Northern Ireland Audit Office

Resettlement of long-stay patients from learning disability hospitals

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
7 October 2009

N I A O
Northern Ireland Audit Office

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KJ Donnelly
Comptroller and Auditor General

Northern Ireland Audit Office
7 October 2009

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Abbreviations

BBC	British Broadcasting Corporation
DHSSPS	Department of Health, Social Services and Public Safety
DRD	Department for Regional Development
DSD	Department for Social Development
EHSSB	Eastern Health and Social Services Board
MHLD	Mental Health and Learning Disability
NIHE	Northern Ireland Housing Executive
OFMDFM	Office of the First Minister and Deputy First Minister
POC	Programme of Care
RPSG	Regional Project Steering Group
RQIA	Regulation and Quality Improvement Authority
UK	United Kingdom

Executive Summary

Executive Summary

Background

1. Around one per cent of the population of Northern Ireland has a learning disability. One quarter of these people have severe or profound learning difficulties and around five per cent suffer with severely challenging behaviour.

2. Prior to the 1970s, people with learning disabilities who could not be cared for at home were placed in institutionalised settings, primarily large hospitals which provided care, protection and segregation. Three learning disability hospitals remain in Northern Ireland: Muckamore Abbey Hospital (Belfast Trust); Longstone Hospital (Southern Trust); and Lakeview Hospital (Western Trust).

3. Attitudes have changed significantly over the years, to the extent where it is now widely recognised that those with learning disabilities have a right to live inclusively and independently within the community. In 1995, a decision was taken by the Department of Health, Social Services and Public Safety (the Department) to resettle all long-stay patients from the three learning disability hospitals in Northern Ireland to accommodation offering a better life for the patient. Resettlement is only pursued where it offers "betterment" for the patient in that it is clinically appropriate, meets the patient's needs, has the potential to better the life of the patient and is in line with the wishes of the patient's family. The decision to resettle all patients within the community has not been universally welcomed. Some of the families of learning disability patients consider that the needs of their relatives are most appropriately met within the hospital setting.

4. In the 10 year period to 2002, the number of long-stay patients in learning disability hospitals in Northern Ireland fell by almost 50 per cent from 878 to 453. However, in the United Kingdom in 2002, Northern Ireland had the highest proportion of people with learning disabilities resident in long-stay hospitals – 222 beds per million population, compared with 15 beds per million in England and Wales and 163 beds per million in Scotland.

Strategic Development

5. In 1997, the Department set a target that all patients in long-stay learning disability hospitals would be resettled by 2002. However, by that time, only half of patients had been resettled (paragraph 4) and none of the three hospitals had been closed to long-stay patients. In subsequent years, various deadlines have been set and, while we accept that targets can be varied for a number of reasons, in our view the continual revision of time targets has hindered the momentum of the resettlement process. We are pleased to note that the Programme for Government 2008-2011 includes the following clear target:

   "By 2013, anyone with a learning disability is promptly and suitably treated in the community and no-one remains unnecessarily in hospital".

6. The Department pointed out that it has set annual resettlement targets and has

exceeded these in recent years. The Department considers that it is making good progress towards the 2013 target.

7. A group was established in 1999 to oversee the resettlement process. However it ceased operating in 2002 pending the outcome of the Bamford Review (see Appendix 1). A further resettlement team was established in 2007, following completion of that Review. In our view, the absence of an oversight group for a five year period suggests a lack of strategic focus and energy. While normal commissioning of services would have continued during this period, we consider that the interests of patients with learning disabilities may not have been championed as effectively as they should have been. However the Department points to the setting of targets and the increased resources allocated year-on-year to resettlement as evidence that momentum has been maintained.

8. In October 2006, the Department advertised what the then Minister of Health considered to be a "crucial" new post - Director of Mental Health and Learning Disability – to take forward the Government's response to Bamford. The recruitment process was unsuccessful. A second recruitment exercise also proved unsuccessful. In May 2007, the Minister announced the setting up of a Mental Health and Learning Disability Board (MHLD Board) to act as one of the driving forces in delivering the reforms recommended by the Bamford Review. Appointments to the Board were announced in June 2007.

9. It is disappointing to note that the recruitment of a Director of MHLD, regarded by the Minister as "crucial", was unsuccessful on two occasions and that the favoured alternative, the MHLD Board, did not meet for the first time until August 2007, 10 months after the Director post was first advertised. However the Department assured us that during this time robust arrangements were in place between it and the Trusts to ensure delivery of the March 2008 resettlement target.

Resourcing

10. Boards and Trusts told us that delays in resettling patients arise primarily because of a lack of sufficient resourcing for alternative forms of provision. Within Northern Ireland, expenditure on learning disability services per head of population has been significantly lower than elsewhere in the United Kingdom and, as a result, progress in resettling patients has been much slower. However, the Department's view is that relative expenditure on learning disability services in Northern Ireland is reflective of the £600 million under-funding of health and social care services when compared with England. We acknowledge that the Department faces real difficulties in meeting current demand for resettlement. However, if the latest target for full resettlement is to be met, learning disability must be given a higher funding priority.

11. In the view of service commissioners, over-emphasis on resettlement, without development of associated care and support services in the community,

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jeopardises the likely success of placements. In extreme cases, this can result in re-admission of learning disability patients to hospital. The Department told us that recent revisions to funding mechanisms will ensure that service commissioners have the appropriate flexibility to decide how best to meet the needs of their patients.

12. Service commissioners are best placed to assess the appropriate balance of funding between the three strands of resettlement, assessment and treatment, and provision of community support, which should be seen as a continuum of care. We welcome the changes introduced to funding mechanisms and share the Department's view that this will help service commissioners to better meet the needs of all learning disability patients.

13. It is clear that significant additional investment will need to be secured to fulfil the policy commitment of full resettlement, to deliver services in line with the Bamford recommendations and to ensure that people with learning disabilities have meaningful choices in where and how they live. It is also important that patients' assessed needs are fully met in their new environment. In recognising that there are limits to available resources we consider it essential that funding strategies should address the three strands of service provision (paragraph 12). We welcome the Department's assurance that its new target to reduce delayed discharge will ensure that a new long-stay population does not develop.

The Long-Stay Population and Options for Resettlement

14. At 31 March 2009, 256[1] patients remained in long-stay hospitals in Northern Ireland. Almost three quarters of these patients have lived in long-stay hospitals for ten years or more. In our view, these patients need to be resettled with the minimum delay as any further extension to their hospital stay may diminish the likely success of their resettlement as dependency on hospital care continues to grow.

15. The Department pointed out that it has set clear targets for resettlement up to 2011. As part of this resettlement programme, all children were resettled by March 2009. The long term target is that by 2013, no-one remains unnecessarily in hospital (see paragraph 5).

16. Of the 200 or so long-stay patients resettled in the six years to March 2009, almost 55 per cent were resettled to either a nursing home or residential home setting. Trusts told us that alternative accommodation options were often very limited and, in view of the level of care required by resettled patients with learning disabilities, transfer to nursing or residential homes sometimes offered the most viable way forward. The Department told us that when targets for resettling long-stay patients from hospitals were first introduced, it was necessary to select people who could appropriately be accommodated in vacant places in nursing and residential homes. As a result, those long-stay patients who required and requested supported living options remained in hospital.

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[1] Figures obtained directly from the three learning disability hospitals show that the number of long-stay patients at March 2009 was 264. However the Department does not agree with this figure and told us that the long-stay population at that date was 256.

17. In future, we recommend that resettlement plans not only ensure that the physical care needs of individuals are met but also enhance the level of integration of people with learning disabilities into the community, enabling them to make friends and have access to community services. The development of a wider range of accommodation options, in line with Bamford's recommendations, should facilitate this. The Department told us that it has pursued, and will continue to pursue, its policy of resettlement where it offers "betterment" for patients, in that it meets both their clinical and social needs and is in line with the wishes of the patients' families.

18. The *Supporting People* initiative, which was launched in April 2003 and is funded by the Department for Social Development (DSD), has given Trusts access to funding to increase the independence of people with learning disabilities. While the initiative undoubtedly assists in providing quality resettlement for people with learning disabilities, differences in planning and funding cycles may create difficulties in a number of schemes.

19. A number of proposed schemes do not comply with the recommendations of the Bamford review in that they provide for more than five beds per unit for people under 60 years of age. A decision to fully comply with Bamford recommendations will have cost implications which will have to be weighed up against the wider health benefits. The Department and service commissioners must continue to give full consideration to all factors, not just cost, before taking any decisions. Again the Department told us that the principle of "betterment" for the patient is paramount and it is on this basis that decisions are made.

20. Agreement needs to be reached between the Department, DSD and the Northern Ireland Housing Executive (NIHE) on the standard of accommodation to be provided. Enhanced accommodation may be required to fully meet the needs of learning disability patients. Where this is the case, additional funding would need to be secured before a decision to progress with such schemes could be taken.

21. Bamford also points out that thought must be given to the future needs of those who currently live with their families. He estimates that there could be as many as 1,600 people requiring alternative accommodation in the next 5-10 years, in addition to the hospital population. People with a disability are living longer and have changing needs throughout their lives. These are key considerations for future policy and funding decisions and have been acknowledged as such by the Department.

The Resettlement Experience and Quality of Outcome

22. The Department considers that, with careful and sympathetic management, resettlement can be successful for all patients – regardless of the length of time the individual has spent in hospital. Careful planning is, of course, imperative. Service

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commissioners and Trusts work closely, not only with the patient and their family but also with various government bodies, to ensure the accommodation is suitable, an adequate care package can be provided and access is available to the full range of public services within the community.

23. A review of cases shows the success of resettlements to date. Of the 157 patients resettled in the five year period to March 2008, only two were so unsettled in their new environment that they were returned to hospital.

24. The view that all long-stay patients can be resettled successfully is not shared by all. The Society of Parents and Friends of Muckamore fully supports the resettlement of delayed discharge patients and those long-term patients who want to be resettled. However, it believes that patients with the most complex needs, who receive a high quality of care, should not be resettled into the community where this is against the patients' wishes and the wishes of their families. The Department believes that, with careful funding and planning, it can improve the lives of those who have been in learning disability hospitals for a very long time by enabling them to live in the community. It continues to meet regularly with the Society of Parents and Friends of Muckamore.

25. Patients with the most complex and challenging needs have still to be resettled and community provision for this level of need has not yet been fully tested. We consider that a proactive response to Bamford's recommendations, and appropriate resources, will be critical in ensuring that any resettlement of the most complex cases is a positive experience for all concerned.

26. The difficulties and risks involved in ensuring quality health and social care services for learning disability patients have been highlighted by a recent review in England. The review identified a number of failings such as poor communication, poor discharge planning and insufficient involvement of family members. It is important that the findings of this review are noted in Northern Ireland and any relevant lessons learned so that learning disability patients resettled in the community, including those with the most complex needs, do not experience similar failings. The Department told us that it takes careful note of all relevant reviews, considers issues raised and determines whether learning can be applied.

Part One:
Introduction and Scope

Part of Longstone Hospital

Part One:
Introduction and Scope

One per cent of the Northern Ireland population is categorised as having a learning disability

1.1 The term *'learning disability'* describes a lifelong condition, arising before the age of 18, which significantly reduces an individual's ability to:

- learn new skills or understand new or complex information (impaired intelligence); and
- live independently (impaired social functioning).[2]

1.2 Levels of learning disability can vary considerably, from those with mild to those with profound disability. Impairments may be sensory, physical or mental.

1.3 In Northern Ireland, an estimated 16,400 people (one per cent of the population) have a learning disability. More than a quarter[3] of these people have severe or profound learning difficulties. Approximately five per cent[4] of people with learning disabilities present severely challenging behaviours.

Care for people with a learning disability is provided in a number of ways

1.4 People with a learning disability generally require some degree of direct care or support for most, or all, of their lives. This support is provided either:

- solely by family members;
- by family members with assistance from service commissioners[5] and Health and Social Care Trusts (Trusts); or
- by specialists employed within the health and social care sector.

Traditionally, institutionalised care for those with learning disabilities has been provided in long-stay hospitals

1.5 Prior to the 1970s, people with learning disabilities who could not be cared for at home were placed in institutionalised settings, primarily large hospitals which provided care, protection and segregation. Three learning disability hospitals remain in Northern Ireland: **Muckamore Abbey Hospital** (Belfast Trust); **Longstone Hospital** (Southern Trust); and **Lakeview Hospital** (Western Trust).

Lakeview Hospital

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[2] *Valuing People: A New Strategy for Learning Disability for the 21st Century*, Department of Health White Paper, March 2001

[3] *Administrative Prevalence of Learning Disability in Northern Ireland*, R McConkey, M Spollen, J Jamison, 2003

[4] *Severe Learning Disabilities and Challenging Behaviours: Designing High Quality Services*, Quereshi (1994) in Emerson, E., McGil, P., & Mansell, J. (1999), Cheltenham:Stanley Thomas

[5] Prior to April 2009, the four Health and Social Services Boards (Boards) were the service commissioners. In April 2009, the Boards were replaced by one Health and Social Care Board for Northern Ireland, supported by five area-based local commissioning groups.

Figure 1: Location of the three Northern Ireland hospitals for people with learning disabilities

In recognition of the need to integrate and include those with learning disabilities in the community, the Department has adopted a policy to resettle all long-stay learning disability patients

1.6 Attitudes to, and services for, people with learning disabilities have changed significantly over the years. Concerns about the appropriateness of long-stay hospitals and the right of patients to live more inclusively and independently have led to a desire, across the United Kingdom (UK), to resettle those with learning disabilities into the community. Appendix 2 provides details of key commitments across the UK.

1.7 As a result of changing attitudes, the Department of Health, Social Services and Public Safety (the Department) took a decision to resettle all long-stay[6] learning disability patients into the community. It is important to note, however, that not all stakeholders share the view that those with learning disabilities should live within the community. Some of the families of learning disability patients believe that a long-stay hospital is the most appropriate setting

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[6] "Long-stay" is a technical term used to refer to a very specific group of patients. The definition of long-stay is at paragraph 3.2.

Part One:
Introduction and Scope

to meet the very complex needs of their relatives (see paragraph 4.5).

Despite the desire to resettle those with learning disabilities into the community, many still remain in long-stay hospitals

1.8 Patients with a learning disability, in any setting, face significant barriers to social and economic participation in the community. Resettlement is intended to promote independence and increase choice, control and inclusion in the community. Despite the desire to provide long-term care for people with a learning disability within the community rather than in hospital, in Northern Ireland at 31 March 2009, 256 learning disability patients remained in long-stay hospitals. Around two-thirds of these were in Muckamore Abbey Hospital. The majority of these patients were less than 60 years old but there was no-one under the age of 16 years (see paragraph 3.3).

1.9 Progress in England, Scotland and Wales appears to have been timelier, with most long-term learning disability patients no longer in long-stay hospitals. In the 10 year period to 2002, the number of long-stay patients in learning disability hospitals in Northern Ireland fell by almost 50 per cent from 878 to 453. However, in the UK in 2002, Northern Ireland had the highest proportion of people with learning disabilities resident in long-stay hospitals – 222 beds per million population, compared with 15 beds per million in England and Wales and 163 beds per million in Scotland.[7] In 2002, the Department initiated a major, wide-ranging and independent review of the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland, known as the Bamford Review (see Appendix 1). This followed similar exercises in England and Scotland.

1.10 The Department told us that, in England, patients were not resettled directly from hospital to the type of accommodation recommended by Bamford. Long-stay hospitals in England were replaced by NHS campuses. These are operated by NHS Trusts and comprise housing, some of which is clustered on one site, with some shared central facilities. Those moved from hospitals to campuses rather than into the community were generally those who had other conditions aside from their learning difficulty, such as a mental health problem or a physical disability. Campus accommodation has been found to lack adequate facilities and practices that cater for the health problems that are common in people with learning disabilities. This was one of the fundamental reasons behind the goal to close all NHS campuses by 2010. In addition, in England patients were also transferred to private learning disability hospitals, the growth of which can be tracked from the time statutory hospitals started discharging patients. There are still some patients in these private hospitals.

There have been obstacles to the timely resettlement of learning disability patients

1.11 The slower progress in resettling patients in Northern Ireland has been due partly

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[7] *The Bamford Review of Mental Health and Learning Disability (Northern Ireland)*, series of reports June 2005 to August 2007

to limited resources but also a shortage of suitable alternatives in the community, which require input from the Department for Social Development (DSD) and the Department for Regional Development (DRD) in relation to housing and transport. In addition, there has been resistance to resettlement from a significant number of patients' carers and relatives. The Department pointed out that the resettlement process is, to an extent, complicated by the need to compassionately address the concerns of those within pressure groups such as "The Society of Parents and Friends of Muckamore Abbey Hospital" (Friends of Muckamore), many of whom believe that the needs of their relatives are best met within a hospital setting (see paragraphs 4.5 to 4.10).

1.12 Resettlement requires a lengthy lead-in time to ensure:

- appropriate placement;
- provision of required community support services;
- construction of accommodation;
- full involvement of patients and their families; and
- compatibility of patients within the group.

1.13 A number of key criteria[8] must be fulfilled before resettlement can be finalised. More specifically:

- no patient should be resettled until the services necessary to meet their assessed needs are in place in the community;
- all aspects of the process must respect the human rights and needs of individual patients;
- any change in service provision should result in betterment for patients;
- patients and their families should be fully involved in decisions; and
- patients should have the necessary support to enable them to express their views.

Delaying discharge from long-stay hospitals can have serious consequences

1.14 The potential consequences of delayed discharge can include:

- causing unnecessary stress, boredom and anxiety to patients;
- increasing the risk of serious incidents and aggression on wards; and
- reducing the likelihood that the patient will cope post-discharge.

Following a 1995 decision to resettle all long-stay patients from the three learning disability hospitals in Northern Ireland, progress has been slow. None of the three hospitals is now likely to be closed to long-stay patients before 2013. The

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[8] *Process to Guide Resettlement from Hospital:* A Multi-disciplinary/Multi-agency Approach, 2004

Part One:
Introduction and Scope

annual cost of running the three hospitals is around £40 million (2007-08 figures). The Department has pointed out that this includes the costs of providing other services such as specialist assessment and treatment. It has also pointed out that the costs of resettlement will be partially offset by the costs of maintaining patients in long-stay hospitals. Further, the intention is not to close the facilities as they serve purposes other than long-stay accommodation.

The consequences of not resettling patients have been highlighted in the media and recognised by the Department as a failing

1.15 Perceived failings by the Department and the Eastern Health and Social Services Board (EHSSB) to execute the timely discharge of long-stay patients from Muckamore Abbey Hospital to the community were reported in the media in early 2007. BBC Northern Ireland ran a series of related news items which focused on delays in the discharge of over 100 adults from Muckamore Abbey Hospital. In particular, reference was made to the case of a man who had been ready to leave hospital for ten years.

1.16 The media reports identified a significant reason for continued hospitalisation as being a lack of funding for appropriate community care. They also highlighted a related problem – because of the amalgamation of patients from both locked and unlocked wards, it was reported that around 20 adults awaiting discharge had been locked up, even though they had never been assessed as needing secure accommodation.

1.17 The Department recognised that this was a failing and that the resettlement programme needed "new attention". In January 2007, an action plan was announced to address the issues involved, including:

- no learning disability patient to stay in hospital for longer than 12 months depending on the level of treatment and assessment they need; and
- by 2014, no learning disability patient to have a hospital as a permanent address.

Since January 2007, a number of targets have been developed, for both adults and children, to drive forward the resettlement programme. These include the Programme for Government target that, by 2013, anyone with a mental health problem or learning disability is promptly and suitably treated in the community and no-one remains unnecessarily in hospital.

This review examines the progress made in resettling patients, accommodation options available and the impact of resettlement on patients

1.18 We examined the Department's management of the resettlement process. We reviewed:

- the strategic commitment to resettlement and the adequacy of funding (Part 2);
- the extent to which the resettlement needs of long-stay patients are

being met through the provision of appropriate resettlement options (Part 3); and

- the experiences of those resettled and the quality of the outcome (Part 4).

1.19 To assist the study, we obtained expert advice and comment from Dr Owen Barr, Head of School of Nursing, University of Ulster.

Part Two:
Strategic Developments and Funding

Part Two:
Strategic Developments and Funding

In Northern Ireland, service commissioners have adopted a three-stranded approach to the resettlement of long-stay patients

2.1 In Northern Ireland, the intention to resettle people with learning disabilities into the community dates from a 1995 policy review[9]. Responsibility for achieving full resettlement falls to the service commissioners (see footnote 5) and Trusts, working in conjunction with the Department, DSD and DRD. Commissioners have adopted a three-stranded approach[10] to future care and treatment of learning disability patients, as follows:

- resettlement from specialist hospitals into the community;
- provision of short-term assessment/ treatment facilities at each of the existing three hospital sites; and
- development of community facilities, both to support those resettled thereby preventing re-admissions, and to support learning disability patients already living in the community so that they do not require admission and become a new long-stay population.

Various target dates have been set for full resettlement of long-stay patients but this has led to uncertainty over when the objective will be achieved

2.2 The initial time target for resettling long-stay hospital patients with learning disabilities was set out by the Department in 1997 but has been subject to several subsequent changes (see Figure 2).

2.3 During this same period, the Department set an annual target[11] for the number of learning disability patients to be resettled:

- 2001 - 02 – 35 people to be resettled
- 2002-03 – no specified number for resettlement
- 2003-04 – minimum of 50 people to be resettled
- 2004-05 – minimum of 50 people to be resettled
- 2006-07 – no specified number for resettlement
- 2007-08 – 40 people to be resettled
- 2008-09 – 60 patients to be resettled compared to the March 2006 total (and a further 60 by March 2011).

2.4 We note the early progress to 2002, which saw the number of long-stay patients in learning disability hospitals fall almost 50 per cent (see paragraph 1.9) and consider it commendable that the Department has continued to set annual resettlement targets. However, it is clear that even with these achievements, the planned numbers for resettlement have not been sufficiently challenging to meet the desired time targets. The Department points out that it is not targets themselves that dictate whether resettlement is achieved

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[9] *Review of Policy for People with a Learning Disability*, DHSS, 1995

[10] *A Model of Community Based Services for People with Learning Disabilities*, Eastern Board, September 1996
Promoting Ability, Northern Board, October 1998
Strategic Review of Services for People with Learning Disability, Southern Board, June 2000
A Strategy for Learning Disability, Western Board, 1996

[11] Targets were published in the annual strategic planning document Priorities for Action. Appendix 3 provides details of specific commitments on learning disability.

Figure 2: Time Targets for Resettlement

Policy Statement	Time Target
Regional Strategy for Health and Wellbeing 1997-2002	By 2002, all remaining long-stay patients to be resettled
A Healthier Future; A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025 (DHSSPS, 2004)	By June 2010, all people with a learning disability living in long-stay hospitals should be able to relocate to appropriate and supportive community accommodation, with the option of holding their own tenancy
Action plan for Discharge of Patients from Learning Disability Hospitals, DHSSPS, January 2007	By 2014, no learning disability patient will have a hospital as a permanent address
Programme for Government 2008-11, OFMDFM, January 2008	By 2013, anyone with a learning disability should be promptly treated in the community and no-one should remain unnecessarily in hospital
Priorities for Action, DHSSPS, April 2008	By March 2009, Trusts should ensure that all children are resettled from hospital to appropriate places in the community

and it would be premature to suggest that the 2013 target will not be met or is not sufficiently challenging, considering that interim resettlement targets have in recent years been surpassed.

2.5 The latest Programme for Government[12] sets a target that, by 2013, anyone with a learning disability should be promptly treated in the community and no-one should remain unnecessarily in hospital. In June 2008, the Department issued a consultation document on how it intends to deliver the vision of the Bamford Review. This replicated the latest Programme for Government target.

2.6 While we accept that targets can be varied for a number of reasons, in our view the continual revision of time targets has hindered the momentum of the resettlement process. We are pleased to note that the Department has now set a clear target date of 2013 for the resettlement of people with learning disabilities.

2.7 If this target is to be achieved, it must be supported by a realistic action plan and related funding which address the three-stranded approach outlined at paragraph 2.1. Any subsequent changes to the target must be clearly documented and published together with an acknowledgement and explanation of the failure to achieve resettlement within proposed timescales.

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[12] *Programme for Government 2008-11*, OFMDFM, January 2008. The Programme for Government highlights the key goals and actions the Northern Ireland Executive will take to drive forward its priority areas. One of these is to promote tolerance, inclusion and health and well-being.

Part Two:
Strategic Developments and Funding

Oversight and direction of resettlement has largely emanated from the Regional Project Steering Group and latterly from the Bamford Review

2.8 In 1999, the Department established a Regional Project Steering Group (RPSG) to provide direction and oversee the resettlement process. The Group contained representatives from the Department, the four Boards, and the North and West Belfast Trust[13] - which had responsibility for the management of Muckamore Abbey Hospital - and operated until the Department commissioned the Bamford review in 2002 (see paragraph 1.9). During this period, resettlement was planned on a ward-by-ward basis so that monies could be released into community provision following ward closure. Two wards were successfully closed but, due to competing calls on available resources, these efforts were not sustainable. In 2007, as part of the Health Minister's action plan (see paragraph 1.17), the Department formed another group, the Regional Resettlement Team, with responsibility for overseeing the discharge of long-stay patients from learning disability hospitals across Northern Ireland. This Team represents all major stakeholders including service commissioners, Trust and hospital staff, representatives from DSD, the NIHE, the voluntary and community sectors and the Friends of Muckamore (see paragraph 4.6).

2.9 Bamford's report on learning disability[14] was published in 2005. It noted major changes in service provision over the previous 20 years, such as a considerable reduction in the size of the three learning disability hospitals, a growth in the provision of alternative accommodation and the availability of a wider range of day centres. It concluded, however, that the failure to fully achieve the aspirations of the 1995 policy review was due to:

- the absence of sufficient resources to build the required community infrastructure;
- the lack of robust implementation arrangements which hold departments and agencies accountable for their actions;
- a misplaced belief that learning disability needs can only be met by the health and social services sector; and
- a failure to fully involve patients and carers in service development and provision.

2.10 Bamford identified 12 core objectives and made 74 recommendations for improving the lives of people with a learning disability. These included two core objectives and ten recommendations in relation to resettlement. These are summarised at Appendix 4.

2.11 In October 2006, the Department advertised what the then Minister considered to be a "crucial" new post - Director of Mental Health and Learning Disability – to take forward the Government's response to Bamford. The recruitment process was unsuccessful. A second recruitment exercise also proved unsuccessful. In May 2007, the Minister announced the setting up of a Mental

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[13] The North and West Belfast Trust is now subsumed within the new Belfast Trust

[14] *Equal Lives Learning Disability Report,* Bamford Review of Mental Health and Learning Disability, September 2005. This was one of a series of reports, the final one being published in August 2007.

Health and Learning Disability Board (MHLD Board) to act as one of the driving forces in delivering the reforms recommended by the Bamford Review. In June 2007, the Department appointed a panel of experts to serve on the MHLD Board, providing advice on, and challenge to, the implementation of the Bamford recommendations. The Board met for the first time in August 2007.

2.12 In October 2007, two years after publication of Bamford's Equal Lives report, the Health Minister said *"It is widely recognised that mental health (and learning disability) has for too long been the Cinderella service within health. I fully accept all the recommendations from Bamford and am committed to their full and effective implementation. I will be working with my Executive colleagues to ensure that mental health (and learning disability) provision is given the attention and finance that it clearly requires and deserves."*

2.13 The Government's formal response to Bamford required input from a range of departments. In its Priorities for Action 2006-08, the Department said its response, including an action plan, would be in place by the end of 2006-07. This was not achieved. A revised date of July 2007 was announced but again this could not be achieved as the Bamford Review was not completed until August 2007.

2.14 In June 2008, the Department issued its consultative document, *Delivering the Bamford Vision*. A series of public consultation meetings was held before the consultation period closed in October 2008. The Department told us that, subject to Executive approval being given in autumn 2009, a cross-departmental action plan will be published in late 2009. Implementation of the action plan will be taken forward by a Health and Social Care Task Force led by the Health and Social Care Board.

2.15 The RPSG, established in 1999 (see paragraph 2.8), ceased operating in 2002 pending the outcome of the Bamford Review. A further resettlement team was established in 2007, following completion of the Bamford Review. In our view, the absence of an oversight group for a five year period suggests a lack of strategic focus and energy. While normal commissioning of services would have continued during this period, we are concerned that the interests of patients with learning disabilities may not have been championed as effectively as they should have been. The Department points to the setting of targets and increased resources allocated year-on-year to resettlement as evidence that momentum has been maintained.

2.16 It is also disappointing to note that the recruitment of a Director of MHLD, regarded by the Minister as "crucial", was unsuccessful on two occasions and that the favoured alternative, the MHLD Board, did not meet for the first time until August 2007, 10 months after the Director post was first advertised. The Department told us out that appointments to the Board were announced in June 2007 and assured us that, during this time, robust arrangements were in place between it

Part Two:
Strategic Developments and Funding

and the Trusts to ensure delivery of the March 2008 resettlement target.

2.17 Bamford's Equal Lives Learning Disability report was published in 2005. The final report of the Bamford review was published in August 2007. The Department told us that the Executive plans to publish its cross-departmental action plan for the period 2009-2011 in late 2009. In our view, the formal response and action plan must be issued as a matter of urgency.

Boards told us that, in their view, limited resources constrained full resettlement

2.18 Successful implementation of a policy requires strategic commitment and adequate resourcing. We noted from our discussions with Boards and Trusts, and review of Board minutes, that limited resources was considered by them to be one of the main constraints to the full resettlement of people with learning disabilities. The Department considers that the views we identified from interviews and review of Board papers are those of individual Board members and are not necessarily the official view of each Board.

2.19 Members of one Board said that the resettlement process needed the same level of attention that was given to reducing hospital waiting lists. They said that resettlement had not been receiving the resources and recognition it deserved, and identified a need for *"committed year-on-year funding to win the confidence of partners in jointly-planned housing schemes"*.[15] In response the Department told us that, from 2008-09, it is providing three-year allocations which identify:

- available resources;
- areas to which resources are to be targeted; and
- expected outcomes.

2.20 In response to media publicity surrounding resettlement issues at Muckamore Abbey Hospital, another Board reported that in its view resourcing had been *"piecemeal"* and that there had been *"no truly decisive policy initiative"* to deal with the problem.[16]

Progress on resettlement in Northern Ireland has been considerably slower than elsewhere in the United Kingdom. This is due, at least in part, to the limited resourcing in Northern Ireland

2.21 In 2005[17], it was identified that Northern Ireland expenditure on learning disability per head of population was significantly lower, at £89, than expenditure in other areas of the United Kingdom. Comparative figures for England, Scotland and Wales were £107, £95 and £119 respectively. In overall terms, given the per capita difference and differing levels of need, expenditure on learning disability in Northern Ireland was 79 per cent less than levels in England. The Department told us that relative expenditure on learning disability services in Northern Ireland is reflective of the extent to which health and social care services are underfunded

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[15] Board minutes, Eastern Health and Social Services Board, 11th January 2007

[16] Board minutes and attached update paper on the situation at Muckamore, Northern Health and Social Services Board, February 2007

[17] *Independent Review of Health and Social Care Services in Northern Ireland,* Professor John Appleby, August 2005

compared with England. It has calculated that, based on the needs of the Northern Ireland population compared with England, health and social care here will be underfunded by £600 million by 2011.

Expenditure on learning disability has risen significantly in recent years but when expressed as a percentage of expenditure on all programmes of care, it has remained constant

2.22 Total expenditure by the Department on the learning disability Programme of Care[18] has increased in recent years from just over £136 million in 2002-03 to just over £200 million in 2007-08, a rise of 47 per cent. However expenditure on learning disability as a percentage of total expenditure on all programmes of care has remained constant at around 7.5 per cent over the period, which indicates there has been no significant diversion of funding to those with learning disabilities.[19]

2.23 Further analysis reveals that expenditure on long-stay hospitals has remained reasonably constant over the period while expenditure on nursing homes and residential homes has increased. The most significant increase over the period has been in relation to supported living, where expenditure has increased from £1.9 million to £8.3 million (335 per cent) since 2002-03 (Figure 3).

Figure 3: Expenditure on elements of learning disability care

Source: Department

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[18] Health expenditure is broken down into nine "programmes of care", one of which is learning disability (POC 6).

[19] The Department told us it has also invested over £30 million in capital projects relating to learning disability in the last five years and a further £23 million is included within its planned capital programme.

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Strategic Developments and Funding

2.24 Boards and Trusts told us that delays in resettling patients arise primarily because of a lack of sufficient resourcing for alternative forms of provision. Within Northern Ireland, expenditure on learning disability services per head of population has been significantly lower than elsewhere in the United Kingdom and, as a result, progress in resettling patients has been much slower. The Department's view is that relative expenditure on learning disability services in Northern Ireland is reflective of the £600 million underfunding of health and social care services here, compared with England. We acknowledge that the Department faces real difficulties in meeting current demand for resettlement. However, if the target for full resettlement is to be met, learning disability must be given a higher resourcing priority.

2.25 In response the Department told us that, as a consequence of the 2007 comprehensive spending review, it has provided additional resources of £7 million, £9 million and £17 million for learning disability for the years 2008-09 to 2010-2011 respectively, to meet a range of specified service developments. These funds are ring-fenced for the purposes defined by the Department. The specific targets to be achieved with the earmarked resources include the resettlement of long-stay patients.

Implementation of the Bamford Review recommendations is expected to require significant additional resourcing

2.26 In May 2007, it was estimated[20] that additional Departmental resources of £173 million (at 2004-05 prices) were required to bring existing services for people with learning disabilities in Northern Ireland into line with Bamford's recommendations.

2.27 The health budget for the Comprehensive Spending Review period 2008 to 2011, announced in January 2008, provides an additional £33 million for learning disability, which will enable the resettlement of 80 learning disability patients from long-stay hospitals, an increase in the number of community-based staff and an increase in respite care.

Revised resourcing mechanisms will give service commissioners more flexibility in meeting the needs of learning disability patients

2.28 The Department sets and promotes policy on learning disability and services must be commissioned on this basis. All three policy strands - resettlement, short-term assessment and treatment, and community provision - must be developed and resourced simultaneously if the overall policy objective of resettlement of all long-stay patients is to be achieved. Service commissioners must decide on the appropriate resourcing of each element from within their own baseline funding and additional funding provided by the Department. However, Board officials told us that, in their view,

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[20] *Reform and Modernisation of MHLD Services: Strategic Priorities for the First Phase of Review Implementation*, Bamford Review, May 2007

Departmental resourcing mechanisms have in the past restricted their ability to meet the needs of all patients.

2.29 Board officials told us that over-emphasis on resettlement, without development of associated care and support services in the community, jeopardised the likely success of placements. In extreme cases, this could result in re-admission of learning disability patients to hospital. The Department told us that recent revisions to resourcing mechanisms will ensure that service commissioners have the appropriate flexibility to decide how best to meet the needs of their patients.

2.30 Service commissioners are best placed to decide the appropriate balance of resources between resettlement, assessment and treatment, and provision of community support, which should be seen as a continuum of care. We welcome the changes introduced to resourcing mechanisms and share the Department's view that this will help commissioners to better meet the needs of all learning disability patients.

Resettlement is intended to improve lives rather than reduce costs

2.31 Resettlement is only pursued where it offers "betterment" for the patient. Individual resettlements only progress where it can be demonstrated that the chosen option:

- is clinically appropriate;
- clearly meets the patient's needs;
- has the potential to better the life of the patient; and
- is in line with the wishes of the patient's family.

In this way, resettlement aims to provide long-term patients with the same rights and choices as the rest of the population. However the process has not been straightforward. The 256 patients still to be resettled include many who exhibit the most severe disabilities and present the most challenging behaviour. They require specialist community accommodation which is often unavailable. Bespoke packages are becoming more costly and Trusts believe individual packages costing in excess of £100,000 will not be unusual. By way of illustration, a recent package arranged by one Trust provides one-to-one care, 24 hours a day, seven days a week. The estimated annual cost of this resettlement is £170,000.

2.32 The changed emphasis on patterns of care initiated under the Department's 1995 policy (see paragraph 2.1) and reiterated by Bamford (see Appendix 4) has led to the expectation that people with more complex needs, who previously would have remained in long-stay hospitals, will live in the community. While available funding has enabled some resettlement of patients with complex needs, the number still to be resettled suggests that, due to competing priorities, resources have not been sufficient to meet the needs of all complex cases.

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2.33 It is clear that significant additional investment will need to be secured by DHSSPS and DSD to fulfil the policy commitment of full resettlement, to deliver services in line with the Bamford recommendations and to ensure that people with learning disabilities have meaningful choices in where and how they live. It is also important that patients' assessed needs are fully met in their new environment. In recognising that there are limits to available resources, we consider it essential that funding strategies should address the three strands of service provision (see paragraph 2.1). The Department told us that this, together with a new target to reduce delayed discharge, should ensure that a new long-stay population does not develop.

Part Three:
The Long-Stay Population and Options for Resettlement

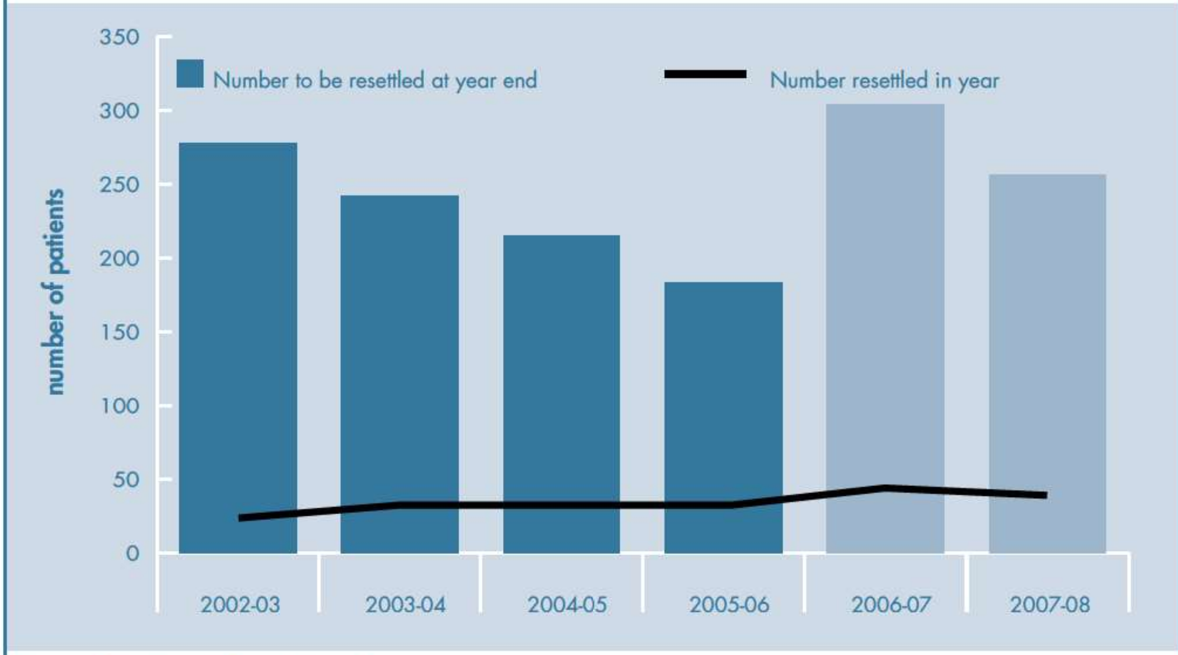
Part Three:
The Long-Stay Population and Options for Resettlement

Although progress in resettling learning disability patients has been made, a large number of patients remain in long-stay hospitals

3.1 Figures provided by the Department show that at 31st March 2009, there were 256 long-stay patients in the three learning disability hospitals in Northern Ireland. Since 2003-04, the number of long-stay patients resettled each year has increased significantly, from 22 in 2003-04 to 41 in 2007-08, and a further 36 in 2008-09 (see Figure 4).

3.2 However Figure 4 shows that, despite the rising resettlement figures, the number of long-stay patients increased in 2007-08. The Trusts told us that the increase related to a redefinition of patient categories as part of the normal process of clarifying definitions for annual targets. The definition of the long-stay population was revised from *'those patients in designated resettlement wards'*, to *'those who had been admitted to hospital prior to 1 April 2006 and had been in hospital for 12 months or more at 31 March 2007 '*. As a result of the redefinition, the number of patients to be resettled rose from 183 at March 2007 to 304 at March 2008, but has reduced to 256 at March 2009.

Figure 4: Resettlement activity in the last six years

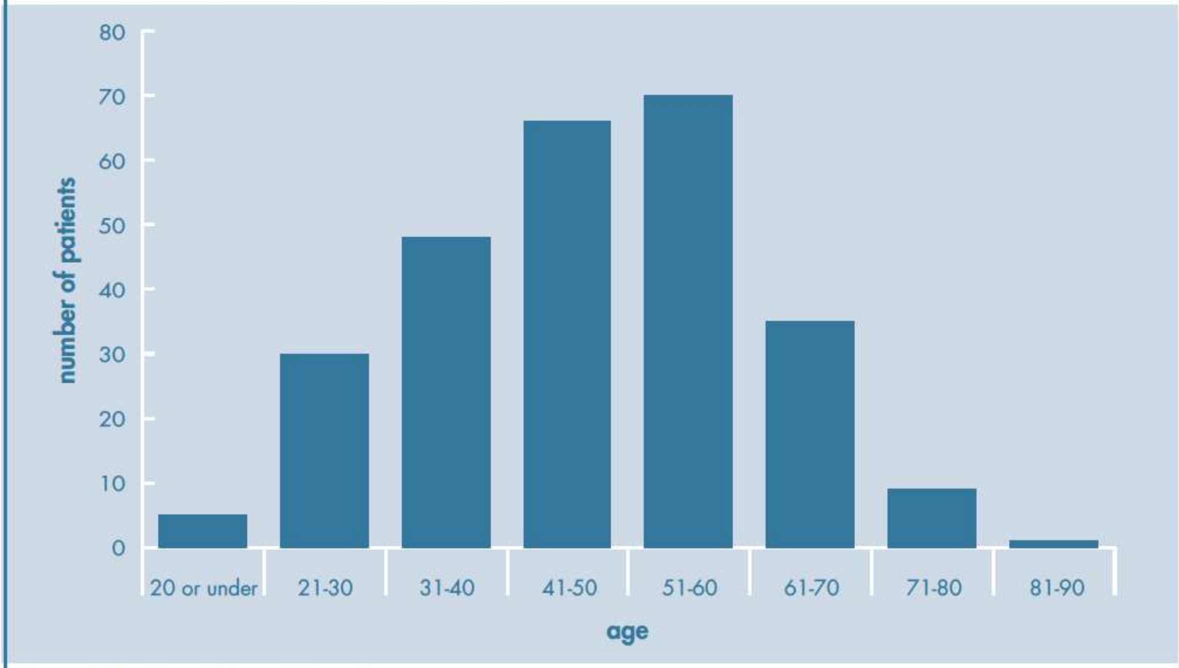


Source: Health and Social Care Trusts
* shading of columns indicates a change in the definition of long-stay population

The majority of long-stay patients are within the 31-60 age range and have been in hospital for at least 10 years

3.3 Figure 5 shows the age-range of the long-stay patients remaining in hospital at March 2009. The majority of these patients (70 per cent) were aged 31-60, a further 13 per cent were aged 30 or younger and finally, 17 per cent were aged 61 or over. There were no children under the age of sixteen.

Figure 5: Age range of long-stay hospital population



Source: Health and Social Care Trusts

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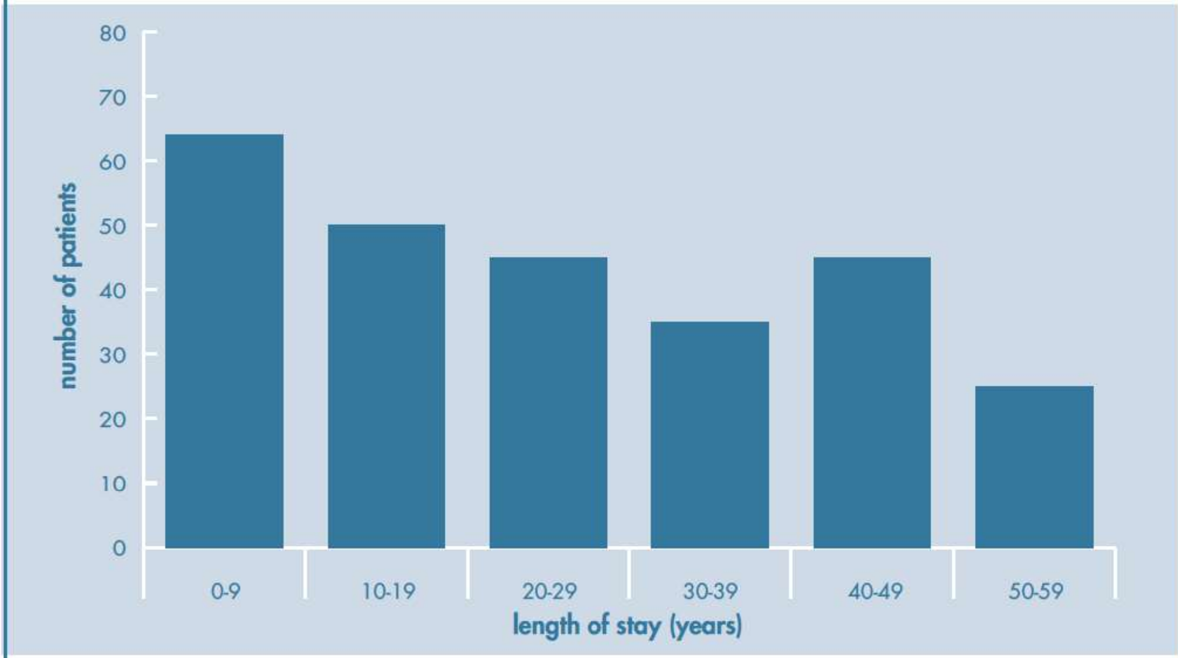
Figure 6: Length of stay of long-stay hospital population



Source: Health and Social Care Trusts

3.4 Figure 6 shows that, at March 2009, most long-stay patients (76 per cent) had been in hospital for 10 years or more. Almost ten per cent had been in hospital for 50 years or more.

3.5 As shown above, progress has been made in resettling long-stay patients with learning disabilities from hospitals. However, 256 people remain in hospital on a long-term basis, 13 years after the policy of resettlement was adopted. In our view, these patients need to be resettled with the minimum delay as any further extension to their hospital stay may diminish the likely success of their resettlement as dependency on hospital care continues to grow.

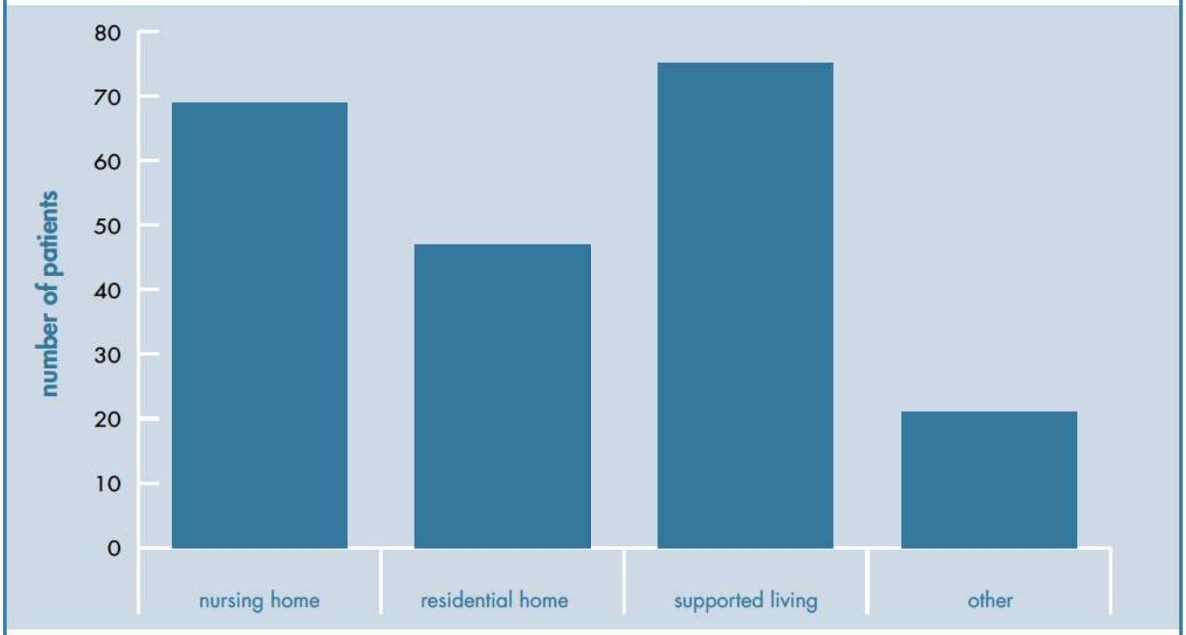
3.6 The Department pointed out that it has set clear targets for resettlements up to 2011 (see paragraph 2.3). As part of this resettlement programme, children were identified as a target group and all children have now been resettled. The long term target is that *by 2013, anyone with a learning disability is promptly and suitably treated in the community and no-one remains unnecessarily in hospital.*

Often, resettlement accommodation offers similar arrangements and conditions to those provided in hospitals for people with learning disabilities, and does not ensure full integration and inclusion in communities

3.7 Of the 200 or so long-stay patients resettled in the six years to March 2009, almost 55 per cent were resettled to either a nursing home or residential home setting (Figure 7). Thirty-five per cent moved to a supported living arrangement and ten per cent moved to other settings such as a challenging behaviour unit or a specialist adult placement scheme.[21]

3.8 This suggests that while many more people now live in smaller more localised settings, they are not fully integrated into the community. Trusts told us that alternative accommodation options were often very limited and, in view of the level of care required by resettled patients with learning disabilities, transfer to nursing or residential homes sometimes offered the most viable way forward. The Department told us that when targets for resettling long-stay patients from hospitals were first introduced, it was necessary to select people who could appropriately be accommodated in vacant places in nursing and residential homes. As a result, those long-stay patients who required and requested supported living options remained in hospital. The Department told us that the development of supported living options requires lead-in

Figure 7: Resettlement destinations in the six years to March 2009



Source: Health and Social Care Trusts

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[21] A small number of agencies have developed adult placement schemes, where families are actively recruited, supported and paid to provide short breaks or long-term homes for selected individuals.

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time with housing providers and assurance that revenue for community support will be available following completion.

3.9 The Bamford Review noted that *"in many cases the accommodation that replaced the hospitals retained many of their features…most obviously sizeable groups of people who were unrelated to each other living together in…care homes and nursing homes with little engagement with local communities."* Bamford considered that there was *"a need for both a wider range of supported living provision, to include adult placement services, and to address the deficiencies identified in large-scale group living environments."*[22] The Department told us that the level of integration will depend on the individual patient and the level of their disability.

3.10 We concur with Bamford that the integration of learning disability patients cannot be achieved without a range of accommodation options. In future, we recommend that resettlement plans not only ensure that the physical care needs of individuals are met but also enhance the level of integration of people with learning disabilities into the community, enabling them to make friends and have access to community services. The development of a wider range of accommodation options, in line with Bamford's recommendations, should facilitate this. The Department told us that it has pursued, and will continue to pursue, its policy of resettlement where it offers betterment for patients, in that it meets both their clinical and social needs and is in line with the wishes of patients' families.

Since April 2003, the Supporting People initiative has provided significant resources for resettling learning disability patients within supported living accommodation

3.11 Since the launch of the national Supporting People initiative in April 2003[23], Trusts have had access to funding to increase the independence of people with learning disabilities. The impact of Supporting People funding is shown in Figure 8, with 35 per cent of resettlements since 2003-04 being provided within supported living accommodation.

3.12 In Northern Ireland, the Supporting People initiative is administered by the NIHE and funded through DSD. The initiative operates through a Commissioning Body, which consists of representatives from NIHE, the four health and social services Boards and the Probation Board. Each Board also chairs an Area Supporting People Partnership group which includes nominated representatives from local health Trusts, NIHE and the Probation Board. These groups identify local needs and determine funding priorities.

3.13 People with learning disabilities have been the primary beneficiaries of the Supporting People scheme (see Figure 9). In the last six years, revenue funding[24] of over £66 million (more than 20 per cent[25] of overall Supporting People funding) has been

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[22] *Equal Lives Learning Disability Report*, Bamford Review of Mental Health and Learning Disability, September 2005, paragraphs 6.1 and 6.12

[23] Supporting People is a UK-wide reform of housing support services involving statutory, voluntary and community sectors. Prior to 2003, housing support services were largely ad hoc.

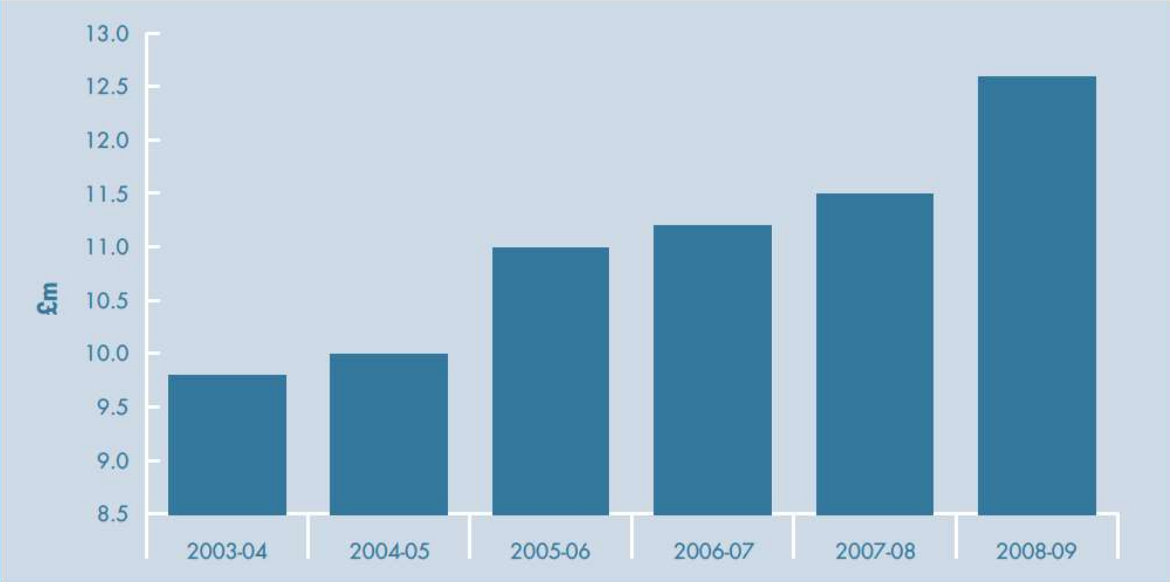
[24] Revenue funding covers the cost of providing advice, help and guidance to occupants. Available services include provision of wardens in sheltered schemes, finance advice and help with benefit claims, and training in basic skills such as cooking and hygiene.

[25] *Supporting People Strategy 2005-2010*, NIHE, September 2005

Figure 8: Resettlement destinations by year

Source: Health and Social Care Trusts

Figure 9: Supporting People funding for learning disability schemes



Source: NIHE

Part Three:
The Long-Stay Population and Options for Resettlement

provided to resettlement projects. The capital costs of the projects undertaken during this period were funded separately under DSD's New Build Programme and amounted to around £20 million. On-going care costs are funded by the service commissioners.

3.14 Over the next three years, 14 supported living schemes are planned under the Supporting People initiative. These include 69 places allocated to learning disability. Funding for these schemes has not, as yet, been guaranteed.

3.15 An evaluation into the financial benefits of the Supporting People Programme has recently been undertaken in England and Wales.[26] The evaluation concluded that the total net financial benefit of Supporting People for those with learning disabilities was £664 million. DSD told us that its Housing Division will undertake a policy evaluation of the administration of the Supporting People programme in Northern Ireland.

Differences in Departmental planning and funding cycles have, in the past, caused problems in the co-ordination of projects

3.16 The Department and DSD explained to us that the main problem in co-ordinating projects is caused by the difference in planning and funding cycles. Capital funding of new-build schemes is typically for a three-year period. However, Supporting People revenue funding from DSD, which provides housing support in the form of advice, help and guidance, is allocated on a yearly basis. Each resettlement scheme can take up to three years to plan, develop and complete and this can be problematic if revenue funding is not guaranteed beyond the first year. Care funding from the Department has, from 2008-09, been allocated on a three-yearly basis.

3.17 Boards considered that revision of their funding cycle from one to three years would enable more accurate planning and ensure full access to available funding. Bamford supported this view stating that *"the capital and revenue cycles of…the Department of Health, Social Services and Public Safety and the Department for Social Development need to synchronise for Supporting People schemes."*

Full compliance with the Bamford Review may result in delays to, or revision of, a number of planned schemes which do not meet Bamford's proposed specifications

3.18 A further complication is that Bamford recommended that, by January 2013, all accommodation units for people under 60 years of age with a learning disability should be for no more than five people. We note that 16 of the 36 proposed schemes included in the Supporting People Strategy are designed to provide 10 or more beds. At least one Board had already adopted the "no more than five people" recommendation for all future schemes.

3.19 DSD told us that the decision on the number of people per scheme generally falls to service commissioners and is based on care considerations. Any future decisions

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[26] *Research into the financial benefits of the Supporting People Programme*, Capgemini UK plc on behalf of the Department for Communities and Local Government, January 2008

by them to fully comply with Bamford's recommendation will have cost implications in terms of reduced economies of scale, and additional funding would have to be given to meet these extra costs.

3.20 In its recent consultation document (see paragraph 2.14), the Department has proposed a pragmatic approach as follows: *"where appropriate and economically viable, DSD will seek to restrict group provision….to no more than five individuals per household"*.

DSD considers that greater clarity and transparency is required in the definition of "housing support" and "care"

3.21 DSD and NIHE are responsible for social housing and have guidance and standards[27] in place for new build schemes and the support provided within those schemes. They acknowledge and support the different standards required for the various client groups, including those with learning disabilities. However DSD considers that greater clarity and transparency is required in the definition of "support services" and "care" (see paragraph 3.16) to avoid confusion. It considers that this would facilitate clearer allocation of responsibilities.

3.22 The Supporting People initiative undoubtedly assists in providing quality resettlement for people with learning disabilities. However, differences in planning and funding cycles have in the past created difficulties in a number of schemes. Bamford stated that planning and funding cycles needed to be synchronised. NIAO notes that, from 2008-09, the Department has made a three-year allocation of funding.

3.23 A number of proposed schemes do not comply with the recommendations of the Bamford review in that they provide for more than five beds per unit for patients under 60 years of age. A decision to fully comply with Bamford recommendations will have cost implications which will have to be weighed up against the wider health benefits. The Department and service commissioners must continue to give full consideration to all factors, not just cost, before taking any decisions. The Department told us that the principle of "betterment" for the patient is paramount and it is on this basis that decisions are made.

3.24 If the long-term hospital population is to be resettled in line with Bamford recommendations, there needs to be provision of a greater range of housing options. Bamford notes, for example, that there is a low level of home ownership among people with learning disabilities. Continued co-operation between DHSSPS and DSD will be essential in helping to overcome these barriers.

3.25 Agreement needs to be reached between the Department, DSD and NIHE on the standard of accommodation to be provided. Enhanced accommodation may be required to fully meet the needs of learning disability patients. Where this is the case, additional funding would need to be secured before a decision

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[27] Housing Association Guide, NIHE

Part Three:
The Long-Stay Population and Options for Resettlement

to progress with such schemes could be taken.

3.26 Bamford also points out that thought must be given to the future needs of those who currently live with their families. He estimates that there could be as many as 1,600 people requiring alternative accommodation in the next 5-10 years, in addition to the hospital population. People with a disability are living longer and have changing needs throughout their lives. These are key considerations for future policy and funding decisions and have been acknowledged as such by the Department.

3.27 We are pleased to note that since September 2007 the Regional Resettlement Team (see paragraph 2.8) meets regularly in order to make progress on these issues. In addition, senior Departmental staff sit on the Supporting People Group which meets regularly to discuss supported housing. We would hope that these groups will make rapid progress in resolving outstanding supported housing issues.

Part Four:
The Resettlement Experience and Quality of Outcome

Orchard House

Part Four:
The Resettlement Experience and Quality of Outcome

Resettlements in recent years have largely been successful, with few resettled patients requiring long-term readmission to hospital

4.1 Each of the three learning disability hospitals (see paragraph 1.5) has a Resettlement Strategy Group in place consisting of Board and Trust representatives, health professionals and representatives of patients and carers. These groups meet regularly (often weekly) to discuss overall progress on resettlement and identify individual resettlement needs. The aim of each of these groups is to ensure a planned approach to resettlement, looking at the needs of individual patients and issues of compatibility where grouped settings are planned. Within each hospital, patients with similar needs are grouped together so that when that group is resettled, a ward can be closed. The related funding can then be released to support development of community services.

4.2 The discharge of patients happens gradually. There is no typical length of time, as resettlement depends on a number of factors. These include the level of the patient's disability (both physical and learning), the availability of suitable alternatives and the wishes of relatives. Initially patients, accompanied by hospital staff, undertake introductory visits to the new setting. In due course, overnight stays are arranged. Next, a trial resettlement begins. A hospital place is kept for the patient during this trial period and the placement is closely monitored. Eventually responsibility for the patient transfers to a community team following a final discharge meeting, and at this point the patient is considered to be resettled.

Figure 10: Resettlement "Breakdowns" 2003-04 to 2007-08

Trust	Breakdowns	Explanation
Belfast	1	One breakdown in 2005-06 due to patient's challenging behaviours
Northern	0	No breakdowns reported
South Eastern	0	No breakdowns reported
Southern	8	During 2006-07 and 2007-08 there were eight cases where resettled patients had to be temporarily readmitted to the Assessment and Treatment Unit because of challenging behaviour but they all returned to their placement
Western	4	A total of four breakdowns, one due to mental health issues, two due to challenging behaviours and one due to complex healthcare needs and dementia. Only one required long-term readmission to hospital

Source: Trusts

4.3 In recent years, resettlement has been largely successful. Few resettled patients have required long-term readmission to hospital. Figure 10 provides details of problems which have arisen in each Trust area.

4.4 The Department believes that careful and sympathetic management of the resettlement process can result in successful resettlement for all patients, regardless of the length of time they have spent in hospital, the complexity of their needs or the challenging nature of their behaviour. The following case examples show that successful resettlement can happen even in very difficult circumstances.

Case Example 1

Two friends, Mary and Jane[28], who had lived in the same ward at a long-stay hospital, were resettled together in a supported living setting.

At the time of resettlement, Mary had been in hospital for over 50 years while Jane had been there for two years. Both Mary and Jane have learning disabilities and severe physical disabilities.

Patients with this level of need are generally resettled in a nursing home setting. However, given the friendship of Mary and Jane, the hospital's Resettlement Strategy Group considered that a supported living scheme would offer more fulfilment to the women.

Mary and Jane now live as tenants of a housing association in a specially adapted bungalow. They receive 24 hour support from staff employed by a voluntary organisation. The Trust monitors their progress and assists in the provision of other services as required.

Case Example 2

John, a young man exhibiting challenging behaviour, had been resident in hospital for a period of four years.

John was successfully resettled in an adult placement with specialist foster parents. The dedication and experience of John's foster parents and the close partnership with the community key worker ensure that John's behaviour can be managed to the extent where he no longer requires long-term hospitalisation.

There has been some family opposition to the resettlement of the most complex cases

4.5 The view that all long-stay patients can be resettled successfully, however, is not shared by all. Some of the families of long-term patients believe that the level and standard of care required by patients with very complex needs can only be provided in hospital.

4.6 Concerned families are represented by the Society of Parents and Friends of Muckamore group[29] (Friends of Muckamore). Although the group fully supports the resettlement of delayed discharge patients and those long-term patients who want to be resettled, it believes that patients with the most complex needs, who receive a high quality of care, should not be resettled into the community

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[28] The names used in the case examples are not the patients' real names.

[29] This group represents the views of those with family members in Muckamore – mostly Eastern and Northern Board residents. No major concerns have so far been raised by families in the Southern and Western Board areas and there are no formal family groups in these areas.

where this is against the patients' wishes and the wishes of their families.

4.7 The main concerns of the Friends of Muckamore are that:

- because of the complex needs of patients, they consider that the hospital provides a safe environment and believe that these patients would not be accepted into the community. They fear that patients would be subject to bullying and harassment;
- the level of care provided at Muckamore could not be replicated in the community. Muckamore provides doctors, psychiatrists, dental services, pharmacy, physiotherapy, dietetics, nursing and a rapid response arrangement with Antrim and Musgrave Park Hospitals;
- the quality of life for Muckamore patients may diminish as a result of resettlement in the community. Friends of Muckamore consider that access to recreational activities such as swimming, bowling and cinema, and day care facilities to help with communication and social skills, while freely available within the hospital, may be limited in the community;
- the much higher cost of community care packages for those with the most complex needs does not represent the best use of taxpayers' money; and
- there is uncertainty over the likely longevity of resettlement to "run for profit" private nursing and residential homes.

The Department and service commissioners are sympathetic to the concerns of family members and in 1995 gave an assurance that resettlement against the wishes of the patient or family would not be pursued

4.8 The Department and service commissioners are sympathetic to the concerns of the Friends of Muckamore. They recognise the importance of family and carer support in the resettlement process and have enshrined their role in resettlement procedures (see paragraph 1.13). The Friends of Muckamore are represented on the Regional Resettlement Team (see paragraph 2.8) and service commissioners have developed advocacy services to work with patients and families to address concerns. These advocates can be health and social care staff, voluntary bodies, or staff from the Patient and Client Council.[30] The Friends of Muckamore consider that the advocacy services are not independent and believe they apply "undue pressure" on families. This concern was similarly identified by Bamford who recommended provision of independent advocacy services in Northern Ireland.

4.9 The Friends of Muckamore group was given an assurance in 1995 that *"no-one shall be required to relocate without their consent or against the wishes of their relatives and carers."* The group told us that it will take legal action where resettlement is enforced against the wishes of patients or their families. However the Department

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[30] Until April 2009, there were four independent area-based councils which represented the public's views and interests and reviewed the work of health and social services. From 1st April 2009, this role is now undertaken by the new Patient and Client Council.

believes that, with careful funding and planning, it can improve the lives of those who have been in learning disability hospitals for a very long time by enabling them to live in the community. It continues to meet regularly with the group.

4.10 Clearly the Friends of Muckamore remain very concerned about the quality of care that their relatives would receive if they were moved into community settings. Patients with the most complex and challenging needs have still to be resettled and community provision for this level of need has not yet been fully tested. We consider that a proactive response to Bamford's recommendations, and appropriate resources, will be critical in ensuring that any resettlement of the most complex cases is a positive experience for all concerned.

The consequences of ineffective provision for learning disability patients have been highlighted in a recent report in England

4.11 The difficulties and risks involved in ensuring quality health and social care services for learning disability patients have been highlighted by a recent review in England.[31] This examined six cases where serious failings resulted in prolonged suffering and inappropriate care for the individuals involved. The failings included:

- poor communication, with information not being accurately passed between professionals, and between professionals and families, and then acted upon;
- a lack of partnership working, for example in discharge planning;
- insufficient importance attached to the views of family members; and
- an absence of independent advocacy services, which should be in place to safeguard the rights of vulnerable people.

The review recommended that all health and social care bodies should review urgently their capacity and capability to meet the additional and often complex needs of people with learning disabilities.

4.12 It is important that the findings of this review are noted in Northern Ireland and any relevant lessons learned so that learning disability patients resettled in the community, including those with the most complex needs, do not experience similar failings. The Department told us that it takes careful note of all relevant reviews, considers issues raised and determines whether learning can be applied.

The impact of resettlement on quality of life depends on the suitability of the placement

4.13 The Department emphasises that it is committed to the overriding principle of betterment and says that patients would not be resettled unless they were assured of a better standard of service and quality of life than in hospital. It recognises that resettlements to suit individual needs, especially the most complex needs, will be

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[31] *Six Lives: the provision of public services to people with learning disabilities,* Local Government and Health Service Ombudsmen, HC 203-1, March 2009

Part Four:
The Resettlement Experience and Quality of Outcome

more expensive than remaining in hospital but says that cost is secondary to quality of life.

4.14 We have been made aware of some particularly successful examples of resettlement schemes:

Case Example 3

One success story of a grouped supported living arrangement is Orchard House in Loughgall, Armagh. It opened in 2005 and has 10 residents. Each person has their own bedroom; there are two homely living rooms and a larger communal sitting room. There are two small kitchens where residents can prepare their own food if they wish, and also a communal kitchen and dining area where food is prepared and served centrally by staff. There is 24-hour staff cover. Residents have a range of day care activities and the freedom to go into the village, for example to the hairdresser or shops. Families can visit at any time and the residents can go and stay with their families at weekends or for holidays. Orchard House has been a great success, yet under the Bamford recommendations, a similar design would no longer be considered as it caters for more than five people.

Case Example 4

One Board undertook a small study of a resettlement scheme, Knock Eden in Portadown, to identify the benefits to patients of living in community settings. The scheme comprises four bungalows, each housing four tenants. Fourteen of the 16 tenants transferred from Longstone Hospital where they had lived for most of their lives. Learning disabilities range from moderate to profound. The benefits identified included improved physical health and well-being, greater choice, more opportunities to use skills, greater community involvement and participation, and a better sense of status and respect. The families of the resettled patients were very positive about the impact on their relatives. This arrangement would be acceptable under Bamford, as each unit is for only four people.

While many recent studies have reported positive outcomes from resettlement, others highlight just how challenging it will be to ensure full integration of those with the most complex needs

4.15 A number of studies in recent years have looked at the experiences of people resettled from long-term hospital.[32] These have reported positive outcomes: people felt happier, healthier and more independent;

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[32] Donnelly et al (1996): *One and two years outcomes for adults with learning disabilities discharged to the community*, British Journal of Psychiatry, 168, 598-606
Donnelly et al (1997): *A three to six-year follow-up of former long-stay residents of mental handicap hospitals in Northern Ireland*, British Journal of Clinical Psychology, 36, 585-600
McConkey et al (2000): *Moving on from Muckamore Abbey Hospital: The outcomes and lessons as perceived by people with learning disabilities, their key-workers, care managers and relatives*, Belfast, EHSSB
McConkey et al (2003): *Moving from long-stay hospitals: the views of Northern Irish patients and relatives*, Journal of Learning Disabilities, 7, 78-93

certain aspects of challenging behaviour had improved; all families felt the placement was at least as good as the hospital and 80 per cent felt it was much better than the hospital. The studies noted, however, that around 75 per cent of people surveyed had moved to alternative large group settings – mostly nursing and residential homes. As a result, there was little change of experience in terms of daytime activities and social networks.

4.16 Bamford commented specifically on the findings of two reviews[33] of supported living options:

- in the first, people had moved to their own tenancies, with support staff from their Health Trust providing assistance. Tenants were *"happy, settled and achieving a higher level of functioning than in their previous accommodation"* and were better able to live "*normal*" lives within their communities;
- the second review looked at three supported living schemes. Each of the schemes contained clusters of houses within a defined area, with one or two tenants in each property. While the tenants considered they had more choice as to how they lived, the review found that they had not experienced any greater degree of social inclusion.

4.17 The findings of these studies indicate mixed success from the resettlement experience. The patients involved were not those with the most complex needs and, in the case of the supported living reviews, they had not come from a long-stay hospital setting. If achievement of social inclusion and integration cannot be managed successfully at this level of need, it confirms just how challenging the integration of patients with the most complex needs will be. One of the reviews concluded that the setting alone does not guarantee inclusion and integration; the support network from a range of agencies and initiatives, such as advocacy and befriending, will also be crucial to success.

Quality needs to be a key consideration in the resettlement of learning disability patients

4.18 A major theme of a recent review of the National Health Service in England[34] is that quality, rather than quantity, should become the guiding principle of the health care system. It defined quality as a combination of patient safety; effectiveness of treatment and care; and patients' satisfaction with their experience. The Department told us that it is developing a service framework for learning disability services which will set out the specific standards expected. In addition, it emphasised that the principle of betterment for the individual is the main focus of the resettlement programme.

4.19 Quality assurance processes in place within health and social services were strengthened in 2003[35] by the introduction

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[33] Maybin M (2000): *Supported living scheme evaluation,* Newtownards, Ulster Community and Hospital Trust
McConkey R and McConaghie J (2001): *Supported Living: An evaluation of three schemes in Northern Ireland for people with learning disabilities,* Ballymoney, Triangle Housing Association

[34] *High quality care for all: NHS Next Stage Review final report,* Department of Health, June 2008

[35] Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

of a statutory duty of quality in the provision of care, and the establishment of the Regulation and Quality Improvement Authority (RQIA) in 2005. RQIA is a non-departmental public body with overall responsibility for assessing and reporting on the availability and quality of health and social care services in Northern Ireland. It is also required to encourage continuous improvement in the quality of care and services throughout all sectors in Northern Ireland.

4.20 If resettlement of long-term patients is to achieve the aspiration of promoting independence, increasing choice and control, and inclusion in communities (see paragraph 1.8), then more needs to be done to ensure quality outcomes. Quality of care of individual patients needs to be reviewed regularly as part of care planning and care management. The Department told us that yearly reviews are undertaken with all resettled clients and their families, to determine if their needs are being met. We found, however, that there is an absence of regularly reported composite information on service quality. As part of the establishment of RQIA, the Department is developing minimum standards for a range of health and social care settings, which will provide the basis for measuring and monitoring the quality of services for people with learning disabilities.

4.21 In our view, patient satisfaction with resettlement services and continuous improvement of those services must be the driving principles of quality management in learning disability services. The Department must utilise the minimum standards and service framework, as well as feedback from clients and their families, to inform a system of continuous improvement. The Department told us that a culture of reviewing, sharing experiences and learning from outcomes already exists within health and social care. Patient satisfaction and continuous improvement of services are the driving principles of the resettlement programme, which provides bespoke services following individual person-centred planning and risk assessment. Account is also taken of health and safety issues, any other impacting policies and best practice guidance.

Appendices

Appendix One:
(paragraphs 7 and 1.9)

Background to the Bamford Review

In 2002, the Department initiated a comprehensive review of mental health and learning disability law, policy and service provision in Northern Ireland.

The findings from the review, known as the *Bamford Review*[36], were published in a series of 10 reports over the period June 2005 to August 2007. These reports set out a 10-15 year reform programme designed to improve services for people with mental health and learning disability problems and their families. While many of the recommendations relate specifically to the health and social care sector, several apply to other sectors across the Northern Ireland Executive (the Executive).

The Executive accepted the thrust of the Bamford Review. In June 2008, it issued a consultation document to stakeholders, *"Delivering the Bamford Vision"*, seeking views on the way forward in terms of implementation. The consultation period has now ended and the Executive shortly intends to publish a cross-departmental Action Plan for the period 2009-11. The Action Plan will specify commitments across all Government departments over the next two years. The Executive will also make a commitment to continued reform after 2011. The pace of change will depend on the availability of necessary resources.

