people with a learning disability in acute general hospitals improved? Are staff trained to support these people? Is information available and accessible?	How many staff have been trained in supporting people with a LD in hospital? RQIA review of GAIN guidelines.
	What has been done to ensure mental health and learning disability services are provided in appropriate, accessible, fit for purpose buildings?	Action 40 (DHSSPS)	What is the service user / carer experience of mental health and learning disability facilities. Are they accessible and fit for purpose?	What capital works / capital build have taken place on MH and LD facilities? Are they fit for purpose? How can they be further improved?
	What measures have been taken to embed a recovery –orientated approach in mental health services?	Action 32 (DHSSPS)	What difference has the recovery approach made to the lives people with mental illness? Has your life improved?	What are the outcomes for people with mental illness as a result of the recovery approach? Are more people in jobs / training / accessing social and

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
				leisure opportunities? Less dependent on medication? Discharged from mental health services?
	Has a Regional model for crisis response and home treatment been implemented?	Action 63 (DHSSPS)	Are people in crisis now able to access appropriate care and support?	How has this impacted on hospital admissions / lengths of stay? Are people more able to be cared for at home?
	What has been done to enhance availability of psychological therapies?	Action 64 (DHSSPS)	Is there improved access to psychological therapies?	How many people are accessing PT on annual basis? What is the outcome in terms of recovery / reduced dependency on medication etc
	What has been done to improve access to CBT programmes?	Action 65 (DHSSPS)	Is there improved access to CBT programmes? How effective has this been for people with mild to moderate	How many people are accessing Beating the Blues? Has this helped

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
			depression?	them / prevented them from having to access Step 3 MH services?
	Has regional guidance on risk management been implemented?		Are people who pose a risk to themselves or others, or who are at risk from others, being assessed and managed appropriately as part of their treatment and care plan?	Has there been a reduction in incidents that could be attributed to new risk management guidance?
	How have personality disorder services been enhanced?	Action 69 (DHSSPS)	Is there better access to services for people with a personality disorder and their carers?	What are the outcomes of the PD service for service users? Has this improved their condition / aided recovery?
	What has been done to improve Dementia services?	Action 72 (DHSSPS)	Have Dementia services improved from a service user / carer perspective?	Quantitative and qualitative evidence from service users, families and carers.
	Have inpatient eating disorder services been	Action 70 (DHSSPS)	What is the patient experience of inpatient eating disorder services in	Are there fewer referrals outside of NI for treatment

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
	introduced?		NI?	of an eating disorder?
	What has been done to improve Perinatal mental health services?	Action 73 (DHSSPS)	Are women with mental health problems in the perinatal period more supported and provided with appropriate services to meet their needs?	Has there been an increase in early detection and treatment of mental illness during pregnancy and the post natal period? How many health professionals trained in identifying perinatal mental health problems?
	Has an assessment of the mental health needs of victims and survivors been completed?	Action 33 (OFMDFM)	How is this assessment informing service need? Are mental health services meeting the needs of victims and survivors?	How many victims and survivors have accessed appropriate mental health services? What has been the outcome for these people?
	Has the Regional CAMHS Service Model been fully implemented across the Region?	Action 62 (DHSSPS)	What is the patient experience of CAMHS in NI? What is the experience of carers? Are young people recovering from mental illness?	Are all CAMH Services available consistently across Northern Ireland? Have waiting lists reduced?

THEME	**ACTIONS** **WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?**	**BAMFORD ACTION PLAN 2012-15 REF**	**BETTERMENT** **HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?**	**EVIDENCE** **HOW DO WE MEASURE SUCCESS?**
				Has the need for inpatient care reduced? Have ECRs reduced? Are there fewer young people transitioning to adult mental health services?
CARERS NEEDS	What has been done to enhance arrangements for respite and short breaks? Are all carers offered a carer's assessment? Have the future caring requirements for people with a learning	Action 37 (DHSSPS) Action 38 (DHSSPS) Action 39 (DHSSPS)	Are carers more supported to continue in their caring role? Do they get breaks from caring? Has there been improvement in the range of options for short break / respite? Is support provided in line with assessment? Are your needs re-assessed when circumstances change? Are carers assisted to plan for the future of their loved ones?	Statistics on number of service users accessing respite services. Is this consistent across the Region? Statistics on number of people offered a carer's assessment. What support is now provided to those people? Has support increased? What arrangements are

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
	disability living with elderly carers been identified?			there if the caring arrangements break down?
EMPLOYMENT& TRAINING	Have HSE provided advice / support to high stress risk work sectors? What has DEL done to provide support to people with mental ill health or a learning disability to access further education, higher education and sustain employment opportunities?	Action 9 (DETI) Actions 16, 17, 18, 20, 21,22, 23, 24 34, 35 (DEL)	Do people in high stress work sectors feel supported in their jobs? Have people with mental ill health or a learning disability been offered the opportunity to access targeted support to participate in the Work Connect programme? For those who availed of this offer, has this specialist support programme improved the employability or employment outcomes for these participants? Are people with mental ill health or a learning disability being assisted to	Has stress-related ill health and absenteeism reduced in high stress work sectors? How many people with mental ill health or a learning disability are participating in the Work Connect programme? How many participants had improved employability as a result? How many participants moved into employment as a result? How many people with a learning disability or mental

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
			stay in work through specialist disability programmes such as Workable and Access to Work? Are people with mental health problems and disabilities being supported to make decisions about and participate in appropriate education, training and employment?	ill health are being supported in the workplace through specialist disability programmes administered by DEL? Improved retention, achievement and success in HE among people with a mental illness or learning disability. Development of a monitoring mechanism for assessing improved retention, achievement and success in further education among people with a mental illness or learning disability will be considered’

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
	What action has been taken by DEL Careers Service to improve working arrangements with post primary schools and statutory support organisations?	Action 19	Have people with mental ill health and/or learning disabilities been able to easily access DEL's Careers Services to assist them in their career decision making. Has DEL's Careers Service engaged with more young people with disabilities? Has engagement with schools and support organisations improved?	Number of partnership agreements with post primary schools and support organisations. The number of transition planning meetings and annual reviews attended by DELs Careers Service. Number of partnership agreements with post primary schools and support organisations. Numbers of referrals from schools and support organisations. The number of transition planning meetings and annual reviews attended by DELs Careers Service.

THEME	**ACTIONS** **WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?**	**BAMFORD ACTION PLAN 2012-15 REF**	**BETTERMENT** **HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?**	**EVIDENCE** **HOW DO WE MEASURE SUCCESS?**
	What support has DEL's Community Family Support Programme (CFSP) provided to people with mental ill health or a learning disability? The CFSP has been designed to help families make life changing decisions to enhance their prospects and to become full participants in society. During the 26 week programme families receive help to address the health, social, economic, educational, employment and	Action 20	Has the programme improved the well being and lives of people with mental illness or a learning disability?	Outcome of evaluation questionnaire which, includes, questions of Locus of Control, Self Efficacy and Well Being, to measure the difference of how people feel about themselves at the start and end of the programme.

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
	training issues that impact on their daily lives. (Nov 13 to March 15) N.B. The CFSP is not exclusively for people with a mental health or learning disability. Therefore empirical data will be limited.			
EDUCATION	Has the Early Years Strategy been introduced?	Action 2	How have children been prepared, supported and encouraged to learn?	How many children have had the opportunity to achieve their potential through early years education? How has the Strategy better equipped pupils to deal with transition to Primary School?

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
	What is the current position with regards to the Review of Special Educational Needs and Inclusion?	Action 26 (DE)	*N/A as SEN legislation not yet introduced*	*N/A as SEN legislation not yet introduced*
	What measures have been taken to improve services for children with challenging behaviours? Have regional guidelines on management of challenging behaviours been implemented?	Action 47 (DHSSPS / DE)	Do parents feel supported in managing their children's challenging behaviours? Do teaching staff feel better equipped to manage children with challenging behaviours?	Are there support services available to help parents manage challenging behaviours? Are schools / teachers trained in the management of challenging behaviours? What strategies are in place regionally for the management of challenging behaviours in school?

THEME	**ACTIONS** **WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?**	**BAMFORD ACTION PLAN 2012-15 REF**	**BETTERMENT** **HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?**	**EVIDENCE** **HOW DO WE MEASURE SUCCESS?**
	What action has been taken to improve transitions planning for young people with a learning disability or mental health problem?	Action 52 (DE)	Do young people feel supported in making informed choices about their future after school? Is the young person's views taken into account? Are parents involved? Are young people well prepared for transition from school?	Does everyone get a transitions plan? Does this plan meet the needs of the person?
	What actions have been taken by DE to promote pupils' emotional health and wellbeing and develop resilience?	Action 10 (DE)	Do pupils feel that their school provides a caring and supportive environment? Are pupils aware of where to seek help if they need it?	Have these actions better equipped pupils to deal with challenging personal situations?
	Has access to independent counselling support been maintained in all post primary schools?	Action 11 (DE)	Are pupils aware of support offered in school and how to access it? How has this service helped you with problems you were experiencing?	Can all pupils of post primary age access independent counselling support in school? Is this service used widely by pupils?

THEME	**ACTIONS** **WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?**	**BAMFORD ACTION PLAN 2012-15 REF**	**BETTERMENT** **HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?**	**EVIDENCE** **HOW DO WE MEASURE SUCCESS?**
HOUSING	Are people with a learning disability or mental illness now not living unnecessarily in hospital? Has DSD scoped capacity/suitability of existing supported housing to maximise resources? Does commissioning of new provision consider capacity / suitability?	Action 13 (DHSSPS)	Do people have a choice about where they live and who they live with? Are people supported to live in the community? Are people resettled from hospital settings integrated in their communities and are they able to access things like leisure and social activities, jobs, training? Do people have a choice who to live with and where? Are people integrated into their local communities?	How many people have been resettled from hospital into the community? Is there evidence that these people have a greater quality of life than before? Is supported housing available for those who need it? Is it suitable, safe and does it provide the support required?
LEISURE & RECREATION	Has DCAL implemented its 10 yr Strategy for Sports and Recreation? What	Action 3 (DCAL)	Are there more opportunities for people with a learning disability or mental illness to participate in sports and recreation? Do people know	Has there been an increase in the number of people with mental illness or a learning disability

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
	measures have been taken to target people with mental illness or a learning disability?		about these opportunities and are the supported to participate?	participating in sports and physical recreation?
BENEFITS / SELF DIRECTED SUPPORT / FINANCE	Has a strategy for improving the uptake benefits been implemented? What measures have been taken to improve benefit uptake?	Action 44 (DSD) Action 43 (DSD)	Is appropriate support provided to improve the uptake of benefits? Have you or your family been encouraged to review your entitlement to benefits?	Has the uptake of benefits increased? Are staff trained in supporting people with a learning disability or mental illness to access benefits?
	What action has been taken to share information with and seek input from people with mental ill health or a learning disability in respect of Welfare	Action 45 (DSD)	Are people with a learning disability or mental ill health informed about the impact of Welfare Reform/ Universal Credit? Do they understand the impact?	How have people with a LD/MH been informed about the impact of Welfare Reform / Universal Credit for them? How have their views / concerns been taken on board?

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
	Reform / Universal Credit?			
	What action has DHSSPS / HSCB taken to increase the uptake of self-directed support?	Action 25 (DHSSPS)	What is the service user / carer experience of self-directed support? Is it easy to access? Does it provide people with choices regarding services to meet their needs?	Has there been an increase in the uptake of self-directed support / quantify this? Is there measurement of outcomes of this vs HSC-provided support?
TRANSPORT	What measures have been taken to improve information on transport for people with a learning disability?	Action 29 (DRD)	Do people with a learning disability have access to the information they need to avail of public transport?	What transport information is accessible and readily available for people with a learning disability?
	What measures have been taken to improve the provision of travel training schemes for people with a learning disability?	Action 30 (DRD)	Are people with a learning disability equipped with the skills to use public transport independently?	What improvements have been made to travel training schemes for people with a learning disability? How many people are accessing these schemes? What are the

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
	Have public transport staff been trained in the needs of people with a learning disability?	Action 31 (DRD)	Are transport staff aware of the needs of people with a learning disability and can they respond to these? Are people with a learning disability supported to access transport?	outcomes eg how many are competent / confident in using public transport? Are more people with a learning disability using public transport independently? Has there been any evaluation of their experience in using public transport?
INFORMATION	Has a central point for information on health services and support available been developed? Has mapping information on all learning disability services been completed?	Actions 46, 51, 61 (DHSSPS)	Do people with mental health problems, learning disabilities and their carers have ready access information about local health services and support available to them?	Qualitative benefits of new information sources.

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
	Has information on CAMHS and adult MH services been published on Trust websites for use by public and clinicians?			
	Has DCAL delivered on the Health in Mind programme, to provide improved information about mental health, skilled people with mental ill health and their families to enable them to access and use information?	Action 36 (DCAL)	Do people with mental ill health have improved access to information and support as a result of the Health in Mind programme?	How many people with mental illness participated in the Health in Mind programme? What have the outcomes of the programme been?
INVOLVEMENT	What has DHSSPS / HSCB done to support employment of experts by experience in the commissioning and	Action 28 (DHSSPS)	How have services improved as a result of the employment of experts by experience?	How many experts by experience are now employed in the delivery of mental health and disability services? Are there better

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
	delivery of mental health and disability services?			clinical outcomes as a result of the employment of experts by experience?
	Is there Personal and Public Involvement (PPI) in planning, commissioning, delivery and evaluation of health services?	Action 42 (DHSSPS)	Do service users and carers feel involved in the design, delivery, management, review and development of mental health and learning disability services? Are service users and carers involved in all aspects of their care?	How are service users and carers involved in the design, delivery, management, review and development of mental health and learning disability services? How does this improve services?
	Has DSD completed research into customers with disabilities?	Action 43 (DSD)	Is there more understanding in DSD of the difference disability benefits makes to people?	How has this research informed policy and strategy in DSD?
BAMFORD STRUCTURES	Has the Bamford Inter-Ministerial Group performed its role effectively?	Action 74 (DHSSPS) Action 75 (DHSSPS)	Were service users and carers involved in the development of the Bamford Action Plan 2012-15?	Has the Bamford Inter-Ministerial Group met its objectives as set out in the Terms of Reference?

THEME	ACTIONS WHAT HAVE GOVERNMENT AND THE BAMFORD STRUCTURES DONE?	BAMFORD ACTION PLAN 2012-15 REF	BETTERMENT HOW HAS THIS MADE PRACTICAL IMPROVEMENTS TO THE LIVES OF PEOPLE?	EVIDENCE HOW DO WE MEASURE SUCCESS?
	Has the Bamford Inter-Departmental Senior Officials' Group performed its role effectively? Have the various Bamford sub-groups performed their roles effectively? Has the Bamford Monitoring Group performed its role effectively?		Are service users and carers represented on all Bamford related groups? Are we receiving feedback from service users and carers on the implementation of Bamford across all sectors? What should be in place after 31 March 2016 to maintain the momentum of the Bamford developments?	Has the Bamford IDSOG met its objectives as set out in the Terms of Reference? Has sufficient and appropriate strategic and operational direction been provided in the implementation of the Action Plan? Is there overlap between groups / structures? Has the BMG met the objectives set in the Terms of Reference?

Department of
Health, Social Services
and Public Safety
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LEARNING DISABILITY SERVICE FRAMEWORK

Working for a Healthier People

INVESTOR IN PEOPLE

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Foreword

As Minister for Health I am determined to protect and improve the quality of health and social care services and ensure that these are safe, effective and focussed on the patient. Driving up the quality of services and outcomes for people will be my underlying priority. I am committed to working, not only to improve health but to tackle inequalities in health.

I am particularly pleased, therefore, to launch the Learning Disability Service Framework for implementation. This Framework aims to improve the health and wellbeing of people with a learning disability, their carers and families, by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.

Service Frameworks aim to set out clear standards of health and social care that are both evidence based and measurable. They set out the standard of care that service users and their carers can expect, and are also to be used by health and social care organisations to drive performance improvement through the commissioning process. The Learning Disability Service Framework is one of five Frameworks to be issued for implementation to date and, that focus on the most significant causes of ill health and disability in Northern Ireland, namely: cardiovascular disease, respiratory disease, cancer, mental health and learning disability. Two further Frameworks, for children and young people and older people are currently at various stages of development.

This latest Framework has been developed actively involving a wide range of people across all aspects of health and social care including, patients, clients and carers, all of whose support has been invaluable. I would like to convey my sincere thanks, to you all, for your immensely important contribution.

Edwin Poots MLA
Minister for Health, Social Services and Public Safety

LEARNING DISABILITY SERVICE FRAMEWORK

Summary of Standards

Safeguarding and Communication and Involvement in the Planning and Delivery of Services

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 1: (Generic) All HSC staff should ensure that people of all ages are safeguarded from harm through abuse, exploitation or neglect.	1. All HSC organisations and organisations providing services on behalf of the HSC have a **Safeguarding Policy** in place, which is effectively aligned with other organisational policies (e.g. recruitment, governance, complaints, SAIs, training, supervision, etc.) The Safeguarding Policy is supported by robust procedures and guidelines.	Establish baseline Performance levels to be determined once baseline established
	2. All HSC organisations and organisations providing services on behalf of the HSC have **Safeguarding Plans** in place.	Establish baseline Performance levels to be determined once baseline established
	3. All HSC organisations and organisations providing services on behalf of the HSC have **safeguarding champions** in place in order to promote awareness of safeguarding issues in their workplace.	Establish baseline Performance levels to be determined once baseline established

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 2: People with a learning disability should as a matter of course make choices or decisions about their individual health and social care needs. This needs to be balanced with the individual's ability to make such decisions and then the views of their family, carers and advocates should be taken into account in the planning and delivery of services, unless there are explicit and valid reasons to the contrary agreed with the person.	1. Evidence that people with a learning disability their family and carers have been involved in making choices or decisions about their individual health and social care needs.	Establish baseline Performance levels to be determined once baseline established.
Standard 3: (Generic) All patients, clients, carers and the public should have opportunities to be actively involved in the planning, delivery and monitoring of health and social care at all levels.	1. To be developed by Commissioners	Establish baseline Performance levels to be determined once baseline established.
Standard 4: Adults with a learning disability should be helped by HSC professionals to develop their capacity to give or refuse informed consent.	1. Organisations that care for and support people with a learning disability have organisational strategies and/or policies for person and public involvement. 2. Evidence that robust processes are in place where capacity has been judged to be an issue within HSC services or services commissioned by HSC.	All HSC organisations Develop and implement SAAT Performance levels to be determined based on outcomes of SAAT.

STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 5 (Generic) All patients, clients, carers and the public should be engaged through effective communications by all organisations delivering health and social care.	1. To be developed by Commissioners	Establish baseline Performance levels to be determined once baseline established.
Standard 6: People with a learning disability should expect effective communication with them by HSC organisations as an essential and universal component of the planning and delivery of health and social care	1. Percentage of people with a learning disability who do not use speech as their main form of communication who have been supported to establish a functional communication system. 2. Develop and agree a regional training plan for staff in both HSC and services commissioned by HSC to raise awareness of communication difficulties and how they may be addressed.	Develop and implement SAAT Performance levels to be determined based on outcomes of SAAT. Regional Training Plan in place. Training is delivered in accordance with Regional Training Plan.
Standard 7: People with a learning disability should receive information about services and issues that affect their health and social wellbeing in a way that is meaningful to them and their family.	1. All HSC organisations should provide evidence that they are making information accessible to people with a learning disability. 2. Each person with a learning disability can access a named person who can signpost them to relevant services.	Development and implementation of SAAT. Performance levels to be determined once baseline established. Establish baseline of information provided Performance levels to be determined once baseline established.

STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 8: People with a learning disability, or their carer, should be able to access self directed support in order to give them more control and choice over the type of care and support they receive.	1 Evidence of provision of accessible information on Direct Payments within HSC organisations.	Develop and implement SAAT. Establish performance levels based on outcomes from SAAT.
	2 Percentage of requests for Direct Payments from people with a learning disability that were approved.	Develop and implement SAAT. Establish performance levels based on outcomes from SAAT.
	3 Number of adults with a learning disability in receipt of Direct Payments expressed as a percentage of those in contact with Trust (regional percentage is 2.25%).	Performance levels to be determined based on available resources and included in final Framework
	4 Number of children with a learning disability in receipt of Direct Payments expressed as a percentage of those in contact with Trust (regional percentage is 3.50%).	Performance levels to be determined based on available resources and included in final Framework
	5 The HSC Board and Trusts have plans in place to extend the range and scope of self directed support including how they will develop skills and expertise in relevant staff.	HSC Board and all Trusts.
Standard 9 (Generic) Service users and their carers should have access to independent advocacy as required.	1. To be developed by Commissioners	Establish baseline Performance levels to be determined once baseline established.

Children and Young People

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 10: From the point at which concerns are raised that a child or young person may have a learning disability, there is an action plan in place to determine the nature and impact of the learning disability	1. Percentage of parents who express satisfaction with the assessment process and how the outcomes were conveyed.	Establish baseline of information provided. Performance levels to be determined once baseline established.
Standard 11: Children and young people should receive child-centred and co-ordinated services through assessment to ongoing care and support from the point at which a determination has been made that they have a learning disability.	1 Percentage of children and young people with a learning disability and carers who have been offered an assessment either under the Family Health Needs Assessment or UNOCINI Assessments. 2 Percentage of children and young people who have an agreed support plan detailing a pathway to receiving appropriate care and support.	Establish baseline Performance levels to be determined once baseline established Establish baseline Performance levels to be determined once baseline established

STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 12: HSC services should respond to the needs of children and young people who have a learning disability and complex physical health needs in a manner that is personalised, developmentally appropriate and which support access to appropriate care.	1 Percentage of parents whose child has a learning disability and complex physical health needs who have an identified key worker with co-ordinating responsibility. 2 Percentage of children and young people with complex physical health needs who have effective transition arrangements in place between hospital and community. 3 Percentage of children with a learning disability and complex physical health needs who have received a multi-professional assessment using the regional universal assessment tool. 4 Percentage of children and young people with a learning disability and complex physical health needs who are receiving care under the integrated care pathway.	Scope requirements and produce audit plan. Audit 50% of information available. 100%. Establish baseline Performance level to be established when baseline is established. Fast Trace arrangements for access to hospital/community services to be audited following establishment of baseline. 90% 95% 98% Establish baseline Performance levels to be determined once baseline established

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 13: Any child or young person who cannot live at home permanently should have their placement/ accommodation needs addressed in a way that takes full account of their learning disability.	1 Percentage of looked after children or young people with a learning disability who cannot live with their families who have a Permanency Plan. 2 Percentage of looked after children or young people with a learning disability who cannot live at home, who have access to specialised placements where the need for this is indicated in the Permanency Plan.	Establish baseline Performance levels to be determined once baseline established Establish baseline Performance levels to be determined once baseline established

Entering Adulthood

Standard 14: Young people with a learning disability should have a transition plan in place before their 15th birthday and arrangements made for their transition to adulthood by their 18th birthday.	1. Percentage of young people who express satisfaction that their transition plan has been implemented within 2 years of leaving school. 2. Evidence of transfer to DES, where appropriate, for health checks for children on transition to adult services.	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes 90% 95% 98%.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 15: People with a learning disability should be supported to have meaningful relationships, which may include marriage and individual, unique, sexual expression within the law, balancing their rights with responsibilities.	1. Regional guidelines on sexuality and personal relationships are developed to ensure a consistent approach.	HSC Board policy developed and agreed.
	2. Trusts to facilitate appropriate training for staff.	40% 80%
	3. Trusts to facilitate appropriate training for service users and family carers.	Level to be established pending development of regional policy.
	4. Increase in the number of people with a learning disability accessing sexual health and reproductive healthcare services.	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes

Inclusion in Community Life

Standard 16: Adults with a learning disability should be able to access support in order that they can achieve and maintain employment opportunities in productive work.	1. Percentage of school leavers with a learning disability who access work placements or employment within one year of leaving school (as percentage of total learning disabled school leaving population).	Establish baseline. Performance levels to be determined once baseline established
	2. Percentage of adults with a learning disability who receive HSC support to help them secure employment (as a measure of those who request support).	Establish baseline. Performance levels to be determined once baseline established

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 17: All adults with a severe or profound learning disability should be able to access a range of meaningful day opportunities appropriate to their needs.	1. Percentage of adults with a severe or profound learning disability who have meaningful day opportunities in mainstream community settings.	Establish baseline. Year on year increase to be determined once baseline established.
	2. Percentage of adults with a severe or profound learning disability who express satisfaction with the choice of day opportunities they can access.	Establish baseline. Year on year increase to be determined once baseline established.
Standard 18: All parents with a learning disability should be supported to carry out their parenting role effectively.	1. Develop and agree a regional protocol between children's and adult services for joint working and care pathways.	HSC Board in collaboration with all Trusts.
	2. Percentage of parents with a learning disability who have a multi-professional/agency competence based assessment.	Establish baseline. Performance levels to be determined once baseline established.
	3. Percentage of parents with a learning disability involved in child protection or judicial processes who have received locally based skills training.	85% 90% 95%
	4. Percentage of parents with a learning disability involved in child protection or judicial processes who have access to the services of an independent advocate.	Establish baseline. Performance levels to be determined once baseline established.

Meeting General Physical and Mental Health Needs

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 19: All people with a learning disability should have equal access to the full range of health services including services designed to promote positive health and wellbeing.	1. All acute hospitals should have an action plan for implementing the GAIN Guidelines for improving access to acute care for people with a learning disability and be able to demonstrate a clear commitment to the implementation of such a plan.	All HSC Trusts establish baseline. Performance levels to be determined once baseline established.
	2. Percentage of GPs who have a system for identifying people with a learning disability on their register.	Baseline as per learning disability DES. Performance levels to be determined once baseline established.
	3. Each GP practice has a designated link professional within local learning disability services.	Establish baseline. Performance levels to be determined once baseline established.
	4. Evidence of reasonable adjustments by health service providers.	Establish baseline. Performance levels to be determined once baseline established.
Standard 20: (Generic) All HSC staff, as appropriate, should advise people who smoke of the risks associated with smoking and signpost them to well-developed specialist smoking cessation services.	1. Percentage of people accessing smoking cessation services who have heard about the service from an HSC professional.	Establish baseline. Performance levels to be determined once baseline established.
	2. Percentage of people accessing smoking cessation services offered by HSC providers who have quit.	Establish baseline. Performance levels to be determined once baseline established.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 21: All people with a learning disability should be supported to achieve optimum physical and mental health.	1. Each HSC Trust has a health improvement strategy for people with a learning disability (children and adults) to address all relevant physical and mental health promotion and improvement needs.	All Trusts have in place a health improvement strategy for people with a learning disability.
	2. Percentage of adults with a learning disability who have an annual health check.	Establish baseline. Performance levels to be determined once baseline established.
	3. Percentage of adults with a learning disability, who have an up to date and active Health Action Plan (HAP) following the annual health check.	Establish baseline. Performance levels to be determined once baseline established.
	4. Percentage of people with a learning disability who have been examined by a dentist in the past year.	Establish baseline. Performance levels to be determined once baseline established.
	5. Percentage of females with a learning disability who access cervical and breast screening services.	Establish baseline. Performance levels to be determined once baseline established.
	6. Percentage of people with a learning disability who have a sight test with an optometrist in the past year.	Establish baseline. Performance levels to be determined once baseline established.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 22: All people with a learning disability who experience mental ill health should be able to access appropriate support.	1. A regional protocol is developed to ensure that people with a learning disability can access mainstream mental health services. 2. Percentage of people with a learning disability and mental health needs who access mainstream mental health services e.g. psychological and talking therapies where indicated in their treatment plan. 3. Percentage of Health Action Plans and health checks which include mental health assessment and mental health promotion.	Protocol in place. Establish baseline. Performance levels to be determined once baseline established. Establish baseline. Performance levels to be determined once baseline established.
Standard 23: (Generic) All HSC staff, as appropriate, should provide people with healthy eating support and guidance according to their needs.	1. Percentage of people eating the recommended 5 portions of fruit or vegetables each day.	Establish baseline. Performance levels to be determined once baseline established.
Standard 24: (Generic) All HSC staff, as appropriate, should provide support and advice on recommended levels of physical activity.	1. Percentage of people meeting the recommended level of physical activity per week.	Establish baseline. Performance level to be determined once baseline established.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 25: (Generic) All HSC staff, as appropriate, should provide support and advice on recommended levels of alcohol consumption.	1. Percentage of people who receive screening in relation to their alcohol consumption.	Establish baseline. Performance level to be determined once baseline established.

Meeting Complex Physical and Mental Health Needs

Standard 26: All people with a learning disability whose behaviour challenges should be able to get support locally from specialist learning disability services and other mainstream services, as appropriate, based on assessed need.	1. Percentage of individuals with significant challenging behaviours who have a Behaviour Support Plan including advance directives in place that detail actions to be undertaken in the event of their challenging behaviours escalating.	Establish baseline. Performance level to be determined once baseline established.
	2. Where challenging behaviours present a significant risk to the individual or others or a risk of breakdown in accommodation arrangements, a specialist assessment has been completed within 24 hours.	Establish baseline. Performance level to be determined once baseline established.
	3. Where challenging behaviours present a significant risk to the individual, a Management Plan has been developed and implemented within 48 hours.	Establish baseline. Performance level to be determined once baseline established.
	4. Evidence that HSC has engaged with other relevant delivery partners in developing and implementing consistent approaches in individual cases.	All HSC Trusts

STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 26 (continued)	5. Percentage of people labelled as challenging who are not living in a congregate setting described as a challenging behaviour or specialist assessment/treatment service.	Establish baseline Performance levels to be determined once baseline established
Standard 27: All people with a learning disability who come into contact with the Criminal Justice System should be able to access appropriate support.	1. Evidence that the HSC has engaged and developed local protocols with relevant delivery partners to achieve consistent and co-ordinated approaches to working with people with a learning disability who have offended or are at risk of offending.	Protocols in place.

At Home in the Community

Standard 28: HSC professionals should work in partnership with a variety of agencies in order to ensure that the accommodation needs of people with a learning disability are addressed.	1. Percentage of support plans that take account of people's aspirations in relation to future accommodation needs, including independent living.	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes
	2. Percentage of parents with a learning disability who have a multi-professional/agency competence based assessment.	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes
	3. Percentage of people in receipt of public funding living in households of 5 people or less with a learning disability.	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes

STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 28 (continued)	4. Percentage of people (including the resettlement population) leaving learning disability hospital within one week after treatment has been completed.	95% 97% 100%
Standard 29 (Generic) All HSC staff should identify carers (whether they are parents, family members, siblings or friends) at the earliest opportunity to work in partnership with them and to ensure that they have effective support as needed**.**	1. Number of HSC Trust front line staff in a range of settings participating in Carer Awareness Training Programmes 2. The number of carers who are offered Carers Assessments 3. The percentage of carers who participate in Carers Assessments	Improvement targets set by H&SC Board in conjunction with Carers Strategy Implementation Group
Standard 30: All family carers should be offered the opportunity to have their needs assessed and reviewed annually.	1. Percentage of carers who express satisfaction at their annual review that their needs as identified in the carers' assessment have been met.	Establish baseline. Performance levels to be determined once baseline established.

Ageing Well

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 31: All people with a learning disability should have the impact of ageing taken into account in having their future needs assessed and proactively managed.	1. Percentage of people whose care plan has been reviewed taking account of issues associated with ageing.	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes
	2. Percentage of carers aged 65 years and over receiving domiciliary or short break support services.	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes
Standard 32: All people with a learning disability should have access to dementia services at whatever age it becomes appropriate for the individual.	1. Percentage of people with a learning disability and dementia who can access appropriate dementia services as required.	Establish baseline. Performance levels to be determined once baseline established.
	2. Percentage of people with a learning disability and dementia who have received additional supports following a dementia diagnosis.	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes
	3. Percentage of HSC professionals and other support providers who have received awareness training on the needs of people with a learning disability and dementia.	Establish baseline. Performance levels to be determined once baseline established.

Palliative and End of Life Care

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 33: (Generic) All people with advanced progressive incurable conditions, in conjunction with their carers, should be supported to have their end of life care needs expressed and to die in their preferred place of care	1. Percentage of the population that is enabled to die in their preferred place of care.	Establish baseline. Performance levels to be determined once baseline established.
	2. Percentage of population with a understanding of advance care planning	Establish baseline. Performance levels to be determined once baseline established.
Standard 34: All people with a learning disability being assessed for supportive and palliative care should have their learning disability taken into account in consultation with them, their carers and learning disability services when appropriate.	1. Palliative care services have mechanisms to identify whether people have a learning disability.	Establish baseline. Performance levels to be determined once baseline established.
	2. Evidence of specific actions in service delivery that make reasonable adjustment for their learning disability.	Establish baseline. Performance levels to be determined once baseline established.

A NOTE ON TERMINOLOGY

The following terms will be used throughout this document:

> ‘carer’ will be used to describe a family member including children and young people or informal carers
>
> ‘HSC organisation’ will be used to describe a variety of health and social care providers, such as, the HSC Board, HSC Trusts and the Public Health Agency.
>
> ‘service user’ will be used to describe those who use learning disability services

A glossary of terms used is provided in Annex A

CHAPTER 1: INTRODUCTION TO SERVICE FRAMEWORKS

Background

The overall aim of the Department of Health, Social Services and Public Safety (DHSSPS) (the Department) is to improve the health and social wellbeing of the people of Northern Ireland (NI).

In support of this the Department is developing a range of Service Frameworks, which set out explicit standards for health and social care that are evidence based and capable of being measured.

The first round of Service Frameworks focuses on the most significant causes for ill health and disability - cardiovascular health and wellbeing; respiratory health and wellbeing; cancer prevention, treatment and care; mental health and wellbeing; and learning disability. Work has also commenced to develop Service Frameworks for children and young people and older people.

Service Frameworks have been identified as a major strand of the reform of health and social care services and provide an opportunity to:

- strengthen the integration of health and social care services;
- enhance health and social wellbeing, to include identification of those at risk, and prevent/ protect individuals and local populations from harm and /or disease;
- promote evidence-informed practice;
- focus on safe and effective care; and
- enhance multi-disciplinary and inter-sectoral working.

Aim of Service Frameworks

Service Frameworks will set out the standards of care that service users, their carers and wider family can expect to receive in order to help people to:

- prevent disease or harm;
- manage their own health and wellbeing including understanding how lifestyle affects health and wellbeing including the causes of ill health

and its effective management;

- be aware of what types of treatment and care are available within health and social care; and
- be clear about the standards of treatment and care they can expect to receive.

All Service Frameworks incorporate a specific set of standards that are identified as Generic. These, essentially, are intended to apply to all the population, or all HSC professionals or all service users, regardless of their health condition or social grouping. These include:

- safeguarding (Generic Standard 1);
- involvement (Generic Standard 3);
- communication (Generic Standard 5);
- independent advocacy (Generic Standard 9);
- smoking prevention & cessation (Generic Standard 20);
- healthy eating (Generic Standard 23);
- physical activity (Generic Standard 24);
- alcohol (Generic Standard 25);
- carers (Generic Standard 29); and
- palliative care (Generic Standard 33).

These Generic standards reinforce the holistic approach to health and social care improvement and reflect the importance of health promotion in preventing medical or social care issues occurring in the first place. Their inclusion ensures:

- equality of opportunity for all;
- the communication of consistent messages to service users and providers of HSC; and
- a consistent approach in the design and delivery of services.

Service Frameworks will be used by a range of stakeholders including commissioners, statutory and non-statutory providers, and the Regulation and Quality Improvement Authority (RQIA) to commission services, measure performance and monitor care.

The Frameworks will identify clear and consistent standards informed by expert advice, research evidence and by national standard setting bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE). The auditing and measuring of these standards will be assisted by the Guidelines and Implementation Network (GAIN) which will facilitate regional audit linked to priority areas, including Service Frameworks.

The standards, in the context of the 10 year Quality Strategy[1], will aim to ensure that health and social care services are:

i. **Safe** – health and social care which minimises risk and harm to service users and staff;

ii. **Effective** – health and social care that is informed by an evidence base (resulting in improved health and wellbeing outcomes for individuals and communities), is commissioned and delivered in an **efficient** manner (maximising resource use and avoiding waste), is **accessible** (is timely, geographically reasonable and provided in a setting where skills and resources are appropriate to need) and **equitable** (does not vary in quality because of personal characteristics such as age, gender, ethnicity, race, disability (physical disability, sensory impairment and learning disability), geographical location or socioeconomic status).

iii. **Person centred** – health and social care that gives due regard to the preferences and aspirations of those who use services, their family and

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[1] Quality 2020: A 10-Year Quality Strategy for Health and Social Care in Northern Ireland

carers and respects the culture of their communities. A person of any age should have the opportunity to give account of how they feel and be involved in choices and decisions about their care and treatment dependent on their capacity to make decisions. In absence of the capacity to make decisions they should listen to those who know and care for the person best.

Involving and communicating with service users, carers and the public

The Department has produced guidance, "Strengthening Personal and Public Involvement in Health and Social Services"[2], which sets out values and principles which all health and social care organisations and staff should adopt when engaging with the public and service users. These include the need to involve people at all stages in the planning and development of health and social care services. This policy position has been strengthened by the introduction of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and the statutory duty it places on HSC organisations to involve and consult with the public. (Art 19)

It is important that the views of service users and carers are taken into account when planning and delivering health and social care. The integration of the views of service users, carers and local communities into all stages of the planning, development and review of Service Frameworks is an important part of the continuous quality improvement and the open culture which should be promoted in HSC.

The Department is committed to involving those who use learning disability services (experts by experience), their carers and wider families. Through the proactive involvement of the service users and carers in the planning of Service Frameworks, it is hoped that concerns and ideas for improvement can be shared and that the standards developed in partnership with service users,

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[2] DHSSPS (2007) Guidance on Strengthening Personal and Public Involvement in Health and Social Care (HSC (SQSD) 29/07) http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

carers and the public will focus on the issues that really matter to them.

It is also important that Service Frameworks provide service users and carers with clear and concise information, which is sensitive to their needs and abilities, so that they can understand their own health and wellbeing needs. To facilitate this, easy access versions will be made available for all Service Frameworks. Service Frameworks will also be made available in various other formats e.g. Braille, large print and audio tape. The Department will also consider requests for other formats or translation into ethnic minority languages.

People are ultimately responsible for their own health and wellbeing and that of their dependents, and it is important that service users, their carers and wider family are made aware of the role they have to play in promoting health and wellbeing.

Involving other agencies in promoting health and wellbeing

Improving the health and wellbeing of the population requires action right across society and it is acknowledged that health and wellbeing is influenced by many other factors such as poverty, housing, education and employment. While Service Frameworks set standards for providers of health and social care services it is essential that HSC services work in partnership with other government departments and agencies both statutory and non-statutory to seek to influence and improve the health and social wellbeing of the public.

People who use health and social care services, including learning disability services, may have complex needs which require inputs from a range of health and social care professionals and other agencies.

The benefits of multidisciplinary team working and multiagency working, including voluntary and community organisations, are well recognised and it is a key component of decision making regarding prevention, diagnosis, treatment and ongoing care. This will be a key theme underpinning the development and implementation of Service Frameworks.

Data Collection

As Service Frameworks are implemented it is important that timely, accurate information is available to support decision-making and service improvement.

To support this, data sources are identified, early in the development stage, to match the key performance indicator (KPI) data definitions. It is through the data source that progress can be monitored. Where robust baseline data is not available Frameworks will be looking to audits, including Self Assessment Audit Tools (SAATs), to gather information, establish baselines and set future performance levels.

Research and Development

It is important that Service Frameworks are based on valid, relevant published research, where available, and other evidence.

Education and Workforce

Education and workforce development occur at individual, team, organisational, regional and national levels: they are part of the drive to promote quality. The ongoing development and implementation of Service Frameworks will influence the education and training agenda and curricula content for all staff involved in the delivery of health and social care. This will require a commitment to lifelong learning and personal development alongside a focus on specific skill areas to ensure that newly qualified and existing staff are in a position to deliver on quality services.

Leadership

Effective leadership is one of the key requirements for the implementation of Service Frameworks and will require health and social care professionals from primary, community and secondary care to work together across organisational boundaries, including other governmental departments and the voluntary and community sectors. It is essential that Service Frameworks are given priority at senior, clinical and managerial level and implemented throughout all HSC organisations.

Affordability

Extensive discussions have been held with key stakeholders on the overall costs of delivering the Learning Disability Service Framework in the context of the very significant challenges facing health and social care services. Many of the standards do not require additional resources and should be capable of delivery by optimising the use of existing funding. Where there are additional costs associated with specific standards, performance indicators and targets will be reviewed and adjusted as necessary, in the light of the available resources in any one year.

Securing additional funding that may be needed to advance some standards will undoubtedly create challenges. However, Service Frameworks constitute the distillation of the best advice and guidance available and there is great value in setting out our aspirations to improve quality in the care of people with a learning disability, even if we cannot commit to achieving every standard fully or as quickly as we would like. Even in the most difficult of times we must continue to set challenging targets in an effort to improve services.

The Department will work closely with the HSC Board, and other stakeholders, in developing an achievable, prioritised implementation plan for this Service Framework that will deliver real benefits and improved quality of services.

CHAPTER 2: LEARNING DISABILITY SERVICE FRAMEWORK

Introduction

The aim of the Learning Disability Service Framework is to improve the health and wellbeing of people with a learning disability, their carers and their families by promoting social inclusion, reducing inequalities in health and social wellbeing, and improving the quality of care.

The Learning Disability Service Framework sets standards in relation to:

- safeguarding and communication and involvement in the planning and delivery of services
- children and young people
- entering adulthood
- inclusion in community life
- meeting general physical and mental health needs
- meeting complex physical and mental health needs
- at home in the community
- ageing well
- palliative and end of life care

The Learning Disability Service Framework is initially for a three-year period from 2013 – 2016. It will be the subject of further review and continuing development as a living document as performance indicators are achieved, evidence of changed priorities emerge and new performance indicators are identified.

Process for developing the Learning Disability Service Framework

The development of Service Frameworks is overseen by a multi-disciplinary Programme Board, which is jointly chaired by the Chief Medical Officer and the Deputy Secretary of the Department. The Learning Disability Service Framework was lead by a Project Board who were accountable to the

Department's Programme Board for ensuring the completion of the project within agreed timescales and to DHSSPS guidelines. The Project Board was informed by a project team with representation from all aspects of the service including service users, carers, advocates and voluntary organisations. The full project membership is set out in Annex B.

In order to develop the standards, 5 working groups were established which ensured broader representation and expertise. These groups and their membership are set out in Annex C. These groups produced the preliminary reports that informed the development of the standards.

External quality assurance was provided by Mr Rob Greig, National Development Team for Inclusion (NDTi) and Dr Margaret Whoriskey, Scottish Executive.

Equality Screening

The Framework has been screened to take account of Section 75 of the Northern Ireland Act 1998 and any potential impact that the Framework might have on Human Rights. It is the recommendation of the Project Team that the Framework does not negatively impact on equality of opportunity and therefore does not require a full Equality Impact Assessment.

Values

The core values outlined in the Equal Lives Review (2005) have been adopted in full in the development of the Learning Disability Service Framework. These core values when enshrined in practice will ensure that independence is promoted for all people with a learning disability. (Annexe D)

Policy and Legislative Context

The Learning Disability Service Framework is congruent with the legal and policy context for the delivery of supports to people with a learning disability.

This has over recent years increasingly been underpinned by concepts of rights, inclusion and citizenship.

The onus on public authorities to promote equality of opportunity is also enshrined in the Northern Ireland Act (1998) which states that "*a public authority shall, in carrying out its functions in Northern Ireland, have due regard to the need to promote equality of opportunity between persons with a disability and persons without.*"

The Reform and Modernisation of Mental Health and Learning Disability Services Review (Bamford - May 2007)

A review of policy, practice and legislation relating to Mental Health and Learning Disability was commissioned by DHSSPS in October 2002. The Review concluded in August 2007 and produced ten reports (Annex E) that detailed the vision for supporting people with a learning disability, promoting mental health and wellbeing at all levels of society and for the delivery of specialist health and social care for everyone who needs it.

The DHSSPS response to Bamford, 'Delivering the Bamford Vision' (2008) (the Action Plan) states, "*the Northern Ireland Executive accepts the thrust of the recommendations*", and sets out proposals to take the recommendations forward over the next 10 – 15 years.

The Learning Disability Service Framework builds on the approaches to supporting people with a learning disability proposed in the Bamford Review and the subsequent Action Plan.

Consistency with other documents

The Learning Disability Service Framework has taken cognisance of reports and documents that have been or are being developed by DHSSPS and other regional groups, including:

- Transforming Your Care (DHSSPS, 2011)
- *Investing for Health* strategies;
- The Quality Framework – as outlined in *Best Practice Best Care (2001);*

- The *Reform and Modernisation* of HSC;
- Personal and Public Involvement (PPI) (DHSSPS, 2007)
- National Institute for Health and Clinical Excellence guidance (NICE)
- Social Care Institute for Excellence guidance (SCIE)

Human Rights and Social Inclusion

A key priority for health and social care services and the wider community is to tackle stigma, discrimination and inequality and to empower and support people with a learning disability and their families to be actively engaged in the process. This is underpinned by legislation from Europe and the United Kingdom (UK) as well as international law. A summary of all the relevant documentation can be found in “Promoting Social Inclusion” (including the UN Convention on the Rights of People with Disabilities[3] (UNCRPD)), The Reform and Modernisation of Mental Health and Learning Disability Services (Bamford - May 2007) and the “Human Rights and Equality” Report (Bamford - October 2006).

Human rights, as enshrined in the Human Rights Act (1998) UK, derive from the fundamental principles that:

- human beings have value and should be treated equally based on the fact that they are human beings first and foremost; and
- human worth is not based on either capacity or incapacity.

Human rights include the right to life, liberty and security and respect for a private and family life.

As this Framework also aims to address the particular issues facing children and young people with a learning disability and their family carers it is also underpinned by the four core principles of the UN Convention on the Rights of Children:[4]

- non-discrimination;

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[3] UNCRPD http://www.un.org/disabilities/default.asp?id=150

[4] UNCRC http://www.article12.org/pdf/UNCRC%20Official%20Document.pdf

- devotion to the best interests of the child;
- the right to life, survival and development; and
- respect for the views of the child.

How to read the rest of this document

Each Service Framework follows an individual’s journey from infancy through to end of life care taking into account the different health and social care needs of children, adults and older people. In the Learning Disability Service Framework each standard is accompanied by a statement written from the perspective of a person with a learning disability, in order to make them more meaningful to those for whom the Framework is primarily aimed.

Each standard sets out the evidence base and rationale for the development of the standard, the impact of the standard on quality improvement as well as the performance indicators that will be used to measure that the standard has been achieved within a specific timeframe. Each standard is presented in the same way. Figure 1 shows the information that is included in each standard.

Explaining the Standards

Overarching Standard This is a short statement that outlines what will be delivered and includes a statement written from the perspective of a person with a learning disability			
Rationale This is a short section that outlines why/how the standard will make a difference for people using learning disability services. **Evidence** This includes brief references for the research evidence or guidance that the standard is based on.			
Responsibility for delivery/implementation			
This lists the HSC organisations tasked with responsibility for delivering the standard. It will include partners in care such as other government departments and agencies and voluntary organisations and community groups that have contractual or service level agreements with health and social care organisations.			
Quality Dimensions			
The impact of the standard on quality improvement is identified in relation to the five core values outlined in the Equal Lives Review (2005) (Annexe D). These include: • Citizenship • Social Inclusion • Empowerment • Working Together • Individual Support			
Performance Indicator This information will be monitored to show if the standard is being delivered.	**Data Source** This identifies where the information will be derived from.	**Anticipated Performance Level** This describes how well the service must perform against this indicator.	**Date to be achieved by** This specifies when the anticipated performance level should be reached.

Figure 1

Many of the standards apply to both adult services and services for children and young people. Each standard has been colour coded for ease of reference. It should be noted that there are some standards that may apply to both adults and young people, for example, Standard 13 (meaningful relationships) but will continue to be colour coded for adult services.

Standard applies to children, young people and adults with a learning disability

Standard applies only to children and young people with a learning disability

Standard applies only to adults with a learning disability

The rest of this document is divided into the following chapters:

Chapter 3	sets out the rationale for developing a Learning Disability Service Framework
Chapter 4	sets out the standards for safeguarding and communication and involvement in the planning and delivery of services
Chapter 5	sets out the standards for children and young people
Chapter 6	sets out the standards for entering adulthood
Chapter 7	sets out the standards for inclusion in community life
Chapter 8	sets out the standards for meeting general physical and mental health needs
Chapter 9	sets out the standards for meeting complex physical and mental health needs
Chapter 10	sets out the standards for at home in the community
Chapter 11	sets out the standards for ageing well
Chapter 12	sets out the standards for palliative and end of life care

CHAPTER 3: WHY DEVELOP A SERVICE FRAMEWORK FOR LEARNING DISABILITY?

Introduction

Learning disability may be defined as follows:

> *A learning disability includes the presence of a significantly reduced ability to understand new or complex information or to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood with a lasting effect on development.* (Equal Lives, 2005)

Prevalence of Learning Disability

In determining the prevalence of learning disability in NI the Bamford Review (2005) cited a study based on information held by the former Health and Social Services Trusts, which estimated the numbers as shown in Table 1.

Table 1: Prevalence Rates (per 1,000) (15)

Age Bands	**Mild/Moderate**	**Severe/Profound**	**Total**
0-19	6432	1718	8150
20-34	2504	1047	3551
35-49	1489	949	2438
50+	1473	753	2226
Totals	**11,898**	**4468**	**16,366**

However, the Review notes that these figures may be an underestimate as many people classed as *possibly having learning disability* may not be making any demands on health and social care services at present but could do so in the future.

Nonetheless, the overall prevalence rate of 9.7 persons per 1000 is higher than that reported for the Republic of Ireland (RoI) and for regions of Great Britain (GB).

The Review also anticipates that there will be increased numbers of people with a learning disability in the next 15 years. In addition, it notes the likelihood that higher proportions of these individuals will have increased care and support needs due to old age or additional complex needs.

Of particular importance to their quality of life is the need to promote their inclusion in society so that individuals with a learning disability can participate in the communities in which they live and access the full range of opportunities open to everyone else.

Developing a Service Framework for people with a learning disability serves a number of functions:

- For people with a learning disability, it details what it is they can expect in terms of care and support to meet their individual needs in ways that they understand and are accessible.
- For carers and families of people with a learning disability, it outlines what it is they can expect in terms of access to services for their family member and of their involvement as partners in the planning processes.
- For staff in front line service delivery, it enables them to communicate effectively in assisting people with a learning disability to access mainstream and specialist HSC services appropriately.
- For commissioners and those with responsibility for the delivery of services in the statutory and independent sectors, it assists them in achieving an integrated model of services and supports around the person in line with the expectations of service users and their families.

Relating the Learning Disability Service Framework to other Service Frameworks

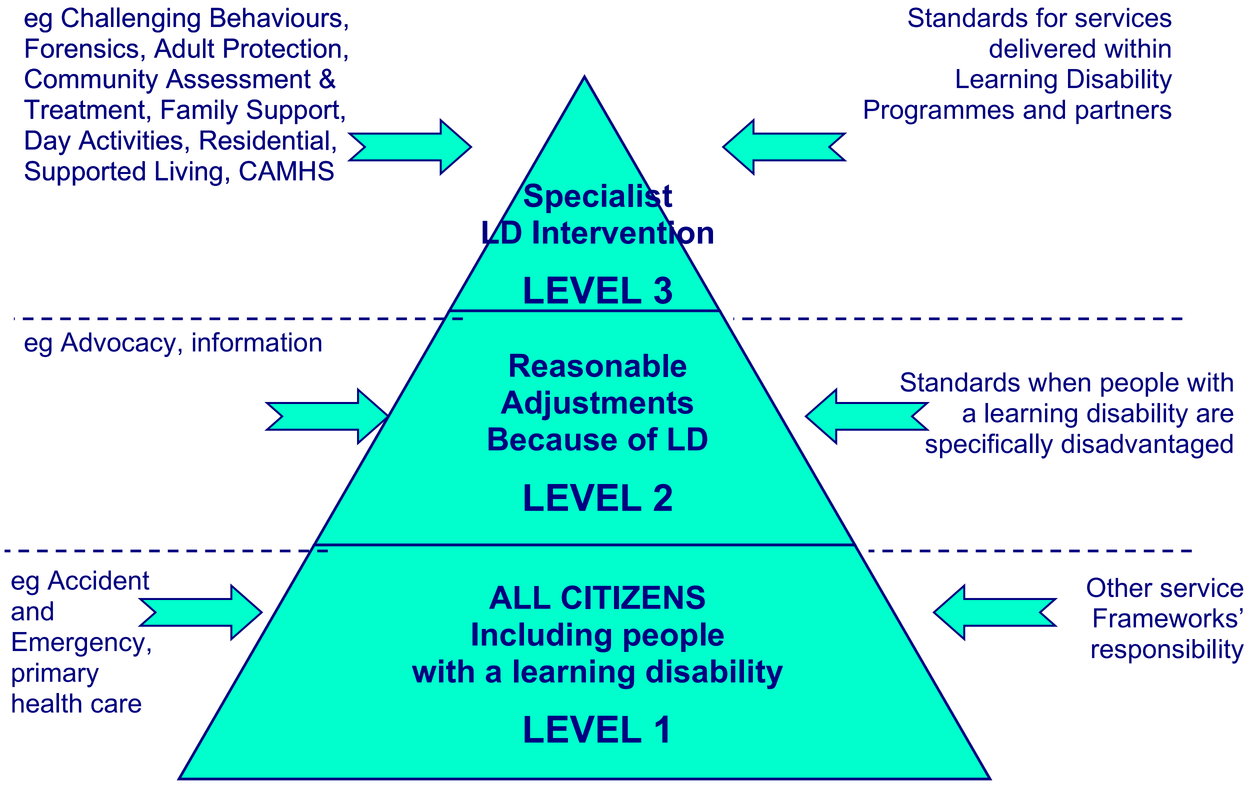

Figure 2

Figure 2 above describes the relationship between the Learning Disability Service Framework and other service frameworks. Each service framework identifies standards related to a specific aspect of health and social care. The needs of people with a learning disability will also be addressed through these frameworks (Level 1).

In many instances HSC providers will need to make adjustments to the care and support they offer in order to make them accessible to people with a learning disability and their families. Current evidence indicates that these necessary adjustments are not consistently in place within HSC services. Standards in the Learning Disability Service Framework will therefore require all HSC services to take the needs of people with a learning disability into account when designing and delivering services (Level 2).

While the basic premise of the Learning Disability Service Framework is that people with a learning disability should access the same HSC services as other people, there are occasions when special expertise or support is required. As services become more inclusive it is anticipated that the volume and range of separate services will decrease as learning disability expertise is developed within mainstream HSC services.

The Learning Disability Service Framework identifies a range of minimum standards that reflect the current service configuration in order to ensure that people with a learning disability and their families are clear about the care and support they can expect from these services (Level 3). Services provided through the non-statutory sector through contractual or service level agreements with HSC Trusts are also expected to meet these standards.

CHAPTER 4: SAFEGUARDING AND COMMUNICATION AND INVOLVEMENT IN THE PLANNIGN AND DELIVERY OF SERVICES

A wide range of people, for a variety of reasons, have been shown to be at risk of harm through abuse, exploitation or neglect. People of all ages, and from all social groupings, have the right to be safeguarded from such harm; to have their welfare promoted; and their human rights upheld. All HSC staff and staff providing services on behalf of the HSC have a dual responsibility with regard to safeguarding: (a) to ensure that all service users are treated with respect and dignity and are kept safe from poor practice that could lead to harm; and (b) that all staff are alert to the indicators of harm wherever it occurs and whoever is responsible; and know how and where to report concerns.

Effective communication is fundamental to the delivery of high quality health and social care. Without it there can be no meaningful partnership with service users and carers. Poor communication is often a significant contributory factor in complaints against HSC organisations and underpins many of the negative user experiences reported in research.

Involving people with a learning disability and their carers in the planning, delivery and monitoring of services helps to ensure that the care and support received meets their needs and aspirations. Involvement has to occur at all levels in HSC from ensuring service users' and carer's views are represented in organisational structures for the design and delivery of services, to securing a person-centred approach in all individual care and support arrangements.

There are particular challenges in meaningfully involving people with learning disability given the communication impairments they may experience and the legacy of discrimination which has served to exclude them from decision making fora in the past. Effective service user involvement needs to be underpinned by access to advocacy and information, alongside a clear understanding of issues related to capacity and informed consent.

Standard 1: (Generic)
All HSC staff should ensure that people of all ages are safeguarded from harm through abuse, exploitation or neglect.

Service user perspective:

"I am protected from harm"

Rationale:
A wide range of people, for a variety of reasons, have been shown to be at risk of harm through abuse, exploitation or neglect. People of all ages have the right to be safeguarded from such harm; to have their welfare promoted; and their human rights upheld. At the same time, they have the right to choose how to lead their lives, provided their lifestyle choices do not impact adversely on the safeguarding needs of others or, within the requirements of the law, of themselves. Decision making in this regard will have to pay due consideration to the age, maturity and capacity of the person. In this Standard, the term safeguarding is intended to be used in its widest sense, that is, to encompass both **preventive** activity, which aims to keep people safe and prevent harm occurring, and **protective** activity, which aims to provide an effective response in the event that there is a concern that harm has occurred or is likely to occur.

All HSC staff and staff providing services on behalf of the HSC have a dual responsibility with regard to safeguarding: (a) to ensure that all service users are treated with respect and dignity and are kept safe from poor practice that could lead to harm; and (b) that all staff are alert to the indicators of harm from abuse, exploitation or neglect wherever it occurs and whoever is responsible; and know how and where to report concerns about possible harm from abuse, exploitation or neglect whether these relate to the workplace or the wider community.

Effective safeguarding can ensure that people are safeguarded and their welfare promoted whether in their own homes; in the community; in families; and in establishments such as children's homes; secure accommodation; residential care and nursing homes; and hospitals. Through safeguarding, and in conjunction with positive engagement of individuals (and as appropriate their family and carers), effective prevention and potential for early intervention is enhanced and promoted and care and service plans are supported to deliver better outcomes. Where safeguarding is promoted, staff are empowered to act as advocates to safeguard vulnerable individuals and professional advocacy and counselling services are provided where required. A learning culture is also evident and staff are knowledgeable about safeguarding and keep abreast of local and national developments and learning, including enquiries, serious case reviews, case management reviews, inquiries and reports.

The quality of outcomes is more consistent, regardless of age, disability, gender, ethnic origin, religion, language, sexuality, political opinion, who pays for their care or their access to HSC provided or purchased services. Application in the wider community of knowledge and expertise gained in the workplace serves to safeguard people more broadly and more generally. The cycle of abusive behaviour(s) and/or neglect is broken.

Evidence:

World Health Organisation (2011) European Report on Preventing Elder Maltreatment
http://www.euro.who.int/__data/assets/pdf_file/0010/144676/e95110.pdf

OFMDFM (2009) Report of the Promoting Social Inclusion Working Group on Disability
http://www.ofmdfmni.gov.uk/report_of_the_promoting_social_inclusion_working_group_on_disability__pdf_1.38mb_.pdf

DHSSPS (2008) Improving the Patient & Client Experience 5 Standards: Respect, Attitude, Behaviour, Communication and Privacy and Dignity
http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf

The Joint Committee on Human Rights (2008) A Life Like Any Other? Human Rights of Adults with Learning Disabilities, Seventh Report of Session 2007-08 Volume 1
http://www.publications.parliament.uk/pa/jt200708/jtselect/jtrights/40/40i.pdf

Council of Europe (2007) Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse
http://conventions.coe.int/Treaty/EN/treaties/html/201.htm

OHCHR (2006) UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment http://www2.ohchr.org/english/law/cat-one.htm

OFMDFM (2005) Ageing in An Inclusive Society – Promoting the Social Inclusion of Older People (currently under review)
http://www.ofmdfmni.gov.uk/ageing-strategy.pdf

DHSSPS (2003) Co-operating to Safeguard Children
http://www.dhsspsni.gov.uk/show_publications?txtid=14022

United Nations (2000) The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children
http://www.uncjin.org/Documents/Conventions/dcatoc/final_documents_2/convention_%20traff_eng.pdf

European Convention on Human Rights http://www.hri.org/docs/ECHR50.html

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board & LCGs • Public Health Agency (PHA) • HSC Trusts • Primary Care	• PCC • RQIA • SBNI, NIASP & LASPs • PSNI • Other statutory agencies & voluntary, community & private sector

Quality Dimension
Citizenship People of all ages will be safeguarded from harm and have their welfare promoted and their human rights upheld. Safeguarding responses are non-discriminatory, and seek to ensure that people of all ages at risk of harm are offered support to keep them safe from harm and to protect them when harm occurs. **Empowerment** Safeguarding interventions must be tailored to the presenting circumstances and to the needs and choices of the individual (provided these do not impact adversely on the safeguarding needs of others or, within the requirements of the law, of him or herself) and his/her circumstance. Decision making in this regard will have to pay due consideration to the age, maturity and capacity of the person. **Working Together** Promotion of self-reliance and personal and professional safeguarding behaviours; builds personal and professional safeguarding capacity; promotion of the welfare of individuals; protection from mistreatment; impairment of health and development is prevented; and individuals are kept safe from harm. **Individual Support** Promotion of self-aware practice; supportive of person-centred engagement; fosters awareness and opportunity for early intervention in poor practice/potentially abusive dynamics; and promotion of individualised safety plans where these are indicated, thereby enhancing services and safeguarding awareness and responses

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1. All HSC organisations and organisations providing services on behalf of the HSC have a **Safeguarding Policy** in place, which is effectively aligned with other organisational policies (e.g. recruitment, governance, complaints, SAIs, training, supervision, etc). The Safeguarding Policy is supported	HSC and provider Organisation annual reports HSC Governance Reviews, e.g. Complaints; SAIs, etc HSC Statutory Functions Reports and Corporate Parent Reports SBNI, NIASP & LASP Annual Reports RQIA Reports &	Establish baseline Performance levels to be determined once baseline established	Year 1 Year 2

by robust procedures and guidelines	Reviews Case Management Reviews (CMRs) Serious Case Reviews (SCRs)		
2. All HSC organisations and organisations providing services on behalf of the HSC have **Safeguarding Plans** in place	As above	Establish baseline Performance levels to be determined once baseline established	Year 1 Year 2
3. All HSC organisations and organisations providing services on behalf of the HSC have **safeguarding champions** in place to promote awareness of safeguarding issues in their workplace	As above	Establish baseline Performance levels to be determined once baseline established	Year 1 Year 2

Standard 2:
People with a learning disability should as a matter of course make choices or decisions about their individual health and social care needs. This needs to be balanced with the individual's ability to make such decisions and then the views of their family, carers and advocates should be taken into account in the planning and delivery of services unless there are explicit and valid reasons to the contrary agreed with the person.

Service user perspective:

"I am involved as a matter of course in making choices or decisions about my health and social care needs."

"My family, other carers and advocates are involved as partners."

"Staff ask for my views and the views of family carers when they are planning and delivering services."

Rationale:
People with a learning disability and family carers report a lack of engagement and exclusion from the planning and decision-making processes, which can result in services being unresponsive to individual needs, strengths and aspirations. It is important to ensure that people with a learning disability and their families are involved as partners in their health and social care.

Services must be delivered in ways that appropriately manage risk for service users, carers and their families. It is acknowledged, however, that in some situations, living with an identified risk can be outweighed by the benefit of having a lifestyle that the individual really wants and values. In such circumstances, risk taking (when it is appropriately managed) can be considered to be a positive action. HSC staff need to work in partnership with service users and carers to explore choices, identify and assess risks and agree on how these will be managed and minimised for the benefit of individual service users, their carers and families.

Evidence:
DHSSPS (2010) Care Management, Provision of Services and Charging Guidance http://www.dhsspsni.gov.uk/hsc-eccu-1-2010.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011) http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability http://www.dhsspsni.gov.uk/equallivesreport.pdf

DHSSPS (2005) A Healthier Future: A Twenty Year Vision for Health and Well

being in Northern Ireland 2005-2025
http://www.dhssps ni.gov.uk/healthyfuture-main.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Trusts	• Other service providers • Advocacy organisations • Families and carers

Quality Dimension

Citizenship
Service users will be involved as partners in the planning and delivery of health and social care services.

Social Inclusion
Involvement will ensure that service users are enabled to access mainstream services and be fully included in the life of the community.

Empowerment
Involving service users in the design and delivery of HSC services ensures that their expertise effectively informs the development of appropriate services.

Working Together
Partnership with service users, their families and carers is only possible if they are proactively involved in decision-making processes. Effective partnerships will contribute to positive health and social care outcomes.

Individual Support
Person-centred support relies on individuals being supported to share their views, hopes and concerns. Involvement is a necessity for the development of person-centred approaches and planning.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Evidence that people with a learning disability, their family and carers have been involved in making choices or decisions about their individual health and social care needs.	HSC Trust reports (care plans)	Establish baseline Performance level to be determined once baseline established	Year 1 Year 2

Standard 3: (Generic)
All patients, clients, carers and the public should have opportunities to be actively involved in the planning, delivery and monitoring of health and social care at all levels.

Service user perspective:

"I will have an opportunity to be actively involved at all levels of health and social care."

Rationale:
Actively involving patients and the public in the planning and provision of health care in general has been noted to bring many advantages to both those who receive and those who provide care. These include:

- Increased patient satisfaction and reduction in anxiety with positive health effects
- Improved communication between service users and professional staff
- Better outcomes of care with greater accessibility and acceptability of services
- Bridging of the gap between those who avail of services and those who provide care
- Recognition of the expertise of the recipient of care developed through experience

Evidence:
DHSSPS (2007) Guidance on strengthening Personal and Public Involvement in Health and Social Care http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

NHS (2006) Healthy Democracy
http://www.nhscentreforinvolvement.nhs.uk/index.cfm?content=90

DHSSPS (2005) A Healthier Future: A Twenty Year Vision for Health and Well being in Northern Ireland 2005-2025
http://www.dhsspsni.gov.uk/healthyfuture-main.pdf

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
http://www.dhsspsni.gov.uk/hpss_qi_regulations.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts • Primary Care	• Other Service providers • Advocacy organisations • Families & carers

Quality Dimension

Citizenship
Effective involvement ensures that the diverse needs of people with a learning disability are taken account of in service planning and delivery. The development of partnerships with service users and carers ensures that their views and aspirations are respected and valued.

Social Inclusion
Involvement helps to address the legacy of disadvantage for people with a learning disability which has led to their voices not being heard effectively in service planning.

Empowerment
Involvement gives a voice to the people most directly affected by decisions within health and social care. Involving them will enable them to have an influence over decisions made that affect their lives.

Working Together
Partnership with service users and carers is only possible if they are proactively involved in decision-making processes. Effective partnerships will contribute to positive health and social care outcomes.

Individual Support
Person-centred support relies on individuals being supported to share their views, hopes and concerns. Involvement is a necessity for the development of person-centred approaches and planning.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
To be developed by Commissioners		Baseline to be established Performance levels to be determined once baseline established	Year 1 Year 2

Standard 4:
Adults with a learning disability should be able helped by HSC professionals to develop their capacity to give or refuse informed consent.

Service User Perspective*:*

"I am helped to give or refuse my consent when decisions are being made that will affect my health or well being"

Rationale:
Respecting peoples' right to determine what happens to them is a fundamental aspect of good practice and a legal requirement. Research shows that people with a learning disability are often denied this right. Health and social care staff report uncertainty about how to ensure capacity and informed consent. This covers a wide range of areas from managing personal finances to consenting to surgery and other medical interventions. A major legislative reform process is underway that will strengthen the legal framework for work in the area of mental capacity and consent. HSC organisations should be working within the spirit of this legislative direction.

Evidence:
DHSSPS (2009) Legislative Framework For Mental Capacity And Mental Health Legislation In Northern Ireland – A Policy Consultation Document
www.dhsspsni.gov.uk/legislative-framework-for-mental-capacity.pdf

Equality Commission Northern Ireland (2008) – A Formal Investigation under Disability Discrimination Legislation to Evaluate the Accessibility of Health Information in NI for People with a Learning Disability
www.equalityni.org/archive/pdf/FormalInvestDisability(Full).pdf

SCIE (2008) Healthcare for All: The Independent Inquiry into Access to Healthcare for People with Learning Disabilities (The Michael Inquiry) Tizard Learning Disability Review, 13(4), December 2008, pp.28-34.
http://www.scie-socialcareonline.org.uk/profile.asp?guid=4f9f7333-2539-4004-af21-26ed14db5f5d

Mencap (2007) Death by Indifference
www.mencap.org.uk/case.asp?id=52&menuId=53&pageno

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

DHSSPS (2003) Reference Guide to Consent for Examination, Treatment or Care www.dhsspsni.gov.uk/consent-referenceguide.pdf

DHSSPS (2003) Seeking Consent: Working with People with Learning Disabilities: http://www.dhsspsni.gov.uk/consent-guidepart4.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary & Acute Care Teams	• DHSSPS • Independent sector • Service users, carers and families

Quality Dimension

Citizenship
The right to self determination is respected and capacity to consent is presumed to exist unless proven otherwise

Empowerment
Paying attention to correct processes for securing consent ensures that the views of people with a learning disability are adequately addressed in decision making.

Individual Support
All health and social care interventions are based on best practice in capacity and consent issues.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Develop and agree a regional training plan that ensures that relevant HSC staff are trained in consent and capacity issues.	HSC reports	All HSC Organisations	Year 2
2 Evidence that robust processes are in place where capacity has been judged to be an issue within HSC services or services commissioned by HSC	SAAT	Development and implementation of SAAT Performance levels to be determined based on outcomes of SAAT	Year 1 Year 2

Standard 5: (Generic)
All patients, clients, carers and the public should be engaged through effective communications by all organisations delivering health and social care.

Service user perspective:

"I am supported by staff who can communicate well with me."

Rationale:
Effective communication (clear, accessible, timely, focused and informative) has a significant impact on all aspects of care provision from disease prevention, to diagnosis, to self-management of long-term conditions.

Poor communication is a significant factor in most complaints against HSC organisations.

Evidence:
DHSSPS (2007) Guidance on strengthening Personal and Public Involvement in Health and Social Care http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

GMC (2006) Good Medical Practice
http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland Order) 2003: www.dhsspsni.gov.uk/hpss_qi_regulations.pdf

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care	• DHSSPS • DE • Other service providers • Service Users & carers

Quality Dimension

Citizenship
As a universal requirement, good communication helps to ensure input by all service users on all aspects of the services they receive assisting in the highlighting of gaps in provision and areas for improvement.

Social Inclusion
Good communication helps to deliver and sustain appropriate patient/client/carer access to services and a clear understanding of the role and responsibilities of the service user in achieving health and care outcomes.

Empowerment
Good communication with patients/clients/carers enables adequate understanding of, consent to and compliance with treatment and care and contributes to audit and monitoring

Working together
Health and care outcomes themselves are enhanced through improved patient partnership and dialogue, including, but not limited to – diagnosis, self-referral, health promotion, disease prevention and management of long term conditions

Individual Support
Person-centredness cannot be delivered or claimed in the absence of good communication with service users. Good communication is a prerequisite of person-centredness.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
To be developed by Commissioners		Baseline to be established	Year 1
		Performance levels to be determined once baseline established	Year 2

Standard 6:
People with a learning disability should expect effective communication with them by HSC organisations as an essential and universal component of the planning and delivery of health and social care

Service user perspective:

"I am supported by staff who can communicate well with me."

Rationale:
Between 50% and 90% of people with a learning disability have some form of communication difficulty. Effective communication has a significant impact on all aspects of care and support provision across the full range of activities that promote health and social wellbeing. Poor communication is often a significant contributory factor in complaints against HSC organisations.

People with speech, language and communication needs, in addition to their learning disability, are amongst the most vulnerable and most in need of effective care and support to reach their potential. Early identification and effective intervention are essential. The current system is characterised by high variability and a lack of equity.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Equality Commission (2008) A Formal Investigation under the Disability Discrimination Legislation to Evaluate the Accessibility of Health Information in Northern Ireland for People with a Learning Disability
http://www.equalityni.org/archive/pdf/FormalInvestDisability(Full).pdf

DSCF (2008) Bercow Report: A Review of services for children and young people (0-19) with speech, language and communication needs
www.dcsf.gov.uk/bercowreview/docs/7771-DCSF-BERCOW%20Summary.pdf

DoH (2008) Better Communication: Improving services for children and young people with speech, language and communication needs. Action Plan to the Bercow Report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091972

DHSSPS (2007) Guidance on Strengthening Personal and Public Involvement in Health and Social Care (HSC (SQSD) 29/07)
http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

GMC (2006) Good Medical Practice
http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
http://www.dhsspsni.gov.uk/hpss_qi_regulations.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care	• DHSSPS • DE • Other Service Providers • Service users and carers

Quality Dimension

Citizenship
Good communication helps to ensure input by people with a learning disability on all aspects of the services that they receive, assisting in the highlighting of gaps in provision and areas for improvement.

Social Inclusion
People with communication difficulties are supported to access mainstream leisure and social activities that promote their integration into mainstream community living and promote their psychological and emotional wellbeing.

Empowerment
Good communication with service users, carers and family enables adequate understanding of, and consent to, the care, support and treatment arrangements offered.

Working Together
There is evidence of good communication between professionals that can determine early identification of communication difficulties and planning to provide the necessary supports to the person with a learning disability, their carer and family and that this is reviewed regularly with particular attention at transition points.

Individual Support
Good communication is a prerequisite of person-centredness.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of people with a learning disability who do not use speech as their main form of communication,	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	Year 1 Year 2

who have been supported to establish a functional communication system.			
2 Develop and agree a regional training plan for staff in both HSC and services commissioned by HSC to raise awareness of communication difficulties and how they may be addressed	HSC reports	Regional Training Plan in place Training is delivered in accordance with Regional Training Plan.	Year 1 Year 2

Standard 7:
People with a learning disability should receive information about services and issues that affect their health and social wellbeing in a way that is meaningful to them and their family.

Service user perspective:

"I receive information about services and issues that affect my health and wellbeing in a way that my family and I can understand."

Rationale:
The particular communication difficulties experienced by many people with a learning disability create additional challenges in accessing information on which to make informed choices and access appropriate supports. Access to HSC services depends on people having information on what is available and how the care and support offered will impact on them. This places an onus on HSC organisations to ensure that people with a learning disability, their carers and their families are informed in a way that takes account of their particular circumstances.

This process will be enhanced by the availability of a named staff member to assist people in understanding the services available.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Equality Commission (2008) A Formal Investigation under the Disability Discrimination Legislation to Evaluate the Accessibility of Health Information in Northern Ireland for People with a Learning Disability
http://www.equalityni.org/archive/pdf/FormalInvestDisability(Full).pdf

DHSSPS (2007) Guidance on Strengthening Personal and Public Involvement in Health and Social Care (HSC (SQSD) 29/07)
http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

Foundation for People with Learning Disabilities (2005) Communication for person-centred planning
http://www.learningdisabilities.org.uk/?view=Search+results&search=Communication+for+person-centred+planning

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Board (including Commissioning Groups) • Public Health Agency (PHA) • HSC Trusts	• DHSSPS, DSD, DE, DEL, DoJ • Other service providers • Advocacy partners • Service users and carers

Quality Dimension

Citizenship
People with a learning disability can only exercise their rights as citizens if they have accessible information about entitlements and services offered.

Social Inclusion
A major barrier to inclusion is the lack of information on which to base informed decision making.

Empowerment
Access to information enables people to speak out about what they need and what is being offered.

Working Together
Provision of information in an accessible manner is a key step towards enabling effective partnership between those who work in services and those who use them.

Individual Support
The development of effective person-centred support relies on individuals being well informed about choices that are open to them.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 All HSC organisations should provide evidence that they are making information accessible to people with a learning disability	SAAT	Development and implementation of SAAT Performance levels to be determined once baseline established	Year 1 Year 2
2 Each person with a learning disability can access a named person who can signpost them to relevant services.	Sample survey of families and service users.	Establish baseline of information provided Performance levels to be determined once baseline established	Year 2

Standard 8:
People with a learning disability, or their carer, should be able to access self directed support in order to give them more control and choice over the type of care and support they receive.

Service user perspective:

"I, or my carer, can request self-directed support in order to give me more control and choice over the type of care and support I receive."

Rationale:
There is growing evidence of the positive outcomes that may be gained by people with a learning disability when they have direct financial control over their supports. Access to Direct Payments as a means of delivering social services in NI has been available since 1996 under the Personal Social Services (Direct Payments) (Northern Ireland) Order 1996. The Carers and Direct Payment Act (NI) 2002 extended access to a much wider group of people. Direct Payments increase choice and promote independence. They provide for a more flexible response than may otherwise be possible for the service user and carer. They allow individuals to decide when and in what form services are provided and who provides them, who comes into their home and who becomes involved in very personal aspects of their lives. Direct Payments put real power into the hands of service users and carers, and allow them to take control over their lives. Whilst uptake of this provision has been low, it has been steadily increasing over recent years.

In England, direct payments have paved the way for investigation into how individual budgets could work to promote choice and control for people using adult social care services. The introduction of individual or personal budgets is part of the wider personalisation agenda in adult social care. At the time of preparing the Learning Disability Service Framework an equivalent policy directive relating to the use of individual budgets is not in place. However, DHSSPS have indicated its commitment, in the Bamford Action Plan, to exploring the benefits of increasing users' direct control over services. The implementation (and review) of this standard will, therefore, evolve alongside future policy developments in this area.

Evidence:
HSC Board/ PHA (2011) Draft Commissioning Plan 2011/12
http://www.publichealth.hscni.net/sites/default/files/Draft%20HSCB%20PHA%20Commissioning%20Plan%202011-2012_0.pdf

DoH (2009) New Horizons: A Shared Vision for Mental Health
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011) http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

SCIE (2009) Research briefing 20: The implementation of individual budget schemes in adult social care. Published Jan 2007, Updated Feb 2009, Addendum March 2009
http://www.scie.org.uk/publications/briefings/briefing20/index.asp

PSSRU (2007) Direct Payments: A National Survey of Direct Payments Policy and Practice http://www.pssru.ac.uk/pdf/dprla_es.pdf

DoH (2007) Valuing People Now: From Progress to Transformation – A consultation on the next three years of learning disability policy
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/LiveConsultations/DH_081014

DHSSPS (2005) Direct Payments: Policy and Practice Review Report
http://www.dhsspsni.gov.uk/direct_payments_policy_and_practice_review_report.pdf

Bamford (2005) Equal Lives (Chapter 10 - Ensuring Personal Outcomes): Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

DoH (2005) Independence, Wellbeing and Choice: Our Vision for the Future of Social Care for Adults in England – Social Care Green Paper
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4116631

Joseph Rowntree Foundation (1999) Implementing Direct Payments for People with Learning Disabilities http://www.jrf.org.uk/sites/files/jrf/F349.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• Welfare Rights Advisers • Advocacy organisations • DEL/DHSSPS/DCAL • Service users and carers.

Quality Dimension

Citizenship
Increased equity exists between service users and service providers where human rights have been respected.

Social Inclusion
Quality of life and wellbeing are improved through being able to have direct control over funding available to support social inclusion activities

Empowerment
Service users and carers experience more choice and control within processes and access services that they have requested and, where necessary, have the support of independent advocates.

Working Together
Change in attitudes and culture with renewed engagement between agencies on joint support planning providing greater flexibility in the way in which supports can be accessed.

Individual Support
People demonstrate improved health and wellbeing from having greater control over how they are supported and having their aspirations met in a more individualised way.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Evidence of provision of accessible information on Direct Payments within HSC organisations.	SAAT	Develop and implement SAAT Establish performance levels based on outcomes from SAAT	Year 1 Year 2
2 Percentage of requests for direct payments from people with a learning disability that were approved	SAAT	Develop and implement SAAT Establish performance levels based on outcomes from SAAT	Year 1 Year 2
3 Number of adults with a learning disability in receipt of Direct Payments expressed as a percentage of those in contact with Trust (regional percentage is 2.25%)	HSC Board and Trust Reports	Performance levels to be determined based on available resources and included in final Framework	
4 Number of children with a learning disability in receipt of Direct Payments expressed as a percentage of those in contact with Trust (regional percentage is 3.50%)	HSC Board and Trust Reports	Performance levels to be determined based on available resources and included in final Framework	

5 The HSC Board and Trusts have plans in place to extend the range and scope of self directed support including how they will develop skills and expertise in relevant staff	HSC Board and Trust reports	HSCB and all Trusts	Year 3

Standard 9: (Generic)
Service users and their carers should have access to independent advocacy as required.

Service user perspective:

"I can get an advocate to support me to speak out about worries I have about the care and support I receive"

Rationale:
People engage with health and social care services at times in their lives when they might be vulnerable or in need of support and / or guidance in relation to decisions about their health and wellbeing. For a whole raft of reasons (age, disability, mental health issues, gender, ethnic origin, sexual orientation, social exclusion, reputation, abuse and family breakdown and living away from home or in institutions), they may also feel discriminated against or simply excluded from major decisions affecting their health and wellbeing. It is at such times that independent advocacy can make a real difference because it gives people a voice; helps them access information so that they can make informed decisions and participate in their own care or treatment.

Independent advocacy is also a means of securing and protecting a person's human rights; representing their interests; and ensuring that decisions are taken with due regard to a person's preferences or perspectives where, for whatever reason, they are unable to speak up for themselves. In strategic terms independent advocacy can contribute to increased social inclusion and justice; service improvements in health and wellbeing; reductions in inequalities across the health and social care sector; and enhanced safeguarding arrangements. Independent advocacy can be delivered in a number of different ways and people may need different types of advocacy at different times in their lives. The most common models are self/group advocacy; peer advocacy; citizen advocacy; and individual/issue-based advocacy (also known as professional advocacy).

In this context, independence means structurally independent from statutory department or agency providing the service. The advocacy provider must be free from conflict of interest as possible both in design and operation and must actively seek to reduce any conflicting interests.

Independent advocacy should be available throughout the care pathway and, in particular, should be available early in the process as this may prevent a crisis developing. An advocacy service should apply not just to service users but to their carers and families. To be effective users need to be aware of advocacy services. Therefore they need to be promoted through accurate and accessible information. Relevant health and social care staff should be aware of the benefits of independent advocacy and the particular importance of independence from service provision.

There is currently a proposal to introduce a statutory right to an independent advocate in the proposed Mental Capacity Bill. Guidance on this right will be issued once the Bill has been finalised.

Evidence

DHSSPS (2012) Developing Advocacy Services – A Policy Guide for Commissioners http://www.dhsspsni.gov.uk/developing-advocacy-services-a-guide-for-commissioners-may-2012.pdf

DHSSPS (2010) Advocacy Research: Summary Paper http://www.dhsspsni.gov.uk/advocacy-research-summary-paper-of-advocacy-provision-october-2010.pdf

Knox, C. (2010) Policy Advocacy in Northern Ireland. University of Ulster, Jordanstown

Alzheimer's Society (2009) Listening Well http://www.alzheimers.org.uk

Horton, C (2009) Creating a Stronger Information, Advice and Advocacy System for Older People. London; Joseph Rowntree Foundation

SCIE (2009) At A Glance 12: Implications for Advocacy Workers available at http://www.scie.org.uk/publications/ataglance/ataglance12.asp

Seal, M. (2007) Patient Advocacy and Advance Care Planning in the Acute Hospital Setting – Australian Journal of Advanced Nursing Vol 24, No 4, pp29-36

Wright, M. (2006) A Voice That Wasn't Speaking: Older People Using Advocacy and Shaping it's Development, Stoke-on-Trent, OPAAL UK (Older People's Advocacy Alliance)

Bamford Review (2006) Review of Mental Health and Learning Disability (NI), Human Rights and Equality of Opportunity Available at www.dhsspsni.gov.uk/bamford

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts • Public Health Agency (PHA)	• Local Commissioning Groups • Primary Care Partnerships • GPs • Voluntary and Community Sector • Independent Sector • PCC

Quality Dimensions

Citizenship

An advocacy service can promote equality, social justice and inclusion of the most vulnerable and disadvantaged. Advocacy can enhance capacity building at a community and individual level, which can ultimately reduce dependency on other health and social care services.

Empowerment
Advocacy services can enable individuals to access information, express their views and wishes and make informed choices about their own health and well being. The service is geared to needs of the individual. The service user will receive a service that best meets their needs at a time, which evidence shows, to be effective and to have maximum impact.

Individual Support
Advocacy services can safeguard users from abuse and exploitation by ensuring that their rights are upheld and their voice heard. An advocacy service can promote equality, social justice and inclusion of the most vulnerable and disadvantaged.

Performance Indicator	**Data Source**	**Anticipated Performance Level**	**Date to be achieved by**
To be developed by commissioners		Baseline to be established	Year 1
		Performance levels to be determined once baseline established	Year 2

CHAPTER 5: CHILDREN AND YOUNG PEOPLE

Work is ongoing in the development of a Children and Young People's Service Framework. It is anticipated that that Framework will address the universal needs of children and young people in Northern Ireland.

This chapter aims to address the particular issues facing children and young people with a learning disability and their family carers and acknowledges the role played by schools and Education and Library Board in the assessment, intervention, support and onward referral of children & young people who may or do have a learning disability. This chapter should be read alongside the other standards set out in this Framework.

Support to families tends to be fragmented and parents report difficulty in accessing services and understanding the range of roles and services that are in place.

It is crucial when concerns emerge that a child may have a learning disability, that a clear action plan is agreed as to how the concerns will be investigated. It is essential that planning and support systems are used to wrap around the child and family to ensure a seamless and co-ordinated approach. Where children have to live away from their family the arrangements in place must take account of their learning disability.

The Learning Disability Service Framework reflects the fundamental position that regardless of diagnosis, a child/young person is a child/young person first, and that children and their families should be fully supported to participate in valued childhood experiences. They should also have access to the same opportunities, life experiences and services as other children and families.

Standard 10:
From the point at which concerns are raised that a child or young person may have a learning disability, there is an action plan in place to determine the nature and impact of the learning disability.

Service User Perspective:

Parents will have an action plan that clearly sets out the steps to be taken for discovering the nature and impact of learning disability their son or daughter may have.

Rationale:
Parents report dissatisfaction with the manner in which supports are organised when concerns begin to emerge that their son or daughter may have a learning disability. Professional efforts are often not well co-ordinated resulting in parents having to manage multiple appointments and, at times, conflicting advice.

Long delays are reported for appointments to specialists and parents can experience great difficulties in accessing the information they need and in understanding the roles that various professionals and organisations play.

Assessment needs to be timely, comprehensive and conducted in a co-ordinated manner.

Evidence:
Power, A (2008) ‘It’s the system working for the system’: carers’ experiences of learning disability services in Ireland: *Health and Social Care in the Community* (2008) http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2524.2008.00807.x/abstract

SCIE (2008) Guide 24: Learning together to safeguard children: developing a multi-agency systems approach for case reviews. www.scie.org.uk/publications/guides/guide24/index.asp

SCIE (2007) Knowledge Review 18: ‘Necessary Stuff’ – The social care needs of children with complex healthcare needs and their families. www.scie.org.uk/publications/knowledgereviews/kr18.asp

DHSSPS (2007) Complex Needs – The Nursing Response to Children & Young People with Complex Physical Healthcare needs. www.dhsspsni.gov.uk/complex_needs_report.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability http://www.dhsspsni.gov.uk/equallivesreport.pdf

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care	• Families • DHSSPS, DE • Early Years providers

Quality Dimension

Social Inclusion
Assessment takes account of the need for the child or young person to have as normal a life as possible and be socially included within the communities in which they live.

Empowerment
Children, young people and their families receive co-ordinated essential information about the services they can expect to receive and the roles that professionals will have in delivering these services and have an identified link person to whom they can refer any problems and with whom they can develop effective relationships.

Working Together
Professionals work together with families to determine a child/young person's condition within a required timeframe and systems are put in place for effective ongoing communication and delivery of supports.

Individual Support
Assessments are co-ordinated effectively between professionals and families and parents are clear as to actions planned by HSC professionals.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of parents who express satisfaction with the assessment process and how the outcomes were conveyed.	Audit of sample family carers	Establish baseline of information provided Performance levels to be determined once baseline established	Year 2 Year 3

Standard 11:
Children and young people should receive child-centred and coordinated services through assessment to ongoing care and support from the point at which a determination has been made that they have a learning disability.

Service user perspective:

"My son or daughter receives services that are child-centred, appropriate and co-ordinated."

Rationale:
The Children Order (NI) 1995 outlines that a child is a 'child in need' by virtue of the fact that he/she is disabled (Art17(C)). Trusts and statutory bodies are required to comply with their statutory duties in respect of children in need, including those in relation to carers needs under this legislation.

Getting the right care and support for children, young people and their families makes a significant impact on positive outcomes in adulthood. A child's needs cover the whole range of public services and resources including play, leisure, housing and education. The involvement of all these interests is essential if we are to avoid confining the lives of children with a learning disability within the health and social care system.

Evidence:
DHSSPS (2009) NI Single Assessment Tool
http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-northern-ireland-single-assessment-tool.htm

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DHSSPS (2009) Integrated Care Pathway for Children & Young People with Complex Physical Healthcare Needs
http://www.dhsspsni.gov.uk/integrated_care_pathway-july09.pdf

DHSSPS (2008) UNOCINI Guidance
http://www.dhsspsni.gov.uk/microsoft_word_-_unocini_guidance_revised_june_2011_inc_mh_domain_elements.pdf

Black, LA *et al* (2008) Lifelines Report An Evaluation Report of the Impact of the Families Services delivered by Positive Futures in Rural and Urban Areas of Northern Ireland. http://www.positive-futures.net/sites/default/files/LIFELINES%20Full%20Report.pdf

Kenny, K and McGilloway, S. (2007) Caring for children with learning disabilities: an exploratory study of parental strain and coping, British Journal

of Learning Disabilities, p221-8.
http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3156.2007.00445.x/abstract

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www.scie.org.uk/publications/knowledgereviews/kr18.asp

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www.dhsspsni.gov.uk/complex_needs_report.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts/Children's Services	• Families • DHSSPS, DE, DCAL • Voluntary and community sector providers

Quality Dimension

Social Inclusion
Assessment and supports take account of the need for the child or young person to have as normal a life as possible and be socially included within the communities in which they live.

Empowerment
Children, young people and their families receive co-ordinated essential information about the services they can expect to receive and the roles that professionals will have in delivering these services and have an identified link person to whom they can refer any problems and with whom they can develop effective relationships.

Working Together
Professionals work together with parents as partners in developing family centred plans to meet the care and support needs of the child and his/her family. Plans must take account that the needs of children and young people with a learning disability cannot be met by health and social care alone and will involve close working with other interests including housing, leisure and education.

Individual Support
Supports are co-ordinated effectively between professionals and the family and the child/young person has a plan in place that is regularly reviewed to ensure that supports remain appropriate.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of children and young people with a learning disability and carers who have been offered an assessment either under the Family Health Needs Assessment or UNOCINI assessments.	Audit/Sampling	Establish baseline Performance levels to be determined once baseline established	Year 2 Year 3
2 Percentage of children and young people who have an agreed support plan detailing a pathway to receiving appropriate care and support.	Audit to include UNOCINI referrals and completed family support and Looked After Children (LAC) pathway assessments following initial referral	Establish baseline Performance levels to be determined once baseline established	Year 2 Year 3

Standard 12:
HSC services should respond to the needs of children and young people who have a learning disability and complex physical health needs in a manner that is personalised, developmentally appropriate and which support access to appropriate care.

Service User Perspective:

"If my son or daughter has complex physical health needs we will receive care and support in a flexible way through services that are age appropriate."

Rationale:
Current services often lack the responsiveness and flexibility required to ensure that children and young people with a learning disability enjoy equal access to the full range of supports that are required to effectively address the needs arising from additional health problems they have. This can result in them receiving care and treatment that is less than optimum, is poorly coordinated, and sometimes delivered in settings, which are not developmentally appropriate.

Children and young people with a learning disability benefit greatly from effective transitions between hospital and community services and sensitive, detailed assessment and care planning across the range of HSC professionals involved with the family.

Evidence:
DHSSPS (2009) Integrated Care Pathway for Children & Young People with Complex Physical Healthcare Needs
http://www.dhsspsni.gov.uk/integrated_care_pathway-july09.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DHSSPS (2009) Families Matter: Supporting Families in Northern Ireland
http://www.dhsspsni.gov.uk/families_matter_strategy.pdf

The Council for Disabled Children (CDC) (August 2009) The use of eligibility criteria in social care services for disabled children
http://www.ncb.org.uk/cdc/home.aspx

DHSSPS (2008) UNOCINI Guidance
http://www.dhsspsni.gov.uk/microsoft_word_-_unocini_guidance_revised_june_2011_inc_mh_domain_elements.pdf

DHSSPS (2007) Complex Needs – The Nursing Response to Children & Young People with Complex Physical Healthcare needs.
www.dhsspsni.gov.uk/complex_needs_report.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability http://www.dhsspsni.gov.uk/equallivesreport.pdf

Beecham,J. et al. (2002) Children with Severe Learning Disabilities: Needs, Services and Costs *Children & Society* pp. 168–181 www.lse.ac.uk/collections/PSSRU/staff/beecham.htm

Sloper, P. (1999) Models of service support for parents of disabled children. What do we know? What do we need to know? *Child: Care, Health and Development*, 25 (2), 85-99. www.ncbi.nlm.nih.gov/pubmed/10188064

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts / Children's Services • Primary and Acute Services	• DHSSPS • Voluntary & Community Sector Providers • Families & carers

Quality Dimension

Citizenship
The rights of the child/young person/family are respected when assessing their needs and practical approaches are taken to meeting these needs that are equitable to the rest of the population.

Working Together
There is a coordinated approach to addressing health and social care needs where parents are clearly signposted to sources of care and support, particularly when the child/ young person moves between hospital and home.

Individual Support
Multi-disciplinary input is effective in providing assessment and supports that the child and family requires using person-centred and family centred approaches that are effective in maintaining, where possible, ordinary family life and are reviewed regularly or at least annually.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of parents whose child has a learning disability and complex physical health needs who have an identified key worker with co-ordinating responsibility	Annual Audit	Scope requirements and produce audit plan. Audit 50% of information available 100%	Year 1 Year 2 Year 3

2 Percentage of children and young people with complex physical health needs who have effective transition arrangements in place between hospital and community.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes. Fast track arrangements for access to hospital /community services to be audited following establishment of baseline	Year 1 Year 2
3 Percentage of children with a learning disability and complex physical health needs who have received a multi-professional assessment using the UNOCINI frameworks.	Trust Reports	90% 95% 98%	Year 1 Year 2 Year 3
4 Percentage of children and young people with a learning disability and complex physical health needs who are receiving care under the integrated care pathway.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes.	Year 1 Year 2

Standard 13:
Any child or young person who cannot live at home permanently should have their placement/ accommodation needs addressed in a way that takes full account of their learning disability.

Service User Perspective:

"If I cannot live at home permanently, my needs will be addressed in a way that takes full account of my learning disability."

Rationale:
A small number of children and young people who have a learning disability cannot live with their natural families. Many have severely challenging behaviours, specific health needs and/or Autistic Spectrum Disorders (ASD). They require support and living arrangements that are sufficiently expert to address their complex individual needs. Decisions about future care and support arrangements need to be taken in a timely manner and in a way that supports permanency.

Evidence:
DHSSPS (2009) Autism Spectrum Disorder (ASD) Strategic Action Plan 2008/09 – 2010/11
http://www.dhsspsni.gov.uk/asd_strategic_action_plan.pdf

DoH (2005) Valuing People: The story so far (p44)
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4107059.pdf

McConkey *et al* (2004). The characteristics of children with a disability looked after away from home and their future service needs. British Journal of Social Work, 34 (4), 561-576. http://bjsw.oxfordjournals.org/content/34/4/561.abstract

Chadwick *et al* (2002) Respite Care for Children with Severe Intellectual Disability and their Families: Who Needs It? Who Receives It? Child and Adolescent Mental Health vol7 (2): 66-72.
http://onlinelibrary.wiley.com/doi/10.1111/1475-3588.00013/full

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts	• DHSSPS • Other Service Delivery Partners

Quality Dimension

Citizenship/Social Inclusion
Children & young people with a learning disability have their needs met within environments that promote social inclusion and full citizenship

Empowerment
Children, young people and their family members are supported to express their views on the care and support services that they require and are supported to maintain links with each other when a child/young person lives away from home.

Working Together
Professionals collaborate to provide responsive services through developing a person-centred Permanency Plan to meet the needs of the individual child/young person.

Individual Support
The Permanency Plan includes arrangements for specialist placements based on the short, medium and long term needs of the individual.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of looked after children or young people with a learning disability who cannot live with their families who have a Permanency Plan.	SOSCARE	Establish baseline Performance level to be determined once baseline established	Year 1 Year 2
2 Percentage of looked after children or young people with a learning disability who cannot live at home, who have access to specialised placements where the need for this is indicated in the Permanency Plan.	SOSCARE	Establish baseline Performance level to be determined once baseline established	Year 1 Year 2

CHAPTER 6: ENTERING ADULTHOOD

The manner in which young people are supported at the time of transition from adolescence to adulthood is a crucial component in determining the degree to which they are enabled to live full and valued lives in their communities.

Supporting effective transition is the responsibility, not only of HSC organisations, but also requires the effective engagement of other government departments, notably DEL and DE, and other agencies. There is scope for improvement in the quality of the transition experience. Many young people have unsatisfactory experiences during the move from school towards adulthood.

Parents and young people should be offered a transitions pathway that outlines their:

- individual interests;
- aspirations;
- strengths and needs including vocational training;
- education;
- employment;
- health profile;
- social supports;
- friendships (including meaningful relationships); and
- social development.

Standard 14:
Young people with a learning disability should have a transition plan in place before their 15th birthday and arrangements made for their transition to adulthood by their 18th birthday.

Service User Perspective:

"I will have a transition plan in place before my 15th birthday."

"I will know the arrangements that are in place for when I leave school before my 18th birthday."

Rationale:
Effective transition planning at an early stage is vital if young people are to move successfully from school towards fuller adult lives. This is a statutory requirement under special education legislation and a recommendation of the Bamford Review. These arrangements should be made in partnership with the young person, their family/carers and adult learning disability services for transition to appropriate adult services in accordance with agreed transition protocols. The objective of this transition planning is to support people into the same life chances as other non-disabled young people e.g. a job, relevant education, positive relationships and the start of living independently.

It is noted that increased numbers of children with statements of special education needs, including those with disabilities are accessing mainstream education. Under the Special Educational Needs and Disability (NI) Order 2005 (SENDO) Code of Practice, transition planning in schools commences for 'statemented' pupils at the first annual review following the child's 14th birthday. The Education and Library Board's (ELB) Transition Service will ensure, in the most complex of cases, that appropriate advice givers will be present as part of the annual review process. Transition planning and services should be available, with young people and carers made aware of them, and able to access transition supports following post primary education with sufficient forward planning to minimise apprehension and stress for those young people and their carers.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DoH (2008) Getting a Life 2008-11 http://www.gettingalife.org.uk

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Special Educational Needs and Disability (NI) Order 2005 (SENDO)

Education (NI) Order 1996 and Code of Practice
http://www.deni.gov.uk/index/7-special_educational_needs_pg/special_needs-codes_of_practice_pg.htm

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• DHSSPS, DE (ELBs, schools and FE colleges), DEL • Education Transitions Co-ordinators • Voluntary agencies • Youth services • Councils • Independent providers • RQIA • Young people and their families • Advocacy organisations

Quality Dimension

Citizenship
A common assessment pathway will help to ensure equity of services for all.

Social Inclusion
Accessible information will be provided to allow young people, their carers and relevant others to participate fully in the development of a transition plan. Such information is available in a range of media and from a wide range of sources. Young people's involvement will create a move away from a narrow focus on services to a broader expression of aspirations for the future.

Empowerment
The process of preparing the Transitions Plan will place the young person and his/her family at the centre of planning for the future

Working Together
Decisions about eligibility for services will be the outcome of a multi-disciplinary assessment, and will be open and transparent for parents. The plan will be developed on a multi-disciplinary/multi agency basis with clear accountability lines for delivery by all the contributors.

Individual Support
A preliminary assessment will feed into an individualised transitions plan. Each plan will reflect the young person's aims and objectives in life including specific individual needs and interests, continuing education and training, employment, social and leisure activities and day opportunities.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of young people who express satisfaction that their transition plan has been implemented within 2 years of leaving school.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	Year 2 Year 3
2 Evidence of transfer to DES, where appropriate, for health checks for children on transition to adult services	DES	90% 95% 98%	Year 1 Year 2 Year 3

Standard 15:
People with a learning disability should be supported to have meaningful relationships, which may include marriage and individual, unique, sexual expression within the law, balancing their rights with responsibilities.

Service User Perspective*:*

"I will be supported to enjoy meaningful relationships."

Rationale:
The Bamford Review promotes the importance of people with a learning disability benefiting from meaningful relationships and the need to offer support, guidance, training and related services to ensure that this happens.

The Human Rights Act 1998 includes the right to respect for privacy and family life, freedom of expression, the right to marry and to found a family and the right not to be discriminated against in respect of these rights and freedoms. This has to be balanced with positive risk taking strategies. Safeguards need to be put in place, where necessary and appropriate, but within a framework that ensures the objective is to support people who are having positive relationships whenever possible.

People with a learning disability have a right to learn about sexuality and the responsibilities that go along with exploring and experiencing one's own sexuality. They have to know how to protect themselves from unplanned pregnancy, HIV and other sexually transmitted infections, and sexual and gender-based violence. Education programmes for people with a learning disability should begin during adolescence as part of their general education. The implementation of this standard will need to be supported by the provisions detailed in Standard 3 (Consent and Capacity).

Evidence:
DHSSPS (2010) Adult Safeguarding: Regional & Local Partnership Arrangements http://www.dhsspsni.gov.uk/asva-_march_2010.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DHSSPS (2008) Sexual Health Promotion Strategy & Action Plan 2008-2013
http://www.dhsspsni.gov.uk/dhssps_sexual_health_plan_front_cvr.pdf

Simpson, A et al (2006) Out of the shadows: A report of the sexual health and well being of people with learning disabilities in Northern Ireland. Newnorth Print Ltd.

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

SCIE (2004) The Road Ahead: Information for Young people with Learning Difficulties, their Families and Supporters at Transition
http://www.scie.org.uk/publications/tra/index.asp

The Human Rights Act, 1998
http://www.direct.gov.uk/en/Governmentcitizensandrights/Yourrightsandresponsibilities/DG_4002951

Responsibility for delivery/implementation	**Deliver and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• DHSSPS, DE (Education and Library Boards and Schools) • Voluntary sector • Service Users • Families

Quality Dimension

Citizenship
The right to personal relationships is enshrined in Human Rights legislation. Meaningful relationships are a fundamental component of health and social wellbeing.

Social Inclusion
People will be supported to access social and leisure opportunities where friendships may be developed.

Empowerment
People will be supported to appreciate the rights, risks and responsibilities involved in personal relationships

Working Together
Staff and family carers will contribute to the development of policies and best practice guidelines in this area.

HSC Trusts will implement the Adult Safeguarding arrangements and staff will be trained appropriately to discharge it.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Regional guidelines on sexuality and personal relationships are developed to ensure a consistent approach	HSC Board Report	HSC Board policy developed and agreed	Year 1

2 Trusts to facilitate appropriate training for staff.	Trust Reports	40% 80%	Year 2 Year 3
3 Trusts to facilitate appropriate training for service users and family carers.	Trust Reports	Level to be established pending development of regional policy	Year 3
4 Increase in the number of people with a learning disability accessing sexual health & reproductive healthcare services.	SAAT	Establish baseline Performance levels to be determined once baseline established	Year 1 Year 2

CHAPTER 7: INCLUSION IN COMMUNITY LIFE

Emotional and social wellbeing are directly related to the degree to which people are able to live valued lives and participate in community opportunities.

For people with a learning disability barriers can exist which prevent them from accessing the opportunities that are open to the rest of society. Many of these barriers do not relate directly to the disability, but rather are the result of discrimination and approaches based on a belief that social education and leisure opportunities need to be provided within the context of HSC provision. This has resulted in the social exclusion of people with a learning disability and the development of services that group people together on the basis of a shared learning disability, rather than addressing individual needs and aspirations.

The HSC has a role in working with others in employment, housing, leisure and education to maximise opportunities that enable people with a learning disability to actively participate in their communities and engage in meaningful daytime activities, friendships, employment and leisure.

The majority of men and women with a learning disability live at home with their families. Appropriate short breaks are often an important component in supporting these arrangements.

Increasingly people with a learning disability express an aspiration to have children. HSC services must work together to ensure that people who have a learning disability are appropriately supported in their parenting role.

Standard 16:
Adults with a learning disability should be able to access support in order that they can achieve and maintain employment opportunities in productive work.

Service User Perspective:

"I will be able to get support to help me find and keep a job."

Rationale:
The Lisbon Agenda (2000) promotes the integration of people traditionally excluded from the labour market. The Bamford Review recommends that agencies should work in partnership to promote and deliver supported employment services. HSC Trust day opportunities strategies promote the development of supported employment as an integral part of service development.

A cultural shift away from a reliance on day centres should be encouraged, towards alternative options which enable individuals with a learning disability to participate in society through day opportunities and work placements that will improve their skills and allow them the opportunity to integrate with others. Those involved in person centred planning should actively consider employment as one of these options.

Evidence:
Beyer S, (2010) Using a Cost Benefit Framework for Supported Employment Policy and Practice: an analysis of 2 UK agencies Journal Appl Res Intellect, Volume 23, 5 (September 2010) pp.447-447
http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3148.2010.00584.x/pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DoH (2009) Valuing Employment Now – Real Jobs for People with Learning Disabilities
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101401

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

DELNI (2008) Pathways to Work (New Deal)
http://www.delni.gov.uk/index/finding-employment-finding-staff/fe-fs-help-to-find-employment/stepstowork.htm (Accessed 15 April 2011)

OFMDFM Promoting Social Inclusion (PSI) Disability
http://www.ofmdfmni.gov.uk/index/equality/disability/disability-promoting-

social-inclusion.htm

Lisbon Agenda (2000) http://www.euractiv.com/en/future-eu/lisbon-agenda/article-117510

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts	• DEL, OFMDFM • Supported employment providers • Northern Ireland Union of Supported Employment (NIUSE)

Quality Dimension

Working Together
HSC staff, in partnership with DEL and others, will enable people with a learning disability to achieve and maintain employment opportunities with ongoing professional support.

Social Inclusion
Historically there have been barriers to opportunities for meaningful employment for men and women with a learning disability. Increasing such opportunities will be a key contributor to improving social inclusion.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of school leavers with a learning disability who access work placements or employment within one year of leaving school (as percentage of total learning disabled school leaving population).	ELB Transition Service	Establish baseline Performance levels to be determined once baseline established	Year 1 Year 2
2 Percentage of adults with a learning disability who receive HSC support to help them secure employment (as a measure of those who request support).	Audit	Establish baseline Performance levels to be determined once baseline established	Year 1 Year 2

Standard 17:
All adults with a severe or profound learning disability should be able to access a range of meaningful day opportunities appropriate to their needs.

Service User Perspective:

"I will be supported to take part in a range of activities during the day"

Rationale:
There is a need for a radical reconfiguration of existing day service provision based on a progressive shift towards a resource model. As alternative provision develops there should be a reduction in the number of people who attend Adult Centres on a full-time basis. It is anticipated that these centres will, in the future, be providing a service to men and women with increasingly complex needs who should also be enabled to access opportunities for community integration. Adult Centres will need to explore the potential to develop sites for meeting the particular needs of people with more complex needs. The potential for Adult Centres to be used as a community resource is particularly under-utilised at present. Partnerships with community and voluntary groups should involve promoting the inclusion of people with a learning disability.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

SCIE (2007) Knowledge Review 14: Having A Good Day? A study of community-based day activities for people with learning disabilities
www.scie.org.uk/publications/knowledgereviews/kr14.asp

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

PCC (2011) My Day, My Way The Bamford Monitoring Group's Report on Day Opportunities
http://www.patientclientcouncil.hscni.net/uploads/research/My_Day_My_Way_FINAL.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts	• Local community organisations • DHSSPS, DEL • FE providers • Local economy

Quality Dimension

Social Inclusion
Reconfiguration of day centres may reduce the number of days attended and an

expansion of wider community options for individuals.

Working Together
Each person will have a person-centred plan which will identify the multi-disciplinary and community inputs required to deliver on that plan. A lead person will be accountable for the delivery of the plan, which must be reviewed 6 monthly.

Individual Support
Admission criteria and processes in day centres will be in line with the standard and clear processes will be in place to consider intake and development of opportunities in local communities.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of adults with a severe or profound learning disability who have meaningful day opportunities in mainstream community settings.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	Year 1 Year 2
2 Percentage of adults with a learning disability supported by HSC who express satisfaction with the choice of day opportunities they can access.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	Year 1 Year 2

Standard 18:
All parents with a learning disability should be supported to carry out their parenting role effectively.

Service User Perspective:

"If I have children I will get support to be a good parent."

Rationale:
An increasing number of adults with a learning disability are becoming parents. In about 50% of cases their children are removed from them largely because of concerns about the children's wellbeing or the lack of appropriate support.

Barriers to the provision of appropriate supports include negative and stereotypical attitudes. Men and women with a learning disability have a right to be parents and where they choose to exercise this right, effective support should be in place to avoid adverse outcomes for them and their children.

If support is provided early it is more likely that the family unit will be successfully supported to stay together.

Evidence:
DoH (2009) New Horizons: A Shared Vision for Mental Health
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf

Aunos, M *et al* (2008) Mothering with Intellectual Disabilities: Relationship Between Social Support, Health and Wellbeing, Parenting and Child Behaviour Outcomes. http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3148.2008.00447.x/abstract

Tarleton, B *et al* (2006) Finding the right support? A Review of Issues and Positive Practice in Supporting Parents with Learning Difficulties and Their Children. The Baring Foundation
www.bristol.ac.uk/norahfry/research/completed-projects/rightsupport.pdf

IASSID Special Interest Research Group on Parents and Parenting with Intellectual Disabilities (2008) Parents labelled with Intellectual Disability. Position of the IASSID SIRG on Parents and Parenting with Intellectual Disabilities. Journal of Applied Research in Intellectual Disabilities, 21: 296–307. http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3148.2008.00435.x/abstract

Booth T *et al* (2006) Temporal discrimination and parents with learning difficulties in the child protection system. *British Journal of Social Work* 36(6), 997–1015. http://bjsw.oxfordjournals.org/content/36/6/997.abstract

SCIE (2006) Knowledge Review 11: Supporting disabled parents and parents with additional support needs.
http://www.scie.org.uk/publications/knowledgereviews/kr11.asp

CSCI (2006) Supporting Parents, Safeguarding Children: Meeting the needs of parents with children on the child protection register http://www.pmhcwn.org.uk/files/supporting_safeguarding.pdf (Accessed 15 April 2011)

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
- HSC Board - Public Health Agency (PHA) - HSC Trusts	- DHSSPS - Community and voluntary sector providers - Advocacy services

Quality Dimension

Citizenship
Independent advocacy support is provided to enable parents with a learning disability to be involved in the decision making process within multi-disciplinary meetings and other decision making fora.

Social Inclusion
Supports provided promote and encourage the parents to become less isolated from the community in which they live.

Empowerment
More parents and their children will be receiving appropriate care and support resulting in a smaller percentage of children of parents with learning disabilities being subject to Care Orders.

Working Together
Professionals work collaboratively across children's and adult's services to provide effective support to the parent and work will continue to develop policy on positively supporting parents with a learning disability to continue caring for their children.

Individual Support
Parents will be better enabled to care for themselves and their children through having their needs properly assessed and being appropriately supported in their parenting role.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Develop and agree a regional protocol between children's and adult services for joint working and care pathways.	HSC Board Report	HSC Board in collaboration with all HSC Trusts	Year 1

2 Percentage of parents with a learning disability who have a multi-professional/agency competence based assessment and subsequently receive appropriate support services	Trust Report	Establish baseline Performance level to be determined once baseline established	Year 2 Year 3
3 Percentage of parents with a learning disability involved in child protection or judicial processes who have received locally based skills training.	Trust Reports	85% 90% 95%	Year 1 Year 2 Year 3
4 Percentage of parents with a learning disability involved in child protection or judicial processes who have access to the services of an independent advocate.	Trust Reports	Establish baseline Performance level to be determined once baseline established	Year 1 Year 2

CHAPTER 8: MEETING GENERAL PHYSICAL AND MENTAL HEALTH NEEDS

Physical and mental health are inextricably linked with each impacting upon the other. The World Health Organisation (WHO) gives equal value to physical and mental health in the definition of health as “a complete state of physical, mental and social wellbeing, not just the absence of disease and infirmity”. People with poor physical health are at higher risk of experiencing common mental health problems and people with mental health problems are more likely to have poor physical health. Many factors influence the health of individuals and communities. Whether people are healthy or not depends a great deal on their circumstances and the environment in which they live. The determinants of health and wellbeing include:

- social environment
- the physical environment
- the person’s individual characteristics and behaviour

Many of these factors of health are not under the direct control of the individual and therefore one person’s health may differ from another’s depending on their circumstances.

Evidence demonstrates that there are significant disparities in health outcomes for people with a learning disability. They experience higher levels of physical and mental ill health, yet have lower access to primary care services, health screening and health promotion activities.

People with a learning disability can experience difficulties when using general health services, hospitals and primary care services. There is a need to proactively ensure that there is equity of access to the full range of health care services enjoyed by the general population. This is enshrined in disability discrimination and human rights legislation.

Standard 19:
All people with a learning disability should have equal access to the full range of health services, including services designed to promote positive health and wellbeing.

Service User Perspective:

"I have equal access to the full range of health services as other people in the community."

Rationale:
It is known that people with a learning disability often experience difficulties when using health services and this can result in their health needs not being effectively assessed or met.

Most people with a learning disability do not require specialist services to address their health needs but many will require a range of reasonable adjustments to help them make use of generic health services such as primary care, acute hospitals and dentistry. Specialist learning disability services are a key resource to support mainstream health services develop the knowledge and skills to do this effectively.

Reasonable adjustments can be many and are wide ranging, but it is important to remember that they must be individualised to the person, and may include such things as:

- longer appointment times
- offering the first or last appointment
- the provision of easy read information to enhance understanding
- close involvement and support of family carers
- appropriate waiting facilities
- pre-admission visits
- fast tracking arrangements when appropriate (e.g. in A&E Departments)

The standard links closely to Standards 4 and 5 (Communication and Involvement in the Planning and Delivery of Services).

Evidence:
Learning Disabilities Observatory: Improving Health and Lives (2010) Health Inequalities Report
http://www.improvinghealthandlives.org.uk/projects/particularhealthproblems

GAIN (2010) Guidelines: Caring For People With A Learning Disability In General Hospital Settings
http://www.gain-ni.org/Library/Guidelines/Gain%20learning.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and

Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Mencap (2007) Death by Indifference
www.mencap.org.uk/case.asp?id=52&menuId=53&pageno

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care (including pharmacy and dental)	• DHSSPS • Service users and carers

Quality Dimension

Citizenship
People with a learning disability are equal citizens and must be able to readily access the full range of services that support their health and social wellbeing as are available to the rest of the population.

Social Inclusion
Primary care services, acute hospital services and other specialist services, such as, palliative care should have knowledge of the specific issues for people with a learning disability accessing these services and make reasonable adjustments accordingly.

Working Together
All generic services should have knowledge of local learning disability specific services and how to access them when required. This includes access to advocacy services.

Individual Support
The provision of all services should be tailored to the individual needs of the person with a learning disability, and reasonable adjustments made accordingly. An individual with a learning disability should be able to make round the clock contact with services and receive the care needed to meet their needs.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 All acute hospitals should have an action plan for implementing the GAIN Guidelines for improving access to acute care for people with a learning disability and be able to demonstrate a clear commitment to the implementation of such a plan.	Trust report	All HSC trusts establish baseline Performance levels to be determined once baseline established	Year 1 Year 2
2 Percentage of GPs who have a system for identifying people with a learning disability on their register.	DES	Baseline as per learning disability DES Performance levels to be determined once baseline established	Year 1 Year 2
3 Each GP practice has a designated link professional within local learning disability services.	Trust report as per GAIN Guidelines	Establish baseline Performance levels to be determined once baseline established	Year 1 Year 2
4 Evidence of reasonable adjustments by health service providers.	Report from HSC Trust learning disability services	Establish baseline Performance levels to be determined once baseline established	Year 1 Year 2

Standard 20: (Generic)
All HSC staff, as appropriate, should advise people who smoke of the risks associated with smoking and signpost them to well developed specialist smoking cessation services.

Service user perspective:

"I will be advised on the dangers of smoking"

Rationale:
Smoking is a major risk factor for a number of chronic diseases including a range of cancers, coronary heart disease, strokes and other diseases of the circulatory system. Its effects are related to the amount of tobacco smoked daily and the duration of smoking.

A number of specialist smoking cessation services have been commissioned in a range of settings across Northern Ireland. These services offer counselling and support in addition to the use of pharmacotherapy by trained specialist advisors.

Evidence:
DHSSPS (2010) Tobacco Control Strategy for Northern Ireland http://www.dhsspsni.gov.uk/tobacco-strategy-consultation.doc

NICE (2008) Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities http://www.nice.org.uk/Guidance/PH10

NICE (2006) Brief Interventions and Referral for Smoking Cessation in Primary Care and Other Settings http://www.nice.org.uk/Guidance/PH1

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts • Public Health Agency (PHA) • Primary Care	• DHSSPS • Families & carers • Voluntary, education, youth and community organisations

Quality Dimension

Citizenship
People with a learning disability can exercise their rights as citizens if they have accessible information to inform decision-making.

Empowerment
All members of the public will benefit from access to public information and education campaigns that raise awareness of issues relating to tobacco use, such as, the health risks to smokers and non-smokers. People who are ready to

stop smoking are able to access specialist smoking cessation services in a choice of settings.

Working together
Brief Intervention Training for Health and Social Care Staff will ensure patients and clients receive consistent and timely advice on smoking cessation. Specialist smoking cessation services will be delivered to regional quality standards ensuring equitable service provision. Provision of information in an accessible format is a key step towards enabling effective partnership between those who work in services and those who use them. HSC professionals should take account of what is important to the person, their relationships and activities in working with them to address issues around smoking. Brief Intervention training for HSC staff will ensure that service users receive consistent and timely advice.

Individual Support
Effective person-centred support should take account of balancing what is important to people with what is important to them in regard to their health and wellbeing. Specialist smoking cessation services will be delivered to regional quality standards ensuring equitable service provision.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
Percentage of people accessing smoking cessation services who have heard about the service from an HSC professional.	ELITE (PHA Stop Smoking Services Report)	Establish baseline. Performance levels to be determined once baseline established	March 2013
Percentage of people accessing smoking cessation services offered by HSC providers who have quit.	ELITE	Establish baseline. Performance levels to be determined once baseline established	March 2013

Standard 21:
All people with a learning disability should be supported to achieve optimum physical and mental health.

Service User Perspective

I will be helped to stay as physically and mentally healthy as possible.

Rationale:
People with a learning disability are more likely to experience major illnesses, to develop them younger and die of them sooner than the population as a whole. They have higher rates of obesity, respiratory disease, some cancers, osteoporosis, sensory impairment, dementia and epilepsy. It is estimated that people with learning disability are 58 times more likely to die prematurely. However, even with such a dramatic health profile, the learning disabled population are less likely to get some of the evidence-based treatments and checks they need, and continue to face real barriers in accessing services. This contributes to preventable ill health, poor quality of life and potentially, premature death.

Effective screening and regular health checks help to identify unmet need and prevent health problems arising. People with a learning disability participate less in screening and regular health checks than the rest of the population. Information on, and activities in, health promotion can be difficult to access.

Evidence:

Learning Disabilities Observatory (2011) The Estimated Prevalence of Visual Impairment among People with Learning Disabilities in the UK http://www.improvinghealthandlives.org.uk/publications/

DoH (2009) Improving the health and well being of people with learning disabilities: world class commissioning www.dh.gov.uk/commissioning

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011) http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DoH (2009) Valuing People Now: A new three-year strategy for people with learning disability
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093377

DoH (2009) Health Action Planning and Health Facilitation for people with learning disabilities: good practice guidance
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096505

DoH (2009) Delivering Better Oral Health: An evidence- based toolkit for prevention – second edition

DoH (2008) High quality care for all: NHS Next Stage Review Final Report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

DHSSPS (2007) Guidance on Strengthening Personal and Public Involvement in Health and Social Care (HSC (SQSD) 29/07)
http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

DHSSPS (2007) Oral Health Strategy for Northern Ireland
http://www.dhsspsni.gov.uk/2007_06_25_ohs_full_7.0.pdf

Disability Rights Commission (2007) Equal Treatment: Closing the Gap: A Formal Investigation into Physical Health Inequalities Experienced by People with Learning Disabilities and/or Mental Health Problems
http://onlinelibrary.wiley.com/doi/10.1111/j.1741-1130.2006.00100.x/abstract

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Foundation for People with Learning Disabilities (2005) Communication for person-centred planning
http://www.learningdisabilities.org.uk/publications/communication-person-centred-planning/

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • Primary Care • HSC Trust (Learning Disability Teams)	• Families • Voluntary and Community providers

Quality Dimension

Citizenship
People with a learning disability are supported to access the full range of screening and health checks as the rest of the population of NI.

Social Inclusion
Screening and health checks are made accessible to people with a learning disability and they are facilitated to participate in these activities.

Empowerment/Individual Support
Individuals will be supported to have regular screening and health checks on all the major illnesses and facilitated to make lifestyle choices that promote their good health and have in place a Health Action Plan as part of their person centred plan.

Working Together
There should be effective liaison and evidence of advance planning between

HSC staff and family carers to fully embrace people with learning disabilities into the system of regular screening and health checks and health promotion activities. This should incorporate the development of Health Action Plans which includes details of health interventions, oral health, fitness and mobility, emotional needs and records of screening tests and identification of those responsible for taking action.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 The PHA and each HSC Trust has a health improvement strategy for people with a learning disability (children and adults) to address all relevant physical and mental health promotion and improvement needs.	Public Health Agency/ Trust Reports (to include reports from voluntary and community organisations Trust has commissioned services from)	All Trusts have in place a health improvement strategy for people with a learning disability.	Year 1
2 Percentage of adults with a learning disability who have an annual health check.	GP Records Health Facilitator records	Establish baseline Performance levels to be determined once baseline established	Year 1 Year 2
3 Percentage of adults with a learning disability who have an up to date and active Health Action Plan (HAP) following the annual health check.	GP records Health Facilitator records Learning Disability Teams	Establish baseline Performance levels to be determined once baseline is established	Year 1 Year 2
4 Percentage of people with a learning disability who have been examined by a dentist in the past year.	Audit	Establish Baseline Performance Levels to be determined once baseline established	Year 1 Year 2
5 Percentage of females with a	GP records	Establish Baseline	Year 1

learning disability who access cervical and breast screening services.	Health facilitators	Performance levels to be determined once baseline established	Year 2
6. Percentage of people with a learning disability who have had a sight test with an optometrist in the past year.	Audit	Establish Baseline Performance levels to be determined once baseline established	Year 1 Year 2

Standard 22:
All people with a learning disability who experience mental ill health should be able to access appropriate support.

Service User Perspective

"If I have mental illness I can get appropriate support."

Rationale:
People with a learning disability and mental health needs require a co-ordinated multi-disciplinary approach to having their needs met through integrated services responding flexibly to the demands of their conditions with clear pathways of care identified so that the most appropriate supports are immediately available to the person and their family carers when required.

Refer also to standard 56 in Service Framework for Mental Health and Wellbeing

Evidence:
DHSSPS (2011) Service Framework for Mental Health and Wellbeing Consultation Document
http://www.dhsspsni.gov.uk/service_framework_for_mental_health_and_wellbeing_-_consultation_version.pdf

DoH (2010) Raising our sights: services for adults with profound intellectual and multiple disabilities A report by Professor Jim Mansell
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114346

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Emerson, E. and Hatton, C. (2007) The Mental Health of Children and Adolescents with Intellectual Disabilities in Britain. *British Journal of Psychiatry* 191, 493-499.
http://bjp.rcpsych.org/cgi/content/abstract/191/6/493

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

NHS QIS (2004) Learning Disability Quality Indicators
http://www.healthcareimprovementscotland.org/previous_resources/indicators/learning_disability_quality_in.aspx

Carpenter, B. (2002) Count Us In: report of the inquiry into meeting the mental health needs of young people with learning disabilities. London: Foundation for People with Learning Disabilities London:
http://www.learningdisabilities.org.uk/publications/count-us-in/

Responsibility for delivery/implementation	Delivery and implementation partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts • RQIA	• DHSSPS • Other service providers

Quality Dimension

Citizenship
Addressing the mental health needs of people with a learning disability requires a combination of services that are consistently available to enable their full participation within the structures of society

Social Inclusion
The mental health needs of people with a learning disability are met in the most appropriate setting.

Empowerment/Individual Support
People with a learning disability and mental illness have person-centred plans in place with clear pathways of care identified and planned to enable them to lead as normal a life as is possible given the conditions of their illness. To involve the person, their parents or family carer in this process empowers the family and the person with a learning disability to make informed choices

Working Together
Services surrounding the person with a mental illness should be co-ordinated and resourced appropriately with a lead person identified to effectively manage and promote the mental health and wellbeing of the person requiring services.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1. A regional protocol is developed to ensure that people with a learning disability can access mainstream mental health services.	HSC Board	Protocol in place	Year 1
2. Percentage of people with a learning disability and mental health needs who access mainstream mental health services e.g. psychological and talking therapies	Audit	Establish baseline Performance levels to be determined once baseline established	Year 2 Year 3

where indicated in their treatment plan.			
3. Percentage of Health Action Plans and health checks which include mental health assessment and mental health promotion	GP Records	Establish baseline Performance levels to be determined once baseline established	Year 1 Year 2

Standard 23: (Generic)
All HSC staff, as appropriate, should provide people with healthy eating support and guidance according to their needs.

Service user perspective:

"I will be provided with healthy eating support and guidance"

Rationale:
Reducing fat and salt in the diet and increasing fruit and vegetable consumption is associated with a reduction in the risk of cardiovascular disease and hypertension.

Having a well balanced and nutritious diet will also help prevent many diseases which are linked to being overweight and obese such as high blood pressure, heart problems, risk of stroke, some cancers and Type 2 Diabetes. In addition, an improved diet can also contribute to an improvement in an individual's mental health and wellbeing.

Evidence:
DHSSPS Draft Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland (2011-2021)
http://www.dhsspsni.gov.uk/showconsultations?txtid=44910

DHSSPS (2005) Fit Futures http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf

WHO (2004) Global Strategy on Diet, Physical Activity and Health
http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf

SCAN (2008) Scientific Advisory Committee on Nutrition. The Nutritional Wellbeing of the British population
http://www.sacn.gov.uk/pdfs/nutritional_health_of_the_population_final_oct_08.pdf

Responsibility for delivery/implementation	Delivery and implementation partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• Primary care team, inclusive of social care

Quality Dimension

Citizenship
People with a learning disability are provided with healthy eating support and advice as are the rest of the population.

Empowerment/ Individual support
Individuals will receive support and advice, appropriate to their needs, in a range of settings to develop skills for healthy eating and be facilitated to make lifestyle choices that promote their good health and wellbeing as part of person-centred

planning.

Lifestyle issues including eating and physical activity choices should be explored through knowledge of what is important to the person. This should take account of what has worked and what has not worked in the past.

Working Together
There should be effective liaison and evidence of advance planning between staff and family carers to fully embrace people with a learning disability into the system of health promotion activities. All stakeholders should promote a consistent nutrition message by using the Eat Well – getting the balance right model.Training and education should be available for child carers / group care workers.

Schools / hospitals / residential care and nursing homes should be supported in the implementation of nutrition standards. Support and advice to develop skills for healthy eating in a range of settings should be available.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1. Percentage of people eating the recommended 5 portions of fruit or vegetables each day.	Northern Ireland Health Survey	Establish baseline Performance level to be agreed thereafter	March 2013

Standard 24: (Generic)
All HSC staff, as appropriate, should provide support and advice on recommended levels of physical activity.

Service user perspective:

"I will be provided with support and advice on physical activity"

Rationale:
The National Institute for Health and Clinical Excellence (NICE) has fully endorsed the importance of physical activity as a means of promoting good health and preventing disease. Lack of physical activity is associated with an increase in the risk of coronary heart disease.

The recently reviewed and updated UK Physical Activity Guidelines, supported by all four CMO's, provide advice and guidance on the recommended levels of physical activity throughout the life course. The report also presents the first time guidelines have been produced in the UK for early years (under fives) as well as sedentary behaviour, for which there is now evidence that this is an independent risk factor for ill health.

Evidence:
DHSSPS Draft Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland (2011-2021)
http://www.dhsspsni.gov.uk/showconsultations?txtid=44910

DoH (2011) New UK Physical Activity Guidelines
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127931

NICE (2006) Public Health Intervention Guidance No.2 Four commonly used methods to increase physical activity: Brief intervention in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling http://www.nice.org.uk/nicemedia/pdf/word/PH002_physical_activity.doc

DHSSPS (2005) Fit Futures http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf

WHO (2004) Global Strategy on Diet, Physical Activity and Health
http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf

Responsibility for delivery/implementation	Delivery and implementation partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• Primary care team, inclusive of social care

Quality Dimension

Empowerment
People with a learning disability will benefit from access to appropriate information and advice on physical activity.

Working Together
HSC staff recognise their responsibility to ensure service users receive consistent and timely health promotion messages.

Appropriate physical activity brief intervention training should be provided for HSC staff to ensure patients and clients receive consistent and timely advice.

Individual Support
Lifestyle issues including physical activity choices should be explored through knowledge of what is important to the person. Paying attention to what works best for the person in undertaking physical activity, working with their interests. This should take account of what has worked in the past and what does not work.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1. Percentage of people meeting the recommended level of physical activity per week.	Northern Ireland Health Survey	Establish baseline. Performance level to be agreed thereafter.	Year 1 Year 2

Standard 25: (Generic)
All HSC staff, as appropriate, should provide support and advice on recommended levels of alcohol consumption.

Service user perspective:

"I will receive support and advice on the use of alcohol"

Rationale:
Excessive alcohol consumption is associated with many diseases such as cancers (oesophagus, liver etc), cirrhosis of the liver and pancreatitis. There are also direct effects of alcohol and an increased association with injuries and violence.

Excessive alcohol consumption can affect the cardiovascular system, and is associated with high blood pressure, abnormal heart rhythms, cardiomyopathy and haemorrhagic stroke.

Evidence:
DHSSPS (2006) New Strategic Direction for Alcohol and Drugs (2006-2011)
http://www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf

SIGN (2003) Scottish Intercollegiate Guidelines Network The Management of harmful drinking and alcohol dependence in Primary Care No 74
http://www.sign.ac.uk/pdf/sign74.pdf

Responsibility for delivery/implementation	**Delivery and implementation partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• Primary care team, inclusive of social care

Quality Dimension

Citizenship
People with a learning disability and alcohol related issues should be able to access mainstream services. They are likely to require the support of learning disability personnel to utilise the services offered by the mainstream addiction teams.

Working Together
Appropriate alcohol brief intervention training should be provided for HSC staff to ensure patients and clients receive consistent and timely advice.

Individual Support
HSC staff should take account of what and who is important to the person now and in the future in relation to lifestyle and where alcohol fits in. Explore how alcohol can be managed in the person's life by taking account of what has worked and what has not worked in the past for this person.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of people who receive screening in relation to their alcohol consumption.	Northern Ireland Local Enhanced Service	Establish baseline Performance level to be determined once baseline established	Year 1 Year 2

CHAPTER 9: MEETING COMPLEX PHYSICAL AND MENTAL HEALTH NEEDS

Children and adults with a learning disability may experience significant additional, complex health needs. Complex physical and mental health needs may be defined as those requiring a range of additional support services beyond the type and amount required by people generally and those usually experienced by people with impairments and long-term illnesses. These needs require a high level of effective integration between specialised and general services.

Supports to children, young people and adults who have complex physical and mental health needs will be most effective if they are based on person-centred planning approaches and within an ethos of ensuring bridging between learning disability expertise and other service settings. (Standard 10 sets out the specific standard for children and young people with complex physical health needs).

Standard 26:
All people with a learning disability whose behaviour challenges should be able to get support locally from specialist learning disability services and other mainstream services, as appropriate, based on assessed need.

Service User Perspective:

I can get support locally from specialist learning disability services if my behaviour challenges services and/or my carers

Rationale:

Emerson (1995) defines 'challenging behaviour' as behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities.

People who present behaviours that challenge services are generally well known to staff working within specialist learning disability services and they are therefore in a position to provide relevant information to other services and support the person and family carers to enable him/her to continue to access these services.

The specialist supports available should include social work, psychiatry, psychology, speech and language therapy, physiotherapy, nursing and any other relevant disciplines and these should be available 24 hours a day, 7 days a week. Should crises occur there needs to be the capacity to respond with appropriate interventions that maintain the person in the community/home in which he/she resides and/or short breaks that provides time out from the situation.

Whilst significant evidence exists as to the need for timely, flexible, home-based support to address challenging behaviours and to prevent unnecessary inpatient admission, work is not complete on the optimum service configuration and models required in Northern Ireland. To develop community based supports and move away from a traditional model of hospital admission will require resource investment and future detailed service planning.

Evidence:

NDTi (2010) Guide for Commissioners of Services for People With Learning Disabilities Who Challenge Services
http://www.ndti.org.uk/uploads/files/Challenging_behaviour_report_v7.pdf

DoH (2010) Raising our sights: services for adults with profound intellectual and multiple disabilities A report by Professor Jim Mansell
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114346

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability

http://www.dhsspsni.gov.uk/equallivesreport.pdf

NHS QIS (2004) Learning Disability Quality Indicators
http://www.healthcareimprovementscotland.org/previous_resources/indicators/learning_disability_quality_in.aspx

Emerson, E (1995) Challenging behaviour - analysis and intervention in people with a learning disability Cambridge University Press

Responsibility for delivery/implementation	Delivery and Implementation Partners
• Commissioning organisations • HSC Trusts • RQIA	• DHSSPS • Family carers • Advocacy providers • Other service providers

Quality Dimension

Citizenship
Providing support to an individual who presents behaviours that are challenging to access mainstream health and social care services maintains their equity with the rest of the population of NI.

Social Inclusion
There are community-based services to meet the needs of people with challenging behaviour.

Empowerment
Incidents of challenging behaviours are reduced when appropriate support mechanisms are available so that they can continue to receive the community - based services they require.

Working Together
Mainstream and specialist services should be collaborating on the needs of people with a learning disability who present behaviours that challenge mainstream services so that the person can access the healthcare services they require and services comply with regional guidelines on the management of challenging behaviours.

Individual Support
Management and intervention for challenging behaviour is practised and the approaches used have proven evidence-based effectiveness and social validity.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of individuals with significant challenging behaviours who have a Behaviour Support Plan including advance directives in	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	Year 1 Year 2

place that detail actions to be undertaken in the event of their challenging behaviours escalating.			
2 Where challenging behaviours present a significant risk to the individual or others or a risk of breakdown in accommodation arrangements, a specialist assessment has been completed within 24 hours.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	Year 1 Year 2
3 Where challenging behaviours present a significant risk to the individual, a Management Plan has been developed and implemented within 48 hours.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	Year 1 Year 2
4 Evidence that HSC has engaged with other relevant delivery partners in developing and implementing consistent approaches in individual cases.	Trust report Audit of voluntary/ community sector	All HSC Trusts	Year 2
5 Percentage of people labelled as challenging who are not living in a congregate setting described as a challenging behaviour or specialist assessment/ treatment service	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	Year 3

Standard 27:
All people with a learning disability who come into contact with the Criminal Justice System should be able to access appropriate support.

Service User Perspective:

I will get support If I come in contact with the police, courts or prisons

Rationale:
Men and women with a learning disability can come into contact with the Criminal Justice System in a range of different ways. They can be suspects, remandees, prisoners or indeed witnesses. However, people with a learning disability can be particularly vulnerable as they may not understand the processes involved, the information given to them, or their rights. The Reed Report (1992) highlighted the needs of mentally disordered offenders and recommended that, where appropriate, people with a learning disability who offend should be directed to HSC services, while emphasizing the need for services to be based on a multi-agency needs assessment.

It is vital that an offender with a learning disability does not go unrecognised and unsupported whilst in the prison system and that care pathways are established between primary care, learning disability services and Criminal Justice Services.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DoH (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf

RCSLT (2009) Locked Up and Locked Out: Communication Is The Key
http://www.rcslt.org/news/events/Locked_Up_NI_post_event_report

Prison Reform Trust (2008) No-One Knows. Police Responses to Suspects Learning Disabilities and Learning Difficulties: A Review of Policy and Practice
www.prisonreformtrust.org.uk

DHSSPS (2006) The Bamford Review of Mental Health and Learning Disability (NI): Forensic Services
http://www.dhsspsni.gov.uk/forensic_services_report.pdf

Reed Report (1992) Review of mental health and social services for mentally disordered offenders and others requiring similar services: Vol. 1: Final summary report. (Cm. 2088) London: HMSO ISBN 0101208820

Responsibility for delivery/implementation	**Delivery and implementation partners**
• HSC Board • HSC Trusts • General Practitioners	• DHSSPS, DoJ • Police Service of Northern Ireland (PSNI) • Probation Board for Northern Ireland (PBNI) • NI Prison Service • NI Courts Service • Youth Justice Agencies • Voluntary and community providers

Quality Dimension

Citizenship
People with a learning disability going through the Criminal Justice System have the same rights as other members of society and there is evidence of good practice available to ensure that this is the case.

Social Inclusion
Offending behaviours have the potential to increase the person's social exclusion and measures must be evidenced within their person-centred plan (PCP) that promotes their social inclusion in mainstream activities upon discharge from any institutional setting.

Empowerment
Measures are in place to minimise the person's vulnerability when they are in contact with the Criminal Justice System

Working Together
There is evidence of multi-disciplinary working practices to ensure that people with a learning disability are supported within the Criminal Justice System.

Individual Support
Community based services are in place which support people, prevent admissions where possible, and facilitate discharge from inpatient and other secure settings. The least restrictive options for individuals should be available.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Evidence that HSC has engaged and developed local protocols with relevant delivery partners to achieve consistent and	HSC Board Report	Protocols in place	Year 1

coordinated approaches to working with people with a learning disability who have offended or are at risk of offending.			

CHAPTER 10: AT HOME IN THE COMMUNITY

To maximise their health and social wellbeing, people with a learning disability should be supported to live in the community close to family, friends and community resources. Where they currently live with family they (the family) should be supported to provide the necessary care and support.

A greater focus on 'purposeful lives' will support people with a learning disability to live as independently as possible. It is vital that people are supported to live in the community and that inappropriate admission to hospital is avoided. People with a learning disability who require hospital treatment should be speedily discharged when the treatment ends to community homes with appropriate care and support. Resettlement of long stay populations, the development of innovative approaches to prevent delayed discharges and the promotion of 'purposeful respite' will enhance outcomes for people with a learning disability, their families and carers.

Standard 28:
HSC professionals should work in partnership with a variety of agencies in order to ensure that the accommodation needs of people with a learning disability are addressed.

Service User Perspective:

"My accommodation needs will be met by staff from different agencies who work well together"

Rationale:
People with a learning disability aspire to have the same standard in living options that are available to their non-disabled peers.

In NI the majority of adult persons with a learning disability continue to live with family carers. As carers age, they may require extra support to maintain their caring role. In addition, people with a learning disability may need support to participate in community activities with their peers.

Person-centred support plans should identify the person's preferred living arrangements and these should be regularly reviewed. It is important that as family carers age they are supported to plan for the future to allow for a smooth transition to new care arrangements either within the family or in supported accommodation (refer to Chapter 12: Ageing Well).

Small-scale, supported living arrangements (5 persons or less) have been shown to offer a better quality of life for people with a learning disability as compared to congregated living arrangements.

People living outside of family care should have a tenancy or occupancy agreement to offer them security of tenure along with an agreement to the number of support hours available to them individually.

People should be involved in decisions about sharing their homes with others. As far as possible they should be offered a choice of accommodation in a locality of their choosing.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

SCIE (2009) At a glance 8: Personalisation Briefing: Implications for housing providers www.scie.org.uk/publications/ataglance/ataglance08.asp

DHSSPS (2008) Residential Care Homes: Minimum Standards
http://www.dhsspsni.gov.uk/care_standards_-_residential_care_homes.pdf

NDA (2007) Supported Accommodation Services for People with Intellectual Disabilities: A review of models and instruments used to measure quality of life in different various settings (Walsh, PN *et al*, 2007)
http://www.nda.ie/website/nda/cntmgmtnew.nsf/0/929ECD4441474CA280257872004B8619/$File/SupportedAccommodation.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

McConkey, R (2005) Fair shares? Supporting families caring for adult persons with intellectual disabilities. Journal of Intellectual Disability Research, vol 49, Issue 8, 600 – 612
http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2788.2005.00697.x/full

NIHE (2003) Supporting People
http://www.nihe.gov.uk/index/sp_home/strategies/independent_living-2/supporting_people_strategy.htm

Responsibility for delivery/implementation	**Delivery and implementation partners**
• HSC Board • HSC Trusts	• DSD • NIHE • Other service and housing providers

Quality Dimension

Citizenship
People with a learning disability have equity of access to housing options similar to the general adult population.

Social Inclusion
People with a learning disability are living in communities.

Empowerment
People with a learning disability are supported to access information and advice to exercise their preference of where they live and who they wish to live with, through the help of independent advocates where necessary and, tailoring support to people’s individual needs to enable them to live full, independent lives.

Working Together
HSC professionals are involved in developing strategies, information and advice to housing providers on identified housing needs of people with a learning disability. Joint planning and partnership working is promoted towards meeting a person’s housing need.

Individual Support
Support Plans are in place that support the person with a learning disability and their carers’ independence. Funding sources are maximised that support this position and planning for the future is incorporated into this process.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of support plans that take account of people's aspirations in relation to future accommodation needs, including independent living	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	Year 1 Year 2
2 Percentage of adults who are living with a single carer or where there are 2 carers and the primary carer is aged over 65 who have a futures plan in place	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	Year 1 Year 2
3 Percentage of people in receipt of public funding living in households of 5 people or less with a learning disability	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	Year 1 Year 2
4 Percentage of people leaving learning disability hospital within one week after treatment has been completed	PfA monitoring	95% 97% 100%	Year 1 Year 2 Year 3

Standard 29: (Generic)
All HSC staff should identify carers (whether they are parents, family members, siblings or friends) at the earliest opportunity to work in partnership with them and to ensure that they have effective support as needed.

Service user perspective:

“ My carer’s needs will be considered and supported”

Rationale:
Carers are central to providing health and social care. People want to live in their own homes as independently as possible and family caring is critical in achieving this goal. Breakdown in caring has a major impact on readmission rates to hospital and unnecessary admissions to residential and nursing home care placements.

Caring is both a demanding and rewarding activity. Evidence shows that unsupported caring can have a negative impact on the physical, social and emotional well being of an adult carer. It is in everyone’s interest to ensure that carers can continue to care for as long as they wish and are able to, without jeopardising their own health and wellbeing or financial security, or reducing their expectations of a reasonable quality of life.

Young carers (children and young people up to the age of 18 years who have a substantive caring role for a member of their family) often do not have an alternative but to be a carer. These children can be lonely, isolated, lose friendships and miss out on education and social activities. Young carers are frequently involved in activities that are developmentally inappropriate and the impact on their lives is unknown. Many young carers go unidentified. This highlights the need to identify young carers and provide support and assistance which will promote their health, development and inclusion in educational and social activities.

Early intervention, individually tailored to the needs of the carer and the cared for person, can be crucial in avoiding breakdown in the caring role. Forming meaningful partnerships with carers and making agreements with them about support to be provided is essential. Carers identify their requirements as respite care, information, personal care for the cared for person and practical and emotional support to continue in their role. This highlights the need for service planning and commissioning based on partnership working between statutory and independent sector and involvement of carers or their representatives to shape future services.

To enable carers to access the right information, support and services, current methods for identifying carers and encouraging them to acknowledge their caring role need to be enhanced. Under the Carers and Direct payments Act, all staff have a duty to inform carers. Staff should be particularly proactive in identifying the presence of younger and older carers.

One of the most important and far-reaching improvements in the lives of carers will be brought about by how health and social care staff view and treat them. Changes in staff knowledge of carers' issues could promote a more positive attitude to carers and this would make a significant difference to the lives of carers. Services should recognise carers both as individuals in their own right and as key partners in the provision of care and support.

Evidence:

PCC(2011) Young Carers in Northern Ireland: A report of the experiences and circumstances of 16 year old carers
http://www.patientclientcouncil.hscni.net/uploads/research/Young_carers_in_Northern_Ireland.pdf

Schubotz & McMullan (2010) The Mental and Emotional Health of 16-Year Olds in Northern Ireland: Evidence from the Young Life and Times Survey. Belfast: Patient and Client Council Report

DSD/ DHSSPS (2009) Review of Support Provision for Carers
http://www.dsdni.gov.uk/ssani-review-support-provision-carers.pdf

DHSSPS (2009) Regional Carer's Support and Needs Assessment Tool
http://www.dhsspsni.gov.uk/eccu2-09.pdf

DHSSPS (2008) Implementation of the Carers Strategy (Training for Carers)
http://www.dhsspsni.gov.uk/microsoft_word_-_circular_hss__eccu__3_2008_-_implementation_of_carers__strategy.pdf

Earley L *et al* (2007) Children's perceptions and experiences of care giving: A focus group study. *Counselling Psychology Quarterly.* 20. 1. pp.69–80

Evason, E. (2007) Who Cares Now? Changes in Informal Caring 1994 and 2006. Research Update 51. Belfast: ARK Publications www.ark.ac.uk

DHSSPS (2006) Caring for Carers Recognising, Valuing and Supporting the Caring Role http://www.dhsspsni.gov.uk/ec-dhssps-caring-for-carers.pdf

DHSSPS (2006) Implementation of the Carers Strategy (Identification of Carers) http://www.dhsspsni.gov.uk/hss__eccu__4-2006_carers_circular_-_signed.doc.pdf

SPRU (2004) Hearts and Minds: The health effects of caring
http://www.york.ac.uk/inst/spru/pubs/pdf/Hearts&Minds.pdf

Olsen R (1996) Young Carers: challenging the facts and politics of research into children and caring. Disability and Society, 11 (1), 41-54

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency • HSC Trusts	• Primary Care – GPs, LCGs • Independent Sector • DSD, DENI

Quality Dimension

Citizenship
Carers will feel valued and able to access the support they need. Staff will be facilitated to understand and value the role of carers.

Social Inclusion
Carers will be recognised as real and equal partners in the delivery of care. All carers, irrespective of age, who they care for or where they live will be directed toward appropriate agencies that can offer advice and support.

Empowerment
Carers will be encouraged to identify themselves as carers and to access information and support to protect and promote their own health and well-being and minimise the negative impact of caring

Working Together
Involving carers in the planning, delivery and evaluation of services improves outcomes for the carer and cared for person. Carers will be identified and supported best through partnerships between the statutory and voluntary sector and by good referral processes

Individual Support
Carers will be identified and signposted to help and support as early as possible in their journey and at times of crisis/transition.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1. Number of HSC Trust front line staff in a range of settings participating in Carer Awareness Training Programmes	Trust Training Report (including Induction programmes)	20% 50%	By end of Year 2 By end of Year 3
2. The number of carers who are offered Carers Assessments 3. The percentage of carers who participate in Carers Assessments	Health & Social Care Board/ DHSSPSNI returns	Improvement targets set by H&SC Board in conjunction with Carers Strategy Implementation Group	Reviewed annually

Standard 30:
All family carers should be offered the opportunity to have their needs assessed and reviewed annually.

Service User Perspective:

"The needs of family members who care for and support me will be assessed and regularly reviewed"

Rationale:
The majority of people with a learning disability live with their families. Nearly one-third live with a single carer and over 25% live with carers aged over 65 years. The pressures of caring can cause stress and ill health. Family carers report difficulties in accessing breaks from their caring responsibilities. The types of short breaks valued by family carers and people with a learning disability are wide ranging and needs to be flexible and responsive to the individual circumstances. This should include adult placement, drop-in services for people with a learning disability and support for the disabled family member to access social and recreational opportunities. A move away from an over reliance on short breaks in residential facilities is therefore signalled. Short breaks should be a positive experience for the person with a learning disability, adding to their lives' experiences as well as giving the family member a break.

Evidence:
NDTi (2010) Short Breaks Pathfinder Evaluation Greig,R., Chapman P., Clayson A., Goodey C., and Marsland D. http://www.education.gov.uk/publications/eOrderingDownload/DCSF-RR223.pdf

DHSSPS (2010) Care Management, Provision of Services and Charging Guidance http://www.dhsspsni.gov.uk/hsc-eccu-1-2010.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011) http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DHSSPS (2009) Regional Carer's Support and Needs Assessment Tool http://www.dhsspsni.gov.uk/eccu2-09.pdf

Black, LA *et al* (2008) Lifelines Report: An Evaluation Report of the Impact of the Families Services delivered by Positive Futures in Rural and Urban Areas of Northern Ireland. http://www.positive-futures.net/sites/default/files/LIFELINES%20Full%20Report.pdf

Kenny, K and McGilloway, S. (2007) Caring for children with learning disabilities: an exploratory study of parental strain and coping, British Journal of Learning Disabilities, p221-8.

http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3156.2007.00445.x/abstract

DHSSPS (2006) Caring for Carers: Recognising, Valuing and Supporting the Caring Role http://www.dhsspsni.gov.uk/ec-dhssps-caring-for-carers.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability http://www.dhsspsni.gov.uk/equallivesreport.pdf

Bamford (2004) University of Ulster Audit of Learning Disability Research in NI http://www.dhsspsni.gov.uk/learning-disability-consultation

Mencap (2003) Breaking point: A report on caring without a break for children and adults with profound learning disabilities. Mencap. London. http://www.mencap.org.uk/campaigns/take-action/our-other-campaigns/breaking-point

Responsibility for delivery/implementation	**Delivery Partners**
• HSC Board • HSC Trusts	• DHSSPS, DSD • Other Service Providers

Quality Dimension

Citizenship
Family carers have a voice in the development of strategies that impact on their role and ability to continue caring for their child, young person or adult

Social Inclusion
Carers are not left in isolation to cope with their role of caring for their child, young person or adult

Empowerment
Carers are better informed of their entitlements through the support and information they receive from professionals and /or independent advocates.

Working Together
Carers are involved in working as equal partners with statutory/other agencies in planning services that are flexible and responsive to meeting their needs and the needs of the person with a learning disability.

Individual Support
Carers of a person with a learning disability will have their support needs assessed and be provided with the services that support the family and / or the individual carer.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of carers who express satisfaction at their annual review that their needs as identified in the carers' assessment have been met.	User and carer feedback	Establish baseline Performance levels to be determined once baseline established	Year 1 Year 2

CHAPTER 11: AGEING WELL

Life expectancy for men and women with a learning disability has increased markedly over recent years. Growing older is likely to present additional challenges for people with a learning disability owing to the impact of their disability.

People with Down's syndrome are at high risk of Alzheimer's disease as they grow older and virtually all people with Down's syndrome who live long enough will develop this type of dementia. In addition, it is estimated that between 20% – 40% of older people with a learning disability are liable to have a mental health problem.

The number of older family carers is also increasing which can create particular challenges, for example, older carers:

- are under greater physical and mental pressures because of their age;
- may be particularly anxious about the future;
- are more likely to be caring alone; and
- may have smaller social support networks.

There has been little emphasis on health and wellbeing for older people with a learning disability or indeed their ageing carers. Ageing well has not been proactively encouraged by service providers. This is reflected in the low number of older people with a learning disability who participate in leisure activities and in concerns about unhealthy life styles.

Standard 31:

All people with a learning disability should have the impact of ageing taken into account in having their future needs assessed and proactively managed.

Service User Perspective:

"As I get older HSC staff will support me to plan for the future taking account of my age"

Rationale:
To avoid unnecessary anxiety to the person with a learning disability and their ageing family carer they both need to think about and plan for the changes that are likely to happen in their lives. Where this is done, crisis intervention should be eliminated in all situations where a person is known to social services and their needs met when there is a requirement to do so. At the same time, plans should also be considered for the family carer, in line with the statutory entitlement to an assessment of carer's needs (as with Standard 29).

People with a learning disability should be enabled to remain in their own home with their family carer for as long as possible with appropriate care and support to do so.

People with a learning disability have the same needs for autonomy, continuity of support, relationships and leisure as other older people.

Evidence:
The Alzheimer's Society (2011) Adaptations, improvements and repairs to the home www.alzheimers.org.uk/factsheet/428

DHSSPS (2010) Improving Dementia Services in NI: A Regional Strategy Consultation Document http://www.dhsspsni.gov.uk/improving-dementia-services-in-northern-ireland-consultation-may-2010.pdf

DHSSPS (2009) Regional Carer's Support and Needs Assessment Tool http://www.dhsspsni.gov.uk/eccu2-09.pdf

DHSSPS (2008) Standards for Adult Social Care Support Services for Carers http://www.dhsspsni.gov.uk/standards_for_adult_social_carer_support_services_for_carers.pdf

DHSSPS (2007) Living Fuller Lives: Dementia and Mental Health Issues in Older Age Report (Bamford) http://www.dhsspsni.gov.uk/living_fuller_lives.pdf

Tinker, Prof (1999) Ageing in place: What can we learn from each other? Kings College London www.sisr.net/events/docs/obo6.pdf

McQuillan *et al* (2003) Adults with Down's Syndrome and Alzheimer's Disease.

Tizard Learning Disability Review 8(4): 4-13.
http://pierprofessional.metapress.com/content/41u62857klh37m32/

Responsibility for delivery/implementation	**Delivery and implementation partners**
• HSC Board • HSC Trusts	• DHSSPS, DSD • Other service providers

Quality Dimension

Citizenship
People with a learning disability have the same right of access to Allied Health Professionals and specialist services, including equitable access to equipment aids and adaptations that assist daily living. They should not be discriminated against because of their learning disability.

Empowerment
People with a learning disability are facilitated to ensure that they have support to express their views and wishes as they plan for their future. People with a learning disability are provided with accessible information and support to understand and make their decisions about the future including information about age-related benefits.

Working Together
People with a learning disability have the right to a seamless transition towards increasing involvement and co-operation with services for older people and this should include any changes between programmes of care/team/Directorates in a pro-active manner.

Individual Support
Plans are in place and reviewed for the time when the carer is unable to continue to care, and is considered as part of the ongoing assessment of client and carers needs.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of people whose care plan has been reviewed taking account of issues associated with ageing.	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	Year 1 Year 2

2 Percentage of carers aged 65 years and over receiving domiciliary or short break support services.	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	Year 1 Year 2

Standard 32:

All people with a learning disability should have access to dementia services at whatever age it becomes appropriate for the individual.

Service User Perspective:

"I can get care and support from dementia services when I need it"

Rationale:
The early stages of dementia in people with a learning disability are more likely to be missed or misinterpreted – particularly if several professionals are involved in the person's care. The person may find it hard to express how they feel their abilities have deteriorated, and problems with communication may make it more difficult for others to assess change. It is vital that people who understand the person's usual methods of communication are involved when a diagnosis is being explored – particularly where the person involved does not use words to communicate. It is important that any prescribed medicine is monitored closely and that other ways of dealing with the situation are thoroughly explored.

People who have Down's Syndrome develop signs of dementia at a much younger age than others resulting in their needs being planned for much earlier.

Carers should be provided with information that helps them identify the earlier onset of dementia symptoms and be provided with appropriate support to continue to care for their adult with a learning disability. Carer's assessments should seek to identify any psychological distress and the psychosocial impact on the carer, including after the person with dementia has been provided with alternative care options.

Understanding a person's past history is crucial to providing person-centred care for someone with a learning disability and dementia.

Evidence:
DHSSPS (2010) Improving Dementia Services in NI: A Regional Strategy Consultation Document
http://www.dhsspsni.gov.uk/improving-dementia-services-in-northern-ireland-consultation-may-2010.pdf

DHSSPS (2010) Adult Safeguarding in NI: Regional & Local Partnership Arrangements http://www.dhsspsni.gov.uk/asva-_march_2010.pdf

Brooker, D (2007) Person-centred Dementia Care – Making Services Better.
http://books.google.co.uk/books?id=FQ3CdTblObwC&pg=Brooker+2007

NICE (2006) Clinical Guideline 42: Dementia - Supporting people with dementia and their carers in health and social care (Revised 2011) http://www.nice.org.uk/nicemedia/live/10998/30317/30317.pdf

Regional Adult Protection Forum (2006) Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance
http://www.shssb.org/filestore/documents/Safeguarding_Vulnerable_Adults_-_3_Nov_06.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Alzheimer's Society (2011) – Learning Disabilities and Dementia
http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=103

An Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing TILDA. Measures will address health, cognitive status, activities of daily living, living situations, social life and overall quality of life within which a descriptive statistical picture of the life experiences of adult persons of ID will be developed. Prof. Mc Carron's research. Commenced September 2008. Due to complete in October 2011. http://people.tcd.ie/mccarrm

Responsibility for delivery/implementation	**Delivery and implementation partner**
• HSC Board • HSC Trusts Dementia Services • Primary Care • RQIA	• DHSSPS • Other service providers • Family carers

Quality Dimension

Citizenship
People with a learning disability and dementia should have the same access to dementia services as everyone else. People with a learning disability and those supporting them should have access to specialist advice and support for dementia. People with a learning disability and dementia should feel equally valued and should not experience barriers to person-centred care.

Social Inclusion
Every effort should be made to ensure people with a learning disability and dementia are cared for at home. When a move is necessary a specific care plan should be drawn up to ensure continuity of care and support for the person and successful transfer of expertise to the new service. People with a learning disability and dementia should not be excluded from services because of their diagnosis, age (whether regarded as too young or too old) or any learning disability.

Empowerment
Treatment and care should take into account each person's individual needs and preferences. Individuals must be given all available support before it is concluded that they cannot make decisions for themselves. Advocacy services and voluntary support should be available to people with a learning disability and dementia and carers separately if required.

Working Together
There should be sharing of skills and expertise between dementia services and learning disability services with equity of access to the most appropriate service delivery area. Referral protocols and pathways need to be clearly defined to facilitate people receiving the right care and attention in the right place at the right time.

Individual Support
Carers (family, staff, statutory and independent residential and nursing care providers) should be provided with information including inter-agency working, support and training to enable them to continue to care for the person with a learning disability and dementia. Care plans should incorporate individual person centred planning principles and should reflect individually assessed dementia care related needs.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of people with a learning disability and dementia who can access appropriate dementia services as required.	Trust generic dementia service	Establish baseline Performance levels to be determined once baseline established	Year 1 Year 2
2 Percentage of people with a learning disability and dementia who have received additional supports following a dementia diagnosis.	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	Year 2 Year 3
3 Percentage of HSC professionals and other support providers who have received awareness training on the needs of people with a learning disability and dementia	HSC Trust report	Establish baseline Performance levels to be determined once baseline established	Year 1 Year 2

CHAPTER 12: PALLIATIVE AND END OF LIFE CARE

Palliative and end of life care focuses on all aspects of care needed by patients and their families, physical, emotional and spiritual. It involves relief of symptoms, making thoughtful decisions, supporting families and providing ongoing care in the appropriate setting. It is important that people in the last phase of life get the appropriate care, at the right time, in the right place, in a way that they can rely on. The following standards are designed to improve the patient and family experience of palliative and end of life care through *holistic assessment* of need, improved coordination of care and a greater focus on choice at end of life.

Standard 33: (Generic)

All people with advanced progressive incurable conditions, in conjunction with their carers, should be supported to have their end of life care needs expressed and to die in their preferred place of care.

Service User Perspective*:*

"I will be supported in my end of life care needs"

Rationale:
Most people would prefer to die at home (including residential and nursing home where this is the person's usual home) where this is possible.

In order to support this, identification of the possible last year/months/weeks of life should take place. Evidence shows that when end of life care needs are identified there is improved quality of life and even prolonged life, compared to when this stage of illness is not identified, particular in non-cancer conditions.

Advanced care planning allows more informed choice of care and enables people to be more supported to die in their preferred place of care.

Palliative care is the active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments. (WHO, 2002)

End of life care refers to the possible last year of life. It helps all those with advanced, progressive, incurable conditions to live as well as possible until they die. It enables the supportive and palliative care needs of both the patient and the family to be identified and met throughout the last phase of life and into bereavement. At this stage however it is often still appropriate to provide acute treatment in conjunction with palliative care, particularly in long term conditions. It includes physical care, management of pain and other symptoms and provision of psychological, social, spiritual and practical support. (National Council for Palliative Care, Focus on Commissioning, Feb 2007).

Evidence:
NCPC (2012) Palliative Care Explained
http://www.ncpc.org.uk/sites/default/files/PalliativeCareExplained.pdf (as accessed on 26 September 2012)

NICE (2011) Chronic Obstructive Pulmonary Disease (COPD): Quality Standard
http://guidance.nice.org.uk/QS10

DHSSPS (2010) Living Matters: Dying Matters – A Strategy for Palliative and End of Life Care for Adults in Northern Ireland.
http://www.dhsspsni.gov.uk/855_palliative_final.pdf

NICE (2010) Chronic Obstructive Pulmonary Disease; Management of Chronic Obstructive Pulmonary Disease in Adults in Primary and Secondary Care http://www.nice.org.uk/Guidance/CG12

Harrison , S et al, (2008), Identifying Alternatives to Hospital for People at the End of Life, The Balance of Care Group / National Audit Office http://www.balanceofcare.co.uk/previous_projects.html

Khan, SA; Tarver, K; Fisher S; Butler C (2007), Inappropriate Admissions of Palliative Care Patients to Hospital: A Prospective Audit, London, Pilgrims Hospices

Pleschberger, S, (2007), Dignity and the Challenge of Dying in Nursing Homes: The Residents' View http://ageing.oxfordjournals.org/content/36/2/197.short

DHSSPS (2006) Regional Cancer Framework: A Cancer Control Programme for Northern Ireland http://www.dhsspsni.gov.uk/eeu_cancer_control_programme_eqia.pdf

NHS (England) (2006) Gold Standards Prognostic Framework Programme, NHS End of Life Care Programme. Prognostic Indicator Papers vs 2.25 http://www.endoflifecare.nhs.uk/eolc/files/GSF-Guide-Prognostic_Indicators-Jul06.pdf

NICE (2004) Improving Supportive and Palliative Care for Adults with Cancer http://guidance.nice.org.uk/CSGSP

NICE (2004) Supportive and Palliative Care (CSGSP): Improving supportive and palliative care for adults with cancer http://www.nice.org.uk/Guidance/CSGSP

NHS Modernisation Agency (2004) Coronary Heart Disease Collaborative: Supportive and Palliative Care for Advanced Heart Failure http://www.improvement.nhs.uk/heart/Portals/0/documents/supportiveandpalliativecare.pdf

NICE (2003) Chronic Heart Failure; Management of Chronic Heart Failure in Adults in Primary and Secondary Care http://www.nice.org.uk/Guidance/CG5

Ellershaw & Wilkinson (2003), Care of the Dying: a Pathway to Excellence, Oxford University Press

Foote, C & Stanners, S, (2002), Integrating Care for Older People – New Care for Old – A Systems Approach, London, Jessica Kingsley

Responsibility for delivery/implementation	**Delivery and implementation partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care	• NICaN Supportive and Palliative Care Network • Primary care team, inclusive of social care • Voluntary palliative care

	organisations - Private nursing home and care providers

Quality Dimension

Citizenship
Earlier identification of palliative care needs and advance care planning will help improve quality of life and support a good death. Inappropriate admissions to hospital at the very end of life will be avoided.

Social Inclusion
People with non cancer conditions will have access to care and services traditionally available mainly to those with cancer conditions only

Empowerment
Involving service users, carers and families ensures that choices and preferences are taken into account in the planning and delivery of services

Working Together
HSC staff work in partnership with learning disability teams in order to ensure that appropriate reasonable adjustments are made to meet the specific needs of people with a learning disability.

Individual Support
Effective joint working between palliative care services and learning disability teams will ensure that the impact of learning disability is appropriately addressed in individual treatment plans.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1. Percentage of the population that is enabled to die in their preferred place of care.	NISRA survey for baseline of the population's preference Registrar General and PAS information for actual place of death	Establish baseline Performance indicator to be determined when baseline established	Year 1 Year 2
2. Percentage of the population with a understanding of advance care planning	NISRA survey for baseline levels	Establish baseline Performance indicator to be determined when baseline established	Year 1 Year 2

Standard 34:
All people with a learning disability being assessed for supportive and palliative care should have their learning disability taken into account in consultation with them, their carers and learning disability services when appropriate.

Service User Perspective*:*

If my health is getting worse and I need extra support towards the end of life staff will take into account my learning disability

Rationale:
Early identification of the supportive, palliative and end of life care needs of patients, their care-givers and family, through a holistic assessment, maximise quality of life for all in terms of physical, emotional, social, financial, and spiritual health and wellbeing.