Implementation within the health and social care sector will be overseen by the Health and Social Care Taskforce (under the control of the Health and Social Care Board). In addition, an independent group, led by the Patient and Client Council, will be set up with a dual role. Firstly, it will report to the Minister on the extent to which implemented change complies with the Bamford vision and secondly, it will provide a link with service users and carers to enable assessment of the improvement in care, treatment and support provided.

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[36] The Steering Committee charged with the review operated under the Chairmanship of Professor David Bamford of the University of Ulster and comprised representatives from various professional and other interested groups in the mental health and learning disability fields. The Review, as a result, is more generally referred to as the Bamford Review.

Appendix Two:
(paragraph 1.6)

Strategic commitments to resettlement

Date	Strategic Development	Impact
1950	European Convention on Human Rights	Enshrined right to life, liberty and security and respect for a private and family life
1957	Mental Health Act	Ended compulsory certification and enabled the discharge of people with learning disabilities from long-stay institutions
1969	Committee of Enquiry into Ely Hospital *(the Howe Report)*	Highlighted problems with institutional care – impoverished conditions, lack of privacy, emphasis on physical care and "custodial" attitudes among staff
1971	Government White Paper *Better Services for the Mentally Handicapped*	Set targets for England and Wales for the next 20 years, to drastically reduce long-stay hospital places (from 52,000 to 27,000) and increase community provision
1979	Committee of Enquiry into mental handicap nursing and care *(the Jay Committee)*	Emphasised the need for community care and a service philosophy based on "normalisation"
1989	Government White Paper *Caring for People*	Confirmed commitment to the development of locally-based health and social care services
1994	Welsh Office Circular 30/94	Formalised the objective of full resettlement and hospital closure, with a target date of April 1999
2000	Scottish Executive Report *The Same As You?*	Set an objective to close all long-stay hospitals in Scotland by 2005
2001	Government White Paper *Valuing People*	Set target date of April 2004 for the closure of all remaining long-stay hospitals in England
2004	Department of Health, Social Services and Public Safety, 2004 A Healthier Future,: *A Twenty Year Vision for Health and Well-being in Northern Ireland*	Set a Northern Ireland target to relocate all people with a learning disability, living in long stay hospitals, by June 2010, by providing appropriate and supportive community accommodation
2005	Bamford Review of Mental Health and Learning Disability (Northern Ireland), *Equal Lives Report*	This will be the basis of the way forward on learning disability policy for the Department

Appendix Three:
(footnote 11 at paragraph 2.3)

Departmental Priorities for Learning Disability

Priorities for Action 2002-03 (March 2002)	• Set a planning goal to improve community infrastructure to support long-term care of vulnerable groups in the community and facilitate discharge from long-stay institutions • Need to focus hospital services on assessment and short-term treatment • Goal that long-term care should no longer be provided in hospital environments • Priority that learning disability patients should enjoy suitable living arrangements outside hospital where that is appropriate • Boards and Trusts should continue the resettlement programme (no specific target – almost 400 still in hospital)
Priorities for Action 2003-04 (February 2003)	• Planning goals include minimising admissions to long-stay institutions and expanding learning disability services • Limited funding identified as a reason for delayed discharges from learning disability hospitals • Priorities include further progress in reducing the number of people in continuing care for whom community care has been assessed as more appropriate • A regionally agreed plan is now in place to resettle those in learning disability hospitals • Boards and Trusts should aim to resettle at least a further 50 people
Priorities for Action 2004-05 (March 2004)	• Boards and Trusts should resettle at least a further 50 people by 31st March 2005 • Boards and Trusts should develop community learning disability services to allow a further 80 people to be looked after in the community by 31st March 2005 • Boards and Trusts should ensure no new long-stay admissions to learning disability hospitals

Priorities for Action 2006-08 (June 2006)	• Bamford Review, to be finalised this year, will provide strategic framework for learning disability services. This will need to be given priority and specific targets will be set for 2007-08 onwards • Department will provide response, including action plan, to Bamford Review by the end of the year • Director of MHLD will be appointed • No specific target for resettlement • Boards and Trusts should continue to reform learning disability services in the community and move away from long-term institutional care
Priorities for Action 2007-08 (January 2007)	• Definitive policies and targets for learning disability will be decided in the context of the inter-departmental action plan to be drawn up by July 2007 in response to Bamford • Principal target - by March 2008, Boards and Trusts should have resettled 40 people from learning disability hospitals • Supplementary target – by March 2008, community learning disability teams should be augmented by 25 staff
Priorities for Action 2008-09 (April 2008)	• Trusts should ensure a 25 per cent reduction in the number of long-stay patients in learning disability institutions by 2011 • By March 2009, Trusts should resettle 60 patients from hospital to appropriate places in the community compared to the March 2006 total, and a further 60 by March 2011 • Trusts should ensure that, by March 2009, 75 per cent of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days, unless there are exceptional circumstances • Trusts should ensure that, by March 2009, all children are resettled from hospital to appropriate places in the community

Appendix Four:
(paragraphs 2.10 and 2.32)

Recommendations of the Bamford Review on the accommodation needs of people with learning disabilities – the Equal Lives report

1. By June 2011, all people with a learning disability living in a hospital should be relocated to the community. Funds need to be provided to ensure that on average 80 people will be resettled per annum over the five-year period from 2006 to 2011.

2. With immediate effect, all commissioners should ensure that they have resourced and implemented arrangements to provide emergency support and accommodation for persons with a learning disability. Hospitals will not provide this service from 1st January 2008.

3. With immediate effect, all new housing with support provision for people with a learning disability should be for no more than five individuals with a learning disability - preferably less - within the same household.

4. By 1 January 2013 all accommodation for people with a learning disability under 60 years of age should be for no more than five people.

5. An additional 100 supported living places per annum for the next 15 years should be developed to enable people to move from family care without having to be placed in inappropriate settings.

6. DSD and DHSSPS should develop clear assessments of future housing needs for people with a learning disability including those who currently live with their families, and agree a continuous three-year funding strategy to resource housing and support arrangements.

7. Housing planners should accumulate and disseminate detailed knowledge on the range of assistive technology that is available to enrich the capacity of people with a learning disability to lead more independent lives in the community.

8. A strategy should be developed by the Department for Social Development to increase opportunities for people with a learning disability to own their own homes where this is a safe and appropriate option.

9. Procedures and criteria for applying for Disabled Facilities Grants should be revised to tackle inconsistencies, reduce bureaucracy and reduce the hidden costs to carers.

10. DSD and NIHE should establish mechanisms to ensure the increased use of floating support linked to an individual's needs, rather than overly relying on accommodation based schemes.

NIAO Reports 2008 - 2009

Title	HC/NIA No.	Date Published
2008		
Social Security Benefit Fraud and Error	NIA 73/07-08	23 January 2008
Absenteeism in Northern Ireland Councils 2006-07	–	30 January 2008
Electronic Service Delivery within NI Government Departments	NIA 97/07-08	5 March 2008
Northern Ireland Tourist Board – Contract to Manage the Trading Activities of Rural Cottage Holidays Limited	NIA 113/07-08	28 March 2008
Hospitality Association of Northern Ireland: A Case Study in Financial Management and the Public Appointment Process	NIA 117/07-08	15 April 2008
Transforming Emergency Care in Northern Ireland	NIA 126/07-08	23 April 2008
Management of Sickness Absence in the Northern Ireland Civil Service	NIA 132/07-08	22 May 2008
The Exercise by Local Government Auditors of their Functions	–	12 June 2008
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Warm Homes: Tackling Fuel Poverty	NIA 178/07-08	23 June 2008
Financial Auditing and Reporting: 2006-07 General Report by the Comptroller and Auditor General	NIA 193/07-08	2 July 2008
Brangam Bagnall & Co Legal Practitioner Fraud Perpetrated against the Health & Personal Social Services	NIA 195/07-08	4 July 2008
Shared Services for Efficiency – A Progress Report	NIA 206/07-08	24 July 2008
Delivering Pathology Services: The PFI Laboratory and Pharmacy Centre at Altnagelvin	NIA 9/08-09	3 September 2008
Irish Sport Horse Genetic Testing Unit Ltd: Transfer and Disposal of Assets	NIA 10/08-09	10 September 2008
The Performance of the Health Service in Northern Ireland	NIA 18/08-09	1 October 2008
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Internal Fraud in the Sports Institute for Northern Ireland/ Development of Ballycastle and Rathlin Harbours	NIA 49/08-09	19 November 2008
Contracting for Legal Services in the Health and Social Care Sector	–	4 December 2008

NIAO Reports 2008 - 2009

2009

Obesity and Type 2 Diabetes in Northern Ireland	NIA 73/08-09	14 January 2009
Public Service Agreements – Measuring Performance	NIA 79/08-09	11 February 2009
Review of Assistance to Valence Technology: A Case Study on Inward Investment	NIA 86/08-09	25 February 2009
The Control of Bovine Tuberculosis in Northern Ireland	NIA 92/08-09	18 March 2009
Review of Financial Management in the Further Education Sector in Northern Ireland from 1998 to 2007/ Governance Examination of Fermanagh College of Further and Higher Education	NIA 98/08-09	25 March 2009
The Investigation of Suspected Contractor Fraud	NIA103/08-09	29 April 2009
The Management of Social Housing Rent Collection and Arrears	NIA 104/08-09	6 May 2009
Review of New Deal 25+	NIA111/08-09	13 May 2009
Financial Auditing and Reporting 2007-08	NIA 115/08-09	20 May 2009
General Report on the Health and Social Care Sector in Northern Ireland 2008	NIA 132/08-09	10 June 2009
The Administration and Management of the Disability Living Allowance Reconsideration and Appeals Process	NIA 116/08-09	17 June 2009
The Pre-School Education Expansion Programme	NIA 133/08-09	19 June 2009
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THE HOSPITAL RESETTLEMENT PROGRAMME IN NORTHERN IRELAND AFTER THE BAMFORD REVIEW

PART 1: STATISTICS, PERCEPTIONS AND THE ROLE OF THE SUPPORTING PEOPLE PROGRAMME

A REPORT FOR THE NORTHERN IRELAND HOUSING EXECUTIVE

John Palmer, Fiona Boyle and Alicia Wood with Steve Harris
North Harbour Consulting

October 2014

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INTRODUCTION AND BACKGROUND

Introduction

The Review of Mental Health and Learning Disability in Northern Ireland, commissioned in 2002 by the Department of Health, Social Services and Public Safety (DHSSPS) from an independent committee led by Prof David Bamford, widely referred to as the 'Bamford Review', provided strong evidence of the need for comprehensive reform of services for learning-disabled people in Northern Ireland[1]. In line with one of the Bamford Review recommendations, service developments for learning-disabled people since the mid-2000s were focussed on the resettlement of people living in a long-stay hospital. A key objective of the review report was[2]:

" ... to ensure that an extended range of housing options is developed for people with a learning disability".

The Northern Ireland Housing Executive (NIHE) played a significant role in helping to deliver the post-Bamford resettlement programme. Housing Executive officers worked alongside the Health and Social Care Board and Trusts in commissioning new services for learning-disabled people being resettled; a significant proportion of the social housing new build programme, which was planned by NIHE, was dedicated to the provision of housing for people who have additional support needs or who need to live in supported housing; the support element in these schemes was funded by the Supporting People Programme for which NIHE has administrative responsibility.

Research aims and objectives

This research was commissioned by NIHE in its role as the strategic housing authority and Supporting People administrative body for Northern Ireland. The overall aim of the research was to provide NIHE and its partners[3] with an account of the way the resettlement programme had been managed, the role of the Supporting People Programme, and an insight into how and to what extent the lives of learning-disabled people who had been resettled from long stay hospitals[4] had changed since taking up their new accommodation.

The original research objectives were:

1. to undertake a brief literature review of relevant research and policy on the resettlement of learning-disabled people from Northern Ireland, Great Britain and the Republic of Ireland (see Part 2);
2. to provide an overview of the models of housing, care and support that have been adopted in NI to help sustain those who have been resettled into a more independent way of life, in comparison with the models available in GB;

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[1] Review of Mental Health and Learning Disability (Northern Ireland) chaired by Prof David Bamford, (2005) *Equal Lives: Review of Policy and Services for people with a Learning Disability in Northern Ireland*, Department for Health, Social Service and Public Safety, Belfast

[2] Bamford, (2005), *op. cit.*, page 8, para 1.15

[3] The partners in this programme were: Northern Ireland Government Departments, statutory health and social care organisations, housing, care and support providers from the independent sector, regulatory bodies and others.

[4] There were three long stay hospitals in Northern Ireland specialising in provision for people with moderate to severe learning disabilities and mental health issues - Muckamore Abbey Hospital, Antrim, operated by the Belfast H&SC Trust; Longstone Hospital, Armagh, operated by the Southern H&SC Trust; and Lakeview Hospital, Derry/Londonderry, operated by the Western H&SC Trust.

3. to provide an insight into the socio-demographic profile and housing circumstances of people who had been resettled, focussing in particular on people who had been resettled since an enhanced version of the resettlement programme was launched on 1 April 2012;
4. to provide an overview of how resettled people perceived their quality of life and how their life had changed since settling in the community;
5. to give a balanced account of the impact of this scheme on the quality of their lives compared to their previous hospital settings as well as the impact on their family/carers;
6. to provide an estimate of the costs to the public purse of supporting and caring for learning-disabled people in the community compared to the hospital;
7. to contribute to a growing evidence base to guide future policy and good practice in addressing the housing and care needs of people with learning disabilities in long-term hospital and community settings.

The research programme

The Housing Executive's original intention was to achieve all of the research objectives in a single project. However, there were unforeseen difficulties in obtaining statistical information on the basis of which to profile the socio-economic characteristics and housing circumstances of the resettled population (objective 3); and it was not possible to identify a survey population of resettled people or construct a sample for interview (objectives 4 and 5). As a result the research was divided into two phases, each looking at the resettlement programme from a different perspective.

Phase 1 was re-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. This included:

- the main features of the learning disability resettlement programme[5] focussing on issues affecting delivery of the programme since the Bamford Commission reported in 2005;
- the models of housing, care and support provision on which the resettlement programme was based;
- the characteristics, quality and costs of the housing and support services that were funded from the Supporting People programme; and
- the perceptions of policymakers, commissioners and service providers involved in the resettlement programme about the way resettlement was carried out, issues affecting the provision of housing and support, and the overall effectiveness of the programme from a policy and delivery point of view.

The main research questions for Phase 1 were as follows.

- How many learning-disabled people were there in Northern Ireland, and what proportion of them had been living as long-stay in-patients in hospital?
- What role did the different agencies play in resettlement?
- Were people resettled into accommodation that was appropriate for their needs and in a timely manner in line with the Bamford Commission's vision?
- Were those involved in policy, commissioning and service delivery generally content with the configuration of accommodation-based services for resettled people?

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[5] The description 'learning disability resettlement programme' was adopted here and elsewhere in the report to differentiate this aspect of hospital resettlement from a parallel programme that resettled people with mental health issues from the same three hospitals.

- How was independence promoted for people who were resettled?
- Alternatively, were some people resettled into institutional settings, which had been the subject of strong criticism by Bamford?
- What forms of housing with support funded from the Supporting People programme were provided to learning-disabled people generally, and to those who have been resettled from a long-stay hospital?
- What standards were achieved in this accommodation, and how much did it cost?
- Did stakeholders believe that resettlement was generally successful for the individuals concerned, and had betterment been achieved for them?
- Did stakeholders believe that the Bamford vision had been realised, and was value for money achieved in the way the programme was carried out?

Phase 1 of the research was completed in early 2014 and this report was submitted to the Housing Executive at that time. However, publication was deferred pending the completion of the second research phase in 2017.

The second phase of research was intended to report on the experiences of people who had been resettled from long stay hospitals. The research looked at the effectiveness of the resettlement process from their perspective, their levels of satisfaction with the outcome, and the impact on their lives that living in the community has had. Face to face interviews took place with twenty two learning-disabled people, their family members and the support staff working in housing support schemes where they were housed after resettlement. Phase 2 of the research is now complete and is reported in: *Boyle F and Palmer J (2017), The Learning Disability Resettlement Programme in Northern Ireland: The experiences of learning-disabled people resettled from long stay hospitals in Northern Ireland, Northern Ireland Housing Executive.*

Methodology for Phase 1

The methodology adopted for Phase 1 combined three different research elements:

- Desk research incorporating an online and library review of literature on the development of policy and practice in the resettlement of learning-disabled people. The review covered literature from NI, GB and the RoI. Key areas for examination included:
    - the evolution of resettlement policy in NI;
    - progress on resettlement in NI;
    - lessons from practice and contextual information for NI;
    - comparison with experience in GB and the RoI; and
    - an over-view of the approaches to independent living and models of housing, care and support available for learning-disabled people in GB for comparison with those found in NI.
- Data collection and analysis included:
    - data on the number, age and types of Supporting People-funded accommodation provided for learning-disabled people after resettlement in NI, in comparison with GB and RoI;
    - historic data on the progress made in resettling people since the Bamford report, and in particular in the three years after 1 April 2012;

  - the characteristics of the housing and support services for learning-disabled people funded from the Supporting People programme generally, and of the particular services in which resettled people are living;
  - information on the quality of housing and support services funded by Supporting People;
  - the per capita and service-level revenue costs (Supporting People Grant only[6]) in housing and support services for resettled people.

- Consultations with policymakers, programme planners, service commissioners and senior managers involved in resettlement, and in the delivery of housing and support services to resettled people, to explore their views and perceptions of:
  - the pace of and influences on the rate of resettlement;
  - standards and issues in the provision of housing, care and support services;
  - views about the aims of the resettlement programme and the extent to which they have been or are being achieved.

The consultations with policymakers, programme managers and practitioners have been used to illustrate and inform parts of this report, and anonymised quotes have been used where relevant. Readers should note that each comment represents an individual's perspective on an aspect of the learning disability resettlement programme based on their particular experience from which trends and extrapolations should not necessarily be drawn. The researchers have used the results of interviews alongside documentary and data evidence as evidence on which to base the research findings and conclusions.

Structure of the report

Following this introduction, the report is divided into four parts:

- Part 1: Main Findings and Conclusions;
- Part 2: The resettlement programme in Northern Ireland;
- Part 3: A comparative perspective in resettlement policy in Great Britain and the Republic of Ireland.

There are five appendices:

- Appendix 1: interviews with policymakers, commissioners and service providers – methodology and list of interviewees;
- Appendix 2: Semi-structured interview schedule;
- Appendix 3: Organisations providing supported housing and independent living services in Northern Ireland funded by supporting people grant;
- Appendix 4: models of housing support adopted in England for learning-disabled people and others with specialised needs - there is also an associated working paper that gives more detail[7];
- Appendix 5: Members of the research team.

Key findings are highlighted in the body of the report in **bold type**. References to source material and sources of data are provided either in the body of the report or in the footnotes.

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[6] Information on social care funding and Housing Benefit was not available in time for incorporation into this report.

[7] North Harbour Consulting (2009),*Bamford Working Paper 2 - Models of housing and support used for learning-disabled people and others with specialised housing and support needs in England*

PART 1: SUMMARY OF FINDINGS AND CONCLUSIONS

The introduction to this report identified ten research questions that were to be addressed in the research. This section of the report sets out the findings and conclusions in relation to each of the research questions. References are contained in the body of the report.

1.1 How many learning-disabled people were there in Northern Ireland, and what proportion of them had been living as in-patients in long-stay hospital?

The 2011 Population Census counted more than 40,000 people (2.2% of the Northern Ireland population) who were identified by the member of the household who completed the Census return as having a long-term 'learning, intellectual, social or behavioural difficulty'. The Census figure is more than double the number of learning-disabled people derived from a study of health and social care records by Prof. Roy McConkey *et al* in 2003 on which the Bamford Review and the development of subsequent policy was based. This difference is not accounted for by estimates of the rate of change in the number of learning-disabled people in Northern Ireland. McConkey *et al* had serious reservations about the accuracy of the health and social care data available to them on which their estimates were based. The authors suggest that planning for the learning disability resettlement programme in its various phases until 2011 may have been based on an underestimate of the numbers.

The study by McConkey *et al* identified 4,500 learning-disabled people who were diagnosed with severe or profound learning disabilities based on health and social care records. Around 300 people from this group were living in hospitals as long-stay patients. The implication of these figures is that a very large majority of people with severe or profound learning disabilities were living outside hospital in 2003.

The Bamford Report *Equal Lives* set out clear aims, objectives and guidelines for the delivery of better services for all learning-disabled people in Northern Ireland. The policy focus on resettling long-stay hospital in-patients was an important strand in the Bamford proposals, but the authors question whether more could have been done following the Bamford Review to improve services for learning-disabled people living outside a hospital setting. Policymakers, commissioners and service providers interviewed for the research commented on the shortage of accommodation and community services for learning-disabled people being resettled from hospital. These comments could apply equally to the availability of services for learning-disabled people previously living in community settings.

1.2 What role did different agencies play in the resettlement programme?

Planning and delivery of the learning disability resettlement programme involved two NI Government Departments (DHSSPS and DSD, now DfC), the Health and Social Care Board, the five Health and Social Care Trusts, the Housing Executive (both the capital planning and programme delivery team, and the Supporting People team), RQIA, selected housing associations and independent sector care and support providers as well as the private sector. Service and business plans, and investment proposals, were assembled at H&SC Trust level, and were then subject to scrutiny and approved at NI level.

Given the complexity of the programme and the number of stakeholders involved at both programme and scheme levels from the 1990s onwards, it is surprising that the research found no evidence of a joint resettlement plan and commissioning strategy being adopted with clear criteria and guidelines for potential services providers in the independent sector.

1.3 Were learning disabled people resettled into appropriate accommodation for their needs and in a timely manner in line with the Bamford vision?

There were long delays in the discharge of long-stay inpatients from the 1990s onwards. Successive resettlement programmes set targets but according to Bamford, the NIAO and those interviewed for this research these were frustrated by a number of factors including:

- lack of coordination between DHSSPS and the DSD;
- the absence of an overall resettlement plan;
- insufficient resources to fund alternative forms of provision;
- misalignment between health and housing funding streams;
- the absence of robust implementation mechanisms to hold Government Departments and agencies to account;
- the absence of a system to monitor performance against targets;
- the absence of formal procurement arrangements for new community-based services;
- a continuing perception that the needs of learning-disabled people could be met in their entirety by health and social services;
- an under-developed culture of involving learning-disabled people and family carers in decisions about the services available to them and that they wanted to receive. This lead to weak engagement by Trusts with patients and families, many of whom resisted proposals for resettlement.

This suggests that early stages of the resettlement programme were not well planned and managed, and that lessons from Bamford and other programme reviews were not learned. After 2012 there was a more effective framework for planning and commissioning new services for the learning disability resettlement programme. As a consequence, progress on the resettlement of those remaining in hospital was faster.

The main resettlement policy was that, wherever possible, people should be able to live in their own homes with the support they needed to help them live as independently as possible in the community. A variety of different types of housing, care and support service were developed for the resettlement programme. A profile of all the supported housing services for learning-disabled people funded by Supporting People in 2014/2015 was developed for the research (List 1), with a parallel profile of SP-funded services that were identified as being developed specifically for resettled people (List 2).

The most striking feature of the analysis of SP-funding for supported housing developed as part of the resettlement programme, however, is the relatively small number of services and bed spaces brought into management across NI as a whole in the period 2003 – 2011. Over the eight financial years between 1 April 2003 and 31 March 2011, an average of 1.5 new housing support services and as few as 6.25 bed spaces that are now identified by the SP team and the H&SC Board as being available for resettled people became available each year. Since 1 April 2012, an average of 6.5 services and 32 bed spaces has been brought into management each year. This is well below the target of 80 additional bed spaces to be developed each year up to 2020 recommended by the Bamford Review and needed to sustain resettlement.

The overall conclusion of the research is that some very good accommodation-based services were developed which fully met the needs of resettled people. However, not all accommodation-based services were of this standard. Interviewees referred to people living in congregate settings where there were more than the Bamford standard of up to five people living together, and in one case up to 50 people living together, sometimes sharing accommodation and facilities. The data analysed for the research corroborates this finding.

These forms of congregate living did not conform to the Bamford principles. Other schemes were institutional, either because even though the service may have been designated as ‘supported housing’ the premises were more appropriate to residential care; or because the service ethos and delivery were outdated. Staff employed in some services continued to adopt traditional practices brought in from health and social care settings which undermined the principle of developing independence for residents.

1.4 Were all stakeholders generally content with the configuration of accommodation-based services for resettled people?

Stakeholders that took part in the consultative interviews organised as part of the research said that there were good, mediocre and poor services. There were said to be a number of obsolete heritage schemes dating from before the Supporting People programme was launched in 2003; and some services that had been commissioned and brought into management since 2003 in which traditional views of how accommodation for learning-disabled people should be configured had taken precedence over the Bamford principles. Some stakeholders said that there was an urgent need to review the suitability of accommodation that was not fit for purpose; and to develop a programme of remodelling or reprovision to which DHSSPS and DSD funding was attached.

1.5 Was independence promoted in the new setting for people who have been resettled, and if so, how was it promoted?

1.6 Alternatively, were people resettled into institutional or hospital-like settings which, irrespective of the models of housing, care and support adopted, were the subject of strong criticism by Bamford?

Participants in the interview programme all subscribed to the Bamford concept of supported living as a basis for promoting independence, where people have real choices about where they live, who they live with and what kind of life they can live. However, some interviewees said that this approach does not suit everyone - people with severe or profound disability for example, or those with challenging behaviours. This view runs counter to the evidence from the research and expert opinion in GB and the RoI set out in Part 3 of the report. The evidence from GB and RoI is supported by others of those who were interviewed for this research who said that people with a history of challenging behaviour placed in a supported living environment had developed new skills and had fewer episodes of challenging behaviour. It seems possible therefore that traditional attitudes to the development of services for learning-disabled people were still influencing some commissioning and referral practices during the resettlement programme.

There were also a number of practical reasons why supported housing was not available to people being resettled. There were anecdotal suggestions that care managers would sometimes refer someone to a residential care or nursing home because there is a vacancy available even if supported living would have been equally or more suitable. Cost factors were also said to be influential in such cases; or care managers may be overly cautious in their assessments of an individual’s suitability for supported living.

1.7 What forms of housing with support funded from the Supporting People (SP) programme were developed for learning-disabled people generally, and particularly for those who were resettled from a long-stay hospital?

The report contains a profile of the types of accommodation funded by Supporting People and how these services were configured. Unfortunately, the research team was unable to establish from the information provided by NIHE and the H&SC Board exactly how many or what proportion of learning-disabled people resettled since Bamford, or indeed since the resettlement programme was revamped in 2012, had moved into SP-funded accommodation. In reviewing the SP data sets given in the body of the report, therefore, it was not possible to say how many people in the services included in either list had been resettled from hospital or had previously been living elsewhere.

In 2014, there were 151 SP-funded services for learning-disabled people in NI (List 1). Of these:

- there were 14 ‘legacy’ services dating from the 1990s that received Special Needs Management Allowance (SNMA), a funding system which formally ended on 31 March 2002;
- Supporting People Grant (SPG) was paid to 137 services – i.e. these were post-2003 schemes.

This list of all the SP-funded services for learning-disabled people contained a substantial number which appeared to represent congregate living. Either there were substantially more than five people living together in a single property, or more than three properties were grouped on a single site.

The total SP contract value for learning disability supported housing services was more than £16.5 million in the 2014/2015 financial year. The mean contract value was approaching £109,000 per annum; and the mean weekly unit price was just below £204.

29 out of the 151 SP-funded supported accommodation services for learning-disabled people were identified by NIHE’s SP team and the H&SC Board as providing specifically for learning-disabled people resettled from long stay hospitals (List 2). The data show that only a few of the services identified as specifically for resettled people represented congregate living suggesting that the development of supported living services under the SP programme had responded positively to the Bamford Review recommendations.

The total SP contract value in the 2014/2015 financial year for services provided specifically for resettled people was £5.396 million (32.6% of the cost of all SP-funded learning disability services for 19% of all SP-funded learning disability services). The mean contract value was £186,000 (170% of the mean value of all SP-funded services for learning-disabled people); and the mean weekly price per bed space was £293 (270% the mean weekly cost per bed space in all SP-funded services for learning-disabled people). These services were more expensive per bed-space than the generality of SP-funded services for learning-disabled people.

1.8 How was this accommodation regulated and how were service standards monitored?

The research showed that there were a number of different approaches to regulating and monitoring the standard of accommodation and the quality of services being delivered to resettled learning-disabled people. Each agency involved in commissioning, service management or regulation had a different remit. As a consequence there was no over-view of service standards, and no evidence to show whether the Bamford vision and objectives were being achieved in practice.

Registered housing associations were and remain subject to regulation by DSD (now The Department for Communities – DfC). There was (and still is) no independent regulatory framework for supported living and the NIHE Supporting People Department that funds these schemes does not have the necessary statutory powers to conduct formal inspections and enforce action. Residential care homes and domiciliary care services were and remain subject to registration and inspection by the RQIA, but accommodation in domiciliary care schemes is not subject to inspection. Some providers were undertaking service-level monitoring; and both H&SC Trusts and some providers had started to commission independent advocates to work with people who had been resettled, reporting more generally on whether services were being delivered effectively and appropriately for individual needs. However, commissioning of advocates was at an early stage in some Trusts.

In spite of the number of approaches to regulation and monitoring, there was no overview of service standards, and therefore no overall evidence was available to show whether the Bamford vision and objectives were being achieved in practice.

All of the services provided specifically for resettled people met Supporting People ‘Minimum Quality Standards’ based on provider self-assessment. However, six providers had been assessed as ‘medium risk’ against a series of political, operational and financial tests carried out by Supporting People as part of the team’s approach to contract management, and one provider was assessed as ‘high risk’. The high risk provider would have been required to manage quality issues by the SP team. RQIA enforcement action was also taking place in respect of this provider because it was a domiciliary and residential care provider in addition to its housing support activities.

Ten out of the 29 services specifically for resettled people were being provided by medium or high risk providers. Medium and high risk providers were working in more than one Trust area. These services operated in three out of the five H&SC Trust areas. The data provided by NIHE suggest that there were both performance and risk issues associated with the providers of a significant number of SP-funded services for resettled learning-disabled people.

1.9 Did stakeholders who were interviewed believe that resettlement was successful for the individuals concerned, and had betterment been achieved for them?

There is strong evidence from the interviews with policymakers, commissioners and service providers that progress had been slow in establishing mechanisms for assessing the betterment in peoples’ lives following resettlement. Each H&SC Trust was developing its own approach, and there was no overall assessment of betterment.

There was a perception among those interviewed that although the resettlement programme had generally been a success from the perspective of resettled people, there had also been detrimental effects caused by programme delays and some resettlement services did not meet modern requirements nor conform to the Bamford principles. These are interviewees’ personal views. However, in the absence of a coherent and coordinated programme of follow-up and evaluation, it is hard to see how those responsible for the resettlement programme can have had a clear idea of the impact on resettled people if the quality of services was not being consistently evaluated, and if one of the key aims – betterment - was not being monitored.

1.10 Did stakeholders believe that the Bamford vision had been realised and was value for money achieved in the way the programme was carried out?

There were mixed views among the people interviewed on the question of whether resettlement had been a success in public policy terms. A majority thought it was successful although implementation could have been better. It was seen as a success in terms of inter-Departmental cooperation; and Ministerial support for the programme was seen as significant in driving it forward. But there were reservations about whether a programme of this kind that is ‘driven from the top’ and which did not carry public opinion with it, was a success even if it was ‘the right thing to do’.

Some interviewees preferred not to comment on the question of whether the resettlement programme represented good value for money. Those that did respond said that, purely in cost terms, it was more expensive than keeping people in hospital. When the social and economic benefits of the programme were taken into account, however, most interviewees thought that it did represent value for money but that value for money could have been improved if planning and commissioning had been better, if fully-costed model services had been developed as exemplars, and if a market for resettlement services had been developed through open procurement and competitive tendering.

PART 2 – THE RESETTLEMENT PROGRAMME IN NORTHERN IRELAND

2.1 LEARNING DISABILITY IN NORTHERN IRELAND

This section provides basic statistics on the definition and prevalence of learning disability in Northern Ireland and the characteristics of the learning-disabled population.

2.1.1 The legal definition of learning disability

The way that 'learning disability' has been legally defined has changed over the years alongside changing perceptions of learning disability itself. Prior to the 1990s, the term used in legislation and public administration was 'mentally handicapped'. In Northern Ireland, the term mental handicap is still used in the relevant legislation and is defined as:

"...a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning" [8].

The concept of mental handicap in public policy was, and to some extent may still be linked to a perception of learning-disabled people as having impairments that prevent them from participating in society, requiring care at home or in an institution. The counterpart of this perception in the wider community was that learning-disabled people were 'different' or 'sub-human' so that it was better if they were kept out of sight. As the following section shows, the majority of learning-disabled people in Northern Ireland were looked after by their families at home. Where this was not the case, however, they were often housed in hospitals and other institutions where they stayed for the remainder of their lives. This policy was justified on the basis that learning-disabled people were safeguarded while ensuring public safety.

Both the legal definition of mental handicap and the way learning-disabled people were looked after were questioned by the Bamford Review Committee (Bamford) following consultation with a wide range of interests, many of whom found the term 'mental handicap' denigrating. Bamford preferred the term 'learning disability' which was defined as:

" ... the presence of a significantly reduced ability to cope independently (impaired social functioning), which started before adulthood with a lasting effect on development" [9].

Bamford added that, in line with the *Equal Lives* model his working group was promoting, this definition should be put into the context of the person's social circumstances and the kinds of support they need in order to live a normal life. **Nevertheless, the term 'mental handicap' is retained in the NI legislation in spite of the significant shift in thinking about learning disability, the rights of learning-disabled people, and the way that learning-disabled people should live their lives that have taken place in the past thirty five years**.

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[8] *Mental Health (NI) Order 1986*, DHSS, quoted in Bamford, (2005) *Equal Lives: Review of Policy and Services for people with a Learning Disability in Northern Ireland*, Appendix H, page 171.

[9] Bamford, (2005) *op. cit.*, p18, para 3.13

2.1.2 The prevalence of learning disabilities in Northern Ireland

The first significant source of information on the prevalence of learning disabilities across Northern Ireland's population is to be found in a study by Prof Roy McConkey and colleagues[10], commissioned by DHSSPS as an input to the Bamford Review and published in 2003.

McConkey *et al* found an overall prevalence of people with learning disabilities of 9.71 per thousand head of population[11], equivalent to slightly less than 1% of the NI population. This figure was based on data taken from two main sources - Soscare[12] and Child Care Health System records. The combined data from these two sources showed 12,273 people with a learning disability known to health and social services in Northern Ireland in 2002[13]. However, McConkey *et al* had reservations about these figures because data from one health board[14] were known to be missing. To compensate for this, adjustments were made to arrive at a further estimate. This put the total number of learning-disabled people in NI across all age groups at between 16,366 - 16,600 people[15]. The lower of these two numbers was used as the baseline figure by Northern Ireland Government Departments and agencies after 2003 as a basis for planning services for learning-disabled people[16].

The McConkey report also provided a methodology for calculating the number and percentage of learning-disabled people according to their age and the severity of their impairment. Using the 16,366 figure as the base line[17], the results of this calculation are set out in Table 1.

Table 1: Number and percentage of learning-disabled people in the general population by age group and by severity of their disability, 2002[18]

Age Bands	**Moderate**		**Severe / Profound**		**Total**	
	%	Number	%	Number	%	Number
0 - 19	39.3%	6,432	10.5%	1,718	49.8%	8,150
20 – 34	15.3%	2,504	6.4%	1,047	21.7%	3,551
35 – 49	9.1%	1,489	5.8%	949	14.9%	2,439
50 +	9.0%	1,473	4.6%	753	13.6%	2,226
TOTALS		**11,898**		**4,468**		**16,366**
Percentage		**72.7%**		**27.3%**		**100.0%**

Just over one quarter of all learning-disabled people were considered to have severe or profound levels of disability.

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[10] McConkey R, Spollen M and Jamison J (2003), *Administrative Prevalence of Learning Disability in Northern Ireland*.

[11] McConkey et al (2003), *op. cit.*, page 3

[12] Social Services Client Administration and Retrieval Environment

[13] McConkey et al (2003), *op. cit.*, page 12, Table 5

[14] McConkey thought that the discrepancy between Soscare and Census data arose because Soscare did not record all Trust patients who were in hospital. He also though it was possible that Muckamore Hospital had patients from other Boards who were not recorded in Soscare.

[15] McConkey et al (2003), *op. cit.*, page 12, Table 5

[16] Interview with Neil Magowan, Head of Learning Disability Policy, DHSSPS, May 2014

[17] McConkey et al (2003), *op. cit.*, page 13, Table 5b

[18] Calculation by the research team based on McConkey's population figure and the percentage of people with moderate or severe/profound learning disabilities by age group that his team identified.

2.1.3 Where learning-disabled people were living in 2002/2003

McConkey found that nearly all learning-disabled people aged 19 years or under (around 8,150 individuals, or half the learning-disabled population in NI) were living with their families. Of those aged 20 years or over:

- between 390 and 470 people (c.3% of the learning-disabled population) people were in hospitals as either short- or long-stay patients (depending on data source used – see Table 2);
- between 1,700 and 1,900 people (c.12% of the learning-disabled population) were in residential care;
- around 6,125 people (c.37% of the learning-disabled population) were in other community settings including living with their families or in supported accommodation of some kind.

These estimates implied that hospital in-patients represented only a minority (13%) of Northern Ireland's learning-disabled people. Taking the figures as a whole, around 14,000 learning-disabled people (87% of the learning-disabled population in NI) were living with families or in other settings outside hospital.

McConkey's 2003 study gave a breakdown of the number of learning-disabled people living in hospital by health board area[19] [20] in 2002 compared with 2001 Census data.

Table 2: Number of patients per originating Trust, 2002

Board	**Based on SOSCARE Records**	**Based on the number of long stay in-patients identified in the 2001 Census**
Southern HSSB	129	118
Western HSSB	41	39
Northern HSSB	69	90
Eastern SSHB	151	220
Combined NHSSB + EHSSB (Muckamore)	220	310
TOTALS	**390**	**467**

McConkey's estimates of the hospital population derived from health board records were significantly lower than the number of long-stay inpatients identified in the 2001 Census.

McConkey also provided an estimate of the proportions of learning-disabled people from each health board who were still living in hospital, by age group and by level of disability in 2002 derived from health board records[21] (Table 3). Two thirds of those living in hospital were classed as having severe or profound learning disabilities.

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[19] There were four health boards in 2003 – the Southern Health and Social Services Board (SHSSB); the Western Health and Social Services Board (WHSSB); the Northern Health and Social Services Board (NHSSB); and the Eastern health and Social Services Board (EHSSB). A reorganisation of health and social care services created the Health and Social Care Board and five Health and Social Care Trusts on 1 April 2007.

[20] McConkey et al (2003), *op. cit.*, page 16, Table 6

[21] McConkey et al (2003), *op. cit.*, page 18, Table 8

Table 3: Percentage of people living in hospital by age group and by severity of their disability

Age Group	**Moderate Learning Disability**	**Severe / Profound Learning Disability**
0 - 19	2%	4%
20 – 34	6%	13%
35 – 49	13%	25%
50 +	13%	24%
TOTALS	**34%**	**66%**

Combining the results from Table 1 and Table 3, it can be seen that **around 300 people in hospital had disabilities that were rated as severe or profound, but a very large majority (c. 4,150) of people with severe or profound disabilities were living outside hospital.** The question of what factors determined whether someone was hospitalised lie outside the scope of this research.

2.1.4 Trends

The McConkey report did not identify trends or make predictions about the future incidence of learning disability or the future numbers of learning-disabled people in the Northern Ireland population. However, Bamford suggested that, on the basis of general demographic and health statistics, there was likely to be an increase in the number of learning-disabled people[22] as a result of:

- increasing life expectancy;
- people with complex health needs living into adulthood;
- more mothers giving birth later;
- increased survival rates for at-risk infants;
- a bulge in the numbers of learning-disabled people born in the 1950s and 1960s;
- a higher birth rate among ethnic minorities with an associated higher rate of learning disabilities in these populations.

Bamford also identified three trends that might tend to offset any increase on the number of learning-disabled people:

- better pre-natal care for expectant mothers with increased availability of pre-natal screening for congenital and other abnormalities[23];
- improved health care and early intervention for at risk infants leading to fewer becoming learning-disabled;
- the advent of gene therapy to correct or ameliorate congenital abnormalities.

Bamford concluded that it was impossible to predict the impact of these trends without further research[24]. He noted, however, that learning disability policy in England was based on an assumed increase in the number of learning-disabled people of 1% per annum. He suggested that the figure might need to be 1.5% per annum in Northern Ireland given the higher birth rate compared with England.

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[22] Bamford, (2005), *op. cit.*, page 21, paras 3.34 and 3.35

[23] However, the abortion of foetuses with congenital and other abnormalities is illegal in Northern Ireland unlike the remainder of the UK and would therefore not be a factor offsetting any increase in the number of learning disabled children born.

[24] Bamford, (2005), *op. cit.*, page 22, para 3.36

Using Bamford's suggested 1% increase per annum benchmark for growth in the population of learning-disabled people as a basis for calculating the increase over McConkey's 2003 baseline number of 16,366 would mean that, in 2014, there could have been around 18,250 learning-disabled people in Northern Ireland (NI). If Bamford's higher annual percentage increase of 1.5% is used, then the number could have been around 19,250.

In publishing calculations of the likely population of learning-disabled people in NI, McConkey was aware that the data on which his work was based were unreliable. In retrospect, the figures may have been an underestimate. Applying McConkey's prevalence rate to the 2011 Census count of people in the general population in NI gives a figure of more than 27,000 learning-disabled people. However, **the 2011 Population Census identified more than 40,000 people (2.2% of the Northern Ireland population) who were identified by the person completing the household's Census return as having a long-term 'learning, intellectual, social or behavioural difficulty'**[25]. Table 4 identifies the number of people with a long-term 'learning, intellectual, social or behavioural difficulty' identified in the 2011 Census compared with the general population for Northern Ireland as a whole and for each of the five Health and Social Care Trust (H&SCT) areas.

Table 4: Number and percentage of learning-disabled people in the general population, 2012

NI and H&SC Trust Area	All usual residents by area	Number of usual residents with learning, intellectual, social or behavioural difficulty by area	Percentage of usual residents with learning, intellectual, social or behavioural difficulties by area (%)
Belfast Trust area	348,204	8,875	2.6%
Northern Trust area	463,297	9,178	2.0%
South Eastern Trust area	346,911	7,741	2.2%
Southern Trust area	358,034	7,258	2.0%
Western Trust area	294,417	7,125	2.4%
Northern Ireland	**1,810,863**	**40,177**	**2.2%**

The largest number of usual residents with learning, intellectual, social or behavioural difficulties was in the Northern Trust area, where there was no long-stay hospital. The smallest number and one of the lowest percentages was in the Southern Trust area, where Longstone Hospital was located and from which most long stay patients had been resettled by the end of 2011. The data therefore show that there was no obvious correlation between the existence of a long-stay hospital and the number and percentage of usual residents with learning, intellectual, social or behavioural difficulties resident in the area.

Extreme caution is needed when comparing McConkey's figures 2003 figures with the 2001 and 2011 Census data. The definition of a 'learning, intellectual, social or behavioural difficulty' adopted in the 2011 Census may well be wider than NHS definitions of 'learning disability' used in resettlement and other returns. In addition, the 2011 Census results are self-declared by the person completing the Census form and do not result from a clinical diagnosis[26].

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[25] http://www.ninis2.nisra.gov.uk/public/pivotgrid.aspx?dataSetVars=ds-3580-lh-63-yn-2009-2012-sk-134-sn-Health%20and%20Social%20Care-yearfilter--

[26] The research team asked the Northern Ireland Statistics and Research Agency (NISRA) to say whether the definition of 'learning, intellectual, social or behavioural difficulty' used in the 2011 Census was the same as the definition used in the data on hospital in-patients. NISRA was unable to confirm this. We also asked whether the definition used in the data on in-patients was the same as the term 'learning disability' used by the Health and Social Care Board and Trusts in compiling resettlement statistics. Again, NISRA was unable to confirm whether or not that was the case.

Taking these two factors into account, the 2011 Census figures are likely to be larger than figures derived from health and social care sources. Nevertheless, they give a possible order of magnitude of Northern Ireland's population of learning-disabled people in 2012.

Census and other data published by NISRA show the number of people with a 'learning, intellectual, social or behavioural difficulty' who were hospital in-patients in 2012[27] with their average length of stay, by H&SC Trust area (Table 5). In compiling this table, the research team has assumed that the definition of 'learning, intellectual, social or behavioural difficulty' is consistent between the Table 4 and Table 5 data sets as a basis for comparison of 'the number of usual residents with a learning, intellectual, social or behavioural difficulty' and 'the number of hospital in-patients'.

Table 5: Number and percentage of learning-disabled people in hospital as an inpatient, with average length of stay, 2012

H&SC Trust	Number of usual residents with a learning, intellectual, social or behavioural difficulty (2011 Census)	Number of Inpatients [28] with a learning, intellectual, social or behavioural difficulty (2012)	Inpatients as % of those with a learning, intellectual, social or behavioural difficulty	Inpatient: Average Length of Stay (months / years)
Belfast Trust area	8,875	1,123	12.7%	68.9 months / 5.7 years
Northern Trust area	9,178	0	0.0%	-
South Eastern Trust area	7,741	0	0.0%	-
Southern Trust area	7,258	174	2.4%	115 months / 9.6 years
Western Trust area	7,125	116	1.6%	52 months / 4.3 years
Northern Ireland	**40,177**	**1,413**	**3.5%**	**73.2 months / 6.2 years**

Table 5 shows that, by 2012, the largest number and highest percentage of people with a learning, intellectual, social or behavioural difficulty who remained as hospital in-patients were accommodated at Muckamore Hospital (Belfast H&SCT) where more than 1,100 people, representing 12.7% of the Belfast Trust area's learning-disabled population, and 79% of Northern Ireland's hospital-based population were living. The Southern H&SCT (Longstone Hospital) and the Western H&SCT (Lakeview Hospital) had relatively small proportions of the area's learning-disabled people in hospital following more rapid discharge and resettlement programmes. Two H&SC Trusts had no long stay hospital in their area so are shown as having a '0' population of in-patients. That does not mean, however, that the two Trusts did not have patients living in a hospital operated by one of the other Trusts.

Table 5 also shows that in 2012, **1,400 learning-disabled people (3.5% of the learning-disabled population) had been resident in hospital for more than 6 years on average. Bearing in mind that the figures for length of stay are averages taken over both short- and long-stay in-patients, the figures suggest that, by 2012, some long-stay learning-disabled patients had been living in hospitals for very long periods of time.**

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[27] http://www.ninis2.nisra.gov.uk/public/pivotgrid.aspx?dataSetVars=ds-3580-lh-63-yn-2009-2012-sk-134-sn-Health%20and%20Social%20Care-yearfilter--

[28] The definition of 'in-patients' in this table includes both long and short stay patients.

2.2 THE LEARNING DISABILITY RESETTLEMENT PROGRAMME IN NORTHERN IRELAND – EVOLUTION AND PROGRESS

In this section of the report we trace the evolution of learning disability resettlement policy and progress in the resettlement of learning-disabled people in Northern Ireland from the early 1990s onwards.

2.2.1 The early years to 2002

Learning-disabled people began to be resettled from hospitals in Northern Ireland from the late 1970s onwards. This is similar to the pattern of resettlement that emerged in Great Britain (GB) and the Republic of Ireland (RoI) - see Part 2. Accurate records are not available for the early phases of the resettlement programme in NI[29]. Bamford (2005) stated that:

"There is no accurate record of all services provided under the learning disability programme of care either by Health and Social Services Trusts or by a sub-contractor in the private or voluntary sector."[30]

Both Bamford and the Northern Ireland Audit Office (NIAO) reported that progress was relatively slow when compared with the pace of resettlement in Great Britain. NIAO records that, in 1992, there were 878 long stay patients in hospitals in Northern Ireland.[31] In 1995, DHSSPS decided that all long stay learning-disabled patients still living in Muckamore, Longstone and Lakeview hospitals were to be resettled into the community[32]. In 1997, DHSSPS set a target that all patients in long stay hospitals were to be resettled by 31 March 2002[33]. However, in the ten years 1992 to 2002, the NIAO records that the number of long-stay patients in NI hospitals fell from 868 to 453[34], a reduction of only 48%. According to the NIAO report, the proportion of learning-disabled people still in hospital in Northern Ireland (222 beds per million people) was higher than in England and Wales (15 beds per million), or Scotland (163 beds per million).

In parallel with the resettlement programme in NI, Bamford reports that there had been some growth in the provision of nursing home and residential care places for learning-disabled people[35]. These services were commissioned by H&SC Trusts either as in-house provision or as provision by independent sector providers. Services for learning-disabled people began to be provided by people with a range of different disciplines other than medical qualifications. Bamford notes that these developments were uncoordinated and a number of difficulties arose as a consequence. The difficulties encountered included lack of information for families about where to go for different services; conflicting advice from different specialists; duplication of services; and gaps in service provision[36].

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[29] See McConkey et al (2003), *op. cit.*

[30] Bamford et al (2005), op. cit., p24, para 3.51

[31] Northern Ireland Audit Office (2009), *Resettlement of long stay patients from learning disability hospitals*, page 2, para. 4

[32] Northern Ireland Audit Office (2009), *op. cit.*, p9, para 1.7

[33] NIAO lists a number of dates and targets for completion of the resettlement programme. None of these were met. See Northern Ireland Audit Office (2009), *op. cit.*, page 16, para 2.3.

[34] This is higher than McConkey's estimate, and very slightly below the 2001 Census figure.

[35] Bamford, (2005), *op. cit.*, page 24, para 3.52

[36] Bamford, (2005), *op. cit.*, page 24, para 3.53

2.2.2 The Bamford Review

In 2002, DHSSPS commissioned an independent review of legislation, policy and provision for people with mental health issues and learning disabilities (the Bamford Review).The review generated ten reports of which Bamford, (2005) *Equal Lives: Review of Policy and Services for people with a Learning Disability in Northern Ireland* is the key text for this study. It seems possible that the decision to commission the Bamford Review was influenced by four factors:

- changing views about learning disability and the way learning-disabled people should be enabled to live their lives and the way services should be provided to meet their needs (these issues are discussed in Part 2 of the report);
- the failure to meet successive targets for the resettlement of learning-disabled people from long-stay hospitals referred to above;
- the need to comply with Section 75 of the Northern Ireland Act 1998[37] which placed a statutory duty on public bodies to promote equality of opportunity *inter alia* between persons with a disability and persons without; and
- the cross-departmental New Targeting Social Need programme[38] introduced in 2001, which aimed to tackle poverty and social exclusion through targeting efforts and available resources within existing programmes on people, groups and areas in greatest objective social need, with a primary aim of reducing social exclusion.

Bamford found that:

" ... learning-disabled people in Northern Ireland do not enjoy equality of opportunity and are often excluded from the opportunities that other citizens enjoy. Their families frequently suffer high levels of social disadvantage and their caring responsibilities can place them under almost unbearable levels of stress. There is evidence of progress having been made, but in order to tackle these difficulties there is a need for major co-ordinated developments in support and services and a continuing change in attitudes over at least the next fifteen years." [39]

In setting out a vision for the future Bamford 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." [40]

The Bamford vision was based on five over-arching values (Figure 1).

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[37] *Northern Ireland Act 1998*, Ch. 47, part vii, Equality of Opportunity, Section 75

[38] See, for example, DHSSPS (2001), *Tacking Equality and Targeting Social Need*

[39] Bamford, (2005), *op. cit.,* page 6, para 1.11

[40] Bamford, (2005), *op. cit.,* Foreword

Figure 1: The 'Equal Lives Values' (authors' emphasis in **blue**)

Citizenship	**People with a learning disability are individuals first and foremost and each has a right to be treated as an equal citizen.** Civil and human rights must be promoted and enforced.
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.** Inclusion recognises both peoples' need for individual support and the necessity to remove barriers to inclusion that create disadvantage and discrimination.
Empowerment	**People with a learning disability must be enabled to actively participate in decisions affecting their lives.** People with a learning disability ... must be supported to have control, to have their voices heard, to make decisions about how to live their lives and about the nature of support they receive.
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.** People with a learning disability must be central to planning and decision making processes.
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.** Service systems that are based on group approaches need to be remodelled to more fully recognise people's individual strengths and needs.

Bamford said that new policies were needed to put these values into practice and set twelve core objectives[41]. Three of these objectives are particularly relevant to this study:

- **Objective 4:** to enable people with a learning disability to lead full and meaningful lives in their neighbourhoods, have access to a wide range of social, work and leisure opportunities and form and maintain friendships and relationships;
- **Objective 5:** to ensure that all men and women with a learning disability have their home in the community, the choice of whom they live with, and that where they live with their family, their carers receive the support they need;
- **Objective 6:** to ensure that an extended range of housing options is developed for men and women with a learning disability.

In a chapter focussing on accommodation and support[42], Bamford noted that many residential services created early in the resettlement programme were institutional in character and retained features of a hospital environment. To combat this trend, the report set out ten recommendations that were intended to govern how learning-disabled people leaving hospitals were re-housed (Figure 2).

Bamford noted that the responsibility for achieving these aims was not confined to health and social services organisations but needed to be shared across agencies in the public, private and voluntary sectors.

The Bamford Values and Objectives have been used in this research as a basis for reviewing the results of the post-Bamford resettlement programme.

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[41] Bamford, (2005), *op. cit.*, page 8, para 1.15

[42] Bamford, (2005), *op. cit.*, pages 59 - 66

Figure 2: The 'Equal Lives Objectives' (authors' emphasis in **blue**)

Recommendation 1	By June 2011, **all people with a learning disability living in a hospital should be relocated to the community**. Funds need to be provided to ensure that on average 80 people will be resettled per annum over the 5-year period from 2006 to 2011.
Recommendation 2	With immediate effect, **all commissioners should ensure that they have resourced and implemented arrangements to provide emergency support and accommodation for persons with a learning disability**.
Recommendation 3	With immediate effect, **all new housing with support provision for people with a learning disability should be for no more than 5 individuals** with a learning disability - preferably less - within the same household
Recommendation 4	By 1 January 2013 **all accommodation for people with a learning disability under 60 years of age should be for no more than 5 people**.
Recommendation 5	**An additional 100 supported living places per annum for the next 15 years should be developed** to enable people to move from family care without having to be placed in inappropriate settings.
Recommendation 6	**The Department for Social Development and the Department of Health, Social Services and Public Safety should develop clear assessments of future housing needs for people with a learning disability** including those who currently live with their families and agree a continuous 3 year funding strategy to resource housing and support arrangements.
Recommendation 7	**Housing planners should accumulate and disseminate detailed knowledge on the range of assistive technology that is available** to enrich the capacity of people with a learning disability to lead more independent lives in the community.
Recommendation 8	**A strategy should be developed by the Department for Social Development to increase opportunities for people with a learning disability to own their own homes** where this is a safe and appropriate option.
Recommendation 9	**Procedures and criteria for applying for Disabled Facilities Grants should be revised to tackle inconsistencies, reduce bureaucracy and reduce the hidden costs to carers**.
Recommendation 10	**Department for Social Development and the NI Housing Executive should establish mechanisms to ensure the increased use of floating support** linked to an individual's needs rather than overly relying on accommodation based schemes.

2.2.3 Post-Bamford policy development up to 2011

Following the restoration of devolved Government in 2007 there was a renewed political focus on achieving a target date for completion of the resettlement programme[43]. The Bamford recommendations received strong Ministerial backing. The main emphasis of the programme focussed on people who had been admitted to hospital prior to 1 April 2006 and who had been in hospital for twelve months or more at 31 March 2007[44]. This group was termed the 'Priority Target List' or 'PTL'. This remained the definition used as a basis for the resettlement programme in 2014. Annual targets for resettlement from the PTL programme were set for each Trust by DHSSPS from 2007 onwards.

In parallel with the resettlement of long stay learning-disabled people, there was an issue about the resettlement of people who were hospitalised for assessment and treatment after the names included in the 2007 PTL were agreed, but who also needed to be resettled. This list, known as the Delayed Discharge List ('DDL'), became a secondary element in the resettlement programme. To prevent that group becoming a new long stay population, DHSSPS and DSD jointly bid for funds to resettle this group alongside the PTL. In effect, two different discharge programmes were run in parallel after 2007/2008. The PTL list was to be

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[43] Interview with Neil Magowan, Head of Learning Disability Policy, DHSSPS, May 2014

[44] DHSSPS (2009), *Evaluation of the 2009 – 2011 Bamford Action Plan*, page 38, para 5.5.43

resettled by March 2015, while resettlement of people on the DDL list was ongoing even though the policy intention was that there should no longer be a long stay resident population in hospitals after the end of March 2015.

The term 'long stay' as used in the Northern Ireland policy context does not therefore refer to the length of time that a learning-disabled person has lived in hospital or the likely length of stay[45]. It refers to a definition developed for the post 1995 resettlement programme of the list of people that were to be resettled as part of the programme. Thus, in 2002, the term was defined as 'those patients in designated resettlement wards'. This changed in 2007 to 'those who had been admitted to hospital prior to 1 April 2006 and had been in hospital for 12 months or more at 31 March 2007'.

2.2.4 Progress on resettlement 2002 - 2011

Data from the 2009 NIAO report show the rate of resettlement activity for each year between April 2002 and March 2008 compared with the programme targets[46]. This period encompasses the time during which the Bamford Review took place and the time immediately following publication of the *Equal Lives* report. No targets for resettlement were set in two of the seven years; the targets for the other five years were not met. Extrapolating the 5-year targets over the seven years, the number resettled is estimated by the authors of this report as being below the target numbers by more than 25% (Table 6).

Table 6: Annual resettlement targets and resettlement activity, 1 April 2002 to 31 March 2009

Year	**Target**	**Number resettled**[47]
Apr 2002 – Mar 2003	35	25
Apr 2003 – Mar 2004	No number specified	30
Apr 2004 – Mar 2005	Minimum of 50	30
Apr 2005 – Mar 2006	Minimum of 50	30
Apr 2006 – Mar 2007	No number specified	40
Apr 2007 – Mar 2008	40	35
Apr 2008 – Mar 2009	60	Data not available
TOTALS	**At least 235**	**Approximately 210**
Extrapolated over 7 years	**(235 / 5)* 7 = 329**	**(210 / 6) * 7 = 245 : Deficit 84 (26%)**

Both the Bamford Review and Northern Ireland Audit Office reports identify reasons why the resettlement programme was slower than intended. The main factors were said to be:

- insufficient resources to fund alternative forms of provision;
- the absence of robust implementation mechanisms to hold Departments and agencies to account;
- a continuing perception that the needs of learning-disabled people could be met in their entirety by health and social services;
- an under-developed culture of involving learning-disabled people and family carers in decisions about the services available to them and that they wanted to receive.

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[45] Source: Northern Ireland Audit Office (2009), *Resettlement of long stay patients from learning disability hospitals*, p26, para 3.2

[46] Northern Ireland Audit Office (2009), *op. cit.*, page 14, paragraph 2.3 and page 26, Figure 4, paragraph 3.2

[47] The numbers are approximations taken from an unpublished bar chart provided by the NI Health and Social Care Board.

A 'post-Bamford' cross-departmental action plan for the period 2009 – 2011 was published covering both the mental health and learning disability resettlement programmes. An evaluation of the Action Plan subsequently carried out by DHSSPS shows that, between 2007 and 2011, 116 learning-disabled people were resettled from long stay hospitals – a reduction in the hospital population of 41%[48]. A year by year breakdown between April 2009 and March 2011 is not available. Once again this performance did not meet the targets.

A further reason why performance on resettlement did not achieve the targets was that there was a slowdown in commissioning new accommodation-based services during the 2010/2011 financial year, when health service funding that had been secured as part of the 2008 – 2011 Comprehensive Spending Review (CSR) allocation was not available due to the impact of the banking crisis on Northern Ireland Government spending[49]. As a result, there was an under-spend on the housing allocation to the resettlement programme in that year because matching health funding was not available.

2.2.5 Policy development on Learning Disability 2011 / 2012

The target that all long-stay in-patients should be resettled by June 2011 was not met. There was a further Ministerial review of the programme in the second half of 2011 in response to the continuing delays in the programme. A new approach was developed for the 2012 - 2015 Comprehensive Spending Review programme. This required DHSSPS funding for resettlement to be aligned with DSD funding for the learning disability component of the social housing and Supporting People programmes. DHSSPS and DSD made a joint bid for resettlement programme funding to the Department of Finance and Personnel (DFP), based on a needs-based profile of all those in hospital that remained to be rehoused in mid-2011[50]. The bids were successful. It was accepted by Ministers that the March 2013 target for completion of the PTL resettlement programme was not likely to be met. The target date was therefore reset to 31 March 2015 – the end of the CSR period.

An updated action plan covering the period 2012 – 2015[51] was also approved. This contained for the first time actions to be taken under the heading 'Supporting People' in relation to improving social inclusion for people with disabilities, the resettlement of long stay patients from learning disability hospitals, commissioning new programmes of housing provision and a series of actions connected with education and training for learning-disabled people living in the community. A new learning disabilities service framework was published. This set out thirty three standards that aimed:

" ... 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." [52]

The standards included:

- the need for involvement by learning-disabled people in the choices and decisions about their health and social care needs;

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[48] DHSSPS (2009), Evaluation of the 2009 – 2011 Bamford Action Plan, Annex A, Quantifiable Targets, page 72

[49] Interview with Aiden Murray, Assistant Director Learning Disability Services, Health and Social Care Board, May 2014

[50] This is the first reference that the research team has found to the development of a resettlement plan based on the aggregate needs as opposed to the numbers of learning-disabled people living as long-stay hospital in-patients.

[51] DHSSPS (2012), Delivering the Bamford Vision: The response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability: Action Plan 2012 – 2015

[52] DHSSPS (2012), Learning Disability Service Framework, Chapter 2, page 30

- information and communication between agencies and with learning-disabled people and their families;
- access to self-directed support, advocacy services and support to maintain employment opportunities and a range of meaningful day time activities for learning-disabled people;
- support to ensure that their accommodation needs were addressed.

For each standard, responsibilities for delivery are identified, as are the quality standards and performance indicators to be achieved. Standard 28, which refers to accommodation needs, stated[53]:

"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.

"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.

Participants in the consultative interviews that took place as part of the research said that the new resettlement plan and new structures agreed in 2011 and starting on 1 April 2012 were critically important:

- a new performance management framework was put into place;
- a revamped Programme Delivery Board was established;
- annual resettlement targets were set for each Trust;
- Trust performance was monitored regularly, and they were held accountable for meeting their targets;
- Trusts were required to make a monthly progress report to the Board; and
- progress was reviewed quarterly by the Programme Delivery Board with reports to the Minister.

On the commissioning side, a remodelled Northern Ireland-wide Supporting People Partnership Board was established bringing together representatives from the H&SC Board, the five H&SC Trusts, NIHE, DHSSPS and DSD, with five area boards (one for each Trust's geographical area) which were and remain responsible for considering needs and processing business plans and commissions for new accommodation-based services.

2.2.6 Progress on resettlement 2012 to 2015

The Health and Social Care Board provided the research team with data on the numbers of learning-disabled people resettled from the PTL and DDL lists between 1 April 2012 and 31 March 2014, with the number remaining to be resettled by 31 March 2015 (Tables 7 and 8).

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[53] DHSSPS (2012), Learning Disability Service Framework, Chapter 10, page 117

Between 1 April 2012 and 31 March 2014, resettlement targets for the PTL were more than fulfilled. 116 people from the priority transfer list were resettled and 49 people remained to be resettled by March 2015. Almost half of those remaining to be resettled were living in Muckamore Hospital (Belfast Trust). Resettlement targets for the DDL were not met. At 31 March 2014, 24 people out of 30 remained to be resettled.

Table 7: Resettlement from the Priority Transfer List 2012 to 2014, by Trust, with numbers remaining to be resettled

Trust area of residence	Target to March 2013	Reported Resettled at 31 March 2013	Target to March 2014	Reported Resettled at 31 March 2014	Cumulative Target to March 2014	Cumulative Reported Resettled at 31 March 2014	Target to March 2015	Remaining to be resettled at 31 March 2014
Belfast Trust	13	9	25	30	**38**	**39**	24	**23**
Northern Trust	6	11	12	6	**18**	**17**	12	**13**
South Eastern Trust	10	10	5	8	**15**	**18**	13	**10**
Southern Trust	6	11	33	30	**39**	**41**	0	**0**
Western Trust	3	1	0	0	**3**	**1**	1	**3**
Northern Ireland	**38**	**42**	**75**	**74**	**113**	**116**	**50**	**49**

Table 8: Resettlement from the Delayed Discharge List 2012 to 2014, by Trust, with numbers remaining to be resettled

Trust area of residence	Cumulative Trust DDL Plans 2013/14 and 2014/15	Cumulative reported resettled at 31 March 2014	Remaining To be resettled by 31 March 2015
Belfast Trust	8	2	**6**
Northern Trust	10	2	**8**
South Eastern Trust	6	0	**6**
Southern Trust	2	2	**0**
Western Trust	4	0	**4**
Northern Ireland	**30**	**6**	**24**

2.2.7 Health and Social Care investment in resettlement since 1 April 2012

The H&SC Board also provided financial information from the five H&SC Trusts on the levels of revenue funding for the learning disability resettlement programme after 1 April 2012. The overall revenue cost over the three financial years 2012 – 2015 was £10.477 million. Table 9 provides a breakdown of the figures for each Trust.

Table 9: Learning disability care costs for the resettlement programme by Trust, 2012 to 2014 (actual) and 2015 (projected)[54]

Trust	1 April 2012 to 31 March 2014	1 April 2014 to 31 March 2015 (estimate)	TOTAL: 2012 - 2015
Belfast Trust	£966,500	£1,264,320	**£2,230,820**
Northern Trust	£1,722,892	£874,519	**£2,597,411**
South Eastern Trust	£1,126,549	£1,697,373	**£2,823,922**
Southern Trust	£2,449,955	No resettlements	**£2,449,955**
Western Trust	No resettlements	£375,000	**£375,000**
Northern Ireland	**£6,265,896**	**£4,211,212**	**£10,477,108**

Table 9 reports revenue funding for new services for people resettled from the priority transfer and delayed discharge lists commissioned from 1 April 2012 (the start of the reorganised resettlement programme) onwards. The total expenditure to 31 March 2014 (£6.265 million) was the full year effect in 2014/15 of all schemes starting in 2012/13 and 2013/14[55]. The Western H&SC Trust figure was zero because it had no resettlements in this period having completed the majority of its programme by 31 March 2012.

The total expenditure to 31 March 2015 of £4.211 million was the full year effect of all schemes funded to date for the year 2014/15. This was additional funding added to the figure of £6.266 million recorded in the previous column. The Southern H&SC Trust figure is zero because it had no resettlements in that year having completed its programme.

2.3 PERCEPTIONS OF THE RESETTLEMENT PROGRAMME – A POLICY AND DELIVERY PERSPECTIVE

A series of consultative interviews was carried out as part of the research with people who had responsibility for resettlement policy, programming and commissioning resettlement services, and those working in the fields of housing, care and support who oversaw service delivery. In this section we report their comments on resettlement policy and delivery.

2.3.1 Perceptions of progress on resettlement

All participants were asked a series of questions exploring their perceptions of the learning disability resettlement programme since the publication of the Bamford report in 2005. This time frame was divided into two parts – 2005 to 2009, when the Northern Ireland Audit Office's critical report *Resettlement of long stay patients from learning disability hospitals* was published; and subsequently from 2009 to 2014. Participants said that 2009 was not an ideal cut-off point for the earlier phases of resettlement because the major review of the programme in 2011 resulted in changes in the way the programme was managed from April 2012 onwards. Nevertheless, there was broad agreement that in the period 2005 to 2009, the need for priority to be given to resettlement was understood by all the agencies involved, but progress was very slow. **Interviewees gave a number of reasons for the slow rate of progress.**

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[54] Trust data on actual and forecast expenditure was presented to the H&SC Board in different formats. The Board has provided an interpretation of the data to make them internally consistent.

[55] The H&SC Board informs the authors that Trusts use these years interchangeably in their submissions.

- **lack of coordination between DHSSPS and the DSD;**
- **misalignment between health and housing funding streams;**
- **the absence of an overall resettlement plan;**
- **the absence of a system to monitor performance against targets;**
- **the absence of formal procurement arrangements for new community-based services;**
- **weak engagement by Trusts with patients and families, many of whom resisted proposals for resettlement.**

This list is similar to the list of factors causing delay identified by Bamford and the NIAO, suggesting that lessons were not learned from the earlier reviews. One participant explained that: *"Bamford set the policy and direction of travel very clearly – the focus was on community care. The practicality of getting it done was the problem."*

The official view given in the interviews was that all the participants in the Bamford Programme had confirmed to their respective Ministers in DHSSPS and DSD that the programme was on track to meet its targets. However, not all interviewees thought this was realistic. There were divergent views on the question of whether the March 2015 target date for completion of the resettlement of PTL patients was likely to be met. It was suggested by some interviewees that many of the people left in hospital from the PTL had acute and complex needs and needed nursing care; while others with challenging or forensic behaviours needed highly bespoke housing and care solutions that took time to develop and were expensive. Other factors including ongoing negotiations between hospital management and health sector trades unions about the redeployment of hospital staff were also referred to.

2.3.2 Issues affecting the rate of resettlement

Participants were then asked to say what they thought were the key issues affecting the rate of resettlement by choosing from a list provided by the interviewer. They were also asked to say which of the issues they had identified were the most significant. The results are set out in Table 10. All thirteen interviewees responded to this question.

Taking an over-view, one participant said:

"The key thing from the commissioner view is to ensure that funding is available to enable Trusts to deliver; then it has to be used; that requires interagency collaboration; then individuals must be resettlement ready. All the ducks have to be lined up between consultants, care managers, and providers for the transitional process – needs assessment, family ready and agreement, funding in place, and an available place."

Table 10: The most significant issues affecting the rate of development

Issue	Number out of 13 respondents who said this was 'Very Significant'
The level of resources allocated to the programme.	9
The availability of appropriate accommodation and support services in the right locations in the community.	9
The effectiveness of inter-department and inter-agency collaboration.	8
The targeting of resources to different aspects of the programme.	6
The availability of appropriate access to day care, educational provision, work and social activities for resettled people.	6
The difficulty of finding appropriate accommodation placements for residents.	5
The reluctance of residents and/or families for them to leave long stay hospital.	5
The availability of community support services for family carers.	4
The need for cultural change within the health and social care sector and the wider community to overcome low expectations of the ability of people with learning disabilities to leave hospital and live in the community.	3
Other factor(s) – 1 respondent each: • NIMBY-ism: Community attitudes towards planning applications for supported housing and group living schemes and opposition to learning-disabled people living in their neighbourhood; • the need to change staff attitudes and re-train staff moving from a hospital to a community setting.	

2.3.3 Factors influencing successful delivery of the resettlement programme

Participants were asked to identify up to five factors which they believed had helped to promote the resettlement programme, and five factors which they felt had hindered the programme. Ten participants offered their views (Tables 11 and 12).

Table 11: Factors that helped to promote the resettlement programme

Factors promoting resettlement	No. out of 13 of respondents identifying each factor
Ministerial or political support for the resettlement programme	2
Introduction of clear targets and a performance management framework for the Trusts	2
The quality and commitment of staff (a) in a Trust and (b) in community-based services	2
The high profile given to early successes, and evidence that resettlement works from the perspective of learning-disabled people and their families	2
Other factor(s) – 1 respondent each: • Joint working between the Board, Trusts, DHSSPS and the NIHE SP team; • availability of services within the community	

Table 12: Factors that hindered the resettlement programme

Factors hindering resettlement	**No. out of 13 respondents identifying each factor**
In a traditional society attitudes are slow to change – there is community resistance with ignorance still a factor; families are risk-averse, their concerns can be a barrier.	4
Negative local publicity in the media; local media have supported and/or prompted local MLAs to campaign against resettlement schemes in their constituencies.	2
Evidence of resistance by some consultants and Trust staff.	2
Other factor(s) – 1 respondent each: • lack of strategic join-up between health and housing; • lack of understanding in health and social care about what supported housing is; • heightened financial risk for housing associations making them reluctant to take on new schemes; • insufficient money in the system to make it as good as it could be; • lack of capacity (*to commission accommodation-based services – interviewer*) on the healthcare side; • important information about individuals who had been resettled not passed on: *"... some Trust staff are reluctant to share case histories, or work with a provider's staff team*."(Provider manager).	

2.3.4 The challenges faced by Trusts in resettling the people currently in hospital

Discussions between members of the research team and policy managers within DHSSPS and DSD before the formal interviews took place indicated that there were still significant challenges being faced by Trusts in resettling the people who were on the priority transfer list but who had still not been resettled in 2013 and 2014. People in this group were said to have complex needs or challenging behaviours. Finding appropriate placements and support was said to be difficult. This issue was followed up in the interviews with policymakers, commissioners and providers. There were a number of comments that explained the implications of needing bespoke solutions for most of the people who remained in hospital.

Table 13: Main difficulties in resettling people with complex needs and challenging behaviours

Main difficulties	**No. of respondents identifying each factor**
High unit cost – the cost of bespoke services compared with the available funding based on rates agreed for the programme as a whole at the outset.	6
Finding the right placement / appropriate accommodation / individual housing with bespoke care and support solutions for people who are challenging.	5
Community integration vs. community opposition even against people with low to moderate needs, so even more so for those with moderate / severe / challenging behaviours.	2
Access to specialised day time activities and facilities.	2
Other factor(s) – 1 respondent each: • finding compatibility between tenants for new 'off the peg' or existing accommodation and support/care services, and associated safety issues; • the level of staffing needed for people with complex needs; • the resilience needed by provider staff to work with people who have complex needs, and the need to provide support mechanisms for staff; • the need for specialised staff training on e.g. deprivation of liberty and human rights; • scheme size and the number of bedrooms required for an individual who needs live-in staff; • support and training for families and carers; • development of services to prevent placement breakdown; • the need for inter-agency collaboration on community safety issues; • ensuring the confidence and competence of provider organisations in meeting complex needs; • the absence of agreed cost models for the resettlement of people with complex needs.	

One participant said:
"Each case is unique. Many people with complex needs cannot live in a congregated living setting because they do not want or cannot live with other people around them for safety reasons. Therefore the unit cost of any placement can be high."

As a result, the costs of resettling some individuals on a bespoke basis were said to be well above the revenue budget of £85 thousand per capita per annum from NHS and social care sources, £21 thousand per capita per annum from the Supporting People budget, plus Housing Benefit funding housing costs for people living in SP-funded supported accommodation.

The intention was that these costs would be an 'average' per capita over the lifetime of the resettlement programme. However, **the figures were announced publicly at the outset of the programme so that Trusts commissioning in-house services, and independent sector providers, were given clear guidance on the prices they could charge. Interviewees said that this has meant that the intended 'swings and roundabouts' in which cheaper services commissioned early in the programme would allow funding for more expensive services commissioned later were not achieved.**

2.3.5 Overview of roles and responsibilities

Participants were asked to say what they thought the role of the H&SC Trusts, and the Housing Executive's Capital Planning and Programming and Supporting People teams were in the planning and delivery of accommodation for people being resettled from long stay hospitals. All those taking part in the interviews gave an opinion.

Health and Social Care Trusts

Interviewees said that Trusts have statutory responsibilities for assessing the needs of learning-disabled people and for ensuring the provision of services to meet those needs. Within that, Trusts have a choice. They can:

- make direct provision themselves;
- procure services from the independent sector directly; or
- procure services through an intermediary such as the Housing Executive.

In each case, interviewees said that Trusts have a duty to ensure that the people they are resettling have accommodation that is appropriate for their needs. If supported housing meets their needs, then they also have a duty to ensure that the support the resettled person needs to retain a tenancy in the community is appropriate. Trusts therefore need a close relationship with the housing association and with the care or support provider to achieve these objectives. The Trust also has a responsibility to ensure consistency throughout the commissioning and procurement process on behalf of the individuals being resettled. Once the person is placed, the Trust's role is to undertake regular service and care reviews and to act on concerns arising from inspections.

Participants from the independent sector expressed concerns about whether, if Trusts have specified a particular type of bespoke provision, there should be a shared commitment with the provider to the future of the service in terms of risk sharing and funding to ensure that the service is sustainable. These interviewees said that they were concerned that over-stretched health and social care budgets could, at some point in the future, leave the provider to meet the costs of provision as is happening in England where the level of funding for people with low to moderate learning disabilities has been reduced or cut (see Part 2).

The Northern Ireland Housing Executive planning and capital programme team's role

Participants said that the NIHE Capital Planning and Programming team had played a crucial role in the commissioning and procurement processes *" ... because more learning-disabled people than was previously the case"* needed supported living in ordinary housing as opposed to being referred to residential and nursing care. The research team believes that this comment reflects a change in commissioning policy rather than a change in peoples' needs *per se*. The change in policy could have been influenced by the availability of funding from the SP programme to offset some of the H&SC costs associated with resettlement (see below).

The partnership between health and social care bodies and the Housing Executive was seen as critical because it unlocked capital funding and capacity for the development of new housing. NIHE's planning team was referred to as a 'facilitator', acting as an intermediary between Trusts and housing associations. The planning team was also seen as important alongside the Supporting People Partnership Board in monitoring progress on new developments and keeping development projects to time and budget. Housing and design is not health's area of expertise, so health sector interviewees said that there it was logical for the Trusts to involve housing professionals to ensure that there was close cooperation in designing and equipping schemes for specific needs and requirements.

The Northern Ireland Housing Executive Supporting People team's role

The link between Supporting People and the Trusts was said to be closer than links between Trusts and the Housing Executive's Capital Planning and Programming team. One participant said:

"... there is good collaboration with the Supporting People team and DSD, but we have questioned why Trusts have to take the lead in developing the business case for housing and support as this takes management resources from our side and that can cause delay".

Another participant, a provider, felt that commissioning was too strongly influenced by health and social care managers and practitioners rather than by housing practitioners.

Like the Housing Executive's planning team, the Supporting People team was seen as a facilitator with a role in enabling a scheme to proceed by committing revenue funding. One participant said:

"The presence of funding for resettlement within the Supporting People programme was highly significant in influencing the Trusts and the commissioning process to move people into supported housing rather than residential care".

While on the one hand this meant that the availability of funding from Supporting People promotes official policy in resettling people into their own homes, there was also a belief among several interviewees that SP funding gave Trusts a financial interest in commissioning supported housing even when it may not have been the best solution for the individual. It was suggested by one participant that: *"... there is not really a shared understanding of what 'good practice' in supported living represents"*, so that the risk of blurred lines between care and support became a possibility.

This view was confirmed by another interviewee who, when asked why a new property development had been criticised by RQIA and the Supporting People team for incorporating a large industrial-scale kitchen and having an institutional feel, said that the design was appropriate for the high level of dependency shown by the people being settled there. This interviewee said that the service should have been commissioned as residential care if the criterion of meeting individual need was being properly applied. However, the Trust involved had been keen to access funding from Housing Benefit and Supporting People in order to reduce its own financial commitment. This suggests that, in some circumstances, there may have been a process of cost transfer between social care and SP budgets taking place unless the boundaries between 'care' and 'support' were very clearly defined and needs assessment was matched with an appropriate commissioner specification.

2.3.6 The commissioning process for accommodation-based care and support services

Participants in the consultative interviews were also asked a series of questions about:

- the commissioning process for accommodation-based care and support services;
- the commissioning criteria for these services;
- how service standards were monitored.

In particular, interviewees were asked to say whether and to what extent they thought the housing, care and support services commissioned since 2007 met the requirements of the Bamford Review values and recommendations.

How accommodation-based services are commissioned

Ten participants answered the question. Two participants said that they did not know any details; one participant said they did not wish to comment.

Representatives of DHSSPS, DSD, NIHE and the H&SC Board tended to have a strategic perception of the commissioning process, whereas interviewees from Trusts and service providers tended to have a more detailed operational perspective. Examples of both structural and operational perspectives are set out in Figure 3. There appeared to be some variation in practice between Trusts.

Figure 3: The process for commissioning accommodation-based services

Respondent role	The commissioning process
DHSSPS / DSD / H&SC Board perspective	Commissioning structures start at area level through the Area Supporting People Partnership Boards which are chaired by a Health and Social Care Board staff member. Area SP Partnership Boards have representation from the H&SC Board, the Trust, Supporting People and others including the Probation Service NI. The need for capital and support funding is identified locally. If the need is assessed as being in line with policy, the agency that has brought the issue to the table will be invited to put a planning group together, develop a business for submission to the SP Commissioning Board (which has Northern Ireland-wide responsibilities). The Trust then confirms that people are ready for resettlement, that there is a strategic need and it is then signed off by NIHE to say that capital funding is available. If approved, funding is allocated to the planning team and the project starts on the ground.
H&SC Trust perspective	Three levels of responsibility were identified: planning, commissioning, and implementation. Planning: part of the resettlement process under the 3 year (2012 – 2015) plan involves identifying those who had been ready for resettlement for at least a year in 2007 that are the primary focus. Alongside the resettlement programme there is the normal process of admissions and discharges and similar issues about discharge have arisen for some of them as in the priority transfer list – i.e. there are some people admitted to hospital after January 2007 who have been identified as ready for discharge but there is nowhere for them to go (the Delayed Discharge List). Commissioning: Having assessed the health, care and housing needs of people on the PTL and DDL, the Trust needs to identify or develop appropriate services for them individually, then as a cohort. Some services are commissioned directly from a partner agency or from in-house providers; or there may be a vacancy in an existing scheme; or the family may have an option. Private and independent sector services are looked at first. If there is nothing suitable there, then the Trust will commission a new build service through the housing association development programme via the Housing Executive. For the latter, a business case is prepared in collaboration with the Trust's planning

	department. That goes first to the Area Supporting People Partnership for review and approval. If approved, the Area SP Partnership allocates care funding for the required number of places, and the Trust liaises with the nominated housing association or tenders the services to private or voluntary sector care providers. The Trust then works with the housing association or provider to develop a cost model and the model of housing, care and support required. The association puts this into its bid for capital to the NIHE Capital Programme Planning Team, and to Supporting People for SP funding. Implementation: This involves service development once a new service has been commissioned, and includes contracting and contract management with independent providers, or with the manager and team of a Trust-provided service. The other part of the role involves care management – assessment of individual needs, the care plan (possibly in conjunction with a housing plan and a provider's care/support plan); the referral process and a review of the process.
Supporting People	At project level, the Supporting People team is involved in scheme by scheme oversight during the planning process led by the Trust with the housing association. The SP team also oversees design principles, assistive technologies etc. Unlike the role of English SP administrative bodies, NIHE acts as a broker and mediator. The SP team also has a strong link with the NIHE Housing Benefit team in respect of the affordability of out-turn rents and welfare reform.

One participant from a Trust added that: *"It is about going out to proven providers of other types of placement and talking to them about different services to meet the urgent and immediate challenges of people who are inappropriately placed. There is a lack of a real market in Northern Ireland. The problem is if you talk to the provider and they name the price, that approach is not going to drive best value."*

Changes in the commissioning process

Participants were then asked to say whether there had been any significant changes in the way commissioning was carried out after 2007. Five participants said that there had been changes; five said that there had been few changes; and three people did not comment.

Those that said there had been significant changes in commissioning had senior roles in Government Departments, NIHE and a Trust. In this view there had been a number of changes in how the commissioning body and the process have worked, with stronger governance, more robust business cases, and better quality control in the period 2012 to 2014 than at any time in the past.

The participants who said that there had not been any significant changes worked for Trusts and service providers. One participant from a Trust said that there had not been any changes yet, but that:

" ... we are working up procurement processes for nursing homes and domiciliary care services in the community. So at the moment it is as we always have done. But more commissioning is now at Trust level rather than at Board level."

From this and similar responses it seems that there was a different understanding of what the term 'commissioning' meant between strategic and policy managers on the one hand and those with operational responsibilities on the other. For the policy and strategic managers, the term implied the whole process from needs-based planning to delivery of an operating service for resettled people. For those with operational responsibilities, the term appeared to be a synonym for 'procurement'. A senior manager's view was that:

"There is a commissioning process for services but we are unaware of any systematic account of how that is being specified. Commissioning is on a relationship basis, in other words, who you know)."

The criteria being applied to commissioning new services

Participants were asked to say what criteria have been employed in commissioning accommodation-based services since 2012. There were ten responses. One response referred to the Department for Finance and Personnel's *Guide to Expenditure Evaluation and Appraisal* (the 'Green Book')[56]. Key questions addressed in the Green Book included:

- Is this proposal aligned with the resettlement policy and the Minister's commitment?
- Is it sustainable - i.e. does it meet need from both the housing and care viewpoint?
- Is it not short term and does it fit a 30 year timescale for capital funding?
- Does it meet the needs of the particular individual, group or cohort?
- Is the proposal affordable and does it represent value for money?

Eight responses gave a more detailed, bottom-up account of how criteria had been developed. Many of the criteria related to the specification of the services needed to meet an individual's needs rather than the commissioning process overall. Four examples of interviewees' responses to this question are set out below.

"Specification, a rigorous tendering process involving housing associations, then usually quality criteria, marking, interviewing, decision and contract award."

"The development of commissioning criteria is case by case, depending on the individual needs being addressed. There have been a few tendering initiatives where the specification is specific to the needs and the type of service."

"Key issues are: suitability of the housing for the individual; the individual's risks and developing a risk plan; based on needs assessment, type of care and support package they need; the staffing they need."

"We adopt a 'horses for courses' approach. We assessed the needs of a number of individuals, and then went out to commission services for that particular group. This is ok for small scale commissioning, but not for large scale nursing homes etc. Therefore it has been piecemeal."

Only one Trust interviewee referred explicitly to a tendering process rather than a discussion with a provider of the kind referred to by some Trusts in the previous section on commissioning. A second Trust indicated that tendering is sometimes considered.

Promoting independence

When asked what they thought was the best solution for learning-disabled people being resettled in terms of maximising their independence, interviewees said that there are choices and options from large group living situations, hub and spoke schemes, small shared houses and single tenancies. These options were said to allow a choice between different services for different levels of dependency. None of the interviewees referred to the 2012 *Learning Disability Service Framework*.

Participants agreed that supported living, where people have had real choices where they live, who they live with and what kind of life they can live is most likely to promote independence and integration into the community. However, some respondents said that this approach does not suit everyone. First preference is a normal home, but some people require more space because of their challenging needs with controls over what they have access to for safety reasons – kitchens for example. A Trust cannot place any individual into

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[56] Department of Finance and Personnel (2012), *The Northern Ireland Guide to Expenditure Appraisal and Evaluation ('NIGEAE'): New DFP guidance on the appraisal, evaluation, approval and management of policies, programmes and projects*

a setting that does not meet their assessed need. If, for example, they have very acute needs or challenging behaviours, Trust managers said that residential care or a nursing home may be the best solution.

There were also suggestions that care managers will sometimes refer someone to a residential or nursing home because there is a vacancy available even if supported living would have been equally or more suitable. Cost factors might be influential in such cases; or care managers may be overly cautious in their assessments of an individual's suitability for supported living.

2.4 THE ROLE OF SUPPORTED HOUSING FUNDED THROUGH SUPPORTING PEOPLE GRANT IN THE NORTHERN IRELAND LEARNING DISABILITY RESETTLEMENT PROGRAMME

Earlier sections of the report found that the learning disability resettlement programme in NI depended heavily on the availability of a number of different models of housing, care and support including nursing care, residential care, supported housing and others. The Bamford Review and successive policy statements from DHSSPS and DSD emphasised the role of supported housing in promoting independence for learning-disabled people. In the following section, we review the role that supported housing and supported independent living funded by the Supporting People programme played in resettlement.

2.4.1 The eligibility of different types of service for Supporting People Grant

Supporting People is a UK-wide programme of revenue funding for the housing support element in independent living services. The programme came into effect on 1 April 2003. It brought together into a single budget a number of pre-existing funding streams including Special Needs Management Allowance (SNMA), funding for older peoples' sheltered housing, Probation Grant, and funding for aids and adaptations in older and disabled peoples' homes. The new system also aimed to remove anomalies, in that some housing support services that were previously being funded from Housing Benefit (HB) had been held to be ineligible for HB funding by the Courts. For those supported housing schemes that were in operation at 1 April 2000, the SNMA they received was incorporated with the amount they were previously receiving for ineligible services from Housing Benefit into a system called 'Transitional Housing Benefit ('THB'). With further adjustments including an element for inflation, THB formed the basis for the initial payment of Supporting People funding (Supporting People Grant – 'SPG') to existing housing support services when that programme went live on 1 April 2003[57].

In an attempt to rationalise which services were eligible for funding from which Departmental budget (Housing Benefit and Supporting People Grant from DSD; domiciliary or residential care payments from DHSSPS), clear definitions of the services eligible for each source of funding were laid down with clear boundaries identified. The rules governing eligibility for Supporting People Funding in Northern Ireland are set out in *Northern Ireland Supporting People Guidance*, 2012[58].

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[57] Note that a small number of schemes for learning disabled people had previously been registered as care homes. When the transition to SP funding took place, it was held that some of these services could not be de-registered because the accommodation was unsuitable for independent living, because the vulnerability of some residents meant that they required a residential care environment, or because there was no capital or revenue funding available to remodel accommodation or fund housing support for independent living. These schemes remained within an SNMA-funded portfolio.

[58] Department for Social Development (2012), *Northern Ireland Supporting People Guidance*

In Northern Ireland, the Supporting People programme provides revenue funding for the Northern Ireland Housing Executive, housing associations, Health and Social Care Trusts and voluntary and community sector organisations to provide housing-related support services to vulnerable people living in temporary and permanent accommodation. Support can be provided in any form of tenure: owner occupied accommodation, social housing or privately rented housing.[59] It is administered by the Housing Executive through its Supporting People team. The programme is overseen by the Supporting People Commissioning Board.

One of the underlying principles for the payment of SPG is that people living in accommodation-based or floating support services that are eligible for SP funding must be living in their own home. Normally, this means that they are owners or leaseholders, or have a tenancy or license agreement with all the rights and responsibilities associated with those forms of tenure. The Supporting People Guidelines state:

"The term 'own home' should be understood in terms of its common usage which implies the principles of control and autonomy for the individual. The management of the property in which the user resides must not constrain the freedoms of the service user beyond those associated with the normal terms of legal occupancy agreements and thereby create an institutional environment."[60]

The purpose of SPG must in all cases be to fund the provision of the 'housing-related support' (i.e. not any personal support or care) a vulnerable individual needs to:

"...develop or maintain the skills and confidence necessary to live as independently as possible in their chosen form of tenancy and to develop the ability to maintain a tenancy."[61]

SPG is also used to fund the costs of intensive housing management (over and above 'normal housing management costs') arising, for example, as a result of the person's disability or because their accommodation is temporary and there is a high turnover of occupants as in the case of temporary accommodation for vulnerable single homeless people. The Guidance states that:

"Housing-related support must, by definition, provide support to the service user in relation to housing-related tasks[62] *... Individuals must be supported to develop and maintain the skills and confidence necessary to enable a service user to live as independently as possible in their own home. In most instances services which undertake those tasks on behalf of a service user cannot be considered compliant with the principles of 'Supporting People' and are therefore not eligible for Supporting People Grant."*[63]

Nursing, personal and domiciliary care services, and specialised counselling, are therefore defined in the Regulations as 'ineligible services' for which SPG is not payable.

The Guidance goes on to say that support services can be provided in a complementary fashion alongside care or other services, but are not personal care. Services that are providing a mix of housing related support and either domiciliary or residential care must therefore be very clear which tasks are being funded from SPG and must not use SPG to subsidise normal housing management, health or social care, or counselling activities.

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[59] Department for Social Development (2012), *op. cit.,* page 8, para 4.1

[60] DSD (2012), *op. cit.,* page 7, para 3.4

[61] DSD (2012), *op. cit.,* page 6, para 3.3

[62] DSD (2012), *op. cit.,* page 8, Section 4.0

[63] DSD (2012), *op. cit.,* page 7, para 3.8

Residential care homes are not eligible for Supporting People funding. They are described as 'excepted' accommodation in the Regulations which state:

Accommodation which is registered under 'The Registered Homes (Northern Ireland) Order 1992[2] where no funding (under Special Needs Management Allowance) was paid by the Department in relation to that accommodation during the financial year ending on 31st March 2003 is excepted accommodation for the purposes of Article 3 of the Housing Support Services (Northern Ireland) Order 2002.[64]

However, if a registered care home was receiving SNMA up to 31 March 2003, they may continue to receive this funding provided that: *"... payment of the allowance fits with the overall policy intention of the Supporting People programme to promote independent living."*[65]

2.4.2 Support services for learning-disabled people currently funded by Supporting People Grant

Data on 2014 – 2015 funding of housing support services for learning-disabled people by the Supporting People programme was provided by the Housing Executive. Additional data on the SP-funded services used in the post-April 2012 resettlement programme was provided by the H&SC Board. Information from these two sources allowed the compilation of two lists of SP-funded accommodation-based services for learning-disabled people.

- **List 1:** contains all accommodation-based and floating support services designated for learning-disabled people being funded by SPG in the 2014 to 2015 financial year irrespective of whether or not they house resettled people. There are 151 services with 1,560 contracted bed spaces in the first list.
- **List 2:** contains a limited number of the List 1 services that are known to house one or more resettled people. There are 29 services with 273 units of accommodation (17.5% of all SP-funded bed spaces for learning-disabled people) in the second list.

It is worth noting at this point that data were not available to establish how many or what proportion of learning-disabled people resettled since Bamford, or indeed since the resettlement programme was revamped in 2012, had moved into SP-funded accommodation. In reviewing the SP data sets below, therefore, it is important to remember that at the time the research was carried out, it was not possible to be certain:

- whether List 1 included some services that were not included in the second list but which also provided accommodation-based support for resettled learning-disabled people;
- whether List 2 contained all the SP-funded services that provided for one or more resettled learning-disabled people;
- how many learning-disabled people resettled from a long stay hospital were supported by each SP-funded service provided with a service in the second list – there could have been a mix of people resettled from long-stay hospitals and other learning-disabled people who were previously living in another community setting – the family home or residential care, for example;
- which resettlement cohort (pre-2007, 2007 – 2011, or post-2012) resettled people supported by these services could be identified with;
- whether the people were resettled from the priority transfer list (i.e. waiting for resettlement since before 31 March 2007) or from the delayed discharge list (post-1 April 2007).

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[64] Department for Social Development (2012), *op. cit.,* page 16, para 6.1

[65] Department for Social Development (2012), *op. cit.,* page 16, para 6.1

In summary, it was not possible to say how many people in the services included in either list had been resettled from hospital or had previously been living elsewhere. The Supporting People team told the research team that it was confident that the vast majority of resettled people would have been included in the 29 services contained in List 2. However, there may have been others outside these schemes. The figures set out below should be taken as giving a general description of supported accommodation for learning-disabled people generally and for those who were resettled from a long-stay hospital.

A profile of List 1 - all SP-funded services for learning-disabled people

Of the 151 SP-funded services for learning-disabled people,

- 14 services received Special Needs Management Allowance (SNMA), a system which formally ended on 31 March 2000 when the Transitional Housing Benefit system came into operation;
    - in ten cases SNMA was paid to independent sector residential care homes;
    - in four cases, SNMA was being paid to shared or self-contained supported housing owned by a registered housing association.
- Supporting People Grant (SPG) was paid to 137 services. Of these:
    - five were floating support schemes for learning-disabled people, two of which were operated directly by a Health and Social Care Trust (Belfast Trust and Western Trust);
    - four were unregistered adult placement schemes, of which two were operated directly by the Southern Trust, one payment was to a specialist voluntary sector provider, and the other appears to have been made to a private household;
    - the remaining 128 services were designated in NIHE records as ‘shared or self-contained supported housing’ of which 27 services were identified as being operated directly by a H&SC Trust.

Some services still received SNMA rather than SPG because they were legacy services that did not fully conform to the post-2003 SPG funding rules, or where accommodation or residents were unsuitable for independent living[66].

The SP data allow an analysis of service type, funding type, and level of funding for each service and provider, and for each Trust area. A list of providers is contained in Appendix 3. The data cover 26 providers, 151 different SP-funded services and 1,560 SP-funded bed-spaces. Tables 14 to 19 below show the figures.

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[66] In England, services that were funded by SNMA at 31 March 2003 and which did not fully comply with the requirements for SPG funding were transferred to the SP programme and were given three years, to 31 March 2006, to conform. Those that failed had SP funding withdrawn with effect from 1 April 2006. Different rules operated for pre-2000 services in Northern Ireland.

Table 14: Overview of the number of providers, services and bed-spaces by H&SC Trust area (2014/2015)

Trust Area	**Number of SP-funded providers operating in Trust area** Note	**Number of SP-funded services in Trust area**	**Number of SP-funded bed spaces in Trust area**
Belfast Trust	7	25	333
Northern Trust	11	36	363
South Eastern Trust	14	47	308
Southern Trust	8	27	314
Western Trust	8	16	242
NORTHERN IRELAND		**151**	**1,560**

Note: The number of providers in this column does not sum to 26 because some providers operate in more than one Trust area.

The number of providers, SP-funded services and bed spaces found in each Trust area varies considerably. The three Trust areas in which one of the long-stay hospitals was located (Belfast Trust, Southern Trust and Western Trust) have fewer providers and services than the two Trust areas with no hospital.

The number of bed spaces in four of the five areas is broadly similar. The Western Trust has fewer SP-funded bed spaces than the other four areas because more of its reprovision programme was completed prior to 2012 and there was a higher proportion of people placed into residential and nursing care.

Table 15: Number and percentage of services provided by the independent sector and by Trusts in each H&SC Trust area

Trust Area	**Number of Providers operating in Trust area** Note	**Number of SP-funded services in Trust area**	**Of which provided by Independent Sector**	**% provided by the Independent Sector**	**Of which, provided directly by Trust**	**% Provided by the Trust**
Belfast Trust	7	25	18	*72.00*	7	*28.00*
Northern Trust	11	36	30	*83.33*	6	*16.67*
South Eastern Trust	14	47	42	*89.36*	5	*10.63*
Southern Trust	8	27	12	*44.46*	15	*55.55*
Western Trust	8	16	15	*88.25*	2	*12.50*
NORTHERN IRELAND		**151**	**117**	***76.97***	**35**	***23.03***

Note: The number of providers in this column does not sum to 28 because some providers operate in more than one Trust area.

Almost one quarter of the services in receipt of SPG providing for learning-disabled people are operated directly by a Trust. There are variations between Trust areas. In the Southern Trust area, 55% of all SP-funded services for learning-disabled people are provided by the Trust; whereas in the Western Trust area 12.5% of these services are provided by the Trust; and in the South Eastern Trust area 10.6% of services are provided by the Trust. It is not clear whether these variations evolved because of different needs and circumstances, because of differences in Trust commissioning strategies, or because there was no overall philosophy and strategy for delivering the resettlement programme across NI as a whole.

Table 16 provides a breakdown of the number of bed-spaces provided by the independent sector and by Trusts, and of the mean number of bed-spaces per service, in each Trust area.

Table 16: Number and percentage of bed spaces provided by the independent sector and by Trusts in each Trust area

Trust Area	**Number of Providers operating in Trust area**	**Number of SP-funded services in Trust area**	**Number of SP-funded bed spaces in Trust area**	**Number of SP-funded beds provided by Independent Sector**	***Mean number of bed spaces per Independent Sector service***	**Number of SP-funded beds provided by Trust**	***Mean number of bed spaces per Trust service***
Belfast Trust	7	25	333	212	*11.8*	121	*17.3*
Northern Trust	11	36	363	312	*10.4*	51	*8.5*
South Eastern Trust	14	47	308	291	*6.8*	17	*3.4*
Southern Trust	8	27	314	156	*13.0*	158	*10.5*
Western Trust	8	17	242	178	*12.7*	64	*32.0*
NORTHERN IRELAND		**152**	**1,560**	**1,149**	***9.8***	**411**	***11.7***
Percentage			*100.00*	*73.65*		*26.35*	

There are a number of findings from Table 16:

- Trusts provide a slightly larger proportion of beds overall than their share of services (26.35% of beds compared with 23.03% of beds);
- the mean number of bed-spaces per service is higher in Trust schemes than in independent sector schemes (11.7 bed spaces per service in Trust schemes compared with 9.8 bed spaces per service in the independent sector);
- the mean number of beds in independent sector services funded by SP ranges from 6.8 beds per service in the South Eastern Trust area, to 13.0 beds per service in the Southern Trust area;
- the mean number of beds in Trust services funded by SP ranges from 3.4 beds per service in the South Eastern Trust area, to 32 beds in the two Western Trust area services;
- in the South Eastern Trust area, the mean number of beds in both independent sector and Trusts schemes is more or less in line with the Bamford requirement that services should not exceed 5/6 beds in size;
- in the Belfast, Southern and Western Trust areas, the mean number of beds in independent sector and Trusts schemes is well above the Bamford requirement;
- in three of the Trust areas (Northern Trust, South Eastern Trust and Southern Trust) the mean number of beds per service in the independent sector is higher than the mean number per service in Trust schemes.

The indications are that a significant number of services provided larger, congregate-type settings than the Bamford Review recommendations. However, the fact that a Supporting People funding contract may cover a large number of bed spaces in a single service does not necessarily imply a congregate setting. Other service models such as core and cluster, or dispersed houses with small numbers of people living in them, may have been adopted. Further work is needed to establish which services fully conform to the Bamford recommendations and which do not.

Table 17 provides data on the type of provider, type of service delivery and mean number of beds in each type of service.

Table 17: Provider, number of services, number and percentage of different types of service delivery and mean number of beds per type of service delivery for each Trust area

Trust Area	**Number of Providers operating in Trust area**	**Number of SP-funded services in Trust area**	**Of which beds in:**									
			Unregistered Adult Placements		**Residential Care Homes**		**Shared or Self – contained Supported Housing**		**Floating Support**		**TOTAL**	
			No. of beds	*%*	No. of beds	*%*	No. of beds	*%*	No. of beds	*%*	No. of beds	*%*
Belfast Trust	7	25	0	*0.00*	16	*10.3*	205	*16.5*	46	*37.7*	333	*100*
Northern Trust	11	36	0	*0.00*	26	*16.7*	325	*26.2*	12	*9.8*	363	*100*
South Eastern Trust	14	47	4	*10.3*	91	*58.3*	272	*21.9*	0	*0.0*	308	*100*
Southern Trust	8	27	35	*89.7*	3	*1.9*	284	*22.9*	0	*0.0*	314	*100*
Western Trust	8	17	0	*0.00*	20	*12.8*	157	*12.6*	64	*52.5*	242	*100*
NORTHERN IRELAND		**152**	**53**		**123**		**1,304**		**80**		**1,560**	*100*
% of all beds				*2.5*		*10.0*		*79.7*		*7.8*		*100*

The significant findings identified in this table are that:

- 10% of SP-funded bed spaces are in 10 registered care homes – these are pre-2003 legacy SNMA-funded services that in England would have been remodelled within three years or funding would have been withdrawn;
- 80% are in forms of shared or self-contained supported housing – there is a further analysis of these services below;
- 8% are in floating support services;
- 2% are in unregistered adult placements;
- there are variations in the proportion of learning-disabled people in each type of accommodation within the Trust areas – for example, 58% of all registered care home placements are in the South Eastern Trust area;
- there is considerable variation in the number of contracted beds in supported housing services receiving SPG in each Trust area.

Table 18 correlates the number of bed spaces in each service, in size bands, with the type of provider.

Table 18: Size bands (number of bed spaces) for shared housing schemes by provider and by Trust area

Trust Area	**Independent Sector Providers : Number of services by number of beds**						**Trust Providers: Number of services by number of beds**					
	1 - 5	**6 - 10**	**11 - 15**	**16 - 20**	**21 - 30**	**31+**	**1 - 5**	**6 - 10**	**11 - 15**	**16 - 20**	**21 - 30**	**31+**
Belfast Trust	6	9	0	3	0	0	2	1	2	0	1	1
Northern Trust	23	3	2	1	1	1	2	1	0	2	1	0
South Eastern Trust	32	5	0	0	3	2	2	2	0	0	0	1
Southern Trust	4	4	1	2	0	1	5	5	0	2	3	0
Western Trust	2	5	1	4	1	1	0	0	0	1	0	1
NORTHERN IRELAND	**67**	**26**	**4**	**10**	**5**	**5**	**11**	**9**	**2**	**5**	**5**	**3**
Percentages by sector	*57%*	*22%*	*3%*	*9%*	*4%*	*4%*	*39%*	*32%*	*10%*	*3%*	*6%*	*10%*

The table includes:

- 78 services for between 1 and 5 people (51% of all SP-funded services for learning-disabled people) that apparently conformed to the Bamford requirements on the desirable maximum number of people living together in a single service;
- 35 services (23%) that had between 6 and 10 bed spaces which, depending on the actual living arrangements – whether they have their own front door for example or are living in close proximity to a significant number of other learning-disabled people - may have broadly conformed to the Bamford requirements;
- 21 services (14%) had between 11 and 20 bed spaces within the scheme, which again depending on the arrangements, might have been acceptable in some circumstances but was more likely to resemble congregate living;
- 18 services (12%) had 21 or more bed spaces;
  - in six cases there were more than 30 bed spaces in the scheme;
  - in two cases there were 50 or more bed spaces.
  - the likelihood is that these services were either mini-institutions or represent other forms of congregate living.

In total, one third of these services had 15 or more contracted bed spaces, and half had more than 5 bed spaces.

There is no evidence from Table 17 that Trusts were more likely than independent sector providers to be managing services with a large number of bed spaces. Nor does the table suggest that there was a preponderance of services with high numbers of bed spaces in any particular Trust area.

SP funding for learning disability housing support services in 2014 - 2015

Table 19 provides information on the contract value, mean contract value per service and mean weekly cost per bed space in SP-funded services.

Table 19: Total SP contract value for learning disability services, mean contract value, and mean weekly unit price by Trust area

Trust Area	**Number of SP-funded services (2014/2014)**	**Total SP contract value (2014/2015)**	***Mean contract value***	**Number of contracted bed spaces**	***Mean no of bed-spaces per service***	***Mean weekly unit price***
Belfast Trust	25	£2,254,642.00	*£90,185.68*	333	*13.32*	*£162.39*
Northern Trust	36	£4,190,756.00	*£116,409.89*	363	*10.08*	*£222.02*
South Eastern Trust	47	£4,367,983.00	*£92,935.81*	308	*6.55*	*£227.03*
Southern Trust	27	£3,585,585.00	*£132,799.44*	314	*11.63*	*£216.16*
Western Trust	17	£2,143,035.00	*£126,060.88*	242	*14.24*	*£171.01*
NORTHERN IRELAND	**152**	**£16,542,001.00**	***£108,828.95***	**1,560**	*10.26*	***£203.92***

The total SP contract value for learning disability support services in the 2014/2015 financial year was more than £16.5 million. The mean contract value was nearly £109,000 per annum; the mean weekly unit price was just below £204.

There was a correlation between the mean number of bed spaces per service in each area and the mean weekly unit price. This suggests that larger aggregations of bed spaces cost less per unit, but this was not necessarily reflected in the overall contract price, which was driven by the number of units as well as unit price.

A profile of the SP-funded services for learning-disabled people known to have been resettled from a long stay hospital (List 2)

Twenty nine out of 151 SP-funded supported accommodation services for learning-disabled people were identified by NIHE's SP team and the H&SC Board as providing for learning-disabled people resettled from long stay hospitals. Of these services:

- 25 services were provided by the voluntary sector and 4 were provided by a Trust;
- SPG funded all 29 services – none were funded through SNMA;
- 27 were described as 'shared or self-contained supported housing';
- 2 were unregistered adult placements[67], one of which was provided by a voluntary sector provider, the other was provided by the Southern Trust.

Table 20 shows the number of providers, the number of services and the number of accommodation units for List 2 services containing resettled people, by Trust area.

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[67] Registered adult placements are not eligible for SP Grant.

Table 20: Overview of the number of providers, services and bed-spaces by H&SC Trust area identified as specifically for resettled learning-disabled people (2014/2015 funding)

Trust Area	Number of SP-funded providers of services identified as for resettled people in area [Note]	% of SP-funded providers of all learning disability services working in the area	Number of SP-funded services for resettled people	% of all SP-funded learning disability services in the area	Number of SP-funded bed spaces for resettled people	% of all SP-funded learning disability bed spaces in the area
Belfast Trust	1	14.29%	1	4.00%	7	2.10%
Northern Trust	7	63.64%	14	38.89%	157	43.25%
South Eastern Trust	6	42.86%	8	17.02%	102	33.12%
Southern Trust	3	37.50%	5	18.52%	64	20.38%
Western Trust	1	12.50%	1	6.25%	16	6.61%
NORTHERN IRELAND			**29**	**19.21%**	**346**	**22.18%**

[Note:] Number and percentage of providers not given as some providers work in more than one area

Comparing these figures Trust by Trust with the figures shown in Table 16:

Belfast Trust area

The Trust did not appear to have prioritised the provision of supported accommodation generally (Table 14) or specifically for the resettlement programme (Table 20). It had seven providers working in the area who provided housing and support for learning-disabled people, but only one service identified as specifically for resettled people.

Northern Trust area

The Trust focussed its provision of supported accommodation on the resettlement programme. Two thirds of the area’s providers of supported housing for learning-disabled people were providing services identified as housing resettled people. It had 54% of all services in NI for learning-disabled people; and 43% of SP-funded bed spaces available for resettled people.

South Eastern Trust area

Almost 43% of the area’s providers of supported housing for learning-disabled people were providing services identified as housing resettled people. However, only 17% of the services and 33% of the beds for learning-disabled people were provided for resettled people.

Southern Trust area

The Trust had not developed as many learning disability services as in some other Trust areas. The area had 17% of the SP-funded learning disability service providers overall, but 23% of the identified providers, 18.5% of services and just over 20% of bed-spaces available for resettled people.

Western Trust area

The Trust had not developed as many services as in some other Trust areas. The area had 17% of the SP-funded learning disability service providers, but only one service representing 8% of the identified providers and 6% of the services and bed spaces for resettled people.

It is noticeable that the three Trust areas within which a long stay hospital was located (Muckamore Hospital/Belfast Trust; Longstone Hospital/Southern Trust and Lakeview Hospital/Western Trust) had fewer SP-funded providers and services than the other two Trust areas.

The number of SP-funded bed spaces available for resettled people in four of the five Trust areas was fairly consistent at between 308 and 363. However, there were relatively few providers, services and bed spaces in the Western Trust area. Information obtained in the interviews suggested that patients from Lakeview Hospital were resettled before the other hospitals and prior to the 2012 resettlement plan being adopted. Perhaps as a consequence of this a significant proportion of resettled people from that hospital were placed in residential and nursing care settings.

The variations between the other Trusts may also be partly explained by commissioning policies which may have varied at different times during the post-2007 resettlement programme. Table 21 shows the date on which each of the services identified as being available to resettled people became operational[68].

Table 21: Operational date for services identified as specifically for resettled people – number of services by commissioning date by Trust

Trust Area	**Became operational pre-2003**	**Became operational between 2003 and 2011**	**Became operational since 2012**	**Operational date not known**
Belfast Trust	0	0	1	0
Northern Trust	2	5	6	1
South Eastern Trust	1	4	3	0
Southern Trust	0	3	2	0
Western Trust	0	0	1	0
NORTHERN IRELAND: Services	**3**	**12**	**13**	**1**
NORTHERN IRELAND: bed spaces	**51**	**50**	**64**	**n/a**
NORTHERN IRELAND: mean bed spaces per service	**17**	**4.2**	**4.9**	**n/a**

Table 21 shows that there was:

- an increase in the commissioning of services after the introduction of the Supporting People programme;
- a sharp fall in the mean number of bed spaces per service across NI as a whole after the introduction of SPG, reflecting the influence of the SP programme on implementation of the Bamford recommendations; and
- commissioning practices varied over time within and between Trusts[69] with more services commissioned in some Trust areas than others.

The Northern and South Eastern Trusts commissioned a small number of services that became operational within each time period. Southern Trust services became operational after the introduction of Supporting People programme in 2003. The single services included in this list commissioned by the Belfast and Western Trusts each became operational after the resettlement programme was revamped in 2012.

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[68] This information is not currently available for all 152 supported accommodation services for learning-disabled people.

[69] Information on the date from which all the other SP-funded services for learning-disabled people became available is not available at present, but will be collected and analysed as part of phase 2 in the research programme.

Resettlement from Muckamore Hospital (Belfast Trust) was continuing at the time of the Phase 1 research. All resettlement activity in the Western Trust area was complete by 2012 and Lakeview Hospital was then closed. Similarly, resettlement of the PTL from Longstone Hospital was completed by the end of 2012 in the Southern Trust area, with smaller numbers of DDL people remaining to be discharged.

The most striking feature of this analysis is the relatively small number of supported housing services and bed spaces brought into management across NI as a whole in the period 2003 – 2011. Over the eight financial years between 1 April 2003 and 31 March 2011, an average of 1.5 services and 6.25 bed spaces that are now identified by the SP team and the H&SC Board as being available for resettled people became available each year. Since 1 April 2012, an average of 6.5 services and 32 bed spaces has been brought into management each year.

Table 16 above shows that, in List 1 services, around half of the SPG-funded accommodation had more contracted bed spaces than the Bamford recommendation limiting the ideal number to five. The Supporting People team provided information about the model of accommodation-based support adopted in each of the List 2 services identified as housing resettled people (Table 22).

Table 22: Number of SP-funded services, properties, bed spaces and mean number of bed spaces per property, by Trust area

Trust Area	**Number of services identified as housing resettled people**	**Number of properties**	**Number of bed spaces**	***Mean number of bed spaces per property***	**Service model not known**
Belfast Trust	1	2	7	*3.50*	0
Northern Trust	14	67	157	*2.34*	2
South Eastern Trust	8	58	102	*1.76*	0
Southern Trust	5	17	64	*3.76*	0
Western Trust	1	3	16	*5.33*	0
NORTHERN IRELAND	**29**	**147**	**346**	***2.35***	**2**

Almost all of the List 2 services that were identified as providing for resettled learning-disabled people fell within a narrow band of numbers of bed spaces–per–property. In most cases therefore, these services do not appear to require learning-disabled people to share accommodation. There are a small number of exceptions:

- In the Northern Trust area, there are two services that contain more than 5 beds in shared accommodation within a single property, and in one case there are 13 self-contained units in a single property;
- In the South Eastern Trust area there is one service with 24 shared accommodation units across six properties, and two single-property services, one with 15 self contained units and the other with 18 self-contained units in the property;
- In the Southern Trust area, there is one service with 23 shared units in 4 properties;
- In the Western Trust area, the single scheme identified as providing for resettled people has a mix of 16 shared and self-contained units in a single property.

SP funding for housing support services specifically for resettled people

Table 23 provides information on the 2014-2015 contract value, mean contract value per service and mean weekly cost per bed space in SP-funded services that have been identified as specifically for resettled people.

Table 23: Total SP contract value for services specifically for resettled people, mean contract value, and mean weekly unit price by Trust area

Trust Area	**Number of SP-funded services (2014/2015)**	**Total SP contract value (2014/2015)**	***Mean contract value***	**Number of contracted bed spaces**	***Mean no of bed-spaces per service***	***Mean weekly unit price***
Belfast Trust	1	£144,872.00	*£144,872.00*	7	*7.00*	*£398.00*
Northern Trust	14	£2,266,341	*£161,881.51*	157	*11.21*	*£277.60*
South Eastern Trust	8	£1,820,807	*£227,600.94*	102	*12.75*	*£343.29*
Southern Trust	5	£990,376	*£198,075.24*	64	*12.80*	*£297.59*
Western Trust	1	£173,596.80	*£173,596.80*	16	*16.00*	*£208.65*
NORTHERN IRELAND	**29**	**£5,395,993.56**	***£186,068.74***	**346**	***11.93***	***£299.91***

- The total SP contract value for support services specifically for resettled people in 2013/2014 was £5.396 million;
- this amounted to 32.6% of the cost of all SP-funded learning disability services for 19% of all SP-funded learning disability services;
- the mean contract value was £186,000 (1.7 times the mean value of all SP-funded services for learning-disabled people);
- the mean weekly price per bed space was £293 (2.7 times the mean weekly cost per bed space in all SP-funded services for learning-disabled people);
- these services were more expensive than the generality of SP-funded services for learning-disabled people;
- the mean weekly cost per bed space in the Belfast and South Eastern Trust areas was well above the mean weekly cost per bed space in the other three trust areas.

2.5 EFFECTIVENESS OF THE RESETTLEMENT PROGRAMME

In this section we report on the quality of housing and support services that have been developed as part of the resettlement programme, and address the question of whether this provision meets the Bamford recommendations as seen from the perspective of the policymakers, commissioners and service providers whom we interviewed.

2.5.1 Assessing the quality of services

The interviews

In the course of the interviews[70], participants were asked to explain the processes by which the quality of the housing, care and support services provided for resettled people were being assessed. All thirteen participants replied to this question.

A number of different agencies have responsibility for monitoring aspects of service delivery in different settings. Each agency or role has a different approach although there may be overlap between them in some of the detail.

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[70] A description of the interview process and a list of interviewees is provided in Appendix 1.

Service users, their families and advocates were identified by interviewees as the first line in the system. After that, the quality of services was said to be variously assessed by:

- Trust care management processes that monitored and reviewed services provided by the Trust and by independent providers;
- Trust in-house provision was also subject to Regulation 28, 29 and 30 visits by RQIA (covering residential, day care and nursing home care);
- Trust services were periodically monitored by Trust auditors;
- the quality of housing association services was monitored through housing associations internal management processes, externally through regulatory inspection by DSD (now DfC), and through contract management by Trusts in their capacity as care and support commissioners;
- the Supporting People department supervised the use of the Quality Assessment Framework version 2 (QAF2)[71] which was designed for self-monitoring by housing support providers from both the statutory and independent sectors. The SP team then used the QAF2 results as a basis for contract management through monitoring of provider returns, announced performance visits and unannounced spot checks;
- The Regulation and Quality Improvement Authority (RQIA) registers nursing, residential and domiciliary care services and inspects care standards and financial probity in registered domiciliary care services, with the addition of an inspection of the accommodation provided in registered care homes.

The general view was that all publicly funded services should have a statement of purpose that incorporates performance indicators and agreed arrangements for how performance will be measured and evaluated. Commissioned services would then be governed by service level agreements, contractual arrangements, key performance indicators (KPIs), and performance reviews. These would be backed up by social worker and care manager visits to services, together with formal review meetings.

RQIA's expectation was and remains that where people are living in a registered service there should be regular reviews of the quality and appropriateness of the services they receive led by the Trust, irrespective of who the provider is. There was also an expectation that the care provider would carry out a monthly survey of residents' satisfaction with their accommodation and services, developing appropriate plans to deal with issues if there were areas of concern. However, interviewees said that, in practice, care management reviews were often led by the provider and this could mean that there was no independence of view in ongoing service reviews.

There was a complex interplay of oversight and regulatory arrangements governing SP-funded services, but there was no independent regulatory framework for SP-funded supported housing. The Supporting People Department did not have the necessary statutory powers or procedures to conduct formal inspections. These services were subject to contract management oversight by the Supporting People team, which came close to a monitoring and inspection process but was not governed by statutory powers[72].

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[71] QAF2 is an updated tool designed to be used by providers for internal self-monitoring as well as by Supporting People teams as a contract management tool. It provides a standard for providers to measure themselves against when delivering services.

[72] The Supporting People team had received legal advice that an interventionist approach to contract management and performance improvement in provider organisations could be deemed to make it a shadow director – i.e. someone who is not a director but who exercises control over a company and therefore assumes risk in connection with management of the company.

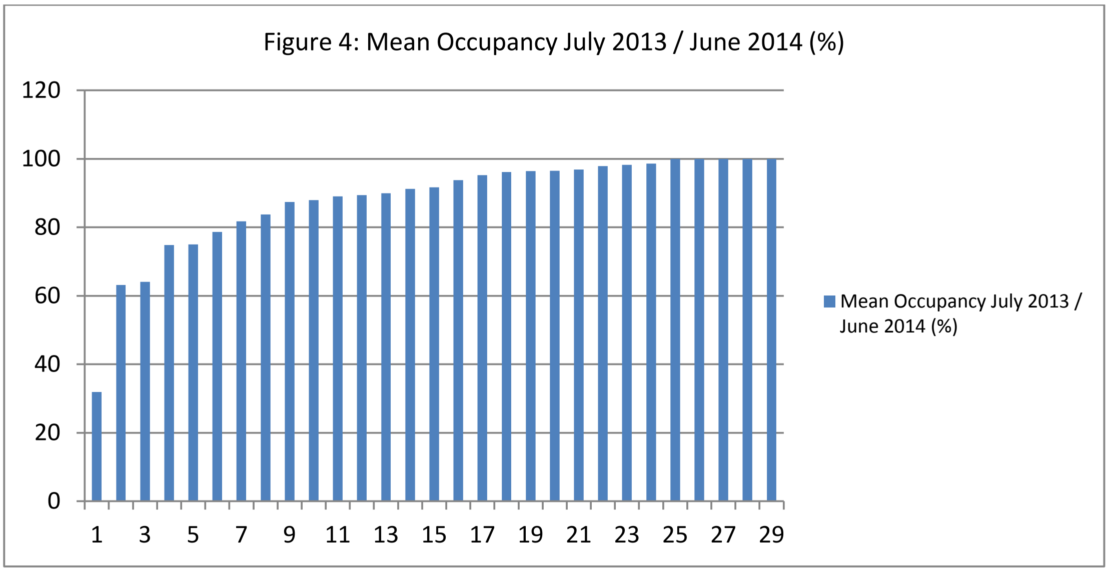
Some interviewees suggested that the SP team's QAF2 monitoring process is not identifying issues in either accommodation or support because it is partly based on self-monitoring by providers. RQIA was said to be 'filling the void' unofficially, reviewing housing support that was provided alongside domiciliary care on an informal basis during inspection visits, offering advisory recommendations rather than statutory actions to be taken. Concerns were expressed by some interviewees about whether or not this was legitimate.

What the Supporting People Programme data show

Data provided by the SP team allow an analysis of some aspects of provider management performance and service quality for the List 2 SP-funded services that were identified as providing accommodation-based support for resettled people.

All twenty nine services providing for resettled people were funded through 'Variable Block Contracts' in which the payment of SPG depended on the number of people provided with housing support at any one time within an overall contracted number of places. Although SPG payments were varied according to the current number of tenancies, the number of people actually supported by each service compared with the contracted number of places was an important indicator of provider service management. These are publicly-funded housing association schemes paid for in most cases by Housing Association Grant. One of the requirements of HAG funding is that accommodation must be well maintained and available for letting or in use at all times. For special needs supported housing services such as these, it would be reasonable to make a small allowance for people moving in and out of the service. However, rapid turnover of residents is not to be expected in learning disability services, and provider service management should be able to maintain occupancy levels of 95% - 100% in most cases. Anything below 85% is treated by the SP team as 'low occupancy'.

The mean occupancy level across the 29 List 2 services identified as providing for resettled people between July 2013 and June 2014 was 87.92%. Figure 4 shows mean occupancy (Y axis) between July 2013 and June 2014 across each of these services (X axis).



Fourteen services (48%) had mean occupancy levels over a twelve month period between 1 July 2013 and 30 June 2014 below 95%; eight services (28%) had occupancy levels below 85%, ranging from 31.87% to 83.72%. There were four low occupancy services in the Northern Trust area, and the single schemes in the Belfast and Western Trust areas were also experiencing low occupancy.

It is not clear whether the existence of a number of services with occupancy levels below 85% reflected lack of demand, weak liaison between providers and their referral agencies (Trusts and others), weak scheme management, or resulted from the provider's policy decision to reduce numbers in order to reduce social pressure among vulnerable residents some of whom may have challenging behaviours.

However, all of the services in this list met Supporting People 'Minimum Quality Standards' derived from the QAF2 self assessment process[73]. The discrepancy between occupancy data and the results of self monitoring by providers may illustrate the shortcomings of the QAF2 process.

As part of its approach to contract management, NIHE also made an assessment of what it called 'Provider Risk'. The risk assessments on which this assessment was based were derived from a summary of the political, financial and operational risk associated with each provider of SP-funded services. There were thirteen providers of services in the list identified as providing support for resettled people. Of these:

- **six providers were assessed by the SP team as 'low risk**;
- **six were assessed as 'medium risk';**
- **one provider was assessed as 'high risk', and RQIA enforcement action was being taken in respect of care services delivered by this provider**.

The risk assessments were summarised as a 'traffic light' system. Table 24 records the risk associated with the services that were provided by the thirteen providers operating in each Trust area.

Table 24: Supporting People 'Provider Risk Assessments by Trust area

Trust Area	**Number of Providers operating in each Trust area** note	**SP-funded providers assessed as 'low risk'**	**SP-funded providers assessed as 'medium risk'**	**SP-funded providers assessed as 'high risk'**	**SP-funded providers who are also registered Dom. Care providers subject to RQIA enforcement action**
		Green	**Amber**	**Red**	**Red**
Belfast Trust	1	1			
Northern Trust	7	3	3	1	1
South Eastern Trust	6	3	3		
Southern Trust	3		2	1	1
Western Trust	1	1			

Note: some providers operate in more than one Trust area. Northern Ireland totals would therefore be misleading.

Seven out of thirteen providers in this list were assessed as medium or high risk by the Supporting People team as part of its contract management processes. In some cases medium and high risk providers were working in more than one Trust area. Thus 10 out of the 29 List 2 services were being provided by medium or high risk providers. Note, however, that these services may not be typical of the entire list of 152 SP-funded services for learning-disabled people.

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[73] Level C in the Quality Assessment Framework vs 2 (QAF2), based on provider self-assessments of Assessment and Support Planning; Security, Health and Safety; Safeguarding and Protection from Abuse: Fair Access, Diversity and Inclusion; and Client Involvement and Empowerment. Level A is 'Excellent'; Level B means that the service can evidence good practice; Level C means that the service meets, and is able to evidence, the required minimum standard but there is scope for improvement. See: Supporting People (undated), *Quality Assessment Framework Guidance*, Northern Ireland Housing Executive, Section 2.2 and 3.1.

The data provided by NIHE suggest that there were both performance and risk issues associated with the providers of a significant number of SP-funded services for resettled learning-disabled people.

2.5.2 Are the Bamford requirements being met or do hospital-like conditions still remain?

Table 18 suggests shows that a significant number (48%) of List 1 SP-funded learning disability services contained more than 5 bed-spaces. 32% of all services contained eleven or more bed spaces. Although some of these services may have been based on patterns of dispersed accommodation, the figures are strongly suggestive that there were a number of examples of what Bamford called 'congregate settings' in these services.

The analysis of 29 List 2 services that were known to provide for resettled people suggests that, in that list, there were very few services that represented congregate living. Even in these services, however, there were a number where quite large numbers of self-contained rooms or flats were contained within a single property. This was not ideal from a 'best practice' perspective.

Participants in the interviews were asked whether all the community-based supported accommodation or care services that had been commissioned for learning-disabled people leaving long stay hospitals since 2007 met the recommendations on size, arrangements and conditions recommended in the Bamford report. Two participants, both of whom had a management role in the delivery of care and support services working for voluntary sector organisations said that all of their schemes followed the Bamford requirements on size, arrangements and conditions. Six participants said that not all the schemes they were associated with *did* conform to the Bamford requirements. Four of these comments are recorded below.

"The criterion that there should be no more than 5 people living together in one scheme is not met; nor is the requirement that there should not be more than three houses in one service. Bamford has influenced thinking, so more schemes are now in Bamford format but not the nursing home and residential care schemes from the past and some schemes that are still being developed. These are not covered by the same aspirations. Schemes with a smaller number of people at higher cost are at one end of the spectrum, but some residential care and nursing home schemes have not changed since Bamford."

"Bamford recommendations are followed in terms of what we see in plans, but not always when built. There was a recent example of an industrial kitchen built in a scheme with other institutionalised arrangements that was labelled as 'supported housing'. The specification for this scheme was too strongly influenced by health and social care practitioners ... Some heritage schemes are obsolete. Greater flexibility in the NIHE capital programme is needed to reconfigure schemes to bring them more into line with the Bamford principles."

"There are still some nursing homes and residential care homes that work on a fairly traditional model. There may also be converted residential care homes that have become Supporting People-funded environments that would not pass current HMO[74] *and space standards. Some are still institutional in format, even though conditions have been improved in terms of en suite arrangements for example. These would not pass the current care home registration space standards. It will take time for these schemes to get up to standard. There are considerations of financial viability that work against modernisation. A service for 15 people is more economical and financially sustainable than a service for 3 to 5 people."*

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[74] HMO – Houses in Multiple Occupation.

"There is a significant number of former residential care homes converted into supported living where it would take a good understanding of the legislation to tell the difference from a registered care home. Some have been extensively remodelled and are qualitatively better but in others the improvements are marginal. And in some the accommodation would in any case not meet current standards for registered care. There are old residential homes, deregistered inappropriately; and new build supported housing services where RQIA does not have the remit to object to the physical standards but where it is clear that they would not meet the standards of a residential care home. But there are some very good schemes and those coming through the commissioning process are now much better."

The interviews with policymakers, commissioners and service providers suggested that there were still a significant number of services that were institutional in character; and there were instances where size criteria had not been fully met, and where ethos and delivery had not changed.

2.6 ATTITUDES TO RESETTLEMENT AND THE IMPACT ON THE RESETTLEMENT PROGRAMME

The research was intended to review the development of policy on resettlement and the way the resettlement programme has developed since the Bamford report. However, it has also uncovered wider issues that had an impact on the level and rate of resettlement and the resettlement process. These issues included attitudes towards learning-disabled people, their personal identity and rights, as well as the perceptions of the policy-makers, commissioners and providers who were responsible for delivering resettlement about the impact of resettlement on the learning-disabled people involved.

From the answers provided by interviewees, it is clear that **changes in resettlement policy over the years had not always been accompanied by changes in the understanding of learning disability, or of the needs and rights of disabled people, whether by health and social care professionals or by the wider community. Almost all the people interviewed for the research commented on parental and family attitudes, community attitudes and the attitude of professional and nursing staff**.

2.6.1 Parental and family attitudes

The interviews contained anecdotal evidence that conflicts sometimes arose between those charged with delivering the resettlement programme, and families who sometimes felt that a learning-disabled family member would be happier or better off in hospital[75]. The Society of Parents and Friends of Muckamore ('Friends of Muckamore')[76] whilst fully supporting the resettlement of people who wanted to be resettled, noted concerns that those with the most complex care needs who received a high quality of care in Muckamore should not be resettled into the community where this was against the patients' and family wishes. Their concerns[77] [78] included fears that:

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[75] Northern Ireland Audit Office (2009), *op. cit*., page 37, para 4.5; and page 38, para 4.8.

[76] The NI Audit Office (2009) *op. cit*., page 27, footnote 29 noted that this group represents the views of those with family members in Muckamore – mostly Eastern and Northern Board residents, and that no major concerns had been raised at that phase by families in the Southern and Western Board areas and there were no formal family groups in these areas.

[77] Northern Ireland Audit Office (2009), *op. cit*., page 38, para 4.7.

[78] Their concerns were also referenced in a NI Assembly debate, 9th February 2009. Carmel Hanna (SDLP) said: *Nevertheless, the Society of Parents and Friends of Muckamore Abbey informs us that a few individuals who have lived in Muckamore for up to 50 years would rather remain there — it is their home. Some patients, and their families, do not wish to be pressurised into community care; they feel better cared for in their present setting.*

- people moving out of hospital would not be accepted into the community and could be subjected to bullying and harassment;
- the level of care provided in Muckamore could not be replicated in the community; and
- that their family member's quality of life and access to recreational activities and day care facilities would diminish as a result of resettlement in the community.

They also had concerns about the potential higher cost of community care based packages and the longevity of funding packages in certain settings e.g. private nursing and residential homes.

In response to these concerns, the Health Minister gave a public assurance to families in 1995 that a member of their family living in hospital would only be resettled into the community if there was clear evidence of 'betterment'[79] for the patient, and provided that it was not against their wishes[80]. This commitment was restated by successive Ministers and remained in place at the time of the research in 2014.

Interviewees suggested that, while this commitment had to be honoured, it had also been important to educate and persuade families about the benefits of resettlement. Some learning-disabled people who had lived in hospital on a long-term basis, and their families, saw positive changes in their friends' lives after resettlement and this helped to change attitudes to resettlement. In other cases, patients were said to have realised that there were very few people left in their ward, and this also influenced them to change their minds. It is clear that the attitudes of families – and indeed of learning-disabled people themselves – were a factor in determining the rate of resettlement and which individuals were resettled first.

2.6.2 Community attitudes

Interviewees said that there had been resistance from some communities to the resettlement of learning-disabled people in their neighbourhood. This took the form of campaigns to prevent the development of a scheme, and press campaigns that sought to denigrate the official policy on resettlement, both of which may have influenced opinion on local councils. There were said to have been instances where learning-disabled people who had been resettled were subjected to harassment by people in their local community. Trust managers said that they were working with local communities to obtain acceptance of the principles of integration, citizenship, and a sense of being part of that community so that the community became protective of people living in the area. This policy was said to be meeting with some success. Interviewees for the research suggest that there was less resistance to resettlement in 2014 than in earlier years.

2.6.3 The attitudes of professional healthcare staff

Resistance to the concept of resettlement for learning-disabled people is also said to have come from all levels of the health and social care sector. Consultants working in hospitals as well as some front-line staff were said to have been concerned about the ability of learning-disabled people to live outside a protective hospital environment. Interviewees suggested that these critical responses to resettlement were caused partly by out of date attitudes towards learning-disabled people, partly by a perceived loss of professional status, and partly

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[79] The term 'betterment' used here was also used in *Equal Lives* to indicate that if a person was resettled there would need to be an improvement in their circumstances outside hospital compared with their lives in hospital. This meant that resettlement of the individual was clinically appropriate, met the patient's needs, and had the potential to better the patient's life.

[80] Northern Ireland Audit Office (2009), *op. cit.*, page 2, para 3

by a fear that jobs would be lost if the resettlement of patients from the hospital they work in reduces the number of staff required. The research team was told by one interviewee that, in at least one Trust[81], relatives of long stay patients who were employed as nursing and ancillary staff refused to co-operate with the resettlement programme. Hostility by staff towards resettlement caused delays in the completion of needs assessments and the discharge of patients.

Ministerial commitments were given to trade unions and staff that no job losses would be involved in the resettlement programme. A work-force review was carried out in 2009 – 2011, and programmes of retraining and re-orientation were put in place for hospital staff moving into residential care[82]; but the problem was said to have remained as an issue in at least one Trust.

Further problems arose from the fact that Royal College of Nursing-qualified staff were reluctant to work outside a hospital setting if a transfer into social care meant that they would lose their RCN professional accreditation[83]. One result of this was that nursing staff that were redeployed from hospital continued ‘traditional’ nursing practices in residential care and supported living environments. NIHE’s Supporting People team, the RQIA and senior Trust managers were still working to resolve these issues at the time of the research.

Professional attitudes towards learning-disabled people were said to have been a barrier to effective resettlement even after a patient had left hospital.[84] The Housing Executive and the RQIA both found that while a service might be commissioned as ‘residential care’ or ‘supported housing’ with specific service requirements, the service being delivered carried all the hall-marks of hospital-like institutional care because staff involved in planning and service provision had been influenced by traditional professional practices[85]. Resolving this issue was identified by Bamford as being critical to the success of the *Equal Lives* approach[86].

“If institutionalised discrimination against people with a learning disability is evident in practice there remains an onus on Government and through them service commissioners and providers to address human rights and equality issues. It is our belief that in order to effectively address these issues services should be guided in future by the values on which the Equal Lives review is based: social inclusion, citizenship, working together and provision of individual support. In addition, efforts must be harnessed to change the attitudes and mind sets that support such discrimination and inequality ... legislative implementation needs to be combined with: education of service staff who may discriminate against people with a learning disability ... providing more integrated housing, education and day opportunities ... learning disability awareness training ... use of local and mass media ... involving people with a learning disability in the design, delivery and management of services.”

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[81] Interview with a senior Trust manager

[82] Interviews with health and social care policy-makers and commissioners undertaken as part of this research.

[83] Interviews with health and social care policy-makers and commissioners undertaken as part of this research.

[84] Interviews with health and social care policy-makers and commissioners undertaken as part of this research.

[85] These are ongoing issues which are discussed in *Working Paper 5: Interviews with policymakers, commissioners and practitioners*.

[86] Bamford, (2005), *op. cit.*, pages 30 - 31

2.6.4 The personal identity and rights of learning-disabled people moving out of hospital

Comments from external stakeholders referred to a number of issues relating to personal identity, documentation and access to personal finances for learning-disabled people living in long stay hospitals and those who had been resettled into the community. It appears that when learning-disabled people were admitted to hospital, their personal monies were lodged by the hospitals in population-wide funds rather than in individualised accounts. As a consequence, it was not always possible to account for the money belonging to individuals at the time they were discharged into the community, and an individual's money was not always transferred into a personal account.

Some factors relating to this issue centred on perceived or actual 'lack of capacity'[87] on the part of the person being resettled, lack of personal identification paperwork, and sometimes action by individual members of staff or staff teams who were *de facto* in charge of patient funds without any locus for doing so[88] and who had a vested interest in the system. In a number of cases the individual being resettled had no National Insurance number or other relevant documentation such as a Passport. This appeared to make the transfer of personal monies to personal accounts difficult. In response, one Trust has procured Birth Certificates and Passports for all those who have been resettled since 1 April 2012[89].

There are a number of issues here, albeit these were not part of this research. Firstly, there were questions around the retention (for long periods of time – in some cases decades) of individuals' funds, which the individual could not access or withdraw. Secondly, and of more relevance to this research, there were barriers to the withdrawal of this money by the individual being resettled at the time of resettlement or thereafter which could have had an impact on their ability to develop a degree of independent life in their local community. On occasions, it is alleged that the allocation of funds to individual accounts was actively obstructed by hospital staff.

Guidance was provided to HSC Trust staff about the transfer of patient's monies during and once resettlement was achieved[90] for those individuals who were deemed to be incapable of managing their own financial affairs. For Belfast HSC Trust this noted that if the patient is resettled on a permanent basis, the 'Appointeeship' should be relinquished by Muckamore Hospital and transferred to the Trust with the responsibility for the patient, so that all the patient's savings and future benefits would be managed by the Trust.

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[87] At present there is no specific and separate mental capacity legislation in Northern Ireland - the Mental Health (1996) Order is the current legislation. The Bamford Review (Report – *A Comprehensive Legislative Framework*, 2007) recommended the development of a single legislative framework for the reform of mental health legislation and for the introduction of mental capacity legislation in Northern Ireland. The consultation period on a new Mental Capacity Bill has just ended (2nd September 2014). This would fuse mental health and mental capacity law into a single piece of legislation, with a view to introduction in the NI Assembly by January 2015 and enactment within the current mandate of the NI Assembly (by end of March 2016).

[88] Interview with a senior Trust manager

[89] Interview with a senior Trust manager

[90] Belfast Health & Social Care Trust, *Resettlement of Patients from Muckamore: Interim Guidance for Staff (in conjunction and agreement with Finance Staff) - Patients Community Resettlement* (https://www.whatdotheyknow.com/request/165614/response/421924/attach/3/Muckamore%20Resttlement%20Patients%20Guidance%20for%20Staff%20May%202012.doc)

2.7 HAS THE LEARNING DISABILITY RESETTLEMENT PROGRAMME IN NORTHERN IRELAND BEEN A SUCCESS?

At the end of the interview, all participants were asked to say whether they thought that the resettlement programme had resulted in betterment in the lives of resettled people, whether it had been a success from a public policy standpoint, and whether it represented good value for money. These questions resulted in the most cautious answers from the interview participants.

2.7.1 Professional perceptions of how Betterment in the lives of learning-disabled people who have moved out of hospital is being assessed and whether participants believe it is being achieved

Interview participants were asked how 'betterment' in the lives of resettled people was being assessed. Seven respondents answered the question; six respondents said that they did not know how betterment is being assessed.

Comments on the way betterment is being assessed

"This was a big problem at the beginning. Our response was the twin approach – quality of life measures before and after they leave hospital, allied to the role of the independent advocate in helping them to express their feelings. Independent advocates have been commissioned by one Trust. Each trust has a separate contract."

"The trust has funding for additional advocacy services. These have been commissioned through a charity which is doing follow up quality of life indicators. Advocates will engage with people to assess quality of life prior to discharge, then after 3, 6, 9 and 12 months. This should have started two years ago but there was a lack of funding."

"We are not assessing it very well. Trusts have not been good at outcome measures."

"There is no formal process. We rely on the services and their managers to ensure that people are 'content'. There is very little info about people who are not happy, but when that happens steps are taken to look into it and if necessary find solutions."

"Not very robustly – through quality of life indicators derived from a number of different sources. SP is looking at outcomes and how developed from a housing perspective using the Bromford [91] *, Reach* [92] *and Driving Up Quality Code* [93] *systems."*

"That is difficult. In the past we did not make the connections between betterment, quality of life etc. But there has been very little investment in advocacy because the Board has not commissioned it. Other trusts have more. We should target it at people who lack capacity and those who have just left hospital."

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[91] Bromford Housing Group developed a system for monitoring the progress of tenants and residents receiving support and evaluating the success of the support provided to help people develop their ability to live independently following introduction of the Supporting People programme in 2003. See http://www.emeraldinsight.com/doi/abs/10.1108/14608790200200030

[92] Warren S, Wood A and Maguire S (2013) *Reach: Support for Living an Ordinary Life – It's My Life*, Paradigm UK, Housing and Support Alliance and Pavilion Publishing. The Reach standards provide guidance for support providers and commissioners on how to meet their responsibilities to the people they support and the relevant regulatory bodies.

[93] Driving Up Quality Alliance (2013) *Driving Up Quality Code: Self Assessment Guide – A guide to help organisations work out what they need to get better at*, a response to the abuse of people living in the Winterbourne View residential care home.

From the responses set out above, **there is evidence that:**

- **progress has been slow in establishing mechanisms for assessing betterment in peoples' lives following resettlement;**
- **each Trust is developing its own approach;**
- **no overall assessment of this critically important aspect of the learning disability resettlement programme had taken place at the time the research was carried out; but**
- **good practice developed by commissioners and providers in England is now being considered for adoption by the NI Supporting People team and others.**

Interview participants were also asked whether they thought that the resettlement programme had been successful for resettled learning-disabled people and whether betterment in their lives has been achieved in ways advocated by Bamford. Ten respondents said that they believed the programme had been a success; three said that they did not know.

Selected comments from those who believed the programme has been a success

"We have been starting from a low base-line in hospital-based services. Muckamore was an old Victorian establishment, with wards, in a remote location, so betterment is anything that is better than that. The bottom line is a better environment with their own bedroom and bathroom, consideration given to peoples' dignity, choice, human rights (dependent on capacity), integration into communities." [94]

"In many instances, yes, the programme has been successful. The majority of people we see have more control over their lives and are receiving services that are more based on their needs. We are now seeing people living successfully in supported housing schemes with higher levels of need than some of those living in residential care."

"From what I have seen there are a number of success stories but this is not an unqualified 'Yes'. There are some exceptional projects. Some projects would need to be revisited and some do not pass the test."

"Many people who have been resettled have lived in hospital for 20 or 30 years. Many of them were not aware of what alternative options existed. The process in terms of the work of multi-disciplinary teams has given cognisance to the core principles of the programme – choice and options taken at the person's pace - but there is a group of hospital residents who should have been out years ago who wanted out. We have let them down."

"Generally, yes. There have been some failures and difficulties, but once resettled after a couple of years most people feel they have benefitted. A small number of families still feel they would have been better off in hospital but that is also changing."

Selected comments from those who say they do not know whether the programme has been a success

"It is hard for me to say as I don't review every individual. My sense is that the majority of people have better lives as a consequence of being resettled.

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[94] Authors' comment: This was not the only interviewee who implied that Human Rights were negotiable for people who lack capacity, although other interviewees were very committed to the principle of promoting Human Rights regardless of the level and nature of the disability.

"... I cannot say whether resettlement has been a success for every individual. This is not a one-off process. People don't just get resettled. The ongoing needs of each individual have to be considered. Their needs and requirements also change, so we need the capacity to make further changes."

"I have seen some services that have been developed by housing associations that have been a success, maybe for people with moderate learning disabilities. Overall, I don't know enough to say."

Overall, there was a perception that:

- **the resettlement programme had been a success from the perspective of resettled people;**
- **the programme had taken too long to complete with adverse effects on the people still living in hospital as long-stay in-patients;**
- **some services do not meet modern requirements and do not conform to the Bamford principles.**

However, these are personal views. In the absence of a coherent and coordinated programme of follow-up and evaluation, it is hard to see how those responsible for the resettlement programme can have a clear idea of the impact on resettled people if the quality of services is not being consistently evaluated, and if one of the key aims – betterment – is not being assessed.

2.7.2 The impact of the resettlement programme in public policy terms

Six interviewees said that the programme had been a success in public policy terms, although reservations were expressed. Of the remainder: two respondents said that they would prefer not to comment; two respondents said they did not know enough to comment; three made non-committal statements.

Selected comments on the effectiveness of resettlement in terms of public policy

"I like to think it has. It would be fairly unusual in NI where two Departments that have different remits have managed over a period of six years to deliver a programme on a consistent long term basis, and a shared set of priorities. Hopefully it will be renewed. "

"Yes, because it is the right thing to do. The Minister has driven it in spite of lobbying from the other direction, shifting from disabled people being hidden to them being integrated and having rights."

"I don't know. There is still bias – some politicians do not grasp that this is policy and the way forward. Their attitude is that people should not be driven out of the hospital. The Antrim Press have run scurrilous articles about people being driven out, dying afterwards and committing suicide. So the policy is there but is not bought into by everybody."

"The resettlement programme has had a high profile in terms of moving people from a hospital into a house; but we need the rest of society to commit to improving the life experiences for people with learning disabilities, allowing their total involvement in the community. 'Destined', a voluntary organisation, drew up a charter and got shops and individuals to sign up in terms of jobs, participation in community life etc for learning-disabled people. We need the rest of Northern Ireland to drive the same agenda otherwise it falls back on health."

"There are still detailed issues that have to be resolved. People should no longer live in hospital just because that is where they can be accommodated rather than because they need assessment and treatment."

There were mixed views on whether the programme was a success in terms of public policy. It was seen as a success in terms of inter-Departmental cooperation. Ministerial support for the programme was seen as significant in driving it forward. But there were reservations about whether a programme of this kind that was 'driven from the top' and which did not carry public opinion could be termed a success even if it was 'the right thing to do'.

2.7.3 Value for money

At the end of the interview, participants were asked whether they thought that the learning disability resettlement programme represented good value for money. Eight participants said that the programme represented good value for money, although some said that value for money could have been better. One participant said that the programme had not been value for money. Four participants either said that they did not know or preferred to make no comment.

Selected comments on value for money in the resettlement programme

"Not in cash terms, but like all major policies that change the landscape, it was perceived as the right thing to do, and that is still the case. In ten years time, if peoples' lives are better, then it will be viewed as a success."

"So far as the money being spent on it is concerned – it is not a cheaper option than keeping people in hospital. Housing and supporting people in the community is more expensive. In the wider context and looking at the social and economic benefits that have been achieved, yes it is value for money – and of course the difference it makes to people's lives is very significant."

"That is a good question. The charge we usually face is that we are doing this on the cheap to save money. However, the reality is that resettlement is costing more than it used to cost to keep people in hospital. But it is good value for money if it adds to the quality of peoples' lives and upholds the principles of equality and inclusion."

"Yes, but it should have provided better value for money if the market had been broadened through a tendering process in advance. Also, with hindsight, staff skills should have been enhanced to give the programme impetus."

"No, because it is always going to be more expensive than keeping someone in a large hospital. But in terms of peoples' lives it has been very cost effective. I would want this for my relative. It is the right thing to do irrespective of the cost. But this last year, the costs will be very high as people with challenging issues are resettled."

"I do not have any evidence for or against. I do have concerns that the intended benefits have not been clearly articulated, so how do we evaluate the programme or 'betterment'."

Interviewees said that purely in cost terms resettlement was more expensive than keeping people in hospital. When the social and economic benefits of the programme were taken into account, however, then most thought that it did represent value for money. Several participants said that value for money could have been better if fully-costed model services had been developed as exemplars, and if a market for resettlement services had been developed through open procurement and competitive tendering.

PART 3: RESETTLEMENT IN GREAT BRITAIN AND THE REPUBLIC OF IRELAND

3.1 CHANGING APPROACHES TO THE PROVISION OF SERVICES FOR LEARNING-DISABLED PEOPLE IN GREAT BRITAIN

This section of the report reviews changing approaches to policy and the provision of services for learning-disabled people in GB and the RoI since the 1990s, as a basis for comparisons with and lessons for the resettlement process in Northern Ireland. Drawing on previous research by the Housing and Support Alliance[95], it also identifies the variety of different models of housing, care and support that have been adopted in England compared with the models that were found by this research in Northern Ireland. Appendix 4 provides more information about the English models of provision.

3.1.1 Policy on learning disability in Great Britain

In 1974 there were 10,496 places provided by the National Health Service in homes and hostels in the community[96] across the UK, but there were still 55,150 beds in hospitals for the 'mentally handicapped'. The UK Government White Paper, *Better Services for the Mentally Handicapped* [97] in 1971 advocated a 50% reduction in long stay hospital placements by 1991 through increasing the provision of local authority residential care places. However, progress in resettling people from hospitals into the community was slow in GB, as it was in NI.