People with a learning disability are entitled to the same services and respect throughout life as anyone else. Good palliative and end of life care is about enabling the individual to live out their potential when faced with an advanced progressive illness. By addressing the physical, emotional, spiritual and social issues which often make us fearful of death, it ensures that all individuals regardless of clinical diagnosis, get the appropriate care, at the right time, in the right place, in a way they can rely on.

Where necessary, reasonable adjustments should be made to take account of the impact of learning disability. Reasonable adjustments can be many and are wide ranging, but it is important to remember that they must be individualised to the person, and may include such things as:

- longer appointment times
- offering the first or last appointment
- the provision of easy read information to enhance understanding
- close involvement and support of family carers
- partnership working between learning disability services and other service providers.
- appropriate waiting facilities
- pre-admission visits
- fast tracking arrangements when appropriate (eg in A&E Departments)

Evidence:
Department of Health, Social Services and Public Safety (2010) *Living Matters: Dying Matters: A palliative and end of life care strategy for adults in Northern Ireland.* DHSSPS, Belfast.

Mencap (2008) Healthcare for All (The Michael Report) Report of the Independent Inquiry into access to healthcare for people with learning disabilities

National Institute for Clinical Excellence (2004) Improving Supportive and

Palliative Care for Adult with Cancer.
NHS (England) (2006) Gold Standards Prognostic Framework Programme, NHS End of Life Care Programme. Prognostic Indicator Papers vs. 2.25
http://www.endoflifecare.nhs.uk/eolc/files/GSF-Guide-Prognostic_Indicators-Jul06.pdf

NICE (2004) Improving Supportive and Palliative Care for Adult with Cancer.
National Institute for Clinical Excellence: London
http://www.nice.org.uk/nicemedia/pdf/csgspmanual.pdf

NICE (2004) Management of Chronic Obstructive Pulmonary Disease in Adults in Primary and Secondary Care.
National Institute for Clinical Excellence: London
http://guidance.nice.org.uk/CG12

Responsibility for delivery/implementation	**Delivery and implementation partners**
• Primary Care • HSC Trusts • Public Health Agency	• Voluntary Palliative Care Organisations • Private nursing home and care providers

Quality Dimension

Empowerment
Involving service users, their carers and families ensures that their choices and preferences are taken into account in the design and delivery of services.

Working Together
Partnership with service users, their carers and families is only possible if they are proactively involved in decision-making processes. Effective partnerships will contribute to positive health and social care outcomes.

Individual Support
Effective person-centred support will ensure that individuals are appropriately assessed for supportive and palliative care.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Palliative care services have mechanisms to identify whether people have a learning disability.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes.	Year 1 Year 2

2 Evidence of specific actions in service delivery that make reasonable adjustment for their learning disability.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes.	Year 1 Year 2

ANNEX A

GLOSSARY OF TERMS

TERM	DEFINITION
Acute Care	Health care and treatment provided mainly in hospitals
Advocacy	A service that provides someone to represent your views or support you in expressing your own views
Allied Health Professionals	Allied health professionals (AHPs) work with all age groups and within all specialties. AHPs work in a range of surroundings including hospitals, people's homes, clinics, surgeries and schools.
Augmented forms of communication	Better more accessible communication
Autonomy	Freedom of will
Capacity (mental)	Being able to understand and use information to make a decision
Care order	Care order is a court order made on the application of a HSC Trust and granted where the court finds the child has suffered or is likely to suffer significant harm.
Care pathway	A plan for the care needed to help a person with a learning disability to move through the different services they may need.
Challenging behaviour	When someone is behaving in a way that might cause harm to themselves or other people. Services are challenged to find a way of managing the behaviour so the chance of harm is reduced.
Citizenship	People with a learning disability being treated equally with other people.
Commissioners	A term used to describe organisations or groups who have been given responsibility for purchasing of health and social services.

Community Care	Services provided outside the hospital setting by HSC professionals and other organisations in the community.
Competency – based	An ability to do something, especially measured against a standard
Crisis intervention	A situation or period in which things are very uncertain, difficult, or painful, especially a time when action must be taken to avoid things getting much worse.
Cross-sectoral	Links between organisations managed by Government and voluntary/ community organisations and private business
Direct Enhanced Services	A Directly Enhanced Service is a specialised service provided by all GPs in N Ireland for adults with severe learning disability
Direct Payments	Direct Payments have been available since 1996 and aim to promote independence by giving people flexibility, choice and control over the purchase and delivery of services that support them. Individuals can opt to purchase services tailored to suit them by means of a Direct Payment from the Trust. From 19 April 2004 Direct Payments were extended to a wider range of service users under the Carers and Direct Payments Act (Northern Ireland) 2002 to include carers, parents of disabled children and disabled parents.
Disparities	A lack of equality between people or things
Domiciliary care	Support or care provided to a person in their own home
Dual diagnosis	Two different illnesses
Eligibility	To meet requirements for a certain criteria
Empowerment	Supporting people to take a full part in making decisions about their life.
Evidence-based practice	Doing things that have been shown to work
Health Action Plan	Describes the care and support you need to look after yourself and stay healthy.

Holistic care	Comprehensive care that addresses the social, psychological, emotional, physical and spiritual needs of the individual.
Independent sector	Organisations that are not managed by Government – includes voluntary organisations, community organisations and private business
Informed consent	Agreement by you to undergo treatment or care after being informed of and having understood the risks involved.
Integrated care pathway (ICP)	A multi-disciplinary outline of anticipated care which identifies how a patient with a specific condition will be supported by a number of professionals or agencies.
Integration	Equal access for all
Inter-agency	Links between different organisations
Legislative	To do with law
Mainstream Services	Services that anyone can use.
Methodologies	Different way of doing research.
Multi-Agency	Staff from different agencies, for example health and social care, education and employment, working together.
Multi-disciplinary	Staff from different professions, for example, nurses, doctors, social workers, working together.
Optimum	Most suitable
Palliative care	The active, holistic care of patients with advanced progressive illness. The goal of palliative care is to achieve the best quality of life for patients and their families.
Partnership working	Different organisations working together to achieve something
Person-Centred	The person and their family and friends are central and fully involved in all aspects of their care. The service, the organisation and its systems are focused on the needs of (what is important to) the individual.

Preliminary reports	Reports done at the start.
Prevalence	How many people in the population have a particular problem
Primary Care	Health and social care services that are generally available to everyone, for example, GP, dentist.
Reasonable adjustments	Actions that service providers should take to make sure people with a learning disability can use their services.
Respite	Support which gives carers a break from their usual caring roles and duties.
SAAT	Self Assessment Audit Tool – a performance management tool designed to measure the delivery of key objectives
Secondary Care	Health and social care services that help people with more complicated needs than those that primary care deal with, but mostly in the community.
Self-determination	A right to decide for self
Self-directed support	Helping people be in control of the support they need to live their life as they chose.
Service Framework	A document that sets out what people can expect the service to provide.
Service User	Anyone who uses, requests, applies for, or benefits from health and social care services.
Social inclusion	Making people with a learning disability feel part of the community they live in.
Statutory sector	Those organisations that are managed by government
Stereotypical	To categorise individuals or groups according to an oversimplified standardised image or idea
Transition	A time in a person's life when big changes are happening, for example, leaving school
Universal	Meaning all

ANNEX B

MEMBERSHIP OF PROJECT BOARD

Dominic Burke	Western Health and Social Services Board (Chair to March 2009)
Fionnula McAndrews	Health and Social Care Board (Chair from April 2009)
Siobhan Bogues	Association for Real Change (Northern Ireland)
Dr Maura Briscoe	DHSSPS (to October 2009)
Peter Deazley	DHSSPS (from October 2009)
Paul Cavanagh	Western Health and Social Services Board (until March 2009 and from September 2009)
Jim Simpson	Western Health and Social Services Board (to August 2009)
Aidan Murray	Health and Social Care Board (from September 2009)

MEMBERSHIP OF PROJECT TEAM

Siobhan Bogues	Association for Real Change (Northern Ireland) (Chair of Project Team)
Charles Bamford	DHSSPS
Orlaigh Cassidy	Service User
Edna Dunbar	Association for Real Change (Northern Ireland) (to September 2009)
Paula McGeown	DHSSPS (from September 2009)
Veronica Gillen	DHSSPS (to September 2010)
Rosaleen Harkin	Western HSC Trust
Sandra Harris	Equal Lives Action Group
Roy McConkey	Expert Board on Mental Health and Learning Disability
Bryce McMurray	Southern HSC Trust
Bria Mongan	South-Eastern HSC Trust
John Mullan	Service User
Jim Simpson	Western Health and Social Services Board (to August 2009)
Miriam Somerville	Belfast HSC Trust
Tom Smith	Southern Health and Social Services Board (until August 2009)
Pat Swann	DHSSPS
Sam Vallelly	Northern HSC Trust
Adrian Walsh	Eastern Health and Social Services Board
Aidan Murray	Health and Social Care Board (from October 2009)
Molly Kane	Public Health Agency (from September 2009)

ANNEX C

MEMBERSHIP OF WORKING GROUPS

ACCOMMODATION

Bryce McMurray	Southern HSC Trust (Chair of Accommodation Working Group)
Richard Black	Southern HSC Trust
Dessie Cunningham	Southern HSC Trust
Tony Doran	Southern HSC Trust
Janet McConville	Southern HSC Trust
Sinead McGeeney	Disability Action
Paul Roberts	Positive Futures
Moira Scanlon	Southern HSC Trust
Tom Smith	Southern Health and Social Services Board
Chris Williamson	NI Federation of Housing Associations

AGEING

Rosaleen Harkin	Western HSC Trust (Chair of Ageing Working Group)
Tony Brady	Carer
Raymond Boyle	Western HSC Trust
Dr Michael Curran	Western HSC Trust
Brendan Duffy	Western HSC Trust
Dr Jennifer Galbraith	Western HSC Trust
Lee McDermott	Western HSC Trust
Mr Brian McGarvey	Mr Brian McGarvey
Pat McLaughlin	Western HSC Trust
Maureen Piggott	Mencap
Isobel Simpson	Western HSC Trust

CHILDREN AND YOUNG PEOPLE

Bria Mongan	South-Eastern HSC Trust (Chair of Children and Young People Working Group)
Sharon Bell	Parent
Dr Ann Black	South-Eastern HSC Trust
Gerry Campbell	NICCY
Heather Crawford	South-Eastern HSC Trust
Jennifer Creegan	South-Eastern HSC Trust
Maurice Devine	DHSSPS
Alice Lennon	South-Eastern Education and Library Board
Agnes Lunny	Positive Futures
Pauline McDonald	Belfast HSC Trust
Marian Robertson	South-Eastern HSC Trust
Colette Slevin	Mencap
Tracey Sloan	Parent

FULLER LIVES

Sam Vallelly	Northern HSC Trust (Chair of Fuller Lives Working Group)
Gareth Anderson	Northern HSC Trust
Ivan Bankhead	Northern HSC Trust
Mildred Bell	Northern HSC Trust
Pauline Cummings	Northern HSC Trust
Molly Kane	Northern Health and Social Services Board
Kate Kelly	Northern HSC Trust
Áine Lynch	North Regional College
Virgina Maxwell	Carer
Oonagh McCann	North-Eastern Education and Library Board
Oliver McCoy	Northern HSC Trust
Gerard McKendry	Service User (Compass Advocacy Group)
Donna Morgan	Northern HSC Trust
Judith Shaw	DEL
Bernie Doherty	DEL

Norman Sterrit	Triangle Housing Association

HEALTH

Miriam Somerville	Belfast HSC Trust (Chair of Health Working Group)
Kate Comiskey	Blair Lodge
Dr Petra Corr	Belfast HSC Trust
Maurice Devine	South-Eastern HSC Trust
Brian Irvine	Service User (Orchardville Training Centre)
Neil Kelly	Belfast HSC Trust
Rosalind Kyle	Belfast HSC Trust
Liz Leathem	Bryson Group
John McCart	Belfast HSC Trust
Dr Colin Milliken	Belfast HSC Trust
Mairead Mitchell	Belfast HSC Trust
Adian Murray	Eastern Health and Social Services Board
Fiona Rowan	Carer
Eilish Steele	Belfast HSC Trust

QUALITY IMPROVEMENT SUB-GROUP

Siobhan Bogues	Association for Real Change (ARC NI)
Edna Dunbar	Association for Real Change (ARC NI) (to September 2009)
Veronica Gillen	DHSSPS (to September 2010)
Seamus Logan	DHSSPS
Patrick Convery	Regulation & Quality Improvement Authority
Maureen Piggot	Mencap NI
Roy McConkey	University of Ulster
Jim Simpson	Western Health & Social Services Board (Until August 2009)
Stella Cunningham	Patient & Client Council
Molly Kane	Public Health Agency

COSTINGS SUB-GROUP

Adrian Walsh	Health & Social Care Board
Siobhan Bogues	Association for Real Change (ARC NI)

Veronica Gillen	DHSSPS (to September 2010)
Paula McGeown	DHSSPS (from September 2009)
Tracey McKeague	Health & Social Care Board
Bria Mongan	South-Eastern HSC Trust
Aideen O'Docherty	DHSSPS
Miriam Somerville	Belfast HSC Trust

ANNEX D

The five core values outlined in the Equal Lives Review (2005):

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

ANNEX E

Bamford Review of Mental Health and Learning Disability Reports

• Mental Health Improvement and Wellbeing	May 2006
• Child and Adolescent Mental Health	July 2006
• Adult Mental Health	June 2005
• Dementia and Mental Health of Older People	June 2007
• Alcohol and Substance Misuse	Dec 2005
• Forensic Services	Oct 2006
• Learning Disability	Sept 2005
• Promoting Social Inclusion	Aug 2007
• A Comprehensive Legislative Framework	Aug 2007
• Human Rights and Equality	Oct 2006
• Delivering the Bamford Vision	2008

ANNEXE F

ABBREVIATIONS

A&E	Accident and Emergency
ASD	Autistic Spectrum Disorders
BMI	Body Mass Index
CSCI	Commission for Social Care Inspection (now Care Quality Commission)
CSR	Comprehensive Spending Review
DCAL	Department of Culture, Arts & Leisure
DE	Department of Education
DEL	Department of Employment & Learning
DES	Direct Enhanced Services
DfES	Department for Education and Skills (England)
DHSSPS	Department of Health, Social Services and Public Safety
DNAR	Do Not Attempt Resuscitation
DoH	Department of Health
DoJ	Department of Justice
DSCF	Department for Children Schools and Families (England)
DSD	Department of Social Development
ELB	Education and Library Board
FE	Further Education
GAIN	Guidelines and Audit Implementation Network
GMC	General Medical Council
GP	General Practitioner
HSC	Health and Social Care
IASSID	International Association for the Scientific Study of Intellectual Disabilities
LASPs	Local Adult Safeguarding Partnerships
LCG	Local Commissioning Group
NDA	National Disability Authority
NDTi	National Development Team for Inclusion

NHS	National Health Service
NIASP	Northern Ireland Adult Safeguarding Partnership
NICaN	Northern Ireland Cancer Network
NICE	National Institute for Health and Clinical Excellence
NIHE	Northern Ireland Housing Executive
NIUSE	Northern Ireland Union of Supported Employment
OFMDFM	Office of First Minister and Deputy First Minister
PBNI	Probation Board for Northern Ireland
PCC	Patient and Client Council
PCP	Patient-centred Plan
PfA	Priorities for Action
PHA	Public Health Agency
PPI	Personal & Public Involvement
PSNI	Police Service of Northern Ireland
QIS	Quality Improvement Scotland
RCSLT	Royal College of Speech and Language Therapists
RoI	Republic of Ireland
RQIA	Regulation & Quality Improvement Authority
PSSRU	Personal Social Services Research Unit
SAAT	Self Assessment Audit Tool
SACN	Scientific Advisory Committee on Nutrition
SBNI	Safeguarding Board for Northern Ireland
SCIE	Social Care Institute for Excellence
SENDO	Special Educational Needs and Disability Order
SIGN	Scottish Intercollegiate Guidelines Network
UNOCINI	Understanding the Needs of Children Northern Ireland
WHO	World Health Organisation

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SERVICE FRAMEWORK FOR LEARNING DISABILITY

Updated October 2016

Working for a Healthier People

INVESTOR IN PEOPLE

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Foreword

As Minister for Health I am determined to protect and improve the quality of health and social care services and ensure that these are safe, effective and focussed on the patient. Driving up the quality of services and outcomes for people will be my underlying priority. I am committed to working, not only to improve health but to tackle inequalities in health.

I am particularly pleased, therefore, to launch the Service Framework for Learning Disability for implementation. This Framework aims to improve the health and wellbeing of people with a learning disability, their carers and families, by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.

Service Frameworks aim to set out clear standards of health and social care that are both evidence based and measurable. They set out the standard of care that service users and their carers can expect, and are also to be used by health and social care organisations to drive performance improvement through the commissioning process. The Service Framework for Learning Disability is one of five Frameworks to be issued for implementation to date and, that focus on the most significant causes of ill health and disability in Northern Ireland, namely: cardiovascular disease, respiratory disease, cancer, mental health and learning disability. Two further Frameworks, for children and young people and older people are currently at various stages of development.

This latest Framework has been developed actively involving a wide range of people across all aspects of health and social care including, patients, clients and carers, all of whose support has been invaluable. I would like to convey my sincere thanks, to you all, for your immensely important contribution.

Edwin Poots MLA
Minister for Health, Social Services and Public Safety

SERVICE FRAMEWORK FOR LEARNING DISABILITY

Summary of Standards

Safeguarding and Communication and Involvement in the Planning and Delivery of Services

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 1 (Generic): All HSC staff should ensure that people of all ages are safeguarded from harm through abuse, exploitation or neglect.	1. All HSC organisations and organisations providing services on behalf of the HSC have a **Safeguarding Policy** in place, which is effectively aligned with other organisational policies (e.g. recruitment, governance, complaints, SAIs, training, supervision, etc.) The Safeguarding Policy is supported by robust procedures and guidelines.	Establish baseline March 2014. Performance level to be determined once baseline established March 2015.
	2. All HSC organisations and organisations providing services on behalf of the HSC have **Safeguarding Plans** in place.	Establish baseline March 2014. Performance level to be determined once baseline established March 2015.
	3. All HSC organisations and organisations providing services on behalf of the HSC have **safeguarding champions** in place in order to promote awareness of safeguarding issues in their workplace.	Establish baseline March 2014. Performance level to be determined once baseline established March 2015.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 2: People with a learning disability should as a matter of course make choices or decisions about their individual health and social care needs. This needs to be balanced with the individual's ability to make such decisions and then the views of their family, carers and advocates should be taken into account in the planning and delivery of services, unless there are explicit and valid reasons to the contrary agreed with the person.	1. Evidence that people with a learning disability their family and carers have been involved in making choices or decisions about their individual health and social care needs.	Establish baseline March 2015. Performance levels to be determined once baseline established. March 2016.
Standard 3 (Generic): All patients, clients, carers and the public should have opportunities to be actively involved in the planning, delivery and monitoring of health and social care at all levels.	1. Percentage of job descriptions containing PPI as responsibility March 2015: senior and middle management March 2016: designated PPI leads at all levels of HSC organisations March 2017: all new job descriptions	Establish baseline and set target March 2014. Monitor progress March 2015. 100% in all new job descriptions March 2016.
	2. Percentage of patients and clients expressing satisfaction	Establish baseline and set target March 2014. Report percentage increase of patient and client satisfaction March 2015.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 3 (Generic): (continued)		Report percentage increase of patient and client satisfaction March 2016.
	3. Percentage of staff who have gained PPI training (details to be agreed for 2015/2016)	Conduct training needs assessment for PPI, commission design of PPI training programme March 2014. Establish baseline and set target March 2015. Monitor percentage of staff trained at different levels in PPI March 2016.
Standard 4: Adults with a learning disability should be helped by HSC professionals to develop their capacity to give or refuse informed consent.	1. Develop and agree a regional training plan that ensures that relevant HSC staff are trained in consent and capacity issues.	All HSC organisations March 2016.
	2. Evidence that robust processes are in place where capacity has been judged to be an issue within HSC services or services commissioned by HSC	Development and implementation of SAAT March 2015. Performance level to be determined based on outcomes of SAAT March 2016.
Standard 5 (Generic): All patients, clients, carers and the public should be engaged through effective communications by all organisations delivering health and social care.	1. Percentage of patients and clients expressing satisfaction with communication	Establish baseline March 2014. Report percentage increase of patient and client satisfaction with communications March 2015.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 5 (Generic): (continued)		Report percentage increase of patient and client satisfaction with communication March 2016.
Standard 6: People with a learning disability should expect effective communication with them by HSC organisations as an essential and universal component of the planning and delivery of health and social care	1. Percentage of people with a learning disability who do not use speech as their main form of communication who have been supported to establish a functional communication system.	Develop and implement SAAT March 2015. Performance levels to be determined based on outcomes of SAAT March 2016.
	2. Develop and agree a regional training plan for staff in both HSC and services commissioned by HSC to raise awareness of communication difficulties and how they may be addressed.	Regional Training Plan in place. March 2015. Training is delivered in accordance with Regional Training Plan. March 2016.
Standard 7: People with a learning disability should receive information about services and issues that affect their health and social wellbeing in a way that is meaningful to them and their family.	1. All HSC organisations should provide evidence that they are making information accessible to people with a learning disability.	Development and implementation of SAAT March 2015. Performance levels to be determined once baseline established March 2016.
	2. Each person with a learning disability can access a named person who can signpost them to relevant services.	Establish baseline of information provided March 2016. Performance levels to be determined once baseline established.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 8: People with a learning disability, or their carer, should be able to access self directed support in order to give them more control and choice over the type of care and support they receive.	1 Evidence of provision of accessible information on Direct Payments within HSC organisations.	Develop and implement SAAT March 2015. Establish performance levels based on outcomes from SAAT March 2016.
	2 Percentage of requests for Direct Payments from people with a learning disability that were approved.	Develop and implement SAAT March 2015. Establish performance levels based on outcomes from SAAT March 2016.
	3 Number of adults with a learning disability in receipt of Direct Payments expressed as a percentage of those in contact with Trust (regional percentage is 2.25%).	Performance levels to be determined based on available resources and included in final Framework.
	4 Number of children with a learning disability in receipt of Direct Payments expressed as a percentage of those in contact with Trust (regional percentage is 3.50%).	Performance levels to be determined based on available resources and included in final Framework.
	5 The HSC Board and Trusts have plans in place to extend the range and scope of self directed support including how they will develop skills and expertise in relevant staff.	HSC Board and all Trusts March 2017.
Standard 9 (Generic): Service users and their carers should have access to independent advocacy as required.	1. To be determined	To be determined.

Children and Young People

STANDARD		
Standards 10-13 withdrawn as they have been picked up in the new Service Framework for Children and Young People:		
	1	

Entering Adulthood

Standard 14:		
Young people with a learning disability should have a transition plan in place before their 15th birthday and arrangements made for their transition to adulthood by their 18th birthday.	1. Percentage of young people who express satisfaction that their transition plan has been implemented within 2 years of leaving school. 2. Evidence of transfer to DES, where appropriate, for health checks for children on transition to adult services.	Develop and implement SAAT March 2016. Performance levels to be determined based on SAAT outcomes March 2017. 90% March 2015. 95% March 2016. 98% March 2017.

STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 15: People with a learning disability should be supported to have meaningful relationships, which may include marriage and individual, unique, sexual expression within the law, balancing their rights with responsibilities.	1. Regional guidelines on sexuality and personal relationships are developed to ensure a consistent approach. 2. Trusts to facilitate appropriate training for staff. 3. Trusts to facilitate appropriate training for service users and family carers. 4. Increase in the number of people with a learning disability accessing sexual health and reproductive healthcare services.	HSC Board policy developed and agreed March 2015. 40% March 2016. 80% March 2017. Level to be established pending development of regional policy March 2017. Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016.

Inclusion in Community Life

Standard 16: Adults with a learning disability should be able to access support in order that they can achieve and maintain employment opportunities in productive work.	1. Percentage of adults with a learning disability who receive HSC support to help them secure employment (as a measure of those who request support).	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.
STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 17: All adults with a severe or profound learning disability should be able to access a range of meaningful day opportunities appropriate to their needs.	1. Percentage of adults with a severe or profound learning disability who have meaningful day opportunities in mainstream community settings, outside of their building based service. 2. Percentage of adults with a severe or profound learning disability receiving support in a building based service, who express satisfaction with the opportunity to experience day opportunities.	Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016. Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016.
Standard 18: All parents with a learning disability should be supported to carry out their parenting role effectively.	1. Develop and agree a regional protocol between children's and adult services for joint working and care pathways. 2. Percentage of parents with a learning disability who have a multi-professional/agency competence based assessment. 3. Percentage of parents with a learning disability	HSC Board in collaboration with all Trusts March 2015. Establish baseline March 2016. Performance levels to be determined once baseline established March 2017. 85% March 2015.

	involved in child protection or judicial processes who have received locally based skills training.	90% March 2016. 95% March 2017.
	4. Percentage of parents with a learning disability involved in child protection or judicial processes who have access to the services of an independent advocate.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.

Meeting General Physical and Mental Health Needs

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 19: All people with a learning disability should have equal access to the full range of health services including services designed to promote positive health and wellbeing.	1. All acute hospitals should have an action plan for implementing the GAIN Guidelines for improving access to acute care for people with a learning disability and be able to demonstrate a clear commitment to the implementation of such a plan.	All HSC Trusts establish baseline March 2015. Performance levels to be determined once baseline established March 2016.
	2. Percentage of GPs who have a system for identifying people with a learning disability on their register.	Baseline as per learning disability DES March 2015. Performance levels to be determined once baseline established March 2016.
	3. Each GP practice has a designated link professional within local learning disability services.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.
	4. Evidence of reasonable adjustments by health	Establish baseline March 2015.

	service providers.	Performance levels to be determined once baseline established March 2016.
STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 20 (Generic): All HSC staff, as appropriate, should advise people who smoke of the risks associated with smoking and signpost them to well-developed specialist smoking cessation services.	1. Number of people who are accessing Stop Smoking Services 2. Proportion of the smoking population who are accessing Stop Smoking Services. 3. Number of people using stop smoking services who have quit at 4 weeks and 52 weeks.	Baseline 2011/12 = 39204. - 4 % year on year increase March 2014 – March 2016. Baseline 2011/12 =10.8%. NICE guidance and the ten year tobacco strategy call for a target of over 5% of the smoking population to be reached, hence target to maintain at >/= 5% March 2014 – March 2016. Baseline 2011/12 = 20,299 for those quit at 4 weeks and 5,889 for those quit at 52 weeks. Target 4% increase in respective numbers year on year March 2014 – March 2016.
Standard 21: All people with a learning disability should be supported to achieve optimum physical and mental health.	1. The PHA and each HSC Trust has a health improvement strategy for people with a learning disability (children and adults) to address all relevant physical and mental health promotion and improvement needs.	All Trusts have in place a health improvement strategy for people with a learning disability March 2015.

	2. Percentage of adults with a learning disability who have an annual health check.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.
	3. Percentage of adults with a learning disability, who have an up to date and active Health Action Plan (HAP) following the annual health check.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.
STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 21:(continued)	4. Percentage of people with a learning disability who have been in contact with community dental services (this includes those previously known to the service or who were previously treated by the service but discharged after their last treatment. a new contact equates to a new patient) 5. Percentage of females with a learning disability who have been referred to cervical and breast screening services following their annual health check. 6. Percentage of people with a learning disability who have been referred for a sight test with an optometrist following their annual health check.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016. Establish baseline March 2015. Performance levels to be determined once baseline established March 2016. Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.
Standard 22: All people with a learning disability	1. A regional protocol is developed to ensure that people with a learning disability can access	Protocol in place March 2015.

who experience mental ill health should be able to access appropriate support.	mainstream mental health services. 2. Percentage of people with a learning disability and mental health needs who access mainstream mental health services e.g. psychological and talking therapies where indicated in their treatment plan. 3. Percentage of Health Action Plans and health checks which include mental health assessment and mental health promotion.	Establish baseline March 2016. Performance levels to be determined once baseline established March 2017. Establish baseline. March 2015. Performance levels to be determined once baseline established March 2016.
STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 23 (Generic): All HSC staff, as appropriate, should provide people with healthy eating support and guidance according to their needs.	1. Percentage of people eating the recommended 5 portions of fruit or vegetables each day.	Baseline for 2011/12 = 32% overall, 26% for males and 36% for females. Target: maintain or at best increase percentage by 1% year on year March 2014 – March 2016.
Standard 24 (Generic): All HSC staff, as appropriate, should provide support and advice on recommended levels of physical activity.	1. Percentage of people meeting the recommended level of physical activity per week.	New physical activity guidelines were launched in 2011 and as such a new suite of questions to establish the percentage of people meeting the recommended level of physical activity per week has been integrated within the 2012/13 Northern Ireland Health Survey. It is anticipated these new baseline results will be available

		in Nov / Dec 2013 March 2014. Performance level to be agreed thereafter.
Standard 25 (Generic): All HSC staff, as appropriate, should provide support and advice on recommended levels of alcohol consumption.	1. Percentage of people who receive screening in primary care settings in relation to their alcohol consumption.	Establish baseline March 2014. Performance level to be determined once baseline established March 2015.

Meeting Complex Physical and Mental Health Needs

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 26: All people with a learning disability whose behaviour challenges should be able to get support locally from specialist learning disability services and other mainstream services, as appropriate, based on assessed need.	1. Percentage of individuals with significant challenging behaviours who have a Behaviour Support Plan including advance directives in place that detail actions to be undertaken in the event of their challenging behaviours escalating.	Develop and implement SAAT March 2015. Performance level to be determined based on SAAT outcome March 2016.
	2. Where challenging behaviours present a significant risk to the individual or others or a risk of breakdown in accommodation arrangements, a specialist assessment has been completed within 24 hours.	Develop and implement SAAT March 2015. Performance level to be determined based on SAAT outcome March 2016.
	3. Where challenging behaviours present a significant risk to the individual, a Management Plan has been developed and implemented	Develop and implement SAAT March 2015.

	within 48 hours. 4. Evidence that HSC has engaged with other relevant delivery partners in developing and implementing consistent approaches in individual cases. 5. Percentage of people labelled as challenging who are not living in a congregate setting described as a challenging behaviour or specialist assessment/treatment service.	Performance level to be determined based on SAAT outcome March 2016. All HSC Trusts March 2016. Develop and implement SAAT March 2017. Performance level to be determined based on SAAT outcomes.
STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 27: All people with a learning disability who come into contact with the Criminal Justice System should be able to access appropriate support.	1. Evidence that the HSC has engaged and developed local protocols with relevant delivery partners to achieve consistent and co-ordinated approaches to working with people with a learning disability who have offended or are at risk of offending.	Protocols in place March 2015.

At Home in the Community

Standard 28: HSC professionals should work in partnership with a variety of agencies in order to ensure that the accommodation needs of people with a learning disability are addressed.	1. Percentage of support plans that take account of people's aspirations in relation to future accommodation needs, including independent living. 2. Percentage of adults who are living with a single carer or where there are 2 carers and the primary carer is aged over 65 who have a	Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016. Develop and implement SAAT March 2015. Performance levels to be determined

	futures plan in place. 3. Percentage of people in receipt of public funding living in households of 5 people or less with a learning disability. 4. Percentage of people leaving learning disability hospital within one week after treatment has been completed.	based on SAAT outcomes March 2016. Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016. 95% March 2015 97% March 2016 100% March 2017.

STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 29 (Generic): All HSC staff should identify carers (whether they are parents, family members, siblings or friends) at the earliest opportunity to work in partnership with them and to ensure that they have effective support as needed**.**	1. Number of front line staff in a range of settings participating in Carer Awareness Training Programmes 2. The number of carers who are offered Carers Assessments 3. The percentage of carers who participate in Carers Assessments	20% March 2015. 50% March 2016. Improvement targets set by HSC Board in conjunction with Carers Strategy. Implementation Group. Reviewed annually. Improvement targets set by HSC Board in conjunction with Carers Strategy. Implementation Group. Reviewed annually.
Standard 30: All family carers should be offered the opportunity to have their needs assessed and reviewed annually.	1. Percentage of carers who express satisfaction at their annual review that their needs as identified in the carers' assessment have been met.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.

Ageing Well

Standard 31: All people with a learning disability should have the impact of ageing taken into account in having their future needs assessed and proactively managed.	1. Percentage of people whose care plan has been reviewed taking account of issues associated with ageing. 2. Percentage of carers aged 65 years and over receiving domiciliary or short break support services.	Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016. Develop and implement SAAT March 2015 Performance levels to be determined based on SAAT outcomes March 2016.
STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 32: All people with a learning disability should have access to dementia services at whatever age it becomes appropriate for the individual.	1. Percentage of people with a learning disability and dementia who can access appropriate dementia services as required. 2. Percentage of people with a learning disability and dementia who have received additional supports following a dementia diagnosis. 3. Percentage of HSC professionals and other support providers who have received awareness training on the needs of people with a learning disability and dementia.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016. Develop and implement SAAT March 2016. Performance levels to be determined based on SAAT outcomes March 2017. Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.

Palliative and End of Life Care

Standard 33 (Generic):		

All people with advanced progressive incurable conditions, in conjunction with their carers, should be supported to have their end of life care needs expressed and to die in their preferred place of care	1. Percentage of the population that is enabled to die in their preferred place of care.	Establish baseline March 2014. Performance levels to be determined once baseline established March 2015.
	2. Percentage of population with an understanding of advance care planning	Establish baseline March 2014. Performance levels to be determined once baseline established March 2015.
STANDARD	**KEY PERFORMANCE INDICATORS**	**ANTICIPATED PERFORMANCE LEVEL**
Standard 34: All people with a learning disability being assessed for supportive and palliative care should have their learning disability taken into account in consultation with them, their carers and learning disability services when appropriate.	1. Palliative care services have mechanisms to identify whether people have a learning disability.	Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016.
	2. Evidence of specific actions in service delivery that make reasonable adjustment for their learning disability.	Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016.

A NOTE ON TERMINOLOGY

The following terms will be used throughout this document:

‘carer’ will be used to describe a family member including children and young people or informal carers

‘HSC organisation’ will be used to describe a variety of health and social care providers, such as, the HSC Board, HSC Trusts and the Public Health Agency.

‘service user’ will be used to describe those who use learning disability services

A glossary of terms used is provided in Annex A

SECTION 1: INTRODUCTION TO SERVICE FRAMEWORKS

Background

The overall aim of the Department of Health, Social Services and Public Safety (DHSSPS) (the Department) is to improve the health and social wellbeing of the people of Northern Ireland (NI).

In support of this the Department is developing a range of Service Frameworks, which set out explicit standards for health and social care that are evidence based and capable of being measured.

The first round of Service Frameworks focuses on the most significant causes for ill health and disability - cardiovascular health and wellbeing; respiratory health and wellbeing; cancer prevention, treatment and care; mental health and wellbeing; and learning disability. Work has also commenced to develop Service Frameworks for children and young people and older people.

Service Frameworks have been identified as a major strand of the reform of health and social care services and provide an opportunity to:

- strengthen the integration of health and social care services;
- enhance health and social wellbeing, to include identification of those at risk, and prevent/ protect individuals and local populations from harm and /or disease;
- promote evidence-informed practice;
- focus on safe and effective care; and
- enhance multi-disciplinary and inter-sectoral working.

Aim of Service Frameworks

Service Frameworks will set out the standards of care that service users, their carers and wider family can expect to receive in order to help people to:

- prevent disease or harm;
- manage their own health and wellbeing including understanding how lifestyle affects health and wellbeing including the causes of ill health

and its effective management;

- be aware of what types of treatment and care are available within health and social care; and
- be clear about the standards of treatment and care they can expect to receive.

All Service Frameworks incorporate a specific set of standards that are identified as Generic[1]. These, essentially, are intended to apply to all the population, or all HSC professionals or all service users, regardless of their health condition or social grouping. These include:

- safeguarding (Generic Standard 1);
- involvement (Generic Standard 3);
- communication (Generic Standard 5);
- independent advocacy (Generic Standard 9);
- smoking prevention & cessation (Generic Standard 20);
- healthy eating (Generic Standard 23);
- physical activity (Generic Standard 24);
- alcohol (Generic Standard 25);
- carers (Generic Standard 29); and
- palliative care (Generic Standard 33).

These Generic standards reinforce the holistic approach to health and social care improvement and reflect the importance of health promotion in preventing medical or social care issues occurring in the first place. Their inclusion ensures:

- equality of opportunity for all;
- the communication of consistent messages to service users and providers of HSC; and
- a consistent approach in the design and delivery of services.

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[1] Generic Standards updated following CMO letter of 29 May 2013

Service Frameworks will be used by a range of stakeholders including commissioners, statutory and non-statutory providers, and the Regulation and Quality Improvement Authority (RQIA) to commission services, measure performance and monitor care.

The Frameworks will identify clear and consistent standards informed by expert advice, research evidence and by national standard setting bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE). The auditing and measuring of these standards will be assisted by the Guidelines and Implementation Network (GAIN) which will facilitate regional audit linked to priority areas, including Service Frameworks.

The standards, in the context of the 10 year Quality Strategy[2], will aim to ensure that health and social care services are:

i. **Safe** – health and social care which minimises risk and harm to service users and staff;

ii. **Effective** – health and social care that is informed by an evidence base (resulting in improved health and wellbeing outcomes for individuals and communities), is commissioned and delivered in an **efficient** manner (maximising resource use and avoiding waste), is **accessible** (is timely, geographically reasonable and provided in a setting where skills and resources are appropriate to need) and **equitable** (does not vary in quality because of personal characteristics such as age, gender, ethnicity, race, disability (physical disability, sensory impairment and learning disability), geographical location or socioeconomic status).

iii. **Person centred** – health and social care that gives due regard to the preferences and aspirations of those who use services, their family and

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[2] Quality 2020: A 10-Year Quality Strategy for Health and Social Care in Northern Ireland

carers and respects the culture of their communities. A person of any age should have the opportunity to give account of how they feel and be involved in choices and decisions about their care and treatment dependent on their capacity to make decisions. In absence of the capacity to make decisions they should listen to those who know and care for the person best.

Involving and communicating with service users, carers and the public

The Department has produced guidance, "Strengthening Personal and Public Involvement in Health and Social Services"[3], which sets out values and principles which all health and social care organisations and staff should adopt when engaging with the public and service users. These include the need to involve people at all stages in the planning and development of health and social care services. This policy position has been strengthened by the introduction of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and the statutory duty it places on HSC organisations to involve and consult with the public. (Art 19)

It is important that the views of service users and carers are taken into account when planning and delivering health and social care. The integration of the views of service users, carers and local communities into all stages of the planning, development and review of Service Frameworks is an important part of the continuous quality improvement and the open culture which should be promoted in HSC.

The Department is committed to involving those who use learning disability services (experts by experience), their carers and wider families. Through the proactive involvement of the service users and carers in the planning of Service Frameworks, it is hoped that concerns and ideas for improvement can be shared and that the standards developed in partnership with service users,

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[3] DHSSPS (2007) Guidance on Strengthening Personal and Public Involvement in Health and Social Care (HSC (SQSD) 29/07) http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

carers and the public will focus on the issues that really matter to them.

It is also important that Service Frameworks provide service users and carers with clear and concise information, which is sensitive to their needs and abilities, so that they can understand their own health and wellbeing needs. To facilitate this, easy access versions will be made available for all Service Frameworks. Service Frameworks will also be made available in various other formats e.g. Braille, large print and audio tape. The Department will also consider requests for other formats or translation into ethnic minority languages.

People are ultimately responsible for their own health and wellbeing and that of their dependents, and it is important that service users, their carers and wider family are made aware of the role they have to play in promoting health and wellbeing.

Involving other agencies in promoting health and wellbeing

Improving the health and wellbeing of the population requires action right across society and it is acknowledged that health and wellbeing is influenced by many other factors such as poverty, housing, education and employment. While Service Frameworks set standards for providers of health and social care services it is essential that HSC services work in partnership with other government departments and agencies both statutory and non-statutory to seek to influence and improve the health and social wellbeing of the public.

People who use health and social care services, including learning disability services, may have complex needs which require inputs from a range of health and social care professionals and other agencies.

The benefits of multidisciplinary team working and multiagency working, including voluntary and community organisations, are well recognised and it is a key component of decision making regarding prevention, diagnosis, treatment and ongoing care. This will be a key theme underpinning the development and implementation of Service Frameworks.

Data Collection

As Service Frameworks are implemented it is important that timely, accurate information is available to support decision-making and service improvement.

To support this, data sources are identified, early in the development stage, to match the key performance indicator (KPI) data definitions. It is through the data source that progress can be monitored. Where robust baseline data is not available Frameworks will be looking to audits, including Self Assessment Audit Tools (SAATs), to gather information, establish baselines and set future performance levels.

Research and Development

It is important that Service Frameworks are based on valid, relevant published research, where available, and other evidence.

Education and Workforce

Education and workforce development occur at individual, team, organisational, regional and national levels: they are part of the drive to promote quality. The ongoing development and implementation of Service Frameworks will influence the education and training agenda and curricula content for all staff involved in the delivery of health and social care. This will require a commitment to lifelong learning and personal development alongside a focus on specific skill areas to ensure that newly qualified and existing staff are in a position to deliver on quality services.

Leadership

Effective leadership is one of the key requirements for the implementation of Service Frameworks and will require health and social care professionals from primary, community and secondary care to work together across organisational boundaries, including other governmental departments and the voluntary and community sectors. It is essential that Service Frameworks are given priority at senior, clinical and managerial level and implemented throughout all HSC organisations.

Affordability

Extensive discussions have been held with key stakeholders on the overall costs of delivering the Service Framework for Learning Disability in the context of the very significant challenges facing health and social care services. Many of the standards do not require additional resources and should be capable of delivery by optimising the use of existing funding. Where there are additional costs associated with specific standards, performance indicators and targets will be reviewed and adjusted as necessary, in the light of the available resources in any one year.

Securing additional funding that may be needed to advance some standards will undoubtedly create challenges. However, Service Frameworks constitute the distillation of the best advice and guidance available and there is great value in setting out our aspirations to improve quality in the care of people with a learning disability, even if we cannot commit to achieving every standard fully or as quickly as we would like. Even in the most difficult of times we must continue to set challenging targets in an effort to improve services.

The Department will work closely with the HSC Board, and other stakeholders, in developing an achievable, prioritised implementation plan for this Service Framework that will deliver real benefits and improved quality of services.

SECTION 2: SERVICE FRAMEWORK FOR LEARNING DISABILITY

Introduction

The aim of the Service Framework for Learning Disability is to improve the health and wellbeing of people with a learning disability, their carers and their families by promoting social inclusion, reducing inequalities in health and social wellbeing, and improving the quality of care.

The Service Framework for Learning Disability sets standards in relation to:

- safeguarding and communication and involvement in the planning and delivery of services
- children and young people
- entering adulthood
- inclusion in community life
- meeting general physical and mental health needs
- meeting complex physical and mental health needs
- at home in the community
- ageing well
- palliative and end of life care

The Service Framework for Learning Disability is initially for a three-year period from 2013 – 2016. It will be the subject of further review and continuing development as a living document as performance indicators are achieved, evidence of changed priorities emerge and new performance indicators are identified.

Process for developing the Service Framework for Learning Disability

The development of Service Frameworks is overseen by a multi-disciplinary Programme Board, which is jointly chaired by the Chief Medical Officer and the Deputy Secretary of the Department. The Service Framework for Learning Disability was lead by a Project Board who were accountable to the

Department's Programme Board for ensuring the completion of the project within agreed timescales and to DHSSPS guidelines. The Project Board was informed by a project team with representation from all aspects of the service including service users, carers, advocates and voluntary organisations. The full project membership is set out in Annex B.

In order to develop the standards, 5 working groups were established which ensured broader representation and expertise. These groups and their membership are set out in Annex C. These groups produced the preliminary reports that informed the development of the standards.

External quality assurance was provided by Mr Rob Greig, National Development Team for Inclusion (NDTi) and Dr Margaret Whoriskey, Scottish Executive.

Equality Screening

The Framework has been screened to take account of Section 75 of the Northern Ireland Act 1998 and any potential impact that the Framework might have on Human Rights. It is the recommendation of the Project Team that the Framework does not negatively impact on equality of opportunity and therefore does not require a full Equality Impact Assessment.

Values

The core values outlined in the Equal Lives Review (2005) have been adopted in full in the development of the Service Framework for Learning Disability. These core values when enshrined in practice will ensure that independence is promoted for all people with a learning disability. (Annexe D)

Policy and Legislative Context

The Service Framework for Learning Disability is congruent with the legal and policy context for the delivery of supports to people with a learning disability.

This has over recent years increasingly been underpinned by concepts of rights, inclusion and citizenship.

The onus on public authorities to promote equality of opportunity is also enshrined in the Northern Ireland Act (1998) which states that "*a public authority shall, in carrying out its functions in Northern Ireland, have due regard to the need to promote equality of opportunity between persons with a disability and persons without.*"

The Reform and Modernisation of Mental Health and Learning Disability Services Review (Bamford - May 2007)

A review of policy, practice and legislation relating to Mental Health and Learning Disability was commissioned by DHSSPS in October 2002. The Review concluded in August 2007 and produced ten reports (Annex E) that detailed the vision for supporting people with a learning disability, promoting mental health and wellbeing at all levels of society and for the delivery of specialist health and social care for everyone who needs it.

The DHSSPS response to Bamford, 'Delivering the Bamford Vision' (2008) (the Action Plan) states, "*the Northern Ireland Executive accepts the thrust of the recommendations*", and sets out proposals to take the recommendations forward over the next 10 – 15 years.

The Service Framework for Learning Disability builds on the approaches to supporting people with a learning disability proposed in the Bamford Review and the subsequent Action Plan.

Consistency with other documents

The Service Framework for Learning Disability has taken cognisance of reports and documents that have been or are being developed by DHSSPS and other regional groups, including:

- Transforming Your Care (DHSSPS, 2011)
- *Investing for Health* strategies;
- The Quality Framework – as outlined in *Best Practice Best Care (2001);*

- The *Reform and Modernisation* of HSC;
- Personal and Public Involvement (PPI) (DHSSPS, 2007)
- National Institute for Health and Clinical Excellence guidance (NICE)
- Social Care Institute for Excellence guidance (SCIE)

Human Rights and Social Inclusion

A key priority for health and social care services and the wider community is to tackle stigma, discrimination and inequality and to empower and support people with a learning disability and their families to be actively engaged in the process. This is underpinned by legislation from Europe and the United Kingdom (UK) as well as international law. A summary of all the relevant documentation can be found in "Promoting Social Inclusion" (including the UN Convention on the Rights of People with Disabilities[4] (UNCRPD)), The Reform and Modernisation of Mental Health and Learning Disability Services (Bamford - May 2007) and the "Human Rights and Equality" Report (Bamford - October 2006).

Human rights, as enshrined in the Human Rights Act (1998) UK, derive from the fundamental principles that:

- human beings have value and should be treated equally based on the fact that they are human beings first and foremost; and
- human worth is not based on either capacity or incapacity.

Human rights include the right to life, liberty and security and respect for a private and family life.

As this Framework also aims to address the particular issues facing children and young people with a learning disability and their family carers it is also underpinned by the four core principles of the UN Convention on the Rights of Children:[5]

- non-discrimination;

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[4] UNCRPD http://www.un.org/disabilities/default.asp?id=150

[5] UNCRC http://www.article12.org/pdf/UNCRC%20Official%20Document.pdf

- devotion to the best interests of the child;
- the right to life, survival and development; and
- respect for the views of the child.

How to read the rest of this document

Each Service Framework follows an individual's journey from infancy through to end of life care taking into account the different health and social care needs of children, adults and older people. In the Service Framework for Learning Disability each standard is accompanied by a statement written from the perspective of a person with a learning disability, in order to make them more meaningful to those for whom the Framework is primarily aimed.

Each standard sets out the evidence base and rationale for the development of the standard, the impact of the standard on quality improvement as well as the performance indicators that will be used to measure that the standard has been achieved within a specific timeframe. Each standard is presented in the same way. Figure 1 shows the information that is included in each standard.

Explaining the Standards

<table>
<tr><td colspan="4">Overarching Standard
This is a short statement that outlines what will be delivered and includes a statement written from the perspective of a person with a learning disability</td></tr>
<tr><td colspan="4">Rationale
This is a short section that outlines why/how the standard will make a difference for people using learning disability services.
Evidence
This includes brief references for the research evidence or guidance that the standard is based on.</td></tr>
<tr><td colspan="4">Responsibility for delivery/implementation</td></tr>
<tr><td colspan="4">This lists the HSC organisations tasked with responsibility for delivering the standard. It will include partners in care such as other government departments and agencies and voluntary organisations and community groups that have contractual or service level agreements with health and social care organisations.</td></tr>
<tr><td colspan="4">Quality Dimensions</td></tr>
<tr><td colspan="4">The impact of the standard on quality improvement is identified in relation to the five core values outlined in the Equal Lives Review (2005) (Annexe D). These include:
• Citizenship
• Social Inclusion
• Empowerment
• Working Together
• Individual Support</td></tr>
<tr><td>Performance Indicator
This information will be monitored to show if the standard is being delivered.</td><td>Data Source
This identifies where the information will be derived from.</td><td>Anticipated Performance Level
This describes how well the service must perform against this indicator.</td><td>Date to be achieved by
This specifies when the anticipated performance level should be reached.</td></tr>
</table>

Figure 1

Many of the standards apply to both adult services and services for children and young people. Each standard has been colour coded for ease of reference. It should be noted that there are some standards that may apply to both adults and young people, for example, Standard 13 (meaningful relationships) but will continue to be colour coded for adult services.

Standard applies to children, young people and adults with a learning disability

Standard applies only to children and young people with a learning disability

Standard applies only to adults with a learning disability

The rest of this document is divided into the following Sections:

Section 3	sets out the rationale for developing a Service Framework for Learning Disability
Section 4	sets out the standards for safeguarding and communication and involvement in the planning and delivery of services
Section 5	sets out the standards for children and young people
Section 6	sets out the standards for entering adulthood
Section 7	sets out the standards for inclusion in community life
Section 8	sets out the standards for meeting general physical and mental health needs
Section 9	sets out the standards for meeting complex physical and mental health needs
Section 10	sets out the standards for at home in the community
Section 11	sets out the standards for ageing well
Section 12	sets out the standards for palliative and end of life care

SECTION 3: WHY DEVELOP A SERVICE FRAMEWORK FOR LEARNING DISABILITY?

Introduction

Learning disability may be defined as follows:

> *A learning disability includes the presence of a significantly reduced ability to understand new or complex information or to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood with a lasting effect on development.* (Equal Lives, 2005)

Prevalence of Learning Disability

In determining the prevalence of learning disability in NI the Bamford Review (2005) cited a study based on information held by the former Health and Social Services Trusts, which estimated the numbers as shown in Table 1.

Table 1: Prevalence Rates (per 1,000) (15)

Age Bands	Mild/Moderate	Severe/Profound	Total
0-19	6,432	1,718	8,150
20-34	2,504	1,047	3,551
35-49	1,489	949	2,438
50+	1,473	753	2,226
Totals	**11,898**	**4,467**	**16,365**

However, the Review notes that these figures may be an underestimate as many people classed as *possibly having learning disability* may not be making any demands on health and social care services at present but could do so in the future.

Nonetheless, the overall prevalence rate of 9.7 persons per 1000 is higher than that reported for the Republic of Ireland (RoI) and for regions of Great Britain (GB).

The Review also anticipates that there will be increased numbers of people with a learning disability in the next 15 years. In addition, it notes the likelihood that higher proportions of these individuals will have increased care and support needs due to old age or additional complex needs.

Of particular importance to their quality of life is the need to promote their inclusion in society so that individuals with a learning disability can participate in the communities in which they live and access the full range of opportunities open to everyone else.

Developing a Service Framework for people with a learning disability serves a number of functions:

- For people with a learning disability, it details what it is they can expect in terms of care and support to meet their individual needs in ways that they understand and are accessible.
- For carers and families of people with a learning disability, it outlines what it is they can expect in terms of access to services for their family member and of their involvement as partners in the planning processes.
- For staff in front line service delivery, it enables them to communicate effectively in assisting people with a learning disability to access mainstream and specialist HSC services appropriately.
- For commissioners and those with responsibility for the delivery of services in the statutory and independent sectors, it assists them in achieving an integrated model of services and supports around the person in line with the expectations of service users and their families.

Relating the Service Framework for Learning Disability to other Service Frameworks

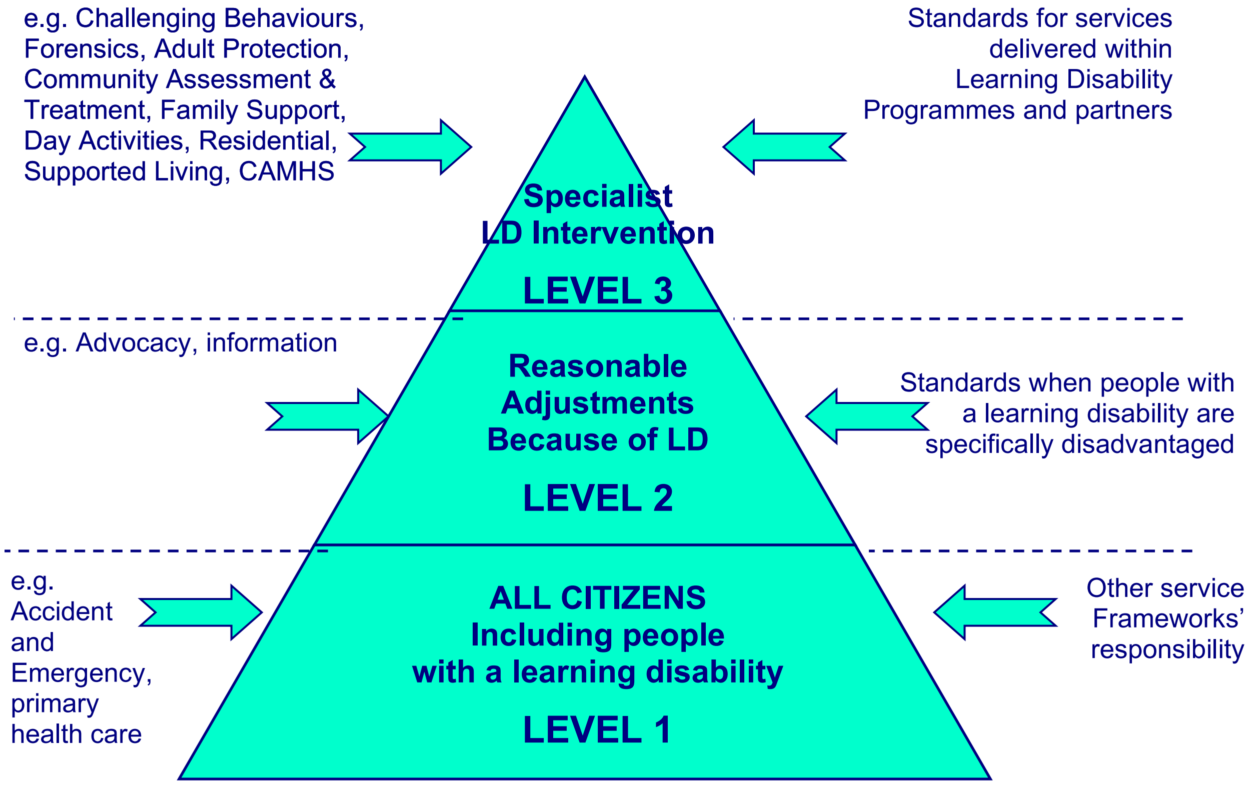

Figure 2

Figure 2 above describes the relationship between the Service Framework for Learning Disability and other service frameworks. Each service framework identifies standards related to a specific aspect of health and social care. The needs of people with a learning disability will also be addressed through these frameworks (Level 1).

In many instances HSC providers will need to make adjustments to the care and support they offer in order to make them accessible to people with a learning disability and their families. Current evidence indicates that these necessary adjustments are not consistently in place within HSC services. Standards in the Service Framework for Learning Disability will therefore require all HSC services to take the needs of people with a learning disability into account when designing and delivering services (Level 2).

While the basic premise of the Service Framework for Learning Disability is that people with a learning disability should access the same HSC services as other people, there are occasions when special expertise or support is required. As services become more inclusive it is anticipated that the volume and range of separate services will decrease as learning disability expertise is developed within mainstream HSC services.

The Service Framework for Learning Disability identifies a range of minimum standards that reflect the current service configuration in order to ensure that people with a learning disability and their families are clear about the care and support they can expect from these services (Level 3). Services provided through the non-statutory sector through contractual or service level agreements with HSC Trusts are also expected to meet these standards.

SECTION 4: SAFEGUARDING AND COMMUNICATION AND INVOLVEMENT IN THE PLANNING AND DELIVERY OF SERVICES

A wide range of people, for a variety of reasons, have been shown to be at risk of harm through abuse, exploitation or neglect. People of all ages, and from all social groupings, have the right to be safeguarded from such harm; to have their welfare promoted; and their human rights upheld. All HSC staff and staff providing services on behalf of the HSC have a dual responsibility with regard to safeguarding: (a) to ensure that all service users are treated with respect and dignity and are kept safe from poor practice that could lead to harm; and (b) that all staff are alert to the indicators of harm wherever it occurs and whoever is responsible; and know how and where to report concerns.

Effective communication is fundamental to the delivery of high quality health and social care. Without it there can be no meaningful partnership with service users and carers. Poor communication is often a significant contributory factor in complaints against HSC organisations and underpins many of the negative user experiences reported in research.

Involving people with a learning disability and their carers in the planning, delivery and monitoring of services helps to ensure that the care and support received meets their needs and aspirations. Involvement has to occur at all levels in HSC from ensuring service users' and carer's views are represented in organisational structures for the design and delivery of services, to securing a person-centred approach in all individual care and support arrangements.

There are particular challenges in meaningfully involving people with learning disability given the communication impairments they may experience and the legacy of discrimination which has served to exclude them from decision making fora in the past. Effective service user involvement needs to be underpinned by access to advocacy and information, alongside a clear understanding of issues related to capacity and informed consent.

Standard 1: (Generic)
All HSC staff should ensure that people of all ages are safeguarded from harm through abuse, exploitation or neglect.

Service user perspective:

"I am protected from harm"

Rationale:
A wide range of people, for a variety of reasons, have been shown to be at risk of harm through abuse, exploitation or neglect. People of all ages have the right to be safeguarded from such harm; to have their welfare promoted; and their human rights upheld. At the same time, they have the right to choose how to lead their lives, provided their lifestyle choices do not impact adversely on the safeguarding needs of others or, within the requirements of the law, of themselves. Decision making in this regard will have to pay due consideration to the age, maturity and capacity of the person. In this Standard, the term safeguarding is intended to be used in its widest sense, that is, to encompass both **preventive** activity, which aims to keep people safe and prevent harm occurring, and **protective** activity, which aims to provide an effective response in the event that there is a concern that harm has occurred or is likely to occur.

All HSC staff and staff providing services on behalf of the HSC have a dual responsibility with regard to safeguarding: (a) to ensure that all service users are treated with respect and dignity and are kept safe from poor practice that could lead to harm; and (b) that all staff are alert to the indicators of harm from abuse, exploitation or neglect wherever it occurs and whoever is responsible; and know how and where to report concerns about possible harm from abuse, exploitation or neglect whether these relate to the workplace or the wider community.

Effective safeguarding can ensure that people are safeguarded and their welfare promoted whether in their own homes; in the community; in families; and in establishments such as children's homes; secure accommodation; residential care and nursing homes; and hospitals. Through safeguarding, and in conjunction with positive engagement of individuals (and as appropriate their family and carers), effective prevention and potential for early intervention is enhanced and promoted and care and service plans are supported to deliver better outcomes. Where safeguarding is promoted, staff are empowered to act as advocates to safeguard vulnerable individuals and professional advocacy and counselling services are provided where required. A learning culture is also evident and staff are knowledgeable about safeguarding and keep abreast of local and national developments and learning, including enquiries, serious case reviews, case management reviews, inquiries and reports.

The quality of outcomes is more consistent, regardless of age, disability, gender, ethnic origin, religion, language, sexuality, political opinion, who pays for their care or their access to HSC provided or purchased services. Application in the wider community of knowledge and expertise gained in the workplace serves to safeguard people more broadly and more generally. The cycle of abusive behaviour(s) and/or neglect is broken.

Evidence:
World Health Organisation (2011) European Report on Preventing Elder Maltreatment
http://www.euro.who.int/__data/assets/pdf_file/0010/144676/e95110.pdf

OFMDFM (2009) Report of the Promoting Social Inclusion Working Group on Disability
http://www.ofmdfmni.gov.uk/report_of_the_promoting_social_inclusion_working_group_on_disability__pdf_1.38mb_.pdf

DHSSPS (2008) Improving the Patient & Client Experience 5 Standards: Respect, Attitude, Behaviour, Communication and Privacy and Dignity
http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf

The Joint Committee on Human Rights (2008) A Life Like Any Other? Human Rights of Adults with Learning Disabilities, Seventh Report of Session 2007-08 Volume 1
http://www.publications.parliament.uk/pa/jt200708/jtselect/jtrights/40/40i.pdf

Council of Europe (2007) Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse
http://conventions.coe.int/Treaty/EN/treaties/html/201.htm

OHCHR (2006) UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment http://www2.ohchr.org/english/law/cat-one.htm

OFMDFM (2005) Ageing in An Inclusive Society – Promoting the Social Inclusion of Older People (currently under review)
http://www.ofmdfmni.gov.uk/ageing-strategy.pdf

DHSSPS (2003) Co-operating to Safeguard Children
http://www.dhsspsni.gov.uk/show_publications?txtid=14022

United Nations (2000) The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children
http://www.uncjin.org/Documents/Conventions/dcatoc/final_documents_2/convention_%20traff_eng.pdf

European Convention on Human Rights http://www.hri.org/docs/ECHR50.html

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board & LCGs • Public Health Agency (PHA) • HSC Trusts • Primary Care	• PCC • RQIA • SBNI, NIASP & LASPs • PSNI • Other statutory agencies & voluntary, community & private sector

Quality Dimension

Citizenship
People of all ages will be safeguarded from harm and have their welfare promoted and their human rights upheld. Safeguarding responses are non-discriminatory, and seek to ensure that people of all ages at risk of harm are offered support to keep them safe from harm and to protect them when harm occurs.

Empowerment
Safeguarding interventions must be tailored to the presenting circumstances and to the needs and choices of the individual (provided these do not impact adversely on the safeguarding needs of others or, within the requirements of the law, of him or herself) and his/her circumstance. Decision making in this regard will have to pay due consideration to the age, maturity and capacity of the person.

Working Together
Promotion of self-reliance and personal and professional safeguarding behaviours; builds personal and professional safeguarding capacity; promotion of the welfare of individuals; protection from mistreatment; impairment of health and development is prevented; and individuals are kept safe from harm.

Individual Support
Promotion of self-aware practice; supportive of person-centred engagement; fosters awareness and opportunity for early intervention in poor practice/potentially abusive dynamics; and promotion of individualised safety plans where these are indicated, thereby enhancing services and safeguarding awareness and responses

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1. All HSC organisations and organisations providing services on behalf of the HSC have a **Safeguarding Policy** in place, which is effectively aligned with other organisational policies (e.g. recruitment, governance, complaints, SAIs, training, supervision, etc). The Safeguarding Policy is supported	HSC and provider Organisation annual reports HSC Governance Reviews, e.g. Complaints; SAIs, etc HSC Statutory Functions Reports and Corporate Parent Reports SBNI, NIASP & LASP Annual Reports RQIA Reports &	Establish baseline Performance level to be determined once baseline established	March 2014 March 2015

by robust procedures and guidelines	Reviews Case Management Reviews (CMRs) Serious Case Reviews (SCRs)		
2. All HSC organisations and organisations providing services on behalf of the HSC have **Safeguarding Plans** in place	As above	Establish baseline Performance level to be determined once baseline established	March 2014 March 2015
3. All HSC organisations and organisations providing services on behalf of the HSC have **safeguarding champions** in place to promote awareness of safeguarding issues in their workplace	As above	Establish baseline Performance levels to be determined once baseline established	March 2014 March 2015

Standard 2:
People with a learning disability should as a matter of course make choices or decisions about their individual health and social care needs. This needs to be balanced with the individual's ability to make such decisions and then the views of their family, carers and advocates should be taken into account in the planning and delivery of services unless there are explicit and valid reasons to the contrary agreed with the person.

Service user perspective:

"I am involved as a matter of course in making choices or decisions about my health and social care needs."

"My family, other carers and advocates are involved as partners."

"Staff ask for my views and the views of family carers when they are planning and delivering services."

Rationale:
People with a learning disability and family carers report a lack of engagement and exclusion from the planning and decision-making processes, which can result in services being unresponsive to individual needs, strengths and aspirations. It is important to ensure that people with a learning disability and their families are involved as partners in their health and social care.

Services must be delivered in ways that appropriately manage risk for service users, carers and their families. It is acknowledged, however, that in some situations, living with an identified risk can be outweighed by the benefit of having a lifestyle that the individual really wants and values. In such circumstances, risk taking (when it is appropriately managed) can be considered to be a positive action. HSC staff need to work in partnership with service users and carers to explore choices, identify and assess risks and agree on how these will be managed and minimised for the benefit of individual service users, their carers and families.

Evidence:
DHSSPS (2010) Care Management, Provision of Services and Charging Guidance http://www.dhsspsni.gov.uk/hsc-eccu-1-2010.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011) http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability http://www.dhsspsni.gov.uk/equallivesreport.pdf

DHSSPS (2005) A Healthier Future: A Twenty Year Vision for Health and Well

being in Northern Ireland 2005-2025
http://www.dhsspsni.gov.uk/healthyfuture-main.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Trusts	• Other service providers • Advocacy organisations • Families and carers

Quality Dimension

Citizenship
Service users will be involved as partners in the planning and delivery of health and social care services.

Social Inclusion
Involvement will ensure that service users are enabled to access mainstream services and be fully included in the life of the community.

Empowerment
Involving service users in the design and delivery of HSC services ensures that their expertise effectively informs the development of appropriate services.

Working Together
Partnership with service users, their families and carers is only possible if they are proactively involved in decision-making processes. Effective partnerships will contribute to positive health and social care outcomes.

Individual Support
Person-centred support relies on individuals being supported to share their views, hopes and concerns. Involvement is a necessity for the development of person-centred approaches and planning.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Evidence that people with a learning disability, their family and carers have been involved in making choices or decisions about their individual health and social care needs.	HSC Trust reports (care plans)	Establish baseline Performance level to be determined once baseline established	March 2015 March 2016

Standard 3: (Generic)
All patients, clients, carers and the public should have opportunities to be actively involved in the planning, delivery and monitoring of health and social care at all levels.

Service user perspective:

"I will have an opportunity to be actively involved at all levels of health and social care."

Rationale:
Actively involving patients and the public in the planning and provision of health care in general has been noted to bring many advantages to both those who receive and those who provide care. These include:

- Increased patient satisfaction and reduction in anxiety with positive health effects
- Improved communication between service users and professional staff
- Better outcomes of care with greater accessibility and acceptability of services
- Bridging of the gap between those who avail of services and those who provide care
- Recognition of the expertise of the recipient of care developed through experience

Evidence:
DHSSPS (2007) Guidance on strengthening Personal and Public Involvement in Health and Social Care http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

NHS (2006) Healthy Democracy
http://www.nhscentreforinvolvement.nhs.uk/index.cfm?content=90

DHSSPS (2005) A Healthier Future: A Twenty Year Vision for Health and Well being in Northern Ireland 2005-2025
http://www.dhsspsni.gov.uk/healthyfuture-main.pdf

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
http://www.dhsspsni.gov.uk/hpss_qi_regulations.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts • Primary Care	• Other Service providers • Advocacy organisations • Families & carers

Quality Dimension

Citizenship
Effective involvement ensures that the diverse needs of people with a learning disability are taken account of in service planning and delivery. The development of partnerships with service users and carers ensures that their views and aspirations are respected and valued.

Social Inclusion
Involvement helps to address the legacy of disadvantage for people with a learning disability which has led to their voices not being heard effectively in service planning.

Empowerment
Involvement gives a voice to the people most directly affected by decisions within health and social care. Involving them will enable them to have an influence over decisions made that affect their lives.

Working Together
Partnership with service users and carers is only possible if they are proactively involved in decision-making processes. Effective partnerships will contribute to positive health and social care outcomes.

Individual Support
Person-centred support relies on individuals being supported to share their views, hopes and concerns. Involvement is a necessity for the development of person-centred approaches and planning.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1. Percentage of job descriptions containing PPI as responsibility March 2014: senior and middle management March 2015: designated PPI leads at all levels of HSC organisations March 2016: all new job descriptions	Audit sample of job descriptions	Establish baseline and set target Monitor progress 100% - in all new job descriptions	March 2014 March 2015 March 2016
2.Percentage of patients and clients expressing	Patient & Client Experience monitoring	Establish baseline and set target	March 2014

satisfaction		Report percentage increase of patient and client satisfaction	March 2015
	Annual Accountability Report	Report percentage increase of patient and client satisfaction	March 2016
3. Percentage of staff who have gained PPI training (details to be agreed for 2014/2015)	Annual Accountability Report Training Report	Conduct training needs assessment for PPI, commission design of PPI training programme	March 2014
		Establish baseline and set target	March 2015
		Monitor percentage of staff trained at different levels in PPI	March 2016

Standard 4:
Adults with a learning disability should be helped by HSC professionals to develop their capacity to give or refuse informed consent.

Service User Perspective*:*

"I am helped to give or refuse my consent when decisions are being made that will affect my health or well being"

Rationale:
Respecting peoples' right to determine what happens to them is a fundamental aspect of good practice and a legal requirement. Research shows that people with a learning disability are often denied this right. Health and social care staff report uncertainty about how to ensure capacity and informed consent. This covers a wide range of areas from managing personal finances to consenting to surgery and other medical interventions. A major legislative reform process is underway that will strengthen the legal framework for work in the area of mental capacity and consent. HSC organisations should be working within the spirit of this legislative direction.

Evidence:
DHSSPS (2009) Legislative Framework For Mental Capacity And Mental Health Legislation In Northern Ireland – A Policy Consultation Document
www.dhsspsni.gov.uk/legislative-framework-for-mental-capacity.pdf

Equality Commission Northern Ireland (2008) – A Formal Investigation under Disability Discrimination Legislation to Evaluate the Accessibility of Health Information in NI for People with a Learning Disability
www.equalityni.org/archive/pdf/FormalInvestDisability(Full).pdf

SCIE (2008) Healthcare for All: The Independent Inquiry into Access to Healthcare for People with Learning Disabilities (The Michael Inquiry) Tizard Learning Disability Review, 13(4), December 2008, pp.28-34.
http://www.scie-socialcareonline.org.uk/profile.asp?guid=4f9f7333-2539-4004-af21-26ed14db5f5d

Mencap (2007) Death by Indifference
www.mencap.org.uk/case.asp?id=52&menuId=53&pageno

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

DHSSPS (2003) Reference Guide to Consent for Examination, Treatment or Care www.dhsspsni.gov.uk/consent-referenceguide.pdf

DHSSPS (2003) Seeking Consent: Working with People with Learning Disabilities: http://www.dhsspsni.gov.uk/consent-guidepart4.pdf

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary & Acute Care Teams	• DHSSPS • Independent sector • Service users, carers and families

Quality Dimension

Citizenship
The right to self determination is respected and capacity to consent is presumed to exist unless proven otherwise

Empowerment
Paying attention to correct processes for securing consent ensures that the views of people with a learning disability are adequately addressed in decision making.

Individual Support
All health and social care interventions are based on best practice in capacity and consent issues.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Develop and agree a regional training plan that ensures that relevant HSC staff are trained in consent and capacity issues.	HSC reports	All HSC Organisations	March 2016
2 Evidence that robust processes are in place where capacity has been judged to be an issue within HSC services or services commissioned by HSC	SAAT	Development and implementation of SAAT Performance levels to be determined based on outcomes of SAAT	March 2015 March 2016

Standard 5: (Generic)
All patients, clients, carers and the public should be engaged through effective communications by all organisations delivering health and social care.

Service user perspective:

"I am supported by staff who can communicate well with me."

Rationale:
Effective communication (clear, accessible, timely, focused and informative) has a significant impact on all aspects of care provision from disease prevention, to diagnosis, to self-management of long-term conditions.

Poor communication is a significant factor in most complaints against HSC organisations.

Evidence:
DHSSPS (2007) Guidance on strengthening Personal and Public Involvement in Health and Social Care http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

GMC (2013) Good Medical Practice
http://www.gmc-uk.org/guidance/good_medical_practice.asp

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland Order) 2003: www.dhsspsni.gov.uk/hpss_qi_regulations.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care	• DHSSPS • DE • Other service providers • Service Users & carers

Quality Dimension

Citizenship
As a universal requirement, good communication helps to ensure input by all service users on all aspects of the services they receive assisting in the highlighting of gaps in provision and areas for improvement.

Social Inclusion
Good communication helps to deliver and sustain appropriate patient/client/carer access to services and a clear understanding of the role and responsibilities of the service user in achieving health and care outcomes.

Empowerment
Good communication with patients/clients/carers enables adequate understanding of, consent to and compliance with treatment and care and contributes to audit and monitoring

Working together
Health and care outcomes themselves are enhanced through improved patient partnership and dialogue, including, but not limited to – diagnosis, self-referral, health promotion, disease prevention and management of long term conditions

Individual Support
Person-centredness cannot be delivered or claimed in the absence of good communication with service users. Good communication is a prerequisite of person-centredness.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
Percentage of patients and clients expressing satisfaction with communication	Patient & Client Experience monitoring report Annual Accountability Report	Establish baseline and set target	March 2014
		Report percentage increase of patient and client satisfaction with communication	March 2015
		Report percentage increase of patient and client satisfaction with communication	March 2016

Standard 6:
People with a learning disability should expect effective communication with them by HSC organisations as an essential and universal component of the planning and delivery of health and social care

Service user perspective:

"I am supported by staff who can communicate well with me."

Rationale:
Between 50% and 90% of people with a learning disability have some form of communication difficulty. Effective communication has a significant impact on all aspects of care and support provision across the full range of activities that promote health and social wellbeing. Poor communication is often a significant contributory factor in complaints against HSC organisations.

People with speech, language and communication needs, in addition to their learning disability, are amongst the most vulnerable and most in need of effective care and support to reach their potential. Early identification and effective intervention are essential. The current system is characterised by high variability and a lack of equity.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Equality Commission (2008) A Formal Investigation under the Disability Discrimination Legislation to Evaluate the Accessibility of Health Information in Northern Ireland for People with a Learning Disability
http://www.equalityni.org/archive/pdf/FormalInvestDisability(Full).pdf

DSCF (2008) Bercow Report: A Review of services for children and young people (0-19) with speech, language and communication needs
www.dcsf.gov.uk/bercowreview/docs/7771-DCSF-BERCOW%20Summary.pdf

DoH (2008) Better Communication: Improving services for children and young people with speech, language and communication needs. Action Plan to the Bercow Report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091972

DHSSPS (2007) Guidance on Strengthening Personal and Public Involvement in Health and Social Care (HSC (SQSD) 29/07)
http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

GMC (2006) Good Medical Practice
http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
http://www.dhsspsni.gov.uk/hpss_qi_regulations.pdf

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care	• DHSSPS • DE • Other Service Providers • Service users and carers

Quality Dimension

Citizenship
Good communication helps to ensure input by people with a learning disability on all aspects of the services that they receive, assisting in the highlighting of gaps in provision and areas for improvement.

Social Inclusion
People with communication difficulties are supported to access mainstream leisure and social activities that promote their integration into mainstream community living and promote their psychological and emotional wellbeing.

Empowerment
Good communication with service users, carers and family enables adequate understanding of, and consent to, the care, support and treatment arrangements offered.

Working Together
There is evidence of good communication between professionals that can determine early identification of communication difficulties and planning to provide the necessary supports to the person with a learning disability, their carer and family and that this is reviewed regularly with particular attention at transition points.

Individual Support
Good communication is a prerequisite of person-centredness.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of people with a learning disability who do not use speech as their main form of communication,	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2015 March 2016

who have been supported to establish a functional communication system.			
2 Develop and agree a regional training plan for staff in both HSC and services commissioned by HSC to raise awareness of communication difficulties and how they may be addressed	HSC reports	Regional Training Plan in place Training is delivered in accordance with Regional Training Plan.	March 2015 March 2016

Standard 7:
People with a learning disability should receive information about services and issues that affect their health and social wellbeing in a way that is meaningful to them and their family.

Service user perspective:

"I receive information about services and issues that affect my health and wellbeing in a way that my family and I can understand."

Rationale:
The particular communication difficulties experienced by many people with a learning disability create additional challenges in accessing information on which to make informed choices and access appropriate supports. Access to HSC services depends on people having information on what is available and how the care and support offered will impact on them. This places an onus on HSC organisations to ensure that people with a learning disability, their carers and their families are informed in a way that takes account of their particular circumstances.

This process will be enhanced by the availability of a named staff member to assist people in understanding the services available.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Equality Commission (2008) A Formal Investigation under the Disability Discrimination Legislation to Evaluate the Accessibility of Health Information in Northern Ireland for People with a Learning Disability
http://www.equalityni.org/archive/pdf/FormalInvestDisability(Full).pdf

DHSSPS (2007) Guidance on Strengthening Personal and Public Involvement in Health and Social Care (HSC (SQSD) 29/07)
http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

Foundation for People with Learning Disabilities (2005) Communication for person-centred planning
http://www.learningdisabilities.org.uk/?view=Search+results&search=Communication+for+person-centred+planning

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board (including Commissioning Groups) • Public Health Agency (PHA) • HSC Trusts	• DHSSPS, DSD, DE, DEL, DoJ • Other service providers • Advocacy partners • Service users and carers

Quality Dimension

Citizenship
People with a learning disability can only exercise their rights as citizens if they have accessible information about entitlements and services offered.

Social Inclusion
A major barrier to inclusion is the lack of information on which to base informed decision making.

Empowerment
Access to information enables people to speak out about what they need and what is being offered.

Working Together
Provision of information in an accessible manner is a key step towards enabling effective partnership between those who work in services and those who use them.

Individual Support
The development of effective person-centred support relies on individuals being well informed about choices that are open to them.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 All HSC organisations should provide evidence that they are making information accessible to people with a learning disability	SAAT	Development and implementation of SAAT Performance levels to be determined once baseline established	March 2015 March 2016
2 Each person with a learning disability can access a named person who can signpost them to relevant services.	Sample survey of families and service users.	Establish baseline of information provided Performance levels to be determined once baseline established	March 2016

Standard 8:
People with a learning disability, or their carer, should be able to access self directed support in order to give them more control and choice over the type of care and support they receive.

Service user perspective:

"I, or my carer, can request self-directed support in order to give me more control and choice over the type of care and support I receive."

Rationale:
There is growing evidence of the positive outcomes that may be gained by people with a learning disability when they have direct financial control over their supports. Access to Direct Payments as a means of delivering social services in NI has been available since 1996 under the Personal Social Services (Direct Payments) (Northern Ireland) Order 1996. The Carers and Direct Payment Act (NI) 2002 extended access to a much wider group of people. Direct Payments increase choice and promote independence. They provide for a more flexible response than may otherwise be possible for the service user and carer. They allow individuals to decide when and in what form services are provided and who provides them, who comes into their home and who becomes involved in very personal aspects of their lives. Direct Payments put real power into the hands of service users and carers, and allow them to take control over their lives. Whilst uptake of this provision has been low, it has been steadily increasing over recent years.

In England, direct payments have paved the way for investigation into how individual budgets could work to promote choice and control for people using adult social care services. The introduction of individual or personal budgets is part of the wider personalisation agenda in adult social care. At the time of preparing the Service Framework for Learning Disability an equivalent policy directive relating to the use of individual budgets is not in place. However, DHSSPS have indicated its commitment, in the Bamford Action Plan, to exploring the benefits of increasing users' direct control over services. The implementation (and review) of this standard will, therefore, evolve alongside future policy developments in this area.

Evidence:
HSC Board/ PHA (2011) Draft Commissioning Plan 2011/12
http://www.publichealth.hscni.net/sites/default/files/Draft%20HSCB%20PHA%20Commissioning%20Plan%202011-2012_0.pdf

DoH (2009) New Horizons: A Shared Vision for Mental Health
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011) http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

SCIE (2009) Research briefing 20: The implementation of individual budget schemes in adult social care. Published Jan 2007, Updated Feb 2009, Addendum 2009
http://www.scie.org.uk/publications/briefings/briefing20/index.asp

PSSRU (2007) Direct Payments: A National Survey of Direct Payments Policy and Practice http://www.pssru.ac.uk/pdf/dprla_es.pdf

DoH (2007) Valuing People Now: From Progress to Transformation – A consultation on the next three years of learning disability policy
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/LiveConsultations/DH_081014

DHSSPS (2005) Direct Payments: Policy and Practice Review Report
http://www.dhsspsni.gov.uk/direct_payments_policy_and_practice_review_report.pdf

Bamford (2005) Equal Lives (Section 10 - Ensuring Personal Outcomes): Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

DoH (2005) Independence, Wellbeing and Choice: Our Vision for the Future of Social Care for Adults in England – Social Care Green Paper
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4116631

Joseph Rowntree Foundation (1999) Implementing Direct Payments for People with Learning Disabilities http://www.jrf.org.uk/sites/files/jrf/F349.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• Welfare Rights Advisers • Advocacy organisations • DEL/DHSSPS/DCAL • Service users and carers.

Quality Dimension

Citizenship
Increased equity exists between service users and service providers where human rights have been respected.

Social Inclusion
Quality of life and wellbeing are improved through being able to have direct control over funding available to support social inclusion activities

Empowerment
Service users and carers experience more choice and control within processes and access services that they have requested and, where necessary, have the support of independent advocates.

Working Together
Change in attitudes and culture with renewed engagement between agencies on joint support planning providing greater flexibility in the way in which supports can be accessed.

Individual Support
People demonstrate improved health and wellbeing from having greater control over how they are supported and having their aspirations met in a more individualised way.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Evidence of provision of accessible information on Direct Payments within HSC organisations.	SAAT	Develop and implement SAAT Establish performance levels based on outcomes from SAAT	March 2015 March 2016
2 Percentage of requests for direct payments from people with a learning disability that were approved	SAAT	Develop and implement SAAT Establish performance levels based on outcomes from SAAT	March 2015 March 2016
3 Number of adults with a learning disability in receipt of Direct Payments expressed as a percentage of those in contact with Trust (regional percentage is 2.25%)	HSC Board and Trust Reports	Performance levels to be determined based on available resources and included in final Framework	
4 Number of children with a learning disability in receipt of Direct Payments expressed as a percentage of those in contact with Trust (regional percentage is 3.50%)	HSC Board and Trust Reports	Performance levels to be determined based on available resources and included in final Framework	

5 The HSC Board and Trusts have plans in place to extend the range and scope of self directed support including how they will develop skills and expertise in relevant staff	HSC Board and Trust reports	HSCB and all Trusts	March 2017

Standard 9: (Generic)
Service users and their carers should have access to independent advocacy as required.

Service user perspective:

"I can get an advocate to support me to speak out about worries I have about the care and support I receive"

Rationale:
People engage with health and social care services at times in their lives when they might be vulnerable or in need of support and / or guidance in relation to decisions about their health and wellbeing. For a whole raft of reasons (age, disability, mental health issues, gender, ethnic origin, sexual orientation, social exclusion, reputation, abuse and family breakdown and living away from home or in institutions), they may also feel discriminated against or simply excluded from major decisions affecting their health and wellbeing. It is at such times that independent advocacy can make a real difference because it gives people a voice; helps them access information so that they can make informed decisions and participate in their own care or treatment.

Independent advocacy is also a means of securing and protecting a person's human rights; representing their interests; and ensuring that decisions are taken with due regard to a person's preferences or perspectives where, for whatever reason, they are unable to speak up for themselves. In strategic terms independent advocacy can contribute to increased social inclusion and justice; service improvements in health and wellbeing; reductions in inequalities across the health and social care sector; and enhanced safeguarding arrangements. Independent advocacy can be delivered in a number of different ways and people may need different types of advocacy at different times in their lives. The most common models are self/group advocacy; peer advocacy; citizen advocacy; and individual/issue-based advocacy (also known as professional advocacy).

In this context, independence means structurally independent from statutory department or agency providing the service. The advocacy provider must be free from conflict of interest as possible both in design and operation and must actively seek to reduce any conflicting interests.

Independent advocacy should be available throughout the care pathway and, in particular, should be available early in the process as this may prevent a crisis developing. An advocacy service should apply not just to service users but to their carers and families. To be effective users need to be aware of advocacy services. Therefore they need to be promoted through accurate and accessible information. Relevant health and social care staff should be aware of the benefits of independent advocacy and the particular importance of independence from service provision.

There is currently a proposal to introduce a statutory right to an independent advocate in the proposed Mental Capacity Bill. Guidance on this right will be issued once the Bill has been finalised.

Evidence

DHSSPS (2012) Developing Advocacy Services – A Policy Guide for Commissioners
http://www.dhsspsni.gov.uk/developing-advocacy-services-a-guide-for-commissioners-may-2012.pdf

DHSSPS (2010) Advocacy Research: Summary Paper
http://www.dhsspsni.gov.uk/advocacy-research-summary-paper-of-advocacy-provision-october-2010.pdf

Knox, C. (2010) Policy Advocacy in Northern Ireland. University of Ulster, Jordanstown

Alzheimer's Society (2009) Listening Well http://www.alzheimers.org.uk

Horton, C (2009) Creating a Stronger Information, Advice and Advocacy System for Older People. London; Joseph Rowntree Foundation

SCIE (2009) At A Glance 12: Implications for Advocacy Workers available at http://www.scie.org.uk/publications/ataglance/ataglance12.asp

Seal, M. (2007) Patient Advocacy and Advance Care Planning in the Acute Hospital Setting – Australian Journal of Advanced Nursing Vol 24, No 4, pp29-36

Wright, M. (2006) A Voice That Wasn't Speaking: Older People Using Advocacy and Shaping it's Development, Stoke-on-Trent, OPAAL UK (Older People's Advocacy Alliance)

Bamford Review (2006) Review of Mental Health and Learning Disability (NI), Human Rights and Equality of Opportunity Available at www.dhsspsni.gov.uk/bamford

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts • Public Health Agency (PHA)	• Local Commissioning Groups • Primary Care Partnerships • GPs • Voluntary and Community Sector • Independent Sector • PCC

Quality Dimensions

Citizenship
An advocacy service can promote equality, social justice and inclusion of the most vulnerable and disadvantaged. Advocacy can enhance capacity building

at a community and individual level, which can ultimately reduce dependency on other health and social care services.

Empowerment
Advocacy services can enable individuals to access information, express their views and wishes and make informed choices about their own health and well being. The service is geared to needs of the individual. The service user will receive a service that best meets their needs at a time, which evidence shows, to be effective and to have maximum impact.

Individual Support
Advocacy services can safeguard users from abuse and exploitation by ensuring that their rights are upheld and their voice heard. An advocacy service can promote equality, social justice and inclusion of the most vulnerable and disadvantaged.

Performance Indicator	**Data Source**	**Anticipated Performance Level**	**Date to be achieved by**
To be determined			To be determined

SECTION 5: CHILDREN AND YOUNG PEOPLE

Work is ongoing in the development of a Children and Young People's Service Framework. It is anticipated that that Framework will address the universal needs of children and young people in Northern Ireland.

This Section aims to address the particular issues facing children and young people with a learning disability and their family carers and acknowledges the role played by schools and Education and Library Board in the assessment, intervention, support and onward referral of children & young people who may or do have a learning disability. This Section should be read alongside the other standards set out in this Framework.

Support to families tends to be fragmented and parents report difficulty in accessing services and understanding the range of roles and services that are in place.

It is crucial when concerns emerge that a child may have a learning disability, that a clear action plan is agreed as to how the concerns will be investigated. It is essential that planning and support systems are used to wrap around the child and family to ensure a seamless and co-ordinated approach. Where children have to live away from their family the arrangements in place must take account of their learning disability.

The Service Framework for Learning Disability reflects the fundamental position that regardless of diagnosis, a child/young person is a child/young person first, and that children and their families should be fully supported to participate in valued childhood experiences. They should also have access to the same opportunities, life experiences and services as other children and families.

Standards 10-13 withdrawn as they have been picked up in the new Service Framework for Children and Young People:

SECTION 6: ENTERING ADULTHOOD

The manner in which young people are supported at the time of transition from adolescence to adulthood is a crucial component in determining the degree to which they are enabled to live full and valued lives in their communities.

Supporting effective transition is the responsibility, not only of HSC organisations, but also requires the effective engagement of other government departments, notably DEL and DE, and other agencies. There is scope for improvement in the quality of the transition experience. Many young people have unsatisfactory experiences during the move from school towards adulthood.

Parents and young people should be offered a transitions pathway that outlines their:

- individual interests;
- aspirations;
- strengths and needs including vocational training;
- education;
- employment;
- health profile;
- social supports;
- friendships (including meaningful relationships); and
- social development.

Standard 14:
Young people with a learning disability should have a transition plan in place before their 15th birthday and arrangements made for their transition to adulthood by their 18th birthday.

Service User Perspective:

"I will have a transition plan in place before my 15th birthday."

"I will know the arrangements that are in place for when I leave school before my 18th birthday."

Rationale:
Effective transition planning at an early stage is vital if young people are to move successfully from school towards fuller adult lives. This is a statutory requirement under special education legislation and a recommendation of the Bamford Review. These arrangements should be made in partnership with the young person, their family/carers and adult learning disability services for transition to appropriate adult services in accordance with agreed transition protocols. The objective of this transition planning is to support people into the same life chances as other non-disabled young people e.g. a job, relevant education, positive relationships and the start of living independently.

It is noted that increased numbers of children with statements of special education needs, including those with disabilities are accessing mainstream education. Under the Special Educational Needs and Disability (NI) Order 2005 (SENDO) Code of Practice, transition planning in schools commences for 'statemented' pupils at the first annual review following the child's 14th birthday. The Education and Library Board's (ELB) Transition Service will ensure, in the most complex of cases, that appropriate advice givers will be present as part of the annual review process. Transition planning and services should be available, with young people and carers made aware of them, and able to access transition supports following post primary education with sufficient forward planning to minimise apprehension and stress for those young people and their carers.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DoH (2008) Getting a Life 2008-11 http://www.gettingalife.org.uk

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Special Educational Needs and Disability (NI) Order 2005 (SENDO)

Education (NI) Order 1996 and Code of Practice
http://www.deni.gov.uk/index/7-special_educational_needs_pg/special_needs-codes_of_practice_pg.htm

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• DHSSPS, DE (ELBs, schools and FE colleges), DEL • Education Transitions Co-ordinators • Voluntary agencies • Youth services • Councils • Independent providers • RQIA • Young people and their families • Advocacy organisations

Quality Dimension

Citizenship
A common assessment pathway will help to ensure equity of services for all.

Social Inclusion
Accessible information will be provided to allow young people, their carers and relevant others to participate fully in the development of a transition plan. Such information is available in a range of media and from a wide range of sources. Young people's involvement will create a move away from a narrow focus on services to a broader expression of aspirations for the future.

Empowerment
The process of preparing the Transitions Plan will place the young person and his/her family at the centre of planning for the future

Working Together
Decisions about eligibility for services will be the outcome of a multi-disciplinary assessment, and will be open and transparent for parents. The plan will be developed on a multi-disciplinary/multi agency basis with clear accountability lines for delivery by all the contributors.

Individual Support
A preliminary assessment will feed into an individualised transitions plan. Each plan will reflect the young person's aims and objectives in life including specific individual needs and interests, continuing education and training, employment, social and leisure activities and day opportunities.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of young people who express satisfaction that their transition plan has been implemented within 2 years of leaving school.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2016 March 2017
2 Evidence of transfer to DES, where appropriate, for health checks for children on transition to adult services	DES	90% 95% 98%	March 2015 March 2016 March 2017

Standard 15:
People with a learning disability should be supported to have meaningful relationships, which may include marriage and individual, unique, sexual expression within the law, balancing their rights with responsibilities.

Service User Perspective*:*

"I will be supported to enjoy meaningful relationships."

Rationale:
The Bamford Review promotes the importance of people with a learning disability benefiting from meaningful relationships and the need to offer support, guidance, training and related services to ensure that this happens.

The Human Rights Act 1998 includes the right to respect for privacy and family life, freedom of expression, the right to marry and to found a family and the right not to be discriminated against in respect of these rights and freedoms. This has to be balanced with positive risk taking strategies. Safeguards need to be put in place, where necessary and appropriate, but within a framework that ensures the objective is to support people who are having positive relationships whenever possible.

People with a learning disability have a right to learn about sexuality and the responsibilities that go along with exploring and experiencing one's own sexuality. They have to know how to protect themselves from unplanned pregnancy, HIV and other sexually transmitted infections, and sexual and gender-based violence. Education programmes for people with a learning disability should begin during adolescence as part of their general education. The implementation of this standard will need to be supported by the provisions detailed in Standard 3 (Consent and Capacity).

Evidence:
DHSSPS (2010) Adult Safeguarding: Regional & Local Partnership Arrangements http://www.dhsspsni.gov.uk/asva-__2010.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DHSSPS (2008) Sexual Health Promotion Strategy & Action Plan 2008-2013
http://www.dhsspsni.gov.uk/dhssps_sexual_health_plan_front_cvr.pdf

Simpson, A et al (2006) Out of the shadows: A report of the sexual health and well being of people with learning disabilities in Northern Ireland. Newnorth Print Ltd.

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

SCIE (2004) The Road Ahead: Information for Young people with Learning Difficulties, their Families and Supporters at Transition
http://www.scie.org.uk/publications/tra/index.asp

The Human Rights Act, 1998
http://www.direct.gov.uk/en/Governmentcitizensandrights/Yourrightsandresponsibilities/DG_4002951

Responsibility for delivery/implementation	**Deliver and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• DHSSPS, DE (Education and Library Boards and Schools) • Voluntary sector • Service Users • Families

Quality Dimension

Citizenship
The right to personal relationships is enshrined in Human Rights legislation. Meaningful relationships are a fundamental component of health and social wellbeing.

Social Inclusion
People will be supported to access social and leisure opportunities where friendships may be developed.

Empowerment
People will be supported to appreciate the rights, risks and responsibilities involved in personal relationships

Working Together
Staff and family carers will contribute to the development of policies and best practice guidelines in this area.

HSC Trusts will implement the Adult Safeguarding arrangements and staff will be trained appropriately to discharge it.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Regional guidelines on sexuality and personal relationships are developed to ensure a consistent approach	HSC Board Report	HSC Board policy developed and agreed	March 2015

2 Trusts to facilitate appropriate training for staff.	Trust Reports	40% 80%	March 2016 March 2017
3 Trusts to facilitate appropriate training for service users and family carers.	Trust Reports	Level to be established pending development of regional policy	March 2017
4 Increase in the number of people with a learning disability accessing sexual health & reproductive healthcare services.	SAAT	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016

SECTION 7: INCLUSION IN COMMUNITY LIFE

Emotional and social wellbeing are directly related to the degree to which people are able to live valued lives and participate in community opportunities.

For people with a learning disability barriers can exist which prevent them from accessing the opportunities that are open to the rest of society. Many of these barriers do not relate directly to the disability, but rather are the result of discrimination and approaches based on a belief that social education and leisure opportunities need to be provided within the context of HSC provision. This has resulted in the social exclusion of people with a learning disability and the development of services that group people together on the basis of a shared learning disability, rather than addressing individual needs and aspirations.

The HSC has a role in working with others in employment, housing, leisure and education to maximise opportunities that enable people with a learning disability to actively participate in their communities and engage in meaningful daytime activities, friendships, employment and leisure.

The majority of men and women with a learning disability live at home with their families. Appropriate short breaks are often an important component in supporting these arrangements.

Increasingly people with a learning disability express an aspiration to have children. HSC services must work together to ensure that people who have a learning disability are appropriately supported in their parenting role.

Standard 16:
Adults with a learning disability should be able to access support in order that they can achieve and maintain employment opportunities in productive work.

Service User Perspective:

"I will be able to get support to help me find and keep a job."

Rationale:
The Lisbon Agenda (2000) promotes the integration of people traditionally excluded from the labour market. The Bamford Review recommends that agencies should work in partnership to promote and deliver supported employment services. HSC Trust day opportunities strategies promote the development of supported employment as an integral part of service development.

A cultural shift away from a reliance on day centres should be encouraged, towards alternative options which enable individuals with a learning disability to participate in society through day opportunities and work placements that will improve their skills and allow them the opportunity to integrate with others. Those involved in person centred planning should actively consider employment as one of these options.

Evidence:
Beyer S, (2010) Using a Cost Benefit Framework for Supported Employment Policy and Practice: an analysis of 2 UK agencies Journal Appl Res Intellect, Volume 23, 5 (September 2010) pp.447-447
http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3148.2010.00584.x/pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DoH (2009) Valuing Employment Now – Real Jobs for People with Learning Disabilities
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101401

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

DELNI (2008) Pathways to Work (New Deal)
http://www.delni.gov.uk/index/finding-employment-finding-staff/fe-fs-help-to-find-employment/stepstowork.htm (Accessed 15 April 2011)

OFMDFM Promoting Social Inclusion (PSI) Disability
http://www.ofmdfmni.gov.uk/index/equality/disability/disability-promoting-

social-inclusion.htm

Lisbon Agenda (2000) http://www.euractiv.com/en/future-eu/lisbon-agenda/article-117510

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts	• DEL, OFMDFM • Supported employment providers • Northern Ireland Union of Supported Employment (NIUSE)

Quality Dimension

Working Together
HSC staff, in partnership with DEL and others, will enable people with a learning disability to achieve and maintain employment opportunities with ongoing professional support.

Social Inclusion
Historically there have been barriers to opportunities for meaningful employment for men and women with a learning disability. Increasing such opportunities will be a key contributor to improving social inclusion.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of adults with a learning disability who receive HSC support to help them secure employment (as a measure of those who request support).	Audit	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016

Standard 17:
All adults with a severe or profound learning disability should be able to access a range of meaningful day opportunities appropriate to their needs.

Service User Perspective:

"I will be supported to take part in a range of activities during the day"

Rationale:
There is a need for a radical reconfiguration of existing day service provision based on a progressive shift towards a resource model. As alternative provision develops there should be a reduction in the number of people who attend Adult Centres on a full-time basis. It is anticipated that these centres will, in the future, be providing a service to men and women with increasingly complex needs who should also be enabled to access opportunities for community integration. Adult Centres will need to explore the potential to develop sites for meeting the particular needs of people with more complex needs. The potential for Adult Centres to be used as a community resource is particularly under-utilised at present. Partnerships with community and voluntary groups should involve promoting the inclusion of people with a learning disability.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

SCIE (2007) Knowledge Review 14: Having A Good Day? A study of community-based day activities for people with learning disabilities
www.scie.org.uk/publications/knowledgereviews/kr14.asp

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

PCC (2011) My Day, My Way The Bamford Monitoring Group's Report on Day Opportunities
http://www.patientclientcouncil.hscni.net/uploads/research/My_Day_My_Way_FINAL.pdf

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Board • HSC Trusts	• Local community organisations • DHSSPS, DEL • FE providers • Local economy

Quality Dimension

Social Inclusion
Reconfiguration of day centres may reduce the number of days attended and an

expansion of wider community options for individuals.

Working Together
Each person will have a person-centred plan which will identify the multi-disciplinary and community inputs required to deliver on that plan. A lead person will be accountable for the delivery of the plan, which must be reviewed 6 monthly.

Individual Support
Admission criteria and processes in day centres will be in line with the standard and clear processes will be in place to consider intake and development of opportunities in local communities.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of adults with a severe or profound learning disability who have meaningful day opportunities in mainstream community settings, outside of their building based service.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2015 March 2016
2 Percentage of adults with a severe or profound learning disability receiving support in a building based service, who express satisfaction with the opportunity to experience day opportunities.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2015 March 2016

Standard 18:
All parents with a learning disability should be supported to carry out their parenting role effectively.

Service User Perspective:

"If I have children I will get support to be a good parent."

Rationale:
An increasing number of adults with a learning disability are becoming parents. In about 50% of cases their children are removed from them largely because of concerns about the children's wellbeing or the lack of appropriate support.

Barriers to the provision of appropriate supports include negative and stereotypical attitudes. Men and women with a learning disability have a right to be parents and where they choose to exercise this right, effective support should be in place to avoid adverse outcomes for them and their children.

If support is provided early it is more likely that the family unit will be successfully supported to stay together.

Evidence:
DoH (2009) New Horizons: A Shared Vision for Mental Health
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf

Aunos, M *et al* (2008) Mothering with Intellectual Disabilities: Relationship Between Social Support, Health and Wellbeing, Parenting and Child Behaviour Outcomes. http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3148.2008.00447.x/abstract

Tarleton, B *et al* (2006) Finding the right support? A Review of Issues and Positive Practice in Supporting Parents with Learning Difficulties and Their Children. The Baring Foundation
www.bristol.ac.uk/norahfry/research/completed-projects/rightsupport.pdf

IASSID Special Interest Research Group on Parents and Parenting with Intellectual Disabilities (2008) Parents labelled with Intellectual Disability. Position of the IASSID SIRG on Parents and Parenting with Intellectual Disabilities. Journal of Applied Research in Intellectual Disabilities, 21: 296–307. http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3148.2008.00435.x/abstract

Booth T *et al* (2006) Temporal discrimination and parents with learning difficulties in the child protection system. *British Journal of Social Work* 36(6), 997–1015. http://bjsw.oxfordjournals.org/content/36/6/997.abstract

SCIE (2006) Knowledge Review 11: Supporting disabled parents and parents with additional support needs.
http://www.scie.org.uk/publications/knowledgereviews/kr11.asp

CSCI (2006) Supporting Parents, Safeguarding Children: Meeting the needs of parents with children on the child protection register http://www.pmhcwn.org.uk/files/supporting_safeguarding.pdf (Accessed 15 April 2011)

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
- HSC Board - Public Health Agency (PHA) - HSC Trusts	- DHSSPS - Community and voluntary sector providers - Advocacy services

Quality Dimension

Citizenship
Independent advocacy support is provided to enable parents with a learning disability to be involved in the decision making process within multi-disciplinary meetings and other decision making fora.

Social Inclusion
Supports provided promote and encourage the parents to become less isolated from the community in which they live.

Empowerment
More parents and their children will be receiving appropriate care and support resulting in a smaller percentage of children of parents with learning disabilities being subject to Care Orders.

Working Together
Professionals work collaboratively across children's and adult's services to provide effective support to the parent and work will continue to develop policy on positively supporting parents with a learning disability to continue caring for their children.

Individual Support
Parents will be better enabled to care for themselves and their children through having their needs properly assessed and being appropriately supported in their parenting role.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Develop and agree a regional protocol between children's and adult services for joint working and care pathways.	HSC Board Report	HSC Board in collaboration with all HSC Trusts	March 2015

2 Percentage of parents with a learning disability who have a multi-professional/agency competence based assessment and subsequently receive appropriate support services	Trust Report	Establish baseline Performance level to be determined once baseline established	March 2016 March 2017
3 Percentage of parents with a learning disability involved in child protection or judicial processes who have received locally based skills training.	Trust Reports	85% 90% 95%	March 2015 March 2016 March 2017
4 Percentage of parents with a learning disability involved in child protection or judicial processes who have access to the services of an independent advocate.	Trust Reports	Establish baseline Performance level to be determined once baseline established	March 2015 March 2016

SECTION 8: MEETING GENERAL PHYSICAL AND MENTAL HEALTH NEEDS

Physical and mental health are inextricably linked with each impacting upon the other. The World Health Organisation (WHO) gives equal value to physical and mental health in the definition of health as “a complete state of physical, mental and social wellbeing, not just the absence of disease and infirmity”. People with poor physical health are at higher risk of experiencing common mental health problems and people with mental health problems are more likely to have poor physical health. Many factors influence the health of individuals and communities. Whether people are healthy or not depends a great deal on their circumstances and the environment in which they live. The determinants of health and wellbeing include:

- social environment
- the physical environment
- the person’s individual characteristics and behaviour

Many of these factors of health are not under the direct control of the individual and therefore one person’s health may differ from another’s depending on their circumstances.

Evidence demonstrates that there are significant disparities in health outcomes for people with a learning disability. They experience higher levels of physical and mental ill health, yet have lower access to primary care services, health screening and health promotion activities.

People with a learning disability can experience difficulties when using general health services, hospitals and primary care services. There is a need to proactively ensure that there is equity of access to the full range of health care services enjoyed by the general population. This is enshrined in disability discrimination and human rights legislation.

Standard 19:
All people with a learning disability should have equal access to the full range of health services, including services designed to promote positive health and wellbeing.

Service User Perspective:

"I have equal access to the full range of health services as other people in the community."

Rationale:
It is known that people with a learning disability often experience difficulties when using health services and this can result in their health needs not being effectively assessed or met.

Most people with a learning disability do not require specialist services to address their health needs but many will require a range of reasonable adjustments to help them make use of generic health services such as primary care, acute hospitals and dentistry. Specialist learning disability services are a key resource to support mainstream health services develop the knowledge and skills to do this effectively.

Reasonable adjustments can be many and are wide ranging, but it is important to remember that they must be individualised to the person, and may include such things as:

- longer appointment times
- offering the first or last appointment
- the provision of easy read information to enhance understanding
- close involvement and support of family carers
- appropriate waiting facilities
- pre-admission visits
- fast tracking arrangements when appropriate (e.g. in A&E Departments)

The standard links closely to Standards 4 and 5 (Communication and Involvement in the Planning and Delivery of Services).

Evidence:
Learning Disabilities Observatory: Improving Health and Lives (2010) Health Inequalities Report
http://www.improvinghealthandlives.org.uk/projects/particularhealthproblems

GAIN (2010) Guidelines: Caring For People With A Learning Disability In General Hospital Settings
http://www.gain-ni.org/Library/Guidelines/Gain%20learning.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and

Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Mencap (2007) Death by Indifference
www.mencap.org.uk/case.asp?id=52&menuId=53&pageno

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care (including pharmacy and dental)	• DHSSPS • Service users and carers

Quality Dimension

Citizenship
People with a learning disability are equal citizens and must be able to readily access the full range of services that support their health and social wellbeing as are available to the rest of the population.

Social Inclusion
Primary care services, acute hospital services and other specialist services, such as, palliative care should have knowledge of the specific issues for people with a learning disability accessing these services and make reasonable adjustments accordingly.

Working Together
All generic services should have knowledge of local learning disability specific services and how to access them when required. This includes access to advocacy services.

Individual Support
The provision of all services should be tailored to the individual needs of the person with a learning disability, and reasonable adjustments made accordingly. An individual with a learning disability should be able to make round the clock contact with services and receive the care needed to meet their needs.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 All acute hospitals should have an action plan for implementing the GAIN Guidelines for improving access to acute care for people with a learning disability and be able to demonstrate a clear commitment to the implementation of such a plan.	Trust report	All HSC trusts establish baseline Performance levels to be determined once baseline established	March 2015 March 2016
2 Percentage of GPs who have a system for identifying people with a learning disability on their register.	DES	Baseline as per learning disability DES Performance levels to be determined once baseline established	March 2015 March 2016
3 Each GP practice has a designated link professional within local learning disability services.	Trust report as per GAIN Guidelines	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016
4 Evidence of reasonable adjustments by health service providers.	Report from HSC Trust learning disability services	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016

Standard 20: (Generic)
All HSC staff, as appropriate, should advise people who smoke of the risks associated with smoking and signpost them to well developed specialist smoking cessation services.

Service user perspective:

"I will be advised on the dangers of smoking"

Rationale:
Smoking is a major risk factor for a number of chronic diseases including a range of cancers, coronary heart disease, strokes and other diseases of the circulatory system. Its effects are related to the amount of tobacco smoked daily and the duration of smoking.

A number of specialist smoking cessation services have been commissioned in a range of settings across Northern Ireland. These services offer counselling and support in addition to the use of pharmacotherapy by trained specialist advisors.

Evidence:
DHSSPS (2010) Tobacco Control Strategy for Northern Ireland
http://www.dhsspsni.gov.uk/tobacco-strategy-consultation.doc

NICE (2008) Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities http://www.nice.org.uk/Guidance/PH10

NICE (2006) Brief Interventions and Referral for Smoking Cessation in Primary Care and Other Settings http://www.nice.org.uk/Guidance/PH1

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts • Public Health Agency (PHA) • Primary Care	• DHSSPS • Families & carers • Voluntary, education, youth and community organisations

Quality Dimension

Citizenship
People with a learning disability can exercise their rights as citizens if they have accessible information to inform decision-making.

Empowerment
All members of the public will benefit from access to public information and education campaigns that raise awareness of issues relating to tobacco use, such as, the health risks to smokers and non-smokers. People who are ready to stop smoking are able to access specialist smoking cessation services in a choice of settings.

Working together
Brief Intervention Training for Health and Social Care Staff will ensure patients and clients receive consistent and timely advice on smoking cessation. Specialist smoking cessation services will be delivered to regional quality standards ensuring equitable service provision. Provision of information in an accessible format is a key step towards enabling effective partnership between those who work in services and those who use them. HSC professionals should take account of what is important to the person, their relationships and activities in working with them to address issues around smoking. Brief Intervention training for HSC staff will ensure that service users receive consistent and timely advice.

Individual Support
Effective person-centred support should take account of balancing what is important to people with what is important to them in regard to their health and wellbeing. Specialist smoking cessation services will be delivered to regional quality standards ensuring equitable service provision.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
Number of people who are accessing Stop Smoking Services	ELITE (PHA Stop Smoking Services Performance Report)	Baseline 2011/12 = 39204 4 % year on year increase	March 2014 March 2015 March 2016
Proportion of the smoking population who are accessing Stop Smoking Services.	ELITE (PHA Stop Smoking Services Performance Report)	Baseline 2011/12 =10.8%. NICE guidance and the ten year tobacco strategy call for a target of over 5% of the smoking population to be reached, hence target to maintain at >/= 5%	March 2014 March 2015 March 2016
Number of people using stop smoking services who have quit at 4 weeks and 52 weeks.	ELITE (PHA Stop Smoking Services Performance Report)	Baseline 2011/12 = 20,299 for those quit at 4 weeks and 5,889 for those quit at 52 weeks. Target 4% increase in respective numbers year on year	March 2014 March 2015 March 2016

Standard 21:
All people with a learning disability should be supported to achieve optimum physical and mental health.

Service User Perspective

I will be helped to stay as physically and mentally healthy as possible.

Rationale:
People with a learning disability are more likely to experience major illnesses, to develop them younger and die of them sooner than the population as a whole. They have higher rates of obesity, respiratory disease, some cancers, osteoporosis, sensory impairment, dementia and epilepsy. It is estimated that people with learning disability are 58 times more likely to die prematurely. However, even with such a dramatic health profile, the learning disabled population are less likely to get some of the evidence-based treatments and checks they need, and continue to face real barriers in accessing services. This contributes to preventable ill health, poor quality of life and potentially, premature death.

Effective screening and regular health checks help to identify unmet need and prevent health problems arising. People with a learning disability participate less in screening and regular health checks than the rest of the population. Information on, and activities in, health promotion can be difficult to access.

Evidence:

Learning Disabilities Observatory (2011) The Estimated Prevalence of Visual Impairment among People with Learning Disabilities in the UK
http://www.improvinghealthandlives.org.uk/publications/

DoH (2009) Improving the health and well being of people with learning disabilities: world class commissioning www.dh.gov.uk/commissioning

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DoH (2009) Valuing People Now: A new three-year strategy for people with learning disability
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093377

DoH (2009) Health Action Planning and Health Facilitation for people with learning disabilities: good practice guidance
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096505

DoH (2009) Delivering Better Oral Health: An evidence- based toolkit for prevention – second edition

DoH (2008) High quality care for all: NHS Next Stage Review Final Report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

DHSSPS (2007) Guidance on Strengthening Personal and Public Involvement in Health and Social Care (HSC (SQSD) 29/07)
http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

DHSSPS (2007) Oral Health Strategy for Northern Ireland
http://www.dhsspsni.gov.uk/2007_06_25_ohs_full_7.0.pdf

Disability Rights Commission (2007) Equal Treatment: Closing the Gap: A Formal Investigation into Physical Health Inequalities Experienced by People with Learning Disabilities and/or Mental Health Problems
http://onlinelibrary.wiley.com/doi/10.1111/j.1741-1130.2006.00100.x/abstract

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Foundation for People with Learning Disabilities (2005) Communication for person-centred planning
http://www.learningdisabilities.org.uk/publications/communication-person-centred-planning/

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • Primary Care • HSC Trust (Learning Disability Teams)	• Families • Voluntary and Community providers

Quality Dimension

Citizenship
People with a learning disability are supported to access the full range of screening and health checks as the rest of the population of NI.

Social Inclusion
Screening and health checks are made accessible to people with a learning disability and they are facilitated to participate in these activities.

Empowerment/Individual Support
Individuals will be supported to have regular screening and health checks on all the major illnesses and facilitated to make lifestyle choices that promote their good health and have in place a Health Action Plan as part of their person centred plan.

Working Together
There should be effective liaison and evidence of advance planning between HSC staff and family carers to fully embrace people with learning disabilities into the system of regular screening and health checks and health promotion activities. This should incorporate the development of Health Action Plans which includes details of health interventions, oral health, fitness and mobility, emotional needs and records of screening tests and identification of those responsible for taking action.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 The PHA and each HSC Trust has a health improvement strategy for people with a learning disability (children and adults) to address all relevant physical and mental health promotion and improvement needs.	Public Health Agency/ Trust Reports (to include reports from voluntary and community organisations Trust has commissioned services from)	All Trusts have in place a health improvement strategy for people with a learning disability.	March 2015
2 Percentage of adults with a learning disability who have an annual health check.	GP Records Health Facilitator records	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016
3 Percentage of adults with a learning disability who have an up to date and active Health Action Plan (HAP) following the annual health check.	GP records Health Facilitator records Learning Disability Teams	Establish baseline Performance levels to be determined once baseline is established	March 2015 March 2016
4 Percentage of people with a learning disability who have been in contact with community dental services (this includes those	Audit	Establish Baseline Performance Levels to be determined once baseline established	March 2015 March 2016

previously known to the service or who were previously treated by the service but discharged after their last treatment. a new contact equates to a new patient).			
5 Percentage of females with a learning disability who have been referred to cervical and breast screening services following their annual health check.	GP records Health facilitators	Establish Baseline Performance levels to be determined once baseline established	March 2015 March 2016
6. Percentage of people with a learning disability who have been referred for a sight test with an optometrist following their annual health check.	Audit	Establish Baseline Performance levels to be determined once baseline established	March 2015 March 2016

Standard 22: All people with a learning disability who experience mental ill health should be able to access appropriate support.

Service User Perspective

"If I have mental illness I can get appropriate support."

Rationale:
People with a learning disability and mental health needs require a co-ordinated multi-disciplinary approach to having their needs met through integrated services responding flexibly to the demands of their conditions with clear pathways of care identified so that the most appropriate supports are immediately available to the person and their family carers when required.

Refer also to standard 56 in Service Framework for Mental Health and Wellbeing

Evidence:
DHSSPS (2011) Service Framework for Mental Health and Wellbeing Consultation Document
http://www.dhsspsni.gov.uk/service_framework_for_mental_health_and_wellbeing_-_consultation_version.pdf

DoH (2010) Raising our sights: services for adults with profound intellectual and multiple disabilities A report by Professor Jim Mansell
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114346

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Emerson, E. and Hatton, C. (2007) The Mental Health of Children and Adolescents with Intellectual Disabilities in Britain. *British Journal of Psychiatry* 191, 493-499.
http://bjp.rcpsych.org/cgi/content/abstract/191/6/493

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

NHS QIS (2004) Learning Disability Quality Indicators
http://www.healthcareimprovementscotland.org/previous_resources/indicators/learning_disability_quality_in.aspx

Carpenter, B. (2002) Count Us In: report of the inquiry into meeting the mental health needs of young people with learning disabilities. London: Foundation for People with Learning Disabilities London:
http://www.learningdisabilities.org.uk/publications/count-us-in/

Responsibility for delivery/implementation	Delivery and implementation partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts • RQIA	• DHSSPS • Other service providers

Quality Dimension
Citizenship Addressing the mental health needs of people with a learning disability requires a combination of services that are consistently available to enable their full participation within the structures of society **Social Inclusion** The mental health needs of people with a learning disability are met in the most appropriate setting. **Empowerment/Individual Support** People with a learning disability and mental illness have person-centred plans in place with clear pathways of care identified and planned to enable them to lead as normal a life as is possible given the conditions of their illness. To involve the person, their parents or family carer in this process empowers the family and the person with a learning disability to make informed choices **Working Together** Services surrounding the person with a mental illness should be co-ordinated and resourced appropriately with a lead person identified to effectively manage and promote the mental health and wellbeing of the person requiring services.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1. A regional protocol is developed to ensure that people with a learning disability can access mainstream mental health services.	HSC Board	Protocol in place	March 2015
2. Percentage of people with a learning disability and mental health needs who access mainstream mental health services e.g. psychological and talking therapies	Audit	Establish baseline Performance levels to be determined once baseline established	March 2016 March 2017

where indicated in their treatment plan.			
3. Percentage of Health Action Plans and health checks which include mental health assessment and mental health promotion	GP Records	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016

Standard 23: (Generic)
All HSC staff, as appropriate, should provide people with healthy eating support and guidance according to their needs.

Service user perspective:

"I will be provided with healthy eating support and guidance"

Rationale:
Reducing fat and salt in the diet and increasing fruit and vegetable consumption is associated with a reduction in the risk of cardiovascular disease and hypertension.

Having a well balanced and nutritious diet will also help prevent many diseases which are linked to being overweight and obese such as high blood pressure, heart problems, risk of stroke, some cancers and Type 2 Diabetes. In addition, an improved diet can also contribute to an improvement in an individual's mental health and wellbeing.

Evidence:
DHSSPS Draft Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland (2011-2021)
http://www.dhsspsni.gov.uk/showconsultations?txtid=44910

DHSSPS (2005) Fit Futures http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf

WHO (2004) Global Strategy on Diet, Physical Activity and Health
http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf

SCAN (2008) Scientific Advisory Committee on Nutrition. The Nutritional Wellbeing of the British population
http://www.sacn.gov.uk/pdfs/nutritional_health_of_the_population_final_oct_08.pdf

Responsibility for delivery/implementation	**Delivery and implementation partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• Primary care team, inclusive of social care

Quality Dimension

Citizenship
People with a learning disability are provided with healthy eating support and advice as are the rest of the population.

Empowerment/ Individual support
Individuals will receive support and advice, appropriate to their needs, in a range of settings to develop skills for healthy eating and be facilitated to make lifestyle choices that promote their good health and wellbeing as part of person-centred planning.

Lifestyle issues including eating and physical activity choices should be explored through knowledge of what is important to the person. This should take account of what has worked and what has not worked in the past.

Working Together
There should be effective liaison and evidence of advance planning between staff and family carers to fully embrace people with a learning disability into the system of health promotion activities. All stakeholders should promote a consistent nutrition message by using the Eat Well – getting the balance right model. Training and education should be available for child carers / group care workers.

Schools / hospitals / residential care and nursing homes should be supported in the implementation of nutrition standards. Support and advice to develop skills for healthy eating in a range of settings should be available.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1. Percentage of people eating the recommended 5 portions of fruit or vegetables each day.	To be determined	Baseline for 2011/12 = 32% overall, 26% for males and 36% for females Target: maintain or at best increase percentage by 1% year on year	March 2014 March 2015 March 2016

Standard 24: (Generic)
All HSC staff, as appropriate, should provide support and advice on recommended levels of physical activity.

Service user perspective:

"I will be provided with support and advice on physical activity"

Rationale:
The National Institute for Health and Clinical Excellence (NICE) has fully endorsed the importance of physical activity as a means of promoting good health and preventing disease. Lack of physical activity is associated with an increase in the risk of coronary heart disease.

The recently reviewed and updated UK Physical Activity Guidelines, supported by all four CMO's, provide advice and guidance on the recommended levels of physical activity throughout the life course. The report also presents the first time guidelines have been produced in the UK for early years (under fives) as well as sedentary behaviour, for which there is now evidence that this is an independent risk factor for ill health.

Evidence:
DHSSPS Draft Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland (2011-2021)
http://www.dhsspsni.gov.uk/showconsultations?txtid=44910

DoH (2011) New UK Physical Activity Guidelines
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127931

NICE (2006) Public Health Intervention Guidance No.2 Four commonly used methods to increase physical activity: Brief intervention in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling http://www.nice.org.uk/nicemedia/pdf/word/PH002_physical_activity.doc

DHSSPS (2005) Fit Futures http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf

WHO (2004) Global Strategy on Diet, Physical Activity and Health
http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf

Responsibility for delivery/implementation	**Delivery and implementation partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• Primary care team, inclusive of social care

Quality Dimension

Empowerment
People with a learning disability will benefit from access to appropriate information and advice on physical activity.

Working Together
HSC staff recognise their responsibility to ensure service users receive consistent and timely health promotion messages.

Appropriate physical activity brief intervention training should be provided for HSC staff to ensure patients and clients receive consistent and timely advice.

Individual Support
Lifestyle issues including physical activity choices should be explored through knowledge of what is important to the person. Paying attention to what works best for the person in undertaking physical activity, working with their interests. This should take account of what has worked in the past and what does not work.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1. Percentage of people meeting the recommended level of physical activity per week.	Northern Ireland Health Survey	New physical activity guidelines were launched in 2011 and as such a new suite of questions to establish the percentage of people meeting the recommended level of physical activity per week has been integrated within the 2012/13 Northern Ireland Health Survey. It is anticipated these new baseline results will be available in Nov / Dec 2013. Performance level to be agreed thereafter.	March 2014

Standard 25: (Generic)
All HSC staff, as appropriate, should provide support and advice on recommended levels of alcohol consumption.

Service user perspective:

"I will receive support and advice on the use of alcohol"

Rationale:
Excessive alcohol consumption is associated with many diseases such as cancers (oesophagus, liver etc), cirrhosis of the liver and pancreatitis. There are also direct effects of alcohol and an increased association with injuries and violence.

Excessive alcohol consumption can affect the cardiovascular system, and is associated with high blood pressure, abnormal heart rhythms, cardiomyopathy and haemorrhagic stroke.

Evidence:
DHSSPS (2006) New Strategic Direction for Alcohol and Drugs (2006-2011)
http://www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf

SIGN (2003) Scottish Intercollegiate Guidelines Network The Management of harmful drinking and alcohol dependence in Primary Care No 74
http://www.sign.ac.uk/pdf/sign74.pdf

Responsibility for delivery/implementation	Delivery and implementation partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• Primary care team, inclusive of social care

Quality Dimension

Citizenship
People with a learning disability and alcohol related issues should be able to access mainstream services. They are likely to require the support of learning disability personnel to utilise the services offered by the mainstream addiction teams.

Working Together
Appropriate alcohol brief intervention training should be provided for HSC staff to ensure patients and clients receive consistent and timely advice.

Individual Support
HSC staff should take account of what and who is important to the person now and in the future in relation to lifestyle and where alcohol fits in. Explore how alcohol can be managed in the person's life by taking account of what has worked and what has not worked in the past for this person.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of people who receive screening in primary care settings in relation to their alcohol consumption.	Northern Ireland Local Enhanced Service	Establish baseline Performance level to be determined once baseline established	March 2014 March 2015

SECTION 9: MEETING COMPLEX PHYSICAL AND MENTAL HEALTH NEEDS

Children and adults with a learning disability may experience significant additional, complex health needs. Complex physical and mental health needs may be defined as those requiring a range of additional support services beyond the type and amount required by people generally and those usually experienced by people with impairments and long-term illnesses. These needs require a high level of effective integration between specialised and general services.

Supports to children, young people and adults who have complex physical and mental health needs will be most effective if they are based on person-centred planning approaches and within an ethos of ensuring bridging between learning disability expertise and other service settings. (Standard 10 sets out the specific standard for children and young people with complex physical health needs).

Standard 26:
All people with a learning disability whose behaviour challenges should be able to get support locally from specialist learning disability services and other mainstream services, as appropriate, based on assessed need.

Service User Perspective:

I can get support locally from specialist learning disability services if my behaviour challenges services and/or my carers

Rationale:
Emerson (1995) defines 'challenging behaviour' as behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities.

People who present behaviours that challenge services are generally well known to staff working within specialist learning disability services and they are therefore in a position to provide relevant information to other services and support the person and family carers to enable him/her to continue to access these services.

The specialist supports available should include social work, psychiatry, psychology, speech and language therapy, physiotherapy, nursing and any other relevant disciplines and these should be available 24 hours a day, 7 days a week. Should crises occur there needs to be the capacity to respond with appropriate interventions that maintain the person in the community/home in which he/she resides and/or short breaks that provides time out from the situation.

Whilst significant evidence exists as to the need for timely, flexible, home-based support to address challenging behaviours and to prevent unnecessary inpatient admission, work is not complete on the optimum service configuration and models required in Northern Ireland. To develop community based supports and move away from a traditional model of hospital admission will require resource investment and future detailed service planning.

Evidence:
NDTi (2010) Guide for Commissioners of Services for People With Learning Disabilities Who Challenge Services
http://www.ndti.org.uk/uploads/files/Challenging_behaviour_report_v7.pdf

DoH (2010) Raising our sights: services for adults with profound intellectual and multiple disabilities A report by Professor Jim Mansell
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114346

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability

http://www.dhsspsni.gov.uk/equallivesreport.pdf

NHS QIS (2004) Learning Disability Quality Indicators
http://www.healthcareimprovementscotland.org/previous_resources/indicators/learning_disability_quality_in.aspx

Emerson, E (1995) Challenging behaviour - analysis and intervention in people with a learning disability Cambridge University Press

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• Commissioning organisations • HSC Trusts • RQIA	• DHSSPS • Family carers • Advocacy providers • Other service providers

Quality Dimension

Citizenship
Providing support to an individual who presents behaviours that are challenging to access mainstream health and social care services maintains their equity with the rest of the population of NI.

Social Inclusion
There are community-based services to meet the needs of people with challenging behaviour.

Empowerment
Incidents of challenging behaviours are reduced when appropriate support mechanisms are available so that they can continue to receive the community - based services they require.

Working Together
Mainstream and specialist services should be collaborating on the needs of people with a learning disability who present behaviours that challenge mainstream services so that the person can access the healthcare services they require and services comply with regional guidelines on the management of challenging behaviours.

Individual Support
Management and intervention for challenging behaviour is practised and the approaches used have proven evidence-based effectiveness and social validity.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of individuals with significant challenging behaviours who have a Behaviour Support Plan including advance directives in	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2015 March 2016

place that detail actions to be undertaken in the event of their challenging behaviours escalating.			
2 Where challenging behaviours present a significant risk to the individual or others or a risk of breakdown in accommodation arrangements, a specialist assessment has been completed within 24 hours.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2015 March 2016
3 Where challenging behaviours present a significant risk to the individual, a Management Plan has been developed and implemented within 48 hours.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2015 March 2016
4 Evidence that HSC has engaged with other relevant delivery partners in developing and implementing consistent approaches in individual cases.	Trust report Audit of voluntary/ community sector	All HSC Trusts	March 2016
5 Percentage of people labelled as challenging who are not living in a congregate setting described as a challenging behaviour or specialist assessment/ treatment service	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2017

Standard 27:
All people with a learning disability who come into contact with the Criminal Justice System should be able to access appropriate support.

Service User Perspective:

I will get support If I come in contact with the police, courts or prisons

Rationale:
Men and women with a learning disability can come into contact with the Criminal Justice System in a range of different ways. They can be suspects, remandees, prisoners or indeed witnesses. However, people with a learning disability can be particularly vulnerable as they may not understand the processes involved, the information given to them, or their rights. The Reed Report (1992) highlighted the needs of mentally disordered offenders and recommended that, where appropriate, people with a learning disability who offend should be directed to HSC services, while emphasizing the need for services to be based on a multi-agency needs assessment.

It is vital that an offender with a learning disability does not go unrecognised and unsupported whilst in the prison system and that care pathways are established between primary care, learning disability services and Criminal Justice Services.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DoH (2009) The Bradley Report: Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf

RCSLT (2009) Locked Up and Locked Out: Communication Is The Key
http://www.rcslt.org/news/events/Locked_Up_NI_post_event_report

Prison Reform Trust (2008) No-One Knows. Police Responses to Suspects Learning Disabilities and Learning Difficulties: A Review of Policy and Practice
www.prisonreformtrust.org.uk

DHSSPS (2006) The Bamford Review of Mental Health and Learning Disability (NI): Forensic Services
http://www.dhsspsni.gov.uk/forensic_services_report.pdf

Reed Report (1992) Review of mental health and social services for mentally disordered offenders and others requiring similar services: Vol. 1: Final summary report. (Cm. 2088) London: HMSO ISBN 0101208820

Responsibility for delivery/implementation	Delivery and implementation partners
HSC Board HSC Trusts General Practitioners	DHSSPS, DoJ Police Service of Northern Ireland (PSNI) Probation Board for Northern Ireland (PBNI) NI Prison Service NI Courts Service Youth Justice Agencies Voluntary and community providers

Quality Dimension

Citizenship
People with a learning disability going through the Criminal Justice System have the same rights as other members of society and there is evidence of good practice available to ensure that this is the case.

Social Inclusion
Offending behaviours have the potential to increase the person's social exclusion and measures must be evidenced within their person-centred plan (PCP) that promotes their social inclusion in mainstream activities upon discharge from any institutional setting.

Empowerment
Measures are in place to minimise the person's vulnerability when they are in contact with the Criminal Justice System

Working Together
There is evidence of multi-disciplinary working practices to ensure that people with a learning disability are supported within the Criminal Justice System.

Individual Support
Community based services are in place which support people, prevent admissions where possible, and facilitate discharge from inpatient and other secure settings. The least restrictive options for individuals should be available.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Evidence that HSC has engaged and developed local protocols with relevant delivery partners to achieve consistent and	HSC Board Report	Protocols in place	March 2015

coordinated approaches to working with people with a learning disability who have offended or are at risk of offending.			

SECTION 10: AT HOME IN THE COMMUNITY

To maximise their health and social wellbeing, people with a learning disability should be supported to live in the community close to family, friends and community resources. Where they currently live with family they (the family) should be supported to provide the necessary care and support.

A greater focus on 'purposeful lives' will support people with a learning disability to live as independently as possible. It is vital that people are supported to live in the community and that inappropriate admission to hospital is avoided. People with a learning disability who require hospital treatment should be speedily discharged when the treatment ends to community homes with appropriate care and support. Resettlement of long stay populations, the development of innovative approaches to prevent delayed discharges and the promotion of 'purposeful respite' will enhance outcomes for people with a learning disability, their families and carers.

Standard 28:
HSC professionals should work in partnership with a variety of agencies in order to ensure that the accommodation needs of people with a learning disability are addressed.

Service User Perspective:

"My accommodation needs will be met by staff from different agencies who work well together"

Rationale:
People with a learning disability aspire to have the same standard in living options that are available to their non-disabled peers.

In NI the majority of adult persons with a learning disability continue to live with family carers. As carers age, they may require extra support to maintain their caring role. In addition, people with a learning disability may need support to participate in community activities with their peers.

Person-centred support plans should identify the person's preferred living arrangements and these should be regularly reviewed. It is important that as family carers age they are supported to plan for the future to allow for a smooth transition to new care arrangements either within the family or in supported accommodation (refer to Section 12: Ageing Well).

Small-scale, supported living arrangements (5 persons or less) have been shown to offer a better quality of life for people with a learning disability as compared to congregated living arrangements.

People living outside of family care should have a tenancy or occupancy agreement to offer them security of tenure along with an agreement to the number of support hours available to them individually.

People should be involved in decisions about sharing their homes with others. As far as possible they should be offered a choice of accommodation in a locality of their choosing.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

SCIE (2009) At a glance 8: Personalisation Briefing: Implications for housing providers www.scie.org.uk/publications/ataglance/ataglance08.asp

DHSSPS (2008) Residential Care Homes: Minimum Standards
http://www.dhsspsni.gov.uk/care_standards_-_residential_care_homes.pdf

NDA (2007) Supported Accommodation Services for People with Intellectual Disabilities: A review of models and instruments used to measure quality of life in different various settings (Walsh, PN *et al*, 2007)
http://www.nda.ie/website/nda/cntmgmtnew.nsf/0/929ECD4441474CA280257872004B8619/$File/SupportedAccommodation.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

McConkey, R (2005) Fair shares? Supporting families caring for adult persons with intellectual disabilities. Journal of Intellectual Disability Research, vol 49, Issue 8, 600 – 612
http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2788.2005.00697.x/full

NIHE (2003) Supporting People
http://www.nihe.gov.uk/index/sp_home/strategies/independent_living-2/supporting_people_strategy.htm

Responsibility for delivery/implementation	**Delivery and implementation partners**
• HSC Board • HSC Trusts	• DSD • NIHE • Other service and housing providers

Quality Dimension

Citizenship
People with a learning disability have equity of access to housing options similar to the general adult population.

Social Inclusion
People with a learning disability are living in communities.

Empowerment
People with a learning disability are supported to access information and advice to exercise their preference of where they live and who they wish to live with, through the help of independent advocates where necessary and, tailoring support to people's individual needs to enable them to live full, independent lives.

Working Together
HSC professionals are involved in developing strategies, information and advice to housing providers on identified housing needs of people with a learning disability. Joint planning and partnership working is promoted towards meeting a person's housing need.

Individual Support
Support Plans are in place that support the person with a learning disability and their carers' independence. Funding sources are maximised that support this position and planning for the future is incorporated into this process.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of support plans that take account of people's aspirations in relation to future accommodation needs, including independent living	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2015 March 2016
2 Percentage of adults who are living with a single carer or where there are 2 carers and the primary carer is aged over 65 who have a futures plan in place	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2015 March 2016
3 Percentage of people in receipt of public funding living in households of 5 people or less with a learning disability	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2015 March 2016
4 Percentage of people leaving learning disability hospital within one week after treatment has been completed	PfA monitoring	95% 97% 100%	March 2015 March 2016 March 2017

Standard 29: (Generic)
All HSC staff should identify carers (whether they are parents, family members, siblings or friends) at the earliest opportunity to work in partnership with them and to ensure that they have effective support as needed.

Service user perspective:

" My carer's needs will be considered and supported"

Rationale:
Carers are central to providing health and social care. People want to live in their own homes as independently as possible and family caring is critical in achieving this goal. Breakdown in caring has a major impact on readmission rates to hospital and unnecessary admissions to residential and nursing home care placements.

Caring is both a demanding and rewarding activity. Evidence shows that unsupported caring can have a negative impact on the physical, social and emotional well being of an adult carer. It is in everyone's interest to ensure that carers can continue to care for as long as they wish and are able to, without jeopardising their own health and wellbeing or financial security, or reducing their expectations of a reasonable quality of life.

Young carers (children and young people up to the age of 18 years who have a substantive caring role for a member of their family) often do not have an alternative but to be a carer. These children can be lonely, isolated, lose friendships and miss out on education and social activities. Young carers are frequently involved in activities that are developmentally inappropriate and the impact on their lives is unknown. Many young carers go unidentified. This highlights the need to identify young carers and provide support and assistance which will promote their health, development and inclusion in educational and social activities.

Early intervention, individually tailored to the needs of the carer and the cared for person, can be crucial in avoiding breakdown in the caring role. Forming meaningful partnerships with carers and making agreements with them about support to be provided is essential. Carers identify their requirements as respite care, information, personal care for the cared for person and practical and emotional support to continue in their role. This highlights the need for service planning and commissioning based on partnership working between statutory and independent sector and involvement of carers or their representatives to shape future services.

To enable carers to access the right information, support and services, current methods for identifying carers and encouraging them to acknowledge their caring role need to be enhanced. Under the Carers and Direct payments Act, all staff have a duty to inform carers. Staff should be particularly proactive in identifying the presence of younger and older carers.

One of the most important and far-reaching improvements in the lives of carers will be brought about by how health and social care staff view and treat them. Changes in staff knowledge of carers' issues could promote a more positive attitude to carers and this would make a significant difference to the lives of carers. Services should recognise carers both as individuals in their own right and as key partners in the provision of care and support.

Evidence:

PCC(2011) Young Carers in Northern Ireland: A report of the experiences and circumstances of 16 year old carers
http://www.patientclientcouncil.hscni.net/uploads/research/Young_carers_in_Northern_Ireland.pdf

Schubotz & McMullan (2010) The Mental and Emotional Health of 16-Year Olds in Northern Ireland: Evidence from the Young Life and Times Survey. Belfast: Patient and Client Council Report

DSD/ DHSSPS (2009) Review of Support Provision for Carers
http://www.dsdni.gov.uk/ssani-review-support-provision-carers.pdf

DHSSPS (2009) Regional Carer's Support and Needs Assessment Tool
http://www.dhsspsni.gov.uk/eccu2-09.pdf

DHSSPS (2008) Implementation of the Carers Strategy (Training for Carers)
http://www.dhsspsni.gov.uk/microsoft_word_-_circular_hss__eccu__3_2008_-_implementation_of_carers__strategy.pdf

Earley L *et al* (2007) Children's perceptions and experiences of care giving: A focus group study. *Counselling Psychology Quarterly.* 20. 1. pp.69–80

Evason, E. (2007) Who Cares Now? Changes in Informal Caring 1994 and 2006. Research Update 51. Belfast: ARK Publications www.ark.ac.uk

DHSSPS (2006) Caring for Carers Recognising, Valuing and Supporting the Caring Role http://www.dhsspsni.gov.uk/ec-dhssps-caring-for-carers.pdf

DHSSPS (2006) Implementation of the Carers Strategy (Identification of Carers) http://www.dhsspsni.gov.uk/hss__eccu__4-2006_carers_circular_-_signed.doc.pdf

SPRU (2004) Hearts and Minds: The health effects of caring
http://www.york.ac.uk/inst/spru/pubs/pdf/Hearts&Minds.pdf

Olsen R (1996) Young Carers: challenging the facts and politics of research into children and caring. Disability and Society, 11 (1), 41-54

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency • HSC Trusts	• Primary Care – GPs, LCGs • Independent Sector • DSD, DENI

Quality Dimension

Citizenship
Carers will feel valued and able to access the support they need. Staff will be facilitated to understand and value the role of carers.

Social Inclusion
Carers will be recognised as real and equal partners in the delivery of care. All carers, irrespective of age, who they care for or where they live will be directed toward appropriate agencies that can offer advice and support.

Empowerment
Carers will be encouraged to identify themselves as carers and to access information and support to protect and promote their own health and well-being and minimise the negative impact of caring

Working Together
Involving carers in the planning, delivery and evaluation of services improves outcomes for the carer and cared for person. Carers will be identified and supported best through partnerships between the statutory and voluntary sector and by good referral processes

Individual Support
Carers will be identified and signposted to help and support as early as possible in their journey and at times of crisis/transition.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1. Number of front line staff in a range of settings participating in Carer Awareness Training Programmes	Trust Training Report (including Induction programmes)	20% 50%	March 2015 March 2016
2. The number of carers who are offered Carers Assessments	HSC Board/ DHSSPS returns	Improvement targets set by HSC Board in conjunction with Carers Strategy Implementation Group	Reviewed annually
3. The percentage of carers who participate in Carers Assessments	HSC Board/ DHSSPS returns	Improvement targets set by HSC Board in conjunction with Carers Strategy Implementation Group	Reviewed annually

Standard 30:
All family carers should be offered the opportunity to have their needs assessed and reviewed annually.

Service User Perspective:

"The needs of family members who care for and support me will be assessed and regularly reviewed"

Rationale:
The majority of people with a learning disability live with their families. Nearly one-third live with a single carer and over 25% live with carers aged over 65 years. The pressures of caring can cause stress and ill health. Family carers report difficulties in accessing breaks from their caring responsibilities. The types of short breaks valued by family carers and people with a learning disability are wide ranging and needs to be flexible and responsive to the individual circumstances. This should include adult placement, drop-in services for people with a learning disability and support for the disabled family member to access social and recreational opportunities. A move away from an over reliance on short breaks in residential facilities is therefore signalled. Short breaks should be a positive experience for the person with a learning disability, adding to their lives' experiences as well as giving the family member a break.

Evidence:
NDTi (2010) Short Breaks Pathfinder Evaluation Greig, R., Chapman P., Clayson A., Goodey C., and Marsland D. http://www.education.gov.uk/publications/eOrderingDownload/DCSF-RR223.pdf

DHSSPS (2010) Care Management, Provision of Services and Charging Guidance http://www.dhsspsni.gov.uk/hsc-eccu-1-2010.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011) http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DHSSPS (2009) Regional Carer's Support and Needs Assessment Tool http://www.dhsspsni.gov.uk/eccu2-09.pdf

Black, LA *et al* (2008) Lifelines Report: An Evaluation Report of the Impact of the Families Services delivered by Positive Futures in Rural and Urban Areas of Northern Ireland. http://www.positive-futures.net/sites/default/files/LIFELINES%20Full%20Report.pdf

Kenny, K and McGilloway, S. (2007) Caring for children with learning disabilities: an exploratory study of parental strain and coping, British Journal of Learning Disabilities, p221-8.

http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3156.2007.00445.x/abstract

DHSSPS (2006) Caring for Carers: Recognising, Valuing and Supporting the Caring Role http://www.dhsspsni.gov.uk/ec-dhssps-caring-for-carers.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability http://www.dhsspsni.gov.uk/equallivesreport.pdf

Bamford (2004) University of Ulster Audit of Learning Disability Research in NI http://www.dhsspsni.gov.uk/learning-disability-consultation

Mencap (2003) Breaking point: A report on caring without a break for children and adults with profound learning disabilities. Mencap. London. http://www.mencap.org.uk/campaigns/take-action/our-other-campaigns/breaking-point

Responsibility for delivery/implementation	**Delivery Partners**
• HSC Board • HSC Trusts	• DHSSPS, DSD • Other Service Providers

Quality Dimension

Citizenship
Family carers have a voice in the development of strategies that impact on their role and ability to continue caring for their child, young person or adult

Social Inclusion
Carers are not left in isolation to cope with their role of caring for their child, young person or adult

Empowerment
Carers are better informed of their entitlements through the support and information they receive from professionals and /or independent advocates.

Working Together
Carers are involved in working as equal partners with statutory/other agencies in planning services that are flexible and responsive to meeting their needs and the needs of the person with a learning disability.

Individual Support
Carers of a person with a learning disability will have their support needs assessed and be provided with the services that support the family and / or the individual carer.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of carers who express satisfaction at their annual review that their needs as identified in the carers' assessment have been met.	User and carer feedback	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016

SECTION 11: AGEING WELL

Life expectancy for men and women with a learning disability has increased markedly over recent years. Growing older is likely to present additional challenges for people with a learning disability owing to the impact of their disability.

People with Down's syndrome are at high risk of Alzheimer's disease as they grow older and virtually all people with Down's syndrome who live long enough will develop this type of dementia. In addition, it is estimated that between 20% – 40% of older people with a learning disability are liable to have a mental health problem.

The number of older family carers is also increasing which can create particular challenges, for example, older carers:

- are under greater physical and mental pressures because of their age;
- may be particularly anxious about the future;
- are more likely to be caring alone; and
- may have smaller social support networks.

There has been little emphasis on health and wellbeing for older people with a learning disability or indeed their ageing carers. Ageing well has not been proactively encouraged by service providers. This is reflected in the low number of older people with a learning disability who participate in leisure activities and in concerns about unhealthy life styles.

Standard 31:

All people with a learning disability should have the impact of ageing taken into account in having their future needs assessed and proactively managed.

Service User Perspective:

"As I get older HSC staff will support me to plan for the future taking account of my age"

Rationale:
To avoid unnecessary anxiety to the person with a learning disability and their ageing family carer they both need to think about and plan for the changes that are likely to happen in their lives. Where this is done, crisis intervention should be eliminated in all situations where a person is known to social services and their needs met when there is a requirement to do so. At the same time, plans should also be considered for the family carer, in line with the statutory entitlement to an assessment of carer's needs (as with Standard 29).

People with a learning disability should be enabled to remain in their own home with their family carer for as long as possible with appropriate care and support to do so.

People with a learning disability have the same needs for autonomy, continuity of support, relationships and leisure as other older people.

Evidence:
The Alzheimer's Society (2011) Adaptations, improvements and repairs to the home www.alzheimers.org.uk/factsheet/428

DHSSPS (2010) Improving Dementia Services in NI: A Regional Strategy Consultation Document http://www.dhsspsni.gov.uk/improving-dementia-services-in-northern-ireland-consultation-may-2010.pdf

DHSSPS (2009) Regional Carer's Support and Needs Assessment Tool http://www.dhsspsni.gov.uk/eccu2-09.pdf

DHSSPS (2008) Standards for Adult Social Care Support Services for Carers http://www.dhsspsni.gov.uk/standards_for_adult_social_carer_support_services_for_carers.pdf

DHSSPS (2007) Living Fuller Lives: Dementia and Mental Health Issues in Older Age Report (Bamford) http://www.dhsspsni.gov.uk/living_fuller_lives.pdf

Tinker, Prof (1999) Ageing in place: What can we learn from each other? Kings College London www.sisr.net/events/docs/obo6.pdf

McQuillan *et al* (2003) Adults with Down's Syndrome and Alzheimer's Disease.

Tizard Learning Disability Review 8(4): 4-13.
http://pierprofessional.metapress.com/content/41u62857klh37m32/

Responsibility for delivery/implementation	**Delivery and implementation partners**
• HSC Board • HSC Trusts	• DHSSPS, DSD • Other service providers

Quality Dimension

Citizenship
People with a learning disability have the same right of access to Allied Health Professionals and specialist services, including equitable access to equipment aids and adaptations that assist daily living. They should not be discriminated against because of their learning disability.

Empowerment
People with a learning disability are facilitated to ensure that they have support to express their views and wishes as they plan for their future. People with a learning disability are provided with accessible information and support to understand and make their decisions about the future including information about age-related benefits.

Working Together
People with a learning disability have the right to a seamless transition towards increasing involvement and co-operation with services for older people and this should include any changes between programmes of care/team/Directorates in a pro-active manner.

Individual Support
Plans are in place and reviewed for the time when the carer is unable to continue to care, and is considered as part of the ongoing assessment of client and carers needs.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of people whose care plan has been reviewed taking account of issues associated with ageing.	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2015 March 2016

2 Percentage of carers aged 65 years and over receiving domiciliary or short break support services.	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2015 March 2016

Standard 32:

All people with a learning disability should have access to dementia services at whatever age it becomes appropriate for the individual.

Service User Perspective:

"I can get care and support from dementia services when I need it"

Rationale:
The early stages of dementia in people with a learning disability are more likely to be missed or misinterpreted – particularly if several professionals are involved in the person's care. The person may find it hard to express how they feel their abilities have deteriorated, and problems with communication may make it more difficult for others to assess change. It is vital that people who understand the person's usual methods of communication are involved when a diagnosis is being explored – particularly where the person involved does not use words to communicate. It is important that any prescribed medicine is monitored closely and that other ways of dealing with the situation are thoroughly explored.

People who have Down's Syndrome develop signs of dementia at a much younger age than others resulting in their needs being planned for much earlier.

Carers should be provided with information that helps them identify the earlier onset of dementia symptoms and be provided with appropriate support to continue to care for their adult with a learning disability. Carer's assessments should seek to identify any psychological distress and the psychosocial impact on the carer, including after the person with dementia has been provided with alternative care options.

Understanding a person's past history is crucial to providing person-centred care for someone with a learning disability and dementia.

Evidence:
DHSSPS (2010) Improving Dementia Services in NI: A Regional Strategy Consultation Document http://www.dhsspsni.gov.uk/improving-dementia-services-in-northern-ireland-consultation-may-2010.pdf

DHSSPS (2010) Adult Safeguarding in NI: Regional & Local Partnership Arrangements http://www.dhsspsni.gov.uk/asva-__2010.pdf

Brooker, D (2007) Person-centred Dementia Care – Making Services Better. http://books.google.co.uk/books?id=FQ3CdTblObwC&pg=Brooker+2007

NICE (2006) Clinical Guideline 42: Dementia - Supporting people with dementia and their carers in health and social care (Revised 2011) http://www.nice.org.uk/nicemedia/live/10998/30317/30317.pdf

Regional Adult Protection Forum (2006) Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance http://www.shssb.org/filestore/documents/Safeguarding_Vulnerable_Adults_-_3_Nov_06.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability http://www.dhsspsni.gov.uk/equallivesreport.pdf

Alzheimer's Society (2011) – Learning Disabilities and Dementia http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=103

An Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing TILDA. Measures will address health, cognitive status, activities of daily living, living situations, social life and overall quality of life within which a descriptive statistical picture of the life experiences of adult persons of ID will be developed. Prof. Mc Carron's research. Commenced September 2008. Due to complete in October 2011. http://people.tcd.ie/mccarrm

Responsibility for delivery/implementation	Delivery and implementation partner
• HSC Board • HSC Trusts Dementia Services • Primary Care • RQIA	• DHSSPS • Other service providers • Family carers

Quality Dimension

Citizenship
People with a learning disability and dementia should have the same access to dementia services as everyone else. People with a learning disability and those supporting them should have access to specialist advice and support for dementia. People with a learning disability and dementia should feel equally valued and should not experience barriers to person-centred care.

Social Inclusion
Every effort should be made to ensure people with a learning disability and dementia are cared for at home. When a move is necessary a specific care plan should be drawn up to ensure continuity of care and support for the person and successful transfer of expertise to the new service. People with a learning disability and dementia should not be excluded from services because of their diagnosis, age (whether regarded as too young or too old) or any learning disability.

Empowerment
Treatment and care should take into account each person's individual needs and preferences. Individuals must be given all available support before it is concluded that they cannot make decisions for themselves. Advocacy services and voluntary support should be available to people with a learning disability and dementia and carers separately if required.

Working Together
There should be sharing of skills and expertise between dementia services and learning disability services with equity of access to the most appropriate service delivery area. Referral protocols and pathways need to be clearly defined to facilitate people receiving the right care and attention in the right place at the right time.

Individual Support
Carers (family, staff, statutory and independent residential and nursing care providers) should be provided with information including inter-agency working, support and training to enable them to continue to care for the person with a learning disability and dementia. Care plans should incorporate individual person centred planning principles and should reflect individually assessed dementia care related needs.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of people with a learning disability and dementia who can access appropriate dementia services as required.	Trust generic dementia service	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016
2 Percentage of people with a learning disability and dementia who have received additional supports following a dementia diagnosis.	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2016 March 2017
3 Percentage of HSC professionals and other support providers who have received awareness training on the needs of people with a learning disability and dementia	HSC Trust report	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016

SECTION 12: PALLIATIVE AND END OF LIFE CARE

Palliative and end of life care focuses on all aspects of care needed by patients and their families, physical, emotional and spiritual. It involves relief of symptoms, making thoughtful decisions, supporting families and providing ongoing care in the appropriate setting. It is important that people in the last phase of life get the appropriate care, at the right time, in the right place, in a way that they can rely on. The following standards are designed to improve the patient and family experience of palliative and end of life care through *holistic assessment* of need, improved coordination of care and a greater focus on choice at end of life.

Standard 33: (Generic)
All people with advanced progressive incurable conditions, in conjunction with their carers, should be supported to have their end of life care needs expressed and to die in their preferred place of care.

Service User Perspective*:*

"I will be supported in my end of life care needs"

Rationale:
Most people would prefer to die at home (including residential and nursing home where this is the person's usual home) where this is possible.

In order to support this, identification of the possible last year/months/weeks of life should take place. Evidence shows that when end of life care needs are identified there is improved quality of life and even prolonged life, compared to when this stage of illness is not identified, particular in non-cancer conditions.

Advanced care planning allows more informed choice of care and enables people to be more supported to die in their preferred place of care.

Palliative care is the active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments. (WHO, 2002)

End of life care refers to the possible last year of life. It helps all those with advanced, progressive, incurable conditions to live as well as possible until they die. It enables the supportive and palliative care needs of both the patient and the family to be identified and met throughout the last phase of life and into bereavement. At this stage however it is often still appropriate to provide acute treatment in conjunction with palliative care, particularly in long term conditions. It includes physical care, management of pain and other symptoms and provision of psychological, social, spiritual and practical support. (National Council for Palliative Care, Focus on Commissioning, Feb 2007).

Evidence:
NCPC (2012) Palliative Care Explained
http://www.ncpc.org.uk/sites/default/files/PalliativeCareExplained.pdf (as accessed on 26 September 2012)

NICE (2011) Chronic Obstructive Pulmonary Disease (COPD): Quality Standard
http://guidance.nice.org.uk/QS10

DHSSPS (2010) Living Matters: Dying Matters – A Strategy for Palliative and End of Life Care for Adults in Northern Ireland.
http://www.dhsspsni.gov.uk/855_palliative_final.pdf

NICE (2010) Chronic Obstructive Pulmonary Disease; Management of Chronic Obstructive Pulmonary Disease in Adults in Primary and Secondary Care http://www.nice.org.uk/Guidance/CG12

Harrison , S et al, (2008), Identifying Alternatives to Hospital for People at the End of Life, The Balance of Care Group / National Audit Office http://www.balanceofcare.co.uk/previous_projects.html

Khan, SA; Tarver, K; Fisher S; Butler C (2007), Inappropriate Admissions of Palliative Care Patients to Hospital: A Prospective Audit, London, Pilgrims Hospices

Pleschberger, S, (2007), Dignity and the Challenge of Dying in Nursing Homes: The Residents' View http://ageing.oxfordjournals.org/content/36/2/197.short

DHSSPS (2006) Regional Cancer Framework: A Cancer Control Programme for Northern Ireland http://www.dhsspsni.gov.uk/eeu_cancer_control_programme_eqia.pdf

NHS (England) (2006) Gold Standards Prognostic Framework Programme, NHS End of Life Care Programme. Prognostic Indicator Papers vs 2.25 http://www.endoflifecare.nhs.uk/eolc/files/GSF-Guide-Prognostic_Indicators-Jul06.pdf

NICE (2004) Improving Supportive and Palliative Care for Adults with Cancer http://guidance.nice.org.uk/CSGSP

NICE (2004) Supportive and Palliative Care (CSGSP): Improving supportive and palliative care for adults with cancer http://www.nice.org.uk/Guidance/CSGSP

NHS Modernisation Agency (2004) Coronary Heart Disease Collaborative: Supportive and Palliative Care for Advanced Heart Failure http://www.improvement.nhs.uk/heart/Portals/0/documents/supportiveandpalliativecare.pdf

NICE (2003) Chronic Heart Failure; Management of Chronic Heart Failure in Adults in Primary and Secondary Care http://www.nice.org.uk/Guidance/CG5

Ellershaw & Wilkinson (2003), Care of the Dying: a Pathway to Excellence, Oxford University Press

Foote, C & Stanners, S, (2002), Integrating Care for Older People – New Care for Old – A Systems Approach, London, Jessica Kingsley

Responsibility for delivery/implementation	**Delivery and implementation partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care	• NICaN Supportive and Palliative Care Network • Primary care team, inclusive of social care • Voluntary palliative care

	organisations - Private nursing home and care providers

Quality Dimension

Citizenship
Earlier identification of palliative care needs and advance care planning will help improve quality of life and support a good death. Inappropriate admissions to hospital at the very end of life will be avoided.

Social Inclusion
People with non cancer conditions will have access to care and services traditionally available mainly to those with cancer conditions only

Empowerment
Involving service users, carers and families ensures that choices and preferences are taken into account in the planning and delivery of services

Working Together
HSC staff work in partnership with learning disability teams in order to ensure that appropriate reasonable adjustments are made to meet the specific needs of people with a learning disability.

Individual Support
Effective joint working between palliative care services and learning disability teams will ensure that the impact of learning disability is appropriately addressed in individual treatment plans.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1. Percentage of the population that is enabled to die in their preferred place of care.	NISRA survey for baseline of the population's preference Registrar General and PAS information for actual place of death	Establish baseline Performance indicator to be determined when baseline established	March 2014 March 2015
2. Percentage of the population with an understanding of advance care planning	NISRA survey for baseline levels	Establish baseline Performance indicator to be determined when baseline established	March 2014 March 2015

Standard 34:
All people with a learning disability being assessed for supportive and palliative care should have their learning disability taken into account in consultation with them, their carers and learning disability services when appropriate.

Service User Perspective*:*

If my health is getting worse and I need extra support towards the end of life staff will take into account my learning disability

Rationale:
Early identification of the supportive, palliative and end of life care needs of patients, their care-givers and family, through a holistic assessment, maximise quality of life for all in terms of physical, emotional, social, financial, and spiritual health and wellbeing.

People with a learning disability are entitled to the same services and respect throughout life as anyone else. Good palliative and end of life care is about enabling the individual to live out their potential when faced with an advanced progressive illness. By addressing the physical, emotional, spiritual and social issues which often make us fearful of death, it ensures that all individuals regardless of clinical diagnosis, get the appropriate care, at the right time, in the right place, in a way they can rely on.

Where necessary, reasonable adjustments should be made to take account of the impact of learning disability. Reasonable adjustments can be many and are wide ranging, but it is important to remember that they must be individualised to the person, and may include such things as:

- longer appointment times
- offering the first or last appointment
- the provision of easy read information to enhance understanding
- close involvement and support of family carers
- partnership working between learning disability services and other service providers.
- appropriate waiting facilities
- pre-admission visits
- fast tracking arrangements when appropriate (e.g. in A&E Departments)

Evidence:
Department of Health, Social Services and Public Safety (2010) *Living Matters: Dying Matters: A palliative and end of life care strategy for adults in Northern Ireland.* DHSSPS, Belfast.

Mencap (2008) Healthcare for All (The Michael Report) Report of the Independent Inquiry into access to healthcare for people with learning disabilities

National Institute for Clinical Excellence (2004) Improving Supportive and

Palliative Care for Adult with Cancer.
NHS (England) (2006) Gold Standards Prognostic Framework Programme, NHS End of Life Care Programme. Prognostic Indicator Papers vs. 2.25
http://www.endoflifecare.nhs.uk/eolc/files/GSF-Guide-Prognostic_Indicators-Jul06.pdf

NICE (2004) Improving Supportive and Palliative Care for Adult with Cancer. National Institute for Clinical Excellence: London
http://www.nice.org.uk/nicemedia/pdf/csgspmanual.pdf

NICE (2004) Management of Chronic Obstructive Pulmonary Disease in Adults in Primary and Secondary Care.
National Institute for Clinical Excellence: London
http://guidance.nice.org.uk/CG12

Responsibility for delivery/implementation	**Delivery and implementation partners**
• Primary Care • HSC Trusts • Public Health Agency	• Voluntary Palliative Care Organisations • Private nursing home and care providers

Quality Dimension

Empowerment
Involving service users, their carers and families ensures that their choices and preferences are taken into account in the design and delivery of services.

Working Together
Partnership with service users, their carers and families is only possible if they are proactively involved in decision-making processes. Effective partnerships will contribute to positive health and social care outcomes.

Individual Support
Effective person-centred support will ensure that individuals are appropriately assessed for supportive and palliative care.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Palliative care services have mechanisms to identify whether people have a learning disability.	SAAT	Develop and implement SAAT	March 2015
		Performance levels to be determined based on SAAT outcomes.	March 2016

2 Evidence of specific actions in service delivery that make reasonable adjustment for their learning disability.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes.	March 2015 March 2016

ANNEX A

GLOSSARY OF TERMS

TERM	DEFINITION
Acute Care	Health care and treatment provided mainly in hospitals
Advocacy	A service that provides someone to represent your views or support you in expressing your own views
Allied Health Professionals	Allied health professionals (AHPs) work with all age groups and within all specialties. AHPs work in a range of surroundings including hospitals, people's homes, clinics, surgeries and schools.
Augmented forms of communication	Better more accessible communication
Autonomy	Freedom of will
Capacity (mental)	Being able to understand and use information to make a decision
Care order	Care order is a court order made on the application of a HSC Trust and granted where the court finds the child has suffered or is likely to suffer significant harm.
Care pathway	A plan for the care needed to help a person with a learning disability to move through the different services they may need.
Challenging behaviour	When someone is behaving in a way that might cause harm to themselves or other people. Services are challenged to find a way of managing the behaviour so the chance of harm is reduced.
Citizenship	People with a learning disability being treated equally with other people.
Commissioners	A term used to describe organisations or groups who have been given responsibility for purchasing of health and social services.

Community Care	Services provided outside the hospital setting by HSC professionals and other organisations in the community.
Competency – based	An ability to do something, especially measured against a standard
Crisis intervention	A situation or period in which things are very uncertain, difficult, or painful, especially a time when action must be taken to avoid things getting much worse.
Cross-sectoral	Links between organisations managed by Government and voluntary/ community organisations and private business
Direct Enhanced Services	A Directly Enhanced Service is a specialised service provided by all GPs in N Ireland for adults with severe learning disability
Direct Payments	Direct Payments have been available since 1996 and aim to promote independence by giving people flexibility, choice and control over the purchase and delivery of services that support them. Individuals can opt to purchase services tailored to suit them by means of a Direct Payment from the Trust. From 19 April 2004 Direct Payments were extended to a wider range of service users under the Carers and Direct Payments Act (Northern Ireland) 2002 to include carers, parents of disabled children and disabled parents.
Disparities	A lack of equality between people or things
Domiciliary care	Support or care provided to a person in their own home
Dual diagnosis	Two different illnesses
Eligibility	To meet requirements for a certain criteria
Empowerment	Supporting people to take a full part in making decisions about their life.
Evidence-based practice	Doing things that have been shown to work
Health Action Plan	Describes the care and support you need to look after yourself and stay healthy.

Holistic care	Comprehensive care that addresses the social, psychological, emotional, physical and spiritual needs of the individual.
Independent sector	Organisations that are not managed by Government – includes voluntary organisations, community organisations and private business
Informed consent	Agreement by you to undergo treatment or care after being informed of and having understood the risks involved.
Integrated care pathway (ICP)	A multi-disciplinary outline of anticipated care which identifies how a patient with a specific condition will be supported by a number of professionals or agencies.
Integration	Equal access for all
Inter-agency	Links between different organisations
Legislative	To do with law
Mainstream Services	Services that anyone can use.
Methodologies	Different way of doing research.
Multi-Agency	Staff from different agencies, for example health and social care, education and employment, working together.
Multi-disciplinary	Staff from different professions, for example, nurses, doctors, social workers, working together.
Optimum	Most suitable
Palliative care	The active, holistic care of patients with advanced progressive illness. The goal of palliative care is to achieve the best quality of life for patients and their families.
Partnership working	Different organisations working together to achieve something
Person-Centred	The person and their family and friends are central and fully involved in all aspects of their care. The service, the organisation and its systems are focused on the needs of (what is important to) the individual.