By the 1980s it had become widely accepted that it was inhumane to keep learning-disabled people in hospitals for life. The seminal report *An Ordinary Life* (Kings Fund 1980)[98] promoted the concept that people with learning disabilities should live in ordinary houses, in ordinary streets and be part of ordinary communities. The *All Wales Mental Handicap Strategy*[99] (Welsh Office, 1983) advocated closure of long stay hospitals in ways that would enable people with learning disabilities to enjoy the full range of life opportunities and choices, have positive identities and roles in their families and communities, exercise choice and develop independence, self respect and self fulfilment.

Changing perceptions of learning disability began to place greater emphasis on the person's human rights, and the social barriers that exclude learning-disabled people from equal and full participation in community life. The concept of 'normalisation'[100] was promoted as a way of changing societal attitudes.

"The reality that not all people are positively valued in their society makes social role valorisation so important ... It can help not only to prevent bad things from happening to socially vulnerable or devalued people, but can also increase the likelihood that they will experience the good things in life. Unfortunately, the good things in life are usually not

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[95] The Housing and Support Alliance is a national charity and membership organisation working with people with learning disabilities, families, advocacy organisations, housing and support providers and commissioners.

[96] *Hansard*, 6 July 1976, (quoted in Psychological Medicine, 1977, 7, 561 – 563)

[97] Department of Health and Social Security. (1971). *Better Services for the Mentally Handicapped* London: DHSS

[98] Kings Fund. (1980). *An Ordinary Life: Comprehensive locally based residential services for mentally handicapped people,* London: Kings Fund.

[99] Welsh Office (1983), *All Wales Mental Handicap Strategy*

[100] Wolfensberger, W. (1992). A *brief introduction to Social Role Valorization as a high-order concept for structuring human services.* (2nd (rev.) ed.). Syracuse, NY: Training Institute for Human Service Planning, Leadership and Change Agentry (Syracuse University).

accorded to people who are devalued in society. For them, many or most good things are beyond reach, denied, withheld, or at least harder to attain. Instead, what might be called 'the bad things in life' are imposed upon them, such as:

1. *being perceived and interpreted as "deviant" due to their negatively-valued differentness. The latter could consist of physical or functional impairments, low competence, a particular ethnic identity, certain behaviours or associations, skin color, and many others;*
2. *being rejected by community, society, and even family and services;*
3. *being cast into negative social roles, some of which can be severely negative, such as 'subhuman', 'a menace', and 'a burden on society';*
4. *being put and kept at a social or physical distance, the latter most commonly by segregation;*
5. *having negative images (including language) attached to them;*
6. *being the object of abuse, violence and brutalization.*

"This is why having at least some valued social roles is so important. In fact, a person who fills valued social roles is likely to be treated much better than people who have the same devalued characteristics, but who do not have equally valued social roles. This is because when a person holds valued social roles, attributes of theirs that might otherwise be viewed negatively are much more apt to be put up with, or overlooked, or dismissed as relatively unimportant." [101]

Thinking also began to change about the nature of services for learning-disabled people, with a shift away from the 'medical model' of service provision which emphasised 'treatment', to a 'social model'[102] where the focus became less about fixing the disability more about removing societal barriers so that disabled people could lead equal lives.

Resettlement outside hospital became the dominant policy throughout the UK from 1990 onwards. The *NHS and Community Care Act (DHSS, 19*90) was a watershed. The Act had a significant impact on the closure of long stay hospitals with a new focus on people with learning disabilities living in well-supported domestic settings that provided flexible care and that were responsive to user and carer needs and preferences. This shift towards a needs-based approach to planning and a mixed economy of services created a greater drive towards community based services. Long stay hospital closure activity increased as a result of the Act.

Despite the focus of the 1990 Community Care Act being on ordinary homes with support however, the majority of people moving-on from long stay hospitals were placed in residential care or group homes. In this period there was a reduction in local authority-run residential homes[103] and an increase in residential care provision from the private and voluntary sectors. Whilst it was reported that many learning-disabled people moving out of institutions were experiencing a better quality of life, there were also concerns that too

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[101] The theory is well summarised using accessible language in: Osburn, J. (1998), *An Overview of Social Role Valorization Theory*, in The International Social Role Valorization Journal/La revue internationale de la Valorisation des roles sociaux, *3*(1), 7-12.

[102] The medical model of disability sees disability purely as a problem of the individual. To put it simply, a disabled person is seen as faulty and in need of treatment through clinical intervention. As a result, disabled people are by definition dependent on others to decide on appropriate treatment and care, and how they should live their lives. The social model recognises that disabled people face disadvantage because their needs are not fully considered in the way that public policy is developed; because of the barriers that are created by an inaccessible physical and institutional environment; and because of direct and indirect discrimination.

[103] Hatton, E. E. (2008). *People with Learning Disabilities in England,* Centre for Disability Research, Lancaster University

many people were living in large scale (i.e. 'congregate') settings that were still institutional in their approach.

A study by Emerson *et al* at Lancaster University [104] concluded that quality of life for learning-disabled people was enhanced in smaller residential settings and that quality of life outcomes were poor in larger congregate type residential care. The type of services that had been developed as part of the long stay hospital closure programmes in England - large residential homes, hostels and NHS campuses - were found to be associated with poorer outcomes than smaller, more homely environments. The study also found that the Welsh and Scottish long stay hospital closure programmes had moved larger numbers of people directly into smaller, homely settings in comparison with the English programme.

In England, Scotland and Wales, strategies were developed that reflected these and similar research findings, and which focussed on independence, equality, rights, choice and control. In England, *Valuing People: A new strategy for the 21st Century* (Department of Health, 2001); In Scotland, *The Same as You, A Review of Services for People with Learning Disabilities* (Scottish Executive, 2000); and in Wales *Fulfilling Lives* (Learning Disability Advisory Group 2001) all strengthened the messages that people with learning disabilities needed real choice in where they lived; and that residential care should not be a default option. *Valuing People* explicitly stated that, with the right support, people with learning disabilities could live in ordinary housing regardless of the level of their disability.

This body of work had a significant impact on the development of public policy and the attitudes of those caring for people with learning disabilities. It influenced the thinking of the Bamford Review Group[105]. Caring moved away from intervention and 'looking after' the disabled person to a more enabling role that encouraged self-help and independence. It was recognised that life in a hospital setting deprived learning-disabled people of the opportunity to live in an ordinary house and to take part in activities in their local community. The personal identity and rights of people with learning disabilities within a long stay hospital setting were clearly not the priority. There was a new emphasis in policy on the resettlement of people from hospitals into the community where they could live a more normal life.

Despite these stronger messages, the shift away from residential care for people with learning disabilities only began to happen on any scale with the introduction of the *Supporting People Programme* in 2003, when funding incentives were made available to develop supported housing and supported independent living. Between 2003 and 2009 a total of 31,238 people with learning disabilities in England received a package of housing with support funded by Supporting People[106].

Even under the Supporting People programme, however, there were widely held assumptions that supported housing and supported living arrangements were only suitable for people with mild to moderate learning disabilities.[107] Thus services developed under Supporting People were mainly targeted at these groups[108]. As long stay hospitals closed, it was people with profound and multiple learning disabilities and challenging behaviour that remained as the last people to move out. Because of the gap in local services for this group and the subsequent NHS Campus Closure Programme, the private sector filled these gaps.

[104] Emerson E et al (1999) *Quality and costs of residential supports for people with learning disabilities*, Lancaster University

[105] Bamford (2005) *op. cit.*, page 16, para 3.6

[106] Department for Communities and Local Government, 2009

[107] There was a similar comment from one of the people interviewed in Northern Ireland.

[108] Joseph Rowntree Foundation (2007*), The impact of the supporting people programme on adults with learning disabilities.* JRF: York

As a result there was actually an increase in in-patient and specialist healthcare provision for people with the most complex care needs. Between 2006 and 2010, while there was a 34% decrease in the number of inpatients in NHS learning disability provider services, there was a 15% rise in the number of inpatients living in independent sector learning disability provider services[109]. Essentially what was being developed was a new form of long stay hospital that meant people with learning disabilities were being placed away from their families and communities in the same way they had been in long stay hospitals in previous decades.

The *United Nations Convention on the Rights of Persons with Disabilities* (United Nations, 2006)[110], to which the UK government is a signatory, sets international standards for the rights of disabled people to live in the community. *Improving the Life Chances of Disabled People* (Cabinet Office 2006) set out commitments across government to meet the policy aims of independent living for people with a disability. *Putting People First* (Centre for Policy on Ageing, 2008) was a multi-agency commitment to self directed support and personalisation that had resulted from a successful piloting of individual budgets for people with learning disabilities. *Valuing People Now* (DoH 2009) was a refreshed strategy for learning disability services that was linked to a 3 year delivery programme that included a NHS campus closure programme. *Valuing People Now* was supported by Public Service Agreement (PSA) 16, which measured the number of adults with a learning disability known to social services who were moving into settled accommodation outside NHS campuses or registered care homes.

Following the international banking crisis of 2008/2009, the UK Government decided to cut public spending. Funding for the Supporting People programme, which had been ring-fenced since 2003, was incorporated into the local authority Area Based Grants system. The ring fence was removed in the interests of bringing about: *"... greater flexibility for local areas in delivering their own priorities for housing-related support and wider welfare and other services"*[111].

After the 2010 general election, PSA 16 became obsolete. The Department of Health's Valuing People Implementation Team and the Department for Communities and Local Government's Supporting People Monitoring Team were dismantled. The Localism Act 2011 shifted emphasis to local authority-led decision making about planning, public services and housing policy. Welfare Reform has further restricted the availability of funding for housing and the income of people with mild to moderate learning disabilities. Taken together, all these factors have meant that those people with mild to moderate learning disabilities who have previously had housing-related support services paid for by Supporting People Grant are now being assessed under increasingly stringent adult social care criteria and in some areas are having services reduced or taken away. There is currently a loss of confidence within the supported housing sector which has tended to postpone the development of new services with little increase in the number of people with learning disabilities living independently[112].

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[109] Improving Health and Lives Learning Disabilities Observatory (2011), *People with Learning Disabilities in England,* IHAL.

[110] *The United Nations Convention on the Rights of Persons with Disabilities* (United Nations, 2006) came into force in May 2008. Under Article 19, States that are party to the Convention including the UK: *"... recognise the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in a normal life."*

[111] *House of Commons Communities and Local Government Committee Session 1998 – 1999* (October 2009), Volume 1, paragraph 188

[112] Mencap (December 2012), *Housing for People with a Learning Disability,* London: Mencap

A view has developed among some commissioners and providers that supported living has become a service type with an associated funding pot reflecting institutional bias in the way vulnerable people should live rather than an ethos influencing the ways in which people can be supported to have real choice and control over their lives.

"The reality for many people accessing support from organisations is that there is often a worrying lack of control over who supports them, when the support is received and how this attends to what really matters to them as individuals. The care and support industry has placed so much importance on meeting minimum standards and professionalising that the most important aspects of care and support, such as human connection and listening to what people want and then doing it, have been lost."[113]

Approaches such as the Reach standards are intended to ensure that there are clear aims and standards for supported living that promote self-determination, inclusion, personalised support and an 'ordinary life'. [114]

With 30 years of policy that has directed and supported long stay hospital closure, all NHS long-stay hospitals finally closed in Wales in 2006 and in England in 2009. In Scotland, there were approximately 200 people still living in long-stay hospitals in 2014.

3.1.2 Republic of Ireland policy on learning disability

The Republic of Ireland (RoI) government first recommended an end to the admission of people with learning disabilities into psychiatric hospitals in 1984[115]. However, many people with learning disabilities continued to live in inappropriate psychiatric settings until the 1990s when a programme for moving the remaining people from these settings began[116]. In 1997 a strategy to move people with learning disabilities out of institutions was outlined in the report, *Services to Persons with a Mental Handicap/Intellectual Disability: Assessment of Need 1997-2001*[117]. This was followed by a *National Disability Strategy* launched in 2004 with a policy of enabling disabled people to access mainstream services. *The Congregate Settings Report*[118] found that more than 4,000 people within the RoI lived in congregate settings (defined as institutional settings with more than 10 residents – a greater number than was adopted in Bamford's definition), of which 93% had a learning disability and 7% had a physical disability.

F. Kelly (2012) explored changes in provision in the period 1999 - 2009 for nearly 8,000 adults living in either congregate or community-based accommodation[119]. Kelly found that, during this period, there was a marked rise in the numbers of people with learning disabilities living in community group homes in the Republic and that, by 2009, just under 50% of people with learning disabilities lived in community settings. The author concluded that:

" ... *although there was a reduction in the number of places in congregated options over the decade, this was not uniform in that increased numbers of persons were living in new forms of congregated provision designated as specialist units*."

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[113] Warren S, Wood A and Maguire S (2013) *op. cit.*, page 5

[114] Warren S, Wood A and Maguire S (2013) *op. cit.*, page 1

[115] G. Holt et al (2000). BIOMED-MEROPE project: service provision for adults with intellectual disability: a European comparison. *Journal of Intellectual Disability Research*

[116] Department of the Environment, 2011

[117] Irish Department of Health, 1997

[118] HSE (2011). *Time to Move on from Congregate Settings*, HSE

[119] Kelly F (2012), *Changes in the provision of residential care for adults with an intellectual disability: a national longitudinal study*

Kelly also found that:

" ... despite unprecedented increased investment in services in this period, on average only 70 new places were created per annum – a 1 per cent increase on total places."[120]

Kelly concluded that institutional models were likely to persist unless there was sustained investment in new models of provision that could be achieved through a planned transfer of resources.

The National Housing Strategy for People with a Disability 2011-2016 reinforced the drive to move people out of institutions with specific aims to:

" ... promote and mainstream equality of access for people with a disability to the full range of housing options available suited to individual and household need... all people with disabilities, including those residing in institutions, are entitled to undergo an assessment of housing need".

As was the case in England, Scotland, Wales and (on the evidence of this research, in some cases in Northern Ireland), the Republic of Ireland replaced institutions with structures that replicated the behaviour of institutions, even if they were smaller in scale. Whilst these services may have improved outcomes over long stay hospitals, they often segregated people from their communities and did not offer a 'normal' life that included friendships, relationships and a community life. In a paper from the National Disability Authority, it was noted that:

"*Greater usage of natural supports can potentially provide benefits for people with disabilities, in terms of their greater independence and for the State, in terms of more cost effective services".*[121]

In the Republic of Ireland there were still 147 people that needed to move on from hospitals at the end of 2010.

3.1.3 Lessons for Northern Ireland

As part of this research, interviews were conducted with Dr Simon Duffy[122] of the Centre for Welfare Reform, and Professor Chris Hatton[123] of Lancaster University. The interviews explored where de-institutionalisation has worked in England, Scotland and Wales, where it has been less successful, and what needs to be done to promote real independence for learning-disabled people. The purpose of each interview was to identify the lessons learned from the resettlement programme that might benefit the process in Northern Ireland.

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[120] Kelly F (2012), *op cit.*,

[121] National Disability Authority. (2011). *A Review of Literature on Natural Community Supports.* NDA

[122] Dr Simon Duffy is Director of The Centre for Welfare Reform; Chair of the Housing & Support Alliance; a policy advisor to the Campaign for a Fair Society; and Honorary Senior Research Fellow at the University of Birmingham's Health Service Management Centre.

[123] Chris Hatton is Professor of Psychology, Health and Social Care at the Centre for Disability Research, University of Lancaster; Co-Director of Improving Health and Lives - the Public Health England Specialist Learning Disabilities Public Health Observatory; and Regional Co-Director of the NIHR Research Design Service North West.

Dr Simon Duffy

Dr Duffy said that the early years of hospital closure in England were fixated on creating large units in the community and a new type of institution, albeit a smaller institution than existed with NHS hospitals. Supported living[124] did not register as an option with policy makers at the time. First phase solutions to hospital closure were 'immature'. In his view, **de-institutionalisation programmes were led by commissioning, procurement and tendering processes that commoditised housing and care solutions, instead of working around individuals to create appropriate and sustainable solutions.**

Scotland began a hospital closure programme later than England and benefitted from the experience gained south of the Border. The programme had more of a rights-based approach. People with learning disabilities were obtaining their own homes, jobs and personalised support. In Scotland, the hospital closure programme developed approaches like *Inclusion Glasgow*[125] where personalised solutions were developed for the people with the most complex needs.

Dr Duffy believes that the style of change when closing hospitals is important. He says that it is difficult to bring about change in structures, especially within bureaucratic systems or where there is no vision, leadership or trust. The processes of change in England were often based on a lack of trust in people with learning disabilities, families and the people employed to support them. Whereas, in Lanarkshire, he saw leaders that had a vision and were able to share that vision with the wider community and find talented people whom they trusted to set up new housing and support services. This led to services that were set up around individual needs, and which have not become outdated models as many of the services set up as a result of closing institutions in England.

Reflecting on lessons learned from being involved in the closure of long stay hospitals in England and Scotland, Dr Duffy offered the following advice:

"Firstly, stop segregating people. Don't go into the business of building group homes as the solution. Reconnect people to their families and communities and support people to have love and relationships in their lives.

"Second, don't go down the commissioning and procurement route. There are obvious opportunities to link hospital closure with self- directed support, attach the funding and support to individuals, and work with care providers to develop Individual Service Funds. Too much power higher up in the process slows everything down. You need mechanical processes to devolve power and let people get on with it."

Professor Chris Hatton

Professor Chris Hatton had wide experience of the long stay hospital closure programmes in Wales and England. He said that in Wales, finance was a major driver for hospital closure. There were poor quality buildings that would have needed a great deal of investment to refurbish, and there would be a significant capital receipt in selling off hospital sites. Thus the initial approach of the *All Wales Strategy* was to build up community services for people with learning disabilities moving on from hospital. However, as these new services quickly became filled with people already living in the community, there was a change of approach. A command and control structure for closing hospitals was instituted, with funding attached to the programme.

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[124] There is no legal definition of supported living, but the term refers to models of housing and support that are built around an individual or a group of individuals and that are separate from housing and personal/domiciliary care functions.

[125] http://inclusion-glasgow.org.uk/

In England, Professor Hatton believes that the hospital closure programme has not resulted in the closure of institutions, with many smaller types of institution still being provided particularly for those with more complex needs. He believes the main reasons for this are that there is a deeply held belief that people with learning disabilities still need safety and separation from the community and as a consequence services have not been developed to meet peoples' needs in their communities. He pointed out that research clearly shows that the more individualised the approach to housing and support, the better the outcomes for individuals are.

Studies consistently show that living in smaller groups has better outcomes than living in larger groups; that challenging behaviour is a function of living in institutional environments; that retaining contacts with people they know and like is related to better quality of life; and that being part of a community, having connections, experiencing belonging and love all relate to better quality of life outcomes.

Professor Hatton offered the following reflections in thinking about the continuation of closing institutions in Northern Ireland.

"Leave behind the belief that learning-disabled people need institutions and don't build specialised houses. More imagination is needed in what we can do to support people - we need to develop better ways to take small scale innovations and scale up and introduce models like Shared Lives[126] *and the Keyring Community Support Network model*[127] [128]*.*

"There are advantages if the care market has not been over developed and professionalised. Use this advantage to work with providers and staff to develop more natural models of support.

"Make sure there are enough good people to lead the process - invest in leadership and vision. Work alongside people with learning disabilities, families and staff, sharing the planning and process of move on.

"Experience has been that most families oppose closure of institutions but also report better outcomes and satisfaction with move-on services. This is evidenced in the Norwegian study of family attitudes to long stay hospital closure Family attitudes to de-institutionalisation: changes during and after reform years in a Scandinavian country".[129]

"Northern Ireland has greater command and control potential because of its government structure so this should be used to its advantage in closing institutions. Northern Ireland has the advantage of dealing with segregated communities and can bring this knowledge and experience to avoid the segregation of people with learning disabilities.

3.1.4 The most successful models of housing, care and support from the perspective of resettlement and integration into community life

In the past, the options for someone leaving a long stay hospital were limited to either a nursing home, a residential care home or a return home to live with the family. In England, a wide variety of models of accommodation have been developed that offer greater choice and more opportunities for independence. Some of these have support or care 'built-in' as part of the service; others have separated out accommodation from care and support.

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[126] http://www.sharedlivesplus.org.uk/

[127] http://www.keyring.org/Home

[128] These and other approaches to providing housing with support for learning-disabled people are described in the next section of this report, Appendix 4 and in more detail in Working Paper 2 accompanying this research report.

[129] Lundeby, J. T. (2006). *Family attitudes to deinstitutionalisation: changes during and after reform years in a Scandinavian country*. Journal of Intellectual and Developmental Disability, 115-119.

Table 25 below compares the models of housing care and support that have been adopted in England with the models that have been identified in the research undertaken to date in Northern Ireland.

Table 25: Models of housing, care and support adopted in England compared with the models identified in Northern Ireland

Models adopted in England	**Was the model identified in Northern Ireland in this research** Note
Provision of separate housing, care and support services	
Supporting People-funded Floating Support Services	Yes
Rented social housing	Yes – Supporting People-funded services may be provided in either social or private rented housing
Private Sector Renting	
Specialist Buy to Let, New Build and Refurbishment Schemes	Not identified so far
Home Ownership	
Various approaches to home ownership exist including: family purchase of a house for the disabled person to live in; Buy to Rent; Privately Financed Shared Ownership; Company Ownership; Inheritance; Discretionary Trusts	It is inevitable that one or more of these approaches to home ownership exists in NI, but it was not part of this research to identify forms of home ownership.
Housing, Care and Support Together (Accommodation Based Services)	
Supporting People-funded accommodation-based services	Yes
Unregistered adult placements (now known in England as 'Shared Lives')	Yes
Unregistered shared group homes	Not identified so far
Extra Care, Sheltered Housing and Core and Cluster	Yes
Residential Care	Yes
Intentional Communities	Not identified so far. There is a debate in England about whether this approach is the right one.
Other forms of support	
Supported Lodgings	Not identified so far
Support Tenants	Not identified so far
Community Support Networks – Keyring	Not identified so far

Note: The fact that a model of housing, care and support has not been identified in this research does not imply that there are no examples in Northern Ireland.

Appendix 4 gives an over-view of the models of housing, care and support that have been adopted in England. A more detailed version of this appendix is available as a separate working paper that is circulated with this report.[130]

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[130] North Harbour Consulting (2014), *Bamford Review: Resettlement of learning-disabled people from long-stay hospitals; Working paper 2: Models of housing and support used for learning-disabled people and others with specialised housing and support needs in England*. The working paper describes each type of housing, care and support service; how the service is accessed by a learning-disabled person; the pros and cons of each service; and how the service is funded. We are grateful to the Housing and Support Alliance for allowing us to draw on previous work they have undertaken in this field.

One way the inherent problems of shared group housing or living in large institutions can be overcome has been for people to have the opportunity to live with a family, in supported lodgings or with another tenant who provides them with support. Accommodation with a family, where sharing family life is part of the arrangement, is referred to as Shared Lives (formerly Adult Placement).

Accommodation in the home of a landlord where family life is not shared is known as Supported Lodgings. Confusingly some Shared Lives families are also called Supported Lodgings providers. This usually means that they offer a lower level of support which is often housing related. Shared Lives families can offer a full range of support including personal care. Supported Lodgings providers do not offer personal care. A support tenant shares the home of someone who has a learning disability. People using both type of scheme have to be over 18 years of age. There is no upper age limit. The two types of scheme are funded differently and are subject to different levels of support and supervision.

Even where some of these models of housing, care and support are to be found in NI, there is a wider question about whether approaches to independent living other than conventional supported housing are being promoted as policy. Further enquiries will be made as part of Phase 2 of the research. As Appendix 4 and the associated working paper demonstrate, there can be many advantages in adopting these models of provision if promoting independence is the goal.

APPENDIX 1

CONSULTATIONS WITH POLICYMAKERS, COMMISSIONERS AND SERVICE PROVIDERS

Research methods

A list of potential participants was agreed between the research team and the Project Advisory Group, with additional suggestions from the Northern Ireland Housing Executive ('NIHE') Research and Supporting People Teams. Participants were drawn from a cross-section of people involved in resettlement policy, planning, commissioning and service delivery.

Thirteen participants were contacted in advance by email, invited to take part and briefed on the purpose of the interviews. A short paper accompanied the initial email explaining the aims and methods of the research, together with a list of the themes to be covered. This was followed up where necessary by telephone. All those invited agreed to participate.

A semi-structured interview schedule was drafted within the research team and agreed with the NIHE research unit AND THE Project Advisory Group which included representatives from NI Government Departments, the H&SC Board and Trusts, the Housing Executive and provider organisations. A copy of the interview schedule is contained in Appendix A. The schedule was used to structure the interviews and was divided into four sections:

- the participant's role in planning or delivering the learning disability resettlement programme;
- progress in the resettlement of learning-disabled people from hospital since 2007[131], and their comments on the key issues affecting the rate of resettlement;
- questions about the provision of accommodation and support for resettled people – who does what, standards and benefits, and how quality is being assessed;
- views about the aims of the resettlement policy and whether they are being achieved in terms of the betterment of people after resettlement, and from a residents', public policy and value for money perspective.

Each participant's response to the questions was typed verbatim on an interview schedule, and an edited copy of the interview notes was subsequently sent to each participant for their approval.

The interview schedule provided a framework for discussion and the generation of comparative data based on each interviewee's personal responses to a series of specific questions and issues. The same questions were asked regardless of the participant's role in the resettlement process. This qualitative approach provided a valuable range of insights into expert opinion on the resettlement programme, its strengths and weaknesses.

The results of these consultations have been used to illustrate and inform parts of this report, and anonymised quotes have been used where relevant. Readers should note that each comment represents an individual's perspective on an aspect of the learning disability resettlement programme based on their particular experience from which trends and extrapolations should not necessarily be drawn. The researchers have used the results of interviews alongside documentary and data evidence to arrive at informed conclusions

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[131] The date Equal Lives was published

The participants

Thirteen people were interviewed. Participants included senior managers from:

- the two Government Departments most closely involved in the learning disability resettlement programme - the Department of Health, Social Services and Public Safety (DHSSPS), and the Department for Social Development (DSD);
- the Health and Social Care Board (the Board);
- four of the five Health and Social Care Trusts (the Trust(s));
- the Regulation and Quality Improvement Authority (RQIA);
- two provider organisations – a charity specialising in the provision of services to learning-disabled people and a specialist registered housing association; and
- the Northern Ireland Federation of Housing Associations (NIFHA).

A list of people interviewed and their roles in the resettlement programme is attached in Appendix B. Additional interviews with service managers who have responsibility for front-line housing and support services, and a workshop for policymakers and commissioners to review research findings and preliminary conclusions, will be carried out in Part 2 of the research[132].

Each participant described their role in the resettlement programme. Two participants said that their role lay primarily in the field of policy, with some overlap into programme funding; two participants said that their primary role was in managing the delivery of front line housing and support services; and two participants said that they were not directly involved in the programme but had responsibilities for regulation in one case and for representing housing association and managing agent interests on the other. The remainder said that their role involved a combination of commissioning, programme management and in some cases oversight of in-house and external service delivery.

Respondents were asked to respond in a personal capacity rather than giving an official departmental or organisational view. They were informed that their personal views would be treated in confidence and reported anonymously. In most cases respondents did give a personal view, although a small number of responses to some questions appeared to be non-committal. In reporting the results of these interviews, the majority of responses have either been aggregated or anonymised to uphold the guarantee of confidentiality and anonymity that was given at the start of each interview. At the end of each interview, the notes were edited and a copy was sent to the interviewee for agreement.

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[132] The research was planned as a single project divided into two parts – contextual research giving background on the learning disability hospital resettlement programme, and interviews with 50 resettled people and their carers. After the research started the Northern Ireland Housing Executive and the research team were informed that the second part of the research involving interviews with resettled people would require approval from the five H&SC Trust Research Ethics Committees. As a consequence the Housing Executive has decided in agreement with North Harbour Consulting (the research contractor) that the research will be divided into two separate contracts, the second of which will be retendered. References to 'Part 2' of the research should therefore be understood to mean that the intention is to carry out a number of tasks to augment the information reported as Part 1 of the research, subject to a successful re-tender by the current research team and subject to contract.

Participants in the consultation interviews

Name	Role	Responsibility within the resettlement programme
Neil Magowan	Head of Learning Disability Policy, DHSSPS	Policy on learning disability and, to a lesser degree, facilitating funding bids.
Stephen Martin	Deputy Director, Housing Policy Delivery, DSD	Responsibility for policy and funding for (a) HA development programme and (b) SP programme.
Aidan Murray	Assistant Director, Mental Health and Learning Disability Services, H&SC Board	Chair of the LD community integration project team; representative from the project team on the community integration programme board co-chaired by Fionnuala McAndrew and Brian O'Kane; represent the Board on the SP Commissioning Body which reviews plans and proposals; executive responsibility for the entirety of the Resettlement Primary Target List programme; seeking required funding from DHSSPS based on the number of people in the PTL; then have a role in accountability for delivery including the reshaping of hospital services post-resettlement.
Linus McLaughlin	Performance Manager, Performance Management and Service Improvement Directorate, H &SC Board	To identify the number of patients in the PTL list remaining to be resettled and agreeing this with the Trusts; to agree the resettlement plans 2012 – 2015; to set up and manage the process for monitoring progress against those plans and targets; to report progress to the Community Integration Programme Board.
Brian O'Kane	Acting Assistant Director, Supporting People, NIHE	SP's role is to commission capital and revenue supported accommodation inc housing. We give the Assistant Director, Development Programme, NIHE, a supported housing capital programme.
Dermot Parsons	Deputy Director, RQIA	Regulation of care services that people receive in their own homes – the 'care' part of 'care and support'; governance assurance of the processes that Trusts follow in resettling people.
John Veitch	Co-Director for Learning and Children's Disability Services, Belfast Trust	As co-director for LD and children's' disability services, responsible for all community based services within the Trust area, and for the hospital residents from Belfast, plus management of Muckamore Abbey Hospital – a regional hospital for LD forensic services, and the primary hospital from Belfast, Northern and SE Trusts.
Alyson Dunn	Assistant Director, Learning Disabilities, Northern Trust	Senior manager responsible for delivery of the programme of care service delivery. That involves a combination of planning, commissioning and operationalising services; and covers community based services, day services, respite services, residential services, and domiciliary care.
Carole Veitch	Operations Manager, Adult Disability Services, South Eastern Trust	Manager driving the hospital resettlement agenda within the Trust with links to the regional group, community services, and with responsibility for identifying individuals for resettlement.
Noreen McComiskey	Assistant Director, Learning Disability Services, Southern Trust	To deliver learning disability resettlement and develop new services.
Rosaleen Harkin	Assistant Director, Learning Disability Services, Western Trust	Oversee the implementation of the DHSSPS targets for the PTL and DD hospital cohorts.

Deirdre McGuile*	Service Manager, Triangle HA	To deliver effective services in line with organisational values and mission and to ensure that there is a high standard f care and support. Triangle is also the housing provider.
Dirk Halfenberg	Assistant Director, NIAMH	The role is to oversee the operational running of the schemes in Armagh, Antrim and Belfast where we have resettled several service users from hospital. All have a service manager.
Cameron Watt	Chief Executive, Northern Ireland Federation of Housing Associations (NIFHA)	NIFHA represents HAs in NI. They are major care and support providers, directly and in partnership with managing charities and Trusts. This is an increasingly complex and risky area for NIFHA members. Funding streams and the future of SP are all issues that are regularly discussed. I have been involved with the CRISP Committee and have made an input into consultations.

APPENDIX 2

SEMI-STRUCTURED INTERVIEW SCHEDULE

Name of Interviewee			
Position			
Organisation Name		Type of Organisation	
Location of interview			
Date of Interview		Time of Interview	
Interviewer comments			

1.0 I would like to ask you first about your own role in delivering the resettlement programme						
1.1 In general terms, what is your role?						
1.2 Would you describe yourself as one of the following? SHOW CARD						
Policymaker?	Planner?	Commissioner?	Funder?	Service Provider?	A combination of these?	None of these
If 'a combination' or 'none of these' please explain:						
1.3 Specifically, what responsibilities for aspects of the resettlement programme do you have?						

2.0 Progress in the resettlement of people with learning disabilities since the publication of <u>Equal Lives – Review of Policy and Services for People with a Learning Disability in Northern Ireland</u> (Bamford 2005)			
First, I'd like to explore your perceptions of the progress that was made in resettling people with learning disabilities from long stay hospitals in the four years immediately following the publication of Equal Lives in 2005 up to the Northern Ireland Audit Office report <u>'Resettlement of long stay patients from learning disability hospitals'</u> in 2009. Please say whether you <u>agree</u> or <u>disagree</u> with the following statement.			
2.1 The rate of resettlement was <u>lower</u>, at about the <u>same level</u> as, or <u>higher</u> than expected between 2005 and 2009. SHOW CARD			
Lower	At the same level	Higher	Don't know
Do you have any comments on the rate of resettlement in that period?			
2.2 Does your response relate to the whole of Northern Ireland or a particular geographical area/areas?			
Whole of NI?		Particular area(s)	
If a particular area, say which			
Next, I'd like to explore your perceptions of the progress that has been made in resettling people with learning disabilities from long stay hospitals in the five years since the Northern Ireland Audit Office report on the resettlement programme in 2009. Please say whether you <u>agree</u> or <u>disagree</u> with the following statement.			
2.3 The rate of resettlement has been <u>lower</u>, at about the <u>same level</u> as, or <u>higher</u> than expected between 2009 and 2014. SHOW CARD			
Lower	At the same level	Higher	Don't know
Do you have any comments on the rate of resettlement in this more recent period?			
2.4 Once again, does your response relate to the whole of Northern Ireland or a particular geographical area/areas?			
Whole of NI?		Particular area(s)	
If a particular area, say which			
2.5 Please comment on the influence that each of the following factors has had on the rate of resettlement between 2009 and 2014. SHOW OPTIONS ON CARD			

	Very significant	Significant	Slightly significant	Not at all significant	Don't know
The level of resources allocated to the programme as a whole?					
The targeting of resources to different aspects of the programme?					
The effectiveness of inter-department and inter-agency collaboration?					
The need for cultural change to overcome low expectations of the ability of people with learning disabilities to leave hospital and live in the community?					
Prompt: Where do low expectations come from?	Residents	Families	Commissioners	Provider organisations	Front line staff
The availability of appropriate accommodation and support services in the right locations in the community?					
The availability of appropriate access to day care, educational provision, work and social activities for resettled people?					
The availability of community support services for family carers?					
The difficulty of finding appropriate accommodation placements for residents?					
The difficulty of assessing and/or ensuring that residents were 'resettlement ready'?					
The reluctance of residents and/or families for them to leave long stay hospital?					
Other factor(s)					

2.6 Please identify up to five factors that you think had the most significant influence on the rate of resettlement of people with learning disabilities into the community between 2009 and 2014

	Very significant	Significant	Slightly significant	Not at all significant	Don't know
The level of resources allocated to the programme as a whole?					
The targeting of resources to different aspects of the programme?					
The effectiveness of inter-department and inter-agency collaboration?					
The need for cultural change to overcome low expectations of the ability of people with learning disabilities to leave hospital and live in the community?					
The availability of appropriate accommodation and support services in the right location in the community?					
The availability of appropriate access to day					

care, educational provision, work and social activities for resettled people?					
The availability of community support services for family carers?					
The difficulty of finding appropriate accommodation placements?					
The difficulty of assessing and/or ensuring that residents were 'resettlement ready'?					
The reluctance of residents and/or families for them to leave long stay hospital?					
Other factor					

2.7 Please comment on why you have chosen your five most significant factors?

2.8 Are there any other factors that you think helped to promote resettlement or which acted as barriers to resettlement?

<u>Promoted resettlement:</u>

<u>Barriers to resettlement:</u>

2.9 What do you think are the most important current issues for policymakers, commissioning and delivery bodies in progressing resettlement?

2.10 On the assumption that most of the people who are easiest to resettle into the community have now been resettled, what are the main difficulties in resettling people with moderate to severe learning disabilities, challenging behaviours or forensic background (e.g. those detained via the Mental Health Acts and the Criminal Justice system)?

3.0 Questions about accommodation and support

I would now like to ask you some questions about post-resettlement accommodation and support.

3.1 Please describe how new accommodation schemes are commissioned.

3.2 Have there been any changes in the commissioning process since 2009? (Yes, go to 3.3; No, go to 3.4)

Yes		No	

3.3 If you answered 'Yes', what were they?

3.4 What criteria are currently being applied for new schemes in the commissioning process?

3.5 Do all schemes – new, recent and heritage - now follow the recommendations on size, arrangements and conditions set out in the Bamford Report on LD services? (Yes to 3.5; No to 3.4)

Yes		No	

3.6 If you answered 'No', in what ways do they differ

3.7 Do some schemes still offer similar arrangements and conditions to those found in a long stay hospital setting? (If Yes, go to 3.7; if No, go to 3.6)

Yes		No	

3.8 If you answered 'Yes', when will these schemes be recommissioned?

3.9 What have been the most successful models of housing, care and support from the perspective of resettlement and full integration into community life?

3.10 Is there now an extended range of different types of housing options developed to meet different needs as a result of the resettlement programme?.

Yes		No	

3.11 How effective has the resettlement process itself been?

Prompt: probe opinion on whether placements have been appropriate, people were fully prepared for the

move combined with the most appropriate models of housing, care and support etc.			
3.12 What do you see as the role of the Northern Ireland Housing Executive in planning and delivering appropriate accommodation required to support the resettlement programme?			
3.13 What do you see as the role of the NIHE Supporting People section in planning and delivering appropriate housing-related support required to support the resettlement programme?			
3.14 What do you see as the role of Health and Social Care Trusts in supporting and overseeing the delivery of housing and support for resettled people?			
3.15 How is quality in accommodation and support being assessed, and by whom?			
How assessed?			
By whom?			
4.0 Views about the aims of the resettlement programme and the extent to which they have been achieved			
4.1 What does the term 'betterment' as used in the Bamford Report on LD services mean for people who have been resettled from long stay hospitals? Prompt: probe both physical and emotional betterment.			
4.2 Can you give any examples?			
4.3 How is the betterment of people who have been resettled being assessed?			
4.4 What criteria are being used to make these assessments and who is making the assessment?			
Criteria:			
Who makes the assessment:			
4.5 How have the values set out in the Bamford Report (2005) been reflected in the way resettlement has taken place? Prompt: 'Citizenship', 'Social Integration and Inclusion', 'Empowerment', 'Working Together', 'Individual Support'			
4.6 Has the resettlement programme been a success from the residents' perspective?			
Yes		No	
4.7 Has the resettlement programme been successful in public policy terms?			
Yes		No	
4.8 Has the resettlement programme provided value for money to the public finances?			
Yes		No	
4.9 Do you have any final comments?			

Following the interview, we will proof read your answers then send them to you for comment to ensure that you are happy with their accuracy.

APPENDIX 3

ORGANISATIONS PROVIDING SUPPORTED HOUSING AND INDEPENDENT LIVING SERVICES FUNDED BY SUPPORTING PEOPLE GRANT

Adult Supported Living (Mr & Mrs Brook)

Apex Housing Association

Autism Initiatives

Belfast Health And Social Care Trust

Board Of Social Witness

Camphill Community Clanabogan

Camphill Community Mourne Grange

Camphill Trust

FACT

Fold HA

Kilcreggan Homes

Mainstay DRP

Mencap

Northern Health And Social Care Trust

Northern Ireland Institute For The Disabled

Oaklee Care and Support Services

Orchard Grove

Positive Futures

Praxis Care Group

Prospects

South Eastern Health And Social Care Trust

Southern Health And Social Care Trust

The Cedar Foundation

The Croft Community

Triangle Housing Association

Western Health And Social Care Trust

APPENDIX 4

MODELS OF HOUSING AND SUPPORT FOR LEARNING-DISABLED PEOPLE AND OTHERS WITH SPECIALISED NEEDS THAT HAVE BEEN ADOPTED IN ENGLAND[133]

Type of Service	**Description**
Supporting People-funded services	
Supporting People-funded accommodation-based services	Supporting People funding pays for services that support people to live independently, known as housing related support. This is delivered by staff in the individual's accommodation through accommodation-based support - staff based in the properties where tenants are living.
Supporting People-funded Floating Support Services	Floating Support services are generally offered to clients living in their own homes/tenancies. It enables them to gain skills and confidence to improve and develop skills to maintain their independence. It is not a service to do things for residents, but a service aimed at enabling people to take control of their lives and make their own decisions. The basic principles of the service are the same as for accommodation -based support.
Provision of separate housing, care and support services	
Rented social housing	Renting an ordinary house from a local authority or housing association is an increasingly common choice for learning-disabled people. If necessary the property can be adapted if it is not already suitable. Properties can be let to one person, or two or three people may share a property either as joint tenants or possibly with each having their own tenancy. Floating support and domiciliary care can be provided to learning-disabled people in their own home so this is a common route to independent supported living.
Private Sector Renting	This is renting an ordinary street property from a private landlord. Charitable organisations letting out properties to a particular needs group are, for rent and housing benefit purposes, also classed as private landlords despite the fact they are not trading for profit.
Specialist Buy to Let, New Build and Refurbishment Schemes	There are a range of specialist housing providers who are able to buy, build or develop accommodation to a specific brief. They may use private or public capital, or raise mortgages to fund this.
Forms of Family Investment: A family or other relatives may be able to provide housing directly. The main options are set out below, but the list is not exhaustive.	
Buy to Rent	Buy to rent is where a parent, or other close relative, buys (or builds) a property and then lets it out to their son or daughter or relation. The parents fund the acquisition commonly repaying the mortgage from the rent charged. This property may be any ordinary house, flat or bungalow – adapted if necessary. It can also be an annexe to the parent's home that is converted or a small bungalow built in the garden of the relatives own home.
Outright Purchase	Better off relatives may be able to buy a property, without borrowing, for their son or daughter to live in. In the long term the property could be: - Inherited on death of parent - Put into a Trust Gifted to a son/daughter now - Gifted or leased to a third party such as a Housing Association.
Privately Financed Shared Ownership	In the mainstream part-buy, part rent programme offered by some housing associations, part of the property is bought by the occupier and part rented from the association. Housing Benefit may be payable on the rent and the purchased share is eligible for Support for Mortgage Interest (SMI). Another option is for the part

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[133] North Harbour Consulting is grateful to the Housing and Support Alliance for providing the information on which this table is based.

	purchased to be funded by relatives rather than SMI. It is also possible for parents to substitute their money for Social Housing or Home Ownership Long Term Disabilities (HOLD) Grant from the Homes and Communities Agency (HCA), which is used in combination with a loan by the housing association to fund the part they retain. This creates a privately financed Shared Ownership option, which is often more flexible than the Homes and Communities Agency regulated model.
Joint Ownership	Joint Ownership is where a group of people pool their resources to buy a property between them. This could be a group of families coming together to acquire a property for their children to share. Anybody who buys a house with a mortgage in conjunction with a husband or wife or partner is technically likely to be a 'joint owner'. This means they will be 'jointly and severally' liable for loan repayments. That is to say if one ceases to pay the mortgage for any reason the other remains liable for all the repayments, not just half. Joint Ownership is therefore commonplace. It is usual for two people to be joint owners but in legal terms it is equally simple for up to four people to be joint owners. So it is possible if unusual, if they have the resources, for up to four disabled people to be the joint owners rather than the parents (or other relatives). Where the owners are parents, those who live in the property will be tenants. There can be more than four joint owners but this is much more complex
Joint Ownership – Parents and Sons/Daughters	A variant on the Joint Ownership theme is for a parent to buy a property jointly with their son or daughter. The reason for doing this is usually not to increase resources but as a way of satisfying a lender that the person they are lending to has 'legal capacity'.
Company Ownership	An alternative to joint ownership for sharing is for a company to be set up to acquire or build property. One example involves 8 parents becoming shareholders in a company set up with the purpose of developing accommodation for people with learning disabilities. Some (or all) of the parents will be directors of the company.
Inheritance	If the property is inherited with the intention that it continues to be occupied by the disabled relative then the various benefits of continuing to live at home may be realised.
Discretionary Trusts	Discretionary Trusts have increasingly been seen as a key mechanism for making long-term financial provision for disabled relatives. Discretionary Trusts are a legal way of putting assets - money, shares and property - aside for a 'beneficiary'. Advice of a solicitor with expert knowledge of Trust law is required. To work in the way intended Trustees must have discretion as to how funds are used, the beneficiary should not be the sole beneficiary and must not have a right to the assets of the Trust.
Getting Housing, Care and Support Together (Accommodation Based Services)	
Unregistered shared group homes	This is a common form of provision for people with learning disabilities in ordinary or purpose built houses shared by a small number of disabled people. Typically this is 3, 4 or 5 people. Each person has their own bedroom, very occasionally two people may share. There will be an established and funded level of staff support, from visiting to 24 hour presence. The rest of the property is communal space used by tenants collectively and normally this will include at least a lounge, kitchen and dining area. There may be additional facilities like a sensory room, laundry, staff sleep-in room and some schemes will for example have en suite bathrooms rather than a shared bathroom. Staff may or may not also live in the group home. What distinguishes an unregistered shared house from a similar building which is designated as a registered care home is whether the care and operational arrangements require registration with the Care Quality Commission as an "establishment" or not. If personal care is provided (defined as physical and intimate touching and not including general social care or housing related support) the care provider will have

	to be registered as a domiciliary care provider by the Care Quality Commission (CQC) but this is different from the whole building and service being registered as a care home. In this circumstance it is only the personal care element of the service that is regulated and monitored by CQC.
Extra Care, Sheltered Housing and Core and Cluster	This option includes three forms of specialist provision - sheltered housing, - extra care and - 'core and cluster'. The first two are usually intended for older people aged 55 plus. They can be allocated to younger people with a learning disability but are particularly relevant for older people including those with learning and/ or physical impairments. There are sometimes reservations about thinking of sheltered housing as an option for disabled people as it implies grouping people together and a possible separation from the community. However, for some people, it is a positive choice. People can rent or choose to buy so this must also be a consideration for older people with a learning disability. It is not however, going to suit everyone. Extra care extends the basic sheltered concept. Core and Cluster is usually on a smaller scale than Extra Care, typically 8-20 self-contained flats and a staff flat or base within a single site dev elopement.
Residential Care	A residential care home is an "establishment" providing accommodation together with personal care. In the past there could be 20 or more people and services were inevitably institutional. More recent care homes are usually smaller, 4 – 8 people. Residential homes are owned and managed by public, private sector or charitable bodies. Some specialise in particular forms of provision, for example for people on the autistic spectrum or those with sensory impairment in conjunction with a learning disability. Care homes are registered with the Care Quality Commission (CQC) under the Care Standards Act 2000. Homes have to meet certain physical standards; they are inspected by the CQC whose reports are published (www.cqc.org.uk/). Staff are required to be trained to a certain level and staffing ratios are laid down.
Intentional Communities	"Intentional communities" is a term used to describe a variety of planned residential communities from eco villages and housing co-operatives to Kibbutzim and Ashrams. Typically members hold common social, religious or spiritual views and share responsibilities and resources. In the present context "intentional communities" refers to schemes of this type set up specifically to house disabled people who live together as part of a supportive community. Historically, intentional communities were often set up as small villages or farms in rural areas but some are newer developments in towns like Milton Keynes or may consist of a number of properties spread across an area.
Other forms of support	
Shared Lives	Shared Lives (SL) arrangements are distinguished by the following features: - They are part of organised SL Schemes that approve and train the SL Carers, receive referrals, match the needs of service users with SL Carers and monitor the arrangements - People using SL services have the opportunity to be part of the SL Carer's family and social networks - SL Carers can use their family home as a resource - SL agreements provide committed and consistent relationships - The relationship between the SL Carer and the person placed with them is of mutual benefit - SL Carers can support up to three people at any one time (two in Wales) - SL Carers do not employ staff to provide care to the people that they support Shared Lives Schemes originally offered long term accommodation and support but there has been growth in the last ten years of a range of other services including

	short breaks and day time support. Kinship support (where the Shared Lives family supports someone living in their own home) is the most recent area of growth and is offered in most areas of the UK.
Supported Lodgings	In Supported Lodgings, individuals receive a low level of (usually housing related) support and do not share in the family life of the landlord. Supported Lodgings Schemes are not registered with the Care Quality Commission as they do not offer personal care. Landlords do not undergo the same level of assessment as Shared Lives Carers and usually receive less support from the Scheme. They are more independent and are not subject to the same matching process. All the costs associated with placements are met by the person living in the accommodation.
Support Tenants	A support tenant shares the home of someone who has a learning disability (it might be a couple). They live with them as a friend or 'flat mate'. They share household tasks and bills just like any other unrelated friends sharing a house might. In addition the support tenant agrees, with the care or support provider, to do some additional things which help the person with learning disabilities live more independently than might otherwise be possible. The learning-disabled person will normally be the tenant or owner of the property. The support tenant is likely to be a lodger. This means they have no security of tenure. This helps to protect the more vulnerable, disabled resident.
Community Support Networks – Keyring	Community support networks are based on a small number of disabled people (up to about 10) who live in close proximity to each other providing friendship and support to each other. Each has their own home or flat although some may choose to share. One property in the network is occupied by a Community Living Worker, a part-time volunteer. The worker provides a small amount of practical help to each member of the network, for example, help with paying bills, correspondence, organising appointments, getting the right benefits. The worker's role is only to bring members together and help them form supportive relationships. There is also a Network Manager who supports Community Living Workers, and also helps tenants with specific, possibly complicated issues like benefits. Each Network Manager will look after three or four networks. There is also an out of hour's helpline. Keyring is a relatively low support option. Network members usually have an individual care package; the Network Manager and Community Living Worker and other members are not expected to be the sole basis of care and support although it is possible for some people they could be. Keyring is the leading charitable provider of this type of community network and the best starting point to check whether there is a suitable network nearby - www.keyring.org – and how to go about applying.

APPENDIX 5

MEMBERS OF THE RESEARCH TEAM

JOHN A D PALMER

ROLE

John Palmer, Managing Director, North Harbour Consulting, is lead consultant and responsible for project management; desktop review of policy documents; NI data collection and analysis; designing themes and the analytical framework for interviews with policymakers and practitioners, resettled people and carers/family/advocates; interviews with policymakers and practitioners in NI; participation in interviewing resettled people and carers/families/advocates; editing working papers; writing the draft and final report; research management.

RESUMÉ

John has been a senior manager, policy analyst and researcher in the town planning and social housing fields including:

- senior lecturer at the Polytechnic of Central London (now University of Westminster) leading teaching and carrying out research in the School of the Built Environment on community planning, housing and social policy;
- management of the external research programme, and responsibility for 100+ general and special needs housing association performance audits across the Midlands for the Housing Corporation;
- chief executive of Ealing Family Housing Association (general needs housing); and Stonham Housing Association (special needs housing including physical and learning disability and mental health services).
- Since 1996, managing director, North Harbour Consulting Limited; completing more than 170 commissions mainly in research and management consultancy for public and non for profit organisations including: the Housing Corporation, the Northern Ireland Housing Executive, the NHS Executive and NHS Trusts, local authorities, general needs and specialist social landlords, and charities providing social welfare services.

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FIONA BOYLE MA

ROLE

Fiona Boyle (FB), Senior Associate, Fiona Boyle Associates, is responsible for providing expert knowledge on policy, practice and agencies in the NI context; advising on desktop review, data collection and interviews with policymakers in NI; lead responsibility for conducting and reporting on interviews with resettled people, and carers/families/advocates; drafting working papers on these subjects; peer review of other working papers, draft and final report; participation in research management.

RESUMÉ

Fiona is the principal consultant with Fiona Boyle Associates. With a first class honours degree in Social Policy, Fiona has 23 years' experience of research, evaluation, lobbying and policy development in the statutory and voluntary sector. Her employment history has covered a broad range of social issues including housing and homelessness, legal studies, social security, poverty and social exclusion. Established in April 2002 as a full-time consultancy, Fiona Boyle Associates specialises in social research and evaluations, development of policy issues and lobbying government at local and national level. Clients have included: NI Assembly (Research & Library Services); Northern Ireland Housing Executive; Belfast City Council; General Consumer Council for N; NI Deaf Youth Association and Action on Hearing Loss NI; Care and support providers including Simon Community NI; Extern; Belfast Central Mission; Engage with Age; Atlantic Philanthropies; CARDI; Housing Associations and housing bodies including NIFHA, Housing Rights Service, SHAC, Oaklee Housing Association, Council for the Homeless NI, The Foyer Federation – NI

SELECTED PUBLICATIONS

F Boyle (2010) *Assessment of the potential for equity release for older owner-occupiers*, NIHE, Belfast
F Boyle (2012) *Sheltered housing in Northern Ireland*, NIHE, Belfast

ALICIA WOOD

ROLE

Alicia Wood (AW), Chief Executive, Housing and Support Alliance is responsible for providing expert knowledge about current policy and best practice in housing, support and promoting independence for learning-disabled people; for advice on working with people who have learning disabilities to the same standards as would be required under the Mental Capacity Act 2005 which applies in England and Wales, but not yet in Northern Ireland; and communication with and involvement of learning-disabled people as active participants in consumer research; desktop review of key policy documents and research, and interviews with policy makers in GB and RoI; advising on the interview programme with resettled people and carers/families/advocates; drafting working papers on these subjects; peer review of other working papers, draft and final report; participation in research management.

RESUMÉ

Alicia is the Chief Executive of the Housing & Support Alliance, a national membership organisation that leads in developing and promoting community based approaches to housing and support. She is also a Fellow with the Centre for Welfare Reform; and a qualified Biodynamic psychotherapist who has worked with people with mental ill health and learning disabilities who have labels of 'challenging behaviour'. Alicia has worked in the statutory and voluntary sectors and has led strategies to create more housing for people with learning disabilities and managed a pilot project to test home ownership options and natural supports for people with learning disabilities. More recently, Alicia led on the national housing delivery plan for people with learning disabilities, working with the Department of Health, the Cabinet Office and the Department for Communities and Local Government. She has also led national development programmes for In Control, Paradigm and the NDTI working on housing, community development and personalisation.

SELECTED PUBLICATIONS

Alicia has written many publications including *Reach Standards in Supported Living*, *Reach Out- personalising community and day services*, *Gadgets, Gizmos & Gaining Independence - the use of Assistive Technology by People with a Learning Disability* and *Choice Based Lettings and People with a Learning Disability*.

STEVE HARRIS

ROLE

Alicia Wood will be assisted by Steve Harris, Senior Advisor, Housing and Support Alliance.

RESUMÉ

Steve is Senior Advisor at the Housing and Support Alliance. His background is in the management of residential care and supported living services in the statutory and voluntary sector. He has also worked on commissioning a wide range of services for Supporting People and Adult Social Care in local government including joint contracting between Supporting People and Adult Social Care. He has extensive knowledge and experience of delivering the full range of housing and support solutions for disabled people including private and social rented, new build with grant, ownership options, family investment options, specialist purchase, networks and dispersed networks, extra care, sheltered housing, support tenants, domiciliary care, supported living and assistive technology. He has worked with the Department for Work and Pensions, Department of Health, Department for Communities and Local Government and the Court of Protection on developing national housing and support policy initiatives.

Building the right support

A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition

October 2015

Classification: Official

Building the right support

A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition

Version number: 1

First published: 30 October 2015

Updated:

Prepared by: Anthony Houlden, Commissioning Policy Manager

Classification: OFFICIAL

Contents

Foreword

Children, young people and adults with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with dignity and respect. They should have a home within their community, be able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.

As a society, we are on a long journey to make that simple vision a reality. We have made enormous strides over several decades. But for a minority of children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition[1], we remain too reliant on inpatient care - as they and their families have been telling us loud and clear.

It is for that reason that, in February 2015, NHS England publicly committed to a programme of closing inappropriate and outmoded inpatient facilities and establishing stronger support in the community, and promised that further details would follow later in the year. This plan meets that commitment.

We know it comes at a time when many people with a learning disability and/or autism, as well as their families/carers are frustrated - that change has been limited and slow, particularly following the appalling scandal at Winterbourne View. We know too that thousands of frontline carers, clinicians, providers and commissioners want to make progress.

This plan sets out how we will do so: supporting local leadership and making available new investment to kick-start change. It means that we now have an opportunity – to make real the rights of people with a learning disability and/or autism, and to help thousands of people lead happier lives.

We know that this challenge is achievable because many parts of the country are already successfully doing it. There is good practice across the country to replicate, and the skills and expertise of thousands of families and front-line staff to build on. ‘Fast track’ areas across England are starting to show what kind of transformational change is possible with strong local leadership building a new generation of community-based services.

Now it is time to deliver across the whole country. This plan sets out how we intend to do so – working with people with a learning disability and/or autism, families, staff, clinicians, providers, and commissioners.

Jane Cummings,
Chief Nursing Officer, England

Ray James, President, Association of Directors of Adult Social Services

Sarah Pickup, Deputy Chief Executive, Local Government Association

Dominic Slowie, National Clinical Director for Learning Disability, NHS England

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[1] Hereafter people with a learning disability and/or autism

1. Executive summary

The journey to date

1.1 Over many decades, as a society we have significantly reduced our reliance on institutional care to support people with a learning disability and/or autism, closing asylums, campuses and long-stay hospitals. For a minority of people however, there is still an over reliance on inpatient treatment for people who could, given the right support, be at home and close to their loved ones.

1.2 Over the last few years hundreds of people from hospital have been supported to leave hospital – but others are admitted in their place, often to inappropriate care settings, so the number of inpatients remains steady. We have not made enough progress when it comes to changing some of the fundamentals of care and support.

1.3 To make this permanent we need a change in culture, a shift in power to individuals and a change in services. We need to see people with a learning disability and/or autism as citizens with rights, who should expect to lead active lives in the community and live in their own homes just as other citizens expect to. And we need to build the right community based services to support them to lead those lives, thereby enabling us to close all but the essential inpatient provision.

1.4 To speed up this process and to help shape a national approach to supporting change, six 'fast track' areas[2] drew up plans over the summer of 2015 and are already making a difference on the ground. Together they envisage shifting money into community services in order to reduce their usage of inpatient provision by approximately 50% over the coming three years. Their plans will result in the development of a range of new community services and the closure of hospital units, including the last standalone learning disability hospital in England.

1.5 This document describes how we intend to build on our experience with fast tracks to implement change across the rest of the country.

The new services we need

1.6 People with a learning disability and/or autism who display behaviour that challenges are a highly heterogeneous group. Some will have a mental health problem which may result in them displaying behaviour that challenges. Some, often with severe learning disabilities, will display self-injurious or aggressive behaviour unrelated to any mental health condition. Some will display behaviour which can lead to contact with the criminal justice system. Some will have been in hospital for many years, not having been discharged when NHS campuses or long-stay hospitals were closed. The new services and support we put in place to support them in the community will need to reflect that diversity.

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[2] Greater Manchester; Lancashire; North East and Cumbria; Arden, Herefordshire and Worcestershire; Nottinghamshire; Hertfordshire

1.7 A national service model, developed with the help of people with lived experience, clinicians, providers and commissioners, outlined in this document and published in full alongside it, sets out the range of support that should be in place no later than March 2019. It should be read in tandem with this plan.

1.8 Implementing this model, and giving people greater power over the services they use, will result in a significantly reduced need for inpatient care. We expect that as a minimum, in three years' time no area will need capacity for more than 10-15 inpatients per million population in clinical commissioning group (CCG) commissioned beds (such as assessment and treatment units), and 20-25 inpatients per million population in NHS England-commissioned beds (such as low-, medium- or high-secure services).

1.9 These planning assumptions will mean that, at a minimum, 45 – 65% of CCG-commissioned inpatient capacity will be closed, and 25 – 40% of NHS England-commissioned capacity will close, with the bulk of change in secure care expected to occur in low-secure provision. Overall, 35% - 50% of inpatient provision will be closing nationally with alternative care provided in the community. The change will be even more significant in those areas of the country currently more reliant on inpatient care. In three years we would expect to need hospital care for only 1,300-1,700 people where now we cater for 2,600. This will free up money which can then be reinvested into community services, following upfront investment.

1.10 These planning assumptions should be seen as the starting point. Commissioners should, working with people with a learning disability and/or autism, be ambitious in thinking about how much further they can go, starting not from the point of what services they have currently but what support people need to live the best possible life.

1.11 Just like the rest of the population, people with a learning disability and/or autism must and will still be able to access inpatient hospital support if they need it. What we expect however is that the need for these services will reduce significantly. The limited number of beds still needed should be of higher quality and closer to people's homes.

1.12 For those that do need this more specialist support in hospital, their length of stay should be as short as possible. We will work with providers, commissioners and clinicians to reduce length of stay overall and ensure areas learn from best practice – for instance one 'fast track' area aims to reduce length of stay in assessment and treatment services to an average of 85 days.

Delivering change

1.13 To achieve this systemic change, 49 transforming care partnerships (commissioning collaborations of CCGs, NHS England's specialised commissioners and local authorities) are mobilising now. They will work with people who have lived experience of these services, their families and carers, as well as key stakeholders to agree robust implementation plans by April 2016 and then deliver on them over three years.

1.14 An alliance of national organisations will support these transforming care partnerships to deliver on this ambitious agenda, including NHS England, Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Health Education England (HEE), Skills for Health, Skills for Care, the Care Quality Commission (CQC), NHS Trust Development Authority (TDA), Monitor, and provider representative organisations, working closely with people with a learning disability and/or autism as well as their families/carers.

1.15 In every part of the country there are people with the skills and experience to deliver effective care and support. These people can be found within health and social care services, and amongst the families and carers who support individuals in their own homes. Successful delivery will depend on them. Their insight will be key to designing, developing and launching new services in the community, and their skills and experience will be central to delivering them.

1.16 As part of this alliance for delivery, and working alongside local commissioners, we will work with provider organisations to mobilise innovative housing, care and support solutions in the community. Our collaboration will focus on supporting commissioners to redesign services, scaling up community-based services, developing the workforce, accessing investment to expand community services, and securing the capital to deliver the new housing needed.

1.17 A new financial framework will underpin delivery of the new care model:

- Local transforming care partnerships will be asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care in a different way that achieves better results
- To enable that to happen, NHS England's specialised commissioning budget for learning disability and autism services will be aligned with the new transforming care partnerships
- CCGs will be encouraged to pool their budgets with local authorities whilst recognising their continued responsibility for NHS Continuing Healthcare.
- For people who have been in hospital the longest, the NHS will provide a 'dowry' – money to help with moving people home
- During a phase of transition, commissioners will need to invest in new community support before closing inpatient provision. To support them to do this NHS England will make available up to £30 million of transformation funding, to be matched by CCGs, over and above the £10 million already made available to fast track areas

- In addition to this, £15 million capital funding over three years will be made available and NHS England will explore making further capital funding available following the Spending Review
- From November 2015, *'Who Pays'* guidance will be reformed to reduce financial barriers to swift discharge

1.18 Before the end of 2018, having built up community support and closed hundreds of beds, we will take stock and look at going further.

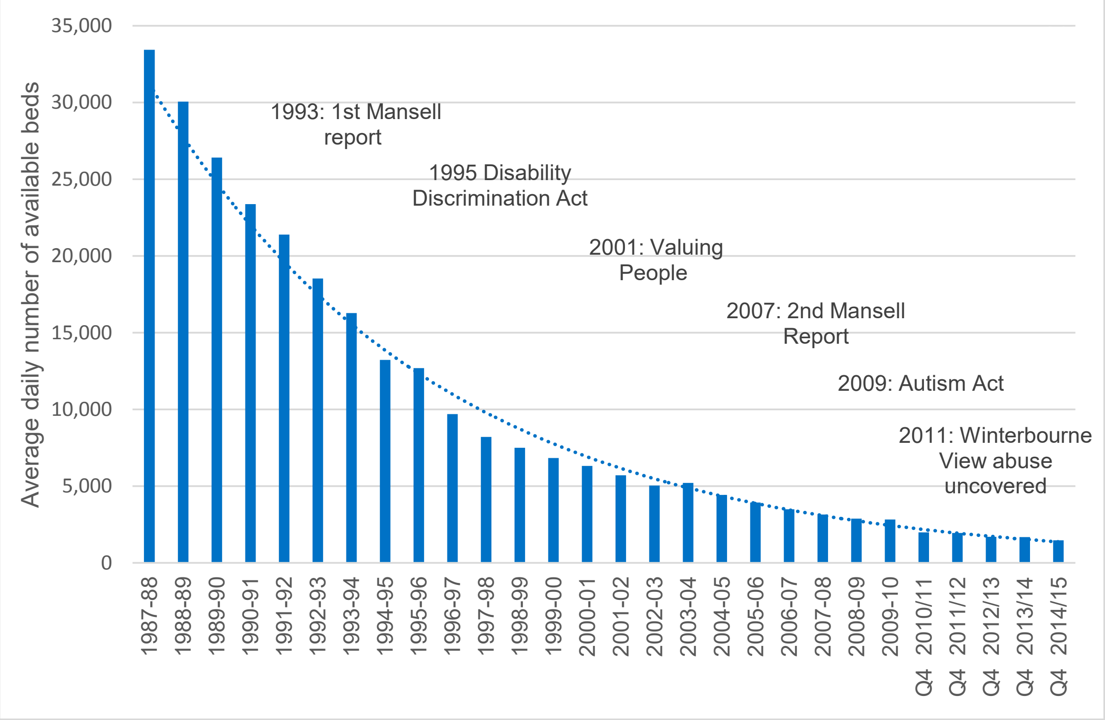
2. The journey to date

Background

2.1 Historically, from the asylum to the long stay hospital, too often people have been routinely placed in institutions away from their homes and communities.

2.2 Rightly, most of these institutions were closed and now the majority of people with a learning disability and/or autism will never come into contact with the types of hospitals – including assessment and treatment services – that are discussed in this document.

Figure 1: NHS learning disability beds since 1987[3]



2.3 The scandal at Winterbourne View, however, was not just an individual episode of appalling abuse. It also highlighted the fact that despite the progress we have made as a society in recent decades, for a small number of people we remain too reliant on hospital care, particularly in some parts of the country (see figure 2 and figure 3).

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[3] Data taken from KH03 collection from all NHS organisations that operate consultant-led beds open overnight or day only. Changes to the way data is collected mean only Q4 data provided from 2010/11. More information: http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/

Figure 2: Geographical variation in reliance on *CCG-commissioned* inpatient services (as at 31 July 2015)[4]

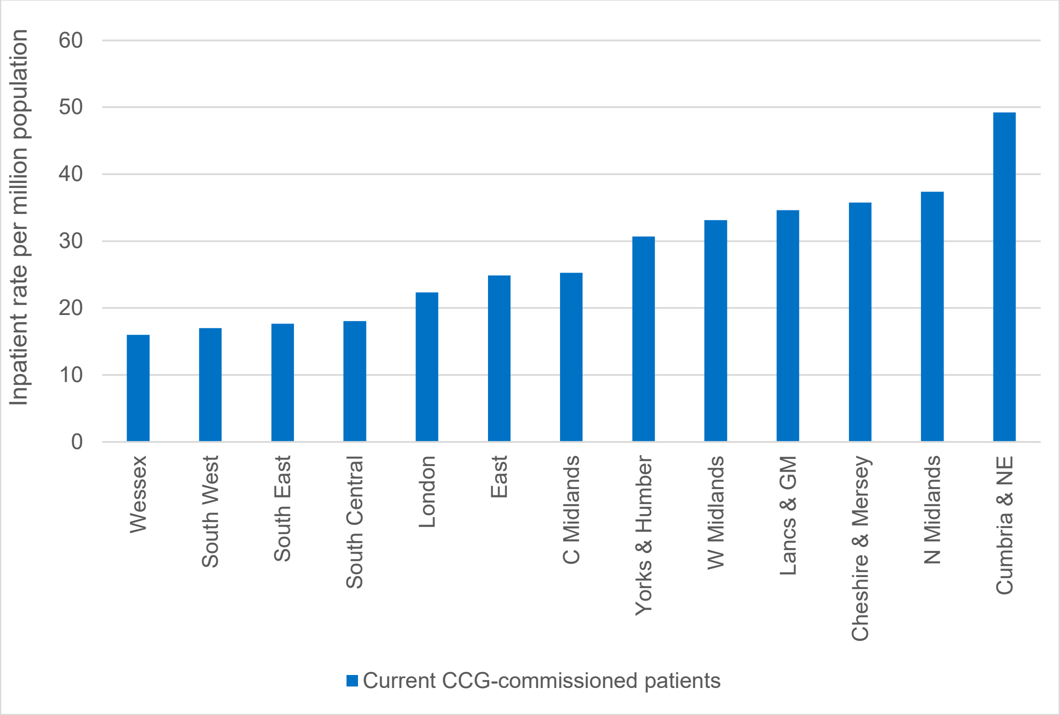
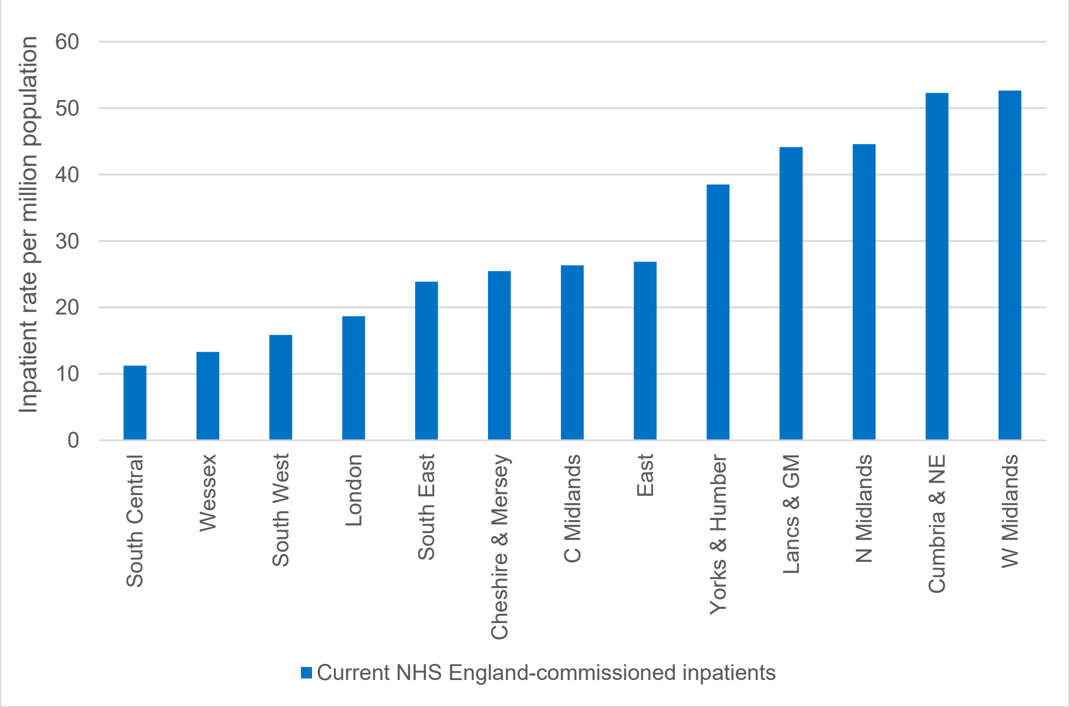


Figure 3: Geographical variation in reliance on *NHS England-commissioned* inpatient services (as at 31 July 2015) [5]



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[4] See Annex C for further notes on the data used in these charts

[5] See Annex C for further notes on the data used in these charts

2.4 To address this longstanding problem recently there has been a renewed push to address these issues with, for instance:

- The CQC introducing a new approach to inspecting learning disability hospitals and the care of people with a learning disability and/or autism in acute hospitals
- New data systems put in place to track the care people are receiving
- The Department of Health's consultation *No Voice Unheard, No Right Ignored: a consultation for people with learning disabilities, autism and mental health conditions* looked at how to strengthen rights, incentives and duties in the wider system, focusing on how people can be supported to live independently in their communities and make choices in their lives. Views were sought on a range of ideas intended to strengthen or build upon existing policies, including possible changes to legislation. The Government will shortly set out the actions it proposes in response to the consultation

2.5 In addition to this, NHS England has rolled out a programme of Care and Treatment Reviews (CTRs) - reviews of individual patients' care to prevent unnecessary admissions and avoid lengthy stays in hospital. These CTRs bring together:

- People with a learning disability and/or autism and their families/carers
- Independent expert advisors – one clinical and one expert by experience
- The responsible commissioner and others involved in the persons care and treatment

These reviews look to see if someone's care is safe, effective and whether they need to be in hospital as well as whether there is a plan in place for the future. By mid-September 2015 over 2,020 CTRs had been completed since their introduction in October 2014. Between March and August 2015, over 750 people in hospital were discharged or transferred.

2.6 Progress has been made. Hundreds of people previously in hospital are now living in their own homes, and the foundations for future progress have been laid.

2.7 Despite this, we know the most significant changes needed lie ahead. For all the progress discharging individuals from hospital, the number of people not living at home remains similar to what it was when CTRs were introduced. Admissions remain high, and some people are in hospital when they are ready to be discharged because the right support is not available.

2.8 As Sir Stephen Bubb highlighted in his report for NHS England[7], we need to change the mix of services available on the ground - shifting our investment into better support in the community and closing some inpatient services. To do this "we need both more 'top-down' leadership...and from the 'bottom up'

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[7] http://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf

more empowerment for people with learning disabilities and/or autism and their families."

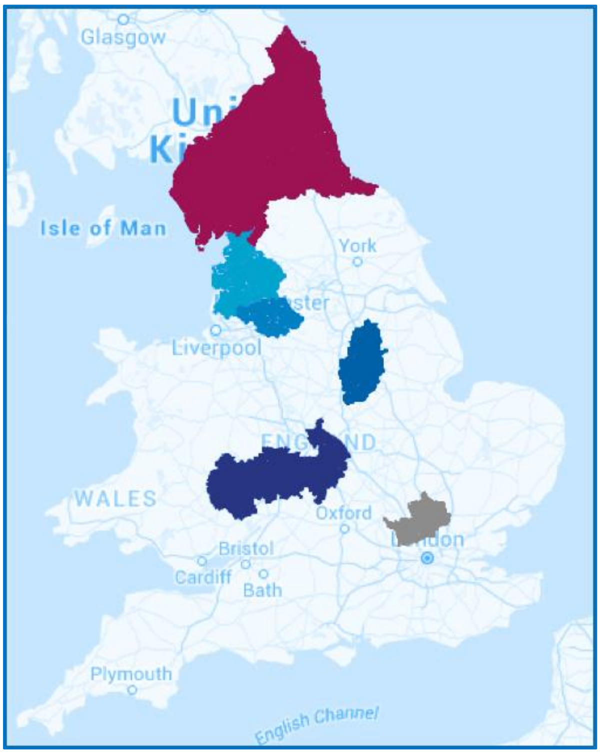
2.9 Six 'fast track' areas have begun that process, and this plan sets out how we will now support the rest of the country to follow suit.

Fast tracks

2.10 Over the summer of 2015, NHS England, LGA and ADASS supported six 'fast track areas'[8] (collaborations of CCGs, local authorities and NHS England specialised commissioners) to draw up plans for service transformation. A £10 million fund was made available to these areas to help fund transitional costs and speed up implementation.[9]

2.11 These areas are highly diverse – in terms of demography, patient flows, provider landscapes, deprivation, urban and rural communities – allowing NHS England, LGA and ADASS to test our approach to a range of different challenges that different communities in England will face as they seek to transform services – from developing the local workforce to designing new community health services to ensuring that funding flows enable change.

Figure 4: Fast track areas



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[8] Greater Manchester; Lancashire; Cumbria and the North East; Arden, Herefordshire and Worcestershire; Nottinghamshire; Hertfordshire

[9] The NHS and local government in these areas spend many millions on care for people with a learning disability and/or autism. The £10 million is not intended to fund all the costs in that new service model

2.12 Each fast track has published its plan and fast track areas are now engaging with local communities and providers to help shape delivery.

2.13 Taken together, fast track plans envisage that bed usage across all six areas will reduce by approximately 50% over the coming three years, freeing up tens of millions of pounds which will be invested in community-based support to prevent hospital admissions.

2.14 Below is a summary of some of the actions that each of the fast track areas are implementing.

Greater Manchester

2.15 The devolution deal for Greater Manchester has resulted in new powers and responsibilities for local leaders. In describing their joint ambition for change, they have prioritised the improvement of services for people with a learning disability and/or autism.

2.16 In terms of bed usage, the Greater Manchester Fast Track uses a range of hospital providers but has a significant number of inpatients in Calderstones Partnership Foundation Trust, which is also used to a large degree to provide care to patients from Lancashire. As such their plans are being jointly developed with the Lancashire Fast Track.

2.17 Their ambition is to reduce their use of 130 inpatient beds by 50%: from 77 non-secure beds to 30 (a 60% reduction) and from 53 secure beds to 35 (a 34% reduction) by 2018/19. To re-provide this care they are creating intensive community support services with robust case management and discharge coordination across the area to enable individuals to receive care at home and improve their care experience.

2.18 Recognising that occasionally the needs of individuals can increase, they are also investing, this year, in six local crisis beds and an in-reach/outreach team providing safe short intensive support when needed.

2.19 Furthermore they are in the process of creating an innovative housing scheme that will ensure round-the-clock care for people with a learning disability and/or autism from early next year.

2.20 A cornerstone of the plan is their intention to retain and build the confidence of the staff, as well as families/carers, to improve quality of care in the community. To do this they intend to deliver a three year family and staff development programme.

2.21 In addition, to monitor the impact of the plan by March 2017 - as part of the wider Greater Manchester Public Sector Reform Programme - there will a formal evaluation assessing its impact over an 18 month period.

Lancashire

2.22 Similarly to Greater Manchester Fast Track, Lancashire uses a range of hospital providers but has a significant number of inpatients in Calderstones Partnership Foundation Trust.

2.23 Lancashire intends to reduce their reliance on non-secure beds by 70% and substantially reduce the numbers of people who come into contact with secure services. This high ambition will be achieved by focussing on putting in place high-quality individual packages of care and creating a hub and spoke community support model (expected to be fully operational by March 2018). They will develop:

- An integrated community learning disability team across the whole of Lancashire
- Crisis intervention and support services across the area
- A small number of community-based assessment and treatment services to prevent unnecessary out of area placements

2.24 To help with developing these services, Lancashire is rolling out a local engagement plan to ensure people impacted by these changes are fully involved in the building up of community capacity and shaping the services they use.

2.25 Their intention to retain staff to work in new models of care is a vital part of the plan. A comprehensive development programme will be rolled out this year, with two CCGs implementing Positive Behavioural Support (PBS) training and a scheme designed to offer rights-based training to improve access to mainstream health and social care services for people with a learning disability and/or autism.

2.26 Finally, in line with the national service model, they expect from April 2017 to reshape advocacy services across the region and develop a more robust model for delivering short break services.

- **Calderstones Partnership NHS Foundation Trust**

2.27 A key plank of the plans being developed in Lancashire and Greater Manchester will be to close and re-provide services offered by Calderstones Partnership NHS Foundation Trust.

2.28 Calderstones Partnership NHS Foundation Trust is the only remaining standalone learning disability hospital trust in England with 223 beds. They have initiated a collaboration with Mersey Care NHS Trust driven by an ambition to develop person-centred care, and sustainable services that stand the test of time, underpinned by a strong quality, clinical and financial case for fundamental changes in local secure mental health and learning disabilities care.

2.29 The plan is for Mersey Care NHS Trust to take over Calderstones Partnership NHS Foundation Trust, which from July 2016 will cease to exist.

2.30 The plans developed by Greater Manchester and Lancashire Fast Tracks with NHS England Specialised Commissioners, subject to consultation, will implement a new service model resulting in a substantial reduction of beds (>60% fewer than currently).

2.31 NHS England will also cease commissioning secure services on the Calderstones site.

2.32 All hospital beds on the current Calderstones site will therefore, subject to consultation, close and be re-provided over the next three years on a case by case basis for each patient, in the community or in new state of the art units elsewhere in the North West, and the Calderstones site will close.

2.33 Ongoing consultation and engagement with people with learning disabilities, their families and carers will be central to the process of change and the commissioners and providers involved are committed to ensuring that patients and families are always involved in decisions about their care and support.

2.34 Calderstones Partnership NHS Foundation Trust and Mersey Care NHS Trust have appointed a joint Medical Director to provide clinical leadership in the process of bringing these two organisations together. The post holder will help sustain and build world class leaders and staff, enabling them to be part of the future.

2.35 The trusts are already focussing on a range of joint quality initiatives with staff to improve quality and increase efficiency - for instance, they have initiated an international collaboration with Stanford Risk Authority (Stanford University) to manage risk and learn lessons in a way that has never been undertaken in the NHS.

Cumbria and the North East

2.36 Compared to the rest of the country, Cumbria and the North East have more individuals with a learning disability registered on GP registers and a higher usage of inpatient services (255 inpatient beds) mainly making use of two key hospital trusts – Northumberland, Tyne and Wear Foundation Trust and Tees Esk and Wear Valleys Foundation Trust.

2.37 These beds are a collection of secure and non-secure beds and are occupied not only by people from the area, but from across the country. Cumbria and North East aim to deliver a 52% reduction (76 beds) in non-secure beds and a 43% reduction (47 beds) in low secure beds. Commissioning action is already underway to facilitate this reduction, with 40 beds being empty at time of publication.

2.38 Building on service improvements in physical health, Cumbria and the North East are creating a single set of standards to incorporate into contracts used locally. Each local authority and CCG is developing and building community capacity, including in 2015/16 new investment in:

- Services to support people with attention deficit hyperactivity disorder and autism across Northumberland, and Tyne and Wear
- Advocacy services
- Carers support

2.39 Localities are also testing new approaches to improving quality. For example, in Newcastle an innovative housing initiative, developed through collaboration between social care providers and an NHS provider, is providing preventative care and treatment to improve the quality of support people with a learning disability and/or autism experience and to avoid unnecessary admissions.

2.40 A central plank to the plan is to retain staff to work in new models of care, and develop and up skill the workforce. For instance, working with Northumbria University and local clinicians they intend to implement a National Vocational Qualification (NVQ) based on PBS training for staff.

Hertfordshire

2.41 For several years Hertfordshire CCGs have been working with Hertfordshire Partnership Trust, Hertfordshire County Council and others to modernise services for people with a learning disability and/or autism, and they have already successfully closed many assessment and treatment beds across the area. But they believe they should go further.

2.42 Their ambition is now to bring adult and children's services together into a dedicated integrated service. This will include a single point of access that will empower service users of all ages to access help, support and appropriate treatment in the community. This model will be consulted on before the end of the year.

2.43 By 2018/19 they expect to reduce their usage of low-secure beds by over 30%, and to reduce length of stay in assessment and treatment beds to an average of 85 days.

2.44 Furthermore, they are establishing an evaluation partnership with Hertfordshire University to test a number of prevention and early discharge services for individuals who have been in contact with the criminal justice system. This includes a strengthened community forensic team to enable faster supported discharge and greater use of community restriction orders, and a Circles Project to deliver community support to people with a learning disability and/or autism who are deemed to be at high risk of sexual offending.

2.45 Recognising that individuals' needs can increase, a number of innovative crisis intervention pilots will be commissioned and evaluated from 2015/16, namely:

- A hosted family crisis support pilot which will provide intensive home support during crisis periods
- A 'crash pad' pilot providing short term accommodation for people who need crisis intervention in situations where there has been a placement breakdown or termination of tenancy

2.46 Finally, Hertfordshire has already begun work to pilot the implementation of integrated personal health budgets, which will start to be introduced from April 2016.

Nottinghamshire

2.47 Nottinghamshire intends to reduce its reliance on non-secure services from 40 occupied beds to 15 (a 63% reduction) and almost halve its usage of low and medium secure beds from 34 to 16 (a 56% reduction). Nottinghamshire now has 65 people in inpatient care in NHS trusts and the independent sector.

2.48 Nottinghamshire's plan has individual rights at its centre and an immediate priority is to commission an increase in advocacy for people during care and treatment reviews. Early plans also include strengthening their existing community learning disability and intensive care and treatment teams, as well as risk registers, so they can confidently support individuals who are at risk of coming into contact with the criminal justice system and subsequent admission to hospital.

2.49 Recognising that confidence of staff and families is paramount to helping individuals stay at home, families will be offered evidence-based parenting training as well as practical and emotional support locally. In addition, to retain and up skill staff to deliver the new care model workforce training will be undertaken to ensure staff have a consistent understanding and approach to working with people who display behaviour that challenges which enables individuals to remain in the least restrictive setting.

2.50 Next year, they will expand their personal health budget offer and tackle gaps in the accessibility of mainstream services. As the needs of individuals can increase, new crisis accommodation will be established as well as new pioneering housing options for people with complex behaviours and those in contact with the criminal justice system as they are discharged from hospital.

2.51 Nottinghamshire will start to pool budgets for crisis care from April 2016 and work towards further alignment and pooling arrangements from April 2017.

2.52 Finally, across Nottinghamshire there are a high number of local inpatient beds (199), many of which are not used by local commissioners. The Fast Track has recognised that the longer term plan of this economy will require strong partnerships with other commissioners across the country.

Arden, Herefordshire and Worcestershire

2.53 Commissioners in Arden, Herefordshire and Worcestershire have been driving forward improvements in learning disabilities for several years and have agreed strategies for improving both physical and mental health and been steadily reducing reliance on hospital beds. They now have 47 people in inpatient care, mainly in Coventry and Warwickshire NHS Trust.

2.54 It is expected that across the area they will reduce the number of beds used by inpatients to 14. This means reducing their usage of non-secure beds from 19 to 3 (an 85% reduction), and of secure beds from 21 to 11 (a 48% reduction). They also intend to reduce their usage of child and adolescent mental health service (CAMHS) beds by children with a learning disability and/or autism by seven.

2.55 These closures are expected to start this year, with a nine-bed assessment and treatment ward shutting (subject to appropriate local consultation).

2.56 Their intention is to redeploy staff working in that unit to new community services, and having learnt from the experience and undertaken appropriate consultation, to apply the learning to other sites.

2.57 In addition, the area plans to develop by November 2015:

- An admission avoidance scheme in Coventry and Warwickshire NHS Trust
- A short-term accommodation for people who need support when a placement breaks down or, for example, if a tenancy breaks down

2.58 Throughout the rest of the year, across Arden, Herefordshire and Worcestershire the aim is to create intensive community support teams which will work with existing mental health crisis teams to provide comprehensive crisis care 24/7. To facilitate this they plan to have a liaison nurse who will work to improve support and the interface between learning disability and wider mental health services.

2.59 From April 2016 a community forensic service will be commissioned to support people to be discharged who are currently out of area and enhance the support locally to avoid future admissions. The aim is to then review the coverage and plan for further closures in 2017/18.

2.60 Finally, Coventry and Warwick Partnership Trust are commissioned by other West Midlands commissioners. The Arden, Hereford and Worcestershire Fast Track is exploring strategic alliances with them to spread learning and support change.

Figure 5: Projected bed usage rates across fast track sites (inpatients per million population)[10]

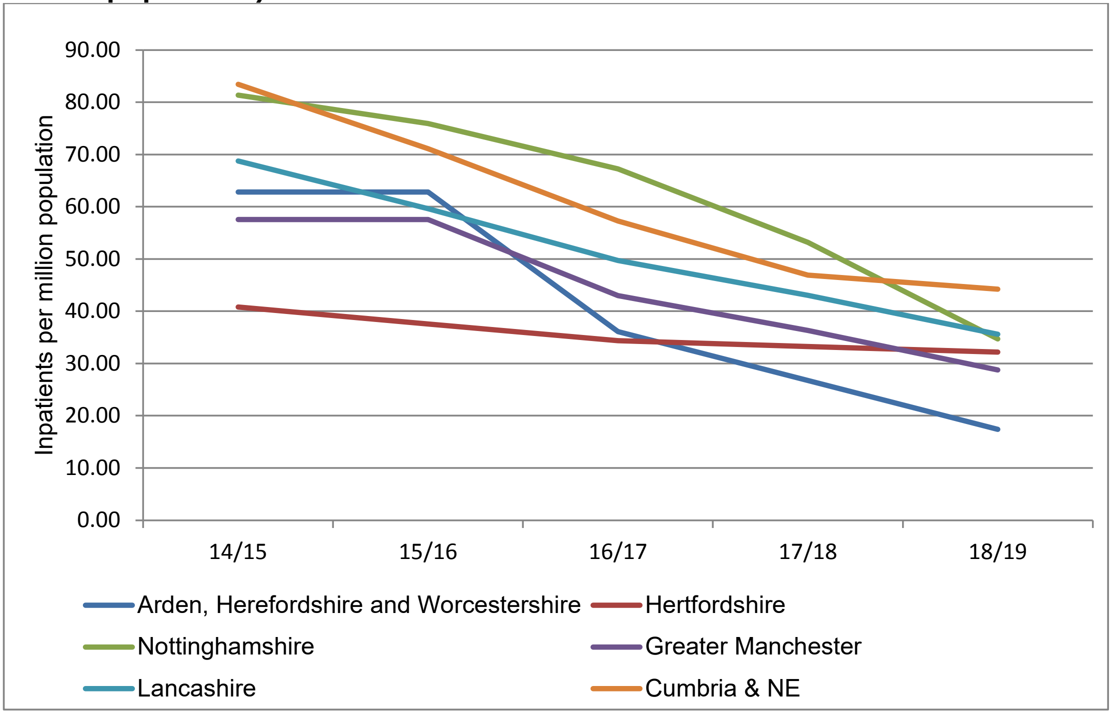
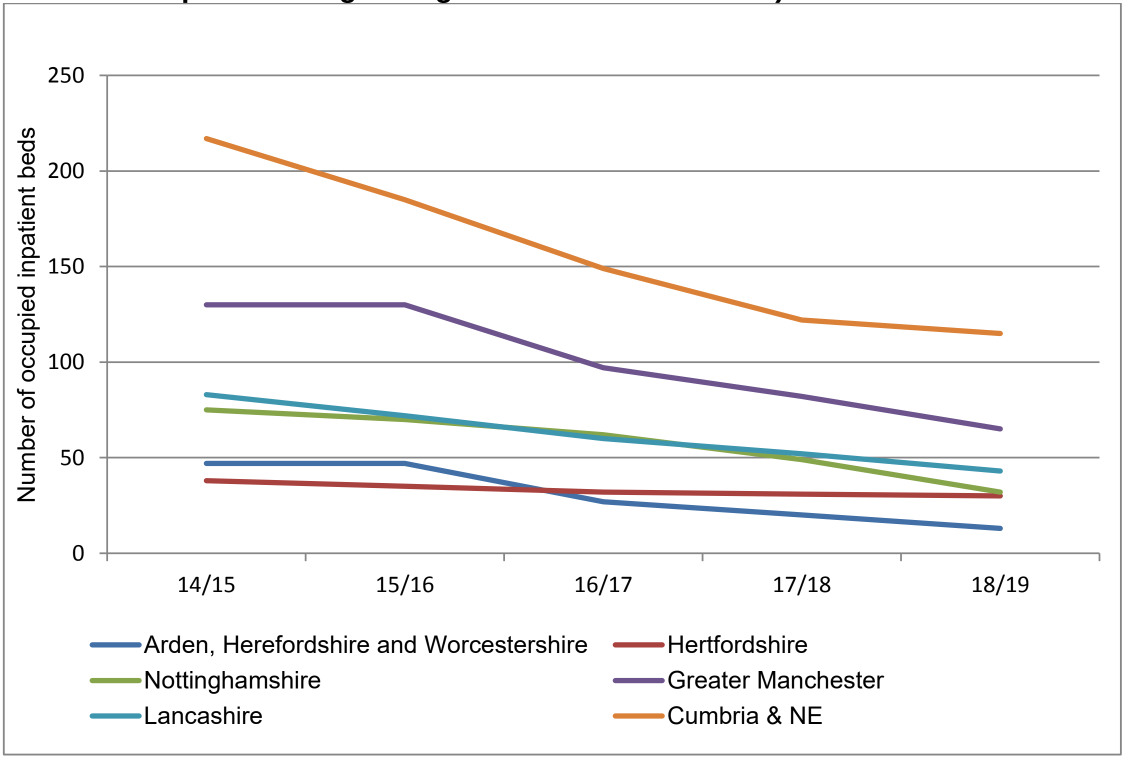


Figure 6: Projected *total* bed usage across fast tracks (chart shows projected number of inpatients originating from the fast track site)[11]



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[10] See Annex C for further notes on the data used in these charts

[11] See Annex C for further notes on the data used in these charts

Figure 7: Projected usage of *NHS England*-commissioned beds across fast tracks (chart shows projected number of inpatients originating from the fast track site)[12]

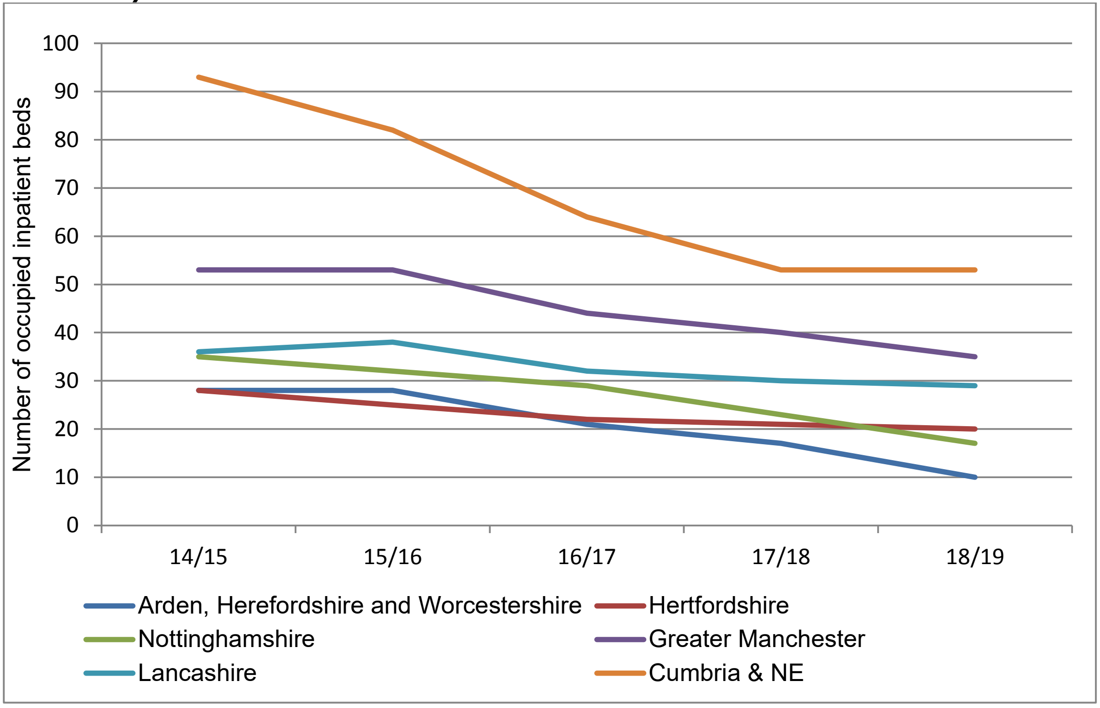
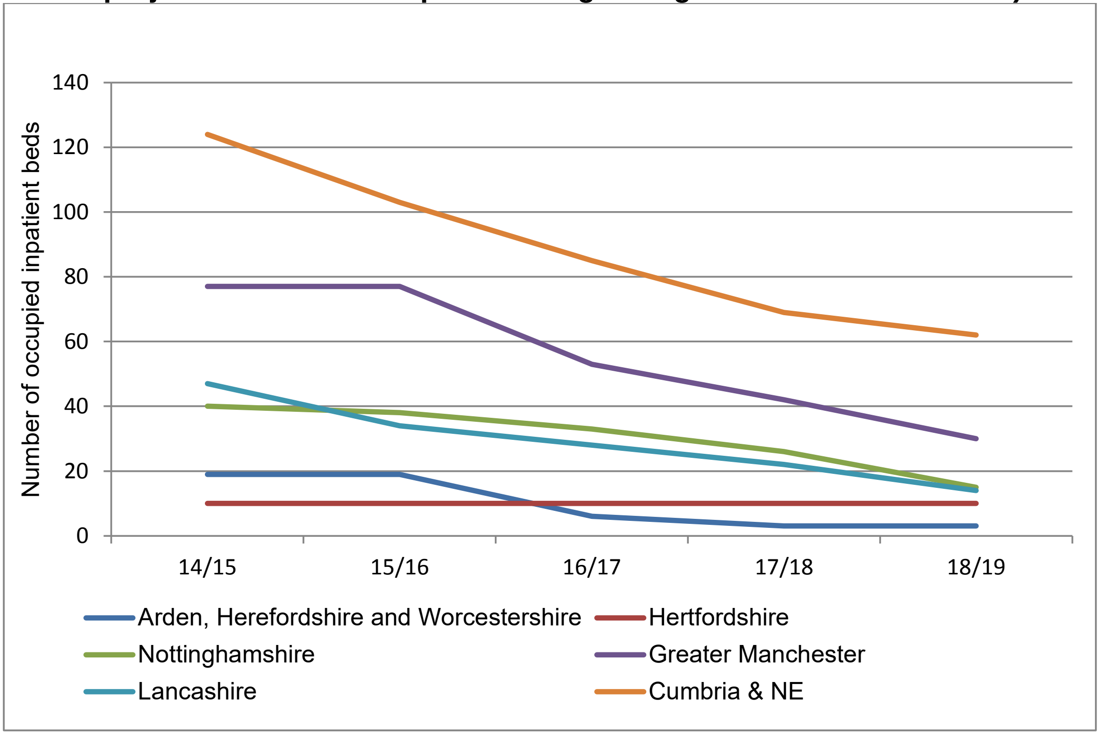


Figure 8: Projected usage of *CCG-commissioned* beds across fast tracks (chart shows projected number of inpatients originating from the fast track site)[13]



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[12] See Annex C for further notes on the data used in these charts

[13] See Annex C for further notes on the data used in these charts

2.61 The action outlined above represent just the start of what the fast tracks will do, and as their plans develop and community services mature we expect the bed reduction trajectories set out in their plans to translate into further closure of individual wards and units. As the fast track areas start to implement their ambitious plans for change, NHS England, LGA and ADASS will draw on our experience of working with them to support the rest of the country to build new community services and close inpatient provision that is no longer needed. The rest of this plan sets out how these new services should look, and how we plan to work together to deliver them.

3. The new services we need

3.1 People with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives and to be treated with dignity and respect. They should expect, as people without a learning disability or autism expect, to live in their own homes, to develop and maintain positive relationships and to get the support they need to be healthy, safe and an active part of society.

3.2 As Professor Jim Mansell highlighted in 1993 and in 2007, however, too rarely do people receive this type of personalised support across their whole life. In turn, many of the behaviours services label as challenging could be prevented from developing if the right support were made available to people and their families or carers when they needed it.

3.3 The changes to services we plan to make are intended to put that right.

Improving services for a heterogeneous group

3.4 People with a learning disability and/or autism who display behaviour that challenges are a highly heterogeneous group. The task of reshaping services will reflect that diversity.

3.5 For people who have been in inpatient settings for a very long period of time, the task facing commissioners will be to resettle those individuals into the community and close the hospital beds behind them. This will include a number of people who will have been in hospital for many years, in some cases having not been discharged when NHS campuses or long-stay hospitals were closed. It is the group of people for whom hospital has effectively become a permanent home, and for whom the task now is to find them a more appropriate home in the community, with the right package of health and care support around them. This is the group who will likely be eligible for NHS-funded dowries when they are ready to be discharged, to help fund their new package of care in the community (see chapter 4 for more detail on how these ‘dowries’ will work).

3.6 Approximately a third of the people currently in hospital have been in inpatient settings for five years or longer. Whilst hospital may be the right place for some of this group (for clinical reasons often combined with Ministry of Justice restrictions), Care and Treatment Reviews have already identified transfer/discharge dates over the coming three years for just under 40% of the individuals concerned, and we would expect that number to rise as we build the right set of services in the community.

3.7 In the main, however, the challenge facing commissioners is as much about preventing new admissions and reducing the time people spend in inpatient care by providing alternative care and support, as it is about discharging those individuals currently in hospital. The task requires: advocacy, early intervention, prevention, ensuring the right set of services are available in the community.

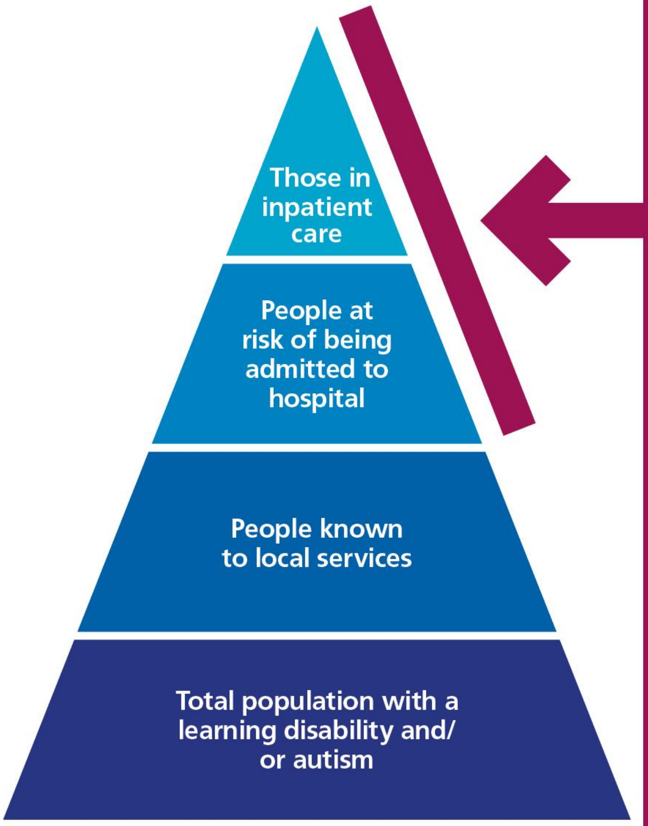
3.8 In many cases, it will involve close collaboration not just between the NHS and social care, but also with parts of the criminal justice system, building on recent joint work between NHS England and the Ministry of Justice to facilitate discharges of patients subject to restriction orders - currently more than one in five of the people in hospital settings have been detained on part III of the Mental Health Act with a Ministry of Justice restriction.

3.9 Transformation will mean redesigning services to better meet a range of common sets of needs. For instance, it will mean better serving children, young people or adults with a learning disability and/or autism who:

- Have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those people with personality disorders, which may result in them displaying behaviour that challenges
- Display self-injurious or aggressive behaviour (not related to severe mental ill health), some of whom will have a specific neuro-developmental syndrome where there may be an increased likelihood of developing behaviour that challenges
- Display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour)
- Often have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system

3.10 The different kinds of shift in service response required to better meet these different needs are set out in more detail in a national service model for commissioners of health and social care services, developed with the support of a group of independent experts, including people with lived experience of services, and published alongside this document.

Figure 9: People for whom we need new services



Pathway redesign for:

- People with a **mental health** problem which may result in them displaying behaviours that challenge
- People who display **self-injurious or aggressive behaviour, not related to severe mental ill-health.** Often a severe learning disability
- People who display risky behaviours which may put themselves or others at risk (this could include fire-setting, abusive, aggressive or sexually inappropriate behaviour)
- People who display behaviours which may lead to contact with the **criminal justice system – often those with lower support needs from disadvantaged backgrounds.**

Resettlement programme for:

- People who have been **in inpatient care for a very long period of time,** having not been discharged when NHS campuses or long-stay hospitals were closed

The service model

3.11 Each local area is different. Local populations have different needs, and their range of providers have different strengths and weaknesses. The mix of services they put in place will need to reflect that diversity. However, there does need to be some national consistency in what services look like across local areas, based on established best practice.

3.12 The national service model, developed with the support of people with learning disability and/or autism, as well as families/carers, and a group of independent experts and published alongside this document, sets out how services should support people with a learning disability and/or autism who display behaviour that challenges.

The National Service Model

1. People should be supported to have a **good and meaningful everyday life** - through access to activities and services such as early years services, education, employment, social and sports/leisure; and support to develop and maintain good relationships.

2. Care and support should be **person-centred, planned, proactive and coordinated** – with early intervention and preventative support based on sophisticated risk stratification of the local population, person-centred care and support plans, and local care and support navigators/keyworkers to coordinate services set out in the care and support plan.

3. People should have **choice and control** over how their health and care needs are met – with information about care and support in formats people can understand, the expansion of personal budgets, personal health budgets and integrated personal budgets, and strong independent advocacy.

4. People with a learning disability and/or autism should be supported to live in the community with **support from and for their families/carers as well as paid support and care staff** – with training made available for families/carers, support and respite for families/carers, alternative short term accommodation for people to use briefly in a time of crisis, and paid care and support staff trained and experienced in supporting people who display behaviour that challenges.

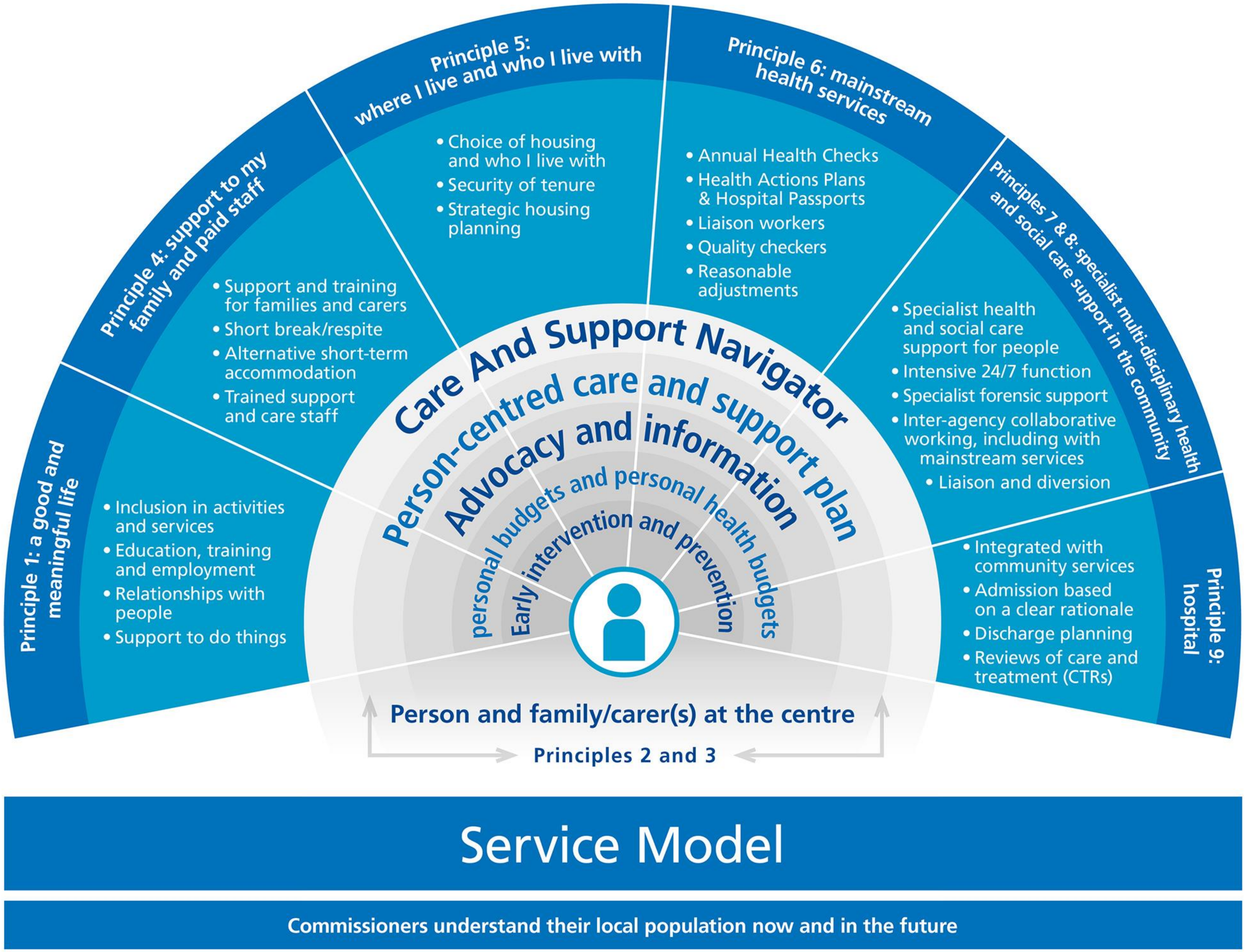
5. People should have a choice about where and with whom they live – with a choice of **housing** including small-scale supported living, and the offer of settled accommodation.

6. People should get good care and support from **mainstream NHS services,** using NICE guidelines and quality standards – with Annual Health Checks for all those over the age of 14, Health Action Plans, Hospital Passports where appropriate, liaison workers in universal services to help them meet the needs of patients with a learning disability and/or autism, and schemes to ensure universal services are meeting the needs of people with a learning disability and/or autism (such as quality checker schemes and use of the Green Light Toolkit).

7. People with a learning disability and/or autism should be able to access **specialist health and social care support in the community** – via integrated specialist multi-disciplinary health and social care teams, with that support available on an intensive 24/7 basis when necessary.

8. When necessary, people should be able to get **support to stay out of trouble** – with reasonable adjustments made to universal services aimed at reducing or preventing anti-social or ‘offending’ behaviour, liaison and diversion schemes in the criminal justice system, and a community forensic health and care function to support people who may pose a risk to others in the community.

9. When necessary, when their health needs cannot be met in the community, they should be able to access high-quality assessment and treatment in a **hospital** setting, staying no longer than they need to, with pre-admission checks to ensure hospital care is the right solution and discharge planning starting from the point of admission or before.



Principle 1: a good and meaningful life

- Inclusion in activities and services
- Education, training and employment
- Relationships with people
- Support to do things

Principle 4: support to my family and paid staff

- Support and training for families and carers
- Short break/respite
- Alternative short-term accommodation
- Trained support and care staff

Principle 5: where I live and who I live with

- Choice of housing and who I live with
- Security of tenure
- Strategic housing planning

Principle 6: mainstream health services

- Annual Health Checks
- Health Actions Plans & Hospital Passports
- Liaison workers
- Quality checkers
- Reasonable adjustments

Principles 7 & 8: specialist multi-disciplinary health and social care support in the community

- Specialist health and social care support for people
- Intensive 24/7 function
- Specialist forensic support
- Inter-agency collaborative working, including with mainstream services
- Liaison and diversion

Principle 9: hospital

- Integrated with community services
- Admission based on a clear rationale
- Discharge planning
- Reviews of care and treatment (CTRs)

Care And Support Navigator

Person-centred care and support plan

Advocacy and information

personal budgets and personal health budgets

Early intervention and prevention

Person and family/carer(s) at the centre

Principles 2 and 3

Service Model

Commissioners understand their local population now and in the future

Reduced need for inpatient services

3.13 With the right set of services in place in the community, the need for inpatient care will significantly reduce, and commissioners will need to have in place far less hospital capacity.

3.14 We will support local commissioners to plan exactly what inpatient capacity they do need, starting with a set of national planning assumptions. Those planning assumptions are that by March 2019, no area should need more inpatient capacity than is necessary at any one time to cater to:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

3.15 In some local areas, use of beds will be lower than these planning assumptions, and we will encourage those local areas to see if they can go still further in supporting people out of hospital settings above and beyond the these initial planning assumptions.

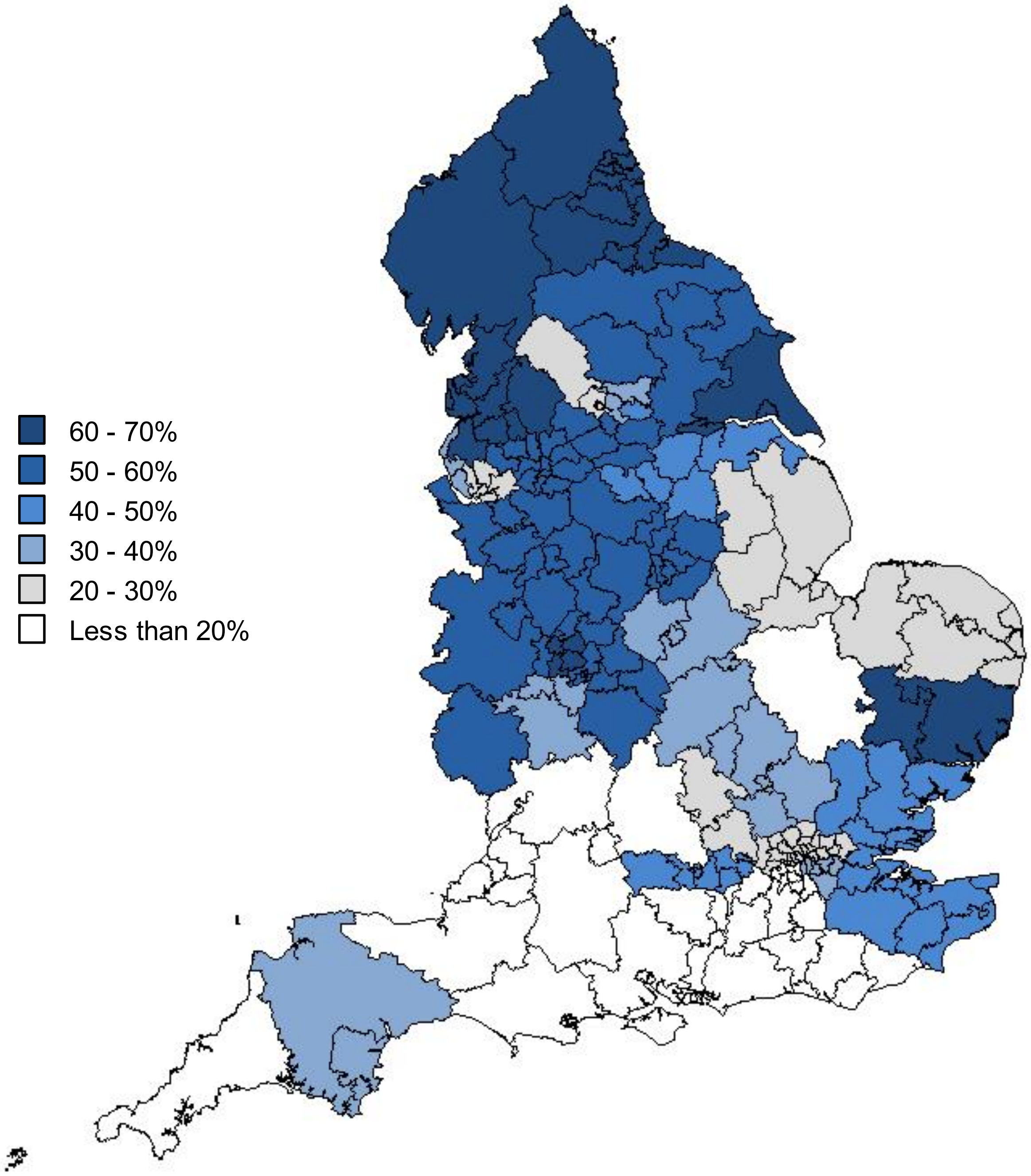
3.16 These planning assumptions are based on what fast track areas have told us they believe is possible, 'sense-checked' against current geographical variation in usage of inpatient services (see figures 2 and 3 below).

3.17 These planning assumptions (10-15 inpatients in CCG-commissioned beds per million population; 20-25 inpatients in NHS England-commissioned beds per million population) would translate to closing, at a minimum:

- 45-65% of CCG-commissioned inpatient capacity (such as assessment and treatment units)
- 25-40% of NHS-England- commissioned inpatient capacity (such as secure services, where we expect the bulk of change to occur in low-secure provision)

3.18 Taken together, that means closing, at a minimum, between 35% - 50% of inpatient provision nationally. In some areas more reliant on hospital care the change will be even more significant, as the following map and charts illustrate.

Figure 10: Reduction in bed usage (%) implied by national planning assumptions, by proposed transforming care partnerships[14]



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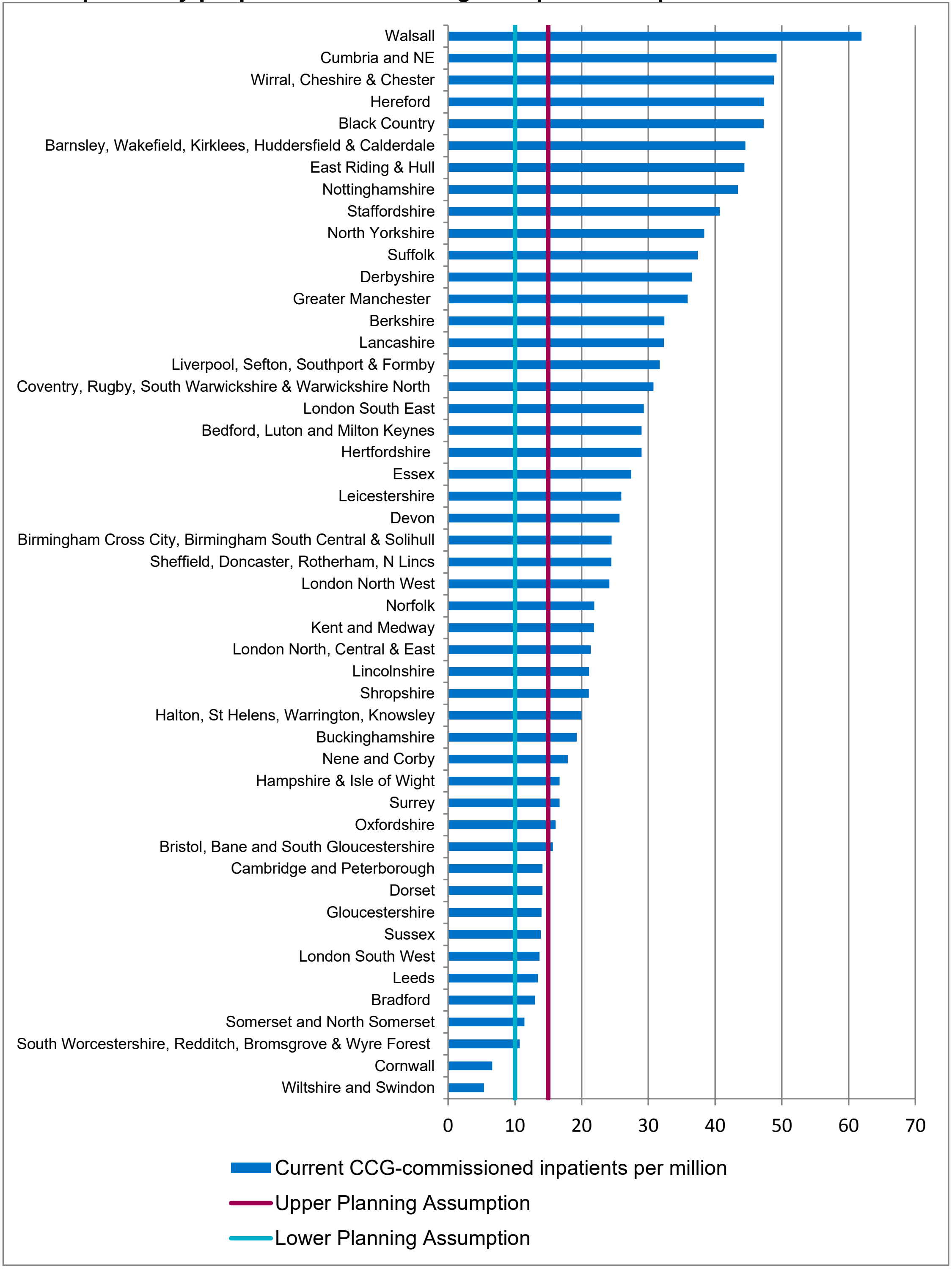
[14] Upper and lower planning assumptions have been applied to current inpatient rates at a transforming care partnership level. The map shows the % reduction in inpatient numbers represented by the midpoint between the projected upper and lower rates for each partnership. See Annex C for further notes on the data used in these charts

Figure 11: Geographical variation in reliance on *CCG-commissioned* inpatient services (as at 31 July 2015), shown against new national planning assumptions by proposed transforming care partnership[15]



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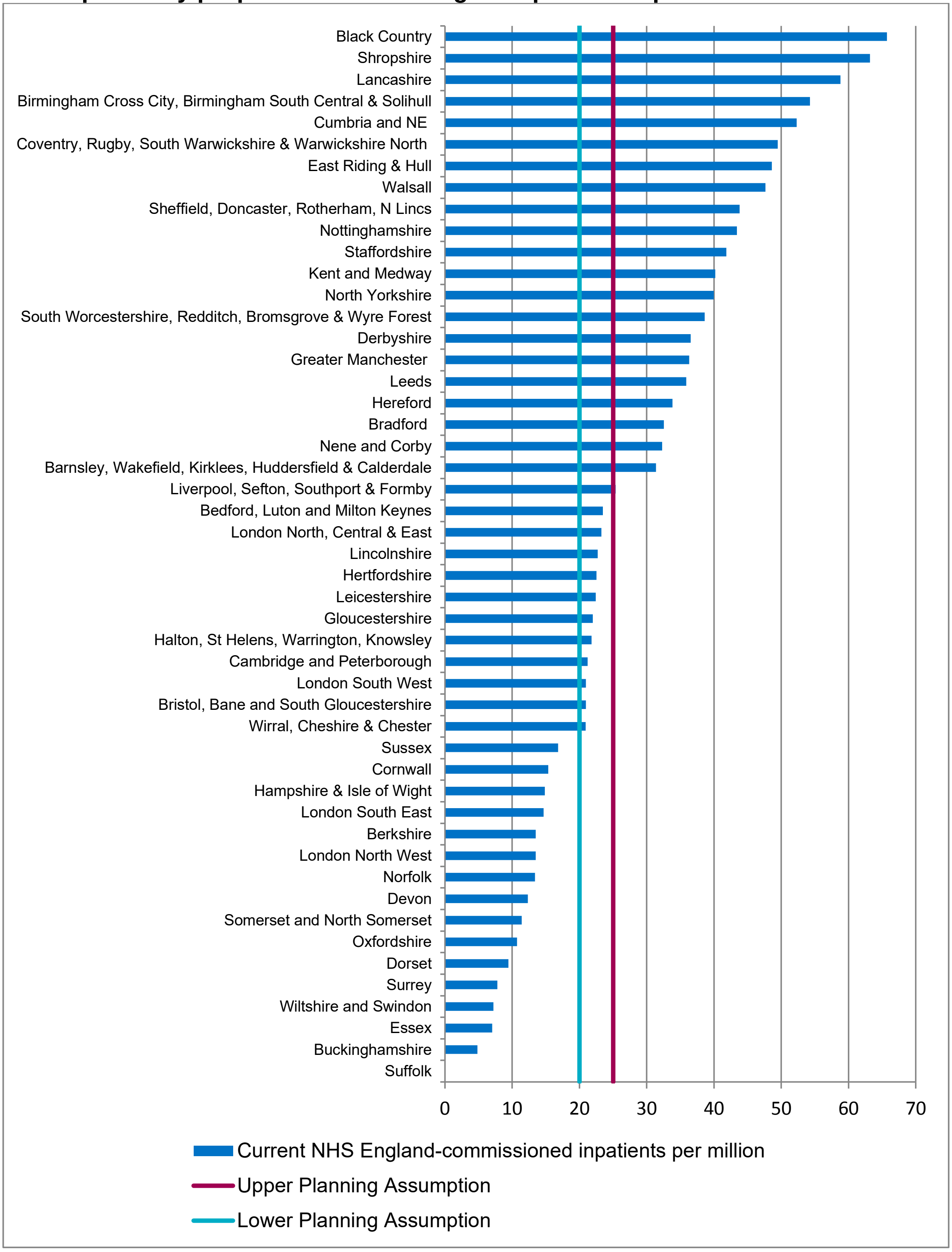
[15] See Annex C for further notes on the data used in these charts

Figure 12: Geographical variation in reliance on *NHS England-commissioned* inpatient services (as at 31 July 2015), shown against new national planning assumptions by proposed transforming care partnership[16]



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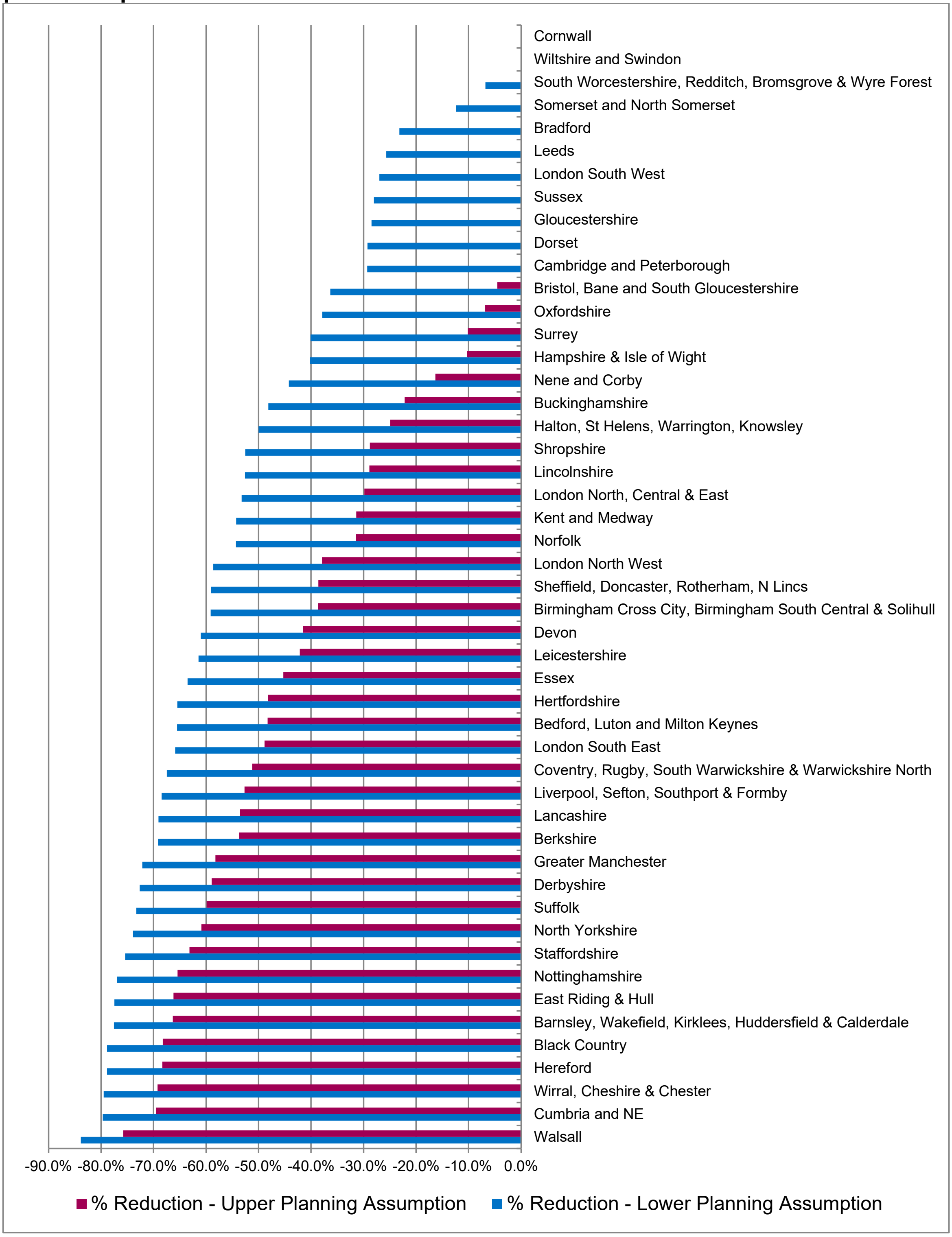
[16] See Annex C for further notes on the data used in these charts

Figure 13: Reductions in usage (%) of *CCG-commissioned* inpatient services implied by national planning assumptions by proposed transforming care partnership[17]



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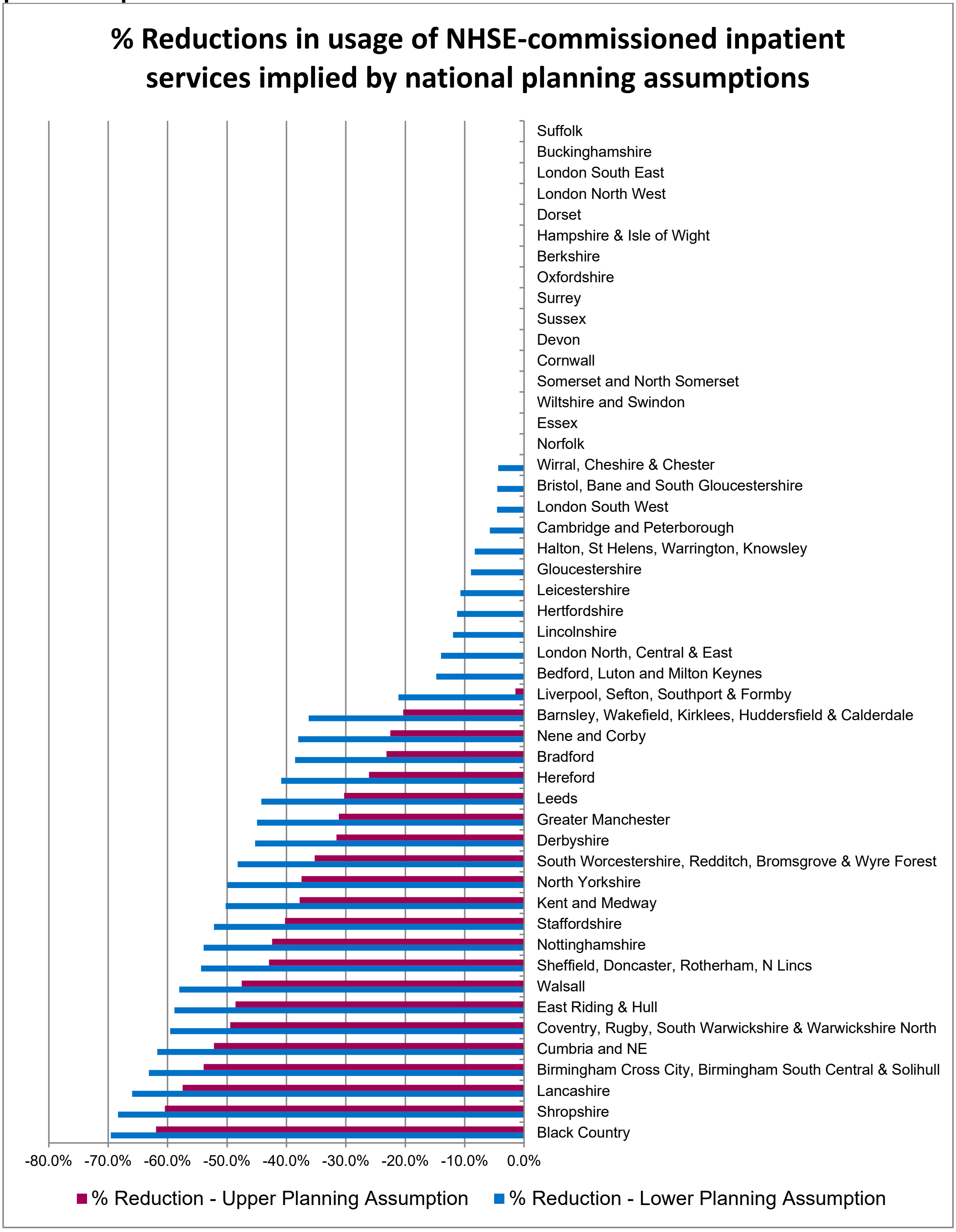
[17] See Annex C for further notes on the data used in these charts

Figure 14: Reductions in usage (%) of *NHS England-commissioned* inpatient services implied by national planning assumptions by transforming care partnership[18]



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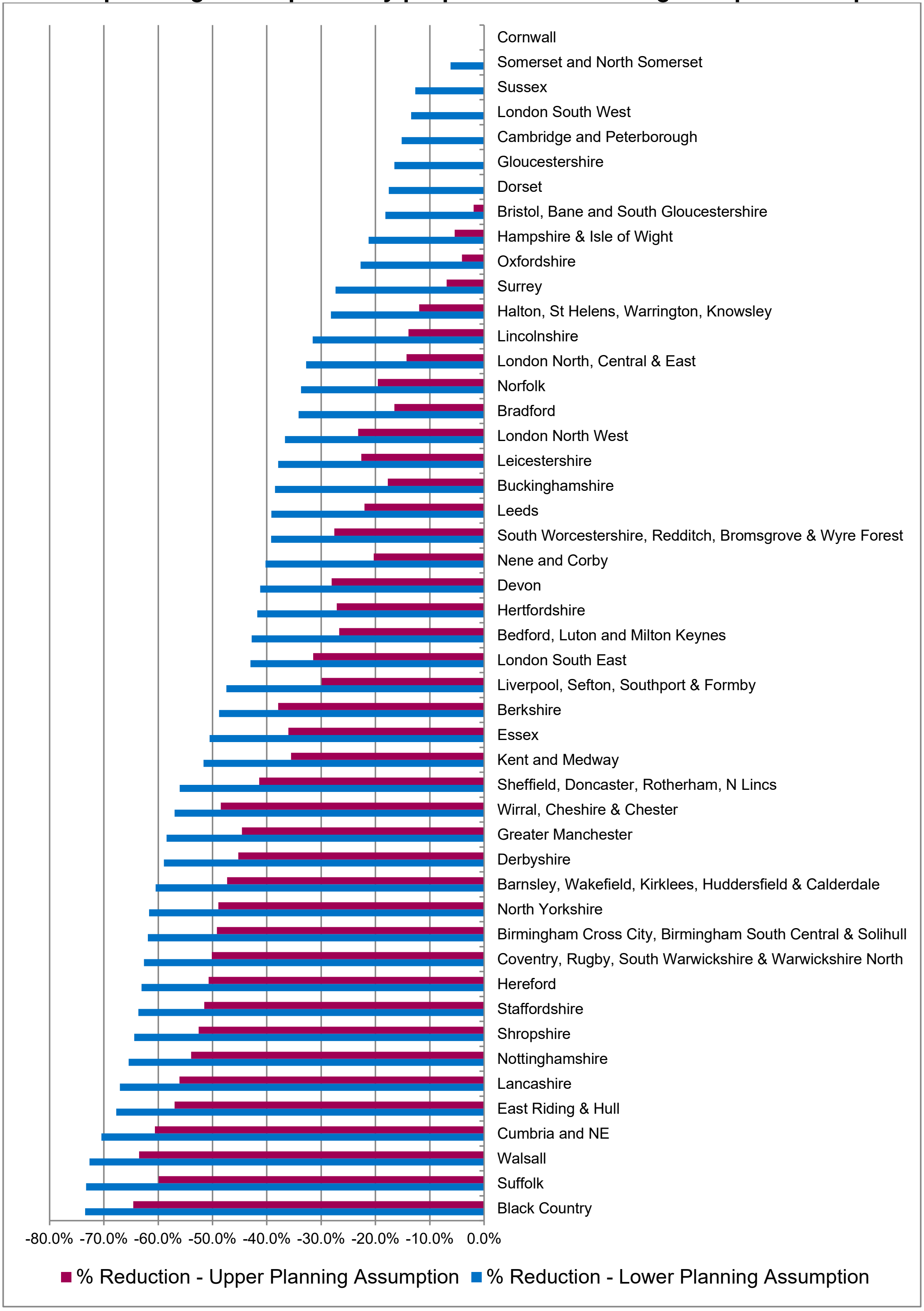
[18] See Annex C for further notes on the data used in these charts

Figure 15: Reductions in *total* usage (%) of inpatient services implied by national planning assumptions by proposed transforming care partnership[19]



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[19] See Annex C for further notes on the data used in these charts

3.19 These national planning assumptions should be seen as articulating a minimum ambition for the coming three years - not a target that, once met, renders the task complete.

3.20 These assumptions are exactly what the term implies – assumptions for local commissioners to use as they enter into a detailed process of planning. Local planning needs to be creative and ambitious based on a strong understanding of the needs and aspirations of people with a learning disability and/or autism, their families and carers, and on expert advice from clinicians, providers and others. The starting point for service planning should be to think creatively about what support would help people to live the best possible life, as opposed to making marginal change to the set of services we have currently – and we will support people with lived experience, clinicians, providers and other experts to work with commissioners and help them think ambitiously and creatively in that way.

3.21 In parallel to these planning assumptions, for the inpatient provision that remains we will work with clinicians, providers and commissioners to reduce the period of time that people spend in hospital, building on and spreading best practice – for instance, Hertfordshire’s fast track plan aims to help reduce length of stay in assessment and treatment services to an average of 85 days. We will also use Care and Treatment Reviews (CTRs) to this end: if someone is still in hospital after six months a mandatory CTR will take place, and people in hospital will also have a right to request a CTR.

3.22 The planning assumptions articulated here should not be seen as describing an ‘end state’ after which services can be set in aspic. We will always want to improve the services and support we make available to people with a learning disability and/or autism. So before the end of 2018, having built up community support and closed hundreds of beds, we will take stock and look at going further with the development of community support and the closure of inpatient services.

3.23 The immediate task now, however, is to start delivering the ambitious changes set out above. What follows is our plan for doing that.

4. Working together to provide new services

Transforming care partnerships

4.1 To deliver the change outlined in the previous chapter, and following what we have learned from the fast tracks, NHS commissioners, in discussion with local government, are mobilising transforming care partnerships – collaborations of CCGs, local authorities and NHS England specialised commissioners.

4.2 Currently the approach to commissioning services for people with a learning disability and/or autism is fractured, with responsibility split between local authorities, CCGs and NHS England. It can be difficult to move funding from one agency to another, to enable the commissioning of less inpatient care and more preventative, community-based services and support. Furthermore, many CCGs will be commissioning for a small number of people with a learning disability and/or autism, making it difficult to take a strategic approach to changing services across the system. Hospitals caring for this group of patients will often be commissioned by a large number of CCGs and NHS England, so that it is difficult for one commissioner to work with those providers to change the services they offer.

4.3 The new transforming care partnerships, currently mobilising, are intended to help address these weaknesses in commissioning arrangements. They will bring together the commissioners responsible for funding health and social care for people with a learning disability and/or autism (CCGs, local authorities with their responsibilities for care and housing, NHS England specialised commissioning), with their budgets aligned or pooled as appropriate. Figure 16 below and Annex A set out further details on how CCGs propose to cluster together in order to work with local authorities and NHS England specialised commissioning hubs in these new partnerships. We expect all CCGs in England to have finished these arrangements by December 2015.

4.4 Transforming care partnerships will be supported to work alongside people who have experience using these services, as well as their families/carers, clinicians, providers and other stakeholders to formulate and implement **joint transformation plans** – closing some inpatient provision and shifting investment into support in the community.

4.5 They will bring commissioners together at a scale larger than most CCGs and many local authorities, with their geographical footprint based on:

- Building where possible on existing collaborative commissioning arrangements (e.g. joint purchasing arrangements amongst CCGs, joint commissioning arrangements between CCGs and local authorities)
- Local health economies of services for people with a learning disability and/or autism (e.g. patient flows, the provider landscape, and relationships between commissioners and providers). Where, for instance, a number of CCGs tend to use the same hospital provider for inpatient services for

people with a learning disability and/or autism, it makes sense for those CCGs to implement change collaboratively
- Commissioning at sufficient scale to manage risk, develop commissioning expertise and commission strategically for a relatively small number of individuals whose packages of care can be very expensive

The challenge

4.6 Each Transforming Care Partnership will be supported to improve outcomes for people with a learning disability and/or autism – both those currently in inpatient services (of whom there are approximately 2,600 nationally) and those in the community at risk of being admitted to hospital without the right support (of whom there are an estimated 24,000 nationally[20]).

4.7 We will support local transforming care partnerships to make progress on three outcomes:

- Reduced reliance on inpatient services (closing hospital services and strengthening support in the community)
- Improved quality of life for people in inpatient and community settings
- Improved quality of care for people in inpatient and community settings

4.8 People with a learning disability and/or autism as well as their families/carers should be supported to co-produce these plans. The change we need to see is as much about a shift in power as it is about service reconfiguration, and that should be reflected not just in the new services and support put in place (where for instance the national service model calls for the expansion of personal health budgets and high-quality independent advocacy), but in the way service changes are planned and delivered.

4.9 We will expect transforming care partnerships to tailor their approach based on local context, but in a way that is consistent with national parameters - in particular, the national service model and minimum planning assumptions on inpatient capacity outlined in chapter 3.

4.10 This work will also need to align with a number of other national priorities, such as:

- Local Transformation Plans for Children and Young People's Health and Wellbeing
- Local action plans under the Mental Health Crisis Concordat
- The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)
- Work to implement the Autism Act 2009 and recently refreshed statutory guidance
- The roll out of education, health and care plans

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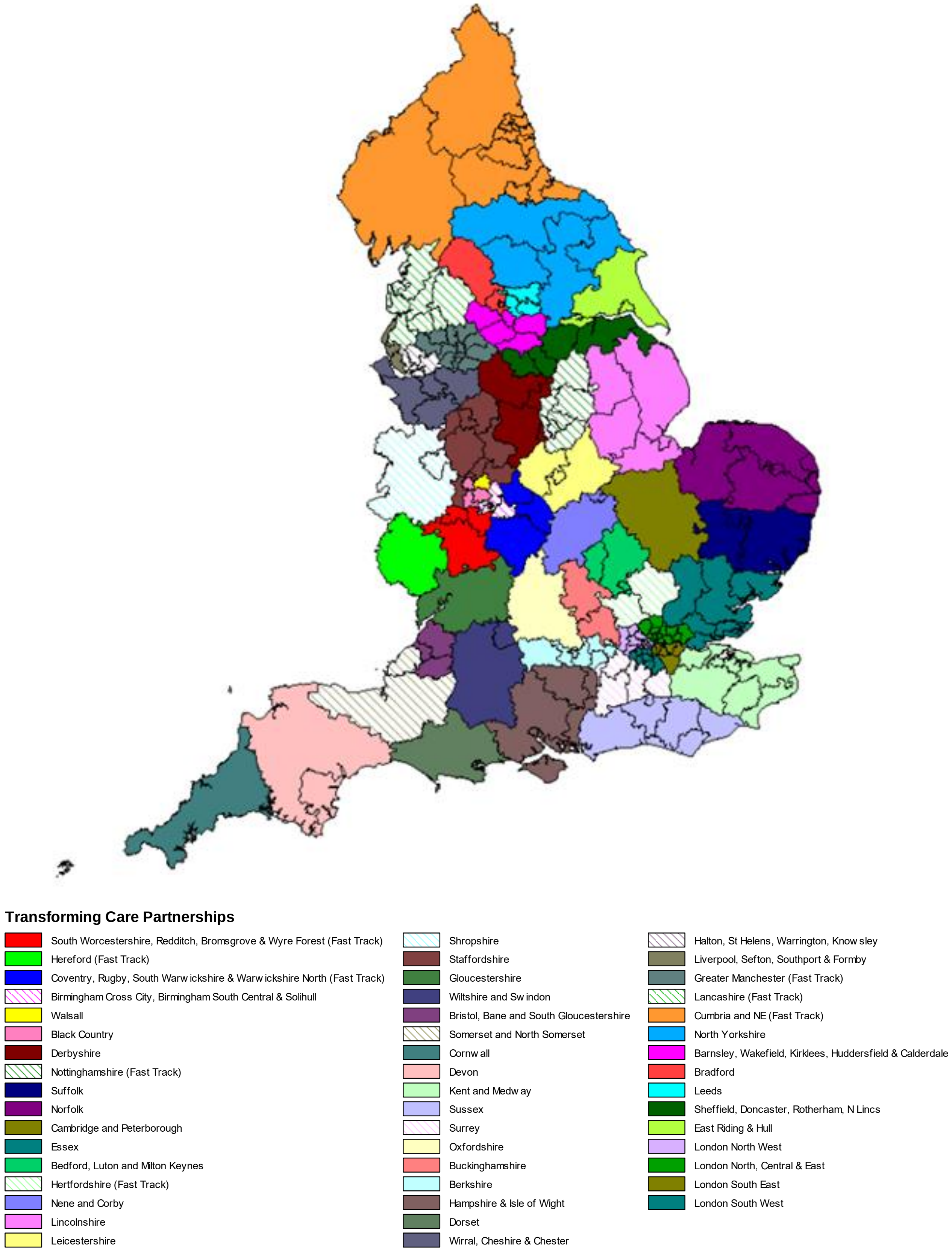
[20] K. Lowe et al, Challenging Behaviours: prevalence and topographies. Journal of Intellectual Disability Research, 51, 625–636 (2007).

Figure 16 – Proposed transforming care partnerships



Supporting local areas

4.11 NHS England, LGA and ADASS will support transforming care partnerships through the different stages of their journey in planning for and implementing change.

Mobilisation

4.12 Local areas will need to have a solid foundation upon which to base transformation, including strong leadership and sound governance, engagement and commitment to joint working amongst a complex range of stakeholders.

4.13 As with the fast track areas, we envisage all transforming care partnerships having a single Senior Responsible Officer (SRO) responsible for the development and delivery of this work.

4.14 Transforming care partnerships will need to engage with and involve a broad range of people, including: all the CCGs; NHS England specialised commissioners; local authorities, including those commissioners responsible for adult and children's social care, education, housing and safeguarding; people with a learning disability and/or autism, their families/carers; clinicians; third-sector organisations; the police and those responsible for the criminal justice system; and relevant Local Education and Training Boards.

4.15 We will support local commissioners in this phase to mobilise the necessary project management resource, governance arrangements and partnership working across the range of organisations who need to be involved.

Understanding the starting point

4.16 Transforming care partnerships will need to base their plans on a strong understanding of: the population they are seeking to achieve better outcomes for (both current inpatients and those in the community at risk of admission without the right support); how much money CCGs, local authorities and NHS England specialised commissioners are currently spending on health and care for that population; which providers are delivering what services for that spend; and how the system is currently performing, its strengths and weaknesses.

4.17 In addition to the above areas will need to understand the estate and housing requirements to implement their plans, and establish whether there are available capital receipts which could be recycled as part of this programme – including those relating to the estimated 2,000 properties used by councils or social landlords to provide housing or care to people with a learning disability but under an NHS charge.

4.18 NHS England, LGA and ADASS will provide data and access to subject matter experts to support local commissioners to understand the strengths and weaknesses of existing local services.

Developing a vision for the future and designing a future model of care

4.19 We will support local commissioners to develop a shared vision of how services will change, in line with the national service model.

4.20 NHS England, LGA and ADASS will support local areas with independent facilitation to bring local stakeholders together to design a jointly-owned future model of care. We will also support commissioners to access a range of experts, such as people with a learning disability and/or autism and their family carers who are 'experts by experience', clinicians, people with experience of person-centred planning - and integrated personal budgets - and providers of innovative community care and support.

Implementation planning

4.21 Local commissioners will need to draw up a road map for implementation, covering issues such as finance, workforce development, market development, or changes to estates.

4.22 NHS England, LGA and ADASS will provide technical expertise to support local areas with implementation planning. Building on the review process developed for assuring fast track plans and in alignment with the process for assuring CCGs' annual plans, local implementation plans will be reviewed and challenged by a range of stakeholders including people with a learning disability and/or autism, their families/carers, clinicians and commissioners from other areas.

Delivery

4.23 We expect local transforming care partnerships to have drawn up robust implementation plans and be delivering against them from 1 April 2016.

4.24 A cross-sector alliance of organisations will support these transforming care partnerships to deliver on this ambitious agenda.

4.25 Working alongside local commissioners, NHS England, LGA and ADASS will work with providers and their representative bodies to rapidly mobilise new housing and care services in the community. This work will focus on supporting providers to:

- Support commissioners to redesign services, including through advice on commissioning plans and market development, expertise on legal frameworks (such as the Mental Capacity Act and Deprivation of Liberty

Safeguards [DoLS]), and supporting individuals and families to design person-centred packages of support
- Deliver appropriate community-based services at scale, including through joint work between social care providers and providers of clinical services, and developing local responses to emergencies
- Train the local workforce within and beyond their organisations (e.g. through PBS training)
- Access the investment needed to expand and improve their offer at pace, including potentially through social investors
- Secure the capital required to deliver high-quality housing in community settings, including through potential social investment solutions such as charity bond issues (see case study below)

Case study – Retail Charity Bonds

In 2014, the first charity bond to be listed on the London Stock Exchange's Order Book for Retail Bonds was launched.

The bond, which raised £11 million to fund accommodation for people with a learning disability, was so oversubscribed it closed its offer period two and half weeks early.

The bond was launched by Retail Charity Bond plc and the funds have been used by Golden Lane Housing, the national charity which provides housing for people with a learning disability, to invest in buying and adapting much-needed community based housing across the country for over 100 people with a learning disability.

4.26 Alongside this work with providers to mobilise new services and housing in the community, we will explore the establishment of a national collaborative improvement programme (co-ordinating peer-learning and shared problem-solving between local areas), and a national accelerated support team able to work intensively with local areas with the biggest challenges and/or struggling to make progress.

4.27 HEE, Skills for Health and Skills for Care will collaborate to support the development of an appropriately skilled workforce to build the capacity to support people in the community. As far as possible, this will include working to support current inpatient staff to develop skills to work in the community. Every transforming care partnership will have a lead HEE contact to support them with planning and delivering workforce change. That lead contact will help them access relevant tools (such as competency frameworks), funding streams and training (for example leadership development or training to support staff in mainstream services to understand the needs of people with a learning disability and/or autism). Annex B sets out some of these resources in more detail.

4.28 NHS England, Monitor and the TDA will work together to support hospitals proactively to shift their business models, increasingly offering NHS assessment and treatment services in the community.

4.29 We will work with the CQC, Monitor, the TDA and local commissioners to ensure that inpatient units are only closed when people living in those units are supported to move in an appropriate and timely way to high quality services that can meet their needs. The CQC is also undertaking work to review their fundamental standards against the service model. When regulating active services (or those seeking registration) these fundamental standards will be used and robust action taken if services are not compatible with these and therefore the new service model.