Preliminary reports	Reports done at the start.
Prevalence	How many people in the population have a particular problem
Primary Care	Health and social care services that are generally available to everyone, for example, GP, dentist.
Reasonable adjustments	Actions that service providers should take to make sure people with a learning disability can use their services.
Respite	Support which gives carers a break from their usual caring roles and duties.
SAAT	Self Assessment Audit Tool – a performance management tool designed to measure the delivery of key objectives
Secondary Care	Health and social care services that help people with more complicated needs than those that primary care deal with, but mostly in the community.
Self-determination	A right to decide for self
Self-directed support	Helping people be in control of the support they need to live their life as they chose.
Service Framework	A document that sets out what people can expect the service to provide.
Service User	Anyone who uses, requests, applies for, or benefits from health and social care services.
Social inclusion	Making people with a learning disability feel part of the community they live in.
Statutory sector	Those organisations that are managed by government
Stereotypical	To categorise individuals or groups according to an oversimplified standardised image or idea
Transition	A time in a person's life when big changes are happening, for example, leaving school
Universal	Meaning all

ANNEX B

MEMBERSHIP OF PROJECT BOARD

Dominic Burke	Western Health and Social Services Board (Chair to 2009)
Fionnula McAndrews	Health and Social Care Board (Chair from April 2009)
Siobhan Bogues	Association for Real Change (Northern Ireland)
Dr Maura Briscoe	DHSSPS (to October 2009)
Peter Deazley	DHSSPS (from October 2009)
Paul Cavanagh	Western Health and Social Services Board (until 2009 and from September 2009)
Jim Simpson	Western Health and Social Services Board (to August 2009)
Aidan Murray	Health and Social Care Board (from September 2009)

MEMBERSHIP OF PROJECT TEAM

Siobhan Bogues	Association for Real Change (Northern Ireland) (Chair of Project Team)
Charles Bamford	DHSSPS
Orlaigh Cassidy	Service User
Edna Dunbar	Association for Real Change (Northern Ireland) (to September 2009)
Paula McGeown	DHSSPS (from September 2009)
Veronica Gillen	DHSSPS (to September 2010)
Rosaleen Harkin	Western HSC Trust
Sandra Harris	Equal Lives Action Group
Roy McConkey	Expert Board on Mental Health and Learning Disability
Bryce McMurray	Southern HSC Trust
Bria Mongan	South-Eastern HSC Trust
John Mullan	Service User
Jim Simpson	Western Health and Social Services Board (to August 2009)
Miriam Somerville	Belfast HSC Trust
Tom Smith	Southern Health and Social Services Board (until August 2009)
Pat Swann	DHSSPS
Sam Vallelly	Northern HSC Trust
Adrian Walsh	Eastern Health and Social Services Board
Aidan Murray	Health and Social Care Board (from October 2009)
Molly Kane	Public Health Agency (from September 2009)

ANNEX C

MEMBERSHIP OF WORKING GROUPS

ACCOMMODATION

Bryce McMurray	Southern HSC Trust (Chair of Accommodation Working Group)
Richard Black	Southern HSC Trust
Dessie Cunningham	Southern HSC Trust
Tony Doran	Southern HSC Trust
Janet McConville	Southern HSC Trust
Sinead McGeeney	Disability Action
Paul Roberts	Positive Futures
Moira Scanlon	Southern HSC Trust
Tom Smith	Southern Health and Social Services Board
Chris Williamson	NI Federation of Housing Associations

AGEING

Rosaleen Harkin	Western HSC Trust (Chair of Ageing Working Group)
Tony Brady	Carer
Raymond Boyle	Western HSC Trust
Dr Michael Curran	Western HSC Trust
Brendan Duffy	Western HSC Trust
Dr Jennifer Galbraith	Western HSC Trust
Lee McDermott	Western HSC Trust
Mr Brian McGarvey	Western HSC Trust
Pat McLaughlin	Western HSC Trust
Maureen Piggott	Mencap
Isobel Simpson	Western HSC Trust

CHILDREN AND YOUNG PEOPLE

Bria Mongan	South-Eastern HSC Trust (Chair of Children and Young People Working Group)
Sharon Bell	Parent
Dr Ann Black	South-Eastern HSC Trust
Gerry Campbell	NICCY
Heather Crawford	South-Eastern HSC Trust
Jennifer Creegan	South-Eastern HSC Trust
Maurice Devine	DHSSPS
Alice Lennon	South-Eastern Education and Library Board
Agnes Lunny	Positive Futures
Pauline McDonald	Belfast HSC Trust
Marian Robertson	South-Eastern HSC Trust
Colette Slevin	Mencap
Tracey Sloan	Parent

FULLER LIVES

Sam Vallelly	Northern HSC Trust (Chair of Fuller Lives Working Group)
Gareth Anderson	Northern HSC Trust
Ivan Bankhead	Northern HSC Trust
Mildred Bell	Northern HSC Trust
Pauline Cummings	Northern HSC Trust
Molly Kane	Northern Health and Social Services Board
Kate Kelly	Northern HSC Trust
Áine Lynch	North Regional College
Virgina Maxwell	Carer
Oonagh McCann	North-Eastern Education and Library Board
Oliver McCoy	Northern HSC Trust
Gerard McKendry	Service User (Compass Advocacy Group)
Donna Morgan	Northern HSC Trust
Judith Shaw	DEL
Bernie Doherty	DEL
Norman Sterrit	Triangle Housing Association

HEALTH

Miriam Somerville	Belfast HSC Trust (Chair of Health Working Group)
Kate Comiskey	Blair Lodge
Dr Petra Corr	Belfast HSC Trust
Maurice Devine	South-Eastern HSC Trust
Brian Irvine	Service User (Orchardville Training Centre)
Neil Kelly	Belfast HSC Trust
Rosalind Kyle	Belfast HSC Trust
Liz Leathem	Bryson Group
John McCart	Belfast HSC Trust
Dr Colin Milliken	Belfast HSC Trust
Mairead Mitchell	Belfast HSC Trust
Adian Murray	Eastern Health and Social Services Board
Fiona Rowan	Carer
Eilish Steele	Belfast HSC Trust

QUALITY IMPROVEMENT SUB-GROUP

Siobhan Bogues	Association for Real Change (ARC NI)
Edna Dunbar	Association for Real Change (ARC NI) (to September 2009)
Veronica Gillen	DHSSPS (to September 2010)
Seamus Logan	DHSSPS
Patrick Convery	Regulation & Quality Improvement Authority
Maureen Piggot	Mencap NI
Roy McConkey	University of Ulster
Jim Simpson	Western Health & Social Services Board (Until August 2009)
Stella Cunningham	Patient & Client Council
Molly Kane	Public Health Agency

COSTINGS SUB-GROUP

Adrian Walsh	Health & Social Care Board
Siobhan Bogues	Association for Real Change (ARC NI)
Veronica Gillen	DHSSPS (to September 2010)
Paula McGeown	DHSSPS (from September 2009)
Tracey McKeague	Health & Social Care Board
Bria Mongan	South-Eastern HSC Trust
Aideen O'Docherty	DHSSPS
Miriam Somerville	Belfast HSC Trust

ANNEX D

The five core values outlined in the Equal Lives Review (2005):

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

ANNEX E

Bamford Review of Mental Health and Learning Disability Reports

• Mental Health Improvement and Wellbeing	May 2006
• Child and Adolescent Mental Health	July 2006
• Adult Mental Health	June 2005
• Dementia and Mental Health of Older People	June 2007
• Alcohol and Substance Misuse	Dec 2005
• Forensic Services	Oct 2006
• Learning Disability	Sept 2005
• Promoting Social Inclusion	Aug 2007
• A Comprehensive Legislative Framework	Aug 2007
• Human Rights and Equality	Oct 2006
• Delivering the Bamford Vision	2008

ANNEXE F

ABBREVIATIONS

A&E	Accident and Emergency
ASD	Autistic Spectrum Disorders
BMI	Body Mass Index
CSCI	Commission for Social Care Inspection (now Care Quality Commission)
CSR	Comprehensive Spending Review
DCAL	Department of Culture, Arts & Leisure
DE	Department of Education
DEL	Department of Employment & Learning
DES	Direct Enhanced Services
DfES	Department for Education and Skills (England)
DHSSPS	Department of Health, Social Services and Public Safety
DNAR	Do Not Attempt Resuscitation
DoH	Department of Health
DoJ	Department of Justice
DSCF	Department for Children Schools and Families (England)
DSD	Department of Social Development
ELB	Education and Library Board
FE	Further Education
GAIN	Guidelines and Audit Implementation Network
GMC	General Medical Council
GP	General Practitioner
HSC	Health and Social Care
IASSID	International Association for the Scientific Study of Intellectual Disabilities
LASPs	Local Adult Safeguarding Partnerships
LCG	Local Commissioning Group
NDA	National Disability Authority
NDTi	National Development Team for Inclusion

NHS	National Health Service
NIASP	Northern Ireland Adult Safeguarding Partnership
NICaN	Northern Ireland Cancer Network
NICE	National Institute for Health and Clinical Excellence
NIHE	Northern Ireland Housing Executive
NIUSE	Northern Ireland Union of Supported Employment
OFMDFM	Office of First Minister and Deputy First Minister
PBNI	Probation Board for Northern Ireland
PCC	Patient and Client Council
PCP	Patient-centred Plan
PfA	Priorities for Action
PHA	Public Health Agency
PPI	Personal & Public Involvement
PSNI	Police Service of Northern Ireland
QIS	Quality Improvement Scotland
RCSLT	Royal College of Speech and Language Therapists
RoI	Republic of Ireland
RQIA	Regulation & Quality Improvement Authority
PSSRU	Personal Social Services Research Unit
SAAT	Self Assessment Audit Tool
SACN	Scientific Advisory Committee on Nutrition
SBNI	Safeguarding Board for Northern Ireland
SCIE	Social Care Institute for Excellence
SENDO	Special Educational Needs and Disability Order
SIGN	Scottish Intercollegiate Guidelines Network
UNOCINI	Understanding the Needs of Children Northern Ireland
WHO	World Health Organisation

Produced by:
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Revised January 2015

From the Permanent Secretary
and HSC Chief Executive
Dr Andrew McCormick

To: Chief Executive, Health and Social Care Board
Chief Executive, Public Health Agency

Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

[redacted]
Email:
[redacted]

Our Ref:

Date: xx October 2012

Dear Colleagues

LEARNING DISABILITY SERVICE FRAMEWORK

This letter formally requests that the Health and Social Care Board (HSC Board) works with the Public Health Agency (PHA) to develop a plan for the phased implementation of the Learning Disability Service Framework. A copy of the Service Framework is available on http://www.dhsspsni.gov.uk/learning_disability_service_framework-2.pdf

Background

As you are aware, work is being taken forward on the development of a range of Service Frameworks for different health conditions and social groupings which set out explicit, evidence-based standards for health and social care.

Service Frameworks set out the standard of care that patients, clients, their carers and wider family can expect to receive and will also be used by health and social care organisations to drive performance improvement.

The Learning Disability Service Framework represents the fifth in a series of Frameworks developed to date (cardiovascular, respiratory, cancer services and mental health). Work has also commenced in the development of Frameworks for children and young people and older people. The aim of the Learning Disability Service Framework is to improve the health and wellbeing of people with a learning disability, their carers and their families by promoting social inclusion, reducing inequalities in health and social wellbeing, and improving the quality of care.

These standards have been developed in partnership with a wide range of stakeholders with representation from all aspects of health and social care as well as service users and carers.

Action Required

The HSC Board, working with the PHA, are asked to submit to the Department a jointly agreed plan by 31 March 2013 for the phased implementation of the Learning Disability Service Framework commencing in April 2013. This should be developed in collaboration with the six Trusts.

At an early stage in this implementation planning process I would ask that a senior professional is identified to lead the process. The Department should b advised of this lead professional by 30 November 2012.

Resources

The Bamford Taskforce, responsible for the implementation of the Learning Disability Service Framework on behalf of the HSC Board/PHA, have provided assurance that the first year activity to baseline the framework is affordable given current resources. The future activity to implement the framework will be subject to yearly review.

Monitoring and Assurance Arrangements

In line with other established performance management arrangements, the Department will seek assurances from the commissioning lead as to the satisfactory implementation and progress against standards and targets set out in each Framework. At the regular performance and accountability meetings, the commissioning lead’s parent organisation will be asked to provide assurances on the progress of the implementation of the Learning Disability Service Framework.

Point of Contact

Should you require any further information please contact Paula McGeown, Safety & Quality Unit – telephone:[redacted] or email:[redacted]

ANDREW McCORMICK

cc: Chief Executives of HSC Trusts
Chief Executive, RQIA

ANNEX A

Final TOR for LDSF – July 2014

Health and Social
Care Board

Terms of Reference

Regional Group for Learning Disability Services Framework (LDSF)

Context:

The Service Framework for Learning Disability standards has been developed over the past 3 years. The Standards were widely consulted on during this time led by the 'Association For Real Change'. (ARC) The Framework was launched by the Minister for health Mr Edwin Poots on the 27th of September 2012.

The Service Framework for Learning Disability is one of five frameworks; the others include Cardiovascular Service, Mental Health and Wellbeing Service, Respiratory Service, and Older Peoples Service Framework.

Service frameworks set clear quality requirements for care. These are based on the best available evidence of the treatments and services that work most effectively for patients. One of the main strengths of each framework is that it is inclusive, having been developed in partnership with health professionals, patients, carers, health service managers, voluntary agencies and others with a particular expertise in each field of care

The aim of the Learning Disability Service Framework (LDSFW) is to improve the health and wellbeing of people with a learning disability, their carers and their families by promoting social inclusion and reducing inequalities in health and improving the quality of care.

The Learning Disability Service Framework sets standards in relation to:

- communication and involvement in the planning and delivery of services
- children and young people
- entering adulthood
- inclusion in community life
- meeting general physical and mental health needs
- meeting complex physical and mental health needs
- at home in the community
- ageing well
- palliative and end of life care

The Learning Disability Service Framework is initially for a three-year period from 2012 – 2015. It will be the subject of further review and continuing development as a living document as performance indicators are achieved, evidence of changed priorities emerge and new performance indicators are identified.

Aim:
The aim of the steering group is to support the coordination and implementation of the LDSFW and ensure better collaboration and communication and consistency in approach among the key statutory agencies across the Region.

Objectives:

- provide leadership and support to the regional and local implementation of the LDSFW ;.
- act as advocates for the LDSFW and communicate progress to relevant others within their organisations;
- engage actively and regularly with the process of implementation.

Actions:
The Regional Group will;

1. Support the development and implementation of the annual audit action plan and prioritisation of standards and KPIs.
2. Agree the LDSFW audit protocol, advise on the audit tools to be implemented and provide guidance on proformas and templates developed to gather data.
3. Support the establishment of short term focused working groups (if and when required) to support the implementation of the audit.
4. Provide a deputy to attend meetings when absence unavoidable and brief appropriately.
5. Agree ongoing monitoring templates and schedule;

Membership:

John Veitch	BHSCT
Siobhan Crilly	GAIN
Iolo Eilian (chair)	HSCB
Una Cushnahan	HSCB
Donna Morgan	NHSCT
Bronagh McKeown	SHSCT
Carol Veitch	SEHSCT
Rosaleen Harkin	WHSCT

Representation from the community/ voluntary sector was discussed at the Regional Group meeting on 23 June 2014. It was agreed that current arrangements and processes within the Trusts to ensure stakeholders engagement with carers, users, community and voluntary sector would used. It was also agreed that a reference group could be established as and when required to ensure community/ voluntary sector input. The Regional Group are happy to share agendas (on request) in advance of quarterly meetings scheduled until March 2015. The Community / Voluntary sector can also request through the Chair to attend meetings (where appropriate).

Operating Arrangements:

- The Regional group will elect a chairperson for 1 year through an open process
- The Regional group will meet quarterly
- The quorum for the group should be at least one representative from each of the representative organisations. A quorum of four members must be present before a meeting can proceed with one member being the Chair.
- If members cannot attend they are requested to send nominee on their behalf
- Internal or external persons may be invited to attend the meetings at the request of the Chair on behalf of the Group to provide advice and assistance where necessary.

Accountability arrangements:

- The Regional group will work under the auspices of the Health and Social Care Board
- Regional group members will be expected to provide feedback to and from their own organisations.

Title: Service Framework for Learning Disability

Year: 3

Lead Professional:	Valerie McConnell / Lorna Conn
Lead Officer:	Una Cushnahan
Report compiled by:	Una Cushnahan
Reporting Period:	April 2017 – March 2018
Report status:	Final (12 mths)

Green	**Standard achieved**	**35**
Amber	**Standard partially or almost achieved**	**14**
Red	**Standard not achieved**	**1**
Black	**Unable to make an assessment or issues with data collection**	**2**
Purple	**Awaiting data**	**0**
White	**No target for this year**	**3**
	Total	**55**

HSCB/ PHA APPROVAL	DATE
SMT Approval	
AMT Approval	

I confirm that the information provided in this report is accurate
Signed: (Lead Professional)
Date:

Red KPIs

Please provide details of the KPIs rated as Red, including what is causing the problem and what action is being taken or is required to solve it.

Standard/KPI	Issue	Action Taken/ Required
ST.22. All people with a learning disability who experience mental ill health should be able to access appropriate support. **PI (2)** Percentage of people with a learning disability and mental health needs who access mainstream mental health services e.g. psychological and talking therapies where indicated in their treatment plan.	This indicator was reported as 'green' in the end of year report (April 2016 – March 2017). The data returned for this reporting period by the 4 of the 5 Trusts were all above 70%. The target for 17 -18 was set at 50% based on 16 -17 performance which was not realistic and not achievable.	There are plans in place to address this indicator through: • The Learning Disability Service Model(under development) – which will explore access to mainstream services for Adults with Learning Disability • Transformational funding - which will identify the training needs of staff working in learning disability settings with regards to mental health. This will inform the future commissioning of training for staff working in learning disability in order to improve the quality of care provided to people with learning disability across a range of settings.

Black KPIs

Please provide details of the KPIs rated as Black, where there are no alternative data sources available or being investigated. Please provide a rationale for any proposed changes.

Standard/KPI	Proposed Change	Rationale
32.1 Percentage of people with a learning disability and dementia who can access appropriate dementia services as required.	No change proposed	Work ongoing with the Regional Learning Disability and Dementia group – Learning Disability Dementia Pathways are being developed by all HSCTs in line with the Regional Dementia Care Pathway. Capacity and demand exercise currently being finalised in line with the pathways. Pilot to base line Down Syndrome at the 30yrs complete (in line with NICE guidelines). Evaluation report to be completed. This will assist with establishing accurate data set for this indicator.
32.2 Percentage of people with a learning disability and dementia who have received additional supports following a dementia diagnosis.	No change proposed	Work ongoing with the regional Learning Disability and Dementia group – Learning Disability Dementia Pathways are being developed by all HSCTs in line with the Regional Dementia Care Pathway. Capacity and demand exercise currently being finalised in line with the pathway. This will assist with establishing accurate data set for this indicator.

1. Introduction

Please provide background paragraph on service framework:

- When was the framework launched?
- Is this the first or second version?
- What are the main aims?
- Who has lead responsibility? Etc.

Background

The Learning Disability Service Framework is one of six frameworks; the others include Cancer Prevention Treatment and Care, Cardiovascular Health and Well Being, Mental Health and Wellbeing, Respiratory Health and Well Being and Older Peoples Service Framework.

The aim of the Learning Disability Service Framework (LDSF) is to improve the health and wellbeing of people with a learning disability, their carers and their families by promoting social inclusion and reducing inequalities in health and improving the quality of care. The HSCB is responsible for reporting progress to the DoH to ensure key performance indicators are being achieved and areas are identified where change in practice is required and overall standards have improved.

The Learning Disability Service Framework is initially for a three-year period from 2014/15 – 2017/18. It will be the subject to further review and continuing development as a living document as performance indicators are achieved, evidence of changed priorities emerge and new performance indicators are identified.

There are 34 standards in the framework and 85 Key Performance Indicators (KPS's). 5 standards and 10 KPIs relating to children and young people have been removed and are now being taken forward by the Children's Service Framework. 10 of the standards and 19 KPIs are referred to as generic in the framework. Monitoring data for the generic standards is collected by the DHSSPS twice a year via the HSCB and PHA. This interim report focuses on providing an update on performance for 24 standards and 55 KPIs.

2. Regional Group

A Regional Group for Learning Disability Service Framework (LDSF) was established in June 2014 to oversee the audit and implementation of the Service Framework (as per table below). This group met quarterly in the first 1 ½ years of the project where project updates were provided by the Project Coordinator in advance of the meetings, as well as audit action plans approved for implementation. Since the baseline for 2015-2016 was established and monitoring systems to manage performance were developed and agreed the Regional Group now meets bi annually.

Iolo Eilian (chair)	Social Care Commissioning Lead for Mental Health and Learning Disability	HSCB
Una Cushnahan	LEARNING DISABILITYSF Project Coordinator	HSCB
Mairead Mitchell	Assistant Director for Learning Disability	BHSCT
Alyson Dunn	Assistant Director for Learning Disability	NHSCT
Miceal Crilly	Assistant Director for Learning Disability	SHSCT
Margaret O’Kane	Assistant Director for Learning Disability	SEHSCT
Rosaleen Harkin	Assistant Director for Learning Disability	WHSCT

3. Performance against Key Priorities (April 2017 - September 2017)

Please provide details of key priorities from last report and performance against each

- Standard 6 PI (2) - Communication Leaflet to be developed and process for implementation agreed –approval from DoH to reword the indicator was confirmed n 26 March 2018.
- Standard 15 (PI2) - Monitor the delivery of the Training by FPA to support HSCT Staff with the implementation of Personal and Sexual Relationship operational protocol for adults with learning disability – a meeting with the HSCTs and FPA to review year 2 of the training took place in February 2018 as the uptake in year 2 of the training was much lower than year 1. A series of actions were agreed to ensure uptake improved in year 3.
- Standard 21 PI (3) - Health and Wellbeing Improvement Plans (Pilot) – agree with the Bamford Monitoring group the Evaluation Report and Recommendations from Pilot for implementation –The HCFs prepared a full report with recommendations on the way forward collated from the evaluation questionnaire that was disseminated to their Learning Disability colleagues involved in the pilot of 30 Health and Wellbeing Action plans (end March 2017).
- Standard 32 PI (1&2) - Learning Disability and Dementia Pilot has been completed. NHSCT plan to provide an evaluation report of the pilot which will include key recommendations for regional implementation/ for consideration in the Learning Disability and Dementia pathway as well as being included in the projected demand and capacity work to help provide indicative costs to implement the pathway.
- Standard 32 PI(1&2) - each of the HSCTs have developed a ‘Pathway for Learning Disability and Dementia’ in line with the Regional Dementia Care Pathway – further work is required to cost the implementation of the Learning Disability and Dementia Pathway in line with HSCBs regional demand and capacity exercise.

- Year 4 of the Case Note Review audit took place during October – December 2017. The data has been analysed and the final report has been issued to the HSCTS for comment.

4. Key Achievements (September 2017 – March 2018)

- Interim Report on the Learning Disability Service Framework progress report for Year 3 (April 2016–Sept 2017) was completed for DoH Service Framework Programme Board.
- Delivery of Year 2 of Relationships, Sexuality Education (RSE) Awareness Training for HSCT Staff working with Adults with Learning Disabilities.
- Standard 32 PI (1&2) - Process and tools to establish base line for adults with Down syndrome has been completed by NHSCT. The pathway for Learning Disability and Dementia is finalised - all of this is working towards will establishing baseline figure of the Number of people with Learning disability and dementia.
- Year 4 of the Case Note Review file audit was completed across the Region (while there was limited access to personnel in Mental Health and Learning Disability to assist and support the audit as per previous years).

5. Key Challenges

Please provide details of the key challenges facing the framework, particularly if they have had an impact on achievement of KPIs etc. Are there any issues the SFPB needs to take action on?

- Standard 32 PI (1&2) - ensure the Pilot to gather base line information for adults with Down Syndrome is implemented in NHSCT and a clear evaluation report is produced which recommends the process and tools that should be used regionally to support baselines for adults with Down Syndrome. It is important to highlight at this stage there is not sufficient resource (financial and human) in the HSCTs to implement this model post evaluation.
- Standard 32 PI (1&2) – agree Pathway for Learning Disability and Dementia in line with the Regional Dementia Pathway - all of this will assist with establishing baseline figure for ‘Number of people with Learning Disability and

Dementia'. HSCB are currently preparing figures to assist with financial projections to support the implementation of the Learning Disability and Dementia pathway. Funding to support the implementation of the new model will be required.

- Standard 21 PI (3) –implementation of Health and Wellbeing Improvement plans (referred to as Health Action Plan in LDSF) across the 5 Trusts.

6. Key Priorities for the next 6 months

Please provide details on what areas will be focussed on over the next six months. This might include a section of the framework, a particular standard, data development, piloting programmes etc.

- Issue annual SAAT (year 3) to the 5 HSCTs to be completed and returned by 30 June 2018 to HSCB. Ensure the SAAT has been updated to include rewording of indicators with clear explanation to the Trusts.
- Quality approve and analyse data received in annual SAAT return and update annual end of year performance excel report 2017 -2018.
- Prepare end of year 2017 -2018 narrative report for SFPB due October 2018.
- Finalise Year 4 Case Note Review Report and issue to the HCTS for onward dissemination.
- Monitor the delivery of the Training provided by FPA to support HSCT Staff with the implementation of Personal and Sexual Relationship Operational Protocol for Adults with Learning Disability. HSCB in partnership with PHA commissioned

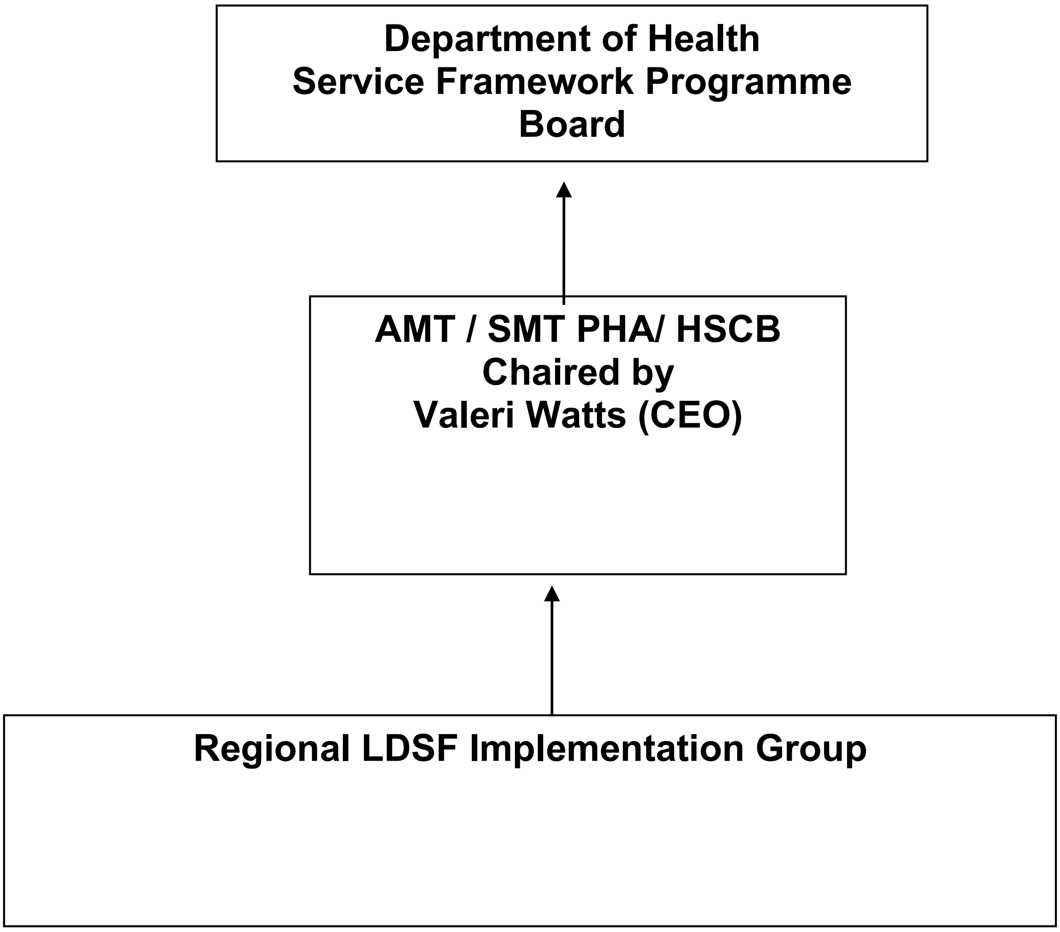
7. Issues for Programme Board consideration

Please detail any issue which requires a decision by the Service Framework Programme Board – this could be amendments to a KPI or the removal of a Standard. Clear rationale must be provided to support your recommendation including an assessment of the consequences if the recommendation is not accepted.

Current Standards/ indicators	Suggested change and rationale
Case Note Review has been completed for the last 4 years to determine baseline and performance for several indicators.	This particular task is very resource intensive as 450 files are audited regionally, and has been completed for the last 4 years. HSCB has seen a significant improvement in the files since the first audit in October 2014. HSCB would like to seek permission from SFPB to not carry out file audit this year.

8. Reporting Structure

Please provide a diagram setting out the reporting structure for the framework. This should include the reporting timetable and any approvals required (e.g. AMT/SMT, regional groups etc.).



Standard	Standard	KPIs	Indicator	PHA/ HSCB		BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT		Data source
				year 3 (2017 -2018) Targets	Year 3 (2017-2018) Achievement	year 3 (2017 - 2018) Targets	Year 3 (2017-2018) Achievement	year 3 (2017 - 2018) Targets	Year 3 (2017-2018) Achievement	year 3 (2017 - 2018) Targets	Year 3 (2017-2018) Achievement	year 3 (2017 - 2018) Targets	Year 3 (2017-2018) Achievement	year 3 (2017 - 2018) Targets	Year 3 (2017-2018) Achievement	
2	People with a learning disability should as a matter of course make choices or decisions about their individual health and social care needs. This needs to be balanced with the individual's ability to make such decisions and then the views of their family, carers and advocates should be taken into account in the planning and delivery of services, unless there are explicit and valid reasons to the contrary agreed with the person.	1	Evidence that people with a learning disability their family and carers have been involved in making choices or decisions about their individual health and social care needs.	NA	NA	85%	92%	85%	94%	85%	96%	85%	89%	85%	93%	**case note review** carried out by HSCB (commissioner led) Nov 2014(Q4)/ Nov 2015/ planned for Nov 2016
4	Adults with a learning disability should be helped by HSC professionals to develop their capacity to give or refuse informed consent.	1	Develop and agree a regional training plan that ensures that relevant HSC staff are trained in consent and capacity issues.	achieved	achieved	NA	NA	NA	NA	Na	NA	NA	NA	NA	NA	training has been costed/ delivery planned in year/ targets established/ awaiting capacity legislation to be issued before training can commence.
		2	Evidence that robust processes are in place where capacity has been judged to be an issue within HSC services or services commissioned by HSC	NA	NA	achieved	achieved	Achieved	Achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved
6	People with a learning disability should expect effective communication with them by HSC organisations as an essential and universal component of the planning and delivery of health and social care	1	Percentage of people with a learning disability who do not use speech as their main form of communication who have been supported to establish a functional communication system.	NA	NA	95%	99%	95%	93%	95%	98%	95%	98%	95%	98%	**case note review** carried out by HSCB (commissioner led) Nov 2014(Q4)/ Nov 2015/ planned for Nov 2016
		2	Develop and agree regional information leaflet to be included in staff training induction packs to raise awareness of communication difficulties that adults with Learning Disability may experience and how they may be addressed.	to be completed	under way	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Desktop research underway to sources examples of leaflets. Links established with HR in each of the HSCTs to support with inclusion of leaflet in induction training.
7	People with a learning disability should receive information about services and issues that affect their health and social wellbeing in a way that is meaningful to them and their family.	1	All HSC organisations should provide evidence that they are making information accessible to people with a learning disability.	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved
		2	Each person with a learning disability can access a named person who can signpost them to relevant services.	NA	NA	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved
8	People with a learning disability, or their carer, should be able to access self directed support in order to give them more control and choice over the type of care and support they receive.	1	Evidence of provision of accessible information on Direct Payments within HSC organisations.	NA	NA	achieved	achieved	Achieved	Achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved
		2	Percentage of requests for Direct Payments from people with a learning disability that were approved	NA	NA	60%	100%	60%	44%	60%	93%	60%	no data returned	60%	no of requests not provided so % could not be calculated	DSF return and provided in DSF report 2017-2018
		3	Number of adults with a learning disability in receipt of Direct Payments expressed as a percentage of those in contact with Trust (regional percentage is 2.25%).	NA	NA	20%	30%	20%	13%	20%	28%	20%	38%	20%	35%	**PMSI** gather this data (Colin Logue). This % calculation is the no of people with LD per trust in effect of Direct payment/ the total LD population per trust (as per DSF 17/18)
		5	The HSC Board and Trusts have plans in place to extend the range and scope of self directed support including how they will develop skills and expertise in relevant staff.	achieved	Achieved	achieved	achieved	Achieved	Achieved	achieved	achieved	achieved	achieved	achieved	achieved	SDS regional project group is taking this work forward/ future data source is SDS project lead (Geraldine Flemming)
14	Young people with a learning disability should have a transition plan in place before their 15th birthday and arrangements made for their transition to adulthood by their 18th birthday.	1	Percentage of young people who express satisfaction that their transition plan has been implemented within 2 years of leaving school.	NA	NA	85%	100%	85%	87%	85%	93%	85%	45%	85%	82%	
		2	Evidence of transfer to DES, where appropriate, for health checks for children on transition to adult services.	NA	NA	achieved	achieved	Achieved	Achieved	achieved	achieved	achieved	achieved	achieved	achieved	All practices run a search and include DOB so each year children having their 18th birthday are automatically included and invited for Health Check.
15	People with a learning disability should be supported to have meaningful relationships, which may include marriage and individual, unique, sexual expression within the law, balancing their rights with responsibilities.	1	Regional guidelines on sexuality and personal relationships are developed to ensure a consistent approach.	achieved	achieved	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Protocol also developed - adopted by each Trust.
		2	Trusts to facilitate appropriate training for staff.	NA	NA	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	**SAAT** - training delivered by FPA - 300 staff to be trained level 1 and 20 level 2.
		3	Trusts to facilitate appropriate training for service users and family carers.	NA	NA	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	PHA have regional contract with FPA who deliver the Just Ask project to carers and service users
		4	Increase in the number of people with a learning disability accessing sexual health and reproductive healthcare services.	NA	NA	5%	1%	5%	4%	5%	8%	5%	0%	5%	not data	**SAAT**
16	Adults with a learning disability should be able to access support in order that they can achieve and maintain employment opportunities in productive work.	2	Percentage of adults with a learning disability who receive HSC support to help them secure employment (as a measure of those who request support).	NA	NA	20%	15%	20%	22%	20%	10%	20%	4%	20%	6%	**SAAT**
17	All adults with a severe or profound learning disability should be able to access a range of meaningful day opportunities appropriate to their needs.	1	Percentage of adults with a severe or profound learning disability who have meaningful day opportunities in mainstream community settings, outside of their building based service.	NA	NA	50%	42%	50%	66%	50%	27%	50%	0%	50%	36%	**SAAT**

		2	Percentage of adults with a severe or profound learning disability receiving support in a building based service, who express satisfaction with the opportunity to experience day opportunities.	NA	NA	95%	99%	95%	94%	95%	97%	95%	98%	95%	96%	to be added by Trusts t**o annual review paper work**
18	All parents with a learning disability should be supported to carry out their parenting role effectively.	1	Develop and agree a regional protocol between children's and adult services for joint working and care pathways.	achieved	achieved	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Achieved
		2	Percentage of parents with a learning disability who have a multi-professional/agency competence based assessment.	NA	NA	80%	52%	80%	42%	80%	39%	80%	87%	80%	100%	**SAAT**
		3	Percentage of parents with a learning disability involved in child protection or judicial processes who have received locally based skills training.	NA	NA	no target agreed	22%	no target agreed	25%	no target agreed	39%	no target agreed	21%	no target agreed	76%	**SAAT**
		4	Percentage of parents with a learning disability involved in child protection or judicial processes who have access to the services of an independent advocate.	NA	NA	no target agreed	22%	no target agreed	12%	no target agreed	35%	no target agreed	21%	no target agreed	100%	**SAAT**
19	All people with a learning disability should have equal access to the full range of health services including services designed to promote positive health and wellbeing.	1	All acute hospitals should have an action plan for implementing the GAIN Guidelines for improving access to acute care for people with a learning disability and be able to demonstrate a clear commitment to the implementation of such a plan.	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	**Achieved - hospital passport also developed and currently being implemented.**
		2	Percentage of GPs who have a system for identifying people with a learning disability on their register.	NA	NA	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	**achieved**
		3	Each GP practice has a designated link professional within local learning disability services.	NA	NA	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	**achieved**
		4	Evidence of reasonable adjustments by health service providers.	NA	NA	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	**achieved**
21	All people with a learning disability should be supported to achieve optimum physical and mental health.	1	The PHA and each HSC Trust has a health improvement strategy for people with a learning disability (children and adults) to address all relevant physical and mental health promotion and improvement needs.	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	**achieved**
		2	Percentage of adults with a learning disability who have an annual health check.	NA	NA	80%	59%	80%	74%	80%	73%	80%	74%	80%	66%	**Integrated Care** - figures provided by integrated care percentage against total LD population for each trust (as per DSF report April 2017-March 2018 - figs available in June 2018)
		3	Percentage of adults with a learning disability, who have an up to date and active Health Action Plan (HAP) following the annual health check.	NA	NA	10%	35%	10%	0%	10%	6%	10%	0%	10%	1%	Regional HCFs group - template for HAP has been developed as well as a patient pathway and guidance notes to support development of HAP. This process and templates to be approved by Bamford Sub group end of sept, anticipate implementation of HAPs before end of the year
		4	percentage of people with a learning disability who have been in contact with community dental services (this includes those previously known to the service or who were previously treated by the service but discharged after their last treatment. a new contact equates to a new patient).	NA	NA	10%	7%	10%	16%	10%	11%	10%	34%	10%	28%	**PMSI** - New dental return - CDS- POC6(HSCB info) figs are new contacts - the first / initial appoint for a patient within an episode of care. This incls appoints for people not previously known to the service or who were previously treated by the service but discharged after their last treatment. a new contact equates to a new patient.
		5	Percentage of females with a learning disability who have been referred to cervical and breast screening services following their annual health check.	NA	NA	10%	9%	10%	6%	10%	8%	10%	4%	10%	3%	**Integrated Care** - Deborah Faulkner providing data collected on the annual data return form from GPs (i.e. no of referrals made as opposed to those that have actually accessed) . Male/ female split applied on total no of adults with LD known to services based on reginal population split for NI being 51%
		6	Percentage of people with a learning disability who have been referred for a sight test with an optometrist following their annual health check.	NA	NA	10%	5%	10%	5%	10%	2%	10%	6%	10%	3%	**Integrated Care** - Deborah Faulkner providing data collected on the annual data return form from GPs (i.e. no of referrals made as opposed to those that have actually assessed)
22	All people with a learning disability who experience mental ill health should be able to access appropriate support.	1	A regional protocol is developed to ensure that people with a learning disability can access mainstream mental health services.	under development through the Regional Mental Health Service Modelling		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	under consideration by the Regional Service Team, anticipating further direction from Bamford Evaluation.
		2	Percentage of people with a learning disability and mental health needs who access mainstream mental health services e.g. psychological and talking therapies where indicated in their treatment plan.	NA	NA	50%	2%	50%	12%	50%	7%	50%	4%	50%	6%	**SAAT -** this work is under development through Talking / psychological Therapy working groups in each of the trusts
		3	Percentage of Health Action Plans and health checks which include mental health assessment and mental health promotion.	NA	NA	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**Achieved** - figure relating to all health checks that ask mental health questions
26	All people with a learning disability whose behaviour challenges should be able to get support locally from specialist learning disability services and other mainstream services, as appropriate, based on assessed need	1	Percentage of individuals with significant challenging behaviours who have a Behaviour Support Plan including advance directives in place that detail actions to be undertaken in the event of their challenging behaviours escalating.	NA	NA	95%	no data	95%	80%	95%	63%	95%	34%	95%	80%	**SAAT**

		2	When challenging behaviours present a significant risk to the individual or others, or a risk of breakdown in accommodation arrangements, appropriate interventions by the community LD teams and treatment services will be put in place within 2 days along with an assessment or review process instigated.	NA	NA	all Trusts to achieve in year	achieved	all Trusts to achieve in year	achieved	all Trusts to achieve in year	Not achieved	all Trusts to achieve in year	achieved	all Trusts to achieve in year	achieved	**SAAT indicator was amended**
		3	When challenging behaviours present a significant risk to the individual, appropriate interventions to support and manage the presenting risks put in place within 2 days and followed up with appropriate assessments or review processes.	NA	NA	all Trusts to achieve in year	achieved	all Trusts to achieve in year	achieved	all Trusts to achieve in year	Not achieved	all Trusts to achieve in year	achieved	all Trusts to achieve in year	achieved	**SAAT indicator was amended**
		4	Evidence that HSC has engaged with other relevant delivery partners in developing and implementing consistent approaches in individual cases.	NA	NA	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved evidence provided in GAIN survey
		5	Percentage of people labelled as challenging who are not living in a congregate setting described as a challenging behaviour or specialist assessment/treatment service.	NA	NA	10%	yes	10%	yes	10%	yes	10%	yes	10%	yes	**SAAT**
27	All people with a learning disability who come into contact with the Criminal Justice System should be able to access appropriate support.	1	Evidence that the HSC has engaged and developed local protocols with relevant delivery partners to achieve consistent and co-ordinated approaches to working with people with a learning disability who have offended or are at risk of offending.	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	**achieved** evidence provided in GAIN survey
28	HSC professionals should work in partnership with a variety of agencies in order to ensure that the accommodation needs of people with a learning disability are addressed.	**1**	Evidence of 'Future Planning' (people's aspirations in relation to future accommodation needs, including independent living) has been discussed with service users, parents and carers (i.e. carer's assessments, annual review papers etc.)	NA	NA	all Trusts to achieve in year	achieved	all Trusts to achieve in year	achieved	all Trusts to achieve in year	achieved	all Trusts to achieve in year	achieved	all Trusts to achieve in year	achieved	**SAAT Indicator reworded**
		2	Percentage of adults who are living with a single carer or where there are 2 carers and the primary carer is aged over 65 who have a futures plan in place.	NA	NA	25%	100%	25%	39%	25%	39%	25%	97%	25%	37%	**SAAT**
		3	Percentage of people in receipt of public funding living in households of 5 people or less with a learning disability.	NA	NA	15%	15%	15%	14%	15%	18%	15%	15%	15%	10%	**SAAT**
		4	Percentage of people leaving learning disability hospital within one week after treatment has been completed.	NA	NA	100%	66%	100%	79%	100%	79%	100%	93%	100%	88%	**PMSI -** discharge data march 2015 (Heather)
30	All family carers should be offered the opportunity to have their needs assessed and reviewed annually.	1	Percentage of carers who express satisfaction at their annual review that their needs as identified in the carers' assessment have been met.	NA	NA	60%	83%	60%	82%	60%	78%	60%	76%	60%	57%	**case note review c**arried out by HSCB (commissioner led)
31	All people with a learning disability should have the impact of ageing taken into account in having their future needs assessed and proactively managed.	1	Percentage of people whose care plan has been reviewed taking account of issues associated with ageing.	NA	NA	50%	69%	50%	19%	50%	100%	50%	64%	50%	54%	**SAAT**
		2	Percentage of carers aged 65 years and over receiving domiciliary or short break support services.	NA	NA	no target agreed	100%	no target agreed	100%	no target agreed	100%	no target agreed	100%	no target agreed	100%	**PMSI** data set/ % provided based on the no of carers 65+ as per DSF and SAAT return 15-16 / as figures for short breaks not collated for carers over 65./ annual./ further discussions with the Trusts and PMSI
32	All people with a learning disability should have access to dementia services at whatever age it becomes appropriate for the individual.	1	Percentage of people with a learning disability and dementia who can access appropriate dementia services as required.	NA	NA	ongoing	ongoing	ongoing	ongoing	ongoing	ongoing	ongoing	ongoing	ongoing	ongoing	**the LD and Dementia sub group are currently developing pathway as well as established baseline**
		2	Percentage of people with a learning disability and dementia who have received additional supports following a dementia diagnosis.	NA	NA	ongoing	ongoing	ongoing	ongoing	ongoing	ongoing	ongoing	ongoing	ongoing	ongoing	**the LD and Dementia sub group are currently developing pathway as well as established baseline**
		3	Percentage of HSC professionals and other support providers who have received awareness training on the needs of people with a learning disability and dementia.	NA	NA	25%	11%	25%	no data returned	25%	84%	25%	no data returned	25%	50%	**SAAT**
34	All people with a learning disability being assessed for supportive and palliative care should have their learning disability taken into account in consultation with them, their carers and learning disability services when appropriate.	1	Palliative care services have mechanisms to identify whether people have a learning disability.	NA	NA	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	**achieved** evidence provided in GAIN survey
		2	Evidence of specific actions in service delivery that make reasonable adjustment for their learning disability.	NA	NA	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	achieved	**achieved** evidence provided in GAIN survey

MMcG-205

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HEALTH AND SOCIAL CARE BOARD

REGIONAL ADULT LEARNING DISABILITY SERVICE MODEL

PROJECT INITIATION DOCUMENT

January 2019

PROJECT NAME	Transformation Project – Adult Learning Disability Service Model and costed implementation plan
DOCUMENT ISSUE DATE	15.01.19
STATUS (Draft, Final)	FINAL
PROJECT SRO	JEROME DAWSON
DOCUMENT OWNER	LORNA CONN

Version history

Version	Key Changes	Date	Author
Draft 1			Lorna Conn
Draft 2	To include proposed timescales	26/10/18	Lorna Conn
Draft 3	As per workshop	9/11/18	Lorna Conn
Draft 4	Incorporating additional feedback	11/12/18	Sara Templer/ Lorna Conn
Draft 5	Incorporating Steering Group feedback	15/01/19	Sara Templer / Lorna Conn

Regional Adult Learning Disability Service Model Transformation Project - Project Initiation Document

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1 Purpose

1.1 The purpose of this Project Initiation Document (PID) is to define the Regional Adult Learning Disability Service Model project, to form the basis for its management, and assist with the assessment of its overall success.

1.2 The PID has two primary uses:

- To ensure that the project has a sound basis; and
- To act as a base document, against which TIG, DoH and HSCB/PHA can assess progress, risks, issues, change, and ongoing viability questions.

2 Introduction/Background

2.1 A number of recent strategic developments and directives have highlighted a need to review Adult Learning Disability service provision. These include:

- The outcomes of the *Bamford Review of Mental Health and Learning Disability*,[1] and the associated *Bamford Action Plan (2012-2015);*[2]
- The *Review of Adult Learning Disability Community Services (Phase II)* (October 2016);[3]
- The draft *Programme for Government (2016-2021);*[4]
- The 10 year approach to transforming health and social care*: Health and Wellbeing 2026: Delivering Together* (2016);[5]
- The *Mental Capacity Act (Northern Ireland) 2016*;[6] and
- Recommendations for the Reform of Adult Social Care, outlined in *Power to People: Proposals to reboot adult care & support in Northern Ireland* (2017).[7]

2.2 Within this broader context, this review is underpinned by the principles and processes outlined in the *Co-Production Guide for Northern Ireland - Connecting and Realising Value Through People* (2018).[8]

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[1] Available at: https://www.health-ni.gov.uk/publications/bamford-published-reports
[2] Available at: https://www.health-ni.gov.uk/publications/bamford-action-plan-2012-15
[3] Available at: https://rqia.org.uk/RQIA/files/4a/4a883fbc-92a7-4fda-97b0-ac2e664e5d8d.pdf
[4] Available at: https://www.executiveoffice-ni.gov.uk/topics/making-government-work/programme-government-and-budget
[5] Available at: https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together
[6] Available at: http://www.legislation.gov.uk/nia/2016/18/contents/enacted
[7] Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/power-to-people-full-report.PDF
[8] Available at: https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people

2.3 Any new model(s) developed and agreed on this basis will also need to take cognisance of emerging relevant reviews and strategic developments, including the independent review of Learning Disability acute level care, which is expected to report in May/June 2019.

3 Project Aims

3.1 The overarching Project Aim is to design a new outcomes based, regionally consistent model for Adult Learning Disability Services that:

- Reflects the needs and expectations of individuals and families;
- Reduces reliance on hospital services and develops person-centred, individualised, inclusive models of community care that promote equality of access; and
- Provides a strategic response to the significant challenges currently facing the Adult Learning Disability programme of care, including:
    - health and social wellbeing,
    - the complexity of need,
    - transitions from children's services,
    - the growing number of delayed discharges from hospital,
    - appropriate accommodation,
    - the provision of short breaks, and
    - support for older carers.

4 Project Objectives

The Project Objectives are to:

4.1 Develop and agree the core principles of the Regional Adult Learning Disability Service Model for Northern Ireland.

4.2 Create an infrastructure which supports service users, families, carers, and other key stakeholders to be involved in the design and development of the service model.

4.3 Ensure meaningful engagement with service users, families, carers, and other key stakeholders in the membership of project oversight and working groups, and participation in consultation events.

4.4 Contribute to the development of regional consistency in the thresholds, access routes, and range of services available to support adults with learning disabilities and their families.

4.5 Improve regionally consistent electronic data bases and collation of existing data which will begin to identify key health and social care needs of adults with learning disabilities and produce local and regional data to inform future commissioning and service planning.

4.6 Contribute to the development of a workforce development and training strategy to support the delivery of effective and efficient services.

4.7 Review current Trust expenditure on Learning Disability services to inform a costed implementation plan to support the successful transformation of Adult Learning Disability Services.

4.8 Produce locally costed implementation plans which can inform development of a regional implementation plan required to support transformation of services.

4.9 Lead consultation events with Trust stakeholders that contribute to the stakeholder consultation on the draft Service Model and implementation plan.

5 Project Terms of Reference

5.1 The Project will deliver:

- A new Model for Adult Learning Disability Services; and
- A costed implementation plan for this Model.

5.2 These outputs will provide the framework for a regionally consistent, whole systems approach to delivering high quality services and support to adults with learning disabilities. This approach will be underpinned by a person-centred focus to ensure individuals receive "*the right care (according to scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcome,*"[9] with consideration given to the interfaces and pathways between the Departments and services involved.

6 Project Benefits

6.1 The delivery of this transformation programme will stabilise and secure long term service provision of Adult Learning Disability Services for the population of Northern Ireland, within the projected funding envelope for the Learning Disability programme of care and the re-alignment of existing funding streams.

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[9] See: *Quality 2020: A 10-Year Strategy To Protect And Improve Quality in Health and Social Care In Northern Ireland,* available at: https://nipecportfolio.hscni.net/compro/attributes/quality2020.pdf

6.2 In providing a strategic response to the significant challenges currently facing the Adult Learning Disability programme of care, the new Service Model will aim to create a context that:

- Allows providers flexibility to design and deliver good services to meet the diverse and changing needs of their local populations; and
- Enables improved planning and increased resilience in the delivery of adult Learning Disability services at a regional level.

6.3 Adults with learning disabilities will experience an improved quality of life through increased choice and access to non-HSC activities and services such as education, employment, day opportunities, social, and sports/leisure activities.

6.4 Carers will experience a higher level of support, and family and community placements are sustained for longer periods, reducing demand for/reliance on care in institutional settings.

7 Project Constraints

Key constraints that apply to this Project include:

7.1 Workforce/recruitment resources within HSC organisations to take forward this project and implement the resulting model.

7.2 Securing buy-in from stakeholders including the ability to demonstrate meaningful engagement and how best to ensure a representative group(s) for all, through the principles and standards of Personal and Public Involvement (PPI), within the time available.

7.3 Ensuring delivery of an evidence-based high quality model for Adult Learning Disability Services that both addresses current pressures and is consistent with the overall vision set out in *Power to People* (2017), within the projected funding envelope for the Learning Disability programme of care, re-aligning existing funding streams as required.

7.4 Limited availability of local, comparable data relating to Learning Disability services.

7.5 Timescales for completion of the programmes of work.

7.6 Resources, both capital and revenue.

8 Assumptions

It is understood from the outset that the Project Implementation Team should ensure that the new Service Model:

8.1 Is outcomes based and aligned with the principles and recommendations of relevant overarching strategic documents and directives (see **Section 2**).

8.2 Is developed through comprehensive stakeholder engagement and involvement arrangements aligned with statutory PPI requirements and the ethos and principles of co-production. The Project communications and engagement strategy will support this approach.

8.3 Takes into account the evidence base for modern, timely, and accessible care, including National Institute for Health and Care Excellence (NICE) and Social Care Institute of Excellence (SCIE) guidelines, professional advice from practitioners and academics across the HSC sector, and the views of users and other stakeholders across the region.

8.4 Will reflect emerging research findings, recommendations, and policy developments, including for example the Independent Review of Acute Level Care in Learning Disability, which will be commissioned in parallel to this Project.

9 Proposed Approach

9.1 To ensure that the Aims and Objectives outlined above are achieved, the Project will be managed and controlled in broad compliance with appropriate project management methodologies. Priority will be placed on achieving progress on agreed and recommended outcomes, rather than process management. A detailed outline of this approach is included at Annex 1.

10 Project Implementation & Timescales

10.1 The Project will be implemented in four phases over the period November 2018 – March 2020. These phases and the draft schedule of delivery are outlined in **Table 1** below.

Table 1: Phased Project Implementation & Timescales

This table should be read in conjunction with the Project Gantt Chart, included at **Annex 3**.

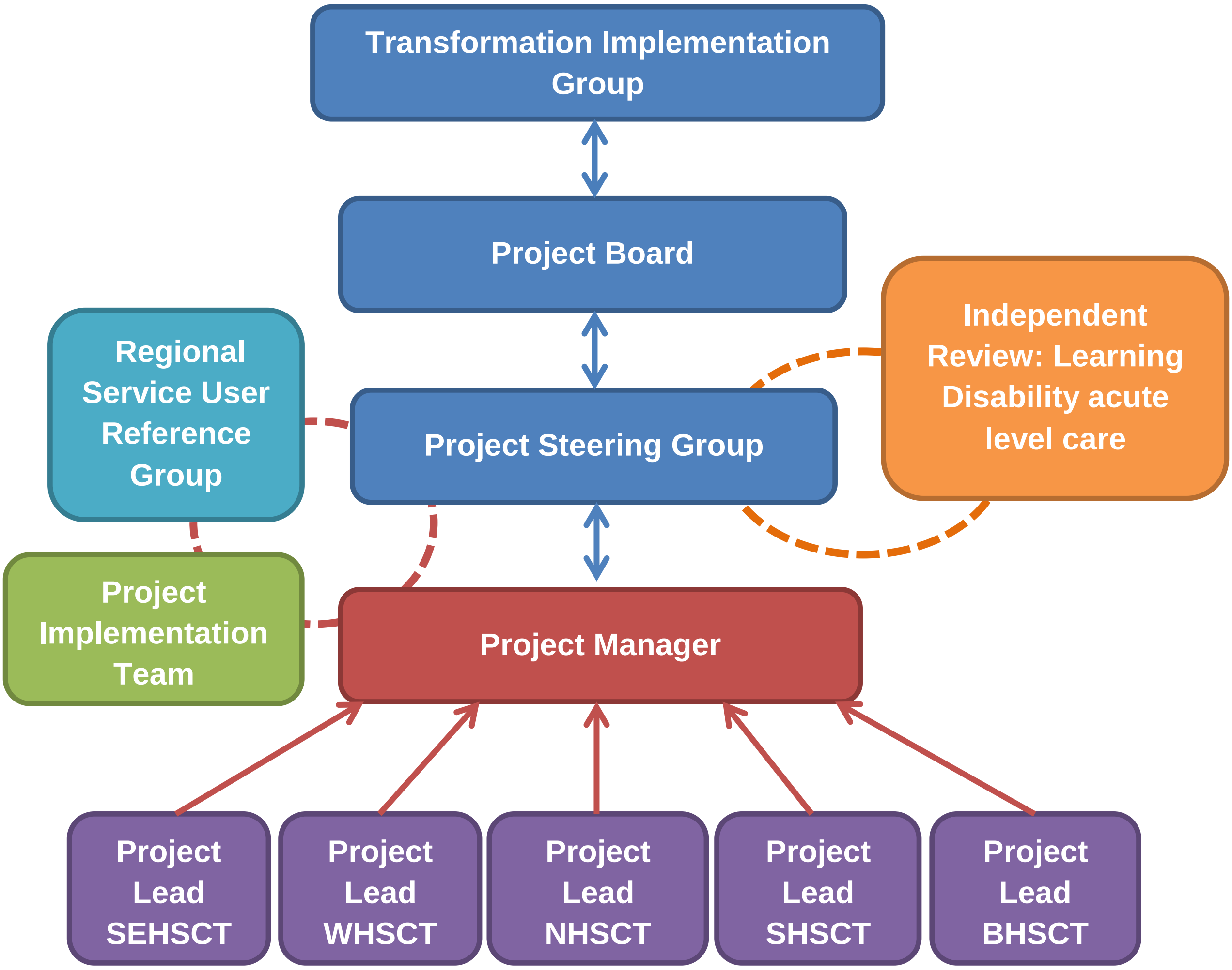
PHASE	DETAIL	PROPOSED TIMESCALES (subject to ongoing review)
1 **Establishment of the Project**	- Draft and agree the Project Initiation Document (PID), which will set out the objectives, governance arrangements and terms of reference of the project, and associated timescales, including for the appointment of the necessary staff.	- PID completed and signed off by Senior Responsible Officer (SRO) and Project Steering Group by 10 January 2019 - Staff appointed: January/February 2019
2 **Scope, Plan, Design** ***and*** **Pre-Consultation Stakeholder Engagement**	- Develop Communication & Engagement Strategy. - Conduct stakeholder engagement. - Review and define project work streams (Steering Group and HSCT Project Leads) (incorporating themes per Planning Workshop on 5 November 2017) - Establish Working Groups to take forward key priorities. - Establish Regional Service User Reference Group. - Develop a regional approach and 'script' for engagement, which draws on techniques from service design and system dynamics. - Develop the draft Regional Adult Learning Disability Service Model. - Develop the draft costed high level implementation plan. - Engage interested parties and stakeholders to seek views on the draft model and costed implementation plan. This phase will include use of available strategic data sources and local data sources to undertake a wider needs assessment which will consider:	- **Overall timescale: 1 December 2018 – 30 September 2019** *Key target dates within this period:* - *Review and define work steams: December 2018 – January 2019* - *Working Groups established: 31 January 2019* - *Regional Service User Reference Group established: 31 March 2019* - *Data collection, research completed: 31 May 2019* - *Development of draft Service Model and costed implementation plan underway: 1 May 2019* - *Draft Service Model and costed implementation plan v1 completed: 31 July 2019* - *Draft Service Model and costed implementation plan v2* ***for consultation*** *completed: 30 September 2019* - *Pre-Consultation communication and engagement completed: 30 September 2019*

PHASE	DETAIL	PROPOSED TIMESCALES (subject to ongoing review)
	- *background to service provision* - *key drivers for change* - *current service profile, including current spend on this Programme of Care* - *current user profile* - *staffing profile* - *geographical profiles* - *rural impact considerations* - *equality impact considerations* - *relevant interdependencies* - *emerging research and policy developments, including for example the independent review of Learning Disability acute level care (expected to report in May/June 2019)* - *Human Rights* It will also include, as appropriate, benchmarking activities aimed at identifying best practice in the delivery of Learning Disability services elsewhere throughout the UK, Ireland, and internationally.	
3 **Consultation**	- Conduct comprehensive engagement and consultation with the system and service users via regional workshops with a wider group of stakeholders to test proposals in draft Service Model.	- Communication and engagement - Ongoing 1 October 2019 – 31 December 2019
4 **Finalise Proposals**	- Refine the draft Regional Adult Learning Disability Service Model and costed implementation plan. - Submit these to the Project Board for consideration and sign off. - Submit approved version to Department of Health.	- Review and integrate consultation feedback: December 2019 – January 2020 - Draft version to Project Board: 23 January 2020 - Final version to Project Board: 26 March 2020 - Submit Final Report and costed implementation plan to Department of Health: by 31 March 2020

11 Project Structure & Governance Arrangements

11.1 Figure 1 below summarises the Project structure and governance arrangements. Further detail is provided at **Annex 2**.

Figure 1: Project Structure & Governance



11.2 Given the time constraints and range of stakeholders involved in this Project, participant organisations and staff are required to demonstrate commitment to the Project purpose, aims, and objectives from the outset. Flexible co-working, timely action, and consistent responsive engagement will be fundamental to the Project's success.

12 Cost/Financial Arrangements

12.2 Financial arrangements will be managed in line with normal governance procedures per HSC governance arrangements.

12.3 The main cost associated with the achievement of the overall objective of the Project will be staff salaries.

12.4 All expenses incurred will be managed by the HSCB/PHA Programme Manager, the Social Care Lead, and Project Manager on a day to day basis and approved by the Project Board.

13 End Project Notification

13.1 In line with the proposed timescales (see **Section 10** above), the Project Manager will submit a Final Report (or end of project report) by 31 March 2020. Once this has been considered by the Transformation Implementation group (TIG), the Project will be closed.

Annex 1: Project Management Approach

1. The Project scope will cover the work necessary to explore and define a draft Service Model to transform adult Learning Disability services in Northern Ireland.

2. A project management approach will be employed to manage the Project and ensure the completion of the Project on time, within available resources and to deliver on the agreed outcomes and objectives.

3. Progress on work plans will be monitored by the Project Manager and the HSCB/PHA Social Care Lead on at least a monthly basis or more frequently as required. This monitoring should ensure that risks are quickly identified and addressed or escalated as appropriate.

4. Following staff appointments, further refinement of work plans will be undertaken to ensure realistic timescales have been established. A Project Gantt chart has been included in **Annex 3**.

5. The Project Manager will report to the Project Board and Project Steering Group in accordance with timescales agreed. Progress reports will:

    - Provide brief verbal (and written) progress reports from the Project Manager on objectives, achievements, communication activity, forward objectives, and any critical issues.
    - Raise any new risks that could impact the Project and determine any actions to mitigate against the risk and/or an approach to mitigate the risk.
    - Consider matters requiring approval and/or issues referred under escalation procedures.

6. Exception reporting to Project Board will be carried out by the Project Manager as required.

7. Risks and Issues may be raised by anyone with an interest in the Project at any time.

8. The Project Manager will have responsibility for maintaining a Risk Register and managing the Risks and Issues Log.

9. Day to day administration for the Project will be managed by the Project Manager and Project Leads.

10. Stakeholders will be regularly informed regarding project progress, its achievements and the actions for the next phase of the Project. This engagement will be specified in the Communication & Engagement Strategy.

Availability of Resources

11. The main assumption at this stage is that staff will be appointed in a timely manner.

12. Capacity building may be required to ensure meaningful engagement with service users and carers.

External Dependencies

13. The Project is externally dependant on the following:

- The co-operation and understanding of Senior Management and Staff of the relevant HSC and stakeholder organisations; and
- Timely decision making.

Key Deliverables

14. The following **key products** will be delivered throughout the life of the project:

- Project Initiation Document;
- Overall project plan;
- Risk Register;
- Interim reports;
- Final Service Model, with costed implementation plan; and
- Post Project Evaluation.

Communication & Engagement Strategy

15. Regular progress reports will be provided to the Project Board and Project Steering Group via the Project Manager and by the Senior Responsible Officer (SRO) to the Transformation Implementation Group (TIG), and if required to the Minister and Health Committee.

16. A communication and engagement strategy will be developed to ensure all relevant stakeholders are kept informed as to the progress of the Project.

Key Stakeholders

17. The key stakeholders for the project include but are not limited to:

    - Minister (when appointed)
    - NI Assembly Health Committee (when appointed)
    - Local populations
    - Public Representatives
    - Service User Representative Groups/service users/carers/families
    - Trade Unions/Staff Representatives
    - Health and Social Care Trusts
    - Health and Social Care Board (HSCB)
    - Public Health Agency (PHA)
    - Regulation and Quality Improvement Authority (RQIA)
    - Other Government Departments and statutory agencies
    - The Community and Voluntary sector, including both advocacy and service providers

Project Controls/Governance Arrangements

18. The Project Governance Arrangements are reflected in Figure 1, Section 11 above. The key internal stakeholders in this governance framework include:

    - Transformation Implementation Group
    - Project Board
    - Service User Reference Group
    - Project Steering Group
    - Project Implementation Team
    - Project Manager
    - 5 HSC Trust Project Leads

    Further details are provided in **Annex 2**.

Project Initiation

19. The project will formally start on confirmation of allocation of Transformational funding.

Annex 2: Group Membership & Project Support

1. **Project Board:** The Service Model Project Board will provide governance and oversight of the project. It will be chaired by HSCB/PHA and will include representation from DOH, Directors with responsibility for Adult Learning Disability from each of the 5 HSC Trusts, HSCB/ PHA, Service Users, and carers. Meetings will be held on a bi-monthly basis in Ballymena, commencing in January 2019.

2. **Regional Service User Reference Group:** The Regional Service User Reference Group will provide lived experience, insight, and expertise, and will be designed to ensure meaningful engagement can occur with service users across each phase of the Project's implementation. This mechanism will allow concepts to be developed and tested. The frequency and location of meetings will be determined by the phase of work, and will be service user led.

3. **Project Steering Group:** The Service Model Project Steering Group will oversee the development of the regional model in accordance with the business case and the transformational bid. It will monitor that the overall vision, objectives and outcomes for the project are delivered within the specified timescales. It will also ensure any risks are identified and mitigated or resolved. It will authorise any deviations from the original project bid. It will be chaired by HSCB/PHA and will comprise representatives from DOH, Assistant Directors of Learning Disability from each of the 5 HSC Trusts, HSCB/PHA, Service Users, carers, and the Project Manager. Membership for the Project Steering Group will be kept under review and will evolve to draw on relevant multidisciplinary experience across HSC as required as the work proceeds. Meetings will be held monthly, at agreed locations.

4. **Project Implementation Team:** The Project Implementation Team will consist of the 5 Trust Project Leads and the Project Manager. The Team will lead on and undertake the detailed analysis and work as outlined within the PID to develop the new Service Model. It will meet as required, at minimum on a monthly basis.

5. **Project Manager:** The Project Manager will coordinate the work of the Project Leads within each of the Trusts and be responsible for ensuring the formulation of an overall regional Service Model and the associated costings that will be co-produced with the key stakeholders. The Project Manager will provide regular updates and reports to the Project Board and the Project Steering Group and monitor progress against the PID to ensure the Project adheres to the agreed timescales.

6. **Project Leads:** Each Project Lead will take specific responsibility within their host Trust for delivering on the Phases 2-4 of the Project. They will take the lead within their Trust for stakeholder engagement as well as in the development of a costed high level implementation plan. Each Project Lead will have responsibility to ensure all relevant stakeholders are involved at local level across the programme of care and multidisciplinary contexts.

7. **Project Administrative Support:** The Project Manager will be supported by secretarial and administrative support which will be located in the HSCB/PHA.

Annex 3: Project Gantt Chart

REF	PROJECT PHASE	DESCRIPTION	OWNER	2018			2019												2020								
				October	November	December	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March	April	May	June	July	August	September
1	1	Develop and sign off Project Initiation Document (PID)	Project Manager	🟩	🟩	🟩																					
2	1	Recruit Staff	Project Implementation Team			🟩	🟩	🟩																			
3	2	Develop Communication & Engagement Strategy	Project Manager		🟩	🟩																					
4	2, 3, 4	Stakeholder Communication & Engagement	Project Implementation Team			🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩						
5	2	Review and define project work streams	Project Steering Group and Implementation Team			🟩	🟩																				
6	2	Establish Working Groups to take forward key priorities	Project Steering Group				🟩																				
7	2	Establish Regional Service User Reference Group	Project Implementation Team / TILII				🟩	🟩	🟩																		
8	2	Data collection and research	Working Groups				🟩	🟩	🟩	🟩	🟩																
9	2	Develop Draft Regional Adult Learning Disability Service Model	Project Implementation Team								🟩	🟩	🟩														
10	2	Develop draft costed high level implementation plan	Project Implementation Team								🟩	🟩	🟩														
11	2	Refine Draft Service Model and costed implementation plan v2 for consultation	Project Implementation Team											🟩	🟩												
12	3	Conduct consultation with the system and service users via regional workshops to test proposals in Draft Service Model and costed implementation plan	Project Implementation Team													🟩	🟩	🟩									
13	4	Refine and finalise Draft Regional Adult Learning Disability Service Model	Project Implementation Team															🟩	🟩								
14	4	Refine and finalise draft costed high level implementation plan	Project Implementation Team															🟩	🟩								
15	4	Submit draft version to Project Board for consideration	Project Manager																🟩								
16	4	Submit final version to Project Board for sign off	Project Manager																	🟩	🟩						
17	4	Submit Final Report outlining recommended Regional Adult Learning Disability Service Model and costed implementation plan to Department of Health	Project Manager																		🟩						

Annex 4: Communication & Engagement Strategy

1. The successful development of the Regional Adult Learning Disability Service Model and costed implementation plan will only be achieved through the sharing of information and experience.

2. Each phase of this Project is therefore underpinned by a commitment to enable and facilitate communication and engagement among the stakeholders to this important work, in line with the ethos and principles of co-production.[10] This means that service users, carers, and staff will be empowered to design the system, work together to develop pathways of support and services, and be partners in the care they receive with increased self-management and choice.

3. The **key stakeholders** for the project include but are not limited to:

    - Minister (when appointed)
    - NI Assembly Health Committee (when appointed)
    - Local populations
    - Public Representatives
    - Service User Representative Groups/service users/carers/families
    - Trade Unions/Staff Representatives
    - Health and Social Care Trusts
    - Health and Social Care Board (HSCB)
    - Public Health Agency (PHA)
    - Regulation and Quality Improvement Authority (RQIA)
    - Other Government Departments and statutory agencies
    - The Community and Voluntary sector, including both advocacy and service providers
    - Local Engagement Partnerships (LEPs)

4. The Project Communication & Engagement Strategy aligns with the phased Implementation Plan, and includes provision to incorporate feedback at every stage as the Draft Service Model is developed. It will culminate in a robust consultation process that will aim to deliver a way forward that is accessible, acceptable to all stakeholders, and that will deliver effective and sustainable services across the region.

5. **Table 1** below shows the outline Implementation Plan aligned to the key Communications Objectives of each phase.

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[10] See: https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people

Table 1: Regional Adult Learning Disability Service Model: Phased Implementation Plan and Associated Communications Objectives

Implementation Phase	Associated Communications Objectives	
1 **Establishment of Project**	**1**	Develop a Project Initiation Document that is informed by the Project's stakeholders.
2 **Scope, Plan, Design *and* Pre-Consultation Stakeholder Engagement**	**2**	Create an infrastructure which supports service users, families, carers, and other key stakeholders to be involved in the design and development of the service model.
	3	Ensure meaningful engagement with service users, families, carers, and other key stakeholders in the membership of project oversight and working groups, and participation in consultation events.
3 **Consultation**	**4**	Lead stakeholder consultation on the draft Service Model and the costed implementation plan, including consultation events with HSC Trust stakeholders.
4 **Finalise Proposals**	**5**	Ensure stakeholders are provided with up to date information on the outcomes of the consultation process, and the progress and submission of the final proposals.

6. **Table 2** below shows the outline Implementation Plan along with the key Communications Activities relevant to each phase.

7. This Communication & Engagement Strategy will be kept under review over the implementation of the Project, and adjusted as necessary in line with learning, feedback, and progress.

Table 2: Regional Adult Learning Disability Service Model: Communications Activities

Objective		Targeted Actions & Implementation Protocol	Timeframe
1	Develop a Project Initiation Document (PID) that is informed by the Project's stakeholders.	- Facilitate stakeholder workshops. - Circulate draft PID for feedback.	Workshop dates: - 1 August 2018 - 9 November 2018
2	Create an infrastructure which supports service users, families, carers, and other key stakeholders to be involved in the design and development of the service model.	**Internal Communication** - Project Implementation Team will meet **monthly** over the whole implementation period. - Project Working Groups will meet **as required** by the relevant work stream over the period January 2019-31 May 2019 to ensure progress on the key priorities, data collection, and research. - Project Steering Group will meet **monthly** over the whole implementation period. - Project Board will meet on a **bi-monthly** basis. **Service User, Carer and Community & Voluntary Sector Engagement** - Regional Service User Reference Group will meet **regularly** in line with the phase of work, and will be service user led **External Communication and Engagement** - Establish stakeholder contact database (email communication). - Circulate 5 quarterly email updates to stakeholder contacts with headline information about Project structure, progress towards consultation, and providing ample information about consultation and events to maximise engagement.	- Ongoing: January 2019 – 31 March 2020 - Regional Service User Reference Group Established: 31 March 2019 - Contact database established: January 2019, kept under review - Webpage established: February 2019 - Quarterly stakeholder email update: commencing March 2019 (coinciding with establishment of Regional Service User Reference Group), concluding March 2020 (with submission of final proposals) - Inclusion in DoH updates on all transformation projects
3	Ensure meaningful engagement with service users, families, carers, and other key stakeholders in the membership of project oversight and working groups, and participation in consultation events.		

Objective		Targeted Actions & Implementation Protocol	Timeframe
4	Lead stakeholder consultation on the draft Service Model and the costed implementation plan, including consultation events with HSC Trust stakeholders.	- **Deliver regional consultation events with HSCT stakeholders.** - **Deliver wider stakeholder consultation events** designed to engage wider stakeholders (per contact database).	- September – October 2019 - October 2019 – January 2020
5	Ensure stakeholders are provided with up to date information on the outcomes of the consultation process, and the progress and submission of the final proposals.	- Maintain **Service User, Carer and Community & Voluntary Sector Engagement** and **External Communication and Engagement** as described above.	- January – 31 March 2020

Independent Review
of the
Learning Disability Resettlement Programme
In
Northern Ireland

Bria Mongan & Ian Sutherland

July 2022

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Acknowledgements

The review team completed significant engagement and received considerable documentary evidence from a wide range of stakeholders and wish to acknowledge and thank those who so kindly shared their expertise.

The review team would like to thank all those who gave so generously of their time to meet with them and contribute to the review most especially the individuals and family carers who have lived experience of resettlement. The richness of their advice and experience has informed our findings and recommendations.

Learning disability care providers from across the voluntary and independent sectors shared their knowledge as system experts with the review team.

The review team benefited from a site visit to MAH and valued the opportunity to meet with patients and ward staff

The directors in each of the HSC Trusts and their senior management teams actively engaged and supported the work of the review team providing documentary evidence and assisted in the identification of the barriers and challenges that need to be addressed to expedite resettlement.

Staff from DoH, SPPG /HSCB also provided considerable documentary evidence, advice and support.

The HSCB/SPPG provided technical and secretarial support and the review team would particularly wish to thank Patricia Elliott for her technical expertise in the production of the report and Caroline McGonigle for her support throughout the fact finding process of the review.

1. Executive Summary

1.1 In October 2021 the Health and Social Care Board (HSCB) commissioned two experienced senior leaders in health and social care to undertake an independent review of the learning disability resettlement programme in Northern Ireland, with a particular focus on the resettlement from Muckamore Abbey Hospital (MAH), which is a specialist learning disability hospital managed by the Belfast Health and Social Care Trust (BHSCT) but located outside Antrim.

1.2 The purpose of the review built on a stated intention from Department of Health and HSCB to strengthen the existing oversight arrangements for the resettlement of patients from MAH and other learning disability hospitals whose discharge plans have been delayed. The review team were required to work with stakeholders to identify both good practice and overarching vision, as well as barriers, and to develop an action plan to ensure that the needs of the patients are being considered and are met. The review was to include consideration of the effectiveness of planning and delivery for the proposed supported living and alternative accommodation schemes which were in development to support the resettlement plans for these individuals.

1.3 There is a strong legislative base and policy framework, although the policy and strategy relating to services for people with learning disabilities/ASD and their families is in urgent need of updating, and this is currently being reviewed. An overarching vision for learning disability services in the 2020's would allow stakeholders to agree a Learning Disability Service Model, which would guide commissioners and providers towards the development of better integrated, community orientated services which will deliver stronger outcomes for people with learning disability and their families. This policy will need to consolidate the outstanding ambition that no-one will live in a specialist learning disability hospital and that hospital will focus on its primary function of offering assessment and treatment only for those people for whom this cannot be made available within a community setting.

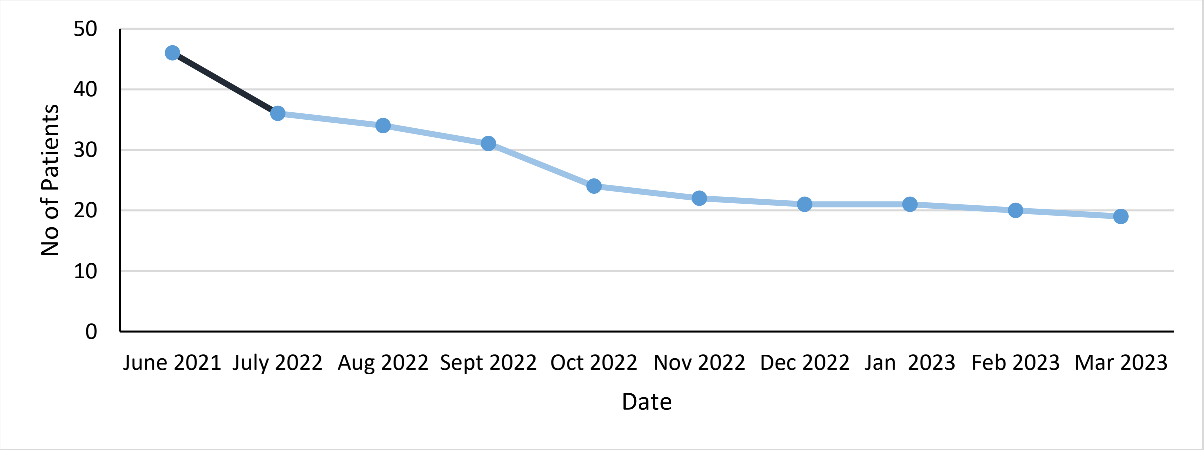
1.4 Leadership and governance with regard to the resettlement programme in Northern Ireland has been less than adequate. Progress and momentum to deliver homes outside of hospital for the remaining cohort has been slow. There were a number of confounding factors that impacted directly on progress. The global pandemic had a massive impact on the capacity and capability of leadership teams to maintain momentum on 'business as usual' priorities, as a determined focus to tackle ovid was required. Similarly during the same period the impact of MAH being identified at a national level as a hospital where patients had not been well safeguarded meant that the operational day to day logistics of maintaining safe practice in relation to sufficient and stable staffing was a significant challenge in itself. Additionally, there has been an extended period of significant organisational change as the regional commissioning functions previously undertaken by the Regional HSCB were ‘transitioned’ back within the DoH under the Strategic Planning and Performance Group, with the new arrangements coming in to effect from the 1.4.22. in order to strengthen the focus on system wide performance management. Whilst these and other factors impacted directly on the progress of resettlement and offers something in way of mitigation for the poor progress of resettlement plans, it does not satisfactorily explain why some Trusts made negligible progress, but for others consistent stepped change was achieved.

1.5 The BHSCT which managed MAH, had a significant challenge to balance the dual responsibility of rapidly improving quality and safety within the hospital, whilst maintaining progress on resettlement for those patients. This balance was not achieved, and the focus shifted away from resettlement to crisis management of MAH. The Trust Board were reassured by the executives that there were plans in place to support the resettlement of these individuals, whereas better scrutiny of the assurances provided would have shown this not to be the case, and that the plans were not robust. Arrangements in BHSCT were further hampered by significant changes in the leadership team for LD services. Other Trusts responsible for resettlement of patients from MAH had made more progress in the development of new services, although the delivery had been slower than hoped with delays relating to building over-runs and recruitment difficulties. The HSCB had made efforts to support regional co-ordination of the resettlement programme, but these were not effective in delivery of a well-co-ordinated programme plan. In particular the HSCB was not good enough in terms of performance management of the resettlement programme which amounted to little more than performance monitoring. We saw some strong leadership by individuals both in the statutory and non-statutory sectors, and whilst the rhetoric was of a robust commitment to collaboration there was little evidence of strong partnership working. In terms of leadership around the delivery of schemes in most cases management grip was weak and this contributed significantly to drift and delay. The voices of people who required resettlement and their families were not well heard within this process and they did not feel that they were empowered or engaged in the process at all levels. Opportunities to learn from their expertise by experience were missed.

1.6 Strategic commissioning and inter-agency working were supported by a clear and explicit strategic priority being identified around resettlement and workforce development in the 2019/20 commissioning plan. The Northern HSC Trust and South Eastern HSC Trust had response plans that were proactive and generally well progressed, but the BHSCT plans failed to progress beyond the preliminary stages. The lack of either effective programme or project management meant there was no over-arching, costed plan. Trusts were planning in relative isolation and communication of joint arrangements was inadequate. Generally there was a tendency by Trusts to initiate new developments without fully exploring whether there was some existing provision within the market that could meet some of the identified need, even if this required some re-design or re-purposing of provision. The new build options, whilst being bespoke, were generally costly in terms of capital and revenue, and resulted in long lead in time to delivery. There was limited evidence of senior engagement with the independent social care sector as strategic partners as well as providers, and therefore market shaping was not evident.

1.7 The review team looked at the approach being taken to individualised care planning. There was a lack of consistency in the documentation used to support care planning for transition from hospital to community, and nor was there an agreed regional pathway for resettlement, which should map out roles and responsibilities within the process. Families and providers both commented that they felt only involved in a limited way in developing assessments and care plans. Of the remaining patients awaiting discharge almost a quarter had been in MAH for more than 20 years and one person for more than 40 years. About a third of this group had also had one or two previous trials in community placements, although there was little evidence of how lessons were learnt from these unsuccessful moves. However, in the 12 months from June 2021 to June 2022 the population in MAH awaiting resettlement had reduced by 20%, and the trajectory of future resettlements by NHSCT and SEHSCT should mean that between September 2022 and March 2023 the population will reduce by a further approximately 50%, leaving around 19 people in MAH awaiting resettlement.

1.8 Whilst progress at the beginning of the review had been slow HSC Trusts have recently reviewed their approach to consider alternative options that have potential for more timely discharge. The review team were pleased to see that this has improved the resettlement trajectory which anticipates that the population will reduce to between 15 and 19 by the end of March, 2023.



1.9 A key element of the review was the operational delivery of provision to meet the needs of this cohort and the wider LD population. There is an impressive range of provision across registered care and supported living settings providing approximately 2,500 places for people with LD in the community. There was a tendency of commissioners and resettlement teams to not engage with providers to consider potential existing opportunities, although this has changed in recent months. The overall trend within supported living schemes is to smaller size provision, with the largest number of schemes offering 3 places. The biggest single issue and risk facing the range and quality of the provision was workforce, and the DoH are now sponsoring work regionally to try to address this challenge which will report in 2023. The quality of care within the independent sector is regulated and inspected by RQIA, and the overall quality is good. There is some very innovative practice emerging within the independent sector, with a strong commitment to the use of Positive Behaviour Support (PBS) models, with some examples of transformational care being provided to individuals in their own new homes. Where provision was strongest there was a strong partnership between providers and local HSC Trust commissioning/care management and clinical services, so that individuals had access to a wide range of highly responsive services.

1.10 The Trust's commissioning of schemes of registered care provision to meet their respective resettlement cohorts was variable. The NHSCT and SEHSCT demonstrated a more proactive and consistent approach to planning of this provision, and consequently have reached a stage where 2 substantial new care settings, along with some smaller scale provision will over the next 6 months provide new homes to approx. 80% of their remaining MAH residents. The BHSCT have over the last 3 years been scoping 3 potential new schemes, but these have never got beyond the most preliminary stages of planning. The review team are more encouraged that the new leadership group responsible for LD within that Trust are now considering other options, including some existing provision which could have the potential to be rapidly re-purposed. In general, and at variance with statements that the Trusts have a learning culture, there has been little rigorous evaluation of the successes and failures within the resettlement programme. The review team heard a rich tapestry of stories from families about their lived experience, and this should form the basis of some qualitative work, but in addition there should be some review of the clinical and social benefits derived by people who have gone through resettlement.

1.11 For families, safeguarding continues to be an abiding concern, which is overshadowed by a loss of trust and confidence in MAH and health and social care systems more generally. The oversight of adult safeguarding will be strengthened when the new adult safeguarding arrangements come in to place, and it is encouraging that an Interim Adult Protection Board (IAPB) was established in 2021. There continue to be issues of concern in relation to the use of physical intervention, and surveillance by CCTV, and for the families the review team met, how these are addressed in community settings is central to the success of placements. There is a need for further consultation with individuals, families and providers to inform regional policies on these important areas moving forward. Family members were clear with the review team that after community placement they would continue to play a key role in assuring and ensuring the safety of their relative, and therefore wanted to see open and flexible access to care environments. Care providers were clear about safeguarding responsibilities but expressed a concern that they experienced considerable variation in the application of thresholds in relation to investigation of safeguarding concerns, and families expressed concern that in some situations investigations were not progressed in a timely fashion.

1.12 Families were an incredibly rich source of evidence to the review team, and their lived experience tells a tale of both success and failure. The full report includes aspects of these accounts. The review team strongly believe that individual families need to be at the centre of these processes and fully engaged within all aspects of the resettlement, but they also need to be able to influence policy and strategy so that their expertise by experience can inform best practice. The review team were struck by the extent to which trauma and distress featured within the experience that was shared, and that all of the professionals working with these individuals and families need a good understanding of trauma informed practice. Trusts were all considering and developing their advocacy and other supports for individuals and families, and they need to further consider how they can put in place opportunities to ensure better communication and engagement and opportunities to organise carer support events such as group gatherings.

2. Terms of Reference

2.1 Terms of Reference: The terms of reference for the review were agreed with the HSCB and DoH, after consultation with senior leaders in learning disability services from the 5 HSC Trusts.

2.2 Purpose of Review: The purpose of the review built on a stated intention from DoH and HSCB to strengthen the existing oversight arrangements for the resettlement of patients from MAH (MAH) and other learning disability hospitals whose discharge plans have been delayed. The review team were required to work with stakeholders to identify both good practice and barriers and develop an action plan to ensure that the needs of the patients are being considered and are met. The review was to include consideration of the effectiveness of planning and delivery for the proposed supported living and alternative accommodation schemes which were in development to support the resettlement plans for these individuals.

2.3 The review team were to work collaboratively with stakeholders, with the commitment of the Chief Executives and the Directors, engaging appropriately with relevant staff, agencies, families and service users.

2.4 Timescale: The timetable for the work was to take place over a 6 month period which began in effect in November 2021.

2.5 The Review Team were required to give particular consideration of the current care plans for all the service users in MAH and critically analyse the actions taken to identify and commission suitable community placements. In addition they were asked to look specifically at the following areas:-

- Length of time patient has been in MAH and where they were admitted from
- Ascertain if resettlement has already been trialled
- Summarise the policy and practice evidence base in relation to resettlement programmes.
- Identify those individuals where plans are absent or weak in relation to their resettlement
- Work with leaders in the appropriate Trusts to ensure that suitable resettlement plans are developed.
- Critically evaluate the progress of resettlement plans as devised by the responsible Trust for the identified individuals.
- Business cases which have been completed or are still in process identifying any positive outcomes and any strategic or operational barriers. Make recommendations for actions that would strengthen or accelerate the delivery of proposed pipeline schemes.

- Review to what extent the engagement strategies employed individually by Trusts, and collectively by the system as a whole have been effective in supporting the delivery of the MAH resettlement programme.

2.6 Inter-Agency Working : The review team were asked to consider whether/how the agencies and professionals involved in resettlement of patients, have worked effectively with each other at each and every stage of the process.

2.7 Parental/Carer Engagement/Advocacy: The review team were also asked to consider as a critical factor whether and to what extent the families of the patients were engaged in decision making around resettlement. In this context the review team were also asked to explore whether and to what extent, independent advocacy and support was provided.

2.8 Outside of Scope: Whilst there are Issues relating to children and young people with learning disability/Autism who may be subject to delayed discharge in other settings, this population were not included within the terms of reference for this review.

3. Methodology

3.1 The HSCB in appointing the review team intended to ensure that an objective, critical appraisal was undertaken of the existing programme of resettlement for individuals with learning disability/autistic spectrum disorder with a primary focus on the remaining population of people who were awaiting discharge from MAH to new homes.

3.2 The review team decided to adopt an approach for the review based on 'appreciative inquiry' (1) this is a strengths-based positive approach to leadership development and organisational change. This approach seeks to engage stakeholders in self-determined change, and incorporates the principle of co-production.

3.3 By adopting this approach the review team were both 'observers' of the system and how it was delivering the required outcomes for people identified for resettlement, but also as 'agents' by helping to seek solutions that would assist key stakeholders to improve the resettlement programme in Northern Ireland.

3.4 The review team adopted the following methods to progress the key lines of inquiry:

- Direct observation and participation in key processes
- Direct interviews with a wide range of stakeholders
- Gathering and analysing data relevant to the resettlement process
- Focus groups – both face and face and digital engagement.

3.5 The initial engagement with the statutory health and social care agencies was through the leadership meetings established by the HSCB to develop and oversee the delivery of effective services for people with a learning disability/ASD. This included the Learning Disability Leadership Group comprising the senior social care leaders from the HSCB, the 5 Trust Directors of Mental Health and Learning Disability Services, along with representation from the DoH and RQIA. Additionally the review team participated in a range of operational and strategic meetings with programme leads for learning disability services within the HSCB and HSC Trusts. Some of these processes were inter-agency and included NIHE representation.

3.6 The review team sought data and documentary evidence from a wide range of organisations including the DoH, HSCB, the 5 HSC Trusts, NIHE, RQIA and other agencies. Information was sought through direct requests and through questionnaire response.

3.7 The review team held an extensive range of engagement sessions with a range of external stakeholders. This included the following:

- Northern Ireland Housing Executive - NIHE
- Regulation and Quality Improvement Authority – RQIA
- Northern Ireland Social Care Council – NISCC
- Patient and Client Council – PCC
- Royal College of Psychiatrists – NI/Learning Disability Division - RCPsych
- ARC Northern Ireland
- Independent Health Care Providers [NI) – IHCP

3.8 The review team felt it was of primary importance that the lived experience of individuals with learning disability/ASD and their carers/families who had been engaged in resettlement had to be well represented within the review. They met with individuals and groups of carers who had either been through or were still going through the resettlement process. This provided some of the richest detail of how the system was working, or not working, for people who wanted to have the opportunity to live in a setting outside of hospital with as much independence as possible.

4. Legislative, Strategic and Policy Context.

In this section we will critically evaluate the legislation and strategic policy across England, Scotland, Wales and the Republic of Ireland to identify models of good practice in reducing delayed discharge patients and preventing hospital admission.

4.1 MAH opened as a regional learning disability hospital in 1949 and by 1984 the in-patient population had grown to 1,428.

4.2 The scale of resettlement between 2007 and 2020 was significant, with reduction in the population at MAH to 46 patients by June 2021. During the period of this review, the Muckamore Abbey population has reduced further to 36 in-patients by July 2022. It is encouraging that further discharges have been achieved however, 10 of the delayed discharge population are from the original Priority Target List (PTL), which relates to patients living in a long stay learning disability hospital for more than a year at 1st of April, 2007, and have been discharge delayed between 16 and 45 years. The impact of institutionalisation for a small number of long-stay patients has been a barrier in transitioning to the community. The complexity of need and range of co-morbidities of recent admissions many of whom have been impacted by previous community placement breakdown, has made discharge particularly challenging. However, the review team visited community resettlement schemes successfully supporting individuals with very complex needs equivalent to the needs of those people delayed in discharge. These examples of good practice highlight that the models of care and support required to build sustainable community placements for individuals with complex needs are already operational in Northern Ireland and the success factors need to be scaled up and embedded in commissioning and procurement processes.

4.3 The pace of progress in relation to finding new homes in recent years has been disappointing, with an increasing number of judicial reviews progressed by patients or their family carers in regards to the failure of HSC Trusts to commission an appropriate community placement for people delayed in hospital. Legal judgements have highlighted that delayed discharge breaches are incompatible with obligations pursuant to section 6 of the Human Rights Act 1998. (Ctrl Click) and Article 8 of the European Convention on Human Rights (Ctrl Click)There is therefore an ethical, strategic and legal imperative to complete resettlement.

4.4 The policy direction in Northern Ireland and Great Britain changed in the 1980's and from that time there have been a series of targets set to reduce the number of in-patients in Learning Disability hospitals and develop resettlement options.

However, targets and deadlines for achieving this have been missed, ignored and repeatedly reset.

4.5 The 1992/97 Department of Health and Social Services (DHSS) Regional Strategy,' Health and Wellbeing into the New Millennium'[1] established a commitment to reduce the number of people admitted to traditional specialist hospitals and a commitment that care should be provided in the community and not in specialist hospital environments. In 1995, a decision was taken by the Department of Health and Social Services to resettle all long-stay patients from the 3 learning disability hospitals in Northern Ireland. The target set by the Regional Strategy for the resettlement of all long-stay patients from learning disability hospitals by 2002 was not met.

4.6 The 2002 Bamford Review of Mental Health and Learning Disabilities represents the key strategic driver shaping delivery of services for individuals with learning disabilities and or Autistic Spectrum Disorder (ASD) over the past 25 years.

4.7 The second report from the Bamford review 'Equal Lives' published in 2005 sets out a compelling vision for developing services and support for adults and children with a learning disability. Equal Lives concluded that progress needs to be accelerated on establishing a new service model, which draws a line under outdated notions of grouping people with a learning disability together and their segregation in services where they are required to lead separate lives from their neighbours. The model of the future needs to be based on integration, where people participate fully in the lives of their communities and are supported to individually access the full range of opportunities that are open to everyone else. This will involve developing responses that are person centred and individually tailored; ensuring that people have greater choice and more control over their life; that services become more focused on the achievement of personal outcomes, i.e., the outcomes that the individuals themselves think are important; increased flexibility in how resources are used; balancing reasonable risk taking and individuals having greater control over their lives with an agency's accountability for health and safety concerns and protection from abuse.

4.8 The Bamford review 'Equal Lives' published in 2005 (ctrl click) included a target that all people with a learning disability living in a hospital should be resettled in the community by June 2011. A priority target list (PTL) of those patients living in a long stay learning disability hospital for more than a year at 1st April 2007 was established to enable monitoring of progress on the commitment to resettlement of long-stay patients. In 2005, the Hospital had 318 patients and a target was set to reduce to 87 patients by 2011.

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[1] *Health and personal social services: a regional strategy for Northern Ireland 1992-1997.*

4.9 'Transforming Your Care' was published by the Minister for Health in 2011(ctrl click) which further strengthened the commitment to close long stay institutions and complete resettlement by 2015. A draft Strategic Implementation Plan was developed to drive forward the recommendations in terms of learning disabilities with a focus on resettlement, delayed discharge, access to respite for carers, individualised budgets, day opportunities , advocacy and Directly Enhanced Services (DES) Whilst this resulted in the development of additional community services the resettlement target was again missed.

4.10 DHSSPS Service Frameworks aimed to set out clear standards of health and social care that service users and their carers can expect. They are evidence based, measurable and are to be used by health and social care organisations to drive performance improvement, through the commissioning process. The Service Framework for Learning Disability was initially launched in 2013 and revised in January 2015 (ctrl click). It sets out 34 standards in relation to the following key thematic areas; safeguarding and communication; involvement in the planning and delivery of services; children and young people; entering adulthood; inclusion in community life; meeting physical and mental health needs; meeting complex physical and mental health needs; a home in the community; ageing well and palliative and end of life care. The standards provide guidance to the sector on how to: improve the health and wellbeing of people with a learning disability, their carers and families, promote social inclusion, reduce inequalities in health and social wellbeing and improve the quality of health and social care services, by supporting those most vulnerable in our society.

4.11 RQIA Review of Adult Learning Disability Community Services Phase II October 2016 (ctrl click) reviewed progress made by the 5 Health and Social Care (HSC) Trusts, in the implementation of 34 standards, relating to Adults with a Learning Disability in the Department of Health (DoH) Service Framework. The review found that none of the 5 community learning disability teams in HSC Trusts demonstrated an evidence base for the model of service configuration they have put in place. The RQIA review concluded that community services have developed more as a result of historic custom and practice in each Trust area, with little sharing of practice noted regionally regarding models of care used by each team. It was difficult for the review team, therefore, to effectively compare and contrast the models of service provision across Northern Ireland. The RQIA review found that there is no agreed uniform model for behavioural support services across the 5 Trusts.

4.12 This review team noted that these findings still apply. Community services are at different stages of development in each of the 5 HSC Trusts and the terminology used to describe similar services varied across HSC Trusts which makes it difficult to compare and contrast services. It is still of concern that there is no agreed model for behavioural support services. Each Trust and care provider organisation have adopted differing accredited programmes with training programmes available only on licence which limits the portability of staff working flexibly across HSC Trusts and the independent sectors. It is of note that consideration was given by a HSC Trust to deploy Trust staff to supplement the care provider workforce to expedite a resettlement however, the barrier to this innovation was that the staff in the Trust and staff in the provider organisation had been trained in different therapeutic interventions and could not work in the same team unless re-trained. It is critical that standardisation of positive behaviour approaches and therapeutic intervention methodologies is considered to maximise collaboration and enable mutual aid at times of crisis.

4.13 'Systems, Not Structures – Changing Health and Social Care' (The Bengoa Report) (DoH, 2016) (ctrl click) Guided by 'The Triple Aim': to improve the patient experience of care (including quality and satisfaction); improve the health of populations and achieve better value by reducing the per capita cost of health care. The report provides a succinct transformation model relevant and useful in the development of the learning disability service model and driving the system towards Accountable Care Systems with the provider sector taking collective responsibility for all health and social care for a given population.

4.14 Health and Wellbeing 2026 – Delivering Together (DoH, 2017) (ctrl click) is the policy response to the Bengoa Report and aligns to Draft Programme for Government with increasing focus on outcomes.

4.15 The emergence in 2017 of allegations of abuse at MAH, resulted in an independent Serious Adverse Incident (SAI) review of safeguarding practices between 2012 and 2017 at MAH. The SAI report exposed not only significant failings in the care provided to people with a learning disability while in hospital and their families, but also gaps in the wider system of support for people with learning disabilities.

4.16 The final 'Way to Go' report (ctrl click) was shared with key stakeholders in December 2018 and a summary of the report was published in February 2019. This resulted in a further public commitment to the families of MAH patients by the DoH Permanent Secretary in 2018 that patients delayed in discharge would be resettled by December 2019. This commitment has not been met.

4.17 The DoH established a Muckamore Departmental Assurance Group (MDAG) to provide assurance in respect of the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH and the Permanent Secretary's subsequent commitment on resettlement made in December 2018. The DoH recognised the need for the HSC system to work together in a co-ordinated way to deliver a coordinated programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment into accommodation more appropriate for their needs. Some of the MDAG actions have not yet been achieved.

4.18 The 'Review of Leadership and Governance at MAH' (ctrl click) was established to build upon the SAI review and the report published in July 2020 highlighted system-wide issues and a failure in the care provided to some of the most vulnerable members of our society. The findings highlighted the need to provide a clear and coordinated regional learning disability pathway similar to that in place for mental health services. HSC Trusts were remitted to carry out a full re-assessment of the needs of their patients in MAH and prepare discharge plans for all those delayed in discharge. The review found that HSC Trusts had not yet completed a full reassessment of all patients and that discharge plans had not been prepared for all patients.

4.19 Many of the findings and recommendations from both the 'Way to Go' report and the 'Review of Leadership and Governance at MAH' (ctrl click) remain relevant and outstanding and will be reiterated in this review. The' Way to Go' report made 2 overarching recommendations; a renewed commitment to enabling people with learning disabilities to have full lives in their families and communities and the development of a Learning Disability strategic framework focused on contraction and closure of the long-stay hospital and a vision for a full lifecycle pathway across children's and adult services. The Leadership and Governance review findings highlight that Discharge of Statutory Function (DSF) reports provided annually by the Trust to the HSC Board, were largely repetitive and did not provide the necessary assurance with insufficient challenge from Trust Board and the HSC Board. This review found that this remains an area of concern and that limited progress has been made in regard to the strengthening of governance to ensure a greater challenge in regard to reporting and accountability arrangements.

4.20 The review team reviewed the strategic policy for Learning Disability services across England, Scotland, Wales and the Republic of Ireland to identify best practice and the learning from actions taken by other regions in regard to learning disability resettlement and avoidance of hospital admission. The review team identified common themes in the strategic direction for Learning Disability services across England and Scotland with focus on hospital avoidance through development of intensive care and support in the community. The following sections provide a high level summary of the key policy and practice evidence which should inform the strategic direction for learning disability services and the resettlement programme in Northern Ireland.

4.21 Despite the evidence base on concern about safety and quality in institutional settings, there has been a lack of progress in the closure of long-stay beds. This issue has been addressed across all jurisdictions over many years and it is important to learn from these experiences and actions. Our review found a striking alignment across all nations in regards to strategic direction with a focus on a Human Rights and person-centred approach. The 2007 Bamford Review of Mental Health and Learning Disabilities has been the key strategic driver shaping the delivery of services for individuals with learning disabilities and/or autism in Northern Ireland. The principles and values underpinning the Bamford review, remain relevant to current policy direction and are in keeping with the strategic direction of other UK nations. Feedback to the review team from a range of stakeholders however, highlighted the effectiveness of the Mental Health strategy in building upon Bamford and the need for refreshed strategic policy for learning disability services.

4.22 The Bamford Review of Mental Health & Learning Disability in 2002 (ctrl click) recommended a comprehensive legislative framework for new mental capacity legislation and reformed mental health legislation for Northern Ireland. The Mental Capacity Act (Northern Ireland) 2016 (ctrl click) has been partially commenced and currently provides a new statutory framework in relation to deprivation of liberty. Part 10 of the MCA will set out the provisions for people in the criminal justice system when enacted. Mental health legislation is complex most especially relating to patients with a forensic history. The review team noted a lack of clarity across the HSC system in regards to patients who have been stepped down from detention in hospital under Art 15 leave. The review team recommends a review of the needs and resettlement plans for all forensic patients.

4.23 There have been a series of high profile scandals following investigations identifying abuse to residents in HSC facilities over the past decade. MAH is the largest adult safeguarding investigation across the UK. On 8th September 2020, the Health Minister announced his intention to establish a Public Inquiry into the allegations of abuse at MAH. The MAH Public Inquiry commenced the hearing sessions of the Inquiry in June 2022 which will run until December 2022

4.24 The Care Quality Commission report (2011) (ctrl click) after inspection of Winterbourne View found a “systemic failure to protect people” Evidence of maltreatment of patients in specialist hospitals in England continued to emerge and eight years later, The Care Quality Commission report on Whorlton Hall (2019) (ctrl click) found people in learning disability hospital being failed and the Care Quality Commission (2019) found evidence of unsafe patient care and abusive treatment by staff at Eldertree Lodge, an in-patient facility for adults with learning disabilities and autism. These scandals have prompted development in strategic policy and a renewed focus on implementation plans to address the long-standing issue of over-reliance on admission to hospital resulting in delayed discharge and institutionalisation.

4.25 Strategic Policy in England- Building the Right Support: A National Plan NHS England et al (2015) (ctrl click) placed emphasis on the “highly heterogeneous” or diverse characteristics of the population referred to as ‘people with a learning disability and/or autism’ This challenge has not been sufficiently addressed in learning disability policy in Northern Ireland to date. The majority of people with learning disability live with their families supported if required by a range of community services. The smaller percentage of those with a range of very complex needs requiring coordinated care and support across justice, housing, mental health, and the range of learning disability provider organisations need to be integrated into future strategic policy and commissioning direction.

4.26 There have been a range of reports on the issue of delayed discharge however, there has been a lack of robust and independent evaluation of what has worked well. England, Scotland and Wales are further developed than Northern Ireland in refreshing the approach needed. This review has identified a number of key themes across the revised strategic policy in England and Scotland that should inform revised strategic direction and short and medium term actions required for Northern Ireland.

4.27 ‘Transforming Care England’ – Oct.2015 (ctrl click) - Good practice guidance covers strategic, operational and micro- commissioning and describes what ‘Good looks like’ with nine Golden threads-core principles. Key actions include;

- ➢ Provide enhanced vigilance and service coordination for people displaying behaviours which may result in harm or placement breakdown.
- ➢ Establish a Dynamic Support Database to provide focus on individuals at risk of placement breakdown and development of proactive rather than reactive crisis driven response- Target those escalating in need/ at risk of admission-risk stratification.
- ➢ Important that experts by experience have been involved in all of the panels. One of the issues has been language – such as database rather than risk register
- ➢ Establish a ‘Change Fund’ from the centre for development of admission avoidance 24/7 intensive support teams
- ➢ Positive Behaviour Service framework and provider engagement
- ➢ Housing Needs Assessment
- ➢ Effective Assessment tools/ Discharge planning meetings- Complex care co-ordinators to focus on transition plans
- ➢ More detailed tracker tool to support analysis and performance management to create a master database-history of discharges, re-admissions and trends.

- Fortnightly meetings on each individual patient with clear projections about the trajectory for discharge and progress over time.
- Specialist LD beds should be increasingly co-located within mainstream hospital settings rather than in isolated stand-alone units.
- The success lies not within systems and processes but within sustainable human relationships and collaboration highlighting the need for system leadership, collaborative working to build a one team approach.

4.28 The NHS 10 Year Plan was published in England in January 2019, and made specific commitments to the improvements to be progressed for people with learning disability and ASD. These included:

- Improve community-based support so that people can lead lives of their choosing in homes not hospitals; further reducing our reliance on specialist hospitals, and strengthening our focus on children and young people
- Develop a clearer and more widespread focus on the needs of autistic people and their families, starting with autistic children with the most complex needs
- Make sure that all NHS commissioned services are providing good quality health, care and treatment to people with a learning disability and autistic people and their families. NHS staff will be supported to make the changes needed (reasonable adjustments) to make sure people with a learning disability and autistic people get equal access to, experience of and outcomes from care and treatment
- Reduce health inequalities, improving uptake of annual health checks, reducing over-medication through the Stopping The Over-Medication of children and young people with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) programmes and taking action to prevent avoidable deaths through learning from deaths reviews (LeDeR)
- Continue to champion the insight and strengths of people with lived experience and their families in all of our work and become a model employer of people with a learning disability and of autistic people
- Make sure that the whole NHS has an awareness of the needs of people with a learning disability and autistic people, working together to improve the way it cares, supports, listens to, works with and improves the health and wellbeing of them and their families.

4.29 ‘Same as You’ (2000) (ctrl click) was the catalyst for Scotland’s long-stay closure programme. ‘Keys to Life’ 10-year Learning Disability Strategy **(**2014) (ctrl click) acknowledged wider system failure in the challenge of expediting discharges and developed a National framework agreement for procurement for specialist residential based care with a focus on the outcomes and rates that will apply. The ‘Coming Home’ report (2018) commissioned by the Scottish Government (ctrl click) highlighted that a significant number of people remained delayed discharge.

A short life working group was set up to undertake a focused piece of work in relation to complex needs and delayed discharge and published their 'Coming Home Implementation report in February 2022 (Gov.Scot) (ctrl click) . The findings and recommendations are broadly similar to the actions arising from Transforming Care England.

- Engagement with experts by experience and wider stakeholders is critical
- First step is accurate data on Needs Assessment at both population and individual level. Quality of assessments were found to be too generic and quality variable and not sufficiently co-produced with families
- Establish a community living change fund over the next 3 years to be used to design community based solutions running concurrently with disinvestment planning.
- Develop a National Dynamic Support Register to create greater visibility in terms of strategic planning and to allow performance management of admissions to hospital supported by a National panel that can troubleshoot individual cases
- Develop a Positive Behaviour framework-
- Produce a guide to support commissioning and procurement of complex care packages and establish detailed understanding of revenue costs of different care packages. The report highlighted a lack of effective scrutiny of data.

4.30 The Welsh Government published a Learning Disability Action Plan 2022- 2026 in May 2022. The plan builds on and incorporates the Improving Lives Programme (2018) (ctrl click) actions with a focus on reducing admissions through increased community based crisis prevention, access to specialised care and highlights the need to promote Positive Behavioural Support and Trauma Informed care.

4.31 The Irish Government published a national policy 'Time to Move On' 2011 (ctrl click)which sets out the way forward for a new model of support in the community The report highlighted that the model is simple in approach but noted significant challenges to delivery. Integral to the strategy was the 'We Moved On' stories of successful transition and promoting the voice to include advocacy, self-advocacy and family advocacy. The review team met with the HSE National lead who advised that bridging funding through a multi-annual investment plan for 5 year period has been established alongside a value for money and policy review of high cost placements to establish the level of funding per person. Robust Needs assessment was also identified as a priority.

The review team found significant learning from engagement with policy leads in England and ROI which have informed this review and findings.

4.32 Tackling the closure of long-stay beds has been a long standing problem for many decades across all UK nations. Recent strategic policy has recognised that the focus should now be on what is achievable rather than being paralysed by the challenges. There has been growing consensus nationally on solutions and next steps. It is critical that a one system approach is developed in Northern Ireland to address the silo working and duplication that remains across the 5 HSC Trusts. Adopting an accountable care approach will drive collaboration between HSC Trusts and the range of organisations involved in supporting individuals who are currently ‘stranded’ in learning disability hospitals.

4.4 Recommendations

- DoH should develop the strategic policy for learning disability services, updating the recommendations arising from the Bamford review to reflect the needs of the highly heterogeneous Learning Disability population and inter-connectedness with the Mental Health and Autism strategies.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better and a regional programme to tell the positive stories of those who have moved on.

5. Leadership & Governance

In the last chapter we consider the policy and strategic context for the delivery of the resettlement programme in Northern Ireland, and in this chapter we want to explore how the leaders within Northern Ireland engaged with this challenge.

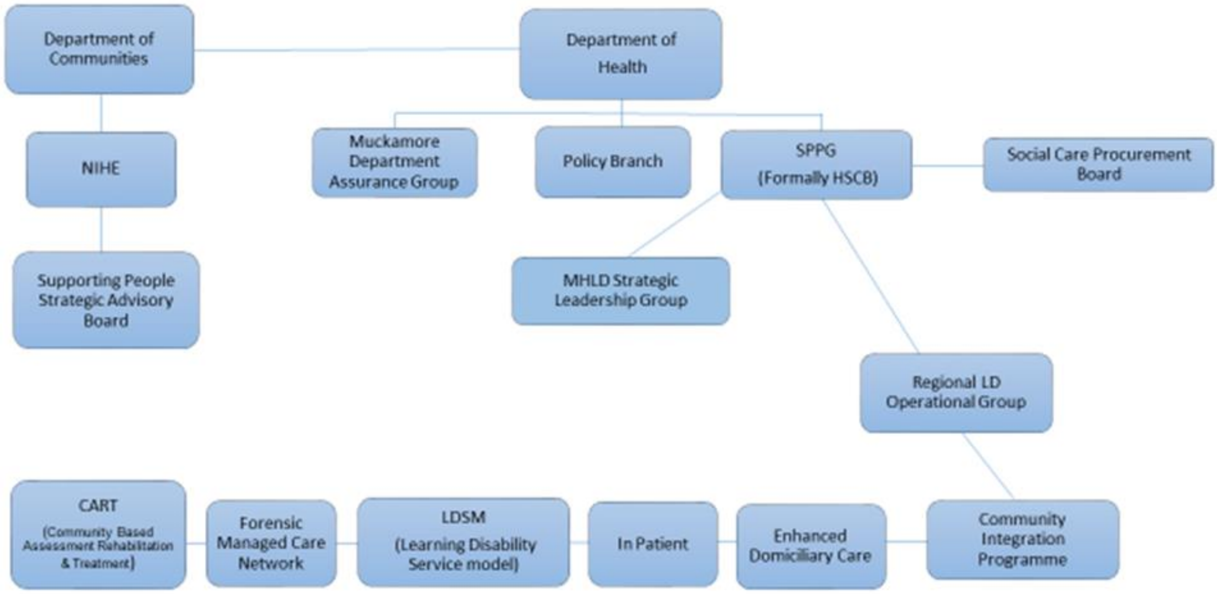
5.1.1 Within the chapter we will look at how we gathered evidence of leadership and impact, and then go on to consider it under the following areas: strategic leadership and governance; leadership for the operational delivery of resettlement outcomes for individuals awaiting discharge following lengthy periods in hospital; and finally how people who use services and their representatives were engaged in this complex arena.

5.1.2 Evidence Gathered: The review team were pleased that in addition to having access to a raft of documentary evidence that we also had direct access to meet with many of the leaders within the system at all levels, and to observe or participate in key meetings within the leadership framework.

5.1.3 Amongst the documentary evidence that we accessed included strategic and policy documents, Trust Board minutes and Trust Corporate Risk Registers. We also attended the Muckamore Departmental Assurance Group (MDAG) and had access to their more recent action plans and minutes. We also had sight of material related to the Delegated Statutory Functions Reports including the composite reports and action plans.

5.1.4 A very rich area of evidence related to engagement with leaders through direct meetings. This included the Mental Health & Learning Disability Strategic Leadership Group (Directors and other senior officers from HSCB/SPPG & Trust Directors); Regional Learning Disability Operational Group (Trust Assistant Directors and Commissioning & Finance Leads in HSCB/SPPG, along with representation from NIHE and RQIA. We had ‘challenge and support sessions with Trust LD Leadership Teams We have tried to represent the statutory leadership framework diagrammatically – *see below*

Learning Disability – Regional Leadership Groups



5.1.5 The review team were particularly grateful for the extensive and generous sharing of views and experiences from a broad range of stakeholders. Importantly this included parents and carers of people who had direct experience of the resettlement process along with charities that represent them such as Mencap. We also met with leaders from other agencies including housing, provider organisations in the independent sector, regulators for services and the social care workforce, and clinical leadership through the RCPsych. (NI) – Learning Disability Faculty.

5.1.6 An important factor needs to be acknowledged from the outset in considering the leadership challenge in relation to the resettlement programme during recent years, and relates to the context from 2019 to 2022. The global pandemic had a massive impact on the capacity and capability of leadership teams to maintain momentum on ‘business as usual’ priorities, as a determined focus to tackle Covid was required. Similarly during the same period the impact of MAH being identified at a national level as a hospital where patients had not been well safeguarded meant that the operational day to day logistics of maintaining safe practice in relation to sufficient and stable staffing was a significant challenge in itself. Additionally, during this period there has been an extended period of significant organisational change as the regional commissioning functions previously undertaken by the Regional HSCB were ‘transitioned’ back within the DoH under the Strategic Planning and Performance Group, with the new arrangements coming in to effect from the 1.4.22. Whilst these and other factors impacted directly on the progress of resettlement and offers something in way of mitigation for the poor progress of resettlement plans, it cannot entirely explain leaders’ failure to deliver timely alternatives to residence in MAH in the context of the long term planning in this area. The individuals in MAH didn’t 'suddenly' need new homes; there had been a lengthy 'gestation' to this situation, and many opportunities for earlier action.

5.1.7 The review considered leadership in three separate contexts. The first was strategic leadership at the most senior level of the organisations involved, including senior leaders in public service, both executive and non-executive. Strategic leadership focuses on establishing the vision and strategic direction, and ensures effective governance, oversight and scrutiny of delivery of strategic objectives. The second is senior operational leadership to ensure that plans for delivery are robust and achieved, and requires effective partnership working between commissioners, providers – both statutory and non-statutory. The third area that we wanted to consider in relation to effective leadership and governance was the extent to which people at the centre of resettlement, particularly those who were being moved to their new homes and their family members, were engaged and involved in the process, and how effectively they could shape and influence leadership. Central to this is the need to understand leadership at all levels, and how this intersects. What the review team were looking for is sometimes referred to as 'the golden thread, that should weave through all the layers of leadership to ensure that there is a seamless route from strategic vision to effective delivery, and that the best outcomes are delivered in the most efficient and cost effective way, with transformational impact on the lived experience of the people who are being resettled from institutional care to new homes within the community.

5.2 Strategic Leadership & Governance

5.2.1 Strategic leadership and governance has been central to the successes and failures within delivery of the learning disability resettlement programme in Northern Ireland. The policy context since the Bamford Review and before was clear that long stay specialist learning disability hospitals should never be someone's permanent home. Whilst the ambition was clear, and some progress was made, the goal was slow to achieve and by July 2021 46 people remained living in MAH, and more than 5 of these had been in the hospital for between 30 and 45 years. The emerging picture of extensive institutional abuse in MAH in 2018 re-focused attention on the lives of people living in MAH both in terms of the day to day safety of people who were living there, and the need to push harder to find new homes for those remaining individuals within high quality community settings. Whilst this was a significant challenge, it wasn't a new one, and had been a stated health and social policy objective in Northern Ireland since 2005, so it had to be asked why it hadn't yet been achieved.

5.2.2 In order to achieve the significant change required in improving the lives of all people with learning disability and ASD, there was a consistent acknowledgement for the need to update the strategic policy. This was a priority recommendation from the previous Independent Review Panel, which required "an updated strategic framework for Northern Ireland's citizens with learning disability and neuro-developmental challenges which is co-produced with self-advocates with different kinds of support needs and their families. The transition to community-based services requires the contraction and closure of the hospital and must be accompanied by the development of local services."

5.2.3 The response to this recommendation was that there should be a co-produced model for Learning Disability Services in Northern Ireland to ensure that adults with learning disability in Northern Ireland receive the right care, at the right time in the right place; along with a costed implementation plan, which will provide the framework for a regionally consistent, whole system approach. This significant task was to be progressed by the HSCB/PHA, and they commissioned a consultation with a wide range of stakeholders which led to the production of a consultation response entitled "We Matter". The final draft of the "We Matter" Learning Disability Service Model was formally presented by the HSCB to officials at the DoH in early October 2021, but to date this has not resulted in the issuing of the long awaited updated strategic framework. It remains important that this work is brought to completion but equally its delay should not have been a reason for a failure on the part of the HSCB and individual HSC Trusts to expedite the resettlement process.

5.2.4 In the next chapter we will explain how in 2019/20, further to a direction from the Permanent Secretary, the regional commissioning framework clearly stated that the resettlement of people from MAH and other LD specialist hospitals remained a strategic priority.

5.2.5 In the context of the significant concerns about MAH the DoH established a Muckamore Departmental Assurance Group (MDAG). The Muckamore Departmental Assurance Group was established to monitor the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff, and the Permanent Secretary's subsequent commitment on resettlement made in December 2018. The Group is jointly chaired by the Chief Social Services Officer and the Chief Nursing Officer, and is made up of representatives from HSC organisations and other key stakeholders, and representatives from families of Muckamore Abbey Hospital patients. It was good to see such a broad constituency, including the families of people living in MAH being brought together. The group undertook considerable work which was organised and monitored through a comprehensive action plan; this was updated and monitored regularly. The plan covered areas such as leadership and governance, safeguarding, resettlement and workforce. In relation to resettlement, after three years of the MDAG operating, all of the actions relating to resettlement continued to be rated as 'red' in relation to delivery. So whilst there was a robust mechanism for holding the system to account and monitoring what had been achieved, in relation to resettlement there was an inertia which represented slow or negligible progress. This led to some considerable frustration across the system, which was evidenced through a number of families launching judicial reviews against health and care organisations to challenge a failure to deliver resettlement outcomes for their loved ones. Despite a well-articulated call to action there was an absolute lack of urgency and focus in the delivery of the resettlement programme.

5.2.6 Within the MDAG action plan the Director of Social Care and Children (DCSC) was the identified lead for all actions in relation to the delivery of the resettlement programme. In order to deliver this the (DCSC) worked with the Trust Directors through a Mental Health and Learning Disability Strategic Leadership Group. The commissioning plan for 2019/20 was clear about the HSCB/PHA strategic priorities and intentions for resettlement and the required Provider Response (set out in Chapter 6; 6.4.6, 6.4.7, 6.4.8). In order to deliver the required action a number of groups were established to progress at pace the resettlement programme, and further explore this under the next section. However, the DSC & C/HSCB also held a responsibility for ensuring that the individual Trusts were held to account in relation to the delivery of their delegated statutory functions (DSF's), and a specific responsibility for performance management in relation to the delivery of the key strategic targets. Whilst there were fully formalised processes for accountability meetings, with remedial action proposed where performance was weak in relation to the delivery of DSF's, this rarely achieved the significant improvement required. In particular in relation to the resettlement programme, the actions taken by senior officers of the HSCB often represented at best performance monitoring, rather than effective performance management.

5.2.7 Effective performance management relies on the provision of valid data, analysis of performance measures, responsible challenge in relation to under-performance, and effective support to address broader barriers that stand in the face of objective achievement. The absence of fully effective performance management allowed for significant drift in the delivery of strategic priorities which directly impacted on the broader issues relating to the continued concerns around the safety of MAH. There has been significant organisational change since the Minister announced the closure of the HSCB, and the transfer of many of the strategic commissioning and performance management functions have reverted to the Strategic Planning and Performance Group within the Department of Health. We have seen a change in tone and approach in relation in the execution of performance management responsibilities both immediately prior to the transfer to SPPG on the 1.4.22 and subsequently. A number of additional senior appointments have been made within the social care team which should strengthen capacity. In light of these changes the review team are hopeful that the challenge and support function essential to effective performance management will continue to improve.

5.2.8 Belfast Health and Social Care Trust are central to the strategic leadership and governance in relation to the care and treatment of people in MAH, as well as to the resettlement process from the hospital. Their leadership responsibility needs to be set in the context of two important reports commissioned by the

Trust. The first of these was "A Way To Go" (2018) which undertook a review of safeguarding within MAH between 2012 and 2017, which identified extensive evidence of catastrophic failings and found that there was a culture of tolerating harm within MAH. The authors went on to express grave concern that it was "shattering that no-one intervened to halt the harm and take charge". The CCTV evidence which supported the findings within this report also became central to the subsequent PSNI investigation of allegations against significant numbers of staff within the hospital. The second important report was the Review of Leadership and Governance at Muckamore Abbey Hospital completed in July 2020. This report described the leadership team at MAH as dysfunctional, with a lack of clarity about leadership, and a sense of dis-connectedness with the BHSCT as a whole. The report concluded that the changes in senior management resulted in confusion for front line staff; there was little evidence of practice development and quality improvement in MAH; that there was insufficient challenge from the Trust Board and HSCB in relation to the DSF reporting, and that feedback provided to the Trust from the HSCB related to failings in meeting resettlement targets. The report also reported on limited escalation of key events or concerns to the Trust Board, and also that "The resettlement agenda at the hospital meant that focus on the hospital as a whole was lost: - relatives/carers of patients and hospital staff's anxieties about closure were not addressed in a proactive way to reinforce the positives associated with patients' transition to care in the community. There was insufficient focus on the infrastructural supports required to maintain discharged patients safely in the community" In the final section of the report its' final recommendation is that, "The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account."

5.2.9 In relation to this recommendation the review team undertook some desk top review of the Trust Board minutes over the preceding year. It was clear that update reports were being brought by the responsible Director in relation to all aspects of the services at MAH. However, we had some concerns about how effective the overview and scrutiny of Trust Board was in relation to certain key elements. In particular there was an acceptance of assurances given that the 16 remaining patients awaiting resettlement from MAH who were the responsibility of the BHSCT had robust plans in place for resettlement. However this was contingent on the proposed service developments which would deliver new homes, and as we will detail in later sections of the report there was no confidence that robust plans were in place for the delivery of such schemes, and that even if in train the earliest date for delivery would have been 2025/2026. In light of this the review team would consider that the Trust Board accepted reassurance from senior leaders, rather than driving for solid assurances which would underpin effective delivery.

5.2.10 One year on from the publication of the Leadership and Governance Review, which recommended that BHSCT consider sustaining the significant number of managerial arrangements instigated following events of 2017 pending the wider Departmental review of MAH services. The current review team looking at the situation through the lens of resettlement find that there appears to have been only limited progress in relation to the changes that were called for. There continues to be some instability in relation to the leadership arrangements, in that during the last 6 months there have been changes of Director, Co-Director, Lead Social Worker and Lead Nurse; and some of these posts are appointed only on an 'interim basis' implying that they may only be temporary appointments, and with none of the incumbents bringing recent senior operational leadership experience in the field of learning disability. Whilst the review team accept the principle of the transferability of skills and that this is particularly important within senior roles, there is also a need to have a sound understanding of the 'business' particularly in the context of risks and opportunities. However the review team also acknowledge the clear commitment that these newly appointed leaders bring to their responsibilities, which could bring significant opportunity to move on at greater speed.

5.2.11 The review team could see that within BHSCT there had been a real vigour, both by Trust Board and the Executive Team, to address the issues that had emerged as the full extent of the institutional abuse at MAH became clear. This posed them with the linked challenges of rapidly improving the quality and safety of care for the patients within MAH whilst ensuring that there was progress at pace to achieve more resettlement. The review team could see that to some extent the former was contingent on the latter, i.e. that the more quickly the population reduced in the hospital through resettlement the sooner that the issues related to safe staffing levels could be addressed as assuming the staffing establishment was retained and the patient population reduced then the nurse:patient ratio improved accordingly. The review team felt that this balance wasn't maintained and that the importance of getting the hospital back to a safe and stable position diverted attention away from the importance of steady and consistent progress in relation to moving patients who were deemed medically and multi-disciplinary 'fit for discharge' to new homes. Therefore as will be laid out in subsequent sections the progress of the proposed schemes to be led by BHSCT effectively slowed almost to a standstill, and so other than for a small number of individuals who were able to move to existing provision there were very few people moved. This is in contrast with the NHSCT and SET who have secured new provision which will shortly become fully operational in the next 6 months and consequently a much higher proportion of their clients have plans where there is confidence that they will move in the near future.

5.2.12 BHSCT had a wider responsibility than the other Trusts as they were managing MAH, and had responsibility for the dedicated resettlement teams located at the hospital who had a pivotal role in being the link and liaison with the local teams within the MAH resettlement team had a pivotal role with all 3 Trust community teams including for the BHSCT, NHSCT, and SEHSCT who ultimately would assume responsibility for the clients upon transition to their new homes. However all three of these Trusts had a shared responsibility for the overall delivery of the resettlement programme. Given the high profile concerns about the safety of MAH, and the linked urgency to find alternative homes for the remaining patients as soon as possible, the review team were concerned that not all Trusts had included resettlement of people with LD/ASD on their Corporate Risk Registers, although in some cases they were on Directorate Risk Registers. Again this may have hampered the ability of Trust Boards to assure themselves that all of the appropriate actions were being progressed to ensure swift actions were being delivered to address the significant risks.

5.3 Leadership in Operational Delivery of the Resettlement Programme

5.3.1 Within the system delivery relies on having senior executive and operational leaders who can take policy and strategy, and ensure that the linked objectives are delivered in practice, and that the outcomes that follow improve the lives of the people with learning disabilities and their families.

5.3.2 Within the HSC system in Northern Ireland this covers a broad range of leaders in senior roles in commissioning, and within statutory and non-statutory provider organisations. We have already mentioned the role of the Mental Health and Learning Disability Leadership Group which comprised Directors across the HSCB and HSC Trusts with input from other key agencies such as PHA and RQIA. It should be noted that some of these Directors had strong clinical and professional backgrounds, and had been well established within an executive role, whilst others were relatively new to role and may have come from other service domains. There was certainly a positive set of working relationships within the group, and whilst there was a well-articulated commitment to work collectively and collaboratively this was not always then evident in the subsequent partnership working. Below this group sat the RLDOG which was chaired by the HSCB, but comprised primarily Assistant Directors/Co-Director from the 5 Trusts. At times it was unclear what role the HSCB held within the RLDOG – whether their role was as convenor and facilitator, or to lead the co-ordination process and take a performance management role within the group. This contributed to a lack of clarity about leadership within RLDOG, and this meant that the commitment and engagement of senior staff from the HSC Trusts could be variable. More clarity about leadership within the RLDOG, with a clearer focus on achieving progress and delivering improved outcomes would have been more helpful. Whilst RLDOG was expected to work on a broader range of service developments and priorities across the learning disability domain, during the 6 months that the review team were involved it primarily focused on resettlement and access to assessment and treatment services within specialist LD hospitals.

5.3.3. The learning disability resettlement programme in Northern Ireland did not have an over-arching programme or project plan. Whilst it was in the commissioning plan as a strategic priority for 2019/20, and Trusts were expected to respond accordingly, this meant that individual Trusts developed their own approaches to addressing the needs of their cohort of patients within the remaining MAH population. Some Trusts addressed this positively and developed fairly robust plans over time, but overall there was a sense that the programme was fragmented. There was certainly some evidence that HSC Trusts were planning in relative isolation. There were examples of Trusts entering discussions with providers about developing services in other Trust areas, without the 'host' Trust being informed or consulted. The HSCB convened another group called Community Integration Programme (CIP) which had a sole focus on the resettlement but it was unclear how this group's role differed from that of RLDOG, particularly given the significant overlap of membership. The HSCB had developed what they called the MAH template which HSC Trusts were asked to complete in relation to their MAH populations and plans for individuals. The review team supported the social care officer responsible for CIP to make some improvements to this so that it could be used more effectively as a 'tracker tool' and then this could support a performance management approach.

5.3.4 In general we found that across significant elements of the HSC system there was poor management grip in relation to the learning disability agenda and this resulted in a lack of momentum and a sense of inertia. The system seemed more pre-occupied with process and there was insufficient focus on solution finding and achieving positive outcomes quickly. The system was also prone to adopting 'crisis-management' approaches linked to pressures escalated from BHSCT in relation to difficulties within staffing or access to admission at MAH. This meant that the system was primarily reactive rather than proactive. We give further examples of how poor leadership hampered progress in delivery in later sections.

5.3.5 Overall the review team felt that the learning disability resettlement programme would have benefitted from an effective project managed approach, which we have seen used to good effect in other similar situations. This would have more effectively co-ordinated the efforts of the system as a whole, and ensured less variation in the overall delivery of agreed outcomes. It also would have facilitated more effective opportunities to engage with providers within the social care market in order to streamline the service developments required to support the resettlement process in a timelier way, and would have brought provider-informed solutions forward for consideration.

5.4 Leadership Engagement with People who Use Services and their Carers.

5.4.1 The review team met with the Chief Executive and Patient Client Council (PCC) senior leadership team who are undertaking the role of Advocate to the Public Inquiry and supported families during feedback on the findings of the Leadership and Governance review team. PPC advised that in their engagement, families talked about the invisibility of learning disability and expressed anger and a lack of trust in the HSC system. PCC also found in their engagement with families that safeguarding was foremost in their concerns. PCC advised the review team that the pain and trauma for families was palpable and that a trauma informed approach would be needed to engage and support families who had been let down so badly.

5.4.2 The feedback from PCC concurs with the feedback the review team received in our own engagement with families in the BHSCT, NHSCT and SEHSCT and sets the context for consideration of leadership engagement with people who use services and their carers across the HSC system. The review team will address the issue of carer engagement in more detail in a chapter 10.

5.4.3 Families reported that they felt learning disability was invisible at government and policy level and comparison was made by some families to the profile of mental health services resultant from the Mental Health strategy and appointment of a Mental Health Champion. Many families reported their fatigue, the emotional toll of life long caring and battling for resources and services over many years.

5.4.4 The Welsh Government 'Improving Lives Programme (2018) placed particular emphasis on communication and effective working relationships at all levels across the system, what they referred to as the softer skills required to drive transformation and improve lives. The importance of and necessity to build trusted relationships was evident at strategic and operational leadership levels but more so in relation to building effective partnership working with individuals and families with lived experience of using services.

5.4.5 It is clear that across the HSC system there is recognition of the need for engagement and involvement of people with lived experience in both the planning and delivery of services however this is easier said than done. Two MAH carer representatives are members of MDAG and the review team observed both carers influencing and holding senior leadership to account through constructive challenge. However, the review team did not see evidence of effective engagement of people who use learning disability services or their family carers influencing the numerous other learning disability work streams established by HSCB/SPPG to contribute to and influence the resettlement agenda. The review team acknowledge that HSCB and the 5 Trusts had significant engagement with individuals with a learning disability and family carers in the development of the draft service model' We Matter'. However this level of contribution was issue specific and has not been sustained.

5.4.6 The review team noted some tensions in the relationships between Trust Directors due to the pressures associated with the challenge of accessing an acute learning disability bed when required. The establishment of a regional bed manager as agreed at MDAG would have significantly mitigated the tension however, there was significant delay by HSCB/SPPG in the actions required to establish this post. The review team were pleased to see and wish to acknowledge that the three Directors co-dependent on MAH have recently committed to working collaboratively with a focus on the mutual aid required to respond to challenges at MAH but also to expedite the remaining resettlement challenge. The Directors have held solution focused workshops establishing time and space for reflection and the development of the trusted relationships that will be required to further enhance a one team approach.

5.4.7 Engagement events with family carers highlighted the importance of continuity of key workers in building effective working relationships at case work level but families also referred to a trusted key worker as their go to person when they had to navigate through different parts of the HSC system or when they were facing challenge or difficult decisions. The turnover of staff at both key worker and managerial level was reported by carers to directly impact on their trust in the HSC system. Relationship based HSC practice and continuity of key worker would significantly improve the experience of people at the centre of resettlement and their family members.

5.4.8 The impact of the turnover at HSC senior management level was raised by external agencies, both external statutory and independent sector provider organisations that generally have experienced stability in senior leadership teams. NIHE Supporting People leaders advised that there has been a loss of memory for HSC Trusts due to the turnover in senior leadership. Voluntary sector leaders also advised the review team that the turnover in Trust HSC leadership is challenging and highlighted variation across Trusts regarding being respected as valued partners with significant expertise. The voluntary and independent sectors are key stakeholders in the delivery of community-based services and will be central to the accountable care approach needed to meet growing demand and challenge. The review team acknowledged that each Trust has held engagement events with provider organisations but the review team saw it as a missed opportunity not to have collaborated given that many care providers deliver across all 5 Trusts.

5.4.9 At operational level, all Trusts have made significant efforts to establish effective engagement strategies as detailed in chapter 10 however, these are at an early stage of development. BHSCT has established a robust infrastructure mapping engagement from Trust Board level with a Non-Executive Director undertaking the role of learning disability lead at Board level, through dedicated forums in MAH and community learning disability services. It is significant that only a very small number of MAH families are in attendance at the MAH Forum meeting. This would suggest a level of disengagement of MAH families. Some MAH families told the review team that they are not willing to attend meetings as they have been led up the hill too many times and only now wish to engage if there is a concrete and viable plan for their loved one’s discharge.

5.4.10 Effective engagement requires trust and openness and this has been seriously impacted due to the allegations of abuse at MAH which has made engagement more challenging. Some families have such a level of distrust that they are not willing to engage with the Trust. It is important that Trusts give this matter consideration. The review team saw missed opportunities for Directors to reach out to families who had raised specific concerns relying instead on delegating to other managers.

5.4.11 The review team had the opportunity to spend time with individual families actively listening to their experiences with some families advising that this made them feel respected and their experience valued. Families also advised that at case planning level they are not always respected as experts by experience.

5.5 Conclusions and Recommendations.

The voice of people with a learning disability and their family carers was not sufficiently evident within leadership processes addressing resettlement. The review team did not see evidence of effective co-production in strategic or operational service planning and delivery.

- Consideration should be given to the development of a Provider Collaborative to bring together the range of organisations delivering specialist learning disability care with statutory HSC leaders.
- HSC system should establish an effective programme and project managed approach for the learning disability resettlement programme
- People with a learning disability and their family carers should be respected as experts by experience with Trusts building co-production into all levels across the HSC system HSC Trust

6. Strategic Commissioning, Planning and Inter-Agency Working

In this chapter we will consider the models and approaches to commissioning and how this can support effective inter-agency working.

6.1 Prevalence of Learning Disability.

6.1.1 At the foundation of good commissioning is understanding the target population and their needs both collectively and individually. Whilst the review was primarily focussed on the population of people experiencing delayed discharge within MAH, this group of individuals with very specific needs based on their experience of living with a disability and in addition their experience of living in institutional care for an extended period of time, it is important to consider them in the context of the wider population of people with learning disability or intellectual disability in Northern Ireland.

6.1.2 The 2021 Northern Ireland (NI) Census data will include data on health and disability, but this element of the data will not be published before September 2022. However the University of Ulster and others undertook data analysis funded by the ESRC (Economic and Social Research Council), which was supported by health and social care organisations, both statutory and non-statutory in Northern Ireland. The research focussed on access and analysis of existing administrative data relating to learning disability in Northern Ireland between 2007 and 2011. Their key findings included prevalence data and demonstrated that within the overall Census Population the prevalence of learning disability was 2.2%; the prevalence rate amongst those aged 15 or younger was 3.8%, whilst the prevalence rate amongst those over 16 was 1.7%. Overall prevalence of learning disability ranged from 1.9% in the NHSCT to 2.5% in BHSCT. From the Census data they found that learning disability was also associated with greater deprivation. Within their conclusions the researchers comment that there is burgeoning international research which continues to detail the extreme disadvantages that are disproportionately faced by those in society living with a learning disability. Additionally they comment that learning disability specifically, at a population level, has either remained unrecorded and undetected or has been camouflaged/hidden/buried within general health data, that have referred to limitations in day-to-day activities or inability to work as a result of health problems or disability. Learning Disability Data & Northern Ireland, Ulster University, *'Enhancing the visibility of learning disability in NI via administrative data research'* Ctrl Click

6.1.3 Mencap is a charity which works across the UK with and for people with learning disabilities and their families. They have published figures calculated using learning disability prevalence rates from Public Health England (2016) and from the Office for National Statistics [2020). They estimate there are approximately 1.5 million people with a learning disability in the UK, indicating that approximately 2.16% of the UK adult population have a learning disability. They indicate that there are 31,000 adults with a learning disability in Northern Ireland, and 11,000 children with a learning disability (0-17).

6.1.4 In simple terms what we know about the 31,000 adults is that the vast majority live in their local communities either independently or semi-independently with support from their families, friends, and support services. Less than 10% of them live in registered care or supported accommodation schemes, and in most circumstances, these are still either within or close to their local communities. At the time of writing there were only around 60 people with learning disabilities in specialist hospital in Northern Ireland which equates to approximately 0.2 % of the total LD population, and of this small group about three quarters were awaiting resettlement or discharge to new permanent homes. In considering the needs of this last group of people we have needed to look at how the system works to meet the needs of the larger population, and to look at how those commissioning services and those providing services ensure positive outcomes for this important group of individuals in our society.

6.1.5 We have commented in a previous section about the importance of developing a regional strategy and service model for services for people with learning disabilities in Northern Ireland. This strategy will need to describe this community and their diverse and varied needs so that regionally work can be completed to develop a strategic commissioning plan which can support the service delivery for this group of people. You will see later in this section that work was commenced by the HSCB and PHA on the development of a Learning Disability Service Model in 2019/20, which resulted in the co-production of a report called “ We Matter “ which is currently being considered by the DoH and will contribute to the production of the final strategy.

6.2 Commissioning Models

6.2.1 Whilst there are numerous models of commissioning the one that we have chosen to identify primarily is “Integrated Commissioning for Better Outcomes” which (ctrl click) was developed by NHSE, the LGA and ADASS as a practical tool for local authorities and NHS commissioners to support improving outcomes through integrated commissioning. It was published in 2018 to support health and social care economies to transform their services through a person centred approach to commissioning which is focussed on the needs of the local area. It emphasises that effective commissioning relies on a strong focus on people, place and population.

The framework identifies what matters most to people:

- *Being the person at the centre, rather than the person being fitted into services.*
- *Citizens, people who use services, patients and carers are treated as individuals.*
- *Empowering choice and control for those people.*
- *Setting goals for care and support with people.*
- *Having up-to-date, accessible information about services.*
- *Emphasising the importance of the relationship between citizens, people who use services, carers, patients, providers and staff.*
- *Listening to those people and acting upon what they say.*
- *A positive approach, highlighting what people can do and might be able to do with appropriate support, not what they cannot do.*

6.2.2 The framework draws on a definition of commissioning developed by the Cabinet Office and Commissioning Academy in its statement about public sector commissioning.

> "*We commission in order to achieve outcomes for our citizens, communities and society as a whole; based on knowing their needs, wants, aspirations and experience.*"

6.2.3 The second example is designed to help the voluntary sector work with the statutory sector and is based on the well-known commissioning cycle model. It describes the 4 stages of commissioning within the commissioning cycle as:

Analysis: this stage aims to define the change that is needed by defining the need – the problem that needs solving – and the desired outcome.

Planning: involves designing a range of options that will work to address the issues identified against the desired outcome.

Securing services: is the process of funding the option or range of options agreed to deliver the defined outcome via an agreed funding method – grant funding, contracting, etc.

Reviewing: entails evaluating the chosen option(s) to see what has worked well and what can be improved further.

Model of Commissioning

Fig 1

6.2.4 It is important to understand that commissioning activity will be essential at all levels within the health and care system. Strategic commissioning needs to support a population based approach underpinned by a strong assessment of needs, which is delivered by senior strategic leaders in partnership with other parts of the system. Locality based commissioning requires HSCT's to ensure that at a local level these strategic ambitions are delivered through the effective purchase and supply of a broad range of directly delivered and commissioned services from providers across the independent providers, both private and charitable/" not for profit". This locality-based commissioning should ensure a sufficient supply of key services including access to registered care in nursing and residential homes, and access to accommodation providing care and support for people with significant needs. Both of the above need to relate closely to 'micro-commissioning' which is where care and support is commissioned in a bespoke way for the needs of an individual through a detailed understanding of their specific needs and requirements, resulting in a personalised care solution. Micro commissioning is directly aligned to the individualised care planning which is described in a later session, and must be underpinned by a commitment to co-production with the individual and as appropriate with the involvement of family.

6.2.5 The review team needed to look at how this broad approach to commissioning had been applied to the needs of the cohort population of people who remained in MAH and who required to be discharged to appropriate community-based accommodation with access to ongoing care and support appropriate to their needs. The approach we took was to review the programme that had been developed in England to address the needs of a similar population; to consider the framework for commissioning both health & care and housing services; and to review how these arrangements had been applied in practice to support the resettlement of the group of people who had been prioritised through direction from the Permanent Secretary.

6.3 Transforming Care in England.

6.3.1 "Transforming Care for People with Learning Disabilities - Next Steps" was published in January 2015 by NHS England, Local Government Association, and Association of Directors of Adult Social Services (ADASS). The report identified a significant change in direction in the policy and practice in relation to gatekeeping admission to specialist learning disability settings, alongside dedicated strategies for admission avoidance and more effective discharge planning. The report relied heavily on a report commissioned by NHS England from Sir Stephen Bubb which reviewed how to accelerate the transformation of key services that people with learning disabilities and their families were looking for. The catalyst for this reform came after the shocking expose by Panorama/BBC in 2011 of institutional abuse of people with learning disabilities and/or autism at Winterbourne View, an independent private hospital at Hambrook in South Gloucestershire. The key organisations committed to strengthen the Transforming Care delivery programme by creating a new delivery board, bringing together the senior responsible owners from all organisations.

6.3.2 Central to the approach within Transforming Care was **a commitment to empower people with learning disability and their families**, and to strengthen people's rights within the health and care system. A key recommendation from Sir Bubb was for NHS England to introduce a "right to challenge "by providing a Care and Treatment Review (CTR) to any inpatient or inpatient's family which requested one. CTR's were to be embedded as "business as usual". Early evidence showed that the use of CTR's was effective in speeding up and strengthening discharge planning for those individuals in specialist learning disability hospitals.

6.3.3 A guiding principle in the approach was to ensure that people get the right care in the right place, and to ensure that people with learning disabilities and/or autism were discharged into a community setting as soon as possible. In parallel there would be the development of robust admission gateway processes so that where an admission to hospital was considered from someone with a learning disability and/or autism, that a challenge process would be in place to check that there is no suitable alternative. The ambition was to reduce the number of people in inpatient settings, reduce their length of stay, and ensure that there was better quality of care both in hospital and community settings. Critically the process also required that where an individual is identified as requiring admission to a specialist learning disability inpatient facility that they have an agreed discharge plan from the point of admission. Work was undertaken in parallel to ensure that services for people with learning disability and/or autism who also have a mental illness or behaviour that challenges were improved both within inpatient and community support provision.

6.3.4 The above approach was supported through strategic commissioning by NHS and local authorities who had a shared responsibility to fund care and support throughout the pathway. This required the health and care system to develop quality standards and outcome metrics which were reflected within the NHS Standard Contract and were then applied with assurance processes undertaken by clinical commissioning groups at a local level to ensure that there were robust arrangements to monitor that individuals were receiving the right care in the right place. To support this strengthened commissioning there was a refocus on the quality of data and information so that those implementing commissioning intentions had access to the right information to ensure effective analysis and decision support.

6.3.5 Within Transforming Care there was a renewed commitment to strengthen regulation and inspection. The Care Quality Commission (CQC) were required to further refine its inspection methodology for mental health and learning disability hospital services, and to ensure that regulatory action is taken. Central to this was an explicit commitment that CQC would work with other partners to develop a clear approach for ensuring that unacceptable mental health and learning disability services were closed through use of its enforcement powers.

6.3.6 In 2017 NHS England followed up with model service specifications within the Transforming Care Programme in the context of “Building the Right Support – National Service Model “ as a resource for commissioners, The model service specifications particularly focussed on (1) enhanced and intensive support, (2) community based forensic support, and (3) acute learning disability inpatient services. These 3 aspects of the service model describe the specialist health and social care provision aimed specifically at supporting people with a learning disability who display behaviour that challenges.

6.3.7 The review team subsequently met with senior officers from the Kent and Medway Integrated Care System who had been responsible for implementation of Transforming Care within their system as strategic commissioners. Their overall conclusion was that Transforming Care had been effective in ensuring a more targeted approach particularly in relation to admission avoidance through more effective gate keeping, and the provision of the dynamic support framework, which was delivered through an inter-agency forum to ensure effective strategies were in place for individuals identified at risk of admission. Additionally, they had received funding from NHSE to improve access to 24/7 intensive support teams. Transforming Care had also ensured that there were fortnightly reviews of all inpatients with a clear focus on the trajectory and progress over time for the individual.

6.3.8 In Kent and Medway there had been a renewed effort in terms of governance with the development of a new governance framework and an oversight board to ensure that partners were accountable for commitments and performance. However even with this strengthened focus 66% of the original population identified still were awaiting resettlement. They reported that there had been some issues in relation to effective working with the Ministry of Justice in relation to those individuals who were within justice domain, and in some situations local authorities had been slow to undertake and progress housing needs assessments. Positives had been the development of a Positive Behaviour Support framework of accredited providers, and a central source of capital funding to support bids for discharge plans for individuals who had specialist accommodation needs. More recently in the early part of 2022 they had found an increase in crisis referrals which they felt could be an acuity surge related to the aftermath of Covid.

6.3.9 At a national level organisations such as Mencap and the Challenging Behaviour Foundation monitor the monthly published data from NHSE and provide a commentary on progress. This reflects a view that whilst Transforming Care has provided an effective framework for the delivery of enhanced services to people with learning disabilities and/or autism whose behaviour can challenge the improvement has been slower than originally hoped for within specified targets, and there is a concern nationally about the growing number of young people being treated within inpatient settings.

6.4 Commissioning of Health and Social Care services in Northern Ireland.

6.4.1 Up until April of 2022 the responsibility for the commissioning of health and social care services sat with the Regional Health and Social Care Board (HSCB) and the Public Health Agency (PHA) in partnership. These bodies set their key priorities and areas for action within a commissioning plan, in response to a Commissioning Plan Direction issued by the Department of Health.

6.4.2 For our purposes we wanted to look particularly at the commissioning plan for 2019/2020, as this identified some actions which were required in light of the exposure of significant abuse of individuals living in MAH which was managed by the BHSCT. The commissioning plan also identifies how resources will be allocated to Health and Social Care Trusts and other providers to maintain existing services and develop new provision.

6.4.3 There are a few general points of note in relation to the 2019/20 commissioning plan. There was little reference in the earlier sections of the document to the needs of people with learning disability in terms of emerging issues or key policy and strategy. It did refer to the production of the "Power to People "Report in 2017 looking at the possible solutions to the challenges facing the Adult Social Care and Support System in Northern Ireland. Additionally, it highlighted the continued commitment of strategic commissioners to supporting Personal and Public Involvement to improve patient and client experience. Central to this would be the embedding of co-production within collaborative working of health and social care systems, including the adoption of co-production and co-design models for the development of new and re-configured services.

6.4.4 In terms of the financial resources made available to Trusts and other providers to meet the needs of people with learning disabilities and their families this amounted to 6.58% of the total allocation for health and social care in Northern Ireland, which comes to approximately £342 million. It should be noted that these allocations may not meet the full cost of services and there may be additional cost pressures emerging for certain groups.

6.4.5 In terms of the specific commissioning commitments in relation to learning disability services made within the 2019/2020 HSCB & PHA Commissioning Plan, these are laid out in a separate short chapter of the overall report. There is a commitment to continue to adopt the Bamford Report principles when developing services for people with learning disabilities, with a particular emphasis on supporting integration, empowerment and 'ordinary lives'. There was also commitment to co-produce with a broad range of stakeholders including people with learning disability and their families, a Learning Disability Service Model (LDSM) based on a regional review of services. Within the population sections of the plan there was no specific reference to the numbers of people with learning disabilities, although the plan did note that, “the number of people with a learning disability and the levels of accompanying complex physical and mental health needs continues to grow in Northern Ireland.”

6.4.6 There were 2 strategic priorities identified which are of relevance to the resettlement programme for people with learning disabilities. The first states “Effective arrangements should be in place to address deficits in assessment and treatment in LD inpatient units as highlighted by the Independent Review of MAH (and other incidents affecting NI patients in private LD hospitals). In relation to this priority the Provider Requirement was, “Trusts should demonstrate plans to develop community based assessment and treatment services for people with a learning disability with a view to preventing unnecessary admissions to LD hospital and to facilitate timely discharge. (CPD2.8)”

6.4.7 The second of the strategic priorities was, “Effective arrangements should be in place to complete the resettlement and address the discharge of people with complex needs from learning disability hospitals to appropriate places in the community (CPD 5.7). In relation to this priority the Provider Requirement stated, “Trusts should demonstrate plans to work in partnership with service providers and other statutory partners to develop suitable placements for people with complex needs.”

6.4.8 In addition there was a specific Skills Mix/Workforce area identified within the commissioning plan for action. This highlighted that, “Effective arrangements should be in place to develop multi-disciplinary services in community settings to address the actions required within the Independent Review of MAH.” The Provider Response required in relation to this area was that “Trusts should demonstrate plans to recruit multi-disciplinary teams to build the community infrastructure to support people with a learning disability outside of hospital settings. Trusts should demonstrate plans to work with their independent sector partners to build the skills and capacity of their workforces to enable them to support and sustain people with complex needs in their community placements.”

6.4.9 These elements of the HSCB’s commissioning plan clearly laid out the expectations of both the Department through its directive and the HSCB/PHA response to progress actions directly relevant to the delivery of the resettlement programme in Northern Ireland. HSCT’s would have been expected to reflect these within their Trust Delivery Plans (TDP’s) so that commissioners had an understanding of the actions Trust’s proposed which could then be monitored at a regional level for progress.

6.4.10 In subsequent sections we will look at how these clear commissioning intentions were executed and to what extent these requirements were delivered.

6.5 Commissioning of Specialist Housing with Support for People with Learning Disabilities in Northern Ireland.

6.5.1 In order to consider how the Trusts were to meet the objectives laid out above it is important to understand the role of the Northern Ireland Housing Executive (NIHE) and housing associations/charities in terms of the provision of specialist housing with support for adults with learning disabilities. The NIHE is the largest social housing landlord in Northern Ireland; it is required to regularly examine housing conditions and housing requirements; it is also required to draw up a wide ranging programme to meet these needs. For individuals with housing needs that have additional support needs this is addressed through the Supporting People Programme. The Supporting People Programme helps people to live independently in the community and is administered by the NIHE in Northern Ireland on behalf of the Department for Communities. The Supporting People Programme grant funds approximately 85 delivery partners that provide over 850 housing support services for to up to 19,000 service users across Northern Ireland, with the total programme operating an annual budget of £72.8m in 2021/22. In relation to schemes for people with learning disability, the current provision has the potential to support 1334 individuals in 149 accommodation-based schemes. With an annual budget of £16.3 million.

6.5.2 The 2015 review of Supporting People recommended the introduction of a strategic, intelligence led approach to identify current and future patterns of need. Consequently, the NIHE and partners developed a Strategic Needs Assessment (SNA). This provides a comprehensive picture of housing needs for people who require additional care and support. It highlighted that people who are living with learning disability mostly require accommodation-based support rather than floating support as their disability is lifelong. A time-bound floating support intervention in these cases is not deemed an adequate intervention. Although floating support services offer the opportunity to allow individuals to remain in their own homes, respondents noted that this does not negate the need for accommodation services for those living with a greater complexity of need.

6.5.3 In terms of the SNA for people with learning disability they conclude that the analysis of current need suggests that there is an undersupply of 224 units. Research previously commissioned by the NIHE (2016) in reference to the resettlement of individuals living with learning disabilities from long stay institutions highlighted that for these people there are several elements of supported housing services that are important:

- location or at least access to public transport network,
- safety
- Integration into the community.

6.5.4 These are important to the individuals to allow for their own independence and the feel of being part of a community. It is apparent from their research that the demand for learning disability services and in particular autism services has increased due to improved diagnosis and treatment services, which in turn will lead to an increased demand on housing support services. As the future calculations show, it is estimated that there will be an undersupply of 479 units for this cohort within a ten-year period.

6.5.5 Additionally, the SNA highlights the important issue of access to capital for housing development. Some providers have highlighted that capital investment would allow them to provide the required level of service to meet the growing demand as well as a wider range of housing support services.

6.5.6 It also refers to some early joint planning work between the NIHE, HSCB and HSCT's in relation to improving planning for the needs of people with learning disabilities. The information gathered and analysed in 706 person pilot conducted by HSCB with HSCTs for people with learning disability the report identifies could help inform future strategic needs assessment particularly if standardised approach were developed.

6.6 How commissioning operated in practice to deliver the resettlement programme for the people awaiting resettlement from MAH.

6.6.1 The commissioning plan from the HSCB/PHA had made an explicit requirement for the resettlement of the remaining people awaiting discharge to be progressed at pace.

6.6.2 In order to progress the HSCB convened a number of groups to support this process. There was a Mental Health/Learning Disability Strategic Leadership Group comprising senior leaders from the Directorate of Children and Social Care in the HSCB and the Directors responsible for learning disability services in each of the Trusts. This group had a leadership role across the whole of mental health and learning disability services, and held a collective strategic responsibility for the delivery of resettlement. This group sponsored 2 subgroups which comprised officers of the HSCB and senior operational staff from the Trusts, including the Assistant Directors/Co-Directors responsible for learning disability services. Initially this only included representation from Belfast, Northern and South Eastern Trusts as the remaining people in MAH awaiting discharge were the responsibility of these organisations by virtue of the individual's original place of residence. These subgroups were (1) the Regional Learning Disability Operational Group (RLDOG) which included some representation from NIHE, and other agencies such as RQIA, and (2) Community Integration Programme (CIP) which looked more specifically at the issues pertaining directly to the resettlement programme.

6.6.3 The review team were able to observe and participate in all of the above groups and in addition had specific meetings with each of the Trust's senior leadership teams responsible for learning disability resettlement.

6.6.4 It was positive that the HSCB had created a structure of groups and meetings to progress the resettlement programme and address related issues, particularly in relation to access to learning disability hospital beds for assessment and treatment. There was a clear commitment from senior leaders to support the delivery of the resettlement programme and to work jointly to face and address the significant challenges.

6.6.5 However we felt that overall the commissioning of services was poorly framed and lacked effective performance management. This meant that the HSCB (and more recently SPPG) has struggled to achieve timely impact in ensuring the Trusts secured new homes for the people awaiting discharge from MAH.

6.6.6 There were a number of particular weaknesses which the review team identified. The HSCB were using a basic table to monitor the status of the individuals in the target population, which the review team assisted with re-design. Updates on this revised 'tracker tool' were sometimes only provided after chase up, and often not validated by the respective Trust AD/Co-Director, so may not have been reliable. Attendance at these key meetings was generally poor and inconsistent, contributed to in some instances by the too frequent changes in personnel in significant delivery or planning roles. Hopefully this report will be a catalyst for the SPPG to review with its partners the effectiveness of both CIP and RLDOG.

6.6.7 Whilst colleagues from other agencies – NIHE and RQIA – were involved in RLDOG it was sometimes unclear how they were expected to engage in the activity to progress schemes and proposals at speed. In particular the housing professionals held a wealth of information and data about activity in the existing system and had expertise in both design and delivery of housing schemes which wasn't always drawn on by colleagues from health and social care. Housing colleagues described how they felt the inter-agency working had become less evident and effective in recent years, partly due to the lack of stable leadership and management arrangements at times in health and social care. They felt that some of the current senior staff lacked the understanding of the housing and Supporting People sector that their predecessors had demonstrated.

6.6.8 Whilst there was a verbalised commitment to working collaboratively, this was sometimes hampered by poor communication between the key partners. This was especially significant where a lead Trust was developing or planning a scheme which had the potential to provide accommodation for individuals from other Trusts. In some instances plans had not been shared with other partners which meant they weren't sighted on proposals for developments to be located in their Trust area, without their involvement in the planning, which had potential to place demand and pressure on local learning disability and other services.

Perhaps the most significant area of concern was the scrutiny of the proposed accommodation schemes and the supporting business cases to develop those schemes by the HSCB and individual Trust Boards. This rarely involved rigorous assurance that the planning for schemes would deliver new accommodation for individuals awaiting resettlement within a reasonable timescale. Subsequently the stated ambition that all people awaiting discharge from MAH would be resettled by the end of 2019 was completely missed, with slow progress verging on inertia beyond that point.

6.6.9 Having set out the regional landscape for strategic commissioning of health, social care and housing we will move in the next sections to look at how Trusts have progressed the individualised care planning (Chapter 7) and local commissioning of new provision to progress the resettlement plans developed for individuals.(within Chapter 8)

6.6.10 Across the system the review team were concerned that there were significant examples of poor or slow decision making, limited communication to support a fully collaborative approach, and weak management grip to address practical barriers that delayed positive outcomes being achieved – an example of this was transition/discharge plans being delayed for sometimes lengthy periods because required adaptations to property had not been completed, or legal advice in relation to placement matters had not been satisfactorily addressed.

6.6.11 There were a few legitimate challenges faced by the HSC system which we acknowledge compromised delivery within agreed timescales. The obvious challenge across the whole system was the global pandemic and the significant impact this had on capacity. This impacted further on workforce issues which all parts of the system described as placing them under real difficulties. Less likely to have been anticipated were the issues in relation to building and estates , as new providers experienced unprecedented pressures in relation to the escalating cost and reduced supply of building materials which slowed the delivery of some schemes.

6.6.12 It is worth noting that all of the Trusts had engaged with some of the well-known providers in the not-for-profit sector, several of whom had a well-tested track record of meeting community demand for care and support to individuals with learning disability and behaviour that can challenge. This had resulted in a small number of resettlements being achieved through the design and delivery of high-quality singleton placements. Some of the families that we had engaged with told us stories of truly transformational and life changing experiences when their relative moved on from hospital to these schemes, and we will return to this in Chapter 8 when we look at the Operational Delivery of Care and Support.

6.6.13 However, it should also be noted that generally the review team found that Trusts often initiated planning for proposed new accommodation schemes without fully exploring the opportunities for potential provision within either existing or re-designed provision. If this had been possible then options for resettlement could have been developed in a much more speedy way.

6.7 Shaping the Independent Health and Social Care Market for People with Learning Disability

6.7.1 In the last few decades across the UK and more widely we have seen a significant shift away from hospital based long term care for people with learning disability towards community based provision. This shift has been driven by a clearer commitment to respecting the human rights of people with learning disabilities which has been enshrined in health and social policy.

6.7.2 Large scale institutional care has been replaced by a mixed economy of alternative care arrangements ranging from large scale group living to individualised specialist housing with dedicated care and support.

6.7.3 In England the responsibilities for market shaping are enshrined in the Care Act (2014) which states that each local authority “Must promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person wishing to access services in the market:

- Has a variety of providers to choose from who (taken together) provide a range of services
- Has a variety of high quality services to choose from

- Has sufficient information to make an informed decision about how to meet the needs in question."

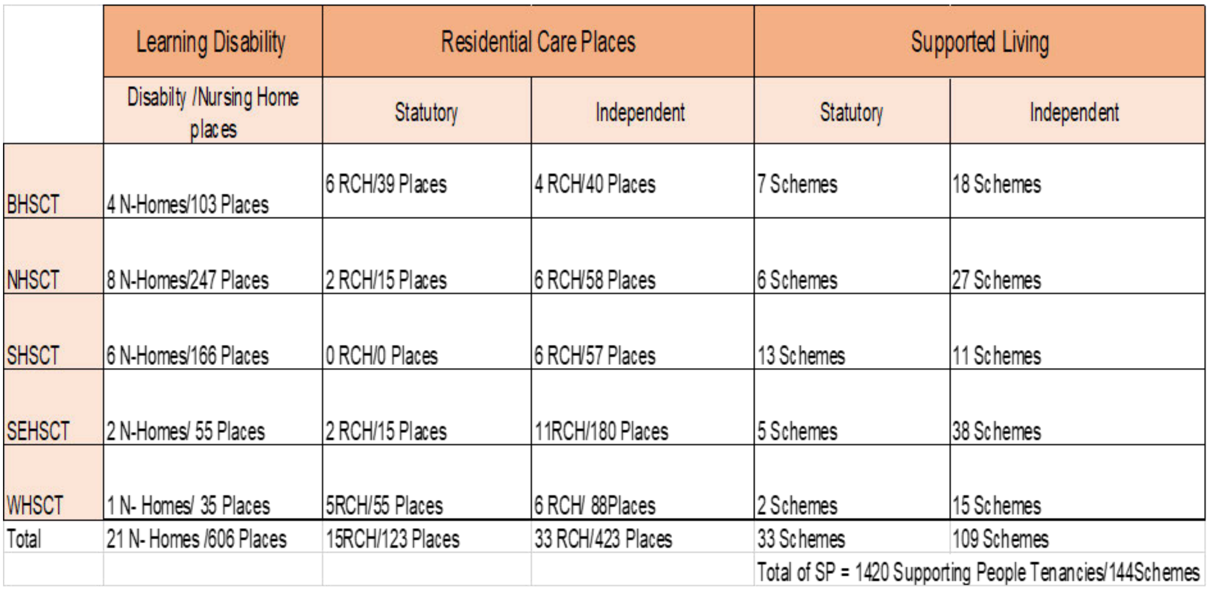
6.7.4 The Care Act reinforces that commissioning should be at the heart of personalised care and support. This includes commissioning with health and care organisations but goes further to include engagement with community development and working with other agencies, for example the community sector.

6.7.5 Whilst a similar statutory responsibility is not placed on HSC Trusts, they do have legal responsibilities to provide services, and should do this not only through direct provision but also by purchasing services from independent sector providers. Implicit within these broader responsibilities is a need to support and shape the market to ensure robust supply and to secure value for the public purse.

6.7.6 The review team found that health, social care and housing agencies held significant data on the current market provision relating to services for people with learning disability. RQIA hold information on each registered provider of nursing or residential care and can provide information not just on the capacity of those providers but also can provide quality information through a highly regulated inspection process. In addition, they are responsible for registering the domiciliary care element of supported living schemes which are responsible for providing the support element. We were impressed by the data that the NIHE hold relating to the 149 accommodation based supported living schemes which included both activity and financial data relating to both housing and HSC investment in these schemes, where the balance of the funding for each scheme is based on a functional analysis of the housing support vs care needs of the clients within the scheme.

6.7.7 However, the review team found that this data was not routinely shared by partners across the sector and that there was no strategic overview of what the market was providing for adults with learning disability across Northern Ireland, and at what cost. Given the availability of significant data we would expect that both strategic and local commissioners of care and housing would undertake some analysis to develop a 'supply map' of care and specialist housing for people with learning disability in Northern Ireland. This could inform strategic commissioning and market shaping, but it would also be of benefit to care managers, individuals seeking care and their families so that they understood the options available to them which could promote choice. This should be a live and dynamic picture of supply.

6.7.8 The review team gathered information from a range of sources, and undertook some analysis to establish an initial supply map, and identify commissioning trends. We will address within the recommendations. Below is a table which shows the overall range and location of registered care settings and supported living schemes in Northern Ireland. This sector provides accommodation capable of meeting a diverse range of needs, all located within the community. In total there are somewhere in the region of 2,500 places in the community for people with learning disabilities and a significant minority of the schemes have been devised to accommodate individuals who additionally have mental health difficulties or behaviour that can challenge. The cost of care across the sector is highly variable and is linked directly to the level of support and care required. For those individuals who live in the registered care sector all of the care costs are met by health and social care (although there could be a small number of 'self-funders'). HSC Trusts purchase places in registered care setting either through block contract or on a 'spot purchased' basis for individuals.



	Learning Disability	Residential Care Places		Supported Living	
	Disabilty /Nursing Home places	Statutory	Independent	Statutory	Independent
BHSCT	4 N-Homes/103 Places	6 RCH/39 Places	4 RCH/40 Places	7 Schemes	18 Schemes
NHSCT	8 N-Homes/247 Places	2 RCH/15 Places	6 RCH/58 Places	6 Schemes	27 Schemes
SHSCT	6 N-Homes/166 Places	0 RCH/0 Places	6 RCH/57 Places	13 Schemes	11 Schemes
SEHSCT	2 N-Homes/ 55 Places	2 RCH/15 Places	11RCH/180 Places	5 Schemes	38 Schemes
WHSCT	1 N- Homes/ 35 Places	5RCH/55 Places	6 RCH/ 88Places	2 Schemes	15 Schemes
Total	21 N- Homes /606 Places	15RCH/123 Places	33 RCH/423 Places	33 Schemes	109 Schemes
				Total of SP = 1420 Supporting People Tenancies/144Schemes	

(RCH – Registered Care Home) Fig 2

6.7.9 For those living within the housing with support provision the individual is usually funded through a combination of rental income which is commonly paid through housing benefit, an element for housing support paid from Supporting People funds, and then a care element paid for by the placing HSC Trust. Obviously in the case of supported living, the financial costs are spread more across 2 government departments – communities and health – and then arranged through the NIHE and HSC Trusts. In supported living the individual will have a secured tenancy, which ensures rights as a tenant under the relevant housing legislation. Additionally, the individual will be eligible to apply for personal benefits and therefore could have more disposable income which can support greater financial choice.

6.7.10 The review team undertook a preliminary analysis of the market and in this context there were some interesting features of the market in Northern Ireland which merit some note. There are vacancies across all sectors, although the data on this wasn't readily held or available when we asked for it from Trusts, yet when talking to providers they all reported some level of vacancy across provision. For some providers in the private sector this was a particular issue in terms of sustainability, and they stated a willingness to work with local commissioners to adapt their services to be more appropriate to need and demand both now and in the future. Across the supported living sector there was somewhere in the region of 5% vacancy, which whilst relatively small did provide some opportunities to meet emerging demand, although the SNA completed by the NIHE indicates that they believe there is under provision for people with learning disability at present.