4.30 We will review governance arrangements for the Transforming Care programme at a national level to ensure it reflects this alliance of organisations supporting local areas to deliver.

Monitoring progress

4.31 Nationally, we will monitor progress on delivery against the overarching outcomes we expect transformation to achieve, namely:

- Reduced reliance on inpatient services (closing hospital services and strengthening support in the community)
- Improved quality of life for people in inpatient and community settings
- Improved quality of care for people in inpatient and community settings

4.32 Reduced reliance on inpatient services will be monitored using Assuring Transformation data,[21] and from January 2016 the Mental Health Services Single Data Set[22] (MHSDS), incorporating data from the Learning Disabilities Census and Assuring Transformation dataset.

4.33 We will explore with transforming care partnerships an appropriate way to monitor improvements in quality of life, but are minded to support areas to roll-out use of the Health Equality Framework tool[23] to monitor quality of life. In particular, we are considering how to support the use of this tool to understand changes to quality of life as people are supported to move out of inpatient services.

4.34 We will support the development of a basket of indicators to monitor improvements in quality of care, aligned with the newly developed service model. This basket of indicators will, as far as possible, be based on existing data sources currently collected in the NHS and social care.

4.35 Furthermore, as part of the role out of the CTRs across the NHS, NHS England will work with system partners on introducing a metric for measuring the outcomes of this process. This may involve introducing a Patient Reported Outcome Measure (PROM) and/or a Patient Reported Experience Measure

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[21] http://www.hscic.gov.uk/article/6328/Reports-from-Assuring-Transformation-Collection

[22] This is replacing the Mental Health and Learning Disabilities dataset

[23] http://www.ndti.org.uk/publications/other-publications/the-health-equality-framework-and-commissioning-guide1/

(PREM). Development of this CTR outcome measure will have to involve people with a learning disability and/or autism, as well as their families/carers, clinicians, providers and commissioners to ensure it is robust and can be used at a national level to assess progress.

4.36 We will also revise the Learning Disability Self-Assessment Framework (SAF) and the Autism Self-Assessment Framework so that they reflect how well local areas are doing in building up support in the community and closing inpatient services.

4.37 With all the measures outlined above, it is important that people are supported to understand who will see their information, how their information will be used and make decisions about sharing their information. People should be given help to do this. For those people who lack capacity, they should still be involved as much as possible in any decisions made in their best interests.

4.38 NHS England will also support people with a learning disability to check the quality of services themselves, through a programme of work to establish a centralised system for NHS Quality Checking by people with a learning disability. Quality checker services train and support experts by experience to audit service quality. Quality checkers use their own experiences to make assessment on the quality of care and support, and to give a view that can be often missing from other forms of quality review. This entails using indicators of quality which people with a learning disability themselves consider to be relevant and important and which may therefore differ from those which have historically been used. Quality checkers with a learning disability will themselves carry out the evaluation, part of which will involve talking to service users about their experiences and views of the service in question. Evaluation of quality checking programmes show them to be an effective and efficient use of resources and to be associated with increases in quality and improved outcomes.

4.39 In addition, pilot work supported by NHS England has also demonstrated the potential of ‘Always Events’ to strengthen the voices of people with a learning disability and/or autism in the quality assurance of services.

4.40 Lancashire Care NHS Foundation Trust - in partnership with the Institute for Healthcare Improvement (IHI), the Picker Institute Europe and NHS England - has co-produced with people with a learning disability a set of ‘Always Events’ to improve the quality and consistency of transitions within and between services. NHS England will expand its work on ‘Always Events’, share the case study from Lancashire and produce a toolkit with IHI to support the further use of this tool in order to improve the responsiveness and accountability of services.

Financial underpinnings

4.41 A new financial framework will underpin and enable transformation.

4.42 Local transforming care partnerships (CCGs, local authorities and NHS England specialised commissioning) will be asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care in a different way to achieve better results. This includes shifting money from some services (such as inpatient care) into others (such as community health services or packages of support). The costs of the future model of care will therefore be met from the total current envelope of spend on health and social care services for people with a learning disability and/or autism. We estimate that the closure of inpatient services of the scale set out in chapter 3 will release hundreds of millions of pounds for investment in better support in the community.

4.43 To enable that to happen, NHS England's specialised commissioning budget for secure learning disability and autism services will be aligned with the new transforming care partnerships, and CCGs will be encouraged to pool their budgets with local authorities whilst recognising their continued responsibility for NHS Continuing Healthcare. CCGs, NHS England specialised commissioning and local authorities will be supported to, where appropriate, put in place governance and financial mechanisms to align or pool resources and manage financial risk. The degree of change and financial risk will inevitably vary across localities, and we will support local commissioners to base decisions on transparent, open-book discussions, focussed on achieving the best outcomes for the people they serve.

4.44 For people who have been an inpatient for five years or more (approximately one third of the total inpatient population) and who are ready for discharge, we expect the transformational change required to be one of 'resettlement' out of hospital and into a more suitable home, as opposed to redesigning services to reduce the 'revolving door' of admissions and discharges. For this group, money will 'follow the individual' through dowries.

4.45 Dowries will be paid by the NHS to local authorities for people leaving hospital after continuous spells in inpatient care of five years or more at the point of discharge. We expect that NHS England will pay for dowries when the inpatient is being discharged from NHS England-commissioned care, and that CCGs will pay for dowries when the individual is being discharged from CCG-commissioned care. Dowries will be recurrent, will be linked to individual patients, and will cease on the death of the individual. An annual confirmation of dowry-qualifying individuals should be undertaken by local authorities and CCGs. Dowries are to be prospective only, and so should not be applied to any patients that have already been discharged. They should apply to those patients discharged on or after 1 April 2016, and only to those patients who have been in inpatient care for five years or more on 1 April 2016 (not any patient who reaches five years in hospital subsequent to that date). They should apply pro rata in the start and finish year. To ensure that the costs of the future model of care fit within the existing funding envelope, it is important that dowries are set at a level which is consistent with this principle. The absolute level of the dowry is not expected to be set nationally, but is to be left to local discussions which should be subject to the principles set out here. In addition to paying for these dowries, the NHS will continue to fund continuing healthcare (CHC) and relevant Section 117 aftercare.

4.46 In addition, from November 2015 *Who Pays* guidance - determining responsibility for payment to providers - will be revised to facilitate swifter discharge from hospital of patients originating from one CCG but being discharged into a different local area. This will ensure continuity of care with responsibility remaining with one CCG rather than being passed from commissioner to commissioner.

4.47 Transformation of this scale will entail significant transition costs, including the temporary double running of services as inpatient facilities continue to be funded whilst new community services are established. The extent of the transition costs will depend on the efficiency of the bed closure programme, and the timing and extent of required new community investment. We will work with commissioners and providers to support the closure of inpatient capacity and development of new community services as efficiently as possible, but we recognise that non-recurrent investment will still be necessary. To support local areas with these transitional costs and building on the approach tested with fast track areas, NHS England will make available up to £30 million of transformation funding over three years, with national funding conditional on match-funding from local commissioners.

4.48 In addition to this, £15 million capital funding over three years will be made available, and NHS England will explore making further capital funding available following the Spending Review.

4.49 As set out in the national service model, alongside these new financial underpinnings to enable transformation we expect to see a significant growth in personalised funding approaches (personal budgets, personal health budgets, and integrated personal budgets as well as education, health and care plans). Local transformation should, for instance, be aligned with existing requirements for CCGs to set out a ‘local offer’ on personal health budgets.

4.50 In some parts of the country, local transformation plans will also need to align with Integrated Personal Commissioning (IPC) pilots. IPC sites are currently testing approaches to enable people to purchase their care (including clinical services currently commissioned using NHS standard contracts) through personal budgets, combining resources from health, social care and other funding sources where applicable. The work these sites are undertaking includes linking cost and activity data across services and trialling new contracting and payment approaches that enable the money to be used differently. As IPC sites progress their work, we will support local transforming care partnerships to learn from them and apply the lessons to their own local areas.

Conclusion

This document started with a simple vision that people with learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying valued lives and to be treated with dignity and respect. They should have a home, be able to develop and maintain relationships, and get the support they need to live healthy, safe and fulfilling lives in the community.

For all the frustration of recent years, it is a vision that we can make real. Thousands of people with a learning disability and/or autism are today supported in the community who would years ago have lived in hospitals. There is good practice across the country. There are thousands of people with the expertise and commitment to make this shift happen, from people with a learning disability and/or autism themselves, families/carers as well as frontline clinicians and staff. We have local leaders across social care, the NHS and criminal justice system ready and willing to take up the challenge. At a national level there is an alliance of organisations committed to breaking down the barriers to change, supporting local leaders to make a difference.

Together we have an opportunity to transform thousands of lives. Together we must seize the day and deliver.

Annex A – Proposed CCG clusters for transforming care partnerships

This table shows how CCGs currently propose to cluster together to work with local authorities and NHS England specialised commissioning to build up community services and close inpatient provision that is no longer needed.

Transforming Care Partnership	**Clinical Commissioning Group (CCG)**
South Worcestershire, Redditch, Bromsgrove & Wyre Forest	NHS South Worcestershire CCG
	NHS Wyre Forest CCG
	NHS Redditch and Bromsgrove CCG
Hereford	NHS Herefordshire CCG
Coventry, Rugby, South Warwickshire & Warwickshire North	NHS Coventry and Rugby CCG
	NHS South Warwickshire CCG
	NHS Warwickshire North CCG
Birmingham CrossCity, Birmingham South Central & Solihull	NHS Birmingham CrossCity CCG
	NHS Birmingham South and Central CCG
	NHS Solihull CCG
Walsall	NHS Walsall CCG
Black Country	NHS Dudley CCG
	NHS Sandwell and West Birmingham CCG
	NHS Wolverhampton CCG
Derbyshire	NHS Erewash CCG
	NHS Southern Derbyshire CCG
	NHS Hardwick CCG
	NHS North Derbyshire CCG
Nottinghamshire	NHS Mansfield and Ashfield CCG
	NHS Bassetlaw CCG
	NHS Newark and Sherwood CCG
	NHS Nottingham City CCG
	NHS Nottingham North and East CCG
	NHS Nottingham West CCG
	NHS Rushcliffe CCG
Suffolk	NHS Ipswich and East Suffolk CCG
	NHS West Suffolk CCG
Norfolk	NHS North Norfolk CCG
	NHS Norwich CCG

	NHS South Norfolk CCG
	NHS West Norfolk CCG
	NHS Great Yarmouth and Waveney CCG
Cambridge and Peterborough	NHS Cambridgeshire and Peterborough CCG
Essex	NHS Basildon and Brentwood CCG
	NHS Castle Point and Rochford CCG
	NHS Mid Essex CCG
	NHS North East Essex CCG
	NHS Southend CCG
	NHS Thurrock CCG
	NHS West Essex CCG
Bedford, Luton and Milton Keynes	NHS Bedfordshire CCG
	NHS Luton CCG
	NHS Milton Keynes CCG
Hertfordshire	NHS East and North Hertfordshire CCG
	NHS Herts Valleys CCG
Nene and Corby	NHS Nene CCG
	NHS Corby CCG
Lincolnshire	NHS Lincolnshire East CCG
	NHS Lincolnshire West CCG
	NHS South Lincolnshire CCG
	NHS South West Lincolnshire CCG
Leicestershire	NHS East Leicestershire and Rutland CCG
	NHS Leicester City CCG
	NHS West Leicestershire CCG
Shropshire	NHS Shropshire CCG
	NHS Telford and Wrekin CCG
Staffordshire	NHS East Staffordshire CCG
	NHS North Staffordshire CCG
	NHS South East Staffordshire and Seisdon Peninsular CCG
	NHS Stafford and Surrounds CCG
	NHS Cannock Chase CCG
	NHS Stoke-on-Trent CCG
Gloucestershire	NHS Gloucestershire CCG
Wiltshire and Swindon	NHS Swindon CCG
	NHS Wiltshire CCG
Bristol, Bane and South	NHS Bristol CCG

Gloucestershire	NHS South Gloucestershire CCG
	NHS Bath and North East Somerset CCG
Somerset and North Somerset	NHS North Somerset CCG
	NHS Somerset CCG
Cornwall	NHS Kernow CCG
Devon	NHS North, East, West Devon CCG
	NHS South Devon and Torbay CCG
Kent and Medway	NHS Ashford CCG
	NHS Canterbury and Coastal CCG
	NHS Dartford, Gravesham and Swanley CCG
	NHS Medway CCG
	NHS South Kent Coast CCG
	NHS Swale CCG
	NHS Thanet CCG
	NHS West Kent CCG
Sussex	NHS Brighton and Hove CCG
	NHS High Weald Lewes Havens CCG
	NHS Eastbourne, Hailsham and Seaford CCG
	NHS Hastings and Rother CCG
	NHS Coastal West Sussex CCG
	NHS Crawley CCG
	NHS Horsham and Mid Sussex CCG
Surrey	NHS Guildford and Waverley CCG
	NHS North West Surrey CCG
	NHS Surrey Downs CCG
	NHS East Surrey CCG
	NHS Surrey Heath CCG
Buckinghamshire	NHS Aylesbury Vale CCG
	NHS Chiltern CCG
Berkshire	NHS Bracknell and Ascot CCG
	NHS Slough CCG
	NHS Windsor Ascot and Maidenhead CCG
	NHS Newbury and District CCG
	NHS North and West Reading CCG
	NHS South Reading CCG
	NHS Wokingham CCG
Hampshire & Isle of Wight	NHS North East Hampshire and Farnham CCG
	NHS North Hampshire CCG

	NHS Portsmouth CCG
	NHS South Eastern Hampshire CCG
	NHS Southampton CCG
	NHS West Hampshire CCG
	NHS Fareham and Gosport CCG
	NHS Isle of Wight CCG
Dorset	NHS Dorset CCG
Wirral, Cheshire & Chester	NHS Wirral CCG
	NHS West Cheshire CCG
	NHS Eastern Cheshire CCG
	NHS South Cheshire CCG
	NHS Vale Royal CCG
Halton, St Helens, Warrington, Knowsley	NHS Halton CCG
	NHS St Helens CCG
	NHS Warrington CCG
	NHS Knowsley CCG
Liverpool, Sefton, Southport & Formby	NHS South Sefton CCG
	NHS Southport and Formby CCG
	NHS Liverpool CCG
Greater Manchester	NHS Bolton CCG
	NHS Bury CCG
	NHS Central Manchester CCG
	NHS Heywood, Middleton and Rochdale CCG
	NHS North Manchester CCG
	NHS Oldham CCG
	NHS Salford CCG
	NHS South Manchester CCG
	NHS Stockport CCG
	NHS Tameside and Glossop CCG
	NHS Trafford CCG
	NHS Wigan Borough CCG
Lancashire	NHS Blackburn with Darwen CCG
	NHS Blackpool CCG
	NHS Chorley and South Ribble CCG
	NHS East Lancashire CCG
	NHS Fylde and Wyre CCG
	NHS Greater Preston CCG
	NHS Lancashire North CCG

	NHS West Lancashire CCG
Cumbria and NE	NHS Cumbria CCG
	NHS Newcastle Gateshead CCG
	NHS North Tyneside CCG
	NHS Northumberland CCG
	NHS South Tyneside CCG
	NHS Sunderland CCG
	NHS Darlington CCG
	NHS Durham Dales, Easington and Sedgefield CCG
	NHS Hartlepool and Stockton-on-Tees CCG
	NHS North Durham CCG
	NHS South Tees CCG
North Yorkshire	NHS Hambleton, Richmondshire and Whitby CCG
	NHS Harrogate and Rural District CCG
	NHS Scarborough and Ryedale CCG
	NHS Vale of York CCG
Barnsley, Wakefield, Kirklees, Huddersfield & Calderdale	NHS Barnsley CCG
	NHS Wakefield CCG
	NHS North Kirklees CCG
	NHS Greater Huddersfield CCG
	NHS Calderdale CCG
Bradford	NHS Bradford Districts CCG
	NHS Bradford City CCG
	NHS Airedale, Wharfdale and Craven CCG
Leeds	NHS Leeds North CCG
	NHS Leeds South and East CCG
	NHS Leeds West CCG
Sheffield, Doncaster, Rotherham, North Lincolnshire	NHS Doncaster CCG
	NHS Rotherham CCG
	NHS North East Lincolnshire CCG
	NHS North Lincolnshire CCG
	NHS Sheffield CCG
East Riding & Hull	NHS East Riding of Yorkshire CCG
	NHS Hull CCG
London North West	NHS Brent CCG
	NHS Central London CCG

	NHS Ealing CCG
	NHS Hammersmith and Fulham CCG
	NHS Harrow CCG
	NHS Hillingdon CCG
	NHS Hounslow CCG
	NHS West London CCG
London North, Central & East	NHS Barking and Dagenham CCG
	NHS Barnet CCG
	NHS Camden CCG
	NHS City and Hackney CCG
	NHS Enfield CCG
	NHS Haringey CCG
	NHS Havering CCG
	NHS Islington CCG
	NHS Newham CCG
	NHS Redbridge CCG
	NHS Tower Hamlets CCG
	NHS Waltham Forest CCG
London South East	NHS Bexley CCG
	NHS Bromley CCG
	NHS Greenwich CCG
	NHS Lambeth CCG
	NHS Lewisham CCG
	NHS Southwark CCG
London South West	NHS Croydon CCG
	NHS Kingston CCG
	NHS Merton CCG
	NHS Richmond CCG
	NHS Sutton CCG
	NHS Wandsworth CCG
Oxfordshire	NHS Oxfordshire CCG

Annex B – Workforce development

i. In every part of the country there are people with the skills and experience to deliver effective care to people with a learning disability and/or autism. These people can be found within health and social care and amongst the people with a learning disability and/or autism themselves, as well as families/carers that support individuals in their own home.

ii. As such, an essential part of delivering each joint transformation plan relies on how areas can harness these skills.

iii. Areas need to develop, focus and refine the skills needed to enable them to work in a different way. They need to manage risk efficiently and have robust and effective ways of intervening in crisis situations that lead to the best possible solutions in the least restrictive environment.

iv. Each area needs to establish mechanisms to understand the skills and competencies that are required to support the specific needs of every individual. Only then will they be able to commission a service that is flexible enough to care for each person and their own specific circumstances. The development of new and innovative approaches to supporting people will be reliant upon the development of a flexible and skilled workforce equipped to adapt and adopt new practices. This may involve commissioning new roles from those traditionally employed within the current provision.[24] Those commissioned to provide such services will need to define competencies and skills required, assess the capability currently available within their workforce, and access appropriate training and development. This will include developing skills to deliver services across all ages in the areas of mental health, autism, managing behavioural problems and offending behaviour.

v. HEE alongside partner organisations Skills for Care and Skills for Health will offer practical support with the aim to:

- **Equip commissioners with the tools and confidence to commission for workforce skills and competencies.** Commissioners are an essential part of the workforce that needs development and support to deliver the new service model. This includes enhancing existing service provision, creating new service models and commissioning beyond the traditional service boundaries, for example placing learning disability nurses in primary and secondary care in order to support health and care professionals to make better decisions. Skills for Care have developed a workforce commissioning model that provides a systematic way of linking service commissioning with workforce commissioning and financial strategy. This can be found here

vi. There are several models for testing workforce assumptions and undertaking Strategic Workforce planning, including Integrated Workforce Planning

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[24] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/309153/Strengthening_the_commitment_one_year_on_published.pdf

Solutions from Skills for Health, and Skills for Care's Workforce Capacity Planning guidance.

- **Work with existing service providers to review the skills and competencies within their existing workforce to identify education and training needs, and facilitate transition to a new way of working.** HEE in partnership with Skills for Health have developed a skills and competency framework which can be utilised to undertake a training needs analysis of the existing workforce, and to build a competency based team model against which new and existing roles can be mapped. The framework, alongside an illustrative animated video, can be found here: HEE Skills & Competency Framework

vii. We are in the process of developing an interactive tool to support the implementation and use of the competence framework.

viii. The Positive Behavioural Support (PBS) Coalition have published a PBS Competency Framework. For ease of use, the PBS competencies have been mapped into the HEE Skills and Competency Framework.

ix. Whilst this framework has been developed primarily for the health care workforce it can be utilised in a range of services. Skills for care have developed a strategy for the social care sector to support functional and employability skills (Core Skills), which impact directly on the quality of care and support services.

- **Ensure that education and training to enable the wider workforce is able to meet the needs of people with a learning disability in all care settings**. Recognising that most people with a learning disability have their health and care needs met by mainstream health care services, HEE commissioned the development of education and training resources 'Learning Disability Made Clear' that can be used by staff in a range of health and care settings to increase their knowledge and support how services can make adjustments to meet specific needs

x. A suite of existing resources developed to raise awareness of the needs of people with autism, have been reviewed and located in one place to enable individuals and organisations to select the most appropriate resource for their needs. A marketing and promotion strategy is underway to ensure these resources are widely accessed by employers, employees, volunteers and carers across the country. These can be found here.

xi. In addition to the above, work is being undertaken to develop specific learning disability and autism skills in the mainstream mental health workforce on whom we will become increasingly reliant as specialist services become more integrated.

- **Developing leadership capability across the system including commissioners, service providers and carers to promote innovation and change services to focus on people's needs.** HEE, Skills for Health and Skills for Care will coordinate access to the various provision and funding streams available across agencies to ensure that creative and innovative leadership activities are supported as part of the national transformation plan

Annex C – Notes on data used in this document

All modelling to produce planning assumptions and charts was based on calculating inpatient rates per million population. The following notes apply to all charts used in this document which describe projected reductions in fast track bed usage and current geographical variation in reliance on inpatient care across England.

- All inpatient rates are based on GP registered population aged 18 and over as at 2013/14
- Inpatient numbers include children under the age of 18 but these patients represent less than 5% of the total inpatient population
- High secure services have been excluded (65 patients[25])

Data on the current position and projections for fast track areas is taken from the fast track plans, but projections exclude Worcestershire (part of Arden, Herefordshire and Worcestershire Fast Track).

The data set used to calculate the current geographical variation as at 31 July 2015 combines information on CCG-commissioned patients from the Assuring Transformation collection and data on NHS England-commissioned patients from NHS England's Local Trackers (this includes information on the home CCG of NHS England-commissioned patients). This means that the presentation of inpatient data is based on where patients originally come from, not where their hospital is located.

Assuring Transformation data is collected and published by The Health and Social Care Information Centre (HSCIC). All rights reserved ©2015. Assuring Transformation data is presented in accordance with HSCIC rules on suppressed data for collections involving small numbers of records.

Not all NHS England-commissioned patients in the Local Tracker data could be matched to a CCG of origin, and these patients are therefore omitted from the analysis of geographical variance on a Transforming Care Partnership level. The geographical analysis presented in Figures 2 and 3 assigns these patients to the locality of their commissioner.

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[25] Number of inpatients in high secure settings suppressed in accordance with HSCIC rules on suppressed data for collections involving small numbers of records. Figure correct as at 31st July 2015.

North Harbour Consulting

THE HOSPITAL RESETTLEMENT PROGRAMME IN NORTHERN IRELAND AFTER THE BAMFORD REVIEW

PART 2: THE EXPERIENCE OF LEARNING DISABLED PEOPLE RESETTLED FROM LONG STAY HOSPITALS

A REPORT FOR THE NORTHERN IRELAND HOUSING EXECUTIVE

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June 2017

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KEY FINDINGS AND CONCLUSIONS

Findings

Responses were obtained from twenty two service users with learning disabilities, their family members and the support staff working in housing support schemes where they were housed after resettlement. The service users had all been resettled from long-stay hospitals between April 2012 and March 2016 as part of the post-Bamford Review resettlement programme. Views were sought on whether the resettlement programme had been successful for resettled people and whether betterment in their lives had been achieved in the ways advocated by the Bamford Review.

There was general contentment expressed by service users with the resettlement process, although this may have been influenced by the extent of their memory of the move from long-stay hospital and their capacity to understand the process. Service users' responses indicated that, in most cases, resettlement had been based on a staged approach in which hospital patients had visited a scheme, had stayed there overnight, and had then been given the opportunity to stay for a slightly longer period before finally deciding to move there permanently. It should be noted that most service users had limited recall of whether a range of accommodation and locations had been offered to them, but their responses suggested that the actual move had not been traumatic or difficult.

Feedback from families was generally very positive about the resettlement process. Family members said they thought that the resettlement process had been well managed and that their family member's life had improved considerably as a result. Other positive factors that were highlighted included:

- Well managed procedures for handover of responsibility for resettled people from hospital staff to the supported housing staff;
- A process for matching people to ensure the compatibility of service users moving to the same scheme; and in most cases,
- A comprehensive level of involvement of both service users and family members in the resettlement process.

However, some difficulties were also noted in individual cases. These difficulties tended to be associated with:

- The service user's assessed 'readiness' for resettlement;
- A perceived lack of compatibility between and a poor mix of tenants living together in a small number of schemes; and
- Delays in identifying suitable sites, obtaining planning permission and community consultation which had delayed resettlement after people were judged by their hospital care managers and medical staff to be ready to move on.

Other limitations to betterment included:

- The location of supported housing schemes, especially those in rural areas or in places where public transport was not available;
- Distance from and lack of accessibility to services; and
- The availability and affordability of external activities including day centres.

The impact of these limitations did raise questions about whether the service user was fully living in and integrated into the wider community, or if they were effectively living in a smaller institution, albeit in a community setting.

There was a general view among scheme managers that strategic oversight had been lacking in terms of the identification of the costs associated with the resettlement programme, and the time schedules for implementation.

A small number of family members identified other concerns. These mainly related to service users with a severe learning disability or complex needs. These included:

- The safety of a small number of resettled people outside the hospital they were familiar with and felt safe in;
- The family's uncertainty about whether resettlement was appropriate for their relative;
- The suitability of people to be resettled in terms of their capacity to do things for themselves and to integrate into the community; and
- Whether the individual would be accepted in the community.

Family members also raised concerns about aspects of the resettlement process, including:

- Lack of parental consultation and involvement;
- The timing and stop/start approach taken by Trusts to resettlement; and
- the lack of appropriate accommodation options.

However, there was evidence that the attitude of these more reluctant family members to resettlement had changed over time from reluctance and outward resistance in some cases to acceptance and support.

Loneliness was an issue raised by a small number of service users who missed the wider environment, on-site activities and interaction with a larger number of people provided by the long-stay hospital.

In a small number of cases poor relations between the scheme and its immediate neighbours had a negative impact on peoples' experience of resettlement. Difficulties included differences of opinion about where staff should park their cars, and complaints about the behaviour of service users.

Families and staff said that, for some service users, resettlement in the community and the potential for betterment had come too late in their lives to make a significant difference. This mainly related to service users aged over 60 who had been in long-stay hospitals for lengthy periods of time. Even in these cases, however, there was clear evidence that the individual had benefited from resettlement.

The research team noted a small number of cases in which the service user was effectively locked away from other service users and the outside world, and their activities were very limited. These individuals' needs required them to live in secure accommodation and they required high levels of supervision and intervention. These cases were largely those with forensic background, a severe learning disability and severe autism. The research team questions whether in this very small number of cases a placement in a supported housing environment was appropriate.

In almost all cases, however, and in spite of these limitations, examples of betterment included more privacy, access to food and drink when the individual wanted it, the ability to see visitors at any time, to have personal belongings and personal space, and to do things for themselves. A majority of responses confirmed that service users were engaged in meaningful day-time activities related to their mental capacity and ability.

Resettlement also appears to have resulted in better family relationships for around half the service users. There was increased frequency of contact, better access, more privacy and new opportunities to interact with their family member. In contrast, in a small number of cases family contact had not been re-established either because parents or the wider family were deceased, or because of the length of time that had elapsed since there had been involvement, or there was minimal contact.

Conclusions

Although it was clear that the resettlement process had been painful for a small number of families, the majority of those interviewed were content with the resettlement process and the move to a supported housing scheme. Most family members said that their loved one had adapted very quickly and very well. The evidence from the interviews was that betterment had occurred in the vast majority of cases. There were notable improvements in the lives of all twenty two people who had been resettled.

Whilst it was clear that life for many of the service users now living in the community was not fully comparable to or consistent with that of non-disabled people, it was nonetheless viewed as being better than their previous experience of life in a long-stay hospital.

Improvements were seen as having come about as a result of service users having more choice, better opportunities to do things and to participate in what could be deemed a more normal life in comparison to life in an institution.

The interviews also showed that service users were happier and brighter, and engaged less in self-harm or the challenging behaviours that had been part of their experience in long-stay hospital.

In addition, service managers and staff provided evidence that other forms of ‘betterment’ had occurred including observation of changes in behaviour, better sleep functions and better interaction with other people. They also talked about quality of life in terms of better family relationships, a better living environment, more privacy and more involvement in activities.

Taken overall, the evidence is that – for those who were interviewed at least - the resettlement programme has resulted in significant betterment compared with life in a long-stay hospital even though the degree of betterment was inevitably influenced by individual levels of disability.

BACKGROUND: THE BAMFORD REVIEW

1. Learning disabled people began to be resettled from long-stay hospitals in Northern Ireland from the late 1970s onwards. In the early 1990s there were more than 880 learning disabled people living in long-stay hospitals. However, progress on resettlement was slow. As a consequence, many people remained in hospital for years after they were assessed as able to be resettled. This remained the case until April 2012 when there were still 250 long-stay hospital patients. On that date a new management system for the learning disability resettlement programme came into effect which speeded up the resettlement process.

2. In 2002, the Department of Health, Social Services and Public Safety commissioned a review of legislation, policy and provision for people with mental health issues and learning disabilities from an independent committee led by Prof David Bamford. Widely known as the Bamford Review, the committee's reports set out a new vision for mental health and learning disability services.

3. Leading a fuller life through active participation in the community and being able to engage in meaningful day-time activities were key themes in the Bamford Review reports, particularly *Equal Lives: Review of Policy and Services for people with a Learning Disability in Northern Ireland*[1]. In a chapter focussing on accommodation and support, Bamford noted that many residential services created early in the resettlement programme were institutional in character and retained features of a hospital environment. To combat this trend, the report set out five core values that the Bamford committee believed should govern how accommodation and support services for learning disabled people should develop. These were:

    - Social inclusion – people with a learning disability are valued citizens and must be enabled to use mainstream services and be fully included in the life of the community;
    - Citizenship – people with a learning disability are individuals and each has a right to be treated as an equal citizen;
    - Empowerment – people with a learning disability must be enabled to actively participate in decisions affecting their lives;
    - Working Together – conditions must be created where people with a learning disability, families and organisations work well together in order to meet the needs and aspirations of people with a learning disability;
    - Individual Support – people with a learning disability will be supported in ways that take account of their individual needs and helps them to be as independent as possible.

4. A key principle in the Bamford vision was that of 'betterment'. Bamford used the term betterment as shorthand for improvements in the quality of learning disabled peoples' lives following resettlement. The term emerged in the mid-1990s when conflict arose between

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[1] Review of Mental Health and Learning Disability (Northern Ireland) chaired by Prof David Bamford, (2005) *Equal Lives: Review of Policy and Services for people with a Learning Disability in Northern Ireland*, Department for Health, Social Service and Public Safety, Belfast

those charged with delivering the resettlement programme at that time, and families who sometimes felt that their family member would be better off in hospital.[2] In 1995, the Northern Ireland Minister of Health at the time gave a public assurance to families that a member of their family living in hospital would only be resettled into the community if there was clear evidence of betterment for the patient and provided that it was not against their wishes[3]. This commitment has been restated by successive Ministers and remained in place during the period of time being examined for this research (April 2012 – March 2016).

5. The term was used in the *Equal Lives* report to indicate that if a person was resettled there would need to be an improvement in their circumstances outside hospital compared with their lives in hospital. There were three tests of whether betterment had taken place: resettlement of the individual was clinically appropriate; it met the patient's needs; and it had the potential to improve the patient's life.

THE RESEARCH

6. The Northern Ireland Housing Executive (NIHE) has played a significant role in helping to deliver the post-Bamford resettlement programme. Housing Executive officers have worked alongside the Health and Social Care Board and Trusts in commissioning new services for learning disabled people being resettled; a significant proportion of the social housing new build programme, which is planned by NIHE, is dedicated to the provision of housing for people who have additional support needs or who need to live in supported housing; and the support element in these schemes is funded by the Supporting People Programme for which NIHE has administrative responsibility.

7. This is the second phase of this research; it was commissioned by NIHE in its capacity as the strategic housing authority and Supporting People administrative body for Northern Ireland. The overall aim of the research was to provide NIHE and its partners[4] with an insight into how and to what extent the lives of learning disabled people who have been resettled from long stay hospitals[5] have changed since taking up their new accommodation.

8. The research has been divided into two phases, each looking at the resettlement programme from a different perspective.

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[2] Northern Ireland Audit Office (2009), *Resettlement of long-stay patients from learning disability hospitals*, page 37, para 4.5; and page 38, para 4.8.

[3] Northern Ireland Audit Office (2009), *ibid* , page 2, para 3

[4] The partners in this programme are: Northern Ireland Government Departments, statutory health and social care organisations, housing, care and support providers from the independent sector, regulatory bodies and others.

[5] There were three long stay hospitals in Northern Ireland specialising in provision for people with moderate to severe learning disabilities and mental health issues - Muckamore Abbey Hospital, Antrim, operated by the Belfast H&SC Trust; Longstone Hospital, Armagh, operated by the Southern H&SC Trust; and Lakeview Hospital, Derry/Londonderry, operated by the Western H&SC Trust.

Phase 1

9. Phase 1 of the research was undertaken by North Harbour Consulting in partnership with Fiona Boyle Associates with advice from the Housing and Support Alliance. The main focus was on the institutional delivery of the resettlement programme including:

   - the evolution of the learning disability resettlement programme[6] since the Bamford Report;
   - the models of housing, care and support provision on which the resettlement programme was been based;
   - the characteristics, quality and costs of those housing and support services that were funded from the Supporting People programme; and
   - the perceptions of policymakers, commissioners and service providers involved in the resettlement programme about the way resettlement had been carried out, issues affecting the provision of housing and support, and the overall effectiveness of the programme from a policy and delivery point of view.

10. Phase 1 of the research concluded that:

    - Progress had been slow in establishing mechanisms for assessing whether betterment had occurred in peoples' lives following resettlement;
    - Each Health & Social Care Trust was developing its own approach;
    - No overall assessment of this critically important aspect of the learning disability resettlement programme had taken place;
    - However, good practice developed by commissioners and providers in other parts of the UK were being considered for adoption by the Trusts and the NIHE Supporting People team.

Phase 2

11. Phase 2 of the research has been led by Fiona Boyle (Fiona Boyle Associates) with the support of John Palmer (North Harbour Consulting) and Gillian Greer (NIHE Research Team). This second phase of research reports on the experiences of people who have been resettled in the period April 2012 to March 2016 following a major reorganisation of the resettlement programme.

12. The focus of Phase 2 has been to interview service users[7], their families and the support staff who work with them to establish whether they thought that the resettlement programme had been successful for resettled learning disabled people and whether betterment in their lives had been achieved in the ways advocated by Bamford.

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[6] The description 'learning disability resettlement programme' has been adopted here and elsewhere in the report to differentiate this aspect of hospital resettlement from a parallel programme that resettled people with mental health issues from the same three hospitals.

[7] Service users who were resettled from long-stay hospitals between 1 April 2012 and up to 31 March 2016. In effect this is service users who were patients in Muckamore Abbey long-stay hospital and Longstone long-stay hospital during this period. All patients from Lakeview Hospital had been resettled prior to 2012.

Identification of the resettled population and sampling

13. There were believed to be around 220 people still living in Muckamore Abbey and Longstone long-stay hospitals in March 2012[8]. The majority of these people had been resettled by March 2016. The research team made a number of approaches to the Health & Social Care Board and the five Health & Social Care Trusts during the period 2014 – 2016, requesting information about the characteristics and location of the people with a learning disability resettled from long-stay hospital from 2012 onwards. This information was not available on the grounds of confidentiality and because Health and Social Care Board stated that the information was covered by the Data Protection Act 1998. An alternative approach was therefore adopted. This involved constructing a sampling framework based on information that was available from NIHE's Supporting People team and from housing associations and housing support providers.

14. NIHE's Supporting People team, which was closely involved in the resettlement programme and had funded housing support services for a substantial number of the people who were resettled, provided the research team with information about supported housing schemes that had played a part in resettlement. This included the service provider's name and landlord, the scheme name where resettled people were thought to be living, and the addresses and number of units for each scheme. This information suggested that the locations of around 80 resettled learning disabled people[9] living in housing support schemes that were funded from the Supporting People programme were known to the Housing Executive. In discussion with the NIHE research and SP teams it was agreed to use this information as a basis for constructing a sample of 25 resettled people, their family members and their support staff who would be interviewed as part of the research. 22 interviews were completed (27.5% of the identified population of people resettled between 2012 and 2016).

15. A considerable amount of administration was involved in making contact with landlord housing associations and their managing agents who operate these schemes, with briefing managers and then negotiating access to the schemes, and with seeking consent from resettled people and their families to take part. In the process, it became clear that some of those who were identified for interview had moderate to profound learning disabilities, lacked sufficient comprehension to understand the aims and requirements of the research, and had weak communication skills. In these cases, where family members who were the responsible adults for the individuals concerned gave their consent, interviews took place with the family and with members of the staff team.

16. Table 1 (following page) provides information on the number of contracted places in schemes identified by the SP team. In addition, the table shows the number of interviews targeted from each provider and the number of interviews achieved.

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[8] Based on discussions with the Health and Social Care Board in 2015.

[9] This was for people with learning disability resettled into supported housing schemes being provided by housing associations, with service provision from the housing association (direct service provision) or by another service provider (including Health & Social Care Trusts and independent providers).

Table 1: Number of resettled people by provider, number of interviews requested and number of interviews achieved

Landlord Housing Association	**Housing Support Service Provider**	**Number of resettled people**	**Number of interviews targeted**	**Number of interviews achieved**	**Notes**
Triangle Housing Association	Triangle HA – direct service provision	24	7	9	6 interviews directly with service users. Interviews with 3 family members
	Autism Initiatives	4	5	2	Interviews with 2 family members
	Mainstay DRP	3		1	Interview with one family member
	Northern HSC Trust	2		2	2 interviews directly with service users
	Sub-total	**33**	**12**	**14**	
Choice Housing Association	Autism Initiatives	2	7	1	One interview with service user and family.
	Inspire Wellbeing	15		2	Interview with one family member. One interview directly with service user
	Sub-total	**17**	**7**	**3**	
Apex Housing Association	Southern HSC Trust	23	5	3	3 interviews directly with service users
	Subtotal	**23**	**5**	**3**	
Northern Ireland Institute for the Disabled	NIID	7	2	2	2 interviews directly with service users
	Subtotal	**7**	**2**	**2**	
TOTAL		**80**	**26**	**22**	

Research process

17. The research process was undertaken in line with Social Policy Association Guidelines on Research Ethics[10] and the general ethical principles for research with vulnerable groups[11] in Northern Ireland. Particular emphasis was placed on the obligations to research participants in terms of protection from harm and in relation to their rights; as well as requirements in terms of informed consent, confidentiality and the sharing of research findings and safe storage of data.

18. Access was obtained in the first place via the housing association and service provider. Depending on the nature of the learning disability exhibited by individuals (ranging from low to moderate to severe) advice was obtained from families (parents/adult siblings) and providers on the best means of obtaining informed consent to take part. Where informed consent was possible, and where the individual gave their consent, interviews were arranged directly with service users with the help of their family member or service provider. However, where there were issues of mental incapacity or lack of communication, the principles of 'best interest'[12] were applied. In cases where informed consent could not be provided an interview was requested via a family member (parent or adult sibling) or a member of the service provider's staff working with the person we wished to interview.

19. All the housing associations and service providers identified in Table 1 were approached to participate in the research and were briefed about the research process. The majority agreed to facilitate access to service users and family members, thus enabling representation across the schemes and geographical locations.

20. A written briefing was given to family members and service users before they were asked whether they wished to take part in the research. The latter was in an easy to understand format including photos. These documents are attached in Appendix 1.

21. A total of 22 interviews were undertaken directly with service users and family members. Additional feedback was provided by service managers and support staff with knowledge of the individual. The interview questions are outlined in Appendix 2. These were primarily for use with service users; but were adapted as appropriate for interviews and discussions with family members and service managers and staff, when responding about service users who could not provide consent and/or did not have communication skills.

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[10] www.social-policy.org.uk/downloads/SPA_code_ethics_jan09.pdf

[11] *Ethical Principles for Researching Vulnerable Groups (2003)* Paul Connolly, University of Ulster

[12] In carrying out this research we wanted to ensure we included all people with learning disabilities, including those with no verbal communication and those that lack mental capacity. Medical Research Council guidance is clear that adults who are not able to consent for themselves should be included in research, provided that this is done in line with relevant legal frameworks and ethical principles, Therefore we have adopted the principles embodied in the Mental Capacity Act 2005 which apply in England and Wales as if they also apply in Northern Ireland.

RESEARCH FINDINGS

22. The research findings are linked to five themes around which the interviews were structured:

- Experience of the resettlement process;
- Betterment for the service user;
- Limitations to betterment;
- Too little, too late and a forgotten few;
- Family contact and family contentment.

23. Service user names and some details relating to their cases have been changed to preserve their anonymity.

Theme 1: Experience of the resettlement process

Service users and their families

24. Service users, family members and carers were asked about their experience of the move from a long-stay hospital to their supported accommodation in the community (the resettlement process). In particular they were asked whether and how they chose the location and type of accommodation, who had helped them make the decision, what options they had been given (location and type of housing), what information they had been provided with, how easy they had found the move, and how easy they had found it to settle in their new home.[13]

25. In most cases resettlement had been based on a staged approach[14] in which hospital patients had visited a scheme, had then perhaps stayed there overnight, and had then been given the opportunity to stay for a slightly longer period before finally deciding to move there permanently.

Service User – 'Doris'

Doris was aged in her mid-50s and had been in Muckamore Abbey long-stay hospital for 30 plus years. She had mild learning difficulties and a good level of verbal communication and understanding. Doris now lives in a two-person bungalow with a co-tenant in a large supported housing scheme. She participates in many activities in her home including cooking and doing the laundry, and has an active life in the community, including different clubs and going on holidays with support in Northern Ireland and England.

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[13] Full interview questions are outlined in Appendix 2.

[14] Depending on the service users' needs, some were moved in one move; this was referred to as a 'direct move'. Others were moved in a gradual, staged or phased move – different terminology was used by different stakeholders.

Doris said she had a range of opportunities to look at the bungalow, to meet the co-tenant and to stay overnight – in advance of resettlement. It was a staged approach.

Doris talked about the process – and remembered how it had happened at Muckamore. She said that [name of doctor] had talked to her about moving – and that she had then come to see the house. She also talked about picking a bed and picking out different things like cushions.

26. Service users who were interviewed were broadly happy with the way resettlement had been carried out, although in most cases this finding was based on their fairly limited memory of the move from a long-stay hospital, and their capacity to understand the process. Their views were expressed simply. For example, they talked about being excited when they first saw the house, and they talked about the phased approach - first going for a visit, then staying for a meal, then staying for one night. In the majority of cases, where service users had good recall, there was no sense that the actual move had been traumatic or difficult. Equally, service users had little recall of whether other accommodation had been offered to them, whether they had looked at it, and how they had been helped to make the move. Each of the service users with recall of the process thought they had settled in comparatively quickly.

They went into Muckamore for the last year (before the service user was resettled) *– the staff knew him when he moved here, how to handle him and what the procedures were.*
Family member

27. Feedback from families was generally very positive about the resettlement process, except for a small number of parents and family members (mainly of service users with severe learning disability or complex needs). In these cases, whilst some parents acknowledged that they had not been happy with their child or sibling being committed to a long-stay hospital, when it came to the proposed resettlement to the community, these families had concerns. These included concerns about safety, the suitability of all the patients being resettled (in terms of their capacity to do things for themselves and to integrate into the community), the uncertainty of the process and whether the resettled placement would work and the individual would be accepted in the community.

28. Safety was a concern for all the families during the resettlement process. This ranged from fear of them being attacked (physical safety), fear of abuse (including by staff who at that point they were only getting to know), fear of fraud (in relation to their finances) and concerns about them being accepted by the community.

29. In addition, a small number of family members suggested that the resettlement process had not adequately taken into account those with profound learning disabilities and other disabilities. Others thought that their family member was better off in a hospital where they were familiar with and trusted the staff.

> *People were moving into this ward from other wards; people were coming in from the community…the situation changed within the ward and safety then became paramount.*
> **Family member**

> *We knew it wasn't right for him… everyone thrown in together… we felt it would be better for him to have a place on his own – so he could listen to music and have his own bedroom and sitting room… we couldn't wait for him to leave – he was in a bad ward for the last year.*
> **Family member**

30. Some family members raised concerns about how certain things had been handled during the resettlement process. These included lack of parental consultation and involvement, particularly at the outset, the timing and stop/start approach and the lack of appropriate accommodation options. However, the attitude of these more reluctant family members appeared to change over time – from reluctance and even resistance in some cases to acknowledgement and acceptance.

31. Although it was clear that the resettlement process had been a painful process for a small number of family members, the majority of family members interviewed were content with the resettlement process and the move to a supported living scheme. Most family members noted that a staged move-in and smooth transition had been provided and that their loved one had adapted very quickly and very well.

32. In addition, in most cases family members felt that there had been a good handover of responsibility, with staff in the supported housing scheme visiting the service user for a period of time in advance of resettlement, and getting to know them and relevant routines.

> *It was staggered, first a short visit, then a visit for tea and then an overnight – she loved it.*
> **Family member**

> *The whole process* was *very well phased over a period of a year. Staff came up to Muckamore – they shadowed staff – then they worked with him. This covered getting up, dressing, the whole routine – how staff approach him. Then there was the reverse role and shadowing where the staff from the scheme worked with him whilst the Muckamore staff supervised.*
> **Family member**

33. In a number of cases the fact that service users were moving with other service users they had known in hospital was noted as helping with the settling in process and familiarisation. This was more likely to occur in resettlement to one of the larger housing support schemes.

Service managers and front line staff

34. Service Managers and staff felt the process of resettlement had been well handled by the housing support provider, the housing association that acted as the landlord, the HSC Trust and the hospital. However they noted some difficulties.

35. Firstly, the resettlement process and timetable were subject to an assessment of the compatibility of different service users in order to ensure that the right mix of people could be accommodated together. This was viewed as being an important issue in relation to the success of resettlement, but it caused delays for individuals.

36. The need for compatibility of co-tenants was very apparent from the interviews. In one case a service user gave mixed feedback in terms of whether he liked living with his co-tenant or not. At first he said "*unfortunately I live with him*" but later said "*he's alright but he doesn't talk to me*". In this case staff noted that the co-tenant had severe autism and did not communicate with other people. However, in another case two co-tenants had been matched prior to resettlement, with one tenant moving from a community placement and the other from a long-stay hospital. This match was said to have worked very well.

37. Secondly, difficulties had arisen in terms of people's 'readiness' for resettlement, including the need for them to learn personal care and life skills, and the extent to which they understood what was involved in the move.

38. In other cases there had been delays in identifying suitable sites, obtaining planning permission and community consultation. They acknowledged that these difficulties had been exacerbated in cases where the disability of the service user was severe or complex.

> *It didn't always end up being a scheme for the people identified at the outset….There was never actually a set timescale from scheme identification through to being open.*
> **Staff member**

39. Service Managers and staff also highlighted difficulties arising from public consultation, suggesting that this had not been helpful in some instances.

40. Overall Service Managers felt resettlement had been a relatively smooth transition with comprehensive involvement of service users and family members.

> *My experience of the resettlement team at Muckamore was very positive – from the social worker with the HSC Trust, to the nurse on the hospital staff – I can't fault them. There was so much to share – everything was on the table – the men's needs and risks.*
> **Staff member**

41. Staff said that they thought service users had been comprehensively involved in the resettlement process. In many cases customer journey maps[15] had been developed by housing associations and service providers in conjunction with the hospital resettlement team, and service users were shown photos of possible locations and schemes, were then driven past the scheme, and then taken to it for progressively longer periods of time.

Service User – 'Sheila'

Sheila's family said that resettlement had taken four years from when it was first mentioned until she was resettled. They gave a number of reasons for this – different locations were offered: some were considered too far away, some were considered unsuitable. The family felt the process was unsettling, too long and drawn out. Once a place was identified, however, the resettlement process was relatively smooth. The only issues had been in relation to the financial and legal aspects of resettlement – getting financial controllership in place and signing a tenancy agreement for someone with limited capacity.

42. In terms of the overall strategic oversight of the resettlement programme, service managers (and some family members) felt there had been a lack of foresight in terms of cost calculations and time schedules for implementation.

Theme 2: Betterment for service users

43. Service users, family members and carers were asked about whether they felt that their lives had benefitted from the move out of hospital into a community setting. In particular they were asked if they were happy where they live now, if they felt happier in comparison to where they used to live and to provide reasons for their answer. In addition, they were asked what things they liked and disliked about where they currently live and where they used to live. An assessment of *life now for the resettled person* was made by the service users themselves, family members and staff. The ability to reflect on this varied across the various respondents.

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[15] Customer journey maps were a photographic and paper based journal, developed for and with service users as part of their 'journey' from a long-stay hospital to a supported housing scheme. This included details of their meetings, photos of trips, planning the various rooms – bedrooms, living room, bathroom, kitchen and outdoor space.

Service users and their families

44. Service users were asked about how they felt in terms of their accommodation and life in comparison to their life in long-stay hospital. Responses were provided by service users, and where appropriate, by family members and carers speaking on behalf of service users who were unable to speak for themselves. In all 22 cases life was seen as better, and 'betterment' was deemed to have taken place. Whilst it was clear that life for many of the service users now living in the community was not fully comparable to or consistent with that of able-bodied people, it was nonetheless viewed as being better than their previous experience of life in a long-stay hospital.

Service User – Tony

Tony was aged 69 and had been in Muckamore Abbey long-stay hospital for more than 30 years. He had mild learning difficulties and a good level of verbal communication and understanding. Tony now lives in a two-person bungalow with a co-tenant in a large supported housing scheme.

This service user said that he liked living here – *all the staff are nice, I have lovely views from the bedroom – it's the best room of all.* It was clear from the service user and staff feedback that this individual's life has changed and developed immeasurably. He is involved in going to a wide range of clubs and activities – on Tuesdays he goes to the Memory Café and on Thursday he goes to a club where he makes things and does colouring in. He also likes to go on trips. On the day we saw him the service user and his key worker were going to the Ulster Museum in Belfast.

There were other clear advantages to the move. Tony has lost over 5 stone in weight – through Slimming World in the community - and is now able to walk around the site and get out and about. Staff commented that the service user, like other tenants, is now able *to lead his life as normal. They are not institutionalised, they don't have to fit into a routine; we make the service to suit their needs.*

45. In some cases, particularly those service users with mild learning disabilities, their own comments indicated that life was considerably better. Improvements were seen as having come about as a result of them having more choice, better opportunities to do things and to participate, and the provision of and access to what could be deemed a more normal life in comparison to life in an institution.

They are *in their own home, treated as an individual. After 40 years of going to the Day Room and asking which nurse is on… These were grown men – but where they came from – they couldn't have buttered their toast, or made a cup of tea, or even put the washing on – they couldn't even identify a potato.*
Staff member

46. Examples were given of 'betterment' experienced by service users in terms of the living environment and physical accommodation, and the type of activities service users were now supported to take part in, in their own homes and in the community. These were deemed to be normal everyday activities as well as rights and opportunities available to everyone else – privacy, access to food and drink when wanted, the ability to see visitors at any time, to have personal belongings and personal space. In particular, when asked about what type of support they needed and received, and what type of things they could do themselves or needed support with[16], responses indicated that service users were now engaged in meaningful day-time activities, related to their mental capacity and ability. Being able to engage in meaningful day-time activities was available to all service users. Participation emerged as a large part of what service users (and their families) viewed as contributing to betterment. Reference was made by those with mild to medium learning disability to the type and range of housework and domestic activities they now participated in.

47. Service users were largely satisfied with their accommodation and the scheme; in particular interviewees mentioning their own bedroom, shared living space, the local neighbourhood and amenities, and the range of things they could do, as a result of living in the community.

Service Users – 'Harry', 'Jim' and 'Nick'

Three male service users in one Supported Living Scheme provided feedback on their experiences. They were aged between 50 and 65 and had been in Muckamore Abbey long-stay hospital for more than 20 years. These service users had mild to medium learning disabilities, all with varying levels of communication and mobility, and some additional needs. They live in a four-bedroom house in a residential setting.

They ... (CONTINUED)

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[16] Section 4 of Interview schedule – see Appendix 1.

They talked about the positive side of living in the house. For two of them, there were no restrictions in terms of visitors (when they came) – in both cases visitors were family coming to take them out. They liked the fact that they could have a snack or drink when they wanted and that all of the items in the house were their own personal belongings. They said they had been part of the process of choosing them; they talked about having their own TV in their bedroom and having DVDs. They also liked the fact they had their own space, could put their things around them, and had privacy in their bedroom. Two of the service users offered to show us their bedrooms and seemed very proud of their furniture and belongings.

One simple example was given by service users of the new-found life they now experienced. In Muckamore the tea was poured from a large jug with sugar and milk already added so there was no personal choice and the person did not make it for themselves. In the house, service users were able to make their own hot drink and to make it to their own taste and strength - a simple but important every day task. They also helped to prepare food and plan meals.

They also talked about being more independent and doing things for themselves. One example given was that they have responsibility for cleaning their rooms one day each week, using the Hoover and changing the sheets on their bed. They compared this to their previous situation in the long-stay hospital – *a person in Muckamore would have come and done it for me.* They talked about shopping in Tesco and Sainsbury's – *there's a smashing café there* - and making a shopping list of things that they liked.

48. Whilst acknowledging their initial reluctance and fears about the resettlement process, the majority of family members pointed to both a sense of betterment and actual examples of better quality of life for their family member. They said that service users were happier and brighter, and engaged less in self-harm or challenging behaviours that had been part of their experience in long-stay hospital.

He's happier here, he smiles more…the self-injuries are not a fraction of what they were…we never see a mark on him.
Family member

49. The family of one service user with a severe learning disability and severe autism noted that life had improved immeasurably for him: ... *he's much better – before he was depressed and had lost weight. It's more normal here – not like a hospital – it's more natural. He can go out for walks with staff or out in the car.*

50. It was noted that challenging and disruptive behaviours were less frequent – *the behaviours were through the roof – but there are less incidents and he isn't displaying poor behaviour. His sleeping patterns and eating patterns are much better.* Staff at this scheme noted that in comparison to the long-stay hospital the resident now had choice: ... *before he would sit down – dinner was set in front of him with no choice – and if he was not quick someone else would eat it*.

> *You couldn't get any better– this is different altogether – they were all institutionalised while they were there. People took the attitude 'out of sight, out of mind' and there was no stimulation.*
> **Family member**

Service managers and frontline staff

51. Service managers and staff were in agreement that 'betterment' had occurred and evidenced this from observation of changes in behaviour, better sleep functions and better interaction with other people. They also talked about quality of life in terms of better family relationships, a better living environment, more privacy and more involvement in activities.

> *What you observe, changes in behaviour, sleep functions…you can see their enjoyment of certain things and responses to you…it's basically a better environment. They have more privacy, more dignity and there are much greater opportunities to be involved. They have choices now – in the past they didn't have choices about what they ate – their food was just delivered to them. It's their quality of life and control over what they can do.*
> **Staff member**

52. Service providers qualified their judgement of betterment by noting that not everything in long-stay hospitals had been negative; and equally, not everything about living in the community was positive. It was acknowledged that these factors had an impact on betterment, and that various aspects of life in the community negatively - and often unintentionally – impacted on the concept and reality of betterment. This was particularly true for service users with severe, complex and additional needs[17].

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[17] Additional needs including recorded criminal background and/or inappropriate sexual behaviour – for these service users resettled into the community it was noted that their day to day experience is closely managed by staff.

53. Staff gave examples of specific changes that had taken place for particular people after they had been resettled. In one case, a female service user had been given an enema on a weekly basis whilst in Muckamore over a period of some years. They noted that: ... *when she came out this stopped because her diet had changed…and more 1:1 attention could be provided to her in terms of her medical and health needs*.

> *It's been very encouraging – the involvement, inclusion and family input. You could see them* (the service users) *growing, nurturing, making choices, going places, doing things, being treated as a normal citizen. It was all about taking risks and managing these appropriately.*
> **Staff member**

54. In another case the sister of a service user, who had visited him over a number of decades in Muckamore, was amazed to find that, when he was resettled, he could walk. His sister did not know he could walk. When she visited Muckamore he had always been brought to her, in the lounge or visiting room, in a wheelchair.

55. Another example cited by staff and family members was what people were wearing. They noted that following resettlement there was a wider availability of different clothing, the fact that clothes were not mixed up with other people's in the laundry and the fact that service users could now make an active choice about what they wanted to wear.

> **Service User – 'Christine'**
>
> Christine was aged 36 and had been in Muckamore Abbey long-stay hospital for 17 years. She had mild learning difficulties and a good level of verbal communication and understanding. Christine now lives in a three-person house with two co-tenants.
>
> She said that she much prefers living in the community in this scheme to living in Muckamore. She described that the ward she lived on – *there were 17 of us – the whole lot of us* – *that there was always people shouting or sick. You didn't have the space you have here. You couldn't choose things at Muckamore. I'm happy here.*
>
> Christine is able to walk to a range of shops, cafes and other services e.g. GP, hairdresser, by herself. It was very clear from the discussion that the range of opportunities she enjoys and her aspirations have greatly increased. The scheme service manager said that when Christine first moved out of Muckamore she needed 1-1 staff support even at the Adult Learning Centre but that now she was able to cope on her own during the day provided that there was staff support in the house overnight. CONTINUED

Christine attends the Adult Learning Centre 5 days per week and is involved in a range of activities including arts, craft, cookery, watching videos and DVDs. Christine said that she felt happy and settled where she is living now. She talked about her sense of freedom.

Theme 3: Limitations to betterment

56. Respondents were asked to say what they thought limited the resettled person's experience of betterment, quality of life and how they feel about themselves. In particular they were asked to speak about what the resettled person disliked about where they now live, and how that compared to the long-stay hospital setting.

57. A number of limitations to betterment were noted by service users themselves and their families. Whilst betterment was the end objective of resettlement for service users, a number of barriers to active participation in the community, ability to and opportunities for engagement in meaningful day-time activities, and actual social inclusion in the community were highlighted. Some of these were based on service users' needs, abilities and capacity, but others were in relation to structural and financial aspects of services in the community, as well as factors such as the location of supported housing scheme the service user was living in.

58. Family members and staff suggested that the physical location of some supported housing schemes had an adverse impact on betterment for service users. This included distance from and lack of accessibility to other services, and appeared to be more of an issue in rural settings. It was also an issue noted in some residential urban settings where, for example, a bus stop was at some distance from the scheme, and access to public transport was therefore impossible for service users. The location of schemes in relation to proximity to family was also noted as a limitation in one case where the family indicated that they would prefer to have their daughter closer to them. This scheme is 10 – 11 miles away from their family home and the family has to make a specific journey to go and see their daughter. The family would prefer if she could live nearer to them, as they feel this would allow more natural family interaction and a better bond to develop between siblings.

59. Transportation was highlighted as a problem in some schemes. The location of some schemes and distance from services, combined with a lack of access to public transport (which was not always suitable for service users) compromised opportunities for service users to have easy access to the wider community. Whilst significant numbers of those who were interviewed owned or had access to a Motability car, other issues were noted about their use. In a number of cases difficulties were noted in the availability of staff able to drive the cars (the minimum age for drivers is 25); reliance on staff availability for driving and supervision of service users; and difficulties ensuring service users could be transported safely. In a number of interviews it was clear that the service user did not have a mobility car, but a co-tenant did. In these cases staff said that they are required to obtain permission for the service user to travel in the car with their co-tenant.

Service User – 'Michael'

Michael was aged 27 and had been in Muckamore Abbey long-stay hospital for one year because previous placements had broken down. He had severe learning difficulties and severe autism, and does not interact well with others. Michael lives in a flat in a supported housing scheme but does not have any interaction with other service users.

Michael does not take part in activities outside the scheme involving other people mainly because he does not mix well. There had been initial discussion of him attending a day centre but this had not emerged as an option.

However, it was also acknowledged that Michael now has opportunities to be part of the wider community – *he likes walking, the cinema and getting a carry out…but he doesn't have the ability to communicate with people.*

Transport was another barrier to doing things in the community. It was noted that the service user now has a mobility car; however, there have been difficulties with this because drivers have to be over 25 and many of the staff are under this age. Also he prefers to sit in the front but regulations require him to sit in the back and this has caused problems. In addition, the service user's behaviour means that it is too unpredictable for him to go on public transport.

In spite of these limitations his family was satisfied that the move from hospital had resulted in improvements in his life and that betterment had occurred for Michael.

60. Service users living in rural settings had limited services or amenities near at hand. Their ability to take part in activities away from where they lived depended on travel by car or taxi, and in most cases required support from staff.

61. Other limitations to betterment included the availability of services. This included a lack of day centre places and suitable, affordable and accessible external activities. It was also noted that, in a number of cases, day centres would not accommodate service users unless they brought staff support with them and this was not always possible.

62. In a number of other cases respondents noted the lack of external opportunities and external interaction for them or their family member. This raised questions of whether the person was fully living in and integrated into the wider community, or was effectively living in a smaller institution, albeit in a community setting.

63. There was acknowledgement that service users were able to do much more for themselves in a supported housing scheme compared with their previous life in a long stay hospital, but there was an underlying suggestion that they were not living the fully independent lives that their disabilities made them capable of in the community.

64. Families of service users with severe learning disability highlighted the limited opportunity for day care or other activities in the community, whereas everything had been on one site in for example, Muckamore Abbey long-stay hospital. In one larger supported housing scheme, the three service users we spoke to had minimal activity or interaction outside of the walls of their scheme.

Service Users – 'Tom', 'Bill' and 'Rosemary'

Tom, Bill and Rosemary were aged between 40 and 49, and had been in Longstone long-stay hospital for more than 25 years. They had mild to severe learning disabilities, all with varying levels of communication and mobility, and some additional needs. They live in six-bedroom houses in a supported housing scheme with 24 SP-funded contracted units.

This scheme is located in a small residential area in a largely rural setting. Whilst there is a small shop nearby, for other amenities service users need to travel by car or taxi. From the interviews with service users and staff it was clear that these service users do not participate in activities outside of the scheme. One service user talked about going to day care when he was in hospital – this was Clover Day Care which was part of Longstone Hospital. This individual now mainly watches TV and listens to the radio, and enjoys going out for a run in the car. Staff said that he does not engage in the structured activities onsite.

For all three service users whilst betterment has occurred in some respects, they appear to spend most of their time in the scheme because there are no day centre opportunities. They have very limited integration into the wider community.

65. There was concern that some of the bigger supported housing schemes (for example, one with more than 15 contracted units) could effectively become mini-institutions and whilst people were resettled in the community, this was not the same as living in the community. Even in the smaller schemes (5 units and less), whilst considerably smaller than the hospital wards in Longstone and Muckamore, there was a feeling that these still could become institutionalised.

A 3-bed house could be as institutionalised as the hospital – but we work very hard to ensure this is not the case.
Staff member

66. A small number of service users, who had the mental capacity to make comparisons with their previous life in hospital talked about missing Muckamore or Longstone. They appeared to miss the wider environment and interaction with a larger number of people, they missed certain members of staff, and they missed activities such as the Cosy Café at Muckamore Abbey and the day centre at Longstone. Loneliness was another issue raised by interviewees. Staff noted that for some service users life in long-stay hospital had provided a level of security and comfort that has not been achievable in their new locations and settings.

A lot of resettled people are lonely. They knew the staff in Muckamore – in many cases for more than 20 years – and they had friends and connections there. It was their home and it was normal to them – it was their life.
Staff member

67. A small number of service users said that they missed the company and environment of the long-stay hospital. One service user talked favourably about his time in Muckamore because he felt he had friends there. When asked if he had friends where he now lives he said: *I had a lot of friends in Muckamore – I do have friends here but not as many here.*

68. Families recognised that some of their hopes for life in the community had not been fully realised, and they had concerns about lack of day-time activities, access to medical facilities and attention, and what would happen to their family member if resettlement broke down. In addition, for those whose family members had been more recently resettled, family members felt that staff did not fully understand the needs of the service user, and were in some cases 'pushing' them to do things beyond their ability and capacity.

She's not in good health at the moment – and yet they're trying to push her to go out to ... restaurants and cafes….I would prefer they wait until she is better….she has a fear of strange places – I think it should be more gradual. There are certain triggers and signs and the staff haven't picked up on these.
Family member

69. Staff and managers comments on betterment can be summed up as follows. They said that not everything in the long-stay hospital had been negative, and equally, not everything about living in the community was positive. Some aspects of life in the community had a negative - and often unintentional – impacted on the reality of betterment.

70. They said that, whilst things were better for the majority of resettled people: *life isn't just totally wonderful for all now. You need to balance it out – it* (resettlement from hospital) *was right for some people and in some situations. But overall it does appear to be better to be resettled out of hospital*.

71. In a small number of cases another factor limiting the experience of betterment was relationships with neighbours. In one supported housing scheme, staff said that they had encountered a number of quite significant and difficult problems with the immediate neighbours. The difficulties had been experienced in relation to where staff park, complaints about the service users smoking and talking in the back garden, one service user allegedly looking through the fence, and one service user creating disturbance by 'coughing' in the back garden. Some of the neighbour response has been significant with tyres slashed on staff cars the involvement of police, and as a result the installation of CCTV. In this scheme, staff feedback indicated that whilst the service users were living 'in the community' in their opinion was that they are not 'integrated' into the community because of neighbour hostility towards them.

72. In a different scheme service users noted that they had experienced problems from the adjacent house. On one side there were noisy parties, and on the other side there was a derelict house which had problems with mice. Elsewhere, family members and staff talked about schemes where neighbours did not speak to either service users or staff, and indeed ignored them.

73. Some family members of service users with a severe learning disability suggested that a further limiting factor in terms of betterment was the number and type of staffing in supported housing schemes. They noted concerns that staff lack medical information and nursing knowledge in respect of the service user. In two cases family members felt staff had insufficient training in dealing with a learning disabled person who also has autism. In a second case, a mother said she had concerns about staff leaving the service provider organisation that the service user had got close to and the impact of this on her daughter's routine.

Theme 4: Too little, too late and a forgotten few

74. In a number of cases family members and staff indicated that resettlement (and the betterment that has been achieved) had come too late in the service user's life for them to get full opportunity and benefit from resettlement. Three service users in one supported housing scheme were now aged in their 60s and 70s. They had been resident in Muckamore Abbey Hospital for between 15 and 40 years respectively.

75. Whilst these individuals had been resettled in the period 2012 – 2016, and resettlement was deemed by staff to have involved a very smooth period of transition, they felt regret that this had not occurred more than twenty years previously. They said that, for these service users, resettlement has almost come too late in their life although they did consider that their quality of life in the supported living scheme is considerably better than at Muckamore Abbey long-stay hospital.

> *It's been very encouraging – the involvement, inclusion and family input. You could see them* (the 3 service users) *growing, nurturing, making choices, going places, doing things, being treated as a normal citizen. It was all about taking risks and managing these appropriately.*
> **Staff member**

76. In a small number of cases, it was clear that the service user was still effectively locked away and restricted, and because of their mental capacity and for other reasons was unable to live without high levels of supervision and intervention. These cases were largely those with forensic background, those with a very severe learning disability and those with severe autism. In the majority of these cases family members and staff did feel betterment had occurred, albeit to a lesser degree than those with mild and moderate learning disability.

Service User – 'Patrick'

Patrick was aged 33 and had been in Muckamore Abbey long-stay hospital for 16 years. He had severe learning difficulties and severe autism, and does not like any noise. Patrick lives in 4-person supported housing scheme but does not interact with other service users. Patrick has his own bedroom and living room and 2-1 support at all times.

Patrick's parents had a vision for their son to live in the community from his teenage years, and have actively lobbied for this. They were content with resettlement in terms of the overall process. However, the main concern for them was the timing and the stop/start approach of resettlement (having initially been told he would be resettled in 2010).

Patrick's parents said that he had adapted to his new home quickly and very well. They had been offered a staged approach to the move but their judgement was that it would be better for their son just to move in one process and this is what was done. *He just took to it…it was as if he knew.*

Despite being isolated in his own quarters and with limited interaction with other service users Patrick's parents talked about how they felt he is now *part of the community.* Overall they felt this was a better place for their son, and that his quality of life was considerably better.

Patrick's parents reflected on how things could be improved further. They felt the Bamford vision had been good but did not go far enough – *Bamford didn't really see beyond getting them out of Muckamore.* The parents felt there was a significant need for more activities in the community for learning disabled people like their son with high needs. They acknowledged that there were day centres but that these were targeted at learning disabled people who were higher functioning.

Theme 5: Family contact and family contentment

77. Responses from around half of respondents (12 out of 22 service users or family members) showed that there was good family contact following resettlement, and that better family contact had been established compared with the situation in hospital. The frequency of contact was said to have increased, the service user was able to phone as well as see their family and the type and range of activities they participate in within the scheme and in the community has increased. Family members referred to better ease of access, more privacy and new opportunities to interact with their family member.

> One service user now has regular fortnightly visits from his sister and they go out together occasionally. He said – *she did visit at Muckamore – but not as much – it was too far.*
> **Service User**

78. However, in a small number of cases family contact had not been re-established, either because parents and members of the wider family were no longer alive, or because of the length of time that had elapsed since there had been any involvement. In a few cases there was limited involvement from family both during and after resettlement. This lack of family contact was historical, possibly linked to the services user's background and the nature of their disabilities; in other cases because of old age, infirmity and the distance to travel.

> **Service User – 'Phelim'**
>
> Phelim spoke about the resettlement process and where he now lives. He was in his late 40s and had been in Longstone long-stay hospital for a long time (he could not recall the length of time). He had mild to moderate learning difficulties and reasonable verbal communication. He lives in a 6-person bungalow in a larger supported housing scheme.
>
> Phelim talked very positively about his life since resettlement – *I like it the best.* His key worker said that one significant improvement for him has been more family involvement. A brother and his wife visit. When Phelim was in Longstone this was once every two years; since moving to the scheme this is now once per quarter. They see him in his room or take him out.

79. In the majority of cases family members indicated that resettlement had resulted in some degree of peace of mind for them, in particular in regard to future provision for their family member. Three family members said they had concerns about future, in particular referring to what would happen to their family member when they passed away or when the service user's longer term needs changed or they needed nursing care.

Appendix 1: Written communication with service users, parents and members of staff in supported housing schemes

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Research into the experiences of learning disabled people resettled from long stay hospitals in Northern Ireland

BRIEFING FOR FAMILIES, CARERS AND SERVICE PROVIDERS

The Northern Ireland Housing Executive has commissioned research into the way in which the lives of learning disabled people who have been resettled from long-stay hospitals (Muckamore Abbey Hospital, Antrim; Longstone Hospital, Armagh; and Lakeview Hospital, Derry/Londonderry), have changed since they took up their new accommodation.

The objectives of the research are to:

- describe the types of accommodation, care and support provided to people who have been resettled, and the ways in which these services are supporting people to experience a more independent way of life;
- provide a socio-economic profile of the people who have been resettled; and
- describe the impact of resettlement on the quality of their lives compared with the lives they lived in their previous hospital settings;

As part of the research, we have been asked to interview 25 learning disabled people who have been resettled from one of the long-stay hospitals; a parent, member of their family or carer; and a service manager who is responsible for providing them with the care and support services they receive.

The interviews will give resettled people and those who are close to them the opportunity to say:

- how resettlement has affected them;
- what they like and what they do not like about the services they are now receiving in comparison with their life in hospital; and
- what difference resettlement has made to their lives.

The research is being carried out by Fiona Boyle (Fiona Boyle Associates) and John Palmer (North Harbour Consulting). Fiona and John have a lot of experience of working with learning disabled people. The interviews will be led by Fiona Boyle. Gillian Greer (Research Officer, NIHE Research Unit) will also support the research process.

We will write to or meet with each of the people that we would like to interview to tell them about the research, to invite them to take part (their written informed consent is required), and to tell them about what will be involved in their interview.

If you would like to find out more about the research, or tell us whether you would like to be involved, please contact:

Mrs Fiona Boyle,
[Address]

Telephone: [ ]
Mobile: [ ]
Email: [ ]

LETTER FOR SERVICE USERS

HOW DO I FEEL ABOUT WHERE I LIVE?

My name is Fiona. This is my picture.

I am interested in the experiences of people who used to live in hospital and who are now living in the community.

I would like to know what it was like moving into your new home, and how you feel about where you live now.

You can have someone with you like a member of your family or someone who looks after you.

It will not take longer than 15 minutes.

You can say yes or no. It is up to you whether you want to take part.

YES  NO 

If you do want to take part, please ask someone to explain what will happen if you say yes.

If you would like me to come to talk to you, please ask someone to help you sign the attached form and return it to me.

Thank you for reading this.

Yours sincerely

Fiona Boyle

Mrs Fiona Boyle

HOW DO I FEEL ABOUT WHERE I LIVE?

If I talk to Fiona about her project "How do I feel about where I live?"

I understand that Fiona will write down some of the things I say.

I understand that what I say will be private.

I understand that I can stop the interview at any time.

If you understand the statements above, you now need to decide whether you would like to take part in the project.

I have decided that I would like to talk to Fiona about her project ""How do I feel about where I live?"

Please put a tick in the No or Yes box.

☐ **No**

☐ **Yes**

Please sign your name here: ……………………………………………

Please print your name here: ……………………………………......

Appendix 2: Semi-structured interview schedule

QUESTIONS FOR SERVICE USERS

Section 1 - Who you live with?

Do you live alone?
Do you want to live alone?
Would you like to live with others?
Do you want to live alone, but be near others? For example, have your own flat or apartment – but in the same block as other people like you.
Would you prefer to live with family members?

Section 2 - The type of accommodation you live in?

Do you like the place (city, town or village) where you live?
How would you compare this to where you lived before – same, better or worse?
How do you want to pay for your housing – rent, buy or other?
What type of accommodation did you live in before – shared house, individual house/bungalow on site, dormitory or shared bedroom with other facilities?
What type of accommodation are they now in? (Researcher to both note this and ask this)
What do you like about this place?
What did you like about the place you used to live (give name)?
Which would you say is better?

Section 3 - The type of area you live in

Do you like the place (city, town or village) where you live?
Are you content with all the things that are close by – LIST – which ones do you have nearby and which ones would you like?

- Open spaces/park
- Shops/supermarket
- High Street or town
- Pub
- Church or place of worship
- Transport – bus or train
- Community facilities – leisure centre, community centre
- College or work places
- Close to people you care about?

Section 4 - The type of support you need and receive?

Tell me what type of support or help do you get to live here?
Do you need help with any of the following:

- *Making drinks and snacks*
- *Making a hot drink*
- *Preparing food*
- *Planning a meal*
- *Cooking*
- *Eating*
- *Going shopping*
- *Managing money*

- *Going to the bank*
- *Going to the post office*
- *Reading and writing*
- *Paying bills*
- *Road safety*
- *Using public transport*
- *Using the telephone*
- *Keeping time*
- *Housework*
- *Doing the laundry*
- *Doing the ironing*
- *Personal care*
- *Getting dressed*
- *Choosing clothes*

Who provides this help and support?
(Check if it's someone that's paid or unpaid – such as family member or friend?)

Section 5 - Making the move to this new accommodation (the resettlement process)

How did you choose to move here (location?) and to this type of accommodation?
Who helped you to make this decision?
Were you given a number of options – both location and type of housing?
Were you able to understand this information?
Who helped you to move?
How was the move – did you find it easy or difficult?
Did you settle within the first few days or weeks?

Section 6 - How you feel now?

Comparison of the before and now – in terms of the accommodation and also their quality of life/how they feel about themselves
Are you happy where you live now?
Do you feel happier here than where you used to live?
Can you tell me why you feel this way?
Is life better now HERE than it was when you lived at INSERT NAME OF PLACE?
Can you tell me why?
What things did you not like about where you used to live?
What things do you not like about where you live now?

Probe:

- Not able to have visitors when you wanted
- Didn't feel like your place or your space
- Not being able to have meals/snacks when you wanted them
- Not being able to have the pictures on the wall you wanted
- Having to share some things – TV room
- Being told to do things by staff.

ACCOMMODATING DIVERSITY

2000 and beyond

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TOWARDS A STRATEGY

FOR SUPPORTING DISABLED PEOPLE

SOUTH & EAST BELFAST TRUST

JANUARY 2000

south
&east
belfast
trust

Bringing
Care
To
People

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TABLE OF CONTENTS

1. INTRODUCTION

Background

For many years now services for disabled people have been provided for the most part under the influence of the medical model. This has focused on loss of function, "handicaps" or impairments and a resulting perception of dysfunction which set disabled people apart from the rest of the "normal" or "able-bodied" in society. The paternalistic model within this approach sought to identify the handicap, impairment or dysfunction and treat it, as far as was humanly possible, with the medical science and technology available to its practitioners at the time.

The science of rehabilitation developed to rectify the "problem" with the aim of returning the person after injury to their optimal physical functioning. The impairment, and indeed the person in whom the impairment existed, was treated.

The science of Normalisation speaks for itself, but the underlying assumption or concept was that there was a "normality" that we helped the person to aspire to or approach. The science of rehabilitation was welcomed but inevitably fell short of expectations as many people could never regain their previous functional ability. For those with congenital impairments rehabilitation had little or no relevance and for many the use of the term was seen as insulting.

Approaching disability solely through the medium of the medical model is now recognised to be inappropriate.

Times have changed, however, and we have begun to recognise **the needs of the whole person** in all aspects whether, physical, mental, social, or emotional. These collectively impact on health and well-being. Ability rather than ***dis***ability is the focus. Emphasis is placed on creating an **inclusive society** where citizens whatever their religion, ethnicity, gender or ability have equity of access and diversity is acknowledged, valued, accommodated and celebrated. The external / environmental factors that combine with impairment and result in disability are recognised as impediments to full participation in life.

These attitudinal, institutional and environmental barriers have all been identified as disabling-denying disabled people opportunities within society and preventing them from actively participating in their own communities. Many argue that anti-oppressive legislation is the only effective way to remove such barriers.

In reality, many face discrimination in their daily lives. Disabled people are more likely to be out of work or in a poorly paid job (70% are unemployed). Buildings and facilities are often inaccessible and disabled people may receive poorer service even when they do gain access to facilities.

The Government has stated it is determined that disabled people have the opportunity to play their full part in a modern society. Significantly an Equality Commission has been set up which now includes disability rights for the first time. The commission is there to make sure disabled people get a fair deal and are treated properly as citizens and free members of society and it intends to make a difference.

Drivers for change

Why have these changes taken place?

They are the outward sign of a significant shift in thinking, particularly over the past 25 years, which has been supported by 7 main drivers:

1) Increased knowledge and understanding allied to a disability rights movement in Britain, Europe and North America.

2) Rising expectations and growing demands for equality of opportunity and equality of access to services and ordinary life.

3) A growing need and changing demography with increasing numbers of disabled people with complex needs living in the community.

4) New legislation to change attitudes and give disabled people more opportunity and control ranging from the Chronically Sick and Disabled persons Act to Disabled Persons Act, Community Care, Direct Payments Bill and Disability Discrimination Act.

5) Enormous technological advances in communications, information technology and aids to daily living which continue to open gateways in daily living, education, training and employment.

6) Advances in medical science.

7) Opportunity for innovation as a result of new monies with a new emphasis including People First, Peace and Reconciliation, European Social Fund and National Lottery.

As a consequence, re-evaluation of services began during the 1980's resulting, during the 1990's, in an expansion of alternative service provision. People First highlighted the need for services to become more flexible and responsive to the assessed needs of individual people. Users of service were to be offered real choices and an emphasis was placed on enabling people, including disabled people, to live independently with a good quality of life in their own homes.

Additionally those using services were to be directly involved in identifying and assessing their own needs and deciding upon which services were required to meet them. **The disability movement has supported this agenda for change, however disabled people themselves have emphasised that community care is not necessarily the same as enabling independent living.**

Local Change

The Trust directly and through partnership with voluntary organisations and other agencies enabled a number of significant developments in the Trust during the 90's – intensive home support for people with MS and brain injury, disability awareness training, improved access to buildings, employment of disabled people in Beechbank, increased user involvement, Inclusion Zone, Balmoral Training Service, Garden Reach and A.C.E.T..

Meeting the Challenge

Despite progress, however, there are mounting pressures on services. The People First budget is at full capacity as a result of steadily increasing numbers of people requiring support in the community. Rising expectations for alternative forms of support, personal control, flexibility and choice will continue to increase pressure on the Trust to provide more, change the services it provides and the way it provides them.

To address all these complex issues and change the way we do things will require clarity of thought and concerted action on behalf of all "stakeholders". These are not simple problems. No one partnership, agency or group alone holds the solutions. To bring about effective and lasting improvement, and to ensure the best use of all available resources, there is a real need for individuals, organisations, communities and agencies to work together even more closely than ever before and to agree a shared agenda. Otherwise we run the risk of energy and resources becoming dissipated.

We will also have to increase our efforts to facilitate disabled people themselves to become central to the planning, implementation, and delivery of services. The Trust will increasingly be challenged to shift power and control back to disabled people.

As a large employer in Belfast, the Trust now has legal responsibilities under the Disability Discrimination Act and the Northern Ireland Act 1998 to ensure fair and inclusive employment practices and service delivery. It must meet these proactively if at the very least we are not to be brought into disrepute. **On the contrary, we must espouse the principles and lead by example.**

The aim of this draft document is to begin to provide a focus and framework to enable change to happen, year on year, the ultimate aim being to maintain and improve the Health, well-being and autonomy of disabled people in South and East Belfast over the next decade.

1.2 A Disability Model

The increasingly accepted model of disability as defined by disabled people themselves, and the model espoused to by the Disability movement is that of the **Social Model of Disability.**

In simple terms, the Social Model of Disability recognises as indicated earlier that people can have impairments which, when combined with disabling external social, environmental and attitudinal factors, result in disability. It is often not the impairment itself which is the limiting factor, but rather a lack of understanding, our own discriminatory attitudes and those of others, barriers to physical access and access to information, which are disabling.

As an organisation that provides support services to disabled people we need to make this model central and develop and adapt our service delivery in ways that promote and build on the person's ability and help tackle the societal, institutional and environmental causes of disability.

1.3 Culture and Diversity

A major challenge for the Trust is to acknowledge and accommodate diversity as an intrinsic and positive aspect of the community that it serves. In acknowledging the diversity of its community the Trust must acknowledge the different cultures among its residents and their different needs, aspirations, and expectations. One such community is the Deaf community where there is a sense of identity, community and indeed language which unites those who identify with that community. In this community the word **deaf** is perceived as positive, as opposed to the negative connotations sometimes associated with the word by wider society. In the deaf community the word is associated with a feeling of belonging, identity and ultimately, culture.

How the Trust as a personal health and social service organisation responds to diversity will ultimately affect our ability to deliver services that respect the dignity of the person, remove discrimination and meet need**.**

Our goal should be to provide services for citizens, not disabled services for disabled people. We will know when we have reached our goal perhaps when we no longer require a specific strategy for services for disabled people.

1.4 Language

The use of language is of great importance as it inevitably reflects the value base of the organisation and the perceptions and attitudes of those working within it. Funding arrangements and organisational structures create their own groupings for managerial efficiency that often do not help convey the values of person-centredness, anti-discriminatory practice and accommodation of diversity, e.g. "physical and sensory disability programme of care".

During the consultation process for this strategy document **disabled people indicated their desire to achieve equality of opportunity, to receive services because they are citizens and to have their diversity acknowledged and accommodated.**

The Trust needs to critically analyse its use of language and how this may impact on disabled people and reinforce prevailing attitudes of exclusion and discrimination. In acknowledging the diversity within its community, the Trust has to recognise that people become disabled as a result of a combination of impairments and disenabling factors within the environment and society itself.

The Trust needs to recognise and fully accept the culture associated with the deaf community, i.e. that many deaf people neither see themselves as “disabled” nor as having a “sensory disability” but rather they are deaf and proud. Nevertheless, very few, if any, deaf people would deny that they are largely discriminated against.

2 AIMS

The overall aim of this strategy is to help maintain, improve and maximise the autonomy of disabled people through the provision of a person-centred service which**:**

- actively promotes social inclusion;
- challenges discrimination;
- acknowledges, values, and accommodates personal and cultural diversity;
- is based on and promotes ability;
- promotes and encourages all aspects of personal control and choice;
- promotes personal empowerment;
- promotes positive health and well-being;
- is accessible;
- challenges the concept of Dependency, promotes personal autonomy, and acknowledges and positively values the concept of interdependence ;
- offers support to families and personal support givers;
- provides support, including appropriate equipment, to people to get the most out of life, as they choose;
- is equitable;
- ensures that all available resources are used as effectively as possible.

3 KEY VALUES AND PRINCIPLES

- Disabled people have a human right to equality of access to all services, including health and social services.

- Inclusion is a right for all, which must be upheld and promoted for those we support. The Trust will place inclusion at the forefront of all actions, responses and interventions on behalf of disabled people. Services therefore will be provided in a manner that maximises inclusion of disabled people. Where necessary it is the duty of the Trust to develop services which challenge discrimination.

- Services and facilities will be fully accessible and locality based.

- Appropriate and accessible information will be provided to aid decision-making and the empowerment of individuals.

- Disability is a societal issue and not solely a health and social services responsibility. The contribution of a range of agencies and the wider community needs therefore to be harnessed in partnership, in order to have maximum impact on the lives and experiences of disabled people.

- Services will be person-centred and support disabled people to realise and retain the fullest possible control over their lives.

- Services will be user-led and assure the rights of disabled people whilst balancing the personal rights of the individual with that of the public. Users of services will be centrally involved in service planning, design and evaluation. User led services will, where possible, be the norm not the exception.

- Services will be sensitive to the legal context in which they operate and be monitored to ensure that statutory obligations are met.

- Services will recognise **the "whole" person** and value the importance of all aspects of their life including their physical health, psychological and emotional well-being, family and social support and spiritual and personal belief systems**. (See "The Whole Person" -section 8)**

- Services will promote a community-focused approach, which supports the person within their natural environment.

- Services will be organised in a manner which maximises opportunity and choice.

- The use of resources will be continually evaluated, with disabled people, to ensure their most effective use and value for money.

4 DISABILITY DISCRIMINATION ACT

The Disability Discrimination Act which was recently introduced gives disabled people new legally enforceable rights in the areas of employment, access to goods and services and facilities. The Act has profound implications for the Trust, both as a service provider and as an employer.

Trust managers and staff need to improve their awareness of, and response to, the needs of disabled people – whether they are clients, carers, or employees. **This is not simply good practice; it is an absolute essential for the Trust in meeting its legal responsibilities under the Act.**

The Act includes: -

Part 2	the Employment provisions
Part 3	Service provisions (including section 21)

Section 21 of the DDA 1995 requires the Trust to:

take reasonable steps to make its services accessible to disabled people.

The Trust will have to:

- take reasonable steps to change practices, policies and procedures which make it impossible or unreasonably difficult for disabled people to use a service;

- provide auxiliary aids and/or services which make it easier for, or enable disabled people to use a service e.g. sign language interpreters and information on audio tape and other accessible formats;

- overcome physical barriers by providing a service by a reasonable alternative method e.g. providing by telephone the services available at a caller enquiry point;

- Take reasonable steps to remove, alter or provide reasonable means of avoiding physical features that make it impossible or unreasonably difficult for disabled people to use a service e.g. provision of ramped access.

5 DEMOGRAPHY

The Policy Planning and Research Unit Surveys of Disability (1992) show that in Northern Ireland around 100,000 people, 40,000 of whom are under 60 years of age, have levels of physical or sensory disability which significantly affect the quality of their lives. (When this is pro rata it is estimated there are 11,000 disabled people in South and East Belfast with 4,000 under the age of 60).

Figures for the year 1998/99 indicate that the Trust was in contact with 2,000 disabled people of all ages (18% of prevalence rate) and approximately 1,100 disabled people under the age of 65 (28% of the prevalence rate).
A number of reports in the last decade have indicated that services provided to disabled people continue to receive a low priority in comparison with services available to other users.

This acknowledged deficit in service for disabled people resulted in service provision for this group being identified as a key area of concern in the 1992/97 regional strategy. There have been a number of encouraging developments; however the pace of improvement in service provision has remained slow. This area still remains a key concern highlighted in Health and Well-being: Into the Next Millennium – The Regional Strategy for Health and Social Well-being in Northern Ireland 1997-2002 (DHSS, 1996), which prioritises the needs of:

- young disabled people aged 16-25;
- newly disabled people;
- disabled parents;
- individuals with traumatic brain injury and their families.

6 STRATEGIC FRAMEWORK FOR SERVICE DELIVERY

In presenting a strategy within which service planning can take place, it is useful to highlight in more detail the key components of a strategic framework. This should facilitate better understanding of where existing services are placed and how they might develop in the future in line with our emerging strategy.

These components are:

- **Empowerment**
- **Inclusion**
- **Information**
- **Tackling Discrimination/ Addressing Inequality**
- **Promoting Health and Well-being**
- **Equipment/ Technology**
- **Partnership**
- **Restoring/ Achieving Quality of Life**
- **Knowledge of the nature (and progression) of chronic illness and acquired and congenital disability.**

7 PRIORITY THEMES

7.1 Empowerment

Empowerment is the transfer of power and control to the person. It can be achieved in a range of different ways and more often than not is a developmental process that enables the person to take control over what affects their lives:

- Accessible Information;
- Person centred assessment / self assessment;
- Appropriate levels of support ;
- **Capacity building leading to self- actualisation, assertiveness, creativity, pride and self- advocacy;**
- Financial control – Direct Payments;
- Direct and sustained consumer involvement in all processes including assessment of need, planning, service development, commissioning, purchasing, decision-making and resource allocation;
- Development of user-led services;
- Advocacy and self-advocacy;
- Life-long Learning : ensure accessible, high quality education and training.

There are a number of key areas in which the Trust can continue to actively shift the balance of power.

As an organisation we need, with the help of disabled people, to critically examine how we support and enable people to ensure we do so in ways that are empowering, not disempowering. We also need to be proactive in empowering disabled people, recognising that this is as legitimate a means of support as providing a service or a piece of equipment (if not more so). Without early capacity building we will not reduce dependency nor develop the pool of confident disabled people to help plan, control, purchase and lead services.

In terms of support and assistance the Trust should strive to support disabled people **with an emphasis on Independent Living as opposed to a rigid focus on Community Care**.

Assistance, where possible, should allow individual access to those services and experiences necessary to allow them to enjoy a real quality of life with meaning which include:

- Education, training and employment
- Leisure and recreation
- Protection from abuse
- Healthcare
- Travel
- Social interaction, relationships, and sexual life

- Spiritual activity
- Meaningful occupation / employment
- Housing

7.2 Inclusion

Inclusion is a right for all, which must be upheld and promoted for those we support. The Trust will place inclusion at the forefront of all actions, responses and interventions on behalf of disabled people. Services therefore should be provided in a manner that maximises the inclusion of disabled people. Where necessary it is the duty of the Trust to develop services, which challenge discrimination within the community.

Significant changes have occurred over the last ten years in terms of how the Trust has focused its investment of resources. The advent of community care and People First funding has enabled the Trust to begin the process of reshaping this investment to the development of more inclusive forms of support. Significant changes in society, social policy, the advent of equality awareness, have all contributed to significant changes in equality of access to education, further education and employment.

Changes in access to education and training, whether in mainstream or specialist provision, and improved transitional arrangements, has resulted, for example, in a significant reduction in the demand from disabled younger people for segregated day care provision. Increased numbers are now making a direct transition from school to further education and some to employment. The expectations of younger disabled people are for ordinary life experiences and second best is not good enough.

These changes need to be acknowledged and built upon, especially for those with acquired disability.

Very few people, if any, are being referred to day support services under the age of 35 unless they have been injured as a result of a road traffic accident or sustained a head injury.

Unfortunately large numbers remain unemployed in the long term and many do not see day support as a desirable or appropriate option even if they have no other form of occupation or activity. Efforts to facilitate inclusive options for these need to be strengthened and adequately resourced.

In addition the Trust needs to continue to wield its influence through partnerships, especially A.C.E.T. and its community development strategy to bring about more inclusive opportunities for disabled people in their own communities and through mainstream services and utilities.

Obviously one of the most influential drivers in respect of the latter is the potential of the Disability Discrimination Act. The Trust however needs to play its part in assisting the empowerment of the individual and groups to maximise its impact.

7.3 Accessible Information

Information is power.

Without high quality accessible information the Trust could not begin to achieve the goal of empowering its residents. Good accessible information is the corner stone of any strategy that sets out to achieve empowerment. Information needs to be appropriate, as defined by the user, timely and accessible. The launch of the gateway project which works on the basis of a single telephone contact number as a communication link for enquiries for all services is a significant development in simplifying access to information on services. This, in conjunction with e-communications, website, etc all have the potential to help develop a transparent and accessible information service.

Provision of information is a service in its own right and as such should be embedded in an **information strategy** which assures progress, direction and quality standards throughout, including access for disabled people as a matter of course. This strategy should be informed through user consultation. Examples of this type of consultation exist already, for example the user focus group with blind and partially sighted people convened through Beechbank House.

7.4 Tackling Discrimination

In reality many, if not all, disabled people continue to face discrimination in their every day lives, in employment, education and in access to services.

Discrimination, whether attitudinal, environmental, or institutional ultimately has an adverse effect on individual health and well being.

Such discrimination can result in lack of money, lack of access to services and information, loss of role, which in turn can often result in isolation and depression and physical ill health.

The Trust has a role and a duty to challenge discrimination and discriminatory practices both within its own services and those of other agencies and organisations. The Trust should promote services that challenge discriminatory practice.

7.5 Addressing Inequality (TSN)

South and East Belfast have 7 out of its 23 wards deemed to be deprived using the Townsend score. In addition, there are significant levels of deprivation in some of these wards, or pockets of deprivation within comparatively affluent wards.

70% of disabled people are unemployed and a high proportion of those working are in low paid jobs. It follows that poverty is a significant factor for a large proportion of disabled people in the community. There is little doubt that social and material deprivation are principal determinants in health status, and health and social care needs.

In considering the health and well-being of its population the Trust must recognise the impact of unemployment, low wages, and poverty on disabled people. In so doing, the Trust may wish to refocus services, for example, encourage and support the idea of benefit uptake sweeps, targeted in areas of known deprivation.

Targeting health and social need is not, however, the remit of the Trust alone. It is only to the degree that all agencies together can address targeting social need that disabled people will see improvement in their lives.

7.6 Promoting Positive Health and Well-being

Promoting positive health and well being is perhaps one of the most neglected areas of disability services, and as such, an area that warrants particular focus in strategic innovation and imagination. There are many factors that lead to ill health and equally many factors that make and keep us healthy (see section 8). When looking at the **whole person** there is a wide range of factors that can lead to poor health, poor quality of life, dependency, and disability other than the direct or indirect effects of physical/sensory impairments themselves. These factors need to be acknowledged and addressed through service changes and developments.

7.7 Equipment

Many disabled and older people need equipment to maintain their independence and quality of life. It is often a key element in discharge from hospital, in rehabilitation, in the community, in services for disabled children and in support for carers. Often however the subject has not received perhaps the priority profile it warrants. There is still scope for improving services for users, for efficiency gains, and for closer collaboration between agencies.

A Guide to good practice in Disability Equipment Services commissioned by the DHSS in 1998 had the following findings:

- For many users equipment provision is a key element of community care.
- Users and health and social care practitioners urgently need better information about equipment
- The statutory sector has a major role to play in breaking down the barriers that exist for disabled people who need equipment
- Collaboration at strategic, as well as operational levels is essential to ensure that all the service components work effectively together.

- There is a need to find creative ways of:

    - consulting and involving users in service planning; and
    - obtaining feedback about equipment in use.

- There is scope to make better use of resources by re-modelling services
- Management information is essential if:

    - costs are to be apportioned realistically; and
    - efficiency savings are to be made

Effective equipment provision is crucial for community, primary health and social care. Ready supply of equipment can facilitate safer hospital discharges, promote independence and be a cheaper alternative to other forms of care. Timely supply may prevent admission to hospital or residential care and indeed help prevent falls and accidents for many older people. Timely supply of or repair to essential equipment should also have clear consumer standards attached. For example a person who has to wait six weeks for repair to their car will not be happy nor feel they have received a good service. The person who has to wait six weeks for the repair of their wheelchair has every right to be at least equally exasperated.

Effective equipment services are crucial contributors to **promoting greater independence in the community**, which was stressed in the recent Social Services White Paper and is a key theme in the National Priorities Guidance for Health and Social Care.

Equipment services for the future should be built on the principles of **consultation, information, choice, accessibility, equity, quality, equality of opportunity and best value** so that they support disabled people, older people and carers, as citizens. Consideration must be given to how **information, assessment and supply** are provided. Obtaining **management information** and measuring **performance and outcomes** must be a priority for managers.

7.8 PARTNERSHIPS

We are committed to partnership as the most effective way of getting the best possible outcomes.

Partnerships are time-consuming and demanding. They can also be difficult and resource intensive. Any partnership entered into must be able to clearly demonstrate strategic importance in terms of the service strategy. It must also be able to demonstrate tangible outcomes in people's lives relative to investment of time and resources. Potential partners must be able to show what they will bring to the partnership and share the same value base as the Trust. Partnerships will be driven by a person-centred agenda, not an institutional one.

The main areas within the physical and sensory disability programme that are likely to be the most strategically fruitful for working in partnership over the next five years are as follows:

a) Partnership with **disabled people.**

b) Partnerships with the **supporters of disabled people.**

c) Partnerships within the Trust between staff in the physical and sensory disability programme and **staff in other areas of identified strategic importance** where the Trust already has recognised expertise i.e. health, health promotion, mental health, children's services and elderly.

d) **Key outside agencies** – Housing, Education, Training & Employment Agencies, Transport and Voluntary services.

e) **Community groups** and organisations that recognise diversity within their community and the need to build an inclusive society – managers and first line staff are best placed to make these linkages.

f) Potential **funders** and **influencers.**

g) **University Departments** to influence both the teaching of future practitioners and research, as well as acting as a source of information and knowledge for Trust staff.

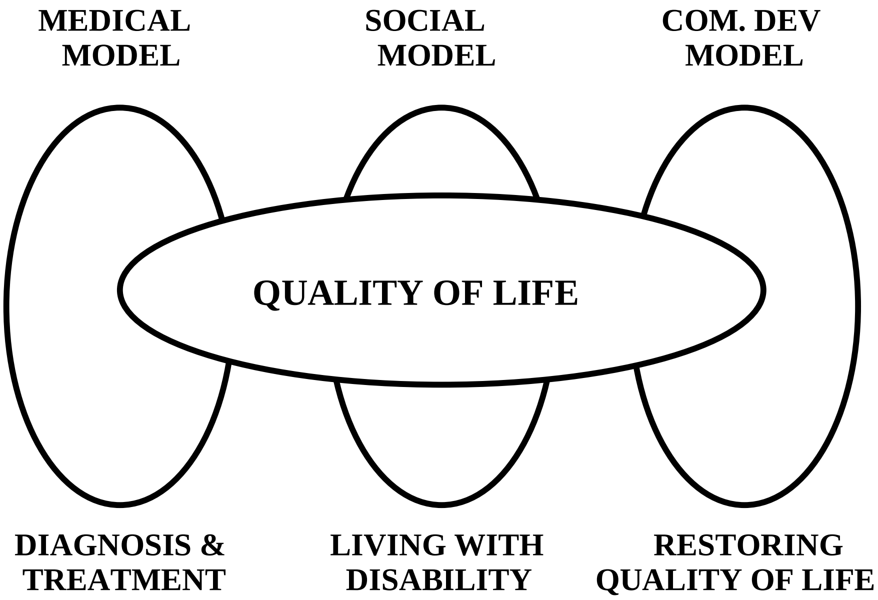
h) **Agencies in Consortium for Education and Training.** The Trust is a founder member of this partnership of agencies and organisations concerned with improving the quality of life of disabled people through education, training and employment. The consortium is a working model of interagency co-operation to which the Trust is highly committed and which it is hoped will grow in influence and serve as a model of good practice beyond the Trust's boundaries.

7.9 Quality Of Life

Fundamental to all citizens, including disabled people, is the need for a good quality of life, whether it is achieving, maintaining or improving quality of life, or restoring it to previous levels after injury or illness.

Through the development of health and personal social services, differing models of intervention have been employed each with its different emphasis and measures of success. However one theme that runs across all models whether it be medical, social or community development, is the issue of quality of life for the citizen. As an organisation we have developed skills and expertise in treatment and diagnosis, and employed significant resource to support people living with disability. The challenge is to develop similar skills and expertise in enabling disabled people to achieve good quality of life. This will inevitably lead to and require a shift in power and control from the organisation and its representatives to disabled people themselves.

The model that follows is an illustration of how our approach to Improving Health and Well-being and Disability has changed over time (from left to right), how our skills have developed and how we have targeted resources:



We have exercised and resourced the Medical model and developed good skills of observation, diagnosis, and treatment. We are more and more moving into the arena of a social model of disability combined with an acknowledgement of the need to adopt a community development approach. Likewise we have developed skills and services to help and support people to live with disability.

Recognising that the fabric that links all these approaches is the pursuit of improved quality of life, we need to learn new skills and develop new services that enable people to maintain and improve their quality of life and restore their previous quality of life where they have lost it.

7.10 Meaningful User Involvement and Participation

Although we have some initiatives under way and some examples of good practice the active involvement of consumers presents a major challenge for the Trust. Very significant benefits can be gained from effective consumer involvement, such as the improved targeting of support and assistance, the creation of greater choice in the support available and improvements in the quality of care that they offer to consumers. Successful consumer involvement will also play a role in achieving the goals of social inclusion, equality of opportunity, public accountability, and empowerment.

Consequently the Trust should strive towards **direct and sustained consumer involvement in all processes including assessment of need, planning, service development, commissioning, purchasing, evaluation, decision making and resource allocation.**

In so doing the Trust should be mindful of the 9 standards for successful consumer involvement as set out in the Social Services Inspectorate Quality Standards: Consumer Involvement in Community Care Services which cover the areas of:

- Policy
- Strategic Planning, Commissioning and Planning

- Operational Service Delivery
- Individual Care Management
- Financing Consumer Involvement
- Service Evaluation
- Training and Development
- Information
- Access to Community Facilities.

7.11 Transitions

Robust, seamless and interagency transitional arrangements are essential for disabled children and young people from as early an age as 14 years. They are essential in that they offer the disabled child a fair start in life in terms of a continuum of medical and health care, career planning and development, early introduction to social skills training in the context of work and life after school, and work to help remove the blocks and barriers that young disabled people face when leaving school and entering the world of work, further education, pre-vocational and vocational training, and adulthood itself.

The Trust is committed to further developing the interagency transitional work already undertaken for children with a learning disability under the auspices of A.C.E.T and extending this to children with physical, sensory and mental Health difficulties.

The Trust is also convinced of the need to ensure and provide a continuum of medical and health care required by young people as they make the transition between paediatric services and adult services. **This may well require a critical examination of medical and rehabilitative services available to these children in the multidisciplinary context. There are already recommendations from research carried out by Dr. Nan Hill within the Trust which highlight the great need for:**

- **A multidisciplinary clinic for young adults with motor impairment the core member of which would be a consultant with a special interest in rehabilitation.**

- **Sessional commitment from an Orthopaedic surgeon.**

- **Access to wheelchair and appliance advice.**

- **Liaison with therapy and social services personnel involved in local Trusts.**

- **A planned transition from paediatric to adult services which provides a framework for the co-ordination of health, social services and post educational needs.**

- **Assessment of community versus hospital based models of provision.**

8 RESHAPING SERVICE PROFILE

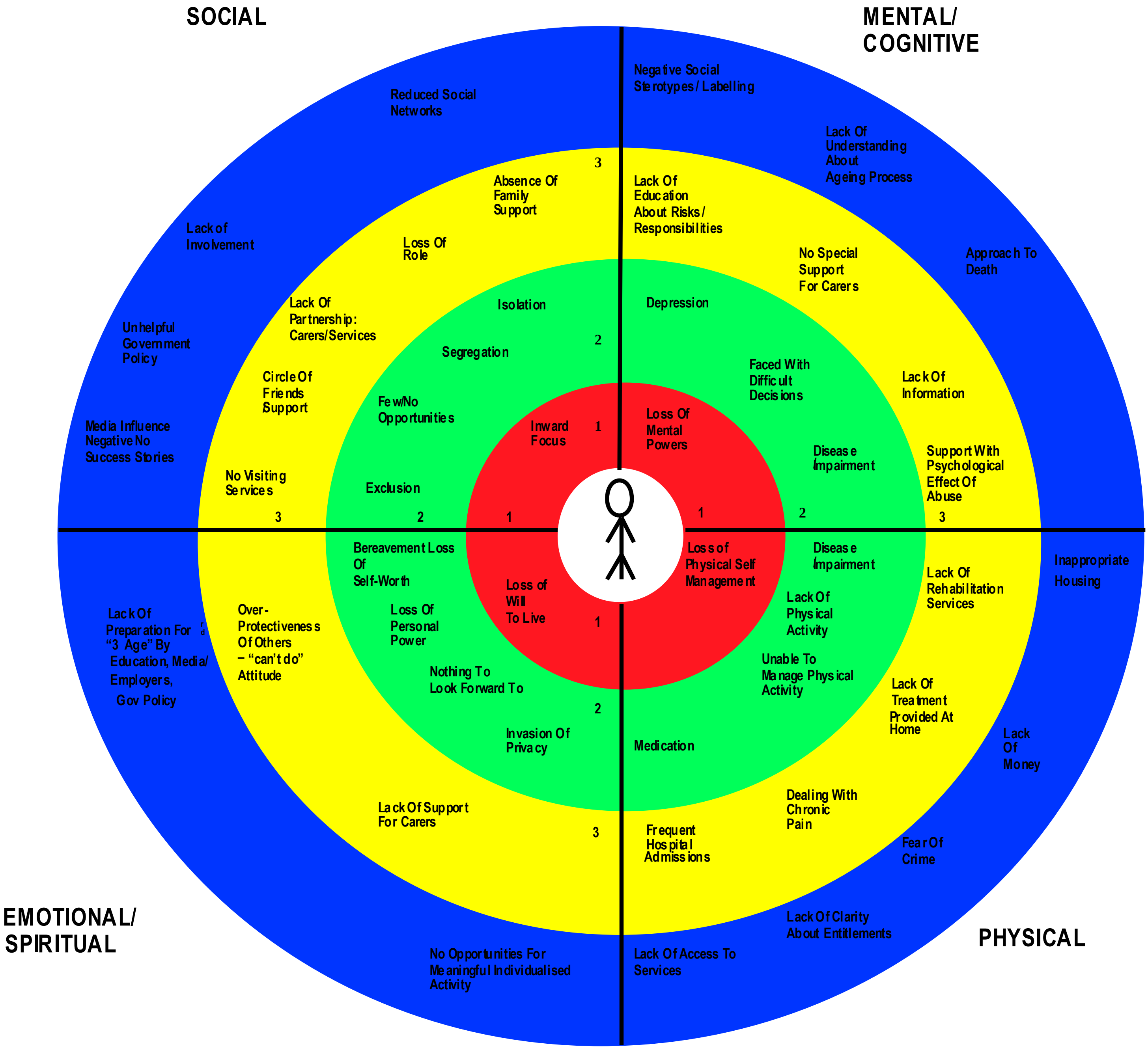
In order to examine how the philosophy and value base outlined in the first seven sections of this strategy can be translated into the shaping of service provision, it is important to focus on models that exemplify person-centredness, the whole-person, and the factors that promote positive health, quality of life, independence and ability.

- **One appropriate medium through which to make this translation (from philosophy to services) is that of an intimate knowledge of illness progression and pathways as experienced and defined by the person, accurate and specific needs assessment, and service user consultation**. These mediums can help reshape and finely tune our services to meet the real needs of disabled people in a timely and appropriate manner.

  By equipping our staff and services with specific knowledge about the person's experience of disabling factors, the pathways and experience of progressive illnesses, and a more intimate knowledge of the factors that make and keep us healthy, we will more effectively match services to actual need. The development of areas of special interest, already commenced in the community teams, would be strengthened by this approach.

  The following model, **picture of factors precipitating decline in health and well-being,** is an holistic way of looking at people's needs taking into account their physical, cognitive, social or emotional/spiritual well-being. This Native American model has been adapted for planning services for older people to demonstrate the different levels of their experience. The inner ring represents the experience of the final stages of living, the next ring represents the individual's experience of self, then the experience of direct support from family, carers and services, and finally their experience of society and community. This is potentially a very helpful model as it encompasses all aspects of the person including external and societal factors which are important in understanding disability. This model may be of assistance if customised by disabled people and could be used to obtain an holistic view of people's strengths and needs, plan support and evaluate where services and activity might be targeted for most impact

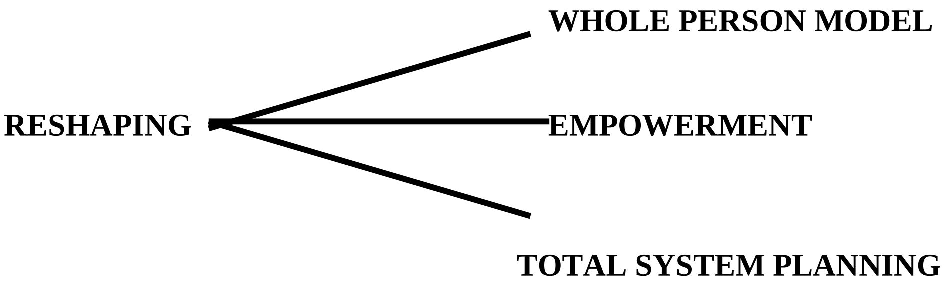
Picture Of Factors Precipitating Decline In Health And Well-Being



1. At the level of the individual
2. At the level of their support – families and or services
3. At the level of society

- Another medium is that of **empowerment.** We are already aware of high levels of dependency, testimonies of low self-esteem and poor self-confidence. **Addressing these issues and promoting positive Health and well-being therefore necessitates capacity building to address issues of poor self-esteem and confidence.** Through listening and identifying the source of the disconnection we can identify the assistance required and facilitate change at what ever level the disconnection occurs.

- Bearing in mind the growth of commissioning of services from the Independent sector and the increasing need for interagency collaboration it is timely to consider a **total systems approach** to the planning, development and delivery of services for disabled people. This approach is of particular relevance in the areas of day support (including leisure and recreation), pre vocational and vocational training, job support and placement. In these related areas of service provision there are already a range of service providers both statutory and independent. It is vital that all these activities are progressed under one strategic framework, within which they are linked and engaged with one another. This approach could help to reduce duplication, maximise efficient use of resource, and help move towards a seamless, "joined-up" service. By mapping out the services currently available - whom they provide for, what they provide, eligibility thresholds etc - we can begin to describe the overall service in terms of interconnections and gaps and move towards a total system.



Current Service Profile with key issues, developments, key outcomes sought and what success might look like

Current Service Profile

Currently, the Trust spends money on the following services:

Domiciliary Support	26%	£850 k
Day Support	27%	£878 k
Admin	8%	£279 k
Nursing Homes	8%	£275 k
Residential Care	8%	£260 k
Social Work	7%	£215 k
PAMs	5%	£157 k
Equipment	4%	£120 k
Transport	3%	£114 k
Wheelchairs	2%	£67 k

9 DOMICILIARY SUPPORT

Domicillary support is maintained through a number of services from home help, through care-managed packages to intensive Home Support. Packages of support all enable the disabled person to remain at home.

The Trust's intensive home care service has demonstrated the ability to care for some of the most severely disabled people, who otherwise would require hospital and nursing care, and has secured credibility from users, professional staff and carers. The service is, however, available to a limited number of people and is significantly costlier than nursing home care, or home care provided by the independent sector, albeit it is considered a much better service. This in turn raises issues of equity and whether the cost of intensive services is too much at the expense of others with lesser needs.

Domiciliary services, whether directly provided or otherwise, still tend to be shaped by the needs of the organisation. ,Domiciliary provision is an area where Direct Payments can potentially have significant impact in enabling the disabled customer to have control over how they shape the service they require.

Challenges

- Quality assure services to test their capacity to meet the needs described by disabled people, carers and advocates.
- Through the development of the appropriate support mechanisms give disabled people a real opportunity to manage their own services through Direct Payments.
- Develop alternative strategies for shopping and home heating currently supported through the home help service.

10 DAY SUPPORT SERVICES

The Trust currently invests £603k in day support services for younger disabled people (excluding Learning Disability). This represents 27% of total investment in the programme. Of the total investment in day support, 30% goes to the voluntary sector who provide a range of service from social day support to pre-vocational and vocational training. However approximately 18% of the total investment in day support is now seen in non-traditional forms of day support which focus on pre-vocational and vocational training with accompanying job support and placement.

	Places	Consumers	Description
Island	60	170	Phs Dis & Elderly
Ravenhill	25	121	Phys Dis & Mental Health
Cityway	10	22	Phys Dis
MS Society	34	34	M Sclerosis
NICOD	18	18	Phys Dis Training centre
Blind Centre		85	Blind & VIP's
Inclusion Zone	19	8	Phys Dis Training Centre
Garden Reach	15	15	Brain Injury Training Centre

There are clear signs in statutory services of a greater emphasis on outreach where one-third to one-half of service users are engaged in outreach and not in the centres 50% of the time. **However, only 5% of the Trust's total investment in day support is directed towards Inclusive, non-segregated options.**

The trend in statutory day support is one of increasing referral of people with complex needs requiring in some instances 1:1 and 2:1 assistance. In the Ravenhill particularly, there are significant numbers of people (N = 100) with dual diagnosis of Physical Disability and Mental Health difficulties and often with associated alcohol related problems.

The development of post school alternatives for young people through mainstream educational establishments and the development of pre-vocational training units e.g. NICOD and Garden Reach, has led over the past ten years to a major reduction in younger disabled people seeking placement in statutory day services. The only young people under 35 years of age tend to be those with acquired disability as a result of head injury for example.

Challenges

- **Creating an Inclusive planning forum for Day Support which would map, plan and further develop services using a total systems approach.**
- **Moving from centre-based outreach to full Socially Inclusive model of support.**
- **Meeting the Day Support needs of an increasing number of disabled people with complex needs without creating a closed segregated environment.**
- **Stimulating community alternatives for people with complex needs and who challenge.**
- **Exploiting innovative business ideas and technology that enables disabled people to develop and lead services.**
- **Enabling real inclusive "Honey- pot "schemes run by disabled people that will be attractive and divert people away from segregated services.**
- **Assisting disabled people to claim back their local communities and the services therein.**
- **Supporting the community to support disabled people.**
- **Enabling disabled people themselves to access and influence community development initiatives.**
- **Further empowering individuals and groups of disabled people.**
- **Exploiting concept of life long learning.**

11 COMMUNITY TEAMS

With ever increasing demands on limited resources it is more important than ever to manage existing resource in ways that provide cohesion and improved integration between services and professionals and ultimately provide a seamless service for the customer.

There is an imperative for services that are already developing specialist knowledge to develop an intimate understanding of disease and illness pathways and how they impact on the lives of chronically ill and disabled people. Customers themselves are gaining more and more access to detailed information on the internet and there will be a consumer expectation that we at least keep up. An intimate knowledge of the impact of disabling conditions will enable professional responses to more closely reflect individual need at any specific time.

Challenges

- **Continue to develop knowledge and expertise based on the individual's experience of disability and illness.**
- **To manage limited resources and services in a more cohesive and integrated manner.**
- **To offer services that enable, empower and increase autonomy.**
- **Use needs assessment to clarify customer need and define core business**

12 DIRECT PAYMENTS/EMPOWERMENT/INDEPENDENT LIVING

One particular tool in promoting control and empowerment is that of Direct Payments. Since the inception of the legislation there has been no uptake of Direct Payments within the Trust, until recently, despite promotional efforts by many staff.

This should not be interpreted as an informed lack of interest on behalf of disabled people. It is clear that the only remaining factor that will significantly improve uptake is that of independent information, support and advice.

Services that provide such independent information, advice and support, for example, Independent Living Centres, can act as an empowering catalyst for disabled people that enables them individually and collectively to become more informed and self-confident and more likely to engage with concepts like Direct Payments. We need to recognise that many disabled people are dis-empowered and lacking self esteem and self-confidence. It is only by directly targeting this aspect of reality that we will have our goals of consumer involvement and consumer-led services realised.

Challenges

- **Acknowledge and consider solutions for the need to provide independent information, advice and support.**
- **Consider the concept of an Independent Living Centre in partnership with disabled people and significant others.**

13 INTERAGENCY COMMUNITY DEVELOPMENT

The Trust is already involved heavily with the A.C.E.T interagency partnership that has a New Deal pilot franchise as one of its current projects. The New Deal project is already proving to be a significant piece in the overall process towards social inclusion, being potentially for many the connection between pre-vocational / vocational training and the world of work. New connections are being made between employers and training organisations which are potentially opening up new opportunities for disabled people. This project has already shown potential to break down and overcome long-standing barriers to full inclusion for disabled people in the world of work.

The big issue is what this method of working can achieve for disabled people in the whole area of community development.
Many of the issues faced by the Trust i.e. limited resources, lack of social inclusion for disabled people, need for shared responsibility, links between deprivation, disability and poor health, all point in the one direction i.e. community development.

Challenges

- **Continue to develop model of interagency working particularly in community development.**
- **Encourage, facilitate and support disabled people to be central to the process.**
- **Support and equip disabled people to take up this challenge, i.e. capacity building.**
- **Ensure that disability is factored into all community development work undertaken by the Trust.**

APPENDIX 1 THE DISABILITY DISCRIMINATION ACT

ACTION REQUIRED BY 1ST OCTOBER 1999

A) **The Trust must develop a strategy, with disabled people, to implement Section 21 (*Discussion document May 1998, may act as basis for this)***
B) **Review practices, policies and procedures.**
C) **Review Information for, and means of communicating with, clients and patients.**
D) **Review disability awareness training for** all **staff.*(underway)***
E) **Develop a programme for auditing access to and around** all **premises, giving priority to toilet facilities.**

ACTION REQUIRED BY APRIL 2000

A) **Have developed a programme of ongoing disability awareness training covering reception staff, in-depth training for specialist staff and induction programmes.**
B) **Have developed an action plan to improve access to services for disabled clients, visitors and staff covering staff awareness and physical improvements.**

(The above should be incorporated into *mainstream* **training and business planning respectively).**

ACTION REQUIRED BETWEEN 2000 AND 2004

Implement Review and if necessary revise the action plan.

TRUST DDA WORKING GROUP RECOMMENDATIONS

The Trust working group on the implementation of the DDA made the following recommendations:

- **Ensure DDA on the agenda of OMT and Diversity Steering Group.**
- **The Trust should openly commit itself to improving, year on year, accessibility both of its services and the information it produces about these services.**
- **Nomination by OMT of senior manager to co-ordinate DDA implementation.**
- **Development of a trust strategy for implementation.**
- **Designating a Disability Adviser.**
- **Introduce DDA issues through Service planning process. All service managers should be made responsible for ensuring that their particular service area and the information provided about it are accessible to all people who are disabled.**

What is preventing your service employing disabled people? What additional support do you need to employ a disabled person? What action do you intend to take to improve access to your service? How do you intend to make information on your service more accessible? How do you prepare your staff to discharge their responsibilities to disabled people?

- **Use Team briefing to alert managers and staff to the requirements of the Act e.g. *what the DDA says and means.***
- **Consideration by HR of widening disability-welcoming statements to more proactive statements that shortlisting requirements can be waived but candidates will be required to demonstrate their ability to do the job. *(Requires Policy change and* occupational *testing system)*.**
- **Further development of module in customer care training to focus on people with special needs. A disabled person should facilitate this module.**
- **Continue reflection on DDA in Selection and Recruitment training.**
- **Ensure focus on " access to work " and "retainer" schemes in managing attendance training.**
- **All training to be reviewed in relation to the DDA and its implications.**
- **Immediately develop programme for auditing Physical Access, to and around, all community facilities, using the "Access to Health Service Premises Audit Checklist" with a view to having an action plan to improve physical access by April 2000.**
- **All new building plans and refurbishments should be quality assured by disabled advisors to ensure accessibility.**

- **Review and audit accessibility of current Trust information with immediate effect, with a view to having an action plan for improvement by April 2000.**

SERVICES FOR PEOPLE WITH A LEARNING DISABILITY

3 STRATEGIC DIRECTION AND PROGRESS

Following the DHSS Review of Learning Disability Policy in 1995, the Regional Strategy for 1997 – 2002 contained targets for reshaping Learning Disability Services. These included the resettlement of all people resident in long-stay hospitals by 2002, the relocation of Children's Services from hospital sites by that date and the development of more locally based assessment and treatment services.

Eastern Board in September 1996 approved a paper entitled "A Model of Community Based Services for People with Learning Disability". It was also agreed that a Learning Disability Steering Group (L.D.S.G) should be set up to implement the service model.

Trust staff have actively supported the development of the new model but have expressed ongoing concern about the absence of a sufficiently robust financial strategy to underpin it. The Trust Chairman subsequently wrote to the Eastern Board Chairman offering, if it would be helpful, to accompany him to the Department to press the case for additional funding so that the strategy could be successful.

In the absence of a firm financial strategy we, meantime, decided to place our primary focus on supporting people already living in the community and where possible to prevent inappropriate hospital admissions. We have, therefore, been reshaping our community services within available resources to bring them into line with best practice and try to meet the increasing need there without recourse to hospital and other institutional provision.

We took the view that it would be wrong to bring people from Muckamore Abbey Hospital back into the community if the resettlement costs could not be met in full, not least because any extra resettlement costs would only add to the severe pressures already in the community and thereby precipitate further admissions to hospital. This would create a "revolving door" and thereby frustrate the declared aim of the whole strategy which was to reduce the number of people in hospital.

Following the Eastern Board's decision in 1996 to take forward the new model of service provision, we played a full part in joint work with the Eastern Board and other Trusts to move things forward. Where resettlement costs could be met by Eastern Board, we made arrangements for the patients affected to live in the community. We also took financial risks in resettling people where a commitment was given in good faith that the recurrent funding would be found in the foreseeable future.

At its Public Meeting in August 1998 Eastern Board formally reviewed the "Learning Disability Programme Service and Financial Strategy".

We note the statement in this paper that the HSS Executive Director of Child and Community Care and other representatives in the DHSS gave unconditional support to the strategy being pursued by Eastern Board. They were reported as regarding the approach as both realistic and pragmatic. A bid had therefore been made to the Department of Finance and Personnel for both new non-recurrent and recurrent funding associated with the programme.

The same report notes that HSS Executive recognised that, without the availability of new finance as identified, the strategic aims of the Department and the Eastern Board cannot be realised except through the transfer of resources from other programmes.

We wish to make it clear that we were not properly consulted about the option of "top-slicing" other programmes if additional funding from the Department was not forthcoming. Nor can we possibly support it given the pressures on Children's Services faced with implementing the Children Order, Elderly Services faced with increasing numbers of very old dependent people, and Mental Health Services where young people are being admitted into adult wards which is leading to a failure to properly discharge statutory functions and creating potential danger for the young people concerned.

We accept, of course, that in the final analysis this issue is a matter for a Purchasing Board, not a Trust, but we consider it would not be right in principle to support "top-slicing" and in practice would be extremely difficult, if not impossible, to implement.

Nonetheless we welcome the Eastern Board's continued commitment in taking forward the new model of community-based services.

We also welcome the acknowledgement that the infrastructure and support for people already living in the community will also need to be enhanced, particularly with a view to meeting increasing demands in the community, reducing the number of admissions to hospital and reconfiguring and improving specialist treatment services and respite care services for children.

The unavailability in the proposed strategy of additional resources for community service developments until the year 2000 will undoubtedly further impede progress towards the reduction targets in assessment and treatment beds. During the intervening period the Trust has no resources to facilitate discharge or prevent unnecessary hospital admissions as People First funds are committed. The situation is further complicated by the fact that the Eastern Board has chosen to project resource allocation for the development of community services, over a ten-year period, beginning year 2000, as opposed to a three-year period, beginning in 1998.

One of the key elements of the whole Strategy is the release of a large dowry from Muckamore Abbey Hospital. If this is not forthcoming for any reason then there will be serious financial consequences. **We remain convinced that the actual costs of resettlement may be in excess of what is budgeted for but accept the Eastern Board has done all it can to develop realistic costings**.

In summary, we approve the philosophy, values and aims of the Learning Disability Strategy but we cannot support "top-slicing" other programmes to compensate for any funding deficit. We will only resettle individuals where the appropriate resources are in place, and in a way that is both safe and appropriate without jeopardising existing community services.

1.1 PROGRESS 1997/98

SUPPORTED HOUSING

- The Trust's Service Strategy is to close residential care facilities as other housing alternatives develop and, where we can, free resources released into community care. The funding released by the closure of Myrtlefield is already being re-invested in home care.

  The restructuring and strengthening of the home care service is well developed and will continue to advance.

- The Belvoir Supported Housing Scheme has been opened, providing supported housing for five individuals, one of whom resettled directly from Muckamore Abbey Hospital.

PUBLICATIONS

- 'Days of Change: A Practical Guide to Developing Better Day Opportunities with People with Learning Difficulties' was published by the King's Fund in 1998. The Trust was **one of five development sites nationally** that contributed to the publication, based on its commitment to develop these kinds of services. We were a direct contributor to the section on service change and redesign.

A.C.E.T. (AGENCIES IN CONSORTIUM FOR EDUCATION AND TRAINING)

- The work of A.C.E.T has continued to develop in target areas. **In May 1997 it formally adopted its first operational plan**. The framework document subsequently launched in December 1997 contained the following objectives :-
  - to define and formalise A.C.E.T's funding relationship with the education sector;
  - to examine and publicise A.C.E.T as a model of inter-agency working;
  - to determine ways in which A.C.E.T can engage with a wider reference constituency;
  - to deliver New Deal for people with a disability or long-term illness in South and East Belfast;
  - to agree a strategy for securing continued funds

  for Disability Programmes post-1999;

  - to implement recommendations from independent travel research and agree co-ordinated promotion of independent travel;
  - to establish a mechanism for effective inter-agency planning of career pathways for young people;
  - to implement the recommendations from the review of the Work and Life Skills Programme;
  - to assess the results of the Community Inclusion Project. These include identifying the education and training needs at a local community level to promote inclusion for deaf and hard-of-hearing people;
  - to devise a transferable model for promoting inclusion in a local community.

- Membership was strengthened and widened to create a broader representation which now includes :-
  - South and East Belfast Trust;
  - The Training and Employment Agency;
  - SKILL – National Bureau for Students with Disabilities;
  - Shadow Trust;
  - Belfast Institute of Further and Higher Education;
  - Northern Ireland Council on Disability;
  - Glenveagh School;
  - TorBank School;
  - Fleming Fulton School
  - Orchardville Society;
  - Royal National Institute for the Deaf;
  - Castlereagh College of Further and Higher Education;
  - Department of the Environment.

- The 'Work and Life Skills Programme completed its third year of accreditation by the Open College Network (OCN), with increasing success in offering higher quality and longer-term work placements.

- A successful workshop was held in February 1997 at which delegates from A.C.E.T member agencies and others (including private sector employers) discussed best practice in supported employment and future strategic direction. A sub-group subsequently produced a report summarising supported employment activities in South and East Belfast and documented quantitative information regarding the number of trainees and outcomes.

- In Spring 1998 a New Deal Working Group was convened to submit an A.C.E.T bid to deliver new deal for people with disability or long-term illness, in South and East Belfast.

- The University of Ulster was commissioned to carry out research into the blocks and barriers preventing people with learning disability from travelling independently. The research was funded jointly by DENI, South and East Belfast Trust, the Training and Employment Agency and the Department of the Environment. The research was adopted by A.C.E.T in February 1998. Barriers were categorised as personal, social and environmental and trip (travel) factors. Recommendations included :-
    - a common Travel Training Scheme should be devised in South and East Belfast;
    - pilot projects should be established;
    - work between South and East Belfast Trust, the Department of the Environment and Translink should be broadened to examine how transport information and signage could be better designed to meet the needs of people with learning disabilities;
    - quality standards should be included in taxis' contracts.

  A video was also shot entitled 'Independent Travel: A New Direction for a Brighter Future' which demonstrates the extent to which independent travel - promoted by agencies working together – can enhance a person's life.

  Working groups are currently taking forward all recommendations from the research into Blocks and Barriers preventing people with a learning disability from travelling independently.

- In June 1998 a workshop, involving all the agencies, was held. The workshop considered the needs of identified school leavers with learning disabilities for the next five years with a view to developing a shared person-centred inter-agency approach to career planning. It is intended to exploit the resources of A.C.E.T to develop 'career options' (including those with complex needs), develop continuity in curriculum across agencies and identify future need. Once need is identified steps can then be taken to address it. This work is ongoing.

TRUST COMMUNITY TEAM RE-STRUCTURING

- In response to the introduction of the Eastern Board's Vulnerable Adults Policy and Procedures, and in recognition of the complex statutory work surrounding people with learning disability, the Trust has re-configured existing services and **established a Vulnerable Adults Social Work Team. Social Work Teams are aligned to Adult Training and Resource Centres**. Already the Social Work Team for Vulnerable Adults and South Belfast Community Social Work Team for Adults with a Learning Disability have been integrated with the Orchardville Training and Resource Centre.

Plans for the attachment of the existing East Belfast Community Social Work Team at McCartney House to the Edgcumbe Training and Resource Centre are well under way.

REVIEW OF RESPITE

- Earlier in the year the Trust commissioned a review of respite carried out in conjunction with Dr Chris Conliffe, Institute for Counselling and Personal Development, entitled 'Respite: An International and Northern Ireland Perspective'.

  In collaboration with parents, professionals, community and business interests **the review looked at best practice in the field of respite for people with a learning disability in the United Kingdom and beyond**. It identified more flexible, responsive and equitable alternatives to existing respite provision, so that users and carers could have a 'conscience free, natural break'.

  We intend to take forward the findings of the review and, as part of an overall service strategy, re-provide respite care away from long-term accommodation.

PERSON CENTRED THINKING

- We continue to provide training to our staff on Person-Centred Thinking and Essential Lifestyle Planning. To date all residential and day-care staff within the Learning Disability Programme have received this training, and work is currently underway to provide it to all fieldwork, social work and nursing staff, and new recruits.

TRAINING FOR PEOPLE WITH LEARNING DISABILITY

- On 1 September 1998, an award presentation was held at the Wellington Park Hotel for people with learning disabilities who had successfully undertaken training provided by the Orchardville Society. In all, 81 people with a learning disability received certificates in a variety of qualifications, including NVQ Level I and II. Thirty had graduated through the Working Life Skills Project and Project Career under the auspices of A.C.E.T, and the remaining 51 through Orchardville Society's own training scheme.

  In 1997, 5 people with a learning disability graduated to full-time employment and in 1998 10 moved into full-time employment.

4 RANGE OF SERVICES

We continue to provide a wide range of quality services including health promotion, domiciliary care, day services, respite and residential care. Services are being reshaped in line with best practice and user demand.

5 COMMISSIONING PRIORITIES

While we fully accept the Eastern Board's strategic priority to resettle people from hospital, incessant pressure continues to build within the community. **We believe, therefore, that the Eastern Board's resettlement priority to meet regional targets must be tempered by an understanding of the issues which continue to confront staff in the community on a daily basis**. These include :-

- the large number of ageing carers in the community;
- the growing number of children with complex needs (physical and behavioural) combined with demographic changes in family structure;
- the anticipated growth in the number of school leavers over the next five-year period and the potential impact on already over-crowded day centres. Projected need for places from the emerging school population over the next five years will outstrip current day placements despite shifts to alternative forms of day care. The Trust has identified gaps in day support options in East Belfast and Castlereagh which will require additional funding if they are to be met;
- the expressed desire of increasing numbers of people with a learning disability to live in ordinary housing;
- the demands and needs of carers for increased practical support and respite (particularly parents of children and ageing carers);
- the increasingly complex needs of people living in the community and demands to meet these;
- the training and development needs of staff so that they can respond to a service that is continually changing.

To successfully address each of these issues will require a lot of imagination and investment of time, energy and financial resources.

Eastern Board is already aware of how, over the past four years, we have tried to strategically address some of these issues by using 'People First' monies to help service re-engineering (particularly the development of supported living) and to try and exploit the potential of resources from outside health and social services. These opportunities are narrowing all the time as our 'People First' monies are fully committed and one of the alternative sources of funding, e.g, housing benefit, is likely to be capped in the near future.

We welcome the acknowledgement in the Eastern Board's Strategy that increased investment in the community will be necessary to manage increased demand and provide an infra-structure to reduce hospital admissions. We will invest any new monies in these areas in line with the Eastern Board's purchasing intent.

During 1998/99 it may be possible for the Trust to begin the process of facilitating further service re-engineering. This could be done in line with our strategy of closing residential care facilities as other housing alternatives develop and where we can, invest resources thereby freed up into the community. **We therefore wish to signal that we are likely to move this year to public consultation on the closure of a further hostel**.

The Trust would welcome the opportunity during this round of contract negotiations to enter into further debate with the Eastern Board as to what priorities it wishes to set for investment for 1999-2002 so that areas of lesser priority can be deferred until such time as funding becomes available.

3.1 HOSPITAL SERVICES

The Trust notes that the Eastern Board has identified a longer term target of 40-50 short-term assessment and treatment beds at Muckamore Abbey Hospital with an interim planning assumption of 70 beds by 2002.

A census carried out last year by hospital staff indicated that we had 87 residents in Muckamore. Of these 13 were assessed as ready for discharge, 37 were ready for discharge but required continued treatment in the community and 37 required continued treatment in hospital.

Currently the Trust has 81 residents in Muckamore Abbey Hospital. Ten were resettled under the 'Clonshee' Agreement prior to 1st April 1998 and a further two after 1st April 1998. We are in final negotiations with Eastern Board officers to agree funding for these resettlements which were undertaken in good faith.

The Trust does not intend to resettle any further patients from South and East Belfast until the funding of those already resettled is agreed, otherwise existing community services could be destabilised. **We will also want to be satisfied that the overall financial strategy for people with a learning disability is robust and a source of recurring expenditure to pay the costs of resettlement has been identified and agreed**.

We estimate that, as a Trust, we will have to resettle between 10-15 people annually over the next four years if targets set in the Eastern Board and Regional Strategies are to be met. The Trust's experience in retraction of our own mental health hospital would, however, suggest that the range of resettlement that can be realistically achieved per year is between 10% and 16% of the population. Using a direct comparison this would suggest that realistically the target for the

Trust should be in the region of 8 - 12 people per year.

Our commitment to implement the new community based Learning Disability Strategy remains strong; however, like the Eastern Board, we remain very concerned about the level of funding presently available. We are also acutely aware that the first six months of the strategy time-frame have already elapsed without a definitive position statement in relation to the totality of the proposed funding strategy.

In the event of a satisfactory resolution to all of the funding issues, we intend during 1998/99 to once again start resettlement using a person-centred assessment approach. Additional community staff time would be dedicated to facilitate the process with residents and staff in Muckamore Abbey Hospital.

Meanwhile we appreciate the pressure on Eastern Board and North and West Belfast Trust to maintain the tertiary treatment service on the Muckamore Abbey site. We accept that presently North and West Belfast Trust, because of its existing expertise in this area, is best placed to provide the tertiary service. As the strategy unfolds, however, we are keen that skills and expertise presently in the hospital will transfer to the community and that over time the balance will shift from a hospital-based treatment service to a community-based treatment service with access to a small number of tertiary treatment beds.

We note that North and West Belfast have yet to put in place a Human Resources Strategy aligned to the changes the Eastern Board wishes to see. Once the strategy is developed we will want to work closely with North and West Belfast on the implications.

3.2 COMMUNITY SERVICES

The Regional Strategy requires that by 2002 the 185 long-stay patients in Muckamore Abbey hospital should no longer be in hospital and the number of adults admitted to hospital should reduce by 50%. As indicated earlier the Trust currently has 81 people resident in the hospital.

If we are to meet these targets it is essential that, in addition to realistic funding, the confidence and competence of staff is increased to manage people with complex needs and challenging behaviour.

To be successful the Learning Disability Strategy will need to be underpinned by the increased transfer of skills, expertise, resources and personnel from the hospital to the community. In the meantime, the Trust has been investing a lot of time and money in equipping staff with the necessary confidence and skills to manage challenging behaviour and develop person centred plans. As a result, a number of people with a learning disability who, previously, would have required hospital admission, are now being successfully maintained in the community.

The Trust is confident that our present hospital admission rate could be further reduced between 1998-2002 by :-

- targeting those most 'at risk' of admission, through the focused work of our newly formed vulnerable adults team;

- developing Intensive Home Support designed specifically to meet the particular needs of service users and their families. We want to adapt the Intensive Homecare Model - successfully developed to meet the needs of the frail elderly, people with very complex physical needs and those with brain injury - to meet the needs of people with learning disabilities;

- providing effective training for carers and staff in recognising and managing complex medical conditions and challenging behaviour.

The Trust is firmly committed to the move towards more flexible day support. This will involve attendance at a range of facilities offering educational, leisure and employment activities in addition to, or as an alternative to, existing Trust day services.

The Trust has facilitated three user-led alternatives to day care in community resource centres in the Ravenhill, Ballynafeigh and Templemore Avenue areas of the Trust. Work is also currently underway with service users at Edgecumbe Social Education Centre to set up a fourth similar, user-led, 'drop in' resource in the local vicinity.

Despite these developments, **current demand and the projected demand for day places from school leavers outstrips the current availability in East Belfast and Castlereagh**. We believe that urgent action is required to provide a third day care resource there or, preferably, develop community alternatives. This is without taking into account the increased demand for day places created by the proposed rapid resettlement of people from Muckamore Abbey hospital.

We have almost completed training of all residential, day care and fieldwork staff working with people with learning disability in person-centred thinking and so we consider we are well placed to take forward the new strategy with a suitably equipped and trained staff.

We have trained a member of staff within the programme in Essential Lifestyle Planning and we hope, following accreditation as a trainer by Christmas, this member of staff will be released for a time-limited period to further develop staff skills in this area.

3.3 SPECIALIST TREATMENT SERVICES FOR CHILDREN WITH LEARNING DISABILITY

We welcome the opportunity to work with the Eastern Board in progressing the commissioning statement on specialist treatment services for children and the four proposed developments therein, namely :-

- provision of a small residential assessment and treatment facility for children primarily with severely challenging behaviour;

- strengthening multi-disciplinary community teams;
- increasing training opportunities for front line staff and families in behaviour management; stress management and communication;
- research into identification of outcomes; family coping mechanisms; families 'at risk'.

We welcome the increased focus the Eastern Board is now giving to this issue and the commitment it has made to strengthen primary and secondary services.

3.4 DISABLED CHILDREN

We shared with the Eastern Board two years ago a local Trust-wide needs assessment for disabled children and their families. The final report entitled 'Remember the Children' drew attention to the lack of vital services, the inaccessibility of others and the sense of anger and frustration felt by the families of disabled children.

Since then some small improvements have been made. With Eastern Board funding we are well placed to increase the number of respite places in the Breakaway Scheme from 40 to 60. The Specialist Child Minding Scheme is also providing support for seven families. We have in addition just appointed a second Consultant Paediatrician and a Paediatric Nursing Sister is beginning to address the nursing requirements of children with complex needs. We continue to develop shared care and fostering arrangements for children with disability and already have had some success in securing placements for children with complex needs.

However, our specialist Children Services Disability Team continues to highlight the real and pressing problems they are facing on a day-to-day basis trying to support very disabled children and their families and their sense of just how little they can offer to ease the 24-hour demands these families face.

Due to the impact of the Children Order, there is now a need to statutorily review community respite placements for children with disabilities under 'Looked After Children' (LAC). Not only does this mark a significant increase of workload for social workers working with children in these circumstances, but the LAC review forms themselves are inappropriate for such family-based respite schemes. The Trust would welcome a review of their appropriateness and application.

We support and are determined to take forward the partnership and inclusive model that best practice demands and we continue to examine how our own mainstream services can be made more accessible. To that end we are working in close partnership with schools, primary care teams, Education and Library Boards, Acute Trusts and voluntary organisations.

Looking to the future, however, there are a number of strategic reviews either just completed, or soon to report, which will set the direction for some years ahead. These include :-

- A Draft Strategy for Children and Young People's Health;
- Review of Child and Adolescent Psychiatry;
- Review of Respite Services for Children with Learning Difficulties;
- Review of Children's Services at Muckamore Abbey Hospital;
- Children Matter : A Regional Review of Residential Child Care Services.

It is vital that all these reviews holistically address the needs of children as children and they are not 'boxed' into the frameworks that make sense to professionals and administrators but not to service users and others. We want to work jointly with the Eastern Board to ensure that a cohesive and comprehensive approach is taken to the needs of all children and families, disabled and not disabled.

The direction services for disabled children ought to take is clear. Services should be comprehensive, based on community support where disabled children actually live, and address need along a spectrum - from prevention to support and intensive care for those in greatest need, including terminal illness.

Services at present continue to be insufficient to meet need and the picture is constantly changing, not least because of advances in medical technology. Within the resources that are available, however, the Eastern Board and Trusts need to get the balance right between all the competing demands in the hospital and in the community. We are not sure that the balance is right at present.

Eastern Board has continued to stress the need to strengthen community services, but as indicated earlier progress has been slow and patchy. The Introduction to the Service and Financial Framework Document draws attention to a list of issues where it is anticipated there will be significant resource impact. The new facilities at the Royal Belfast Hospital for Sick Children will open 1998/99 and we understand the extra costs may run into many hundreds of thousands of pounds. Commissioners have already committed to the improvement of Paediatric Intensive Care Services at the Royal Belfast Hospital for Sick Children and it is anticipated that a bid will be submitted soon for enhanced Paediatric Oncology Services. The total bill we consider will run well in excess of £1 million.

Against these pressures to invest in hospital treatment and care, we need to be careful that a proper balance is struck so that resources are allocated to meet the needs of people, not the needs of institutions. **It is therefore imperative that real weight is given to the often less visible demands of very severely disabled children and their families living 24-hours a day for a lifetime in their own homes and community. We look to the Eastern Board to**

strike this balance as a Commissioner and we want to work jointly with them to achieve it.

Within the community recent Eastern Board and DHSS Reports have highlighted the following :-

- children with disabilities in inappropriate long-term or respite placements (within our own Trust there are 17 people with learning disabilities aged 16-19 years, using adult hostel provision for respite). (Children Matter Report);
- those families of children with a learning disability receiving a respite service feel that it is sufficient for their needs and complain about the lack of availability (1997 survey);
- two-thirds of those getting a respite service would benefit from more (1997 survey);
- three main providers of residential respite stop taking children when they become 14 or 16 years old (1997 survey);
- most respite provision in the 1997 survey appeared to be allotted to children with learning disabilities. Very little was known about the needs and preferences of carers with children with physical and sensory disabilities;
- respite in what are perceived to be hospital settings is not a favoured option.

These corroborate our own findings.

The Trust welcomes the statements in the Eastern Board's Commissioning Statement on Respite Care Services for all children with disabilities which highlighted the need for the following service changes and developments :-

- re-provision of existing hospital and residential respite services into a number of small (4-place) residential units for children who are highly dependent with nursing needs;
- establishment of a number of small (4-place) residential units for children who require constant supervision and whose behaviour is difficult to manage in family settings;
- enhancement of family-based respite schemes, domicilary services and leisure and holiday respite.

If and when realised, these developments will give hope to families who have grown tired of good intentions not marked by real improvements on the gound.

We remain concerned about the feasibility and funding available for the proposed residential units. In the meantime, the Trust is currently in early discussions with a local provider in respect of developing a small residential unit for children requiring respite who are highly dependent with nursing needs. Currently we have 39 families using facilities at Forest Lodge which is proposed for closure in 2000. **The Trust, however, is worried that funding released from the closure of Forest Lodge will be**

inadequate to meet the cost of alternative provision. Furthermore the Trust is equally concerned that the closure and release of funds will come too late, as developments need to be underway immediately if the resource at Forest Lodge is to be provided elsewhere by 2000. The Trust would welcome further discussions with the Eastern Board on these pressing matters.

In respect of the numbers of 16-19 year olds receiving respite in adult hostels (see earlier), it is the Trust's intention to make a bid to the Department of Health and Social Services, in response to the 'Children Matter' Report, for a respite unit for adolescents.

3.5 PEOPLE WITH A LEARNING DISABILITY AND DEMENTIA

The Trust welcomes the opportunity to work with the Eastern Board in identifying current and projected numbers of these people and any gaps in service provision. We also recognise the increasing number of carers with the onset of dementia who are caring for people with a learning disability.

3.6 DIRECT PAYMENTS

The Trust is aware that there is information from Great Britain which indicates that direct payments have been taken up by people with learning disability there. New organisations have also been formed to facilitate potential recipients giving informed consent. We are led to believe that innovative schemes have been developed which promote choice and independence and we will be studying these in more detail.

Despite our best efforts there has been little, if any, interest in people with physical disability taking up direct payments and getting schemes off the ground in learning disability may prove even more challenging. **Something more radical than the present approach is needed and we will be looking at a range of alternatives.**

Belfast Health and
Social Care Trust

New Directions

A conversation on the future delivery of health and social care services in Belfast

CONTENTS:

APPENDICES

Foreword

Belfast Health and Social Care Trust was formed in April 2007 from the merging of six Trusts, four of which were acute – the Royal Hospitals, Belfast City Hospital, the Mater Hospital and Green Park - and two Community Health and Social Services Trusts, serving north and west Belfast and south and east Belfast.

The new Belfast Trust aims to build on the fine legacy established by the six Trusts to deliver integrated and seamless citizen-centred health and social care.

The Trust has set out in a draft document entitled “The Belfast Way” - its values and objectives for the future delivery of its service to achieve excellence for the citizens of Belfast.

The challenge for Belfast Trust is to create an overarching and unified health and social care system for the population we serve. We believe the delivery of services should be simplified. Unnecessary duplication and fragmentation of services should be reduced and services should be more clearly signposted for our patients, clients and their carers. The integration of hospital and community services under new management structures was the first step towards delivering services that are centred round people and not institutions.

Belfast Trust believes it is timely to modernise the way we deliver our health and social care. We want to reform and renew our services so we can deliver care in a faster, more flexible, less bureaucratic and more effective way to our citizens. The Trust aims to have the right care, delivered by the right person in the right place. The Trust is also undertaking an organisational reform programme which focuses on how best we use our resources, performance improvement and effective service delivery. The programme is called MORE – Maximising Outcomes Resources and Efficiencies. It will complement this modernisation process to examine how Belfast Trust will deliver its services in the future, as well as addressing the challenging efficiency agenda.

It is against this background that the Belfast Trust has started a process to examine how it will deliver its services in the future. The exercise has been given added impetus by the Minister of Health, Personal Social Services and Public Safety who intends to look at what building projects will go ahead in the next 10 years.

The first overview of the strategic direction for services is detailed in this consultation paper. The ideas in this paper represent an initial direction of travel for the way services will be provided in the future. Each key proposal for change will be consulted upon further - to whatever extent is necessary, in keeping with the Trust’s commitment to consult with staff, service users and the public at large.

Guiding Principles

The approach to reviewing and reorganising the services of the Trust must be guided by some general principles. The principles proposed by the Trust are:

Improve health and wellbeing and reduce health inequalities – This is the core purpose of the Trust.

Focus on prevention of illness, early assessment and intervention. This is a key objective of the Trust.

Focus on individual needs and choices – This concept is embedded in all service aspirations. Our Trust will deliver citizen – centred health and social care.

Provide safe, high quality, effective care – This is a core objective of the Belfast Trust.

Improve accessibility to services – promote equity and welcome diversity – Our aim is to improve the universal accessibility of services through ensuring that services are delivered equitably to all sections, including cultural minorities. The Trust will simplify and improve arrangements for accessing its services.

Localise where possible, centralise where necessary – Services are more easily accessed by people when they are delivered locally, while specialist services benefit from the concentration of expertise and experience required to deliver the highest possible levels of clinical care. The Trust therefore aims to provide its services locally where the standard of service can be assured and centralise its services where it will raise the quality of provision.

Integrate services (through partnerships working) – We aim to meet the challenge of delivering maximum benefit from the integration of acute, community and social care services for our population. Working in partnership with individuals, community organisations, voluntary and statutory agencies results in more appropriate care and treatment, improved outcomes, better experience for our service users, improved health and wellbeing for communities and greater social inclusion.

Provide clear directions to services, reducing fragmented and frustrating services – Service flow, in a complex health care system, is recognised as a pivotal challenge to service delivery. Our Trust will reform and renew its services to deliver care in a faster, more flexible, less bureaucratic and more effective way to its citizens.

Maximise utilisation of assets – There is a clear need to make best use of all existing health and social care infrastructure across the Trust and keep the need for new buildings to a minimum while also addressing risk issues, such as those attached to ageing buildings.

QUESTION 1:

The Trust is seeking your views on the principles outlined to guide the modernisation and reform of services across Belfast.

Do you have any comments or suggested additions to the general principles outlined?

Proposals for the modernisation and reform of services

The Trust has started the process of reviewing how services could be delivered in the future. We have outlined proposed models of care which are based on discussions within the Trust. The models are set in the context of policy decisions set out by the Department of Health and Social Services and developed in the Assembly's Programme for Government. The intention is now to consult on the direction of travel for future service provision with the users of our services, the public and the key stakeholders, including General Practitioners.

In writing this consultation document the Trust thought it would be useful to guide you through the complex range of Trust services by asking questions that follow the stages of life when you may need to access Health and Social Care Services from the Belfast Trust. For example the Trust has posed the question "Where do I go if I need support because I am an older person?" We have described the principle guiding how we provide services and described the model of care favoured by the Trust. The Trust then asks the following questions which we would like you to consider:

QUESTION 2:

Do you agree with the principles outlined?