6.7.11 HSC Trusts continue to be a major direct provider of services to this client group both in registered care and supported living. Trusts operate 31% of the registered care settings for people with learning disabilities accounting for almost a quarter of the registered care places. In the supported living accommodation schemes 24% of the schemes were operated by the local HSC Trust. There is considerable variability in the extent to which Trusts continue to operate as providers. For instance, the SHSCT operate 55% of the supported living schemes in its area, but the WHSCT operates 11% of the supported living schemes in their area. This raises some interesting questions which the review team haven't fully explored in terms of the delineation of roles for Trusts both as commissioners and providers of care.

6.7.12 In relation to the registered nursing home sector these are all private sector operators. There are 21 specialist learning disability nursing homes in Northern Ireland, and the majority are operated by local providers some of whom have entered the market because of a family related interest in learning disability care or are led by professionals who previously worked within statutory services. However, 60% of the specialist nursing homes are located within 2 Trust areas of the NHSCT and SHSCT, with the majority in the NHSCT.

6.7.13 Further strategic inquiry is merited in relation to the type of need being met by statutory versus non-statutory as anecdotally this appeared to be based on historical context rather than based on strategic decisions. There could be a rationale for the HSC Trusts continuing to be such a significant provider, especially if this was to meet a category of need that the market for social care had struggled with, but again anecdotally this didn't appear to be the case.

Providers pointed out that as statutory providers were using Agenda for Change terms and conditions in employment arrangements within their direct provision, this placed Trusts at a tactical advantage in terms of recruitment and retention of staff. We will return to this issue in the later section on workforce.

6.7.14 Engagement with Private Sector Providers: we engaged with provider sector providers through a number of focus group sessions organised by 2 of the network organisations representing providers across the independent sector. These were ARC (NI) and Independent Health Care Providers (IHCP). The sector engaged very readily in the review and were keen to give their views and share their experiences of working within the wider system. Generally, providers, especially those in the private sector, felt that the resettlement teams and HSC Trusts had not engaged them in a strategic discussion about the sector's potential in meeting the needs of people awaiting discharge from long stay institutions. Several providers described that whilst they may not have been considered in the first instance, there were several occasions where they had been asked to consider and had admitted some individuals who had experienced unsuccessful placements elsewhere. In these cases several of the subsequent placements had gone on to be both successful in terms of client outcomes and stability over time.

6.7.15 Generally, providers expressed concern about the lack of effective partnership between commissioners and providers. In particular they felt that HSC Trusts were unwilling to engage in negotiations around 'risk-sharing' in terms of contractual measures that ensure a reasonable level of income to support the borrowing necessary to allow capital development and borrowing. This was more of an issue for smaller providers who were newer to the market. Providers also expressed a general view that whilst there was extensive engagement with HSC Trusts care management staff and contracting teams in relation to contract review, there was little discussion about forward planning or potential for service development. Additionally, several providers worked with a number of commissioning agencies or HSC Trusts and commented on the variability in processes and overall approach. Given the size of Northern Ireland there definitely should be consideration given to the development of a commissioning collaborative operating under a single commissioning framework. Nursing and independent residential care providers commented that they were being expected to operate under out of date nursing/residential care contracts with amendment through letter of variation, and these arrangements were not fit for purpose. This proved unsatisfactory, particularly in the context of the complexity of need of some of the clients.

6.7.16 The statutory sector within health and social care have organised their activity through the Social Care Procurement Board (SCPB) which was chaired by the

Director of Children and Social Care at the HSCB/SPPG with representation from each of the 5 Trusts and legal services. The SCPB has been going through a 'refresh' process to review its role and how it operates. Its revised draft terms of reference include:

The Social Care Procurement Board will:

a) Develop a Social Care Regional Procurement Plan that places all approved procurement projects within the overarching strategic commissioning landscape and includes the rationale for each procurement project being taken forward.
b) Ensure any request for a regional procurement project is only approved when the project can demonstrate a clear and unambiguous link with the Programme for Government and strategic commissioning plan for a related programme for care.
c) Establish a Social Care Procurement Project Delivery sub group for the operational management of the Social Care Regional Procurement Plan, with the Chair of the sub group to be a member of the Social Care Procurement Board.
d) Establish additional specialist sub groups in response to strategic commissioning needs.

6.7.17 Whilst it is encouraging to see this renewing of the SCPB it is imperative that they engage effectively in broader strategic engagement with providers so that commissioning strategies are informed and shaped with intelligence from the sector itself. There needs to be a recognition that the commissioned services with independent sector constitute a multi-million pound investment which has a massive impact on the lives of people with disability. Additionally, as elsewhere in the rest of the UK and Europe there is a growing recognition of the demographic shift in the population of adults with learning disability/ASD and behaviour that challenges leading to massive increases in demand which are related to the exponential growth in numbers of people diagnosed with LD and ASD, and the improved life expectancy of people with learning disability.

6.7.18 Several Trusts have provided us with information about provider engagement events or have established regular provider forums, to improve their partnership working. This would be best progressed through greater regional collaboration which could be supported by the SCPB's prioritisation of this important area of work.

6.7.19 Critical to this work will be developing an understanding of the pricing structure for care, and in particular the significant variation in costs across the sector. It will be important to understand both financial viability and financial sustainability of this relatively small cohort of specialist providers.

6.8 Finance and Value for Money

6.8.1 Commissioners, both strategic (regional) and local (within Trusts) have a broad duty to ensure value for money in relation to all expenditure within the public purse. This responsibility is scrutinized by the Northern Ireland Office who can pursue Value for Money Audits in relation to key areas of work.

6.8.2 The review team were not required in the context of the terms of reference for this review to undertake a detailed analysis of the costs associated with the resettlement programme, but there are a number of observations that we would make in the context of strategic commissioning.

6.8.3 The review team have had discussions with finance officers within the HSCB regarding the commissioning of learning disability services, including the services provided at MAH and the alternatives being proposed through the resettlement schemes.

6.8.4 The costs associated with the funding of MAH is linked to the funding of the resettlement costs. In the past a 'dowry' system applied where each individual being resettled from a long stay hospital received an allocated sum to support their resettlement, but there was a broad acceptance that the dowry was often insufficient to cover the costs of the placement. Whilst the dowry was person specific once it was no longer required to support that named individual, then it could be incorporated in to the base funding for future community placements at some point.

6.8.5 In more recent years this has been replaced with a requirement that the HSCB would receive costed proposals for the resettlement of an individual, directly linked to the cost of a placement or place within a newly developed scheme, and there is an approval process. This requires the HSC Trust to submit a client specific business case for each individual with complex needs, in which the Trust is required to lay out provisions for capital and on-going revenue costs, and should demonstrate value for money to the public purse. The business case must also demonstrate what elements, if any, are funded through sources of funding outside of health, usually housing/supporting people funds. This include access to personal benefits – housing and welfare payments, rental costs, or Supporting People funding towards housing support and some elements of management costs within schemes.

6.8.6 In broad terms the costs associated with the funding for MAH is linked to the funding of the resettlement costs. There would have been an assumption that a certain proportion of resettlement costs were linked to an expectation of ward closure and decommissioning of beds as the patient population reduced. In reality there should have been a decommissioning plan agreed between the BHSCT and HSCB linked to the resettlement programme, but this doesn't appear to have been put in place.

6.8.7 In recent years the number of patients leaving the hospital has been relatively low. However in addition the number of patients remaining in MAH is substantially lower that the commissioned beds. Costs within MAH have escalated dramatically as there has been an increased reliance on funding of substantial agency staff to replace staff who have been placed on suspension during the course of the PSNI investigation.

6.8.8 This has meant that in the last several years the BHSCT has had to seek additional funds non-recurrently from the HSCB to cover these additional substantial cost pressures.

6.8.9 The other factor to consider is the cost of the alternative homes that are being commissioned for people moving on from MAH through resettlement. Through the ‘tracker tool’ the Trusts have reported on discharge planning for each individual and where there is a scheme either nearing completion or with a costed business case approved they provide indicative costs. Not all Trusts provide this information, but based on the return from the NHSCT the annual costs of the new provision range from £212k to £500k per annum for the majority of clients. It should be noted that there was one client who had costs significantly higher than has been quoted in the range but as this was deemed an exceptional individual with what could be considered the most complex needs that individual hasn’t been included in the range.

6.8.10 As stated previously the SCPB will need to consider benchmarking the costs of these specialist community placements so that SPPG, HSC Trusts and others can establish what ‘value for money’ looks like in this domain. Additionally it has to be recognised that the community placements should provide significant quality of life benefits to those individuals who have previously lived in MAH.

6.8.11 Whilst the review team did not have access to detailed cost per bed data for MAH, based on our discussions with finance officers it would appear that the cost of hospital bed in MAH per annum currently is significantly higher than even the highest costed placement within the range of placements provided by NHSCT, and substantially higher than the estimated average cost of a community placement. In addition it has to be considered that for placements in specialist supported living schemes, a proportion of the costs will be shared with housing.

6.8.12 In the context of the position laid out above there needs to be consideration of the opportunity costs in this situation. A simple definition of ‘opportunity cost’ is “opportunity cost is the forgone benefit that would have been derived from an option not chosen or pursued”. The review team consider that if the resettlement of the target group of patients had been achieved more quickly and within the timescale of the original directive from the Permanent Secretary in 2018, then there were opportunities for cost efficiencies in relation to the cost of community placement relative to the cost of continuing hospital placement for these individuals. This may be open to alternative interpretation and debate, but there is certainly merit in considering this as part of any more formal evaluation of the resettlement programme.

6.9 Recommendations

In summary the conclusions and recommendations from this chapter are:

- The DoH needs to produce an overarching strategy for the future of services to people with learning disability and their families, to include a Learning Disability Service Model.
- In the context of the overarching strategy the SPPG will develop a commissioning plan for the development of services going forward. This should include the completion of resettlement for the remaining patients awaiting discharge from MAH, and progress the re-shaping of future specialist LD hospital services.
- Strategic commissioners within health, care and housing should convene a summit with NIHE, Trusts, Independent Sector representatives, and user/carer representation to review the current resettlement programmes so that there is an agreed refreshed programme and plan for regional resettlement.
- The SPPG and NIHE/Supporting People should undertake a joint strategic needs assessment for the future accommodation and support needs of people with learning disability/ASD in Northern Ireland
- The Social Care Procurement Board should urgently review the current regional contract for nursing/residential care and develop a separate contract for specialist learning disability nursing/residential care.

7. Individualised Care Planning

In this section we will review the policies, and discharge planning guidance in place nationally to identify good practice; critically review the individualised care planning arrangements in place in each of the 5 HSC Trusts and assess their effectiveness.

7.1.0 As part of evidence gathering, the review team issued a questionnaire to all 5 HSC Trusts requesting confirmation of the assessment tools and care planning procedures and processes relied on to support discharge planning.

7.1.2 Engagement with family carers and provider organisations, provided rich information to the review team in regards to the effectiveness and experience of discharge planning and this feedback highlighted a gap between the perception of statutory HSC Trust teams leading the discharge planning and the experience of other stakeholders.

7.1.3 The review team analysed the information returned by HSC Trusts and completed a review of research and available guidelines and best practice relating to individualised care planning. The review of policy and guidelines highlighted the need to plan discharge from the moment of admission. The Care Quality Commission- Brief Guide; discharge planning from Learning Disability assessment and treatment units August 2018, (ctrl click) provides a useful checklist of what needs to be in place for effective discharge planning;

- At the point of admission, the care plan should include a section on 'when I leave hospital' and the discharge plan discussed at each meeting
- Ensure family and the individual are involved with clear goals agreed
- Discharge plans need to contain a date, an identified provider and discharge address
- Evidence that the person is being supported to develop skills for independence and living in the community
- Evidence that information is shared appropriately with providers to prepare for discharge with the outcomes of assessment and treatment clearly stated.

7.1.4 There are a range of relevant Guidelines to inform effective assessment and care planning. NICE guidelines- 'Challenging Behaviour and Learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges' (ctrl click) highlights the importance of understanding the cause of behaviour and need for thorough assessments so that steps can be taken to help people change their behaviour The DoH Guidance 'Positive and Proactive Care: reducing the need for restrictive interventions (2014) (ctrl click) is also based on a positive and proactive care approach The Care Quality Commission, Brief Guide: Positive behaviour support (PBS) for people with behaviours that challenge (2018) (ctrl click) provides the policy position and helpful good practice case examples.

7.1.5 Promoting Quality Care' Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability services(May 2010) (ctrl click) states that a crisis plan should be included in the care plan and specify triggers and warning signs with explicit proactive and preventative strategies in the care plan. Effective assessment and care planning is central to supporting the transition of individuals from hospital to the community who have highly individual communication and support needs. Guidance and policy highlight that an essential lifestyle plan alongside the positive behaviour support plan should be central to discharge planning in addition to core assessment tools. The Centre for the advancement of PBS-(BILD) (ctrl click) advocate a whole organisational approach to embed PBS with all staff having a basic understanding of PBS and its value base. The learning from resettlement placements that have broken down and feedback from families and care providers highlights that positive support plans have not always been in place and that further work is required to ensure regional standardisation in regards to the quality of assessments and the tools used.

7.1.6 Questionnaires returned by HSC Trusts highlighted a lack of consistency regionally in the documentation used to develop care plans supporting a person's transition from Learning Disability hospital to the community. HSC Trusts use a range of assessment templates which are not always collated into one document. All HSC Trusts used the Northern Ireland Single Assessment Tool (NISAT) DoH Procedural Guidance- February 2019 (ctrl click). However, this comprehensive care management assessment tool is generic and not sufficiently person centred. Some Trusts, appropriately supplemented the NISAT with a range of assessment tools, including 'Essential Lifestyle plans 'Promoting Quality Care assessment, Functional assessment, Motivation assessment scale and Behaviour support plan. If a person is displaying challenging behaviours, a functional assessment can help uncover the reasons behind that behaviour. Knowing the function, allows changes to be made that reduce challenging behaviour. It is essential that discharge planning is person centred and that the information is accessible and available to all the stakeholders involved in supporting the person to move on from hospital. This highlights that assessment tools will only be effective if the organisational culture is based on positive behaviour support for people with behaviours that challenge and staff trained to understand and evaluate communication and to implement proactive and preventative strategies in response to triggers and warning signs to avoid escalation and crisis. Review of strategic policy across

England, Scotland and ROI confirmed that all prioritised the development of a positive behaviour framework.

7.1.7 The review team recommend that HSC Trusts collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans. The review team recommend that the learning disability strategy / learning disability service model to be progressed by DoH takes the evidence base for PBS and learning from other UK nations into consideration.

7.1.8 The discharge process requires sufficient flexibility to ensure agility and prevent the process being risk averse, however, an overarching pathway that maps out who does what at critical stages of the process is required. The review found that there is no overarching resettlement/ discharge policy that informs the roles and responsibilities of the range of organisations, teams and individuals involved. Indicative timelines for case transfers between teams and organisations is required so that individuals and their families know what to expect at each stage of the transitions pathway. The review team recommend that HSC Trusts collaborate with all stakeholders to develop a resettlement pathway and operational procedure.

7.1.9 Most Trusts were clear that it is the community HSC Trust that has the lead role for discharge planning rather than the hospital team however, this was not consistently applied regionally. The review team worked with all HSC Trusts throughout the period of the review with agreement reached that the community HSC Trust held responsibility and accountability to lead resettlement planning once the patient had been identified as ready for discharge. The community HSC Trust will be reliant on the MAH team who have the contemporaneous experience of caring for the patient to provide clinical information and input to the care plan however the community HSC Trust should hold a challenge function in addressing any discharge delay.

7.1.10 The MAH resettlement co-ordinator has a central role in facilitating meetings and coordinating the information the hospital team need to share with community Trusts and provider organisations. Provider organisations had to develop their own care plans from information shared by the MAH team and the assessment completed by the relevant HSC Trust, whilst getting to know the patient during in-reach. They reported significant weaknesses with this approach.

7.1.11 It was generally recognised that it is a complex task to develop care plans for community living based on behaviours and triggers evident in an institutional setting. This highlighted that the community teams should lead the discharge care planning processes with active collaboration with families and provider organisations which was not always evident in the review.

7.1.12 Learning from failed placements and engagement events with provider organisations and with families, highlighted that not all care plans were robust in highlighting the key issues and risks for the individual. Families shared their experience of resettlement placements breaking down within weeks and months of the trial placement with recurring themes; staff not knowledgeable or trained in Positive Behaviour approach, inexperienced staff relying on physical interventions and care plans that did not reflect the level of support that would be required in the community.

7.1.13 Families were confused by the process of handover between teams due to a lack of clarity regarding the roles of the community learning disability team, the dedicated resettlement team and the MAH team when a patient is discharged on trial. Families were unclear of the process for standing down the resettlement team and transitioning to the community learning disability team. Some families who had experienced placement breakdown during trial resettlement felt that the process was too focused on the MAH multi-disciplinary team for advice and support rather than involvement and wraparound services from the community learning disability team. Some families expressed the view that their loved family member was returned to MAH at the first challenge when more should have been done to sustain the community placement. There should be a clear process mapped out through the resettlement pathway providing clarity of roles and mapping out indicative timeframes for transitions between teams for patients and families long the resettlement pathway.

7.1.14 Care providers reported a negative experience of care planning due to gaps in the information that should have been provided by HSC Trusts. Assessments were stated to be based on the current behaviours in an institutional setting and not on the hopes and dreams that should be central to strength based person centred planning

7.1.15 There was insufficient evidence of the learning from things going wrong being used to improve discharge planning regionally and no evidence provided that the learning is shared with care providers. Care providers also highlighted that the focus tends to be on what has gone wrong rather than on what is going right and that the HSC system should collate the learning from successful placements. The review team recommend that HSC Trusts collaborate with key partners to share the learning when things have gone wrong as well as the success factors when resettlement has worked well and celebrate positive resettlement stories.

7.1.16 The review team were tasked to review the care plans for all the service users in MAH and critically analyse the actions taken to identify and commission suitable community placements. The terms of reference asked the review team to look specifically at the MAH population profile by the length of time the person has been in MAH, where they were admitted from and if resettlement has already been trialled. The analysis of the thirty six current in-patients and 4 patients on extended leave is presented in the following charts.

Table 1.1 MAH current population by length of stay (Inclusive of 36 in-patients and 4 patients on extended leave).

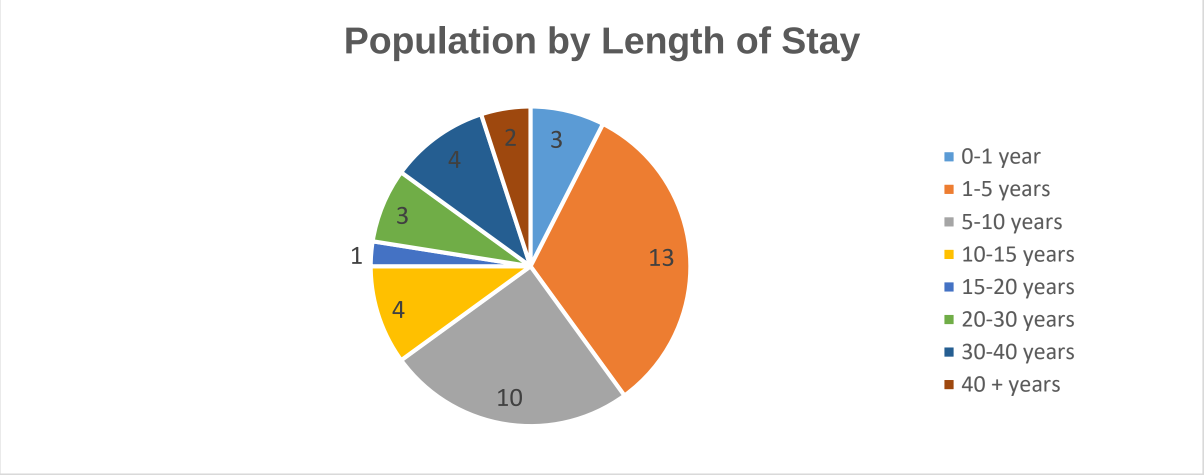


Fig 3

7.1.17 The original Patient Target List (PTL) was established to target long-stay patients for resettlement who had been in-patient at MAH for more than one year in 2007. The analysis of length of stay of the current in-patient population identified ten patients from the PTL list who have not been resettled of whom six have been in MAH over thirty years and 2 in MAH over forty years. The range of lengths of stay for the remaining 16 delayed discharge patients not on the PTL list, varies by HSC Trust. SEHSCT range between 2 and 4 years. BHSCT range between 2 and seven years and NHSCT range between 2 and ten years.

7.1.18 The hospital has been virtually closed to admissions over the past 2 years however, it is of note that the 3 admissions in the past year were all BHSCT patients. Two of these admissions were from a respite facility managed by BHSCT and one from a facility managed by an independent sector provider. It is clear that HSC Trusts are responding to a higher level of acuity and risk in the community than previously however, further action is needed to embed hospital avoidance measures through community treatment and intensive support to prevent further admissions and adding to the delayed discharge population.

7.1.19 The impact of new admissions on a long stay population is significant due to the challenge of managing very diverse and competing needs. The majority of patients in MAH are NOT on active treatment and should be progressing on a skills development and transitions pathway. Unplanned new admissions have the potential to impact on the opportunities and quality of life for longer stay patients if the focus in the hospital is on managing risk and crisis response. It is critical that community based crisis response and intensive support services are further developed to prevent crisis admissions.

Table1.2 MAH Admitted From

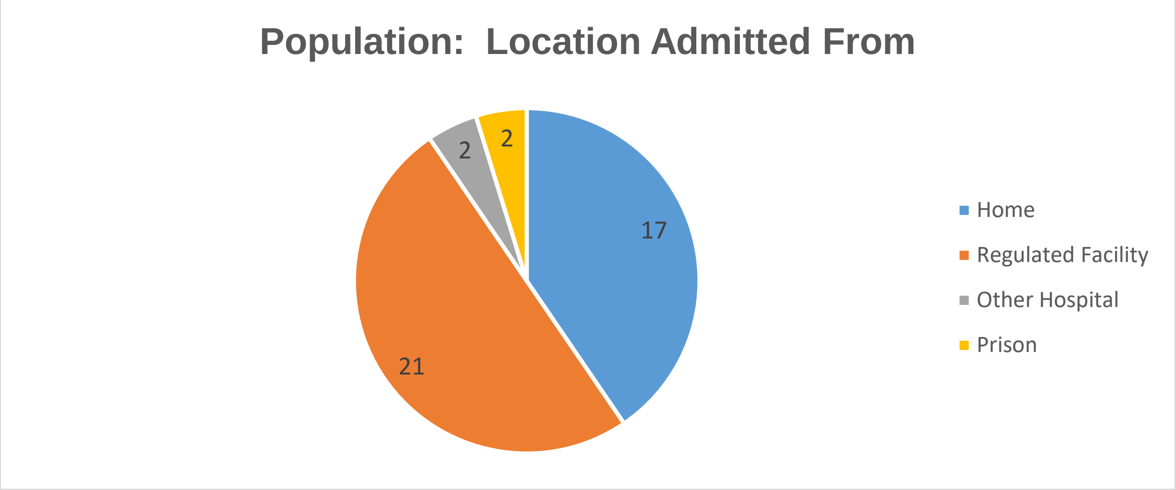


Fig 4

7.1.20 Patients with longer lengths of stay were more likely to have been admitted from home, but those admitted in more recent years were likely to have been admitted from a range of regulated facilities. Two patients transferred from prison and 2 of the MAH patients transitioned from the children's inpatient facility the Iveagh centre. Children & Young People with learning disability were not in scope for this review however, feedback from family carers stressed that a lifecycle approach to planning is essential to effectively project and plan for transitions and that children, young people and their family carers should have a say and input into planning adult services as a key stakeholder. Analysis of the data relating to where patients have been admitted from, highlights that recent admissions have all been from regulated learning disability facilities managed by both statutory and independent sector providers. The review team did not see evidence of the learning from these crisis admissions however, the evidence base and policy/commissioning direction in England and Scotland highlights the need to step up wraparound intensive support services to meet the needs of the individual but also to wraparound the staff teams often struggling to respond.

7.1.21 The review team had the opportunity to visit people in supported living environments who had previously been transferred to medium secure hospital in the UK and were now successfully returned to their home community. The success factors in sustaining the placement reported by both the Independent sector provider and the Trust was the level of collaboration, responsive and pro-active interventions by the Trust Learning disability forensic team. The independent sector care staff talked about the importance of building relationships and trust with statutory colleagues. The Welsh Government's 'Improving Lives Programme (2018) placed particular emphasis on communication and effective working relationships at all levels across the system. The emphasis on these 'softer' skills within the Improving Lives programme of change is significant. The review team received feedback from statutory, independent sector providers and from families highlighting concerns about the lack of openness, trust and respect in relationships. Families reported that lack of continuity of key workers has impacted on developing trusted relationships alongside the fact that their trust in the HSC system has been broken due to the allegations of abuse at MAH. Care Providers and HSC Trusts expressed negative experiences in the contracting and monitoring of services due to a lack of trust.

7.1.22 It is critical that community based intensive wraparound services are developed to prevent placement breakdown and prevent hospital admission. However there is also a need to get back to basics and spending time repairing and building relationships which should be informed by the values underpinning the HSC Collective leadership strategy (ctrl click) to ensure effective person centred planning and collaboration with all relevant stakeholders

Table1.3 MAH current population Number of previous trial placements

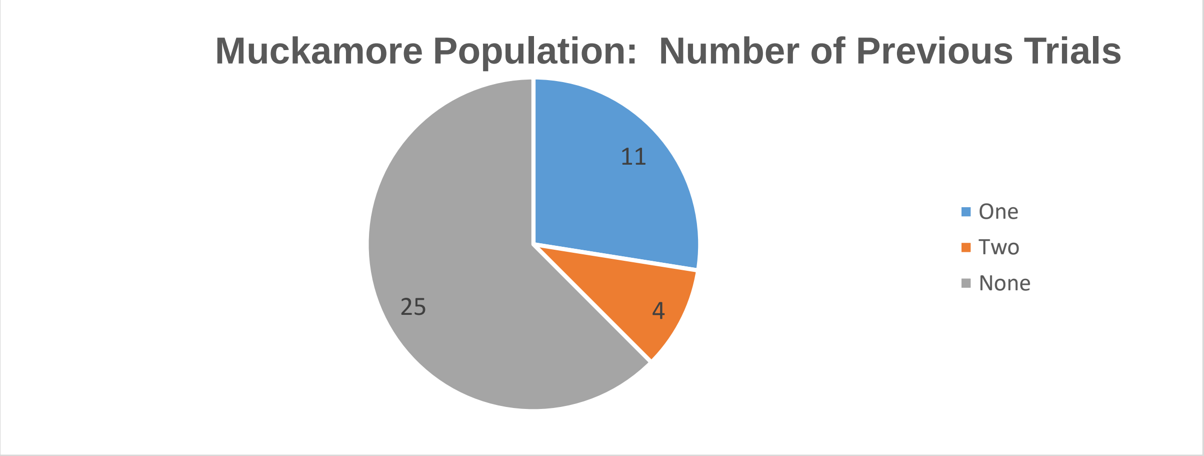


Fig 5

7.1.23 In regards to previous trial resettlement, the analysis confirmed that all PTL long-stay patients had at least one previous trial placement with one PTL patient who had been offered 2 placements but would not leave the hospital. A small number of patients who had become institutionalised by having lived most of their adult lives in hospital were distressed by the experience of trial resettlement, which were then unsuccessful. This is a key reminder that whilst we should be ambitious for timely resettlement the primary importance is getting the resettlement right first time in order to prevent further breakdown causing trauma and distress. The majority of patients who have not yet had a previous trial placement are the more recent admissions or the small number of patients subject to a hospital order with restrictions with step down from detention requiring collaboration with the Department of Justice.

7.1.24 MAH serves 3 HSC Trusts, the BHSCT which manages the hospital, the NHSCT and SEHSCT. The WHSCT has its own Learning Disability in-patient beds at Lakeview Hospital and the SHSCT has its own Learning Disability in-patient beds at Dorsey hospital. There are a few out of area placements. SHSCT has one patient in MAH. NHSCT has one patient in Dorsey and one patient in Lakeview.

7.1.25 At commencement of the Review of Resettlement, there was a total of sixty Learning Disability in-patients delayed in discharge regionally; 46 at MAH, 8 in Dorsey Hospital and 8 in Lakeview Hospital.

7.1.26 The review team established the baseline MAH Population in June 2021 and updated the population baseline as of 11th July 2022. It is encouraging to note that there have been ten discharges between June 2021 and July 2022 however 3 admissions. The NHSCT had the highest in-patient numbers at commencement of the review however, BHSCT now has the highest number of in-patients.

Table 1.1: Patients by HSC Trust – June 2021

Trust of Residence	**Number of In-Patients**
NHSCT	21
BHSCT	16
SEHSCT	8
SHSCT	1
WHSCT	0
Total	**46**

Fig 6

Table 1.2: - Patients by HSC Trust-11th July 2022

Trust of Residence	**Number of In-Patients**
NHSCT	14
BHSCT	15
SEHSCT	6
SHSCT	1
WHSCT	0
Total	**36**

Fig 7

7.1.27 The review team critically evaluated the progress of resettlement plans as devised by the responsible Trust for each patient in MAH and reviewed all business cases which have been completed or are still in process, to identify any strategic or operational barriers and make recommendations for actions to accelerate the delivery of proposed pipeline schemes. The review team reviewed the data submitted by all 5 Trusts on the monthly tracker to HSCB/SPGG and met with Northern Ireland Housing Executive, Supporting People leads to validate information relating to Supporting People schemes. Through this analysis, the review team identified individuals where plans are absent or weak requiring alternative plans.

7.1.28 At the outset, the review team met with the Director and senior management team of each of the 5 HSC Trusts to discuss their approach to discharge planning, to clarify the specific plans in place for each patient and the business cases being progressed directly by the Trust or reliance on schemes being progressed by another HSC Trust. The review team assessed discharge plans against deliverability and timescale for discharge. There were common issues raised by all HSC Trusts with the key challenge to discharge noted as workforce recruitment and capability alongside gaps in the community services infrastructure required to maintain community placements.

7.1.29 Tracking resettlement from the 1980's, has seen a clear move over the years from large institutional settings to smaller nursing and residential homes in the community and progression to supported living models based on single tenancy or small number of people sharing

7.1.30 The focus currently has moved to new build bespoke schemes that have a minimal design to delivery timeline of between 2 and 5 years which has become a significant delay factor. BHSCT has 3 capital schemes in the pipeline. Minnowburn which was a BHSCT only scheme for 5 patients and the On-Site and Forensic schemes to accommodate patients from all 3 HSC Trusts. The timelines for the new build schemes have drifted and most are still at an early stage of development. The review team view the uncertainty of projected discharge dates for these capital schemes as unacceptable and highlighted the requirement for alternative options to be pursued.

7.1.31 The review team were concerned that robust needs assessments had not been completed for patients identified for the On-Site and Forensic schemes resulting in a lack of clarity about the appropriate service model and whether registration of the On-Site scheme should be for a nursing home or residential facility. Robust Needs assessment should be the basis for any procurement or service development. It was a recurring issue throughout the review that insufficient attention has been given to needs assessment at individual case and population level.

7.1.32 The review team obtained information from Supporting People and data from RQIA in regards to regulated nursing and residential schemes which highlighted vacancies in current schemes. Feedback from provider organisations suggests that Trusts have not worked sufficiently with provider organisations to explore how current capacity could be customised to meet need with view to speed of implementation. This requires fresh thinking and imagination based on robust needs assessment. It would appear that the HSC system has become risk averse and focused on bespoke new build schemes.

7.1.33 HSC Trusts need to be clear about risk appetite based on robust Assessment of Need/Risk and analysis of what is working for similar needs in the community. Delivering this challenging agenda also requires a corporate and regional approach to ensure the relevant skill set promotes fresh thinking and delivery.

7.1.34 HSC Trusts narrative and reporting in relation to resettlement plans was repetitive, providing reassurance rather than assurance based on evidence. Trust Boards should have challenged the timelines presented for resettlement and queried contingency arrangements for expediting earlier discharges. At the commencement of the review, all HSC Trusts reported that discharge plans were in place for the majority of their patients however the review team's analysis identified that most plans were still at scoping stage and therefore lacked the robustness and detail required to establish a reliable trajectory for tracking performance. Delegated Statutory Function reports for all HSC Trusts focused on the lack of community living options, rather than on breach of Human Rights and did not provide the assurance required. There was insufficient challenge by Trust Boards and the HSCB/SPGG.

7.1.35 Four discharge placements had already been commissioned and had been available from commencement of the review including 3 planned discharges to Cherryhill (BHSCT Supported living). One of the Cherryhill discharges was delayed due to the wait for minor adaptation work. This matter should have been escalated for urgent approval through senior management rather than rely on routine processes. Three of the Cherryhill discharges were delayed due to staffing shortfall and requirement to recruit additional staff. In light of the fact that discharge placements for 3 patients were available, there should have been a more strategic approach taken in regards to deployment of the workforce with view to reducing the MAH in-patient population. BHSCT had a strategic focus on the stability of the MAH workforce with daily monitoring and reporting given the reliance on agency staff. This appeared to impact on decision making about using agency staff to transition with the patient until sufficient staff could be recruited and trained. The bigger picture of reducing the population through more flexible utilisation of the workforce to expedite the discharges was raised by the Co-Director but not progressed. The complexity of the logistics associated with workforce allocation cannot be underestimated however, the delay and drift in discharging 3 patients added to the staffing pressures in MAH. Prioritising a consultation with legal services in relation to the fourth patient who had a placement already commissioned by community LD services was agreed but not actioned, resulting in drift. In this specific case, the community HSC Trust and the BHSCT should have been working more collaboratively to an agreed action plan. It was concerning to note the drift in these specific cases despite the opportunities being highlighted to the involved HSC Trusts by the review team. Whilst there are recognised delays associated with new build schemes there should have been more focus on those discharges that could have been expedited more speedily.

7.1.36 The review team completed an analysis of resettlement plans, revised the performance tracker tool and provided advice to HSC Trusts on the immediate actions required to accelerate resettlement and strengthen reporting and accountability arrangements.

- Advice to Trusts to rethink the deliverables to focus on speed of implementation given the unacceptable timelines for new build schemes still at initial development stage
- Advice to BHSCT to extend the TOR for the On-Site project chaired by Director to include the Forensic scheme given the inter-dependencies for the NHSCT and SEHSCT on both schemes
- Advice to NHSCT to engage the care provider for the new build scheme Braefields, to agree concurrent admissions rather than the eighteen month phased implementation as planned.
- Advice to Trusts to review available capacity in the nursing home and residential/ supported living schemes and agree how placements could be tailored to meet need
- Advice to Trusts to urgently re-assess patients identified for the Forensic scheme and bring forward individual discharge solutions.

- Advice to all Trusts to prioritise the focus on individual cases with an increased potential for early discharge rather than focus on new build schemes.

7.1.37 The landscape changed throughout the period of the review, with HSC Trusts revising their plans in recognition of the long lead in time for new build schemes. The review team welcome the fresh thinking and renewed collaboration between the Belfast, South Eastern and Northern Trusts evident from April 2022 resulting in solution focused workshops to address the long standing challenges associated with delayed discharge. Consideration was given to the development of an interim model on the MAH so that patients pending discharge to community placements would be cared for in a social care model as part of transition planning. However, due to the continuing pressure on workforce availability and capability which is evident in MAH, the thinking is rapidly changing with re-focus on building individual placement discharge options rather than on an interim on-site social care solution. The review team completed a stocktake of all plans at commencement and end of the review fieldwork and will present the analysis on progress on a Trust by Trust basis and summarise the projected discharges by end March 2023.

7.1.38 The SEHSCT was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and are now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for 4 patients appear to be realistic and deliverable. The Trust plans to discharge 2 patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from 1 patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and 1 young person who transferred from a children's facility.

7.1.39 The NHSCT's discharge planning was based on 2 new build schemes and a number of individual bespoke placements. The NHSCT was reliant on the BHSCT delivering the On-Site scheme for 1 patient and the forensic scheme for 1 patient. The NHSCT has robust plans in place for six NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023. Two patients have commissioned placements at named schemes with discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all 3 learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of patients from Dorsey and Lakeview   In summary the NHSCT has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefield scheme from end April to end August 2022.

7.2 BHSCT – Regional Role as the Trust Responsible for MAH

7.2.1 Reducing the MAH population is a strategic priority and should be a significant measure in providing assurance about safe and effective care in MAH. Reducing the population would defacto reduce workforce challenges and support the remodelling of the hospital site with view to re-establishing patient flow and acute admissions. The Leadership and Governance report (2020) highlighted that the Trust focus on resettlement came at the cost of scrutiny of the Safety and Quality of care of those in-patient. Given that BHSCT has the lead role for the management of MAH as well as the delivery of 2 schemes that other HSC Trusts were co-dependent on, namely the Forensic and On-Site schemes, a review of BHSCT Board agenda and minutes for 1 year, 2020/21 was completed by the review team to identify the level of scrutiny and challenge to address the delayed discharges from MAH.

7.2.2 The analysis of Trust Board minutes confirmed that MAH is a substantive standing agenda item at each Trust Board with update report and papers on safety metrics and workforce presented by the MH/LD Director. Updates on the number of patients in MAH are provided however, there was limited scrutiny in regards to the resettlement plans for BHSCT patients or the capital business cases in development.

7.2.3 The review team found that the pendulum appears to have swung to a primary focus at Belfast HSC Trust Board on the development of safety metrics and workforce stability with limited challenge to the timelines proposed for resettlement of BHSCT in-patients.

7.2.4 The following updates on the MAH population and resettlement plans were provided to Belfast Trust Board by the Director of Mental Health and Learning Disability services.

- Oct 2020 Director reported 43 patients, 2 on trial and 1 on home leave. Further 5 BHSCT discharges expected to proceed.
- Dec 2020 Director reported- 47 patients – 3 on trial. NHSCT-20, BHSCT-17, SEHCT-8, SHSCT-1, WHSCT-1
- April 2021- Number of patients noted as 43 - 2 on trial resettlement and 1 on extended home leave. Expect another 5 discharges of BHSCT patients in the next 6-months by September 2021.

The Executive Director of Social Work reported satisfactory compliance with requirements specified in the Delegated Statutory Functions Scheme of delegation. The DSF report- noted 6 successful discharges and further 5 on trial resettlement with plans in place for a further 16 resettlements. The report noted a lack of community placements for LD impact on delayed discharge.

- Nov 2021- Director for strategic development updated on planning for On-Site business case.4 patients meet criteria. Outline specification drawn up and shared with capital panning team. Design team secured to complete feasibility study of the MAH site. Steering group has held 4 meetings.
- January 2022- Director update- 39 patient- 4 on trial and 1 on extended leave only 2 on active treatment. Chairman sought clarification on timeframe for the On-Site resettlement business case. Director reported that the timeframe for the On-Site scheme was 2024/2025. Further business case to be developed for forensic scheme- Requires identification of appropriate site.
- BHSCT's Delegated Statutory Functions report 2021/22 lacked scrutiny from Trust Board. It is of note that BHSCT reported that resettlement plans were in place for 15 patients and no plan in place for 1 patient.

7.2.5 Analysis of the regular updates to Belfast HSC Board and through the Delegated Statutory Function reports in regards to progress on resettlement, highlight the repetitive narrative based on plans in the early stages of development which were not robust enough to provide assurance in regards to projected discharge dates.

7.2.6 Whilst the Chairman of the BHSCT sought clarification on timeframe for the On-Site resettlement business case on 1 occasion and Director advised that the timeframe for scheme completion was 2024/2025, this appears to have been accepted rather than discussed or challenged.

7.2.7 BHSCT's dedicated resettlement team was funded for 2 community integration co-ordinators and a Social Worker to develop Essential Lifestyle plans. The Social Work post and 1 of the coordinator posts are vacant. A senior manager post established to review SEA's and develop an action plan on the lessons learned is also vacant.

7.2.8 BHSC Trust had 16 patients in MAH at commencement of the independent review and still has 15 patients in MAH at 11th July 2022. Our analysis of the current position for BHSCT in regards to revised planning is that BHSCT has robust discharge plans in place for 2 patients to transition to current nursing home and supported living vacancies by September 2022. However, the plans for the remaining 13 patients have not been confirmed in regards to named scheme or estimated discharge date and remain plans in development. There are 3 major challenges for revised plans, Workforce recruitment, re-registration of schemes and most significantly the time required to engage and gain agreement from family carers. This is a dynamic environment and the summary and trajectory provided by the review team reflects the position at 11th July 2022.

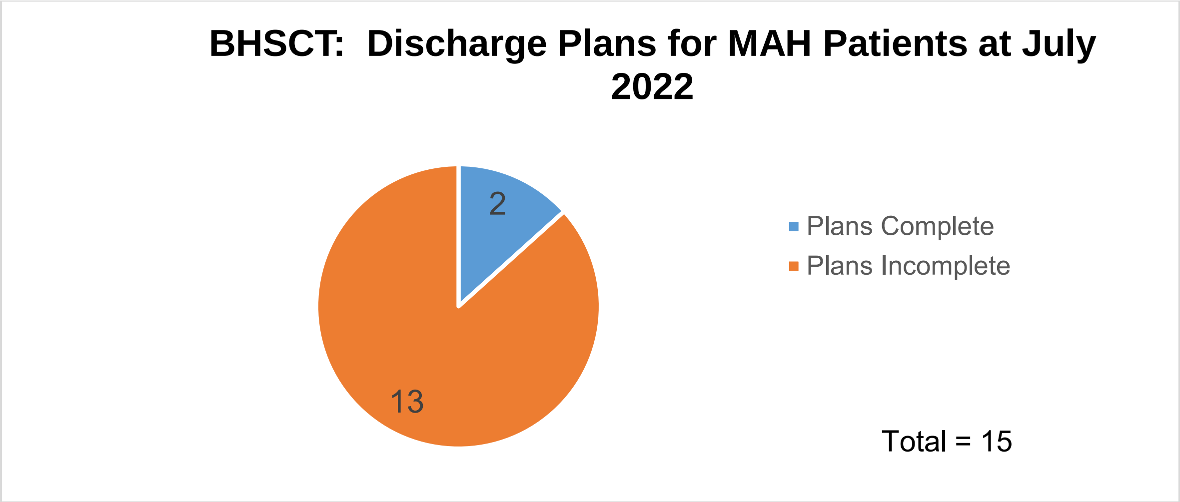


Fig 8

7.2.9 The review team considered in detail how the Trusts developed plans, proposals and accommodation services to meet the aggregated needs of this group as identified through their individual care plans in Chapter 8.

7.3 SEHSCT - Resettlement plans

7.3.1 SEHSCT completed a number of capital business cases some years ago significantly reducing the Trust's long-stay in-patient population to eight patients at commencement of the review and 6 in- patients at 11th July 2022.

- The Trust was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and The Trust is now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for four patients appear to be realistic and deliverable. The Trust plans to discharge two patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from one patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and one young person who transferred from a children's facility.

- SEHSCT has a new build scheme in development in partnership with a care provider but recognised that this will not be a viable option for MAH discharges given the long lead in time
- It is of note that one SEHSCT patient has been on extended home leave with an extended support package from March 2020 with family taking the patient home at the onset of the Covid pandemic. BHSCT also had one patient on extended home leave for similar reasons. An evaluation of how the extended home leave placements have been maintained for this lengthy period without return to MAH should be completed to inform future support models aimed at admission avoidance.

7.3.2 The review team have used the Care Quality Commission - Brief Guide; definition that a discharge plan needs to have an identified care provider, an address and a discharge date to be agreed as a discharge plan. The review team used this definition to assess the robustness of the SEHSCT updated discharge plans. SEHSCT has a confirmed placement at Mallusk scheme for one patient with discharge expected in August 2022. The Trust has commissioned a nursing home placement for one patient with discharge date in August 2022. SEHSCT expect an additional patient to transfer to a specialist facility in the Republic of Ireland with discharge expected by September 2022. Three of the SEHSCT 6 patients have robust discharge plans and imminent discharge dates. A plan is in development for one patient and 2 patients do not have a robust plan.

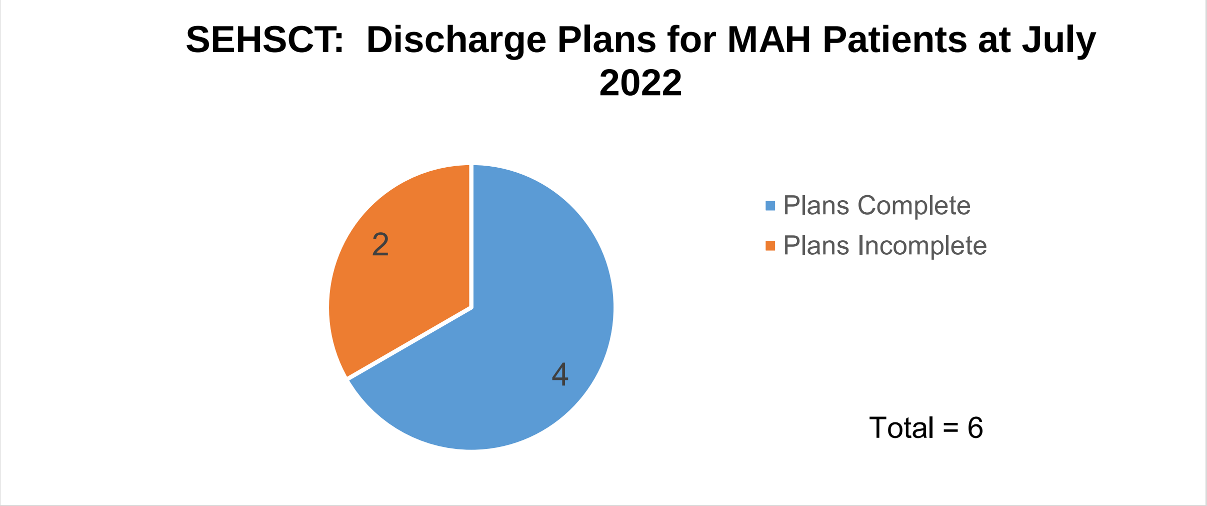


Fig 9

7.4 Northern HSC Trust – Resettlement plans

7.4.1 Historically the NHSCT has been reliant on hospital admission resulting in the highest number of patients to resettle regionally. At the outset of the independent review, the NHSCT had nineteen delayed discharge patients in

Muckamore Abbey Hospital, 1 patient delayed in Lakeview Hospital and 1 patient delayed in Dorsey Hospital

7.4.2 The Northern HSC Trust's discharge planning was based on two new build schemes and a number of individual bespoke placements. The Northern HSC Trust was reliant on the Belfast HSC Trust delivering the On-Site scheme for one patient and the forensic scheme for one patient. The NHSCT has robust plans in place for 6 NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023.Two patients have commissioned placements at named schemes with discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all three Learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of their patients from Dorsey and Lakeview Hospitals. In summary the Northern HSC Trust has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work for the Braefields scheme moving the handover date from end April to end August 2022.

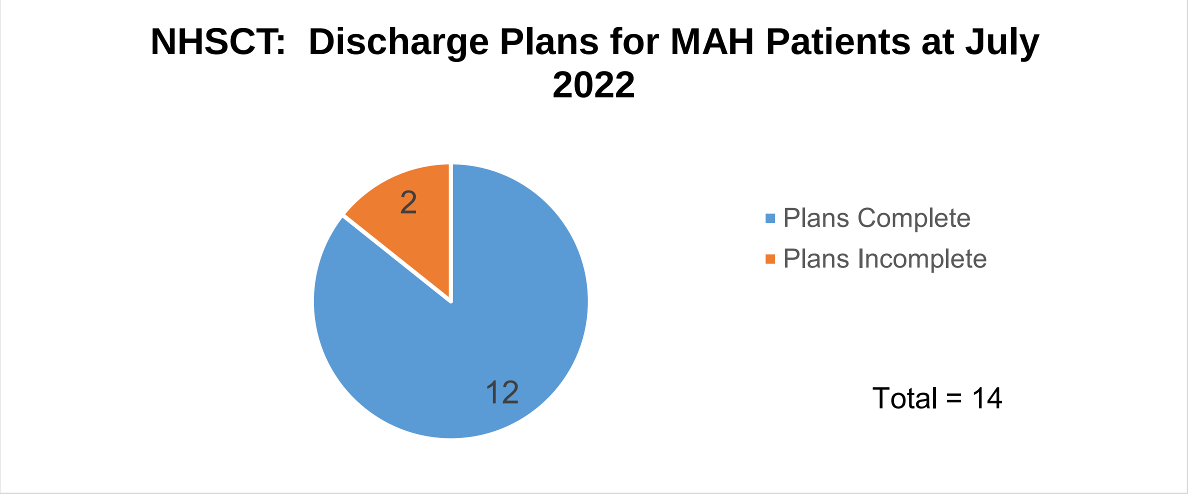


Fig 10

Key findings; the analysis of the review of Individualised care planning has highlighted a number of concerns and themes

- HSC Trusts were not responsive to data requests with responses missing deadlines and monthly performance monitoring templates not being robustly completed with key data missing or not updated.
- The narrative from HSC Trusts was repetitive and had not been sufficiently challenged by HSC Trust Executive teams, Trust Boards or the HSCB/ SPPG resulting in significant delay in identifying and challenging the lack of progress.

- Proposed discharge plans were not assessed against an agreed definition for a discharge plan, namely that a plan requires a confirmed care provider, confirmed scheme address and confirmed estimated discharge date to be agreed as a robust discharge plan.
- HSC Trusts were asked by the review team to validate the data supplied by RQIA and Supporting People and provide additional data on housing with support placements not captured in the NIHE and RQIA data sets. A questionnaire was developed by the review team to collate data from HSC Trusts to establish a regional supply map. The response from HSC Trusts was poor and not reliable. The HSCB/SPGG completed an exercise in 2020 to complete Needs assessment for Housing with Support. The variation regionally in demand reflected the poor quality of the information returned by HSC Trusts based on a range of interpretations of the questions.
- There is a need to get back to basics to ensure effective person centred planning and collaboration with all relevant stakeholders in the development of discharge plans. There appeared to be a lack of dialogue between HSC Trusts and providers to share the lessons learned from failed placements. The learning from trial placement breakdowns should inform discharge planning and will only be achieved through an integrated care approach based on partnership and collaboration.

Recommendations

- SPPG needs to strengthen performance management across the HSC system to move from performance monitoring to active performance management holding HSC Trusts to account.
- SPPG should establish a regional Oversight Board to manage the planned and safe resettlement of those patients not currently under active assessment or treatment
- Consideration needs to be given to building highly specialist community based crisis response support teams to promote admission avoidance.
- A regional positive behaviour framework should be developed with the standard of training for all staff working in learning disability services made explicit in service specifications and procurement.
- Learning disability strategy / service model to be progressed by DoH should incorporate the evidence base for PBS and learning from other UK nations
- HSC Trusts should collaborate with all stakeholders to develop a resettlement pathway and operational procedure.
- HSC Trusts should ensure that the lived experience of the person and their family is effectively represented in care planning processes and the role of

family carers as advocates for their family member is recognised and respected.

- HSC Trusts should collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans

8. Operational Delivery of Care and Support

In the previous chapters we have talked about the strategic and commissioning framework for services, and also have considered the importance of good individualised care planning. In this chapter we need to consider the delivery of care and support and the experience of the individuals who have gone through resettlement and their families.

It is worth briefly revisiting what the current mapping of accommodation, care and support services looks like. There are 21 specialist LD nursing homes in NI offering a total of 606 places; there are a total of 48 residential care homes (15 statutory and 33 independent) offering a total of 546 places (123 statutory residential care places and 423 independent residential care places); and there are 149 accommodation based supported living schemes for people with learning disabilities offering a total of 1334 places across Northern Ireland.

8.1 Range of provision available:

8.1.1 There is a really impressive array of different types of homes for people with learning disabilities, and this diversity reflects the heterogeneous nature of the learning disability who will have a wide range of needs and wishes that need to be considered for each individual. This diverse picture also reflects significant variation in the cost of care, again dependent on a range of factors but primarily the needs of the individual and the staffing associated with those needs to ensure a safe and stable quality of care can be routinely delivered. In this context schemes which are designed and very bespoke to the particular needs of an individual will be higher than for those living in group living environments, where there may be 'economy of scale' factors to reduce the care costs. There has to be a recognition that for some individuals living with other people poses too significant a challenge and their needs can only be met in living alone situations, although there is always a need to ensure that these individuals have access to social relationships and community interaction as appropriate. Some providers have moved to try some innovation through congregated settings, but with separate living accommodation.

Range of provision available throughout Northern Ireland

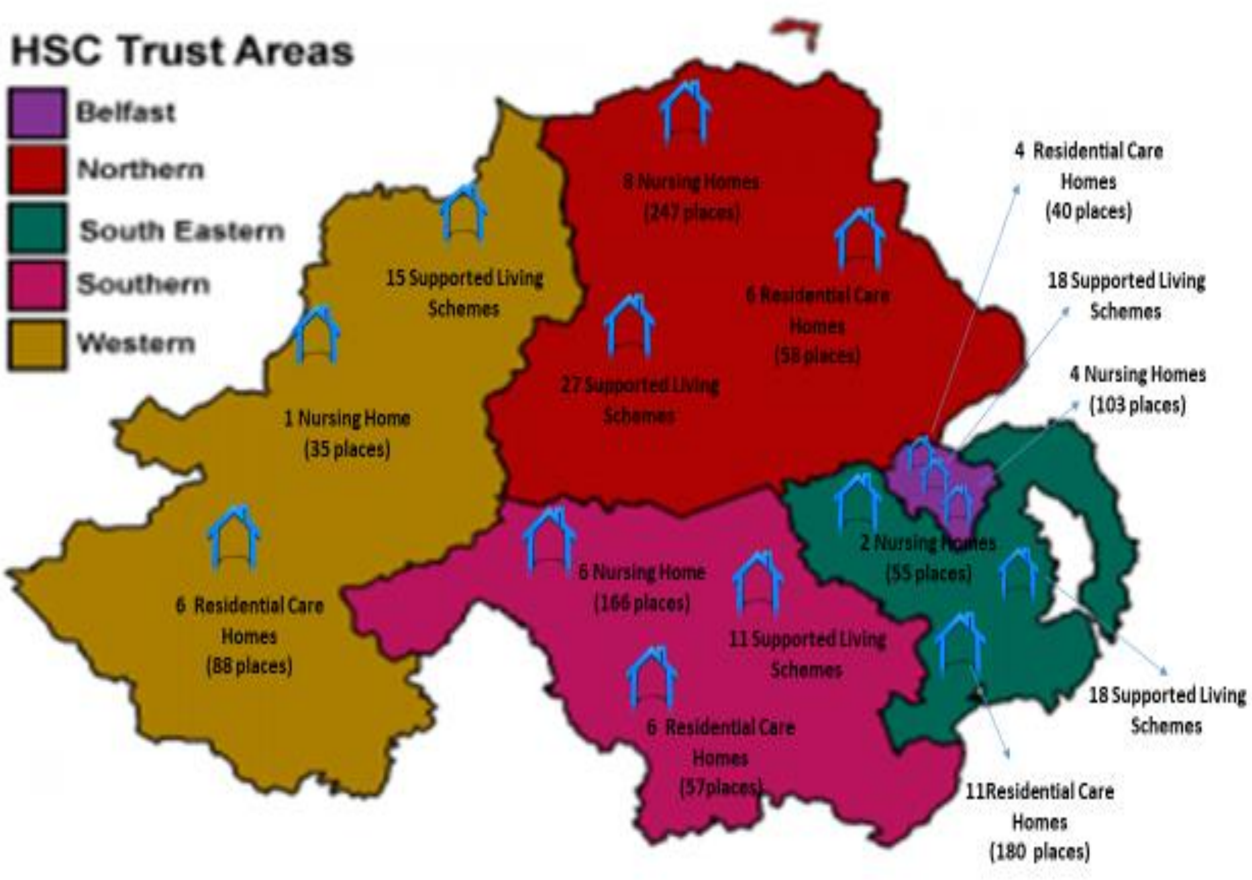


Fig 11

8.1.2 The broad thrust within the Bamford Review had been towards smaller group living options, and away from large congregated community settings. The bar chart below shows the spread of size within accommodation-based supported living schemes funded through Supporting People and HSC funding agreements, and the general trend is in favour of smaller schemes. Whilst this is a welcome change of direction the emerging policy and strategic positions in relation to both learning disability and adult social care within Northern Ireland will need to address the sustainability of funding as demand increases linked to the demographic changes that we can expect for this population.

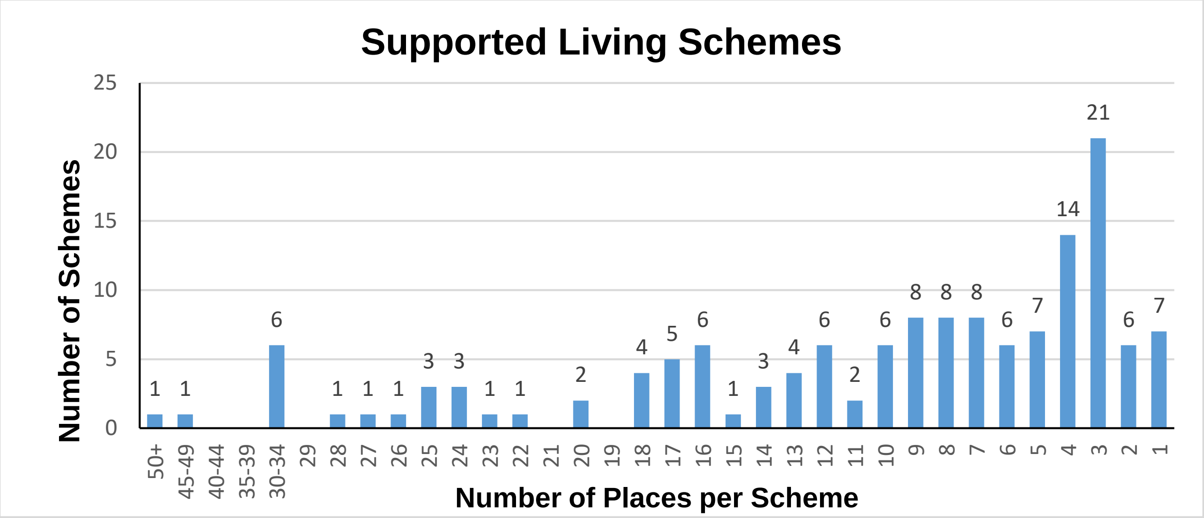


Fig 12

8.1.3 It is also important to recognise that within the independent sector it is highly probable that in the current population of residents and tenants within their settings that there will be individuals with similar needs profiles to those individuals who are awaiting resettlement from hospital. The sector has already demonstrated a readiness to meet the needs of individuals with complex needs often relating to co-morbidity of learning disability and mental health issues along with behaviour that can challenge. We heard several success stories which should be a strong foundation for understanding what works well for this group of especially vulnerable individuals.

8.2 Workforce

8.2.1 It is fair to say that across all stakeholders workforce was the single biggest concern, both in terms of the existing and future provision. Providers and NISCC as the regulator of the social care workforce expressed concern about the continuing need to develop a skilled and stable workforce across the sector. The inability to both recruit and retain a social care workforce was a massive risk for the sustainability of the existing provision and the most significant barrier for the proposed new developments. This has seriously hampered progress of several of the resettlement schemes which it is hoped will provide new homes for existing people living in MAH.

8.2.2 The models supporting the development of many of the new schemes are psycho-social rather than medical. Therefore the workforce will need to have skills in the delivery of psychological and social interventions, along with an understanding of the need to re-refer to specialist clinical services as and when appropriate. Most providers were now adopting Positive Behaviour Support as central to their service offer, although we heard concerns expressed by the

Royal College of Psychiatrists about the 'fidelity' of this approach which was often variable in both delivery and positive outcomes. There was certainly some anecdotal evidence to suggest that in some settings some of the least qualified and experienced staff were working with some of the clients with most complex needs. This sometimes resulted in poor continuity linked to high turnover of staff.

8.2.3 However the workforce issue was also a mixed picture. Some of the more established providers with a longer track record of service provision had better ability to recruit and retain staff, and some of the not for profit organisations had also recruited specialists in psychology or positive behaviour support to provide consultancy and support to their own provision. We also heard some providers describe how they had expanded the skill base within their teams by recruiting professionals from other disciplines such as teaching or youth and community work. Similarly we were impressed that some of the private providers described very stable teams, who were generally recruited from the local community with high rates of retention.

8.2.4 We have commented in an earlier section about the issues related to differential rates of pay, and particularly the disparity between statutory and non-statutory services in terms of Agenda for Change profiled pay in services provided by HSC Trusts. Whilst rates of pay are going to vary across the sector there needs to be some discussion within the sector to ensure that this isn't operated in a way that becomes a barrier to stability within the workforce. An integrated workforce strategy that looked at staffing across the whole landscape of learning disability services should be linked to the Learning Disability Strategy and Service Model, and should provide better learning and developmental opportunities as well as supporting greater mobility across sectors and roles. The review team are encouraged that MDAG has oversight of a regional workforce review across adult learning disability teams and services. This review has a wide scope of the learning disability workforce across statutory, private and independent sectors. A multi-disciplinary team has been put in place to undertake this important piece of work which is expected to complete in 2023; a survey has been undertaken to establish the baseline of the current workforce as of 31st March 2022.

8.3 Quality of Care within Services

8.3.1 Given the size and nature of the sector it has to be recognised that quality could be variable. However, there was certainly encouraging signs that would suggest that services were of good quality in many settings. RQIA have a responsibility to inspect registered care settings and in doing so seek the views of residents and staff. Generally in most registered care settings these are positive, with positive comments about compassionate and caring staff in many settings. Whilst it could be argued that these may be more subjective than objective observations, RQIA are working with ARC and PCC through projects like “Tell It Like It Is” to ensure that there are a range of ways of accessing the views of people living within these settings and their families.

8.3.2 The review team were able to visit one particularly innovative example of a bespoke placement for a young man who was living with learning disability and ASD, and who was being supported to live on his own with 24/7 on-site support. He had successfully been transitioned back from a long term specialist placement in another part of the UK. The staff team supporting him were especially attuned to designing support appropriate to his needs and tolerances, as well as addressing the significant risks both within his home setting and when accessing the community.

8.4 Resettlement Process and Outcomes:

8.4.1 Broadly speaking the resettlement process could be split in to 3 phases – (1) pre-placement which included assessment and consultation to identify suitable placement opportunity; (2) transition phase which focuses on the planned move and immediate monitoring and support intensively immediately after placement; and (3) ongoing post placement support, including contingency plan to manage ‘crisis’.

8.4.2 One area of concern was that the region didn’t appear to have developed a regionally agreed resettlement/transitions pathway for people who were transitioning from hospital settings. Several stakeholders raised this as a concern. Families felt that they were insufficiently involved in developing these plans at times of a critical move. We asked the BHSCT as the lead Trust in terms of resettlement to provide us with the resettlement pathway, and after a gap of several weeks they issued us with a ‘draft resettlement pathway’ which we believe was produced without consultation with other Trusts, families or providers. Whilst it was good to see a willingness to develop an agreed pathway, we would have expected it to have previously been in place and to have gone through a co-production process. Consequently there was a great deal of variability to the quality of pre-placement arrangements and transition plans.

8.4.3 There were key issues which an agreed pathway and protocol could have resolved. Central within this would be where the primary responsibility for resettlement lay – especially what role the hospital multi-disciplinary team had in relation to the process relative to the role and responsibilities of the receiving/home Trust who would have on-going responsibility for supporting the placement. We certainly were told of a concern that the hospital teams held an overly prominent level of sway in terms of choice of placement and the parameters of moves, including the extent to which ‘leave’ was extended for lengthy periods beyond the point where the individual had left the hospital. Several providers commented that the assessment of the client’s needs provided by the hospital was sometimes not fit for purpose in terms of how they would devise a plan of care and support appropriate to the new care setting. Often the hospital had limited experience or understanding of how the client might be in other community-based settings. There was a general view that hospital perspectives could be overly risk averse, and rarely acknowledged the significant experience of the more established providers. The review team drew a conclusion that it was imperative that Community Learning Disability Teams/Services of the receiving/home Trust needed to take the lead during the transition phase and to act as an effective bridge between the hospital at the point leading up to discharge and the provider as they accepted the client.

8.4.4 Sadly several of the families that were willing to share their experience had gone through a process of placement break down, and we heard some harrowing accounts of how placement disruption was handled. However it is important to note that for many of these individuals and their families the system continued to support them and ultimately they found suitable new homes.

8.4.5 In terms of the third phase of post-placement support, again we heard of a very mixed picture from providers. Some providers talked about a lack of clarity between the roles of different teams.

8.4.6 Where systems described placements going well there were a number of key features which are worthy of note. The extent to which the ‘new’ staff supporting the client had an opportunity to begin to establish a working relationship and understand the individual and how best to meet their needs was an important foundation stone. Plans that had considered contingency if things started to go wrong were more robust, and in particular access to additional dedicated support from local Trust services at times when a crisis was emerging was particularly important. There is some variability between HSC Trusts in relation to the extent that they have been able to develop these specialist levels of support, although all are making moves in that direction. One provider described that their ability to support some individuals with very high levels of challenge and potential risk because of the responsiveness of the Trust services when they ‘put up the flag’. In this scenario it was the strong and established partnership between the provider and the Trust services – clinical and commissioning – that gave them the resilience to support a number of individuals with the highest levels of need. In this situation there was clear evidence of effective communication, joint working and mutual respect and support, all of which was focused on keeping the client at the centre of the process.

8.4.7 Whilst in all areas we heard about providers and local commissioners having engagement through contract review processes, there didn’t appear to be well established broader engagement across the sector to support more effective partnership working. We felt that at a time when the health and social care system is committed to further development of integrated care systems, that there could be some work done here to support an integrated care pathway for these individuals with significant complexity of need.

8.5 Local Commissioning by HSC Trusts of Accommodation Schemes to address the needs of Individual Resettlement Plans

8.5.1 In chapter 7 the review team laid out what we found in relation to the evidence for good individualised care planning and the current level of practice. In order to find accommodation solutions for the individuals awaiting resettlement the Trusts needed at a local level to commission, either singly or jointly, new schemes that could meet the requirements for this clearly identified population.

8.5.2 There was distinct variation in relation to how effectively the development of new accommodation schemes was executed by individual Trusts.

8.5.3 Positively the NHSCT had worked well with a small number of trusted providers to develop several schemes which then had the potential to accommodate most of their remaining patients from MAH. At the time of the review this had ensured that business cases had been approved for social care and housing funding as appropriate, and the development of these schemes had reached completion of the buildings and were now moving to transition planning contingent on successful recruitment and staffing of the schemes.

8.5.4 Historically the NHSCT had historically been reliant on hospital admission resulting in them having the highest number of patients to resettle regionally. At the outset of the independent review, the NHSCT had 19 delayed discharge patients in MAH, 1 patient delayed in Lakeview Hospital and 1 patient delayed in Dorsey Hospital

8.5.5 The NHSCT’s discharge planning was based on 2 new build schemes and a number of individual bespoke placements. The NHSCT was reliant on the BHSCT delivering the On-Site scheme for 1 patient and the forensic scheme for 1 patient. The NHSCT has robust plans in place for six NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023. Two patients have commissioned placements at named schemes with discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all 3 learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of patients from Dorsey and Lakeview In summary the NHSCT has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefield scheme from end April to end August 2022.

8.5.6 The Mallusk new build scheme was completed 2021 with 2 admissions to date with significant and unacceptable delay in the care provider recruiting sufficient staff to support further admissions to the remaining six places. This scheme will accommodate another 4 NHSCT patients and 1 SEHSCT patient.

8.5.7 The Braefields new build scheme for seven places has been developed to accommodate six patients from Muckamore and 1 NHSCT patient in Lakeview hospital. The NHSCT patient in Dorsey. Hospital is in the process of transitioning to a vacancy in a community scheme by end July 2022.

8.5.8 The NHSCT plans to discharge twelve MAH patients prior to end March 2023 to named and commissioned placements. These plans are viewed as robust – 6 to Braefields, 4 to Mallusk and the other 2 patients to named supported living and nursing home vacancies. The plans for the remaining 2 MAH patients are in development and not yet robust. The review team remain confident that the Mallusk and Braefields schemes will come to completion within the coming 6 – 9 months, and that this would allow the majority of the NHSCT clients to transition to their new homes. Whilst there had been some slippage in the time scale, their robust plans had supported effective review and senior leaders within the Trust engaged effectively with providers to challenge poor progress against agreed timescales.

8.5.9 SEHSCT completed a number of capital business cases some years ago significantly reducing the Trust's long-stay in-patient population to eight patients at commencement of the review and six in- patients at 11th July 2022.

8.5.10 The SEHSCT, by working effectively in tandem with the NHSCT had been able to support the delivery of a number of schemes that would offer new homes to their remaining patients/clients. SEHSCT had the smallest number of clients remaining and relied on a mix of engagement with the collaborative inter-Trust schemes, and singleton or bespoke solutions. This allowed them to demonstrate that they had robust plans with a realistic potential of positive outcomes, although again recruitment difficulties for providers tended to be the limiting or constraining factor which delayed delivery.

8.5.11 The SEHSCT was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and are now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for 4 patients appear to be realistic and deliverable. The Trust plans to discharge 2 patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from 1 patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and 1 young person who transferred from a children's facility.

8.5.12 SEHSCT has a new build scheme in development in partnership with a care provider but recognised that this will not be a viable option for MAH given the long lead in time, and therefore will be likely to meet future emerging need.

8.5.13 It is of note that 1 SEHSCT patient has been on extended home leave from MAH with an extended support package since March 2020 with family taking the patient home at the onset of the Covid pandemic. BHSCT also had 1 patient on extended home leave for similar reasons. An evaluation of how the extended home leave placements have been maintained for this lengthy period without return to MAH should be completed to inform future support models aimed at admission avoidance.

8.5.14 The Belfast HSC Trust (BHSCT) was an outlier in terms of its ability to successfully progress robust plans to deliver resettlement outcomes for the 15 patients who were their responsibility. However, it is worth making a few contextual comments in relation to the Belfast Trust's system wide responsibility. BHSCT had management responsibility for the provision of the hospital services provided at MAH, which dated back over an extended period of time. This meant that the Director and Co-Director in BHSCT responsible for learning disability services were balancing the ongoing delivery of the MAH hospital services, which faced significant safeguarding and staffing issues following the allegations of abuse, alongside the responsibility to support the resettlement not only of their own clients, but also of the patients in MAH who originated from other Trust areas. It should be noted that the HSCB had funded some additional dedicated staff posts within BHSCT to support the regional resettlement programme(detailed in chapter 7), and that the HSCB had provided substantial additional non-recurrent funding in light of the financial pressures associated with the heavy reliance on agency staffing within MAH staffing levels. The review team acknowledge that this placed the leadership team in BHSCT under considerable pressure, and it is to be regretted that this appears to have hampered their commitment to delivering the overarching resettlement requirements.

8.5.15 The BHSCT had through its planning processes proposed that the majority of its clients could be resettled through a number of dedicated new schemes. The primary focus of the new schemes was around 3 groups of patients. The first of these was patients who had been described as having a ‘forensic’ profile and required specialist provision specific to their needs. The second group was a small number of patients, most of whom had lived in MAH for several decades, and for whom it now appeared there should be a dedicated ‘on-site ‘provision’ that would allow them to remain in situ but within a new or re-purposed accommodation on the hospital site. The third group were 5 patients, all from the BHSCT area, who had been identified for a new provision within the Belfast.

8.5.16 To meet the needs of these 3 distinct group of patients within MAH BHSC Trust’s resettlement plans centred on 3 new build schemes in development since 2019. The 3 capital build schemes were planned to accommodate ten of the BHSCT patients. One patient for the On-Site scheme, 4 patients for the forensic scheme and 5 patients for the Minnowburn scheme which was a proposed development but not projected to be ready until at least 2025. The review team met with Northern Ireland Housing Executive’s Supporting People leads in regards to the planning process for the Belfast Trust’s Supporting People schemes in development and the strategic outline case (SOC) submitted for the forensic scheme and the process and timelines for full business case and delivery. Supporting People also provided update on discussions with BHSC Trust in regards to their plans for the Minnowburn proposal. The review team analysed the SOC submitted by the Trust and minutes of the Strategic Advisory Board meetings chaired by NIHE Supporting People Director. The review team noted confusion and drift in the range of schemes submitted by BHSCT as strategic outline cases. The SOC was drafted and submitted by a senior planning manager with extensive experience of previous resettlement schemes. When this manager retired it would appear that both organisational memory and experience were lost when he left, resulting in drift with SOC not progressing to full business cases as agreed.

8.5.17 At commencement of the review, the plan for the forensic scheme was a 12 place extension to an existing scheme, Knockcairn/Rusyhill. The original plan was for a twelve placement scheme to accommodate both MAH patients and BHSCT community clients and a strategic outline case (SOC) was submitted to Supporting People. Further analysis concluded that this design would not meet the needs of the remaining forensic population. Supporting People advised the review team that the full business case for the forensic scheme was anticipated in October 2019 but not received- Supporting People also highlighted that no funding from Supporting People has been ring-fenced therefore BHSCT will require to fund both capital and revenue funding.

8.5.18 BHSCT then asked a Housing Association to identify a suitable site for a new build scheme. Seven sites were identified however, location of the majority of sites were unsuitable for a forensic scheme due to proximity to high density areas. Preferred sites were identified in both the NHSC Trust and SEHSCT areas with the second confirmed as the most suitable. Given the inter-dependencies of the NHSCT and SEHSCT on this scheme all 3 HSC Trusts should have been collaborating on decision making but this was not the case, and the other Trusts were unaware of these proposals. Given the delays in progressing the business case, the NHSCT and SEHSCT are now scoping alternative individual placements with view to agreeing more timely discharge dates for their forensic patients.

8.5.19 The Belfast Trust Co-Director has now advised the Housing Association to take no further action to purchase a site pending further discussion in relation to needs assessment and current demand for a forensic new build scheme. The forensic scheme has been in development since 2019. Priorities have changed over the 3 years the outline case has been in development undermining the planning assumptions underpinning the proposed scheme. The process highlights confusion and drift and illustrates poor planning and delivery.

8.5.20 Minnowburn scheme for 5 BHSCT patients. The Minnowburn scheme requires disposal of a current BHSCT property/ site through Public sector trawl with an eight stage process and earliest delivery timeframe 2024/25 Whilst this scheme is in development it will not be ready until at least 2025. Alternative individualised discharge plans are now required given the long lead in time for project delivery.

8.5.21 MAH On-Site Provision: The picture in relation to the ‘on-site’ provision was particularly confused. The DoH had made it clear to Trusts that there should be consideration given to an on-site re-provision for those individuals for whom MAH had effectively been the only home they had known as adults. Whilst the letter from the DoH refers to a small number anticipated to be less than 10, at the point where the review team were considering the revised plans for individuals, only 4 patients had been identified as potentially requiring the onsite facility. The letter was clear that this provision should be separate from the assessment and treatment provision within the hospital. Four long-stay patients met the criteria identified; 1 BHSCT client, 1 NHSCT client and 2 SEHSCT clients. A project team was established chaired by the BHSCT Director and membership included SEHSCT and NHSCT representatives along with other key stakeholders. A design team was appointed to compete a feasibility study. In our meetings with senior staff responsible for learning disability services at the time in BHSCT there was a lack of clarity as to what type of provision was required, in terms of models of nursing provision, or social care and housing.

There seemed to be lengthy delays in establishing the feasibility of re-purposing some of the existing hospital estate and the associated indicative costs. In recent months due to the escalating concerns about the delay in the progression of plans for this provision by BHSCT the 2 other Trusts responsible for 3 of the 4 targeted clients have decided that the proposed on-site provision no longer represents the best option for their individuals and are pursuing other potential solutions. In light of this the BHSCT will need to consider how best to meet the needs of the 1 remaining patient who was in the cohort of 4.

8.5.22 Whilst all of these schemes had been in development since 2019 or earlier, at the point of the review in early 2022 none of these schemes had progressed beyond the most preliminary stages and given the dynamic position in terms of changes in the needs of the broader population the rationale underpinning the original cases for the schemes became unsustainable. In reality there were not credible plans in place for delivery of these schemes, and both capital and revenue funding had not been secured.

8.5.23 We have previously referenced the significant changes in leadership and planning roles, which was particularly apparent within BHSCT. This meant that there never seemed to be a maintained momentum for delivery of these proposed schemes through a rigorous project management approach. Given these difficulties and delays the projects failed to progress beyond the drawing board stage, and in the most recent discussions the other Trusts have indicated that they are pursuing alternatives to the proposed joint venture for a forensic scheme and on-site provision; they now want to consider separate provision on a smaller scale for their own clients. This has effectively meant that the considerable time and effort expended in the original proposals have not delivered and were ineffective. Additionally, it means that the assurances provided to the BHSC Trust Board regarding the robust plans being in place for the individuals concerned was not underpinned by realistic and deliverable planned schemes.

8.5.24 However, the recent ‘refresh’ of the senior operational leadership within the Learning Disability Team at BHSCT has brought some encouraging signs of a new approach. They are urgently reviewing all their plans, in the context of the rapidly changing picture as other Trusts review and accelerate plans for individuals. The additional catalyst for this revised approach and more rapid progress relates to the significant supply and financial pressures that the staffing situation in MAH is creating. In this context the BHSCT has shown a real willingness to look at re-purpose and re-design of some existing provision as an alternative to new build options. This could significantly improve the speed of the resettlement for the BHSCT residents who are patients in MAH, although these proposals are at a very early stage of consideration and have yet to be tested fully in terms of feasibility, and acceptability to the individuals who will be offered these accommodation options, and their families.

8.5.25 Recent contingency planning due to staffing pressures at MAH and request to HSC Trusts to bring forward alternative plans to replace the capital schemes with lengthy and unpredictable delivery dates, has changed the discharge planning position for the 3 HSC Trusts with patients in MAH. BHSCT are responding positively to this new challenge and are scoping discharge options. The Trust has identified supported living schemes in the BHSCT area with under occupancy which may provide viable discharge options. These plans are in an early stage of development but show promise. The Care Quality Commission- Brief Guide; discharge planning from Learning Disability assessment and treatment units (August 2018), highlights that a discharge plan needs to have an identified care provider, an address and a discharge date. The review team have used this as the basis for judging if the discharge options proposed by all HSC Trusts are robust enough to provide confidence and predictability in regards to timeline for discharge.

8.5.26 BHSC Trust had 16 patients in MAH at commencement of the independent review and still has 15 patients in MAH at 11th July 2022. Our analysis of the current position for BHSCT in regards to revised planning is that BHSCT has robust discharge plans in place for 2 patients to transition to current nursing home and supported living vacancies by September 2022. However, the plans for the remaining 13 patients have not been confirmed in regards to named scheme or estimated discharge date and remain plans in development. There are 3 major challenges for revised plans, Workforce recruitment, re-registration of schemes and most significantly the time required to engage and gain agreement from family carers. This is a dynamic environment and the summary and trajectory provided by the review team reflects the position at 11th July 2022.

8.6 Lessons Learnt and Evaluation:

8.6.1 We know that many stakeholders within the overall system are committed to supporting a learning culture, which adopts a ‘lessons learnt approach’. Organisations like RQIA have supported the adoption of Quality Improvement [QI] methodologies in supporting providers to promote continuous improvement within their services, and as previously identified the work that RQIA, ARC and the Patient and Client Council are doing within the ‘Tell It Like It Is' Project are encouraging. However, we were disappointed that there didn’t appear to have been any systematic evaluation of the experience of individuals who had been resettled, both successfully and unsuccessfully. It felt that there were opportunities to undertake some audit activity and also to consider whether there is scope for pre and post placement Quality of Life measures to be applied so that there is some empirical evidence of the improvement in individual's lives. Although many people told us stories, both good and bad, of the experience of people during the resettlement process we didn't come across any evidence of this being properly documented, and consequently the voices of the people at the centre of this process often went unheard. There is undoubtedly potential for a more formal evaluation of the experience of those who have been resettled contributing to a better understanding of what works well and what doesn't.

8.6.2 On a positive note leaders and citizens across the system talked passionately about the need for better sharing of good practice models, and the need to ensure that the stories about the valued lives of people with learning disability must be communicated through a positive narrative available to the public and society at large in Northern Ireland. This laudable ambition is one that we believe everyone involved in this process would willingly support.

8.7 Recommendations

- The sector should be supported to develop a shared workforce strategy, informed by the consultation being undertaken by the DoH as part of the workforce review, to ensure that it there is a competent and stable workforce to sustain and grow both the sector in terms of size and quality, so that it is responsive to significantly changing demand.
- HSC Trusts should urgently agree a regional pathway to support future resettlement/transition planning for individuals with complex needs.
- HSC Trusts should establish a local forum for engagement with LD providers of registered care and supported living to develop shared learning and promote good practice through a collaborative approach to service improvement.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better.

9. Safeguarding

In this chapter we will consider the legislation and policy relating to Adult Safeguarding in Northern Ireland, the learning from RQIA inspections, the findings from previous independent investigations of failures in the care provided to vulnerable adults and the views and concerns of family carers and their lived experience relating to safeguarding.

9.1 We have talked in previous chapters about the fact that the confidence of family carers in the HSC system's ability to Safeguard and protect people with a learning disability has been impacted significantly due to findings of abuse at MAH. We gathered evidence through our direct engagement with family carers which included family carers whose loved one has already been resettled and living in the community, as well as MAH family carers. All raised safeguarding as a significant concern with the review team. Family carers provided feedback to the review team about the actions they wish to see addressed in regards to their concerns about adult safeguarding and protection and their views and experiences will be explored later in this chapter.

9.2 It is important to set the concerns and expectations of family carers and the findings of this review in the context of Adult Safeguarding legislation, policy and practice in Northern Ireland.

9.3 A review of Safeguarding policy and practice was not within the scope of this review however, the review team analysed the findings from previous independent investigations of failures in the quality of care provided to vulnerable adults in Northern Ireland to inform our recommendations about individualised care planning and the commissioning and procurement of services to support discharges from Northern Ireland's Learning Disability Hospitals.

9.4 The recommendations arising from the 'Home Truths' report on the Commissioner for Older People's investigation into Dunmurry Manor care home (2018) and the CPEA Independent whole systems review into safeguarding at Dunmurry Care Home (2020) have resulted in a draft 'Adult Protection Bill' (July 2021) which will introduce additional protections to strengthen and underpin the adult protection process; provide a legal definition of an 'adult at risk' and in need of protection and define the duties and powers on all statutory, voluntary and independent sector organisations. An Interim Adult Protection Board (IAPB) was established in February 2021. It is clear to the review team that significant steps have been taken by the Department of Health to update legislation and policy in regards to adult safeguarding.in Northern Ireland in response to the learning from failures in care.

9.5 The Muckamore Departmental Assurance Group (MDAG) was established to monitor the effectiveness of the HSC system's response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff. The action plan monitored by MDAG, includes an action to complete a review of Adult Safeguarding culture and practices at MAH to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. This action is focused on safeguarding culture at MAH however, our engagement with the wider HSC and care providers highlighted variation both in practice and attitudes cross the Trusts. RQIA inspections of other learning disability hospitals in Northern Ireland also highlight ongoing concern about standards of safeguarding practice.

9.6 Current Safeguarding policy and practice is guided by; 'Prevention and Protection in Partnership Policy' (DHSSPS) 2015 and the adult Safeguarding Operational Procedures – 'Adults at Risk of Harm and Adults in Need of Protection' (HSCB) 2016. The policy highlights that adult safeguarding arrangements should prevent harm from happening and protect adults at risk. Safeguarding is a continuum from taking steps to prevent harm through to protection highlighting that safeguarding is everyone's business and not just the business of statutory safeguarding teams. The stories shared by family carers later in this chapter and in chapter 10, put the spotlight on psychological and emotional harm and fact that more could have and should have been done to prevent harm.

9.7 RQIA carried out a review of safeguarding in Mental Health and Learning Disability hospitals (2013) looking specifically at the effectiveness of safeguarding arrangements. A recommendation from the RQIA review was that the DHSSPS should prioritise the publication of the Adult Safeguarding Policy framework. RQIA published a follow up report, Safeguarding of Children and Vulnerable Adults in MH/LD Hospitals in NI (2015) following inspection in the Southern HSC Trust.

9.8 The Bamford Review of Mental Health & Learning Disability recommended a new comprehensive legislative framework for mental capacity legislation and reformed mental health legislation for Northern Ireland. This has been taken forward by the implementation of the Mental Capacity Act (NI) 2016 which has a Rights based approach and brings new safeguards in regards to deprivation of liberty and consent. The Mental Capacity Act (NI) 2016 provides a statutory framework for people who lack capacity to make a decision for themselves and provides a substitute decision making framework. The Act is being implemented in phases. Phase one implemented from December 2019 included provision of Deprivation of Liberty Safeguards (DOLS') and a DOLS Code of Practice. DOH (April 2019) The Mental Capacity Act (NI) 2016 is intended to protect the human rights and interests of the most vulnerable people in society who may be unable to make decisions for themselves and offer enhanced protections to people lacking capacity. The Act is principles-based and sets out in statute that it must be established that a person lacks capacity before a decision can be taken on their behalf. It emphasises the need to support people to exercise their capacity to make decisions where they can. This legislation will change and shape practice across learning disability services with a focus on Best Interests. Decision making in complex areas such as the use of CCTV will be addressed in more detail later in this chapter.

9.9 Whilst progress has been made in regards to legal safeguards for decision making in respect of individuals who lack capacity and in regards to placing adult safeguarding on a statutory footing, incidents highlighting concerns about safeguarding and restrictive practices remain current in practice.

9.10 This is evidenced in an RQIA inspection report following an unannounced inspection at Lakeview Learning Disability Hospital between August and September 2021 which identified a number of matters of significant concern in relation to adult safeguarding and incident management. A further inspection was completed in February 2022 which found that progress had been made in a number of areas however, there had been limited progress with regards to adult safeguarding and incident management. The RQIA inspection report noted areas for improvement relating to adult safeguarding including a review of the use of CCTV to support adult safeguarding.

9.11 The ‘Way to Go’ report made a recommendation that In addition to CCTV’s safeguarding function as a tool to prevent harm rather than as a means to ensure safe and compassionate care, CCTV should be used proactively to inform training and best practice developments at MAH CCTV needs to be considered This recommendation is included in the MDAG action plan and the BHSCT CCTV policy group continue to engage with stakeholders to reach agreement, on best practice in MAH .The review team were advised that Questionnaires have been issued to family members, carers, patient and staff to seek feedback and engagement around the use of CCTV on site

9.12 CCTV was a central issue of concern for MAH families in the context of discharge planning. Some of the MAH family carers stressed the importance of CCTV in providing them with assurance. Families stressed that CCTV has been central to establishing abuse at MAH and that they hold significant concerns about CCTV not being in place in community settings. The review team were advised about one case where this issue created delay in progressing plans for discharge due to the Trust and the family holding differing views of what could be put in place. During engagement events with families, the review team were advised that some families see the need for CCTV as a consequence of their loved one being the subject of abuse at MAH and that maintaining similar monitoring in the community setting is an important bridge for these families. The debate on the use of CCTV between the family and the Trust in one case could be a barrier to discharge with potential to cause delay. CCTV played an important role in recording potentially abusive behaviour by staff in Dunmurry Manor Care Home, Winterbourne View as well as MAH. The initial concerns were not initiated by CCTV but rather used to explore concerns raised by family which led to the identification of concerns. Given the importance family carers placed on CCTV, the review team reviewed the actions taken by RQIA to address this issue.

9.13 RQIA issued Guidance on the use of overt closed circuit televisions (CCTV) for the purpose of surveillance in regulated establishments and agencies (May 2016) The guidance was aimed at assisting registered providers in meeting the best interests of service users when considering the use of overt CCTV systems and reminds them of the requirements of the Data Protection Act 1998 and Article 8 of the European Convention on Human Rights-Right to respect for private and family life. The guidance states that CCTV should not be used in rooms where service users normally receive personal care and that a policy must be in place which outlines the provider’s position on the use of CCTV. The RQIA also commissioned Queen’s University Belfast to carry out a review of the effectiveness of the use of CCTV in care home settings (January 2020) which was commissioned in response to concerns regarding the quality of care and the potential for abuse in care home settings. The research highlighted that this is a complex ethical matter in the context of existing law and guidance. Expectations on the use of CCTV creates tensions between the needs of residents, family members and those providing care. The review completed on behalf of RQIA concluded that there was insufficient research evidence to support the proposed use of CCTV in care home settings.

9.14 Given the importance placed on this issue by some MAH families, the review team recommend further consultation with individuals, family carers and care providers to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.

9.15 The review team considered how the feedback provided by families in regards to their concerns about safeguarding should contribute to the discharge planning process and in supporting an individual through the transition process to a home in the community. Family carers were clear in their feedback to the review team that they have an active role in safeguarding by staying observant and alert to concerns and any change in their loved one’s presentation. Families advised that they view flexible visiting and having access to the living environment of their loved one as central to building confidence in safeguarding for the family. MAH family carers expressed concern and frustration due to the visiting restrictions required at MAH in response to the Covid pandemic.

9.16 The following patient story highlights a family’s concern about the care arrangements and impact of the living environment on their son. The family highlighted to the review team that the focus at MAH has been on physical abuse of patients by staff but that in their case their concern is about psychological and emotional abuse.

'Family shared the story of their son who returned to MAH following a traumatic breakdown in trial resettlement placement after six months. His parents advised that they have not been advised to date that their son has been the subject of physical abuse, however, they highlighted that their son has suffered emotional and psychological abuse associated with both his in-patient stay in MAH and in regards to a trial resettlement placement. The family expressed concern about the quality of care in both the community placement and in MAH. Their experience of the community placement which had been a new build resettlement scheme was that it operated as a mini institution rather than to the vision of supported living that they had expected. The family were advised after the decision to end the placement was made by the care provider who did not think their son was compatible with other residents. The family experience of discharge planning and trial resettlement has not been positive and they reflected that the discharge planning was not effective and caused harm to their son due to the care provider not being in a position to meet his needs.
The family advised that since his return to MAH their son has regressed. The family expressed further concern about the impact of the Covid restrictions on visiting and in the reduction of the range of activities available which the family believe is detrimental to preparation for their son leaving MAH. The family talked about their experience of MAH being poor and their confidence in the HSC system significantly impacted.'

9.17 This story about the lived experience of a patient, highlights that transitions between services should be handled smoothly and systematically with attention given to ensuring the person's individual needs are well communicated between services. It also highlights that family carers should be seen as important partners in the care planning approach. The chapter on individualised care planning provides further case examples when communication between services was not as effective as it should have been. For individuals with behaviour that may challenge, it is critical that discharge planning is progressed in line with 'Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability services' (2010) with a clear Safety Plan agreed and the family consulted about what is needed to safeguard and protect. The written care plan needs to detail any risks as well as what should happen in a crisis. We give further consideration to good discharge planning in the chapter on individualised care planning, highlighting the need for regional standardisation on the range of assessment and care planning tools used to ensure that individuals are safeguarded. A Person centred safety management plan should be central alongside a functional assessment and essential lifestyle plan and the family fully consulted and engaged in the resettlement planning process. We also highlighted that the risk assessment should be shared with relevant agencies and that the specialist knowledge and communication skills required to care for the individual should be defined and embedded in commissioning specifications and contracts.

9.18 Independent sector providers provided feedback to the review team on their experience of the adult safeguarding policy and procedures in practice which highlighted variation across trust areas. Care providers reflected variation in regards to thresholding of safeguarding referrals and variation in the attitude and support from different safeguarding teams. The review team recommend the review of Adult Safeguarding culture MAH is extended across community settings to address the experiences of key stakeholders including families and care providers.

9.19 Care providers also raised the use of restraint and the need to ensure appropriate focus on management strategies that enable preparation for discharge to the community. There has been growing recognition of the importance of reducing the need for restraint and restrictive intervention. DoH launched a public consultation on a draft regional policy on the use of restrictive practices in HSC settings in July 2021. It is critical that further review and analysis of incidents across all care providers in learning disability services is progressed to ensure learning and to inform the DoH review. The review team did not see evidence of effective sharing of learning from the analysis of incidents and SAI's with independent sector providers.

9.20 Feedback from family carers about safeguarding policy and procedures highlighted concerns that investigations were not progressed in a timely way which causes anxiety for the family. Trusts have highlighted workforce capacity issues. Given the impact of the ongoing PSNI investigation of alleged abuse at MAH and the evidence being provided to the Public Inquiry, more needs to be done to address the impact of delay in safeguarding investigations for families. Engagement with family carers highlighted that their concerns about safeguarding relate to current experience as well as the historic allegations of abuse which are the subject of ongoing police investigation and the focus of the Public Inquiry. It is critical that the experience of individuals and their family carers is heard and addressed.

Recommendations

In summary the conclusions and recommendations from this chapter are

- Further consultation with individuals, family carers and care providers to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.
- Contracts or service specifications for services for people with a learning disability should ensure that safeguarding requirements are adequately highlighted and that arrangements for monitoring are explicit.
- HSC should ensure that capacity in Adult Safeguarding services is maintained to ensure timely investigation and any challenges clearly reported in the Trust Delegated Statutory Function report.

- HSC Trusts should review visiting arrangements for family carers to ensure flexibility and a culture of openness so that families access their loved one's living environment rather that a visiting room.
- HSC Trusts should have arrangements in place to share learning about safeguarding trends and incidents with care providers.

10. Advocacy and Carer Engagement

This section will address the extent to which engagement strategies employed by HSC Trusts and collectively by the HSC system as a whole have been effective in supporting the delivery of the MAH resettlement programme; the extent to which families and patients were engaged in decision- making around resettlement and to what extent Advocacy support was provided.

Sincere thanks are owed to the family carers who engaged with the review team and so generously shared their personal experiences and stories. The families provided the review team with rich information about their lived experience which has shaped the findings for this review.

10.1 Participation and engagement with a wide range of stakeholders was central to the review however, the priority for the review team was to hear the voice of people with a learning disability and their family carers who have lived experience of delayed discharge and the resettlement journey. This was achieved in a number of ways;

- The review team issued a letter to every family with a loved one in MAH extending an invitation to contribute to the review of resettlement. Meetings were held at a neutral venue in the NHSCT, SEHSCT and BHSCT areas to bring families in each HSC Trust area together to hear their individual stories and common experiences.
- Some families did not wish to attend a public meeting but wished to meet with the review team. This was facilitated by home visits and zoom calls.
- The review team met with the 2 family carer representatives on the Muckamore Departmental Assurance group.
- The review team met with families of people who have already been resettled from MAH and whose placements have been successful
- The review team visited individuals with learning disability resettled in their community placement.
- The review team met patients and staff at MAH.
- The review team met with the Patient Client Council in regards to their role in providing Advocacy and supporting families involved in the MAH Public Inquiry.
- Meetings were arranged with Voluntary and Independent Care provider organisations who facilitated meetings with families.
- Engagement with RQIA - to learn about user experience from Inspections

10.2 Engagement strategies employed across the HSC

10.2.1 The Health and Personal Social Services (Quality, Improvement and Regulation) Order 2003 (ctrl click) applied a statutory duty of quality on the HSC Boards and Trusts. The 5 key quality themes which remain relevant to this review are:

- Corporate leadership and accountability of organisations
- Safe and effective care
- Accessible, flexible and responsive services
- Promoting, protecting and improving health and social well being
- Effective communication and information

10.2.2 The quality standards launched in 2006 (ctrl click) includes a standard for effective communication and information. HSC organisations are expected to have active participation of service users and carers and the wider public based on openness and honesty and effective listening.

10.2.3 The Bamford review recommended independent advocacy highlighting the need to support individuals to express and have their views heard. The principle of involving people in decisions about their care has been embedded in policy for many years. In 2012, the Department for Health and Personal Social Services (DHSSPS) launched a 'Guide for Commissioners- Developing Advocacy services' (ctrl click) introducing principles and standards. The DoH 'Co-Production Guide for Northern Ireland (2018) (ctrl click) recognised that co-production takes time and is a developmental process based on building relationships to support effective partnership working with service users and carers.

10.2.4 In the BHSCT's Serious Adverse Incident investigation report, 'A Way to Go', advocacy in MAH was described as '*not as uncomfortably powerful as it should be*' and stated 'it *is possible that the long association that advocacy services have had with the hospital and the impact of protracted delayed discharges have blunted its core purpose*'. The report also acknowledges that 'episodic contact is unhelpful' however, did not address the question of how family members, where they exist, are supported to act as the primary advocate for their loved ones as active partners in their care.

10.2.5 There is significant learning from the Scottish Government's approach to citizenship and involvement. 'A stronger Voice' Independent Advocacy for people with Learning Disability 2018 (Scottish Commission for LD) (ctrl click) states that Independent Advocacy can empower people

- To be listened to
- Understand what is happening and why decisions are made

- Be involved in decision making processes
- Become more confident and able to self-advocate

10.2.6 The review team sought to establish the engagement strategies in place across the HSC system at a population and individual case level. It was evident that all HSC Trusts have a formal infrastructure in place at organisational level to meet their patient and public engagement duty through established committees. This review however, was primarily focused on the experience of individuals and families and the extent to which their voice was heard at individual case level and in influencing the policy and practice in learning disability services.

10.2.7 The Muckamore Abbey Assurance Group (MDAG) has 2 family carers as members representing the views of families with lived experience. At Departmental and HSCB/SPPG level there is limited evidence of engagement and involvement of service users and carers in the development of policy, however, ensuring that this is effective and that the experience of individuals is one of being respected and valued is challenging. The Covid pandemic significantly impacted on business as usual, however, there is limited evidence of meaningful engagement with individuals and carers prior to the pandemic or currently in the range of learning disability work streams led by HSCB/SPPG.

10.2.8 There is variation in the engagement strategies within learning disability services in each of the HSC Trusts however, all HSC Trusts are continuing to review and improve the arrangements in place.

10.2.9 This was evident in BHSCT who have an action plan in place to address the recommendations arising from the 'Review of Leadership and Governance at MAH' (2020) (ctrl click) which includes a 'Communication and Engagement plan' the appointment of an engagement lead for learning disability and a non-Executive Director undertaking a lead for learning disability at Board level and being a visible champion for people with a learning disability and carers. The terms of reference for a range of engagement Forums were shared with the review team. There is a separate forum for MAH families with regular newsletters. The forum for community learning disability has a number of sub-groups to engage carers about transitions and accommodation. The BHSCT was the first Trust to establish a Carers Lead post to represent the views of people with lived experience of learning disability however, this post is now vacant. Whilst this is a positive step, further work and time is required to improve the number of families involved and engaged in the learning disability forums. There are only a small number of the MAH families actively involved in the MAH forum which reflects a significant level of disengagement due to the breach of trust experienced by families following disclosure of abuse at MAH. The review team completed home visits with MAH families who have lost trust in the BHSCT and whose level of anger, pain and ongoing concerns about Safeguarding and Quality of service at MAH, highlight that a trauma informed and reconciliation approach is needed. The review team observed a number of occasions when engagement about a specific issue may have had a better outcome if the engagement and direct discussion with the family had been escalated to Director Level. Two discharge coordinator posts based at MAH had been funded to coordinate discharges across all patients. One of the discharge coordinator posts is now vacant. The resettlement team at MAH has reduced in size over the past year with an additional post-holder who had completed person-centred planning not filled. The NHSCT and SEHSCT lead the discharge planning for their own patients however, central coordination is required to arrange discharge meetings and to ensure that the range of information required from the MAH teams is available. The review team recommend that BHSCT considers the demand and capacity in the MAH resettlement team.

10.2.10 The NHSCT have also revised their approach to engagement and invited the review team to a public meeting organised by the Trust to engage their MAH families. A key learning point from this engagement event was the recognition that all of the families who attended in person on the evening had a shared experience of being involved in discharge planning for the new Braefields scheme. The families expressed the view that it is their perception that families have deliberately been kept apart and that the principle of stronger together should be embedded so that families can offer each other mutual support and identify common concerns and themes. This raises the need for the HSC system to recognise and value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy.

10.2.11 The NHSCT strengthened their resettlement team recently, appointing a senior manager with oversight responsibility for monitoring progress against resettlement plans. The NHSCT is also in the process of appointing a lead Carers post to work in partnership with the senior management team to influence learning disability policy and service development. The review team met with NHSCT families who had a poor experience of communication however, there was positive feedback from a number of families about the relationship with the Trust's resettlement co-ordinator who has been in post for a lengthy period. The continuity of the relationship was valued by the families and highlights the importance of a key worker role, described to by families as the go to person for families trying to navigate across complex services.

10.2.12 SEHSCT has a long established Carers Forum for Learning disability who engage with the Trust in regards to policy and service development but also provide advocacy and representation of the views of people with learning disability and carers. The SEHSCT's in-patient population has reduced to just six patients whose age and range of needs are very diverse. A young person who transitioned a few years ago from a children's in-patient facility, a patient on detention though a Hospital Order with restrictions and an individual in his late 70's who has lived most of his adult life in MAH. The Trust's engagement with the remaining families is though the key worker, as the discharge solutions needed for the remaining patients are bespoke and highly personalised. The Trust had a dedicated post ensuring Essential Lifestyle discharge planning for all SEHSCT MAH patients transitioning to the community over the past years. This post is now vacant. There is evidence that using the tools of essential lifestyle planning is effective in developing a meaningful person-centred discharge plan. The review team recommend that all HSC Trusts embed essential lifestyle planning in the discharge pathway.

10.2.13 In summary, it is encouraging to see that the engagement strategies in all of the HSC Trusts have developed, but further time and effort is required to address the hurt and harm experienced by MAH families and to build the relationships and bridges needed to facilitate honest and mature dialogue and co-production. Overall across the HSC system, the voice of carers was not sufficiently evident within the leadership processes and there was limited evidence at all levels of effective co-production with carers.

10.3 The Voice of People in MAH - extent to which families and patients were engaged in decision- making around resettlement

10.3.1 Most of the families who attended the engagement meetings had previous experience of a trial resettlement that had broken down and were keen to share their experience of discharge planning and what went wrong.

10.3.2 There was not one voice but there were recurring themes from the review team's engagement with MAH families.

- Lack of trust, anger and families reporting invisibility of LD services
- Significant Safeguarding concerns
- Traumatic impact of abuse disclosures given the blind trust families had over many years seeing MAH as safety net
- not being involved or respected as expert by experience
- not being involved in relevant care planning meetings
- Experience of at least one trial placement breakdown

10.3.3 Some families talked about the culture and attitudes they had experienced over the years with HSC staff trying to ‘persuade’ them to accept a placement with a number of families referring to passive aggressive through to hostile approaches. Families referred to not being valued or acknowledged as experts by experience.

The following story of a mother’s experience highlights the impact of culture and unhelpful communication styles;

10.4 A Mother’s Story

10.4.1 Shared the story of a trial placement for her son which broke down within months. The family felt that the environment was appropriate however staff were not adequately trained or competent. Mother did not feel listened to or respected as an expert by experience who knew the triggers and warning signs that staff should have been attentive to. Family expressed the view that MAH did not provide enough information about relevant incidents on the care plan

10.4.2 When asked what needed to improve, the review team were advised by the family that resettlement needed to be accelerated and the following areas addressed;

- Better training for staff and assessment of competencies in key areas.
- An understanding of trauma and recognition of the experience and impact on families as well as their loved ones.
- Family carers valued as experts by experience and fully included in all decisions and meetings
- Better communication – Improvement needed to ensure communication is respectful and effective.
- Possibly some tools like a carers charter; an explicit statement of expectations and principles

10.4.4 The review team were advised that the family have experienced a breach of trust and confidence in the Trust and wider HSC system. The feedback provided to the review team confirmed that further work is required to ensure that all families feel effectively engaged in decision-making around resettlement and the monitoring of trial placements.

10.4.5 A number of families spoke to the review team about the importance of getting the culture, leadership and model of care right. The stories shared by families demonstrate the need for a tiered advocacy framework so that issues of complexity or dissension can be supported and facilitated more effectively through independent advocacy. Families also told the review team that they have increasingly escalated to legal advocacy through the courts when the issues are systemic about failure to commission a service rather than about individual care planning.

10.5 Patient Story

10.5.1 The family confirmed that significant discharge planning had been progressed prior to the trial resettlement placement and expressed their disappointment and anger that the placement broke down within weeks resulting in their family member being returned to MAH without the family being advised in advance. The family had visited the trial placement daily and witnessed that the care staff were not competent to provide the care required. The family highlighted that the focus should not be on the number of staff required but on the culture, leadership and support the staff receive in addition to training and skills development. The family hold the HSC Trust accountable for commissioning the service and feel that HSC Trusts need to seek assurance that care staff have the appropriate competences.

10.5.2 The family believe that timely resettlement is in the best interests of their loved one and are actively involved in the planning for another trial discharge. The learning from the failed trial resettlement for the family was that they should be seen as a member of the multi-disciplinary team and involved in all meetings and decisions about care.

10.6 The Voice of People who have been successfully resettled

10.6.1 The review team met with a number of families whose family member has been resettled for some time. The narrative and experience of discharge planning and transition arrangements between MAH and the community are in stark contrast to the experiences shared by current families. It is of note that resettlement in the 1990's was strategically led and was progressed at scale with families reporting clarity about the process. This is best summarised through the story of a father who was very resistant to resettlement when the process commenced.

10.7 Lessons from what has gone well- A Father's story

10.7.1 The family of this young man were not keen on resettlement as they believed that their son was settled at MAH and that he was safe and secure. They were fearful of the unknown and had no experience or understanding of supported living services. The family advised that discharge was well planned and that they had been able to consider a number of options. What has worked is that the care provider is open with the family who are made aware if their son's behaviour is changing. The staff identify the triggers that may result in deterioration and discuss with the family. The family advised the review team that their main concern prior to transition was safeguarding in the community. The family view the ability to visit their son flexibly and unannounced in his own home as providing then with real time assurance about his care rather than the formality of appointments. The family advised that the outcomes that demonstrate that resettlement has improved the quality of life for their son are numerous including the level of engagement he enjoys in activities in his own community, the fact that the parent/ child relationship has changed with their son supported to make adult decisions and personal choices about how he wishes to celebrate birthdays and Christmas. The family compared their son's life now to when he was in MAH and advised that he is living a fulfilling life and is central to his care planning. The family's advice in regards to what can be done to expedite or improve resettlement planning was quite simply 'Get it Done'.

10.8 Story of a young man with very complex behavioural needs living in Supported Living

10.8.1 The review team met with a young man now supported in a specialist supported living placement in the community having previously experienced admissions to MAH and other specialist in-patient facilities. The sustainability of this placement for a young man with very complex needs and challenging behaviour was stated by the care provider to be down to the partnership working between the care provider and the statutory learning disability team. The care provider uses a Positive behaviour approach with staff trained and competent in the methodology. The care provider highlighted that the responsiveness and wraparound support from the statutory team at times of increased challenge, actively reduces the potential for placement breakdown. The review team spoke to the young man and his care staff directly who described the full and active life the young man experiences and the support he receives to make personal choices. Additional positive outcome has been improvement in the young person's physical health with weight loss through a fun focused activity schedule. It was helpful for the review team to see an example of positive behaviour approach in action. The care staff reported that the model provides them with the support they need and they feel part of a wider specialist team.

10.8.2 This young man has needs equivalent too many of the patients in MAH who have been discharge delayed many years and this story is a helpful reminder that supported living models rather than new build bespoke are effective for individuals whose behaviour can challenge. Voluntary sector care provider organisations stressed to the review team that the primary focus should be on a Positive behaviour approach and a skilled and competent workforce not just on the built environment.

10.9 Extent Advocacy support was provided regarding resettlement

10.9.1 The Review of Leadership and Governance at MAH recommended that the BHSCT should review and develop advocacy arrangements at MAH to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

10.9.2 BHSCT has recently commissioned an independent review of advocacy services which is due to report by September 2022.

10.9.3 There are a number of Advocacy service providers engaging with MAH families. NHSCT commission independent advocacy services from Mencap for their families. SHSCT commission independent advocacy services from Disability Action for their families and Bryson House provides the independent advocacy service for both Belfast and SEHSCT. Families reported confusion about the roles of the various advocates involved, which is heightened when there is more than one advocate involved with the family.

10.9.4 The landscape has become more confusing for families with the Patient Client Council (PCC) providing direct advocacy support to MAH families. The review team met with the PCC Chief Executive and senior management team, who advised that PPC had been asked to provide support during the Leadership and Governance review feedback to families. In addition, the PPC provided a report on the engagement with current and former patients, families and carers regarding the terms of reference of the Public Inquiry. The PCC are now acting as the Independent Advocate for the Public Inquiry into MAH. As a result, the PPC has appointed a dedicated worker to build relationships with MAH families. The review team did not see evidence that the impact of the extended role for PCC on the long-standing commissioned independent advocacy services was considered or discussed between the various advocacy providers. Families reported that current arrangements are confusing and reported a lack of clarity about definition of advocacy, lack of clarity about roles and provided examples when an advocate from PCC and Bryson house were working at cross purposes. The situation was resolved but further review is required. The review of advocacy services commissioned by the BHSCT should bring forward recommendations to address the concerns raised by families.

10.9.5 Some families welcomed the relationship with the advocate involved with the family but struggled to provide examples when the advocate had made a difference in the resettlement outcome. There was confusion between a befriending and advocacy role with families stressing that it was the relationship they appreciated rather than the challenge function.

10.9.6 The following patient and carer story highlight the key issues raised by families in regards to advocacy. The strongest message was that family carers should be the first and primary step in advocating for their loved one.

10.10 Story of Long-Stay patient and experience of Advocacy

10.10.1 A mother met with the review team to share the story of her son who has been in-patient at MAH for some time. The story tells of a family who have maintained close contact with their son. The family have dreams for their son to experience community living with enhanced personal choices and less bound by hospital routines. However, a trial resettlement went badly wrong with the police being called by the care provider and their son being traumatically returned to MAH. The family believe the placement broke down because the care staff did not have the competencies to cope with behaviour that challenges. The family did not feel they were involved in care planning and expressed the view that they were advised by professionals rather than consulted.

10.10.2 The family talked about their experience with advocacy and felt strongly that the family are the strongest advocates in speaking up for their son. The family expressed confusion as there have been 2 advocates involved with the family and they are unclear about their respective roles. Family did not know why advocates became involved and state their view was not sought on the matter. The family advised that their experience of advocacy has not been positive and referred to the fact that the advocates turn up at meetings but the family were not able to identify when the advocate had made a difference. The family expressed the view that advocates had agreed on occasion to do something but did not follow up. The family felt that they are the only ones in their son’s life for the long haul and will continue to speak up for their son. The family do not call themselves advocates but felt they provide a strong voice for their son.

10.10.3 The review team have reviewed the Terms of Reference for the comprehensive review of advocacy commissioned by BHSCT. The issues raised by families should be addressed by that review.

10.10.4 Other family carers reflected on current concerns about Safeguarding and the Quality of care in MAH. The families acknowledged that the Covid pandemic impacted on routine business but expressed concern that patient activities being curtailed directly impacted on quality of life and preparing for transition to the community. Families also reported that the visiting restrictions implemented in response to the Covid pandemic raised anxiety about safeguarding arrangements due to visits being electronic or having to pre-book visiting with no access to their loved ones ward or living environments. Family carers feel they have an active role in Safeguarding by staying observant and alert to concerns and any change in presentation. Families advised that they view flexible visiting and having access to the living environment of their loved one as central to building confidence in safeguarding for the family

10.10.5 Whilst there is relationship complexity across the wide range of stakeholders involved in the resettlement pathway, there is an urgent need to repair relationships and build trust. Families stressed to the review team that professionals talk about services but for the families it is their lives. The change that families want to see in the culture and attitudes across HSC services does not require radical reorganisation. The HSC Collective Leadership strategy (2017) (ctrl click) describes the values needed to promote shared leadership across boundaries and partnership working between those who work in HSC and the people they serve. Families stressed the need for a return to basics to achieve effective person centred planning and involvement of families in all meetings about care and decisions based on openness and respect. A regional one system approach and effective engagement and partnership working with family carers will be required to ensure the effective delivery of the final stage of the MAH resettlement programme

Recommendations

- HSC organisations need to value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy.
- Family members should be listened to and receive a timely response when they advise things are deteriorating
- Advocacy support should be available and strengthened at all stages of care planning-HSC Trusts must ensure that there is a clear pathway and clarification to explain the role of different advocacy services.
- HSC Trusts should utilise the Lived Experience of families who have supported a family member through successful resettlement to offer peer support to current families
- HSC Trusts should arrange group meetings so that families with loved ones being considered for the same placement can support each other and share experiences
- HSC Trusts should improve communication and engagement with families when placements are at risk of breakdown

- Families should be seen as integral to the care planning and review process and invited to all meetings
- A regional policy on the use of CCTV in learning disability community placements should be co-produced with relevant stakeholders.

11. Conclusions

Conclusions

11.1 The review team were determined from the outset of the review to ensure that the experience and voice of those with lived experience and their family carers informed the solutions and actions required to expedite resettlement .The review draws on the experience of people with learning disability who have been successfully resettled and those who have experienced breakdown and returned to MAH. The stories shared with the review team by family carers, brings into stark reality the impact that the allegations of abuse at MAH has had on family carers. In contrast, the stories shared by family members who have experienced successful resettlement, provide evidence of the positive outcomes and improved quality of life their loved ones are now experiencing.

11.2 It is important not to underestimate the challenge of planning for the resettlement of the remaining population whose needs are complex. The review team considered the learning from the policy and practice evidence base in relation to resettlement programmes across the UK and Republic of Ireland and a detailed analysis is contained in Chapter 4. Transforming Care for People with Learning Disabilities - Next Steps" was published in January 2015 The report identified a significant change in direction in the policy and practice in relation to gatekeeping admission to specialist learning disability settings, alongside dedicated strategies for admission avoidance and more effective discharge planning. Actions that should be considered for Northern Ireland include;

- ➢ providing enhanced vigilance and service coordination for people displaying behaviours which may result in harm or placement breakdown;
- ➢ Establish a Dynamic Support Database to provide focus on individuals at risk of placement breakdown and development of proactive rather than reactive crisis driven response-
- ➢ Implementation of a Positive Behaviour Service framework and provider engagement
- ➢ Effective Assessment tools/ Discharge planning meetings- Complex care co-ordinators to focus on transition plans
- ➢ More detailed tracker tool to support analysis and performance management to create a master database-history of discharges, re-admissions and trends.

11.3 Feedback from a wide range of stakeholders highlighted the need to refresh the strategic policy and service model for Learning Disability in Northern Ireland.

The above actions should be central to policy development but will require system leadership at all levels across the HSC.

11.4 The Learning Disability resettlement programme in the 1990s was successful overall, achieving a significant reduction in the long-stay population. The success factors appear to be that the resettlement programme was strategically and regionally led with ring fenced funding agreed across Department for Communities and the DOH with robust project management monitoring progress against targets. The current resettlement programme would benefit from a similar approach as it is currently a bottom up approach and lacks cohesion and direction. The data provided by the Trusts on progress on resettlement plans was not adequately scrutinised internally in the Trusts or externally by the HSCB/SPPG. The review team advised the HSCB/SPPG officers on actions to establish a more effective tracker tool to improve performance management.

11.5 In general we found that across significant elements of the HSC system there was poor management grip in relation to the learning disability agenda and this resulted in a lack of momentum and a sense of inertia and drift. It is critical that a one system approach is developed in Northern Ireland to address the silo working and duplication that remains across the 5 HSC Trusts involved in supporting individuals who are awaiting discharge from learning disability hospitals. The review team were pleased to see improved collaborative working led by the three directors within the past few months to seek solutions to the delayed discharge challenge and agree mutual aid in response to supporting MAH

11.6 The importance of and necessity to build trusted relationships was evident at strategic and operational leadership levels but more so in relation to building effective partnership working with individuals and families with lived experience of using services. The review team did not see evidence of effective engagement of people who use learning disability services or their family carers influencing the numerous learning disability work streams established by HSCB/SPPG to contribute to and influence the resettlement agenda. Whilst the review team did see evidence of new initiatives in the BHSCT and NHSCT to build an infrastructure to support engagement with family carers, they do not yet reach the MAH families who have disengaged due to the breach of trust they have experienced. People with a learning disability and their family carers should be respected as experts by experience with Trusts building co-production into all levels across the HSC system.

11.7 Family carers raised safeguarding as a significant concern and the review team recommend further engagement with care providers, family carers and Trusts to discuss their expectations and concerns about CCTV.

11.8 The area of strategic commissioning also requires a refreshed approach. Strategic commissioning needs to be underpinned by a strong assessment of needs. It was a recurring finding at strategic and operational levels that needs assessment was not robust. The review team identified models of commissioning which could inform improvements in Northern Ireland. “Integrated Commissioning for Better Outcomes” was published in 2018 to support health and social care economies to transform their services through a person centred approach to commissioning which is focussed on the needs of the local area. In Kent and Medway a new governance framework and an oversight board has been established to ensure that partners were accountable for commitments and performance. Accountability needs to be strengthened across HSC in Northern Ireland in regards to performance management against resettlement.

11.9 Engagement with independent sector care providers and Supporting People leads highlighted to the review team that knowledge and memory has been lost due to the turn-over in senior leaders most especially in BHSCT. Further work is required to build effective working relationships with key strategic partners to address barriers to resettlement.

11.10 The review team sourced data from RQIA and Supporting People in regards to the number of placements and schemes for learning disability and sought additional information from Trusts to form the basis of a supply map as seen in chapter 6. There does not appear to have been any analysis or strategic oversight to inform market shaping and this should be addressed by HSCB/SPPG and Trusts to inform strategic and micro commissioning.

11.11 Further development of social care procurement is urgently required and the review team recommends the development of a commissioning collaborative. Training and skills development on commissioning and procurement is required across the system.

11.12 The review team reviewed the care planning tools used by Trusts to support discharge planning. There is variation across the Trusts and the review team recommends that work is progressed to develop an over-arching resettlement pathway and standardise assessment tools to ensure that the needs of patients are considered as outlined in chapter 7. The learning from placement breakdowns highlights that discharge plans on occasion have not been sufficiently robust.

11.13 The review team scrutinised the current care plans for all the service users in MAH and critically analysed the actions taken by the responsible Trust to identify and commission suitable community placements. The analysis of length of stay, the location the patient was admitted from and number of previous trial placements is presented in chapter 7.

11.14 The review team have assessed the robustness of discharge plans using the Care Quality Commission definition of a plan .Namely there has to be a named provider, address and confirmed discharge date. If this detail is not available the plan is incomplete. It is critical going forward that there is clarity and consistency in Trusts reporting on progress against discharge plans. The review team recognise that there are plans in development for some patients that show promise but in establishing a trajectory the system should only rely on plans that meet the definition outlined.

11.15 The South Eastern and Northern Trusts had taken steps some years ago to plan capital schemes that have already delivered or due to be operational in the next months. The BHSCT is an outlier in this regard with three capital business cases still in the early stage of development with the earliest date for completion 2025/26. The NHSCT and SEHST had been co-dependent on two of the three BHSCT schemes namely the forensic and on-site for a small number of their patients but are now pursuing other placements options.

11.16 As a result SEHSCT in-patient population at MAH has reduced to 6 patients. Robust plans are in place for 4 patients with no plan yet in place for two forensic patients. Two of the SEHSCT patients will be discharged by end August 2022 and an additional placement by end September 2022.

11.17 NHSCT has made good progress in delivering 2 new build schemes. Mallusk and Braefields which is due to complete end August 2022. NHSCT has taken additional steps to commission a number of individual placements in current schemes and plans to discharge 14 NHSCT patients by March 2023 This includes 12 MAH patients and the two NHSCT in out of area placements in Dorsey and Lakeview hospitals. NHSCT has 2 patients in MAH with plans not yet complete. the NHSCT has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefields scheme from end April to end August 2022.

11.18 BHSCT has been reliant on the 3 capital business cases providing for 10 BHSCT patients. This includes the Minnowburn scheme for 5 BHSCT patients and the Forensic and On-Site schemes. Given the long lead in time BHSCT is now seeking alternative options to facilitate a more timely discharge. Whilst the BHSCT has adopted a refreshed approach with view to utilising available voids the plans are not yet complete. As a consequence only 2 of the 15 BHSCT patients have robust plans in place and 13 have plans that are not complete.

Reduction in Number of Patients in MAH between June 2021 and July 2022 and trajectory for Robust planned discharge by end March 2023

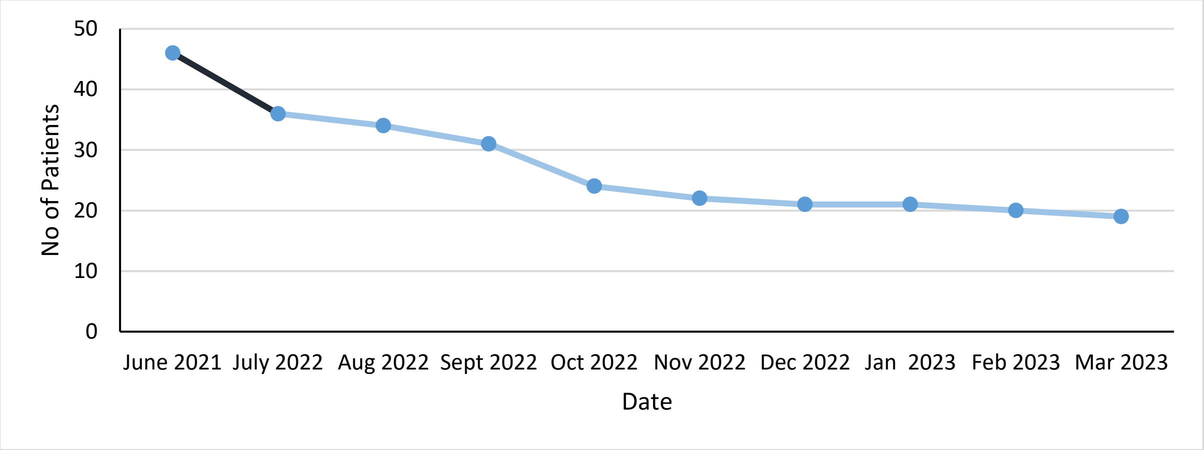


Fig 13

11.19 Fig 13 illustrates the discharge trajectory based on robust plans and robust timeframes. This is a conservative trajectory and the review team have confidence that further individual discharges will be progressed. It is encouraging to note that Trusts have responded to the recent challenge to develop contingency plans and that schemes in planning for some time now have confirmed discharge dates. The MAH population at 11th July 2022 was 36 in-patients, Fig 13 shows that the projected in-patient position by end March 2023 based on completed discharge plans is expected to reduce to 19 patients with potential for further individual discharges. Based on the analysis of the Trusts discharge plans against the Care Quality Commission definition of a discharge plan it is reasonable to assume that a further 17 patients will be discharged by end March 2023.

12. Recommendations

DOH

- The DoH should produce an overarching strategy for the future of services to people with learning disability/ASD and their families, to include a Learning Disability Service Model.
- The Learning Disability sector should be supported to develop a shared workforce strategy, informed by the consultation being undertaken by the DoH as part of the workforce review, to ensure that there is a competent and stable workforce to sustain and grow both the sector in terms of size and quality, so that it is responsive to significantly changing demand.
- People with a learning disability and their family carers should be respected as experts by experience and co-production built into all levels of participation and engagement across the HSC system.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better and a regional programme to tell the positive stories of those who have moved on, to include audit of proved clinical and quality of life outcomes.

SPPG

- In the context of the overarching strategy the SPPG should develop a commissioning plan for the development of services going forward. This will include the completion of resettlement for the remaining patients awaiting discharge from MAH, and progress the re-shaping of future specialist LD hospital services.
- SPPG should establish a regional Oversight Board to manage the planned and safe resettlement of those patients not currently under active assessment or treatment or deemed multi-disciplinary fit for discharge across all specialist learning disability inpatient settings in Northern Ireland.
- SPPG needs to continue to strengthen performance management across the HSC system to move from performance monitoring to active performance management, and effectively holding HSC Trusts to account.
- SPPG should develop a more detailed tracker tool to create a master database of discharges, readmissions and trends and establish a clear definition of a discharge plan to provide clear projections about the trajectory for discharge and progress over time.

- The Social Care Procurement Board should urgently review the current regional contract for nursing/residential care and develop a separate contract and guidance for specialist learning disability nursing/residential care.
- The SPPG and NIHE/Supporting People should undertake a joint strategic needs assessment for the future accommodation and support needs of people with learning disability/ASD in Northern Ireland.

SPPG and Trusts

- Strategic commissioners within health, care and housing should convene a summit with NIHE, Trusts, Independent Sector representatives, and user/carer representation to review the current resettlement programmes so that there is an agreed refreshed programme and explicit project plan for regional resettlement.
- SPPG and Trusts should develop a database of people displaying behaviours which may result in placement breakdown to provide enhanced vigilance and service coordination ensuring targeted intervention to prevent hospital admission and support regional bed management.

Trusts

- Trust Boards should strengthen oversight and scrutiny of plans relating to resettlement of people with learning disability/ASD in specialist learning disability hospitals.
- A regional positive behaviour support framework should be developed through provider engagement with the standard of training for all staff working in learning disability services made explicit in service specifications and procurement.
- HSC Trusts should collaborate with all stakeholders to urgently agree a regional pathway to support future resettlement/transition planning for individuals with complex needs.
- HSC Trusts should collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans.
- HSC Trusts should ensure that the lived experience of the person and their family is effectively represented in care planning processes and the role of family carers as advocates for their family member is recognised and respected.
- HSC organisations need to value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy at all stages of care planning and develop a clear pathway clarifying the role of different advocacy services.

- HSC Trusts should arrange group meetings so that families with loved ones being considered for the same placement can support each other and share experiences and utilise the Lived Experience of families who have supported a family member through successful resettlement to offer peer support to current families.
- The review team recommends a review of the needs and resettlement plans for all forensic patients delayed in discharge from LD Hospitals.
- HSC Trusts should establish a local forum for engagement with LD providers of registered care and supported living to develop shared learning about safeguarding trends and incidents and promote good practice through a collaborative approach to service improvement.
- Further consultation with individuals, family carers and care providers should be progressed to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.
- HSC Trusts should ensure that capacity in Adult Safeguarding services is maintained to ensure timely investigation and any challenges clearly reported in the Trust Delegated Statutory Function report.
- HSC Trusts should ensure that Contracts or service specifications for services for people with a learning disability have safeguarding requirements adequately highlighted and that arrangements for monitoring are explicit.
- HSC Trusts should review visiting arrangements for family carers to ensure flexibility and a culture of openness so that families access their loved one’s living environment rather that a visiting room.

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Appendices

Appendix 1: The Review Team

The HSCB appointed a 2 person review team who were required to possess a strong understanding of health and social care policy and practice in Northern Ireland and Great Britain along with extensive experience in leadership roles directly related to health and social care.

The review team comprised:

Bria Mongan

Ian Sutherland

Appendix 2: Biographies

Bria Mongan and Ian Sutherland

Bria Mongan

Bria has significant Executive level experience within Health and Social Care organisations. Bria completed a Masters in Social Work in 1980 and remains registered as a social worker with the NISCC. Bria retired in May 2020 following a forty year career in Health and Social Care services working across all programmes of care. Prior to retirement, Bria was the Executive Director of Social Work and Director of Children's services in South Eastern HSC Trust. Bria previously was the Director of Adult Services and Prison Healthcare and was accountable for leading mental health and learning disability services including leadership in resettlement programmes. Bria is currently an associate with the HSC Leadership centre.

Ian Sutherland

Ian is an experienced leader in health and social care. He is a psychology graduate, who trained as a social worker in Nottingham in 1986, and completed an MSc in Health and Social Services Management at the University of Ulster in 1994. He has worked as a practitioner and senior leader in both Northern Ireland and England, holding three Director posts. His most recent leadership role was as Director of Adults and Children Services in Medway Local Authority, England. In this role he led partnership commissioning between health and social care in relation to delivery of the Better Care Fund objectives. He has served as a Trustee of the Social Care Institute for Excellence, and is currently an associate with the HSC Leadership Centre in Belfast.

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
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Learning Disability Strategic Action Plan

January 2023

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1. Introduction

1.1 This paper sets out a plan to address the challenges in supporting children and adults with learning disabilities. It provides an overview of the strategic and operational context, highlights key gaps in policy, practice and service provision and outlines the need for a strategic response.

1.2 To date, there has been considerable activity at Trust and regional level to meet the needs of a growing and increasingly more complex learning disability population. However, there remains a need to consolidate existing workstreams and to develop a co-ordinated, coherent and consistent strategic response to the challenges faced across the Programme of Care.

1.3 The gaps in both children and adult services (outlined in Sections 2 and 3 below) will require system-wide change to better respond at an earlier stage and to address the current projections of rising complexity of need. The body of work set out in this paper aims to better enable Trusts to commission and deliver the right level and blend of services for people with learning disabilities.

2. Strategic Context and Background

Bamford: Equal Lives

2.1. *Bamford: Equal Lives* ('Bamford') was published in 2005 and set out an ambitious vision to better support people with learning disabilities. Bamford was based on the strategic intent of moving away from segregated service provision and isolation.

2.2. In 2016, a DoH evaluation found that there had been many achievements in the development of learning disability services since Bamford. At that stage, achievements included:

- The resettlement of most people living in long-stay hospitals into the community;
- Improved physical healthcare and dental services;
- The commencement of the shift towards a Day Opportunities model;
- More short breaks/respite for carers;
- Improved participation in sport; and
- The introduction of new Special Educational Needs legislation.

2.3. However, the evaluation also found that significant gaps remained in services to support people to live full and independent lives in the community. This included gaps in community Learning Disability teams and infrastructure and a failure to meet growing demand and increasing complexity of need. In addition, it found significant gaps that cut across Departments, including the provision of housing to expedite resettlement, which would provide meaningful choices to those living in the family home; transition planning from children to adult services, which intersects with Special School provision and day opportunities; and the provision of transport to access wider community services.

2.4. It was recommended that a co-ordinated response from the Executive, under the auspices of the Programme for Government, was required to address the gaps in service provision. Unfortunately, these gaps still remain in 2022. In addition, there is also variation across Trusts on the types of services and pathways available to services users and families. Further detail on the challenges faced by the system is outlined in Section 3 of this paper.

2.5. The principles set out in Bamford continue to have validity and learning disability services in Northern Ireland continue to be guided by them. However, it is recognised that the landscape has changed, with a growing population and life expectancy of people with learning disabilities, growing complexity of presentation in children and adults, and the impact of resettlement on community services and workforce. In addition, the Covid-19 pandemic and subsequent HSC response has significantly impacted the delivery of community services and while yet to be fully quantified, has impacted the physical and mental health of service users, carers, and families.

Health Inequalities

2.6. UK-wide research over decades has demonstrated that individuals with a learning disability are dying prematurely from avoidable causes. People with a learning disability often have poorer physical and mental health than the general population and often face barriers to accessing the right care, in the right place, at the right time. In addition, people with a learning disability are more likely to experience mental health problems but are less likely to be able to access mental health services.

Adult Learning Disability

2.7. Adult Learning Disability is the third largest programme of care at £413m (year ending 2019/20) and has been growing at a rate of 7-8% per annum for the preceding five years. While population estimates vary on the total number of people with learning disabilities, the Programme of Care currently supports 9,000 adults known to services and their families.

2.8. It is expected that the LD programme of care will continue to grow, reflecting the increasing rates of disability and behavioural complexity amongst children who are now surviving into adulthood, and the increased likelihood of people with learning disabilities living to older age with associated complexity and comorbidities.

2.9. Despite the level of investment, Trusts focus significant attention on crisis management. Delayed discharges remain a problem and there are workforce pressures across statutory and independent sector services. In addition, a lack of clarity at a policy level, compounded by confusion surrounding the future of service model, has resulted in an increasing and unsustainable use of high-cost bespoke individual placements, some of them out-of-country, which brings additional challenges.

2.10. It is also important to recognise the impact the abuse at Muckamore Abbey Hospital (MAH) has had on learning disability services and the challenge of working in this field in Northern Ireland.

Children with Disabilities (CwD)

2.11. There are 4,601 children known to social services[1] that have a disability. 46% of children known have a learning disability and 39% of children known have Autism and/or ADHD. Children with learning disabilities typically present with an accompanying diagnosis of autism and a cohort will also present with physical disabilities.

2.12. There is a notable interface between HSC services to support CwD and special educational need. Over 64,500 pupils in schools have some form of special educational need, representing approximately 18% of the entire school population. More than 22,000, or 6.3% of pupils, have a statement of special educational needs. Over 6,600 pupils are enrolled in 39 dedicated special schools. In addition to this, more than 2,700 are educated in learning support centres in primary and post-primary schools. The SEN population has steadily increased by 5% per annum in recent years, requiring increasing levels of HSC support to assess and support children.

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[1] To note, there are children who have a learning disability who are not known to social services. They may be known to earlier intervention services, e.g., Health Visitors or Sure Start, or have not yet presented with a level of need that may require social care.

3. Key Challenges

3.1. The strategic context and background information point to a range of key challenges that require consideration and action:

Provision of day services

Bamford outlined that people with people learning disabilities should be provided with more meaningful and diverse day activities, such as supported employment, volunteering, and further education. In Northern Ireland, the shift to community-based day opportunities has enabled service users to access more diverse and meaningful activities, providing a platform to develop independent life skills and potentially reduce the need for residential care in older age.

However, by 2019/20, the HSC spent six times more on buildings-based adult day care than community-based day opportunities. Furthermore, the current suite of day opportunities in Northern Ireland are subject to financial risk, particularly in light of the conclusion of the European Social Fund in March 2023.

Acute assessment and treatment

It is recognised that previous usage of inpatient learning disability beds primarily reflected a deficit within community infrastructure and services – proper calibration of services will therefore reduce future demand for inpatient care. It must also be recognised that there will be an ongoing need for people with a learning disability to access appropriate inpatient care in a timely fashion. All assessment and treatment for people with a learning disability should primarily occur on an outpatient basis when needed, with admission to inpatient care available where this is essential. Admission in these circumstances should in most cases be on a planned basis, for the shortest possible time, to respond to a clear clinical need with outpatient and inpatient clinical teams working in partnership to, among other things, facilitate timely discharge where this is appropriate. In addition, further work is needed to better enable people with a learning disability to access mainstream mental health services.

Resettlement

An Oversight Board, chaired by Dr Patricia Donnelly, has been established to expedite the discharge of the remaining patients in Muckamore Abbey Hospital (MAH), over the next 12-18 months. The remit of the Board includes all delayed discharge learning disability patients currently being accommodated in regional inpatient beds. While there has been progress in the resettlement programme, this places further pressure on the community learning disability workforce, which will require additional MDT community support, and add further pressure to independent sector workload and supported living providers.

The Minister's intention to close MAH, subject to public consultation, will also create pressure on the remaining learning disability specialist beds in Northern Ireland. Any decision to close MAH will therefore need to be accompanied by a carefully planned transition to alternative models of provision within a defined timescale.

Housing provision

While most people with learning disabilities live in the family home, this is not always through meaningful choice. To enable a person with a learning disability to live more independently, a blend of housing and HSC services are required, underpinned by effective capital planning. Supported living is a growing model of care, although schemes vary significantly dependent on assessed need. It is evident that further work is needed at policy level to define the roles and responsibilities of Health and Housing. In addition, there is a growing practice of commissioning bespoke individual housing solutions, presenting high cost (£500k to £1m) and unsustainable pressures to current LD workforce. Such arrangements also further promote segregation and are not aligned to the vision of Bamford: Equal Lives.

The growing complexity of children with disabilities

In response to growing behavioural complexity and rates of placement breakdown, Trusts have fully utilised residential beds, resulting in the closure of respite facilities to accommodate emergency placements. In addition, there are a number of children who have been inappropriately accommodated in the Iveagh Centre, an inpatient unit for children with complex needs. These actions have attracted interest from the RQIA, judiciary, sector advocates, and more importantly, has significantly reduced the level of support available to children assessed to need this kind of support.

The increase of children with special educational needs (SEN)

The number of children requiring special educational placements has been increasing at a rate of 5% per annum. HSC are required in law to co-operate with education to identify and assess children with SEN and provide the necessary therapeutic and support services. The current rate of population growth presents significant challenges to the Allied Health Professional workforce and wider HSC.

Transitions

Transitions straddle issues of legislation, service provision, change and capacity. It is recognised that this has been an area of significant challenge and further work is needed to better co-ordinate and standardise transitions between children and adult HSC services for those with learning disabilities. There should be a clear pathway from children to adult services, with planning ideally commencing at age 14 – ultimately, children with disabilities should become adults without diminution or interruption of services.

Day services and respite for adults

In February 2022, the Minister outlined his decision and expectation to remobilise adult day care and short breaks. However, Trusts have yet to reach full pre-pandemic capacity. This is being addressed by SPPG. Failure to fully restore these services increases the likelihood of placement breakdown and necessity for more expensive residential care or specialist inpatient beds.

4. Work Completed to Date

4.1. A range of work has been taken forward to start the process of addressing the key challenges outlined in Section 3, including:

- The development of a Learning Disability Service Model for Adults; and
- The development of a Framework for the redesign of services for Children with Disabilities.

Learning Disability Service Model

4.2. In 2018, the Department commissioned the Health & Social Care Board to develop a service model for adult learning disability services. The project aimed to provide a strategic response to the significant challenges across the programme of care, including health inequalities; growing complexity of need; transition from children's services, over-reliance on inpatient services and accompanying delayed discharges; accommodation gaps; a lack of meaningful day activity; insufficient short break provision and support for older carers.

4.3. The progression of the service model was also underpinned by a Regional Review of Acute (Inpatient and Intensive Community Services) in October 2019. This review informed the development of a regional commissioning direction for Community Based Assessment, Rehabilitation and Treatment (CART) services in March 2022.

4.4. The draft service model was submitted to the Department in July 2021. The assessment of the draft model was significantly delayed by resources being diverted to dealing with the pandemic, with the result that the evaluation was not finalised until March 2022. It concluded that further work on the model is required, which includes:

- Establishing a baseline of services to identify gaps at a service and workforce level;
- Identifying evidence-based models of practice that can be piloted and replicated in Northern Ireland to address growing pressures;
- Developing a costed implementation plan;
- Generating further consensus with families and service users on the way forward for learning disability services;
- Developing a strategic approach to manage transitions between children and adult services; and
- Ensuring that statutory impact assessments have been completed.

4.5. In addition, the Directors of Learning Disability in the Trusts have highlighted a number of issues with the service model and have outlined a range of proposals for addressing them.

4.6. The Resettlement Review (2022) noted it remains important that the service model is brought to completion to underpin the delivery of an overarching strategy for learning disability. The progression of this work would better enable SPPG to develop a commissioning plan for the development of services going forward. In addition, implementing a consistent service model across Trusts would address the longstanding issue of regional variation in the provision of learning disability services.

Framework for Children with Disabilities (CwD)

4.7. It is evident that the level and range of community services for children with disabilities should be enhanced and delivered at an earlier stage. SPPG has therefore developed a draft Framework for CwD to, among other things, recalibrate community services, thereby reducing the need for inpatient care and the rate of delayed discharge.

4.8. Recognising the rising demand for CwD services and the increased complexity of case presentations, the draft Framework outlines a model of practice based on the principles of:

- Early intervention;
- Collaboration and multi-agency working;
- Co-design and decision making with families; and
- Person-centred care.

4.9. The draft Framework has been submitted to the Department for consideration; it outlines four strategic strands of work, as follows:

- *Improving our early offer of help and community-based supports*: To reduce the rate of family breakdown a shift is required to move away from crisis-driven practice.

- *Developing additional effective residential short breaks, fostering and intensive family support*: Short Breaks are a critical part of support infrastructure for supporting families with disabled children in the community.

- *Rethinking our approach to residential provision and how we support CwD effectively in out of home placements*: To respond to the growing demand for bespoke purpose designed residential settings for children with complex disabilities requiring full time care.

- *Getting transition right*: Improving transitions between children and adult services has been a longstanding challenge, requiring active participation from a wide range of stakeholders across health and education.

4.10. Further adjustment to the draft Framework is required to strengthen the evidence base and further engage with service users and families. In addition, it is important further develop the framework to manage the resource implications for children with Special Education Needs on Health & Social Care services.

4.11. Implementation of the Framework will require significant re-design of existing services, workforce development and investment. The delivery of the CwD Framework will also need to take account of the outcome of the Independent Review of Children Social Care Services, which is due to report in June 2023.

4.12. While the Framework is applicable across the spectrum of childhood disability, it is recognised that attention is most required to meet the needs of children with learning disabilities and/or autism. Further work is required to finalise the draft Framework, ensure alignment/integration with existing Departmental strategies and frameworks (including the LD Service Model), and to the provide costings for implementation.

5. Actions

5.1. The following key actions will be taken forward to address the key challenges:

Action 1 Finalise the Adult Learning Disability Service Model

5.2. This work will be focused on addressing the gaps identified earlier in this paper in and developing a fully costed implementation plan. This work will be taken forward in conjunction with Action 2 (below): *Implementation of the CwD Framework*, to ensure consistency of approach and to address transitions management.

5.3. The completion of this work will produce a finalised service model for adult learning disability services, underpinned by a fully costed implementation plan. This will enable SPPG and Trusts to better commission the right level and blend of services to support people in the community at an earlier stage, reducing the need for acute inpatient care, high-cost bespoke arrangements and ECRs. It is intended to standardise provision across the region, ensuring that service users and families can access the same pathways and services aligned to assessed needs. In addition, it will provide the Department with a platform to better engage and work with the Departments of Education, Communities, Economy and Infrastructure.

Action 2 Finalise the Children with Disabilities Framework

5.4. The Framework will be finalised, and a costed implementation plan will be developed to support the framework, together with the establishment of appropriate monitoring and oversight arrangements that will ensure complementarity with the Adult Learning Disability Model.

5.5. Central to the implementation of the framework is the development of a new model of residential provision for children with complex needs (strand 3 above). This will enable Trusts to accommodate children currently residing in emergency placements (respite beds and ECRs), while ensuring that future demand can be met. Better longer term residential provision will, among other things, unblock the current respite beds across the region that are unavailable to children residing in the community. For those returning from ECR arrangements, there are potential cost savings that can be used to fund residential provision and to enhance early intervention and community-based supports, ultimately preventing the escalation of need and associated placement breakdown.

5.6. By ensuring delivery alongside Action 1, this will enhance the current transitions planning process and pathway, which was identified as a significant gap by the Bamford Evaluation.

Action 3 Develop Learning Disability Governance Structure Options

5.7. To drive and oversee implementation of the Learning Disability Service Model and CwD Framework, options will be developed on a new overarching LD governance structure, which addresses connectivity with the Muckamore Departmental Assurance Group, the Regional Oversight Board for Resettlement, and involvement of NI Executive Departments.

5.8. The governance structure will be underpinned by an overarching Departmental Learning Disability Work Plan, which will consolidate the extensive number of workstreams/plans and will be overseen by the new governance structure to deliver consistency, ensure complementarity and promote greater accountability and transparency.

Action 4 Review evidence and data

5.9. A review of data and research will be undertaken on an ongoing basis to build & enhance the evidence base to support the development of future Learning Disability policy.

5.10. It is critical to improve the quality and consistency of data in order to establish a baseline position and enable the measurement of progress in relation to activity, reach and outcomes. This work will initially review the existing data collated by Trusts for performance management purposes, to inform the development of a new standardised data framework.

5.11. External research and evidence will be used to identify models of national and international best practice. There may also be a need to commission evidence-based reviews to explore experiences faced by people with learning disabilities in Northern Ireland to determine whether and where inequality exists.

5.12. A more detailed action plan is attached at **Appendix A**. It identifies key milestones, indicates a target delivery date for each of the actions above and identifies action owners..

6. Delivery, Reporting and Governance

6.1. To deliver against the key actions outlined above, a Departmental Task & Finish Group will be established, chaired by the Director of Disability & Older People and supported by the Learning Disability Unit.

6.2. Draft Terms of Reference are attached at **Appendix B** and will be finalised at the first meeting of the Group.

6.3. The Group will comprise key stakeholders across the Department, Trusts and the Independent Sector, to initially include:

Mark McGuicken	Director of Disability and Older People
Sean Scullion	Head of Muckamore Abbey Review Team
Nigel Chambers	Head of Learning Disability (LDU)
Jennifer Mooney	Head of Looked After Children and Adoption Policy Unit
Lynn Woolsey	Deputy Chief Nursing Officer
Siobhan Rogan	Nursing Officer for Learning Disability & Mental Health
Darren Strawbridge	Professional Social Work Officer
Randal McHugh	Programme Manager (Learning Disability)– SPPG
Caroline McGonigle	Social Care Lead (Mental Health & Learning Disability) – SPPG
Una Cushnahan	Project Manager (LDSM) – SPPG
Maurice Leeson	Programme Manager (Children with Disability) - SPPG

Chief Allied Professions Officer	TBC – Post currently vacant
Senior Medical Officer – Mental Health/ Learning Disability	TBC – Post currently vacant
Leslie-Anne Newton	Association for Real Change (Umbrella Group for LD Independent Sector and Trusts)
TBC	Trust Director/Assistant Director – Adult Learning Disability
TBC	Trust Director/Assistant Director - Children with Disability

6.4. It is proposed that the group would be established for an initial period of six months and extension will be subject to TMG decision. Due to the scope of work planned, it will be necessary to establish sub-groups as well as utilising existing structures to ensure delivery of the actions.

6.5. The work of the Task & Finish Group will be periodically informed by the views of Trusts, independent sector providers, service users and families through communication channels, already established by the LDU, SPPG and professional colleagues.

Reporting & Governance

6.6. The Group will provide monthly reports on progress to the Grade 3 Social Services Policy Group, who will in turn ensure that TMG is updated on progress and key issues or areas of concern.

Appendices

Appendix A – Action Plan

Appendix B – Task & Finish Group Terms of Reference

Appendix A – Action Plan

Action	Activities	Lead/ Key stakeholders	Target
Action 1: Finalise the Adult Learning Disability Service Model	• Review overarching policy position for LD. • Engagement with Trusts, Independent Sector, Service Users & Families. • Desk-based exercise to address deficits and develop costings.	**LDU/ SPPG/ External stakeholders**	31 July 2023
Action 2: Finalise the Children with Disabilities Framework	• Establish SPPG-led sub-group. • Develop proposals to enhance connectivity to SEN planning. • Develop a costed implementation plan • Develop a new model for residential care	**SPPG/ LDU/ FCPD/ External stakeholders**	31 July 2023
Action 3: Develop Learning Disability Governance Structure Options	• Review of learning from DoH structures • Development of governance tools, including a LD Action Plan • Develop exit strategy for existing LD governance structures (inc. MDAG)	**LDU/ T&F Group/ Wider DoH Groups**	30 April 2023
Action 4: Review evidence and data	• Desk-based review of existing research • Assessment of existing Trust indicators/metrics • Development of framework to standardise data collection, analysis and reporting	**LDU/ Academics/ SPPG/ Trusts**	30 April 2023

Appendix B – Draft Task & Finish Group Terms of Reference

Purpose

The Department has approved a Strategic Action Plan to address the growing pressures across learning disability services and to provide a focus for future strategic planning and regional commissioning of learning disability services.

The Group will progress a body of work across four key actions:

- Finalising the Adult Learning Disability Service Model and developing a costed implementation plan.
- Finalising the Children with Disabilities Framework and developing a costed implementation plan.
- Developing Learning Disability Governance Structure Options.
- Reviewing learning disability evidence and data.

The Group will develop costed proposals where necessary, clearly identifying decisions to be taken by the Permanent Secretary and those that will need to be made by a future Minister of Health.

Membership

Mark McGuicken	Director of Disability and Older People
Sean Scullion	Head of Muckamore Abbey Review Team
Nigel Chambers	Head of Learning Disability (LDU)
Jennifer Mooney	Head of Looked After Children and Adoption Policy Unit
Lynn Woolsey	Deputy Chief Nursing Officer
Siobhan Rogan	Nursing Officer for Learning Disability & Mental Health
Darren Strawbridge	Professional Social Work Officer
Lorna Conn	Programme Manager – MH & LD - SPPG
Una Cushnahan	Project Manager (LDSM) – SPPG
Maurice Leeson	Programme Manager (Children with Disability) - SPPG
TBC	Chief Allied Professions Officer
Leslie-Anne Newton	Association for Real Change

Trust Director/Assistant Director – Adult Learning Disability
Trust Director/Assistant Director - Children with Disabilities

Membership will be reviewed following the development of a project plan.

Frequency of Meetings

Meetings will be held monthly.

Timescales for Implementation

By July 2023, subject to review.

MDAG/04/19

Muckamore Departmental Assurance Group (MDAG)

Minutes of Meeting

2pm, Friday 30 August 2019

Castle Buildings

Attendees:	**Apologies:**
Sean Holland (Dept of Health)(Joint Chair)	Ian McMaster (Dept of Health)
Charlotte McArdle (Dept of Health)(Joint Chair)	Don Bradley (South Eastern Trust)
Mark Lee (Dept of Health)	Mary Hinds (Public Health Agency)
Rodney Morton (Dept of Health)	
Aine Morrison (Dept of Health)	
Sean Scullion (Dept of Health)(Note)	
Marie Roulston (Health and Social Care Board)	
Marie Heaney (Belfast Trust)	
Brenda Creaney (Belfast Trust)	
Francis Rice (External Nursing expert)	
Barney McNeaney (Southern Trust)	
Bria Mongan (South Eastern Trust)	
Karen O’Brien (Western Trust)	
Oscar Donnelly (Northern Trust)	
Lourda Geoghan (Regulation and Quality Improvement Authority) (observer)	
Dawn Jones (Family representative)	
Brigene McNeilly (Family representative)	
Brenda Aaroy (Belfast Trust)	
Eileen McEneaney (Strengthening the Commitment collaborative)	
Stephen Matthews (Cedar Foundation)	
Petra Corr (Northern Ireland British Psychological Society)	
Gavin Davidson (Queen’s University, Belfast)	

Agenda Item 1 - Welcome/Introductions/Apologies

1. The Co-Chairs welcomed attendees to the first meeting of the MDAG, extending a particular welcome to the family representatives. Sean Holland began the meeting by reminding members of the commitments on resettlement made by the Permanent Secretary to the families of in- patients at Muckamore, and he also re-iterated on behalf of the HSC system the apology the Permanent Secretary had previously given to families for the events at Muckamore.

2. Introductions were made and apologies noted.

Agenda Item 2 – draft Terms of Reference and governance structures

3. Charlotte McArdle set out the context for the Group, and advised that its purpose was to provide the Permanent Secretary and any incoming Minister with assurances on the effectiveness of the HSC system's response to the SAI review and the Permanent Secretary's subsequent commitments on resettlement, and also that current services at Muckamore are being delivered in a safe, effective and Human Rights compliant manner.

4. Members agreed the importance of ensuring the Group had effective arrangements in place to ensure the voices of families, carers and individual patients were adequately represented. The Group agreed this would be an essential component in building trust and restoring families' confidence in the services provided at the hospital, and discussed potential arrangements for engaging with the other families involved. It was suggested that it might be helpful to approach the Patient Client Council to seek advice and support with this.

AP1: Consult with the Patient Client Council to develop proposals for extending family and individual patients' involvement in the work of MDAG. (Action: DoH)

5. Subject to this, members agreed the draft Term of Reference for the MDAG and the associated governance structure. It was also agreed that the group would meet monthly initially, with frequency of meetings kept under review depending on progress towards delivery of the Action Plan.

6. The issue of a recent appointment as part of the work to implement the Mental Capacity Act was raised by a family representative. Sean Holland explained that he had recently become aware of this, and as a precautionary measure had taken a decision to rescind this appointment, without prejudice to any of the ongoing investigative processes.

Agenda Item 3 - Highlight Report

7. Sean Holland introduced the Highlight Report, which will be updated for each meeting of MDAG, and will allow members to maintain oversight of progress towards delivering on the HSC Action Plan.

8. Mark Lee provided an overview of the report, including updates on the police investigation, staffing position in the hospital, current resettlement position, measures taken to stabilise services in the hospital, contingency planning, engagement by the Belfast Trust with the East London Foundation Trust as a ‘critical friend’, the Learning Disability Service Model project and review of acute in-patient care and the proposed Leadership and Governance review of the Hospital.

9. Brenda Creaney clarified that 19 hospital staff were currently on suspension, and Marie Heaney confirmed the present in-patient population as 58. She also confirmed that planning for discharge was ongoing for all patients currently in the hospital, with a number of related business cases in progress.

10. The co-Chairs stressed the importance of MDAG being provided with accurate and consistent information on discharge planning with an appropriate level of detail, and also emphasised the urgency in progressing any relevant business cases. They also clarified that DoH will engage with other Government Departments as required to facilitate timely discharge arrangements.

11. Members discussed the Learning Disability Service Model Transformation project, and Marie Roulston advised that the independent panel reviewing acute care services for people with a Learning Disability as a workstream of the Service Model project was now expected to report on 16th September.

12. The Group discussed uptake of the current on-line survey being used by the project to gather service user and family views on service provision, and stressed the importance of family and service user involvement at all levels of the Transformation project. Charlotte McArdle advised members that there may be a different way to engage families and that is through a workshop supported by the Patient Client Council if engagement in the survey is low.

13. The co-Chairs reiterated the Department’s commitment to the principles of co-production underpinning the project, and agreed that an update on the engagement work being taken forward by the Transformation project team would be brought to the next MDAG meeting.

AP2: Provide an update on levels of service user/family participation in on-line engagement survey, and consider steps to facilitate family involvement at Project Board level (Action: HSCB).

14. Mark Lee updated members on the measures in place to ensure services at Muckamore are being delivered safely and sustainably, including an update on contingency planning arrangements. The Group was advised that the Belfast Trust have developed a contingency plan for the hospital, and this will be provided to DoH.

AP3: Belfast Trust contingency plan to be provided to DoH. (Action: Belfast Trust)

15. Members discussed the visit to Muckamore earlier in the summer by a team from the East London Foundation Trust, who were invited to visit the Hospital in a ‘critical friend’ capacity. It was clarified that any learning emerging from the team’s findings would be shared with the Mental Health and Learning Disability Improvement Board.

Agenda Item 4 – Update on spend of additional funding

16. Marie Roulston provided an update on the process for allocating funding to Trusts to address identified inescapable pressures in Learning Disability services. Members discussed a number of related issues, including workforce pressures, skill mix and training, morale of staff working in the hospital and measures being taken by the Belfast Trust to support them, staff retention, and the role of third sector organisations.

17. Charlotte McArdle acknowledged concerns raised by family representatives that some staff in the hospital feel their voices are not being heard, and asked Marie Heaney and Francis Rice to consider measures to address this.

AP4: Review and consider options to strengthen engagement with hospital staff. (Action: Belfast Trust)

Agenda Item 5 – Draft HSC Action Plan

18. Sean Holland acknowledged that calls had been made from a range of sources for a public inquiry into the events at Muckamore, and reiterated that no decision had yet been taken on this. He advised members of the legislative requirement that decisions on public inquiries are ultimately for Ministers to take, and it is likely that a decision on this will one of the first items to be considered by any new Minister, when appointed.

19. He went on to introduce the draft action plan to members, noting that while it needed further work to finalise the actions and timescales it was being shared with the Group in its current draft state, both in the interests of transparency and also to promote a discussion about the Group's objectives.

20. Mark Lee advised that MDAG will monitor and oversee delivery against the actions set out in the plan, with a progress update to be provided to the Permanent Secretary following each meeting. He stressed the importance of input from HSC organisations to inform the final plan, particularly in relation to identifying and agreeing appropriate and deliverable timescales for actions, and reminded Trusts to forward any comments on the plan as soon as possible.

AP5: Comments on actions and timescales in draft plan to be forwarded to DoH (Action: HSCB/PHA/HSC Trusts)

21. Sean Holland clarified that the plan sought to address all the recommendations made in the Level 3 SAI report in the most appropriate way, setting out the rationale for this clearly. Gavin Davidson advised that the work underway to deliver the actions in the plan should be informed by international best practice, and he also stressed the importance of a standardised approach to evaluating plans.

22. Members agreed the importance of a shared understanding across the HSC system of the actions required, and it was suggested and agreed that a glossary would be a useful addition to the plan.

AP6 – Glossary of terms to be added to Action Plan (Action: DoH)

23. Members also emphasised that effective engagement and partnership arrangements with accommodation providers will be key to delivery of the Permanent Secretary's commitments on resettlement. Sean Holland advised that DoH had been fully engaged with the Department for Communities in relation to this, and indicated that in this context the DfC Permanent Secretary was scheduled to visit the Mews Supported Living scheme in Belfast, following a recent visit to the facility by Richard Pengelly. Mark Lee advised members that DoH will provide input on the current Department for Communities-led consultation on the proposed introduction of a standardised rate for Supporting People schemes.

Agenda Item 6 – Leadership and Governance Review

24. Mark Lee advised members that this review had been instigated to address a gap in the Level 3 SAI review, and DoH had commissioned the Health and Social Care Board and Public Health Agency to develop draft Terms of Reference for the review. These had been prepared and were currently being considered by the Department. Members requested that the Terms of Reference be brought to the next MDAG meeting.

AP7: Draft Terms of Reference for the Leadership and Governance review to be tabled at next MDAG meeting (Action: DoH)

Agenda Item 7 – Timescale for Permanent Secretary meeting with families

25. Sean Holland reminded members that the Permanent Secretary had previously committed to regular meetings with families to update them on progress on his commitments, and sought views on an appropriate timescale for these meetings. Family representatives indicated they would prefer any such meetings to be held only when there was definitive progress to report, as

individual families have specific caring commitments which impact on their capacity to attend meetings.

26. Sean Holland agreed to reflect these comments to the Permanent Secretary, and it was agreed that a meeting should be arranged when a completed Action Plan was agreed.

Agenda Item 8- Format of reporting

27. Charlotte McArdle asked members for any further views on the format for reporting to the Group. Mark Lee advised members that the format of the highlight report which will be brought to each MDAG meeting is still being refined, and a performance dashboard will be developed to show progress against the key objectives in the action plan.

Agenda Item 9 – Date of next meeting

28. Sean Holland advised members that future meeting dates would be identified and circulated to members as quickly as possible. Members suggested that it would be helpful to consider potential alternative venues for future meetings, with the Antrim area proposed as a suitable compromise.

AP8: Circulate dates for future meetings and identify potential alternative meeting venues (Action: DoH)

Agenda Item 10 - Any other business

29. There was no other business.

Summary of Action Points

Ref.	Action	Respon-sible	Update	Open/ closed
30/8/AP1	Consult with the Patient Client Council to develop proposals for extending family and individual patients' involvement in the work of MDAG	Dept of Health		
30/8/AP2	Provide an update on levels of service user/family participation in on-line engagement survey, and consider steps to facilitate family involvement at Project Board level	Health and Social Care Board		
30/8/AP3	Copy of Belfast Trust contingency plan to be provided to DoH.	Belfast Trust		
30/8/AP4	Review and consider options to strengthen engagement with hospital staff.	Belfast Trust		
30/8/AP5	Comments on actions and timescales in draft plan to be forwarded to DoH	Health and Social Care Board/Public Health Agency/ Trusts		
30/8/AP6	Glossary of terms to be added to Action Plan	Dept of Health		
30/8/AP7	Draft Terms of Reference for the Leadership and Governance review to be	Dept of Health		

	tabled at next MDAG meeting			
30/8/AP8	Circulate dates for future meetings and identify potential alternative meeting venues	Dept of Health		

Learning Disability Unit

September 2019

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 30 October 2019

Portmore, Muckamore Abbey Hospital

Minutes of Meeting

Attendees:		Apologies:	
Sean Holland	DoH(Joint Chair)	Ian McMaster	DoH
Charlotte McArdle	DoH(Joint Chair)	Oscar Donnelly	Northern Trust
Marie Roulston	HSCB	Jackie McIlroy	DoH
Mark Lee	DoH		
Maire Redmond	DoH		
Sean Scullion	DoH (Note)		
Aine Morrison	DoH		
Briege Quinn	PHA		
Margaret Kelly	Mencap		
Stephen Matthews	Cedar Foundation		
Brigene McNeilly	Family representative		
Brenda Aaroy	Belfast Trust		
Dawn Jones	Family representative		
Marie Heaney	Belfast Trust		
Brenda Creaney	Belfast Trust		
Bernie Owens	Belfast Trust		
Francis Rice	External Nursing expert		
Barney McNeaney	Southern Trust		
Karen O'Brien	Western Trust		
Don Bradley	South Eastern Trust		
Alyson Dunn	Northern Trust		
Petra Corr	Northern Ireland British Psychological Society		
Lourda Geoghan	RQIA (observer)		
Gavin Davidson	QUB		
Eileen McEneaney	Strengthening the Commitment collaborative		

Agenda Item 1 - Welcome/Introductions/Apologies

1. The co-Chairs welcomed attendees to the third meeting of the MDAG. Introductions were made and apologies noted.

Agenda Item 2 - Minutes of Previous Meeting

2. The minutes of the previous MDAG meeting on 30 August were agreed.

Agenda Item 3 - Update on Actions

3. Seán Holland provided an update on the action points arising from the previous meeting. A summary of these is attached at **Annex A.**

Agenda item 4 - Information Sharing / Technology

4. The Group discussed the continuing media interest in Muckamore, the content of recent reporting about staff suspensions and whether there was any scope to influence this. Family representatives stressed the negative impact the media reports were having on patients and their families, referencing in particular speculation about the potential closure of Muckamore. It was emphasised that no decisions have yet been taken on the long-term future role of the hospital. Members recognised the importance of ensuring that patients and their families are kept advised in a timely fashion of any developments in relation to the hospital, and agreed that the Belfast Trust should review their current communication arrangements, with appropriate input from families.

AP1: Existing communication arrangements with families and carers to be reviewed, in partnership with families/carers. (Action: Belfast Trust)

Agenda Item 5 - Highlight Report and Dashboard

5. Mark Lee provided an overview of the highlight report, including the current position on the police investigation, and clarified that 36 staff were currently on precautionary suspension as a result of viewing of historic CCTV footage. He highlighted a regional initiative to bolster the current nursing workforce at the hospital as an important element of the ongoing contingency planning arrangements for services at the hospital. He advised that the Permanent Secretary had recently formally signed off the HSC Action Plan, and was keen to follow up his previous meeting with the families. The timing and arrangements for a meeting were being considered. An updated reporting dashboard was presented to the group which had been amended to reflect comments and feedback from the 01 October MDAG. Members discussed the content of the dashboard, and suggested that it would be useful to include metrics on readmissions to Muckamore Abbey.

AP2: Updated dashboard to be tabled at next MDAG meeting for agreement (Action: DoH)

6. Mark Lee also updated members on progress on resettlement, advising that an estimated 12 patients have discharge dates over the next 2 months, and that the regional operational delivery group established to progress the resettlement programme held its second meeting on 16 October. He further advised of a revision to the timescale for the LD Service model project, with an initial draft of the Service Model now expected in November.

7. Marie Roulston advised that contingency plans setting out how each Trust will ensure continuity of care for the current in-patient population had now been received from each of the 5 Trusts. Mark Lee advised that these would be collated and circulated to MDAG.

AP3: Individual Trust contingency plans and a Regional Plan for the future role of the hospital to be amalgamated and circulated to MDAG (Action: DoH).

8. Bernie Owens provided an update on new staffing arrangements and responsibilities at Muckamore as follows:
   - Bernie Owens has taken responsibility for the safe and sustainable running of Muckamore Hospital;
   - Marie Heaney is responsible for Intellectual Disability community services, resettlement and Adult Safeguarding across the Trust;
   - Carol Diffin has lead responsibility for historic viewing of CCTV and associated safeguarding processes;
   - Gilllian Traub becomes co-director of Muckamore; and
   - Patrica McKinney has been appointed as the Divisional Lead Nurse.

9. Brenda Creaney advised the Group that Moira Mannion, co-Director of Nursing, who has worked for many years across the Belfast Trust was retiring from 31st October and wished her well in her retirement.

Agenda item 6 - Update on MAH Staffing Position

10. Francis Rice provided an update on the current nursing staffing position at the hospital, and advised that a new staffing model is being developed which would calculate the number of staff required for each ward. The model will also inform the daily situation report to the Department to provide assurance on safe staffing levels. He further advised that policy in the hospital on use of special observations is being reviewed in consultation with medical staff and also outlined that measures are being introduced to facilitate registered agency nursing staff working at the hospital to take charge of wards. He confirmed that all agency staff receive full Trust training, and Brenda Creaney highlighted that agency staff had been fully integrated into the hospital including wearing Trust rather than Agency uniforms.

11. Francis Rice advised of concerns about staffing levels over the Christmas period as a significant number of agency staff (approximately 75%) employed at the hospital had indicated an intention to return home for the holiday period. He updated the group on incentives being offered to nursing staff willing to relocate to work at Muckamore on a temporary basis and clarified that these incentives would also be extended to staff already working in Muckamore as part of ongoing work to stabilise the hospital. In response to a query he clarified that the incentives would not be extended to staff who were on sick-leave or those who had been placed on precautionary suspension. He also advised of engagement with staff who were currently working out their notice to reconsider their employment at the hospital in light of the incentives, but with limited success.

12. Seán Holland emphasised that this is a system wide issue and not just a Belfast Trust issue and as such it needs a collective regional approach. Trust Directors confirmed that they were working to identify qualifying staff in their Trusts who might be willing to re-locate to work in Muckamore, although it was highlighted that this was in the context of already existing staffing pressures at the other Learning Disability services.

13. The group discussed business continuity planning for Muckamore in the event of strike action by nursing unions, and suggested it might be helpful to consider approaches to retired nurses who had previously worked in Muckamore. Francis Rice advised that this had been done and that a number of these staff were already registered as bank staff, but that he would revisit this option. A family

representative took the opportunity to say how impressed she was with the agency staff in terms of their competency and kindness.

Agenda Item 7 - HSC Action Plan progress report

14. Máire Redmond confirmed to members that the HSC action plan had been formally agreed by the Permanent Secretary and that he had indicated his intention to meet again with families to provide an update on progress. Arrangements for a meeting will be advised in the near future. She further advised that the Action Plan was still a work in progress and that whilst the majority of actions had been given an initial RAG rating from the relevant responsible owner/owners, a small number (4) remained to be agreed. Máire Redmond also advised that work would be taken forward to agree RAG ratings for these actions, and that an update on progress would be sought against each action ahead of the next meeting of MDAG. A family representative raised an issue around communication with staff in relation to addressing an issue in one of the wards onsite, and Brenda Creaney agreed to follow this up with the Trust Estates Department.

AP4: Update on HSC Action Plan to be provided for next MDAG (DOH)

Agenda Item 8 - Update on Regional Operational Delivery Group

15. Members noted that an update on the Operational Delivery Group's work had already been provided under agenda item 5. It was suggested that it would be helpful for the Group to consider the issue of re-admissions to the hospital, with a view to considering any lessons emerging from breakdown of community placements, with appropriate engagement from providers.

AP5: RLDODG to monitor and analyse re-admission rates to identify and disseminate any learning arising (HSCB)

Agenda Item 9 - Psychiatric Support for people leaving Muckamore

16. Marie Roulston advised that Trusts have highlighted the need for psychiatric outreach support as a key success factor in maintaining community placements and thus facilitating the successful resettlement of patients. It was acknowledged that other professional support, such as AHP and psychology, also played an important role in this. Members agreed effective outreach was critical to facilitate and maintain successful placements in the community, and that a regional person centred approach was required. Seán Holland agreed that a regional solution was

required and asked that a presentation be made to MDAG to clarify roles and responsibilities in the provision of these services.

AP6: Develop a presentation for MDAG to clarify roles and responsibilities iro psychiatric and other professional outreach and support (HSCB).

Agenda item 10 - Report on Safeguarding Processes in MAH

17. Marie Roulston advised the Group that the review of Adult Safeguarding processes at the hospital has been completed by the Health and Social Care Board, and the draft report is being considered. She agreed that a copy of the report would be issued to MDAG in advance of the next meeting.

AP7: Report on Safeguarding Processes at MAH to be circulated for next MDAG meeting (HSCB)

Agenda item 11 - Update on engagement with all families/media activity

18. Brenda Aaroy provided the Group with an update on the Belfast Trust's programme of engagement with families, including production of a regular newsletter for patients, families and staff, the circulation of a factsheet from meetings of MDAG, and a forthcoming meeting at the hospital on Monday 4 November between families and officials from the Department of Health. The Chief Executive of the Patient Client Council will also attend this meeting. Gillian Traub also advised the Group that she was working on developing a process of internal communication for staff in Muckamore.

Agenda item 12 - MAH Leadership and Governance Review update

19. Briege Quinn advised the Group that the HSCB and PHA were in the process of commissioning this review. A couple of suitably qualified individuals had been identified for the review and it was hoped appointments would be confirmed shortly. She noted that the timescale for completion of the review was very tight and would welcome some flexibility to ensure the scale and quality of the review. The Group recognised this will be challenging and will be kept under review, but considered it was premature to agree an extension at this stage. Marie Roulston advised that the Terms of Reference had been agreed, and would be circulated to MDAG members ahead of the next meeting.

AP8: Terms of reference to be included in papers for November MDAG meeting (HSCB/PHA)

Agenda Item 13 - Update on Acute Care Review, and development of regional plan for acute in-patient care

20. Marie Roulston advised that the report remains in draft and invited feedback from members by 20th November. Briege Quinn informed the Group that the Review Panel members would be available to discuss the report at a meeting arranged for 22nd November. Seán Holland emphasised the significance of this work and the importance of progressing the recommendations.

Agenda Item 14 - Update on Engagement Work with DfC

21. The Group was provided with an update on the ongoing programme of work on Supporting People being taken forward jointly by the Department of Health and Department for Communities. The involvement of housing representatives on the Regional Learning Disability Operational Delivery Group (RLDODG) was highlighted as helpful by Alyson Dunn. The Group acknowledged that effectively meeting the very specific resettlement needs of some of the remaining in-patient population at Muckamore may require exploring other accommodation and support options, including potentially a model of statutory HSC provision. It was noted that any successful model of provision will need to be designed around individuals' needs.

22. A family representative asked about plans for those in-patients who have expressed an unwillingness to leave Muckamore. Seán Holland advised that any discharge plans will be based on assessed need and the wishes of the patient and that in individual cases this may involve developing bespoke housing arrangements. He indicated that Trusts may need to consider alternative models for this, and in this respect should not be constrained by existing models of provision. He clarified that both Departments would be willing to support Trusts in this regard, and that representatives from the Department for Communities (DfC) will be invited to MDAG as required to advise on potential solutions.

23. A family representative referenced recent media reporting about an historic safeguarding report into events at another ward on the hospital site, and asked to see a copy of this. Following a discussion about confidentiality, it was agreed the full report should not be shared as it contained names of individuals. Seán Holland

asked instead that a synopsis of the report be produced and circulated to the Group.

AP9: Synopsis of Ennis Ward Safeguarding Report to be shared with MDAG (Belfast Trust)

Agenda Item 15 - Date of next meeting

24. The next meeting will be held on 27th November on the Muckamore site if possible, with details of the venue to be confirmed.

Agenda Item 16 – Any other business

25. There was no other business.

Summary of Action Points

Ref.	Action	Respon-sible	Update	Open/ closed
30/10/AP1	Existing communication arrangements with families and carers to be reviewed, in partnership with families/carers.	Belfast Trust		
30/10/AP2	Updated dashboard to be tabled at next MDAG meeting for agreement.	DoH		
30/10/AP3	Individual Trust contingency plans and a Regional Plan for the future role of the hospital to be amalgamated and shared with all families.	DoH		
30/10/AP4	Update on HSC Action Plan to be provided for next MDAG.	DoH		

30/10/AP5	RLDODG to monitor and analyse re-admission rates to identify and disseminate any learning arising.	HSCB		
30/10/AP6	Develop a presentation for MDAG to clarify roles and responsibilities iro psychiatric and other professional outreach and support.	HSCB		
30/10/AP7	Report on Safeguarding Processes at MAH to be circulated for next MDAG meeting.	HSCB		
30/10/AP8	Terms of reference for Leadership and Governance review to be included in papers for November MDAG meeting.	HSCB/ PHA		
30/10/AP9	Synopsis of Ennis Ward Safeguarding Report to be shared with MDAG	Belfast Trust		

Annex A

Update on Action Points

<u>MDAG 01 October 2019</u>

Ref.	**Action**	**Respon-sible**	**Update**	**Open/ closed**
01/10/AP1	Updated dashboard to be tabled at next MDAG meeting for agreement.	DoH	Update provided and discussed under agenda item 5.	Closed
01/10/AP2	Individual Trust contingency plans and a Regional Plan for the future role of the hospital to be amalgamated and shared with all families.	DoH	Final Contingency plan not received in advance of meeting; to be provided for next MDAG.	Open
1/10/AP3	Safeguarding Process Map and Report to be circulated to MDAG members when completed.	HSCB	Draft report being considered by HSCB/DoH – final version will be circulated to MDAG when agreed.	Open
01/10/AP4	Fact sheet to be issued to Belfast Trust following MDAG meetings for circulation to families and staff at Muckamore.	DoH/ Belfast Trust	Fact sheet circulated with MDAG papers; the fact sheet will be produced and distributed after each MDAG meeting.	Ongoin g
01/10/AP5	Update on engagement work with the Department for Communities to be tabled at next MDAG meeting.	DoH	Circulated with MDAG papers and discussed under agenda item 14.	Closed
01/10/AP6	Circulate feedback from student nurses on placement at Muckamore.	Belfast Trust	This was circulated with MDAG papers in advance of meeting.	Closed
01/10/AP7	Acute Care Review Report to be shared	HSCB	Report circulated with MDAG papers and	Closed

	with families and carers.		discussed under agenda item 13.	
01/10/AP8	Include a summary of new deprivation of liberty provisions in the MDAG factsheet.	DoH	This was included in the fact sheet which was distributed on 07 October.	Closed
01/10/AP9	Prepare Action Plan progress report for consideration by MDAG.	DoH/ HSCB/ Trusts	RAG rated action plan circulated and discussed under agenda item 7. This will remain a monthly action.	Ongoing

MDAG – 30 August 2019

Ref.	Action	Respon-sible	Update	Open/ closed
30/8/AP1	Consult with the Patient Client Council to develop proposals for extending family and individual patients' involvement in the work of MDAG	DoH	Rodney Morton advised that following discussions with Patient Client Council, a proposal has been provided for independent advocacy to support the work of MDAG. A business case for this is being developed.	Closed
30/8/AP2	Provide an update on levels of service user/family participation in on-line engagement survey, and consider steps to facilitate family involvement at Project Board level	HSCB	The survey closed at the end of Sept with over 670 with over 1800 individuals engaged in local events. The results are currently being collated and analysed and these will inform the preparation of a high level first draft of	Closed

			the Service Model, which is expected to be ready by the end of October.	
30/8/AP3	Copy of Belfast Trust contingency plan to be provided to DoH.	Belfast Trust	Contingency plans have from 4 of the 5 Trusts (including Belfast Trust) have been provided to DoH. Western Trust plan in development.	Closed
30/8/AP4	Review and consider options to strengthen engagement with hospital staff.	Belfast Trust	Update provided under agenda item 6.	Closed
30/8/AP5	Comments on actions and timescales in draft plan to be forwarded to DoH	HSCB/ PHA/ Trusts	Comments from HSCB and Belfast Trust provided, and draft plan amended accordingly.	Closed
30/8/AP6	Glossary of terms to be added to Action Plan	DoH	Glossary of terms has been added– this will be kept under review.	Closed
30/8/AP7	Draft Terms of Reference for the Leadership and Governance review to be tabled at next MDAG meeting	DoH	ToRs tabled at 1 October meeting	Closed
30/8/AP8	Circulate dates for future meetings and identify potential alternative meeting venues	DoH	Dates up to end of December have been circulated and venues will be confirmed.	Closed

Muckamore Departmental Assurance Group (MDAG)

10am, Wednesday 27 November 2019

Portmore, Muckamore Abbey Hospital

Minutes of Meeting

Attendees:		Apologies:	
Sean Holland	DoH(Joint Chair)	Bernie Owens	Belfast Trust
Charlotte McArdle	DoH(Joint Chair)	Brenda Aaroy	Belfast Trust
Marie Roulston	HSCB	Don Bradley	South Eastern Trust
Mark Lee	DoH	Gavin Davidson	QUB
Maire Redmond	DoH		
Sean Scullion	DoH (Note)		
Aine Morrison	DoH		
Ian McMaster	DoH		
Briege Quinn	PHA		
Stephen Matthews	Cedar Foundation		
Brigene McNeilly	Family representative		
Dawn Jones	Family representative		
Marie Heaney	Belfast Trust		
Brenda Creaney	Belfast Trust		
Francis Rice	External Nursing expert		
Barney McNeaney	Southern Trust		
Karen O'Brien	Western Trust		
Margaret O'Kane	South Eastern Trust		
Oscar Donnelly	Northern Trust		
Petra Corr	Northern Ireland British Psychological Society		
Lourda Geoghan	RQIA (observer)		

Agenda Item 1 - Welcome/Introductions/Apologies

1. The co-Chairs welcomed attendees to the fourth meeting of the MDAG. Introductions were made and apologies noted. Seán Holland advised members that due to the importance of these meetings, an explanation at Trust Chief Executive level would be sought in the event of apologies being provided for 2 meetings in a row.

Agenda Item 7 – MAH Staffing Position

2. Members agreed to take this agenda item first. Francis Rice provided an update on the current staffing position at Muckamore and advised that a further 2 members

of staff had been placed on precautionary suspension in the past week, bringing the total number of suspensions to date to 38 and that one member of staff had agreed to withdraw their resignation. He advised that 11 members of staff (7.5 whole time equivalents) from the South Eastern and Northern Trusts have so far agreed to work in Muckamore Abbey Hospital on a temporary basis. He advised the group that staffing rotas for the forthcoming holiday period had been developed and indications at this stage were that safe staffing levels were sustainable during this period. He noted however the potential difficulties in maintaining services in the event of any increase in levels of sick leave, any further staff suspensions as a result of the ongoing police investigations and also the ongoing industrial action. He also expressed a concern about the capacity to maintain safe staffing levels at the hospital in the medium term.

3. In relation to work to mitigate effects of the ongoing industrial action on the hospital, Charlotte McArdle advised that talks with Trade Union side (TUS) were ongoing and Brenda Creaney added that TUS would be asked to treat Muckamore as a derogation. Charlotte McArdle acknowledged the intensive work on staffing undertaken by Francis Rice, Belfast, Northern and South Eastern Trusts and Francis Rice acknowledged the support he'd received from the Department and the Belfast Trust.

4. A family representative suggested that some family members might be willing and available to help out at Muckamore if that would be of help. Seán Holland stressed the need to ensure that relatives should not feel pressured to help out.

5. This offer was welcomed and it was agreed that a communication should be issued to family members advising that any additional support they were able to provide would be gratefully received.

AP1: Circulate communication to families/carers of in-patients advising that Belfast Trust would welcome any additional family support during the forthcoming holiday period (BHSCT)

Agenda Item 2 - Minutes of Previous Meeting

6. The minutes of the previous MDAG meeting on 30 October were agreed.

Update on Actions

7. Seán Holland provided an update on the action points arising from the previous meeting. A summary of these is attached at **Annex A.** It was agreed that a note of the action points from each meeting would be circulated to members within 24 hours, given the monthly timetable for meetings.

AP2: Action points from each MDAG meeting will be circulated to members within 24 hours of the meeting. (DOH)

8. The Group was advised that further work was required in relation to the contingency plans provided by each of the HSC Trusts to develop a regional contingency plan, and this would be discussed at the next Adult Mental Health & Learning Disability Improvement Board meeting.

9. Comments were invited on the synopsis of the Ennis ward safeguarding investigation report which had been provided by Belfast Trust and circulated to members. Mark Lee advised that since the last MDAG meeting, DoH had received a request for a copy of the full report, which was being dealt with under Freedom of Information legislation. Aine Morrison advised the Group that she had been the Designated Officer in the safeguarding investigation and that the original report was a summary report of a complex safeguarding investigation. She had concerns that the conclusions summarised in the synopsis included the more positive findings but omitted the findings that were of more concern. Charlotte McArdle acknowledged the learning for all involved, and proposed that the full report should be circulated to the group. Aine Morrison advised members that the investigation had been conducted with the PSNI under Adult Safeguarding Joint Protocol arrangements, and accordingly the PSNI's views on disclosure of the report should be sought.

10. Family representatives expressed their shock at the content of the report, and also their concern about a lack of clarity on what actions had been taken to address the findings. Seán Holland gave a commitment that all requests for information received by MDAG would, in the interests of transparency and building trust, be responded to in line with all relevant information management legislation. A family representative asked whether the safeguarding investigation should now be re-opened in light of the current investigation and was advised that the PSNI

investigation had resulted in 2 staff members facing criminal charges. Seán also asked Aine Morrison, as the lead investigator on the Ennis safeguarding investigation to provide a separate briefing for relatives on the Report.

AP3: Requests for information raised at MDAG meetings to be responded to in line with relevant information management legislation. (DOH)

AP4: Briefing for relatives on Ennis Report to be arranged. (DOH/BHSCT)

Agenda item 4 - Update on meeting with families 04 November

11. Seán Holland provided a summary of the issues that had been raised at the Friends of Muckamore Support Group meeting held on Monday 4 November. These included arrangements for communication with families and carers, advocacy support for families and concerns around the resettlement programme. In response to a question from a family representative about the role of the Patient Client Council (PCC), Charlotte McArdle advised that the Department has provided a resource to allow the PCC to engage with families and suggested that Vivian McConvey be invited to join MDAG; this was agreed by the Group.

AP5: Vivian McConvey to be invited to join MDAG (DOH)

12. A suggestion from a family representative for a ‘one-stop shop’ event for families and carers to allow them to seek support and advice on an individual basis about the services available to support their relatives was considered and supported by the Group. Seán Holland suggested it would be helpful to seek the support of the PCC to organise an event. Members agreed that the PCC should be approached to ask for their support in organising the event.

AP6: Belfast Trust to approach PCC to seek support in organising one stop shop event (BHSCT)

13. Brenda Creaney provided an update of the engagement work currently being taken forward by Belfast Trust, including issue of the 3rd Muckamore newsletter and the management team joining the Trust’s Carers Forum on 18th November. She advised the group that further work will be done including agreeing a tailored communication approach between each family member and the management

team, and seeking feedback on how communication could be improved more widely. She also advised that the Trust is engaging with the PCC in its role as an advocate.

14. Seán Holland referred to a proposal received from a family representative in relation to installing CCTV in all areas of LD facilities (including bedrooms). He advised that the Department is looking at the use of CCTV in facilities, and will be communicating with HSC organisations about this in the near future.

15. Seán Holland also referred to a paper he had received from a family representative outlining the pressure (expressed as bullying and intimidation) that some families felt they were being put under by HSC staff in order to expedite the resettlement programme. The Group agreed that this was not acceptable and Seán undertook to advise Trust Directors of Social Work of the issues raised by families around resettlement and to remind them of the principles underpinning resettlement.

AP7: Trust Directors of Social Work to be advised of issues raised by families around resettlement and reminded of the principles underpinning resettlement (DoH)

16. The co-chairs of the Group reiterated their commitment to continued participation in meetings with families for as long as the families find this to be helpful. It was clarified that anyone with an interest in the hospital was very welcome to attend Support Group meetings, with the next meeting scheduled for 2 December. Seán Holland reiterated a commitment made at the Friends of Muckamore meeting that additional family representatives were welcome to attend MDAG.

Agenda Item 5 - Highlight Report and Dashboard

17. Mark Lee provided an overview of the highlight report, including the current position on the police investigation, and clarified that 38 staff were currently on precautionary suspension as a result of viewing of historic CCTV footage. He highlighted a regional initiative to bolster the current nursing workforce at the hospital as an important element of the ongoing contingency planning arrangements for services at the hospital.

18. Brenda Creaney advised the Group of a Belfast Trust presentation provided to RQIA which provides detail of ongoing work including to re-modelling Multi-disciplinary Teams, ward based leadership, a new staffing model for the hospital and re-admissions to Muckamore.

AP8: Belfast Trust presentation to RQIA to be circulated to MDAG (BHSCT)

19. Seán Scullion presented the reporting dashboard to the group which had been updated to reflect comments at last MDAG on 30th October. He advised that work is continuing with the Regional Learning Disability Operational Delivery Group (RLDODG) to develop and improve reporting arrangements on the resettlement programme and highlighted the ongoing work to review placement break downs and to monitor re-admissions to Muckamore to identify learning. Petra Corr suggested it would be helpful to see a report on all the restrictive practices in the highlight report. Marie Heaney advised that it would be possible to provide this information on a monthly basis.

AP9: Reporting on use of restrictive practices at the hospital to be included in MDAG highlight report and meeting agendas (DoH)

20. Seán Scullion advised that the Permanent Secretary's commitment to resettle all the remaining Priority Target List patients by end of December is not likely to be met. Petra Corr suggested it would be more helpful to progress with meaningful safe placements than push to get patients out quickly. Marie Heaney advised that the Belfast Trust had established a work stream on resettlement and the key messages coming from providers were a lack of central planning and assumptions being made which weren't borne out by infrastructure. Other issues identified are staff terms and conditions, difficulties in recruitment, training and community support. She further advised that she was working on a paper to refresh the resettlement programme, and that patient and carer involvement would be a part of a new project.

21. The Group discussed the difficulties in providing suitable placements and the challenges for providers. Aine Morrison highlighted that there have been some very successful placements which have delivered significant improvements in quality of life for individuals. Seán Holland stressed the need to identify and understand the limiting factors impacting on successful resettlement, to inform the development of

proposals to overcome these. Marie Heaney undertook to bring proposals to the Group.

AP10: Proposals to address barriers to resettlement to be tabled for consideration by MDAG (Belfast Trust/HSCB)

Agenda Item 6 - HSC Action Plan progress report

22. Máire Redmond provided an overview of the HSC Action Plan which contains 43 actions, of which 1 is rated red (progress required), 37 amber (work in progress) and 5 green (completed). She advised that two updates were provided after the papers were circulated and that the progress report will be updated to reflect these. She reminded members that the plan was a living document, and progress (including any delays) would continue to be reported to MDAG.

Agenda Item 8 - Update on Regional Operational Delivery Group

23. Members noted that an update on the Operational Delivery Group's work had already been provided under agenda item 5. It was suggested that it would be helpful for the Group to consider the issue of re-admissions to the hospital, with a view to considering any lessons emerging from breakdown of community placements, with appropriate engagement from providers. Marie Roulston advised that work was underway to provide Positive Behaviour Support training to staff and providers in the New Year and that funding for this was being sourced.

AP11: Information on numbers of re-admissions to MAH due to community placement breakdown (including those occurring at weekends) to be provided to MDAG (HSCB)

24. Marie Roulston further advised that a meeting to discuss regional psychiatric support would be held on 02 December, and that a workshop is being organised for 11 December to consider the findings of the Acute Care Review and to develop and agree an implementation plan.

Agenda Item 9 – Report on Safeguarding arrangements in MAH

25. Marie Roulston referred to the report of the review of Adult Safeguarding Processes at the hospital which had been circulated with papers for the meeting;

it was agreed that any comments or questions from members arising from this would be considered at the December MDAG meeting.

Agenda item 10 – Leadership and Governance Review update

26. Briege Quinn advised that 2 individuals, Maura Devlin and Marion Reynolds, had agreed to join the independent team taking forward the Leadership and Governance Review and that a third individual had been approached. She also clarified that the Terms of Reference circulated to members was not the final version, and when these were agreed a timeline for completion of the review will be included.

AP12: Leadership and Governance review Terms of Reference to be agreed and finalised (PHA/HSCB)

Agenda item 11 - Forensic Scoping work update

27. Marie Heaney updated the Group on a scoping exercise being carried out to consider the potential to provide an in-patient forensic service for people with a Learning Disability on the Knockbracken Healthcare Park site. She advised that a workshop was planned for January, and a proposal paper will be developed for submission to DoH.

Agenda item 12 - Pathway for student feedback

28. The Group discussed the arrangements to review feedback from students from all disciplines who had undertaken placements at the hospital as part of their professional training. Rodney Morton advised that the Department was exploring the mechanisms by which student experiences and perspectives were fed back to placing universities, and that assurance would be sought from universities in relation to this.

Agenda Item 13 - AOB

29. Seán Holland noted that a number of MDAG members have previously worked at the Hospital, and that in the interests of transparency a register for the declaration of any conflicts should be established. The Group agreed with this suggestion.

AP13: Declaration of Interests form to be circulated to MDAG members (DoH)

Agenda Item 14 - Date of next meeting

30. The next meeting will be held on 18th December.

Summary of Action Points

Ref.	Action	Respon-sible	Update	Open/ closed
27/11/AP1	Circulate communication to families/carers of in-patients advising that Belfast Trust would welcome any additional family support during the forthcoming holiday period	BHSCT		
27/11/AP2	Action points from each MDAG meeting to be circulated to members within 24 hours.	DoH		
27/11/AP3	Requests for information raised at MDAG meetings to be responded to in line with relevant information management legislation.	DoH		
27/11/AP4	Briefing for relatives on Ennis Report to be arranged.	DoH		
27/11/AP5	Invite Vivian McConvey to join MDAG.	DoH		
27/11/AP6	Belfast Trust to approach PCC to seek support in organising one stop shop event.	BHSCT		
27/11/AP7	Trust Directors of Social Work to be advised of issues raised by families around resettlement and reminded of the principles underpinning resettlement.	DoH		

27/11/AP8	Belfast Trust presentation to RQIA to be circulated to MDAG	BHSCT		
27/11/AP9	Reporting on use of restrictive practices at the hospital to be included in MDAG highlight report and meeting agendas.	DoH		
27/11/AP10	Proposals to address barriers to resettlement to be tabled for consideration by MDAG.	BHSCT / HSCB		
27/11/AP11	Information on numbers of re-admissions to MAH due to community placement breakdown (including those occurring at weekends) to be provided to MDAG	HSCB		
27/11/AP12	Leadership and Governance review Terms of Reference to be agreed and finalised.	HSCB/ PHA		
27/11/AP13	Declaration of Interests form to be circulated to MDAG members.	DoH		

ANNEX A

Update on Action Points

MDAG 30 October 2019

Ref.	Action	Respon-sible	Update	Open/ closed
30/10/AP1	Existing communication arrangements with families and carers to be reviewed, in partnership with families/carers.	Belfast Trust	BHSCT to update MDAG on progress.	Open
30/10/AP2	Updated dashboard to be tabled at next MDAG meeting for agreement.	DoH	Dashboard updated and circulated with papers for 27 Nov meeting for further consideration.	Closed
30/10/AP3	Individual Trust contingency plans and a Regional Plan for the future role of the hospital to be amalgamated and shared with all families.	DoH	The HSCB is co-ordinating the development of a regional contingency plan for consideration by MDAG.	Open
30/10/AP4	Update on HSC Action Plan to be provided for next MDAG.	DoH	November update circulated with papers for 27 Nov meeting.	Closed
30/10/AP5	RLDODG to monitor and analyse re-admission rates to identify and disseminate any learning arising.	HSCB	Discussed at RLDODG meeting on 13 November – proposal to be developed by RLDODG for consideration by MDAG.	Open
30/10/AP6	Develop a presentation for MDAG to clarify roles and responsibilities iro psychiatric and other	HSCB	HSCB to present to MDAG – date to be advised.	Open

	professional outreach and support.			
30/10/AP7	Report on Safeguarding Processes at MAH to be circulated for next MDAG meeting.	HSCB	Report circulated with papers for 27 Nov meeting.	Closed
30/10/AP8	Terms of reference for Leadership and Governance review to be included in papers for November MDAG meeting.	HSCB/ PHA	ToRs circulated with papers for 27 Nov meeting.	Closed
30/10/AP9	Synopsis of Ennis Ward Safeguarding Report to be shared with MDAG	Belfast Trust	Synopsis provided by Belfast Trust on 26 November.	Closed

MDAG 01 October 2019

Ref.	Action	Respon-sible	Update	Open/ closed
01/10/AP1	Updated dashboard to be tabled at next MDAG meeting for agreement.	DoH	Update provided and discussed under agenda item 5.	Closed
01/10/AP2	Individual Trust contingency plans and a Regional Plan for the future role of the hospital to be amalgamated and shared with all families.	DoH	Final Contingency plan not received in advance of meeting; to be provided for next MDAG.	Open
1/10/AP3	Safeguarding Process Map and Report to be circulated to MDAG members when completed.	HSCB	Draft report circulated to MDAG for 27 Nov meeting.	Closed
01/10/AP4	Fact sheet to be issued to Belfast Trust following MDAG meetings for circulation to families and staff at Muckamore.	DoH/ Belfast Trust	Fact sheet circulated with MDAG papers; the fact sheet will be produced and distributed after each MDAG meeting.	Ongoing
01/10/AP5	Update on engagement work with the Department for Communities to be tabled at next MDAG meeting.	DoH	Circulated with MDAG papers and discussed under agenda item 14.	Closed
01/10/AP6	Circulate feedback from student nurses on placement at Muckamore.	Belfast Trust	This was circulated with MDAG papers in advance of meeting.	Closed
01/10/AP7	Acute Care Review Report to be shared with families and carers.	HSCB	Report circulated with MDAG papers and discussed under agenda item 13.	Closed

01/10/AP8	Include a summary of new deprivation of liberty provisions in the MDAG factsheet.	DoH	This was included in the fact sheet which was distributed on 07 October.	Closed
01/10/AP9	Prepare Action Plan progress report for consideration by MDAG.	DoH/ HSCB/ Trusts	RAG rated action plan circulated and discussed under agenda item 7. This will remain a monthly action.	Ongoing

MDAG – 30 August 2019

Ref.	**Action**	**Respon-sible**	**Update**	**Open/ closed**
30/8/AP1	Consult with the Patient Client Council to develop proposals for extending family and individual patients' involvement in the work of MDAG	DoH	Rodney Morton advised that following discussions with Patient Client Council, a proposal has been provided for independent advocacy to support the work of MDAG. A business case for this is being developed.	Closed
30/8/AP2	Provide an update on levels of service user/family participation in on-line engagement survey, and consider steps to facilitate family involvement at Project Board level	HSCB	The survey closed at the end of Sept with over 670 with over 1800 individuals engaged in local events. The results are currently being collated and analysed and these will inform the preparation of a high level first draft of the Service Model, which is expected to	Closed

			be ready by the end of October.	
30/8/AP3	Copy of Belfast Trust contingency plan to be provided to DoH.	Belfast Trust	Contingency plans have from 4 of the 5 Trusts (including Belfast Trust) have been provided to DoH. Western Trust plan in development.	Closed
30/8/AP4	Review and consider options to strengthen engagement with hospital staff.	Belfast Trust	Update provided under agenda item 6.	Closed
30/8/AP5	Comments on actions and timescales in draft plan to be forwarded to DoH	HSCB/ PHA/ Trusts	Comments from HSCB and Belfast Trust provided, and draft plan amended accordingly.	Closed
30/8/AP6	Glossary of terms to be added to Action Plan	DoH	Glossary of terms has been added– this will be kept under review.	Closed
30/8/AP7	Draft Terms of Reference for the Leadership and Governance review to be tabled at next MDAG meeting	DoH	ToRs tabled at 1 October meeting	Closed
30/8/AP8	Circulate dates for future meetings and identify potential alternative meeting venues	DoH	Dates up to end of December have been circulated and venues will be confirmed.	Closed

MDAG/1/20

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 18 December 2019

Boardroom, Muckamore Abbey Hospital

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Chair)	Charlotte McArdle	DoH
Mark Lee	DoH	Marie Roulston	HSCB
Máire Redmond	DoH	Brenda Aaroy	Belfast Trust
Sean Scullion	DoH (Note)	Don Bradley	South Eastern Trust
Aine Morrison	DoH	Eileen McEnaney	Strengthening the Commitment collaborative
Ian McMaster	DoH	Dawn Jones	Family rep
Siobhan Rogan	DoH	Bernie Owens	Belfast Trust
Brigene McNeilly	Family representative	Barney McNeaney	Southern Trust
Margaret Kelly	Mencap	Brenda Creaney	Belfast Trust
Marie Heaney	Belfast Trust	Stephen Matthews	Cedar Foundation
Francis Rice	External Nursing expert	Rodney Morton	DoH
Karen O'Brien (by t/conference)	Western Trust	Briege Quinn	PHA
Margaret O'Kane (by t/conference)	South Eastern Trust		
Oscar Donnelly	Northern Trust		
Petra Corr	Northern Ireland British Psychological Society		
Gavin Davidson	QUB		
Lourda Geoghan	RQIA (observer)		

Agenda Item 1 - Welcome/Introductions/Apologies

1. The Chair welcomed attendees and noted apologies received for the meeting. He advised members that there was a reduced attendance at the meeting as a result of the involvement of a number of Group members in the Health and Social Care emergency planning arrangements which were operating in relation to ongoing industrial action.

Agenda Item 2 - Minutes of Previous Meeting/Update on actions

2. The minutes of the previous MDAG meeting on 27 November were agreed.

3. Seán Holland provided an update on the action points arising from the previous meeting. A summary of these is attached at **Annex A.**

4. Members welcomed the offer relatives had extended at the previous meeting to provide additional support on Christmas Day, and in support of this families had queried whether there was any scope to open the day care facilities on site on Christmas Day. The Belfast Trust representatives agreed to explore this.

AP1: Consider options to provide access for relatives to hospital facilities on Christmas Day (BHSCT)

5. Members discussed the arrangements to brief families on the contents of the historic Ennis Adult Safeguarding investigation, and agreed that briefing should be offered in the first instance to the families of the patients who were in Ennis Ward at the time of the investigation.

6. The Group noted that there had been a number of historic investigations carried out into allegations and complaints made at different times about services at the hospital, and agreed the importance of identifying any recurring themes emerging from these. Members agreed that the Leadership and Governance Review should consider how learning from any relevant historic safeguarding investigations was disseminated, and the Terms of Reference for the Review should be reviewed to ensure they fully reflect this.

Agenda item 3 - Update on meeting with families on 2 December

7. Mark Lee provided a summary of the issues that had been raised at the Friends of Muckamore Support Group meeting held on Monday 2 December. Issues raised included engagement with families on resettlement plans for their relatives, the provision of advocacy support for families and the central role of outreach services in supporting community placements.

8. The Chair reiterated his previous commitments to continue Departmental attendance at Support Group meetings for as long as families considered it helpful, and also suggested that for future meetings families might wish to consider in advance whether there were any specific issues they would find it useful to be briefed on.

Agenda Item 4 – Update on MAH staffing position

9. Francis Rice updated members on the staffing position at the hospital, and advised that the majority of services provided at the hospital had obtained a derogation from the current industrial action, which was welcomed by the Group.

10. He also updated the Group on the current vacancy position at the hospital, with 71.4 whole time equivalent vacancies, and a further 40 staff currently placed on precautionary suspension. Uptake of the initiative to attract additional nursing staff to work at the hospital had not been as successful as hoped, with four staff from other Trusts availing of this to date; a further three individuals had expressed an interest. Members discussed possible options to maximise uptake of the initiative among the potential pool of applicants, including promotion of the positive findings from the most recent RQIA inspection of the hospital.

11. In response to a query from a family representative, Francis confirmed that he expected safe staffing levels to be maintained over the Christmas and New Year holiday period.

Agenda Item 5 – Update on Regional Operational Delivery Group/Outcome of Acute Care workshop

12. The Regional Operational Delivery group met on 9 December and is progressing a number of aspects of work in support of the resettlement programme. The next meeting is scheduled for 15 January, and a fuller update will be tabled at the January meeting of MDAG.

13. Máire Redmond reminded MDAG of the context to the Acute Care workshop, which was organised to consider the next steps in implementing the findings of the

independent panel who had carried out the review of acute in-patient services for people with a learning disability. A number of members who had attended the workshop provided a readout of discussions at the event, with key messages emerging around the centrality of multi-disciplinary teams and the importance of addressing workforce issues.

14. The Chair clarified that the review carried out by the independent panel was part of the wider Transformation project to develop a new service model for Adult Learning Disability Services which is due to report next spring, and as such no final decisions have yet been taken on the potential future configuration of services. The new model is being developed on an inclusive co-produced partnership basis with input from all stakeholders and will be subject to a period of public consultation before presentation to any incoming Minister for their consideration.

Agenda Item 6 – MAH Leadership and Governance Review Update

15. Máire Redmond advised members that three appointments had now been agreed to the independent team who will be carrying out the review of Leadership and Governance arrangements at the hospital, and identified these as Marion Reynolds, Maura Devlin and David Bingham. She confirmed that regular meetings with the panel would be scheduled to oversee progress on the review.

16. The Chair requested that pen pictures of the panel members be circulated to MDAG members when the appointments are confirmed, and Máire confirmed that these would be provided along with the Terms of Reference for the review.

AP2: Terms of Reference for Leadership and Governance review and pen pictures of review team to be circulated to MDAG (DoH)

Agenda Item 7 - AOB

17. The Chair advised members that RQIA had carried out a follow-up unannounced inspection of the hospital commencing on 10th December and invited Lourda Geoghan to update the Group on the findings from this.

18. Lourda Geoghan advised members that the inspection had taken place to review progress towards addressing the issues identified in the three Failure to Comply notices issued by RQIA in August, following 2 unannounced inspections at the hospital carried out earlier in the year. Overall, the findings from the inspection were positive, with inspectors reporting that significant improvements have been made since the previous inspection in April.

19. Lourda extended thanks on behalf of the inspection team to staff on site, who she reported had been welcoming and open during the inspection. She advised that a detailed feedback session on the inspection findings had been held with hospital staff, and a full inspection report would be prepared by RQIA in due course. Of the three failure to comply notices, the staffing notice would be lifted in full with immediate effect, with the safeguarding and financial governance notices expected to be lifted in due course, subject to provision of satisfactory auditable evidence of embedded and sustained improvement in relation to a number of aspects of the notices.

20. The Group welcomed the inspection findings, and acknowledged the work that had been carried out by hospital staff to deliver the required improvements to services. The Chair extended his thanks to both RQIA and Belfast Trust staff for their contribution to delivering these. Members considered it was important that this positive development be communicated more widely, and agreed that possible options for this should be explored. Lourda Geoghan offered to deliver a presentation on the inspection findings to the Friends of Muckamore support group.

AP3: Consider options for positive media piece to communicate RQIA follow-up inspection findings (DoH)

21. Members were also given an update on the recent good practice visit by a group of Departmental and Belfast Trust staff to East London Foundation Trust, which was arranged to reciprocate the ‘critical friend’ visit by a team from East London to Muckamore in the summer.

22. The Group acknowledged the importance of developing learning partnerships with other providers in delivering service improvements, and agreed that the Belfast Trust and the Health and Social Care Board should work together to disseminate the learning emerging from the partnership with East London regionally across all HSC Trusts. It was also agreed that the Patient and Client Council should be asked to develop options to involve families and carers in this work.

AP4: Develop proposals to disseminate regionally good practice learning emerging from Belfast Trust's partnership with East London Foundation Trust (HSCB/BHSCT/PCC)

Agenda Item 8 - Date of next meeting

23. The Chair acknowledged the work of MDAG to date, and advised that the next meeting will be held on 23 January.

Summary of Action Points

Ref.	Action	Respon-sible	Update	Open/ closed
18/12/AP1	Consider options to provide access for relatives to hospital facilities on Christmas Day.	BHSCT		
18/12/AP2	Terms of Reference for Leadership and Governance review and pen pictures of review team to be circulated to MDAG	DoH		
18/12/AP3	Consider options for positive media piece to communicate RQIA follow-up inspection findings/	DoH		

18/12/AP4	Develop proposals to disseminate regionally good practice learning emerging from Belfast Trust's partnership with East London Foundation Trust.	BHSCT/ HSCB /PCC		

ANNEX A

Update on Action Points from 27 November

Ref.	Action	Respon -sible	Update	Open/closed
27/11/AP1	Circulate communication to families/carers of in-patients advising that Belfast Trust would welcome any additional family support during the forthcoming holiday period	BHSCT	E-mail circulated to relatives by BHSCT on 27 Nov.	Closed
27/11/AP2	Action points from each MDAG meeting to be circulated to members within 24 hours.	DoH	Draft action points circulated 28 Nov.	Ongoing
27/11/AP3	Requests for information raised at MDAG meetings to be responded to in line	DoH	Will be actioned as required	Ongoing

	with relevant information management legislation.			
27/11/AP4	Briefing for relatives on Ennis Report to be arranged.	DoH	BHSCT making arrangements for briefing.	Open
27/11/AP5	Invite Vivian McConvey to join MDAG.	DoH	Invitation letter from joint MDAG Chairs issued 10 Dec.	Closed
27/11/AP6	Belfast Trust to approach PCC to seek support in organising one stop shop event.	BHSCT	BHSCT in discussions with PCC to arrange event.	Open
27/11/AP7	Trust Directors of Social Work to be advised of issues raised by families around resettlement and reminded of the principles underpinning resettlement.	DoH	Sean Holland will raise at next regional meeting of Trust Directors of Social Work scheduled for January.	Open
27/11/AP8	Belfast Trust presentation to RQIA to be circulated to MDAG	BHSCT	Presentation circulated to members on 17 Dec.	Closed
27/11/AP9	Reporting on use of restrictive practices at the hospital to be included in MDAG highlight report and meeting agendas.	DoH	Will be added to highlight report and agenda for future MDAG meetings in New Year	Ongoing
27/11/AP10	Proposals to address barriers to resettlement to be tabled for consideration by MDAG.	BHSCT / HSCB	Will be tabled at MDAG meeting in New Year.	Open
27/11/AP11	Information on numbers of re-admissions to MAH due to community placement breakdown (including those occurring at weekends) to be provided to MDAG	HSCB	Will be tabled at MDAG meeting in New Year.	Open

27/11/AP12	Leadership and Governance review Terms of Reference to be agreed and finalised.	HSCB/ PHA	ToR to be circulated to MDAG members for comments.	Open
27/11/AP13	Declaration of Interests form to be circulated to MDAG members.	DoH	Circulated to members on 13 Dec.	Closed

MDAG/6/20

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 19 February 2020

Laburnum Suite, Dunsilly Hotel, Antrim

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Eileen McEnaney	Strengthening the Commitment collaborative
Charlotte McArdle	DoH (Joint Chair)	Brigene McNeilly	Family representative
Mark Lee	DoH	Barney McNeaney	Southern Trust
Marie Roulston	HSCB	Bernie Owens	Belfast Trust
Rodney Morton	PHA	Petra Corr	Northern Ireland British Psychological Society
Ian McMaster	DoH		
Siobhan Rogan	DoH		
Dawn Jones	Family rep	**Also in attendance**	**Agenda item 13**
Brenda Aaroy	Belfast Trust	David Bingham	Leadership and Governance Review
Máire Redmond	DoH	Katrina McMahon	Leadership and Governance Review
Sean Scullion	DoH (Note)		
Aine Morrison	DoH		
Don Bradley	South Eastern Trust		
Marie Heaney	Belfast Trust		
Brenda Creaney	Belfast Trust		
Karen O'Brien	Western Trust		
Oscar Donnelly	Northern Trust		
John McEntee	Southern Trust		
Margaret Kelly	Mencap		
Stephen Matthews	Cedar Foundation		
Francis Rice	External Nursing expert		
Briege Quinn	PHA		
Vivian McConvey	PCC		
Gavin Davidson	QUB		
Lourda Geoghan	RQIA (observer)		

Agenda Item 1 - Welcome/Introductions/Apologies

1. The joint Chairs welcomed attendees and noted apologies received for the meeting. Members were advised that Vivian McConvey had accepted the invitation to represent the Patient Client Council on the Group, and Vivian was welcomed to her first meeting as a Group member.

2. The Chairs also provided an update on the current number of staff on precautionary suspension at the hospital, including the recent removal from the site of two agency staff following concerns about practice in Erne Ward raised by contemporaneous viewing of CCTV footage.

Agenda Item 2 - Minutes of Previous Meeting

3. The joint Chairs noted that the January meeting had been postponed due to pressures associated with installation of new Minister and Executive. The minutes of the previous MDAG meeting held on 18 December were agreed (Paper MDAG/1/20).

Agenda item 3 – Update on Action Points.

4. Charlotte McArdle provided an update on the action points outstanding from the previous MDAG meetings held on 18 December and 27 November. A summary of the updates is attached at **Annex A.**

5. These included the extended availability of hospital facilities for patients' families over the holiday period, a planned reciprocal visit to Northern Ireland by the East London Foundation Trust in April, an update on arrangements for briefing families of patients involved in the Ennis Ward Adult Safeguarding Report, and feedback from communication with families on the resettlement programme. It was made clear by the Chairs that there has been no change of policy in respect of resettlement, though the importance was recognised of giving due regard to the views and concerns of families and carers in developing suitable community placement options, which must meet the specific needs of individuals.

6. Members agreed that the Belfast Trust should review their arrangements for communicating with families, and also indicated that it would be helpful for the Group to meet with the team from East London during their planned visit in April.

AP1: Explore scope to improve and expand current communication arrangements with patients' families/carers, including social media channels (BHSCT)

AP2: East London Foundation Trust to be invited to meet with MDAG (BHSCT)

Agenda Item 4 – Update on MAH staffing position

7. Sean Holland advised members that the Minister had recently approved a three-month extension to the incentive scheme established to encourage staff to relocate to work in the hospital, and invited Francis Rice to update members on the current staffing position. Francis advised members there were currently 82 staffing vacancies, and five live applications for vacant posts. He confirmed there had been no further resignations beyond the six advised at the previous MDAG meeting, who were still working notice periods. While welcoming the Minister's decision to extend the incentive scheme, he reported that uptake of this remained disappointing. In relation to the future, he remained concerned about the long term sustainability of services at the hospital, in view of the reliance on use of agency and bank staff and also the current staff vacancy levels.

8. Members discussed options to address the workforce issue, and agreed the importance of a regional approach to this. Brenda Creaney advised members of interest expressed in opportunities at the hospital at a recent recruitment event, and noted that there are 26 Learning Disability Nursing students who are due to graduate this summer. The Group discussed potential options to engage with these students to promote working in Muckamore as a positive career choice, and Charlotte McArdle undertook to explore these further.

AP3: Engage with current cohort of undergraduate LD nurses to promote the hospital as an employer (DoH).

Agenda Item 5 – Update on engagement with families

9. Sean Holland advised members that the January meeting of the Society of Parents and Friends had been postponed due to inclement weather, and that the Permanent Secretary had attended the February meeting. He also noted that a one stop shop event had been held in Antrim Civic Centre, which had provided a useful opportunity to engage with families on resettlement issues. He reiterated the Department's commitment to engagement with families for as long as this was considered to be helpful, and advised members that the Minister had also met with families on two occasions recently. Seán stressed the need for more channels of communication with families.

10. Vivian McConvey noted that there are a number of groups and advocacy organisations working to support families, and that the PCC is trying to understand each of these groups and bring them together. She further advised that the PCC was taking forward the development of an engagement strategy.

11. Members considered it was important that patients should also be given the opportunity to contribute their views, and it was agreed that the Belfast Trust would carry out an evaluation and critical analysis of current engagement arrangements with MAH patients, and present the findings from this to MDAG.

AP4: Carry out an evaluation and critical analysis of current engagement arrangements with MAH patients, and present findings to April MDAG meeting (BHSCT).

Agenda Item 6 – Contingency Planning

12. Sean Holland reiterated to the Group the importance of this work, and also of an appropriate regional approach to delivering on this. Marie Roulston advised that work was continuing to develop a regional contingency plan.

Agenda Item 7 – Highlight Report and Dashboard

13. Mark Lee provided a summary of the current highlight report (Paper MDAG/2/20), including updates on progress with resettlement, use of seclusion, the Learning

Disability Service Model Transformation project, the Acute Services Review and the Leadership and Governance review.

14. Sean Holland welcomed the report, and highlighted the importance of effective arrangements to monitor the work of MDAG.

Agenda Item 8 – Report on use of restrictive practices

15. Brenda Creaney provided the Group with an overview of the Belfast Trust report on the safety metrics at the hospital. Charlotte McArdle acknowledged the progress that has been made in reducing rates of seclusion and physical interventions. A number of contributing factors to this were noted, including enhanced staff training, increased use of reflective practice, a reduction in patient numbers, improved communication between the hospital and outside providers reinforced by outreach arrangements for hospital staff and increased use of a multi-disciplinary team approach to delivering care and treatment.

16. Stephen Matthews noted that an appropriately skilled workforce is a key factor in determining the success of community placements, and that this should be reflected accordingly in workforce planning.

Agenda Item 9 – HSC Action Plan update

17. Maire Redmond presented an update on the MAH HSC Action Plan, and sought views from members on the current reporting format. Sean Holland clarified that any proposed changes to the status or timescale of individual actions within the plan should be formally raised with the Department to facilitate presentation to MDAG for consideration. It was agreed that progress reports in respect of a number of individual actions in the plan would be commissioned.

AP5: Updates on status of individual Action Plan targets to be commissioned (DoH).

Agenda Item 10 – Update on Regional Operational Delivery Group

18. Marie Roulston advised members that the February meeting of the Operational Delivery Group had been organised as a workshop and had involved Trust Directors of Mental Health and Learning Disability. The Group had agreed to revisit existing Trust resettlement plans with a view to amalgamating these into a single regional plan. The workshop had also considered supported living facilities and barriers to resettlement.

Agenda Item 11 – Update on Acute Care Review

19. Marie Roulston advised members that a number of clinicians had been identified to progress work to implement the Review's findings, and the Terms of Reference for this was currently being developed.

Agenda Item 12 – Proposals to address barriers to resettlement

20. Marie Heaney gave a presentation to the Group on work carried out by the Belfast Trust to identify and address barriers to resettlement, and members discussed the lessons emerging from this. Issues raised included potential for regional application of the findings, guidance for front-line staff, involvement of independent providers, links to the LD Service Model project work, the role of Supporting People and also the existing structures established to oversee the resettlement programme. It was agreed that the Department and the Health and Social Care Board should jointly review the effectiveness of the regional resettlement process and structures, with a view to making recommendations for improvement.

AP6: Review effectiveness of regional resettlement process and structures and make recommendations for improvement (DoH/HSCB)

Agenda Item 13 – Briefing from the Leadership and Governance Review Independent Panel

21. David Bingham, Chair of the Independent Panel carrying out the Leadership and Governance Review joined the meeting to brief the Group on the Panel and their planned programme of work. He provided an overview of the methodology the

panel intend to use in carrying out the review, and clarified that the panel's review would include consideration of any historic safeguarding investigations which had been carried out within the time period defined in the Terms of Reference for the review. He also advised that the panel intended to engage with families and patients. It was agreed that regular progress updates on the panel's work will be provided to MDAG.

Agenda Item 14 – Any other business

22. Charlotte McArdle suggested it would be useful for MDAG to be updated on progress made by the hospital on delivering the improvements set out in the Quality Improvement Plan developed to address the findings in recent RQIA inspection reports. Lourda Geoghan agreed to update members on this at the next MDAG meeting.

AP7: Update to be provided on implementation of RQIA Improvement Plan for Muckamore. (RQIA)

23. Gavin Davidson advised members that a symposium had been arranged for 28 February on the findings of a study commissioned from QUB by RQIA on the use of CCTV in care home settings, and extended an invitation to any members who wished to attend.

AP8: Issue reminder to MDAG on an RQIA Symposium - The Effectiveness of the Use of CCTV in Care Home Settings on 28th February in QUB (DoH)

<u>Summary of Action Points</u>

Ref.	Action	Respon-sible	Update	Open/ closed
19/2/AP1	Explore scope to improve and expand current communication arrangements with patients' families/carers,	BHSCT	The interim senior management team in MAH have already explored and expanded	Open

	including social media channels.		communication arrangements with patients' families/carers. These measures include: Full SMT attendance at BHCST Carer's Forum. Discussion at Carer's Forum about how best to expand contribution/attendance of families at the meeting. All families/carers written to and offered 1:1 meeting with SMT. Unfortunately no responses were received. Full SMT participation in recent event at the Antrim Civic Centre Full engagement with the Patient Client Council (PCC), and all our Advocacy Organisations. The PCC have employed a new advocate, Ms Sharon Magorian, for a period of 4-6 months for Muckamore Abbey Hospital. The Trust	

			will be writing out to families of our patients to introduce Sharon and to encourage families to meet with her. She will provide the SMT with feedback. PCC has indicated that they will be offering home visits to families, as part of their engagement work and they will evaluate if there are any other ways that we should be using to communicate with families. MDAG Highlights and other relevant information shared with families/carers via mailshot. SMT attended a meeting of the Society of Parents and Friends of Muckamore SMT have also met with Billy Moore and Brigene McNeilly and will continue to do so regularly. Production of bi-monthly Muckamore Abbey Hospital Newsletter. Distribution of Muckamore Parents & Friends meeting	

			invitations by post to families The March newsletter will be issued to families and staff week beginning March 16th The team will discuss the potential use of social media at the next BHSCT Carer's Forum.	
19/2/AP2	East London Foundation Trust to be invited to meet with MDAG.	BHSCT	When BHSCT have confirmed dates for a visit of ELFT colleagues to NI, these dates will be shared with MDAG. This is not likely to take place for at least a couple of months in light of COVID -19.	Open
19/2/AP3	Engage with current cohort of undergraduate LD nurses to promote the hospital as an employer.	DoH	Work is progressing by nursing group to take this forward	Open
19/2/AP4	Carry out an evaluation and critical analysis of current engagement arrangements with MAH patients, and present findings to April MDAG meeting.	BHSCT	The PCC have employed a new advocate, Ms Sharon Magorian, for a period of 4-6 months for Muckamore Abbey Hospital. Sharon will be meeting with our patients to talk about what matters to them. We hope that this feedback will help us critically evaluate our current	Open

			arrangements and inform us of where we need to make changes/ improvement	
19/2/AP5	Updates on status of individual Action Plan targets to be commissioned.	DoH	Commissioned 5 March.	Open
19/2/AP6	Review effectiveness of regional resettlement process and structures and make recommendations for improvement.	DoH/ HSCB	This review has not progressed due to involvement in COVID -19 work.	Open
19/2/AP7	Update to be provided on implementation of RQIA Improvement Plan for Muckamore.	RQIA	RQIA to provide at next scheduled MDAG	Open
19/2/AP8	Issue reminder to MDAG on an RQIA Symposium - The Effectiveness of the Use of CCTV in Care Home Settings on 28th February in QUB	DoH	Issued 21 February	Closed

ANNEX A

Update on Action Points from 18 December

Ref.	Action	Respon -sible	Update	Open/ closed
18/12/AP1	Consider options to provide access for relatives to hospital facilities on Christmas Day.	BHSCT	BHSCT advised relevant facilities were open and offer extended to families	Closed

18/12/AP2	Terms of Reference for Leadership and Governance review and pen pictures of review team to be circulated to MDAG	DoH	Circulated 14 February.	Closed
18/12/AP3	Consider options for positive media piece to communicate RQIA follow-up inspection findings/	DoH	Media reports ran on 20 December.	Closed
18/12/AP4	Develop proposals to disseminate regionally good practice learning emerging from Belfast Trust's partnership with East London Foundation Trust.	BHSCT/ HSCB /PCC	Further ELFT visit being arranged for April – to include invite to meet with MDAG.	Open

Update on Action Points from 27 November

Ref.	Action	Respon -sible	Update	Open/cl osed
27/11/AP1	Circulate communication to families/carers of in-patients advising that Belfast Trust would welcome any additional family support during the forthcoming holiday period	BHSCT	E-mail circulated to relatives by BHSCT on 27 Nov.	Closed
27/11/AP2	Action points from each MDAG meeting to be circulated to members within 24 hours.	DoH	Draft action points circulated 28 Nov.	Ongoing
27/11/AP3	Requests for information raised at MDAG meetings to be responded to in line	DoH	Will be actioned as required	Ongoing

	with relevant information management legislation.			
27/11/AP4	Briefing for relatives on Ennis Report to be arranged.	DoH	BHSCT contacting families involved – to be completed by end February	Open
27/11/AP5	Invite Vivian McConvey to join MDAG.	DoH	Invitation letter from joint MDAG Chairs issued 10 Dec.	Closed
27/11/AP6	Belfast Trust to approach PCC to seek support in organising one stop shop event.	BHSCT	BHSCT in discussions with PCC to arrange event.	Closed
27/11/AP7	Trust Directors of Social Work to be advised of issues raised by families around resettlement and reminded of the principles underpinning resettlement.	DoH	Letter from SH issued to Trust Ch Exes on 24 January and also shared with families.	Closed
27/11/AP8	Belfast Trust presentation to RQIA to be circulated to MDAG	BHSCT	Presentation circulated to members on 17 Dec.	Closed
27/11/AP9	Reporting on use of restrictive practices at the hospital to be included in MDAG highlight report and meeting agendas.	DoH	Report provided under agenda item 6 at 19 Feb meeting	Ongoing
27/11/AP10	Proposals to address barriers to resettlement to be tabled for consideration by MDAG.	BHSCT / HSCB	Presentation made to MDAG meeting on 19 Feb –agenda item 12	Closed
27/11/AP11	Information on numbers of re-admissions to MAH due to community placement breakdown (including those occurring at weekends) to be provided to MDAG	HSCB	Will be tabled at MDAG meeting in New Year.	Open

27/11/AP12	Leadership and Governance review Terms of Reference to be agreed and finalised.	HSCB/ PHA	ToR circulated to MDAG members on 14 Feb and signed off at meeting on 19 February.	Closed
27/11/AP13	Declaration of Interests form to be circulated to MDAG members.	DoH	Circulated to members on 13 Dec.	Closed

MDAG/09/20

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 24 June 2020

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Mark Lee	DoH
Charlotte McArdle	DoH (Joint Chair)	Marie Roulston	HSCB
Maire Redmond	DoH	Oscar Donnelly	Northern Trust
Ian McMaster	DoH	Briege Quinn	PHA
Aine Morrison	DoH	Bernie Owens	Belfast Trust
Siobhan Rogan	DoH	Vivian McConvey	PCC
Sean Scullion	DoH (Note)	Stephen Matthews	Cedar
Valerie McConnell	HSCB		
Lorna Conn	HSCB		
Dawn Jones	Family representative		
Brigene McNeilly	Family representative		
Eileen McEnaney	Strengthening the Commitment collaborative		
Margaret O'Kane	South Eastern Trust		
Gillian Traub	Belfast Trust		
Brenda Creaney	Belfast Trust		
Karen O'Brien	Western Trust		
Pauline Cummings	Northern Trust		
Barney McNeaney	Southern Trust		
Margaret Kelly	Mencap		
Petra Corr	NI British Psychological Society		
Gavin Davidson	QUB		
Emer Hopkins	RQIA (observer)		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Sean Holland welcomed attendees and noted apologies received. He advised he would chair the first part of the meeting, and Charlotte McArdle would join the meeting to take over the Chair role for the second part. He noted that meetings of the Group had been paused since February due to the Covid-19 pandemic, and welcomed a number of new members to the Group. Members noted that the meeting was being held by video-conference in light of the

continuing Government guidance on social distancing, and this arrangement would be kept under review for future meetings.

Agenda Item 2 - Minutes of Previous Meeting

2. The minutes of the previous meeting held on 19 February meeting were agreed by members.

Agenda Item 3 – Update on Action Points.

3. The Chair updated members on the actions arising from previous meetings. These included sharing feedback from the Belfast Trust's engagement with the East London Foundation Trust and the possibility of a further visit from the East London Trust, work to encourage the current cohort of undergraduate Learning Disability nurses to consider working in the hospital, arrangements to brief families on the Ennis Report, resettlement performance and also highlighted a number of the workstreams overseen by MDAG which had been impacted by the challenges of dealing with Covid-19. A number of further action points were agreed.

AP1: Following on from 19/2/AP2, consider arrangements for reciprocal visit from East London Foundation Trust (BHSCT)

AP2: Following on from 19/2/AP6, commission review of effectiveness of regional resettlement process and structures (DoH)

AP3: Circulate copy of report on CCTV in Care Home settings to MDAG members (DoH)

Agenda Item 4 – Covid-19 impact and recovery proposals

4. The Chair outlined the impact on services of dealing with the Covid-19 pandemic, and updated members on recovery proposals for the Health and Social Care system, including the establishment of a Management Board to oversee this work. He advised that dealing with the pandemic had presented

unique and unprecedented challenges to health and social care services, and was likely to continue to place additional demands on mental and physical health services, and learning disability services. The requirement for increased infection prevention measures in the future will also likely impact on service capacity. The Chair noted however that mortality rates in Northern Ireland from Covid 19 for people with a learning disability had been significantly lower than those in other jurisdictions.

5. The Group was also updated by the HSCB representatives on the ongoing work to resume business as usual, including short break and respite services, with Trusts aiming to restart these services in July.

6. The Chair highlighted the importance of specialist service provision for adults with a learning disability who require acute mental health treatment, and the HSCB advised they were working to improve services for these patients.

Agenda Item 5 – Update on MAH staffing position

7. Members were given an update from Belfast Trust representatives on the current staffing position in the hospital. They were advised that 40% of the current nursing workforce are long term agency staff. An active recruitment campaign is continuing and the Trust were recently successful in recruiting 8 Band 5 registrants, as well as 5 newly registered staff. To date the Trust have placed 59 staff on precautionary suspension as a result of the ongoing investigations, 39 of whom are currently employed in the hospital. In addition, the Trust have placed 47 staff on supervision. 15 of these staff are no longer working in the hospital, and the Trust are liaising with the current employers of these staff to ensure they are aware of their supervisory arrangements. The Trust also recently appointed 2 senior nursing advisers who are due to take up their posts in July.

8. Family representatives expressed concerns that staff involved in incidents of alleged abuse may still be working with patients. Trust staff advised that a number of measures were in place to mitigate this, such as for example, contemporaneous viewing of CCTV footage, which it was noted had identified a

potential safeguarding incident recently. Members also noted the important contribution of effective multi-disciplinary team working in preventing safeguarding incidents.

9. Family representatives expressed their appreciation to the hospital team for how services were managed through the demands placed on services by the Covid-19, noting the low infection rate in the hospital and that the Trust had implemented their contingency plan to manage the Covid 19 outbreak declared in April when a number of patients and staff had tested positive for the virus. The outbreak was declared to be over on 12 May, and MDAG members expressed their appreciation to the hospital team for their work to successfully contain the outbreak.

Agenda Item 6 – Update on engagement with families

10. The Belfast Trust advised that work in partnership with the Patient Client Council to carry out an evaluation and critical analysis of engagement arrangements with MAH patients had been delayed due to the Covid-19 arrangements. The Chair noted this and asked that an update be brought to the next meeting of MDAG.

AP4: Findings of evaluation of engagement arrangements to be brought to September MDAG meeting (BHSCT)

Agenda Item 7 – Muckamore Abbey Hospital Regional Contingency Planning

11. The Chair reminded members that the Department had written to the Health and Social Care Board in January to commission the development of a regional contingency for the current in-patient population, and invited HSCB representatives to provide an update.

12. Valerie McConnell advised that contingency plans had been developed in response to Covid-19 and that these would be helpful in informing a regional contingency plan for the hospital. She agreed to bring forward proposals at the next MDAG meeting.

AP5: Regional contingency proposals for the hospital population to be brought to September MDAG meeting (HSCB)

Agenda Item 8 – Highlight report and dashboard

13. The Chair referred members to paper MDAG/07/20. Sean Scullion provided a summary of key points from the highlight report, including updates on the Adult Safeguarding and PSNI investigations, progress with resettlement, the hospital's Covid 19 contingency plan, the Learning Disability Service Model Transformation project, the Acute Services Review and the Leadership and Governance review. A number of workstreams have been delayed due to the Covid 19 pandemic and members were given updates on the revised timescales for these.

Agenda Item 9 – HSC Action Plan update

14. The Chair referred members to paper MDAG/08/20, and Maire Redmond updated the Group on the status of individual actions, with 11 rated red, 24 amber and 8 green. The Chair noted that the timescales for a number of targets had slipped, and emphasised that the programme of work set out in the Action Plan remained a priority. Members agreed that an analysis of the current position, including revised timescales, be brought to the next MDAG meeting for consideration.

AP6: An analysis of the current action plan, including revised timescales, to be brought to September MDAG meeting (DoH)

Agenda Item 10 – Position Updates

15. The Chair invited updates on a number of workstreams. Valerie McConnell updated members on the current position with the Learning Disability Service Model project, and also advised that the Regional Learning Disability Operational Delivery Group would reconvene shortly. Brigene McNeilly queried the level of carer/family involvement in the development of the model, and

Valerie agreed to circulate details of family and carer involvement in the project to date.

AP7: Details of carer and family involvement in the development of the Learning Disability Service Model to be circulated to MDAG members (HSCB)

16. Margaret Kelly queried whether the proposed model would be subject to public consultation once developed. The Chair advised that consideration would be given to the level of public consultation required.

17. Valerie also advised that work on the implementation of the Acute Care Review findings which had been paused as a result of Covid-19 was shortly to recommence.

18. Maire Redmond updated members on the Leadership and Governance review, and advised that the panel now expected to deliver their report by the end of July. Dawn Jones asked about the next steps when the review is complete, and the Chair advised the Minister was keen to hear the review's findings with a view to identifying any learning and required improvements to services.

Agenda Item 11 – RQIA Improvement Plan for Muckamore update

19. Emer Hopkins provided an update on the methodology employed by RQIA in developing an improvement plan for the hospital following the unannounced inspections last year, and how RQIA monitored the plan to ensure the required improvements were introduced. The Group welcomed the progress made by the hospital team in addressing the areas for improvement RQIA had identified through their inspections, and noted that the improvement notices had now been lifted.

20. The family representatives noted and welcomed the reduction in the use of seclusion as a behavioural management tool, and considered the aim should be to work towards no seclusion. The Chair agreed that use of seclusion should be minimised with a view to ending its use.

21. The family representatives also asked about plans to resume normal visiting arrangements for patients, and the Chair advised that Departmental guidance on visiting was currently under review, with the aim of updating this by the end of June.

Agenda Item 12 – Any other business

22. The Chair recorded the Group's appreciation of the contribution made to the work of MDAG on behalf of carers by Brenda Aaroy who has left her post in Belfast Trust, and members also agreed that a new carers' representative be invited to join the Group.

Agenda Item 13 – Date of next meeting

23. A proposed date of 26 August was suggested for the next meeting, though this was subsequently amended to Wednesday 2 September.

Summary of Action Points

Ref.	Action	Respon-sible	Update	Open/ closed
24/6/AP1	Following on from 19/2/AP2, consider arrangements for reciprocal visit from East London Foundation Trust	BHSCT		Open
24/6/AP2	Following on from 19/2/AP6, commission review of effectiveness of regional resettlement process and structures	DoH		Open
24/6/AP3	Circulate copy of report on CCTV in Care Home settings to MDAG members	DoH		Open
24/6/AP4	Findings of evaluation of engagement arrangements to be brought to September MDAG meeting	BHSCT		Open
24/6/AP5	Regional contingency proposals for the hospital population to be brought to September MDAG meeting	HSCB		Open
24/6/AP6	An analysis of the current action plan, including revised timescales, to be brought to September MDAG meeting	DoH		Open
24/6/AP7	Details of carer and family involvement in the development of the Learning Disability Service Model to be circulated to MDAG members	HSCB		Open

MDAG/09/20

ANNEX A

Update on Action Points from 19 February

Ref.	Action	Respon-sible	Update	Open/ closed
19/2/AP1	Explore scope to improve and expand current communication arrangements with patients' families/carers, including social media channels.	BHSCT	The interim senior management team in MAH have already explored and expanded communication arrangements with patients' families/carers. These measures include: Full SMT attendance at BHCST Carer's Forum. Discussion at Carer's Forum about how best to expand contribution/attendance of families at the meeting. All families/carers written to and offered 1:1 meeting with SMT. Unfortunately no responses were received. Full SMT participation in	Open

			recent event at the Antrim Civic Centre Full engagement with the Patient Client Council (PCC), and all our Advocacy Organisations. The PCC have employed a new advocate, Ms Sharon Magorian, for a period of 4-6 months for Muckamore Abbey Hospital. The Trust will be writing out to families of our patients to introduce Sharon and to encourage families to meet with her. She will provide the SMT with feedback. PCC has indicated that they will be offering home visits to families, as part of their engagement work and they will evaluate if there are any other ways that we should be using to communicate with families. MDAG Highlights and other relevant information shared with families/carers via mailshot. SMT attended a meeting of the	

			Society of Parents and Friends of Muckamore SMT have also met with Billy Moore and Brigene McNeilly and will continue to do so regularly. Production of bi-monthly Muckamore Abbey Hospital Newsletter. Distribution of Muckamore Parents & Friends meeting invitations by post to families The March newsletter will be issued to families and staff week beginning March 16th The team will discuss the potential use of social media at the next BHSCT Carer's Forum.	
19/2/AP2	East London Foundation Trust to be invited to meet with MDAG.	BHSCT	See 24/6/AP1	Closed
19/2/AP3	Engage with current cohort of undergraduate LD nurses to promote the hospital as an employer.	DoH	Work is progressing by nursing group to take this forward	Open
19/2/AP4	Carry out an evaluation and critical analysis of current engagement arrangements with MAH patients, and present	BHSCT	See 24/6/AP4	Closed

	findings to April MDAG meeting.			
19/2/AP5	Updates on status of individual Action Plan targets to be commissioned.	DoH	See 24/6/AP6	Closed
19/2/AP6	Review effectiveness of regional resettlement process and structures and make recommendations for improvement.	DoH/ HSCB	See 24/6/AP2	Closed
19/2/AP7	Update to be provided on implementation of RQIA Improvement Plan for Muckamore.	RQIA	Provided at June MDAG	Closed
19/2/AP8	Issue reminder to MDAG on an RQIA Symposium - The Effectiveness of the Use of CCTV in Care Home Settings on 28th February in QUB	DoH	Issued 21 February	Closed

Update on Action Points from 18 December

Ref.	**Action**	**Respon-sible**	**Update**	**Open/ closed**
18/12/AP1	Consider options to provide access for relatives to hospital facilities on Christmas Day.	BHSCT	BHSCT advised relevant facilities were open and offer extended to families	Closed

18/12/AP2	Terms of Reference for Leadership and Governance review and pen pictures of review team to be circulated to MDAG	DoH	Circulated 14 February.	Closed
18/12/AP3	Consider options for positive media piece to communicate RQIA follow-up inspection findings/	DoH	Media reports ran on 20 December.	Closed
18/12/AP4	Develop proposals to disseminate regionally good practice learning emerging from Belfast Trust's partnership with East London Foundation Trust.	BHSCT/ HSCB /PCC	Further ELFT visit being arranged for April – to include invite to meet with MDAG.	Closed (see 24/6/AP1)

Update on Action Points from 27 November

Ref.	Action	Respon-sible	Update	Open/closed
27/11/AP1	Circulate communication to families/carers of in-patients advising that Belfast Trust would welcome any additional family support during the forthcoming holiday period	BHSCT	E-mail circulated to relatives by BHSCT on 27 Nov.	Closed
27/11/AP2	Action points from each MDAG meeting to be circulated to members within 24 hours.	DoH	Draft action points circulated 28 Nov.	Ongoing
27/11/AP3	Requests for information raised at MDAG meetings to be responded to in line	DoH	Will be actioned as required	Ongoing

	with relevant information management legislation.			
27/11/AP4	Briefing for relatives on Ennis Report to be arranged.	DoH	BHSCT contacting families involved – to be completed by end February	Open
27/11/AP5	Invite Vivian McConvey to join MDAG.	DoH	Invitation letter from joint MDAG Chairs issued 10 Dec.	Closed
27/11/AP6	Belfast Trust to approach PCC to seek support in organising one stop shop event.	BHSCT	BHSCT in discussions with PCC to arrange event.	Closed
27/11/AP7	Trust Directors of Social Work to be advised of issues raised by families around resettlement and reminded of the principles underpinning resettlement.	DoH	Letter from SH issued to Trust Ch Exes on 24 January and also shared with families.	Closed
27/11/AP8	Belfast Trust presentation to RQIA to be circulated to MDAG	BHSCT	Presentation circulated to members on 17 Dec.	Closed
27/11/AP9	Reporting on use of restrictive practices at the hospital to be included in MDAG highlight report and meeting agendas.	DoH	Report provided under agenda item 6 at 19 Feb meeting	Ongoing
27/11/AP10	Proposals to address barriers to resettlement to be tabled for consideration by MDAG.	BHSCT / HSCB	Presentation made to MDAG meeting on 19 Feb –agenda item 12	Closed
27/11/AP11	Information on numbers of re-admissions to MAH due to community placement breakdown (including those occurring	HSCB	Will be tabled at MDAG meeting in New Year.	Open

	at weekends) to be provided to MDAG			
27/11/AP12	Leadership and Governance review Terms of Reference to be agreed and finalised.	HSCB/ PHA	ToR circulated to MDAG members on 14 Feb and signed off at meeting on 19 February.	Closed
27/11/AP13	Declaration of Interests form to be circulated to MDAG members.	DoH	Circulated to members on 13 Dec.	Closed

MDAG/12/20

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 2 September 2020

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Brenda Creaney	Belfast Trust
Charlotte McArdle	DoH (Joint Chair)	Gillian Traub	Belfast Trust
Maire Redmond	DoH	Bernie Owens	Belfast Trust
Mark Lee	DoH	NI British Psychological Society representative	
Ian McMaster	DoH		
Aine Morrison	DoH		
Siobhan Rogan	DoH		
Sean Scullion	DoH (Note)		
Marie Roulston	HSCB		
Briege Quinn	PHA		
Rodney Morton	PHA		
Dawn Jones	Family representative		
Brigene McNeilly	Family representative		
Aidan McCarry	Family representative		
Margaret O'Kane	South Eastern Trust		
Tracy Kennedy	Belfast Trust		
Patricia McKinney	Belfast Trust		
Karen O'Brien	Western Trust		
Petra Corr	Northern Trust		
Barney McNeaney	Southern Trust		
Stephen Matthews	Cedar		
Vivian McConvey	PCC		
Gavin Davidson	QUB		
Tony Stevens	RQIA (observer)		
Lynn Long	RQIA (observer)		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Sean Holland welcomed attendees and noted apologies received. He advised members that the meeting was again being held by video-conference in light of

the continuing Government guidance on social distancing, and this arrangement would be kept under review for future meetings.

2. He advised members that Margaret Kelly had left the Group to take up a new post, and extended his appreciation to her for her contribution to the work of MDAG. A replacement for her on MDAG would be identified as soon as possible.

3. He also advised the Group that David Bingham, the Chair of the independent panel who carried out the Leadership and Governance review into the hospital would join the meeting to brief members on the Review's findings.

Agenda Item 2 - Minutes of Previous Meeting

4. The minutes of the previous meeting held on 24 June were agreed by members, subject to amendment of the wording on two specific points highlighted by members.

5. Sean Holland noted that the summary of the key points from the 24 June meeting which had been circulated to members following the meeting had subsequently been reported on in the media. As there is a risk that some of the information contained in MDAG minutes may have the potential to enable the identification of individual hospital in-patients with attendant implications for their confidentiality, he proposed that in future full MDAG minutes should be produced immediately following meetings and published on the Department's website once agreed by MDAG members. The Group indicated their agreement to this.

Agenda Item 3 – Update on Action Points.

6. Sean Holland provided an update on the open action points arising from previous meetings. He advised that the Belfast Trust will provide an update on their engagement with the East London Foundation Trust at the next scheduled MDAG meeting. He noted that the Department had arranged a meeting with the HSCB to agree the way forward for the resettlement programme, and advised

that members would be provided with an update on this at the next MDAG meeting.

7. He noted the report on the evidence for the effectiveness of CCTV in care homes had been circulated to members and updated members on the Belfast Trust's contact with the relatives of patients involved in the Ennis report. He asked that the Belfast Trust update the group of the listening event planned for families following publication of the Leadership and Governance Review be brought to the next MDAG meeting. He further asked that an update as to progress of the Regional Contingency Plan also be brought to the next meeting.

Agenda Item 5 - Implementation of Leadership and Governance Review recommendations

8. Seán Holland provided a summary of the recommendations from the Review report and members agreed that these are monitored through MDAG by adding to the current HSC action plan.

Agenda Item 6 – Update on MAH staffing position

9. The Chair asked for an update on this agenda item pending David Bingham joining the meeting. Patricia McKinney advised that as of 31st August 2020 there are 30.82 whole time equivalent registered Learning Disability nurses (Band 5-7 inclusive) and 100.08 whole time equivalent Nursing assistant (Band 3) substantive staff in MAH (inclusive of Maternity leave and Sick leave).

10. The Trust have secured a 12 month commitment from the agency who provides the largest number of registrants on site for 50 whole time equivalent registrants, and have worked with the Belfast Trust nurse bank to secure this commitment which will help to maintain and sustain services over the Winter and into next year.

11. Recruitment is continuing with eight band 5 registrant posts offered in recent recruitment exercises. Four staff have started and a further one will start in early September.

12. Patricia also updated members on arrangements instigated by the Nursing and Midwifery Council (NMC) to support the pandemic response which allowed nursing students to opt in to join the workforce in a paid capacity for their final 6 months, whilst still retaining their student status. The Department of Health issued guidance to employers that students who opted in to the paid arrangements should be remunerated at Band 4 (AfC). They were also supported in their learning during this time. The feedback from the students was very positive. It was also clear from feedback from the teams that these students were very valued by them. There were 7 transition students in MAH. Four of the students were subsequently offered posts in the hospital and are included in the numbers above.

Agenda Item 4 – Leadership and Governance Review briefing

13. David Bingham joined the meeting to provide members with a briefing on the report of the Leadership and Governance review. He summarised the methodology the panel used in their review and also the key findings, which were that vulnerable patients and their families were failed by the hospital which operated as a place apart out of the line of sight of the Trust, the Muckamore hospital management team was dysfunctional, the Ennis report was a missed opportunity to identify institutional abuse, Trust governance arrangements were ineffective and advocacy arrangements lacked independence.

14. Sean Holland welcomed the briefing and invited members to raise any questions.

15. Family representatives indicated they had found reading the report to be very distressing and expressed concern that senior Trust staff were not being held to account for the failings identified. They considered that the findings were further evidence that people with learning disabilities were not regarded as a priority by health and social care services. One of the family representatives asked Group members for their views on the report's findings.

16. Sean Holland advised he was ashamed to be associated with what had happened at the hospital, and stressed the need for real changes to address these issues. He noted in particular the findings in relation to shortcomings in adult safeguarding arrangements and also referenced similar findings emerging from reports on Dunmurry Manor.

17. Charlotte McArdle acknowledged the report made difficult reading, and felt the same feelings of shame, devastation and anger described by Sean Holland. Charlotte commented that with hindsight of course things could have been different and committed to learning the lessons and making necessary changes. Charlotte said as a mother and sister it was by luck that she was not standing in the relatives' shoes of people in Muckamore Abbey Hospital. She also stressed the importance of addressing perceptions that people with learning disabilities were viewed as a lower priority for HSC services.

18. Another family representative expressed frustration with difficulties in making contact with senior Trust staff which contributed to a breakdown in trust between families and hospital staff. Concerns were also expressed that incidents were continuing to occur at the hospital, and that families were not being involved in planning for the future direction of the hospital.

19. Sean Holland noted the concerns raised, and indicated he would be willing to discuss these further with family representatives in a separate meeting.

AP1: Meeting to be arranged between Sean Holland, HSCB and MDAG family representatives (Action: DoH).

20. Marie Roulston on behalf of the Health and Social Care Board expressed empathy with families on the content of the report, and advised she had shared with Trust Directors of Social Work to ensure the lessons it contained on working with vulnerable adults were disseminated across all services. She reiterated the commitment of the HSCB to work with the Department and Trusts to ensure all necessary changes were implemented.

21. Rodney Morton acknowledged the report was painful for families and that it indicated nurses had let patients down, and extended an apology for that. He

stressed the importance of independence in delivering effective advocacy, and asked whether the panel had identified any measures which might strengthen this.

22. David Bingham advised that the panel had found that advocacy arrangements in place at the hospital had been directed primarily towards facilitating resettlement, and suggested contracts between the Trust and advocacy organisations be reviewed to ensure conflicts of interest are avoided.

23. Family representatives indicated they had raised this issue repeatedly with the Trust and the HSCB without success, and suggested that each patient should have an independent advocate.

24. Tracy Kennedy advised that the report's content had been shared with all staff on site through a number of briefing sessions, and that all staff had been directed to the full report published on the Department's website. A summary had also been circulated to staff who were not at work. She expressed an apology for past failings at the hospital, and advised that the Trust were working to ensure there would be no recurrence of these across the Trust's Learning Disability services.

25. Sean Holland advised members that the Minister was considering the review's findings, and had signalled his intention to meet again with patient's families. Arrangements for this were being made.

26. The family representatives asked whether a decision had been made on a public inquiry, and Sean Holland advised that the Minister wished to consult further with families on the appropriate form of inquiry.

27. The family representatives asked about arrangements for family and carer involvement in planning decisions and advised that many families and carers had become disillusioned with arrangements to engage with them, pointing to limited family involvement on the Trust Carer's Forum as evidence of this.

28. Vivian McConvey acknowledged the difficulties, and suggested that a one-to-one approach tailored to individual's wishes might help to deliver improved

levels of engagement. She advised she would dedicate a member of the Patient Client Council staff to this work with the aim of working with families to develop a plan for effective advocacy arrangements at the hospital. The family representatives indicated they would be willing to support this approach, and Vivian advised she would implement this through contact with the MDAG family representatives initially.

AP2: Contact MDAG family representatives to agree implementation of plan to improve advocacy arrangements at the hospital (PCC)

29. Tracy Kennedy advised the hospital team on site were willing to engage with families and carers in whichever forum was preferred by families and carers.

30. Marie Roulston stressed the importance of effective engagement arrangements being in place across all Learning Disability services, including services for children with disabilities, and Siobhan Rogan made the point that any such arrangements must also make provision to facilitate input from patients.

31. David Bingham advised that the panel had queried whether the current ownership of Muckamore Abbey Hospital by the Belfast Trust was the optimal arrangement, and also whether the predominantly medical model of services in place at the hospital was the appropriate one in the future.

32. Sean Holland thanked David Bingham for his briefing and for the work carried out by the independent panel. He indicated that the remaining items on the meeting agenda would be carried forward for consideration at the next MDAG meeting, which will be held on 28th October.

Summary of Action Points

Ref.	Action	Respon-sible	Update	Open/ closed
2/09/AP1	Meeting to be arranged between Sean Holland,	DoH		

	HSCB and MDAG family representatives			
2/09/AP2	Contact MDAG family representatives to agree implementation of plan to improve advocacy arrangements at the hospital	PCC		

MDAG/15/20

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 28 October 2020

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Charlotte McArdle	DoH (Joint Chair)
Mark Lee	DoH	Aine Morrison	DoH
Maire Redmond	DoH	Barney McNeaney	Southern Trust
Ian McMaster	DoH	Dawn Jones	Family rep
Siobhan Rogan	DoH	Stephen Matthews	Cedar
Sean Scullion	DoH (Note)	Rodney Morton	PHA
Marie Roulston	HSCB	Brenda Creaney	Belfast Trust
David Petticrew	HSCB		
Briege Quinn	PHA		
Gillian Traub	Belfast Trust		
Brigene McNeilly	Family rep		
Aidan McCarry	Family rep		
Margaret O’Kane	South Eastern Trust		
Karen O’Brien	Western Trust		
Petra Corr	Northern Trust		
Mandy Irvine	NI British Psychological Society		
John McEntee	Southern Trust		
Vivian McConvey	PCC		
Gavin Davidson	QUB		
Lynn Long	RQIA (observer)		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Sean Holland welcomed attendees and noted the apologies received, including one on behalf of the Joint Chair. He welcomed Mandy Irvine to her first meeting of the MDAG as a representative of the NI British Psychological Society.

Agenda Item 2 - Minutes of Previous Meeting

2. The minutes of the previous meeting held on 2 September were agreed by members. Members also agreed they were content for nil responses to

circulation of the draft minutes to be interpreted as consent to publication of the minutes on the Departmental website.

Agenda Item 3 – Update on Action Points.

3. Sean Holland provided an update on the open action points arising from the June and September meetings of the Group. In relation to 02/09/AP1, he advised that he and Maire Roulston had met with the MDAG family representatives on 11th September, and discussed a number of issues, including safeguarding arrangements and communication with families. For 02/09/AP2, Vivian McConvey advised that she had also met with family representatives on the PCC's behalf on a number of occasions, and Belfast Trust representatives had also attended some of these meetings. A common theme emerging from these meetings was the complexity of ongoing work aimed at engaging with and involving families. Gillian Traub advised the Belfast Trust had agreed to develop a communications plan.

4. The Chair noted the importance of ensuring robust arrangements are in place to identify and address any emerging adult safeguarding issues. He also asked that all current ongoing engagement work be mapped and that an easy reference summary guide to this be produced.

AP1: Produce an easy reference guide summarising all strands of ongoing engagement work impacting on Muckamore Abbey Hospital (Action: PCC/Belfast Trust)

5. Referring to 24/06/AP1, the Chair noted that the Belfast Trust will deliver a presentation at the next MDAG meeting on their engagement work with the East London Foundation Trust.

6. In relation to 24/06/AP2, Mark Lee provided an update on work being taken forward by the Department and HSCB to review the effectiveness of current arrangements for resettlement of patients, including proposals to refresh the transitions group and the potential recruitment of an independent Chair. As part of this work, he also highlighted the recent letter from Sean Holland to the

Belfast Trust commissioning proposals for a model of residential care provision on the Muckamore Abbey Hospital site.

7. Sean Holland advised that proposals arising from this work would be brought to MDAG for consideration. He confirmed that the proposed residential care provision on the hospital site would cater for a range of dependency levels, and would offer an alternative option to those patients who have expressed a wish to continue to live on the current site. He indicated any proposed model would be subject to consideration by MDAG and also a wider consultation process, and would align with the wider strategy direction being developed through the Learning Disability Service model work. He also advised this was being developed to address concerns raised by families that a number of specific patients had expressed a wish to remain living on the hospital site.

8. Lynn Long advised RQIA had held some preliminary discussions with the Trust in regard to the regulatory status of the proposed new facility. Sean Holland clarified that his priority was identifying how to deliver the appropriate support for individuals to live independently. He emphasised that the Department was prepared to make any necessary decisions on commissioning or regulation arrangements to deliver an effective outcome.

9. Sean Holland advised members that updates on the remaining open action points (24/06/AP3, 24/06/AP4 and 24/06/AP5) would be covered under agenda items 6 and 10.

Agenda Item 4 – Public Inquiry update

10. Sean Holland reminded members that Minister had made a statement on a Public Inquiry on 8th September, and invited Mark Lee to update the Group on this.

11. Mark Lee advised members that work was underway in the Department to establish the sponsor function for the Inquiry which will be responsible for making the necessary support arrangements, including the recruitment of additional staff, preparing business cases, identifying premises and IT

requirements etc. To maintain impartiality, this function has been located in the Department's Corporate Management Directorate.

12. Arrangements for a process of engagement with families on the Terms of Reference for the Inquiry and the appointment of a Chair were also being taken forward in partnership with the PCC and with assistance from the Belfast Trust.

13. In response to a query from a family representative, it was clarified the involvement of the Trust in this process related solely to identifying contact details for patients who had been admitted to the hospital during the potential time period to be examined by the Inquiry.

14. Vivian McConvey outlined for members plans for the proposed engagement process and the avenues for providing input to this. She advised that the PCC will dedicate a staff member to this work.

15. The Chair advised that there would also be a public call through advertisements in the media for input to the Inquiry, and that the Inquiry would be a standing agenda item at future MDAG meetings.

AP2: **Update on the Public Inquiry to be a standing agenda item for MDAG meetings (Action: DoH)**

Agenda Item 5 – Update on MAH staffing position and impact of Covid

16. Gillian Traub provided an update on the current nursing staffing position at the hospital, advising that safe staffing levels were currently being maintained. The block booking contract for 50 WTE nursing staff remains in place and is working well. 13 Band 3 staff were recently recruited, and a rolling recruitment programme is ongoing. The 15% pay enhancement is due to end on 31 October, and work to manage expectations around this has been ongoing. This is not expected to have a negative impact on either the morale of existing staff or the continuing recruitment programme.

Agenda Item 6 – Engagement with families

17. Gillian Traub updated members on progress with this work, and advised that following feedback from families the focus of this had moved to an ongoing process of engagement rather than a one-off event. She advised members that planning was underway to hold a series of independently facilitated virtual engagement sessions to be held in November. The Chair asked that an update on these be provided at the next meeting of MDAG.

AP3: Update on engagement sessions to be provided at next MDAG meeting (Action: BHSCT)

Agenda item 7 – Future of Muckamore Abbey Hospital

18. Sean Holland advised members that this agenda item had been included at the request of one of the family representatives.

19. Aidan McCarry clarified that this had been prompted by his concerns about the future arrangements for the care of his brother, currently an in-patient at the hospital. He considered that if any patients were to continuing living on site, then it would be important that facilities were modernised appropriately to meet their needs. He confirmed he would be happy for his brother to stay if the appropriate level of support and accommodation was provided on-site.

20. Sean Holland referred to the earlier discussion on work to commission a new model of care involving the development of bespoke accommodation on the site, and stressed that any model of care provision must meet all relevant current standards and good practice guidance.

21. Gillian Traub noted that the work to agree a model of service for LD for NI is an urgent issue, which is inclusive of but not limited to, the form and function of Muckamore Abbey Hospital. There are various discussions – the role of PICU, the proposal for a supported living facility on site, the discussion around assessment and treatment pathways, the number of inpatient beds required – that need to be pulled together and a clarity reached. This is important for those

staff in Muckamore Abbey Hospital to understand what their future may hold, but also for all Trusts to understand what workforce model they should be recruiting into for the future.

22. Members agreed that any proposed new model of care on the hospital site should be in the context of the ongoing work to develop a new regional model for learning disability services, and also that families must be fully involved in decision making on this.

Agenda Item 8 – Highlight report and Dashboard

23. Mark Lee referred members to paper MDAG/13/20, and provided a summary of the key points from the highlight report. He noted that one patient was currently in active treatment, and the other 46 patients were delayed discharges. There are currently no positive Covid-19 patients in the hospital.

24. Lynn Long advised members that RQIA were currently undertaking a 2-day unannounced inspection at the hospital, which had begun on 27th October. She expected that feedback from the findings of this would be made available to the Trust, the Department and families early next week.

25. David Petticrew queried the highlighted delivery date for the Learning Disability Service Model, and Mark Lee confirmed this was the expected date for sign-off of a draft of the Model.

26. Brigene McNeilly raised concerns about the level of family involvement in the work to develop the new Service Model. The Group discussed the methodology that had been used in the development of the Model. Sean Holland advised that the draft model should be accompanied by a report detailing the family and carer involvement used in its development. He also advised that the draft model would be subject to a public consultation process, and asked that a further meeting be arranged involving the PCC and family representatives to allow them to provide feedback on the draft model.

AP4: Meeting with family representatives to be arranged to provide feedback on draft Service Model. (Action: HSCB/PCC)

Agenda Item 9 – HSC Action Plan analysis

27. Maire Redmond referred members to paper MDAG/14/20, which included a progress update on the Action Plan. She drew member's attention in particular to Appendix A which set out proposed revised timescales for those targets whose timescale had slipped, for consideration and approval by MDAG.

28. Sean Holland indicated it would be helpful for MDAG to be asked to consider measures to address those targets where timescales were expected to slip in advance of the expiry of the target date. He also advised it would be helpful to have a simpler mechanism for reporting on progress towards implementation of the Action Plan, which would enable MDAG to more effectively discharge its oversight function. He reminded members of MDAG's responsibility to challenge the system and hold it to account for any failure of delivery.

29. Members acknowledged the complexity and inter-dependencies in the various workstreams currently underway in relation to Learning Disability services, which are reflected in the Action Plan, and the difficulties this presents in monitoring overall progress.

Agenda Item 10 – Regional Contingency Plan

30. Marie Roulston updated members on work to develop a regional contingency plan for the hospital, and advised that a task and finish group chaired by the HSCB had been established to take this forward. A separate group, also chaired by the HSCB, is progressing the recommendations from the acute care review.

31. She suggested it would be helpful to discuss the inter-dependencies involved at the next Mental Health and Learning Disability Improvement Board meeting scheduled for 19 November, and consider how these could best be presented

in the HSC Action Plan. Members agreed with this approach, and asked that an update be provided at the next MDAG meeting.

AP5: HSC Action Plan to be considered at November MHLD Improvement Board, and proposals brought to next MDAG meeting. (Action: HSCB/HSC Trusts)

Agenda Item 11 – Position Updates

32. These updates were covered in discussions on previous agenda items.

Agenda Item 12 – AOB

33. There were no items of other business.

Agenda Item 13 – Date of next meeting

34. It was proposed that the next meeting be scheduled for Wednesday 16th December at 2pm. Members indicated their agreement to this.

<u>Summary of Action Points</u>

Ref.	Action	Respon-sible	Update	Open/ closed
28/10/AP1	Produce an easy reference guide summarising all strands of ongoing engagement work impacting on Muckamore Abbey Hospital	PCC/ BHSCT		
28/10/AP2	Update on the Public Inquiry to be added as a standing agenda item for MDAG meetings	DoH		

28/10/AP3	Update on engagement sessions to be provided at next MDAG meeting.	BHSCT		
28/10/AP4	Meeting with family representatives to be arranged to provide feedback on draft Service Model.	HSCB/ PCC		
28/10/AP5	HSC Action Plan to be considered at November MHLD Improvement Board, and proposals brought to next MDAG meeting.	HSCB/ HSC Trusts		

MDAG/18/20

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 16 December 2020

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Charlotte McArdle	DoH (Joint Chair)
Mark Lee	DoH	Margaret O'Kane	South Eastern Trust
Maire Redmond	DoH	Barney McNeaney	Southern Trust
Ian McMaster	DoH	Emer Hopkins	RQIA
Siobhan Rogan	DoH		
Aine Morrison	DoH		
Sean Scullion	DoH (Note)		
Marie Roulston	HSCB		
Rodney Morton	PHA		
Briege Quinn	PHA		
Gillian Traub	Belfast Trust		
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Aidan McCarry	Family rep		
Teresa McKee	South Eastern Trust		
Karen O'Brien	Western Trust		
Petra Corr	Northern Trust		
Mandy Irvine	NI British Psychological Society		
Stephen Matthews	Cedar		
Vivian McConvey	PCC		
Gavin Davidson	QUB		
Lynn Long	RQIA (observer)		
La'Verne Montgomery (in attendance for agenda item 4)	DoH		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Sean Holland welcomed attendees, and noted the apologies received from Charlotte McArdle, Emer Hopkins, Margaret O'Kane and Barney McNeany.

Agenda Item 2 - Minutes of Previous Meeting

2. The Chair noted that the minutes of the previous meeting held on 28 October had been published on the Department's website. There were no further comments on the minutes.

Agenda Item 3 – Update on Action Points.

3. Sean Holland provided an update on the open action points arising from previous meetings of the Group. In relation to 28/10/AP1 and the production of an easy reference summary of all ongoing engagement work, he advised members that the Muckamore Abbey Hospital November newsletter included a guide to who's who at the hospital, information on how to raise a concern and how to provide feedback to the hospital team. The next edition of the MAH newsletter will include an overview of all current engagement work.

4. In relation to 28/10/AP2, he advised members that an update on the Public Inquiry had been added as a standing agenda item to the MDAG agenda.

5. For 28/10/AP3, the Chair advised members that virtual engagement sessions had been scheduled for the New Year, with independent facilitation. In addition the Belfast Trust intend to ask families/carers to complete a questionnaire in January 2021 designed to improve the Trust's understanding of families' experience of involvement.

6. The Muckamore Carer's Forum was relaunched on 9 December 2020 and was independently facilitated. Brigene McNeilly provided an update for the Group on this inaugural meeting, which considered issues relating to communication with relatives and also the hospital visiting arrangements over the Christmas holiday period. She advised that the next meeting of the Forum was scheduled for 12 January.

7. Sean Holland advised members that the Belfast Trust was also in the process of recruiting a Personal and Public Involvement Officer for Trust Learning Disability Services, with interviews for this post planned for January. He noted

that a family representative would be included on the interview panel for the post. Brigene McNeilly confirmed she was participating in the panel.

8. Dawn Jones advised that she hadn't attended the first meeting of the Forum due to the narrow range of people involved and queried the point of the Forum. She expressed frustration at a failure to take forward actions that had been previously agreed.

9. Gillian Traub clarified that the Forum aimed to offer families an opportunity to get involved and influence developments on the hospital site. She acknowledged there were challenges around widening the levels of family involvement.

10. Marie Roulston agreed that communicating effectively was fundamental to driving up levels of involvement, and advised that she had met with the Belfast Trust and the Patient Client Council to explore options for improving this. Brigene McNeilly advised that one of the Trust non-Executive Board members had agreed to be involved in the work of the Forum.

11. The Chair noted the frustration expressed by Dawn, and she asked that this be recorded in the meeting minutes.

12. The Chair provided an update on 28/10/AP4 on engagement on the Learning Disability Service Model, noting that a meeting with family representatives was held on 26 November.

13. Marie Roulston advised the Group that the family representatives had welcomed the opportunity to meet, and that the draft model had been circulated to MDAG members in advance of today's meeting, with a view to delivery of a presentation on the Model. Unfortunately pressures on Group members' time due to pandemic related priorities precluded to this being provided at today's meeting, but it was agreed that the presentation would be delivered at the next scheduled MDAG meeting.

AP1: Presentation on the draft Learning Disability Service Model to be delivered at next meeting of MDAG (Action: HSCB/PHA)

14. Family representatives noted that the draft model which runs to 143 pages had been provided to members on the morning of the MDAG meeting, which was insufficient time to consider it adequately, and queried whether hard copies of meeting papers could be provided to members in advance of meetings. They also reiterated previously expressed concerns about the extent of family and carer involvement in the development of the model.

15. Sean Holland noted the views expressed by family representatives, and agreed that papers for future meetings would be issued seven days in advance of scheduled meetings, with hard copies provided to members as required.

AP2: Issue papers (by hard copy as required) to MDAG members no later than seven days in advance of scheduled meetings. (Action: DoH)

16. In relation to 28/10/AP5, the Chair invited Marie Roulston to update members on work to review the MAH HSC Action Plan.

17. Marie Roulston advised the Group that following the Director's meeting in November, an overview report documenting all the current workstreams was being prepared and this would be tabled at the next MDAG meeting. It was intended to draw on this to consider options to streamline the current Action Plan. Sean Holland reminded members it was important that MDAG was able to track progress on the actions set out in the Action Plan.

18. Further to 24/06/AP1, the Chair noted that the Belfast Trust will deliver a presentation at the next MDAG meeting on their engagement work with the East London Foundation Trust.

Agenda Item 4 – Update on Public Inquiry

19. Sean Holland introduced La'Verne Montgomery, the Director of Corporate Management in DoH, who has been asked to sponsor the Public Inquiry to ensure independence.

20. La'Verne thanked members for the invitation to the meeting, and advised that she had had no previous involvement with any issues relating to Muckamore Abbey Hospital. She explained that she had been asked to lead on the sponsorship of the Inquiry, and would be supported in this by Fiona Marshall who was responsible for establishing the Inquiry, including appropriate governance and financial arrangements, and also by Lynne Curran who was the secretary designate for the Inquiry, responsible for supporting the Inquiry Chair in running the Inquiry.

21. She advised she had been working with the Minister to facilitate his engagement with relatives and patients to inform his decision on a Chair for the Inquiry and also the Inquiry Terms of Reference. As part of this, a number of events involving families, facilitated by the Patient Client Council (PCC) and hosted by the Minister, were held last week. She advised that a clear message emerging from families at was that the Inquiry needed to address issues of abuse as current and not to be seen as historical.

22. La'Verne advised that she was working with the PCC to address, through the appropriate channels, any issues of immediate concern raised at the events, and also to prepare a report summarising the views expressed by families and patients, which would be shared with engagement participants for accuracy checking. Engagement with patients and former patients would be progressed in the New Year, with arrangements for this to be finalised.

23. The Minister will draw on the views expressed to inform his decision on an Inquiry Chair, and he will then consult with the Chair to finalise and agree the Terms of Reference for the Inquiry.

24. La'Verne advised members that she was working on an indicative timescale of having the Inquiry established by the summer, and that work was proceeding to meet this timescale.

25. She also advised that she had met with Trust Assistant Directors of Learning Disability, who hold the contact details for families and patients, who had issued letters about the engagement events to families on the Minister's behalf.

26. Brigene McNeilly passed on her thanks to all involved in arranging the engagement event she had attended. Dawn Jones noted that some of the letters from the Minister on the events were not individually addressed, and expressed disappointment at the lack of personal communication.

27. La'Verne indicated she was conscious of this, and had discussed with Assistant Directors how this might be addressed for future communication in this regard.

28. The Chair noted the Inquiry process is likely to be a lengthy one, and thanked La'Verne for her update.

Agenda Item 5 – HSC Action Plan – Exception report

29. The Chair referred members to paper MDAG/16/2020, and invited Sean Scullion to present the update report on the Action Plan.

30. Sean Scullion summarised the content of the paper. Following discussion, the Chair acknowledged the work carried out to date, and asked that further work be taken forward with a view to streamlining the actions in the Plan and reporting arrangements to facilitate MDAG's oversight role on the progress being made towards implementation of the Plan so that members can see clearly what work has been done to implement actions.

31. Marie Roulston agreed to work with Departmental and PHA colleagues to take this work forward in the New Year.

AP3: Progress a review of actions in HSC Action Plan, and bring an update to next MDAG meeting. (Action: DoH/HSCB/PHA)

Agenda Item 6 – Staffing update including impact of Covid 19 and Christmas Cover

32. Gillian Traub updated members on the current staffing situation in the hospital, noting the workforce is currently stable although the level of agency staff remains high. She advised members plans were in place to maintain safe staffing levels through the Christmas holiday period.

33. Sean Holland recorded the Group's gratitude for the work being done by the Trust to ensure services at the hospital remain safe and stable.

34. Gillian Traub advised that an agency staff member had recently been recruited to a permanent night co-ordinator post. She also informed members that the recent second outbreak of Covid-19 at the hospital had now been closed, and a programme of patient vaccination was due to start in the hospital today.

35. Dawn Jones asked whether there were any plans to include hospital staff in the vaccination programme.

36. The Chair advised that rollout of the vaccination programme is taken forward independently of the hospital, and access to vaccination is determined on the basis of maximum impact.

37. Rodney Morton noted that prioritisation of access to the vaccine is nationally determined, with advice provided on prioritising various staff and population groups. Sean Holland advised that there was some scope for regional variation in the context of this.

38. Rodney Morton also sought assurance that the agency staff employed at the hospital were subject to supervision arrangements in line with those in place for directly employed staff, and Gillian Traub indicated the Trust were working to implement this.

Agenda item 7 – Highlight report and Dashboard

39. Maire Redmond referred members to paper MDAG/17/20, and provided an overview of the key points in the paper. She noted that to date 70 staff were currently on precautionary suspension, and 15 staff had been arrested. Staffing at the hospital was being supplemented by agency staff, and an ongoing contract with a nursing agency was in place to support this. Two patients had been successfully resettled in the past year, and there are plans in place to resettle a further three patients on the primary target list by March 2021, and a further seven by March 2022.

40. Dawn Jones queried the use of the primary target list terminology, which she considered suggested that the resettlement of a number of patients is being prioritised.

41. Aine Morrison advised the primary target list of patients was established some time ago as part of the Bamford review to facilitate the monitoring of progress on resettlement, and as such was no longer relevant, with no distinctions in place on resettlement priority for the current in-patient population.

42. Sean Holland confirmed to the Group that all current hospital patients are afforded an equal resettlement priority, and that MDAG will monitor progress on resettlement for all patients on this basis.

43. Brigene McNeilly noted that there had been no new admissions to the hospital since 2019, and queried where patients were being admitted.

44. Marie Roulston advised that fortnightly meetings had been convened by the HSCB to review this, and confirmed that the last new admission to the hospital was at Christmas 2019. Analysis showed that some patients had been admitted to psychiatric wards in Trusts, one had been admitted to Lakeview in the Western Trust, while others were being supported in community settings. Work was being taken forward to scope how many in-patient beds were required regionally, and a short-term plan to manage admissions was being developed as a precursor to development of a long-term model.

45. Petra Corr indicated that provision of adequate support in community settings was the ideal scenario, but acknowledged that access to appropriate acute in-

patient care was also required. In the meantime other options are explored, including admission to LD in-patient facilities in other Trusts, or alternatively access to Mental Health in-patient beds, though this is not always appropriate.

46. The Chair advised that experience from other regions should be considered in developing solutions, and indicated that learning from East London Foundation Trust would be useful in this regard.

47. Brigene McNeilly noted the long term impact on patients of time spent in psychiatric settings, and Marie Roulston confirmed this had been factored into the work which was underway.

Agenda Item 8 – AOB

48. There were no items of other business.

Agenda Item 9 – Date of next meeting

49. The Chair advised members that the next meeting was scheduled for Wednesday 24 February at 2pm. He also indicated that he would be willing to facilitate separate meetings before that, should individual members consider this was necessary. Any such request should be communicated by members to Maire Redmond in the first instance.

<u>Summary of Action Points</u>

Ref.	Action	Respon -sible	Update	Open/ closed
16/12/AP1	Presentation on the draft Learning Disability Service Model to be delivered at next meeting of MDAG	HSCB/ PHA		
16/12/AP2	Issue papers (by hard copy as required) to MDAG members no later than seven days in	DoH		

	advance of scheduled meetings			
16/12/AP3	Progress a review of actions in HSC Action Plan, and bring an update to next MDAG meeting.	DoH/ HSCB/ PHA		

MDAG/0 /21

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 24 February 2021

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Rodney Morton	PHA
Charlotte McArdle	DoH (Joint Chair)	Brenda Creaney	Belfast Trust
Mark Lee	DoH	Margaret O'Kane	South Eastern Trust
Maire Redmond	DoH	Barney McNeaney	Southern Trust
Ian McMaster	DoH	Stephen Matthews	Cedar
Siobhan Rogan	DoH		
Aine Morrison	DoH		
Sean Scullion	DoH (Note)		
Marie Roulston	HSCB		
Lorna Conn	HSCB		
Brendan Whittle	HSCB		
Emer Hopkins	RQIA (observer)		
Briege Quinn	PHA		
Gillian Traub	Belfast Trust		
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Aidan McCarry	Family rep		
Margaret McNally	Family rep		
Lyn Preece	South Eastern Trust		
Karen O'Brien	Western Trust		
Petra Corr	Northern Trust		
John McEntee	Southern Trust		
Mandy Irvine	NI British Psychological Society		
Gavin Davidson	QUB		
Vivian McConvey	PCC		
La'Verne Montgomery (for agenda item 4)	DoH		
Martina McCafferty (for agenda item 7)	HSCB		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Sean Holland welcomed attendees, and noted the apologies received from Rodney Morton, Brenda Creaney, Margaret O'Kane, Barney McNeany and Stephen Matthews. He also welcomed Margaret McNally to her first meeting of the Group, and explained she has joined the Group in her capacity as a relative of a past patient at the hospital. He advised members that this would be Marie Roulston's final meeting and on behalf of members wished her well in her upcoming retirement. He also welcomed her successor, Brendan Whittle, to his first meeting of the Group.

Agenda Item 2 - Minutes of Previous Meeting

2. Charlotte McArdle noted that the draft minutes of the previous meeting held on 16 December were circulated to members on 22 December. No comments were received, and the minutes had therefore been published on the Department's website as an agreed record of the meeting. There were no further comments on the minutes.

Agenda Item 3 – Update on Action Points.

3. Sean Holland provided an update on the open action points arising from previous meetings of the Group. He advised that 16/12/AP1 and 16/12/AP3 would be addressed at agenda items 7 and 8 respectively. He noted that 16/12/AP2 had been actioned, with papers issued to members on 16 February and by hard copy on request. He also advised that in relation to 24/6/AP1, it was intended that a presentation from the Belfast Trust on the East London Foundation Trust visit would be included on the agenda at the next scheduled MDAG meeting in April.

Agenda Item 4 – Update on Public Inquiry

4. Charlotte McArdle welcomed La'Verne Montgomery to the meeting and invited her to update members on the work of the sponsor team taking forward the MAH Public Inquiry.

5. La'Verne expressed her appreciation for the support provided by the PCC in the engagement work that had been carried out to date. She advised the sponsor team had written to families and current and former patients of MAH asking for their e-mail addresses to facilitate future communication with them on the Inquiry, though hard copy letters will still be issued for those who do not wish to receive email communication. A newsletter is planned for issue in the next week to provide interested parties with an update on progress. A report summarising the findings of the engagement work is being prepared by the PCC. It is planned that this will be submitted to the Minister as soon as possible to inform his decision on the appointment of a Chair to the Inquiry, with the proposed timescale of March for this decision to be taken. Once the Minister has made his decision on his preferred candidate for the Inquiry Chair, he will liaise closely with the Chair to develop the Inquiry Terms of Reference.

6. Charlotte McArdle extended thanks to all the families and patients, the PCC and La'Verne's team for their work to date on establishing the Inquiry.

Agenda Item 5 – Advocacy at MAH

7. Charlotte McArdle invited Vivian McConvey to update members on the PCC's work on advocacy arrangements at MAH.

8. Vivian advised members that the PCC had appointed Eleanor Good as a new member of staff to take forward a programme of MAH related advocacy work. She detailed the activity undertaken as part of the engagement process on the Public Inquiry since Christmas, which included press advertisements inviting contributions from current and former patients and their families, 22 in-person interviews with 22 current and past patients, 17 follow-up interviews with families, and advised a report summarising the findings of the engagement work was in preparation.

9. She also advised members of Eleanor's involvement with the MAH Carer's Forum. She had provided advocacy support to the families of three former

Muckamore patients who have had ongoing concerns about a residential care provider. She also provided advocacy support to one former patient in relation to their interactions with mental health services and family intervention teams, and to the mother of a former patient regarding her concerns in relation to access to respite care. She had assisted the mother of a patient who experienced a failed resettlement with a complaint to the ombudsman, and made 5 referrals to the Client Support Service within the PCC to support some families with additional issues regarding provision of current services or to be supported to make relevant complaints. In addition 21 cases had been escalated for Adult Safeguarding investigations.

10. Charlotte McArdle asked whether this activity had been helpful to families. Brigene McNeilly and Aidan McCarry indicated that they were very appreciative of the support Eleanor had provided to families. Gillian Traub also confirmed that the input from the PCC had been helpful for the Belfast Trust, and informed the Group that in line with the recommendation in the Leadership and Governance review, the Trust is finalising a co-produced Terms of Reference for an evaluation of the current advocacy arrangements at the hospital.

Agenda Item 6 – Regional Contingency Plan

11. Sean Holland reminded members of the context for the Plan, which was linked to the ongoing staffing challenges at the hospital and the corresponding need to have contingency arrangements in place. He invited Marie Roulston to update the Group on progress with this.

12. Marie Roulston welcomed Lorna Conn to the meeting in her new role as the Regional Lead for resettlement, and invited her to update the Group on the progress made to develop a regional contingency plan.

13. Lorna advised members that a regional Task and Finish Group was taking this forward, drawing on existing Trust contingency plans, and was meeting monthly to consider solutions. Following their meeting in January, a draft paper had been shared with Trusts, and their feedback was awaited. A workshop event

had been organised for tomorrow (25 February) with clinical and social care leads to consider care pathways and next steps.

14. Petra Corr noted that an important element of the workshop will be ensuring consideration is given to models of provision for patients with a mild learning disability, and in particular the extent to which this cohort of patients can access acute mental health beds. In this context, Sean Holland reminded members that one of the core values in Equal Lives' was that mainstream services should be adapted to meet the needs of people with a learning disability.

15. Charlotte McArdle was supportive of this approach, and noted that appropriate provision should be in place within mainstream services to support people with learning disabilities and enhance the service provided to them.

16. Lorna Conn noted the comments, and stressed the importance of retaining a focus on the wider picture. She also noted that the importance of workforce considerations.

Agenda item 7 – Learning Disability Service Model

17. Charlotte McArdle reminded members of the concerns that had been raised by family representatives at previous MDAG meetings about the level of carer involvement in the development of We Matter', the Learning Disability Service Model. She noted that a meeting with family representatives on this issue had been held in November, and welcomed Martina McCafferty to the meeting to update MDAG on the draft Service Model.

18. Martina delivered a presentation to members on the Service Model project, setting out the background, details of engagement with service users and carers, a summary of the outcomes and the next steps. She advised the Group that a delivery plan had been developed for the Model, and drew members' attention to the likely funding requirement to realise this. She outlined the proposed reporting arrangements for the Model and also some of the challenges for its implementation.

19. Charlotte McArdle commended the project team for their work in developing the draft model, and welcomed the emphasis on a cross Governmental approach to delivery. She noted that effective outcome measures will be important in measuring the success of the Model, and suggested that the indicators established for the Learning Disability Service Framework may be useful in this regard.

20. Briege Quinn agreed there was an opportunity to align the Service Model delivery arrangements with existing workstreams, and Sean Holland noted that it was important that increasing levels of social well-being also be included as an outcome.

21. Emer Hopkins also welcomed the Model, and asked how the interface with the Mental Health Strategy and Action Plan would be managed. Mark Lee noted the inter connected nature of the mental health and learning disability programmes of care, and advised that the oversight structures in place, including the Mental Health and Learning Disability Improvement Board, reflected this.

22. Sean Holland advised members that the Minister was developing proposals for an Adult Safeguarding Bill which would take account of the views of people with learning disabilities. Brigene McNeilly asked about the plan to engage with families in relation to this. Vivienne McConvey advised that work was underway to engage with interested parties and that she would be happy to consider any requests to engage. She agreed to contact Brigene after the meeting to make the necessary arrangements for this.

23. Charlotte McArdle thanked Martina McCafferty for her presentation.

Agenda Item 8 – HSC Action Plan – Exception Report

24. Sean Holland referred members to paper MDAG/02/2021, and invited Sean Scullion to update the Group. Sean Scullion updated members on the work that had been undertaken with the HSCB and PHA to review the actions in the plan. He advised that the actions had been grouped by a number of proposed

themes, and the completed actions had been moved to a separate section of the plan so that progress made to date in delivery of the plan is clearer. He also provided a summary of the current RAG status of the actions in the plan, and updated members on the position with the actions rated red.

25. Dawn Jones advised she found the restructured plan much easier to interpret and was supportive of the proposed changes. Members noted and agreed the update.

Agenda Item 9 – Highlight Report and Dashboard

26. Charlotte McArdle referred members to paper MDAG/03/2021 and invited Maire Redmond to update members on the Highlight Report. Maire Redmond advised members that in line with the agreement at the December MDAG meeting, the dashboard had been extended to cover all in-patients whose discharge had been delayed, removing the distinction between PTL and other patients. She advised that there were currently 44 in-patients in MAH, one of whom was in active treatment, and there are plans in place to resettle 5 patients this year, a further 21 in 2021/22 and 12 in 2022/23.

27. Brigene McNeilly queried the accuracy of this information which suggests that all patients have a resettlement plan in place whereas her relative did not currently have a plan in place.

28. Gillian Traub acknowledged the importance of quality assuring the information provided to MDAG and indicated that the Trust had different data on the number of resettlements achieved in 2020, compared to the report tabled for the meeting. Lorna Conn advised the information provided to MDAG through the Highlight Report was based on returns from Trusts, and undertook to raise the accuracy of this with Trusts at the next meeting of the Regional Learning Disability Operational Delivery Group on Thursday 25 February.

29. Charlotte McArdle asked that correct figures be circulated to MDAG as soon as these were available, and in advance of the next meeting of the Group. Sean

Holland asked that the vaccination figures in the report also be confirmed as part of this and an update circulated to members.

AP1: Quality assure information on discharge plans and vaccination numbers in Highlight Report, and circulate updated information to MDAG members. (Action DoH/HSCB/Trusts)

30. Maire Redmond advised members there were currently 67 staff on precautionary suspension and there had been 15 arrests as part of the PSNI investigation, with no charges brought to date. A number of staff have been dismissed by the Belfast Trust following disciplinary procedures. She also advised members that Anne O’Reilly had been appointed as a Learning Disability Champion for the Belfast Trust.

31. Gillian Traub updated members on the current nursing staffing position at the hospital, and advised that the Trust were carefully monitoring this. She advised there had been a number of Covid 19 outbreaks at the hospital in the past year which had been challenging, and she noted that there was currently also a number of medical staffing vacancies.

32. Brigene McNeilly referred to the graph on page 6 of the Highlight Report and asked why there had been a recent rise in the number of seclusion events. She raised a number of concerns about the current levels of care being provided at the hospital, in particular the proportion of agency staff employed and their skill mix, which she advised was disproportionately weighted towards mental health registrant staff. She indicated she had identified a range of concerns about the treatment of her relative over the past year which she linked to care being delivered by inappropriately trained staff, and queried whether this was contributing to an increased use of seclusion. She suggested that the Department should consider reviewing the on-site care arrangements at the hospital.

33. Charlotte McArdle advised that weekly reports on nursing staffing are provided to the Department. She also advised members that the aim was to address the current reliance on the use of agency staff at the hospital though this was

proving to be challenging. Mark Lee advised that the Department was aware of a number of recent incidents, and had raised these in discussions with the Trust. Conversations with the Trust and RQIA in relation to these are ongoing, and in this context he indicated it would be helpful if the concerns raised by Brigene could be shared more widely. Brigene indicated she was willing to forward these as required, and reiterated her concern about the care being provided to her relative.

34. Charlotte McArdle agreed an urgent conversation would be initiated with the Trust on receipt of a summary of the concerns raised by Brigene. She suggested these concerns should also be raised with the Divisional Nurse at the hospital.

35. Brigene advised she had already done so, and raised some further concerns about her relative's access to benefits and personal possessions.

36. Charlotte McArdle advised the concerns raised needed to be resolved, and asked Gillian Traub to follow up the issues raised after the meeting.

AP2: Concerns raised by family representative to be followed up with Belfast Trust. (Action: Belfast Trust)

Agenda Item 10 – MDAG Declaration of Interest Register

37. Sean Holland advised members that a Declaration of Interest Register had been established for MDAG, and returns for this had been received from the majority of members. He noted that 8 members had declared a previous involvement with MAH.

38. Maire Redmond advised that the previous involvement declared was mainly in a work related capacity, and indicated that individual declarations could be shared with members of the Group, subject to agreement from the individual members involved. Dawn Jones considered this would be helpful. Maire Redmond clarified that there was no requirement for family representatives on the Group to submit declarations. Sean Holland advised that any members'

deputies who have attended meetings on an occasional basis should also be asked to complete declarations.

AP3: Issue declaration of involvement forms to MDAG deputies, and circulate copies of completed forms to MDAG members. (Action: DoH)

AOB

39. There were no items of other business.

Agenda Item 11 – Date of next meeting

40. The Chair advised members that the next meeting was scheduled for Wednesday 28 April at 2pm.

Summary of Action Points

Ref.	Action	Respon-sible	Update	Open/ closed
24/02/AP1	Quality assure information on discharge plans and vaccination numbers in Highlight Report, and circulate updated information to MDAG members.	DoH/HSCB/ Trusts		
24/02/AP2	Concerns raised by family representative to be followed up with Belfast Trust.	Belfast Trust		
24/02/AP3	Issue declaration of involvement forms to MDAG deputies, and circulate copies of completed forms to MDAG members.	DoH		

MDAG/0 /21

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 28 April 2021

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Rodney Morton	PHA
Charlotte McArdle	DoH (Joint Chair)	Karen O'Brien	Western Trust
Mark Lee	DoH	Stephen Matthews	Cedar
Maire Redmond	DoH	Gavin Davidson	QUB
Ian McMaster	DoH		
Siobhan Rogan	DoH		
Aine Morrison	DoH		
Sean Scullion	DoH (Note)		
Darren McCaw	DoH		
Lorna Conn	HSCB		
Brendan Whittle	HSCB		
Emer Hopkins	RQIA (observer)		
Briege Quinn	PHA		
Deirdre McNamee	PHA		
Gillian Traub	Belfast Trust		
Brenda Creaney	Belfast Trust		
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Aidan McCarry	Family rep		
Margaret McNally	Family rep		
Margaret O'Kane	South Eastern Trust		
Petra Corr	Northern Trust		
Maria O'Kane	Southern Trust		
John McEntee	Southern Trust		
Christine McLaughlin	Western Trust		
Mandy Irvine	NI British Psychological Society		
Vivian McConvey	PCC		
La'Verne Montgomery (for agenda item 4)	DoH		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Sean Holland welcomed attendees, and noted the apologies received from Rodney Morton, Stephen Matthews, Karen O'Brien, and Gavin Davidson. He advised members that Barney McNeaney had retired from the Southern Trust and would be replaced on MDAG by Dr Maria O'Kane.

Agenda Item 2 - Minutes of Previous Meeting

2. Sean Holland noted that the draft minutes of the previous meeting held on 24 February were circulated to members on 2 March. Following receipt of a number of comments from members, the draft minutes were amended and published on the Department's website as an agreed record of the meeting. There were no further comments on the minutes.

Agenda Item 3 – Update on Action Points.

3. Sean Holland provided an update on the open action points arising from previous meetings of the Group. He advised that in relation to 24/02/AP1, work had been carried out with the HSCB and the Belfast Trust to address the information quality issues raised by some members, and an updated dashboard had been circulated to members.

4. In respect of 24/02/AP2, Sean Holland asked the Belfast Trust to provide an update on the concerns raised by a family representative. Gillian Traub advised that the Trust had met with the family representatives concerned to discuss the issues they had raised on staffing and adult safeguarding. She noted that an update on staffing will be provided under agenda item 6, and advised that work was continuing to address the issues raised.

5. Sean Holland noted that 24/02/AP3 had been actioned, with copies of relevant declarations circulated to members. It was agreed that declaration of involvement forms would be circulated to any new members on joining MDAG.

AP1: Declaration of involvement forms to be issued to new MDAG members (Action: DoH)

6. Sean Holland further noted that 16/12/AP1 and 16/12/AP2 had been actioned and were now closed. He also advised that the Action Plan update referred to in 16/12/AP3 was included as a separate item on the meeting agenda, and this will be a standing item for future MDAG meetings.

7. Finally, he noted that 24/6/AP1 had been outstanding for some time, and it was agreed that the Belfast Trust would deliver a presentation on the learning from the Trust's engagement with the East London Foundation Trust (ELFT) at the next scheduled MDAG meeting.

AP2: Presentation on engagement with ELFT to be delivered at une MDAG meeting (Action: BHSCT)

Agenda Item 4 – Update on Public Inquiry

8. Sean Holland welcomed La'Verne Montgomery to the meeting and invited her to update members on the work of the sponsor team taking forward the MAH Public Inquiry.

9. La'Verne advised the Group that the sponsor team intended to issue monthly newsletters on progress, with the April newsletter expected to issue shortly. The PCC report on the consultation with patients and families had been received by the Department on 12 March. She advised that the Minister intends to publish the report, and will write to families and patients to inform them before doing so. The Minister is considering the content of the PCC report, and this will inform his decisions on the Inquiry's purpose, scope, timeframe, power to make recommendations, as well as the background of the Inquiry Chair and arrangements for engagement with patients and their families.

10. La’Verne also advised that as required by the Inquiries Act, the Minister had recently written to the Secretary of State for Northern Ireland to request his approval to potentially extend the scope of the Inquiry outside the timeframe permitted in the Act. She advised members that the Secretary of State had agreed in principle to this, though he had asked for sight of the Inquiry’s Terms of Reference in advance of giving his formal approval.

11. La’Verne updated members on the feedback from families and patients which had indicated a preference for an Inquiry Chair with a legal background and from outside Northern Ireland, supported by a panel with relevant professional expertise. She also outlined the work to establish the secretariat support for the Inquiry, noting that the Chair will be consulted on these arrangements once appointed.

12. Gillian Traub asked which time periods were outwith the scope of the Inquiries Act, and it was clarified that the Secretary of State’s consent was required to extend the Inquiry’s remit to cover the period prior to December 1999, and also subsequent periods when devolution was not in force.

13. Sean Holland thanked La’Verne for her update.

Agenda Item 5 – MAH Regional Contingency Plan

14. Brendan Whittle referred members to paper MDAG/05/21, and summarised the work that had been carried out by the HSCB and the five Trusts to develop a contingency plan in the event of an unexpected closure of the hospital. He advised that if implementation of the contingency plan became necessary, it would be activated by the Belfast Trust within two hours of any potential closure. A risk assessment would be conducted by the Belfast Trust and the HSCB, and an incident control team would be established. There were a number of options for further action which would be determined in light of events and the nature of the issues prompting activation of the plan. He advised that the plan would be finalised for approval by the Mental Health and Learning Disability Improvement Board, with a final plan to be presented again to MDAG in due course.

15. Sean Holland noted the plan was intended for use in an emergency situation, and invited comments from members.

16. Gillian Traub noted concern about the potential impact of activating the plan, and stressed that work was being done to avoid a situation where there was no alternative but to do so. There are monitoring arrangements in place to be sensitive to staffing levels on the site, such that any deterioration would be picked up as early as possible to afford maximum time for mitigation.

17. Brigene McNeilly queried the circumstances which might lead to the activation of the plan. Sean Holland reiterated the activation of the plan would be a measure of last resort, and noted that staffing issues were likely to be the main risk to the safe operation of services at the hospital. He added that cost pressures were not anticipated to be a potential trigger point for the plan.

Agenda Item 6 – Staffing in MAH

18. Sean Holland noted that staffing at the hospital remained an ongoing concern and invited the Belfast Trust to update the Group on the current position.

19. Brenda Creaney advised members that a significant proportion of the hospital workforce were agency staff, and that families had raised concerns about the quality of care being provided. There were currently 72 agency staff employed at the hospital, made up of 50 registrants and 22 non-registrants. One of the agencies used by the hospital is currently subject to enforcement action. The Trust provide weekly updates on the nursing workforce to the Department.

20. Sean Holland queried whether there was scope to offer permanent contracts of employment to agency staff, and Brenda advised that any agency staff who expressed an interest in permanent employment would be considered, providing they were able to meet the necessary requirements of employment.

21. Brigene Mc Neilly asked whether the situation at the hospital had deteriorated recently, and Brenda advised that it was stable at present and was monitored closely.

22. Sean Holland asked whether the Trust had taken any steps to recruit from the current student nurse cohort, and Gillian Traub advised that the recruitment programme for the hospital was ongoing. She advised that 10 additional Band 3 staff had been appointed in January, and noted the importance of maintaining a balance between experienced and newly qualified staff.

23. Brenda Creaney advised members that 69 staff were on suspension and 58 staff were on training and protection plans, and that 1 further suspension was pending along with 3 further staff to be placed on supervision and training.

24. Margaret McNally noted the importance of a trained community workforce in supporting patients who had been resettled to community placements, and asked about plans to roll out training for this workforce.

25. Sean Holland advised that the new Learning Disability Service Model reflected the need to have an appropriately skilled community workforce, with access available to specialist multi-disciplinary skills where required.

26. Aine Morrison asked about the reasons behind the additional staff being placed on protection plans. Brenda Creaney advised that these decisions had been based on new information arising from viewing of historical CCTV footage, and agreed to provide further detail on these cases.

AP3: Provide update on status of additional protection plans and detail of concerns which required these (Action: BHSCT)

27. Emer Hopkins advised that RQIA were currently participating in the Adult Safeguarding governance arrangements at the hospital, and were satisfied that the Trust was managing these effectively. She noted that RQIA considered the DAPO resource should be strengthened, but wished to reassure families that RQIA continued to challenge the Trust and were satisfied with progress being made.

28. Gillian Traub acknowledged the challenges the Trust had faced in staffing the adult safeguarding service and noted that recruitment efforts were continuing. She undertook to continue reporting to MDAG on this.

Agenda item 7 – Removal of services from MAH

29. Sean Holland advised that a family representative had asked that this issue be included as an agenda item, and invited them to provide an update.

30. Brigene McNeilly noted that the Positive Behaviour Support Service had been removed from the hospital recently and updated the Group on the impact this had had on families and patients.

31. Gillian Traub advised that some MAH staff had recently been moved from the hospital to address a crisis situation which had arisen in community services. She stressed that this was a temporary solution, and there were no plans to withdraw this service permanently from the hospital. She noted there had also been some pressures on the service due to staff absences.

32. Sean Holland asked whether the service had been fully reinstated, and Gillian advised some staff absence was ongoing which the Trust was working to manage. She agreed to bring an update on the Positive Behaviour Service to the next meeting of MDAG. Petra Corr advised that Trusts aim to work collaboratively on the delivery of this service, and the Northern Trust had accordingly been providing support.

AP4: Provide update report on MAH Positive Behaviour Service (Action: Belfast Trust)

Agenda Item 8 – MAH HSC Action Plan – Exception Report

33. Sean Holland referred members to paper MDAG/06/2021, and invited Sean Scullion to update the Group on progress with delivery of the Action Plan. Sean

Scullion summarised the key points from the report, including a summary of the current RAG status of the actions in the plan, and an update on the actions rated red. He also outlined a proposal to develop an Action Plan risk register for consideration at the next MDAG meeting.

34. Sean Holland noted the report and suggested it would be helpful for the owners of the actions rated red to be invited to provide progress updates on these actions at MDAG meetings.

AP5: Arrange for updates on red rated actions to be provided by action owners at MDAG meetings (Action: DoH)

Scoping exercise for facility on site

35. Sean Holland noted that a family representative had asked for an update on this issue.

36. Brigene McNeilly reminded members that this exercise had been discussed previously at an MDAG meeting, and the Belfast Trust had subsequently advised that a scoping exercise had been carried out. She asked for an update on this, and whether this exercise had been informed by input from families.

37. Mark Lee explained the context to this exercise, which had been initiated by correspondence from the Department to the Belfast Trust in September 2020 commissioning a scoping exercise on options to develop an on-site supported living facility for the small number of patients who no longer required active treatment but who had been resident on the hospital site for a significant part of their lives.

38. He advised that the Belfast Trust had carried out some preliminary scoping work with input from the other placing Trusts with a view to engaging with patients and families to seek their views on potential options. He stressed that no decisions would be taken pending discussions with families.

39. Gillian Traub advised that initial consideration had been given to the assessed needs of those patients who might wish to be considered for an on-site option, and this would inform a process of engagement with patients and their families to develop an options appraisal for a future model of on-site provision. She indicated that a roadmap for this process would be developed, and agreed to provide an update report for the next meeting of MDAG.

AP6: Provide an update report on progress towards a future model of on-site provision (Action: BHSCT)

Resettlement update

40. Sean Holland referred members to paper MDAG/07/21, and invited each of the three Trusts involved to summarise the resettlement status of their in- patient populations.

41. Gillian Traub advised that the Belfast Trust currently has 15 patients in MAH. Of these, 3 have firm discharge dates in the summer, 7 patients have planned moves to two new supported living facilities which are at business case stage with an anticipated resettlement date of 2023, a planned move for 1 patient to Cherry Hill is progressing and 4 patients have no identified options at present. Of these 4 patients, Gillian advised that 2 are potential candidates for the future on-site proposal and the Trust are considering bespoke procurement exercises to identify suitable options for the remaining 2 patients.

42. Petra Corr provided an update on the Northern Trust in-patients, advising that the Trust currently has 20 patients placed in the hospital. 1 patient is on trial leave, 12 have confirmed or potential community placements and are progressing towards discharge, and the Trust are working to identify suitable placements for the remaining 8 patients, involving bespoke procurement exercises and also consideration of the on-site proposal.

43. Margaret O'Kane updated members on the South Eastern Trust patients, advising that the Trust currently have 8 patients in the hospital. 1 patient is on

extended home leave and 3 have planned discharge dates in September. 2 patients have planned moves to the proposed new community facilities currently at business planning stage, and the Trust is exploring options including the on-site proposal for the remaining 2 patients, one of whom has had a number of previous failed resettlements.

44. John McEntee and Christine McLaughlin also updated the Group on the current resettlement position in their Trusts' respective facilities.

45. Sean Holland noted the current resettlement position and expressed concern at the proposed discharge timescales for a significant proportion of the current regional in-patient population. He asked that the HSCB provide a regional overview of the current resettlement programme with a particular view to scrutinising and expediting resettlement arrangements for the most complex cases.

AP7: Develop a regional overview of progress on the resettlement programme, with a particular focus on the most complex cases (Action: HSCB)

Agenda Item 9 – Highlight Report and Dashboard

46. Sean Holland referred members to paper MDAG/08/21 and invited Maire Redmond to provide an update.

47. Maire Redmond advised members that all CCTV footage had now been viewed at least once, and that the 16th arrest had recently been reported in the media. She advised that there were currently about 70 staff on precautionary suspension and that the Adult Safeguarding Strategic Governance meetings were continuing. She further advised that the Department continues to engage with both Belfast Trust and the RQIA to ensure that we understand the safeguarding process within the Trust.

48. Maire further noted the recent announcement by the Public Prosecution Service of their intention to charge 7 individuals, and that 8 further files remained under consideration.

49. Brigene McNeilly asked whether any work had been done with families in expectation of the announcement in due course of the names of the individuals who had been charged, as this disclosure may potentially be traumatic for the families of current and previous patients in the hospital.

50. It was noted that the PSNI were reluctant for operational reasons to advise in advance of decisions on prosecutions. Members were in agreement that the announcement of decisions on prosecutions of identified individuals who had worked at the hospital had the potential to be traumatising for current and past patient and their families, and consideration should be given to establishing appropriate arrangements to provide support for patients and their families. As a first step, Gillian Traub agreed to raise this on behalf of all Trusts at the Belfast Trust's next scheduled meeting with the PSNI.

AP8: Arrangements for notifying patients and families of decisions to prosecute to be raised at next Belfast Trust meeting with PS I (Action: Belfast Trust)

Agenda Item 10 – AOB

Admissions of LD patients

51. Sean Holland updated members on admissions to LD assessment and treatment facilities, noting that admissions to MAH had been effectively suspended for some time and that this position was unlikely to be sustainable in the longer term. He advised that the Northern and Belfast Trusts had been exploring potential options for alternative provision, and were aiming to develop these further. Further updates on developments with this work would be brought to MDAG in due course.

52. Members noted this was Briege Quinn's final MDAG meeting, and the Chair extended thanks to her for her contribution to the work of the Group and wished her well for the future.

53. Brigene McNeilly referred to the Highlight Report, and queried the reason for the apparent spike in the seclusion events in January.

54. Gillian Traub advised that a number of patients in the hospital had been unsettled at that time, and this had resulted in a temporarily higher than usual use of seclusion to manage these patients. She noted more recent data showed the level had dropped since this spike. Sean Holland acknowledged that such spikes may occur from time to time for a variety of reasons, but it was important that arrangements are in place to closely monitor, review and learn from such instances.

Agenda Item 11 – Date of next meeting

55. The Chair advised members that the next meeting was scheduled for Wednesday 30 June at 2pm.

Summary of Action Points

Ref.	Action	Respon-sible	Update	Open/ closed
28/04/AP1	Declaration of involvement forms to be issued to new MDAG members.	DoH		
28/04/AP2	Presentation on engagement with ELFT to be delivered at June MDAG meeting.	Belfast Trust		
28/04/AP3	Provide update on status of additional protection plans and detail of concerns which required these.	Belfast Trust		
28/04/AP4	Provide update report on MAH Positive Behaviour Service.	Belfast Trust		
28/04/AP5	Arrange for updates on red rated actions to be provided by action	DoH		

	owners at MDAG meetings.			
28/04/AP6	Provide an update report on progress towards a future model of on-site provision.	Belfast Trust		
28/04/AP7	Develop a regional overview of progress on the resettlement programme, with a particular focus on the most complex cases.	HSCB		
28/04/AP8	Arrangements for notifying patients and families of decisions to prosecute to be raised at next Belfast Trust meeting with PSNI.	Belfast Trust		

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 30   une 2021

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Charlotte McArdle	DoH (Joint Chair)
M ire Redmond	DoH	Mark Lee	DoH
Siobhan Rogan	DoH	Ian McMaster	DoH
Aine Morrison	DoH	Brendan Whittle	HSCB
Sean Scullion	DoH	Emer Hopkins	RQIA (Observer)
Darren McCaw	DoH (Note)	Aidan McCarry	Family rep
Lorna Conn	HSCB	Martin Quinn	HSCB
Rodney Morton	PHA		
Deirdre McNamee	PHA		
Gillian Traub	Belfast Trust		
Brenda Creaney	Belfast Trust		
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Margaret O’Kane	South Eastern Trust		
Petra Corr	Northern Trust		
John McEntee	Southern Trust		
Karen O’Brien	Western Trust		
Mandy Irvine	NI British Psychological Society		
Vivian McConvey	PCC		
Gavin Davidson	QUB		
La’Verne Montgomery (for agenda item 4)	DoH		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Sean Holland welcomed attendees, and noted the apologies received from Charlotte McArdle, Mark Lee, Ian McMaster, Brendan Whittle, Emer Hopkins, Aidan McCorry, and Martin Quinn.

Agenda Item 2 - Minutes of Previous Meeting

2. Sean Holland noted that the draft minutes of the previous meeting held on 28 April were circulated to members on 6 May. Following receipt of a number of comments from members, the draft minutes were amended and published on the Department's website as an agreed record of the meeting. There were no further comments on the minutes.

Agenda Item 3 – Update on Action Points.

3. Sean Holland provided an update on the open action points arising from previous meetings of the Group. He advised that in relation to 28/04/AP1, a declaration of involvement form had been issued to Dr Maria O'Kane and would be shared with members once received. This action was now closed.

4. In respect of 28/04/AP2, it was noted that the ELFT presentation was on today's agenda at item 5 and as a result was now closed. Sean Holland advised that a copy of the presentation would be circulated to members by the MDAG secretariat.

AP1: ELFT presentation to be circulated to members. (Action: DoH)

5. Sean Holland noted that further to 28/04/AP3, an update from the Belfast Trust on additional safeguarding information and protection plans was included as Agenda item 8 for today's meeting.

6. Sean Holland advised that in relation to 28/04/AP4 Belfast Trust had provided an appendix 2 to the highlight report setting out the MAH psychological Therapies Support and the key aspects of each role the action is now closed.

7. 28/04/AP5 was included on today's agenda at item 7, had been actioned and was now closed.

8. In relation to 28/04/AP6, Sean Holland asked Gillian Traub to provide an update on progress towards a future model of on-site provision. Gillian Traub advised that work was ongoing and the steering group, including the three Trusts involved and the HSCB, had now met twice to examine the feasibility of

a facility on site. Each Trust has assessed their patients' suitability for this, and although six potential patients had initially been identified, the most likely outcome was a facility providing for four patients supported by a nursing care model. Details of these assessments have been provided to the Estates Department in the Belfast Trust to gauge if this could be provided within the existing on-site infrastructure. Further detail will then be collated to help inform the timeframe, costs and workforce model required.

9. In respect of 28/4/AP7, Sean Holland asked Lorna Conn for an update on the development of a regional overview of progress on the resettlement programme. Lorna Conn provided an outline of work currently being taken forward by the HSCB in relation to resettlement, adding she would like some additional time to consider the recent proposal received from the Department commissioning work to examine and further develop current processes. Sean Holland advised members that work was underway within the Department to look at processes around resettlements. Sean also emphasised that the status quo was not sustainable and all options available to reduce the time taken to achieve successful resettlements, however radical, would be examined, with any proposals emerging from this work to be brought to MDAG for consideration. He also confirmed that the needs of individual patients would remain the paramount consideration.

10. Brigene McNeilly welcomed this work, and noted that efforts to resettle some individuals had been ongoing for 25 years. Lorna Conn confirmed she would welcome further discussion on potential improvements to the resettlement process.

11. Further to 28/04/AP8 Gillian Traub agreed to provide an update at the next meeting of MDAG as she had not yet engaged with PSNI.

12. Sean Holland confirmed that 24/02/AP1 was now closed following validation of the data presented in the resettlement dashboard.

13. Finally, in relation to 24/02/AP2 Sean Holland requested an update from Gillian Traub. Gillian advised that work was ongoing per the update given at the April MDAG.

Agenda Item 4 – Update on Public Inquiry

14. Sean Holland welcomed La'Verne Montgomery to the meeting and invited her to update members on the work of the sponsor team taking forward the MAH Public Inquiry.

15. La'Verne advised the Group that today was a significant day for progress as the Minister had published the PCC report and announced the appointment of Tom Kark QC as Chair of the Inquiry. La'Verne confirmed that detail on the appointment of the Chair was shared in advance with those families the sponsor team and PCC hold contact details for before being formally announced by the Minister through a written statement in the Assembly at noon. La'Verne also confirmed that written detail on the appointment would be placed on the Departmental internet site.

16. La'Verne advised that the next steps would involve the Terms of Reference for the Inquiry being considered by the Chair ahead of formal approval by the Minister, and consideration by the Chair of the Panel support he will require. La'Verne confirmed that the Chair had also received a copy of the PCC report and this would be a key document in relation to his decision making. She advised it was planned to formally launch the Inquiry as soon as possible, with a proposed date of 1 September for this.

17. Dawn Jones welcomed the appointment and asked for an overview on the Chair and his qualifications and experience. La'Verne advised that the newly appointed Chair met a number of the key requirements identified by patients and families, including that he came from outside Northern Ireland, has suitable legal experience of issues likely to come up in the work of the Inquiry, is an experienced QC and part time Judge and has had extensive training in interviewing and questioning vulnerable witnesses. La'Verne provided a brief overview of Mr Kark's CV highlighting his work as Senior Counsel to the Mid-

Staff Inquiry and leading the review of the fit and proper persons test in the NHS, England. Dawn Jones expressed her satisfaction that both the medical and legal aspects were covered.

18. Brigene McNeilly asked La'Verne to convey thanks to the Minister, as he has lived up to the commitments he made to families, and the process to establish the Inquiry has been handled very well to date.

19. Sean Holland noted that the Minister has been very proactive in the establishment of the Inquiry and thanked La'Verne for her update.

Agenda Item 5 – East London Foundation Trust (ELFT) Presentation

20. Sean Holland advised members that, further to action point 28/04/AP3, it had been agreed that the Belfast Trust would provide detail to MDAG on the Trust's engagement with the East London Foundation Trust (ELFT) at today's meeting and invited Gillian Traub to provide the detail.

21. Gillian Traub delivered a presentation on the consultation between the Belfast Trust and the ELFT, setting out the background, detail of the engagement between the Trusts which covered learning disability services in both Muckamore and a number of community settings, a summary of the main findings including areas of good practice, those for development, and outcomes and recommendations.

22. Karen O'Brien advised that feedback received on the role of the Acute Liaison Nurse for Learning Disability used in the Western Trust had highlighted the positive difference this had made. Further to this, Rodney Morton advised that investment was being made in learning disability nursing in Northern Ireland with 20 new posts being created and there was potential to work with the Trusts to use one of these posts to develop a learning disability liaison nurse. Brenda Creaney confirmed the Belfast Trust would be keen to work with the other Trusts on this but highlighted the need to ensure this did not risk destabilising the Muckamore workforce.

23. Siobhan Rogan queried the figure for the population served by the ELFT quoted in the second slide. Brenda Creaney agreed to seek clarification and provide confirmation.

AP2: ELFT population served figure to be confirmed. (Action: Belfast Trust)

Agenda Item 6 – MAH HSC Action Plan – Exception Report

24. Sean Holland referred members to paper MDAG/10/2021, and invited Darren McCaw to update the Group on progress with delivery of the Action Plan. Darren McCaw summarised the key points from the report, including a summary of the current RAG status of the actions in the plan, and an update on the actions rated red including a request to approve a proposed revised completion date for A30 to September 2021.

25. Sean Holland noted the report and confirmed members' agreement to amend the completion date for A30 as outlined in the report.

AP3: Completion date for HSC Action Plan Action A30 to be updated to September 2021 (Action: DoH)

Agenda Item 7 – Progress Update – Actions Rated Red

26. Sean Holland advised that further to agreement at the April meeting there would be a focus at each meeting on a number of the actions rated red within the HSC Action Plan. This will be a rolling process to allow for consideration of all the red-rated actions. Sean confirmed that updates on four actions would be provided at today's meeting the Belfast Trust providing updates on actions A29 and A21 and the HSCB providing updates on actions A39 and A40.

27. Sean invited Gillian Traub to provide the updates from the Belfast Trust. Brenda Creaney provided an update in relation to A29, advising that, the Trust had recently received additional investment from the HSCB for the creation of a number of new specialist nursing posts at Band 7, 8A and 8B to deliver the workforce plan for specialist nursing across learning disability services, which

would include Muckamore. She advised the Trust were seeking to extend the deadline for the delivery of this action to allow this work to develop. Rodney Morton confirmed that the Chief Nursing Officer has prioritised investment in Learning Disability nursing to develop specialist nursing roles. He advised that the posts at Band 8 level were specialist posts and regional job descriptions for these roles were being collated, however it would likely be September before the posts were filled. Brenda Creaney advised the Belfast Trust were seeking to agree the potential to bring staff in via training for these roles in order to develop their own staff and potentially attract nurses with the relevant skills back into learning disability nursing roles.

28. Sean Holland queried the proportion of Learning Disability nurses who choose to work in non-specialist roles, and indicated that the Learning Disability Service Model needs to recognise and address this disparity. Members outlined some of the factors which contribute to this, and Rodney Morton noted work to create a career framework with a view to addressing this issue.

29. In relation to A21, Gillian Traub advised that following feedback from the ELFT visit in 2019 the Trust seclusion policy has been significantly revised and is scheduled to go to the Trust Standards and Guidelines Committee meeting in August for sign off.

30. Sean Holland thanked Gillian for the updates and invited Lorna Conn to provide the HSCB updates.

31. Due to the linked nature of actions, A39 and A40, Lorna provided a combined update advising that the regional review of admissions criteria and the development of a regional bed management protocol for LD services under A39 was dependent on the appointment of the regional bed manager post outlined in A40. Due to the non-recurrent nature of the funding provided in 2019/20 and the inability to appoint to the post at that time, action A40 had not been completed.

32. Lorna further advised that given the work carried out at the time, and other related pieces of work since, it would be helpful to further consider how this

could be moved forward should funding be made available. Karen O'Brien raised the potential to combine the proposed learning disability bed management role with the already established mental health bed management network in order to achieve a better outcome. Sean Holland requested that a meeting be organised between Mark Lee, Brendan Whittle and Lorna Conn to examine potential options for funding in order to move to recruitment and requested an update be provided at the next meeting of MDAG.

AP4: Meeting to discuss funding options re A40 to be organised between the DoH and HSCB. (Action: DoH)

AP5: An update on progress in relation to A40 to be provided at the MDAG meeting in August. (Action: HSCB)

Agenda Item 8 – Highlight Report and Dashboard

33. Sean Holland referred members to paper MDAG/11/21 and invited Máire Redmond to provide an update.

34. Máire Redmond highlighted a number of new items included in the report including the recent ward re-profiling exercise that had been carried out at Muckamore Abbey Hospital in order to make use of the most modern of the wards on-site and the potential decommissioning of the Erne Ward. Máire also advised that the DoH are engaged in ongoing discussions with the Belfast Trust on the range of information provided to MDAG, through the Highlight Report, and scope to improve this. As a result of these discussions, additional information on adult safeguarding processes has now been included in the Highlight Report. Máire invited Gillian Traub to provide a presentation to members on the additional safeguarding information proposed for inclusion in the Highlight Report. She confirmed a copy of the presentation would be circulated following the meeting.

AP6: Copy of BHSCT adult safeguarding presentation to be circulated to MDAG members (Action: DoH)

Expanded information iro safeguarding

35. Gillian Traub provided a presentation to the Group setting out the additional adult safeguarding detail which is proposed for inclusion in the Highlight Report. This covered the period from 1st January 2020 to 31st May 2021 and was collated from the single Trust database used to record this information. Gillian advised work was being taken forward to ensure detail on the database was as comprehensive and accurate as possible and confirmed that for future meetings up to date data will be provided.

36. Gillian provided an overview of the ongoing work within the Trust to avoid any repetition of past safeguarding failings, and to demonstrate the priority given to patient safety. She provided information on two distinct adult safeguarding data sets staff on patient referrals and patient on patient referrals. Detail was provided on screening processes, investigations, outcomes and continuous learning from investigations in order to enhance these processes. Sean Holland acknowledged that the DoH was demanding in terms of the information being sought from the Trust in order to provide assurances on safeguarding processes, and Gillian advised the Trust would continue to develop the information provided with Departmental colleagues.

37. Brigene McNeilly expressed concerns that the information provided did not reflect her recent experience of adult safeguarding within Muckamore which was extremely poor. She considered that those involved in the safeguarding team appeared unsure of processes and this had increased the anxiety she and her family had around their relative’s care. Dawn Jones indicated her agreement with Brigene’s comments, adding that she felt safeguarding was one of the weakest parts of Muckamore and also highlighted her concerns in relation to the inexperience, competence and attitude of some staff involved in safeguarding arrangements.

38. Gillian Traub advised that, in order to remove any potential conflict with the provision of care at Muckamore, the Adult Safeguarding team were a separate team, but who remain under the management of the Belfast Trust who have a responsibility to ensure the service remains fit for purpose. Gillian said it was a

concern that the Trust was not meeting expectations in this area.

39. Aine Morrison advised members that the Department was working with the Belfast Trust and RQIA on a number of safeguarding issues which have been of concern to the Dept. These issues have included the number and nature of safeguarding referrals that have been made in the past 18 months, the adequacy of protection plans relating to staff members on site about whom there are some concerns arising from the CCTV viewing and the application of regional adult safeguarding policy. Aine informed the meeting that the Department has commissioned an external file review of Muckamore adult safeguarding referrals involving allegations about staff behaviour. The Department is concerned that there appears to be a high number of these referrals although acknowledges that benchmarking this is difficult. The Trust has explained to the Department their belief that the thresholds for referral and investigation are very low and that this accounts for the numbers. The external file review will examine thresholds for referrals and investigations as well as looking at levels of harm or potential harm being caused by the incidents that had been reported.

40. Vivian McConvey queried whether an additional forum was required to engage with families on the concerns being expressed about safeguarding arrangements at the hospital. Sean Holland advised the Department was already reviewing the adult safeguarding arrangements in Muckamore and he suggested that this work would benefit from considering feedback from those families and carers who have been engaged with the adult safeguarding team. Sean requested that the Belfast Trust consider systematically collecting data in relation to families' experience of adult safeguarding in order to fully understand the experience of adult safeguarding in addition to the data collected.

AP7: BHSCT to consider collecting feedback from all those affected by adult safeguarding investigations. (Action: Belfast Trust)

41. Sean Holland advised the family representatives that he was happy to follow up directly with them and the Belfast Trust and PCC on any issues they may have in relation to adult safeguarding.

42. The family representatives welcomed this offer, and considered that further work is needed to improve Adult Safeguarding arrangements.

43. Aine Morrison noted that ongoing protection arrangements were in place arising from the viewing of historic CCTV footage, and discussions were continuing about current activity on-site.

44. Gillian Traub noted her presentation was based on a summary of safeguarding referral data, and acknowledged that families were expressing a lack of confidence in the current arrangements, which the Trust would wish to address. Gillian noted that the Trust had previously highlighted to the Department significant challenges due to vacancies within the adult safeguarding service and difficulties with recruitment. Some recent recruitment had taken place which meant that there are very new team members who are less experienced. The complexity and demands of the work of this team also have an impact.

45. Sean Holland reiterated his offer to be involved in discussions with families as appropriate, and noted that in addition to the activity data, it was important to understand families' experience of safeguarding.

46. Sean Holland advised members that he is also Chairing a group working to place adult safeguarding arrangements onto a statutory footing in Northern Ireland, which was also reviewing policies and procedures in this area. This work will include the creation of new criminal offences that can be committed in relation to adult safeguarding for members of the public or staff. He noted that if members considered it would be helpful, a presentation on the draft legislation could be arranged for MDAG.

Agenda Item 9 – AOB

47. None raised.

Agenda Item 10 – Date of next meeting

48. The next meeting is scheduled for Wednesday 25 August at 2pm.

Summary of Action Points

Ref.	Action	Respon-sible	Update	Open/ closed
30/06/AP1	ELFT presentation to be circulated to members.	DoH	Circulated 8 July 2021	Closed
30/06/AP2	ELFT population served figure to be confirmed.	Belfast Trust	Belfast Trust confirmed as 1.3m from ELFT website. This is broken down as follows East London population served 750,000 Bedfordshire and Luton population served 630,000	Closed
30/06/AP3	Completion date for HSC Action Plan Action A30 to be updated to September 2021.	DoH	Date updated	Closed
30/06/AP4	Meeting to discuss funding options re A40 to be organised between DoH and HSCB	DoH	Meeting arranged for 2 August 2021	Closed
30/06/AP5	An update on progress in relation to A40 to be provided at the MDAG meeting in August.	HSCB		
30/06/AP6	Copy of Belfast Trust adult safeguarding presentation to be circulated to members.	DoH	Circulated to members 15 July 2021	Closed
30/06/AP7	BHSCT to consider collecting feedback from all those affected by	Belfast Trust		

Ref.	**Action**	**Respon-sible**	**Update**	**Open/ closed**
	adult safeguarding investigations.			

MDAG/XX/21

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 25 August 2021

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Charlotte McArdle	DoH (Joint Chair)
Mark Lee	DoH	Rodney Morton	PHA
Máire Redmond	DoH	Vivian McConvey	PCC
Siobhan Rogan	DoH	Margaret O'Kane	SEHSCT
Aine Morrison	DoH	Maria O'Kane	SHSCT
Ian McMaster	DoH	John McEntee	SHSCT
Darren McCaw	DoH	Brendan Whittle	HSCB
Teri Gourley	DoH (Note)		
Lorna Conn	HSCB		
Maurice Leeson	HSCB		
Gillian Traub	Belfast Trust		
Moira Kearney	Belfast Trust		
Brenda Creaney	Belfast Trust		
Carol Diffin	Belfast Trust		
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Lyn Preece	South Eastern Trust		
Petra Corr	Northern Trust		
Karen O'Brien	Western Trust		
Deirdre McGrenaghan	PCC		
Emer Hopkins	RQIA (Observer)		
La'Verne Montgomery (for agenda item 4)	DoH		
Mandy Irvine	NI British Psychological Society		
Gavin Davison	QUB		
Grainne Close	Mencap		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Sean Holland welcomed attendees, and noted the apologies received. He highlighted the lack of a representative from the Southern Trust and asked that

a letter be drafted to the Chief Executive of the Trust. He advised members that this would be Gillian Traub's and Mark Lee's final meeting as they were moving on to new roles. He thanked them for their contribution to date and wished them well. He welcomed Moira Kearney to her first meeting, who would be replacing Gillian Traub.

AP1: Letter to be drafted and sent to Chief Executive of Southern Trust re lack of **representative at MDAG meetings. (Action: DoH)**

Agenda Item 2 - Minutes of Previous Meeting

2. Sean Holland noted that the draft minutes of the previous meeting held on 30 June were circulated to members on 8 August. Following receipt of a number of comments from members, the draft minutes were amended and published on the Department's website as an agreed record of the meeting. There were no further comments on the minutes.

Agenda Item 3 - Update on Action Points – S Holland

3. Sean Holland provided an update on the open action points arising from previous meetings of the Group. He advised that in relation to 30/06/AP1, the ELFT presentation had been circulated to the members of MDAG. **This action is now closed.**

4. In respect of 30/06/AP2, the Belfast Trust had confirmed the ELFT population in East London. This information was provided in the minutes of the previous meeting. **This action is now closed.**

5. Sean Holland advised that in relation to 30/06/AP3, a completion date for HSC Action Plan, Action 30 had now been updated and **this action is now closed.**

6. Sean Holland noted that work had been ongoing in regards to 30/06/AP4, and asked Lorna Conn for an update on this. She was pleased to note that a meeting between DoH and HSCB had taken place, the job description for the regional bed manager had been reviewed to include both learning disability and

mental health and the HSCB are now in a position to recruit for this position. **This action is now closed.**

7. Sean Holland provided an update on 30/06/AP6, stating that the safeguarding presentation had been circulated to members and **this action was now closed.**

8. Sean Holland asked the Belfast Trust for an update in regards to 30/06/AP7. Gillian confirmed that this had not progressed and committed to giving an update at the next meeting.

9. Sean Holland advised that in relation to 28/04/AP3, an update was provided at the June MDAG meeting and that safeguarding would be a standing agenda item going forward. **This action is now closed.**

10. In relation to 28/04/AP4, an update report on MAH positive behaviour support has been provided and **this action is now closed**.

11. Sean Holland noted that in relation to 28/04/AP5, this has now been added as a standing agenda item and was on the agenda at agenda item 8. **This action is now closed.**

12. In respect of 28/04/AP6, Sean Holland advised that there were ongoing meetings with the BHSCT, looking at a potential future facility and design options. A meeting is being arranged between the Department, Board and Trusts and an update will be provided at the next meeting. Gillian Traub confirmed a Steering Group had been established and meetings are planned with families.

13. Sean advised that Petra Corr will provide an update on 28/04/AP7 at Agenda Item 9 in relation to delays in some current planned resettlements and added that the Department and Board have been examining the processes around resettlement to determine how timescales could be reduced. A meeting is due to take place at the end of the week in relation to this.

14. Sean asked Belfast Trust for an update in relation to 28/04/AP8. Carol Diffin advised that she had contacted the PSNI about this issue but has not yet received a complete answer. She agreed to provide an update at the next meeting.

Agenda Item 4 – Update on Public Inquiry

15. Sean Holland welcomed La'Verne Montgomery to the meeting and invited her to update members on the work of the sponsor team taking forward the MAH Public Inquiry.

16. La'Verne advised the Group that the Chair Tom Kark QC is currently considering the PCC report along with other information to help inform the Terms of Reference (ToR) for the Inquiry. Once the ToR is drafted it will be shared with Minister Swann for consideration/approval.

17. La'Verne advised that July and August had been busy months appointing the Senior Team for the Inquiry. She advised that Sean Dorran QC had been appointed as Senior Counsel, Joan MacElhatton as Solicitor to the Inquiry and Jaclyn Richardson as Secretary to the Inquiry. Jaclyn will be taking up her post from 6 September 2021.

18. La'Verne informed members that the Chair is completing prior commitments and will be fully committed to the Inquiry from 1 October. The ToR for the Inquiry and discussions with the Secretary of State on agreement on the timeframes to be covered by the Inquiry should be complete prior to this in order to facilitate this start date. The ToR will be published prior to formal launch.

19. Brigene McNeilly questioned what support would be offered, not only to those families and patients directly involved with the Inquiry, but also for those families who are on the periphery of the Inquiry. La'Verne advised that the Department will continue to work with the PCC in their role to establish what further support will be required by those affected by the Inquiry.

20. Brigene asked for clarity on what was meant by ‘further support’ and La’Verne confirmed this was support outside of what was currently in place. La’Verne assured that this support will be offered to all families that they hold contact details for and they would also reach out to others, for example through support groups, the media, etc.

21. Sean Holland went on to stress that it is understandable that some families will have issues with trusting the support systems currently in place and that a facility to access support that is free and independent, in addition to those formal services, will be made available. La’Verne advised that whatever support networks were designed, they would be brought back to MDAG as a touch-point in order to ensure it would meet the needs of all.

22. Mandy Irvine advised that it should not be assumed that all families want only independent support, but for those who have had a previous positive experience, they could continue to make use of their familiar support.

23. Sean Holland advised that there will be a menu of support available to families and thanked La’Verne for her update.

Agenda Item 5 – Safeguarding Audit at MAH update

24. Sean Holland advised members that the DoH commissioned a safeguarding audit file review last month. The review is complete, however there is no formal report as yet. Sean invited Aine Morrison to give an update on this.

25. Aine noted that she is still waiting on a formal written report. A summary was given by the auditors and further discussions have taken place on the need to have a formal report prepared.

26. Dawn Jones raised that she still does not have a social worker in Muckamore Abbey Hospital and Sean Holland assured her that he would look into this and come back to her on this matter.

AP2: The provision of a Social Worker at MAH for Dawn Jones to be confirmed. (Action: DoH)

27. Aine provided an overview on the background to commissioning the safeguarding audit, which arose from concerns over the number and nature of safeguarding referrals in relation to staff on patient incidents. Aine advised that discussions had been held with both the Trust and the RQIA who felt the numbers of cases could be explained by low thresholds and an over reporting of incidents due to the level of scrutiny staff are under.

28. Aine advised that:
    - The audit had been performed by an independent team of four auditors. Three of the auditors were from a social work background and the fourth had a background in learning disability nursing.
    - A sample of 60 staff on patient referrals was selected by the team; of the 60, 40 had been screened in by the Trust and 20 screened out meaning that the reported issue was not deemed to meet an adult protection threshold although it may have required some other action.
    - Safeguarding forms not user friendly and do not support the process or the recording of the process well.
    - Quality of recording poor in many instances, particularly re the rationale for decision-making.
    - A lack of follow up recording, particularly where incidents were waiting for PSNI input with no evidence of protection plans being reviewed regularly during this waiting period.
    - A lot of incidents linked to a small number of patients but a lack of evidence that these were being considered in the round, seemed to be largely dealt with as entirely separate incidents.
    - Inappropriately low thresholds for referrals in a significant number of referrals but screening thresholds were appropriate.
    - Some suggestion that safeguarding processes are being engaged to protect staff rather than the necessary or right thing for patients.

- A lack of evidence that wider protection issues had been considered when agency staff were no longer being employed in the hospital such as consideration of regulator referral or follow up re other employment.
- Good practice evident in speedy and thorough initial responses, communication with families and referrals to PSNI.
- Variability in DAPO response. Some DAPOs very thorough and comprehensive in their recording which showed good professional decision making. Others much less comprehensive in their recording.
- Agency staff appear disproportionately involved in incidents of concern.
- Of the screened in referrals, whilst acknowledging that some investigations were inconclusive and that some were ongoing, overall the team felt that there was likely to be substance to a significant proportion of them whilst acknowledging it was very difficult to firmly evidence a lot of them.
- Some of the staff behaviours in the screened in referrals were for responses to patients that should have been very obviously inappropriate. This led the reviewers to have concerns about the knowledge, skills and experience of these staff.

29. As a result of the audit, the Belfast Trust were asked to immediately follow up in three areas;

  - ➢ Review any cases where there had been some actions taken in relation to an agency member staff because there were concerns about their behaviour towards patients. This could include agency staff who stopped working in MAH of their own accord or where a decision had been made to stop using a particular staff member. The purpose of the review is to ensure that all necessary protective actions were taken in respect of these staff including referrals to professional regulatory bodies as appropriate.
  - ➢ Immediately review all cases where there has been more than two adult safeguarding referrals involving the same patient. This is to ensure that incidents have not been considered in isolation.
  - ➢ Review the referrals to identify what had been the outcome of each investigation adult safeguarding documentation in response to the auditors’

comments that the records lacked any conclusion in a large number of cases.

30. Sean thanked Aine for her update and added that it was clear that a number of safeguarding issues have been identified in this review but also to be noted that some of the issues were system issues which we know need improved and would be addressed through a process of reform of adult safeguarding systems.

31. Brenda Creaney raised a query with Aine in relation to the holding of regulatory actions and information about nursing staff, advising that detail wouldn't normally be held in patient files, but would be held by the Bank Office. Aine acknowledged that regulatory referral may well sit elsewhere to be actioned but that as the consideration of wider protection issues sits with the DAPO, she would have expected it to be referenced in the safeguarding records.

32. Brigene McNeilly advised that from her recent experience there is a lack of accurate recording. Auditors can only work with what information they have and this may not be a true reflection of how safeguarding is in Muckamore. She asked if there is some way staff can be provided with more training that will help them to record more accurately.

33. Sean stressed that staff not recording information correctly could also be caused by the forms not being fit for purpose and these will need reviewed.

34. Re any PSNI delays, Carol advised that regular meetings with the PSNI take place and that processes take time to allow them to gather the information that is required.

35. Dawn Jones highlighted her concern over the safeguarding forms and asked why it took until now to realise they weren't fit for purpose and why actions were not taken sooner. Sean noted that the issue had emerged during a number of safeguarding review processes and that it would form part of the ongoing reform of adult protection services.

Agenda Item 6 – Unannounced Inspection

36. Sean Holland invited Emer Hopkins to provide an update on the RQIA unannounced inspection that recently took place at Muckamore Abbey Hospital. Emer advised that this was quite a drawn out inspection process, with a number of follow-ups and engagements with families. She further advised that RQIA are working with the Belfast Trust to incorporate findings from the Safeguarding Audit into an Improvement Plan.

37. Emer outlined that the inspection was carried out between 30 July and 10 August and went on to note that six inspectors were assigned to different wards and had an onsite presence for over 5 days and that a lot of time was spent with patients and staff. She advised that the findings concluded that there are good systems in place and timely referrals are being made. She also advised that the inspectors highlighted that staff at the hospital appear to be hyper vigilant and are being extra cautious by reporting themselves and others; this they felt was due to staff feeling they under constant scrutiny.

38. Emer also acknowledged the outcome of the adult safeguarding file audit.

39. Emer stressed that it was evident that there are some gaps in skills and experience, especially in relation to agency staff. There are also a growing number of staff who are the subject of protection plans because of concerns about their behaviour and improvements are needed by way of broader support. She added that work is needed to re-engage both adult safeguarding teams and ward staff in order to improve relationships between them.

40. Emer also advised that the inspection team had spoken to a number of families and patients in the community and broadly the feedback was that staff are compassionate to patients needs and have a good experience of care. Emer commented that the Trust are being proactive, trying to make the best use of the site, the staff skills set and also reorganising patients to provide them with a better ward environment. She also noted that there is some quality leadership on site. Emer did however voice concerns over the sustainability of the site and

the significant staff shortages, especially with a growing number of staff on protection plans and a number absent due to COVID. She further noted that it is important to re-energise resettlement plans.

41. Emer advised that their report is well advanced and will be shared with the Trust. The improvement plan will also be published and she is happy to meet with families following this. She highlighted that learning can be shared with other services and the same themes and practice issues are evident from other inspections.

42. Dawn Jones noted the vast improvement in her experience with the RQIA Inspection experience this time. She thought it was remarkable that the RQIA contacted her. Emer stressed that she hoped for a better inspection experience going forward and thanked Dawn for her participation

Agenda Item 7 - MAH HSC Action Plan – Exception Report

43. Sean Holland referred members to paper MDAG/13/21, and invited Darren McCaw to update the group on progress with delivery of the Action Plan. Darren summarised the key points from the report, including a summary of the current RAG status of the actions in the plan, and an update on the actions rated red. He provided an update on a number of actions that were reported as completed and have been moved to Section A of the Action Plan.

Agenda Item 8 - Progress update - Actions rated red

44. Sean Holland confirmed that updates on three actions would be provided at today's meeting; the HSCB would be providing updates on actions A12, A13 and A14; Sean Holland invited Maurice Leeson to provide a progress update for these.

45. Maurice provided an update in relation to A12, advising that an Assistant Directors' meeting had been set up and had produced a Disability Framework that included a number of strands including Early Intervention and Transitions. In terms of transition from Child and Adult Mental Health Services (CAMHS)

to Adult Mental Health Services (AMHS) at age 18, there was transition work still to be finalised and a separate paper was being produced for this. An additional member of staff will be recruited in October to focus on transitions.

46. In relation to A13, Maurice advised that costings for an implementation plan for the new regional framework for reform of children's autism, ADHD and emotional wellbeing services, including consideration of the services required to support them into adulthood had been completed by the Department and HSCB and submitted. Work was to include additional support for those transitioning between services.

47. Maurice advised that in relation to A14, a working group has been set up in terms of Iveagh and the HSCB and Trust are working their way through reviewing exit plans. An operational policy is also being developed for the Centre.

Agenda Item 9 - Highlight Report and Dashboard

48. Sean Holland referred members to paper MDAG/14/21 and invited Maire Redmond to provide an update.

49. Máire noted that there was a delay in issuing the resettlement dashboard due to a member of staff in the HSCB who was unexpectedly unavailable.

50. Maire Redmond advised members that there are currently 41 patients with a delayed resettlement in Muckamore, the last resettlement taking place in May. Máire advised that a planning meeting in relation to resettlement was being organised and this would address how to drive the resettlement of patients' in Muckamore forward.

51. Máire noted that a number of resettlements to the Mallusk facility planned to take place by the end of August have now been pushed back as Inspire have advised that they have been unable to recruit all the staff required to allow

these transitions to take place. Máire asked Petra Corr to provide any further details on this.

52. Petra Corr advised that due to the complexity of the patient needs those patients due to transition to the Mallusk facility were on a phased resettlement plan over a period of 18 months. The start date for a number of these resettlements has been delayed because of challenges for Inspire with recruiting staff. However the facility is open and a patient from SEHSCT has moved into their new home. Progress is being made on the resettlement of an individual from MAH who is due to move in October subject to safe staffing levels being in place. Petra noted that there are significant staff pressures regionally with nurses and social care staff; a number of the placements require 2:1 care at all times and a high level of staffing is required.

53. Petra also pointed out that a NHSCT resettlement to Positive Futures took place in July. Máire noted that the July resettlement is not reflected in the current dashboard, but should be updated in the next report.

54. Máire asked members to recall that a briefing paper in relation to the psychology service supporting Muckamore was provided to the last MDAG and the Trust have advised that efforts to recruit into the psychology team are ongoing.

55. Máire stressed that while we are aware that current nurse staffing levels, with the combination of substantive, long-term agency and bank nursing staff are considered to provide a safe level of care; staffing levels remain a fundamental vulnerability. The Trust have asked for a meeting with the Department, RQIA and HSCB to discuss this further; this has been arranged for 08th September.

56. Máire noted that Belfast Trust has highlighted the proposed opening of three in-patient beds in Holywell Hospital and noted that there have been no inpatients admitted to Muckamore since December 2019. Máire asked Petra for an update on the proposed ward in Holywell Hospital. Petra advised that they are working to get the beds open as soon as possible. One bed has been

opened on a temporary basis due to a crisis. The plan is to close this again and reopen it when all works were completed and staffing in place to enable the safe opening and running of the ward. She further advised that the Trust was progressing with recruitment of staff for the new ward and admissions would focus on a South Eastern and Northern Trust partnership.

57. Brigene McNeilly asked if there were currently any beds available in Cherryhill. Gillian Traub advised that the facility is currently in use. There is a plan to move two patients of Muckamore Abbey Hospital into the two remaining places in Cherryhill once staffing and CCTV issues have been resolved. Gillian was not sure of the exact number of patients in Cherryhill currently, but agreed to find out and share with members.

AP3: Gillian Traub to share exact number of current patients currently in Cherryhill and the number the facility will house. (Action: Belfast Trust)

Agenda Item 10 – AOB

58. Máire Redmond advised that following the June MDAG the Belfast Trust circulated minutes of the meeting to the relatives of current in-patients. It had been queried why the minutes are not circulated to relatives of all current and former patients. Máire noted that not all relatives inform the Trust when their contact details such as home address or e-mail address change and as such this would not be possible. She advised that a previous exercise to contact all relatives of current and former patients to ask them to engage with the public inquiry had resulted in a large volume of letters being returned ‘not known’ at this address. Máire advised that minutes from meetings are published on the Department of Health’s website.

59. Gillian Traub noted that an open, honest and transparent approach is best and that experience has also shown that some families do not wish to be provided with information. She suggested that the Trust write to all current and former families where contact details are held on their database advising that the MDAG meetings take place and minutes from these are published. A link to

these would be provided that would allow families to access them. Information from the meetings would be provided to current families going forward.

60. Sean added that the Inquiry would also give ongoing open channels of communication with families.

AP4: Belfast Trust to contact families of former and current in-patients to advise them that minutes of MDAG meetings are published on the Department's website and also to provide a link to these. (Action: Belfast Trust)

61. Máire advised that it was noted at the MDAG meeting in April that the Department would develop a risk register that would be brought to a future meeting. Maire confirmed that work is ongoing with professional colleagues and Internal Audit in the Department and a draft will be shared with the Trust in advance of being brought to MDAG to consider.

AP5: Department to share draft Risk Register with Belfast Trust, in advance of bringing to MDAG. (Action: DoH)

Agenda Item 11 – Date of next meeting

62. The next meeting is scheduled for Wednesday 27th October at 2pm.

<u>Summary of Action Points</u>

Ref.	Action	Responsible	Update	Open/ closed
25/08/AP1	Letter to be drafted and sent to Chief Executive of Southern Trust re lack of representative at MDAG meetings.	DoH		
25/08/AP2	The provision of a Social Worker at MAH for Dawn Jones to be confirmed.	DoH		
25/08/AP3	Gillian Traub to share exact number of current	Belfast Trust		

Ref.	Action	Responsible	Update	Open/ closed
	patients currently in Cherryhill.			
25/08/AP4	Belfast Trust to contact previous and current families to provide them with information on MDAG meetings and provide link to published minutes on Department’s website.	Belfast Trust		
25/08/AP5	Department to share draft Risk Register with Belfast Trust, in advance of bringing to MDAG.	DoH		

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 22 December 2021

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Seán Holland	DoH (Chair)	Karen O'Brien	Western Trust
Linda Kelly	DoH	Rodney Morton	PHA
Mark McGuicken	DoH	Deirdre McNamee	PHA
Máire Redmond	DoH	Gavin Davidson	QUB
Siobhan Rogan	DoH	Mandy Irvine	NI British Psychological Society
Aine Morrison	DoH	Aidan McCarry	Family rep
Ian McMaster	DoH	Vivian McConvey	PCC
Darren McCaw	DoH		
Teri Gourley	DoH (Note)		
Brendan Whittle	HSCB		
Lorna Conn	HSCB		
Moira Kearney	Belfast Trust		
Brenda Creaney	Belfast Trust		
Carol Diffin	Belfast Trust		
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Margaret McNally	Family rep		
Margaret O'Kane	South Eastern Trust		
Petra Corr	Northern Trust		
Carina Boyle	Western Trust		
Dr Maria O'Kane	Southern Trust		
Emer Hopkins	RQIA		
Lynn Long	RQIA		
Grainne Close	Mencap		
Meadhbha Monaghan	PCC		
Bria Mongan (for agenda item 4)			
Ian Sutherland (for agenda item 4)			

Agenda Item 1 - Welcome/Introductions/Apologies

1. Seán Holland welcomed attendees, and highlighted that the meeting for October 2021 was cancelled due to a number of apologies. The Department tried to reschedule this meeting but it was not possible to get a suitable date.

2. Seán Holland introduced Mark McGuicken who has taken over the role of Mark Lee, as Director of Disability and Older People in the Department and Linda Kelly, interim Chief Nursing Officer (CNO) to the group. He advised that normally the CNO would co-chair the meeting, but as this was Linda Kelly's first meeting, this would not be the case.

3. Seán Holland noted apologies received.

Agenda Item 2 – Minute of Previous Meeting

4. Seán Holland noted that the draft minutes of the previous meeting held on 25 August were circulated to members on 2 September. Following receipt of a number of comments from members, the draft minutes were amended and published on the Department's website as an agreed record of the meeting. There were no further comments on the minutes.

Agenda Item 3 - Update on Action Points – S Holland

5. Seán Holland provided an update on the open action points arising from previous meetings of the Group. He advised 25/08/AP1 had been actioned, the letter to the Southern Trust had been sent and this action was now closed.

6. In relation to 25/08/AP2, this had been raised with the Belfast Trust and given workforce pressures within social work there is not an individual social worker assigned to all wards. If a patient requires a social worker, cover is available across site. Seán Holland advised Dawn Jones if she would like to pursue this further, he was happy to do so offline.

7. He went on to note that 25/08/AP3 had been actioned and is now closed. The number of patients currently in Cherryhill had been provided by Moira Kearney, with an occupancy of six and two further planned resettlements to the site.

8. Seán Holland invited Moira Kearney to provide an update in relation to 25/08/AP4 and she advised that the Belfast Trust had written to families in late summer to share a link with them on how to access the minutes to MDAG meetings. If anyone faced any difficulties with this, the Trust would be happy to

provide a hard copy. She had asked for requests by 6 December and had received no further correspondence. Action now closed.

9. In relation to 25/08/AP5, Seán Holland advised that work has been continuing on the development of an MDAG risk register. Following engagement with Departmental professional colleagues and Internal Audit, a revised template was shared with the HSCB and BHSCT in late October for their consideration and any comments. Responses have now been received and are currently being considered by the Department. It is hoped to circulate a draft Risk Register to Members for the next meeting.

10. Seán Holland asked Moira Kearney to provide an update on 30/06/AP7. Moira Kearney noted that questionnaires are issued to families by the Belfast Trust to provide feedback on those who have been affected by safeguarding at Muckamore Abbey Hospital (MAH). They are currently investigating ways to refine their approach and further work on this is due to commence in January 2022.

11. Seán Holland provided an update on 28/04/AP6 and advised that a meeting to discuss the future onsite service model, was held with the Belfast Trust on 11 November. He advised that there was further work to be done, including further engagement with the Belfast Trust and he would provide an update at the next meeting.

12. Seán Holland advised in relation to 28/04/AP7, that Bria Mongan and Ian Sutherland were attending the meeting today to provide an overview of their work on resettlement.

Agenda Item 4 – Resettlement

13. Seán Holland welcomed Bria Mongan and Ian Sutherland to the meeting and asked them to provide a verbal update to the group on their work to date.

14. Bria Mongan gave an overview of both her and Ian Sutherland's backgrounds and noted their lengthy experience in Learning Disability. She advised that both she and Ian had been commissioned to complete a review on resettlement and

referred members to the Terms of Reference (ToR) for the review which had been included with the papers circulated for this meeting.

15. She highlighted that this first phase of work was primarily fact finding and advised that meetings had taken place with patients and staff at MAH, the senior teams of all 5 Trusts and the Northern Ireland Housing Executive (NIHE). Further meetings are due to take place with 3rd sector, independent and voluntary organisations in the New Year.

16. Bria Mongan provided an overview to members on a number of schemes that are currently in progress and discussed a number of resettlements that are due to take place over the next number of months. She also provided information on a number of at risk schemes, where there are no concrete plans for these going forward and highlighted that there were no resettlement plans for four individuals.

17. Bria Mongan advised that the second part of resettlement work that she and Ian will undertake will be to analyse the information they have received and provide a number of recommendations. She went on to highlight enthusiasm displayed by the Trusts and their teams but acknowledged that there was also signs of inertia and drift. She emphasised the moral and strategic imperative to push resettlement forward. Seán Holland also highlighted the legal imperative to expedite resettlement as recent judicial reviews had found the delays unacceptable.

18. Ian Sutherland stressed the importance for a whole system approach across Trusts to expedite the resettlement process as whilst he is hearing about collaboration from the Trusts he is not seeing sufficient evidence of this in practice.

19. He stressed that whilst the resettlement process has been slow over the past year as reflected in the dashboard, there will be movement in the next 12 months, with up to a quarter of patients due to be resettled. Going forward Bria Mongan and Ian Sutherland plan to engage with families in coming months.

20. Ian Sutherland highlighted the issues across the social care workforce and the risk this poses for the programme. He stressed that there needs to be improvement in the capacity and capability of the workforce.

21. Seán Holland noted that the long delays in resettlement are unacceptable and the Department are keen to collaborate with the Trusts and see actions being delivered regionally. He added that there needs to be a whole system approach both in resettlement and in bed management for in-patient acute beds. Where there are no resettlement plans for patients, the Department will seek to raise this with Trust Chief Executives, as this should be at the front and centre of every Trust.

22. Siobhan Rogan advised that there is currently an Extra Contractual Referral (ECR) being considered for a patient ready to be discharged and asked if there was any update on the situation, as more localised solutions are preferred. Seán Holland noted that he was keen not to discuss individual cases. Brigene McNeilly asked for clarity on what an ECR was and Seán Holland advised that it is when there is a lack of service within Northern Ireland and the needs of a patient cannot be met, therefore a service is purchased outside of the country. He stressed that this is never a good option for the patient or family.

23. Carina Boyle noted that the Western Trust are also facing challenges with resettlement and agreed that collaboration has to be real and it is an interagency responsibility and asked how the Trusts would fix the situation. Ian Sutherland advised that resettlement needs to take place on regional basis, and noted the good practice he has seen in South England, where authorities have collaborated. He did emphasise that there is evidence of good provision in Northern Ireland, however there are gaps for those with very complex needs. Brigene McNeilly stressed the importance of keeping patients close to their families. Seán Holland reassured her that this approach was for emergency situations only. Margaret McNally reiterated what Brigene McNeilly said, and highlighted the importance of getting the balance right in relation to the distance families have to travel.

24. Bria Mongan highlighted the helpful discussions they had held with the Housing Executive, but added that there had been a lot of change in Senior Management roles within the trusts and therefore it would be helpful for refreshment in the arrangements of progression with housing partners. There are plans for a workshop to provide providers with this information in the New Year.

25. Seán Holland advised that the Department are keen to move to a regional approach for learning disability services to include resettlement and acute bed management arrangements to align with mental health bed management. Brendan Whittle highlighted the significant progress in mental health bed management and that he was also keen to work towards a whole system approach for learning disability.

26. Seán Holland thanked Bria Mongan and Ian Sutherland for their overview and noted that he looked forward to early sightings of their recommendations.

Agenda Item 5 – Public Inquiry Update

27. Seán Holland advised that La'Verne Montgomery usually made herself available to provide an update on the Public Inquiry; however she was not available for the meeting today. He invited Máire Redmond to provide an update.

28. Máire Redmond advised that the Inquiry has made significant progress since it was officially set up on 11 October 2021 and it will be moving into premises in the Corn Exchange in the Cathedral Quarter of Belfast January 2022. She noted that in response to the drive to encourage people with experiences of MAH to contact the Inquiry team, it has now received around 80 contact forms.

29. She further advised that the first phase of the Inquiry will focus upon evidence from those with experience relating to the care of patients within Muckamore Abbey Hospital from the perspective of the patients and that this is likely to be provided by patients, ex-patients, their relatives and carers. The second phase of the Inquiry will focus upon a smaller group of people either with experience of caring for those within the hospital or with knowledge of how the hospital

worked but not necessarily with direct experience themselves. This might include, nurses and other staff working at Muckamore Abbey Hospital as well as those with responsibilities for resettlement or the transportation of patients to and from Muckamore Abbey Hospital. The Panel expects to begin hearing witnesses from phases one and two in spring of 2022.

30. Máire Redmond also advised that the Inquiry has issued voluntary document requests to twenty-one potential document providers, including the Department. This initial request has been a scoping exercise to establish whether those contacted have material relevant to the ToR and the categories of such material, as well as the volume of it. The Inquiry team is currently reviewing the correspondence to follow up with more specific document requests. She highlighted that Seán Holland had issued a number of letters to the Department to ask officials not to destroy or delete any records that may be of relevance.

31. Seán Holland thanked Máire Redmond and noted we will aim to routinely have an update on the Inquiry at each meeting.

Agenda item 6 – Safeguarding at MAH

Unannounced Inspection at Muckamore feedback – Emer Hopkins

32. Seán Holland invited Emer Hopkins to provide an update on the RQIA inspection. Emer Hopkins noted that the report of the RQIA Inspection that took place from 28 July – 19 August 2021 was published on the RQIA website in December and advised that the Inspection team have met with family members, including the carers group to discuss the report.

33. She advised that the Inspection focused on a number of areas including safeguarding and a number of recommendations have been made including the Trust being recommended to improve interactions with family members and improved communication between the Adult Safeguarding Group (ASG) and other staff on site. Emer Hopkins highlighted the persistent challenges

with the staffing levels, stability and experience of the ASG team and that the team are trying to address this. She also advised that the Inspection highlighted a picture at a point in time and that the picture may have changed.

34. Emer Hopkins also emphasised that the RQIA are happy to discuss and engage with anyone over the Inspection findings. The Belfast Trust agreed to provide a paper copy of the report to individuals who wished to read it in this format.

AP1: Belfast Trust to provide a paper copy of the RQIA Inspection report to those family members that request this (Belfast Trust)

35. Emer Hopkins also provided an overview on the role of RQIA and highlighted the role they have in the Safeguarding Governance Group. She advised that the RQIA not only fulfil their role through Inspections but also on an ongoing basis, for example the RQIA plan to meet with Belfast Trust in the New Year and are keen to be open to address challenges.

Update on actions arising from DOH commissioned audit – BHSCT

36. Seán Holland invited Carol Diffin to provide an update on the actions arising from the DoH commissioned independent adult safeguarding audit. She advised that some actions from the audit were completed and others were ongoing.

37. Carol Diffin provided an overview of the safeguarding challenges and advised that she has had follow up conversations with Aine Morrison to discuss thresholds. She advised that there needs to be consistency with safeguarding reporting and that she is currently working with the DAPOs to address this. In addition she advised that there is ongoing work and training with line management and staff, including the ASG team to ensure a clearer understanding of roles and responsibilities.

38. Aine Morrison agreed that some progress had been made and that useful conversations on safeguarding had taken place; in particular around practice and procedures, structures and the role of the DAPO. She also noted that 2 out

of 3 urgent actions from the DOH commissioned safeguarding audit had not been completed. She outlined a number of actions that need addressed, including the quality of the DAPOs response to the safeguarding referral, inappropriate behaviours of some staff and the lack of relevant experience, skills and value base of some members of the ASG team. Aine Morrison advised that the Department is keen to work with the Trust on these issues and highlighted the need for the Belfast Trust to develop an action plan to address all the recommendations in the DOH commissioned audit.

AP2 DOH to write to Belfast Trust seeking an action plan to address the recommendations from the independent safeguarding audit. (DoH)

39. Carol Diffin advised that when there has been more than one referral per patient, the safeguarding paperwork did not lend itself to this. The DAPO takes account of this situation in their practice; however it is not noted in the paperwork.

40. Aine Morrison noted that the Department had sought further information on the action points arising from the safeguarding audit. Brenda Creaney advised that she had not seen these queries and asked for them to be sent to her. Brendan Whittle asked for himself and Lorna Conn to be copied into this correspondence.

AP3: Department to follow up in writing to Belfast Trust with queries arising from update on safeguarding audit action points. HSCB to be copied into correspondence. (DoH/Belfast Trust)

Agenda Item 7 – MAH HSC Action Plan – Exception Report (MDAG 19/21)

41. Seán Holland invited Darren McCaw to update the group on progress with delivery of the Action Plan. Darren McCaw provided an update on the paper circulated in advance of the cancelled October meeting and advised that there had been no change to the number of completed actions, these remained at

25. He noted that two actions had moved beyond their target date and as a result moved from amber to red, there are now 18 red rated actions.

42. Darren McCaw also provided an update on the Action Plan for December and advised that there had been no changes reported by action owners on any of the ratings contained within the Action Plan. He advised that there are 18 actions rated as red, 11 actions rated amber and 25 green actions.

Agenda Item 8– MAH Action Plan - Progress update – Actions rated red

43. Seán Holland confirmed that updates on three actions would be provided at today's meeting and invited Siobhan Rogan to provide and update on A30.

44. Siobhan Rogan advised members that whilst some stakeholder engagement had taken place, engagement with individuals with a Learning Disability had not been able to take place as desired due to the Covid pandemic. The team are currently analysing the information they have received to date to theme the responses and, in due course will produce a report with recommendations.

45. Darren McCaw was invited to provide an update on A37 and A46. He advised that A37 was now rated as red as the target date of September 2021 had not been met. He noted that the Learning Disability Multi-Disciplinary Team Workforce Review would ideally have been considered as part of the outworkings of the Learning Disability Service Model but as this has not yet been agreed it was felt that phase 1 of this work i.e. to establish a current baseline of the workforce could commence. He advised that Pauline Cummings, who has recently retired from her post as Learning Disability Assistant Director in the Northern Trust was appointed as Project Co-ordinator for the Review on 18 October 2021.

46. Darren McCaw further advised that a bid for future funding to enable the Review to continue through the 2022/23 financial year has been made by the Department.

47. Darren McCaw informed members that the draft ToR had been updated and will be considered at the first meeting of the project group planned for January 2022. This will be chaired by Director of Disability and Older People's Directorate, Mark McGuicken. The Department are also arranging a meeting with the PCC for the New Year to explore the possible assistance of the PCC on engagement with service users/families/carers to provide their experience and input into the work of the Group.

48. In respect of A46; a plan for the future configuration of services to be delivered on the Muckamore Abbey Hospital site; Darren McCaw noted that Belfast Trust were asked in September 2020 to explore options for the development of a resettlement option on the Muckamore Abbey Hospital Site. A meeting to discuss next steps for this took place between the Department and the Belfast Trust on 11 November. At this meeting Seán Holland advised that he would be open to considering any options that were brought forward and committed to providing additional clarity on what is expected in relation to this proposed development. This was initially due to be discussed further at a meeting with the Trust in December which unfortunately had to be cancelled; a further meeting will be arranged for early in the New Year. Darren McCaw advised that the Department continue to engage with the Health and Social Care Board and Trusts on ways to enhance current resettlement processes, including the work Bria Mongan and Ian Sutherland are taking forward.

Agenda item 9 – Highlight Report and Dashboard (MDAG 20/21)

49. Máire Redmond highlighted that there has been one resettlement of a patient from MAH since the June MDAG meeting. She emphasised the difficulties with the planned resettlements and the ongoing issues with recruitment of staff.

50. Máire Redmond advised that she would not go into great detail on the highlight report, as this was circulated in advance of the meeting. She referenced paragraph 4.3 of the report which highlights that funding has been secured to support the opening of 3 Learning Disability in-patient beds in

Holywell. She asked Petra Corr for an update as to the planned opening of this unit.

51. Petra Corr advised that there had been preliminary plans for this unit to open earlier in the year however after discussions with RQIA they advised that the vacant ward in Holywell that was identified for this purpose did not meet the standards for an inpatient LD service and that capital work was required on the site. The process is currently in the design phase and work on the unit is due to begin in January 2022.

52. Petra Corr also provided an overview on the current position for the recruitment of staff for the unit; she advised that this is an ongoing process with further interviews due to take place in December and the New Year. She also noted that while timescales are dependent on a number of factors it is hoped that the unit will open in June 2022.

53. Máire Redmond highlighted the concerns previously raised by Belfast Trust of the new unit attracting staff from MAH, and stressed the already fragile staffing situation in MAH. Brenda Creaney advised that conversations about staffing would need to take place between the Belfast Trust and Northern Trust outside of the meeting.

AP4 Belfast and Northern Trust to discuss potential negotiations on notice period for staff transferring between Trust Hospitals (Belfast/Northern Trust)

54. Máire Redmond highlighted that from 30 September there had been three new admissions to MAH, with one patient successfully discharged. She stressed the challenging situation that the hospital is facing and noted that the Trust has advised that there can be no further admissions to the hospital, unless there are further discharges. She added that the Belfast Trust are managing the situation and are keeping the Department informed of the fluid situation.

55. Brigene McNeilly raised concerns over the current staffing situation in MAH, and asked for an update on the current COVID outbreak within one of the

wards and for reassurance that the hospital was providing a safe staffing level.

56. Moira Kearney advised that the Belfast Trust share the same concerns on staffing. She informed the Group that Senior Management meet with staff twice a day to monitor the staffing levels. She further advised that the Trust are reviewing the potential to redeploy appropriately trained staff into the wards, staff being asked to cover additional shifts and seeking additional staff from bank and agency staff and calling out to retired staff. She also advised of the significant vulnerabilities in the community services that is adding to the complexity of this problem.

57. Brigene McNeilly also expressed her concern over injuries being sustained by patients, due to behaviours escalating, because they are being asked to isolate due to the current Covid outbreak. Moira Kearney advised that the Trust are following PHA guidelines on infection and control of COVID, and assured the Group that they are monitoring the situation hour by hour.

58. Seán Holland noted that it is an upsetting situation and highlighted that the Belfast Trust have been keeping the Department well informed of the situation and are looking at other Trusts for support. He emphasised that this is a situation that is being replicated across a number of services and will continue to do so over the next number of weeks, but they will maintain the best service they can.

Agenda Item 10 – AOB

59. None raised.

Date of Next Meeting

60. The next meeting is scheduled for Wednesday 23 February at 2pm.

Summary of Action Points

Ref.	**Action**	**Responsible**	**Update**	**Open/ closed**
22/12/AP1	Provide a paper copy of the RQIA Inspection report to those family members that request this.	Belfast Trust		
22/12/AP2	DoH to write to Belfast Trust seeking an action plan to address the recommendations from the independent safeguarding audit.	DoH		
22/12/AP3	Department to follow up in writing to Belfast Trust with queries arising from update on safeguarding audit action points. HSCB to be copied into correspondence.	DoH/Belfast Trust		
22/12/AP4	Belfast and Northern Trust to discuss potential negotiations on notice period for staff transferring between Trust Hospitals.	Belfast/Northern Trust		

MDAG/04/22

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 23 February 2022

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Seán Holland	DoH (Chair)	Mark McGuicken	DoH
Linda Kelly	DoH	Rodney Morton	PHA
Máire Redmond	DoH	Gavin Davidson	QUB
Siobhan Rogan	DoH	Aidan McCarry	Family rep
Aine Morrison	DoH	Margaret McNally	Family rep
Ian McMaster	DoH	Grainne Close	Mencap
Darren McCaw	DoH	Darren Strawbridge	DoH
Teri Gourley	DoH (Note)	Brenda Creaney	BHSCT
Brendan Whittle	HSCB		
Lorna Conn	HSCB		
Catherine Cassidy	HSCB		
Deirdre McNamee	PHA		
Moira Kearney	Belfast Trust		
Paula Forrest	Belfast Trust		
Carol Diffin	Belfast Trust		
Margaret O'Kane	South Eastern Trust		
Petra Corr	Northern Trust		
Karen O'Brien	Western Trust		
Heather Trouton	Southern Trust		
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Emer Hopkins	RQIA		
Vivian McConvey	PCC		
Mandy Irvine	NI British Psychological Society		
Kerry Loveland-Morrison (for agenda item 4)	DoH		
Bria Mongan (for agenda item 5)	HSCB		
Ian Sutherland (for agenda item 5)	HSCB		
Gillian Seeds (for agenda item 6)	DoH		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Seán Holland welcomed attendees and introduced Heather Trouton to her first MDAG meeting in her role as the new interim Director of Mental Health and Learning Disability in the Southern Trust.

2. Seán Holland noted apologies received from Mark McGuicken, Rodney Morton, Gavin Davidson, Aidan McCarry, Margaret McNally, Grainne Close, Darren Strawbridge and Brenda Creaney.

Agenda Item 2 – Minute of Previous Meeting

3. Seán Holland noted that the draft minutes of the previous meeting held on 22 December were circulated to members on 7 January. Following receipt of one suggested amendment, the draft minutes were published on the Department's website on 20 January as an agreed record of the meeting. There were no further comments on the minutes.

Agenda Item 3 - Update on Action Points – S Holland

4. Seán Holland provided an update on the open action points arising from previous meetings of the Group. In relation to 22/12/AP1, the Belfast Trust advised that there were no requests for a paper copy of the report as of last week, however an opportunity for carers to request a copy of the report was also provided through the December carers forum.

5. Seán Holland advised that in relation to 22/12/AP2, he wrote to Cathy Jack on 13 January, and on 16 February he received an action plan from the Belfast Trust that is under consideration by his colleagues in the Department. He advised that a further safeguarding action, 30/06/AP7, was still ongoing and the Department have been liaising with the Belfast Trust in relation to this matter. He advised that an update on 22/12/AP3 would be provided under the Safeguarding agenda item by Aine Morrison.

6. It was noted that 22/12/AP4 was still ongoing, the timeline for the Northern Trust unit has been pushed back, however the Belfast and Northern Trusts are in discussion on how staff transfers will be managed.

7. Seán Holland advised that, in relation to 25/08/AP5, the Department are still working on the draft risk register and hope to circulate for the next meeting.

8. Seán Holland outlined that there has been extensive engagement between the Department, HSCB and Belfast Trust to progress 28/04/AP6. The Belfast Trust are currently carrying out a feasibility study of the on-site proposal which is now due to complete at the end of March 2022.

9. Moira Kearney provided an update for 30/6/AP7. Work on this has been delayed due to staff pressures and an update on this will be provided at the next meeting.

10. Seán Holland noted that an update in relation to 28/04/AP7 would be provided by Ian Sutherland and Bria Mongan at agenda item 5.

Agenda Item 6 – Public Inquiry Update

11. Seán Holland advised Members that he was going to take agenda item 6 out of sequence to enable Gillian Seeds to provide her update on the Public Inquiry and welcomed Gillian to the meeting.

12. Gillian noted that her update was timely as the Chair of the Inquiry just released an update statement. She agreed to send the Inquiry update to the Muckamore Abbey Review Team following the meeting that it could then be circulated to MDAG members.

AP1: Public Inquiry update statement to be circulated to members. (DoH)

13. Gillian advised that the Inquiry team have now moved into their offices at Corn Exchange and have leased two floors. One floor will provide office space for the Inquiry team and another floor will provide suitable space for a hearing room, as well as additional seating to any members of the public and press who wish to watch the proceedings over a live feed. There are a number of further smaller rooms to accommodate Core Participants, however it is

unlikely that all Core Participants can be provided with a private room on every hearing day. Arrangements for the use of such rooms will be circulated in due course.

14. Gillian provided an overview of the Inquiry team and highlighted that the solicitor to the Inquiry had now changed. Lorraine Keown from Cleaver Fulton Rankin has now taken on this role, replacing Joan MacElhatton.

15. Gillian also provided information in relation to the Document Management System; ‘Box’ and outlined how this would work. She advised that Core Participants would be given advance access to relevant material including statements as they become available. The system incorporates a number of features to ensure that confidentiality is respected and preserved.

16. She went on to advise that over ninety-five individuals have now contacted the Inquiry to offer Witness Statements. Introductory letters have been sent out to all those who have contacted the Inquiry to provide information and the process of taking statements from the first phase of witnesses will be commencing shortly. All of the statement takers have been provided with vulnerable witness training from Professor Penny Cooper. Counsel will also receive training specific to their role with witnesses. The Inquiry has also engaged a number of intermediaries who will be available to assist in the taking of statements where necessary, and it has also engaged a number of counsellors who are available to provide assistance to anyone affected by the work of the Inquiry, whether through the process of the taking of statements, or later in the proceedings during hearings.

17. Gillian provided information in respect of Core Participants and outlined that a number of individuals who are either affiliated to Action for Muckamore or to The Society of Parents and Friends of Muckamore have been designated as Core Participants. She also advised that organisations including the Department of Health, RQIA and Belfast Trust have also been designated as Core Participants and there was potential for others to be added further to the agreement of the Chair.

18. Gillian also provided information on document providers and outlined that fifty-eight letters have now been issued to identify those who may hold documents relevant to the Terms of Reference. A number of orders under Section 21 of the Inquiries Act have also been issued requiring the production of documentation to the Inquiry. The Inquiry team is engaging with a number of document providers to discuss the production of the relevant material to the Inquiry.

19. It was also noted that a further virtual engagement session is to be held on 9 March 2022 at 5pm and the Inquiry secretary can be contacted for the details or addition to the session.

20. Gillian also provided an outline of the indicative dates for the sitting of the Inquiry, as contained within the Inquiry Chair’s statement, for information.

21. She further advised that the Inquiry are offering appropriate psychological support to individuals involved in the Inquiry. An offer from the Secretary to the Inquiry to attend a future meeting of MDAG to provide detail on the operation of the Inquiry if felt useful was also raised.

22. Brigene McNeilly asked if there are facilities available for carers who want to view and listen to proceedings online from home. Gillian advised that she would go back to the Secretary of the Inquiry to find out if this was part of the contract that has been put in place.

AP2: Public Inquiry Sponsorship team to contact Public Inquiry team to find out if facilities will be put in place to allow proceedings to be viewed online. (DoH)

23. Aine Morrison provided information on the support that will be provided for people with a learning disability and their carers advising that engagement is ongoing with the trusts and HSCB to discuss the systems and processes that need to be put in place

24. She noted that all trusts have been asked for a representative to help take forward this piece of work and asked trusts to make this a priority. Mandy Irvine added that any longer term support would need to be discussed in relation to what each trust can provide and that they have been in touch with the Inquiry secretariat in relation to provisions and requirements. Aine Morrison noted that it would be advantageous for all trusts to use a common protocol.

25. Seán Holland added that meetings with HSCB and the trusts are key, however it is important that carers are consulted to capture their views on what support is needed. Brigene McNeilly agreed and emphasised the importance of ensuring inclusion of those carers who are on the periphery of the Inquiry who may then also need support as details become available throughout the course of the Inquiry. Sean noted the point and highlighted that it was important the system responded to that need.

26. Siobhan Rogan queried whether the communication strategy for the Inquiry would provide detail in Easy Read format etc. to aid understanding. Gillian Seeds agreed to raise with the Inquiry Secretary to get assurance that the strategy would cover this. She also advised that key easy to read documents are available on the Inquiry website.

AP3: Follow up with Inquiry Secretary to get assurance that their communication strategy for the Inquiry would provide detail in Easy Read format (DoH)

Agenda Item 4 – Adult Safeguarding Bill

27. Seán Holland welcomed Kerry Loveland-Morrison to provide an overview on the work she is taking forward on the Adult Safeguarding Bill. Kerry delivered a presentation to members on this work and provided information on the consultation process, service user input and outcomes of the consultation. She went on to outline the next steps for the Bill and advised that work was

continuing on the drafting of the Bill with the aim of introducing the Bill early in the next Assembly mandate.

28. She also advised that there will be a second consultation carried out for the Statutory Guidance and the Department will continue to engage with key stakeholders.

29. Ian Sutherland asked if the PSNI have been engaged in the process given the key role that they have in the execution of the outlined functions. Kerry Loveland-Morrison advised that the PSNI are very engaged through the Transformation Board and are involved at a policy development level, particularly in the financial and powers of entry processes.

30. Seán Holland advised that Kerry Loveland-Morrison would provide a further update at a future meeting, when, subject to the views of the new Health Minister, the Bill would be going through the Assembly.

AP4: Adult Protection Bill presentation to be shared with group members (DoH)

Agenda Item 5 – Resettlement

31. Seán Holland welcomed Bria Mongan and Ian Sutherland to the meeting and asked them to provide a verbal update to the group on their work to date.

32. Bria provided information on the three stages of their work. She advised that Phase 1 had been completed and they were currently in Phase 2, which involves engagement with a number of providers including RQIA, PCC, NISCC and ARC and others.

33. She also provided an overview of planned discharges and noted that by the end of the year the number of delayed discharge patients in Muckamore should be reduced to 16. An update was also provided on progress in relation to the three schemes being led by Belfast Trust, Minnowburn, onsite provision and a forensic site. She expressed concern at the degree of focus for a new build for the onsite proposal and noted that the refurbishment of a current building on

the Muckamore site would help to expedite the process. She went on to further advise that there have been three sites identified by a housing provider as potentially suitable for the forensic site.

34. Bria also advised that the Directors from the Belfast, Northern and South-Eastern Trusts held a workshop to discuss resettlement plans and she was due to meet with them on 25 February to discuss the outcome of this and an update would be provided for the next meeting.

35. She further advised that work was now moving to the third stage, to analyse the findings and complete a report including recommendations. Work is also continuing with trusts to review the tracker tool, moving it from performance monitoring to a performance management tool.

36. Brigene McNeilly asked if there were any plans to meet with carers and Bria emphasised the importance of families and carers within this work and advised that they planned to meet with them, including where resettlements had been successful, and were taking guidance from PCC and ARC on this.

37. Ian Sutherland advised that he was concerned that bigger projects were not delivering quickly enough and noted the importance of supply maps and using information on the composition of care that is already there to help inform decision making.

38. He provided a summary of findings on the composition of care in specialist learning disability nursing homes, residential care homes and Supporting People schemes.

39. He noted that although workforce is an issue for some providers, this is variable and tends not to be an issue for local, well established providers. He also noted that trusts continue to be major providers, providing about a third of registered care home places. He advised that the trusts are currently delivering and commissioning care and added that if the trusts were to exit the delivery model, then this might potentially help provide more resilience to the system. Ian

advised that many of these issues have scope to be addressed through a more collaborative model or framework.

40. The need to have regional data on vacancy rates within the system to help aid resettlements was discussed and Ian Sutherland outlined rates in Supporting People schemes as an example, where there is an estimated 10% void rate.

41. Seán Holland noted that the delays in resettlement are unacceptable and that the Department was keen for performance management to be carried out by trusts to ensure any issues or areas of good practice are identified.

42. Brigene McNeilly highlighted that the delays experienced by her family were a stain on the system. Brigene further added that although many providers have a number of places available, the cohort of patients remaining in Muckamore have extremely complex needs and unless these places are suitable for that level of need then they would not be suitable given the more specific requirements needed. Ian Sutherland agreed that places need to be suitable and appropriate, however he suggested that, where trusts are providing support to providers for placements, there may be the potential to clarify with the providers if they would have further scope to provide bespoke placements as required.

43. Sean Holland highlighted the need to look at how commissioning was being carried out if it was repeatedly not delivering what was needed.

44. Petra Corr noted that the engagement and support from Ian Sutherland and Bria Mongan is very well received from the Trusts. She advised that the Belfast, Northern and South Eastern Trusts are in the process of developing a collaborative approach to create solutions to expedite resettlement. Petra agreed to share more detail on this at the next meeting.

AP5: Belfast, Northern and South Eastern Trusts to provide information on their collaborative work to expedite resettlement. (BHSCT, NHSCT, SEHSCT)

45. Karen O'Brien advised that the issues being faced are common across the region, including an issue with the training of staff. She advised the Western Trust are also working with providers to get to a position of bespoke provision being provided in relation to both the placement and staffing. This also includes expansion to cover the wider workforce to ensure they are trained to manage those with complex needs in order to help sustain long term placements. She advised this work needs to take place with providers to ensure this happens and is a focus for them.

46. Bria Mongan advised that part of the resettlement work will involve looking at procurement and commissioning going forward regionally. Seán Holland agreed with the need for a regional approach.

47. Dawn Jones outlined her agreement with Karen O'Brien's comments and further expressed concerns around her engagement with staff in Muckamore Abbey Hospital and in particular improvements required with the resettlement social work team. Dawn advised that the sense of trust has been lost. Seán Holland offered to engage with Dawn Jones separately on these issues.

48. Seán thanked Ian and Bria for their update adding that the focus on data and analysis of that data was long overdue and he looked forward to updates on this work.

Agenda item 7 – Safeguarding at MAH

49. Seán Holland invited Aine Morrison to provide an overview on Safeguarding at MAH.

50. Aine advised that the Department had written to the Belfast Trust in January in relation to a number of issues including delays in putting protection arrangements in place and safeguarding processes. She advised that a response from the Belfast Trust to the issues raised has recently been received and the Department are considering this.

51. Aine further advised that the Department has also had a number of recent meetings with the Belfast Trust in relation to safeguarding policy and procedures and the work has included the mapping of Trust safeguarding practice against policy. She also noted that there has been significant improvement in the involvement of the DAPO, however further changes are needed to ensure the DAPO is leading on safeguarding. Further meetings are planned to continue this work.

52. Carol Diffin agreed that recent meetings have been constructive and confirmed that they have focussed on historical investigation processes, which are evolving and being guided by the PSNI. Carol Diffin confirmed that current investigations do follow prescribed policy and procedures.

53. Dawn Jones noted that whilst the historical safeguarding issues are important there are also issues with current safeguarding arrangements in Muckamore Abbey Hospital. Dawn emphasised the importance of ensuring linkages are made between historic and current investigations. Carol Diffin agreed and advised that they are being managed under two separate processes, whilst trying to make sure they both link up. Brigene McNeilly expressed concerns with the ongoing investigation process, citing her own experience, adding it feels like no answers are being provided and the ongoing delay has been horrendous. Dawn voiced her concerns after a staff member from the Belfast Trust told her that her standards were too high for her son and that he was more difficult to manage than most patients. It was agreed that Moira Kearney and Carol Diffin would follow up with both Dawn and Brigene in relation to these issues.

AP6: Belfast Trust to liaise with family reps in relation to ongoing concerns in Muckamore Abbey Hospital. (BHSCT)

Agenda Item 8 - BHSCT Advocacy Review

54. Moira Kearney provided an overview of the work of the Advocacy Review to date. She advised that the Terms of Reference (ToR) for this had been drafted and a meeting with parents and carers was due to take place this week. Belfast

Trust are continuing to work with ARC and TILI and will be working to establish focus groups.

55. Vivian McConvey advised Moira that she had not received a copy of the ToR and asked if it could it be sent to the PCC. Moira assured her that this had been sent to PCC but that she would follow up and send the ToR directly to her.

Agenda Item 9 – MAH HSC Action Plan – Exception Report (MDAG 03/22)

56. Seán Holland invited Teri Gourley to update the group in relation to progress with delivery of the Action Plan. Teri Gourley provided an update on the paper circulated in advance of the meeting and advised that updates on open actions had been provided by their owners and are detailed in the updated Action Plan. Teri advised that the Departmental Internal Audit unit had recommended that Responsible Officers should be assigned to each action within the Action Plan, and that those actions rated as red should be examined and updated with a new realistic timescale. Revised timescales are still required from the Department, Belfast Trust and HSCB and assigned Responsible Officers for actions are still outstanding from the Belfast Trust. It is planned to have this completed by the next meeting.

57. Teri advised that verbal updates on three actions would be provided today on A5, A26 and A40.

58. Teri noted that one action, A32, had moved beyond its target date and as a result had moved from amber to red. Another action, A13, had moved from red to green as work on this was now complete. She summarised by noting that there are now 18 red, 10 amber and 26 green actions.

Agenda Item 10 – MAH Action Plan - Progress update – Actions rated red

59. Máire Redmond was invited to provide an update on A5. She outlined that this action relates to the Learning Disability Service Model that is currently with the Department, after being submitted by the Board in July last year and a presentation by the HSCB to the Department in October. She advised that work on this had been on hold due to a lack of resources, however additional

resources have been found and work is now progressing. This should be completed by end of March 2022.

60. Moira Kearney was invited to provide an update on A26. She advised that an information paper in the form of a newsletter had been circulated to families and staff. This newsletter provides information on the services within Muckamore. It is planned that this would be issued on a quarterly basis. Moira was happy for it be circulated to members also.

AP7:Muckamore Abbey Hospital Newsletter to be issued to Group members after the meeting. (DoH)

61. Lorna Conn provided an update in relation to A40 relating to the appointment of a Regional Learning Disability Bed Manager. She advised that there had been a problem with their HRPTS system that prevented the advertised post from being visible on the system, however after a software fix this has been fixed. The advert went live on 11 February and is due to close on 25 February.

62. Lorna further advised that in relation to the updated timescales and Responsible Owners for the red actions in Annex A, the HSCB are happy to engage in the process. She noted that this is not a straightforward process as some actions have a series of owners and therefore it will take time to ensure this is completed correctly.

Agenda item 11 – Highlight Report and Dashboard (MDAG 20/21)

63. Máire Redmond advised that the highlight report and dashboard were circulated in advance of the meeting and highlighted that as per the update provided by Bria and Ian under agenda item 5 that a number of discharges are due by the end of the year to Mallusk and Braefields. It is therefore expected that the number of patients remaining in Muckamore will reduce to 16 at the end of 2022.

64. Máire also noted the ongoing issues with the staffing situation in the hospital and advised that this is being monitored daily by Belfast Trust. She highlighted that the planned discharges should help improve the workforce and staffing issues. She highlighted the ongoing discussions between the Department, HSCB, RQIA, Belfast, Northern and South Eastern Trusts to identify measures to support Belfast Trust due to the fragile staffing situation and expedite some discharges from the hospital without damaging the risk of placement success.

65. Máire referred to page 2 of the highlight report which advised that PSNI and ASG teams are still viewing the CCTV footage and that the level of CCTV footage to be viewed can fluctuate. She invited Heather Trouton to provide information in respect of the recent pilot of bodycams by staff in the Southern Trust.

66. Heather Trouton advised that the pilot is being rolled out on the mental health side, in Bluestone hospital. She noted that incidents of abuse had fallen by half since the pilot started. She advised that the pilot was due to end in March 2022, however it will more than likely be rolled out further across other areas in the Trust.

67. Seán Holland asked Heather to keep the Department updated on the outcomes on the pilot.

AP8:Provide update to Department on the outcomes of the pilot bodycam scheme. (SHSCT)

68. Dawn Jones added that she felt the body cams would be useful and should include use in bedrooms. Brigene McNeilly agreed with Dawn and added that although the body cams will not prevent abuse, it will provide evidence for use in any investigations. It would be a safeguard for those that are vulnerable and would provide safeguards for staff that are doing their job well. Brigene McNeilly referenced previous research in relation to the use of CCTV footage which was inconclusive as to whether or not the use of CCTV prevented

abuse. She highlighted how key it had been in highlighting the abuse in Muckamore.

69. Seán Holland added that in relation to use of CCTV, it would be useful to see any and all data in relation to outcomes of any trials or studies, and that it was important to remain open to all views and findings. Data to be shared with the Group once received.

70. Dawn Jones also added that she was upset to hear about the recent death of a patient in Muckamore and gave her condolences to the family. Dawn Jones raised the lack of communication from the Belfast Trust to families in relation to this, adding she had read about it in a newspaper. Seán Holland suggested that the Belfast Trust will likely reflect on Dawn Jones' comment.

Agenda Item 12 – AOB

71. None raised.

Date of Next Meeting

72. The next meeting is scheduled for Wednesday 27 April at 2pm.

Summary of Action Points

Ref.	Action	Responsible	Update	Open/ closed
23/02/AP1	Public Inquiry update statement to be circulated to members.	DoH	Circulated to Members 23 February 2022	Closed
23/02/AP2	Public Inquiry Sponsorship team to contact Public Inquiry team to find out if	DoH		

Ref.	**Action**	**Responsible**	**Update**	**Open/ closed**
	facilities will be put in place to allow proceedings to be viewed online. (DoH)			
23/02/AP3	Follow up with Inquiry Secretary to get assurance that their communication strategy for the Inquiry would provide detail in Easy Read format.	DoH		
23/02/AP4	Adult protection Bill presentation to be shared with group members	DoH	Circulated to Members 23 February 2022	Closed
23/02/AP5	Belfast, Northern and South Eastern Trusts to provide information on their collaborative work to expedite resettlement.	Belfast Trust, Northern Trust, South Eastern Trust		
23/02/AP6	Belfast Trust to liaise with family reps on ongoing concerns in Muckamore Abbey Hospital.	Belfast Trust		
23/02/AP7	Muckamore Abbey Hospital newsletter to be issued to Group members after the meeting.	DoH	Circulated to Members 23 February 2022	Closed

Ref.	Action	Responsible	Update	Open/ closed
23/02/AP8	Provide update to Department on the outcomes of the pilot bodycam scheme.	Southern Trust		

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 27 April 2022

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Seán Holland	DoH (Chair)	Moira Kearney	BHSCT
Lynn Woolsey	DoH (Chair)	Margaret McNally	Family Rep
Maria McIlgorm	DoH	Ian Sutherland	DoH
Mark McGuicken	DoH	Rodney Morton	PHA
Sean Scullion	DoH	Aidan McCarry	Family rep
Siobhan Rogan	DoH		
Ian McMaster	DoH		
Darren Strawbridge	DoH		
Darren McCaw	DoH (Note)		
Brendan Whittle	DoH (SPPG)		
Lorna Conn	DoH (SPPG)		
Catherine Cassidy	DoH (SPPG)		
Mary Emerson	PHA		
Carol Diffin	Belfast Trust		
Brenda Creaney	Belfast Trust		
Margaret O'Kane	South Eastern Trust		
Petra Corr	Northern Trust		
Karen O'Brien	Western Trust		
Jan McGall	Southern Trust		
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Lynn Long	RQIA		
Vivian McConvey	PCC		
Mandy Irvine	NI British Psychological Society		
Elaine Armstrong	Cedar Foundation		
Gavin Davidson	QUB		
Grainne Close	Mencap		
Bria Mongan	DoH		
Gillian Seeds (for agenda item 4)	DoH		
Jaclyn Richardson (for agenda item 4)	MAHI		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Seán Holland welcomed attendees and introduced Lynn Woolsey, Deputy Chief Nursing Officer, to her first MDAG meeting as co-Chair. It was agreed

that Sean would chair this meeting to enable Lynn to observe and familiarise herself with the agenda items and attendees. Seán also welcomed back Sean Scullion who had replaced Máire Redmond as head of the Muckamore Abbey Review Team.

2. Apologies were noted from Moira Kearney, Margaret McNally, Ian Sutherland, Rodney Morton and Aidan McCarry.

3. Seán advised members that since the last meeting the HSCB had been dissolved on 31 March 2022 with the transfer of functions into the Strategic Planning and Performance Group (SPPG) within the Department of Health.

Agenda Item 2 – Minute of Previous Meeting

4. Seán Holland noted that the draft minutes of the previous meeting held on 23 February were circulated to members on 3 March. Following receipt of amendments, the draft minutes were published on the Department's website on 25 March as an agreed record of the meeting. There were no further comments on the minutes.

Agenda Item 3 - Update on Action Points

5. Seán Holland provided an update on the open action points arising from previous meetings of the Group. In relation to 23/02/AP1, it was confirmed that a copy of the statement had been circulated to members on 23 February; in regards of 23/02/AP2, whilst the procurement process was ongoing, members were advised that a link would be provided to enable virtual viewing; and on 23/02/AP4, a copy of the presentation had also been circulated to members on 23 February. As a result of these updates, these actions were now closed.

6. Seán Holland advised that in relation to 23/02/AP3, there was an Easy Read section on the Inquiry's website which provided an Easy Read version of the Terms of Reference and work was ongoing on producing easy Read versions of the Chair's statements. Members were advised that the Inquiry Secretary would provide an update on this action under agenda item 4.

7. It was noted that 23/02/AP5 was still ongoing, with the Belfast, Northern and South Eastern Trusts producing a proposal paper which has been submitted to the SPPG and is currently under consideration.

8. In relation to 23/02/AP6, concerning an issue raised by a family representative, Seán Holland apologised for the inaccurate update he had been provided with for today's meeting and it was agreed that the Belfast Trust would follow up and contact the family representative member involved to address their concern.

9. Jan McGall provided an update in relation to 23/02/AP8. Jan advised that, following the small scale pilot study of bodycams in a mental health setting within the Southern Trust, whilst it was too early to draw definitive conclusions the early data was suggesting a correlation between the wearing of bodycams and the reduction in incidents of violence and aggression when compared with figures from the previous year. Jan further advised that the evaluation was ongoing and more detailed data should be available in around four weeks' time. Seán requested that detail from the study be shared in order to aid considerations of the work of the Adult Safeguarding Bill Team around CCTV and bodycams. Gavin Davidson also highlighted a recently published systemic review on body worn cameras in public services and agreed to share a link to the report for circulation to members.

AP1: Link to review on body worn cameras to be shared with MDAG secretariat for circulation to members. (Action: Gavin Davidson/DoH)

10. Seán Holland advised that engagement was ongoing with the Belfast Trust in relation to 22/12/AP3 and that an update would be provided under agenda item 7 today.

11. Members were advised that in work was continuing on 22/12/AP4 with the Belfast and Northern Trust discussions continuing to manage the process for the transfer of staff and avoid any destabilisation at Muckamore.

12. In relation to 25/08/AP5, Seán outlined that work on the draft Risk Register is continuing, however it has currently been delayed due to pressures on the team and prioritisation of requests from the Inquiry. It is hoped to be ready for the June meeting.

13. For 28/04/AP6 (an update on progress towards a future model of on-site provision at Muckamore), and 28/04/AP7 (develop a regional overview on resettlement), members were advised that updates on both would be provided under agenda item 6.

Agenda Item 4 – Public Inquiry Update

14. Seán Holland welcomed Gillian Seeds and Jaclyn Richardson, Inquiry Secretary, to the meeting to provide an update on the Public Inquiry.

15. Jaclyn Richardson advised that whilst work was ongoing in preparation for the commencement of the Inquiry hearings, there would be a short delay to the start of these as the statement taking process was moving slightly slower than anticipated. It was anticipated that live evidence would start to be heard in June. Once started, hearings would run from 10am to 4:30pm, with usual breaks included. It was confirmed that hearings would not take place on Fridays or on Bank or other holidays.

16. Members were advised that the Inquiry Chair had released a statement this morning which outlined the Core Participants to the Inquiry. The statement has been published on the Inquiry website and it was agreed a link would be provided for sharing to members of MDAG. Current Core Participants include a number of individuals who are either affiliated to Action for Muckamore or to The Society of Parents and Friends of Muckamore, the Department of Health, RQIA, Belfast Trust and the Police Service of Northern Ireland (PSNI).

AP2: Link to MAHI Chair's statement of 27 April 2022 to be circulated MDAG by secretariat. (Action: DoH)

17. Jaclyn confirmed that the Inquiry had received a large number of documents to date and were in the process of analysing these, in addition, 109 potential witnesses have come forward so far. She advised that Cleaver Fulton Rankin are taking statements on behalf of the Inquiry, and are currently taking Phase 1 statements in relation to evidence around the treatment of patients at Muckamore, and providing these to the Inquiry team once complete.

18. In relation to the continuing criminal investigation, members were advised that a memorandum of understanding (MOU) has now been agreed between the Inquiry, PSNI and Public Prosecution Service (PPS) to ensure clear lines of communication and understanding. A copy of the MOU is published on the Inquiry website and Jaclyn offered to provide copies to MDAG members if required.

19. Jaclyn advised that work on the Inquiry premises at Corn Exchange in Belfast is ongoing and arrangements for audio visual and stenography provision are currently being put in place. Live streaming of proceedings will be made available via a link on the Inquiry website and transcription services will also be available if required. Jaclyn further advised that witnesses will have the option to give evidence remotely if preferred and that systems will be in place to enable witnesses to provide their evidence anonymously.

20. Further to the work on the building outlined, Jaclyn advised that the building will be available to the public and Core Participants in week commencing 23 May to enable them to see the premises and familiarise themselves with the building and rooms in advance of use later. Jaclyn also extended an invitation to MDAG members to visit the Inquiry building during week commencing 9 May if desired. It was agreed that this would be arranged by MDAG secretariat following today’s meeting.

AP3: E-mail to issue to MDAG members seeking expressions of interest and dates/times available in week of 9 May to visit MAHI premises and include contact details for Jaclyn Richardson. (Action: DoH)

21. Jaclyn advised that the Chair would be making his opening statement in week commencing 6 June and would introduce the Inquiry Panel and Senior Counsel to provide an opening address. There would also be the option for Core Participants to provide an opening statement that week, with these limited to one hour in length.

22. Jaclyn provided an overview of the Inquiry's anticipated schedule, which included closed viewing of CCTV material for the panel and a number of oral evidence sessions ahead of a recess at the end of week of 4 July until recommencement in September which would continue until December. The Hearings dates for next year will be released in due course. Jaclyn also confirmed that support services would be available on hearing days, videos would be added to the Inquiry website to explain the witness process and further material in Easy Read format would be added to the Inquiry website.

23. Jaclyn further added that registered intermediaries are available to support witnesses. Jaclyn explained that registered intermediaries are recruited by the Department of Justice and help with the work of the Courts by providing assistance to anyone with a learning difficulty or requires assistance to understand legal questions in a form that can be more easily understood. Where possible, individuals will have the same registered intermediary throughout.

24. In response to a query from Brigene McNeilly, Jaclyn also confirmed that wider support will be available for those families outside the immediate support network provided they have come forward and are assisting the Inquiry. This additional support can be accessed through Jaclyn. Further to a suggestion by Seán Holland, Jaclyn also agreed to the addition of a support section on the Inquiry website to help make more accessible.

25. Gillian Seeds provided an update on the work of the Inquiries Sponsorship team within the Department advising that they were ensuring adequate funding and resources was available to the Inquiry team and that they were also engaging with Departmental colleagues, to ensure any resource or

finance requirements for the Department were considered and in place.

26. Dawn Jones queried who were the Departmental colleagues referred to, and Seán Holland clarified that Gillian's team were not involved in the substantive work of identifying and providing Departmental material to the Inquiry, but were instead responsible for ensuring the Department is adequately resourced to ensure requests from the Inquiry are met. They would have no role in the substantive work of the Inquiry, which is independent of the Department.

27. Jaclyn advised that she would be happy to attend MDAG in the future to provide detail on the work of the Inquiry as required. Seán Holland thanked both Jaclyn and Gillian for their updates.

Jaclyn Richardson and Gillian Seeds left the meeting.

Agenda Item 5 – MAH Leadership Roles Update

28. Seán Holland advised attendees that the Belfast Trust had made a number of recent changes to their Collect Leadership Team (CLT), covering services at both community and Muckamore Abbey Hospital and invited Brenda Creaney to provide an update. Brenda advised that following the recent changes the Clinical Director is Dr Ken Yeow, the interim Co-Director for Learning Disability is Natalie Magee, the Divisional nurse is Billie Hughes, and the Divisional Social Worker is Tracy Reid.

Agenda Item 6 – Resettlement

29. Seán Holland outlined the significance of the resettlement issue given the small proportion of current MAH patients requiring assessment and treatment and welcomed Bria Mongan to provide an update on the Resettlement Project. Bria advised that completion of the report has been delayed due to the fact that the arrangements to meet with families took longer than anticipated and included individual home visits as well as events in the Northern Trust, Belfast Trust and South Eastern Trust areas. In addition, Bria advised that Ian Sutherland was temporarily unable to assist with the work of the review due to unexpected

absence for medical reasons but is due to resume work imminently. Bria advised that she is hopeful that the report will be completed by mid-May 2022.

30. In relation to an update on the work of the resettlement project since the last meeting, Bria advised that work has been continuing with Phase 3 of the project. A number of engagements had been held with family members of Muckamore patients; both those whose family members have been successfully resettled and also those still resident in Muckamore, the latter group including both Dawn Jones and Brigene McNeilly who are family representatives on MDAG.

31. Feedback from the engagement with families was outlined, including the significant emotional toll felt by those families where placements had broken down and also where there were unmet expectations and trust had been lost. Bria raised the need to consider the provision of trauma informed support to both families and staff in these cases.

32. The importance of being able to visit their loved ones in Muckamore unannounced was also highlighted as an important area of assurance for families, as planned visits were not felt able to provide this level of assurance and families need to feel they can access the wards with more flexibility going forward.

33. Families had also put forward the view that the same level of opportunities to access daily living activities and level of engagement was not available at present compared to before Covid.

34. Families also felt that they were stronger together and more effort should be made to link up families whose loved ones are being considered for similar placements. Families didn’t feel consistently valued or utilised.

35. Bria also advised that a small number of families strongly felt that Muckamore continued to provide the best option for their family members.

36. Bria finished her update on the outcomes of the Phase 3 engagements by advising that there was a mixed view on engagement, with some of the families evidencing consultation fatigue and keen to see clear outcomes from engagement.

37. Bria also provided a brief summary of the outcomes of the work of Phase 1 and 2 highlighting:
    - There was no single pathway that mapped out process across all stakeholders;
    - The need for a regional supply map;
    - The need for integrated work streams, and the migration of the HSCB into the Department was cited as an opportunity to look at this;
    - The need for a Regional Procurement Board to help shape the market;
    - The need for enhanced collaboration; and
    - Changes needed to contracting/monitoring of services.

38. In summarising the key findings of the final report, Bria advised that many of its recommendations would reflect recommendations from previous reports. There was however a need to reset and refresh the overall approach to resettlement, and this should be taken forward by a one team regional approach and performance and progress managed by a regional Partnership Board. The urgent need for completion of the Learning Disability Service Model was also flagged as key to provide the necessary strategic direction for services in the region.

39. In response to the point raised on visiting arrangements, Brenda Creaney recognised the difficulty that current arrangements were causing families and advised that revised guidance from the Trust around visiting at Muckamore had issued yesterday. Brenda encouraged families to liaise with Billie Hughes or to contact her directly to see what could be done to facilitate visits. Seán Holland emphasised the point that access to the hospital was key to assuring families about the safety of their relatives. Brenda confirmed her team were cognisant of that and would work with families to address any issues.

40. In response to the point raised on the provision of meaningful activities, Mary Emerson queried whether access to AHP services was available. Bria added the feedback received indicated less organised activity since Covid and there was a perception that this was a reflection of current staffing and competencies of ward staff. Brenda Creaney advised that OT and Speech and Language therapy was still available on the site, but agreed that activities had reduced over the past period. Brenda added that the Trust were looking into this and she would seek an update. Seán Holland acknowledged the challenges Covid had presented, but reminded members that if there is a lack of access to AHP services this would have a potential impact on the timescales for resettlement. He reiterated that the current delays on resettlement constituted a system disgrace, and must be an absolute priority for all involved in this work. It was agreed that the Belfast Trust would provide an update on AHP activity and support being provided, with a specific focus on how this was preparing people for resettlement and identifying any current deficits.

AP4: Belfast Trust to provide an update on AHP activity and support in preparing people for resettlement and highlighting any deficits. (Action: Belfast Trust)

41. Brendan Whittle referred to the slow progress on those placements that are in hand and the need for concurrent planning for alternative placements in the interim, and advised that a proposal has been received on concurrent planning in recent weeks. He indicated this will need to be discussed with the RQIA and policy colleagues in the Department to see if it can be expedited. Brendan also raised concerns that recent CLT changes in the Belfast Trust may lead to delay in progressing these resettlements. Bria Mongan offered to collate the number of resettlements that it is believed could be expedited and to discuss potential to progress these with the SPPG and Trusts.

AP5: Detail on resettlements that can be progressed now to be collated and discussed with SPPG and Trusts to take forward. (Action: Bria Mongan)

42. Dawn Jones advised it had been a pleasure to meet Bria and Ian Sutherland and to talk to someone who appeared to care, had an interest in what was being said and showed compassion. Brigene McNeilly reiterated and agreed with Dawn's comments, and added that whilst recent management changes may be concerning, as a carer, in some circumstances it has been a relief.

43. Seán took the opportunity to thank the family members who had shared their experiences with Bria and Ian, particularly given the personal cost to families of doing so.

44. Brigene also queried if the resettlement project report would be published or shared and if feedback would be sought. Seán confirmed he would have no issue with the report being shared or circulated to those who wanted to see it.

45. Brigene highlighted the need to ensure that any actions from the final report of the resettlement review would be taken forward and not allowed to drift. Seán Holland agreed with Brigene, adding that the expectation of the Minister would be that the implementation of any recommendations would be robustly performance managed.

46. Dawn Jones noted the importance of compassion and empathy being displayed by staff responsible for providing care to their relatives, and the role this played in building levels of trust among families. Seán Holland reaffirmed the need to ensure that any trust placed in the system is not misplaced and the necessary actions are taken forward to implement the recommendations from the review.

Agenda item 7 – Safeguarding Audit Update

47. Seán Holland invited Carol Diffin to provide an update on the recent Safeguarding Audit at MAH. Carol Diffin advised that the Trust were working on the recommendations from the Adult Safeguarding audit and recent changes to the CLT in the Trust were in support of this. The Trust were also streamlining a number of recommendations from the audit and from RQIA inspections into one action plan.

48. Carol provided an update on the Adult Safeguarding audit actions that had been completed, highlighting the outcome of one investigation had been changed following a review. She also advised induction training had been completed for agency staff working in Muckamore.

49. In terms of ongoing actions, Carol advised that any safeguarding issues involving agency or bank staff were being followed up with their employers. Carol also advised that where any new incidents arose, a process has now been put in place to take account of any previous issues and this work is ongoing. The Trust are also actively trying to recruit more DAPO's to reduce pressure on those currently in post and to help improve the quality of detail in Adult Safeguarding records. On the issue of reporting thresholds, Carol outlined the need for a piece of work on the current thresholds and this would need to be completed before any changes would be made. Carol further added that the Trust had appointed a new manager of the Adult Safeguarding team, Jacintah McCaffrey, who would help with stabilisation of the team.

50. Lynn Woolsey queried if the outcomes of work by the Belfast Trust on the different action plans were reported to MDAG. Seán Holland confirmed that the role of MDAG was to receive assurance on work being taken forward in relation to Muckamore and resettlement. Carol confirmed she was happy to bring an update on the action plan to the next MDAG meeting.

AP6: An update to be provided on the streamlined action plan on ASG audit and RQIA recommendations for the June MDAG. (Action: Belfast Trust)

51. Lynn Woolsey also queried if there was a revised timeframe for the completion of the resettlement review being carried out by Bria Mongan and Ian Sutherland. Bria advised she was due to meet with Ian Sutherland on 29 April and would have a better idea after that meeting, however the initial date for completion of the end of April would now likely be the middle of May, dependant on Ian's availability. Bria added that she expected the report would be ready in advance of the next MDAG meeting and would be provided to SPPG, who commissioned the review, once complete. Brendan Whittle confirmed that the

recommendations from the final report would be brought to the next MDAG meeting.

AP7: Actions from completed Independent Review of Resettlement to be brought to June MDAG. (Action: DoH)

Agenda Item 8 – RQIA Inspection Findings

52. Lynn Long provided an overview of the recent unannounced inspection at Muckamore which took place on 2 March. Lynn advised that verbal feedback had been provided to the Trust and there had also been engagement with Dawn Jones since the inspection clarifying the work of the RQIA in Muckamore including their engagement with the Belfast Trust, and the Patient Client Council (PCC). The inspection looked at a number of areas including how resettlement was being taken forward, the meeting of physical healthcare needs, staffing, and the leadership and governance of the hospital. The report was currently at final draft stage and a draft would be shared with the Belfast Trust for factual accuracy checks in the next couple of weeks.

53. Lynn outlined the initial findings, advising that there was more of a focus on resettlement, however they agreed that more work was needed in this area and in-reach and out-reach had recently recommenced. Lynn confirmed that all frontline staff engaged were aware of resettlement plans for patients, where patients had plans in place. It was also confirmed that physical healthcare needs were being met.

54. The need for further improvement in relation to safeguarding was highlighted and the new CLT in place within the Trust should take forward work in relation to this. Lynn also highlighted that the new social work model on site was not yet as it should be and there was engagement with the Trust on this. In relation to staffing, there continued to be concerns on the current levels, particularly around the ratio of substantive Trust staff. On leadership and governance, this area was linked to findings on staffing and Adult Safeguarding, however it was noted that Trust staff were also picking up on issues and taking steps to address.

Agenda Item 9 – MAH HSC Action Plan – Exception Report (MDAG 03/22)

55. Darren McCaw provided an update on the paper circulated in advance of the meeting and advised that updates on open actions had been provided by their owners and are detailed in the updated Action Plan. Darren advised that work on meeting the Departmental Internal Audit unit recommendations that Responsible Officers should be assigned to each action within the Action Plan, and that those actions rated as red should be examined and updated with a new realistic timescale was ongoing, and would need to take account of the new structures following the dissolution of the HSCB on 31 March 2022.

56. Darren advised that due to the busy agenda for today's meeting there would be no verbal progress updates on specific red rated actions for this meeting, but these would resume for the June meeting.

57. Darren noted that since the last update a further action, A53, had been reported as complete and four further actions A6, A38, A41, and A44 had now moved beyond their target completion date and therefore were now rated red. Darren summarised by noting that there are now 22 red, 5 amber and 27 green actions within the plan.

58. Given the level of red actions now within the Plan, Seán Holland suggested that a discussion be held offline on how to manage the completion of these actions and ensure action owners were held to account.

AP8: Develop proposals for the management of red rated actions within the HSC Action Plan to completion. (Action: DoH)

Agenda Item 10 – Highlight Report and Dashboard (MDAG 04/22)

59. Sean Scullion advised that the highlight report and dashboard were circulated in advance of the meeting and highlighted that there were currently 38 patients in Muckamore Abbey Hospital, with four on trial resettlement and that a breakdown, by Trust, was provided in table 1.1 within the report. Sean also

confirmed that one resettlement had taken place in February with a further number of planned resettlements to take place in the coming months.

60. Members were also advised that CCTV viewing was ongoing, as detailed in Table 3 within the report. The update on staffing within the hospital, including ongoing efforts to recruit additional staff within Section 3 of the report was also highlighted as was the update on the advocacy review within Section 5 of the report.

Agenda Item 11 – AOB

61. None raised.

Date of Next Meeting

62. The next meeting is scheduled for Wednesday 29 June at 2pm.

MMcG-224
MDAG/07/22

Summary of Action Points – MDAG 27 April 2022

Ref.	Action	Responsible	Update	Open/ closed
27/04/AP1	Link to review on body worn cameras to be shared with MDAG secretariat for circulation to members.	Gavin Davidson/DoH	Circulated to members 30 May 2022	Closed
27/04/AP2	Link to MAHI Chair's statement of 27 April 2022 to be circulated MDAG by secretariat.	DoH	Circulated to members 27 April 2022	Closed
27/04/AP3	E-mail to issue to MDAG members seeking expressions of interest and dates/times available in week of 9 May to visit MAHI premises and include contact details for Jaclyn Richardson.	DoH	E-mail issued to members 27 April 2022	Closed
27/04/AP4	Belfast Trust to provide an update on AHP activity and support in preparing people for resettlement and highlighting any deficits.	Belfast Trust		
27/04/AP5	Detail on resettlements that can be progressed now to be collated and discussed with SPPG	Bria Mongan		

Ref.	Action	Responsible	Update	Open/ closed
	and Trusts to take forward.			
27/04/A6	An update to be provided on the streamlined action plan on ASG audit and RQIA recommendations for the June MDAG.	Belfast Trust		
27/04/AP7	Actions from completed Independent Review of Resettlement to be brought to June MDAG.	DoH		
27/04/AP8	Develop proposals for the management of red rated actions within the HSC Action Plan to completion.	DoH		

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 31 August 2022

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Seán Holland	DoH (Chair)	Lynn Woolsey	DoH
Maria McIlgorm	DoH (Chair)	Aine Morrison	DoH
Mark McGuicken	DoH	Margaret McNally	Family Rep
Sean Scullion	DoH	Aidan McCarry	Family rep
Siobhan Rogan	DoH		
Ian McMaster	DoH		
Darren McCaw	DoH (Note)		
Brendan Whittle	DoH (SPPG)		
Lorna Conn	DoH (SPPG)		
David Petticrew	DoH (SPPG)		
Moira Kearney	Belfast Trust		
Brenda Creaney	Belfast Trust		
Tracy Reid	Belfast Trust		
Margaret O'Kane	South Eastern Trust		
Petra Corr	Northern Trust		
Jan McGall	Southern Trust		
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Lynn Long	RQIA		
Vivian McConvey	PCC		
Mandy Irvine	NI British Psychological Society		
Elaine Armstrong	Cedar Foundation		
Gavin Davidson	QUB		
Grainne Close	Mencap		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Seán Holland welcomed attendees and informed members of the recent retirement of Carol Diffin, and confirmed Tracy Reid as her replacement on MDAG. Sean paid tribute to Carol's contribution to the work of MDAG and extended his best wishes for her retirement. Apologies were noted from Lynn Woolsey and Aine Morrison.

2. Sean advised members of a change to the agenda for today's meeting, with the update on the final report of the Independent Review of Resettlement from Bria

Mongan and Ian Sutherland deferred to a subsequent meeting. This was to allow time for all families and the Minister to be fully briefed on the findings of the Review. A high level summary of the Report would instead be provided for today's meeting.

Agenda Item 2 – Minute of Previous Meeting

3. Seán Holland noted that the draft minutes of the previous meeting held on 27 April were circulated to members on 4 May for consideration. Following receipt of a number of amendments, the draft minutes were published on the Department's website on 30 May as an agreed record of the meeting. There were no further comments on the minutes.

4. Sean noted that the meeting scheduled for June had been cancelled, however the MDAG co-Chairs had met on 4 July with family members.

Agenda Item 3 - Update on Action Points

5. Seán Holland provided an update on the open action points arising from previous meetings of the Group. Actions 27/04/AP1, 27/04/AP2 and 27/04/AP3 had been actioned, and were confirmed as closed.

6. In relation to 27/04/AP4 concerning an update from the Belfast Trust on AHP support to prepare people for resettlement, Moira Kearney requested this be deferred to the October meeting where a full update would be provided. This was to allow time for the completion of work being taken forward with Dr Patricia Donnelly, Bernie Owens and Dr Peter Sloan to review resettlement.

7. Séan advised that updates in relation to actions 27/04/AP5, 27/04/AP6 and 27/04/AP8 would be covered under agenda items 4, 6 and 9 respectively. Attendees were also reminded that an update on 27/04/AP7 had been provided in the Chair's opening remarks, with the deferral of the update on the final Report from the Independent Review on Resettlement to the October meeting.

8. Regarding action point 30/06/AP7, Tracy Reid provided an update on the process the Belfast Trust had established to collect feedback from anyone

affected by adult safeguarding investigations, and also work by the Trust to bring additional resource to Muckamore. Attendees were advised that the Trust were working with all new staff to ensure the process was being followed, and there had been engagement with carers' representatives to also provide an avenue for feedback to be collected independent of the DAPO. She confirmed that an opportunity to provide direct feedback was offered to relatives following the conclusion of investigations, although recognising that not everyone was comfortable with this, a questionnaire had been introduced so that feedback can also be provided in writing. Following a query from Séan Holland, Tracy agreed the Trust would provide an update on collated feedback at the next MDAG meeting.

9. Vivian McConvey highlighted an issue that had been raised with the Patient and Client Counsel by families who had been through this process, querying if there was any opportunity for families to provide independent comment during the investigative process in order to help inform this. Dawn Jones agreed this would be helpful and asked about the current format. Tracy advised that the questionnaire is completed with the families during a conversation, however if this was not suitable, she confirmed the Trust would be happy to review this. Tracy also offered to follow up offline directly with Dawn. Dawn advised that she had received no feedback or paperwork during previous engagement with the safeguarding process and had contacted Moira Kearney about this. Moira Kearney advised that Dawn's query was being investigated and she would provide a response to Dawn. Moira also added that the Trust was planning to develop an action plan for this. Dawn also queried the training provided for DAPOs.

10. Brigene McNeilly agreed with the points raised by Vivian and Dawn and suggested that any potential anxiety caused by the face to face completion of the questionnaire could be addressed by posting out the questionnaire for completion and return.

AP1: Belfast Trust to engage with the PCC and families on potential design changes to the ASG feedback process. (Action: Belfast Trust)

11. Séan Holland noted that all staff undertaking a DAPO role are required to undergo appropriate training, and advised that the forthcoming Adult Safeguarding Bill will place this requirement on a statutory footing, with a recognised qualification accredited by the NI Social Care Council.

Agenda Item 4 – Resettlement Project Report

12. As referred to in his opening remarks, Séan Holland advised attendees that a full update on the final Report would be provided at a future MDAG meeting by the Review team, Bria Mongan and Ian Sutherland, once all families and the Minister had been briefed. Pending this, he invited Brendan Whittle to provide members with a brief high level summary of the Review's findings.

13. Brendan Whittle confirmed that the final report from the Review had been received by the Department on 9th August and shared with the Department's senior management team. A submission was being prepared for the Minister providing advice on the next steps following the Review. He advised that the Review Team wished to meet with families to brief them on the Review's findings, and arrangements for this were being made.

14. Brendan went on to highlight a number of high level findings from the Review, including:
    - The pace of resettling individuals from Muckamore has been too slow;
    - The focus on safe staffing in Muckamore has possibly distracted from progressing the resettlement programme;
    - Governance arrangements around resettlement should be strengthened,
    - Noted families concerns about the safety of Muckamore, and an over-reliance on agency staff; and
    - The importance of a clear strategy for the future of Muckamore and Learning Disability services more generally.
15. Brendan noted that the Minister has agreed that Dr Patricia Donnelly will take forward work in regard to Governance arrangements around resettlement and

added that the conclusions and findings from the Review would be provided to the Minister, together with proposals for implementation. Following this, Ian and Bria will meet with families to provide a detailed briefing on their findings and recommendations.

16. Dawn asked how long this will take, and Brendan confirmed that he expected this to happen over the next number of weeks and advised he was meeting with the Review Team later this week to agree a timetable for this.

17. Séan acknowledged the Review's finding that resettlement for some patients has not progressed at the pace we would like. He added that Trusts have been overly optimistic in their projections on the pace of resettlement, and drift on this issue needs to be addressed. Mark McGuicken advised that a submission on the Review findings was being prepared for the Minister.

18. Dawn asked whether there is a resettlement team in Muckamore to oversee this work. Séan advised that there are resettlement teams in each of the Trusts, and it is important that their work is properly co-ordinated. Moira Kearney confirmed that the Belfast Trust have staff members who liaises with the other Trusts who have placed patients in Muckamore. Moira added that, following on from the work with Dr Donnelly, weekly meetings and clinics have been held over recent weeks to build up a live information picture, and this will be shared with families in the coming weeks.

AP2: Belfast Trust to share up to date information on resettlement with families. (Action: Belfast Trust)

19. Séan also highlighted the importance of involvement of Allied Health Professionals and Multi-Disciplinary Team (MDT) input to achieving successful resettlements and stressed the need for this support to be strengthened. Brigene McNeilly acknowledged the support her family receive from the MDT involved in her relative's care, with regular planning meetings held. Dawn advised that while she had had this support in the past, she felt this was lacking at present. Moira advised that the support described by Brigene is what the

Trust expect to deliver to families, and agreed that the Trust would pick this issue up directly with Dawn to try and resolve.

AP3: Belfast Trust to discuss level of MDT support provided to Dawn Jones to resolve any issues. (Action: Belfast Trust)

20. Mark McGuicken advised members that the membership of the Regional Resettlement Oversight Board to be led by Dr Donnelly will also include senior Departmental colleagues. The overarching aim of the Oversight Board will be to ensure a consistent approach is taken to resettlement across the system. Séan Holland confirmed that the urgency around completing the resettlement programme has been communicated to Trust Chief Executives by the Permanent Secretary of the Department, and if Dr Donnelly identifies any barriers to this in the course of her work, these will be referred to Chief Executives as necessary.

21. Séan Holland introduced Maria McIlgorm, the new Chief Nursing Officer for the Department, who had joined the meeting. Maria introduced herself to the Group, and provided a brief summary of her background, including her experience of managing a LD service in Edinburgh. Maria outlined that she has been working closely with the Belfast Trust on setting a range of performance measures in order to help provide assurance, and was keen to progress work on a new strategic direction for wider LD services.

Agenda Item 5 – Update on Staffing Position

22. Moira Kearney provided an update on the staffing position at Muckamore, which continues to be challenging, highlighting an increasing reliance on Agency cover. She advised that the Trust were working to identify and address any skills gaps that may exist.

23. Moira confirmed that recruitment efforts were ongoing by the Trust, but that a number of gaps still remained, particularly at Band 6 Nurse Leader level on wards. In light of these gaps, the Trust had taken a decision to employ a further Lead Nurse, meaning that there would now be two of these posts on site. In

addition, the Trust also have a Nurse Consultant in place who spends 50% of their time on the wards with staff. The Trust will also have a number of new nurse registrants joining in September, although it was noted these staff are required to undertake a six month preceptorship programme to provide them with support and assess their skills.

24. She also updated members on a number of recent appointments, including Dr Peter Sloan who has taken up the role of LD Head of Division, Dr Paul Devine who is providing peer support, and Ciara Rooney who joined as Interim Service Manager at the start of August. Additional DAPO's had also been moved onto site by the Trust, and increased regional support for the service was also being put in place by the Trust. MDAG members were advised that although the nurse staffing levels remained challenging, the Social Work staffing cohort had been strengthened, and a small number of vacancies still existed in other elements of the team at Muckamore, such as AHPs and Psychological support.

25. Members were advised that, following their recent visit, the East London Foundation Trust (ELFT) had also offered peer support to the Trust.

26. Brenda Creaney added that the Trust was struggling to recruit in a number of areas, and she was working on a reporting dashboard with Maria McIlgorm. Brenda outlined the fragile position the Trust was in with the increasing reliance on Agency staff who could potentially leave with minimal notice, although a number of these staff had been working at Muckamore for some time.

27. Dawn Jones welcomed the update from the Trust and referred to a staffing crisis in Muckamore. She queried how the training and backgrounds of Agency staff were checked. Brenda confirmed that background checks were a requirement in law and were carried out by the Nursing and Midwifery bank in the Trust. In addition the Trust had set requirements and levels of training needed for any Agency staff working on site, and added that additional safeguarding and MAPA training were also provided. Staff were also subject to an ongoing review process, and where any performance issues were identified additional training was provided. Occasionally, where there was an

incompatibility with the work, staff would be let go. Brenda also highlighted the importance of feedback from families as part of the oversight process. Dawn advised she had raised issues on staffing with Tracy Reid. Brenda advised Dawn that her team were responsible for the checks on staff, and members of the team, including Brenda, can be contacted directly if any issues arise.

28. Brigene queried whether training was given to staff on interaction with patients, as in her experience she had not witnessed much patient interaction from staff. Dawn echoed this view adding this was something she had raised recently, with any interaction witnessed being provided by those coming onto the wards, such as AHP staff, rather than ward staff. Brenda Creaney confirmed that training was provided to staff, but if families' experience was that there was insufficient interaction, then that should be escalated to senior Trust staff to investigate. Moira Kearney advised that on that point, an activity log was being introduced into each individual patient's care plan so that activity provision can be monitored. Brigene thanked Moira for the update and confirmed that was something that would be of interest.

29. Dawn asked if any planning had been done in case Muckamore had to close suddenly. Séan Holland confirmed that this was an acknowledged risk, and work had been done with Trusts to mitigate this. Such a scenario would likely mean introducing temporary emergency arrangements, such as for example the use of nursing homes placements, without time for normal resettlement processes to be completed. Séan added that reducing the risk of an unplanned closure was one of the factors driving the focus on well planned resettlements taking place at pace. Brendan Whittle advised attendees of engagement with Trusts on this, and that efforts to reduce this risk had focussed on moving additional staff into Muckamore, rather than moving patients out of Muckamore.

Agenda Item 6 – Safeguarding Audit Update

30. Seán Holland referred members to the update at the April MDAG meeting from the Belfast Trust on work to streamline the outcomes from the safeguarding audit and RQIA inspections into one plan, and invited Tracy Reid to provide an update. Tracy confirmed that the Trust continued to engage with the

Department on the outcomes of the audit for clarification in order to address the recommendations effectively. Tracy advised that the ASG Action Plan had been completed and the Trust had allocated additional resource to implement this. The Action Plan will be shared with the Department and RQIA for consideration and comments.

31. The Trust were working to improve their ability to respond to and screen allegations quickly and also deal with historic cases. Staffing resource was a key focus, with the recent appointment of Ciara Rooney and continuing work to add additional staff to the team. However as previously referenced, there are significant challenges with recruitment and retention at present, with Muckamore providing its own challenges in this regard.

Agenda item 7 – RQIA Inspection Findings

32. Seán Holland advised members that there had been a recent unannounced RQIA inspection at Muckamore during July, adding that the final report was being collated and families would then be briefed on the outcome of the inspection. Séan invited Lynn Long to provide an update on the inspection. Lynn provided a high level overview confirming that it was a comprehensive inspection carried out over different time periods and across all wards, and had identified concerns about staffing levels, and adult safeguarding.

33. Feedback had been provided to the Trust on 29 July and a further meeting was held with the Trust on 4 August. As a result of this, and ongoing meetings with the Trust, the RQIA have decided not to take enforcement action at this time against the Trust. Lynn advised that the Trust are providing updates on a fortnightly basis to the RQIA, and the RQIA are also planning to carry out a follow-up inspection.

34. Lynn confirmed that the RQIA had also met with the Department to set out their findings, and advised attendees that a key element to ensure improvement would be the alignment of all Trust actions plans following recent audits and inspections. Progressing resettlement would also help to address some of the

current staffing challenges at Muckamore. Lynn advised that the Trust was planning engagement with the families on the outcome of the inspection and the RQIA intended to issue the draft report to the Trust in the coming weeks for factual accuracy checking. Moira Kearney confirmed the Trust welcomed the feedback and would be in touch with families once the draft report had been received.

35. Séan Holland acknowledged the difficulty in striking an appropriate balance between managing the current staffing difficulties while maintaining compliance with standards, and the challenges this presented for Trust staff. Work to improve services is an ongoing process, and involves a partnership approach between the Trust, RQIA and the Department. In this context, he referred to work being taken forward with the Chief Nursing Officer to develop dashboard indicators as a key element to help inform improvement updates.

Agenda Item 8 – Update on East London Foundation Trust Visit

36. Sean Holland reminded MDAG that the Belfast Trust have been engaging with the East London Foundation Trust (ELFT) for some time as a critical friend, and invited Moira Kearney to provide an update from the latest visit. Moira advised that staff from the ELFT had visited the Belfast Trust on 1st and 2nd August and had met with Trust colleagues, and also Dr Donnelly, who was able to join on the 2nd August. Items discussed included the current staffing issues, delays in resettlement and the current unavailability of Muckamore for new admissions. The ELFT team shared their experience of similar change and are continuing to work with the Trust to provide support, including further visits and offers of individual peer support to the Trust.

37. Séan Holland outlined the ongoing nature of the support, and queried whether there might be an opportunity for relatives to also directly engage with the ELFT to share their experiences. Moira confirmed the Trust were happy to facilitate this.

AP4: Belfast Trust to make arrangements for relatives and carers to directly engage with the ELFT. (Action: Belfast Trust)

Agenda Item 9 – MAH HSC Action Plan – Exception Report (MDAG 12/22)

38. Darren McCaw provided an update on the paper circulated in advance of the meeting and advised that updates on open actions had been provided by their owners and are detailed in the updated Action Plan. Darren noted that since the last update a further action, A26, had been reported as complete meaning that all actions under the Governance theme had now been completed. Attendees were also advised that an action reported as complete in the June update, A53, had been returned to amber as the action continued to be ongoing. Darren summarised by noting that there are now 21 red, 6 amber and 27 green actions within the plan

39. Darren advised that further to the action point from the April meeting to develop proposals for the management of red rated actions within the HSC Action Plan to completion (27/04/AP8), the Department had carried out a review of the incomplete actions. The review considered the application of the RAG rating included in the Action Plan, reported progress on each action, and detail from an initial synopsis of the recommendations from the Independent Review of Resettlement that had been provided to the Department during the final drafting process. Members were advised that the draft outcome of the review was then shared with Action Owners for consideration in parallel with the normal process to provide updates on the Plan for circulation ahead of today's meeting.

40. The review proposed changes to the rating of a number of those actions which, since the drafting of the HSC Action Plan, are either being progressed as business as usual or were outside the responsibility of the Department. Changes were also proposed to the rating of a number of actions whose red rating reflected that although the initial completion date had passed, work in support of the action was either on track for completion, or awaiting the outcome of other work or decisions being taken.

41. He advised that if MDAG members were content to agree the proposed changes, this would mean the updated Action Plan would then contain 34 green rated actions, 17 amber rated actions and 3 red rated actions. Members were

also advised that the Action Plan will likely need to be further reviewed to take account of the recommendations in the final report of the Independent Review of Resettlement.

42. Darren further advised that, in light of the proposed changes to the Action Plan, it was now proposed to table the draft Risk Register for the October meeting to allow the scoring of the risks contained within the draft to be updated to reflect MDAGs consideration of the findings of the review of the HSC Action Plan.

43. Dawn Jones queried the inclusion of A53 within the HSC Action Plan as it related to a specific complaint, given that other complaints are not included. Sean Scullion confirmed that it had been included in the HSC Action Plan as a one of the recommendations from the Leadership and Governance Review Report, which were incorporated within the HSC Action Plan to monitor their implementation. Séan Holland accepted that it was not appropriate to include a specific complaint for monitoring as part of the Action Plan. Mark McGuicken confirmed that the Action Plan would be further reviewed in light of the final report from the Independent Review of Resettlement, and would take this into account.

AP5: HSC Action Plan to be updated to reflect proposed changes brought to August 2022 MDAG. (Action: DoH)

Agenda Item 10 – Progress on Red Rated Actions

44. Séan Holland advised attendees that verbal updates would be provided in relation to A29 by the Belfast Trust and A39 and A40 by SPPG.

45. Moira Kearney provided an update on A29, outlining a number of recent specialist appointments made by the Trust and confirming that the Trust would continue to progress the workforce plan.

46. Lorna Conn provided updates on A39 and A40 advising that, in respect of A39, two regional workshops had been held to date with a follow up workshop planned in advance of monthly workshops to consider the Mental Health

workforce plan. Lorna also confirmed that, with regards to A40, an appointment had been made to work across both Mental Health and Learning Disability services to manage capacity.

Agenda Item 11 - Highlight Report and Dashboard (MDAG 13/22)

47. Sean Scullion advised that the highlight report and dashboard were circulated in advance of the meeting and outlined that there were currently 37 patients in Muckamore Abbey Hospital, with three on trial resettlement and that a breakdown by Trust was provided in paragraph 1.1 within the report. Sean highlighted the detail on resettlement provided in the report in the graph contained in paragraph 1.2, and confirmed that one further resettlement had taken place in June with a further number of planned resettlements to take place in the coming months.

48. Sean also advised that CCTV viewing was ongoing, as outlined in the tables on page 2 of the report, and was now over 90% complete. The update on staffing within the hospital, including ongoing efforts to recruit additional staff detailed within Section 3 of the report was also highlighted, as was the update on the summary of the latest findings from the work of the real time feedback team within Section 6 of the report.

49. Brendan Whittle asked that for factual accuracy purposes, the reference to SPPG on page three in the highlight report should be amended to reflect the recent establishment of SPPG as part of the Department.

50. Petra Corr queried the detail included in the Highlight Report in relation to progress with resettlements, advising that the Northern Trust had more resettlements in the final stages of completion than were outlined in the tables included. Moira Kearney confirmed that the figures included in the report reflected those that had formally left the Trust on resettlement. Mark McGuicken added that the format of future updates to MDAG may be revised to provide clearer detail and clarity on detail.

51. Maria McIlgorm also advised that, once the detail had been confirmed for inclusion on the Dashboard, updates could be provided from Nursing colleagues within the Department for future Highlight Report updates.

Agenda Item 12 – AOB

52. No substantive items were raised under AOB.

53. Séan Holland advised MDAG that today's meeting would be his final meeting as co-chair of the Group as, after 20 years in the Department of Health, he was taking up a new post in the coming weeks. Séan thanked colleagues, and particularly the family representatives, for all their support and work to try make things better within the system.

54. Dawn Jones thanked Séan for all he had done to try and make things better for families, including her own, adding that it was appreciated by all the families.

55. Brigene McNeilly agreed with the sentiments from Dawn, adding her hope that Séan's legacy would be a better life for all their relatives.

Date of Next Meeting

56. The next meeting is scheduled for Wednesday 26 October at 2pm.

Summary of Action Points – MDAG 31 August 2022

Ref.	**Action**	**Responsible**	**Update**	**Open/ closed**
31/08/AP1	Belfast Trust to engage with the PCC and families on potential design changes to the ASG feedback process.	Belfast Trust		
31/08/AP2	Belfast Trust to share up to date information on resettlement with families.	Belfast Trust		
31/08/AP3	Belfast Trust to discuss level of MDT support provided to Dawn Jones to resolve any issues.	Belfast Trust		
31/08/AP4	Belfast Trust to make arrangements for relatives and carers to directly engage with the ELFT.	Belfast Trust		
31/08/AP5	HSC Action Plan to be updated to reflect proposed changes brought to August 2022 MDAG.	DoH		

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 26 October 2022

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Mark McGuicken	DoH (Chair)	Peter Toogood	DoH
Lynn Woolsey	DoH (Chair)	Maria McIlgorm	DoH
Sean Scullion	DoH	Karen O'Brien	Western Trust
Aine Morrison	DoH	Jan McGall	Southern Trust
Darren Strawbridge	DoH	Margaret O'Kane	South Eastern Trust
Darren McCaw	DoH (Note)	Petra Corr	Northern Trust
Brendan Whittle	DoH (SPPG)	Moira Kearney	Belfast Trust
David Petticrew	DoH (SPPG)	Mandy Irvine	NI British Psychological Society
Lorna Conn	DoH (SPPG)	Siobhan Rogan	DoH
Brenda Creaney	Belfast Trust	Aidan McCarry	Family rep
Tracy Reid	Belfast Trust	Margaret McNally	Family Rep
Billie Hughes	Belfast Trust		
Teresa McKee	South Eastern Trust		
Christine McLaughlin	Western Trust		
Roisin O'Hare	Southern Trust		
Gareth Farmer	Northern Trust		
Bria Mongan			
Ian Sutherland			
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Lynn Long	RQIA		
Vivian McConvey	PCC		
Elaine Armstrong	Cedar Foundation		
Gavin Davidson	QUB		
Grainne Close	Mencap		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Mark McGuicken welcomed attendees and informed members that following Séan Holland's move, Peter Toogood, the interim Head of the Social Services Policy Group, will take over the role of MDAG co-Chair with Maria McIlgorm, the Chief Nursing Officer. However, as neither Peter nor Maria were available for today's meeting, Mark and Lynn Woolsey, the Deputy Chief Nursing Officer,

would chair the meeting. Mark noted apologies from Karen O'Brien, Jan McGall, Margaret O'Kane, and Petra Corr, who had all nominated deputies for today's meeting. Apologies were also noted from Moira Kearney, Mandy Irvine, and Siobhan Rogan.

Agenda Item 2 – Minute of Previous Meeting

2. Mark McGuicken noted that the draft minutes of the previous meeting held on 31 August were circulated to members on 21 September for consideration. Further to this, the draft minutes were published on the Department's website on 12 October as an agreed record of the meeting. There were no further comments on the minutes.

Agenda Item 3 - Update on Action Points

3. Mark McGuicken provided an update on the open action points arising from previous meetings of the Group.

4. In relation to the actions from the August meeting, 31/08/AP1 was confirmed as closed as the Belfast Trust were continuing to collect data on the adult safeguarding process through the questionnaire and were also engaging with the PCC and families on the effectiveness of the feedback process. In relation to 31/08/AP2, Mark advised that resettlement information had been shared by the Trust and this action point could therefore be closed. In response to a further query from Dawn Jones about the Belfast Trust staff team who attended the family engagement event on the public consultation launch on 24 October, it was agreed that the Belfast Trust will provide families with an update on the make-up of the senior team at Muckamore. Brigene McNeilly commented that in her view the Trust's arrangements for communicating with families had deteriorated recently, and Tracy Reid undertook to consider how processes might be improved.

AP1: Details of the current senior team at Muckamore to be provided to families. (Action: Belfast Trust)

5. In relation to action 31/08/AP3, Dawn Jones confirmed that a meeting with the Trust had taken place and this action is therefore closed. For action 31/08/AP4, Tracy Reid asked that this be carried forward to the December meeting and with regard to 31/08/AP5, Mark noted that an update on proposed MDAG reporting arrangements would be provided under agenda item 8 and on that basis this action point could be closed.

6. Updates on outstanding actions carried forward from previous meetings were also provided. Tracy Reid advised that in relation to 30/06/AP7, the Belfast Trust were reviewing their process for collecting feedback information. A summary report on feedback provided to date had been provided by the Trust for today’s meeting and this was included as an Annex to the circulated Highlight report.

7. Billie Hughes advised that the Belfast Trust were still working to collate information on levels of AHP activity to address 27/04/AP4, and requested that the update on this be deferred to the December meeting. Mark McGuicken agreed to this, and asked that an update of AHP availability on site be provided at that meeting.

8. Dawn Jones advised members of issues she had experienced with the level of AHP support provided for her son.

9. The Chair noted her concerns, and asked that Belfast Trust representatives consider how these might be addressed in advance of the next meeting of MDAG.

10. Actions 27/04/AP5 and 27/04/AP7 were both confirmed as closed as work was progressing on resettlements, and an update on actions from the final report of the Independent Review of Resettlement was on the agenda for today’s meeting. It was agreed that action 27/04/AP6 should remain open, pending further discussions between the Department and Belfast Trust on the report provided by the Trust.

Agenda Item 4 – Resettlement Project Report

11. Mark McGuicken reminded members that a briefing for MDAG on the final report of the Independent Review of Resettlement had been deferred from the August meeting until today to allow the review panel time to brief the families, Trusts, and Minister on the findings of the review. He advised that Ian Sutherland and Bria Mongan who carried out the review met with families and Trusts on 28 September. In his subsequent announcement on 29 September, the Minister had welcomed the findings of the review and accepted all the recommendations.

12. In endorsing the review, the Minister also announced he was considering options for the future provision of services at Muckamore and that he intended to make a further statement on this in the coming weeks. Mark advised attendees that following an engagement event with the families of current patients and senior Departmental and Trust officials, the Minister had announced on 24 October the launch of a public consultation on the proposed closure of Muckamore Abbey Hospital.

13. Mark invited Ian and Bria to present an overview of the review and the recommendations contained in their final report. Ian Sutherland began by extending thanks on behalf of himself and Bria Mongan to all those who had so generously engaged with the review and candidly shared their experiences. Ian added that they were delighted that the Minister had accepted the report and endorsed the recommendations, and that the report had broadly been received positively.

14. Ian and Bria gave a presentation outlining the work of the review and highlighted a number of areas in particular, including:
    - the duration of the review and range of groups they had engaged with;
    - the development of a resettlement tracker tool;
    - progress made in reducing the number of delayed discharge patients regionally over the timescale of the review;
    - learning drawn from legislation in other jurisdictions;

- the need for improvements in leadership and governance arrangements for oversight of the resettlement programme, with a particular focus on reducing instability in teams and the need to ensure better communication with, and involvement of, families;
- the need for improved data to help inform both strategic commissioning and operational delivery arrangements;
- the need for a shared workforce strategy, as the review had found some evidence of a mis-match between qualifications of staff and complexity of patients; and
- although not formally included within the scope of the review, safeguarding arrangements had also been considered and a number of issues had been raised around the notification of families and the length of time taken to progress investigations.

15. Members were advised that the final report contained 25 recommendations, a number of which echo and reiterate recommendations from other reviews. In order to ensure progress in implementing the recommendations, the panel proposed the development of a thematic reporting approach to assist in delivering a consistent system response.

16. An overview of the recommendations was provided and a number of areas were highlighted, including:
    - the Regional Resettlement Oversight Board has already been established and has begun its work;
    - the tracker tool introduced through the review should be further developed to facilitate oversight of progress;
    - further work should be taken forward through the Social Care Procurement Board to identify need and develop a separate contract for specialist learning disability nursing and residential care;
    - the need for a joint strategic needs assessment to be taken forward with the NIHE;
    - a database should be developed of individuals displaying behaviours that may contribute to placement breakdown, to enable proactive interventions to prevent breakdowns;

- the importance of regional adoption of a Positive Behaviour Support (PBS) approach;
- clarity on advocacy arrangements for families, including facilitating arrangements for family support groups where their relatives were being resettled to the same location;
- the need for individualised solutions for patients;
- the need for wider engagement with provider organisations to ensure all potential resettlement options are considered;
- further work required on the use of CCTV;
- the need to ensure effective adult safeguarding capacity in Trusts, and that contracts or service specifications also include provision for adult safeguarding; and
- the importance placed by families on facilitation of unannounced visits to their relatives as an important source of assurance about safeguarding arrangements.

17. Mark thanked Bria and Ian for their work on the review, and the comprehensive report they had produced. Mark advised members that a revised thematic reporting approach was being developed for MDAG, which was designed to facilitate the Group in its oversight role. Mark further confirmed that a significant amount of work was ongoing in relation to resettlement, driven by the Oversight Board with a focus on delivering successful resettlements.

18. Dawn Jones thanked Ian and Bria for their work on the review, a sentiment supported by Brigene McNeilly, and asked whether MDAG members had had an opportunity to read the final report. Dawn also echoed the view that PBS training should be more widely available for staff.

19. In relation to the public consultation on the proposed closure of Muckamore, Dawn asked if there are plans to hold any engagement events in addition to the online response process to ensure that respondents are given the opportunity to provide responses that fully reflect their views. Brigene McNeilly agreed that

such events would be useful adding that some respondents may prefer a face-to-face conversation rather than completing an online form.

20. Vivian McConvey suggested an engagement session would allow families and patients the opportunity to fully share their experiences and views on the consultation questions. Mark McGuicken advised that the consultation was on a specific policy question around the future of Muckamore Abbey Hospital, and was being asked in the wider context of ongoing work to finalise the Learning Disability Service Model (LDSM), which would in turn may be subject to a separate public consultation in due course. Mark added that the work on the LDSM may not be complete before the closure of the Muckamore consultation however, he appreciated that both issues were interrelated. After discussion, members agreed that a further face to face engagement session with families on the proposed closure of the hospital would be arranged with the support of the PCC during the consultation period.

AP2: Further face to face engagement session with families and residents to be arranged as part of the public consultation, with support from the PCC. (Action: DoH/PCC)

21. Dawn Jones queried whether senior Departmental staff would provide comment on the content of the report. Mark noted that senior staff in the Department had provided advice to the Minister on the report and that its recommendations should be accepted.

Agenda Item 5 – Update on Staffing Position

22. Further to discussion earlier in the meeting under agenda item 3, the Chair clarified that the names of the recently appointed psychiatry leads at Muckamore had been provided to members at the August MDAG meeting and were duly recorded in the minutes from that meeting. Mark apologised to BHSCT staff for the previous oversight and Tracy Reid thanked Mark for providing this clarification.

23. Brenda Creaney and Tracy Reid provided an update to members on the current staffing position at the hospital. It was confirmed that efforts to recruit additional staff continued, but despite this the staffing situation remains fragile. Tracy Reid advised members that Ciara Rooney had recently taken up appointment as DAPO and would act as the single point of referral for ASG cases.

24. Aine Morrison asked about the backlog of ASG referrals, and Tracy Reid advised that 36% of these were currently closed.

25. Mark McGuicken confirmed that the enhanced remuneration arrangements being offered as part of the Muckamore Abbey Workforce appeal had been extended until December, but noted that these arrangements were unlikely to continue beyond this point.

26. Dawn Jones asked whether the Belfast Trust had a contingency plan in place should agency staff wish to return home over the Christmas period. Brenda Creaney confirmed that the Trust were currently engaging with the agencies to encourage their staff to work in the hospital over the Christmas period and were working on negotiating a financial incentive in relation to this. Dawn added that in her experience, Muckamore was short staffed every weekend and this had prompted her query around the Christmas break. Brenda advised that the hospital was currently operating with 85 – 90% agency staff at present, and whilst this was not where they wanted to be at this time, it was hoped that this position would improve as new staff bedded in. Brenda offered to ask Billie Hughes to follow up with Dawn in relation to the staffing position, and also to ask the newly appointed senior nurses at Muckamore to meet with Dawn. Dawn also requested that staff acknowledge and respond to her e-mails in a timely manner. Brenda confirmed that she would ask Billie Hughes to follow up on this as well.

AP3: Billie Hughes to follow up with Dawn Jones on the staffing position and responses to e-mails. (Action: Belfast Trust)

AP4: Meeting to be arranged between Dawn Jones and the newly appointed senior nurses at Muckamore. (Action: Belfast Trust)

Agenda Item 6 – Safeguarding Audit Update

27. Mark McGuicken confirmed that the Department had received the requested report on safeguarding. To allow Departmental professional staff to consider the report, he advised this agenda item would be deferred to the next meeting to enable a fuller discussion to take place.

Agenda item 7 – RQIA Inspection Findings

28. Mark McGuicken reminded attendees that the RQIA had carried out an unannounced inspection at Muckamore in July, and a high-level overview of the findings had been provided at the August meeting in advance of engagement with families. Members were advised that the final report had now been published, and Mark invited Lynn Long to provide an update on the inspection.

29. Lynn advised that the majority of the update on the inspection had been provided at the August meeting and confirmed that the RQIA are continuing to work with the Belfast Trust to address the issues highlighted in the inspection. Lynn noted the interrelation between RQIA's improvement activity and the ongoing work led by Aine Morrison with Belfast Trust to strengthen safeguarding arrangements.

30. Lynn emphasised that RQIA was continuing to monitor the Trust's progress to address the inspection findings, and advised members that she was happy to provide copies of the report to MDAG members. Mark McGuicken confirmed that the Department would arrange for the report to be circulated to MDAG members.

AP5: RQIA Muckamore Abbey Hospital unannounced inspection report to be issued to MDAG members. (Action: DoH)

Agenda Item 8 – MAH HSC Action Plan – Revised Reporting Arrangements (MDAG 15/22)

31. Darren McCaw referred members to the paper circulated in advance of the meeting. He advised that, further to members' agreement to the changes proposed at the August meeting, an updated version of the HSC Action Plan had been circulated for information. As a result of the agreed changes, the Action Plan now contained 3 red, 15 amber and 35 green rated actions.

32. Darren also advised that, further to discussion at the August MDAG, arrangements for reporting to MDAG on the HSC Action Plan were also being reviewed in light of the recommendations from the recent Independent Review of Resettlement, and also to ensure MDAG members had proper oversight of all actions relevant to the MDAG terms of reference. This was in the context of a larger piece of work being taken forward to develop a new governance structure, which is intended to have oversight of the implementation and delivery of all relevant Action Plans and recommendations relating to Learning Disability services.

33. As a result, a new thematic reporting format for MDAG purposes is being proposed, which will focus primarily on those actions and updates relating to Muckamore and MDAG's terms of reference, with the areas proposed for inclusion outlined in the circulated paper. Members were advised that as this was a work in progress, a draft of the new report format had not been circulated for today's meeting but will be tabled instead for consideration at the December meeting.

34. Brendan Whittle welcomed the proposed direction of travel to reporting on a thematic basis, which should improve the effectiveness of MDAG's oversight role for Muckamore, and added he looked forward to seeing the detail for agreement.

35. Dawn Jones agreed that the move to thematic reporting seemed a very good idea, although she felt the gap between updates was long, given MDAG was a bi-monthly meeting. Mark McGuicken advised that holding meetings bi-monthly

reflected the amount of work that was taking place between each meeting, and confirmed that a more detailed update would be provided at the next meeting.

Agenda Item 9 – Highlight Report (MDAG 16/22)

36. Sean Scullion provided an update on the Highlight report circulated in advance of the meeting, noting that most of the detail within the report had already been covered during the meeting. Sean highlighted that four staff had been redirected to support the Muckamore adult safeguarding team to help address outstanding cases. Members were also advised that CCTV viewing was now over 90% complete, with viewing completed for two ward areas.

37. Sean confirmed that the overall number of patients in Muckamore was now 35, with one patient discharged since the last meeting in August. It was also confirmed that the Regional Oversight Board had now met on two occasions so far, with the resettlement tracker tool being used to aid the work on resettlements.

38. Sean also drew members attention to the range of reporting tables in relation to adult safeguarding and patient safety set out within the paper. The current nursing situation at Muckamore was summarised and Sean advised that 73 staff had responded to date to the current Muckamore Abbey Workforce Appeal. Finally, Sean highlighted the inclusion of a Muckamore adult safeguarding closure feedback engagement survey as an annex to the paper for information.

Agenda Item 12 – AOB

39. No substantive items were raised under AOB.

Date of Next Meeting

40. Attendees were advised the next meeting is currently scheduled for Wednesday 21 December at 2pm. However, given the proximity of this date to the Christmas holidays, the potential to bring the meeting forward one week would be examined by the Secretariat.

AP6: Members' availability for week commencing 12 December to be checked for potential rearrangement of December meeting (DoH)

Summary of Action Points – MDAG 26 October 2022

Ref.	Action	Responsible	Update	Open/ closed
26/10/AP1	Names and contact details of the senior team at Muckamore to be provided to families.	Belfast Trust		
26/10/AP2	Further face to face engagement session with families and residents to be arranged as part of the public consultation, with support from the PCC.	DoH/PCC		
26/10/AP3	Billie Hughes to follow up with Dawn Jones on the staffing position and responses to e-mails.	Belfast Trust		
26/10/AP4	A meeting to be arranged between Dawn Jones and the newly appointed senior nurses at Muckamore.	Belfast Trust		
26/10/AP5	RQIA Muckamore Abbey Hospital unannounced inspection report to be issued to MDAG members.	DoH	Circulated to MDAG members 28 October 2022	Closed
26/10/AP6	Members availability for week commencing 12 December to be checked for potential	DoH	Meeting rearranged to 12pm on 13	Closed

Ref.	Action	Responsible	Update	Open/ closed
	rearrangement of December meeting.		December 2022	

Muckamore Departmental Assurance Group (MDAG)

12pm, Tuesday 13 December 2022

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Peter Toogood	DoH (Chair)	Moira Kearney	Belfast Trust
Lynn Woolsey	DoH (Chair)	Jan McGall	Southern Trust
Mark McGuicken	DoH	Aidan McCarry	Family rep
Maria McIlgorm	DoH (items 7 – 11)	Margaret McNally	Family Rep
Sean Scullion	DoH		
Aine Morrison	DoH		
Darren Strawbridge	DoH		
Siobhan Rogan	DoH		
Darren McCaw	DoH (Note)		
Brendan Whittle	DoH (SPPG)		
David Petticrew	DoH (SPPG)		
Lorna Conn	DoH (SPPG)		
Tracy Reid	Belfast Trust		
Peter Sloan	Belfast Trust		
Margaret O'Kane	South Eastern Trust		
Lisa Brady	Western Trust		
Roisin O'Hare	Southern Trust		
Petra Corr	Northern Trust		
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Wendy McGregor	RQIA		
Vivian McConvey	PCC		
Grainne Close	Mencap		
Mary Emerson	PHA		
Mandy Irvine	NI British Psychological Society		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Peter Toogood welcomed attendees and introduced himself as the new interim Head of the Social Services Policy Group. Peter clarified that following Séan Holland's move, his role had been split with Peter taking over as the Head of Social Services Policy Group and Aine Morrison taking on the role of the Chief Social Work Officer. Peter advised that Maria McIlgorm had been delayed in joining today's meeting, and he would co- chair the meeting with Lynn Woolsey,

the Deputy Chief Nursing Officer. Peter thanked attendees for accommodating the rescheduled date for today's meeting, and advised that apologies had been received from Moira Kearney, Jan McGall and Lynn Long.

2. Tracy Reid advised that Brenda Creaney and Billie Hughes were also unable to join the meeting, and introduced Peter Sloan who is acting as Interim Director of Mental Health, Intellectual Disability & Psychological Services for the Belfast Trust in Moira Kearney's absence.

Agenda Item 2 – Minute of Previous Meeting

3. Peter Toogood noted that the draft minutes of the previous meeting held on 26 October had been circulated to members for consideration as usual and, in the absence of any comments being received by the requested date, had been published on the Department's website as an agreed record of the meeting. However, a number of comments were subsequently provided, and the published minutes were amended to reflect these. Peter reminded members that as agreed at the September 2020 MDAG meeting, minutes of these meetings are routinely published on the Department's website, and asked that any comments be provided in a timely fashion to facilitate this. There were no further comments on the minutes.

Agenda Item 3 - Update on Action Points

4. Peter Toogood provided an update on the open action points from previous meetings of the Group. For the open actions from the October meeting, attendees were advised that in relation to 26/10/AP1 the names and contact details of the senior team at Muckamore had been shared at a recent meeting of the Trust's Carer's forum. Regarding 26/10/AP2, MDAG were advised that an update paper had been circulated on the proposed engagement in advance of today's meeting and this will be discussed under Agenda Item 7.

5. In relation to 26/10/AP3, Dawn Jones confirmed that her next MDT meeting was due to take place at 2pm today and while it may be that the update sought would be included on the agenda for this, Dawn advised that Billie Hughes had not confirmed this with her. Tracy Reid agreed to follow up with Billie Hughes.

6. With regards to 26/10/AP4, Tracy Reid advised that correspondence had issued to all families via e-mail and hard-copy letter advising of two dates, 15 December and 24 January, for families to meet with Muckamore's Collective Leadership Team. Dawn Jones advised that she had e-mailed Billie Hughes last week on this action and had been advised that the e-mail and letter had issued on 5 December, but she had not yet received these. Dawn also advised that she had not been notified of these dates to meet with Muckamore's Collective Leadership Team. She asked Brigene McNeilly had she attended the Carers Forum, as she does not. Brigene confirmed that she had received the letter and that she had also been the sole attendee at the Carer forum meetings for approximately the last year. Tracy confirmed that she would look into communications to identify any issues and would respond directly to Dawn and others affected to try and resolve these.

7. Peter confirmed that actions 26/10/AP5 and 26/10/AP6 were both now closed as the RQIA report had issued to members following the October meeting and the December meeting had been rescheduled.

8. Updates were also provided on open actions carried forward from previous meetings. In relation to 31/08/AP4, following discussion on the potential value of facilitating direct engagement between relatives and carers and the ELFT team, and given the ELFT is primarily acting as a critical friend and providing clinical advice to Trust staff in this capacity, it was agreed that the Belfast Trust would liaise in the first instance with the ELFT on this point. The Chair requested that the Trust provide an update on the outcome of this engagement in advance of the next meeting of MDAG.

9. In relation to 27/04/AP4 the Chair noted that the Belfast Trust had provided a summary of the Leadership and MDT structure at Muckamore which had been included as an Annex to the circulated Highlight Report. Tracy Reid confirmed that there was nothing further to add in relation to this action point, and the Chair confirmed this action was closed.

10. Finally, regarding action 27/04/AP6, it was confirmed that an update would be provided under Agenda Item 6 of today's meeting.

Agenda Item 4 – RQIA Inspection Update

11. Peter Toogood reminded attendees that the final RQIA inspection report had been circulated following the October meeting and advised that the Belfast Trust were due to provide their next update to the RQIA in January. Peter invited Wendy McGregor to provide an update.

12. Wendy confirmed that the RQIA had formally written to the Belfast Trust to request a progress update be provided by the end of January 2023. Wendy also advised that the RQIA is continuing to liaise with the Trust on adult safeguarding arrangements. She confirmed that the RQIA are monitoring information provided by the Trust on all current adult safeguarding incidents and had noted an improvement with these, and also a reduction in the backlog of historical cases. Tracy Reid added that there was also significant attendance from the RQIA at ASG strategy meetings and the invitation to the RQIA to attend these meetings remained open.

13. The Chair confirmed that MDAG would continue to monitor progress on the Trust's response to the inspection and the related action plan.

Agenda Item 5 – Update on Staffing Position

14. Tracy Reid advised members that the staffing position continues to be challenging on the Muckamore site, and the level of contracted agency staff on site remains high. The forthcoming industrial action will also likely impact on services at Muckamore, however the Trust has sought derogations to help minimise this. Attendees were also advised that work was ongoing to ensure there was sufficient cover in place over the forthcoming holiday period. Tracy also confirmed that the situation was being regularly monitored and engagement was continuing with agencies to enable access to additional staff should they be needed.

15. Brigene McNeilly raised an issue with the temporary removal of the appropriate level of observations from her brother for a period last week due to staffing issues, and asked for reassurance from the Belfast Trust that this would not happen again over the Christmas period. Brigene explained that this had happened on a previous occasion which had resulted in her brother suffering an injury. Tracy Reid apologised for this on behalf of the Trust, and agreed that it was not acceptable. She added that while it was not possible to give a categoric assurance that there would be no repeat of this, she could confirm that the Trust was making every effort to prevent any recurrence. Brigene accepted that staff were working very hard, but was concerned this may happen again.

16. Lynn Woolsey added that she and Maria McIlgorm had recently met with Billie Hughes and Brenda Creaney to discuss the Trust's data on safety related incidents, and had sought reassurance from the Trust on their escalation processes for these. She considered it would be helpful to seek an update on this from the Trust at the next meeting.

AP1: Update to be provided on work to address current staffing challenges at Muckamore. (Belfast Trust)

Agenda Item 6 – Safeguarding Audit Update

17. Peter Toogood reminded MDAG that this agenda item related to the independent audit of safeguarding referrals at Muckamore which was carried out last year, and invited Aine Morrison and Darren Strawbridge to provide an update on progress.

18. Aine Morrison advised that the Department was engaging with the Trust to work through the outstanding actions and provide clarification on a number of issues, and this work was progressing satisfactorily. Aine confirmed that a written progress update had now been received from the Trust and the Department will review this and respond to the Trust.

19. Tracy Reid noted that the Trust considered that all actions had been progressed and rated as green, and this work was nearing completion. The Trust were awaiting feedback from the Department. Aine agreed that significant progress had been made.

20. Peter noted that members would welcome an update on the status of the action plan at the next MDAG meeting.

Agenda Item 7 - Proposal for public consultation engagement events (MDAG/18/22)

21. Peter Toogood drew members attention to the paper circulated in advance of the meeting, and invited Vivian McConvey to provide an update on planning for the Muckamore public consultation engagement events.

22. Vivian highlighted the query in the paper for the Department around the facilitation of current Muckamore patients to respond to the consultation, advising that this was not considered within the paper and would be for the Department to consider. Peter confirmed that four current Muckamore patients had recently written to Dr Patricia Donnelly on that point and that she intended to meet the authors of the letter to discuss. Mark McGuicken added the Department was cognisant of the concerns of current patients about the future of the hospital, and noted the important role of patient advocates in supporting patients to contribute their views.

23. Vivian provided an overview of the paper, and highlighted engagement with relatives and advocates on the planning arrangements for the engagement sessions which were scheduled to take place via video conference on 9 and 10 January 2023. Vivian advised that the PCC would also provide dedicated support to address any queries or issues arising outside these sessions. The respective roles of the PCC and the Department in the sessions were set out in the paper and she confirmed that the PCC would produce an aggregated report of responses made at the events, which would highlight as far as possible if contributors also intended to make individual responses to the consultation.

The draft report will be shared with contributors for review before being finalised and submitted to the Department for consideration as part of the response to the public consultation.

24. Dawn Jones thanked Vivian for the update and welcomed this approach. She queried what the Department would do with the report. Peter Toogood advised that the PCC would support contributors' voices to be clearly heard, and the Department will consider the report along with the other responses received through the consultation. A quantitative analysis will be carried out of the responses received as part of a structured process of considering all the comments provided through the consultation, which will be used to inform production of a consultation analysis report.

25. Dawn advised that while her view was that Muckamore should close, it will be important to be clear about how services currently being provided by the hospital will be replaced. Peter agreed that there was a need to set this out, and he confirmed that in the event of a final decision that Muckamore should close, any closure would not take effect until adequate alternative service provision was in place.

26. Brigene McNeilly advised she was glad to hear that patients were mentioned in the consultation process as they would be impacted the most by any decision on the future of the hospital, particularly since Muckamore had effectively become home for a number of patients, given the length of time they had lived there.

27. Mark McGuicken highlighted that the engagement events were currently being organised to deliver on a commitment given at the consultation launch event, and confirmed that participation in the engagement events did not preclude individuals involved also making their own individual responses to the consultation. Mark pointed out however it was important to ensure that consultation responses were not double counted, and Vivian advised that the PCC would reflect on how best to do this.

28. Siobhan Rogan flagged the need to disaggregate responses to the consultation from individuals and families. Vivian suggested that further thought should be given to engagement with current in-patients. Mark McGuicken advised that the Department was very aware of the importance of supporting current in-patients in providing their views, but was equally conscious that the needs of some current in-patients may mean they will find engaging directly in the consultation on the hospital's future to be difficult and potentially traumatising.

Agenda Item 8 – MDAG Revised Reporting Arrangements (MDAG/19/22)

29. Sean Scullion referred members to the circulated paper MDAG/19/22 which provided an update on the revised reporting arrangements to MDAG further to discussions at the previous two MDAG meetings on a new thematic reporting format, outlining that the circulated paper represented a first draft of this new format. Sean provided detail on the sections proposed for inclusion in the report, and advised that an overarching action plan was being developed which will include all relevant recommendations from the range of extant action plans and reports relevant to Learning Disability services as part of the ongoing work to finalise the Learning Disability Service Model (LDSM) and associated oversight arrangements. As a result, he noted that the paper remained a work in progress pending the completion of this work and invited comments on the draft.

30. Tracy Reid raised the need for the report to include detail on ongoing work in relation to wider Learning Disability services to help provide context. Sean advised that the intention was that this work would be reflected in the new governance arrangements for regional Learning Disability services which would accompany the new LDSM. The new streamlined report for MDAG is intended to provide MDAG members with clear oversight of those actions relevant to MDAG's Terms of Reference. Peter Toogood agreed it would be helpful for reporting arrangements to MDAG to be placed in the context of wider governance arrangements for regional Learning Disability services.

31. Brendan Whittle welcomed the detail in the paper in relation to the ongoing work on the LDSM, and noted that reporting and oversight would be strengthened by

the development of a thematic action plan to accompany the new reporting format. Sean confirmed this was being taken forward through the work on the LDSM which would also include the development of a single overarching thematic action plan for Learning Disability services which will encompass all relevant action plans and outstanding recommendations. Mark McGuicken agreed with the principle of an overarching action plan for Learning Disability services, and noted the aim of the refocused reporting format for MDAG was to move to a more strategic and thematic way of reporting on progress in relation to Muckamore, which would facilitate MDAG members in their oversight role.

32. Mary Emerson agreed that the report was very helpful and suggested the inclusion of AHP input would help better inform the detail on resettlement. Sean confirmed that the report was a work in progress, and it would be important to ensure all relevant linkages and learning were reflected in the report. Mark McGuicken suggested that this level of detail might be of more relevance to the work of the Regional Resettlement Oversight Board, who could in turn include any relevant updates in their reporting to MDAG. Mary confirmed that she would be content with this approach.

33. Peter Toogood suggested it might be timely to review the Terms of Reference for MDAG. A review would also provide the opportunity to take stock generally of the current reporting arrangements for Learning Disability services, to identify any duplication and opportunities to streamline these.

AP2: MDAG Terms of Reference to be reviewed in the context of the proposed new reporting arrangements for regional Learning Disability services. (DoH)

34. Brendan Whittle advised that it may be useful to bring the proposed LDSM overarching action plan to the next meeting of MDAG to help provide clarity.

AP3: Draft LDSM overarching action plan to be circulated with the papers for the February MDAG meeting. (DoH)

Agenda Item 9 – Highlight Report (MDAG/20/22)

35. Sean Scullion referred members to the Highlight Report paper circulated in advance of the meeting, and highlighted some key messages in the Report, relating to the work of the adult safeguarding team at Muckamore, continuing CCTV viewing, ongoing work of the Family Liaison Officers at Muckamore and updates on the current work in relation to the LDSM and the Independent Review of Acute Care Services.

36. Members were advised that the overall number of patients in Muckamore was now 29, down from the baseline figure of 36 patients in August, with 7 patients discharged. Progress reports on a number of community placement schemes was provided, and Sean noted that, as Dawn Jones had mentioned earlier in the meeting, an update on the Minnowburn scheme had not been included and this would be provided in future reports.

37. Sean highlighted the inclusion of updates in relation the Belfast Trust's ongoing work with the ELFT and communication with families, and drew members attention to the diagram setting out the nursing management structure at Muckamore included on page 12, and also the diagram which set out the leadership and MDT structure at the Hospital included at Annex A on page 15.

38. Peter Toogood suggested that the content of the Highlight Report should be considered to identify any areas of overlap with the Thematic Report, and be modified accordingly.

AP4: Highlight and Thematic Reports to be reviewed to identify and remove any areas of duplication. (DoH)

39. Lorna Conn queried the detail included in the Highlight Report on the current status of the Independent Review of Acute Care services. Mark McGuicken clarified that the draft proposal was now with his team and not with SPPG as indicated in the Highlight Report.

40. Lynn Woolsey advised that work has been ongoing with the Belfast Trust on the development of a staffing and safety dashboard, and it was agreed that the

Belfast Trust would provide an update at the next MDAG meeting on this work as the dashboard reporting could also assist MDAG to meet its responsibilities set out in the Terms of Reference.

AP5: Update to be provided for the February MDAG meeting on the revised safety dashboard developed with the Department. (Belfast Trust)

41. Dawn Jones noted the update on the Muckamore leadership and MDT structure outline provided in the Highlight Report and queried the inclusion of a specific member of staff as she understood that they had retired. Tracy Reid confirmed that the individual staff member in question had recently returned under the 'retire and return' scheme to work on some areas within Muckamore.

42. Dawn also advised members that a member of the management team had recently visited her son's ward without prior notice to ward staff, which had caused some degree of concern over access to the ward. Dawn confirmed that she was subsequently able to clarify this individual's identity. Tracy Reid confirmed that anyone entering wards should be clearly introducing themselves, and would feed this back to the team. Dawn also advised that an offer had been made to have this incident referred for screening, however she had no further update on this. Tracy agreed to follow up on this also with Ciara Rooney.

43. Petra Corr welcomed the amended Thematic Report and the work to be taken forward with this and the Highlight Report, and queried if there had been any changes made to the screening out processes which might have resulted in the reduction on staff on patient adult safeguarding referrals as indicated in the table on page 8 of the Highlight Report. Tracy Reid confirmed that all staff on patient referrals were now being processed through a central point of referral involving one DAPO. This had improved consistency in the screening out process, and also assisted in identification of any potential patterns emerging. Petra advised that it would be helpful to explore this further, as the Northern Trust had made a similar change in Holywell and had seen similar results. Aine Morrison suggested that the improvement may also be down to the impact of

inappropriate referrals being screened out. Tracy confirmed that additional training provided on reporting thresholds may also have improved consistency.

AP6: Detail to be provided on changes made by the Belfast Trust to the referral process for staff on patient referrals. (Belfast Trust)

Agenda Item 10 – AOB

44. No items were raised under AOB.

Agenda Item 11 - Date of Next Meeting

45. Attendees were advised the next meeting is currently scheduled for Wednesday 22 February 2023 at 2pm.

46. Peter thanked attendees again for taking the time to attend this rescheduled meeting and wished all a quiet and peaceful Christmas and New Year.

Summary of Action Points – MDAG 13 December 2022

Ref.	Action	Responsible	Update	Open/ closed
13/12/AP1	Update to be provided on work to address current staffing challenges at Muckamore.	Belfast Trust		
13/12/AP2	MDAG Terms of Reference to be reviewed in the context of the proposed new reporting arrangements for regional Learning Disability services.	DoH		
13/12/AP3	Draft LDSM overarching action plan to be circulated with the papers for the February MDAG meeting.	DoH		
13/12/AP4	Highlight and Thematic Reports to be reviewed to identify and remove any areas of duplication.	DoH		
13/12/AP5	Update to be provided for the February MDAG meeting on the revised safety dashboard developed with the Department.	Belfast Trust		

Ref.	Action	Responsible	Update	Open/ closed
13/12/AP6	Detail to be provided on changes made by the Belfast Trust to the referral process for staff on patient referrals.	Belfast Trust		

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 22 February 2023

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Peter Toogood	DoH (Chair)	Moira Kearney	Belfast Trust
Lynn Woolsey	DoH (Chair)	Gavin Davidson	QUB
Mark McGuicken	DoH	Mary Emerson	PHA
Sean Scullion	DoH	Siobhan Rogan	PHA
Kevin Scullion	DoH (Observing)	Lynn Long	RQIA
Aine Morrison	DoH	Brenda Creaney	Belfast Trust
Nigel Chambers	DoH (Agenda item 3)	Margaret O'Kane	South Eastern Trust
Darren McCaw	DoH (Note)	Petra Corr	Northern Trust
Brendan Whittle	DoH (SPPG)	Aidan McCarry	Family rep
David Petticrew	DoH (SPPG)	Margaret McNally	Family Rep
Lorna Conn	DoH (SPPG)		
Randal McHugh	DoH (SPPG)		
Peter Sloan	Belfast Trust		
Billie Hughes	Belfast Trust		
Tracy Reid	Belfast Trust		
Jan McGall	Southern Trust		
Gareth Farmer	Northern Trust		
Karen O'Brien	Western Trust		
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Wendy McGregor	RQIA		
Vivian McConvey	PCC		
Grainne Close	Mencap		
Elaine Armstrong	Cedar Foundation		
Mandy Irvine	NI British Psychological Society		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Peter Toogood welcomed everyone to the meeting and advised that apologies had been received from Gavin Davidson, Mary Emerson, Siobhan Rogan, Lynn Long, Brenda Creaney and Petra Corr. Brigene McNeilly advised of an apology from Aidan McCarry and an apology on behalf of Margaret O'Kane was also provided. In the absence of Mary Emerson and Siobhan Rogan, it was confirmed there was no PHA representative in the meeting.

Agenda Item 2 – Minute of Previous Meeting

2. Peter Toogood noted that the draft minutes of the previous meeting held on 13 December had been circulated to members for consideration on 9 January, and following receipt of a number of comments, an updated version of the minutes had been published on the Departmental website on 1 February. There were no further comments on the minutes.

Agenda Item 3 - Update on Action Points

3. Updates were provided on the open action points from previous meetings with Peter advising that in relation to the actions from the December meeting, 13/12/AP1 would be covered under Agenda Item 5 of today's meeting. With regards to 13/12/AP2, 13/12/AP3 and 13/12/AP4, he advised members that progress on these actions would be dependent on the work to implement the Learning Disability Strategic Action Plan. Attendees were advised that the Plan had recently been approved by the Top Management Group (TMG) in the Department and implementation work was now underway. Peter invited Nigel Chambers to provide an update on this work.

4. Nigel advised that the paper approved by TMG had outlined the challenging context for children's and adult learning disability services across both inpatient and community provision, and the need to better align services to provide more joined up and effective provision. The establishment of a Task & Finish Group (T&F Group) for a period of six months had been agreed by TMG to progress the various strands of this work. The work will include the collation of baseline detail to understand the current position and the examination of approaches in other jurisdictions to identify best practice. This will then be used to test against the draft Learning Disability Service Model and Children with Disabilities Framework to aid their finalisation and production of costed implementation plans.

5. Further to queries from members, Nigel confirmed that the T&F Group was currently comprised of policy, planning and performance colleagues from the Department, but this would be widened through the engagement of relevant

stakeholders such as carers, HSC colleagues, professional bodies and professionals during the process as the work dictated. Vivian McConvey emphasised the importance of early engagement with stakeholders to allow them to inform the work as it progressed. Nigel agreed to follow up separately with Mandy Irvine on the involvement of professional bodies. Peter Toogood highlighted the need for meaningful co-production and asked that updates on this work be provided to MDAG to ensure they were sighted on developments.

6. In relation to 13/12/AP5, Peter advised that this would be covered under Agenda Item 7.

7. Tracy Reid provided an update on 13/12/AP6, and confirmed that the Trust had reviewed to ensure that standardised threshold criteria were being utilised and had also implemented a central DAPO gateway which had improved consistency and timeliness of referrals. Members were also advised that alternative adult safeguarding responses were being used to aid responses where referrals did not meet thresholds. Aine Morrison confirmed that she was supportive of the approach the Trust have taken.

8. Updates were also provided on open actions carried forward from previous meetings. Members were advised that an update on 26/10/AP3 would be provided under Agenda Item 5. In relation to 26/10/AP4, Dawn Jones confirmed that she received a notification from the Trust for the meetings and had attended the second meeting, at which Dr Margaret Flynn and one other person were in attendance. In response to a query from Dawn on attendance at the first meeting, Billie Hughes confirmed that there had been no attendees for the first meeting, highlighting that the Trust had engaged with families and carers at a Christmas party earlier that day. Dawn highlighted that she had not received notification of the Christmas party until three days after it had taken place. Billie confirmed that an apology had been provided to Dawn for this delay and that a new system had been implemented for communication with Dawn which should improve this. Peter Toogood confirmed that this action was now closed.

9. Finally, in relation to 31/08/AP4, Peter Sloan confirmed that the Belfast Trust were engaging with the East London Foundation Trust (ELFT) specifically as a critical friend and a provider of clinical advice and wished to maintain this relationship. He explained that direct engagement with relatives and carers was outside the role of ELFT, and the Trust had instead engaged Dr Margaret Flynn to advise them on arrangements for communication with families. On this basis, Peter Toogood confirmed he was content for this action to be closed, although he added that the potential for this type of communication with the ELFT would be kept under review.

Agenda Item 4 – RQIA Inspection Update

10. Wendy McGregor advised that the Belfast Trust continued to be monitored under the serious concerns process with an action plan update received from the Trust on 4 February. The update was currently being reviewed to inform RQIA's next steps. Peter Sloan confirmed that the Trust had nothing further to add and was awaiting feedback from the RQIA.

11. Wendy also confirmed that RQIA continued to be notified of any adult safeguarding incidents that met the agreed threshold with the Belfast Trust. She advised that RQIA also aim to attend all adult safeguarding strategy meetings, and should RQIA be unable to provide an attendee for a meeting, minutes of the meeting will be provided to RQIA for review.

12. Mark McGuicken noted that this will be maintained as a recurring agenda item for MDAG to allow progress updates to be provided to members following RQIA's engagement with the Belfast Trust.

Agenda Item 5 – Update on Staffing Position

13. Peter Sloan provided an update on the current staffing position, and highlighted that detail on this had been included in the circulated Highlight Report paper (MDAG/02/23). In relation to nursing, members were advised that the overall position was largely unchanged with the Belfast Trust now achieving 90% of safe staffing levels, with agency staff making up around 85% of these staff. Detail on current vacancy levels was provided, noting high vacancy rates in the

deputy and Charge Nurse categories, and the vacancy position in the adult safeguarding and psychology services was also outlined. Peter confirmed that the Trust had redeployed staff to the adult safeguarding team to ensure safe staffing levels were maintained.

14. Peter advised that on the medical staffing side, two consultants, one substantive and one locum, had left the service since the December MDAG meeting. It was confirmed that the Trust was taking steps to manage these vacancies with action underway to recruit replacement staff, as well as engagement with agencies and working with existing consultants and locums to maintain a safe level of care.

15. Peter Toogood emphasised the importance of continued scrutiny of the staffing position, and the need for the Trust to take all necessary steps to maintain the staffing levels required.

Agenda Item 6 – Safeguarding Audit Update

16. The Belfast Trust have submitted their finalised action plan to DOH and are awaiting an outcome from DOH. Aine Morrison confirmed that significant progress continued to be made on progressing the action plan, with a small number of items remaining to be clarified with the Belfast Trust. She expected that these will be addressed shortly, and a further report will be provided at the next meeting of MDAG to confirm all actions had been completed. Tracy Reid confirmed the Trust would continue to work with Departmental colleagues to finalise these.

17. Peter Toogood noted the importance of maintaining focus on this work, and welcomed the commitment to provide a further update at the next MDAG meeting.

Agenda Item 7 – Safety Dashboard

18. Billie Hughes provided an overview of the updated safety dashboard which used the weekly ‘safety in time’ report to aggregate detail to help provide month

on month trend detail for analysis. The dashboard, which had been developed in partnership with professional colleagues from the Department's Chief Nursing Officer Group, will form part of the Muckamore governance arrangements and will be submitted to the Department each month along with a highlight report containing supporting analysis.

19. Billie highlighted some key points from the dashboard, outlining the improving trend on safe staffing levels, the number of shifts per ward where there were two or more registered nurses on the ward and a chart setting out monthly staffing levels, by profession, in Muckamore. Members were advised that there were improvements in education and training rates. Billie further advised that there continued to be gaps in leadership roles, significantly at Band 6 and Band 7 levels, although more senior grades had been enhanced to help address these gaps. Finally, Billie confirmed that the patient experience team provided a monthly report on their engagement activity, with recent detail indicating an 80 - 90% satisfaction rate with the care provided.

20. Brendan Whittle commented it was encouraging to see the improvements outlined, particularly the enhanced leadership roles above Band 8 and noted the improvements in safe staffing levels. Billie advised that a number of graphs setting out some of this detail had been included in the February Highlight Report, and a fuller dataset would be included in the next report.

21. Peter Toogood thanked Billie for the helpful update, and welcomed the addition of this detail to the assurance process which would help ensure MDAG were sighted on any emerging issues.

Agenda Item 8 – Update on MAH Public Consultation

22. Sean Scullion advised that the public consultation on the proposed closure of Muckamore Abbey Hospital had closed on 24 January 2023. The consultation had launched on 24 October 2022 and, allowing an extra week for the Christmas holiday period, had remained open for a 13-week consultation period. During the consultation period the PCC had also facilitated two virtual engagement events and provided a dedicated phone line service for feedback,

and Sean thanked the PCC team involved for all their work around these events. Members were also advised that a small number of extensions to the deadline had been agreed in response to requests from some respondents, and a full set of responses had now been received.

23. Sean confirmed that a total of 117 responses had been received to the consultation with a further 19 facilitated through the PCC process - 13 from the engagement events and 6 written responses. Responses had been received from a range of individuals and organisations, including relatives and carers of current and past patients, former patients, patient representative groups, Trust staff, trade unions, political parties, independent sector organisations, professional bodies and academics.

24. Sean advised that work on the analysis of the responses received has now begun and a summary report will be prepared. Pending completion of the final report, an initial analysis of the responses to question one has indicated a majority of respondents are in agreement with the proposal to close the Hospital. With regard to question two, initial indications were that a majority agreed that closure of the Hospital would be consistent with the wider policy aims for learning disability services.

25. In terms of next steps, Sean confirmed that once the analysis of responses had been completed and a summary report produced, advice on the way forward would be provided for consideration either by a Minister, or alternatively by the Department's Permanent Secretary should a Minister not be appointed in the interim. Peter Toogood noted that the next steps would be informed by the political situation, and, in the absence of a Minister, advice would be provided to the Permanent Secretary.

26. Brendan Whittle queried the length of the extensions given and the expected timeframe for a decision. Sean advised that the extensions granted were relatively short. In relation to the potential timeframe for a decision, members were advised that the work involved was being expedited to enable advice to be produced for a Minister or Permanent Secretary as quickly as possible.

However, competing demands on the team, particularly in relation to dealing with requests from the Muckamore Abbey Hospital Inquiry, meant it was difficult to provide a definitive timeframe.

AP1: Confirmation to be provided on the length of extensions granted to potential respondents to the MAH Consultation. (DoH)

27. Mark McGuicken confirmed that an update on progress on the analysis of the responses to the consultation would be provided at the next MDAG meeting, and the final analysis report would be circulated to MDAG members once completed and agreed, as well as being published on the Department's website.

Agenda Item 9 – Update on MDAG Revised Reporting Arrangements (MDAG/01/23)

28. Darren McCaw referred members to the circulated paper (MDAG/01/23), and drew their attention to the progress update on the draft Strategic Action Plan for Learning Disability, as summarised by Nigel Chambers earlier in today's meeting. He advised that, pending work being progressed by the Task and Finish Group to develop a revised governance structure for Learning Disability services, the focus of the themes in the update report would continue in the interim to relate primarily to the remaining open actions in the MAH HSC Action Plan.

29. Darren summarised the content of the paper, highlighting that seven patients had been resettled since the Regional Resettlement Oversight Board began meeting in August 2022 and confirming that Peter Toogood has now replaced Sean Holland as the Chair of the Adult Protection Transformation Board.

30. Brendan Whittle suggested it would be helpful for MDAG to have sight of the mapping of the relevant actions and recommendations into the proposed Strategic Action Plan to provide assurance that all relevant outstanding actions are captured. Sean advised that the Task & Finish Group would be carrying out a detailed piece of work on the mapping of all relevant actions and

recommendations into the Plan. Peter Toogood agreed it was important that MDAG be sighted on this mapping work to ensure effective oversight of its evolution and development.

Agenda Item 10 – Highlight report (MDAG/02/23)

31. Sean Scullion provided an update on the circulated Highlight Report (MDAG/02/23), advising that as with the thematic report, consideration of the content within the Highlight Report would be informed by the work on the draft Strategic Action Plan. He noted that some initial work had been carried out to remove obvious areas of duplication between the two reports.

32. Sean highlighted a number of areas within the report outlining current work in relation to adult safeguarding referrals, with associated trend detail from the Trust provided in the paper, the work being taken forward by the Task & Finish Group on the Learning Disability Service Model, Acute Care Review and resettlement review and an update on the current inpatient population at Muckamore including progress on resettlement schemes. Sean also drew members attention to the updated detail from the Trust on the leadership and MDT structure at Muckamore that was included at Annex A of the paper and finally, the current arrangements for the Trust's communication with families as outlined in Section 5.2 of the paper.

33. Billie Hughes advised of a small update to the detail within the paper, advising that the weekly resettlement meetings outlined on page six of the paper had since moved to fortnightly since the paper had issued.

34. Further to a query from Lynn Woolsey on the update provided on the viewing of CCTV footage, Billie confirmed that this related to the viewing of historical material and agreed to include more detail on the set viewing schedule in future highlight reports.

AP2: Belfast Trust to add detail of CCTV viewing schedules to their future highlight reports. (Belfast Trust)

35. Dawn Jones sought clarification on whether ongoing safeguarding issues were still being reported on by the Belfast Trust. Billie Hughes confirmed that both ongoing and outstanding issues were still being reported on. Tracy Reid added that there was a continuing focus on adult safeguarding issues in the Trust and this would continue.

36. Lynn Woolsey advised that the additional safety dashboard reporting information to be provided in the highlight report for the April MDAG meeting would not all be necessarily required for MDAG in the future. Nursing colleagues in the Department would liaise with the Belfast Trust to advise on future requirements.

37. Brendan Whittle suggested that the detail provided in the chart on page 12, outlining the percentage of weekly staffing achieved against plan, be brought up to date for future reports. Billie Hughes confirmed that this has been amended and will provide detail to the nearest month end when provided in future.

38. Dawn Jones queried the use of the 100% figure in the table of overall incident totals included on page two of the report as it was not clear what this meant. Following discussion Tracy Reid agreed to provide clarification on the detail contained within the table for inclusion in the next report.

AP3: Clarification on the detail contained within the 'Overall Incidents Totals identified by PSNI and Adult Safeguarding' table to be provided in the April Highlight Report. (Belfast Trust)

39. Peter Toogood welcomed the development of the report, and noted the breadth of information it provided would be further enhanced by the additional dashboard items discussed.

Agenda Item 11 – AOB

40. Vivian McConvey advised members that today's meeting would be her last as a member of MDAG as she was retiring as the Chief Executive of the PCC. Vivian added that details of her successor would be announced in due course once confirmed. Peter Toogood extended his thanks on behalf of MDAG for Vivian's contribution to the Group and passed on MDAG's best wishes to her for the future.

41. Lorna Conn also advised that today would also be her last MDAG meeting with Randall McHugh taking over her learning disability post in SPPG.

42. David Petticrew advised members that he was part of a team that had recently met with the Telling It Like It Is (TILII) group to discuss resettlement issues. At the meeting TILII had advised that they were keen to communicate their views on their experiences of Muckamore, and how they valued the staff contribution to this, to MDAG and had queried how they might be able to do this. Mark McGuicken suggested that, subject to agreement from Belfast Trust clinical and professional colleagues, he would arrange to meet TILII along with David Petticrew to hear their views first hand.

43. Both Billie Hughes and Tracy Reid advised that if patients felt that they were not having their voices heard then this was something that the Belfast Trust would wish to address and improve. They noted it was important that the patient voice was heard and that effective mechanisms existed to enable this.

44. Brendan Whittle, Grainne Close and Dawn Jones all concurred on the importance of MDAG hearing the patient voice in relation to services at Muckamore, with Dawn adding that it was about showing the patients appropriate respect.

45. Mark McGuicken agreed with the Belfast Trust that an effective mechanism was required to ensure dialogue was ongoing and enabled views to be reflected back to MDAG. The potential was raised for this to be explored with ARC or TILII.

46. Peter Toogood confirmed it was clear that the consensus from members was that this was the right and important way to proceed. He suggested that as a first step Mark McGuicken and David Petticrew should make arrangements to meet with patients' representatives group to hear their views first hand, and then consider potential options for an ongoing communication channel for the patient voice to MDAG. Peter asked that an update on this issue be provided at the next MDAG meeting.

AP4: Update to be provided to MDAG on initial engagement with TILII and work to consider options for ongoing engagement with the patient voice. (DoH/Belfast Trust)

47. Mark McGuicken drew to members' attention the recent request issued by the Muckamore Abbey Hospital Inquiry which had been circulated with the MDAG meeting papers, inviting current and past members of staff and management at Muckamore to contact the Inquiry to provide detail of their experience. Mark encouraged all MDAG members to publicise and share this request as widely as possible.

Agenda Item 12 - Date of Next Meeting

48. Attendees were advised the next MDAG meeting is currently scheduled for Wednesday 26 April 2023 at 2pm.

Summary of Action Points – MDAG 22 February 2023

Ref.	**Action**	**Responsible**	**Update**	**Open/ closed**
22/02/AP1	Confirmation to be provided on the length of extensions granted to potential respondents to the MAH Consultation.	DoH		
22/02/AP2	Belfast Trust to add detail of CCTV viewing schedules to their future highlight reports.	Belfast Trust		
22/02/AP3	Clarification on the detail contained within the 'Overall Incidents Totals identified by PSNI and Adult Safeguarding' table to be provided in the April Highlight Report.	Belfast Trust		
22/02/AP4	Update to be provided to MDAG on initial engagement with TILII and work to consider options for ongoing engagement with the patient voice.	DoH/Belfast Trust		

MDAG/01/19

MUCKAMORE ABBEY HOSPITAL DEPARTMENTAL ASSURANCE GROUP:
TERMS OF REFERENCE

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1. Introduction

1.1 This paper sets out the Terms of Reference (ToR) for the Muckamore Abbey Hospital (MAH) Departmental Assurance Group (MDAG).

2. Purpose

2.1 The MDAG is being established to provide the Department of Health (DoH) (and any incoming Minister) with assurance in respect of the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff, and the Permanent Secretary's subsequent commitment on resettlement made in December 2018.

2.2 MDAG is intended to provide the DoH with a clear line of sight on progress towards delivering the commitments set out in the MAH HSC Action Plan, and provide a forum for the escalation of issues and risks from the Mental Health and Learning Disability Improvement Board which acts at the regional oversight group for this work.

2.3 The core purposes of MDAG are to assure the Permanent Secretary of the DoH (and any incoming Minister) that:

i. the services being delivered at MAH continue to be safe, effective and fully Human Rights compliant;

ii. the commitment given by the Permanent Secretary to resettle the primary target list of patients is met, and the issue of delayed discharges is addressed;

iii. the team on site at MAH is given the support and resources necessary to achieve their goals; and

iv. the lessons learned from MAH (including the SAI report) are put into practice consistently on a regional basis in line with wider policy on services for people with learning disabilities, and also inform the work underway to transform Learning Disability services in each Trust.

3. Membership & Frequency of Meetings

3.1 Initially, MDAG will meet at least once a month, but the frequency of meeting will be kept under review, subject to satisfactory progress being made.

3.2 The group will be chaired jointly by the Chief Social Worker and the Chief Nursing Officer. Membership will also include:

i. key DOH policy and professional staff;
ii. representatives from the MAH families;
iii. external nursing expert appointed by CNO;
iv. RQIA;
v. BHSCT;
vi. SEHSCT;
vii. NHSCT;
viii. SHSCT;
ix. WHSCT
x. HSCB;
xi. A Chair of the Strengthening the Commitment Collaborative;
xii. PHA;
xiii. Representative from the British Psychological Society,
xiv. Representatives of specialist accommodation providers; and
xv. Appropriate academic expertise.

3.3 Additional attendees may be required for specific discussions, with MDAG able to call on expert advice and analysis as required.

3.4 The Secretariat will be provided by the Mental Health, Disability and Older People's Directorate.

4. Outcomes

4.1 MDAG seeks to assure the DoH Permanent Secretary (and any incoming Minister) that the following outcomes have been achieved:

i. all patients have been resettled in line with the Permanent Secretary's commitment of December 2018; and

ii. the recommendations of the independent investigation have been delivered or substantially delivered.

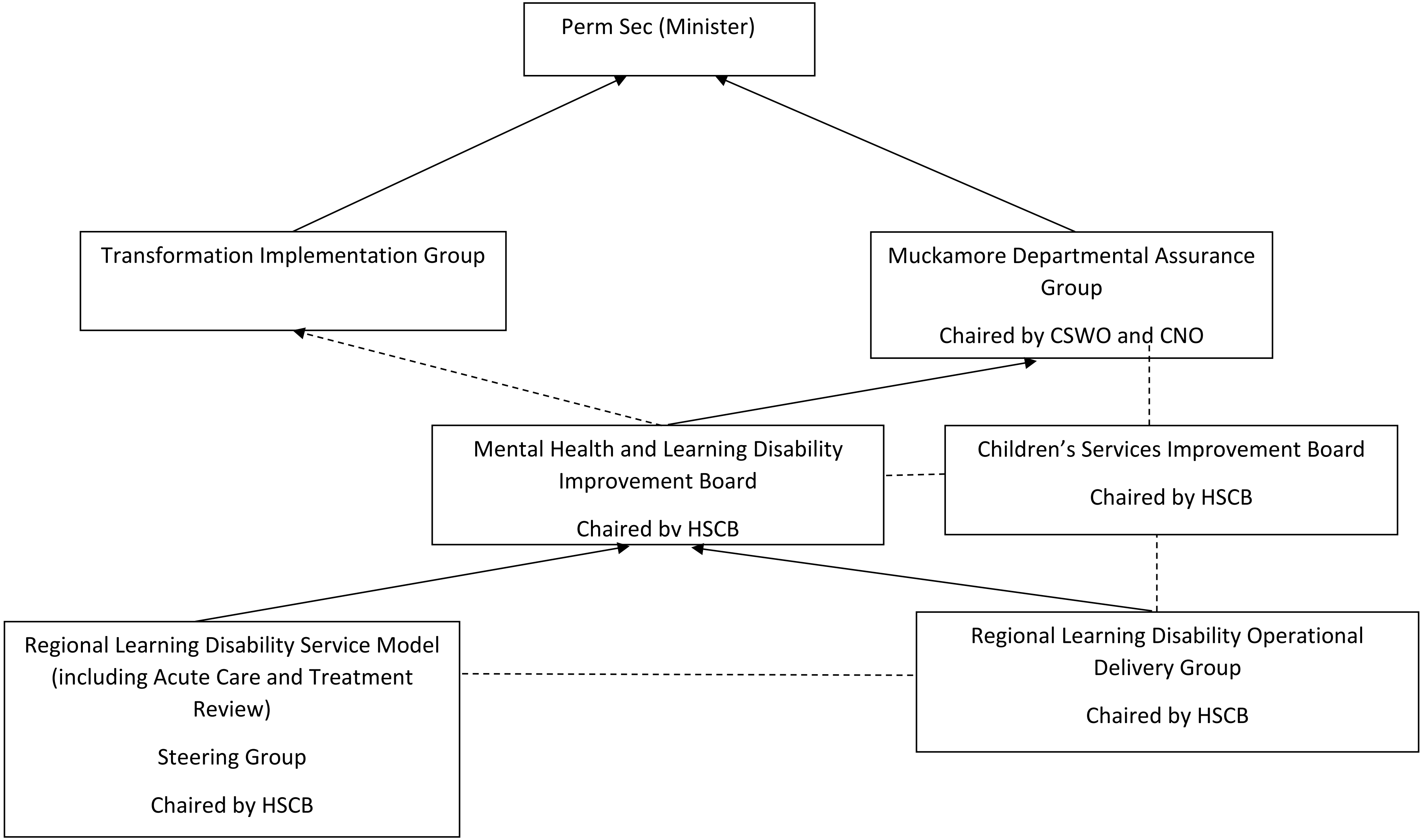
5. Review & Duration

5.1 The effectiveness of these ToRs and the membership of MDAG will be reviewed after the first six months of operation.

5.2 It is intended that MDAG will dissolve, once the outcomes set out at 4.1 have been met.

MMcG-229

Muckamore Abbey Hospital HSC Response – Draft Governance Structure



DRAFT

MUCKAMORE ABBEY HOSPITAL
HSC ACTION PLAN
RISK REGISTER 2021

Introduction

1.1 The Muckamore Department Assurance Group (MDAG) was established to provide the Department of Health (DoH) and Minister for Health with assurance in respect of the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff, and the Permanent Secretary's subsequent commitment on resettlement made in December 2018.

1.2 MDAG is intended to provide the DoH with a clear line of sight on progress towards delivering the commitments set out in the MAH HSC Action Plan, and provide a forum for the escalation of issues and risks from the Mental Health and Learning Disability Improvement Board which acts at the regional oversight group for this work.

MDAG Objectives

1.3 The core purposes of MDAG are to assure the Permanent Secretary of the DoH and the Minister for Health that:

i. the services being delivered at MAH continue to be safe, effective and fully Human Rights compliant;

ii. the commitment given by the Permanent Secretary to resettle the primary target list of patients is met, and the issue of delayed discharges is addressed;

iii. the team on site at MAH is given the support and resources necessary to achieve their goals; and

iv. the lessons learned from MAH (including the SAI report) are put into practice consistently on a regional basis in line with wider policy on services for people with learning disabilities, and also inform the work underway to transform Learning Disability services in each Trust.

MDAG Risk Register

1.4 The purpose of this document is to record and update the key risks threatening the achievement of the HSC Action Plan and to identify the controls in place, and under development, to mitigate and manage those risks.

1.5 The identification, assessment, management and monitoring of risk is integral to the achievement of the objective of the MDAG. The MDAG Risk Register is a living document, which is reviewed and updated on a regular basis to take account of the changing nature of risk.

Key Risks Summary at 26 October 2021

	Risk	Owner	Residual Risk	
			Position Oct 21	Position Aug 22
1.	**MAPR1 –** Arrangements in place to protect patients in MAH from abuse are not sufficiently protective.	M Kearney (BHSCT)	**10**	**10**
2.	**MAPR2 –** Patients deemed fit for discharge are unduly delayed.	B Whittle/L Conn (SPPG)	**12**	**12**
3.	**MAPR3 –** Service provision at MAH cannot be maintained safely and is not viable.	M Kearney (BHSCT)	**9**	
4.	**MAPR4 –** Regional services are not sufficiently reformed to enable patients or carers/families to access appropriate services or support at the right time.	B Whittle/L Conn (SPPG)	**9**	
5.	**MAPR5 –** Patients and their carers/families are not sufficiently involved in decisions about their care and treatment.	M Kearney (BHSCT) P Corr (NHSCT) M O'Kane (SEHSCT) M O'Kane (SHSCT) K O'Brien (WHSCT)	**6**	

Key Risk: MAPR1 – Arrangements in place to protect patients in MAH from abuse are not sufficiently protective

Risk Appetite – Averse

Link to MDAG Objectives	Link to HSC Action Plan Action	Risk Owner	Inherent Risk		Current Controls in Place	Residual Risk		Action Planned	Target Date	Action Owner – Name Title Org.	Action RAG Status
			I	L		I	L				
i	A9 A21 A22 A23/31 A25 A26 A27 A32 A44 A45 A47 A48 A51 A52 A54	M Kearney (BHSCT)	5	3	• Adult Safeguarding data provided by BHSCT for consideration at bi-monthly Muckamore Departmental Assurance Group (MDAG) meetings. • RQIA unannounced inspections at MAH. • Statutory framework for Deprivation of Liberty in place. • BHSCT policy 'Seclusion within Learning Disability Inpatients Services Procedure – Children and Adults' in place • Regional guidance 'Use of Restraint, Seclusion and Restrictive Interventions Policy' and 'Regional Guidance Document on the use of Seclusion' developed and being considered by officials. • CCTV in place in MAH, regularly reviewed and retained per existing	5	2	• Complete a review of Adult Safeguarding culture and practices at MAH to inform wider regional safeguarding policies and procedures.	30/06/2020	M Kearney Interim Director Mental Health and Intellectual Disability BHSCT	🟥
								• Carry out a regional review of Adult Safeguarding to inform regional policy and procedures.	31/12/2021	B Whittle Director Children & Social Care SPPG L Conn Programme Manager (MH & LD) & Resettlement Lead SPPG	🟥
								• Complete a review of the accountability arrangements for Delegated Statutory Functions (DSF).	31/03/2022	A Morrison DCSWO DoH	🟥

Key Risk: MAPR1 – Arrangements in place to protect patients in MAH from abuse are not sufficiently protective

Risk Appetite – Averse

Link to MDAG Objectives	Link to HSC Action Plan Action	Risk Owner	Inherent Risk		Current Controls in Place	Residual Risk		Action Planned	Target Date	Action Owner – Name Title Org.	Action RAG Status
			I	L		I	L				
					regional HSC and national guidance and legislation. • CCTV used to inform and amend staff practice. Independently reviewed footage which reflects good practice of highlights areas for concern is shared with staff. • An Operational Group made up of ASG team, HR Management, both MAH, & RQIA and PSNI meet every 3 weeks to review management decisions in relation to the safeguarding referrals made. • Families provided with an information booklet on making a complaint on behalf of their relatives. • Any breaches of requirements are brought to the attention of the BHSCT Board in the first instance before going to the SPPG/PHA.			• Consider extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and inspecting all hospital provision.	30/04/2025	A Dawson Director Safety and Quality Unit DoH	🟧
								• Complete a review of advocacy services at MAH to ensure they provide a robust challenge function for all patients and support for relatives/carers.	31/03/2021	M Kearney Interim Director Mental Health and Intellectual Disability BHSCT	🟥

Key Risk: MAPR1 – Arrangements in place to protect patients in MAH from abuse are not sufficiently protective

Risk Appetite – Averse

Link to MDAG Objectives	**Link to HSC Action Plan Action**	**Risk Owner**	**Inherent Risk**		**Current Controls in Place**	**Residual Risk**		**Action Planned**	**Target Date**	**Action Owner – Name Title Org.**	**Action RAG Status**
			I	**L**		**I**	**L**				
					• Pending review of DSF accountability arrangements greater challenge being brought by the SPPG to ensure the degree which these functions are discharged. • BHSCT reviewed management arrangements as part of the Chief Executive's overall review of Directorate and Divisional structures in 2021 - new Directorate for Mental Health, Learning Disability and Psychology Services created. • An information paper on lawful practices the hospital may undertake with (i) voluntary and (ii) detailed patients has been developed and shared with families and staff.						

Key Risk: MAPR2 – Patients deemed fit for discharge are unduly delayed

Risk Appetite – Cautious

Link to MDAG Objectives	Link to HSC Action Plan Action	Risk Owner	Inherent Risk		Current Controls in Place	Residual Risk		Action Planned	Target Date	Action Owner – Name Title Org.	Action RAG Status
			I	L		I	L				
ii	A1 A2 A6 A7 A39 A40 A41	B Whittle/L Conn (SPPG)	3	5	• Policies/guidelines such as Promoting Quality Care: Good Practice in the Assessment and Management of Risk in MH & LD (May 2010) and the Standards for Assessment and Care Management (DHSS 1999) • Monthly updates on progress with resettlement planning/discharges provided at the Regional Learning Disability Oversight Delivery Group (RLDODG) chaired by the SPPG. • Monthly community integration meeting hosted by SPPG to progress discharge planning/identify discharge dates.	3	4	• Engagement between DoH and SPPG on ways to help enhance current resettlement arrangements including ○ independent review of resettlement processes/current plans – final report with SPPG; ○ monthly updates on resettlement planning/discharges at monthly CIP and RLDODG meetings; ○ resettlement progression also discussed at DSF review meetings; ○ Patricia Donnelly support to the BHSCT Jul/Aug 2022 to aid resettlement planning and actions.	31/03/2022	Mark McGuicken Director D&OPD DoH Brendan Whittle Director Children & Social Care SPPG Lorna Conn Programme Manager (MH & LD) & Resettlement Lead SPPG	🟥
								• Carry out a full re-assessment of the needs of patents in MAH, with a view to preparing contingency plans for patients and updated discharge plans/target date.	30/11/2019	M Kearney Interim Director Mental Health and Intellectual Disability BHSCT P Corr	🟥

Key Risk: MAPR2 – Patients deemed fit for discharge are unduly delayed

Risk Appetite – Cautious

Link to MDAG Objectives	Link to HSC Action Plan Action	Risk Owner	Inherent Risk		Current Controls in Place	Residual Risk		Action Planned	Target Date	Action Owner – Name Title Org.	Action RAG Status
			I	L		I	L				
										Director of Mental Health, Learning Disability and Community Wellbeing NHSCT M O’Kane Director of Adult Services and Healthcare in Prison SEHSCT M O’Kane Interim Director of Mental Health and Disability Services SHSCT C McLaughlin Assistant Director Adult Learning Disability WHSCT	🟥
								• Develop an overall regional resettlement plan and agreed timeline for all inpatients in MAH assessed as medically fit for discharge.	30/11/2019	B Whittle Director Children & Social Care SPPG L Conn	🟥

Key Risk: MAPR2 – Patients deemed fit for discharge are unduly delayed

Risk Appetite – Cautious

Link to MDAG Objectives	**Link to HSC Action Plan Action**	**Risk Owner**	**Inherent Risk**		**Current Controls in Place**	**Residual Risk**		**Action Planned**	**Target Date**	**Action Owner – Name Title Org.**	**Action RAG Status**
			I	**L**		**I**	**L**				
										Programme Manager (MH & LD) & Resettlement Lead SPPG	🟥
								- Commission HSC Trusts to develop robust Crisis and Intensive Support Teams, including local step up/down services, flexible staff resources and Community Treatment services to support resettlement from MAH.	31/03/2022	B Whittle Director Children & Social Care SPPG L Conn Programme Manager (MH & LD) & Resettlement Lead SPPG	🟥
								- In conjunction with DfC/DoF and housing providers, identify barriers to accommodation provision and develop innovative solutions to support individuals specific needs and inform development of a long term sustainable accommodation strategy for people with LD.	30/09/2020	M McGuicken Director D&OPD DoH B Whittle Director Children & Social Care SPPG L Conn Programme Manager (MH &	🟥

Key Risk: MAPR2 – Patients deemed fit for discharge are unduly delayed

Risk Appetite – Cautious

Link to MDAG Objectives	Link to HSC Action Plan Action	Risk Owner	Inherent Risk		Current Controls in Place	Residual Risk		Action Planned	Target Date	Action Owner – Name Title Org.	Action RAG Status
			I	L		I	L				
										LD) & Resettlement Lead SPPG Trusts	🟥
								- Support HSC Trusts to complete a regional review of admissions criteria and develop a regional bed management protocol for LD services.	31/12/2019	B Whittle Director Children & Social Care SPPG L Conn Programme Manager (MH & LD) & Resettlement Lead SPPG	🟥
								- Appoint a regional bed manager for all 3 current in-patient LD units.	30/11/2019	B Whittle Director Children & Social Care SPPG L Conn Programme Manager (MH & LD) & Resettlement Lead SPPG	🟥
								- Taking into account the outcome of the independent	31/03/2022	B Whittle Director Children & Social Care	🟥

Key Risk: MAPR2 – Patients deemed fit for discharge are unduly delayed

Risk Appetite – Cautious

Link to MDAG Objectives	**Link to HSC Action Plan Action**	**Risk Owner**	**Inherent Risk**		**Current Controls in Place**	**Residual Risk**		**Action Planned**	**Target Date**	**Action Owner – Name Title Org.**	**Action RAG Status**
			I	**L**		**I**	**L**				
								review of acute care for people with LD, support HSC Trusts to develop regional care pathways for inpatient care to ensure that admissions are planned and delivered in the context of an overall formulation.		SPPG L Conn Programme Manager (MH & LD) & Resettlement Lead SPPG	🟥

Key Risk: MAPR3 – Service provision at MAH cannot be maintained safely and is not viable.

Risk Appetite – Averse

Link to MDAG Objectives	Link to HSC Action Plan Action	Risk Owner	Inherent Risk		Current Controls in Place	Residual Risk		Action Planned	Target Date	Action Owner – Name/Title	Action RAG Status
			I	L		I	L				
i, iii, iv	A5 A29 A30 A34 A37 A50 A55	M Kearney (BHSCT)	3	4	• BHSCT regular monitoring of staffing levels at MAH including weekly reporting of nursing staffing levels to DoH • BHSCT weekly Safety Report reviewed by the senior management team in MAH and shared with the multi-disciplinary team. • BHSCT rolling advertisements for Band 5 and Band 3 nursing staff and the Senior Nursing Team continuing to maintain a focus on workforce recruitment and retention. • BHSCT review of service provision and staffing and consolidation of patients/staff on MAH site to smaller number of wards. • BHSCT Chief Executive holds Directors to account for achievement against their objectives	3	3	• Develop specialist staff training and a model of support to upskill the current workforce providing care to people with complex needs and challenging behaviours to support current placements and develop capable environments.	30/09/2021	B Whittle Director Children & Social Care SPPG L Conn Programme Manager (MH & LD) & Resettlement Lead SPPG RQIA HSCTs	🟧
								• Provide training on the above to an agreed cohort of staff.	30/06/2022	B Whittle Director Children & Social Care SPPG L Conn Programme Manager (MH & LD) & Resettlement Lead	🟧

Key Risk: MAPR3 – Service provision at MAH cannot be maintained safely and is not viable.

Risk Appetite – Averse

Link to MDAG Objectives	**Link to HSC Action Plan Action**	**Risk Owner**	**Inherent Risk**		**Current Controls in Place**	**Residual Risk**		**Action Planned**	**Target Date**	**Action Owner – Name/Title**	**Action RAG Status**
			I	**L**		**I**	**L**				
					and use of a Quality Management System (QMS) enables the Trust Board to provide proactive ongoing challenge rather than being reactive to issues escalated to it.					SPPG	🟨
								• Develop a workforce plan for specialist nursing provision in MAH in line with findings from ongoing regional work.	30/06/2020	M Kearney Interim Director Mental Health and Intellectual Disability BHSCT	🟥
								• Complete a review of Learning Disability Nursing.	30/09/2021	S Rogan Professional Nursing Advisor for Mental Health and Learning Disability DoH	🟨
								• Develop an evidence based plan for recruitment, training and retention of a sufficiently skilled multi-disciplinary workforce for both inpatient and community services.	30/09/2021	M McGuicken Director, D&OPD DoH	🟨
								•	31/01/2021	M Kearney Interim Director Mental Health and	🟥

Key Risk: MAPR3 – Service provision at MAH cannot be maintained safely and is not viable.

Risk Appetite – Averse

Link to MDAG Objectives	**Link to HSC Action Plan Action**	**Risk Owner**	**Inherent Risk**		**Current Controls in Place**	**Residual Risk**		**Action Planned**	**Target Date**	**Action Owner – Name/Title**	**Action RAG Status**
			I	**L**		**I**	**L**				
										Intellectual Disability BHSCT	🟥
								• Draft Regional Contingency Plan for MAH to be finalised by SPPG/Trusts and agreed with DoH.	30/11/2021	B Whittle Director Children & Social Care SPPG HSCTs M McGuicken Director, D&OPD DoH	🟧

Key Risk: MAPR4 – Regional services are not sufficiently reformed to enable patients or carers/families to access appropriate services or support at the right time.

Risk Appetite – Cautious

Link to MDAG Objectives	**Link to HSC Action Plan Action**	**Risk Owner**	**Inherent Risk**		**Current Controls in Place**	**Residual Risk**		**Action Planned**	**Target Date**	**Action Owner – Name/Title**	**Action RAG Status**
			I	**L**		**I**	**L**				
i, iii, iv	A3 A8 A10 A11 A12 A13 A14 A15 A16 A17 A19 A20 A24 A33 A35 A36 A38 A42 A43 A46 A49	B Whittle/L Conn (SPPG)	3	4	• Independent review of current service model/provision for acute care of people with LD (inpatient and community) and associated clinical pathways to inform a future best practice model completed. • Current forensic LD services reviewed to identify and address service development needs to support people in community settings. • Draft co-produced, outcomes based, Learning Disability Service Model (LDSM), seeking to inform the development of a regionally consistent model for community and acute services produced and shared with the DoH for consideration. • Review carried out on the capability of current	3	3	• Consideration and feedback to be provided on Learning Disability Service Model (LDSM)	17/11/2021	M McGuicken Director, D&OPD DoH	🟨
								• In the context of the Reform of Adult Social Care, establish a regionally agreed framework for higher tariff placements which specifies what staff and service requirements justify a higher tariff.	31/03/2021	B Whittle Director Children & Social Care SPPG L Conn Programme Manager (MH & LD) & Resettlement Lead SPPG	🟥
								• Develop a regionally consistent pathway for children transitioning from Children's to Adult services.	31/03/2021	B Whittle Director Children & Social Care SPPG L Conn Programme Manager (MH & LD) &	🟥

Key Risk: MAPR4 – Regional services are not sufficiently reformed to enable patients or carers/families to access appropriate services or support at the right time.

Risk Appetite – Cautious

Link to MDAG Objectives	Link to HSC Action Plan Action	Risk Owner	Inherent Risk I	Inherent Risk L	Current Controls in Place	Residual Risk I	Residual Risk L	Action Planned	Target Date	Action Owner – Name/Title	Action RAG Status
					providers of support housing, residential and nursing homes to meet the needs of people with complex needs. • In conjunction with NIHE, developed a robust strategic, intelligence led housing needs assessment to support the planning and development of special needs housing and housing support to inform future funding decisions for adult LD. • Co-produced Open Access policy for MAH implemented (and Lakeview and Dorsey). • Nnew evidence based model for high intensity therapeutic interventions designed to minimise the need for restrictive practices introduced in ???? • Families involved in needs assessment and care planning processes. •					Resettlement Lead SPPG	🟥
								• Finalise and develop a costed implementation plan for the new regional framework for reform of children's autism, ADHD and emotional wellbeing services.	31/12/2020	B Whittle Director Children & Social Care SPPG L Conn Programme Manager (MH & LD) & Resettlement Lead SPPG	🟥
								• Review the needs of children with LD currently being admitted to Iveagh and to specialist hospital/placements outside NI with a view to considering of specialist community based service should be developed locally to meet their needs. This should be aligned to the ongoing regional review of children's residential services.	31/12/2020	B Whittle Director Children & Social Care SPPG L Conn Programme Manager (MH & LD) & Resettlement Lead SPPG	🟥

Key Risk: MAPR4 – Regional services are not sufficiently reformed to enable patients or carers/families to access appropriate services or support at the right time.

Risk Appetite – Cautious

Link to MDAG Objectives	Link to HSC Action Plan Action	Risk Owner	Inherent Risk		Current Controls in Place	Residual Risk		Action Planned	Target Date	Action Owner – Name/Title	Action RAG Status
			I	L		I	L				
								• Community Based Assessment Rehabilitation and Treatment model (CART) for people with a LD and complex needs being developed to deliver community and home treatment services/support placements for people with LD in order to avoid assessment and treatment in hospital unless indicated/necessary.	31/03/2022	B Whittle Director Children & Social Care SPPG L Conn Programme Manager (MH & LD) & Resettlement Lead SPPG	🟥
								• Plan for the future configuration of services to be delivered on MAH site being developed in partnership with patients, relatives and carers.	30/06/2021	MDAG M McGuicken Director D&OPD DoH	🟥
								• Specific care sensitive indicators being developed for inpatient LD services and community care environments.	xx/xx/xxxx	B Whittle Director Children & Social Care SPPG L Conn Programme Manager (MH & LD) &	🟥

Key Risk: MAPR4 – Regional services are not sufficiently reformed to enable patients or carers/families to access appropriate services or support at the right time.

Risk Appetite – Cautious

Link to MDAG Objectives	Link to HSC Action Plan Action	Risk Owner	Inherent Risk		Current Controls in Place	Residual Risk		Action Planned	Target Date	Action Owner – Name/Title	Action RAG Status
			I	L		I	L				
										Resettlement Lead SPPG	🟥

Key Risk: MAPR5 – Patients and their carers/families are not sufficiently involved in decisions about their care and treatment.

Risk Appetite – Averse

Link to MDAG Objectives	Link to HSC Action Plan Action	Risk Owner	Inherent Risk		Current Controls in Place	Residual Risk		Action Planned	Target Date	Action Owner – Name/Title	Action RAG Status
			I	L		I	L				
i, iv	A4 A18 A28 A53	M Kearney (BHSCT) P Corr (NHSCT) M O'Kane (SEHSCT) M O'Kane (SHSCT) K O'Brien (WHSCT)	3	4	• Membership of MDAG includes family representatives. • BHSCT appointed a carer's consultant; the Carer Involvement and PPI Lead for Adult Learning Disability Services. • BHSCT produced a communication tool for engagement with families/carers. • BHSCT produced and circulated a schedule of Trust meetings with families. • Updates on progress against actions within the HSC Action Plan provided at bi-monthly MDAG meetings.	3	2	• BHSCT to develop ongoing timetable of meetings with families and carers.	XX/XX/XX	M Kearney Interim Director Mental Health and Intellectual Disability BHSCT	🟧

DEFINITIONS

Risk Appetite Statement

1. This statement outlines the risk appetite of the Muckamore Department Assurance Group (MDAG).

2. The purpose of the risk appetite statement is to articulate the amount of risk that MDAG is prepared to accept, tolerate or be exposed to in pursuit of its objectives.

3. The following classifications of risk appetite are as set out in HM Treasury guidance *'Risk Appetite Guidance Note' Annex A: Risk appetite tools IV: Risk appetite scales* (Risk Appetite Guidance Note (publishing.service.gov.uk)).

Classification	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

4. In general MDAG operates an **Averse** risk appetite in relation to most categories of risk, recognising the areas where MDAG cannot afford to fail, for example in meeting its statutory responsibilities.

5. However in certain areas a **Cautious** risk appetite may be adopted by MDAG in order to enable the pursuit of the most effective method of achieving its desired outcomes and where the risks are calculated to be appropriately balanced with the level of reward. Where a cautious approach has been adopted, this will be in collaboration with families/carers and professional colleagues.

Assessment of Risk – Impact

The impact of a risk on the successful achievement of a business objective is measured on a rising scale of 1 to 5, where 1 represents ‘insignificant’ impact and 5 stands for ‘catastrophic’ impact. The table below is provided as helpful guidance to illustrate the differing levels of impact a realised risk may have on a number of criteria. Measurement is generally subjective so, when recording an impact assessment, it is it important to document the assumptions underlying the assessment.

Impact	Non-achievement of key objectives	Reputation/Publicity	Financial consequence	Litigation
	Anything that poses a threat to the achievement of the department’s objectives, programmes or service delivery for citizens	Anything that could damage the reputation of a department or undermine the public’s confidence in it	Failure to guard against impropriety, malpractice waste or poor value for money (financial scale indicative only)	Failure to comply with regulations such as those covering health and safety and the environment
1. Insignificant	Minor non-compliance	Within unit Local press <1 day coverage	Negligible financial loss - less than £1,000	Minor out-of-court settlement
2. Minor	Single failure to meet internal standards	Regulator concern Local press <7 day of coverage	Low financial loss - between £1,000 and £9,999	Civil action Improvement notice
3. Moderate	Repeated failures to meet internal standards	National media <3 day coverage Department executive action	Medium financial loss - between £10,000 and £99,999	Class action Criminal prosecution Prohibition Notice
4. Major	Failure to meet national standards	National media >3 day of coverage Questions in the Assembly	High financial loss – between £100,000 and £499,999	Criminal prosecution – no defence
5. Catastrophic	Gross failure to meet professional standards	Full Public Enquiry	Extreme financial loss - £500,000 or more	Executive officer fined or imprisoned

Assessment of Risk – Likelihood

The likelihood of a risk occurring is also measured on five-part scale, rising from 1 (rare) to 5 (almost certain to occur). Again, as experience and subjectivity play a large part in this assessment, it is important to document the assumptions underlying the assessment. The table below illustrates the degrees of assessed likelihood.

CODE	DESCRIPTOR	DESCRIPTION
1	Rare	<5% likelihood of impact happening
2	Unlikely	5% to 20% likelihood of occurrence
3	Possible	20% to 50% likelihood of occurrence
4	Likely	50% to 80% likelihood of occurrence
5	Almost Certain	>80% likelihood of occurrence

Assessment of Risk – Level of Risk

Level of risk is a product of the values for Impact and Likelihood, and is determined by applying each of these to the matrix below. The four parameters are Low, Medium or High. For example, a risk with a 'Moderate' impact and 'Almost Certain' likelihood would have High level of risk whereas a risk with a 'Moderate' impact and 'Possible' likelihood would constitute a Medium level of risk.

IMPACT	**Risk Quantification Matrix**				
5 - Catastrophic	**Low (5)**	**Medium (10)** MAPR1	**High (15)**	**High (20)**	**High (25)**
4 – Major	**Low (4)**	**Medium (8)**	**High (12)**	**High (16)**	**High (20)**
3 - Moderate	**Low (3)**	**Medium (6)** MAPR5	**Medium (9)** MAPR4 MAPR3	**High (12)** MAPR2	**High (15)**
2 – Minor	**Low (2)**	**Low (4)**	**Medium (6)**	**Medium (8)**	**Medium (10)**
1 – Insignificant	**Low (1)**	**Low (2)**	**Low (3)**	**Low (4)**	**Low (5)**
	1 **Rare**	**2** **Unlikely**	**3** **Possible**	**4** **Likely**	**5** **Almost Certain**
	Likelihood				

Muckamore Departmental Assurance Group (MDAG) October 2022

MAH HSC Action Plan – Revised Reporting Arrangements

Ref: **MDAG/15/22**

Introduction

1. This report provides an update on changes to the MAH HSC Action Plan further to MDAG's agreement to the proposed changes to the Plan as outlined at the 31 August meeting.

2. Members will also recall that, in light of the recommendations from the final Report of the Independent Review of Resettlement (Review Report), the potential for a further review of the HSC Action Plan reporting format was raised at the August meeting. This paper also provides an outline of those proposed changes.

Updated HSC Action Plan

3. As discussed and agreed at the August meeting, changes to the ratings of a number of actions have been made to more accurately reflect their progress towards completion. A further action, A53 (relating to an individual complaint against the Belfast Trust by the family of a patient), has been removed from Section G of the Plan (Leadership and Governance Review recommendations) and placed in Section A (Completed Actions) noting that it is not for monitoring through the Action Plan.

4. An updated version of the HSC Action Plan has been circulated with the papers for today's meeting and a summary of the current status of the revised actions in the Plan is set out in the table below, including the change in each from the August update.

Summary of Progress against Targets – October 2022

🟥	🟧	🟩	**TOTAL**
3(-18)	**16(+10)**	**35(+8)**	**54**

RED - Progress required **AMBER** – Work in progress **GREEN** – Completed

Proposed new reporting format

5. Given the increasing number of Action Plans and recommendations/actions arising recently from a number of sources, including reviews of safeguarding, RQIA inspections and the Review Report, the Department is developing a new governance structure to oversee the implementation and delivery of these plans and associated actions. This will help to ensure a consistent overview of progress and work still to be done is available and the necessary mechanisms are in in place, through a single group, to manage the delivery of outstanding actions. Following MDAGs' consideration of this proposed new reporting arrangement, this new arrangement will be presented to the Top Management Group within the Department of Health for their endorsement.

6. Potential changes to the structure and format of reporting to MDAG were raised during discussion on the HSC Action Plan at the August MDAG. As a result of this proposed new governance structure, this would also be an opportune time to refocus the MDAG reporting arrangements to ensure that updates provided to members are relevant to the MDAG Terms of Reference, and focus on issues that are directly related to the continued provision of safe and effective care on the site. A copy of the existing HSC Action Plan, updated to reflect the discussion at the last MDAG, has been included for information only. We do not intend to cover this in detail at the meeting.

7. The updated format will help ensure that any relevant learning and recommendations from the Review Report are also included alongside other

current outstanding actions, and updates will be provided on a thematic basis. This more focussed reporting is intended to assist MDAG in meeting its objectives set out in the Group's Terms of Reference.

8. As this is currently a work in progress, no draft revised template has been circulated to MDAG ahead of the October meeting for discussion. It is planned to issue a revised template for consideration by MDAG in advance of the December meeting.

9. The proposed themes for inclusion in the new format for progress reports to MDAG are:

- **Completed Actions**: setting out those actions that have been completed during the lifespan of MDAG;
- **Resettlement**: one update will be provided to include supporting data on expectations for resettlements in the timeframe between meetings, and as the year progresses, data on outcomes against those expectations;
- **Workforce**: both detail on staffing levels at Muckamore and also detail on work to understand the current level of the LD workforce and what the system will require to meet current and future needs;
- **Safeguarding**: this should provide more specific detail from the Belfast Trust in relation to Muckamore and include supporting data to help identify and outline trends to enable MDAG to receive assurance on safeguarding practice at the Hospital or raise queries for further information it may feel necessary. Detail on the Adult Safeguarding Bill will also be provided by exception when there is progress to report; and
- **Leadership & Governance Review Recommendations**: updates under this theme will be by exception where there have been developments relevant to Muckamore.

10. In relation to the Transformation and Children and Young People themes, currently included in the HSC Action Plan, progress on the completion of any outstanding actions will be monitored through the new governance structure being developed.

11. The theme of Governance is no longer included as all the recommendations within the HSC Action Plan in relation to governance have been completed. Any new recommendations or actions in relation to governance at Muckamore will be picked up by the new governance structure currently being developed.

Current Updates

12. In the absence of a revised Action Plan update for this meeting brief updates on each of the areas for inclusion in the revised Plan are outlined below.

Resettlement

13. Work is continuing on progressing the resettlement of those delayed discharge patients at Muckamore with the first meeting of the new Resettlement Oversight Board taking place on 11 October 2022. A second meeting is scheduled for 25th October. Since the August meeting of MDAG, one further patient has been resettled from Muckamore, meaning that there are currently 35 patients on site. In terms of potential resettlement timeframes for these patients, 14 patients are currently projected to be resettled by the end of December 2022 with a further 15 patients are projected to be resettled between January and June 2023. The remaining six patients are still to have their timescale for resettlement confirmed.

14. Further detail in relation to the current status of resettlement plans and schemes is outlined in the Highlight Report – October 2022 (paper MDAG/16/22), circulated with the papers for the October meeting.

Workforce

15. The Belfast Trust have confirmed that they are due to have five new RNLD nurses joining, and that two interim lead nurses at Senior Nurse Manager level took up post on 20 September. The Trust continues to carry high vacancy rates at Deputy Ward Sister/Charge Nurse and Ward Sister/Charge Nurse. Efforts are ongoing to recruit in a number of areas including Nursing and

Psychology Staff. Again, further detail is outlined in the Highlight Report – October 2022 (paper MDAG/16/22).

16. In relation to the regional workforce review of adult learning disability teams and services, the deadline for receipt of responses to a baseline survey issued in May to both acute and community services in HSC Trusts, and to independent and private providers, was further extended to 17 October due to a disappointing response rate. In order to encourage responses, the Project Lead has written directly to a number of providers who have contracted services with HSC Trusts and this approach has shown some progress. It is anticipated this will enable a more complete picture of the workforce to be collated by the end of October. Following this, the Project Lead is planning engagement opportunities with people with learning disabilities and carers to share the findings. A further phase of the review may also be required to consider the views of those directly in receipt of services, carers and staff. This will be determined at a later stage.

17. It is planned that the returns received will also inform the compilation of a directory of services available across the region, including contact details for those services.

Safeguarding

18. The Belfast Trust is currently working with the Department to review the Trust's current weekly safety report to consider any revisions necessary. To provide the necessary assurance to MDAG on safeguarding trends at Muckamore the Trust have provided some trend analysis detail to MDAG. This includes detail of referrals, numbers of patient on patient and also staff on patient referrals, medication, physical interventions and seclusion. These are also contained in the Highlight Report – October 2022 (paper MDAG/16/22).

19. The Department continues to work with the Trust in relation to adult safeguarding, including on the development of their combined adult safeguarding action plan and the implementation of the actions contained within it.

20. Following the completion of their independent review of resettlement, the Department have also approached Bria Mongan and Ian Sutherland to carry out a wider review of safeguarding practices. Updates on progress with the work will be provided in future meetings.

Leadership &Governance Review Updates

21. Work in relation to the recommendations from the Leadership and Governance Review contained within the HSC Action Plan continues with work on making the Delegated Statutory Functions reporting process more outcomes based being taken forward by the Department. As outlined under the workforce update, the Belfast Trust have appointed two interim Senior Nurse Managers to lead on governance and performance in Muckamore. Further to the Minister's announcement on 29 September, options for the future of services provided on the Muckamore site are currently being considered.

Summary

22. Subject to members' consideration, agreement is sought from MDAG for the implementation of these proposed changes. MDAG members are asked to:

i) Note the updated HSC Action plan containing the changes agreed at the August meeting;
ii) Note the current work ongoing to develop a new governance structure and reporting format to oversee the implementation of the recommendations/actions from the HSC Action Plan and other recent reports; and
iii) Note the interim updates included in this paper.

Central Nursing and Midwifery Advisory Committee (CNMAC)

Notes from Meeting on 14 September 2015 at 2.00 PM

Room C3.18, Castle Buildings

Attendees:

Charlotte McArdle	DHSSPS	(Chairperson)
Caroline Lee	DHSSPS	
Breedagh Hughes	RCM	
Owen Barr	UU	
Tanya McCance	UU	
Nicki Patterson	SEHSCT	
Carol Cousins	FSHC	
Francis Rice	SHSCT	
Verena Wallace	DHSSPS	
Sonja McIlfatrick	UU	
Mary Hinds	PHA	
Angela McLernon	NIPEC	
Olive Macleod	NHSCT	
Mary Frances McManus	DHSSPS	
Heather Finlay	DHSSPS	
Patricia McStay	PHA	
Donna Gallagher	OU	
Maura Devlin	NMC	
Sam Porter	QUB	
Brenda Devine	NIPEC	
Kathy Fodey	RQIA	

In Attendance:

Malcolm Artt	DHSSPS	(Secretariat)

Apologies:

Alan Corry-Finn	WHSCT
Brenda Creaney	BHSCT
Gavin Fergie	UNITE
Glynis Henry	CEC

Heather Monteverde	Macmillan/LTCANI
Janice Smyth	RCN
Eoin Stewart	UNISON

1. Welcome

1.1 The Chair welcomed members to the meeting of the Central Nursing and Midwifery Advisory Committee (CNMAC).

1.2 Apologies recorded as above.

2. Chairman's Business

2.1 *Update on Membership*

2.1.1 Charlotte advised the group that a submission would need to be sent to the Minister for the new members of CNMAC and an invite would need to be issued to Professor Carol Curran to join the group.

2.2 *Minutes from Previous Meeting Held on 09 February 2015*

2.2.1 Charlotte stated that a line in these minutes relating to Ministerial advice may need amended so final approval of the minutes cannot be given at this time.

2.3 *Minutes from Previous Meeting Held on 20 May 2015*

2.3.1 Charlotte informed the group that Lord Willis had accepted an invitation to speak at the CNO Conference. The remaining actions were completed and the minutes agreed.

3. Revalidation

3.1 Angela McLernon gave a brief overview of the most recent Revalidation Programme Board meeting. Angela advised the group that Jackie Smith from the NMC had attended the meeting on the 10 September. Jackie had stated that they had been given the go ahead from Wales and England. Angela advised that the general consensus of the NI programme board was to also go ahead although some concerns remained around fitness to practice and the role of the confirmer. Angela also stated that as yet there was still no agreement if CPD hours would be 35 or 40 but the final decision would be made at the NMC council meeting on the 08 October 2015. Further concerns were raised around nurses in primary care and the independent sector. Charlotte advised that they were doing all they can to ensure that all nurses were aware of Revalidation. A query was raised regarding costs. Charlotte stated that the KPMG report showed that only large organisations required support for revalidation and that nurses were already obtaining more CPD than was required so it would be likely that costs would be minimised.

4. Nurses Working in Supported Housing/Living

4.1 Update provided by Charlotte from a meeting internally to the dept. This meeting was attended by Charlotte, Alan Corry Finn, Kathy Fodey, Chris Matthews and a representative from DSD. Charlotte said that at the meeting it was agreed that there is a need to recognise the contribution of the mental health and learning disability nurses who work in supported living/housing. Kathy also stated that previously there was a working group in the Department who were looking at the issues but this had stalled. Kathy advised the group the Chris Matthews would like to get the working group started up again. Charlotte stated that Alan and Francis Rice were currently working on a model for one of the facilities and it would be brought back to the table for further consideration once completed.

5. Finance

5.1 Charlotte advised that due to the current political issues, there is still no agreed budget and no money available to spend apart from money that had already been committed.

6. Band 5 Recruitment

6.1 An update was provided in the papers prior to the meeting. Francis advised that a task and finish group had been established and had so far met on 2 occasions. The discussions had centred on: issues and challenges, information requirements and potential solutions. It was noted that the RCN have a similar group set up but it is more focused on the independent sector whereas this group focuses more on the statutory sector. Francis stated that a database is to be set up to gather information from all the Trusts in one day relating to the Band 5 waiting lists. . This baseline information can then be used as a foundation to provide short and long term solutions. Francis hopes to have the work completed by the time CNMAC meet again in November. Charlotte suggested that it would be beneficial for someone from the Department to join the group. Kathy Fodey also suggested that the group look at the BSO website as she feels that it is very difficult to navigate.
Action – Caroline to identify someone from the Department to join the task and finish group.

7. Review of Midwifery Supervision

7.1 Olive advised that the work was completed at the end of June and is now with the CNO. This will feed into a 4 country approach which is being led by David Foster of DH England. The group were also advised that the legislation of the supervision of midwives is going to change which could take up to 18 months. The principle is to develop a new supervision model for NI using the NIPEC work, considering whether to do it as a policy or as secondary legislation. The next steps pending ministerial approval will involve a task force group to work on the NI model taking the best of supervision of midwives identified in Kingfisher report and others. Charlotte noted her thanks to Olive and the group for their work.

8. Career Pathway

8.1 The Pathway is to be launched at the NIPEC conference on the 16 September 2015. The Pathway is a positive piece of work promoting nursing in NI for people who are considering nursing as a career. The Pathway contains sections on becoming a nurse, information for overseas nurses, returning to practice and staying on the register. Charlotte thanked Nicki Patterson and all who worked on the Pathway.

9. NMC

9.1 Update from Maura Devlin. The main topic of conversation remains Revalidation. The NMC are also holding an engagement event on 24 September 2015 in relation to pre-reg. The NMC will also be meeting with the CNO in early October to discuss the Shape of Caring Review and the draft response from the NMC will be tabled at the November council meeting.

10. Delegation Framework

10.1 The Framework was commissioned in June 2015. NIPEC are currently preparing a paper for the CNO's consideration which will then be emailed to the group and will be tabled at the next CNMAC meeting.
Unison has contacted the CNO to raise concerns that domiciliary care workers are undertaking the administration of medicines. Charlotte has agreed to meet with Unison and other relevant parties about this matter.

11. Abbreviations

11.1 Papers relating to this were issued prior to the meeting. Brenda Devine advised the group that there was mixed views on this subject. Brenda stated that in partnership with the HSC Patient Safety Forum, NIPEC had recently produced a paper relating to the use of abbreviations and they were keen to take the work forward. Concerns have been raised that some of the abbreviations have more than one meaning and this could cause confusion.

The RCN's Director has written to NIPEC stating that they do not believe this work should be progressed due to professional guidance already available from the NMC. The group held a short discussion on the merits of using abbreviations and the need to have a core list, further to which it was decided that the CNO would discuss the issues with the RCN prior to any decision being made. This would be raised at the next meeting.

12. Review of CNMAC Terms of Reference

12.1 A short discussion took place to decide if CNMAC should remain a statutory group. It was agreed that it should remain statutory at this time. It was also agreed to remove "NMC Officer from Scotland" from the membership section of the TOR. The rest of the document was agreed.

Action – remove "NMC Officer from Scotland" from the TOR.

13. Update from CNMAC Subgroups

13.1 *CNMAC Safety Quality and Experience Subgroup*

Tanya McCance advised that the SQE group were focusing on the Nursing and Midwifery Strategy. Tanya provided the group for with a copy of the strategy. Tanya asked if the group had any feedback, to send it to Caroline Lee by the end of October.

13.2 *CNMAC Strategic Workforce and Education Subgroup*

Caroline provided feedback on behalf of Alan Corry Finn and Professor Carol Curran. Caroline advised that a small task and finish group had been set up to look at issues surrounding the amount of nurses going to work overseas. Caroline also said that she had sent out questionnaires to students and met a group of them with the aim of selling Northern Ireland as an employer of choice. Maura Devlin raised concerns regarding the recruitment of nurses to the independent sector. Charlotte advised that plans were at an early stage to consider a "grow your own nurses" approach to support the independent sector.

13.3 *CNMAC Research and Development Subgroup*

Sonja advised that the R&D group last met at the end of June. Correspondence had been received from the 5 Directors of Nursing regarding the possible pilot of the Advanced Learning Apprenticeship from DEL. Sonja is currently following up on this correspondence.

13.4 *ICT Subgroup*

Kathy Fodey advised that it has been proposed that the ICT subgroup change its name to Ehealth and Informatics. The group will shape its work plan from the overarching document, the "Ehealth and Care Strategy" and will provide advice and guidance to CNMAC. Kathy stated that the TOR had been revised to reflect the advice and guidance role. Kathy also advised that the Trusts will be taking part in a scoping exercise and she would be meeting Caroline to discuss further. It was also noted that Heather Finlay will be the DHSSPS rep on this group.

14. Any Other Business

14.1 Revised MRPQ Directive - UK wide consultation lead by DH England

Mutual recognition of Professional Qualifications Directive into UK Law. European Professional Card (EPC) designed to allow professionals to move freely and quickly around EU. Applicable to Nurses, Pharmacists and Physios from January 2016. Regulators are concerned and have asked for an extension to implementation which is unlikely to be successful. Concerns were also raised that some member states do not require the same level of qualifications as required in the UK. Maura also raised concerns that if the nurses were only to work here for a few months then they would be regulated by their own country and not by the NMC.

15. Date and Time of Next Meeting

15.1 The next meeting will take place on Friday 11 December 2015 at 10.00am, Room C3.18, Castle Buildings.

Action Point Register

No	Date	Action	Responsibility	Progress	Status
AP5	20.05.15	Submission to sent to Minister to approve Professor Carol Curran's membership of CNMAC.			OPEN
AP6	14.09.15	Caroline to identify someone from the Department to join the task and finish group.	Caroline Lee		OPEN
AP7	14.09.15	Remove "NMC Officer from Scotland" from the TOR.	Secretariat	COMPLETED	CLOSED

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Central Nursing and Midwifery Advisory Committee (CNMAC)

Notes from Meeting on 10 June 2016 at 10.00 AM

Room D2 Lecture Theatre, Castle Buildings

Attendees:

Charlotte McArdle	DHSSPS	(Chairperson)
Caroline Lee	DHSSPS	
Angela McVeigh	SHSCT	
Olive Macleod	NHSCT	
Heather Finlay	DHSSPS	
Patricia McStay	PHA	
Brenda Creaney	BHSCT	
Janice Smyth	RCN	
Glynis Henry	CEC	
Carol Cousins	FSHC	
Donna Gallagher	OU	
Verena Wallace	DHSSPS	
Maura Devlin	NMC	
Kathy Fodey	RQIA	
Mary Hinds	PHA	
Angela McLernon	NIPEC	
Alan Corry Finn	WHSCT	
Gavin Fergie	UNITE	

In Attendance:

Malcolm Artt	DHSSPS	(Secretariat)
Brenda Divine	NIPEC	
Angela Reed	NIPEC	

Apologies:

Eoin Stewart	UNISON
Sam Porter	QUB
Nicki Patterson	SEHSCT
Carol Curran	UU
Mary Frances McManus	DHSSPS
Breedagh Hughes	RCM
Heather Monteverde	Macmillan
Owen Barr	UU
Sonja McIlfatrick	UU
Tanya McCance	UU
Maura Devlin	NMC

1. Welcome

1.1 Charlotte McArdle welcomed members to the meeting of the Central Nursing and Midwifery Advisory Committee (CNMAC).

1.2 Apologies recorded as above.

2. Chairman's Business

2.1 Minutes from Previous Meeting Held on 10 March 2016.

The minutes were agreed with one amendment.

2.2 Membership

Charlotte announced that there would be a few changes to the membership of the CNMAC group. Francis Rice has now taken up the position of interim Chief Executive of the SHSCT. Angela McVeigh is now the interim EDON and will be attending CNMAC. Olive Macleod is taking up the role of Chief Executive of the RQIA, Sam Porter is leaving QUB and the new head of school will replace him at CNMAC. Once the changes have taken place a submission will be sent to the Minister.

3. Supervision Framework

Charlotte stated that this piece of work has come about due to the changes in midwifery regulation. Olive has chaired a group that is developing common standards across nursing and midwifery. Charlotte has asked NIPEC to take work forward that will bring together the 3 work streams, safeguarding supervision, midwifery supervision and nursing supervision. Angela advised that subject to discussion she would set up a programme board which would have 3 subgroups to look at the 3 different areas of supervision. Brenda stated that there has already been quite a bit of work done in the midwifery task and finish group. Olive said that she was aware of the level of support that midwifery has and would nursing to be brought up to the same standard. Angela stated that she believes that the work can be done quite quickly but the implementation could take longer.

4. Strengthening the Commitment (Learning Disability Nursing)

Charlotte advised that there were 2 papers for discussion. The first is the 'Northern Ireland Action Plan for Learning Disability Nursing Northern Ireland Collaborative Progress Report Sept 2014 - March 2016'. The second is the workforce paper. The description of the LD nursing workforce was undertaken by the Regional Collaborative for LD nursing. Both papers were issued to the group prior to the CNMAC meeting. Glynis stated that following the work completed by the 4 countries on Strengthening the Commitment a NI action plan was launched in June 2014 by the CNO. From this a regional collaborative was formed which was chaired by Glynis. Glynis then highlighted the main points of the paper. Charlotte noted her thanks to Glynis for her work and asked for her thanks to be passed on to Frances and the members of the Regional Collaborative.

Glynis then gave an update on the Workforce Review. One of the key items to take forward was the profile of the LD nursing workforce. Information was requested from the NMC to determine the number of registrants in Learning Disability nursing in NI. A scoping exercise was carried out in Trusts, the independent sector and other organisations. Glynis stated that at this time NI was the only one of the 4 countries to have been able to collate this data. Findings indicated around 625 LD nurses in NI with 326 of these holding a dual qualification. A large number of these nurses were due to retire within the next 5 years. There are 229 Health care Assistants within the LD workforce. Recruitment difficulties are an issue in the independent sector and some of the Trusts especially recruiting LD nurses in children's nursing and community. There is also a concern that the skill of non medical prescribing is not being used. LD nurses often work within a social care model.

Janice stated that the RCN had received copies of letters which had been issued by NISCC indicating to LD nurses. The contents of the letters suggested that LD nurses working in social care settings should be registered with NISCC. Janice has written to the NMC about this issue but has not received a response at this time. Charlotte suggested that she write to the NMC on behalf of CNMAC to raise this issue with them again. Charlotte stated that she did not think nurses should not be required to be regulated by two different organisations.

Charlotte asked the group for suggestions in taking the work forward. Janice suggested that they need to develop the career pathway to provide leadership in Learning Disability nursing. Mary also stated that they need to value the importance of LD nurses and the registration issue should be resolves as soon as possible. Donna highlighted that investing in HCA's to support LD nurses was necessary and suggested the Certificate in Healthcare Practice could be an effective way to achieve this.

It was agreed to taking forward the LD work under 4 themes

1. Career Pathway which will be taken forward by the NI Regional Collaborative for LD Nursing.
2. Regulation
3. Access to training

4 Reform of adult social care.

AP1 – Charlotte to write to the NMC to seek clarification regarding regulation.

5. CPD Independent Sector

Janice Smyth raised a concern that there is a lack of support for nurses working in the independent sector. Nurses working in Nursing Homes do not have enough access to clinical skill development and therefore are unable to skill up other staff. Glynis advised that the CEC does have clinical skills labs and they do support the independent sector but they do charge a fee. Olive advised Janice that in the NHSCT 32 nursing homes are receiving upskilling and support from one band 7 nurse. Charlotte stated that some of the other Trusts are running similar programmes. Janice suggested that they should capture this information to make staff aware that these programmes are taking place. Charlotte also advised that there is a bid to June monitoring for a post to support training in LTCs for the independent sector. Donna also advised that they have 2 bids in with the Department for Education for 25 healthcare assistants and 5 nurses for Bsc honours courses. Janice also stated that there are concerns at the turnover of staff in the care homes. Alan also said that he is aware of the issue but even though their pay may be near the same, the homes can't offer the same T&Cs as the Trusts. Charlotte asked if an education piece to support the independent sector through the winter was needed.

AP2 - Mary to pull together information relating to Trust support in the independent sector.

6. Support for Mentorship in the Independent Sector

Janice again stated that his was an issue that was affected by the turnover of staff and there are no resources for practice placements for the role of post reg nursing students. Charlotte advised that an SWE group is looking at practice placements and it is one of the recommendations coming out of the primary care framework. Donna also advised that they are currently running 2 pilots and the students spend time with mentors in their own organisations.

There are also 5 or 6 places given over to the independent sector in each Trust.

7. Service Model and Nurses Roles in Supported Housing Facilities.

Heather gave a brief update. Following the discussion at the last meeting Heather checked if nursing was represented at the Adult Care and Support group. Heather was able to confirm that nursing was represented by the CNO on the project board.

8. Revalidation

Angela advised that 93% of Registrants have now registered online and the NMC are preparing for an expected 'bottleneck' in September. Angela also advised the group that Miles Wallace has moved to the media team at the NMC. Sarah Clarke will be the new Revalidation contact.

9. Band 5 Recruitment

Heather Finlay reported on the recent recruitment campaign to the Philippines. 239 Conditional offers were made and accepted subject to the full range of pre-employment checks including NMC requirements.

It is currently expected that the first appointees will arrive to NI in November 2016. All will initially be employed at Band 3 until they undertake their OSCE's prior to NMC registration. Overall this was a very successful campaign where the standard of applicants was very high. The campaign to Romania was not successful. The HSC process and documentation agreed prior to the campaign was not adhered to by the European recruitment agency. The environment for the candidates undertaking the two written assessment was also not suitable, nor was the accommodation for HSC Team. Further trips to Romania have been cancelled. Brendan McGrath, Lynn Fee and Karen Patterson are going to Italy for the recruitment campaign. The timelines for recruitment of EU nurses is 39 weeks and non EU nurses is 48 weeks. All groups involved in the recruitment are meeting regularly. Work is also ongoing with the recruitment of nurses locally as well as the overseas nursing.

Alan advised that the SWE subgroup asked him to raise a concern about the scale and the cost of the overseas recruitment campaign and questioned if more work could be done to recruit locally rather than overseas. An 18 month post grad nursing programme is available in England. An action from the recent SWE meeting is to explore this as a potential option Donna is aware of the course and will be meeting the other universities to discuss it. Donna also advised that through work with the SHSCT, they have been able to increase the number of students on the OU course from 50 to 69. Charlotte noted the concerns of the subgroup but felt there was no choice as they need to maintain safe numbers. Charlotte has discussed the issue with the Minister and with good evidence; it may be possible to increase student numbers locally.

10. Update from the Nursing and Midwifery Task Group

There is a submission with the Minister and Charlotte has also had discussions in relation to the Task Group. Charlotte hopes to have the response from the Minister soon as to whether the Task Group will go ahead.

11. Update from CNMAC subgroups

11.1 CNMAC Safety, Quality and Experience Subgroup

Caroline advised that she had met with Tanya and Angela and discussed the overlaps between the PD group in NIPEC and the SQE subgroup. Tanya has asked if CNMAC would agree to the merger of the 2 groups. The group agreed to merge and the PD group would be stood down.

11.2 CNMAC Strategic Workforce and Education Subgroup.

Heather Finlay gave an update from the SWE subgroup. Heather advised that there is an ongoing task and finish group focusing on practice placements. The group has met twice and have a further meeting planned. Initial findings are that placement capacity is not a major issue and challenges arise with the flow of the students. There is still work to be done around educational audits and primary care. Heather also advised that MAPA is still being discussed. It was also noted that there is also some membership gaps on the group so some further nominations requests may be sent out.

11.3 CNMAC Research and Development Subgroup.

No update was able to be provided.

11.4 CNMAC Ehealth and Infomatics Subgroup.

Kathy has confirmed that the group is to be called Ehealth and Infomatics subgroup. Kathy advised that the membership has been refreshed. The Ehealth and Care Strategy has now been launched and an implementation plan is being drafted. All organisations have to send back their responses regarding the 6 aims of the strategy. Kathy and Heather plan to ask each of the other subgroups where the Ehealth and Infomatics agenda would have an impact on their work area. Heather and Kathy will take forward

Charlotte suggested it would be useful to have a CNMAC workshop to review the work of the 4 subgroups and give direction for future work. ..

AP3 – Change the subgroup name on the agenda.

AP4 - Dates to be obtained for the other CNMAC subgroup meetings

AP5 - CNMAC Workshop to review work of the subgroups

12. AOB

12.1 Glynis advised that work is ongoing in the Quality 2020 task group which focuses on Simulated Based Education and Human Factors training. Further discussions will be taking place with the universities to discuss what is happening from the nursing perspective.

12.2 Geraldine Walters has been appointed by the NMC as Director of Education, Standards and Policy at the NMC.

13.1 The next meeting will take place on Thursday 08 September 2016 at 10.00am, Room D2 Lecture Theatre, Castle Buildings.

Action Point Register

No	Date	Action	Responsibility	Progress	Status
AP1	10/03/16	Charlotte to write to the NMC to seek clarification regarding regulation.	Charlotte McArdle		Open
AP2	10/03/16	Mary to pull together information relating to Trust support in the independent sector.	Mary Hinds		Open
AP3	10/03/16	Change the subgroup name on the agenda.	Admin	Completed	Closed
AP4	10/03/16	Dates to be obtained for the other CNMAC subgroup meetings.	Kathy/Heather		Open
AP5	10/03/16	CNMAC Workshop to review work of the subgroups	Charlotte/Admin	Completed	Closed

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Central Nursing and Midwifery Advisory Committee (CNMAC)

Notes from Meeting on 8 September 2017

10.00 am - Room D2 Lecture Theatre, Castle Buildings

Present:

Rodney Morton	DoH (Chairperson)
Heather Finlay	DoH
Mary Hinds	PHA
Carol Cousins	Four Seasons Health Care
Angela McLernon	NIPEC
Tanya McCance	UU
Cathy McCusker	NIPEC
Prof Donna Fitzsimons	QUB
Donna Gallagher	Open University
Sonja McIlfatrick	UU
Ethel Rodrigues	Unite Union
Caroline Lee	CEC
Maura Devlin	NMC
Janice Smyth	RCN
Kathy Fodey	RQIA
Mary Frances McManus	DoH

In Attendance

Naomhín McGarrity	DoH	(NMTG)
Kevin Curran	DoH	(Secretariat)
Brendan O’Neill	DoH	(Transformation Team)

Apologies:

Charlotte McArdle	DoH	Heather Monteverde	Macmillan
Professor Carol Curran	UU	Brenda Creaney	BHSCT
Eileen McEneaney	NHSCT	Eoin Stewart	UNISON
Maurice Devine	CEC	Breedagh Hughes	RCM
Dr Bob Brown	WHSCT	Nicki Patterson	SEHSCT
Angela McVeigh	SHSCT	Verena Wallace	DoH

1. WELCOME AND APOLOGIES

Rodney Morton welcomed everyone to the meeting as Chair of CNMAC in the absence of the CNO, Charlotte McArdle.

Rodney informed the meeting that Dr Bob Brown has taken up his role as the new Executive Director of Nursing in the Western Trust. He also, advised that Angela McVeigh is due to retire in October 2017 and noted that in the interim period Bryce McMurray will fulfil the EDoN role when she retires. On behalf of the CNO and CNMAC, Rodney thanked Angela for her valued contribution to CNMAC and wished her all the best for the future.

The apologies above were noted.

2. NOTE AND ACTIONS FROM CNMAC MEETING HELD ON 7 JUNE 2017

The minutes of the last meeting were agreed without amendment.

It was noted that action points AP1 and AP2 were complete and action point AP5 is on the agenda for discussion. Heather Finlay provided an update on progress with the Advanced nurse Programme (AP3) and a fuller update will be available for the meeting in December. In regards to Action Point AP4, Heather advised that this issue is scheduled for discussion at the SWE meeting which will not be held until 18 September, before reporting back to CNMAC.

3. TIG UPDATE

Rodney introduced Brendan O'Neill, Transformation Team to the meeting to update CNAMC on the work of the Transformation Implementation Team (TIG). Brendan provided a background to the membership and role of TIG and how this fits into the Delivering Together framework. This included using various venues around HSC trusts to raise the visibility and its progress with upcoming targets such as the workforce strategy and the draft guide for co-production.

Discussion included the fact that the pace of the work has slowed due to the absence of a minister but this has given opportunities to build on new evidence to help support progress of any new models. Regardless, TIG has the capability to complete certain things without Ministerial Approval and these will be progressed.

The Department recently advertised for a new Director of Communications and the process for this appointment is now well advanced.

Rodney thanked Brendan for the update and contribution to the discussion. Brendan left the meeting.

4. PHA – TERMS OF REFERENCE ON THE CONTRIBUTION OF ALL NURSES AND MIDWIVES TO PUBLIC HEALTH

Mary Hinds presented a draft paper on developing a framework which maximises the contribution of all nursing and midwifery staff to Public Health which will be co-produced with service users and carers as well as other stakeholders who are both internal and external to the HSC.

Mary explained how the project will be progressed using a co-production and co-design method to develop a new framework for public health nursing and midwifery contribution at an individual, community and population level across the life course. The group will also consider recommendations for an extended system for formal recognition of expertise and skill in public health nursing and midwifery practice in a way that is clear to colleagues, employers, patients and the public.

Members were supportive of the draft terms of reference and proposed organisational membership of the group it was agreed that comments on the paper should be forwarded to Mary Hinds.

Action Point: CNMAC members to provide comments by 22 October 2017.

5. NURSING AND MIDWIFERY TASK GROUP (NMTG)

Rodney informed CNMAC that at the recent NMTG meeting held on 31 August 2017 Sir Richard was very pleased with the advancements made by all the groups to date and had recorded his thanks to the subgroups and Project Team.

Naomhín Love updated members on the progress made by the NMTG followed by a progress report provided by each the subgroup Chair, as follows:

- Caroline Lee advised that the Workforce Subgroup had met earlier in the morning and arrangements for the workshops are at final stages. She also reported that the subgroup has recruited a Disability nurse and her contribution at meetings leading up to the workshops has been very valuable.
- Mary Hinds, Chair of the Population Subgroup, provided an update on progress on the two indicators, Healthy Weight and Positive Mental Health and Well-Being. She advised that this subgroup will hold 5 workshops giving a rationale on why the group agreed these which included ensuring they attract the leaders for the future to the workshop.
- Tanya McCance, Chair of the HSC Nursing Care subgroup provided an update on the progress of the Primary Care and Acute Care subgroups. The outcome was that these two subgroups merged into one team as their research highlighted that they had independently identified the same indicators for consideration. This included agreement at NMTG meeting on

31 August that this group will focus on the three areas identified; Respiratory Conditions; Frail/Elderly and Diabetes. Tanya advised that the group will work towards preparations for workshops and requested ideas/comments from members on attracting people to attend.

Action Point: Comments/views on attracting people to attend HSC Nursing Care workshops to Naomhín Love/Tanya McCance by 22 October 2017.

Naomhin left the meeting.

6. MENTAL HEALTH NURSING REVIEW

Rodney Morton presented a paper on the Mental Health Nursing Review and updated on progress including the membership of the group, highlighting that there are still a few people missing, particularly student nurses. The review will consider four strands; Children and & Young People and Families; Adult Specialist/Specific Mental Health Teams; Older People; and, Professional Interfaces.

Rodney advised that Professor Tony Butterworth has been approached as a critical friend to lead the group and that a workshop will be held on 19 September 2017. Rodney advised that the work of the group will reflect that of the NMTG by following an outcomes based approach using coproduction.

After discussion it was noted by Ethel Rodrigues that the unions are not included in the membership. Rodney explained RCN are represented on the group and agreed as the work develops to engage with Unite and Unison on the key messages. It was also suggested it might be useful to engage with the Community and Voluntary Sectors. Rodney agreed to reflect this in the planning of the work. The paper was noted and Rodney welcomed the support of CNMAC in taking this work forward.

Action Point: Rodney Morton to consider the membership of the Mental Health Nursing Review group to include Union representation.

7. UPDATE ON CO-PRODUCTION PAPER

Rodney provided an update on the work undertaken on co-production, advising that the practical Guide “Co-production - A ‘How To’ Guide to Delivering Transformational Change Together “had been issued for comment. Responses have been received and are being considered with revisions to the document being prepared for presentation to TIG in October. Some members advised that they had not seen the Guide. Rodney advised that the draft co-production guide will be issued to CNMAC for comment.

Action Point: Issue co-production paper to CNAMC and invite comment.

8. INTERNATIONAL RECRUITMENT

Heather Finlay updated members on the international recruitment campaign. To date, 74 nurses have arrived in Northern Ireland, 20 have either achieved their NMC registration or awaiting their NMC registration. 17 EU nurses have had their contract terminated or gone home to their country of origin with failure to achieve IELTS level 7 attributed as the main reason. There is a further non EU campaign underway this month to India and the Philippines.

Achieving IELTS level 7 in the written component is challenging and the NMC are reviewing this. There are currently 102 nurses in India and the Philippines with level 6.5 achieved. Home Office delays in responding to queries and Visa progression issues due to the differing pay scales between NI and the rest of the UK are further factors impacting on timescales.

9. NMC CONSULTATIONS

Rodney reminded members that the NMC consultations on Education Standards; Proficiency Standards and Medicines Management will close on 12 and 14 September. Rodney thanked Angela McLernon and NIPEC on the success of their workshops and advised that the CNO will be responding to the consultations.

This was noted by CNMAC members.

10. REVALIDATION UPDATE

Rodney referred CNMAC to the report from the NMC on the good progress for Northern Ireland with 92 percent successfully revalidated.

This was noted by members

11. CLINICAL ACADEMIC CAREER PATHWAYS

Donna Fitzsimmons introduced the draft Clinical Academic Careers paper prepared in partnership with Sonja McIlfatrick. She provided a background to the paper as well as detailing the current challenges in sustaining R&D skills within the clinical and academic workforce.

Sonja provided a briefing on the other aspects of the papers including the various models that exist across the Ulster and QUB universities as well as the proposed way forward. Sonja sought comment, as well as ideas and suggestions for improvement, on the draft paper from CNMAC which should be forwarded to Donna and Sonja within 4 weeks.

Action Point: To provide comments on the draft Clinical Academic Career Pathway paper within 4 weeks of issue.

12. ANY OTHER BUSINESS

Janice Smyth advised members that the RCN Congress will be held in Belfast from 12 – 16 May 2018 at the Waterfront Hall, Belfast.

Rodney advised that the All-Ireland CNO Conference is planned for Wednesday 6 December in the Titanic Conference Building and members were asked to hold the dates for both events.

13. DATE OF NEXT MEETING

Friday 8 December 2017 at 10.00am, Castle Buildings

CNMAC Action Point Register

No	Date	Action	Responsibility	Progress	Status
1	**7/6/2017**	Consider if baseline figures are available to evaluate the advanced Nurse Practitioners programme by next meeting.	**Heather Finlay**	**In Progress** **Verbal update will be provided at meeting on 8 December**	**Open**
2	**7/6/2017**	Discuss older nursing and midwifery staff and pressures on the workforce with workforce strategy group by next CNMAC Meeting.	**Heather Finlay**	**In Progress**	**Open**
3	**8/9/2017**	Comments on PHA paper on contribution of all nursing and midwifery staff to Public Health to Mary Hinds by 22 October	**CNMAC Members**	**Completed**	**CLOSED**
4	**8/9/2017**	Comments / views on attracting people to attend HSC Nurse Care workshops to Naomhín Love / Tanya McCance by 22 October 2017	**CNMAC Members**	**Completed**	**CLOSED**
5	**8/9/2017**	Rodney Morton to consider Unite and Unison as members of the MHNR group	**Rodney Morton**	**In Progress**	**Open**
6	**8/9/2017**	Issue co-production paper to CNAMC and invite comment.	**Rodney Morton**	**Completed**	**CLOSED**
7	**8/9/2017**	To provide comments on the draft Clinical Academic Career Pathway paper within 4 weeks of issue to Donna Fitzsimmons and Sonja McIlfatrick.	**CNMAC Members**	**In Progress** **One comment received from Angela McLernon (see below)***	**CLOSED**

*On page 3, under '*Proposed Way Forward for Discussion'* that another point is added as follows:-

- *Capture details of the workforce already educated to Masters level and provide support to these practitioners in the use of evidence*

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Central Nursing and Midwifery Advisory Committee (CNMAC)

Notes from Meeting on 27th June 2019

10.00 am - Room D2 Lecture Theatre, Castle Buildings

Present:

Rodney Morton	DoH (Chair)
Heather Finlay	DoH
Mary Hinds	PHA
Prof Carol Curran	UU
Donna Gallagher	Open University
Angela McLernon	NIPEC
Prof Tanya McCance	BHSCT
Marion Ritchie	UNISON
Nicki Patterson	SEHSCT
Heather Trouton	SHSCT
Caroline Lee	CEC
Michael Quinn	BHSCT?
Gary Loughlin	?
Emma Westcott	RCN
Candace Imerson	RCN
Emma Murray	DoH Minutes

Apologies:

Charlotte McArdle	DoH
Brenda Creaney	BHSCT
Dr Bob Brown	WHSCT
Eileen McAneaney	NHSCT
Prof Donna Fitzsimons	QUB
Karen Murray	RCM
Prof Sonja McIlfatrick	UU
Pat Cullen	RCN
Heather Monteverde	Macmillan
Carol Cousins	FSHC
Mary Frances McManus	DOH
Maura Devlin	NMC
Ethel Rodrigues	UNITE

1. WELCOME AND APOLOGIES

Rodney Morton welcomed all to the meeting and the apologies were noted. Rodney also noted the groups condolences for Brenda Creaney

2. MINUTES OF LAST MEETING

The minutes of the March meeting were agreed and an update on actions followed.

Action Point 1: The updated versions of the recommendations will be circulated

Action Point 2: Closed - The Hyponatremia update was shared with the papers

Action Point 3: Closed – Angela advised that Janice had shared contact details

Action point 4: Rodney provided an update on RPS FW for prescribers. The NMC have already posted this on their website and highlighted that there is currently no regional guidance for Northern Ireland. CNO and Pharmacy colleagues are having ongoing discussions. Pharmacy colleagues will be issuing Guidance with input from Nursing. It was noted that although there are current UK wide guidance there is some difference relating to the Safe and Secure Storage of medicines which is different in Northern Ireland. The letter currently sitting with CNO will need to be revised and issued.

3. Encompass Presentation

Gary Loughlin and Michael Quinn provided an update on the progress of the Encompass project. Following the presentation the group discussed the project noting how exciting the project was. Donna Gallagher discussed the need for nominations from nurse educators including the Open University as well as including Student Nurses in the roll out of training. Gary suggested that he return to CNMAC in 4-6 months in order to provide a demonstration of Encompass. Gary also highlighted the need for nominations from nursing for a variety areas including the work streams and Trainers. Gary also advised that he would discuss the training roles with the CEC

ACTION POINT – Gary Loughlin to return to CNMAC in 6 months for Demonstrations and farther update.

ACTION POINT – The possible nominations for encompass to be discussed at the next CNO Directors meeting

ACTION POINT – Gary Loughlin will contact Caroline Lee in CEC to discuss Encompass training roles

4. NURSING AND MIDWIFERY WORKFORCE UPDATE

Prof Tanya McCance provided on update on the progress of the Task Group On the 13th May representatives from the Task Group met with the Chief Executives Forum and discussed a number of areas of the Report including the Terms of Reference, Staffing and Grading, the value of Nursing and the Key findings And Final recommendations. Tanya reported the Chief Executives were extremely positive and had endorsed the recommendations. Tanya went on to advise that the Executive Summary needs to be finalised and that the report will be going to Perm Sec on 14th August. Once it has been to TMG and TIG it will be published and officially launched.

ACTION POINT: The Nursing and Midwifery Task Group presentation to be shared with CNMAC members under the agreement that it will not be shared.

5. HYPONATREMIA INQUIRY UPDATE

Rodney provided a brief update on the Hyponatremia inquiry and noted that the briefing will be shared along with the minutes. Rodney also highlighted that the communications regarding the Inquiry has been updated on the Department website as of today

ACTION POINT **-** The Hyponatremia briefing to be issued to CNMAC members along with the Note of the meeting

6. NURSING AND MIDWIFERY WORKFORCE UPDATE

Vacancies

Heather advised that workforce vacancy rates are now being published on the Department website quarterly. The nursing and midwifery vacancy rate at 31st March has increased to 11.5% with the total number of vacant posts 2,272. The vacancy rate for Nursing and Midwifery support staff is 8% however there is no evidence to suggest there is a shortage of applicants for these posts as there is no waiting list. The group advised that this maybe be down in part to delays caused by staff changes in BSO. Heather noted that the figures are concerning and that in some pockets of the profession the vacancy rate may be as high as 30%. The group highlighted that the care is provided just not by permanent staff and vacancies are being filled with Bank and agency staff. Heather also highlighted that the pre reg places have increased to their highest level of 1025 in 2019/20 as well as noting that the increased pre reg places previous commissioned will begin graduating in 2019 which will impact on the vacancy rate. Donna also noted the standard of those graduating is extremely high.

International Nursing Recruitment

The current target remains 622 by 2020 however going on predicted numbers 413 it is now a more realistic target. The original target of 622 will take longer no to achieve however there are ongoing conversions with the suppliers.

Learning Disability

Heather noted that Siobhan Rogan has been seconded to the Department until March 2020 to undertake a Learning Disability Review which will be co-chaired by CNO and Sean Holland

NI Audit Workforce Planning Report

Heather advised that the Northern Ireland Audit Office have completed Workforce Planning Review. The draft report is currently with the Department for comment and confirmation of factual information contented within it.

Advanced Nurse Practitioner.
The details regarding the Advance Nurse Practitioner course will be issued soon and will need 3 nominations from each Trust. Each nominee will also need to complete the Non-medical prescribing course. Letters will then be issued to the Universities

7. FUTURE NURSE/ FUTURE MIDWIFE

Angela McLernon provided an update highlighting that there has been significant activity with the process on target. The details regarding the first 3 gateways where discussed. Angela noted that PHA have advertised for a Professional officer.
Angela then noted that the 2 events for Future Midwife have both went very well. She also highlighted that the curriculum will differ due to the PAD. She also noted /that the practice placements will need to be relooked at and noted that there will be a workshop on 2nd July which she encouraged everyone to attend. Angela advised that ongoing communication regarding Future Nurse Future Midwife including Twitter and workshops. Rodney thanked NIPEC for all their hard work.

8. STATEGIC WORKFORCE & EDUCATION (SWE) CNMAC SUBGROUP UPDATE

Prof Carol Curran provided an update on the recent SWE CNMAC meeting which she chaired on 13th June. Carol noted the sub group recognise important remit of SWE to review learning from SAI's and have agreed to devote November 19 meeting to this. Carol also discussed the issues and the Regional Education Forum and queried whether they should report to CNMAC SWE. Carol also advised that at the last meeting the group had agreed to raise a number of topics with CNMAC which included; the ECG budget reductions and the impact of them on the profession, Zoning and practice placements, pay rates and the implications on retention of staff. Rodney advised that this would only be for noting as there are other forums to discuss pay issues, however that they are accurately aware of the issues and noted that this was raised within the Task Group.

9. NURSING NOW

Rodney noted that Mary Frances had provided an update on Nursing Now which was circulated with the papers for the meeting and that a sub group has been formed.

10. NMC VISIT AND STRATEGY DISCUSSION

Rodney welcomed Emma Westcott and Candace Imerson from NMC who presented on the new NMC strategy for 2020-2025. Following the presentation there was a group discussion

11. AOB

- The group discussed the Mental Capacity Training. This is to be raised as an agenda item at the next CNMAC in September. Maurice Devine and Rosaline Kelly be invited to attend

  ACTION POINT – Mental Capacity Training added to CNMAC September meeting. Maurice Devine and Rosaline Kelly be invited to attend
- Rodney also highlighted the current cohort for the creating caring cultures programme have completed their residentials and suggested that it may be relevant to have father discussions with Charlotte and Directors of Nursing at the next CNO directors meeting if this programme should be offered to another group.

  ACTION POINT – Creating Caring Cultures added to Agenda onf the CNO Directors meeting

DATE OF NEXT CNMAC MEETING

- **13th September 10.00 am, D2 Lecture Theatre, Castle Buildings**

CNMAC Action Point Register

No	Date	Action	Responsibility	Progress	Status
1	**22/03/19**	The Nursing and Midwifery Task Group presentation to be shared with CNMAC members once corrections have been made.	**Emma Murray**	**In Progress**	**Open**
5	**22/03/19**	Martin Bradley to be invited to the next meeting	**Heather Finlay**	**In Progress**	**Open**
1	**27/06/19**	Gary Loughlin to return to CNMAC in 6 months for Demonstrations and farther update.	**Emma Murray**	**In Progress**	**Open**
2	**27/06/19**	The possible nominations for encompass to be discussed at the next CNO Directors meeting	**Emma Murray**	**In Progress**	**Open**
3	**27/06/19**	Gary Loughlin will contact Caroline Lee in CEC to discuss Encompass training roles	**Gary Loughlin** **Caroline Lee**	**In Progress**	**Open**
4	**27/06/19**	The Hyponatremia briefing to be issued to CNMAC members along with the Note of the meeting	**Emma Murray**	**In Progress**	**Open**
5	**27/06/19**	Mental Capacity Training added to CNMAC September meeting. Maurice Devine and Rosaline Kelly be invited to attend	**Emma Murray**	**In Progress**	**Open**
6	**27/06/19**	Creating Caring Cultures added to Agenda on the CNO Directors meeting	**Emma Murray**	**In Progress**	**Open**

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Central Nursing and Midwifery Advisory Committee (CNMAC)

Notes from Meeting on 18th September 2020 @ 10.00 am

Via Teleconference (Zoom)

Present:

Prof Charlotte McArdle	DoH (Chair)
Heather Finlay	DoH
Mary Frances McManus	DoH
Dr Dale Spence	DoH
Rodney Morton	PHA
Prof Carol Curran	UU
Angela McLernon	NIPEC
Karen Murray	RCM
Nicki Patterson	SEHSCT
Heather Trouton	SHSCT
Caroline Lee	CEC
Prof Sonja McIlfatrick	UU
Dr Bob Brown	WHSCT
Prof Donna Fitzsimons	QUB
Heather Monteverde	Macmillan
Suzanne Pullins	NHSCT
Anne Trotter	NMC
Laura Glover	DoH Secretariat

Apologies:

Maura Devlin	NMC
Brenda Creaney	BHSCT
Carol Cousins	FSHC
Marion Ritchie	UNITE
Prof Tanya McCance	UU
Donna Gallagher	OU
Ethel Rodrigues	Unite
Pat Cullen	RCN

1. WELCOME AND APOLOGIES

Charlotte opened the meeting and welcomed all those in attendance and the apologies were noted.

2. CHAIR'S OPENING REMARKS

The chair noted the following changes to CNMAC membership.

- Maura Devlin is standing down as the NI NMC representative from CNMAC. In her absence Charlotte acknowledged Maura's valued contribution to CNMAC. She will be replaced in October by Eileen McEneaney as the NMC representative.
- Heather Monteverde standing down as the Independent and Voluntary sector representative. Charlotte thanked Heather for her valued contribution to CNMAC and advised that she will be working with the Department of Health on the Cancer Strategy.
- Suzanne Pullins was welcomed as a new member of CNMAC, Suzanne replaces Eileen McEneaney as the interim Executive Director of Nursing in the Northern Trust.

3. NOTES / ACTION POINTS FROM LAST MEETING: 26th June 2020

The minutes of the last meeting were agreed and an update on actions followed.

AP1 - Gary Loughran to return to CNMAC in 6 months. This action was deferred to next meeting. **Ongoing.**

AP1 – Laura to share the details of the NMC webinars with CNMAC members. Completed. **Closed.**

AP2 - Laura to share the Nursing and Midwifery Task Group Report Implementation slides with CNMAC members. Completed. **Closed.**

AP3 - CNO to advise members in writing once co-chairs are confirmed for the NMTG strategic themes. This item will covered later in agenda. Completed. **Closed.**

4. NMC REVIEW OF POST REGISTRATION STANDARDS

A welcome was extended to Anne Trotter, Assistant Director of Education in NMC. Anne was invited to present on the NMC review of post registration standards. A copy of the NMC paper: *Modernising post-registration regulated specialist practice community qualifications*, was circulated to members prior to the meeting.

Anne introduced the paper advising that the review of post registration standards began in 2019. This included the SCPHN third part of the register and the Specialist Practice qualifications.

A UK post registration standards steering group was established with representation from CNO offices, education providers, professional organisations and unions. There had been two meetings prior to lockdown. Recommendations were agreed by NMC Council in January 2020

1) To replace the current generic Specialist Community Public Health Nursing standards with a core set of standards, and in addition, three bespoke sets of standards for each of the following groups; Occupational Health Nurses, Health Visitors and School Nurses

2) To scope the content of the proposed new qualification in community nursing, which would replace the current specialist practice qualifications (SPQs) in District Nursing, Community Children's Nursing, Community Mental Health Nursing, Community Learning Disabilities Nursing and General Practice Nursing. The new qualification would encompass a core set of standards and any bespoke standards for each of the individual specialties as required.

Due to the impact of COVID, a series of engagement webinars were very successful with high numbers participating. An independent research company has been undertaking a thematic analysis of stakeholder feedback data.

Feedback indicates there is general consensus on SCPHN with core standards being drafted. Mary Frances is the NI representative on the SCPHN group.

The position with SPQ is more contentious with differing dimensions and variant views across the four UK countries. Advanced practice regulation in the context of

SPQ has been raised, however the NMC has taken no decisions on regulation of advanced practice as yet.

Anne advised the timeline for the post registration standards review was that Council would approve in December, with consultation to commence in January 2021

Some discussion took place. Charlotte raised a concern that NI participation in the NMC engagement webinars was solely within an individual capacity and did not necessarily represent or align with the NI strategic direction.

All agreed this was a complex area that may not meet our needs in NI with potential implications particularly on community nursing practice. Careful consideration was needed, especially given the important strategic drivers such as Delivering Care, DN framework and NMTG Report, embedding nursing roles with a strong public and population health approach.

Charlotte noted that the NMC have agreed that in NI we will be able to make decisions aligned to our own strategic direction in taking the profession forward.

ACTION POINT 2 & 3 (Mary Frances)

a) Set up a Strategic Leaders Forum to facilitate discussion and inform the strategic response.
b) Share the draft standards SCPHN with CNMAC members.

Charlotte thanked Anne for the update. Anne left the meeting.

5. NURSING AND MIDWIFERY TASK GROUP REPORT

Charlotte provided an update on the Nursing and Midwifery Task Group Report. Following discussion at June CNMAC, the implementation model and co-chairs for the Strategic Themes have been agreed, subject to Ministerial approval, which is yet to be obtained.

1) **Population Health** – Rodney Morton (PHA) and Dr Jenny McNeill (QUB)
2) **Workforce Stabilisation –** Preeta Miller (WPD) and Rita Devlin (RCN)
3) **Enhancing Roles of Nurses & Midwives** – Prof Tanya McCance (UU) and Carol Cousins (IS)

Charlotte advised some uncertainties regarding the pandemic however; she was content the groups could be established with deferral of theme three work stream until Tanya McCance returns. She advised the supporting infrastructure needed further work and that there would be key roles for Linda Kelly, Heather Finlay and Dale Spence

Bob Brown commented he would be keen to see work progress on the nursing and midwifery strategy which hopefully will align with the strategy being developed by Western Trust to be completed in 2021. Charlotte acknowledged the need to develop the regional strategy and that any local strategy development meantime should reflect the clear direction in the Task Group Report

Nikki Patterson added that she felt it was important to maintain the enthusiasm generated by the launch of the report. Rodney endorsed a recent SET event that focused on the Task Group Report, providing an opportunity to connect with staff and make the recommendations meaningful.

7. FUTURE NURSE, FUTURE MIDWIFE UPDATE

Angela McLernon provided an update on Future Nurse, Future Midwife. The Future Nurse programme has gone live. Future Midwife will commence in September 2021.

Angela thanked everyone involved in the Programme Board. She advised that:

- A transitioning group had been established called the NI Practice Learning Collaborative. Chaired by Sharon McRoberts and Karen McCutcheon, the group met in mid-August and plans to meet monthly.
- The Midwifery Expert Reference Group (MERG) continue to meet monthly, and an NMC approval visit has been planned for QUB in November.
- The Midwifery On-Going Record of Achievement (MORA) work is ongoing with a good response to the survey in June 2020.
- Future Nurse electronic Northern Ireland Practice Assessment Document (eNIPAD) work is well underway, thanks to the Universities and should be implemented in September.
- Practice Placements

Angela highlighted there were concerns about practice placement availability for students and the challenges around COVID and the re-build agenda. She noted significant work was ongoing with continued partnership working between the universities and practice education teams.

Charlotte inquired if there were issues with practice placements in midwifery? Dale Spence confirmed there were some challenges with intrapartum placements however this was being managed at present.

Donna Fitzsimons advised that QUB are currently 400 student placements short and highlighted this as a critical issue as the placements are needed from late October. Sonja McIlfatrick also expressed concerns regarding UU students – highlighting in particular the lack of community placements which urgently needed addressed.

Heather Finlay advised that placement shortages were raised at the recent FNFM working Group. Covid related causes due to reconfiguration or closure of wards/units had been cited as contributing factors, reducing placement availability. The tireless efforts of practice education teams to secure placements was acknowledged and leadership of Sharon McRoberts who contributed to the FNFM working group discussion as co-chair of the NI Practice Learning Collaborative (NIPLC) was appreciated. Heather advised that it is imperative that placements are facilitated and that the CNO has asked for a monthly monitoring report from the NIPLC.

Charlotte reinforced these comments highlighting students should be working shifts over the 24/7 period and additional places must be found. Acknowledging the difficulty presented by COVID, she reminded the committee of the assurances received from Directors of Nursing that students would be accommodated when the additional places were being agreed.

Nikki Patterson agreed there needs to be a determined push to accommodate student placements and noted the importance of speedy escalation of any issues to the Directors of Nursing. Charlotte agreed this action should be instigated without delay

Action Point 4 - Directors of Nursing to ensure urgent escalation mechanisms are in place within their respective organisations to address any shortfall in the availability of student placements

There were various suggestions put forward as to where student placements could be obtained including the NI Hospice.

Charlotte highlighted workforce challenges within theatre nursing. Students should be accommodated to introduce them to the speciality pf theatres as undergraduates.

It was highlighted that Occupational Health services have no nursing students at present – again another valuable learning experience.

Rodney suggested that students could be utilised to work in contact tracing as part of a public health placement, it was agreed that he would link with the universities and put together a package for this.

Action Point 4 - Rodney to link with the universities and develop a package for students in Public Health Agency

8. WORKFORCE AND EDUCATION UPDATE

Heather Finlay provided an update on Workforce and Education

Vacancy update

The vacancy rate is published quarterly on the Department of Health website; the latest figures are from 30th June 2020 and have encouragingly shown a downward trend over the past few quarters, however workforce shortages still remain a challenge.

	Vacancies 30th June 2020	Vacancy Rate	March 20
Nurses	1,716	9.5%	11.1%
Midwives	70	5.0%	6.6%
Total	1,786	9.1%	10.7%

	Vacancies at 30th June 2020	Vacancy Rate	March 20
Nursing & Midwifery Support	253	4.0%	6.4%

Action Point 5 – Heather to prepare a comparison table of the vacancy rate over the past year to be sent out with the minutes.

Heather highlighted that there are particular workforce concerns in Mental Health and Learning Disability nursing, and thanked QUB who are working on providing destination statistics for their graduate nurses in these areas.

Belfast Trust is currently doing some work with ROI and hope to recruit mental health nurses in line with NMC guidelines.

International Recruitment

The project aimed to recruit 622 nurses to the HSC by March 2020. On 23rd March 2020, the Minister agreed to the immediate suspension of all international nurse recruitment in order that HSC resources could be directed towards managing COVID-19. As at the project suspension on 23rd March, there were 504 international nurse arrivals, of which 458 remain in post-suspension now lifted with 320 nurses expected to be recruited during the remainder of 2020.

Safe Staffing Delivery Framework

Safe Staffing Framework Delivery Group (SSFDG), consists of Departmental, HSC employer and trade union representatives and will report to the Minister through Workforce Policy Directorate. It will complement the work other groups, including the Workforce Strategy Programme Board. The Terms of Reference have been finalised and await Ministerial approval. A regional Agency Reduction Implementation Group set up as a sub group of the SSFDG.

9. EDUCATION UPDATE

Pre-Registration Commissioning

The first 300 of the additional 900 places over the next 3 years have been commissioned for 2020/21 making a total of 1325 places. Some additional places were granted to QUB due to the additional A Level intake this year.

Post-Registration Commissioning

The nursing and midwifery post registration education budget for 2020/21 was uplifted to £10m in line with commitment given by the Minister in the Framework agreement. There has also been additional funding secured this year for Primary Care nursing and nursing in the care home sector.

Caroline Lee advised all Covid related programmes from CEC are free and stated that if given direction from the Department she would consider opening up non-Covid programmes to the independent sector and primary care free of charge. Charlotte thanked Caroline for this and believed it would be welcomed by these sectors.

Students and Paid Placements

Heather noted the positive feedback on the contribution of students joining the workforce in a paid capacity under the NMC emergency arrangements to the pandemic. Charlotte discussed the possibility of providing paid placements for final year students in their last few months. Charlotte will check with NMC and before any Departmental discussions regarding.

10. FLU VACCINATION PROGRAMME

Mary Frances McManus provided an update on the flu vaccination programme. The 2020/21 Flu campaign is particularly important this winter. There has been an additional investment of £750,000 across the region, the previous uptake was 70 - 75% this year's target is set for 95% There are three main programmes:

1. **Children's Vaccination Programme -** Anti-vaccination issues are a challenge. This group will cover all school age children up to and including those in year 8.
2. **General Practice and Primary Care Programme -** This group will cover all children age 2 – 4, those over 65 years old, pregnant women and those under 65 years in a clinical risk group. A decision has yet to be made on whether those between 50 and 65 years old will be included.
3. **Health and Social Care Programme** – A lot of work has gone into focusing on this group. The Target set for uptake by Health Care Workers is 75%, last year the uptake by HSC staff was only 41.2%. The HSC workforce can be vaccinated at one of 386 community pharmacy vaccination clinics or by peer vaccinators. Independent sector workforce can receive vaccines via their employer or also at community pharmacy clinics. The Department have

developed a letter to encourage everyone to take the vaccine. Caroline asked that as BSO have front line workers they need to be included in any circulars being sent out. Mary Frances will ask Jane to add them the circulation list. Caroline said that several trusts have been looking for training for immunisers.

Sonja McIlfatrick asked for clarification on students getting the flu vaccine, normally they are sent to their own GP to have this, Charlotte confirmed that students can be vaccinated at the community pharmacy clinic or peer vaccinator clinic, she floated the idea of student peer vaccinators.

Details of the clinics will be published on the Public Health Agency website.

11. UPDATE STRATEGIC WORKFORCE AND EDUCATION CNMAC SUBGROUP

Carol Curran provided an update from the last SWE CNMAC subgroup meeting, which was held on Friday 4th September 2020.

Carol began by acknowledging the contribution of all education providers in response to COVID and the commitment shown by the CNO in leading the workforce in such difficult times.

The second issue escalated from SWE was the difficulty in obtaining practice placements for students which has been discussed during the meeting.

Finally, she raised the issue of the new Nightingale Hospitals and need for a regional approach to staffing. Charlotte confirmed that this will be the case.

12. ACCESS TO EDUCATION (BAME)

An update on BAME from the last CNMAC meeting was given. Issues were raised regarding access to post registration education. New guidance from NIRAC advised that they are accepting degrees awarded in the Philippines for level three study. As yet, Indian and African nurses are unable to directly access modules. QUB will further explore this.

A Task and Finish group, chaired by Sonja McIlfatrick, will take forward education access issues

Caroline Lee is including BAME in the planned Valuing Diversity in Nursing Workshop. She is due to meet with Paula Smith at BSO to get the numbers of staff involved and the grade mix to be sure that it is parallel with the overall workforce. Caroline will liaise with Sonja on this.

13. AOB

Leadership opportunities for part time Band 6 and 7 in the CNO's team were advertised. There has been encouraging interest in these posts and shortlisting is soon to commence. The posts are:

Learning Disability Review – 1 part time post
Restraint and Seclusion - 1 part time post
Clinical Care Framework – 2 posts
Healthly Child, Healthy Future – 1 post
Nursing & Midwifery Strategy – 2 posts.

6. ENHANCING CLINICAL CARE IN CARE HOMES FRAMEWORK AND RAPID LEARNING INITIATIVE.

Linda Kelly joined the meeting and delivered a presentation, a copy of the slides were sent to CNMAC members.

14. DATE OF NEXT MEETING: 4th December 2020 @ 10am

Action Point Register

No	Date	Action	Responsibility	Progress	Status
1	**27/06/19**	Gary Loughran to return to CNMAC in 6 months for demonstrations and further update.	**Emma Murray**	**In Progress**	**Open**
2	**23/09/20**	Mary Frances McManus send Laura the draft standards SCPHN to share with CNMAC members.	**Laura Glover**	**Complete**	**Closed**
3		Mary Frances McManus to set up a Strategic Leaders Forum to facilitate discussion and inform the strategic response.	**Mary Frances**		**Open**
4		Directors of Nursing to ensure urgent escalation mechanisms are in place within their respective organisations to address any shortfall in the availability of student placements	**Directors of Nursing**		**Open**
5	**23/09/20**	Heather to prepare a comparison table of the vacancy rate over the past year to be sent out with the minutes.	**Heather Finlay**	**Sent out with these minutes.**	**Open**

FROM: **Phil Rodgers**

Workforce Policy Directorate

Maria McIlgorm

Chief Nursing Officer

DATE: **3 August 2022**

1. **PETER MAY – CONTENT PM 05/08/22**
2. **ROBIN SWANN MLA, MINISTER**

SUB/**/2022 - PROFESSIONAL ALERTS POLICY**

SUMMARY

Issue:	Policy Review of the scheme for the issue of alert notices for healthcare professionals in Health and Social Care in NI.
Timing:	Routine
Financial Implications:	None
Legislation Implications:	None
Equality Implications:	The NI Human Rights Commission (NINRC) has raised concerns in relation to the issue of alerts about members of staff who are under investigation, and

seeks clarity about the human rights that have been factored into the scheme policy. The NIHRC is particularly interested in the right to a fair trial, and whether or not representations are invited from individuals to influence the decision-making process.

FOI Implications: None.

Special Adviser's Views:

Executive Referral: N/A

Presentational issues: Potential for issues to be raised by the Human Rights Commission which may attract media interest. To be cleared by Press Office.

Recommendation: That you:

(i) note the background to this submission in relation Scheme for the issue of Alert Notices for HSC Professionals in HSCNI and consider the three options listed.

(ii) select the option to revoke the policy with reliance in all future cases being placed in the regulators, namely the Nursing and Midwifery Council and the Health and Care Professions Council, to manage issues of concern for members of HSC nursing, midwifery and allied health professions staff.

Introduction

1. The Professional Alerts Policy applies to two professional groups:
    - Nursing & Midwifery Professions
    - Allied Health Professions (AHPs).

2. This is a joint submission from the Director of Workforce Policy and the Chief Nursing Officer outlining the proposal to revoke the Professional Alerts Policy following an internal review.

3. The information considered to inform the decision is presented in the below briefing:
    - Current regulation of Nursing & Midwifery and Allied Health Professionals
    - Professional Alerts Policy background
    - Internal Audit
    - Issues with the existing Professional Alerts Policy
    - Options
    - Recommendation.

Current Regulation of Nursing & Midwifery and Allied Health Professions

4. **Nursing and Midwifery Professions** – are regulated by the Nursing and Midwifery Council (NMC) as set out in the following governing legislation - the Nursing and Midwifery Order 2001 ('the Order') which was created under powers in the Health Act 1999. The Order sets out the primary purpose of protecting the public, the structure of the organisation and the functions and activities. The NMC is accountable to the Privy Council and the Professional Standards Authority.

5. The key principles of NMC's Fitness to Practice covers;
   - managing the risk that a nurse, midwife or allied health professional poses to patients or members of the public in the future;
   - making final fitness to practice decisions swiftly and publishing the reasons openly; and
   - taking regulatory action when there is a risk to patient safety that is not being effectively managed by an employer.

6. These principles are balanced against the recognition that employers can be best placed to deal with concerns about nurses' or midwives' practice, unless the risk to patients or the public is so serious that immediate action may be warranted or in cases where a nurse may work in more than one setting, or not have an employer.

7. **Allied Health Professions –** are regulated by the Health and Care Professions Council (HCPC). Anyone can raise a concern regarding an AHP through HCPC's fitness to practice process. HCPC can take action when there are serious concerns about a health and care professional's knowledge, skills or behaviour.

8. A key principle of both regulators is to protect the public by making sure all registrants are safe, meet the standards of training and skills and have up-to-date knowledge of their practice and expected behaviours.

9. Both regulators can make two types of Interim Orders during an investigation, *before* the allegation has been decided or decisions have yet to take effect, which will impact a registrants capacity to practice:

    - An Interim Suspension Order (ISO). The effect of this is to suspend the individual's registration, resulting in no right to practice anywhere in the UK.

    - An Interim Conditions of Practice Order (ICOPO). The effect of this is to impose conditions which must be adhered to in order to practice lawfully anywhere in the UK.

10. The panels responsible for making such decisions make no findings of facts. The process is a risk assessment undertaken by the panel exercising professional judgment. There does however need to be a prima facie case in respect of the substantive allegation of impaired fitness to practice. They have to take a proportionate approach, starting with considering if an order is necessary, and if it is they have to consider whether they can formulate conditions which are sufficient, workable and enforceable. Only if they can't formulate such conditions can they decide to impose an ISO.

11. If an interim order application is going to be made, the application and notice of the application hearing are prepared within the first 15 days of the referral being received, and notice given of an application hearing within the first 28 days of the referral being received.

12. Whilst the NMC carries out a regulatory role, employers are encouraged to follow general good employment practices when considering prospective employees, such as seeking references, checking registrations at interview stage and undertaking Access NI checks.

Professional Alerts Policy Background

13. In April 2010, the Department issued guidance to the HSC regarding the issuing of alert letters by Chief Professional Officers - HSC JNF (1) 2010. (Annex **A**). The scheme provides a means of alerting employers to potential serious concerns about a health professional's performance or conduct that could place patients, staff or the public at serious risk **whilst** investigations from the respective regulators are taking place.

14. Circular HSC (JNF) (1) 2010 requires HSC employers to (and recommends that independent contractors) request that the relevant Chief Professional Officer, issues an alert in relation to a current or former member of staff, when information comes to light that suggests that the individual poses a significant risk of harm to patients, staff or the public and intends or may intend to seek permanent or temporary work in the NHS/HSC or elsewhere in that capacity.

15. The HSC Circular governing the Issue of Alert Notices is underpinned by a Direction (**Annex B**) and advises that the guidance covers all health care professionals regulated by the following Regulatory Bodies "The Nursing and Midwifery Council" and the "Health and Care Professionals Council[1]", however, in practice the schemes operate in 2 slightly different ways for the various staffing groups:

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[1] In NI the HCPC regulate the following, determined as AHP professions, Arts, drama and music Therapists, Podiatrist, Dietitian, , Occupational Therapist, Orthoptist, Physiotherapist, Prosthetist/Orthotist, Radiographer, Speech and Language Therapist.

- **Nursing & Midwifery Professions** - When there is a concern raised about an individual’s fitness to practice by an HSC employer regarding a nurse of midwife the Department will review the information provided and if appropriate may issue an alert letter at any stage of the process. The Department will only issue an alert where it is considered that an individual poses a significant risk of harm to patients, staff or the public and intends to or may intend to seek permanent or temporary work in the HSC in that capacity and there is a pressing need to issue an alert notice. The Department contact all relevant HSC and independent sector employers as listed in point 18 below and the individual concerned to inform them an Alert has been issued. The Department review all live alert notices on a 6 monthly basis to ensure they are regularly reviewed and can be revoked as soon as there is evidence that they should no longer remain live. The individual concerned and the HSC employer and independent sector employers will be informed by the Chief Nursing Officer when an alert has been revoked. The Chief Nursing Officer in the Department of Health maintains a secure list of all alerts that she has issued and, where applicable the date the alert was revoked. Details of alerts that have been revoked are kept for five years.

- In 2015 the then CNO wrote to HSC and independent employers to highlight that the scope of the scheme for nursing staff under investigation by employers extended across **all** health and social care settings and not just HSC Trusts, as discussions with stakeholders from across the sector showed that some health and social care providers were not aware of the alert letter system. As such, all registered establishments and agencies (nursing homes, nursing agencies, etc) that employ nursing staff must have systems in place for processing CNO Alert letters. In line with the guidance, the responsibility for requesting the issue of the alert rests with the employer (ie the Chief Executive, Executive Board member, or registered person).

- **Allied Health Professions** - The process for raising concerns about an Allied Health Professional's fitness to practice is attached at **Annex C**. In the context of when there is a concern raised about an individual's fitness to practice this is coordinated entirely by the HCPC to investigate the complaint and to take appropriate action. Under the process HCPC are supposed to issue a monthly list of Alerts to the Chief AHP Officer, however, the Chief AHP Officer has confirmed that DoH has not received any Alerts from HCPC during the last year. The DoH Chief AHP Officer has advised that there is currently no formal process in place for HSC to raise a concern to the Department or to raise a concern that they believe has either safeguarding or public protection issues. A recent AHP case was raised through the Nursing Alerts process. If there is a HCPC inspection/hearing there is no feedback process to the employer. Once a concern has been raised to HCPC the onus is on the individual to inform their employers or would be employers that a concern has been raised against them.

16. An alert may only be issued by the CNO (unless the role has been delegated to the Deputy Chief Nursing Officer due to the CNO's absence) and only where the CNO agrees that an individual poses a significant risk of harm to patients, staff or the public and intends or may intend to seek permanent or temporary work in the NHS/HSC in that capacity, and there is a pressing need to issue an alert notice.

17. Representations are not invited from the individual at the alert decision-making stage, but they are notified if a decision is made to issue an alert.

18. When the decision is made to issue an alert regarding a nurse, midwife or allied health professional, the CNO writes to the following HSC and independent sector employers:

- Chief Executive, Public Health Agency;
- Chief Executive, HSC Board (for cascade to GP Practices);
- Chief Executives, HSC Trusts;
- Chief Executive, Business Service Organisation;
- Chief Executive, RQIA (for cascade to independent sector employers);
- Chief Executive, Patient Client Council;
- Chief Executive, NI Guardian Ad Litem Agency;
- Chief Executive, NI Social Care Council;
- Chief Executive, NIPEC;
- Chief Executive, NIMDTA;
- Chief Executive, NI Blood Transfusion Service;
- Chief Executive and Registrar, Nursing and Midwifery Council;
- Director of Nursing and AHPs, PHA;
- Directors of Nursing, HSC Trusts;
- Director of Human Resources, BSO;
- Directors of Human Resources, HSC Trusts;
- Head of School of Nursing and Midwifery, QUB;
- Head of School of Nursing, UU; and
- Senior Lecturer, Faculty of Health and Social Care OU (Belfast).

19. It should also be noted that the CNO for Northern Ireland shares the decision with the other 5 CNO’s across the UK.

20. Concerns may arise about the conduct and performance of a healthcare professional in a number of different ways, including concerns raised by other staff, findings arising from internal investigations, the disciplinary process, information from the regulatory bodies, complaints, police investigations, appropriate bodies outside the UK and information arising from the audit and inspection process.

21. The letter advises the recipient that contact should be made with the Director of Nursing (contact number provided) within the Trust which has requested the alert, if the named individual makes an application for a post

or locum work as a nurse, midwife or allied health professional in the recipient's organisation (or is already employed).

Internal Audit

22. Internal Audit undertook a review of the Alert Scheme in June 2018 and their report makes a number of recommendations, including that the scheme is reviewed and updated. A list of the recommendations, and the current position, put forward by Internal Audit are attached at **Annex D**.

Issues with the existing CNO Professional Alerts Policy

23. In undertaking a full review of the policy Workforce Policy Directorate and CNO Office have identified a number of issues which have become apparent with the current HSC circular and guidance document:

i. [redacted]

ii. [redacted]

iii. The Chief Commissioner of the NI Human Rights Commission (NIHRC) has written to the Department with regard to the policy. This correspondence alludes to concerns raised with the Commission in relation to the issue of alerts about members of staff who are under investigation, and seeks clarity about the human rights that have been factored into the scheme policy. The NIHRC is particularly interested in the right to a fair trial, and whether or not representations are invited from individuals to influence the decision-making process. The Commission had written to you in 2018 and 2019 highlighting their concerns. The Permanent Secretary responded to the Commission back in May 2019 (**SCORR 0298/2019 refers**) stating that a review would now be undertaken and offered a meeting with the Commission to discuss the issues of concern; and

iv. NIHRC most recently contacted the Department on 27 June 2022 to advise that the policy continues to be raised with the Commission as a matter of concern. NIHRC sought a formal update in respect of the progress of reviewing the policy and requested that a timeline for completion of the review be shared.

v. The Circular governing alert letters for Doctors, and Dentists who are Trust employees, is appended at **Annex F**. This guidance is applicable to Northern Ireland. Annex B of that document sets out criteria which is applied to determine when an alert letter will be issued and Annex C of that circular details the process for issuing an alert letter. The wording regarding exoneration and cancellation is clear and robust. This is not the case in the current iteration of the Scheme for the issue of Alert Notices for Nursing, Midwifery and Allied Health Professionals in HSCNI.

vi. The new DoH Chief Nursing Officer, Maria McIlgorm, has discussed the alert process with the other CNO's across the UK. They have all confirmed that this practice does not happen within any of the other countries, which indicates that the practice disproportionately impacts registrants in Northern Ireland. Recent concerns have been raised about the process by CNO's in Scotland and Wales in relation to data protection.

vii. General Data Protection Regulations (GDPR) became EU Legislation in April 2016. Given the significant concerns in regard to potentially breaching data privacy laws outlined by GDPR, the CNO contacted the Northern Ireland Information Commissioner’s Office (ICO) to seek advice. ICO advised that as the data shared was protected under the previous data protection regime, it is very likely that it can be continued to be shared in line with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. However, ICO highlighted that whilst it can provide general advice and guidance on the legislation it regulates, it is not familiar with other legal requirements or considerations that may shape how information is processed by an organisation.

Options

(i) **Do nothing**

- Some Nursing and Midwifery stakeholders from within the Northern Ireland HSC sector have reported that they consider some aspects of the find Professional Alerts Policy as positive, namely that they have concerns around whether the timeline to which the NMC are working sufficiently prevents risk of further potential harm occurring in the intervening weeks/months and they believe the policy may help to address this.

- However, the NMC risk assessment undertaken at the screening stage occurs within the first 48 hours for all cases, and within 24 hours if there is an initial view taken that an interim order may be required. The risk assessment process continues throughout the life of the substantive case and is repeated every time a new piece of information is received.

- If an interim order application is going to be made, the application and notice of the application hearing are prepared within the first 15 days of the referral being received, and notice given of an application hearing within the first 28 days of the referral being received.

- The NMC has a Key Performance Indicator (KPI) for interim orders, which is that the 28 day notice is achieved in at least 80% of cases. In 2020 – 2021, the NMC achieved 78%. In 2019 – 2020, the NMC achieved 81%.

- Following a presentation of this data by NMC representatives at a recent CNO Business Meeting, NI Nursing and Midwifery leaders sounded unanimous support of the process and voiced that previous concerns had been allayed in relation to a delay in issuing interim orders.

- There is therefore an argument to be made that the Alert letter process is merely pre-empting the work of the NMC fitness to practice hearing, with the added concern that the NMC will be in receipt of more detailed information on which to base their final decision.

- In addition, this option would fail to address the other issues discussed in relation to the CNO Professional Alerts Policy.

(ii) **Amend Professional Alerts Policy**

- [redacted]

- However, amending the current policy will fail to address the other issues discussed, such as the whether the policy disproportionately effects the Nursing, Midwifery and Allied Health Professions, disproportionately effects registrants from Northern Ireland, and the concerns raised by NIHRC regarding whether registrants have the right to a fair trial, and whether or not representations are invited from individuals to influence the decision-making process.

(iii) **Revoke the policy and rely on the NMC and HCPC investigation process**

- Revoking the policy to rely on the investigation processes of the relevant regulators would address the issues raised in relation to its implementation. [redacted] It would also relieve potential concerns around the compliance of the policy with GDPR.

- Whilst it has been reported that stakeholders within the Northern Ireland HSC sector hold the opinion that the policy provides an additional level of safeguarding, given that the Alert policy is not national, nor has any basis in law, as highlighted above, risks remain whether we have the policy in place or not. It would seem reasonable to leave the responsibility with the regulator, as is the case in the other 3 UK countries, and employers, albeit accepting that this does not negate the employers' responsibility to manage concerns in the first instance.

- It should be noted that as part of governance procedures employers are encouraged to follow general good employment practices when considering prospective employees, such as seeking references, checking registrations at interview stage and undertaking Access NI checks. Employers should also seek regular updates on staff regulation status within their organisations. Should this option be decided, the

Department will write to all relevant employers to remind them such statutory responsibilities.

Overall Assessment

24. The current Alerts Policy is an additional level of administration but more importantly it creates risk for the Department that it will be legally challenged in relation to its appropriateness, unfairness and inconsistencies.

25. Given that no other jurisdiction operates an Alert Policy for Nursing, Midwifery and AHP's and they maintain reliance on the regulator to provide the objective and independent assessment of any issue of serious concern raised against a member of staff – it is recommended that NI should adopt the same approach. Given the issues involved, communication of any decision will need to carefully managed.

Recommendation

26. It is recommended therefore that you:

    (i) note the background to this submission in relation the Scheme for the issue of Alert Notices for HSC Professionals in HSCNI and consider the three options listed;

    (ii) select the option to revoke the policy with reliance in all future cases being placed with the regulators, namely the Nursing and Midwifery Council and the Health and Care Professions Council, to manage issues of concern for members of HSC nursing, midwifery and allied health professions staff. The Department would then write formally to the circulation list, highlighted at point 17, to inform them of the decision.

Philip Rodgers	**Maria McIlgorm**
Workforce Policy Director	**Chief Nursing Officer**

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Annex A

HUMAN RESOURCES DIRECTORATE
PAY AND EMPLOYMENT UNIT

Chief Executive of each HSC Body[2] Heads of Education, Beeches Management Centre and North West Consortium

For information:

Director of Finance and

Director of Human Resources of each body

Room D1.4

Castle Buildings

Upper Newtownards Road

BELFAST

BT4 3SQ

[redacted]

[redacted]

Email: [redacted]

Your Reference: **HSC JNF (1)2010**

19 April 2010

Dear Colleagues

ISSUE OF ALERT LETTERS FOR HEALTH CARE PROFESSIONALS UNDER INVESTIGATION BY HSC EMPLOYERS

1. The guidance set out in the Annex to this Circular covers the issue of alert letters for health care professionals that come under the Regulatory bodies listed in Appendix 1 and employed in HSC. These arrangements have been

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[2] The Health and Social Care Board, HSC Trusts, the Public Health Agency, the Business Services Organisation, the Northern Ireland Blood Transfusion Service Agency, the Northern Ireland Guardian ad Litem Agency, the Northern Ireland Practice & Education Council for Nursing, Midwifery & Health Visiting (NIPEC), the Northern Ireland Social Care Council (NISCC), the Patient & Client Council, the Northern Ireland Regulation and Quality Improvement Authority and the Northern Ireland Medical and Dental Training Agency (NIMDTA)

agreed by the relevant trade unions. The Department has Directed that this scheme should be adopted by all Health and Social Care bodies. This guidance does not apply to the independent sector but it is recommended that independent contractors should incorporate this scheme into their own procedures.

Summary

2. An alert letter is the way in which all HSC employers are made aware of a health professional whose performance or conduct could place patients, staff or the public at serious risk. They cover situations where health professionals who pose a hazard to patients, staff or the public may move from their present HSC employer to work elsewhere in a health or social care setting in any capacity, whether or not requiring registration, before their regulatory body has had the chance to consider interim suspension or other measures. Even where such measures are in place, alert letters are intended to reduce the risk of inappropriate employment in any capacity.

3. It is also a way in which all HSC employers are made aware of a health professional who may reasonably be considered to pose a serious potential or actual risk to patient care, staff safety or the public because their performance or conduct seriously compromises the effective functioning of a clinical team.

4. Alert letters are not intended to be issued in every case where an individual's performance or conduct is being considered by their HSC employer. An alert letter is intended to cover situations where an individual under investigation moves on or could move on before the assessment process is completed.

Action

5. HSC employers are required to implement these arrangements for the issue of alert letters with immediate effect.

Enquiries

6. Enquires about the contents of this Circular should be directed to the Pay and Employment Unit of the Human Resources Directorate, Room D1.4, Castle Buildings, Upper Newtownards Road, Belfast, BT4 3SJ, telephone 028 90522832, email; p&e@dhsspsni.gov.uk.

7. Employees should direct personal enquiries to their employer.

Further Copies

8. Copies of this Circular can be obtained from the Department's extranet site at **http://extranet.dhsspsni.gov.uk** .

Diane Taylor.

DIANE TAYLOR

Deputy Director

MAINTAINING HIGH PROFESSIONAL STANDARDS

SCHEME FOR THE ISSUE OF ALERT NOTICES
FOR HEALTH CARE PROFESSIONALS IN HEALTH & SOCIAL CARE
IN NORTHERN IRELAND

THE ISSUE OF ALERT NOTICES FOR HEALTH CARE PROFESSIONALS

Summary

1. The DHSSPS has strengthened the current arrangements for the issue and revocation of alert notices for health care professionals in Northern Ireland.

2. The system is described in the attached scheme. This requires Health and Social Care (HSC) bodies to request alerts in line with the requirements contained within this system.

SCHEME FOR THE ISSUE OF ALERTS REGARDING HEALTHCARE PROFESSIONALS IN NORTHERN IRELAND

Introduction

1. The issue of an alert is a way by which HSC bodies and professional organisations, as listed in Appendix 1, can be made aware of a registered healthcare professional whose performance or conduct gives rise to concern that patients, staff or the public may, in future, be at risk of harm either from inadequate or unsafe clinical practice or from inappropriate personal behaviour. It is also a means of ensuring that HSC organisations are made aware of healthcare professional that may pose a threat to patients, staff, or the public because their conduct seriously compromises the effective functions of a team or delivery of service.

2. The alert system is intended to cover those situations where an HSC employer considers that a member of their healthcare staff may pose a threat to patient safety if they worked in that professional capacity. The alert system is not part of either the HSC employees' disciplinary process or statutory regulatory framework. It is an integral part of the system for pre-employment checks. It is intended as a means of alerting prospective employers to check that the applicant's employment record is complete and appropriate references are obtained and that information relevant to safe employment is known in advance of an appointment being made.

3. Employers should always undertake comprehensive checks on registration, qualifications and references and carry out Enhanced Disclosure Certificates by AccessNI, Criminal Records checks and occupational health checks in accordance with normal recruitment policies.

4. This guidance requires HSC bodies to implement and manage the alert scheme in accordance with the steps described within this scheme. These requirements are mandatory for HSC bodies.

5. In developing this system, consideration has been given to human rights issues, as they affect the employer/employee relationship. In making decisions careful adherence to the procedures contained within this scheme will ensure that the rights of those who are subject to an alert are respected. Of particular importance is the need to ensure that alerts are regularly reviewed so that they can be revoked as soon as there is evidence the alert should no longer remain live. However, an alert will not be

revoked solely on the basis of an assurance from the individual unless this is binding on their permission to practice (e.g. an undertaking to the professional regulatory body or a court).

Who is covered by the alert system?

6. The alert system covers any healthcare professional currently subject to statutory regulation by one or more of the bodies listed in Appendix 1.

Triggering an alert

7. An alert may only be issued by the Chief Professional Officer, DHSSPS and only where it is considered that an individual poses a significant risk of harm to patients, staff or the public and intends or may intend to seek permanent or temporary work in the NHS/HSC in that capacity, and there is a pressing need to issue an alert notice. Other bodies may also request the issue of an alert (see paragraph 17-18).

8. Concerns may arise about the conduct and performance of a healthcare professional in a number of different ways, including concerns raised by other staff, findings arising from internal investigations, the disciplinary process, information from the regulatory bodies, complaints, police investigations, appropriate bodies outside the UK and information arising from the audit and inspection process. The issue of an alert is a serious step and should only be considered where a significant risk of harm to patients, staff or the public has been identified. It is important that investigations are brought to a conclusion, even when employees have left the HSC body, both to safeguard future patients and staff elsewhere and in the interests of the individual (who may otherwise be left with an unresolved alert).

9. An alert may be issued where the regulatory body has not yet decided to take action to make an interim suspension order or take other measures. Where the regulatory body has taken interim measures, the alert should remain live as it is intended to reduce the risk of inappropriate employment in any capacity. This will enable the HSC body to provide a full reference if requested by a prospective employer.

10. An alert should not be issued in circumstances where an individual's performance or conduct is being considered by their HSC employer.

Other staff and bogus professionals

11. In exceptional circumstances a situation may arise in which a member of staff not covered by paragraph seven may pose a threat to public safety and is likely to seek employment elsewhere (e.g. a staff member who falsely holds himself out to be a healthcare professional and is seeking work in the NHS/HSC in that capacity). In such circumstances, it would be a proportionate response to take action based upon the principles contained within this scheme to safeguard public protection.

Who in the DHSSPSNI should issue an alert?

12. Alerts must be issued on behalf of the DHSSPS by the Chief Professional Officer in the DHSSPS. The Chief Professional Officer is formally responsible for assessing whether or not an alert should be issued and remains in place, and for formally revoking an alert when appropriate. The Chief Professional Officer must ensure that appropriate professional advice is taken before an alert is issued.

13. The Chief Professional Officer must delegate responsibility for occasions when they are not available to issue an alert personally. Such occasions may arise during periods of annual leave, sickness absence or other planned absences. The Chief Professional Officer retains overall responsibility for overseeing the process for issuing and revoking alerts and should be notified of all alerts issued in his or her absence on returning to work.

The role of the employing/referring body

14. There will be circumstances when information comes to light that suggests that a particular individual, who may be a current or former employee, poses a significant risk of harm to patients, staff or the public and intends or may intend to seek permanent or temporary work in the NHS/HSC or elsewhere in that capacity.

15. Responsibility for requesting the issue of an alert must be made at Chief Executive or Executive Board member level. Employers may wish to seek their own legal advice in complex cases or those in which there is any doubt about the incidents or behaviour which gave rise to the concerns. The request must contain the name and last known address of the individual who is the subject of the notice. It must also contain a summary of the circumstances which gave rise to the request including a summary of all relevant information, an assessment of the relevant risks and any advice taken. The request must also explain what action the HSC body has already taken in respect of the individual to the relevant health regulatory body and must state the gender and ethnic origin of the individual, if known.

16. An assessment of the degree of risk should be based on the circumstances of each individual case taking into account the advice of the Director of the professional group in the HSC body. Other sources of advice include the regulatory body and other professional organisations. Where relevant professional advice is not available within the HSC body, advice may be obtained from an appropriate source in another HSC body. The National Patient Safety Agency has developed an incident decision tree that may help evaluate whether incidents, which gave rise to initial concern, raise doubts about the conduct or performance of a particular individual. In all cases, the employing/referring body should consider carefully what other measures could be taken, other than issuing an alert notice, to ensure the protection of the public. In the particular case of midwives, this should include referral to the local supervising authority.

Requests for alerts from other bodies

17. Where an education provider considers that an alert should be issued in respect of a professional in training, he or she should seek advice from the Chief Professional Officer in the DHSSPS.

18. There may be instances where another body (e.g. a non - HSC employer) considers that an alert should be issued in respect of a healthcare professional that they employ or have previously employed. In such cases they should contact the Chief Professional Officer in the DHSSPS to discuss the details of the case, so that he/she can decide whether to issue an alert. The Chief Professional Officer in the DHSSPS may issue an alert notice in any circumstance considered appropriate provided that having taken appropriate advice, he/she is satisfied that a healthcare professional (or person holding himself out to be a healthcare professional) poses a significant risk of harm to patients, staff or the public and may seek work in the NHS/HSC in that professional capacity.

The role of the DHSSPS

19. When the Chief Professional Officer in the DHSSPS has considered the request from the referring body, he/she should consult with relevant senior professional colleagues.

20. If, in light of all the information presented to the DHSSPS, the Chief Professional Officer agrees that the individual concerned may pose a significant risk of harm to patients, staff or the public and may seek work in the NHS/HSC/Private Sector in that professional capacity and there is a pressing need, he/she may issue an alert. The DHSSPS must advise the referring body

whether or not an alert will be issued, and the reasons behind the decision. The DHSSPS must issue an alert to the bodies listed in the footnote[3] and to the individual concerned.

Action following the decision to issue an alert notice

21. If the DHSSPS issues an alert, the referring body must refer the case to any relevant statutory regulatory body or professional body with disciplinary powers as a matter of urgency, if this has not been done already (see paras 36-37). There may be exceptional circumstances when immediate referral might not be appropriate, for example when investigations are ongoing to gather evidence to support a referral to the regulatory body. In such circumstances referral must be made at the earliest possible opportunity. If investigations conclude that a referral to a regulatory body is not warranted, the referring body should ask the DHSSPS to revoke the alert without delay. In the case of midwives, the NMC and the local supervising authority should be informed of the issue of the alert and notify the DHSSPS of any action it takes.

22. Once an alert is issued, the individual concerned must be notified by the DHSSPS within seven days (in writing to their last known home address and, where appropriate, their registered address). He/she should be given a summary of the DHSSPS reasons for this action. He/she may ask the DHSSPS to review its decision.

23. If, for whatever reason the DHSSPS is satisfied that h/she does not in fact represent a threat to patients, staff or the public, the alert must be formally revoked. This should be notified to the individual concerned and the referring body, by the DHSSPS as soon is as practicable.

Circulation of alerts

24. The alert will be issued in the form of a letter by the Chief Professional Officer, DHSSPS to the Chief Executives of all Health and Social Care Bodies listed in footnote 2, the Chief Professional Officers for Scotland, Wales and England and the regulatory body which regulates the profession or purported profession of the individual to whom the letter relates. The notification [see Appendix

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[3] The Health and Social Care Board, HSC Trusts, the Public Health Agency, the Business Services Organisation, the Northern Ireland Blood Transfusion Service Agency, the Northern Ireland Guardian ad Litem Agency, the Northern Ireland Practice & Education Council for Nursing, Midwifery & Health Visiting (NIPEC), the Northern Ireland Social Care Council (NISCC), the Patient & Client Council, the Northern Ireland Regulation and Quality Improvement Authority and the Northern Ireland Medical and Dental Training Agency (NIMDTA)

2 for a model] will ask them to contact a named officer at the referring body for a written reference, if the individual concerned contacts them with a view to obtaining employment.

25. The Chief Professional Officer in the DHSSPS may also send copies of the alert notice to other organisations which provide services to the HSC and which, in the opinion of the DHSSPS, may be approached by the subject of the alert notice with a view to seeking work. The Chief Professional Officer should carefully consider the degree of risk posed by the subject of the alert and the interest of the third party in obtaining the information.

26. Alerts are strictly confidential and should be marked 'alert system in confidence'. They should only be shared within an organisation on a strict 'need to know' basis, and should be stored securely. An alert should be part of the employment record of the referring body. The same procedure and circulation list should apply when an alert is revoked.

Action to take on receipt of an alert

27. If an employing body becomes aware that an employee or prospective employee or an applicant for inclusion on its list is the subject of a current alert, then they should contact the referring body, as set out in the written notification.

28. Where contact is made by telephone, care must be taken to ensure that information is provided in a fair and consistent matter. Details should be based on the factual information provided to the DHSSPS or other facts that have subsequently emerged.

29. The employing body should then review the information provided by the individual in their application forms in the light of the information provided by the referring body, and take any appropriate action to ensure that the safety of patients and the public is maintained.

Monitoring and revocation of an alert

30. The DHSSPS must keep the alert notice under review to ensure it is regularly reviewed so it can be revoked as soon as there is evidence the alert should no longer remain live. A review should take place no later than six months from the last review. However, an alert should not be revoked solely on the basis of any undertaking unless this is binding on the practitioner (e.g. an undertaking to the regulatory body or a court). If new circumstances come to light that give rise to further concerns about the individual, the process to issue another alert notice should begin again.

31. The subject of the notice may at any time seek a review of the decision to issue an alert where new evidence or information comes to light. This should include the outcome of any proceedings by the police, the civil courts, regulatory body, disciplinary proceedings as appropriate or any information arising from the source of the concern which initially gave rise to the request for an alert to be issued. This will ensure that where information comes to light, which shows that the individual concerned does not pose a threat to the patients or staff, the DHSSPS can consider revoking the alert at the earliest opportunity. However, the DHSSPS will still need to take account of all the circumstances that gave rise to the issue of an alert in the first place.

32. Each case must be considered on its merits and alerts should not remain in force any longer than is necessary to ensure the protection of patients, the public and staff. DHSSPS will therefore review decisions when any further information comes to light and carry out a review no later than six months from the last review. The review will be a proactive process during which the DHSSPS will contact the sources of the concern, which originally resulted in the issue of the alert notice, to establish whether there have been any changes in circumstances or any new information which should be taken into account in deciding whether the alert notice should remain in force. The individual concerned will be informed by the Chief Professional Officer when an alert has been revoked.

33. The Chief Professional Officer in the DHSSPS will maintain and keep up to date a secure list of all alerts that he/she has issued and, where applicable the date the alert was revoked. There is an obligation on the DHSSPS to hold up to date information in respect of the person who is the subject of the alert, as far as it is reasonably practicable to do so. The Chief Professional Officer in the DHSSPS will compile an annual statistical return for the Departmental Board and the Minister.

34. The Chief Professional Officer in the DHSSPS must keep details of the alert for five years after it has been revoked. The existence of a revoked alert would form an important piece of evidence should the same individual again be considered to pose a threat to patients or staff at a later date.

35. If having consulted the contact point named in the alert an employer wishes to appoint an individual who is currently subject to an alert (or include them on their list) the employer will need to consider what safeguards need to be put in place. The employer may also wish to notify the Chief Professional Officer which issued the notice so that he/she is aware that the practitioner is working in the NHS/HSC/or private sector. The Chief Professional Officer can then consider whether further action is required

such as reviewing the notice or notifying the regulatory body of the subject of the alerts' continued employment in the NHS/HSC/or private sector. Where the Chief Professional Officer is made aware of such a decision he/she may wish to seek their own legal advice.

Liaison with the statutory regulatory bodies

36. Where an alert is issued the case should have been referred to the appropriate regulatory body by the referring body (or in the case of midwives, the local supervising body) as a matter of urgency, unless there are exceptional circumstances. The purpose of doing this is for the regulatory body to consider whether any further action is required by it to protect patients, staff or the public.

37. If the regulatory body concludes its consideration of the case in terms that allow the individual concerned to remain in practice, either with or without conditions, the Chief Professional Officer will review the need for the alert to remain in place. It does not automatically follow that the alert will be revoked – there may be other good reasons for it to continue.

38. Prospective employers contacting a regulatory body regarding the registration status of an individual will also be informed if an individual is being considered formally under their fitness to practise procedures, in accordance with the appropriate rules governing disclosure of information to employers. This two-pronged approach strengthens protection for patients, staff and the public.

Appendix 1

List of Regulatory Bodies:

The Nursing and Midwifery Council

The Health Professions Council

Appendix 2

Standard contents for an alert notice

1. Always mark the covering letter **"ALERT NOTICE: MANAGEMENT IN CONFIDENCE**"

2. The notice must :

- be addressed to the Chief Executive of the body
- contain the subject's full name, their national insurance number and/or date of birth if known and the name of the body where they work or where they formerly worked (normally the body which triggered the alert system)
- include the registration number of the individual, if registered by one of the statutory regulatory bodies
- explain in what capacity the subject formerly worked and in what specialty and in what other capacity they can work
- state clearly the name, position, address and telephone number of the person to be contacted should the subject submit an application for employment

No further information about the individual or the case may be included in the alert notice.

Annex B

THE HEALTH AND SOCIAL CARE (REFORM) ACT (NORTHERN IRELAND) 2009

THE HEALTH AND SOCIAL CARE (GENERAL PROVISIONS) (NO 2) DIRECTION (NORTHERN IRELAND) 2010

The Department of Health, Social Services and Public Safety[1] in exercise of the powers conferred on it by section 3 of the Health and Social Care (Reform) Act (Northern Ireland) 2009[2], and of all other powers enabling it in that behalf, hereby directs as follows:-

The provisions for the issue of alert letters as set out in the schedule shall be adopted with immediate effect by all HSC bodies identified in Section 1 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

Diane Taylor

Senior Officer [3]of the Department of
Health, Social Services and Public Safety

19th **April 2010**

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[1] *See* Art. 3(6) of S.I. 1999/283 (N.I. 1)

[2] 2009 c.1 (N.I.)

[3] *See* Art. 4(3)(b) of S.I. 1999/283 (N.I. 1)

Annex C

Department of
Health
www.health-ni.gov.uk

Raising a concern about an Allied Health Professional's (AHPs) fitness to practice

All AHPs must be registered with the Health and Care Professions Council (HCPC) to work within the HSC in Northern Ireland. HCPC procedures and processes have been developed in full consultation with the public, health and social care professionals and other key stakeholders.

AHPs must be registered with the HCPC in order to take up a post within any HSC organisation. All organisations will check this prior to appointment.

As the regulator, HCPC is set up to protect the public. To do this, HCPC keep a Register of properly qualified health and care professionals who meet the standards for their training, professional skills, behaviour and health.

In Northern Ireland the following professions are identified as AHPs and all are regulated by HCPC:

- art, drama and music therapists;

- podiatrists,
- dietitians;
- occupational therapists;
- orthoptists;
- physiotherapists;
- prosthetists/orthotists;
- radiographers; and
- speech and language therapists.

All of these professions have at least one professional title that is protected by law. This means, for example, that anyone using the titles ‘physiotherapist’ or ‘dietitian’ must be registered with HCPC.

The HSPC operates by approving and upholding high standards of education and training, and continuing good practice, working in partnership with the professional bodies.

In the context of when there is a concern about an individual’s fitness to practice this is coordinated entirely by the HCPC to investigate complaints and to take appropriate action.

Alert lists

HCPC does not notify the DoH on individual cases, the department receives monthly alerts lists which give details of all hearings that have taken place in the last month. Their purpose is to alert employers of staff they have in their employment who have undergone fitness to practice proceedings. The DoH AHP Lead Officer circulates this alert list monthly to all relevant stakeholders.

Previous alert lists must be withdrawn from circulation two months from the date of issue. For an up to date list of all upcoming hearings and the outcomes of previous hearings please visit http://www.hcpc.org/complants/hearings/.

Anyone can contact the HCPC and raise a concern about a registrant. This includes members of the public, employers, the police and other professionals.

HCPC will not normally take further action if information is provided anonymously (where the person providing the information does not give their name). This is because HCPC want to operate a fair and transparent process and cannot go back and ask for more information if they do not know who has contacted them.

However, as the main function is to protect the public, this means that if information given anonymously relates to serious and credible concerns about a registrant's fitness to practice, HCPC may disregard this and consider taking further action. HCPC can also investigate concerns relating to events which occurred at any time; however, will not normally proceed with concerns that are raised more than five years after the events giving rise to them. This is because it is better if HCPC are informed about concerns as close to the events as possible. This will ensure they can get the best possible evidence and can contact people who are able to remember events easily.

If a concern is raised about a registrant, HCPC will treat the individual fairly and explain what will happen at each stage of the process. HCPC will give details of a **case manager** who will then support the individual if they have any questions and who will keep them up to date with the progress of their investigation.

The allocated case manager may change during the course of the investigation. If this happens, the individual will be advised and will always have a named contact. The case manager is impartial and does not take the side of either the professional or the persion making HCPC aware of concerns. Their role is to manage the case throughout the process and to gather relevant information.

They act as a contact for everyone involved in the case. They cannot give you legal advice; however, they can explain how the process works and what is considered when making decisions.

Types of concerns

The types of cases HCPC can consider are those that call into question whether a registrant's fitness to practice is 'impaired' (negatively affected) by:

- misconduct (behaviour which falls short of what can be reasonably expected of a registrant);
- a lack of competence (lack of knowledge, skill or judgement, usually repeated and over a period of time) which means a registrant is unfit to practice;
- a caution or conviction for an offence in the UK (or somewhere else for an offence that would be a crime if it was committed in the UK);

- the registrant's physical or mental health (long-term, untreated or unacknowledged physical or mental health condition);

- a decision made by another regulator responsible for health and social care; or

- being included on a barred list, which prevents them working with vulnerable adults or children.

HCPC can also consider allegations about whether an entry to the Register has been made fraudulently or incorrectly. For example, the person may have given false information when they applied to be registered.

Article 22(6) of the Health and Social Work Professions Order 2001 states that if an allegation is not made in the normal way, HCPC can take the matter forward if it appears that a fitness to practice allegation should be made. This means that even if someone who has referred a matter to HCPC wants to withdraw from the process, HCPC may still take the matter forward.

The time a case takes to reach the end of the process can vary depending on the nature of the investigation HCPC may need to carry out, and how complicated the issues are. As a result of this, each stage of the process may take either a shorter or longer period of time.

When HCPC are investigating a case, they will need to inform the registrant(s) involved. Information is likely to include the name of the person who raised the concern. HCPC will make sure that their contact details and other personal sensitive information are removed from the documents they issue.

Protected titles

It is a criminal offence for someone to claim that they are registered with HCPC when they are not, or to use a protected title that they are not entitled to use.

The HCPC will prosecute people who commit these crimes. If a registrant does not meet the **standards**, they can take action, which might include stopping them from practising.

Meeting HCPC standards

In order to remain registered, a therapist must continue to meet the standards that are set for their profession. These standards are how registrants' 'fitness to practice' is determined.

It is important that to meet the standards each therapist is able to practice safely and effectively. HCPC also want to ensure that each individual maintains high standards of personal conduct and do not do anything, which might affect the public's confidence in an individual or their profession.

HAZEL WINNING
AHP Lead Officer
5 July 2016

MAHI - STM - 118 - 1608

MMcG-237

Annex D

Internal Audit Recommendations

1. The policy relating to the issue of alert notices is ambiguous and contradictory and has not been reviewed since 2010
    a. **To be addressed at policy review meeting.**

2. Inadequate internal procedures which provide little guidance and omit Healthcare Professional Alert Notices (HPANs).
    a. **Addressed. We are continuously improving our internal procedures. We are currently creating detailed written instructions that explain how an alert request should be dealt with from start to finish.**

3. Decision tree design requires amendment to clarify rationale for decisions made.
    a. **Unaddressed. There is no record of a more recent decision tree template on TRIM since the alert audit took place.**

4. Gap in National Clinical Assessment Service (NCAS) process as the Department are currently not receiving HPANs from Scotland or Wales.
    a. **Unaddressed. The department occasionally received HPANs from England, however, there have still been none received from Scotland or Wales. According to our Alerts spreadsheet, there has been no alerts received from Scotland or Wales in 2.5 years. Guidance required on whether this should be amended and included within policy.**

5. CNO Alert spreadsheet is not user friendly and is not being updated on a timely basis
    a. **Addressed. The spreadsheet has since been amended and works as a valuable tool for the recording, monitoring and review of cases. It ensures that reviews are carried out on a timely basis.**

6. Inadequate process for reviewing bf cases and for tracking / monitoring Nursing Midwifery Council (NMC) / employer requests leading to delays in carrying out six month reviews;
    a. **Addressed. Appropriate columns have been added to the alerts spreadsheet that allow for better monitoring. This ensures 6 monthly reviews are carried out within the correct timeframe.**

7. Non-compliance with Departmental information management requirements and retention of records (hardcopy files / disposal).
    a. **Unaddressed. The audit states that our current maintenance of physical records is "not in line with information management guidance as hardcopy files should only be maintained when there is a need to retain documents for original signatures etc. and if this is necessary the file should be registered with Information Management Unit (IMU)." Guidance required advising on process and timescales.**

Annex E

[redacted]

[redacted] [redacted]

[redacted]

[redacted]

[redacted]

c. [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

3. [redacted]

Caroline Lee [Mrs] **Deputy Chief Nursing Officer**

Annex F

Circular HSS (TC8) 6-98 Medical & Dental Alerts

Circular HSS(TC8)
6-98.pdf

Annex D

Update against Previous Recommendations

Recommendation ***(including Report Reference Number and Priority)***	**Management Responses per Final Report**	**Imp. Date**	**Internal Audit Finding as per Follow-up Review**	**Evaluation**	**Further Management Response and Revised Implementation Date**
1. Report Ref. 3.1.1 – Priority 2 Management should liaise with Workforce Policy Directorate (WPD) to progress the review of the HSC JNF (1) 2010 as soon as possible.	Accepted Management in CNO Group and WPD will prioritise the outstanding review of the content and implementation of the Alert policy and underpinning Circular.	31/12/18	**Partially Implemented** The revised policy (HSC JNF (1)) and preferred option requires ministerial approval. We can confirm that the policy has been reviewed by WPD and this review is due to be submitted to the new Minister by the end of March 2020. We confirmed that meetings with stakeholders including the NI Human Rights Commission have taken place, and scoping of potential options for	🟡	Please insert Management Response and amended implementation date here

			consultation, based on an analysis of models across the UK, has been completed.		
2. Report Ref. 3.1.1 – Priority 3 Management should consider introducing a standard template to aid referring bodies in supplying all necessary information.	Accepted Management will incorporate this consideration into the review.	31/12/18	**Fully Implemented** We confirmed that an updated template was issued to all Health and Social Care Trusts in July 2018. The template has been implemented and is now used by all organisations making a referral to the Department, with all templates individually password protected.	🟢	N/A
3. Report Ref. 3.1.2 – Priority 3 Management should review and expand on the in-house CNO Alert Procedures to ensure that it provides guidance on all aspects of the CNO Alert Process and provide adequate guidance on the decision making process.	Accepted Management will review the in-house CNO Alert Procedures to include the decision making process.	31/12/18	**Partially Implemented** We confirmed that written instructions have been created outlining all administrative processes required for the Directorate to effectively respond to Alert Requests.	🟡	Please insert Management Response and amended implementation date here

			This document includes instructions regarding the HPAN process, however there is no information included regarding the decision making process as this is dependent on the ministers decision on the policy review (3.1.1 refers).		
4. Report Ref. 3.1.3 – Priority 3 Management should ensure that all CNO alert requests are reviewed by the CNO on receipt to determine if a priority panel meeting is required.	Accepted Management will ensure that all CNO decisions relating to the receipt of CNO alert requests are available.	31/12/18	**Fully Implemented** We confirmed for a sample selected- On receipt of CNO Alert requests / updates from employer, these are emailed to CNO to consider if a priority meeting is required. CNO then informs if these are to be scheduled onto the monthly meetings or if an urgent ad hoc meeting is to be set up.	🟢	N/A
5. Report Ref. 3.1.4 – Priority 2	Accepted	31/12/18	**Fully Implemented**	🟢	N/A

Management should ensure that the CNO Alert Status spreadsheet is complete / accurate and updated on a timely basis.	Management will review the CNO alert status spreadsheet and ensure it is updated on a timely basis.		We confirmed that an updated spreadsheet has been implemented and is fully operational. The spreadsheet used is a vital resource in preparing for monthly meetings.		
6. Report Ref. 3.1.5 – Priority 2 Management should establish a process to clearly identify when six month reviews are due so that sufficient time is allowed for NMC / employer updates to be requested and returned for consideration at the alert panel meetings.	Accepted Management will establish a process to identify when 6 monthly reviews are due.	31/12/18	**Fully Implemented** We confirmed that the alert spreadsheet has been amended to include a '6 month review date column', which was found to be accurately updated on a timely basis.	🟢	N/A
7. Report Ref. 3.1.5 – Priority 2 Management should ensure that alert notices are reviewed every six months as stated within the alert policy.	Accepted Management will ensure CNO alerts notices are reviewed every 6 months.	31/12/18	**Fully Implemented** We confirmed that a full review of ALL live cases took place from Sept – Dec 2019 so these are now all up to date with new 'bf' dates set for going forward.	🟢	N/A

8. Report Ref. 3.1.5 – Priority 2 Management should establish a process for escalating and resolving issues relating to failure by employers to supply update requests or providing late/poor quality responses.	Accepted Management will establish a process to address employer's failure to supply adequate, timely information.	31/12/18	**Fully Implemented** We confirmed that the new written administrative instructions now include the need for update requests to be sent to employers one month in advance as part of the review process. If no response is received after two weeks, a duplicate request is issued and there are escalation procedures if not received (or of poor quality) by the given date which is done through the Nursing Officer. We also noted that letters / information are all password protected for confidentiality purposes.	🟢	N/A
9. Report Ref. 3.1.6 – Priority 2 Management should liaise with IMU to ensure that arrangements for the retention and disposal of personal data are in line with data protection regulations. Following this review personal data should be retained /	Accepted Management in CNO Group and Workforce Policy Directorate with IMU will review the arrangements in line with	31/12/18	**Partially Implemented** Management have liaised with and received IMU guidance on the retention and disposal of data for both digital and hard copy information – hardcopies to be destroyed when case	🟡	Please insert Management Response and amended implementation date here

disposed of in line with agreed arrangements.	Data Protection Regulations		'stood down' and digital after one year. At time of this review there were still hard copies being retained that were no longer required. Management have informed us that these arecurrently in the process of being removed / destroyed and a 'stood down' documents will be destroyed by May 2020. The implementation of the digital retention requirements may be impacted upon by the minister's decision on the policy review, (see 3.1.1 (1) above, which will dictate the period.		
10. Report Ref. 3.1.6 – Priority 3 Management should carry out a review of the information required within CNO Alert requests to ensure that sufficient information is supplied to allow full consideration of the areas included within the CNO Alert decision tree as well as ensuring that only essential personal information is requested.	Accepted Management will carry out a review of the essential information required.	31/12/18	**Fully Implemented** We confirmed that the decision tree template used by the Alerts Panel now includes a text box for the panel chair to record reasoning for the decision. A new template has been implemented that only requests essential information from	🟢	N/A

			Trusts regarding Nurses referred.		
11. Report Ref. 3.1.7 – Priority 2 Management should liaise with the CNOs or equivalent in Scotland and Wales to determine if the regional legislation / policy allows for professional alerts to be copied to the CNO.	Accepted Management and Workforce Policy Directorate will liaise with CNO office in Scotland and Wales to establish the process.	31/12/18	**Partially Implemented** As per report ref: 3.1.1 above, the outcome of the policy review is to be submitted to the Minister for approval. Management have liaised with the CNOs in Scotland and Wales and they are considering stopping their CMO Alerts process. Depending on what option the Minister proceeds with may have an impact on this recommendation.	🟡	Please insert Management Response and amended implementation date here

12. Report Ref. 3.1.7 – Priority 3 Management should liaise with CMO / Professional Officers to make them aware of this issue so they can determine if NCAS alerts are restricted to specific countries also.	Accepted Workforce Policy Directorate will liaise with CMO.	31/12/18	**Not Implemented** Management are awaiting the minister's decision on the policy review to ascertain if this recommendation needs to be taken forward. May be no longer applicable.	🔴	Please insert Management Response and amended implementation date here
13. Report Ref. 3.2.2 – Priority 3 Management should ensure that the relationship between CNO Alerts and early alerts are clearly documented within guidance / policy as well as outlining the actions available to the CNO.	Accepted Management will ensure that the relationship between CNO Alerts and early alerts are clearly documented within guidance/policy as well as outlining the actions available to the CNO.	31/12/18	**Not Implemented** Management are awaiting the minister's decision on the policy review to ascertain if this recommendation needs to be taken forward. May be no longer applicable.	🔴	Please insert Management Response and amended implementation date here
14. Report Ref. 3.1.9 – Priority 3	Accepted	31/12/18	**Fully Implemented**	🟢	N/A

Management should review and amend the decision tree as necessary to ensure that it clearly reflects HSC JNF (1) 2010. In addition it should clearly record the areas considered and rationale for the decision taken.	Management will review and amend, in line with policy review.		We confirmed that the decision tree template used by the Alerts Panel now includes a text box for the panel chair to record reasoning for the decision. This will be kept under review and if there are any further changes required as a result of the ministers decision on the policy review these will be made.		
15. Report Ref. 3.1.10 – Priority 2 When reviewing the HSC JNF (1) 2010 (ref 3.1.1 above) management should consider establishing a reciprocal arrangement with ROI counterparts to ensure that Alerts are received from ROI. This is of particular importance given the ease of commuting between the two regions.	Accepted [redacted]	31/12/18	**Not Implemented** Management are awaiting the minister's decision on the policy review to ascertain if this recommendation needs to be taken forward. May be no longer applicable.	🔴	Please insert Management Response and amended implementation date here

🔴 Not Implemented

🟡 Partially Implemented (aspects not addressed)

MAHI - STM - 118 - 1624

MMcG-237

🟢 Implemented

FROM: **Tim Johnston**
NMAHP

DATE: **17 November 2022**

TO: **Philip Rodgers**
Director of Workforce Policy

REVOCATION OF THE PROFESSIONAL ALERTS POLICY - DIRECTION

BACKGROUND

1. You will recall that before his departure from office Minister Swann agreed to revoke the CNO Alerts policy with reliance in all future cases being placed with the regulators, namely the Nursing and Midwifery Council and the Health and Care Professions Council, as part of their existing arrangements to manage issues of concern for members of HSC nursing, midwifery and allied health professions staff.

ACTIONS TO DATE

2. At the most recent Alerts meeting, you and CNO Maria McIlgorm agreed the wording of letters to be issued to:

    a. the Sector (to inform of the policy revocation);
    b. those currently subject to an Alert; and
    c. employers of those with an Alert in issue.

3. [redacted]

RECOMMENDATION & NEXT STEPS

4. Prior to issuing the letters, however, we have been advised that since the Alerts Policy was underwritten by a Direction (The Health and Social Care (General Provisions) (No. 2) Direction (Northern Ireland) 2010), cancelling the policy would require the making of a new Direction to cancel the existing one. I have prepared the required direction (see **Annex A**), [redacted] [redacted] I have also confirmed that this approach is in order, despite the lack of a Minister in post, with Seán Garland, the Department's Legislation Liaison Officer.

5. If you are content, could you please sign (make) this Direction as a matter of urgency? Once we have confirmation that the Direction has been made, we will issue all the requisite letters and bring the policy to its formal conclusion.

6. Thank you

Tim Johnston
NMAHP

cc.
Maria McIlgorm (CNO)
Lynn Woolsey (DCNO)
Mary Frances McManus (DCNO)
Seán Garland
Jane Kinney (DSO)
Stephen Galway
Melanie McClurg
Calum Grant
Alex Larmour
Claire Williams
Patricia O'Neill
Press Office

Annex A

D I R E C T I O N S

2022 No. 6

THE HEALTH AND SOCIAL CARE (REFORM) ACT (NORTHERN IRELAND) 2009

The Health and Social Care (General Provisions) (No. 2) Direction 2010 (Revocation) Direction (Northern Ireland) 2022

The Department of Health in exercise of the powers conferred on it by Article 4 of the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 ([1]), paragraph 6(2) of Schedule 3 to the Health and Personal Social Services (Northern Ireland) Order 1991 ([2]), Article 6(2) of the Health and Personal Social Service (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 ([3]) and section 6 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 ([4]), directs as follows:

1. The Health and Social Care (General Provisions) (No. 2) Direction (Northern Ireland) 2010 is revoked.

Sealed with the Official Seal of the Department of Health on 18th November 2022

Philip Rodgers
A senior officer of the Department of Health

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[1] [1990 No.247 (N.I.3)]
[2] [1991 No. 194 (N.I.1)]
[3] [2003 No. 431]
[4] [2009 c. 1]

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Regional Policy on the use of Restrictive Practices in Health and Social Care Settings

And regional operational procedure for the use of Seclusion

Northern Ireland

Consultation Report

March 2023

INTRODUCTION

1. This paper summarises the findings from the public consultation, which closed in October 2021, on Regional Policy on the use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the use of Seclusion, Northern Ireland.

2. The final Policy, incorporating feedback received where appropriate, has been published alongside this consultation report.

BACKGROUND

3. In August 2005, the Human Rights Working Group on Restraint and Seclusion issued *Guidance on Restraint and Seclusion in Health and Personal Social Services*. The working group was commissioned by the then Department of Health, Social Services and Public Safety (DHSSPS) and the guidance was issued by the DHSSPS.

4. In the period since this guidance was issued, the issue of restrictive practices, including restraint and seclusion in health and social care services, has continued to be under discussion. In that context and as part of the Mental Health Action Plan published on 19 May 2020, the Department of Health (DoH) committed to review restraint and seclusion and to develop a regional policy on restrictive practices and seclusion and a regional operating procedure for seclusion (Mental Health Action Plan, Action 6.5). The draft regional policy was the conclusion of this work.

5. The review commenced in February 2020. Due to impacts of COVID-19 and its restrictions, the project was paused from April 2020. The project recommenced in September 2020 and formally reported its findings in March 2021. The review team worked extensively with relevant stakeholders when developing the guidance and the input received was broadly positive throughout this development process.

PURPOSE OF THE POLICY

6. The regional Policy on the Use of Restrictive Practices in Health and Social Care Settings provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion across all areas where health and social care is delivered in Northern Ireland. The emphasis is on elimination of the use of restrictive practices and on minimising their use.

7. The Policy draws upon the views of people who use health and social care services, those who have experience of restrictive practices, restraint and seclusion, and best practice from other jurisdictions in the UK and across the world. It aims to ensure that when restrictive practices are used, they are managed in a proportionate and well-governed system. This Policy will play a key role in protecting people, by reducing the risk of misuse and the potential over-reliance on restrictive practices.

8. The use of restrictive interventions, restraint or seclusion may be necessary on occasions, for example, as one element of managing a high-risk situation. Best practice highlights that restrictive interventions, restraint and seclusion should only be used as a last resort when all other interventions have been exhausted and there is a presenting risk to the person or to others. Nevertheless, some of those who have been involved with or subject to seclusion, restraint and/or restrictive interventions, recall traumatic experiences which can hinder recovery and relationship building. Reports from across the UK and Ireland have highlighted the need for change regarding the use of restrictive interventions, restraint and seclusion.

9. The Policy document sets out the standards required for: minimising the use of restrictive interventions, restraint and seclusion; and decision making, reporting and governance arrangements for the use of any restrictive practice.

10. The draft Policy was developed using co-production principles and has included involvement from service users, carers, people with lived experience, professionals, academics, providers of services and policy officials.

11. It is anticipated that the new Policy, once agreed, can be delivered within existing funding, as the policy represents current best practice and compatibility with statutory requirements. Consideration of any additional training requirements to implement the revised policy may be required.

12. Across the statutory sector, implementation of the policy will be led by the DoH Strategic Planning and Performance Group (SPPG) and HSC Trusts. In the independent and Community and Voluntary (C&V) sectors, it will be for each organisation to consider what, if any, implementation work will be required.

PUBLIC CONSULTATION

13. The draft regional Policy on the Use of Restrictive Practices in Health and Social Care Settings was published for a 12-week period of public consultation from 7 July 2021 to 1 October 2021, following an intensive period of co-production. Four impact assessment screening documents were also included as part of the consultation document:
    - Equality and Human Rights;
    - Regulatory;
    - Rural; and
    - Children's Rights.

14. Additional supporting documentation was provided in the form of:
    - A consultation document providing supporting background information.
    - An Easy Read version of the draft Policy.

15. All documentation was published on the DoH website and the draft Policy was available in alternative formats on request. All of the views, comments and suggestions made during the consultation period have been considered by the Department and have played a role in informing the final version of the revised Policy.

CONSULTATION RESPONSES

16. In total, there were 25 responses to the consultation. Of these, 20 were from professional organisations and 5 were from private individuals.

17. In Section 2 of the consultation questionnaire, respondents were asked if they agreed with the draft Regional Policy. Respondents were also asked if they agreed with the Equality Impact Assessment and associated Screenings.

18. There was broad agreement with the overall direction of travel, with 96% of respondents indicating that they agreed with the content of the draft Regional Policy.

19. As part of this feedback, it was particularly noted that:

    - Respondents demonstrated enthusiasm for the overarching vision and approach.

    - The principle of a rights-based approach, and of the involvement of the individual in decision-making regarding their care, were widely endorsed.

    - The Standards, Key principles and Key actions were welcomed.

    - The co–design and co–production undertaken to inform the draft Policy were welcomed, particularly service user representation.

    - There was strong advocacy that a wide range of stakeholders should be involved in the policy going forward, and in monitoring its implementation and evaluating its impact. This includes children and young people, parents and carers, representatives from equality and human rights organisations, and professional organisations such as for example, the Regulation and Quality Improvement Authority (RQIA).

20. Other key comments or emerging themes included:

- That the guidance appears to be focussed more on adult services, rather than children's services, and a suggestion that separate guidance in relation to children should be included.

- There was support for the embedded person-centred rights-based approach.

- There was an acknowledgement that those with communication difficulties experience challenges in being heard, with an emphasis on the value and importance of inclusive communication strategies and practices.

- It was noted and emphasised that a multidisciplinary approach is essential at all stages.

- There were a number of comments on training, with calls for it to be: regionally defined; provided for staff at all grades, particularly those who work in specialist roles and/or facilities; and that it should be based on low arousal techniques and be trauma informed.

- There were strong comments made in relation to regionally adopting all standards across statutory and non-statutory organisations.

21. Other more general points included:
    - There were several suggestions on wording changes to support clarity.

    - There was a request to provide more clarity on any use of mechanical restraint, and that the term 'secure setting' be defined.

    - A number of responses mentioned the use of CCTV and suggested clarifying and refining the commentary on the use of this.

- There were also several responses suggesting that there should be recognition of the potential mental health impact on staff who are involved in restraint and seclusion.

DEPARTMENTAL RESPONSE AND NEXT STEPS

22. The completion of the final Policy has only been possible thanks to the significant contribution from many individuals and organisations who provided their expert advice throughout the co-production process. The Department is very thankful for the high levels of engagement and support received across sectors.

23. The Department welcomes the broadly positive response to the draft Policy, and a large proportion of the suggestions and comments made during the consultation have been incorporated in the final Policy document. The positive response, and all the constructive feedback, is a direct result of the ongoing engagement and co-production prior to the consultation.

24. As specified during the public consultation, responses from professional organisations will be published in full and these can be accessed via the Department's website at: [DN: link to be inserted once available]

ANNEX A

List of Organisations who responded

1. Association for Real Change (NI) (ARC)
2. British Association of Social Workers (BASW)
3. Belfast Health & Social Care Trust (BHSCT) Therapeutic Support Service
4. British Medical Association (BMA)
5. Education Authority NI
6. Equality Commission NI
7. Information Commissioners Office (ICO)
8. Northern Health and Social Care Trust (NHSCT)
9. NI Commissioner for Children and Young People (NICCY)
10. NI Human Rights Commission (NIHRC)
11. Praxis Care
12. Police Service Northern Ireland (PSNI)
13. Queen's University Belfast (QUB) – Mental Health Teaching Team, School of Nursing and Midwifery
14. Royal College of Nursing (RCN)
15. Royal College of Psychiatrists (RCPsych)
16. Royal College of Speech and Language Therapists (RCSLT)
17. The Regulation and Quality Improvement Authority (RQIA)
18. Southern Health and Social Care Trust (SHSCT) – Children and Young People Services
19. Southern Health and Social Care Trust (SHSCT)
20. Telling It Like It Is (TILII)

MMcG-240

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Regional Policy on the use of Restrictive Practices in Health and Social Care Settings

And regional operational procedure for the use of Seclusion

Northern Ireland

March 2023

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1. Introduction

Purpose of this Guidance

1.1. Restrictive Practice is an umbrella term that refers to the entire range of interventions that are considered restrictive and which infringe a person's rights.

1.2. This policy provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion across all areas where health and social care is delivered in Northern Ireland, with the emphasis on, ideally, elimination of their use, but certainly a minimisation of their use. It is applicable across the lifespan - children, young people[i], adults and older people, to all health and social care staff and within all health and social care services.

1.3. The policy draws upon the views of people who use health and social care services, those who have experience of restrictive practices, restraint and seclusion, and best practice from other jurisdictions. It aims to ensure that when restrictive practices are used, they are managed in a proportionate and well-governed system. This will assist in protecting people, reducing the risk of misuse and potential over-reliance on restrictive practices.

1.4. The use of restrictive interventions, restraint or seclusion may be necessary on occasion, as one element of managing a high-risk situation. Best practice highlights that restrictive interventions, restraint and seclusion should only be used as last resort when all other interventions have been exhausted and there is a presenting risk to the person or to others.[ii] [iii] [iv] Nevertheless, some of those who have been involved with or subject to seclusion, restraint or restrictive interventions recall traumatic experiences which can hinder recovery and relationship building. Reports from across the UK and Ireland have highlighted the need for change regarding the use of restrictive interventions, restraint and seclusion.[v] [vi] [vii] [viii] [ix]

1.5. The use of restraint and seclusion across health and social care settings and services in Northern Ireland is difficult to quantify, with challenges in capturing and articulating data on a regional basis. Whilst many organisations will have their own governance systems relating to monitoring the use of seclusion, there will be clear benefits to an agreed regional approach to this.

What will this Policy do?

1.6. This regional policy sets out the expectations for minimising use of restrictive interventions, restraint and seclusion. It also provides requirements for decision making, reporting and governance arrangements for the use of any restrictive practice. The policy provides this through seven standards.

1.7. The standards are underpinned by the principle of early intervention measures to minimise and eliminate their occurrence and promote the principle of least restriction possible. The standards set out in this policy must be applied to the management of behaviours of concern and distressed reactions, even if they are unforeseen, or in contexts where they cannot be anticipated and/or responses pre-planned.

1.8. This policy sets accountability for the minimisation strategy at the top level of each organisation, emanating from the drive for a rights-based approach to practice, culture, and policy from the centre of organisational decision-making. Organisations must establish a baseline of the use of all restrictive interventions to enable organisational minimisation strategies.

1.9. This policy requires the development of a standardised, regional approach to recognition, implementation, recording, monitoring, learning and quality improvement. This will improve the understanding of what constitutes restraint, seclusion and interventions that fall under the umbrella term of restrictive practices and will drive minimisation strategies, embedded in a rights-based approach.

Who is this Policy for?

1.10. This policy is intended for use by people who work in health and social care across all health and social care services in both statutory (which refers to all six Health and Social Care Trusts) and non-statutory sectors (which refers to all other services providing health and social care). Health and social care staff working in non-health settings, and the employing organisation, should also consider the requirements of this policy document in conjunction with other legislation, policy and procedure relevant to the particular work setting, using it to inform their decision-making and practices.

Status of this Policy

1.11. This policy is issued by the Department of Health with the clear expectation that all Health and Social Care organisations understand their individual and collective roles and that they implement the guidance in full.

1.12. This policy is issued with strong recommendation for implementation in full by non-statutory health and social care providers.

1.13. HSC organisations commissioning services from non-statutory health and social care providers will include compliance with this policy within contracting arrangements.

1.14. Anyone working in a health and social care setting must follow all relevant legislation. There are a number of legal requirements relating to restrictive practices. At all times people working in the health and social care system must be mindful of the requirements under human rights obligations and must always act with the best interests of the patient/person in mind.

1.15. In Northern Ireland care homes are by law required to only use restraint when it is in the welfare of the patient. Each instance of restraint must be recorded in respect of each resident[x] [xi]. This policy does not remove or change this requirement.

1.16. When commenced in full, the Mental Capacity Act (Northern Ireland) 2016 will provide requirements relating to restraint when a person over 16 lacks capacity to consent to the action[xii]. This policy is compatible with that Act.

1.17. If restraint becomes a deprivation of liberty, a legal authority must be in place for the deprivation of liberty to be lawful. This can be the Mental Health (Northern Ireland) Order 1986[xiii], the Mental Capacity Act (Northern Ireland) 2016, an Order from a Court or another statute. Only in emergency situations can the common law defence of necessity be relied upon.

1.18. Seclusion is always a deprivation of liberty and must therefore have a legal authority prior to being carried out. Secluding a person without a legal authority is unlawful.

2. The Standards

1. **All organisations must use the standard definitions to identify all interventions which are potentially restrictive.**

2. **All local policies and practices must embed use of the *Three Steps to Positive Practice Framework* when considering and reviewing the use of restrictive interventions.**

3. **Effective and person-centred communication must be central to care and treatment planning.**

4. **Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans.**

5. **Organisational strategies and related policies for minimising the use of restrictive interventions must follow a shared and consistent content.**

6. **Roles and responsibilities are defined in terms of monitoring, reporting and governance.**

7. **Any use of seclusion as a last resort intervention must follow the regional operating procedures.**

3. Key Principles

3.1. Restrictive Practice is an umbrella term that refers to the entire range of interventions that are considered restrictive and which infringe a person's rights.

3.2. Evidence of therapeutic benefits for use of restraint and seclusion is limited.

3.3. Organisations must have robust monitoring arrangements in place that provide assurances that restrictive practices are used only as a last resort, and that any restrictive practice used provides a therapeutic benefit to the person.

3.4. Minimisation strategies, culture change and practice improvement will only be successful with robust monitoring, oversight and assurance, led by identified individuals in each organisation.

Rights Based Approach

3.5. The value of each and every person receiving services is recognised through service delivery founded on a rights-based approach which empowers and involves the individual in decision making.

3.6. The lived experience is a critical contribution for all aspects of minimisation strategies.

3.7. Rights based approaches, evidenced based interventions, robust monitoring and governance, and a drive to "always do better" for people receiving services and staff delivering care, treatment and support will be the foundations of any and all policy and practice. The routine use of *Three Steps to Positive Practice*[xiv] will contribute to ensuring that any use of any restrictive practice, restraint or seclusion has been considered as the least restrictive, most therapeutic intervention available to meet a person's needs.

3.8. The routine use of *Three Steps to Positive Practice* will drive any culture change necessary to realise the organisation's minimisation strategy at both practice and strategic levels.

3.9. Transparency is key in building relationships, authentic communication, developing person-centred, rights based and evidence-based care. Transparency must therefore be part of treatment and support plans, reviewing and debriefing incidents, and improving service delivery.

4. Key Actions

Leadership and Accountability throughout Health and Social Care Statutory and Non-Statutory Organisations

Action 1. Health and Social Care organisations, where restrictive interventions are used, must develop minimisation strategies centred on rights based and evidence based positive and preventative approaches.

Action 2. HSC organisations must embed the use of the *Three Steps to Positive Practice Framework* ensuring that any restrictive practice has been considered through a “least restrictive” lens.

Action 3. Non-statutory health and social care organisations, where restrictive interventions are used, should develop minimisation strategies centred on rights based and evidence based positive and preventative approaches.

Action 4. Non-statutory organisations should embed the use of the *Three Steps to Positive Practice Framework* ensuring that any restrictive practice has been considered through a “least restrictive” lens.

Action 5. Identified senior staff are responsible and accountable for leading the restrictive practice minimisation strategy for their own organisation, as well as contributing to a regional vision of eliminating unnecessary restrictive interventions, restraint and seclusion.

Action 6. Leadership will be modelled in practice by organisations adopting/developing “Positive Practice” champions/teams.

Monitoring, Oversight and Assurance

Action 7. Each individual organisation is responsible for ensuring the requirements of this policy are implemented, providing evidence of monitoring, oversight and action to address deviation from the policy.

Action 8. Identified individuals in each organisation will lead the minimisation strategy, driving culture change and practice improvement underpinned by robust monitoring, oversight and assurance.

Action 9. The DoH Strategic Performance and Planning Group (SPPG) will be tasked with overall monitoring of organisations’ implementation of restrictive practice minimisation strategies and plans and providing assurances. SPPG will work with all organisations involved to set the systems and structures in place to facilitate this.

Action 10. This will include establishing systems and processes for standardising terminology across the region to allow data collection, mandatory reporting etc., leading to a baseline position to inform minimisation strategies. This will also involve developing regional quality improvement programmes, aiming to support organisations and staff in safely and effectively implementing the minimisation strategy.

Action 11. The Public Health Agency (PHA) through its safety and quality functions, will support analysis of incident reporting for the purposes of learning and service improvement and develop regional quality improvement initiatives informed by that data analysis and learning.

Action 12. The Regulation and Quality Improvement Authority (RQIA) will have a monitoring and assurance role consistent with their role and function set out in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, Mental Health (Northern Ireland) Order 1986, Mental Capacity Act (Northern Ireland) 2016, service specific regulations and inspection key themes. This will include reviewing the implementation of rights-based approaches for individuals and achievement of organisational restrictive practice minimisation measures.

5. Standard 1 – All organisations must use the standard definitions to identify all interventions which are potentially restrictive.

Restrictive Practices

Restrictive practices are those that limit a person's movement, day to day activity or function.

Restrictive Interventions

Environmental restrictions

The use of obstacles, barriers or locks to prevent a person from moving around freely. This could also include the use of electronic monitoring.

Psychological restrictions

Depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do.

Coercion

The practice of persuading someone to do something by using force or threats.

Observation

A restrictive intervention of varying intensity in which a member of healthcare staff observes and maintains contact with a person to ensure the person's safety and the safety of others.

Restraint

Physical Restraint

Any direct physical contact where the intervener prevents, restricts or subdues movement of the body, or part of the body, of another person.

Mechanical Restraint

The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.

Chemical Restraint

The use of medication, which is prescribed and administered for the purposes of controlling or subduing acute behavioural disturbance, or for the management of on-going behavioural disturbance.

Seclusion

The confinement of a person in a room or area from which free exit is prevented.

5.1. The use of restrictive interventions can be traumatic for all those involved. They have the potential to have a long-term negative impact on people subject to the intervention and the staff involved, with damage to any therapeutic relationship. There must be a focus on person centred practice and promotion of positive relationships, to support recognition of any potentially restrictive intervention is recognised as aiming to minimise/eliminate such interventions.

General principles for any use of restrictive practices

These principles apply across the lifespan, but specific techniques may need adjusted to suit individuals, for example, children, young people, older people, condition specific considerations, etc.

Decisions to use restrictive practices must be supported by robust justification.

Children and young people should never be subject to seclusion.

Restrictive interventions, restraint and seclusion should not be used for reasons related to disability.

Any use of restrictive practices must only be considered as a last resort.

Initial attempts of restraint should as far as possible be non-physical.

There must be a real possibility of imminent harm to the person or to staff, the public or others if no action is undertaken.

Any use of restrictive practice must be most effective and therapeutic intervention possible with regards to reducing behaviours associated with risk and/or their impact.

The nature of the technique used must be proportionate to the risk of harm and the seriousness of that harm and be the least restrictive option that will meet the need.

Any restriction should be imposed for no longer than absolutely necessary.

Restrictive interventions, restraint or seclusion must never be used as discipline, to inflict pain or humiliation, or a substitute for the provision of proper, person-centred care.

Use of restraint or seclusion must be considered in the context of the legal authority for its use, and fully compliant with a rights-based approach.

5.2. There is significant value in all health and social care organisations using the same language and descriptors to identify all interventions which are potentially restrictive[xv]. Therefore, all organisations must use the standard definitions to identify all interventions which are potentially restrictive, including restraint measures and seclusion, across all health and social care settings, statutory and non-statutory. This will support staff in identifying which practices are restrictive and contribute to considered decision making about their use.

5.3. "Restrictive practice" is an umbrella term that refers to the entire range of interventions that are considered restrictive – from a person's walking aid, controlling their access to kitchen cupboards, covert administration of medication, or continuous observations, through to various methods of restraint and on to seclusion at the far end of restrictive measures that infringe a person's rights.

5.4. This definition encompasses all restrictive practices and is wide enough to invoke a considered thought process around any and all interventions that may be potentially restrictive. Even though an intervention may be considered to be in an individual's best interest or to ensure safety, it may still potentially be restrictive and should be considered as such.

Restrictive Practices

5.5. In its broadest sense, the regional definition incorporates any and all restrictive practices; those which are obvious, for example, hands on physical restraint or the use of seclusion, as well as those which are less obvious, including coercion and psychological measures like controlling how often and for how long someone watches television.

5.6. Organisations must identify and include all potentially restrictive interventions, including those that are not always obvious. With effective definitions it will be possible to monitor the use of restrictive practices or put in place mechanisms to minimise their use; actions which protect both people who use health and social care services and staff implementing the measures.

5.7. Recognising and acknowledging the use of restrictive interventions in the context of the regional definition will enable organisations and individual staff to understand the extent to which restrictive practices are used in the everyday care, treatment and support they deliver, realising the ethical and legal implications.

5.8. Every use of restrictive practice must be described in a care/support/treatment plan that meets the requirements of the *Three Steps to Positive Practice Framework,* ensuring that it is the least restrictive, most effective and therapeutic intervention that will be used for the shortest period of time possible, with a defined review period specified. Using the *Three Steps to Positive Practice Framework* will ensure that the intervention is supported by best evidence for its use and is human rights compliant and lawful.

Environmental Restrictions

5.9. Environmental restrictions include the use of obstacles, barriers or locks to prevent a person from moving around freely. It could also include the use of electronic monitoring in the form of 'wandering' technology such as 'tag' monitors or alarm mats. If the restrictive intervention prevents a person from leaving, the intervention constitutes a deprivation of that person's liberty and a breach of the international Human Rights law (European Convention of Human Rightsxvi Article 5, or the United Nations Convention on the Rights of the Childxvii, Article 37), and is unlawful unless undertaken within a legislative framework.

5.10. The Mental Health (Northern Ireland) Order, 1986, The Mental Capacity Act (Northern Ireland) 2016, The Children (Northern Ireland) Order, 1995, and in some cases individual Court Orders provide authorisations for lawful health and social care related deprivations of liberty. Whilst the common law Doctrine of Necessity will allow a temporary deprivation of liberty, to keep a person safe from immediate danger, any sustained or planned deprivation of liberty is only lawful when used with the most appropriate legislation. This includes any use of seclusion.

5.11. Organisations have a responsibility to ensure that staff are aware of and fully understand the relevant legislation and apply that legislation comprehensively and correctly. At an individual practitioner level, the values, competencies and professional registration requirements of health and social care staff dictate understanding and practice compliant with current legislation.

Psychological/Psychosocial Restrictions

5.12. Psychological/psychosocial restriction refers to depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do. This could include "punishment" interventions for children such as potentially removing contact with parents or carers[xviii] or access to social interaction/digital access, withholding nutrition or fluids, or corporal punishment, to force compliance.

5.13. All staff must be aware that the use of body language, non-verbal and paraverbal communication, in an attempt to apply control or force compliance are equally restrictive interventions, and possibly constitute coercion.

5.14. Health and social care staff have a responsibility to keep people safe and healthy. For those who cannot understand the consequences of making positive and negative choices/do not have the capacity to understand such consequences, due to neurodevelopmental and/or cognitive difficulties and challenges, there will sometimes be a necessity to "control" choices to keep people safe, for example limiting access to unhealthy food choices.

5.15. There are times when strategies to increase motivation to complete less preferred, but essential or important tasks required to build skills and independence, could be considered as making "someone do something they don't want to do". However, health and social care professionals must understand how this can relate to the imbalance of power between those who provide a service - staff - and those who use the service. Power imbalance can lead to the use of coercion, abuse and degrading treatment[xix].

Coercion

5.16. Coercion is defined as the practice of persuading someone to do something by using force or threats. However, in reality, coercion may not be obvious "force or threats", but much subtler. Coercive atmospheres create tension and conflict, with the potential to generate increasingly restrictive staff interventions and environments. Coercive language and behaviour will harm relationships and damage therapeutic milieus and is something of which staff must always be conscious. Coercion should never be used in any of its forms.

> ***"If you take all your medicines, I will be able to tell the doctor and you won't have to go back to hospital"***
>
> ***"If you don't have any fizzy drinks this week, you will be able to see your mummy at the weekend"***
>
> *Some examples of more subtle coercive practice*

Observation

5.17. Observations are "*restrictive interventions of varying intensity in which a member of the healthcare staff observes and maintains contact with a person to ensure the person's safety and the safety of others*". While it is clear that the intention is to provide a therapeutic component or opportunity, observation as an intervention is restrictive and often limits a person's movement, day to day activity or function[xx] [xxi].

Restraint

5.18. Restraint must only be used as an emergency last resort when all other non-restrictive measures have been exhausted and only when the specific risks to self or others posed by the individual's behaviour cannot be managed by other reasonable means. The use of restraint should always be viewed as a temporary solution to any behaviour causing concern and should only be used following assessment and decision making measuring the likelihood and severity of the outcome.

5.19. Any restraint should represent the least restrictive intervention, for the least amount of time possible, and a reasonable, and proportionate response to the prevailing risks[xxii].

5.20. The application of restraint for any reason is an imposition on an individual's rights and dignity, by its nature restricts a person's liberty, and in some cases may subject the person to an increased risk of physical and/or psychological harm[xxiii].

5.21. The use of restraint must also be considered in the context of the legal authority for its use. All use of restraint must be monitored and recorded. Monitoring must be proportionate to the level of restriction. Regulated services registered with the Regulation and Quality Improvement Authority[xxiv] must ensure alignment with any relevant standards applicable to the setting. For the statutory sector, this means ensuring that the same level of recording takes place, regardless of setting.

Physical Restraint

> *"Physical restraint can be humiliating, terrifying and even life-threatening. It should only be used as the last resort, when there is no other way of de-escalating a situation where someone may harm themselves or others."*

5.22. Physical restraint is defined as any direct physical contact where the intervener prevents, restricts or subdues movement of the body, or part of the body, of another person. The use of any physical restraint is not without risks, despite any legal and professional justifications. Staff must be aware of the potential risks involved when applying any physical restraint technique to minimise the potential impacts that are associated with the use of physical restraint[xxv]

5.23. Health and social care staff must also be aware that certain groups are more vulnerable to risks and adverse outcomes associated with restraint – either intrinsically, or because they are more likely to be restrained. These groups are those people with serious mental health illness, intellectual disabilities or cognitive impairment, people from ethnic minority groups, individuals with high BMI, men aged 30-40, children and young people below the age of 20[xxvi].

5.24. Prone restraint must not be used by health and social care staff unless in exceptional circumstances[xxvii] [xxviii] [xxix].

5.25. Any other uses of physical restraint must not be prolonged (exceeding 10 minutes) unless in exceptional circumstances and must follow best practice standards. Alternative non-physical interventions must be considered before and during the restraint episode. If restraint is required for longer than 10 minutes alternative non-physical interventions such as rapid tranquillisation or seclusion should be considered.

5.26. For these reasons and in line with NICE guidelines any use of physical restraint reaching or exceeding the threshold of "prolonged" must be subject to a formal incident review, in line with organisational policy.

5.27. A person who suddenly stops resisting a physical restraint intervention may be experiencing cardio-respiratory de-compensation which is a medical emergency.

5.28. In the circumstance where physical restraint may be required:

- Staff must be appropriately trained by an accredited training organisation;

- Deliberate pain or the threat of use of pain must not be used by staff in an attempt to force compliance;

- People must not be restrained in a way that impacts their airway, breathing or circulation - pallor, cyanosis or complaining of not being able to breathe are clear indicators of respiratory arrest or positional asphyxia;

- The mouth and/or nose must never be covered, and techniques should not incur pressure on the neck region, ribcage and/or abdomen;

- There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor;

- One member of staff involved must take overall responsibility for monitoring the person's airway and physical condition throughout the restraint event. If the person's physical condition and/or their expressions of distress give rise to concern, the restraint should cease immediately;

- Avoid "taking the person to the floor". If this is unavoidable, any movement towards the floor is dictated by the person as they descend; staff involved should support the safety of the descent. Where possible a supine position must be used instead of a prone position. However, **if** there are exceptional circumstances where prone restraint is unavoidable, it should be for the shortest amount of time possible[xxx] [xxxi].

- Clinical observations including pulse, respiratory rate, temperature, blood pressure and observation of the person's colour should be undertaken during the event and for a period of time after the event to be determined by the lead clinician.

5.29. In the exceptional circumstances where physical restraint is considered for use for a child or young person[xxxii], staff must have the appropriate training to ensure that they undertake any interventions in line with NICE guidelines[xxxiii]. NICE advise that restraint[xxxiv] techniques are adjusted according to the child or young person's height, weight and physical strength. Staff must also be trained in the use of resuscitation equipment on children and young people.

5.30. If possible, staff members who are the same sex as the child or young person should undertake the physical restraint intervention. There may be times when physical restraint is required to safely support a person with essential personal care needs, specialist care and treatment or in an emergency for essential medical treatment, in the circumstances where the person cannot provide/lacks the capacity to provide informed consent[xxxv] [xxxvi]for the intervention.

5.31. The use of restraint for clinical treatment, essential treatment in an emergency or for essential care tasks has been differentiated from that of physical restraint in regard to the rationale and intention of using holding skills.[xxxvii] However, health and social care staff must be aware that these techniques are considered physical restraint and they must be trained in their use.[xxxviii] [xxxix]

5.32. Physical restraint for clinical treatment, essential treatment in an emergency or for essential care tasks cannot proceed where a person has the capacity to provide informed consent but chooses to withhold that consent.

5.33. In circumstances where a person requires physical restraint to meet their needs as result of lack of capacity and inability to consent to an intervention, then this should be agreed within the context of best interests and by a multi-disciplinary team, using the *Three Steps to Positive Practice Framework*. As with all restrictive practices, physical restraint in these circumstances must only be used in the context of a last resort, least restrictive and most effective intervention. A detailed care plan is required where physical restraint might be used for essential clinical treatment, essential treatment in an emergency or for essential care tasks.

5.34. Any and every use of physical restraint, including when used for clinical treatment, essential treatment in an emergency or for essential care tasks, should be subject to a review of the restraint event and the person's care and treatment plans amended where required and appropriate, to mitigate against continued need for the use of restraint.

5.35. The review should include:

- the type of restraint technique employed;
- the date and the duration of the intervention;
- the names of the staff and people involved;
- reasons for using the restraint technique employed (rather than an alternative less restrictive approach);
- whether the person or anyone else experienced injury or distress;
- the person's views of the incident (if appropriate, through family, caregiver or advocate);
- what follow-up action was taken, including the need for any formal emotional support.

Mechanical Restraint

5.36. Mechanical restraint is the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control[xl].

5.37. Mechanical restraint can involve the use of authorised equipment, for example handcuffs or restraining belts, applied in a skilled manner by designated healthcare professionals. Its purpose is to safely immobilise or restrict movement of part(s) of a person's body. This type of intrusive mechanical restraint should not be used outside of a designated secure setting[xli]. It must only be used in limited and exceptional circumstances for management of extreme violence directed towards others, or to limit self-injurious behaviour of extremely high frequency or intensity.

5.38. Nice guidelines[xlii] advise against use of this type of restraint for children and young people.

5.39. Organisations must have policies for the use of this type of restraint, detailing what would constitute the limited and exceptional circumstance of extreme violence/self-injurious behaviour that would warrant use of such equipment, in which designated facility and the robust governance arrangements that authorises, monitors, and reviews their use.

5.40. The use of mechanical restraint should be avoided where possible. However, there may be exceptional circumstances where mechanical restraints (other than those for exceptional use within secure settings only (5.31 above)) are required to limit self-injurious behaviour of high frequency or intensity, for example, use of arm splints, use of cushioned helmets etc.

5.41. Mechanical restraint may also, for example, be the use of “safe space” equipment, lap straps, bed rails and harnesses for the purposes of preventing harm to the person or endangering others, and by their nature restrict liberty. The use of the *Three Steps to Positive Practice Framework* will assist in the assessment, planning and review of these measures in these exceptional circumstances and provide assurances regarding the application of a proportionate and least restrictive use of mechanical restraint.

5.42. Mechanical restraint in these cases must be:

- robustly assessed as the least restrictive measure possible that will maintain the safety, well-being and dignity of the person;
- part of a support/care plan that includes actions and interventions that aims to bring about the circumstances where continued use of mechanical restraint will no longer be required (where possible);
- reviewed at pre-determined intervals, according to the individual’s unique situation, to include:
    - the type of mechanical restraint used;
    - the date and the duration of the intervention;
    - reasons for using the type of mechanical restraint (rather than an alternative less restrictive approach);
    - whether the person or anyone else experienced injury or distress;
    - the person’s views on the use of mechanical restraint (if appropriate, through family, caregiver or advocate);
    - any amendments to care/support plans or follow up action, including the need for any formal emotional support.

5.43. Mechanical restraint should not be used:

- as a substitute for other less restrictive interventions;
- as a form of discipline or punishment;

- as a substitute for inadequate staffing levels;
- as a substitute for staff training in crisis prevention and intervention to manage aggressive, harmful behaviours; or
- when seclusion is being used simultaneously.

Chemical Restraint

5.44. Chemical restraint refers to the use of medication to control or subdue acute behavioural disturbance, or the management of on-going behavioural disturbance. It is important to recognise that it can bring therapeutic benefit to a person experiencing particularly distressing symptoms, such as hallucinations.

5.45. Acute Behavioural Disturbance is an acute mental state associated with an underlying mental or physical disorder[xliii]. The symptoms associated with acute behavioural disturbance range from agitation, distress and actual or potential aggression and violence, that causes the person to harm themselves or cause harm to another person, or where a person causes damage to property, with the intent to use objects to harm self or others.

5.46. Responses to and management of acute behavioural disturbance will require combined evidence based and therapeutic strategies, including management and treatment of physical ill health, de-escalation, and other non-pharmacological approaches[xliv], to be used in advance of a pharmacological approach, and/or along with a pharmacological approach.

5.47. In these cases, the purpose of the use of medication is to “control or subdue” behaviours which may potentially result in harm to the person or to others. This use of medication is considered chemical restraint.

5.48. Potentially sedating medications might be used over months or even years in the management of on-going behavioural disturbance. This captures a wide range of practice from high dose sedating medications over a period of weeks (when an individual might be experiencing a very acute disorder) through to occasional use of low dose medications which may cause a degree of sedation in individuals with long term conditions. The use of these medications aims to bring relief from behavioural or psychological symptoms associated with long term neurodevelopmental or neuropsychiatric conditions (e.g. autism, dementia etc) and will therefore be therapeutic

5.49. Staff should assess whether the person will accept oral medication as part of a de-escalation technique where non-pharmacological de-escalation techniques were not adequate to diffuse anger or avert aggression, and there is not an immediate risk of violence or aggression. This is sometimes known as “pre-rapid tranquillisation. NICE[xlv] guidelines advise that oral Pro Re Nata (PRN) medication on its own is not de-escalation.

5.50. If the pharmacological response is rapid tranquillisation – medication by the parenteral route (which means by methods other than taken orally, usually intramuscular injection or exceptionally, intravenously, if oral medication is not possible or appropriate and urgent sedation with medication is needed) – a formal incident review is required for each episode of administration.

5.51. Health and social care staff who are involved in the management of Acute Behavioural Disturbance using pharmacological responses must follow the requirements set out in local policy and procedure, relevant best practice guidance and/or regional protocols.

5.52. There are situations where the use of medication to undertake a specific procedure – for example general anaesthesia for dental extraction - *is* intended to subdue, control or restrict the individual, to allow the intervention to proceed. The use of pharmacology in this circumstance is not in response to acute behavioural disturbance but is nonetheless considered chemical restraint. Staff should recognise the intervention as chemical restraint and use the *Three Steps to Positive Practice Framework,* to determine that the proposed pharmacological response is the least restrictive, most proportionate intervention available at that time.

5.53. There are situations where the use of medication in the treatment of a particular illness, condition or presentation is not intended to subdue, control or restrict that individual, but potentially has restrictive side effects. In these cases, the intent behind the medication must be considered.

5.54. In all cases where potentially sedating medications are being used for management of behavioural symptoms, irrespective of the nature or degree of 'restriction' these might cause, the *Three Steps to Positive Practice* will provide a useful framework for decision-making and interdisciplinary review of the use of potentially sedating medications in line with NICE guidance.

Frequency of review of the use of restrictive practices

5.55. The regional procedures for use of seclusion (Standard 7) dictate a specific timeline for review of its use. However, it is not appropriate to define a "minimum/maximum" timeframe for review of other restrictive practices within this policy document.

5.56. The frequency for review of the use of restrictive practices will be agreed on an individualised basis and in the context of changing presentation, assessed risk of harm to the person or others, changing circumstances and/or any fluctuation in capacity to consent to interventions.

5.57. For example:

- the presentation of a person with delirium who is subject to restrictive practices, such as close observation or deprivation of liberty, may change day to day, meaning that any restrictive practice should be reviewed on a daily basis;

- a person with advanced dementia who requires to be deprived of liberty is unlikely to present significantly differently day to day, meaning that the intervals between review periods will likely be longer;
- the requirement for the use of arm splints to manage the risk of a person causing harm to themselves will be assessed and reviewed at every use, possibly multiple times per day, with the shortest interval possible between review to allow the mechanical restraint intervention to end;
- the use of PRN medication and Rapid Tranquillisation will be reviewed after every use as part of an incident review with the intention of mitigating against recurring use;
- The use of physical restraint will be reviewed after the restraint event with the intention of mitigating against recurring use.

5.58. The Three Steps to Positive Practice requires an agreed timeframe for review of any restrictive practice, before the intervention is initiated.

Seclusion

5.59. Seclusion is the confinement of a person in a room or area from which the person is not free to leave.

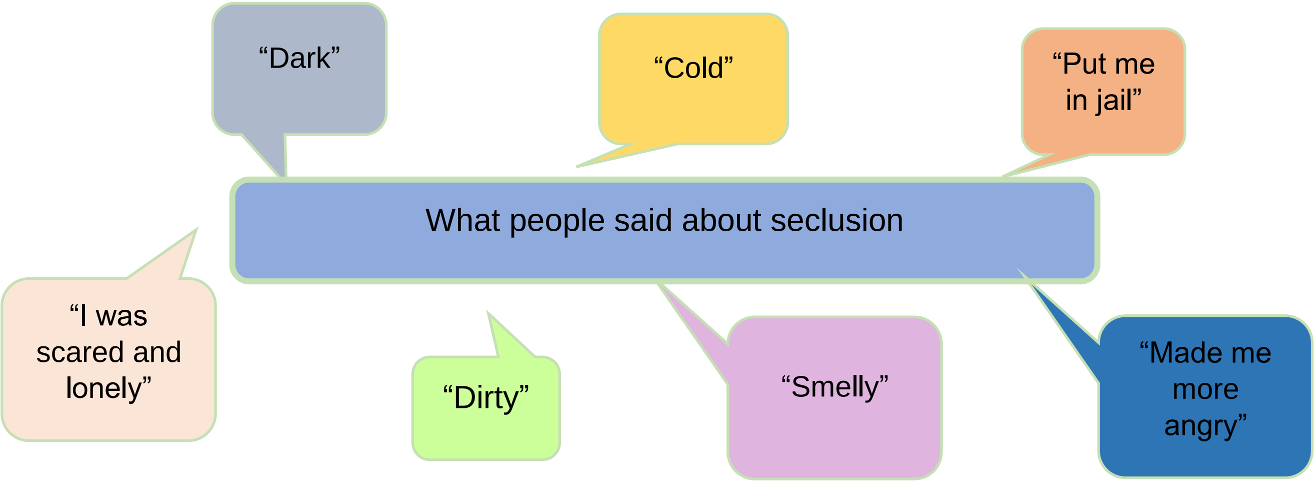
5.60. Children and young people should not be subject to seclusion.

5.61. Not being free to leave does not require a locked door. It can be staff locking the door but can also be the person believing that the door is locked, staff holding the door handle, blocking exit, refusing exit, coercing the person and so on. The key point being that the person being secluded can only leave the confinement area when permitted to do so.

5.62. If seclusion is required, it must only be used:

- As a last resort intervention in an emergency where there is an unmanageable risk to others and other less restrictive methods are deemed insufficient to manage that immediate risk;
- When a person is, or is liable to be, detained in accordance with an appropriate legal framework;
- In a hospital setting in a room or suite specifically designated for this purpose;
- In accordance with the regional operating procedures (see Standard 7).

5.63. Worldwide evidence provides no definitive conclusion that the use of seclusion has a therapeutic benefit[xlvi]. It can be seen as punitive and can cause psychological harm.[xlvii] [xlviii] The use of seclusion can often be a traumatic experience for those involved and can cause potential damage to therapeutic relationships compromising recovery and well-being.



5.64. In every circumstance where a person is confined in a room, or an area, and the person is not free to leave, no matter the name given to the intervention, the person is subject to deprivation of liberty, which may also amount to seclusion.[xlix] Seclusion used outside of the circumstances set out at 5.62 is not acceptable. Seclusion used outside of a legal framework breaches human rights and is unlawful. This applies to both adults and children. A health and social care professional using seclusion outside of a lawful process may be subject to prosecution for false imprisonment or unlawful detention of the person.

5.65. There is no such thing as “consenting” to deprivation of liberty and therefore no one can consent to seclusion, even if the situation is believed to be one where the person has “requested” seclusion and/or can “ask” to be released. Health and social care staff must consider the practice in question in the context of the definition and the circumstances in which it is considered for use. Plans should be put in place to replace the seclusion intervention as soon as is possible with an intervention that has an evidence based therapeutic intent, with the aim of eliminating any use of seclusion for that individual.

5.66. Some individuals may express a preference for seclusion rather than physical restraint, for example, in circumstances that they exhibit behaviours that present an immediate and unmanageable risk of serious harm to others when acutely mentally unwell. This is not to be confused with a person “consenting” to seclusion but can be an important aspect of care planning. Advance statements – a written statement which primarily informs all staff of the person’s wishes, feelings, beliefs, values and preferences regarding their future treatment – is recommended.

5.67. All those who are capable and wishing to do so should be encouraged to make an advance statement with regards to the use of any restrictive intervention. An advance statement does not provide legal authority but must be taken into account by all health and social care professionals when making decisions about the management of a person where their behaviour is presenting as a risk towards themselves or others.

5.68. There may be circumstances where a person is confined to an area supported by staff, promoting the use of a lesser stimulating environment to support emotional regulation. Decision making around an intervention such as this must provide therapeutic benefits and outcomes for the person, which must be clearly set out in care/support plans.

5.69. All staff must be aware that their actions, if preventing free exit, amount to a deprivation of liberty. All staff must consider if, in implementing the intervention, their action amounts to secluding the person, that is – are they acting in an emergency, confining a person in response to an unmanageable risk of harm to others where other responses have been deemed insufficient?

5.70. Where the intervention amounts to deprivation of liberty, there must be a regular review process that reflects the least restrictive approach for the least amount of time possible. The person's care and treatment plan must be reviewed to consider other proactive and positive approaches to prevent re-occurrence.

5.71. Where the intervention amounts to seclusion, there must be an urgent, in-depth review of the person's care and treatment plan, with the aim of eliminating any use of seclusion for that individual with an intervention that has an evidence based therapeutic intent.

5.72. All staff need to ensure that they are acting within the requirements of this regional policy, and relevant legislative frameworks.

5.73. Seclusion must not happen outside of the hospital environment. NICE guidelines[l] advise against the use of seclusion in the emergency department.

5.74. If an emergency situation occurs outside of the hospital setting where a person requires to be deprived of their liberty in circumstances that amount to seclusion, urgent and in-depth review of the incident and the person's care and treatment plans is required, and appropriate therapeutic actions taken to avoid recurrence. However, seclusion outside hospital cannot be part of the person's care plan and must only ever be in response to an emergency.

Long term segregation

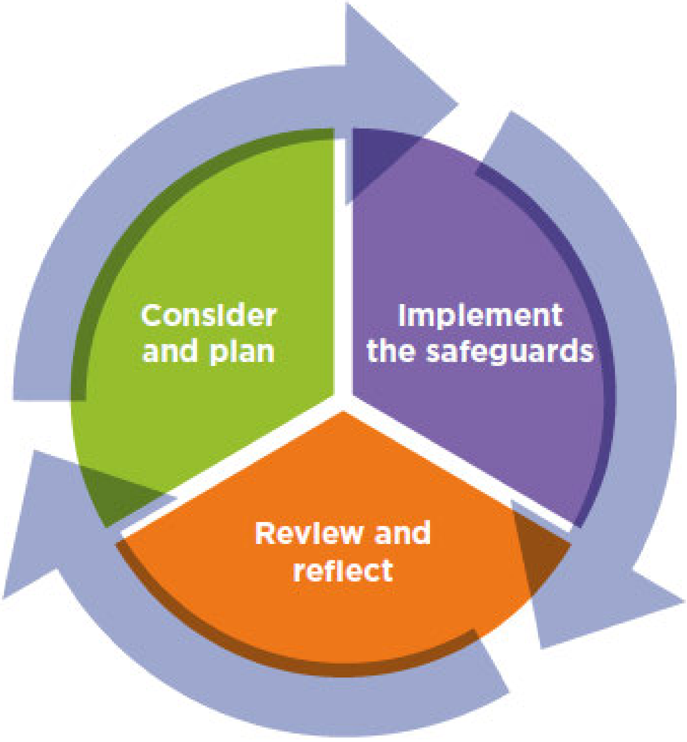
5.75. People can be subjected to a range of restrictions that fall short of seclusion but may result in an extreme restriction of social contact over a prolonged period of time. It is different from seclusion.

5.76. While formal 'long term segregation' is not a recognised form of care in Northern Ireland, people can spend very long periods of time with minimal or no contact with their peers and without having any time out of the health and social care facility, be that a hospital, a care home, or their own home. This is comparable to long term segregation. It is key that policies and procedures provide safeguards for people who may be subject to this type of arrangement. Segregation from others is a form of restrictive intervention.

5.77. Staff must be alert to this practice, recognise it as restrictive and use the *Three Steps to Positive Practice Framework* to ensure there is a clear plan to minimise and eliminate the use of segregation as quickly as possible.

5.78. Organisational policies must include mechanisms and safeguards that prevent any person being cared for, supported, or treated in a situation that amounts to long-term segregation.

6 Standard 2 – All local policies and practices must embed the use of the *Three Steps to Positive Practice Framework* when considering and reviewing the use of restrictive interventions

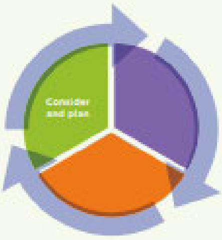


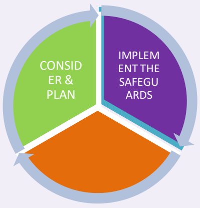
6.1. All local policies and practices must embed the use of the *Three Steps to Positive Practice Framework* when considering and reviewing the use of any restrictive intervention, from locking cupboard doors right through to use of seclusion.[li] [lii]

6.2. There are occasions when the use of restrictive practice is unavoidable in order to keep a person or others safe from harm. Not all restrictive interventions are inherently wrong, harmful or illegal; they are sometimes necessary and could form part of health and social care delivery. In this context it is essential that any use of restrictive practice is therapeutic, ethical and lawful.

6.3. *The Three Steps to Positive Practice* is a collaborative Royal College framework designed and endorsed by the Royal College of Nursing, Royal College of Psychiatrists, the British Association of Social Workers, and the Royal College of Occupational Therapists. This framework assists health and social care professionals to think about culture and practices and to guide professional, ethical and legal decision making when considering the use of potentially restrictive practices document, supporting legal, ethical and professional decision making around the use of restrictive interventions, every time a decision is made, or an action is taken.

6.4. *The Three Steps to Positive Practice* is a continuous and cyclical process which requires a health and social care professional to routinely adhere to all three steps of the framework. This framework has been designed to be applied at points of assessment, implementation, evaluation and review, and in situations where the use of restrictive interventions has been in place for some time or associated with a particular environment.

STEP 1 Consider and plan 	Has a multi-disciplinary discussion around how to keep the person (or others) safe resulted in recommending a potentially restrictive practice? Does the proposed intervention or the way in which care is being delivered: • limit the person's movement, daily activity or function; • result in the loss of objects or activities that the person values; or, • require the person to engage in a behaviour that he/she would not engage in given freedom of choice? If you answer yes to any of these questions, then the proposed intervention is potentially restrictive.	You must ensure that a multi-disciplinary discussion has taken place before you proceed. The plan must be discussed with the person and/or their representative, including advocates. Decisions must be clearly documented and communicated to all parties. Remember that some decisions may require a legal opinion.
	What other less restrictive options have been considered?	You must ensure that other, less restrictive options, starting from the point of no restriction or least restriction have been discussed. A clear rationale must be documented to evidence why they are not appropriate at this time.
	How will the proposed intervention reduce risk, and build or retain the person's skills and the opportunities available to them?	You must ensure that the proposed intervention is the best and only approach to reducing an identified risk and achieving therapeutic benefit. You must ensure that the proposed intervention is a positive and evidence based therapeutic approach which clearly articulates how the intervention will reduce the identified risk. The intervention must also support the person's ability to develop and retain skills and learn through experiences.

Implement the safeguards  	Is this proposed intervention considered to be in the person's best interests?	You must consider the areas of capacity and consent when deciding if the proposed intervention is in the person's best interests. You must ask questions if you are not satisfied that the evidence confirms that the implementation of the proposed intervention will be in the person's best interests. Documentation must clearly record the formal discussions and processes involved in reaching a multi-disciplinary agreement.
	How do I ensure that I am using a rights-based approach?	You must ensure that the plan is fully considerate of human rights and the FREDA principles and can be implemented under an appropriate legal framework. You must support the person and their representatives to understand their rights and provide information on how they can raise any objections or complaints.
	What professional accountability frameworks must be considered?	You must ensure that the decisions you make are ethical and fully considerate of your individual professional responsibilities, and your organisation's accountability and governance structures.
STEP 3 Review and reflect  	Has a regular and timely review of the intervention been planned?	You must ensure that a pre-determined timeframe for review of the intervention has been agreed before the intervention is implemented.
	Is there a plan to ensure that the intervention will be for the shortest length of time possible?	You must ensure that there is a positive therapeutic care plan that includes a planned reduction of the restrictive practice. The review must re-consider steps 1 and 2.
	Are there mechanisms available to you as an individual and to your team to enable reflection about the impact of using restrictive interventions?	You must recognise that the use of restrictive interventions, especially restraint, can have a negative emotional impact. It is important that opportunities for supportive discussion and reflection are made available to you and your colleagues.

6.5. The Three Steps to Positive Practice Framework seeks to build a culture of practice embedded in a rights-based approach as the "norm". The truest articulation of a rights-based approach that meets the needs and circumstances of the individual is based on person-centred culture and practice, which will be realised with embedding the rights-based approach of this framework in policy. A professional using the framework is directed towards the use of a rights-based approach, thereby ensuring the minimisation of such interventions. As the agreed regional framework, every member health and social care staff must follow the Three Steps to Positive Practice Framework when considering the use of any restrictive practice. Where the process is not being implemented and staff are aware of the use of restrictive practices, it should be recognised as a potential safeguarding issue. Staff must escalate their concerns using organisational reporting processes highlighting the requirements of this regional policy.

Rights Based Approach

6.6. A rights-based approach to health and social care means two things – ensuring that the rights of individuals enshrined in law, known as "Human Rights"[liii] [liv] [lv] are upheld and influence decision making about health and social care delivery; and practice that is shaped by the core principles and values that put the person receiving the service at the centre of decision making about that service, the FREDA principles. A rights-based approach means that all restrictive practices must be subject to appropriate procedural safeguards. In particular, a fair balance must be struck between the severity and consequences of interfering with the rights of the person restricted, the main purpose of which is to ensure the safety of the individual and others.

6.7. A rights-based approach puts the person at the centre of decision making supporting an individualised plan to meet their individual needs. The person subject to the restrictive practice and/or their representatives must be actively involved in all consultation, decision-making and monitoring processes regarding the use and minimisation of restrictive practices. This is an essential aspect of the partnership working that is required in developing proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people**.**

Human Rights

6.8. The application of Human Rights is particularly relevant to a rights-based health and social care provision. These rights are realised through European Convention on Human Rights (ECHR), The United Nations Convention on the Rights of the Child (UNCRC) & the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). There are additional internationally accepted human rights standards, which may have relevance for how health and social care staff and organisations shape rights-based practice[lvi] [lvii]

6.9. These legal frameworks set out how both individual practitioners and organisations must provide and deliver health and social care services. They recognise and protect the dignity of all human beings, and impose legal duties on authorities, both local and national, to respect the human rights set out in the Conventions in their decisions and actions. Importantly, ECHR, UNCRC and UNCRPD are vital in providing a rights-based approach to health and social care delivery, protecting the key human rights set out in the table below:

	Specific Article		
	ECHR	**UNCRC**	**UNCPD**
Right to life The right to life is protected by law.	2	6	10
Prohibition of Torture The right not to be tortured or treated in an inhumane or degrading way.	3	37	15
Right to Liberty and Security The right not to be deprived of liberty "arrested or detained" – except where there is proper legal basis.	5	37	14
Right to Respect for Private and Family Life The right to family, relationships, well-being, privacy, correspondence and home, including seeing family and being heard.	8	16	22 23
Prohibition of Discrimination The right not to be treated differently because of race, religion, sex, political views or any other personal status, unless this can be justified objectively.	14	2	5

6.10. Every health and social care professional must understand the rights enshrined in human rights law and how this must influence their practice and be alert to the potential for breaches of human rights in everyday practice[lviii].

6.11. These laws are not mutually exclusive. The ECHR applies to every human being, adult and child, with the UNCRC and UNCRPD providing more explicit detail of human rights law and rights specifically for children and persons with disabilities respectfully. The additional internationally accepted human rights standards contribute to full recognition and application of human rights.

6.12. Health and social care organisations are corporately responsible for creating the circumstances which ensure that staff understand and apply human rights laws and for ensuring that the human rights of everyone who uses their services are upheld. All organisations should ensure that all policy and practice are compatible with the relevant human rights instruments[lix].

FREDA Principles

6.13. A rights-based approach can be achieved by applying the FREDA Principles, the core values that shape practice and which underpin the articles in the human rights frameworks.

6.14. The FREDA Principles are the basis of good health and social care which should be used mutually and individually to inform decision making, supported by inclusive communication strategies. They are a useful guide for health and social care staff to ensure that everyone for whom they are providing care, treatment, support and/or services is:

- Treated with dignity and respect;
- Provided with care which best suits their individual needs;
- Able to live free from abuse, neglect or discrimination;
- Able to participate in the choices and decisions made about their lives;

Fairness

- Fairness means ensuring that when a decision is made with a person using a service about their care and support, the person’s views are sought, listened to and weighed alongside other factors relevant to the decision. It is important that decisions are made in a way that is clear and fair to allow others to know how they might be treated in similar circumstances. If a decision interferes with a person’s human rights, this must be legally justified, proportionate and only taken when all other alternatives have been considered.

Respect

- Respect is the objective, unbiased consideration and regard for the rights, values, beliefs and property of other people. Respect applies to the person as well as their value systems.

Equality

- Equality means people having equal opportunities and being treated no less favourably than other people on the grounds set out in legislation. These grounds include: sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or any other status.

Dignity

- Dignity means treating people with compassion and in a way that values them as human beings and supports their self-respect, even if their wishes are not known at the time.

Autonomy

- Autonomy is the ability of a person to direct how they live on a day-to-day basis according to personal values, beliefs and preferences. In a health and social care setting, autonomy involves the person using a service making informed decisions about their care, support or treatment.

6.15. Whilst the principal components of a rights-based approach are modelling the core values in the FREDA principles to support the fulfilment of an individual’s human rights, there are other elements that are essential in the realisation of a rights-based approach.

Working within a Legislative Framework

6.16. Restrictive interventions must only be used within a relevant legislative framework. All health and social care professionals must be familiar with the laws which are relevant, to them, their area of practice and their organisation. This protects the individual, staff and the organisation.

6.17. The use of legislative frameworks allows staff to make reasonable and proportionate decisions regarding the use of restrictive interventions. It is important that the justification process is reflective and inclusive of legal, professional and ethical considerations. Organisations must provide the necessary mechanisms, supports and environments to ensure employees can operate within all relevant legislative requirements.

6.18. This includes understanding that every starting point in decision making regarding care, support and treatment is presuming that every adult can make that decision independently (given the correct support to do so where needed), and that the person can provide or withhold consent to that care, support or treatment. This is a foundation step in a rights-based approach to service delivery, putting the person at the centre of the decision-making process.

6.19. Continuing with a restrictive intervention in the situation where a capacitous person withholds consent can only happen in circumstances permitted by the Mental Health (Northern Ireland) Order, 1986, a High Court Declaratory Order or in response to an immediate risk of harm to a person or others around them using the common law Doctrine of Necessity.

6.20. In the situation where a person aged over 16 years has been assessed as lacking the capacity to independently make decisions regarding care, support or treatment, (and if detention for care and treatment in a hospital in accordance with the Mental Health Order does not apply) the Mental Capacity Act (Northern Ireland) 2016 sets out the requirements in terms of lawful deprivation of liberty with all other decisions requiring collective “best interests’” discussions and agreements.

6.21. An adult with parental responsibility can provide consent for a child. In addition to the legislation above, The Children (Northern Ireland) Order 1995, The Children (Secure Accommodation) Regulations (Northern Ireland) 1996, The Age of Majority Act (Northern Ireland) 1995 as well as Gillick Competence principles must be considered relating to decisions involving children.

6.22. As noted at 5.64, there is no such thing as consenting to deprivation of liberty. For a young person aged 16-17, where legislation permits a parent or the State with parental responsibility to provide consent for care and treatment, health and social care staff and organisations must be aware that this does not extend to consenting to deprivation of liberty[lx].

6.23. The situation is less clear for those under 16 years of age. However, in the absence of any definitive Court ruling, where a legal process exists, for example, the Mental Health Order or The Children Order, it is advisable to use the legal process to ensure the child or young person has access to the safeguards within the processes that protect their rights.

6.24. In all circumstances, adherence to a rights-based approach to minimising the use of restrictive interventions will be achieved through the routine use of the *Three Steps to Positive Practice Framework*.

6.25. A list of relevant legislation is provided at Appendix 9. Whilst this is a wide-ranging list, it may not be exhaustive. Health and social care staff may be aware of other legislation that may be applicable to their practice and/or where they deliver their service.

6.26. It is vital that organisations and individual staff work to the legislative framework applicable to their service delivery and practices at any particular time and be aware of and responsive to changes in relevant legislation.

Staff Support

6.27. Even when a decision to implement a restrictive intervention is the last resort, lawful, ethical and in a person's best interests, staff involved can find the implementation of restrictive practices morally and emotionally challenging. Witnessing or being directly involved in a restrictive practice could contribute to work-related stress.

6.28. The Three Steps to Positive Practice includes "reflection" as a supportive mechanism for staff within the Framework and must be considered as important and essential as every other part of the process. There are various evidence-based methodologies to guide this type of activity, for example, structured de-briefing. Structured de-briefing (which has been included as a requirement within the operational procedure for use of seclusion) provides emotional and educational support immediately following incidences of behaviours that challenge and can contribute to the reduced use of restrictive practices. However, those involved should be mindful that the process of discussing incidences in which restrictive practices have been used may be traumatic for both person subject to the intervention and the staff involved or witnessing the event. Organisations must ensure that opportunities for supportive discussions and reflection for individuals and teams are provided as standard, with other pastoral type support available where an individual member of staff might require additional support.

Advocacy

6.29. Advocacy in all its forms seeks to ensure that people can have their voice heard. Organisations should involve an independent advocate in all "best interests" decision-making processes, particularly where a restrictive practice is proposed, if there is an advocate available. For those unable to articulate their views about their care, support and treatment for whatever reason advocacy can be an important method by which a person can be considered and protected in what might be quite complex decision making about how they live their lives and how their care is provided. This is an essential element of a rights-based approach.

Provision of Appropriate Training

6.30. Organisations providing services where people's behaviours can present as a risk, have at times a challenging job that requires a specialised skill set to balance risk, welfare and safety. Training that includes any form of restrictive intervention has potential risks associated and is distressing for everyone involved.

6.31. For this reason, organisations must ensure that the training delivered to staff in the management of such behaviours is accredited and provided by a certified training body. The content must provide training models which are strong on proactive and preventative strategies, human rights-based interventions, and embrace the monitoring, oversight and assurance required in relation to restrictive practices. This approach minimises the use of restrictive practices and creates and maintains a positive and enabling service delivery culture beyond the application of physical restraint or other restrictive interventions.

6.32. Organisations and line managers are responsible for continual assessment of staff competence.

6.33. Education providers are expected to incorporate the principles in this policy into all pre-registration courses preparing future health and social care practitioners.

Co-Production

6.34. Working in partnership is about realising value through people; identifying and using their different skills, experience, and expertise and working supportively and collaboratively to deliver improved outcomes and experiences of health and social care by being part of designing, planning and delivering those improvements.[lxi]

6.35. Crucially, it is also about providing a direct link to the co-design, co-production and co-delivery of services, at strategic level, so those improvements can be embedded and cascaded to benefit everyone in Northern Ireland.

6.36. By connecting those providing health and social care, those with lived experience of care, their families and carers, staff, policy makers and local communities in the planning, delivery and evaluation of healthcare services, people will truly be at the heart of making decisions and choices about services. Doing so supports people to receive the service they want and need with better outcomes and enables service providers to deliver better quality, more targeted health and social care provision.

7 Standard 3 – Effective and person-centred communication must be central to care and treatment planning.

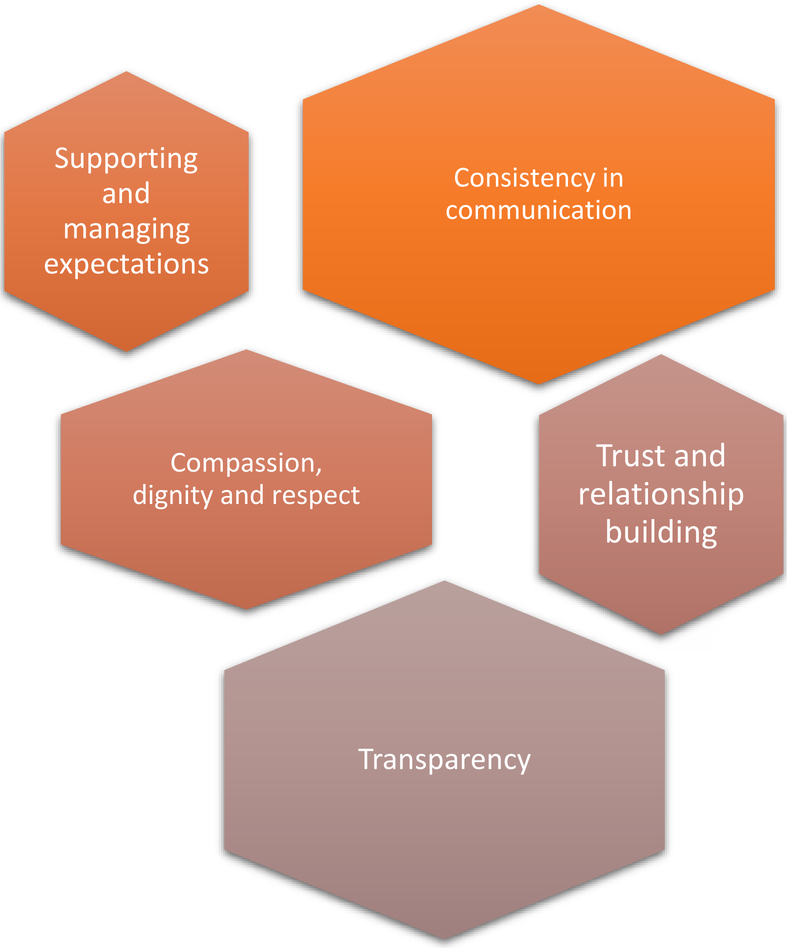
7.1 Inclusive, effective and person-centred communication must be central to care and treatment planning. Inclusive or total communication means sharing information in a way that everybody can understand.[lxii] A person centred approach to communication is a commitment to include a person in all aspects of their care, to gain an understanding of who they are and how to support them best,[lxiii] promoting proactive and ethical methods of reactive and ethical restrictive interventions.[lxiv]

7.2. The Royal College of Speech and Language Therapists has developed a set of practice standards[lxv] that describe what "good communication" looks like, with supporting references and resources. Whilst these were developed in the first instance to support inclusive and effective communication for people with learning disability and autism, they are equally applicable and supportive for anyone who experiences speech, language or communication challenges. Organisations should use the standards to shape their communication policies and practice.

Standard 1 There is a detailed description of how best to communicate with individuals.	In order to communicate effectively it is essential that everyone understands and values an individual's speech, language and communication needs. Individuals should be supported and involved, together with the people who know them best, to develop a rich description of the best ways to interact together. This description needs to be agreed, active, regularly updated and readily available. The description is sometimes referred to as a communication passport, guideline or profile. It includes the best ways of supporting their understanding and expression, the best methods of promoting interaction and involvement and describes 'how to be with someone'
Standard 2 Services demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services.	Individuals with speech, language and communication needs are often either excluded from patient experience feedback processes or included in a tokenistic way. There is a risk that their needs and opinions are assumed, misinterpreted or ignored. All communication needs to be inclusive. For service providers, this means making sure they recognise that people understand and express themselves in different ways. For individuals this means getting information and expressing themselves in ways that meet their needs[lxvi]. Inclusive Communication is an approach that seeks to 'create a supportive and effective communication environment, using every available means of communication to understand and be understood'.[lxvii] For services to demonstrate inclusion and involvement innovative and creative solutions to understanding the views of individuals are often required due to the nature of communication needs.
Standard 3	Staff working in specialist hospital and residential services must recognise communication difficulties. They must

Staff value and competently use the best approaches to communication with each individual they support.	understand that they need to change their communication style to support the service user and have the knowledge and skills to adapt their communication levels, styles and methods. Staff are aware of factors that impact on communication, especially hearing, sight and sensory integration. They understand that what they say and how they say it matters and can impact positively or negatively on the individual. Staff also understand how good communication underpins informed consent and capacity. They are able to promote the individual's understanding and expression and create opportunities for positive communication.
Standard 4 Services create opportunities, relationships and environments that make individuals want to communicate.	An understanding, welcoming and socially rich environment is fundamental to relationships for all individuals, and particularly people with communication needs. Relationships are central to wellbeing. Getting the communication environment right will contribute to enabling people to live valued and meaningful lives. Individuals need to have the opportunity to communicate about all the things that all people talk about in everyday life such as dreams, hopes, fears, choices as well as everyday wants and needs. Good communication needs to be considered broadly. It is about social interactions – greetings, sharing stories and fun. It is the quality of interaction that contributes to overall emotional and mental wellbeing; providing a sense of belonging, involvement and inclusion. Interaction may not necessarily involve speech. For someone without formal language, interactive approaches are a way of 'being' with another person, making meaningful contact with those who are hard to reach or easy to ignore. It may be about very basic early developmental interaction and communication and relationship building.
Standard 5 Individuals are supported to understand and express their needs in relation to their health and wellbeing.	It is essential to consider communication needs in order to support individuals with their health. Arriving at a diagnosis can prove difficult if a person cannot describe signs and symptoms easily, or their behaviour is misunderstood and misconstrued. Staff need to be aware of how individuals communicate about their health and how they show that they are in pain. This includes considering ill health as a cause for changes in behaviour. Knowing how much a person can understand is also essential in making a decision about their capacity to have a health treatment. It is also required to meet the principles of nursing practice that everyone can expect[lxviii]. This includes treating individuals with compassion and dignity and providing person-centred care.

Key Themes underpinning inclusive, effective and person-centred communication



7.3. Inclusive and effective communication is a key element within an organisational restrictive practice minimisation strategy, centred on collaborative relationships.

7.4. Transparent and trusting relationships support the foundation for effective communication sharing and being able to support a person and their families to be part of their care and treatment. Use of independent advocacy will be an important support for a person in articulating their views for planning their care and treatment. Relationships based on transparency and openness can address the power imbalance so often felt by people dependent on service provision.

7.5. This is especially important in terms of sharing of information[lxix]. Sharing of information between the members of the interdisciplinary team and the person's wider support system is to be expected in pursuit of positive outcomes for the person. However, a balance required with respect to what information can or should be shared with others regarding the person's care and treatment – balancing confidentiality and right to privacy in any communication seeking to develop care and treatment plans with those who know the person best.

7.6. Professionals must also remember that their professional registrations and "Codes of Conduct" require a professional duty of candour, regardless of any potential future statutory requirement.

7.7. A Partnership approach to care and wellbeing is vital. It underpins a rights-based approach, further developing the positive relationships required to ensure that people feel protected, treated fairly, listened to and respected. The organisational ethos must be one of leading from the top and by example where policies, procedures and management of practice sets out a co-production approach as an organisational value.

7.8. How communication happens is important. Those with speech, language or communication needs (SLCN) require services and processes to be inclusive and accessible to enable full participation in all decision making. People with SLCN may need support to make decisions. Their needs must be considered in terms of how they communicate/understand and what support is required to promote involvement and empowerment. This will include those who know the person best – possibly a family member, or someone who works closely with them, as well as the possible need for specialist professional staff for example, nursing staff, speech and language therapy staff, psychology staff and other allied health professional staff. It is a potential breach of a person's human rights if staff are unable to communicate in a way that the person understands.

7.9. Staff must be appropriately trained in a range of communication methods and inclusive communication strategies to ensure that the people that they care for are understood. For some individuals, the fluctuating nature of communication must be acknowledged and recognised, supporting flexibility whereby staff can adapt to meet the needs of the person. Effective communication skills and identifying a person's needs are vital in supporting them and preventing situations escalating to the point where restrictive interventions, restraint or seclusion is required.

7.10. This may include identifying barriers to effective and inclusive communications, such as sensory impairment or the need for translation.

7.11. This also includes proverbial communication training (voice, tone, pace) which supports a trauma informed approach to care delivery and the use of de-escalation techniques which consist of a variety of psychosocial techniques, aiming to reduce disruptive and/or behaviours of concern and risk using verbal and non-verbal communication skills.

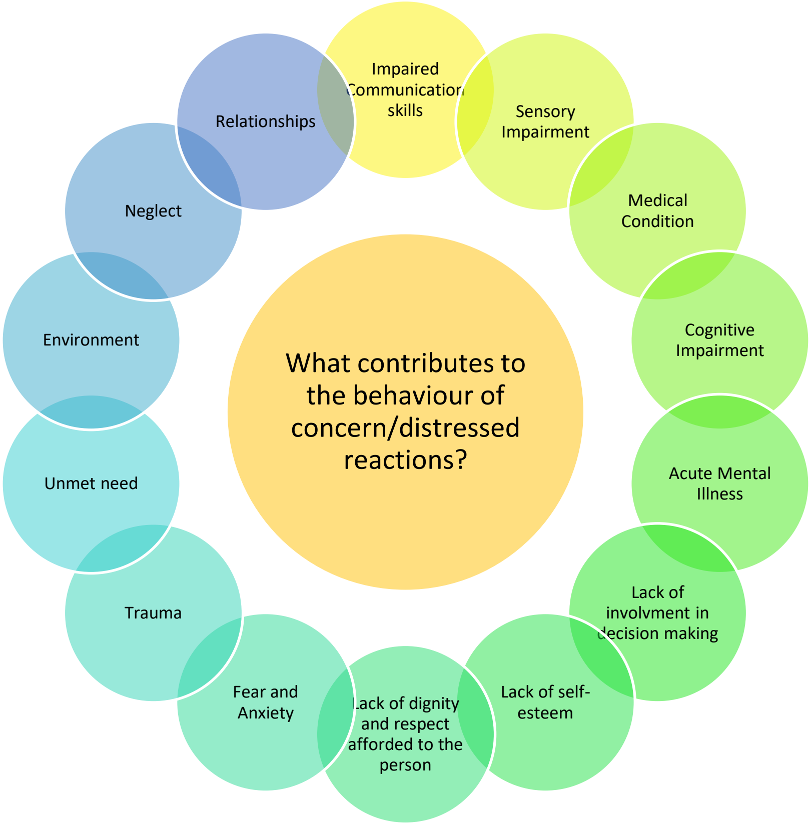
7.12. Organisations should recognise when additional staff training is required, with access to and use of appropriate communication support tools which assist staff to facilitate effective communication. Behaviours of concern and distressed reactions are communicating something; therefore, it is essential that people are helped to communicate in a way that is supportive and as safe as possible– physically and psychologically.

8 Standard 4 – Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans

8.1. Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans. All organisations must adopt positive approaches in the delivery of care, support and treatment plans that deliver proactive and preventative strategies, to better support the people using services and improve outcomes that support a better quality of life.

8.2. Using positive, proactive and preventative evidence-based strategies will support working towards reducing reliance on reactive and restrictive interventions[lxx]. This is a crucial component of a rights based, person centred approach, steering the organisational drive to minimise the use of restrictive interventions, restraint and seclusion, and must be reflected in organisational policy through to individual practice.[lxxi] [lxxii] [lxxiii] [lxxiv]

8.3. The key to establishing positive and proactive approaches is the need for health and social care staff to understand the reason and meaning behind behaviour. This will include areas such as environment, understanding history, and understanding family support and family dynamics, which could be influencing or contributing to how or why an individual behaves in a particular way.



8.4. Positive and proactive interventions assist the development of a therapeutic relationship between health and social care staff and those that they care for. The establishment of a therapeutic relationship aids communication, promotes recovery and supports the development of skills building to allow people to express themselves appropriately, therefore reducing the likelihood of behaviours of concern.

8.5. Underpinning positive, proactive and preventative approaches requires:

- Training for staff
- Cultural change Strategies
- Implementing preventative approaches
- Individualised co-produced support plans
- Positive cultures
- Rights based, person centred care delivery
- Clear governance arrangements
- Effective communication skills & inclusive communication strategies
- Inclusion of Recovery Based Approaches
- Inclusion of Trauma Informed Approaches

8.6. Proactive strategies may include:

- Incorporated meaningful activities.
- Promoting mental health and well-being.
- Promoting outdoor activity to support good mental and physical well-being.
- Promoting engagement using structured daily activities and routine.
- The removal of precipitating factors such as changes within the environment.

- Promoting the use of an environment and strategies to support the person to develop alternative behaviour patterns to support their needs.
- Use of communication aids to support identification and understanding of the person's needs[lxxv].
- Respecting culture and ethnicity.
- Working in partnership, ensuring that people (where capable) are involved in decision making around their care and treatment.

8.7. Creating a therapeutic culture and environment is key in supporting a person who may display a behaviour of concern and/or a distressed reaction which presents as a risk towards themselves and/or others. Staff must consider the physical environment, in addition to other external environmental factors, when thinking about proactive and preventative strategies to support the person.[lxxvi]

8.8. Preventative strategies may include:

- Use of relaxation.
- Individual personalised therapeutic activities/routines to promote wellbeing and behaviours and reduce avoid the need for a restrictive practice.
- Offering opportunity to discuss thoughts/feelings.
- Supportive approach – communicating in a way that suits the individual person and their needs.
- Environmental cues, optimal use of lighting, colour, contrast, signage, noise reduction, or stimulation as preferred by the individual, temperature, space and the ability to walk and explore freely but safely, other people.
- Timely access to specialist assessment and comprehensive, evidence-based treatment.

8.9. Providing person centred care is essential to the development of care and treatment plans. In order to provide good quality care and support to a person, it is important that all professionals are able to work together in partnership with the person, and their families and/or carers identified as partners in care, to ensure respect and dignity is afforded to everyone involved.

8.10. Cognisance of preventative and proactive measures in care and support provision are critical to the application of a rights-based approach in all health and social care settings. In order to ensure this is threaded throughout all policy and practice proactive measures must be considered in advance of any decision making regarding the planning and implementation of care, treatment and support plans. This requires staff, teams and services to define proactive measures several steps back in any organisational and service delivery planning or decision-making processes.

8.11. Staff must be aware of the accumulative impact of a number of separate restrictive interventions, the potential for physical and psychological risks to the person, as well as unintended consequences of any restrictive practice.

8.12. When health and care needs are appropriately assessed and met, crises are rare. Analysing behaviours to identify antecedents and anticipating an individual's needs, including any current or potential behaviours of concern or risk assessments, should initiate discussion around proactive steps in care, treatment and support that are likely to reduce or prevent any need for consideration or use of restrictive practices. Where required, for those with SLCN challenges, specialist assessment and support by speech and language therapy services may be necessary.

9 Standard 5 – Organisational strategies and related policies for minimising the use of restrictive interventions must follow a shared and consistent content

9.1 All organisations must follow a minimum policy content format in relevant policy documents that includes details of the organisational strategy for minimising the use of restrictive interventions. Language used must be free from jargon and accessible to all age groups and abilities. Terminology must be regionally standardised.

9.2 People using health and social care services have a legitimate expectation of consistent treatment and application of approaches, particularly those who might move between different settings. Scope for differing interpretation is unfair and potentially detrimental. Therefore, a consistent approach in all aspects of application of this policy and, in particular, setting the context for practice, implementation and oversight in local and organisational policy, is important in articulating the wider principles and values that people should expect and indeed be in receipt of, from health and social care provision.

9.3 All organisations must have clear vision, values and philosophy that demonstrate how they aim to eliminate, where possible, or minimise the use of restrictive interventions within services. Any restrictive practice elimination/minimisation programme should address leadership, the use of data to inform practice, specific reduction tools, development of the workforce, and use of models for post incident review

9.4 It is important there are mechanisms by which organisations can produce evidence demonstrating the steps have been taken within the service to eliminate or minimise restrictive interventions.

9.5 Local and organisational policy frameworks should be co-produced and must include as a minimum:

- the organisational values that underpin the approach to minimising restrictive interventions;
- the detail of the organisational vision and strategy for minimising restrictive interventions;
- details of job roles within the organisation with specific restrictive practice minimisation responsibility and accountability;
- communication requirements and strategies;
- standard definitions;
- clear professional/clinical guidance;
- reference to working within current legislative frameworks and professional registration requirements;

- an emphasis on positive, proactive, preventative and evidence-based interventions and strategies;
- how the Three Steps to Positive Practice Framework as the organisational methodology for considering and reviewing the use of restrictive interventions is embedded and operationalised;
- details of accredited training required, including training required for specific interventions;
- details of interfaces with other regional and local policies, agreed protocols and any associated requirements;
- reference to clear recording, reporting, monitoring and governance arrangements (including how data will be used in the minimisation strategy, ensuring alignment with the UK Data Protection Act 2018 (DPA18) & the General Data Protection Regulations (UK GDPR));
- support mechanisms for those who are subject to restrictive interventions; and
- support mechanisms for staff who restrict, restrain and/or seclude those in their care.

10 Standard 6 – Roles and responsibilities are defined in terms of monitoring, reporting and governance

10.1 Each organisation must define roles and responsibilities within their restrictive practice minimisation strategies in terms of monitoring, reporting and governance.

10.2 A total organisational approach is required in the minimisation of restrictive interventions at the organisational level[lxxvii]. A regional approach is also required to understand behaviours and responses, the impact of those responses with analysis of that understanding underpinning actions required to minimise use of restrictive interventions.

Roles and Responsibilities

Department of Health (DoH)

10.3 The Department of Health (DoH) is responsible for setting regional policy and holding overall accountability for regional minimisation of restrictive practices, restraint and seclusion.

Strategic Performance and Planning Group (SPPG)

10.4 The Strategic Performance and Planning Group (SPPG) in DoH is responsible for monitoring the effectiveness of Health and Social Care Trust (HSCT) strategies in minimising the use of restrictive practices, restraint and seclusion.

10.5 SPPG must appoint a relevant Director who is responsible for:

- Agreeing the structures for reporting data and supporting narrative with Trusts and non-statutory provider organisations to ensure that the requirements of this regional policy can be produced in the format that facilitates both organisational and regional information across all relevant services;

- Agreeing the detail of data to be collected and format for reporting (in line with the Information Commissioner’s Office guidance for data sharing)[lxxviii] , ensuring consistency across statutory and non-statutory provider organisations, with particular reference to agreeing terminology;

- Providing assurances regarding robust incident specific review and analysis of use of prolonged physical restraint, rapid tranquillisation and seclusion (and any incidents that amount to seclusion); and

- Providing a monitoring and assurance report on behalf of the Department of Health on an annual basis regarding the effectiveness of Trust strategies in minimising the use of restrictive practices, restraint and seclusion.

Provider Organisations – Health and Social Care Trusts (HSCTs)

10.6 Each Health and Social Care Trust is responsible for approving their evidence-based and co-produced restrictive practices minimisation strategy.

10.7 Each HSCT must appoint an identified Director who is responsible and accountable for realising the organisational minimisation of restrictive practices, restraint and seclusion.

10.8 The Director is responsible for:

- Articulating the organisational vision and strategy to minimise the use of restrictive practices across all services;
- Developing the required policy and embedding the processes required to implement the restrictive practice minimisation strategy ensuring adherence to the regional policy;
- Obtaining the baseline information and data and achieving the subsequent restrictive intervention minimisation set out within organisational strategy;
- Oversight of the organisational use of restrictive practices, restraint and seclusion, to include specific issues escalated via restrictive practice analysis and reporting;
- Oversight of the review of incident-by-incident use of prolonged physical restraint, rapid tranquillisation, and seclusion (or incident that amounts to seclusion) and the agreed plan to mitigate against any recurrence;
- Oversight of assurances provided by non-statutory services regarding minimisation of the use of restrictive practices; and
- Preparation and submission of six-monthly assurance reports with monitoring data to SPPG.

Provider Organisations – Non-Statutory Provider Organisations

10.9 This policy cannot make requirements on non-statutory organisations. However, this policy provides non-statutory best practice recommendations:

- Non statutory provider organisations should appoint an identified health and social care Director /Senior Manager who is responsible and accountable for realising the organisational minimisation of restrictive practices, restraint and seclusion.
- The identified Director /Senior Manager is responsible for:
    - Articulating the organisational vision and strategy to minimise the use of restrictive practices across all services;

  - Developing the required policy and embed the processes required to implement the restrictive practice minimisation strategy ensuring adherence to the regional policy;

  - Obtaining the baseline information and data and achieving the subsequent restrictive intervention minimisation set out within organisational strategy;

  - Oversight of the organisational use of restrictive practices, restraint and seclusion, to include specific issues escalated via restrictive practice analysis and reporting;

  - Oversight of the review of incident-by-incident use of prolonged physical restraint, rapid tranquillisation, and seclusion (or incident that amounts to seclusion) and the agreed plan to avoid any recurrence; and

  - Providing reports where required to commissioning HSCTs and RQIA.

Regulation and Quality Improvement Authority (RQIA)

10.10 RQIA will have a monitoring and assurance role consistent with their role and function set out in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order, 2003, Mental Health (Northern Ireland) Order, 1986, Mental Capacity Act (Northern Ireland) 2016, service specific regulations and inspection key themes. This includes reviewing the implementation of rights-based approaches for individuals and achievement of organisational restrictive practice minimisation measures.

Monitoring

Incident by Incident Review

10.11 Management of incidents that carry significant risk must be subject to incident-by-incident review (which should not be confused with de-briefing) no longer than 72[lxxix] hours after the incident to establish learning and promotion of preventative strategies in the work towards minimisation of restrictive interventions.

10.12 This includes incidents of: [lxxx]

- prolonged physical restraint;
- rapid tranquillisation;
- seclusion; and
- any incident that amounts to seclusion.

10.13 The use of a formal incident-by-incident review process is important in identifying the causes of the incident and the impact on all those involved. Doing so will create learning for prevention of further incidents, improvements in an individual’s care plan and safety improvements for all.

10.14 Incident by incident review considerations:

- undertaken within 72 hours of the incident
- undertaken in collaboration with people who use services
- includes staff independent of the service where the incident took place
- uses information recorded in the immediate post-incident debrief, including reports from staff, the person involved and any witnesses if further information is needed
- identifies any triggers for the incident and what could have been done differently
- includes analysis of agreed strategies, how they were used, use of a right based methodology and why these measures were unsuccessful in de-escalating
- how could impact have been minimised
- review of risk assessments/plans and any required inclusion for new evidence based therapeutic interventions
- barriers that prevent change and how they can be addressed

Restrictive Practice Register

10.15 All organisations must retain restrictive practice registers at local service level, maintained and reviewed by the local service manager.

10.16 The register must provide a current overview of the number and type of restrictive interventions in use within a service, supporting the link from local minimisation actions to the overall organisational strategy.

Leading Positive Practice

10.17 Organisations may wish to consider adopting a “Positive Practice Champion” role (smaller organisations), or “Positive Practice Teams” (larger organisations).

10.18 The Champion or Team is key in supporting the organisation’s minimisation strategy at service delivery level to produce better outcomes for people. This may include:

- assisting and contributing to the detail of minimisation strategy and implementation plans;
- supporting the implementation of minimisation plans, monitoring effectiveness and value to the individual, the service and the organisation;
- undertaking audit of practice in line with minimisation strategy and plans;
- advising on policy content, communication strategies, terminology and language;
- advising and supporting quality improvement initiatives for minimisation of restrictive interventions;
- supporting de-brief and review processes;
- undertaking training needs analysis;
- contributing to data analysis; and
- producing data reports, quality assessment reports, quality improvement recommendations.

Learning for Improvement

10.19 Learning for improvement in safety and quality is essential – for individuals, for services and for the system as a whole. The Public Health Agency through its safety and quality functions, is responsible for supporting analysis of incident reporting for purposes of learning and service improvement and developing regional quality improvement initiatives informed by that data analysis and learning.

11 Standard 7 – Any use of seclusion as a last resort intervention must follow the regional operating procedures

11.1 Seclusion is the confinement of a person in a room or area from which free exit is prevented.

Purpose

11.2 The operating procedure set out below provides the requirements for all health and social care organisations for the use of seclusion. HSC Trusts must follow this procedure.

Scope

11.3 Seclusion is an intervention of **last resort**. Seclusion must only be used in hospitals in a room or area that has been specifically designed for that purpose.

11.4 The designated room or area that has been specifically designed for the use of seclusion must not be used for any other purpose.

11.5 Seclusion can only be used where a person is (or liable to be) detained in hospital within an appropriate legal framework.

11.6 Seclusion can never be voluntary or consented to. Some individuals may express a preference for seclusion rather than physical restraint, for example, in circumstances where they exhibit behaviours that present an immediate and unmanageable risk of serious harm to others when acutely mentally unwell. This is not to be confused with a person "consenting" to seclusion and does not provide legal protection for seclusion. Expressed preferences may be part of care planning and may form part of an advance statement. This does not provide legal authority but should be considered by all health and social care professionals when making decisions about the management of a person where their behaviour is presenting as a risk towards themselves or others.

Responsibilities, Accountabilities, Duties

Chief Executive

11.7 The Chief Executive of each organisation is responsible for:

- Ensuring that there is a policy in place that governs the safe use of seclusion, which all staff have access to.
- Ensuring the ethos of *last resort* and *least restrictive* is embedded within organisational culture to work towards the minimisation of restrictive interventions.

Directors

11.8 The Directors of relevant areas are responsible for:

- Ensuring that all staff are aware and compliant in the delivery of the seclusion operating procedures.
- Ensuring that any local level procedures are reflective of the ethos outlined within the regional seclusion operating procedures.
- Ensuring that all episodes of seclusion are documented and recorded appropriately.
- Ensuring that all staff are appropriately equipped with knowledge and skills required in understanding and managing incidents of crisis behaviour/acute behavioural disturbance that may require seclusion.
- Ensuring that all incidents of seclusion are appropriately governed/audited in line with individual organisational procedures.

Service Specific Lead Nurse/Social Worker

11.9 Service Specific Lead Nurses/Social Workers are responsible for:

- Completion of a training needs analysis and overseeing training for seclusion awareness and any other relevant training needs (including Deprivation of Liberty Safeguards, Mental Health (NI) Order 1986, Human Rights etc.), and ensuring training is accessible for all staff.

Service Manager/Assistant Service Manager

11.10 Service Managers/Assistant Service Managers are responsible for:

- Monitoring overall compliance with the policy.
- Ensuring that all staff who require the training have access to it.
- Ensuring that clear systems for reviewing those who require seclusion and recording are in place.

Inter-disciplinary Team (IDT)

11.11 All Inter-Disciplinary Team staff are responsible for:

- Being aware of the policy and being compliant in the delivery of the operating procedures

- Ensuring that an IDT approach is taken in reviewing, developing and updating treatment plans and risk assessments.
- Ensuring that there is clear communication and regular incident reviews as per NICE guidelines.

Line managers

11.12 Line managers are responsible for:

- Ensuring that mechanisms are in place so that all staff are aware of the policy and are compliant in the delivery of operational procedures.
- Ensuring that all staff attend mandatory training which includes seclusion operating procedures.
- Promoting an ethos of human rights-based approach where staff are committed to protecting the rights of those they care for and treating them with dignity and respect.
- Ongoing monitoring and review of working practices regarding seclusion operating procedures.
- Where possible ensuring that the person, families and carers are included in decision making regarding the use of seclusion.

All staff

11.13 All staff are responsible for:

- Complying with the operational procedures.
- Reporting any untoward incidents regarding seclusion in line with organisational safeguarding procedures and incident reporting procedures.
- Ensuring that any episode of seclusion is documented and recorded appropriately.
- Working with people in line with a human rights-based approach.
- Having an understanding of integrated experience – the understanding of the potential impact of their behaviour towards people in their care and how this can affect the behaviour of others, becoming a precipitating factor.
- Where possible, ensuring that the person, families and carers are included in decision making regarding the use of seclusion.
- Ensuring care plans and risk assessments being kept up to date.

- Organisational policies must be referred to and contact should be made (where or if required) with the relevant organisation's training team for support and guidance on the management of a person presenting with unmanageable risk and/or supporting transition of the person to designated seclusion room.

Procedure for Seclusion

Use of seclusion

11.14 There are several factors that need to be considered with regards to the use of seclusion.

11.15 Seclusion can cause psychological harm with no definitive evidence that it has any therapeutic benefit. The use of seclusion can often be seen as negative and a non-therapeutic experience, with potentially harmful physical and psychological effects. The effectiveness and adverse effects of seclusion and restraint seem to be similar, although the evidence base for both is limited.

11.16 Seclusion must only be used in an emergency in response to an unmanageable risk of harm to others where other responses have been deemed insufficient. However, seclusion may form part of a patient's care plan for use in emergency situations.

11.17 In the absence of clinical guidance to review every potential situation that may arise, any interventions regarding the use of seclusion will be based on clinical judgement by the relevant nursing and medical staff who are involved. All interventions regarding the use of seclusion must be a last resort option that is proportionate and justifiable to the presenting risk.

11.18 Seclusion might be used as an alternative to physical restraint or rapid tranquillisation. The factors influencing this will be specific to the individual and situation, and the individual's preference should be determined as soon as possible.

11.19 The use of seclusion for a person not detained in accordance with a relevant legal framework will necessitate a review of their legal status with a view to legal detention. Seclusion, outside of an emergency, is unacceptable, potentially unlawful and in breach of human rights and could be considered as a crime as result of false imprisonment of the person.

11.20 Seclusion should **not** be used:

- Where there is a risk of suicide.
- Where a person is engaging in self-harm or there is evident risk of serious self-harm.
- Due to a lack of resources to manage an incident where the person is displaying risk behaviour.

- As a punitive action.
- As part of a treatment plan – unless the person has completed an advance statement expressing their wishes/preference.
- Where mechanical restraint is also in use.
- Where a person has a pre-existing condition that staff are aware of and where care plan documentation indicates seclusion should not be used.

Seclusion Room

11.21 Seclusion should only occur in a room or area designed specifically for that purpose.[lxxxi,lxxxii,lxxxiii]

11.22 Seclusion room specifics:

- The construction of the room must be designed to withstand high levels of violence with the potential to damage the physical environment e.g. walls, window, doors and locks.
- There should be no:
  - ligature points;
  - access to electrical fixtures that could pose a risk of harm.
- There must be an anti-barricade door system.
- The room must allow for staff to be able to clearly observe and hear the person within the designated room.
- The designated room should be in an area free from others but not isolated.
- The person in seclusion must be able to have a clear view of the outside environment but those on the outside must not be able to have any view of the person within seclusion.
- The room must be large enough to support the person and team of staff (who may be) required to use physical interventions during transition to seclusion.
- Adequate lighting must be provided, in particular a window in order to provide natural light. Lighting should be able to be controlled both by the person within seclusion and those external.
- The room must be equipped with adequate temperature and ventilation system with heat sensor for effective monitoring.
- The room must be decorated in a calming manner that appears non-threatening to the person.

- The room must be kept clean and fresh.
- The room must have direct access to washing and toilet facilities.
- The room must be safe and secure.
- There must be a visible clock.
- There should be limited furnishings. Any furnishings must be as safe as possible and must not include anything that could potentially cause harm. Furnishing must be comfortable and in good condition.

11.23 To ensure that the designated seclusion room or suite is maintained appropriately, all organisations should ensure the following mechanisms are in place:

- Weekly maintenance check (see Appendix 1).
- Ensure the designated room remains locked at all other times when not in use.
- Is part of routine cleaning schedules (in situations where the room requires deep clean, each organisation should follow individual IPC procedures and set out interim guidance for management of the person should seclusion require early termination to facilitate deep cleaning).
- Ensure that only appropriate equipment i.e. soft furnishings are kept within the designated room/suite.

11.24 If at any stage there is requirement for maintenance work to be carried out, then each organisation should ensure that there is interim plan in place for management of a person in an emergency situation where there is deemed unmanageable risk and ensure that all staff are aware of the interim arrangements.

Commencement of Seclusion

Decision to seclude

11.25 Seclusion should only ever be used as an emergency intervention.

11.26 The use of seclusion must always be a reasonable and proportionate response to the level of risk shown and where decision making clearly shows that there has been consideration to the use of other restrictive interventions. Decision making might reflect the use of seclusion as a safer alternative than prolonged restraint or the use of medication.

11.27 The decision to seclude a person is based on clinical professional judgement regarding knowledge of the patient and potential unmanageable risk towards others.

11.28 The person making the decision to seclude should be:

- The nurse in charge of the team providing the person's care at the time of seclusion;

OR

- A doctor with responsibility for the care of the person or the duty doctor on call.

11.29 The person making the decision to seclude should ensure that:

- There is an appropriate legal framework in place;
- They have seen the person immediately before seclusion commences;
- They have consulted with the team providing the person's care at the time of seclusion;
- They are familiar with relevant aspects of the person's healthcare records (e.g. risk assessment) as far as possible;
- They are aware of the person's advance wishes in relation to what should happen in an emergency, as far as possible;
- The intervention is necessary, appropriate and can happen safely, and that reasonable alternatives have been considered;
- The necessary observation and review can take place to monitor the person's physical and mental wellbeing; and
- Where required, individual organisation search policies are adhered to, if there are concerns about any items that a person may have.

Review Process

11.30 There are a number of review processes which should be commenced as soon as a period of seclusion is initiated.

11.31 All reviews should be considered as an opportunity to determine whether the seclusion period can be terminated or if it requires continuation.

Roles and Responsibilities

Medical staff

11.32 Medical reviews must be carried out in person and must include the following:

- Assess and review the need for seclusion period to continue;
- Review mental and physical health;
- Review level of risk towards others;
- Review level of observations;
- Review potential risk to self; and
- Review prescribed medication and consider/assess any potential adverse effects of medication.

11.33 If a doctor was involved in the decision to seclude then their assessment at the time seclusion was commenced will be considered as the first medical review and they will not be required to complete a separate first medical review.

11.34 If a doctor was not involved in the decision to seclude then they must be notified to attend immediately to undertake the first medical review. The first review should take priority over routine tasks or any of those which are anticipated to cause further delay. Any potential delay should be discussed with the Consultant Psychiatrist on call, to ensure that any delays are considered reasonable and justifiable.

11.35 Where the seclusion period is so short that the doctor does not visit before termination then this must be recorded on the seclusion care plan and within the person's care record.

11.36 Medical reviews must take place every four hours - one of which should be undertaken by the person's Consultant Psychiatrist within 24 hours unless stipulated during the first internal IDT review.

11.37 A medical review should be undertaken by the Consultant Psychiatrist at least once in every 24-hour period.

11.38 Medical staff must complete an individualised seclusion care plan in partnership with nursing staff and provide input following the review process.

11.39 The outcome of the medical review must be documented in the person's care record.

Senior Management

11.40 Senior management staff will be contacted by nursing staff to inform them of the commencement of a period of seclusion.

11.41 The senior manager in receipt of the call should arrange to attend the ward to receive a report on the decision to seclude – the senior manager should sign records acknowledging receipt of the report and any other information or advice provided. If the senior manager does not attend in person, the nurse in charge must document the detail of conversation and decisions agreed as per telephone conversation. The senior manager should email confirmed details of the conversation and agreement reached to the nurse in charge as soon as possible

11.42 The senior manager should provide support and guidance to support the person within seclusion and staff involved in managing the period of seclusion.

11.43 The Senior Manager should discuss presentation, risks and agreed management plan with nurse in charge.

Nursing Staff

11.44 Nursing staff will contact and inform the multi-disciplinary team (who have caring responsibility for the person) of the commencement of a period of seclusion period as soon as possible, making a contemporaneous entry in the person's records. They will also contact the senior manager to inform them of the commencement of the period of seclusion.

11.45 The nurse in charge will complete a formal review of the on-going seclusion every one hour during the seclusion period to ascertain if there is an opportunity for seclusion to be terminated. If it is not yet safe to terminate seclusion, the nurse in charge will review the implementation of the seclusion care plan actions to ensure that everything that can be done to end the period of seclusion is being done.

11.46 Every two hours, the nurse in charge will be accompanied by a registered nurse to ascertain if there is an opportunity for seclusion to be terminated. Ideally the second nurse should not be directly involved in the incident that led to a decision to seclude. If it is not yet safe to terminate seclusion, both nurses will review the implementation of the seclusion care plan actions to ensure that everything that can be done to end the period of seclusion is being done.

11.47 Outcomes for the nursing reviews should be recorded contemporaneously in the person's care records.

11.48 Where a doctor fails to attend immediately, as requested, to complete the first medical review (where they were not a part of the initial decision to seclude) an incident form should be completed by the nurse in charge, for review by senior management.

11.49 The next of kin/significant others should be informed in a timely manner of the necessity for seclusion but in a considerate manner taking into account the time of day/night. Consent for sharing information should be clarified[lxxxiv].

Reviews of seclusion

Internal multi-disciplinary team review

11.50 An internal multi-disciplinary team review must include the patient, their doctor, nurse in charge, and other professionals who may usually be involved with the person. An initial review must be carried out as soon as practicable once the seclusion period commences.

11.51 An internal review must also take place once in every 24-hour period of continuous seclusion.

Independent multi-disciplinary team review

11.52 If a patient is secluded for more than 8 hours repeatedly or 12 hours over a period of 48 hours, there must be an independent review undertaken by professionals who were not involved in the incident that led to the period of seclusion or where part of the decision to commence the seclusion period. The review must include the patient, with a review team comprising of a doctor, nurse and other professionals, and an independent advocate.

11.53 Even if the seclusion period has since ended, once a trigger point has been reached, the review must be held. If the seclusion period is ongoing, then the independent review can make additional recommendations as appropriate to the seclusion care plan.

Recording and Documentation

11.54 Seclusion records must include as a minimum:

- Personal details of the person in seclusion;
- Date and time the seclusion commences;
- Decision to seclude the person, preceding incident(s) and other unsuccessful measures used to manage the situation (including use of physical intervention where required to support transition to seclusion room);
- If search procedure was required;
- Nurse in charge details;
- Details of doctor contacted;
- Details of senior manager (or others) contacted;
- Legal status of person – and any actions taken to review legal status;
- Date and time of termination of seclusion;

- Consent for information sharing with next of kin and / or family; and
- The Seclusion care plan.

11.55 A seclusion care plan must be completed as soon as the seclusion period commences. It must reflect the person-centred care needs of the person and record the actions that should be taken to end the period of seclusion in the shortest time possible.

11.56 A seclusion care plan must include as a minimum:

- Personal details;
- Known clinical needs (including mental and physical considerations);
- How de-escalation strategies will continue to be used;
- Outline actions towards termination of seclusion;
- Recognising signs where behaviour is no longer considered an unmanageable risk towards others, e.g. evidence of tension reduction, improved communication etc;
- How potential risks may be managed;
- Reference to individual care plans, support plans, behaviour support plans, sensory regulation strategies etc;
- Meeting of food/fluid needs;
- Meeting of needs in regard to personal hygiene/dressing;
- Meeting of elimination needs (with specific reference to how privacy and dignity will be managed);
- Medication reviews (in consultation with a doctor or other as delegated);
- Monitoring of physical observations;
- Person’s views in regards to the seclusion process; and
- Information about informing next of kin and/or families as stated within individual support plans or as previously discussed in advance statements regarding emergency situations.

11.57 A template for a seclusion care plan is included in Annex B.

Observations

11.58 A registered nurse must observe and monitor the person and their action's whilst in the seclusion room and determine whether seclusion can be terminated.

11.59 The registered nurse may be outside the person's room (or in an adjacent room with a connecting window), provided that the person can fully see the registered nurse and can continuously observe and hear the person.

11.60 CCTV must not be used to replace continuous staff presence. CCTV does not replace the usual observation process but can be used to enhance observation and to increase safety and security of the person within the seclusion room. The observing nurse should remain in the immediate vicinity (directly outside the seclusion room door) and be available to provide immediate (including discrete) observation and assessment at any stage during the seclusion period. Immediately after the commencement of the seclusion period, the person must be placed on 1:1 observation. **A registered nurse** must be delegated to undertake 1:1 observation of the person within the seclusion room, for the period of seclusion. The registered nurse must be exempt from undertaking other duties for the period of seclusion.

11.61 Observation of a person subject to seclusion involves a range of other professional and intricate competencies, including assessment, using clinical judgement, making clinical decisions, risk management, and, very importantly, the delivery of person centred and human rights-based care. Therefore 1:1 observation of a person in seclusion should be only undertaken by a registered nurse.

11.62 Consideration must be given to the registered nurse chosen to support the person in seclusion, and any potential impact on the person. This must be considered on an individual basis.

11.63 An observation record must be documented at a minimum of every 15 minutes; this can be reviewed based on clinical presentation and risk assessment.

11.64 The registered nurse completing the observations must monitor the following:

- Physical appearance and documenting any evidence of physical ill health such as shortness of breath, unusual facial pallor or potential cyanosis;
- Mental state presentation;
- What the person is doing or saying whilst in seclusion;
- Level of communication; and
- Level of alertness/awareness (particularly following administration of medication).

11.65 If medication has been administered prior to the person entering seclusion, with intent to subdue acute behavioural disturbance, individual organisational policies (developed in line with regional guidelines) should be followed and the person should be observed in accordance with same.

11.66 It may be difficult at this time to complete full clinical monitoring and NEWS chart. As a minimum the registered nurse observing, should record:

- Person’s respiration rate;
- Person’s response to verbal or tactile stimulation;
- Person’s level of movement;
- Person’s level of awareness; and
- Any attempts to complete physical monitoring, whether successful or not, must be recorded.

11.67 Observing staff must have access to a personal alarm or call system should they need to seek urgent assistance in an emergency.

11.68 Handover between staff observing must be documented. Observing staff should be able to respond to a situation where patient safety becomes compromised i.e. self-injurious behaviour.

Care of the Person in Seclusion

11.69 During a period of seclusion, staff must ensure that a good level of care is maintained and delivered, ensuring that the person’s privacy and dignity is maintained. The health, safety and wellbeing of the person is paramount.

Personal care/elimination/dressing needs

11.70 Seclusion rooms must have toilet and shower facilities.

11.71 Staff must be able to supply the person with toilet paper, hand soap, towels and other hygiene products as and when required.

11.72 If a person is in seclusion for a period prolonging 24 hours, they should be encouraged and, where required, assisted to meet their personal hygiene needs.

11.73 A persons’ privacy and dignity must be maintained at all times throughout seclusion. Items of clothing must only be removed where there is potential for the person to use the items of clothing as ligatures and cause serious risk of harm to self.

11.74 Each individual organisation must consider the use of tear proof clothing should it be required.

Provision of food/fluids

11.75 The provision of food must not be denied to the person within seclusion. All meals and drinks must be provided as normal.

11.76 Crockery and utensil items that are considered safe to use i.e. plastic and non-metallic must be used.

11.77 All offers, acceptance and refusal of food and fluid items must be documented within the seclusion observation form and within the person’s records.

Accessing seclusion room in planned or unplanned scenarios

11.78 Staff may at times be required to enter the seclusion room in planned/unplanned scenarios. Planned scenarios may include (but are not exhaustive to) facilitating reviews, supporting access to toilet/showering facilities, providing food/fluids or administering medication.

11.79 Unplanned scenarios may include (but are not exhaustive to) when the person’s health, safety and wellbeing is compromised, deterioration in clinical presentation or engaging in risk behaviour where there is imminent risk to the person.

Administration of Rapid Tranquillisation whilst the person is in seclusion

11.80 There may be occasions where the person in seclusion may require the administration of medication via rapid tranquillisation. If required, staff should refer to the guidance within local policy and procedure, relevant best practice guidance and/or regional protocols.

11.81 Staff must be aware of potential side effects and be prepared to address any complications that may arise.

11.82 A registered nurse must observe the person within sight. A doctor and nurse in charge must review the seclusion care plan and associated risks and consider the termination of seclusion once rapid tranquillisation has had the desired effect.

11.83 If there is an identified risk to the person at any time, then the seclusion room must be entered at the earliest and safest opportunity.

11.84 In a scenario where staff are unable to clearly see the person within seclusion due to covering of the head or face, the observing staff member should encourage the person to remove the covering to maintain observations and also assess the person’s clinical and physical presentation. If the person is non-communicative the observing staff member should seek immediate assistance and assess the need to enter the seclusion room. This will be a decision based on clinical judgement and the need to maintain safety of the person whilst in the seclusion room.

11.85 Any need for staff entry or exit of the seclusion room (outside of a response to an emergency) must be informed by careful application of specific skills learnt in training for managing situations where an individual presents with behaviour of concern/distressed behaviour.

Termination of Seclusion

11.86 Seclusion must be terminated at the earliest opportunity when it is assessed to no longer be required.

11.87 The seclusion care plan must detail safe management and support of the person on the ending of seclusion, and during reintegration of the person to the general ward setting within the hospital.

11.88 If the person is sleeping, then the risk is no longer immediate and unmanageable, and seclusion must be terminated. The continuation of observation if the person is sleeping will be based on clinical judgement of the situation at the time.

11.89 Opening of the seclusion room door in order to facilitate reviews, support access to toilet or showering facilities, provide food/fluids, administer medication does not constitute an end to seclusion.

Post Seclusion

11.90 Nursing staff will complete the documentation required for the seclusion period. The end of seclusion must be recorded in the observation record by the nurse in charge.

11.91 When seclusion is ended, a body chart must be completed. The next of kin must be informed of the termination of seclusion (taking into account consent from the person and appropriateness of the time of day/night to provide update).

11.92 Following seclusion, the nurse in charge must make arrangements for the room to be reviewed, maintenance checks to be complete and cleaning procedures in line with IPC guidance.

Incident review

11.93 The purpose of a post incident review is to provide opportunity for learning and provide support to the person and staff. A post incident review must take place as soon as possible, but no later than 72 hours[lxxxv] following termination of seclusion.

11.94 There must be a designated person to lead the incident review, and where possible they should not have been involved in the seclusion incident.

11.95 The review process must include discussing the incident with the person secluded to ascertain their thoughts and views.

11.96 The review will consider the following key points:

- What happened during the incident?
- Why did it happen? (Possible triggers, precipitating factors or early warning signs/Any noticeable patterns)
- How can a recurrence be avoided?
- What might be done differently the next time?
- What has been learned?
- Any changes to care plan or risk assessments?
- Any additional emotional support required for the person who has been secluded and any staff involved in the seclusion?

Use of CCTV in a Period of Seclusion

11.97 The use of CCTV for a period of seclusion within a hospital setting is to enhance the safety of all involved. The use of CCTV must not replace staff presence[lxxxvi]. Where organisations use CCTV, staff must refer to individual organisational policies for guidance. Data protection requirements[lxxxvii] related to the use of CCTV must be incorporated in organisational policies for use of CCTV and guide decision-making for each individual use of CCTV for monitoring a period of seclusion. This will include a Data Protection Impact Assessment[lxxxviii] that outlines the necessity, fairness and proportionality of the decision to use CCTV to monitor a period of seclusion. In addition to the above, each organisation that uses CCTV to monitor a period of seclusion should consider and outline how the proposed processing meets the seven key principles under the UK GDPR.

11.98 CCTV does not replace the usual observation process but can be used to enhance observation and to increase safety and security of the person within the seclusion room.

11.99 The privacy and dignity of the person must be protected at all times.

Emergency scenarios

Fire Alarm

11.100 If the fire alarm was to sound whilst a person is in seclusion, the observing staff member must immediately seek direction from the nurse in charge and take direction in line with evacuation procedures.

11.101 Where there is a potential immediate risk to life, then seclusion must be terminated, and the person escorted out of the building in line with evacuation procedures to the nearest fire assembly point.

11.102 There must be an appropriate level of staffing in order to enter seclusion and evacuate the person.

Medical emergency

11.103 All staff involved must have the appropriate training and associated skills in order to manage a medical emergency.[lxxxix] [xc]

Monitoring and Governance

11.104 Organisations must develop their policies in support of the regional seclusion operating procedures in regard to the monitoring and governance arrangements for the use of seclusion.

11.105 The Seclusion Audit tool (see Appendix 6) provides an opportunity for the Nurse with overall responsibility of the hospital ward, in which seclusion occurred, to review key procedures and processes.

12 Appendices

Appendix 1 – Seclusion Maintenance Record

Seclusion Maintenance Record

DATE		**TIME**	

SIGNED	
PRINT NAME	
IS THE ROOM FIT FOR USE/SATISFACTORY/WORKING ORDER: **ALL STAFF SHOULD ASSESS THE ROOM AND ENSURE ADEQUATE STANDARDS**	

	YES/NO	**COMMENTS/ACTION (IF REQUIRED)**
Safe (free from harm/weapons)		
Clean		
Lighting		
Heating		
Clock		
Locks		
Appropriate furnishings		
Doors/Door Frames		
Vision Panels		
Flooring		
Windows		
Skirting/Window Frames		
CCTV		
Ventilation		
Safety alarms in area		

ANY OTHER COMMENTS/ACTIONS REQUIRED FROM MAINTENANCE CHECK:

Appendix 2 – Record of Seclusion

<u>Record of Seclusion</u>

Person	**D.O.B** **Hospital Number** **Paris Number**
Ward	**Date of completion**
Date seclusion commenced	**Time seclusion commenced**
Name of those involved in decision to seclude:	**Name of professional initiating seclusion (doctor, nurse):** **Print Name:** **Signature:** **Designation:**
<u>Medical Staff</u> **Name of Doctor/Duty doctor informed of seclusion period:** **Time informed:** **Signature of Doctor who attended:** **Time attended seclusion:** **Were there problems in contacting doctor?** **If yes, please state what/why:** **Did Doctor attend to review immediately?** **If no, please state why?**	**<u>Senior Management or Other (outside of usual working hours)</u>** **Name of Senior Management/Other informed of seclusion period:** **Time informed:** **Signature of Senior Management/Other who attended:** **Time attended seclusion:** **Were there problems in contacting senior management?** **If yes, please state what/why:**

If no, complete incident form, reference no:	

Decision to seclude (Events leading to initiation of seclusion)

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Alternative measures utilised prior to decision that seclusion was required as last resort option

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____

Where Search procedures required due to potential risk of harms:

Yes ☐

No ☐

Items on the person within the seclusion room, if any items were removed for potential to cause harm (i.e. ligatures) Please detail below:

Not applicable ☐

Tear proof clothing required ☐

Consent to share information with NOK/family ☐

Consent to share information

Consent provided through advance statements ☐

Detail below where consent may not have been sought to information share/provide update (i.e. lack capacity)

____

____

____

Were Physical intervention techniques required? Yes ☐ No ☐

Was 'as required' / 'rapid tranquillisation' medication administered? Yes ☐ No ☐

Incident Form Complete: Yes ☐ No ☐

Datix number:

Termination of Seclusion

Date seclusion terminated	**Time seclusion terminated**

Duration of seclusion (total):

Name of those involved in decision to terminate seclusion:

Name of professional terminating seclusion:
Print Name:

Signature:

Designation:

Post Seclusion

Clinical observations complete ☐

Debriefing with person ☐

Debriefing with staff ☐

Incident review ☐

Appendix 3 - Seclusion Care Plan

Seclusion Care Plan

Person	**D.O.B** **Hospital Number** **Paris Number**
Ward	**Date of completion**
Date seclusion commenced	**Time seclusion commenced**

Clinical needs of the person/Physical and Mental state considerations/Potential risks
Management of any potential risks as outlined above
De-escalation strategies and outline of actions that will continue to be used to support termination of seclusion at earliest opportunity
How to recognise signs of tension reduction in person
Meeting person's needs and how this is planned for during seclusion period (food/fluid/elimination/personal hygiene/clothing)

Person’s views regarding seclusion process
Process of information sharing as in main care plan

Appendix 4 – Seclusion Observation Record

Seclusion Observation Record

A documented report **must** be made at least **every 15 minutes** or more frequently if required (including during reviews etc.).

Things to observe: person’s physical and mental state presentation, person’s behaviour, communication, personal hygiene, therapeutic interventions, food and fluid intake.

<table>
<tr><td colspan="2"></td><td>Person
DOB</td><td colspan="2">Hospital No:
Paris No:</td></tr>
<tr><td></td><td></td><td>Name of professional who initiated seclusion:</td><td colspan="2">Hospital setting:</td></tr>
<tr><td>Date</td><td>Time</td><td>Comments</td><td colspan="2">Print and Sign Name
Signature/Designation</td></tr>
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<tr><td></td><td></td><td></td><td colspan="2"></td></tr>
<tr><td></td><td rowspan="2">Hourly review by Nurse in Charge</td><td rowspan="2"><u>Comments</u></td><td rowspan="2"><u>Outcome</u></td><td>NIC signature</td></tr>
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<tr><td rowspan="2"></td><td rowspan="2">Hourly review by Nurse in Charge</td><td rowspan="2"><u>Comments</u></td><td rowspan="2"><u>Outcome</u></td><td>NIC Signature</td></tr>
<tr><td></td></tr>
</table>

Appendix 5 – Seclusion Review Record

Seclusion Review Record

There are a number of review processes which should be commenced once a seclusion period is commenced.
All reviews should be considered as an opportunity to determine whether the seclusion period can be terminated or if it requires continuation.

Medical Staff Review

Initial Assessment by Doctor/Duty Doctor *(Required immediately if the Doctor is not the professional implementing period of seclusion):* **Discussion:** **Outcomes:**
Name and Designation Print________________ Signature___________________

_______ **Hour Review by Doctor/Duty Doctor:** **Discussion:** **Outcomes:**
Name and Designation Print________________ Signature___________________

Nursing Staff Reviews

2 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge

Discussion:

Outcomes:

Name and Designation Print________________ Signature___________________

Name and Designation Print________________ Signature___________________

_______ Hour Review by 2 Registered Nurses, one who is the Nurse In Charge

Discussion:

Outcomes:

Name and Designation Print________________ Signature___________________

Name and Designation Print________________ Signature___________________

Internal IDT Review

Names of those participating in Internal IDT review: **Discussion:** **Outcomes and Actions**
Name and Designation Print________________ Signature___________________ **Name and Designation** Print________________ Signature___________________ **Name and Designation** Print________________ Signature___________________ **Name and Designation** Print________________ Signature___________________ **Name and Designation** Print________________ Signature___________________

Independent IDT Review

Names of those participating in Independent IDT review: **Discussion:** **Outcomes and Actions:**
Name and Designation Print________________ Signature___________________ **Name and Designation** Print________________ Signature___________________ **Name and Designation** Print________________ Signature___________________ **Name and Designation** Print________________ Signature___________________ **Name and Designation** Print________________ Signature___________________

Appendix 6 – Seclusion Audit Form

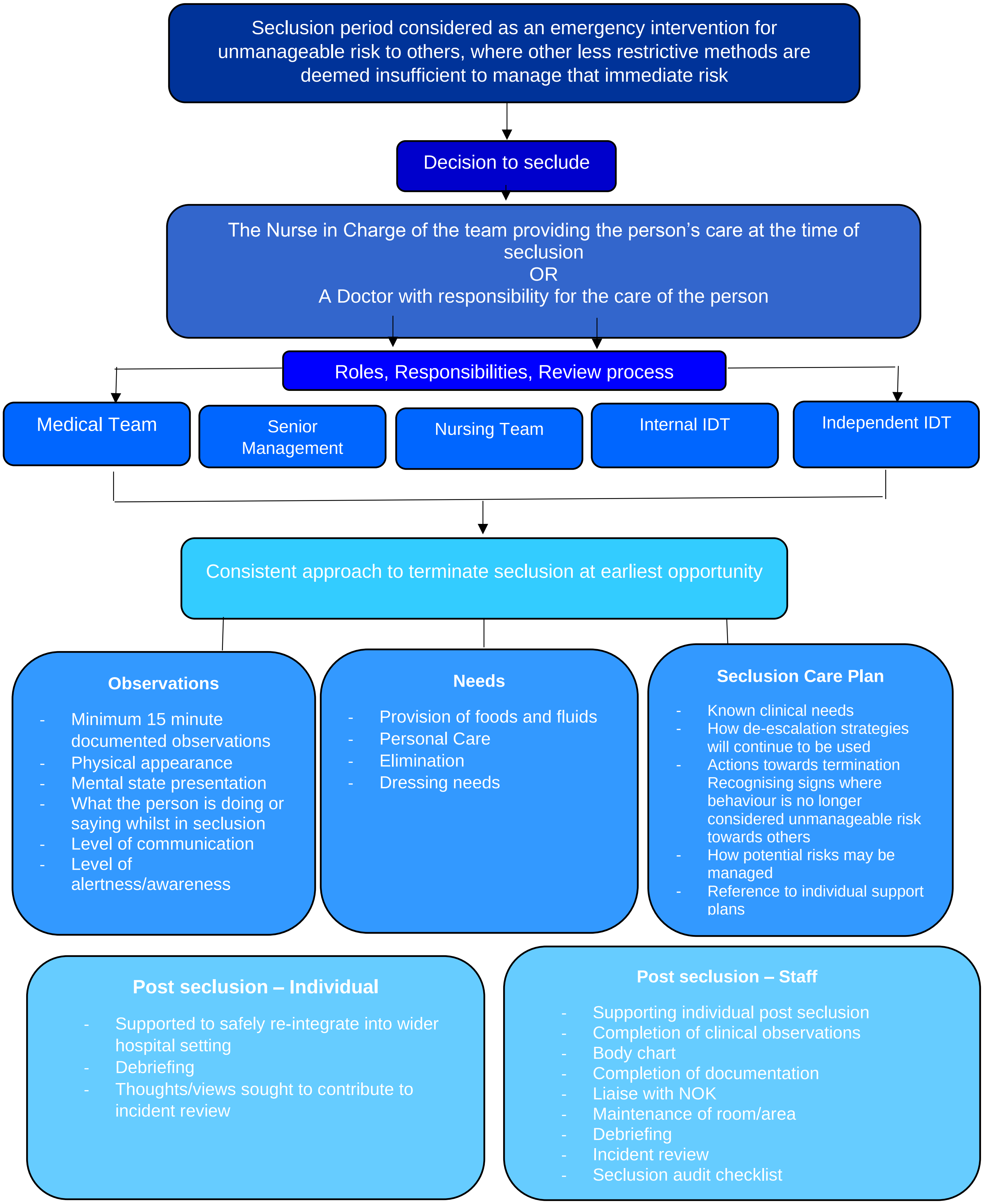
Seclusion Audit Form

		Yes	No	N/A	Comments
1.	Is there evidence that other alternative interventions were considered prior to the use of seclusion				
2.	Has the following documentation been completed as required:				
	• Record of Seclusion				
	• Seclusion Care plan				
	• Seclusion Observation record				
	• Seclusion Review record				
	• Seclusion maintenance record				
	• Incident form				
	• NEWS Chart (or equivalent)				
3.	Is there evidence that seclusion process was explained to the person If additional resources are required to support/aid understanding, is it evidenced that they were utilised				
4.	If a doctor was not the professional authorising seclusion, did they attend for review immediately If not, was an incident form complete				
5.	Is there evidence of completion/attempts to complete clinical observations during seclusion period				
6.	Is there evidence that following administration of medication before/during seclusion period that the following was monitored:				
	• Respiration Rate				
	• Response to verbal or tactile stimulation				
	• Level of movement				
	• Level of awareness				
	If no, is it evidenced as to why staff were unable to monitor and record				
7.	Was the person searched prior to entering seclusion				
	• Is this evidenced				
	• Is it evidence that this was discussed with the person and rationale explained				
8.	Is it evidenced that the NIC completed an hourly review				

9.	It is evidenced that medical staff completed 4 hourly reviews after initial review				
10.	Is it evidenced that Nursing staff completed 2 hourly reviews x 2, one whom being the NIC				
11.	Is it evidenced that seclusion met the trigger for internal IDT review Did an internal review take place Are the outcomes of this evidenced and actions agreed				
12.	Is it evidenced that seclusion met the trigger for an independent IDT review Did an independent review take place Are the outcomes of this evidenced and actions agreed				
13.	Is it evidenced that consent has been given to share information with NOK/family. If not, are reasons explained as to why				
14.	Is there evidence that the person was offered food/fluids				
15.	Is there evidence of incident review by IDT following period of seclusion Is there key learning identified Are there actions set out to prevent incident from re-occurring Has this been reflected in the person's care record and where required care record and risk assessments updated				
16.	Is there evidence of post incident debrief • For the person who required seclusion • For staff involved				

Appendix 7 – Seclusion Flowcharts

Quick Reference Chart – Procedure for Seclusion



Seclusion period considered as an emergency intervention for unmanageable risk to others, where other less restrictive methods are deemed insufficient to manage that immediate risk

Decision to seclude

The Nurse in Charge of the team providing the person's care at the time of seclusion

OR

A Doctor with responsibility for the care of the person

Roles, Responsibilities, Review process

Medical Team

Senior Management

Nursing Team

Internal IDT

Independent IDT

Consistent approach to terminate seclusion at earliest opportunity

Observations

- Minimum 15 minute documented observations
- Physical appearance
- Mental state presentation
- What the person is doing or saying whilst in seclusion
- Level of communication
- Level of alertness/awareness

Needs

- Provision of foods and fluids
- Personal Care
- Elimination
- Dressing needs

Seclusion Care Plan

- Known clinical needs
- How de-escalation strategies will continue to be used
- Actions towards termination Recognising signs where behaviour is no longer considered unmanageable risk towards others
- How potential risks may be managed
- Reference to individual support plans

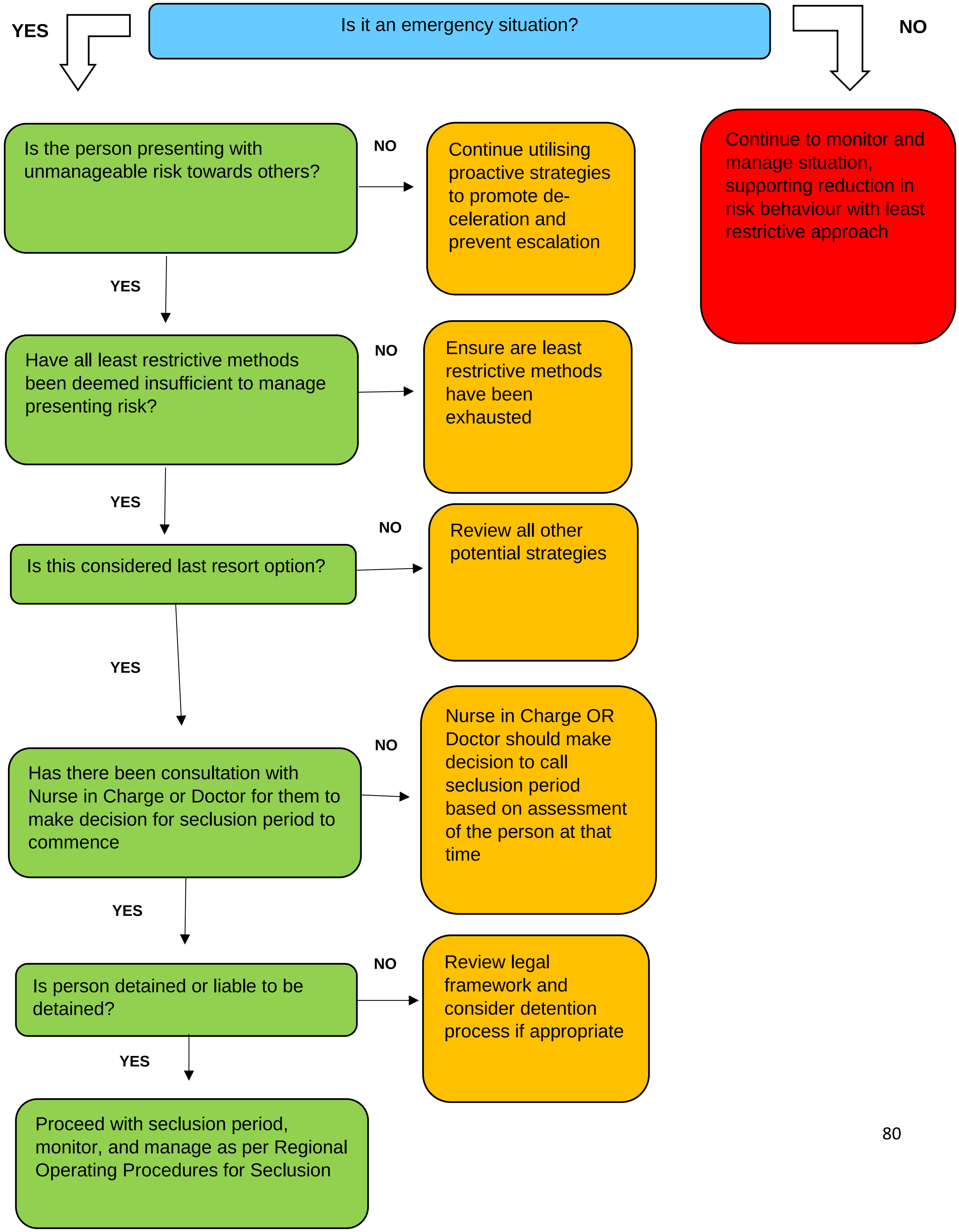
Post seclusion – Individual

- Supported to safely re-integrate into wider hospital setting
- Debriefing
- Thoughts/views sought to contribute to incident review

Post seclusion – Staff

- Supporting individual post seclusion
- Completion of clinical observations
- Body chart
- Completion of documentation
- Liaise with NOK
- Maintenance of room/area
- Debriefing
- Incident review
- Seclusion audit checklist

Quick Reference Flowchart – Decision to Seclude



Quick reference flowchart – Roles and Review process

Medical Team

- Assess and review need for seclusion period to continue
- Review mental and physical health
- Review level of risk to others
- Review level of observations
- Potential risk to self
- Review medication and potential adverse effects

- If the doctor was not involved in the decision to seclude the person, then they must attend immediately to complete review
- Medical review complete every 4 hours
- Medical reviews must take place every four hours - one of which should be undertaken by the person's Consultant Psychiatrist within 24 hours unless stipulated during the first internal IDT review
- Document review within review record and care plan
- Complete seclusion care plan with nursing staff and make amendments as required following review

Senior Management

- Provide support and guidance to person in seclusion and staff supporting
- Discuss presentation, potential risks and agreed management plan with NIC
- Assure appropriate resources in place until termination

- Senior management staff will be contacted by nursing staff to inform them of commencement of a period of seclusion
- The senior manager in receipt of the call should arrange to attend the ward to receive a report on the decision to seclude – the senior manager should sign records acknowledging receipt of report and any other information or advice provided. If the senior manager does not attend in person, the NIC must document the detail of conversation and decisions agreed as per telephone conversation.

Nursing Team

- Monitor physical and mental state presentation of person via observations
- Inform and update professionals and NOK
- Complete and review seclusion care plan
- Completion of documentation

- Commence 1:1 observations at commencement of seclusion
- Registered nurse must monitor and observe the person in seclusion
- An observation record must be documented at a minimum of every 15 minutes
- NIC must complete formal hourly review
- NIC and further RN (ideally one not involved in decision to seclude) will undertake formal 2 hourly review

Internal IDT

- Review seclusion period and incident that led to seclusion
- Review care plan and ensure appropriate actions in place to terminate seclusion at earliest opportunity
- Document any actions required

- An initial internal IDT review of the need for seclusion will be carried out as soon as practicable once the seclusion period commences.
- An internal IDT review will include the person's doctor, nurse in charge, and other IDT professionals who may usually be involved with the person
- An internal IDT review should take place once in every 24 hour period of continuous seclusion

Independent IDT

- Independent professionals **not** involved in initial incident or that led to decision to seclude
- Review seclusion period and incident that led to seclusion
- Review care plan and ensure appropriate actions in place to terminate seclusion at earliest opportunity
- Document any actions required

- An independent IDT review should take place where a person has been secluded for 8 hours consistently or 12 hours intermittingly during a 48 hour period
- Even if the seclusion period has since ended, once a trigger point has been reached, the review must be held. If the seclusion period is ongoing then the independent IDT review should make recommendations as appropriate to the seclusion care plan

Quick reference guide– Care of the person in seclusion

During a period of seclusion, staff must ensure that a good level of care is maintained and delivered, ensuring that their privacy and dignity is maintained. The health, safety and wellbeing of the person is paramount.

Clothing

-If there are any concerns regarding use of clothing as potential ligatures or concealing of unsafe items

- Follow local organisational policy Search procedures
- Document if anything found during search that is deemed unsafe
- If any items or clothing deemed unsafe and require removal due to potential to compromise safety then they must be removed by staff who have received appropriate training and are competent
- Privacy and dignity should be maintained at all times
- If tear proof clothing is required then this must be provided

Personal Care/Elimination

- Encouragement and prompting for individual to meet personal care needs
- Support for individual where required
- Access to appropriate items/resources

- Privacy and Dignity should be maintained at all times
- Providing of resources i.e. hygiene products to support person to meet their needs
- Support individual as required to meet personal care and elimination needs

Food/Fluids

-All meals and drinks must be provided as normal

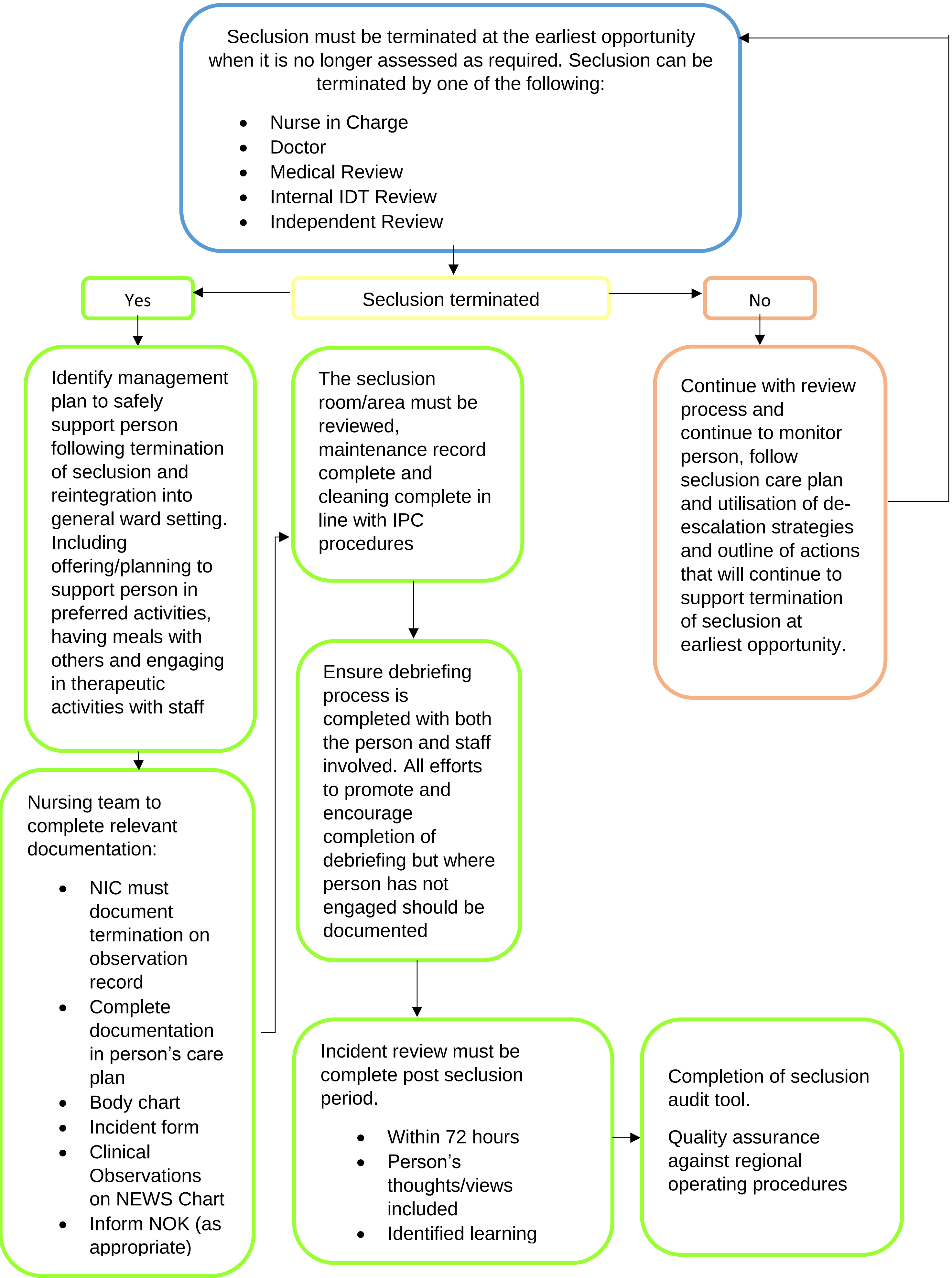
- All offers/acceptance and refusal of food and fluid items should be documented within the seclusion observation form and within the person's records
- Consider use of fluid chart to monitor and document fluid intake and promote adequate fluid intake as required
- Safe to use crockery and utensil items provided

Safety

- Any potential risk to the person
- Deterioration in clinical presentation

- If there is an identified risk to the person at any time then the seclusion room must be entered at the earliest and safest opportunity (Staff must have complete required training and be deemed competent)
- This will be a decision based on clinical judgement and need to maintain safety of the person whilst in the seclusion room.

Quick reference flowchart – Termination of Seclusion



Seclusion must be terminated at the earliest opportunity when it is no longer assessed as required. Seclusion can be terminated by one of the following:

- Nurse in Charge
- Doctor
- Medical Review
- Internal IDT Review
- Independent Review

Seclusion terminated

Yes

No

Identify management plan to safely support person following termination of seclusion and reintegration into general ward setting. Including offering/planning to support person in preferred activities, having meals with others and engaging in therapeutic activities with staff

The seclusion room/area must be reviewed, maintenance record complete and cleaning complete in line with IPC procedures

Continue with review process and continue to monitor person, follow seclusion care plan and utilisation of de-escalation strategies and outline of actions that will continue to support termination of seclusion at earliest opportunity.

Ensure debriefing process is completed with both the person and staff involved. All efforts to promote and encourage completion of debriefing but where person has not engaged should be documented

Nursing team to complete relevant documentation:

- NIC must document termination on observation record
- Complete documentation in person's care plan
- Body chart
- Incident form
- Clinical Observations on NEWS Chart
- Inform NOK (as appropriate)

Incident review must be complete post seclusion period.

- Within 72 hours
- Person's thoughts/views included
- Identified learning

Completion of seclusion audit tool.

Quality assurance against regional operating procedures

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Appendix 9 – Relevant Legislation

Legislative Context

Relevant legislation and Guidance should always be adhered to and staff should ensure that they are up to date with the most up to date Legal framework relating to use of Seclusion.

Criminal Law Act (1967)
Data Protection Act (2018)
Disability Discrimination Act (1995)
European Convention on Human Rights
Mental Capacity Act (Northern Ireland) 2016
Mental Capacity Act (Northern Ireland) 2016 – Deprivation of Liberty Safeguards – Code of Practice
Mental Health (Northern Ireland) Order 1986 and Code of Practice
Northern Ireland Act 1998
Northern Ireland Children's Order (1995)
Race Relations (Northern Ireland) Order (1997)
Section 75 of the Northern Ireland Act (1998)
Special Educational Needs and Disability Act (Northern Ireland) 2016
The Age of Majority Act (Northern Ireland) 1969
The Children (Northern Ireland) Order 1995
The Children (Secure Accommodation) Regulations (Northern Ireland) 1996
The Criminal Justice (Children) Northern Ireland Order 1998
The Day Centre Setting Regulations (Northern Ireland) 2007
The Equality Act 2010
The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
The Health and Safety at Work Act 1974
The Human Rights Act (1998)
The Protection of Children and Vulnerable Adults Order (Northern Ireland) 2004
The Public Order (Northern Ireland) Order 1987
The United Nations Convention on the Rights of the Persons with Disabilities, 2006
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Appendix 10 - Acknowledgements

Rosaline Kelly	Author and Project Lead
Amanda Scott	Author and Project Manager
Claire Henry	Project Officer

The Project Team would like to offer thanks to those professionals, service user representatives, family members, carers, and other organisations who contributed to the guidance document through focus groups and staff engagement events.

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Deirdre McNamee	Representative of Public Health Agency
Lynn Woolsey	Representative of SHSCT
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Membership of Project Development Working Group

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Rachael McMaster	Representative of RCN (Learning Disability)
Rosalind Beattie	Representative of RCN (Forensics)
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Focus Group involvement from:

ArcNI
Cause
Bryson House
Mencap
VOYPIC

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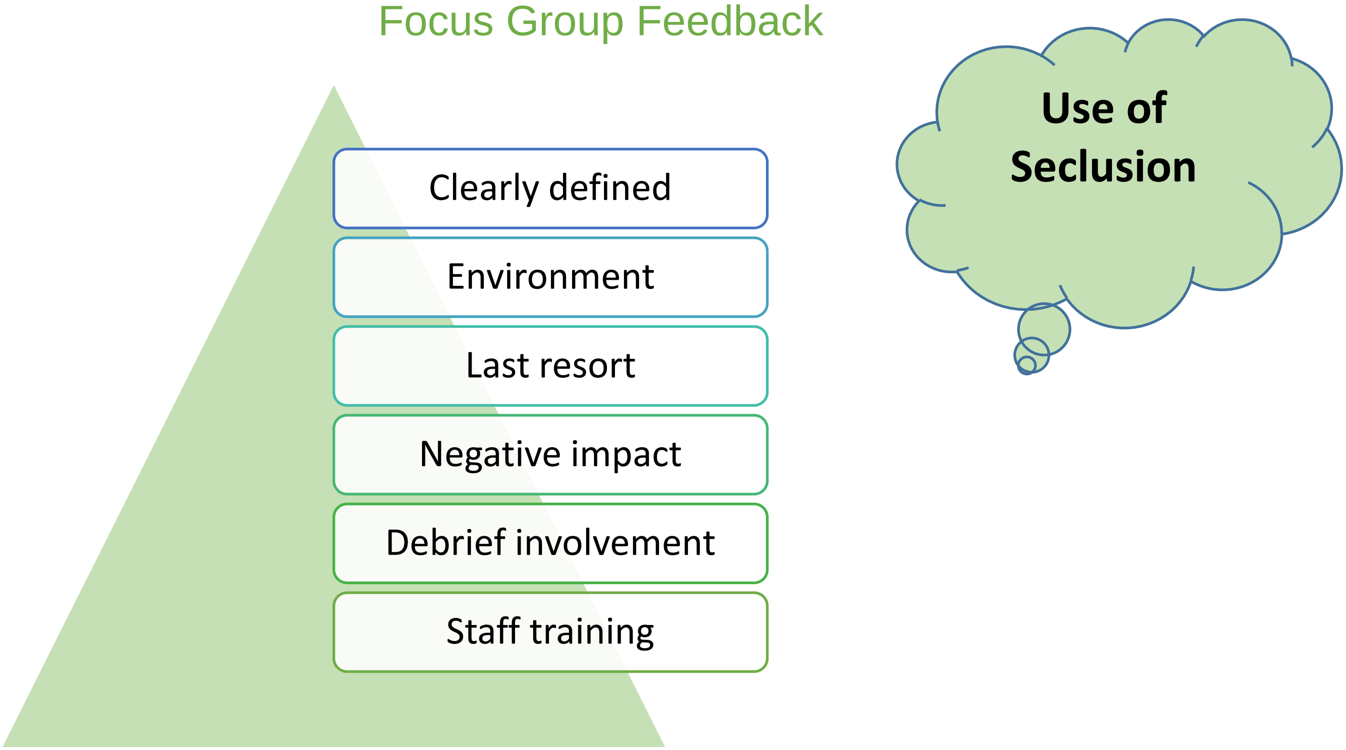
Appendix 11 – Themes and Feedback

Focus Group Feedback



All focus groups agreed that seclusion should only be used as a last resort once all other methods had been exhausted.

Focus groups agreed that reasons for using seclusion should clearly be defined and communicated to the person, their families and carers.

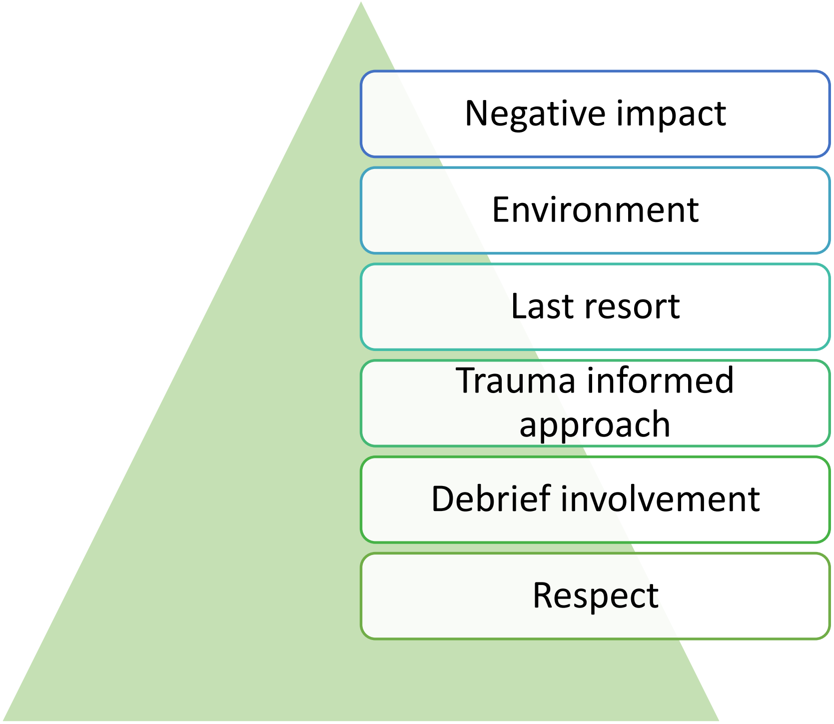
Focus groups fed back that seclusion had a negative impact on their health and wellbeing and in some cases made them feel worse.

Seclusion rooms have been described as “cold, dark, lonely, disgusting, like a jail”. A low stimulus room would be nice. Comfortable, safe, calming, with drinking water available. Possibly slow, quiet, calming music in the background.

Staff should know their patients and their specific needs; this would help to avoid incidents arising as staff would be able to recognise triggers. Staff should try to deescalate in the first instance. Focus groups members did recognise that sometimes staff are at risk too but felt that staff need more training.

Feedback suggested that staff should have conversations and a debriefing process should be completed, with the person and their families/carers, whenever an incident occurrs.

Use of Restraint



Negative impact

Environment

Last resort

Trauma informed approach

Debrief involvement

Respect

All focus groups agreed that restraint should only be used as a last resort, however members agreed that sometimes there is a need for restraint, especially if someone may hurt themselves or others.

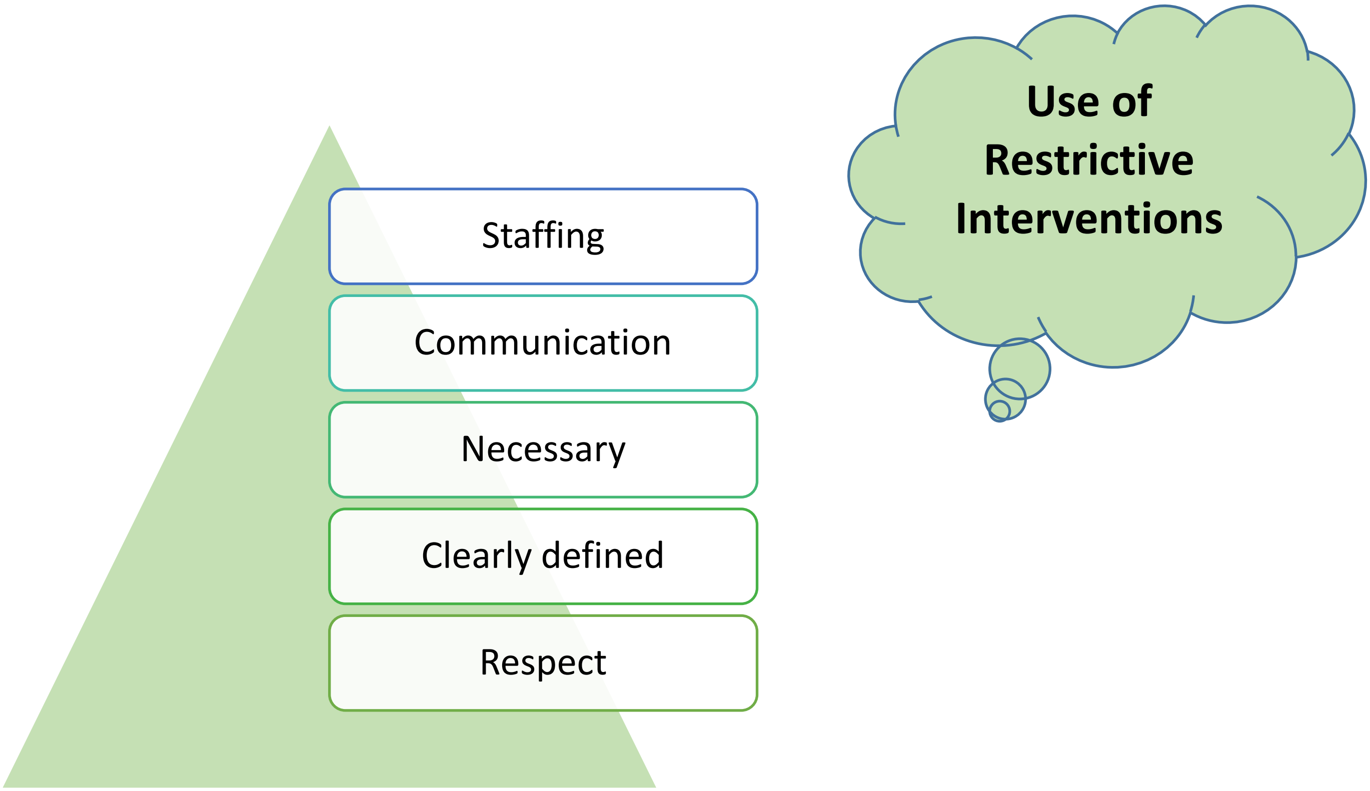
Accommodation or the environment in which a person is living should be spacious to help de-escalate emotion and reduce any potential for physical or chemical restraint.

All focus groups agreed that being restrained was negative to a person's health and wellbeing.

Group participants called for a trauma-informed care approach in order to help identify triggers and encourage sensitivity in approach.

Families should be informed about any use of restraint to discuss what and why, in order to create better understanding.

Focus groups said they realised staff were at risk of being hurt, but they want to be respected and listened to.



Feedback suggested that staff don’t always have enough time and felt that staff shortages should not affect them being able to live their life or restrict their movements.

Focus group participants acknowledged that sometimes restrictive interventions are needed in order to keep individuals well, like sleep hygiene, but suggested restrictive interventions should be reviewed every fortnight/month.

Participants suggested there should be better communication between staff and patients. They thought staff should be explaining why they are taking things away or locking doors.

Feedback asked for clearer definitions of restrictive interventions and suggested that any restrictions should be agreed to through dialogue and not just enforced.

Feedback suggested that staff should be respectful of age and patient needs for example accommodating for later bedtimes, allowing freedoms like accessing beverage making facilities or items that are self-soothing.

Focus group feedback included suggestions regarding the use of developing technology in accommodations, such as use of keypads, water taps being on a timer, showers on a timer and better monitoring devices.

Staff Engagement Day

Feedback from breakout room discussions

It's important to identify and explore options around practises, while balancing risk and safeguarding patients.

We need to ensure all interventions are captured consistently.

Human rights for patients starts on ground floor.

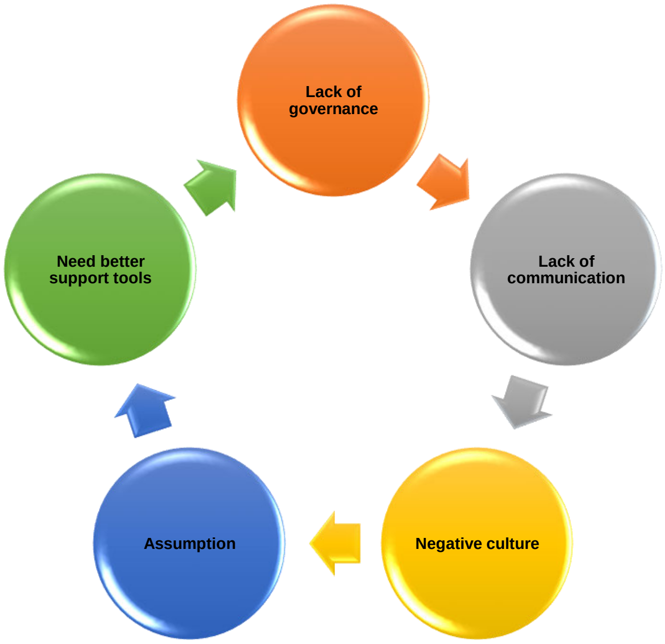
Better leadership to help staff to feel valued.

It's important to view the person as human.

There should be clearer evidence of how you're actually supporting people.

Emerging Themes

The Importance of Definitions



Lack of governance

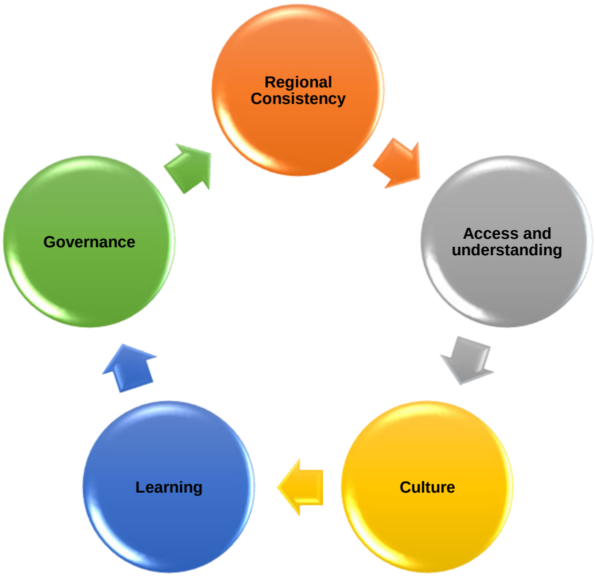
Lack of communication

Negative culture

Assumption

Need better support tools

Utilising data to Inform Practice



Regional Consistency

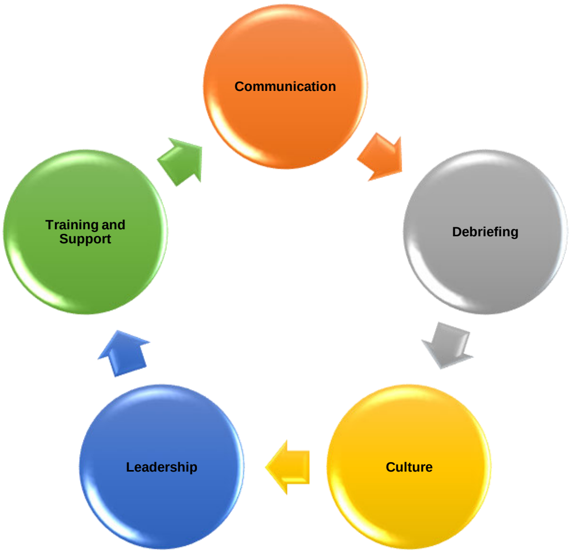
Access and understanding

Culture

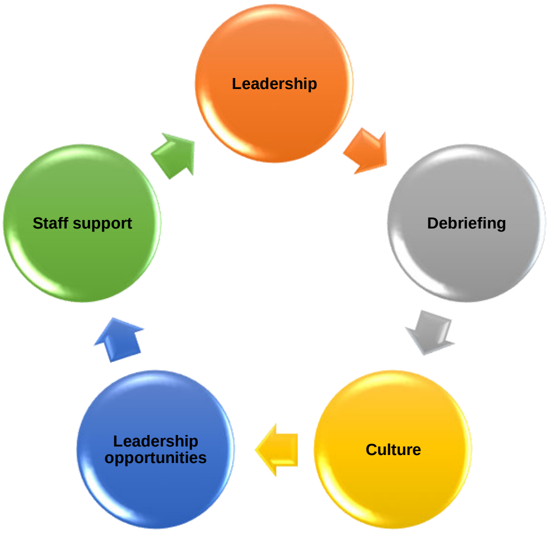
Learning

Governance

How human rights affects those that we care for



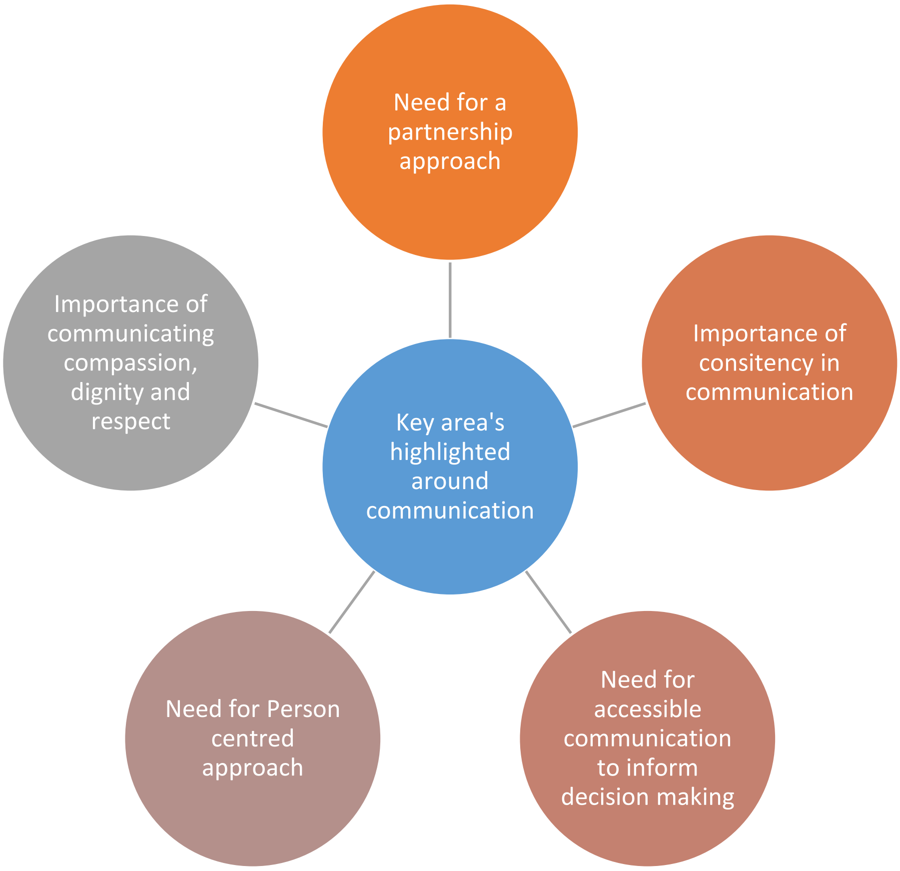
Supporting Cultural Change



Communication Sub-Group Feedback

Throughout engagement with those who helped develop this policy, communication was a repeated theme. Reports of poor communication impacting on the quality-of-care delivery could be rectified by a partnership approach and regular, authentic communication that will assist informed decision-making, allowing for more person-centred, more therapeutic and less restrictive alternative strategies to be agreed.

This is considered critical to minimising restrictive interventions.



Whilst not everyone expressed a negative experience, it was agreed that this did not suggest that improvements in effective communication would not be important.

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Muckamore Departmental Assurance Group (MDAG) August 2022

Highlight Report

Ref: MDAG – 13/22

MDAG Highlight Report	
MDAG Objectives	i. The services being delivered at Muckamore continue to be safe, effective and fully Human Rights compliant; ii. The commitment given by the Permanent Secretary to resettle patients is met, and the issue of delayed discharges is addressed; iii. The team on site at Muckamore is given the support and resources necessary to achieve their goals; and iv. The lessons learned from Muckamore (including the Serious Adverse Incident report) are put into practice consistently on a regional basis in line with wider policy on services for people with learning disabilities, and also inform the work underway to transform Learning Disability services in each Trust.

Update

Safeguarding

During July the Team continued to work on the following areas:

- Viewing raw footage in respect of Sixmile Treatment Ward;
- Reviewing referrals received from the Police regarding Cranfield 1 Ward and processing these;
- Ensuring the robustness of protection plans;
- Maintaining and quality assuring the database;
- Notifying and supporting affected families where incidents of concern are identified. This includes cross-Trust liaison work;
- Supporting affected families on an ongoing basis, completing carers assessments and providing additional support when information in respect of MAH, including the PSNI investigation and the Public Inquiry is placed in the Public domain;
- Providing information when requested by the external disciplinary investigators or the PSNI in respect of their criminal proceedings; and
- Undertaking ASG single agency investigations where the police have determined that the incident does not meet a criminal threshold but where the ASG team have determined it is still an ASG incident.

Due to the pressures being experienced in Muckamore Abbey Hospital in respect of processing ASG referrals the focus of the team shifted in August to the following:

- Two staff working full time at MAH to review a number of current ASG referrals;
- Two staff remaining in the Historic Team to review the ASG referrals that had been received from the Patient Client Counsel a number of months ago but still required to be investigated. These staff would also respond to any urgent safeguarding issues raised by the PSNI through the ongoing historic investigation;
- The FLOs continue to support the affected families; and
- The MAPA assessor has continued in her role as usual.

Viewing of CCTV footage
Hours Footage Viewed by ASG Team as at 12 August 2022

WARD	TOTAL HRS TO BE VIEWED	TOTAL HRS VIEWED	TOTAL % VIEWED	TOTAL HRS OUTSTAND ING	TOTAL 5 OUTSTANDING	No of AM shifts still to view	No of PM shifts still to view	No of Night shifts still to view
PICU	3552	3552	100%	-	-	-	-	-
SIXMILE A	4440	4440	100%	-	-	-	-	-
SIXMILE T	4464	3126	70.03%	1338	29.97%	27	33	84
CRANFIELD 1	3552	3534.5	99.51%	17.5	0.49%*	-	1	1
CRANFIELD 2	3552	3534.5	99.51%	17.5	0.49%*	-	1	1
TOTAL	**19.560**	**18,187**	**92.98%**	**1373.00**	**7.02%**	**27**	**35**	**86**

*corrupted files-viewed by PSNI instead.
19560 hours denotes the hours in total of shifts to be viewed. This total needs to be multiplied by the number of cameras to be viewed per shift to understand the true figure. The total number of cameras varies from Ward to Ward

Overall Incident Totals identified at 12 August 2022

Total incidents identified	1720	100%
Total incidents completed	1524	89%
Total outstanding of incidents identified to date (Still to be reviewed)	196	11%

*NB: the total no. of incidents to be viewed will fluctuate whilst footage continues to be viewed.

Family Liaison Role

In the period between 3 June 2022 and 12 August 2022 the following Family Liaison work has taken place:

Home visits	63
Telephone calls	577
Emails	259
Text messages	573
Video conferencing	81

The team support a total of 36 families whose loved ones have been identified through the historic investigation. The Family Liaison Officers have supported a number of families, at the request of the families, to support them in engaging with the Public Inquiry.

Operational Group meetings

The Operational Group comprising of representatives from ASGMAH team, HR/Management, RQIA and the PSNI continue to take place every three weeks to review the management decisions in relation to the safeguarding referrals made.

Safeguarding Governance Group

The next meeting of this group is due to take place on 25th August 2022.

Learning Disability Service Model Transformation Project

The Department of Health was able to secure an additional resource to expedite consideration of the LD Service Model. This work has now been completed and analysed by officials. Further discussion with the Social Care and Children's Directorate within the Strategic, Planning and Performance Group (SPPG, formally the HSCB) are now required on the next steps. Following this, advice will be produced for the Minister on what action is to follow.

Independent Review of Acute Care services

Following the completion of the Acute Care Review, work was undertaken to consider the development of a consistent model of Community Based Assessment and Treatment (CART) for individuals who present with challenging behaviour, Autism Spectrum Disorder (ASD) and/or forensic needs. A draft CART proposal has now been prepared and is currently with the SPPG for consideration. Further investment will be required in order for Trusts to develop these services.

Independent Review of Resettlement

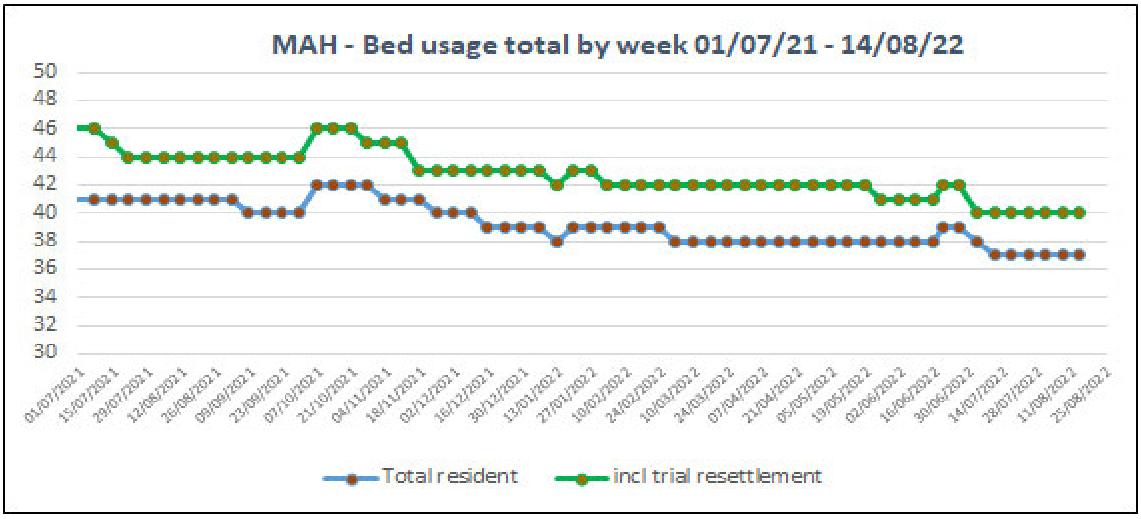
The Independent Review of Resettlement has now been completed with the final report submitted to the SPPG for consideration on next steps. They are recommending areas for actions across a range of themes, including policy, leadership and inter-agency working, evaluation of resettlement plans, appraisal of business cases, engagement strategies and whole system working and advocacy and carer support.

Muckamore Abbey Hospital Patients

1.0 Muckamore Abbey Hospital Patient Population

1.1 MAH Inpatient Numbers

The number of patients in residence remains at **37.** There are **3** patients on trial resettlement placements, and **1** patient continues on extended home leave at the request of family. The graph below displays the number of inpatients resident in Muckamore Abbey Hospital and the number of patients on trial resettlement:-

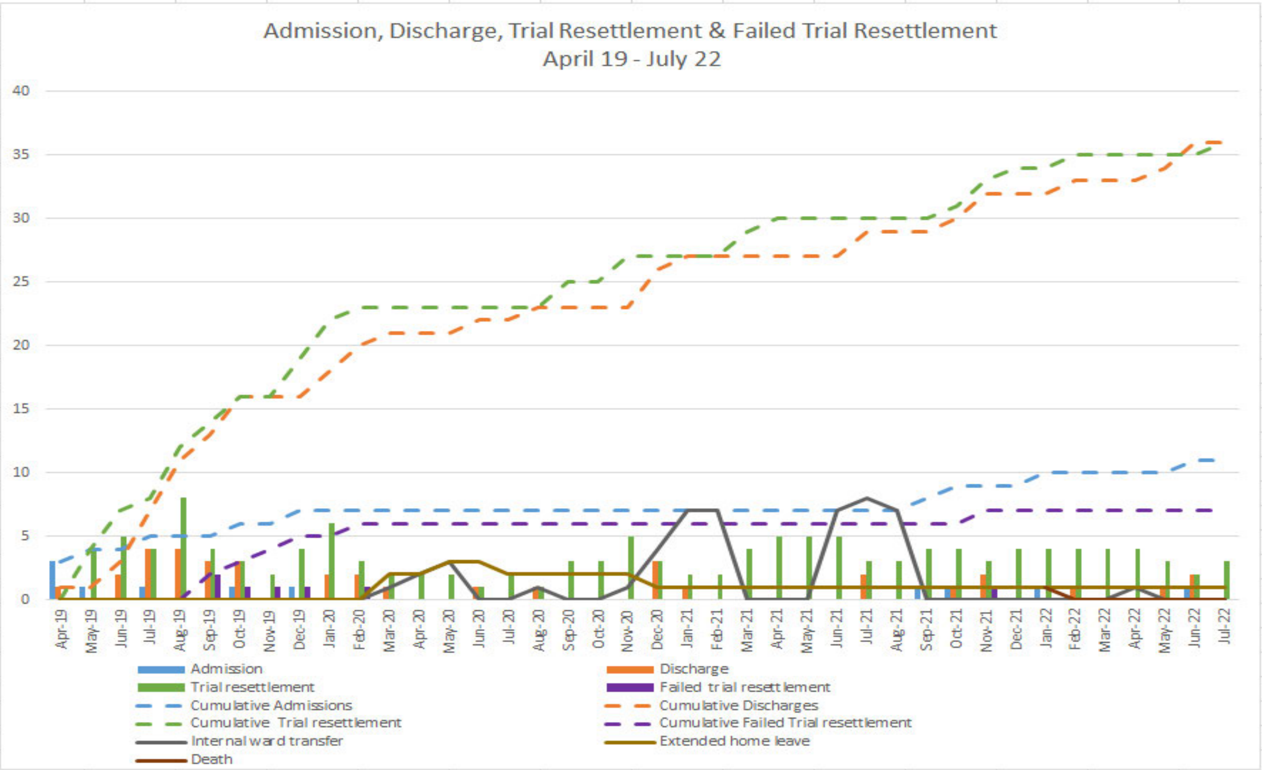


Patients in Muckamore Abbey Hospital by Trust of Residence are as follows: -

Trust of Residence	Number of Inpatients	Number of Patients on Trial Resettlement
Northern HSC Trust	14	1
Belfast HSC Trust	15	1
South Eastern HSC Trust	7	0
Southern HSC Trust	1	0
Western HSC Trust	0	1

1.2 Monthly MAH Admissions, Trial Resettlements and Discharges

The graph below plots the monthly, and year to date, number of patients admitted, discharged, on trial resettlement or having returned from an unsuccessful trial resettlement.



Admission: admitted during month

Discharge: discharged during month

Trial resettlement: pts on TR on last day of month (not included if discharged/failed trial resettlement during the month)

Failed TR: Returned to MAH during the month

Cumulative Admissions: Number of actual patients

Cumulative Discharges: Number of actual patients

Cumulative Trial resettlements: Number of actual patients

Cumulative failed TR: Number of actual patients

Internal ward transfer: No of pts transferred within the month

Extended home leave: Pts on EHL on last day of the month

1.3 Rate of Resettlement – 2021/22

The table below shows the year to date position for 2021/2022:

	2021/22			
	Successful Resettlement - patient discharged	**Failed Resettlement** - patient returned	**Ongoing Resettlement**	**Success Rate**
BHSCT	3	1	1	**75%**
NHSCT	4	0	1	**100%**
SEHSCT	0	0	0	**-**
WHSCT	0	0	1	**-**
Total	**7**	**1**	**3**	**88%**

2. Patient Safety

A weekly Safety Report provides assurance on patient safety metrics which is reviewed by the senior management team in MAH and shared with the multi-disciplinary team. There is also a weekly Live Governance call for all clinical areas to feedback on the previous week's incidents and any other governance issues.

The weekly Safety Report provides an update and analysis of the use of restrictive practices on site, and also provides data over time in order to identify trends. Data is provided on the following-

- Adult Safeguarding referrals
- Incidents involving physical intervention
- Use of seclusion
- Use of voluntary confinement
- Use of prone and supine restraint
- Use of rapid tranquilisation

2.2 CCTV Viewing

CCTV contemporaneous viewing continues on a daily basis to a set schedule. The recordings are then quality assured on a Monday by an Assistant Service Manager (ASM) and a Designated Adult Protection Officer (DAPO) to ascertain if there have been any practice or ASG issues highlighted. If this is the case CCTV is viewed again by the ASM and the DAPO.

3. Staffing Levels

3.1 Nurse staff

Current nurse staffing levels, with the combination of substantive nursing staff, long-term agency staff and nurse bank staff, are currently providing a safe level of care, supported by use of the nursing model. Nurse staffing levels for w/e 25 July 2022 can be found in **Appendix 1** – this information is provided by the Trust to the Department of Health on a weekly basis.

MAH continues to have a large proportion of nurse staff resource provided by Agency staff. The agency staff have been in MAH for some period of time. The nurse staff requirement for the patients on site is made up of 83% provision from nurse agency.

There is 60% vacancy at Deputy Ward Sister/Charge Nurse and 75% vacancy at Ward Sister/Charge Nurse despite ongoing recruitment internal and external to Belfast Trust. Due to the ongoing vacancies a further Lead Nurse has been appointed to focus on nurse leadership, support and governance and will be directly working with the nurse teams.

The ongoing regional nurse workforce appeal has led to some staff being redeployed to MAH, albeit small numbers. There continues to be need for balance of support from staff in numbers and the desire to maintain a stable workforce for the patients who require consistency of care, and this is managed on an ongoing basis.

The Nurse Development Lead, the Nurse Consultant for ID and the ID Clinical Lecturer continue to roll out the training plan to ensure the nurse staff on MAH have the skills required in relation to ID, relational security and Positive Behaviour Support (PBS).

The Nurse Consultant will spend 50% of her time on the wards with staff providing leadership regarding patient engagement therapeutic activity and leadership regarding care planning.

In August 2022, 2 Senior Nurses were successful at interview to support the ward staff, lead on governance and performances within the teams due to the absence of the Ward and Deputy Ward Leaders. It is expected they will take up post in September 2022.

3.2 Medical Staff

The small team of 2.5wte Consultant Psychiatry team providing input to Muckamore Abbey Hospital continues to represent a vulnerability for the service. Dr Peter Sloan has joined ID as Chair of Division as part of his role. Dr Paul Devine has joined the team for peer support and additional clinical advice in relation to resettlement of forensic patients.

3.3 ASG Staff

An Interim Service Manager for ASG took up post on 4 August 2022. Additional DAPO/IO's are being moved to the service area to support case closure and additional DAPO and IO hours secured from overtime arrangements.

Regional agreement for other Trust support in undertaking patient on patient investigations is being currently looked at to provide additional support. Additional resource identified for Business and Admin support to team and is currently being recruited to.

3.4 Psychology Staff

There continue to be vacancies within the psychology team providing support to the Hospital – efforts to recruit continue.

Staff Counsellor Sessions – 12 Sessions offered per week.

This service continues to offer support to staff.

4.0 RQIA

RQIA carried out a 3 week inspection in July 2022. Following a meeting with RQIA and Belfast Trust Staff in August 2022, an action plan has been developed to provide assurances of the actions taken around the concerns raised, specifically staff numbers, consistency, leadership and skills and Safeguarding concerns. Due to the seriousness of the concerns monitoring of progress is essential.

5.0 Other Developments

5.1 ELFT Visit to MAH

Dr Sanjay Nelson, Consultant ID and Ms Ruth Cooper, Operational and Strategic Lead for ID in East London Foundation Trust (ELFT) visited MAH on 1 and 2 August 2022. They met with ID Collective Leadership team, Interim Director Mental Health, Intellectual Disability, Executive Director of Nursing, User Experience and Allied Health Professionals and the Medical Director. Mrs Patricia Donnelly joined the discussions on 2 August 2022. Over the 2 days ELFT colleagues had the opportunity to hear from staff at MAH and visit the inpatient wards. Discussions took place in relation to the ongoing issues associated with MAH including staff availability, delay in resettlement, ability to admit patients for assessment and treatment and MAHI. The ELFT team shared their experiences of moving from large institutional provision of care to bespoke services in the community, with wrap around teams to provide care during times of escalation of need. Actions agreed for further exploration included clarity of diagnosis for current patients, care planning in conjunction with the community teams, focus on resettlement, patient, carer and advocacy involvement. ELFT stressed the importance of strategic direction for ID services in Belfast Trust and the region.

Dr Nelson offered independent support in relation to the review of patient assessment needs, support for medical staff of what difference would look like. Ms Cooper offered support for nurse and care models, learning forums and divisional nurse support.

Further meetings and visits will be arranged.

5.2 Resettlement

Dr Patricia Donnelly is providing support during July and August 2022 with the resettlement of the Muckamore Abbey Hospital (MAH) patients. She will act as a critical friend, provide advice and support to the Clinical Leadership Team at MAH in the development of plans and implementation of individual resettlement plans. Dr Donnelly’s support and work will link closely with the existing resettlement work streams.

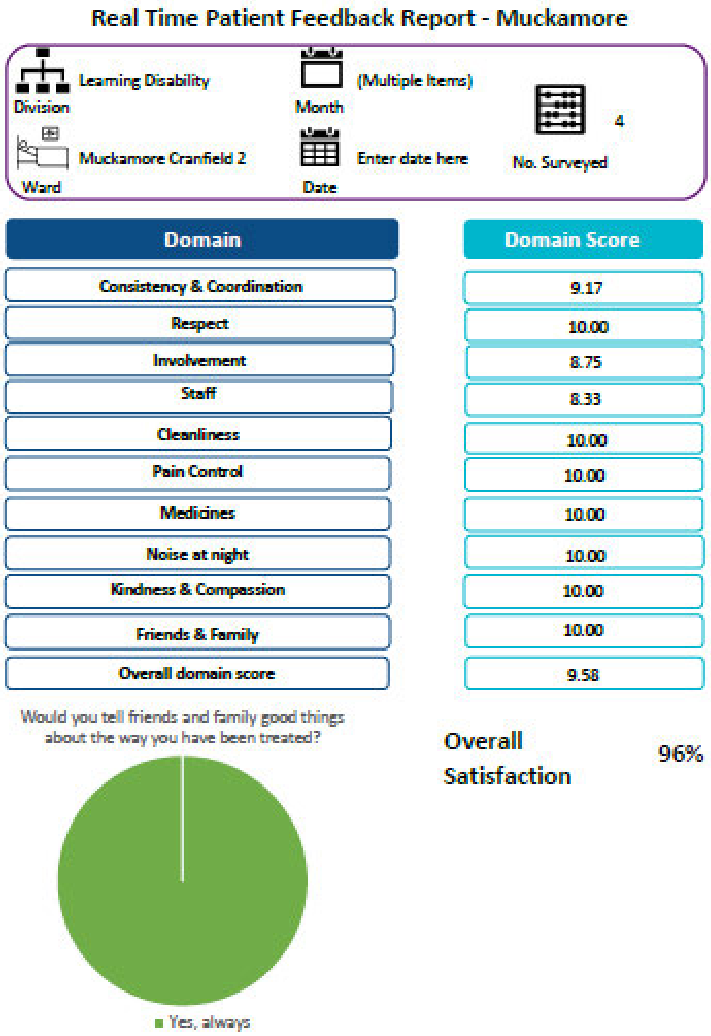
The Review of Resettlement carried out by Bria Mongan and Ian Sutherland has been completed and the final report is with the SPPG for consideration.

6.0 Patient and Client Feedback

6.1 Real Time Patient Feedback

Following development of new tools with staff and Speech and Language Therapy and in conjunction with the MAH Patient Council and TILII to create Talking Mats, the Real Time

Patient Feedback Team come to the Hospital every 2 weeks. The combined 7 July and 4 August 2022 is below.



Real Time Patient Feedback Report - Muckamore

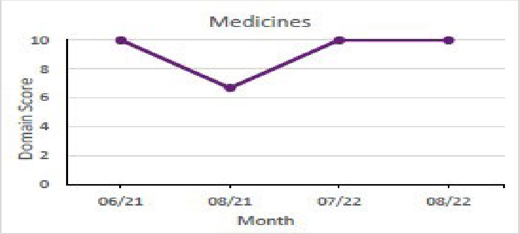
Division: Learning Disability
Month: (Multiple Items)
Ward: Muckamore Cranfield 2
Date: Enter date here
No. Surveyed: 4

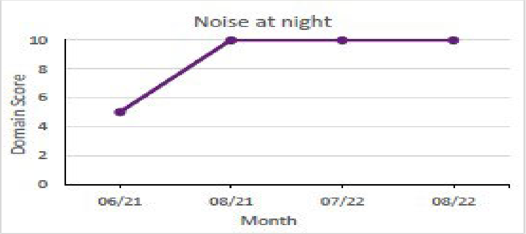
Domain	Domain Score
Consistency & Coordination	9.17
Respect	10.00
Involvement	8.75
Staff	8.33
Cleanliness	10.00
Pain Control	10.00
Medicines	10.00
Noise at night	10.00
Kindness & Compassion	10.00
Friends & Family	10.00
Overall domain score	9.58

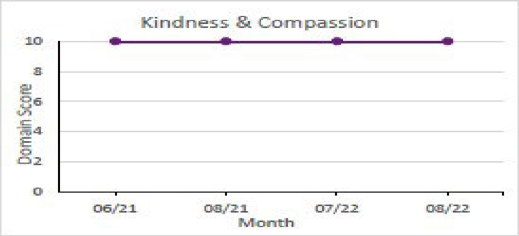
Would you tell friends and family good things about the way you have been treated?

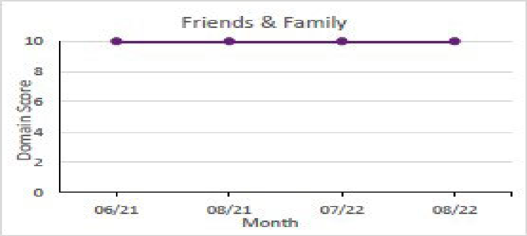
🟩 Yes, always

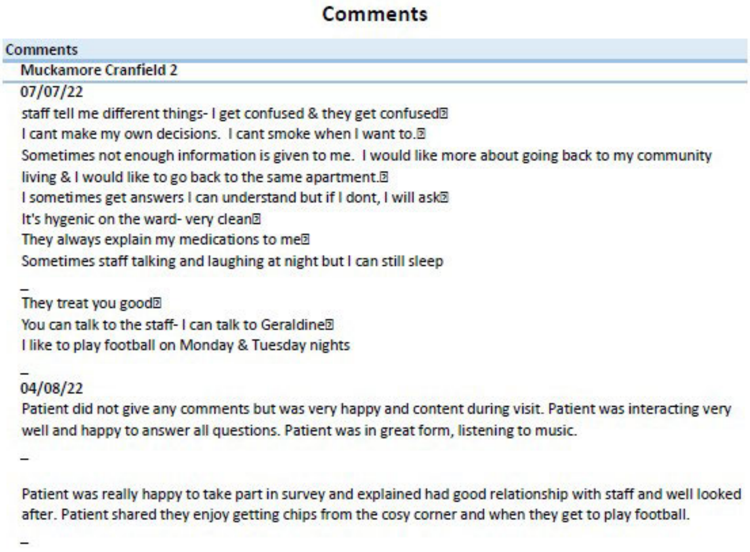
Overall Satisfaction 96%


Medicines
Domain Score
10
8
6
4
2
0
06/21
08/21
07/22
08/22
Month


Noise at night
Domain Score
10
8
6
4
2
0
06/21
08/21
07/22
08/22
Month


Kindness & Compassion
Domain Score
10
8
6
4
2
0
06/21
08/21
07/22
08/22
Month


Friends & Family
Domain Score
10
8
6
4
2
0
06/21
08/21
07/22
08/22
Month



Comments

Comments

Muckamore Cranfield 2

07/07/22

staff tell me different things- I get confused & they get confused⍰
I cant make my own decisions. I cant smoke when I want to.⍰
Sometimes not enough information is given to me. I would like more about going back to my community living & I would like to go back to the same apartment.⍰
I sometimes get answers I can understand but if I dont, I will ask⍰
It's hygenic on the ward- very clean⍰
They always explain my medications to me⍰
Sometimes staff talking and laughing at night but I can still sleep

_
They treat you good⍰
You can talk to the staff- I can talk to Geraldine⍰
I like to play football on Monday & Tuesday nights

_
04/08/22

Patient did not give any comments but was very happy and content during visit. Patient was interacting very well and happy to answer all questions. Patient was in great form, listening to music.

_

Patient was really happy to take part in survey and explained had good relationship with staff and well looked after. Patient shared they enjoy getting chips from the cosy corner and when they get to play football.

_

APPENDIX 1

3.1 : Nurse Staffing w/c 25 July 2022

Figures exclude those on sick leave, maternity leave and annual leave

Ward	Total	Plan Nursing wte	BHSCT Staff Available wte	Agency Block booking	Other Backfill (bank/add hours/OT)	Variance after Backfill	% achieved against plan
Cranfield 1	8	35.28	4	26.2	1.00	-4.08	**88.44**
Cranfield 2	8	41.81	6.41	29	0.34	-6.06	**85.50**
Donegore	5	26.51	10.02	10.7	2.93	-2.86	**89.22**
Killead	10	41.44	8.93	22	5.61	-4.90	**88.18**
Sixmile	11	36.03	9.91	19.4	5.70	-1.02	**97.18**
Total	**42**	**181.07**	**39.27**	**107.30**	**15.58**	**-18.92**	**89.55**

All new and Agency staff are engaging in a bespoke Induction designed to orientate staff to LD patients.

Sick Leave			Maternity Leave			Annual Leave		
Reg	**Non Reg**	**Total**	**Reg**	**Non Reg**	**Total**	**Reg**	**Non Reg**	**Total**
3.32	**22.51**	**25.83**	**2.00**	**3.37**	**5.37**	**2.82**	**12.18**	**15.00**

GUIDANCE ON ABUSE
OF VULNERABLE ADULTS

GUIDANCE ON ABUSE OF VULNERABLE ADULTS

INTRODUCTION

1.1 The purpose of this guidance is to ensure that all purchasers and providers of services to vulnerable adults have in place policies and practical arrangements for the prevention, detection and investigation of abuse.

1.2 Everyone has a right to freedom from abuse. Vulnerable people cannot always protect themselves from abuse. The Department is of the opinion that it is only when clear policy guidance is issued at area level and statements and codes of practice are drawn up at a local level - indeed within individual facilities including non-statutory facilities - that the complex factors interacting in abuse of vulnerable adults can be dealt with adequately. This guidance sets out the issues involved.

DEFINITION OF ABUSE

2.1 How abuse is defined will determine the circumstances in which intervention takes place. The following definition is suggested:-

The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is the expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship.

2.2 Abuse can occur within any client group; it can take many forms; and it can occur in any setting. This guidance is applicable to abuse of all vulnerable adults, elderly people, people with a physical or learning disability and people suffering from mental illness; and covers all types of abuse, including neglect.

2.3 Appendix 1 identifies different forms of abuse and their associated indicators.

those with

including a sensory impairment,

PRINCIPLES

3.1 There are a number of principles which should underpin policy and guidance on abuse. These are:-

- vulnerable adults have a right regardless of their disability, age, gender, and cultural or ethnic background, to expect:-
    - to be accorded the same respect as any other adult;
    - information on, and practical help in, keeping themselves safe and protecting themselves from abuse;
    - guidance and assistance when making a complaint or seeking help as a consequence of abuse;
    - an urgent investigation of alleged, suspected or confirmed abuse;
    - to be supported in making their own decisions about how they wish to proceed in the event of abuse, and to whom they wish to confide; and to know that their wishes will only be overridden if it is considered necessary for their safety or the safety of others;
    - to be supported in bringing a formal complaint under a Board's or HSS Trust's Complaints Procedure if they are not satisfied with the outcome of any investigation. Complaints procedures should take account of the needs of vulnerable adults;
    - to be supported in reporting the circumstances of any abuse to independent bodies such as the police, Registration and Inspection Units, and the Mental Health Commission;
    - to receive, where they have been abused, support, education, counselling, therapy, and treatment;
    - redress, where possible, regardless of whether their case was determined by a court or other means;
- parents, informal carers and advocates have a right to expect the vulnerable adult's rights to be respected and to act on his or her behalf where they are not;
- where it is necessary to protect the victim from further abuse, alternatives which do not involve removing him or her from the place where the abuse has taken place and which minimise disruption should be explored;
- there should be good communication between those working with the victim, carers and the abuser;

- where a member of staff has good reason to believe that any person with whom he or she is in contact presents a risk to a vulnerable adult he or she should bring this to the attention of the appropriate authority.

3.2 Where there may be a conflict in applying these principles, protection of the vulnerable adult from further abuse should be the paramount consideration.

RECOGNISING AND PREVENTING ABUSE

4.1 Everyone having contact with vulnerable adults should be aware of what abuse is and the indicators of abuse. Providers of services, whether in the statutory, voluntary or private sectors should ensure that staff receive training in abuse awareness. Informal carers should be given appropriate information on abuse.

4.2 Abuse may be prevented and the opportunity for its occurrence reduced through the following measures:

- clear policy and practices on abuse issues;
- sound selection and recruitment procedures. The Department's Pre-Employment Consultancy Service (PECS) is available to approved organisations with posts involving substantial access to people with a learning disability. The Registered Homes (Northern Ireland) Order 1994 provides that registration will be refused or withdrawn where anyone concerned in carrying on or intending to carry on a home, or employed or to be employed in a home is not a fit person;
- induction and ongoing training;
- good supervision and management practices;
- minimising the opportunity for routine, unsupervised access to vulnerable adults;
- increasing family and informal carer awareness of abuse through appropriate training;
- access to an advocate, especially for people with communication difficulties;
- education about personal relationships. Advice on personal and sexual development of people with a learning disability is set out in the Department's circular letter of 17 May 1990.

REPORTING ABUSE

5.1 Local codes of practice should set out clearly the reporting procedures to be followed where abuse is suspected. Procedures may vary according to the circumstances of the case, for example according to the setting in which the abuse has occurred, the form of abuse, or to whether the abuser is a member of staff, a family member or other informal carer, a visitor or any other person.

5.2 Particular attention needs to be given to abuse by staff and/or management in hospitals, nursing homes, residential care homes, day centres or other institutional settings. In this type of situation it may not be desirable or appropriate for the victim or others to approach the management and very often the victim is too afraid to speak out.

5.3 Staff may also be reluctant to report suspicions or evidence in certain circumstances. Everyone working with vulnerable adults should understand that they have a responsibility for their protection and to take the appropriate action. **Everyone has a duty to report suspected, alleged or confirmed incidences of abuse.** When a member of staff suspects or has evidence that abuse is taking place this should be reported **immediately**.

INVESTIGATING ABUSE

6.1 Local codes of practice should indicate the circumstances when an allegation of abuse **must** have an initial investigation **within 24 hours**. In all other circumstances allegations of abuse should be subject to an initial investigation within 72 hours. Further action will be determined by the outcome of the initial investigation.

6.2 The investigation of abuse should be conducted in a sensitive, but effective, manner so as to minimise any further distress to the victim. This will be particularly important in cases which require police involvement or a medical examination.

6.3 Investigation of abuse should normally proceed with the consent of the victim (where he or she is able to give such consent). Consent is the voluntary and continuing agreement of the victim to the action to be taken in pursuit of an investigation, based on an adequate knowledge of the nature, purpose and likely effect of that action. The victim may be reluctant to cooperate with any investigation or to consent to any disclosure to the police eg where the abuser is a family member or other close friend. This should not preclude pursuit of the investigation or the involvement of the police. Cases of physical or sexual abuse will normally require a medical examination with the consent of the victim.

6.4 The objectives of an investigation into abuse should include:

- establishment of the facts;
- an initial assessment;
- protection of the victim: where the abuser is himself or herself a vulnerable adult he or she will also need protection.

6.5 The investigation of abuse is often a complex process as abuse is rarely witnessed and many forms of abuse eg sexual, psychological or financial abuse, are more difficult to detect than others. It is essential that all professionals having contact with a vulnerable adult have a mechanism for sharing concerns and information. Codes of practice should specify reporting arrangements where abuse is suspected and mechanisms for sharing concerns and information by everyone in contact with the vulnerable adult.

FOLLOW UP ACTION

7.1 Where action has been taken to protect a victim of abuse or suspected abuse the outcome should be monitored to determine the effectiveness of that action. Arrangements for monitoring should be set out in codes of practice. Where the victim is considered to be still at risk the case should be reviewed **within 24 hours** and further action taken as considered necessary to safeguard the victim.

TRAINING ISSUES

8.1 Training is the cornerstone of any strategy for the protection of vulnerable adults. Policy guidance, statements and codes of practice should:-

- identify the lead role in ensuring that all who work with vulnerable adults, regardless of whether they are employed or volunteers and of where and by whomsoever they are employed, receive appropriate training; and
- determine what training is appropriate.

8.2 Training programmes should include:-

- recognition of signs of potential abuse (see Appendix 1) and what immediate action to take;
- investigation of abuse;
- provision and monitoring of protection from abuse;
- multi-disciplinary and inter-agency cooperation.

ACTION

9.1 Boards should, if they have not already done so, establish clear policies for dealing with abuse throughout their areas. They should ensure that providers with whom they contract for services have in place a statement and codes of practice on abuse which complies with Board policies.

9.2 The Department appreciates that this is a difficult and complex area. It is also aware that there will be much in common in the guidance appropriate in each Board. Boards may therefore consider that production of policy guidance on abuse is an area in which they might cooperate (with advice from provider units) with a view to producing guidance to which they could subscribe absolutely or with a minimum of adaptation. Work already undertaken by a Board or Trust in the area of abuse may assist in this task. In preparing their guidance, Boards may find the publications listed in Appendix 2 helpful.

9.3 Providers are asked to draw up a statement on abuse in accordance with Board policy, and a code or codes of practice on the prevention, detection, reporting and investigation (including involvement of the police) of abuse, and follow up action. They should ensure that their statements and codes of practice are brought to the attention of all staff. In preparing their codes of practice providers may find the publications listed in Appendix 2 helpful.

9.4 A clause on abuse should be included in service contracts and agreements. Fulfillment of this clause should feature in contract monitoring procedures.

9.5 Periodic reviews of policy guidance, statements and codes of practice should be undertaken to ensure that these are updated in the light of national, regional or local developments.

9.6 The Management Executive will monitor the action taken by Boards and Trusts on the requirements of this circular. General Managers and Chief Executives are asked to advise the Management Executive by 30 June 1996 of the action they have taken, or plan to take, in pursuance of this circular.

APPENDIX 1

FORMS OF ABUSE AND ASSOCIATED INDICATORS

The indicators listed below under each form of abuse are not exhaustive nor should they be taken as definitive proof that abuse has taken place. Many could equally indicate an alternative form of abuse. There may be other indicators which should not be ignored.

The victim may be subject to a number of forms of abuse.

Adults with particular disabilities can be more susceptible to certain types of abuse than others. For example adults with a learning disability may be unwitting victims of sexual or financial abuse. Immobile adults are less able to avoid certain forms of physical abuse.

Often the victim will be too intimidated, or afraid to complain that he or she is being abused. Those with communication difficulties may be unable make their to complaints understood.

Any suggestion that all is not well should be seen as an indicator of possible abuse of one form or another.

Physical Abuse

The consequences of physical abuse can range from mild discomfort to serious injury and even death through:

- physical assault
- deprivation of nutrition
- force feeding
- administration of inappropriate medication
- withholding prescribed medication
- over-sedation
- inappropriate restraint

Indicators

Multiple bruising
Black eyes
Bite marks
Injuries not consistent with explanation given
Explanations of injuries inconsistent with medical findings
Repeated attendance at GP surgeries or Casualty Departments for injuries which are not adequately explained
Signs of malnutrition
Signs of force feeding eg bruising around mouth
Poor safety standards
Inadequate heating
Inappropriate drug therapy
Non-treatment of illness or injury
Substance mis-use
Withdrawal of supplied aids eg hearing aid, glasses etc
Change in personality/behaviour

Sexual Abuse

This is involvement in sexual activities to which consent has not been given or cannot be given, or which violate the social/sexual taboos of family roles, or which are against the law. Consent is the voluntary acquiesence to the sexual activity based on an adequate knowledge of its nature, purpose, and consequences. Staff should have a clear understanding of the complexities involved in ascertaining someone's ability to give consent.

Sexual abuse can take many forms:

- lewd or licentious behaviour
- pornographic photography
- indecent exposure
- harassment, serious teasing or innuendo
- touching especially of breasts, genitals, anus or mouth
- penetration or attempted penetration
- masturbation of either or both persons

Indicators

Signs of avoidance or fear
Pain, bruising or bleeding in the genital, vaginal or anal areas
Blood stained underclothing
Difficulty in walking/sitting
Frequency of urine
Other discharges
Faecal smearing
Venereal disease
Oral bruising or ulceration
Inappropriate relationships
Overt sexual behaviour/language
"Love" bites
Change in personality/behaviour

Psychological/Emotional Abuse

Psychological and emotional abuse can be particularly difficult to detect. It can be inflicted by:-

- intimidation, humiliation, harassment, threatening or insulting behaviour, causing fear, rejection, verbal abuse
- lack of appropriate stimulation
- denial of basic rights including choice, opinion or privacy
- overprotection - not allowed to live a normal life
- involuntary isolation

Indicators

Withdrawn, agitated, anxious or fearful behaviour
Isolation
Inappropriate or improper dress
Unkept or unwashed
Overt subservience, anxious to please
Denied or unreasonably restricted access
Change in personality/behaviour

Financial Abuse

Financial abuse is interference with or deprivation of finances by any of the following means:-

- theft
- withholding money or benefits money can buy
- forced signing over of social security benefits, pensions or other property
- withdrawal of money from bank or other accounts
- deprivation of appropriate care in order to retain benefits of both cash and kind
- refusal of care because of financial cost
- blocking access to material goods
- mis-use of property or finances
- inappropriate charging for services
- fraud

Indicators

Unpaid bills
Lack of appropriate clothing
Lack of food
Unkempt appearance
Unexplained withdrawal of money from accounts
Disparity between assets and satisfactory living conditions
Inappropriate interest by family members or others in assets

Neglect

Neglect is the wilful failure to provide appropriate care and may include:

- failure to provide care and attention
- failure to access available support
- omission in exercise of duty to care

- provision of inappropriate care and attention

- deprivation of equipment

Indicators

Lack of appropriate clothing
Lack of food
Unkempt appearance
Signs of malnutrition
Inadequate heating
Lack of essential equipment

APPENDIX 2

REFERENCE MATERIAL

NO LONGER AFRAID The Safeguard of older people in domestic settings (Social Services Inspectorate, Department of Health, London 1993).

IT COULD NEVER HAPPEN HERE! The prevention and treatment of sexual abuse of adults with learning disabilities in residential settings (The Association for Residential Care (ARC) and National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities (NAPSAC) 1993).

CONSENTING ADULTS? Sexual abuse and adults with learning disabilities - a framework for practice guidance (ENABLE, Glasgow 1993).

There may also be a range of relevant material on abuse published by Local Authorities in Great Britain and by Boards and Trusts in Northern Ireland.

Management Executive
CHILD AND COMMUNITY CARE DIRECTORATE

Tel: (01232) 524443
Fax: (01232) 524421

To: Board General Managers/Chief Executives
Trust Chief Executives
Central Services Agency

28 March 1996

Dear Sir/Madam

GUIDANCE ON ABUSE OF VULNERABLE ADULTS

The attached guidance has been produced as a consequence of the findings and recommendations in the Social Services Inspectorate Report 'An Abuse of Trust'. The Management Executive is of the view that vulnerable adults can be as susceptible to abuse as children.

A draft of the guidance was issued for comment to Boards, Trusts, and relevant professional, staff, voluntary and private organisations on the 8 November 1995. There was overwhelming agreement amongst respondents of the need for the guidance, and widespread support for the principles in the guidance and for local policy statements and operational codes of practice. Accordingly, the attached guidance is little changed from the published draft.

The guidance identifies the key issues involved in the prevention, detection, reporting and investigation (including police involvement) of abuse, and follow up action. It provides a framework which Boards may wish develop in policy statements and which Trusts and other providers may draw upon in developing operational statements and codes of practice

Action

Health and Social Services Boards and Trusts are asked to ensure that the guidance is brought to the attention of all relevant staff and is put into practice.

General Managers/Chief Executives of Boards and Chief Executives of Trusts are asked to advise the Disability and Mental Health Unit by **30 June 1996** of the action they have taken in pursuance of this circular.

The Central Services Agency is asked to send a copy of the guidance to all General Practitioners.

Your faithfully,

P A CONLIFFE
Director

cc: As per attached list

Health and Personal Social Services Northern Ireland
Dundonald House, Upper Newtownards Road, Belfast BT4 3SF. Tel: 650111

cc: Health and Social Services Councils
Alzheimer's Disease Society
Association of British Neurologists (NI)
Association of Elderly Care Nursing
Association of Mental Handicap Nurses
British Association for Social Workers
British Geriatrics Society
British Medical Association
British Psychological Society
Central Council for Education & Training in Social Work
Community Psychiatric Nursing Association
Crime Branch
Criminal Justice Services Division NI Office
Dementia Development
Department of Nursing
District Nursing Association
Health Visitors Association
Institute for Counselling and Personnel Development
MENCAP
NICOD
NIPSA
NI Regional Group of the British Association of
Northern Ireland Board Royal College for Nursing
Probation Board for Northern Ireland
Rape Crisis and Sexual Abuse Centre
REN Mental Health Society
Royal College of Gps
Royal College of Midwives
Royal College of Psychiatrists
RUC CARE Branch
School of Occupational Therapy
The National Board for Nursing Midwifery and Health
Visiting for NI
The Sandown Group
Threshold Richmond Fellowship NI LTD