Do you have any suggested additions to these principles?

Do you agree with the Trust's favoured model of care?

In Appendices 1 and 4 of this document we have outlined how you can respond to the consultation document.

How do I get access to Community Health and Social Care Services and be informed about services that are available to me?

The Trust's strategy is to **localise services where possible and centralise where necessary**.

We have established a network of seven Wellbeing and Treatment Centres, strategically located within the main community sectors across Belfast. These are intended to be single access points for information, advice and services. They are intended to increasingly offer out of hospital services, complementing the work of general practice and acute care.

The Grove Centre in north Belfast, has recently opened. The Knockbreda Centre will open in early 2009. Carlisle Centre in north Belfast, Bradbury Centre in south Belfast and the Arches Centre in east Belfast have been open for some time now. The Shankill Centre and West Belfast Centre are set to open in 2010.

Community services will be provided in the seven major Wellbeing and Treatment Centres. These are "one-stop shops", which are easy to access as they are based on main roads in the heart of the community. **Services that will be available in these Centres** vary slightly between each Centre but all have dentistry, occupational therapy, physiotherapy, speech and language therapy. Social workers for children, older people and people with physical or learning disabilities are based in these centres as well as health visitors and midwives. These staff often work in multi-disciplinary teams. One of the Trust's plans is to relocate a number of outpatient clinics from the hospital settings to these Centres.

QUESTION 3:

(a) Do you agree with the Trust's strategy to "localise where possible and centralise where necessary"?

(b) Do you believe the range of services offered at Wellbeing and Treatment Centres is appropriate?

(c) Do you think other services could be offered in the Wellbeing and Treatment Centres?

Any further comments:

Where do I go if I am having a baby?

The Belfast Trust's underpinning principle is that pregnancy and childbirth are normal life events. Its top priority is to provide safe, high quality care for all parents and their babies in the local community and across the Region.

Principles

Central to the delivery of the Belfast Trust's Maternity Services are **Choice, Continuity and Control:**

- Women have the right to choose how and where to give birth. This choice should be supported by high quality information and evidence based clinical advice that ensures maximum participation in decision making.
- One to one midwifery care should be given to women during labour and childbirth in order to make sure that they have individualised attention and support, with continuity of carer.
- Maternity services should be locally accessible and comprehensive with clear evidence of joint working across multidisciplinary teams and sectors.
- There should be specific services for women with poor obstetric or medical history or complications in early pregnancy.
- A comprehensive antenatal diagnostic and screening service should be available and offered to women in order to detect, where possible, any maternal problems or fetal abnormalities at an early stage.
- Holistic care should be provided. The women and her family's circumstances should be assessed holistically. Psychological and social need should be identified early and managed appropriately.
- Postnatal care should be provided to facilitate the transition to motherhood by making sure ill health is prevented or detected and managed appropriately including a multi professional, multi agency service for women who have, or are at risk of, postnatal depression and other mental illness.

The Belfast Trust's **model of care** favours a holistic, community based model of maternity care which incorporates a wide range of services in a variety of settings including the women's own home, Wellbeing and Treatment Centres, a midwife led unit and a single inpatient obstetrics unit.

At present, inpatient obstetric services are provided at the Mater Hospital and the Royal Jubilee Maternity Service on the Royal Hospitals site. The Belfast Trust favours the provision of inpatient obstetric services including neonatal services on a single site (on the Royal Hospitals site), complemented by the provision of a midwifery led unit (at the Mater Hospital). Post natal care will be provided in the home following early discharge focussing on the promotion of normality. Community midwifery teams will provide ongoing assessment, monitoring and support of mothers and infants.

QUESTION 4:

(a) Do you agree with the principles outlined?

(b) Should additional principles be established?

(c) Do you agree with the Trust's favoured model of care?

Any further comments:

Where do I go if I need to access services for children?

The Belfast Trust has responsibility to provide a range of both health and social services not only to its local resident childhood population but it has also been commissioned to provide many regional and sub regional services such as, specialist acute services, Child and Adolescent Mental Health Services and Adoption Services.

While the Trust is responsible for services to children presenting with health related conditions or social life experiences which require assessment and intervention, we also provide universal services to all Belfast children such as immunising programmes, child health surveillance, dental services and school nursing.

Belfast Trust has also a particular responsibility to provide services to vulnerable children. This group includes children with disabilities, children at risk of harm, children in need, looked after children and children from minority communities. The Trust however holds the view that services to vulnerable children should be provided within the context of services for all children to avoid the stigma of labelling and exclusions.

Principles

Central to the delivery of the Belfast Trust's children's services are the following principles:

- Paramouncy of a child's best interests**,** which should be determined in consultation with parents, the child and appropriately trained and experienced professionals.

- Participation of children and their families in the design, delivery and evaluation of services. The voice of the child needs to be heard.

- Partnerships between the Belfast Trust and the local community, the voluntary sector, other statutory bodies such as the Belfast City Council, Belfast Education Board and the Police Services of Northern Ireland. In many instances these partnerships involve sharing resources such as staff and buildings.

- Promotion of positive child health is key to the Belfast approach which we believe will impact on childhood illness, child abuse and neglect and infant mortality. This involves assisting parents at an early stage to give their children a good start and support into adulthood. It involves an emphasis on prevention and family support as well as assisting young people to make healthy lifestyle choices.

- A child focussed service, with experienced, safe and skilled children practitioners.

- The child remaining at home with their parents or where this is not possible within an environment where parents can remain in close proximity to the child providing the necessary reassurance and support. Only in circumstances where there are no other appropriate options should a child receive care or treatment overnight away from their natural family environment.

- A place of safety and security. When a child is required to come into hospital or care facility such facilities should not be co-located with adult services and should deliver high quality, specialist, evidence based care / treatment. These units should have access to such interventions and specialist expertise to minimise the requirement for the child to remain away from the family home for extended periods of time.

The Trust favours a model of care which incorporates a wide range of services to children in a variety of child focused settings including the child's own home, day care / family facilities, health centres, children's homes and acute inpatient centres. The Trust is committed to providing high quality assessment and treatment and intervention across the continuum of care including prevention, health promotion, family support, highly specialised treatment and proportionate statutory intervention.

QUESTION 5:

(a) Do you agree with the principles outlined above?

(b) Do you have any suggested additions to these principles?

(c) Do you agree with the proposed model of care?

Any further comments:

Where do I go if I need support or care because of my physical or sensory disability?

The Trust's **principles** for the care of people with physical or sensory disabilities are to:

- Respect the individuality of service users and carers
- Ensure that services are person centred and offer maximum choice of service
- Enable disabled people to have the fullest possible control over their lives and to maximise their independence and inclusion in their chosen communities
- Promote a community development approach to services to maintain people in their own environment and to promote partnership working across organisations and groups
- Provide accessible information, services and facilities
- Involve service users and their carers fully in service development and evaluation
- Co-ordinate services to maximise continuity and a holistic approach
- Ensure that services are provided within agreed timeframes
- Promote efficient and effective high quality services that offer positive outcomes and value for money.

The Trust favours a **model of care** that continues to provide a range of specialist rehabilitation services on a single site, Musgrave Park Hospital. This will include acquired brain injury rehabilitation, spinal cord injury rehabilitation, amputee rehabilitation and post fracture rehabilitation for older persons.

Patients requiring non urgent but essential admission for expert multi-disciplinary assessment of neurological disorders, deterioration in neurological status and subsequent decline in functional ability will be co located with the specialist rehabilitation services.

The Trust's services plan is that people with physical or sensory disability should be supported to live as independently as possible in the community. Following medical diagnosis and treatment the Trust's physical and sensory disability teams will offer advice on the range of services available. These teams will continue to work in partnership with other statutory bodies (eg the Housing Executive and the voluntary sector (eg Royal National Institute for the Blind) to maximise independence. Physical and Sensory Disability teams will be based in Wellbeing and Treatment Centres.

QUESTION 6:

(a) Do you agree with the principles outlined above?

(b) Should additional principles be established?

(c) Do you agree with the Trust's favoured model of care?

Any further comments:

Where do I go if I need support because I have a learning disability?

The Trust's **principles** for services for people with learning disabilities are:

- Service users should be in control of their lives
- Service users should have their rights respected
- Clients with a learning disability should have equity of access to all services provided by the Trust
- The availability and range of appropriate therapies and treatments should increase in community settings.

The Trust favours a **model of care** that supports people with a learning disability to enjoy and live full lives in their local communities through provision of a range of family, voluntary and statutory support services.

Muckamore Abbey Hospital will continue to provide inpatient assessment and treatment services but after 2016 it should not be a home for life for people with a learning disability. Providing there is betterment in their care, people should experience community living.

The Trust plans to develop, in partnership with other agencies, homes for life in the community that will provide high quality accommodation and support for people with learning disabilities including those with complex and challenging needs.

Also, in partnership with others, the Trust plans to expand the availability of small respite units and develop a small number of community treatment beds for people in Belfast. We will also work with other partners to increase employment and access to local leisure activities for people with learning disabilities.

Additionally the Trust plans to develop new day service accommodation across the city for people with complex needs and challenging behaviour who require high levels of support.

QUESTION 7:

(a) Do you agree with the principles outlined above?

(b) Do you have any suggested additions to these principles?

(c) Do you agree with the Trust's favoured model of care?

Any further comments:

Where do I go if I am an adult and need mental health services or I have an acute mental illness?

The Trust’s strategy is to provide a modern, responsive mental health service in a range of settings. The aim is to move away from hospital-based models of services to early intervention and community support. Hospital services should be focussed on acute episodes requiring short stay assessment and treatment services. The resettlement of long-stay mental health clients into the community should be speeded up.

The **principles** guiding the strategic service plan for mental health services are:

- Service users should be supported to keep in control of their lives
- Service users should have their rights respected
- Service users with a mental illness should have equity of access to all services provided by the Trust
- Clear pathways of care must be developed, with a particular emphasis on the need for early intervention services
- Psychological therapies and treatments should be more available in both hospital and community settings
- Services should be developed for those at greatest risk in the community, for example, Travellers and members of minority groups.

The Trust favours a **model of care** that provides more community based services such as day treatment services and crisis beds in the community. Services will be provided locally within the community. Admissions to acute inpatient mental health beds will be reduced because of early intervention and continuity of treatment and care in the community.

At present, acute inpatient mental health services are provided at Belfast City Hospital, the Mater Hospital and Knockbracken Healthcare Park. The Trust favours the development of a single acute inpatient mental health facility to accommodate patients whose acute mental health crisis cannot be managed and treated within the home setting. The emphasis is to provide short term assessment and treatment.

The single acute inpatient mental health facility will be part of a network of residential, day care and treatment centres provided locally throughout Belfast.

QUESTION 8:

(a) Do you agree with the principles outlined above?

(b) Do you have any suggested additions to these principles?

(c) Do you agree with the proposed model of care?

Any further questions:

Where do I go if I need acute hospital services (that is emergency services, planned care and long term chronic condition management)?

The key service delivery principles developed by the Trust are as follows:

- To localise services where possible and centralise services only where necessary
- To centralise and develop networks for major trauma, heart conditions and stroke
- To develop clear pathways to access appropriate emergency care (including urgent care for chronic admissions) and primary care in GP out-of-hours services
- To provide a single point of contact for emergency chronic condition admissions
- To re-profile services to make best use of each emergency department and to improve patient flows, to provide a range of services to patients to access and meet targets
- To develop protected elective services and thereby improve patient flows and effectively and efficiently meet access targets
- To reduce unnecessary duplication and fragmentation of services.

Based on these principles the **Trust proposes** that:

Emergency Services would be retained at the Mater Hospital, Belfast City Hospital and Royal Hospitals. However, there would be differentiation of services to improve patient care, based on the type of patient's condition and needs.

Cardiology services would be provided at the Mater Hospital, Belfast City Hospital and Royal Hospitals. Services should be localised where possible and centralised where necessary, and delivered in the location most appropriate to the patient pathway and condition.

The provision of a major acute hospital; encompassing trauma services, emergency services and a heart centre on the Royal Hospitals site.

The provision of a range of acute hospital services and a Regional Ophthalmic Centre (including a unit for planned eye surgery and treatment) on the Mater Hospital site, as part of a larger ambulatory care centre.

The provision of a range of acute hospital services, encompassing cancer and renal services, the chronic admissions centre as well as the major elective centre for Belfast (including an elective orthopaedics unit) on the Belfast City Hospital site.

The provision of specialist rehabilitation services on Musgrave Park Hospital site.

QUESTION 9:

(a) Do you agree with the principles outlined above?

(b) Do you have any suggested additions to these principles?

(c) Do you agree with the Trust's favoured model of care?

Any further comments:

Where do I go if I need support because I am an older person?

The Trust's Strategy for Older Peoples Services aligns with the Eastern Health and Social Services Board's Strategy and the following **service principles** have been identified:

- The promotion of health and wellbeing
- Maximising independence
- The promotion of appropriate long term living options
- Better dementia services and improved mental health among older people

The Trust will achieve this through:

- The promotion of improved health and wellbeing through supporting older people to live independently
- Maximising the independence of older people through access to specialist rehabilitation and integrated care teams
- Targeting and improving support for carers
- Enhancing the quality and care offered by nursing and residential homes
- The development of new models of care for older people with dementia and mental health problems including crisis intervention and increased community based approaches

The **model of care** favoured by the Trust is that older people should be maintained in their own homes, supported by a network of care services that enable them to maintain their quality of life.

Acute hospital care should only be accessed for assessed need and no long term decisions regarding an older persons future care should be made in that setting.

By developing a fuller range of long term living options, in partnership with housing providers and the independent sector, we will be able to re-provide our own residential services in more appropriate settings.

QUESTION 10:

(a) Do you agree with the principles outlined above?

(b) Do you have any suggested additions to these principles?

(c) Do you agree with the Trust's favoured model of care?

Any further comments:

Appendix 1

Programme of consultation

New Directions is the beginning of a conversation between Belfast Trust and the citizens we serve on how we should deliver services in a faster, more flexible, less bureaucratic, and more effective way.

The consultation period for *New Directions* will open on 29 August 2008 and close on 7 November 2008.

We are sending this paper to services users and key stakeholders to ensure we consult as widely as possible. We will also hold a series of public meetings where any further comments can be raised and discussed. These meetings will be widely publicised. We will also meet with specific stakeholders.

Based on the responses we receive, a report will be presented to Trust Board on 20 November 2008. This Trust Board meeting is open to the public.

Further consultation may be required on specific service issues as a result of the responses we receive. We are committed to ensuring that we consult broadly on these issues.

Appendix 2

Equality

This paper, New Directions – A Conversation on the Future Delivery of Health and Social Care Services in Belfast represents an initial direction of travel for the way services will be provided in the future. Each key proposal for change will have the Equality and Human Rights implications fully considered and assessed at the appropriate time in accordance with the Trusts statutory requirements.

The Trust is keen to seek your initial views and comments on any Equality or Human Rights issues you consider relevant.

Please let us know if you consider there are any potential impacts on the Equality of Opportunity or Good Relations duties contained in Section 75 of the Northern Ireland Act 1998.

Please let us know if you consider there are any potential Human Rights implications based on the Articles contained in the Human Rights Act 1998.

Please include your comments in the response.

Appendix 3

Availability in other formats

New Directions is available in a range of alternative formats on request including:

- Large font
- Audiocassette
- Braille
- Computer disc
- Minority ethnic languages
- DAISY
- Easy-read
- Electronic version

Please request an alternative format from the address supplied in Appendix 4.

Appendix 4

Your invitation to comment

Please tell us your name and address at the beginning of your reply. If you are commenting on behalf of an organisation, please tell us its name and what it does. If you have consulted other people or organisations, please let us know.

Responses in writing should be sent to:

William McKee, Chief Executive
Belfast Health and Social Care Trust
c/o Public Liaison Services
Communication Department
1st Floor, Nore Villa
Knockbracken Healthcare Park
Saintfield Road
Belfast BT8 8BH

Alternatively, comments may also be emailed to:
Publicliaison@belfasttrust.hscni.net

It would be helpful if you could entitle your email ‘Consultation’.

Appendix 5

Freedom of Information Act (2000) – Confidentiality of Consultations

Belfast Trust will publish an anonymised summary of responses following completion of the consultation process; however your response, and all other responses to the consultation, may be disclosed on request. We can only refuse to disclose information in limited circumstances. Before you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a general right of access to any information held by a public authority, namely, Belfast Trust in this case. This right of access to information includes information provided in response to a consultation. We cannot automatically consider information supplied to us in response to a consultation as information that can be withheld from disclosure. However, we do have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity, should be made public or withheld.

Any information provided by you in response to this consultation is, if requested, likely to be released. Only in certain circumstances would information of this type be withheld.

TRUST DELIVERY PLAN

APRIL 2008 – MARCH 2011

Belfast Health and
Social Care Trust

CONTENTS

1. LOCAL CONTEXT

The Belfast Trust was born out of the first wave of the Review of Public Administration (RPA), becoming operational on 1 April 2008. It is formed from six legacy Trusts formerly delivering Health and Social Care in the Belfast area – Belfast City Hospital Trust; Greenpark Healthcare Trust; Mater Informium Hospital Trust; North & West Belfast Community Trust; Royal Hospitals Trust and South & East Belfast Community Trust.

It has been a period of major transformation in the first year of the Trust, with the appointment of a new Board of Directors, the creation and population of new organisational structures and the introduction of new systems and processes across all services in the Belfast Trust area.

The new structures are designed to offer the opportunity to improve Health and Social Care across Belfast with a greater focus on delivering services in networks based around the needs of individuals and less round institutions or locations.

Looking ahead over the next few years the Trust must seize the opportunity to strategically reform services in Belfast to produce integrated, coherent, efficient and above all, high quality services to the citizens of Belfast and beyond. This will necessitate a review and where necessary a rationalisation of services so they are delivered in coherent networks across Belfast.

2008 – 2011 coincides with the first budget period of the Northern Ireland Assembly, which offers significant financial opportunities and challenges for Health and Social Care across Northern Ireland. In order to create revenue for re-investment each Health and Social Care Trust must find 3% efficiency savings per annum in each of the next three years. When combined with an inherited underlying deficit, this will result in the Belfast Trust having to find around £130 million savings over the next three years.

We have established the MORE (Maximising Outcomes and Resource Efficiencies) Programme as the overarching vehicle which will help us to reform and improve our services and enable the release of the necessary savings.

Running alongside our financial responsibilities, is the core responsibility for the Belfast Health and Social Care Trust to improve services. We will, as we did in 2007 / 08, put arrangements in place to deliver the Ministers objectives and targets as outlined in Priorities for Action (PFA). This led to a significant improvement in services last year, particularly in terms of access to services e.g. waiting times, cancer treatment times, discharge delays, A & E waiting times, but also in the early reform and improvement of other areas such as Learning Disability, Foster Carers and in Human Resource Targets. The Belfast Health and Social Care Trust is committed to achieving the Ministers targets in 2008 / 09.

In addition to Priorities for Action we have been developing a “Vision” for the Health and Social Care Services in Belfast. This vision, “The Belfast Way” sets out our purpose, values, accountability and rules and our corporate objectives. These corporate objectives are incorporated into five themes as follows: Quality and Safety;

Modernisation and Reform; Partnerships; Our People and our Resources. In each of these areas we have set objectives for ourselves, which supplement those in Priorities for Action, providing us with a broader, balanced range of goals which provide assurance to our public that our services are safe, high quality and improving.

2. DELIVERY PLANS FOR PSA/MINISTERIAL TARGETS

Ref : BT 1
PRIORITY AREA 1: IMPROVING HEALTH AND WELLBEING

PSA 1.10: By September 2008, ensure that a comprehensive HPV immunisation programme is in place, with a view to achieving a long term reduction of 70% in incidence of cervical cancer

1. Related Ministerial target:

    - Trusts should, by March 2009, ensure the delivery of the second dose of HPV vaccination to 90% of girls who are in Year 9 in 2008/09

TRUST RESPONSE:

- The Trust has been allocated £87,820 from the EHSSB to deliver this screening programme this year. The allocation however fell short of the £108,166, which the Trust initially estimated as being required to deliver the programme.

- While the Trust is hopeful that the programme can be implemented successfully beginning in September 2008, this is dependant on a number of factors:

    - Successful recruitment of staff
    - Child Health System software in place
    - Co-operation of schools
    - Uptake of the 3 vaccines by girls in Year 9
    - Attendance rates at Mop Up Clinics.

- The Trust is taking forward planning to address the above.

- In Year 1 the actual costs of the programme will be monitored with a view to highlighting any additional support and/or resources required in further years in addition to any impact on the Core School Health Programme.

- The Trust will actively work towards the delivery of the target in the timescales required however given the factors above the achievement of the 90% target by March 2009 will represent a significant challenge.

PRIORITY AREA 1: IMPROVING HEALTH AND WELLBEING

Ref : BT 2

PSA 1.11: By December 2009, ensure that a comprehensive bowel screening programme for those aged 60 – 69 is in place, with a view to achieving a 10% reduction in mortality from bowel cancer by 2011

1. Related Ministerial target:

    - Bowel cancer screening: by December 2009, Trusts should have established a comprehensive bowel screening programme for those aged 60-69 (to include appropriate arrangements for follow-up treatment)

Trust response:

- It has been agreed that the implementation of the bowel screening programme will be managed through the Regional Cancer Services Steering Group. Plans to support the delivery of the target will be developed through the mechanism.

- The Trust will work in conjunction with the Regional Group to develop plans to fully implement a comprehensive Bowel Cancer Screening Programme for the 60-69 age group by December 2009. A draft project plan is currently being developed regionally.
- The Trust will establish a Bowel Screening Project Board which will link to the Cancer Services Steering Group.

- The project board will cover all areas of the screening process including the first stage testing FOB's (Faecal Occult Blood) followed by the need for colonoscopy for those deemed positive.

- The Board will instigate a scoping exercise of the demand and the current service in Belfast to determine how the screening would/could be carried out. It is likely that a business case will be prepared as it is expected that the current capacity for FOBs etc.. will be insufficient. A regional approach is likely.

- The Belfast Trust managerial structure for endoscopy is being reorganised to drive forward the necessary changes required to achieve JAG accreditation. The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) quality assure endoscopy throughout the UK and JAG accreditation is required for each endoscopy unit involved in the bowel screening programme.

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PRIORITY AREA 1: IMPROVING HEALTH AND WELLBEING

Ref : BT 3

PSA 1.12: By March 2009, extend the regional breast cancer screening programme to cover those aged 65 - 70

Trust response:

- The NI Breast collaborative group have undertaken work to identify the requirements within the EHSSB area to clear the backlog of patients in preparation for the age extension screening programme. The Trust is in the process of confirming additional capacity needed to address the backlog of patients requiring screening. Once confirmed a plan will be drawn up and its delivery monitored.

- Recurrent resource has been confirmed from the Eastern Board for the age extension to the screening programme.

Ref : BT 4
PRIORITY AREA 1: IMPROVING HEALTH AND WELLBEING

1. Ministerial target (no PSA target)

    - Trusts should, by March 2010, establish screening arrangements for abdominal aortic aneurysm.

Trust response:

- The Trust will participate in any regionally led process in relation to the development of screening arrangements for Abdominal Aortic Aneurysm.

- The Trust is currently assessing its ultrasound capacity across Belfast to assess how the demand for additional abdominal aortic aneurysm screening required to meet the target is likely to be met. This is being assessed alongside capacity issues for the other targets, which have a demand stream into this imaging modality. When this is understood, a service development proposal will be submitted to the commissioners.

Ref : BT 5
PRIORITY AREA 1: IMPROVING HEALTH AND WELLBEING

1. Ministerial target (no PSA target)

   - Trusts should, by March 2010, make arrangements to extend the scope of antenatal screening for foetal anomalies.

TRUST RESPONSE :

- The NICE guidelines for antenatal screening have been introduced fully across the Belfast Trust's maternity service. On the Royal site a regional genetic service is also provided.

- This target will be met within the available resources until guidance is produced which will allow a service development proposal to be developed. Monitoring of uptake will be obtained from the NIMATS system.

- The Trust continues to have reservations about extending further the scope of antenatal screening given that the aim is to obtain information about foetal abnormalities, in the absence of investment in counselling services or Departmental guidance on abortion.

PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES

Ref : BT 6

PSA 2.1: By 2009, ensure a 10% reduction in the number of hospital patients with staphylococcus aureus bloodstream infections (including MRSA), and a 20% reduction in case of clostridium difficile infections

1. Related Ministerial target:

    - Healthcare associated infection: by March 2009, Trusts should secure a 10% reduction in staphylococcus aureus blood stream infections (including MRSA), and a 20% reduction for clostridium difficile.

TRUST RESPONSE :

- The Trust has developed a patient safety action plan, which has already been submitted to the Department. The action plan sets out the measures and milestones proposed by the Trust to achieve the targets set out above.

- The Trust's baseline and targets for 2008/09 in relation to the above are as follows:

    - MRSA - Baseline 114 (reported cases in 2006/07)
      MRSA – Target for 2008/09 is 103 reported cases

    - MSSA - Baseline 126 (reported cases in 2006/07)
      MSSA – Target for 2008/09 is 113 reported cases

    - C Diff - Baseline 326 (reported cases in patients over 65 yrs in 2006/07)
      C Diff – Target for 2008/09 is 261 (reported cases in patients over 65 yrs)

- A copy of the relevant patient safety action is available if required.

Ref : BT 7

PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES

1. Ministerial target (no PSA target).

    - Other quality measures: by April 2008, Trusts must submit to the Department for approval and monitoring, quality improvement plans that include Trust-specific targets for: ventilator associated pneumonia; surgical site infection; central line infection; and, the crash calls rate.

      Trusts should ensure that their Trust Board receives a monthly report detailing performance against each of the HCAI targets and other quality measures detailed above.

Trust Response :

- The Trust has developed patient safety action plans, which have already been submitted to the Department. The action plans set out the measures and milestones proposed by the Trust to achieve the targets set out above.

- Copies of the relevant patient safety action plans submitted to the Department are available if required.

- The Trust Board meets bi-monthly and a report will be submitted to each Board meeting on progress in relation to Trust HCAI targets.

Ref : BT 8
PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES

1. Ministerial target (no PSA target).

   - All HSS Organisations [Boards, Trusts, Agencies, Family Practitioner Services & Out of Hours Services] should ensure that, by June 2008, they have in place a plan for full implementation by January 2009 of the new HSC complaints procedure.

Trust response:

The Trust understands that the draft procedure entitled Complaints in Health and Social Care – Guidelines for Resolution and Learning has now been submitted to the Minister for approval, following which it will be issued to the Health and Social Care in Northern Ireland for implementation on 1 April 2009.

The Trust has been involved in a number of working groups associated with the drafting of the new guidelines and is in the process of ensuring the recently developed draft Complaints Policy and Procedure takes cognisance of the scope of the new proposals, i.e.:

- provide effective local resolution;
- improve accessibility;
- clarify the options for pursuing a complaint;
- promote the use and availability of support services, including advocacy;
- provide a well defined process of investigation;
- promote the use of a range of investigative techniques;
- promote the use of a range of options for successful resolution, such as, the use of independent experts, lay persons and conciliation;
- resolve complaints more quickly;
- provide flexibility in relation to target response times;
- provide an appropriate and proportionate response;
- provide clear lines of responsibility and accountability;
- improve record keeping, reporting and monitoring; and
- increase opportunities for shared learning across the HSC.

Ref : BT 9

PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES

1. Ministerial target (no PSA target).

   - Boards, Trusts, the NI Blood Transfusion Service and the NI Regional Medical Physics Agency should ensure that, by September 2008, they have Improvement Plans in place to implement the recommendations arising from the governance and thematic reviews undertaken by RQIA in 2007-08.

2. Trusts to provide details below of action being taken to ensure achievement of the above Ministerial target.

Trust response:

- Following the RQIA Clinical and Social Care Governance Review in February 2007 the Trust submitted as required a Quality Improvement Plan which addressed the recommendations in their report. This improvement plan was developed into a Trust action plan. An update on progress was carried out in April 2008 across the service groups.

- To date no report on the March 2008 review has been received by the Trust. Dependent on the date of receipt the Trust will have an action plan agreed by September 2008

- In relation to other reviews e.g.Hyponatremia, C.Diff, etc where reports have been provided and recommendations made the necessary action plans have been developed

Ref : BT 10
PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES

1. Ministerial target (no PSA target).

- Trusts should ensure that, by March 2009, their delivery of residential, domiciliary and day care is compliant with care standards, as evidenced by RQIA inspections.

Trust Response:

Residential Care Older People:

- The Trust continues to meet the care standards with regard to its own provision of residential care, evidenced by the ongoing inspection process. All recommendations and requirements in this area are met within the response times. These are also evidenced by the Trust's own internal audit procedures to include monitoring of complaints, acknowledgements, adverse incidents and event monitoring, regular visits from designated managers and liaising with other outside bodies, professionals and organisations.
- The Trust ensures that residents and their representatives are fully involved and consulted with regard to care provided through involvement in the care planning process and the provision of person centred care. Ongoing training for residential staff in the provision of person centred care will continue to be a priority
- The Trust will continue to ensure appropriate inputs from the multi-disciplinary teams to ensure the health and social care needs of residents are met.
- The Trust will develop new residents guides as required by the standards. These will be updated following the amalgamation of the Trust's under RPA to ensure that the documentation is current and reflects the new Trusts position.
- The Trust will continue to provide and develop a comprehensive programme of activities and events for residents.
- The Trust will continue to undertake internal financial audits to ensure financial accountability in the handling of residents' monies and property.
- The Trust will seek to develop processes to ensure that residents' views are taken into account in all matters affecting them and there are forums and systems where residents and their representatives can express their views and be consulted.
- The Trust has submitted their Annual Quality Reviews in respect of each residential facility which details outcomes delivered for residents together with identified areas for improvements, action plans and time scales. These reports have also indicated how residents' views can be taken into account.

Day Care:

The Trust awaits the publication of the Day Care Standards in respect of day care and once issued will ensure compliance with care standards. Currently staff have been working to the draft standards to ensure they meet all requirements in preparation for the inspection process. The Trusts day care facilities have all been registered as per the regulations. The Trust will examine current resources and ensure that staff have ongoing training to meet the regulations and requirements in respect of the care standards

Physical Disability Services:

The Trust will ensure that delivery of residential, domiciliary and day care is compliant with care standards, as evidenced by RQIA inspections.

This will be achieved through governance arrangements which will ensure:

- robust contracting arrangements with independent providers and the monitoring and review of contracts;

- regular monitoring and review of service users in residential, domiciliary and day care facilities and;

- ensuring that any concerns regarding care standards or quality issues are addressed immediately.

Ref : BT 11
PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES

1. Ministerial target (no PSA target).

    - Trusts must submit to the Department, by April 2008, for approval and monitoring, quality improvement plans that include Trust specific targets for adherence to good practice on mental health inpatient care as regards risk assessment, inpatient review and discharge planning.

TRUST RESPONSE:

- The Trust has developed an action plan, which has already been submitted to the Department. The action plan sets out the measures and milestones proposed by the Trust to achieve the targets set out above.

- A copy of the relevant patient safety action plan submitted to the Department is available if required.

Ref : BT 12

PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.1: By March 2011, ensure a 21 - week waiting time for drug therapies for treatment of severe arthritis

Trust response:

- The Trust response relates to Rheumatology (if other specialties are to be included e.g. Dermatology, this will need clarified by the DHSSPS)

- Following the achievement of the Ministerial target for 31st March 2008, the current maximum waiting for patients is around 2 years.

- A regional workshop is being set up in late June to discuss a consistent approach to attaining the 21 week target by March 2011. This will be a phased approach over the 3 years. The milestones towards the 2011 should be agreed at that workshop and part of the approach will be reviewing the location of services for current and new patients, to facilitate treatment closer to home. Discussions are also taking place in the next few week with South Eastern Trust in relation to repatriation of appropriate patients

- A Business Case will be submitted to treat 255 patients within the 2009/10 financial year to reduce waiting time to 18 months.

- The DHSS&PS Specialist Drugs Committee has approved common data returns which commenced in May 2008.

March 2009	March 2010	March 2011
To be confirmed	Maximum 18 months waiting time for drug therapies for treatment of severe arthritis (to be confirmed)	Maximum 21 week waiting time for drug therapies for treatment of severe arthritis

Ref : BT 13
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.2: By March 2009, no patient will wait longer than 9 weeks for a first outpatient appointment, 9 weeks for a diagnostic test, and 17 weeks for inpatient or day case treatment

1. Related Ministerial targets:

- Elective care (consultant led): Trusts should ensure that, from April 2008, no patient waits longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment, reducing to 9 weeks for outpatients, 9 weeks for diagnostics and 13 weeks for treatment by March 2009. Commissioners and providers should work towards a total journey time of 25 weeks or less by March 2011

- Trusts should ensure that, by March 2009, all urgent diagnostic tests are reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks.

Trust Response:

Access Targets:

- The Trust has submitted delivery plans to the Boards, which set out the estimate resources requirements to meet the elective access targets by March 2009. The plans indicate that a significant level of investment will be required within Belfast to sustain the waiting time of 21 and reduce to 13 weeks and also to facilitate the reduction to 9 weeks.

- Delivery plans have been submitted as non-recurrent at this stage (as requested by the Boards), however there are a number of specialties that require recurrent funding to ensure the targets can be sustained. Non-recurrent investment has meant that the Trust continues to be reliant on recruitment of locum staff and independent sector capacity in a number of specialties in order the deliver the targets this year. This is not the desired position for sustainable service delivery.

- At this stage the Trust would highlight particular pressures related to the above in the following specialties ;
    - Urology
    - Paediatric Neurology
    - Paediatric Surgery
    - Community Paediatrics

- Resource requirements (excluding Orthopaedics) required at this stage have been estimated in excess of £20m. Orthopaedics resource requirements are being collated at present.

- The Trust has set out the internal milestones to be achieved to deliver the above targets and these are set out in the table below:

ACCESS TARGETS
TIMETABLE 2008/2009

IPDC	OP
April = 21 weeks Patient booked on waiting list on/or before: **5 DECEMBER 2007**	13 weeks
May = 20 weeks Patient booked on waiting list on/or before: **12 JANUARY 2008**	13 weeks
June = 19 weeks Patient booked on waiting list on/or before: **18 FEBRUARY 2008**	12 weeks
July = 19 weeks Patient booked on waiting list on/or before: **20 MARCH 2008**	12weeks
August = 18 weeks Patient booked on waiting list on/or before: **27 APRIL 2008**	11 weeks
September = 17 weeks Patient booked on waiting list on/or before: **3 JUNE 2008**	11 weeks
October = 16 weeks Patient booked on waiting list on/or before: **11 JULY 2008**	10 weeks
November = 15 weeks Patient booked on waiting list on/or before: **17 AUGUST 2008**	10 weeks
December = 14 weeks Patient booked on waiting list on/or before: **24 SEPTEMBER 2008**	9 weeks
January = 13 weeks Patient booked on waiting list on/or before: **1 NOVEMBER 2008**	9 weeks

Diagnostic Test Reporting Targets:

- The Trust has submitted action plans to relation to the DRTT standards. Once formal monitoring arrangements commence for this area the Trust will review actions related to the achievement of the target.

Ref : BT 14
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

1. Ministerial target (no PSA target)

   - Elective care (AHP): Trusts should ensure that, from April 2008, no patient waits longer than 26 weeks from referral to commencement of AHP treatment, reducing to 13 weeks by March 2009.

Trust response:

- Belfast Trust is currently sustaining the 26 week PFA target and has plans in place to reduce to 13 weeks by December 2008.
- A bid for non recurrent resources has been made through the Eastern Board and we are awaiting approval.
- The Trust has set interim target for reductions in waiting lists. PTLs are produced on a monthly basis and these are monitored weekly. The milestones for the reduction in the waiting lists are as per that set out for Inpatient services.
- The Trust is also participating in the regional access groups and from these defined access criteria and models of care will be agreed. From this work a detailed capacity and demand study will be prepared on the regionally agreed criteria and we will work with Commissioners to agree what is required (non recurrent and recurrent) for a 13 week delivery model.

Ref : BT 15
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.3: By March 2009, 95% of patients will, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment

1. Related Ministerial target:

   - Trusts should ensure that, from April 2008, 75% of patients wait, where clinically appropriate, no longer than 48 hours for inpatient fracture treatment, increasing to 95% by March 2009.

Trust Response:

The Trust has achieved the 75% target during the month of April.

A range of actions introduced in 2007/08 are being sustained. These include the following:

- Additional operating sessions introduced to help meet this target.
- Trauma Co-ordinators and Trauma Aides are now all in post to help ensure targets are met and that patients are treated in a timely way.

Further actions to be taken forward in 2008/09 are outlined below:

- Additional weekend working by Orthopaedic Consultants.
- Capital bids for fracture theatre equipment have been submitted which should help ensure cancellations of patients do not occur.
- Additional diagnostics e.g. protected echo and CT scanning slots have been negotiated to prevent patient delays.
- Additional AHP staff are to be recruited to provide weekend cover. The additional AHP support should also help reduce patient length of stay, which will create additional capacity so that patients are not managed at home due to unavailability of inpatient beds.
- Additional investment in RBHSC to provide additional theatre sessions.
- Further work to reduce delays in discharge of patients with infection.

The Trust anticipates that the target will be achieved by March 2009.

Ref : BT 16

PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.4: By March 2009, 98% of cancer patients will commence treatment within 31 days of decision to treat, and 95% of patients urgently referred with suspected cancer will begin treatment within 62 days

1. Related Ministerial target:

    - Trusts should ensure that, from April 2008, 98% of patients commence treatment within 31 days of the decision to treat; from April 2008, 75% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days, increasing to 95% by March 2009.

2. Trusts should detail below their proposed plans for ensuring the achievement of the above PSA / Ministerial targets. Plans should include proposals (as per the allocation letter) to:

    - ensure by 31 March 2009 that radiotherapy capacity for an additional 600 patients is available from 2010/2011 onwards, and

    - the introduction thereafter of new evidence based treatments that have been shown to improve patient outcomes.

Trust response: 31/62 day target

- The Trust continues to produce daily and weekly patient level reports to facilitate monitoring by operational and senior managers. This includes daily monitoring of appointments within 14 days of referral for all new referrals. Escalation arrangements are in place where capacity is not available to meet this internal target.

- Weekly monitoring reports are also provided at specialty and service group level to ensure tracking of patients progress in relation to the 31 and 62 day targets.

- The Trust has appointed a modernisation manager for cancer services to ensure a senior manager focus on reviewing patient pathways and service improvements required to assist the Trust in meeting the target.

- Regional Cancer Services funding of £2m has been made available to the Trust this year to cover service developments, access targets and cancer service framework developments for 2008/09. The Trust’s share of the investment will be used to modernise and re-design services. In areas such as Thoracic Surgery and PET CT scanning it will secure additional capacity. Prostate brachytherapy, (a treatment previously not available within N Ireland) will also be provided, along with an enhanced Cervical brachytherapy service. Additional Oncologists will also be appointed in sub-Specialist areas on a Province wide basis. Pro-active tracking of patients through the Cancer pathway will be improved with the appointment of further Patient Navigators within the Cancer Services team. Funding will ensure that the vast majority of tumour site areas will now be covered. For the local, as opposed to the Regional services, funding has been allocated to enhance capacity for the Breast Radiology service and also Physiology support to a combined Lung Clinic.

- There is however a risk however that insufficient funding will not allow the Trust to put in place the required level of service to effect maximum impact on the revised targets.

Trust response: Radiotherapy Capacity

- The agreed Regional view is that plans should be put in place to commission a Radiotherapy Centre on the Altnagelvin site. Additional regional capacity will therefore be made available through this approach, led by the commissioners and the WHSST.

- The Linear Accelerators at the Cancer Centre are providing more activity than was estimated in the Cancer Centre Investment plan.

Ref : BT 17
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

1. Ministerial target (no PSA target)

   - A & E: Trusts should ensure that, from April 2008, 95% of patients attending A&E are either treated and discharged home, or admitted within four hours of their arrival in the department. By March 2009, Trusts should ensure that this level of performance is achieved in individual hospital sites.

Trust response:

- At the end of March 2008, the Trust achieved, 90% of all patients attending A&E treated, admitted or discharged home with the 4 hour target

- Actions undertaken by the Trust in 2007/08 will continue into 2008/09, however achieving 95% in each hospital will be extremely challenging across individual sites, particularly in RBHSC due to its regional nature and the RVH due to the unplanned impact of major Trauma. Lack of additional resources for the emergency departments has also been a limiting factor.

Actions 2008/2009

In addition to continuing to implement the SDU action plan, the Trust is undertaking the following actions to facilitate progress towards the achievement of the 4 hour standard:

- There is an urgent need to open observation wards and to have an increased level of middle grade doctor cover out of hours. The Trust is seeking resources from Boards to support the development of the above.

- The Trust is in discussions with NHSSB re the significant impact of increasing NHSSB residents attending and being admitted to the Mater.

- The Trust is currently developing an Emergency Nurse Practitioner (ENP) service on the Mater site. Recruitment is ongoing for vacant posts. This will provide opportunity for the streaming of patients through the emergency department. A Belfast Trust forum has been established to share good practice and standardise best practice guidelines for ENP services across all of the emergency departments.

- A forum has been established to review current practice in the management of DVT across the Belfast Trust. Work is ongoing to standardise the assessment processes and standardise a patient pathway. Future developments will include service delivery on a single site.

- The Trust has developed an escalation policy. Predictive indicators are being used to assess the level of pressure. This policy is currently in testing and on the whole has been effective for down turning escalation. This policy will have a formal evaluation in June 2008.

- The Trust is currently developing and testing transfer protocols to facilitate the safe transfer and appropriate placement of patients across sites within the Belfast Trust to maximise use of capacity.

- The Trust is currently progressing a major Review of Unscheduled care provision within the Belfast Trust

- The Trust is facilitating the SDU Rolling Audit Team in June 2008. This audit will be followed by development of action plans to support delivery of Trust objectives.

Ref : BT 18

PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.5: By March 2011, ensure a 10% reduction in mortality and disability from stroke

1. Related Ministerial target

   - The Northern Ireland Ambulance Service should ensure that, by March 2009, paramedic-administered thrombolysis is available throughout NI

Trust response:

- Resources have been identified by commissioners over the next three years to improve the management of stroke patients.

- The Trust has submitted a draft proposal for year 1 within the resources available which will see the expansion of stoke services across Belfast and the introduction of thrombolysis. A further case is to be developed which will support timely provision of CT access and plans for year 2 and 3.

- The Trust participates in the Regional Stroke Forum and has established a Stroke Services Steering Group to oversee the full implementation of the stroke strategy.

- The Trust will work with commissioners to develop an appropriate hospital register to measure death and disability rates associated with stroke.

- The Trust supports the commissioners view that a reduction in mortality and disability from stroke of 10% by 2011 will depend not only on the service improvement but will crucially depend on the reduction in risk factors.

Ref : BT 19

PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.6: By March 2009, at least 50% of patients (rising to 60% by 2010) should receive dialysis via a fistula, and no patient should wait longer than nine months for a live donor transplant (six months by 2010)

1. Related Ministerial target:

    - Trusts should, from 2008 – 09, provide capacity for an additional 40 patients per year to commence dialysis therapy (increasing by a further 40 patients in both 2009 – 10 and 2010 – 11)

Trust response:

Fistular access:

- The Trust has recorded at present 43% of patients using fistulas for dialysis treatment with a further 7% who have been provided with fistula, but are currently unable to use them for reasons such as needle phobia or because they waiting for further interventional treatment to enable use of the fistula.

- The Trust is taking forward the recruitment of additional renal transplant surgeon, wef 1st August 2008.

- We are also working with DHSSPS Regional Renal Group to produce action plan and appropriate care pathway to meet this target.

- Part of the solution may entail additional theatre capacity against which a bid will be made.

- The Trust believes the 50% target should be achievable this year. However increasing % usage does required cooperation and agreement from patients to change to this form of dialysis. This Trust will continue to work with patients to facilitate increased use of fistula for dialysis treatment.

Regional target (dialysis target):

- The NHSCT are to submit a Business Case for additional capacity and the BHSCT are currently supporting the NHSCT with additional capacity until this process is complete.

- The Trust is also working with Commissioners to expand it’s capacity for patients on Home Haemodialysis, at a rate of 20 additional patients per year, funding permitting.

Ref : n/a

PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.7: By March 2011, NIAS to respond to 75% of life threatening calls within eight minutes

1. Related Ministerial target

- Ambulance Service: from April 2008, the Northern Ireland Ambulance Service should respond to an average of 70% of Category A (life-threatening) calls within eight minutes, with performance in individual Board areas being improved to at least 62.5% by March 2009.

2. Northern Ireland Ambulance Service should detail below their 2010 milestone to achieve the PSA target within the timescales set.

March 09	March 2010	March 2011
Average of 70% of life threatening calls responded to within 8 minutes At least 62.5% of life threatening calls responded to within 8 minutes at individual Board level	**	Average of 75% of life threatening calls responded to within 8 minutes

3. Northern Ireland Ambulance Service should detail below its proposed plans for ensuring the achievement of the above PSA / Ministerial targets. Plans should provide sufficient detail to facilitate monitoring by the Department of progress with proposed service developments and associated resource utilisation. This should clearly indicate the scale of resources per annum being invested to achieve this target, analysed by commissioner.

No Trust response required

Ref : BT 20
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

1. Ministerial target (no PSA target)

   - Boards and Trusts should ensure that arrangements are in place to ensure the timely and effective implementation of the Department's cardiovascular service framework. An action plan should be developed, in conjunction with primary care, and submitted for Departmental approval by December 2008.

2. Trusts should detail below their proposed plans for ensuring the achievement of the above Ministerial target. Plans should include proposals (as per the allocation letter) for:

   - from April 2009, implementation of actions to achieve the service related targets in the Cardiovascular Service Framework,

   - improved services for patients with heart failure, including the appointment from April 2009 of heart failure nurses from across Northern Ireland,

   - improved capacity for diagnostic angiography over the CSR period to achieve and maintain maximum waiting targets; and

   - improved community rehabilitation services so that all patients with heart disease who could benefit from rehabilitation have the opportunity to participate in a suitable programme

   The additional resources ear-marked for these services must ensure a cumulative additional 700 cardiac surgery procedures/ cardiological interventions etc are provided by March 2011.

Trust response:

Cardiovascular Service Framework:

- The Trust is working with the Regional Cardiac Network to produce prioritised action plan.
- We have received confirmation from Commissioners of available funding in areas of Cardiac MRI, Adult Congenital, Inherited Disorders and Pulmonary Vein Isolation (pvi) to support the delivery of the target.

Heart failure:

- The Trust is working with the EHSSB in relation to the further expansion of the heart failure service and we are currently recruiting a dedicated heart failure specialist . The Trust has also sought funding for additional nurses.

Diagnostics - angiography:

- The Trust has identified a significant gap between demand and capacity for cardiac revascularisation. We are currently seeking additional recurrent funding for 3 additional Cath lab lists and appropriate support services to meet the demand.

Community Rehabilitation:

- The Trust has introduced the York database to monitor outcomes of Cardiac rehab services and is currently seeking recurrent funding for time limited nursing posts throughout the Trust.

Additional procedures:

- The Trust has secured recurrent funding to guarantee delivery of 1000 major cardiac surgical procedures in 2008/09 (200 recurrent additional from the financial baseline of 800).

- The Trust is also engaged with the regional cardiac network (chaired by Dr David Stewart), which will lead the production of the delivery action plan to achieve the 2011 target. The Trust understands the target relates to both Cath Lab procedures and cardiac procedures.

- The Trust anticipates the action plan being finalised by the summer.

Ref : BT 21
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

1. Ministerial target (no PSA target)

   - Trusts should ensure that, from April 2008, all urgent GP referrals for breast cancer are seen within 14 days of the receipt of the referral, with all urgent breast cancer referrals – from both GPs and other practitioners – being seen within 14 days by March 2009.

Trust response:

- Daily tracking of patient referrals and appointments is in place within the Trust.
-
- The 100%, 14 day target for referrals from GP'S was achieved by the Trust in January 2008. Sustaining this will however be extremely difficult in 2008/09 particularly due to insufficient Radiology capacity.

- A bid is with commissioners (through Cancer Access funding) for additional investment in the Independent Sector to support the Breast radiology service. The Trust has also discussed with the commissioner the need for recurrent funding for an additional breast radiologist. The commissioner is to confirm that resources can be made available for this development.

- Due to reduced Breast Surgeon capacity, the Trust is currently proceeding with a proleptic Breast Surgeon (with Breast Reconstruction) appointment. Two Staff Grade doctors who have been working in this speciality are also leaving in August. These posts will be re-advertised.

- The Trust requires the successful appointment to all of the above posts to enable the target to be achieved.

Ref : BT 22

PRIORITY AREA 3: IMPROVING ACUTE SERVICES

1. Ministerial target (no PSA target)

    - Trusts should ensure that, by March 2009, a dedicated paediatric and neo-natal intensive care transport service is in place on a 24/7 basis.

2. Trusts should detail below their proposed plans for ensuring the achievement of the above Ministerial target. Plans should include proposals (as per allocation letter):

    - to improve critical capacity by providing additional critical care beds and developing critical care outreach services, and

    - measures to sustain and develop vulnerable regional services, including regional paediatric specialities, genetic services and GUM services.

Trust response: Dedicated paediatric and neo-natal intensive care transport service

Plans to support the provision of the intensive care retrieval service are outlined below:

- The regulatory college authorities have approved the job description for a new Paediatric Intensive Care Unit (PICU) consultant with a special interest in transport. This post will be advertised within the next month.

- Two middle grade paediatric trainees will be appointed in August 2008; these posts have been approved as part of the paediatric training programme.

- Teleconferencing incorporating PICU in Belfast and three of the area hospitals, enabling case discussion and review of practice occurs monthly. Regional audit arrangements are currently being piloted.

- Robust measures are in place to deliver training for all grades of transport staff. Outreach education has been implemented to support current transports by regional hospitals.

- Transport equipment, including 2 specially designed ambulance trolleys have been sourced, costed and purchased. A dedicated ambulance vehicle is ready for use.

- Negotiations are continuing with regard to ambulance staffing – a contractual agreement and appropriate funding are required and the Trust is discussing this with the Ambulance Service.

- Neonatal nurses – the Trust is awaiting the outcome of a decision regarding a business case submitted for neonatal nurses. Neonatal transports cannot commence until these staff are in post.

- Medical staffing - For a 24/7 transport service additional PICU and NICU consultant PA's are required, also at least 5 WTE additional middle grades

A number of actions are dependant on funding, contractual agreements, staff selection and recruitment. The Trust has however identified that additional staffing (over that funded at present) are required to facilitate the delivery of a 24/7 service. We are currently seeking clarification on the funding. The Trust has a meeting with RMSC in June to discuss these and other matters.

With additional staffing and pending successful recruitment and training of staff, the Trust may be able to commence transport during the week (Mon – Fri for defined hours during the day) by March 2009 (not 24/7 as noted in the target).

Ref : BT 23
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

1. Ministerial target (no PSA target)

    - Trusts should ensure that, by June 2008, they have plans in place for the immediate development of services to preserve the sight of people affected by age related macular degeneration, consistent with the emerging evidence base for treatment of this condition.

Trust response:

- The Health and Social Services Boards, through their Health and Well-being Investment Plans (HWIPS) have already identified funding to support the development of services. (In anticipation of the NICE final guidance, and expected Northern Ireland ratification, by June 2008 of the guidance.) The Belfast HSC Trust had previously submitted a business case to the Regional Medical Services Group in November 2007 and a refreshed proposal has now been submitted to consolidate this work in anticipation of the final NICE guidance.

- The business case seeks to secure funding to provide the drug therapy, which is administered over a two year period, and the significant infrastructure, both revenue and capital to deliver the service.

- It is intended that the service be delivered through the Ophthalmic Clinic at the Royal Victoria Hospital which will be the intended central clinic having specialist macular medical staff.

- The Trust has projected a demand figure of 780 people based on incidence figures and the current population of Northern Ireland, however this projection is not supported by the historical presentation figures for age related macular degeneration and will need careful refinement. The Trust has suggested a treatment model for the next two years and this will support a growth in demand for treatment.

- The Trust would intend to purchase a tailor-made information package which will support the clinical and financial aspects of the developing service and will also facilitate patient and service monitoring.

Ref : BT 24

PRIORITY AREA 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

PSA 4: 1: By March 2010, 45% of people with assessed community care needs supported at home

1. Related Ministerial target

   - Trusts should ensure that, by March 2009, 44% of people in care management have their assessed care needs met in a domiciliary setting.

Trust response:

- At March 2008 the Trust recorded 53% of the people with community care needs as receiving care in their own home. The figure provided by the Trust relates to care managed clients.

- The Trust understands that the Department has now advised that all clients in receipt of a domiciliary care package are to be considered as included in the target. If all clients in receipt of domiciliary care package are to be included then the Trust should exceed current target.

Ref : BT 25

PRIORITY AREA 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

PSA 4.2: From April 2008, no older person with continuing care needs will wait more than eight weeks for a completed assessment, with the main components of care met within a further 12 weeks

1. Related Ministerial target

- Trusts should ensure that, from April 2008, older people with continuing care needs wait no longer than eight weeks for assessment to be completed and have the main components of their care needs met within a further 12 weeks.

Trust response:

- The Trust currently meets the 8 week target for assessment and expects this to be sustained in 2008/09.

- The Trust has discussed with the Department the need for definitional guidance in relation to main components of care to ensure consistency of reporting across Trusts in relation to the 12 week target. The Trust will be able to properly assess its baseline once this is taken forward.

- Information collated by the Trust at the end of March 2008 indicated 26 clients waiting more than 12 weeks for the main components of care. Reasons for wait include lack of funding for full assessed care package, capacity not available in services areas, client choice of placement not available.

- Pending the outcome of guidance on definitions, achieving the target will be dependent on resource and capacity availability. (The latter is significantly reliant on independent sector provision being available when required).

- Recurrent additional resources have not been made available to meet increased demand for long term care packages by the commissioner.

Ref : BT 26
PRIORITY AREA 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

PSA 4.4: From March 2009, 90% of patients with continuing complex care needs will be discharged from an acute setting within 48 hours of being declared medically fit, and no complex discharge will take longer than seven days – in all cases with appropriate community support

1. Related Ministerial target

   - Complex discharges: Trusts should ensure that, from April 2008, 90% of complex discharges take place within 48 hours, with no discharge taking longer than seven days.

TRUST RESPONSE:

- Baseline: An analysis of complex discharges during 2007/08 indicates that 65% of discharges took place within 48 hours.
- Improving the timescale of complex discharges has required the commissioning of a significant number of additional care packages requiring a commitment of resources in excess of recurrent funding available within the Trust.
- The target for 2008/09 will continue to represent a significant challenge within the Trust both in terms of resources requirements and capacity of independent sector provision. A particular issues relates to availability of services over the weekend which are currently not in place.
- Baseline figures for the month of April 2008 indicate 63% of complex patients were discharged within 48 hours.

2008/09 actions: To address the new target the following is planned by the Trust :

- Ongoing daily monitoring reports at ward level to indicate the status and time waiting for all medically fit patients. These are provided to all relevant managers within the Trust.
- Senior manager now appointed for intermediate care service to take the lead in this area to ensure optimal use of services available across the Belfast area to facilitate earlier discharge. This will include a redesign of hospital and community processes to facilitate 7 day rapid access to all intermediate services, where further assessment, rehabilitation and care planning will take place.

- Additional investment will also be required for domiciliary care packages, expansion of intermediate care and increased district nursing support (including inreach) to enable the Trust achieve this target.

- The Trust is awaiting the outcome of its HWIP proposals in order to take forward the initiatives described above which are essential to achieving this target.

PRIORITY AREA 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

Ref : BT 27
PSA 4.5: All other patients will, from April 2008, be discharged from hospital within six hours of being declared medically fit.

1. Related Ministerial target

    - Trusts should ensure that, from April 2008, all non-complex discharges take place within a maximum of six hours.

TRUST RESPONSE:

- At March, 96% of all non complex discharges took place within 6 hours in March 2008. The Trust has undertaken ongoing detailed audit analysis to review reasons for delays which include the following:
    - patients waiting for transport via ambulance or family member (an estimated 25% of delays);
    - evening ward rounds identifying patients as medically fit when in reality they cannot go home until the following morning as packages may need to be restarted;
    - patients waiting for discharge letters/scripts to be written.

Actions ongoing during 2008/09 will include the following:

- The Trust has established a working group, which meets on a monthly basis to review issues associated with delays. A senior manager has also been given protected time to focus on delayed discharges.
- Information reports are now generated centrally on a daily basis and when a breach occurs ward managers are responsible for validating the information and completing a detailed breach report.
- The Trust is reinforcing the importance discharge planning from the point of admission including the allocation of estimated discharge dates (EDD). This includes reminders that all patients families should be informed of the expected date of discharge as soon as possible.
- The criteria for booking ambulance transport is being reissued to all wards and audits of adherence to policy will be carried out.
- Identifying where possible, patients who will require additional support on discharge and starting the process of putting arrangements in place as early as possible.

- Ensuring that the correct data is entered onto the system by the continued validation of information reports. Identify trends and audit where possible to ensure accuracy.

- Reminding medical staff of the need to ensure discharge summaries and scripts are completed as soon as is possible following the decision to discharge.

- Continued collaboration with agencies outside the Trust. In particular NIAS to ensure waiting times for ambulances are reduced.

- Liaison with SDU to discuss the impact of evening ward rounds on the Trust's ability to increase discharges between 8am -1pm. If patients are well enough to go home following the evening ward round they will. The effect of this reduces the number of patients going home in the morning as they have already gone the previous evening.

- Increasing the role of nurse led discharge within the Trust.

- Delays due to families providing transport may be addressed by the provision of a discharge lounge facility for afternoons and evenings.

The Trust will continue to monitor this target and review how internal processes can be improved to increase performance towards 100%.

Ref : BT 28

PRIORITY AREA 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

1. Ministerial target (no PSA target)

   - Boards and Trusts should ensure that arrangements are in place to ensure the timely and effective implementation of the Department's respiratory service framework. Action plans should be developed, in conjunction with primary care, and submitted for Departmental approval by February 2009

Trust response:

- The Respiratory Service Framework document is still under development and the final performance indicators have not been agreed. It is anticipated that the draft document will be completed by the summer and it will then be forwarded to the Department for sign off. Trust staff have contributed to the development of the framework through representation on the project team.

- The Trust understands that the timescale for a public consultation has been revised to October to accommodate the consultation of the Cardiovascular Framework first. Once the consultation process is completed the framework will be launched.

- In terms of implementation (pending the publication of the final framework), the Trust believes there will be some clear resource implications e.g. sleep service and palliative care.

- The Trust has in place an internal Respiratory Steering Group, which will lead the development of the local implementation plan (including the setting of milestones) once we have the final framework document is available.

- Work is also required for paediatric respiratory services and Trust officers are currently working with the commissioners including Dr Jenny Jingles (respiratory lead at the EHSSB) in relation to this service area. Dr Jingles also sits on the Trust Respiratory Steering Group.

- The Trust will work with commissioners and the Respiratory Service Framework working group to develop the required action plan by February 2009.

Ref : BT 29
PRIORITY AREA 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

1. Ministerial target (no PSA target)

   - Trusts should ensure that, by March 2009, the number of direct payment cases increases to 1,000 (rising to 1,500 by March 2011

Trust response:

Belfast Health and Social Care Trust share of the above is to provide an additional 54 Direct Payments in place by March 2011.

As of 31st March 2008 the Trust had 153 users in receipt of Direct Payments with the breakdown across the Programmes of Care as follows;

Adult PH&D	57
Learning Disability	29
Elderly	23
Mental Health	1
Children with Disabilities	43

Cumulative expenditure across the Trust for 2007/08 was:

£335,918	(N&W Legacy Trust)
£746,029	(S&E Legacy Trust)
£1,081,946	**TOTAL**

To meet targets the Trust's interim targets are to ensure a further 20 packages are in place by 2008/09, 40 by 2009/10 and 54 by 2010/11 (as per EHSSB HWIP). This will require a further expenditure of around £130,000 in 2008/09.

The Trust has a Direct Payments Development Group, which meets quarterly to address operational and strategic issues, and the Chair of the group attends the Regional Reference Group to ensure continuity of information flow.

There has been a steady growth in the uptake of Direct Payments across the Trust as a result of increased awareness, implementation of the Regional Training Strategy and specific actions identified within the Trust Development Group. The following action plan is proposed to assist the Trust in achieving the Priorities for Action targets.

1. A project worker has been funded by the EHSSB to assist the Trust in developing a strategy to address low take up in specific areas, with the aim of increasing the number of people in receipt of Direct Payments. The project is currently identifying the reasons behind the low take up with a view to identifying appropriate remedial action. An interim plan has been

produced. This post has been funded for one year and recommendations will be implemented by December 2008.

2. The Trust is continuing to implement recommendations from the DHSS Training Strategy and has recommended that training in Direct Payments be considered mandatory for all staff.

3. Training on Direct Payments has been reviewed and modified to ensure it continues to meet staff needs. Refresher Training for staff working with Direct Payments has been organised for May and will take place on a twice-weekly basis across the Trust.

4. A Development Group meets quarterly with representation from all Programmes of Care across the Trust. It deals with operational and strategic issues and was set up to ensure the Trust carries through with the recommendations of the DHSS Review (April 2005) and that Direct Payments continue to be given a high priority within all Programmes of Care.

5. An audit is to be carried out across the Trust to ensure the recommendations of the EHSSB review (April 2005) have been carried out. The audit will be carried out by March 2009.

6. A Steering Group has been set up, under the Chairmanship of a Co-Director, which will consist of Senior Managers from all Service Groups to ensure recommendations from the Regional Development Group and the Trust Development Group are implemented.

Ref : BT 30
PRIORITY AREA 5: IMPROVING CHILDREN'S SERVICES

PSA 5.1: By March 2011, reduce by 12% the number of children in care.

1. Related Ministerial targets:

- Children: Trusts should ensure that, by March 2009, the number of children in care is reduced by 3% in comparison with the figure at March 2008 (rising to a 12% reduction by March 2011).

- Trusts should, by June 2008, have developed agreed regional guidance on the use of family group conferencing for children and young people and, by March 2009, ensure that at least 500 children and young people whose assessed need is on levels 1, 2 or 3 measured on the Hardiker model should have participated in a family group conference.

- Trusts should, by December 2008, have in place a regional, independent, birth parent mediation service available to all birth parents where adoption is the plan, and must have agreed a regional model for a post-adoption contact mediation and facilitation service and a therapeutic support service.

- Trusts must, by March 2009, provide family support packages to 1,000 vulnerable young people each year as part of new family support services [increasing to 3,500 each year by 2011], and have in place a dedicated outreach programme targeted at young people aged 18 and under who are homeless or at risk of homelessness.

Trust response:

Looked After Children:

The baseline figures relating to looked after children and targets for the Trust are set out below:

Baseline – March 2008
604 Children and Young People Looked After by the Belfast Health and Social Care Trust

March 2009	March 2010	March 2011
Target number LAC = 586 (3% reduction)	Target number LAC = 556 (8% reduction)	Target number LAC = 531 (12% reduction)

ACTIONS TO ADDRESS REDUCTION:

- The Trust has identified the number of Children Looked After in the care of parents.
  86 in North and West Legacy Trust
  14 in South and East Legacy Trust
  Total – 100 Children

  The Trust is taking forward a Review Children Looked After at home in the care of their parents to assess, is any of these children can be discharged from Care. This may be
    (1) through the Courts where a Court Order exists, or;
    (2) through agreement with parents / carers supported by a Family Support Service.

- The Trust will continue application of the Regional Permanency Policy to progress children to adoption, as appropriate and therefore out of the Looked After System.

- The Trust will take forward a programme to promote / facilitate the consideration of and application for Residence Orders by Carers to bring children out of the Looked After System.

- The Trust is taking forward the development of a Family Support Strategy to:
  (a) prevent Children's admission to care,
  (b) facilitate Children's safe discharge from care.

- The Trust would highlight however that admissions to care are on the basis of need and following professional assessment. Reductions therefore in the number of LAC cannot be guaranteed.

Family Group Conferencing:

- The Trust is working with the commissioners on the development of regional guidance on the use of family group conferences.

- The Trust will continue to prioritise the use of Family Group Conferencing as a strategy to:

  (1) prevent Children's admission into care,
  (2) facilitate the safe discharge of Children from care.

Birth Mediation Services:

The plan for a regional Independent birth parent mediation service, and a regional model for post adoption contact mediation and facilitation service and a therapeutic support service, is being taken forward by Health and Social Services Boards.

The Belfast Trust has a post adoption team providing support for direct and indirect contact and will collaborate in shaping of any regional service.

Family support packages: Refer PFA 5.2

Ref : BT 31
PRIORITY AREA 5: IMPROVING CHILDREN'S SERVICES

PSA 5.2: By March 2011, provide family support interventions to 3,500 children in vulnerable families each year.

Trust response:

To address the target, the Trust will take forward the following actions:

- Clarification on how the target is to be assessed and monitored will be required and the Trust will discuss with the commissioner how best to identify the current levels of Family Support Interventions across the Belfast Health and Social Care Trust.

- A database will be required to monitor progress towards the achievement of this target. The EHSSB have identified in the HWIP the milestones identified below. The Trust is to agree with the EHSSB, the Belfast Trust share of the milestones below.

March 2009	March 2010	March 2011
family support interventions provided to 400 children in vulnerable families (EHSSB)	family support interventions provided to 895 children in vulnerable families (EHSSB)	family support interventions provided to 1390, children in vulnerable families (EHSSB)

The following actions to support the delivery of the target will also be taken forward:

- Establishment of Family Support Teams through programme restructuring (September 2008)

- Recruitment of Family Support Social Workers / Senior Practitioners to develop and deliver a Family Support Strategy (September 2008 – HWIP funding proposed for the Belfast Trust in 2008/09, £87K and £100k)

- Funding support to deliver a range of support activities for vulnerable children and young people aged under 18 years who are at risk of homelessness (HWIP funding proposed for the Belfast Trust, Year 1 - £0.245m, year 2 - £0.171m, year 3 - £0.256m)

- In partnership with users and providers identify short falls in service provision.

- Identify priorities to meet identified / assessed need.

Ref : BT 32
PRIORITY AREA 5: IMPROVING CHILDREN'S SERVICES

PSA 5.3: By March 2011, increase by 50% the proportion of care leavers in education, training or employment at age 19.

1. Related Ministerial targets:

- Trusts should, by September 2008, have in place a plan setting out how they intend to achieve an increase by March 2010 of 300 foster carers across Northern Ireland from the March 2006 total and, by March 2009, have agreed regionally a priority salaried foster care initiative targeted at older young people in care.

- Trusts should, by September 2008, confirm to the Department (via their respective Directors of Children's Services) that all eligible, relevant and former relevant young people have pathway plans and personal advisers in place, in line with statutory requirements and Departmental guidance.

- Trusts should, by September 2008, have established a 6-month pilot therapeutic support scheme in two intensive support residential children's homes.

- Trusts should, by December 2008, have put in place the regionally agreed guidance and arrangements to support young people aged 16-17 in care to engage in part-time and full-time employment and, by March 2009, must have appointed dedicated development workers within transition teams as part of a training, education and employment support scheme for young people aged 16+ in care or who have left care.

Trust response: Care Leavers in Education / Training etc

The Trust will be undertaking the following actions to address the target:

- Baseline: The Trust will confirm its baseline based on the figures for 2007/08 (available shortly). For the period 1.4.07-31.9.07, of 29 care leavers (aged 18 years), 14 were recorded as unemployed. For the same period of the 8, 16/17 year olds leaving care, 4 were unemployed.

The Trust will be undertaking the following actions to address the target:

- Establishment of four 16+ transition teams across Belfast Trust, managed by a dedicated Service Manager and the recruitment of transition workers (subject to Dept. guidelines) to specialise in preparing young people for adulthood. (HWIP investment Yr 1- £86k, Yr 2 - £24k, Yr 3 - £37k),

- Creation of a Forum with voluntary organisations (Opportunity Youth and Include Youth) to develop employability scheme: Sept 2008,

- Establishment of a Children Looked After Support Service to target the two intensive residential children's homes: Sep 2008. The EHSSB HWIP proposes funding of £73k (Yr1) to support the appointment of career co-ordinators to support this development.

- The EHSSB have also identified within it's HWIP funding to support living arrangements for care leavers (as a consequence of changes to Supporting People funding arrangements). £0.124m (Yr 1), £0.049m (Yr 2), £0.044m (Yr 3) has been identified against the Belfast Trust.

Trust response: Foster Carers Increase

3. Trusts should detail below their 2009 milestone to achieve the Ministerial target for foster carers within the timescales set

March 2009	March 2010
Trust contribution to target to be confirmed with EHSSB	increase of 300 in the number of foster carers from the March 2006 total

- The target for Northern Ireland is for an increase of 300 foster carers by March 2010, but the target for Belfast Trust is to be confirmed with the EHSSB. At the end March 2008, the Trust recorded 454 foster carers.

- The Trust has an active recruitment group, which has implemented an advertising drive to attract new carers. The group ran a very noticeable poster campaign in March 2008 on local buses across the whole of Belfast and will be following up with advertisements at bus stops throughout the city. The aim is to recruit carers within the Belfast and inner Belfast area, as previously many carers have been from outside Belfast.

- The Trust will be moving into new specialist teams over the next few months (on the agreed regional model) and one team will focus specifically on Recruitment and Assessment of new carers.

- The Trust has re-launched its Adolescent Fostering Scheme, run in partnership with Barnardos. The Adolescent Fostering Partnership aims to place young people aged 13-17 years, who are displaying more challenging behaviour. It is hoped to increase the current number of 12 carers and to support them, where appropriate, to look after more than one young person at a time.

Trust response: Salaried Foster Carers

4. **Trusts should detail below their proposed plans for ensuring the achievement of the above milestones and PSA / Ministerial targets. Plans should include proposals (as per the allocation letter) for:**

   - **by March 2011, increase the number of foster carers who are salaried by 100, focusing specifically on foster carers recruited to work with older children in care**

- The EHSSB has identified funding to purchase 36 places across the EHSSB area. The Trust's share of this is 22 places, with investment of £289k over 3 years.

- The Trust already has a scheme for older children in care (Adolescent Fostering Partnership) and believes that this scheme, which has been reviewed and realigned over the past six months, will significantly increase placement numbers for young people.

Trust response: Pathway plans / personal advisors:

- The Trust will by September 2008 have recruited and appointed its full quota of personnel advisers. All eligible, relevant and former relevant young people will have pathway plans in place in line with the target.

Trust response: Therapeutic Support Service

- The EHSSB HWIP has identified funding for the following initiatives to support delivery of the target.
  - Appointment of a CLASS manager (children looked after support service) to co-ordinate the delivery of the service (£48k).
  - In years 2 and 3 funding to provide additional therapeutic support (£43k).

PRIORITY AREA 5: IMPROVING CHILDREN'S SERVICES

Ref : BT 33

PSA 5.4: By March 2011, increase by 25% the number of care leavers aged 18 – 20 living with former foster carers or supported family

Trust response :

Trust milestones in relation to the target are set out below.

March 2009	March 2010	March 2011
10% increase (i.e. 4 young people) in the number of care leavers aged 18 – 20 living with their former foster carers or supported family over baseline figure (40 young people) at 31 March 2008	17.5 % increase (i.e. 7 young people) in the number of care leavers aged 18 – 20 living with their former foster carers or supported family over baseline figure (40 young people) at 31 March 2008	25% increase (i.e. 10 young people) in the number of care leavers aged 18 – 20 living with their former foster carers or supported family over baseline figure (40 young people) at 31 March 2008

The Trust will be taking forward the following actions in response to the target:

- Establishment of 4 transition teams 16+ across Belfast Trust. Managed by a dedicated service manager at 8a Band: Oct 2008.
- Awareness training of former fostering scheme to be part of Fostering Service Training: June 2008.
- Aftercare/transition team to identify any young person due to be discharged from long term foster care.
- Transition social worker to attend LAC twelve months prior to last LAC review and provide information on former foster care scheme.
- The EHSSB HWIP identifies funding of an additional 21 placements within the Belfast Trust (£86k over the 3 years).

Ref : BT 34

PRIORITY AREA 5: IMPROVING CHILDREN'S SERVICES

PSA 5.5: By March 2011, reduce by 12% the number of children requiring to be placed on the child protection register who are looked after

Trust response:

Trust milestones in relation to the target are set out below.

March 2009	March 2010	March 2011
3% reduction in number of children required to be placed on the CPR against baseline of 31st March 2008 i.e. 5 children	6% reduction in number of children required to be placed on the CPR against baseline of 31st March 2008, i.e. 10 children	12% reduction in number of children required to be placed on child protection register against baseline of 31 March 2008 (i.e. 20 children)

- Baseline activity of number of children on Child Protection Register who are Looked After as of 31.3.08 for the Belfast Trust is 171 children.

In response to the target the Trust will be taking forward the following actions:

- Undertake a review of this group of children re: placement information, age, length of time on the register and reasons for registration.

- Review the practice of placing young people in residential care on the child protection register.

- Re-establish Therapeutic Support Service for LAC to support those young people displaying risk taking behaviours.

- The EHSSB have identified HWIP funding to support the following developments related to the target:

  - strengthening family support intervention teams with the appointment of additional social work staff (Belfast Trust Yr 1 - £112k, Yr 2 - £0k, Yr 3 - £47k);
  - Funding to support the appointment of additional staff to support Gateways teams (Belfast Trust Yr 1 - £112k, Yr 2 - £0k, Yr 3 - £47k).

Ref : BT 35
PRIORITY AREA 6: IMPROVING MENTAL HEALTH SERVICES

PSA 6.1: By March 2011, ensure a 10% reduction in admissions to mental health hospitals and

- substantially strengthen community and mental health teams from 2008 – 9 onwards, leading to an increase of the equivalent of over 200 staff by 31March 2011.
- strengthen Personality Disorder Services by establishing, by March 2010, a suitably skilled multi disciplinary team in each Trust, and further developing such services by 31 March 2011.
- recruit, train and extend the role of clinical staff to deliver the psychotherapies of the Bamford Review and Welfare Reform Green Paper.
- increase the choice of evidence based psychological therapies for people with mild to moderate depression and other mental health issues.
- from April 2008, begin the development of a regional Eating Disorders Unit.
- ensure that, in developing and reforming services, appropriate consideration is given to the practice set out in New Ways of Working.
- identify and fill gaps in existing advice and information services, taking into account the potential contribution made by the voluntary sector.

Trust response: Reduction in Mental Health Admissions

The Trust milestones and key actions in response to the target are set out below

March 2009	March 2010	March 2011
3.3%	6.6%	10% reductions in admissions to mental health hospitals

The Trust would request further clarification in respect of this target. The Trust needs clarity of which specialties within mental health are included in the target. Service developments which will contribute to a reduction in hospital admissions are out lined below.

Crisis House

The opening of the 6-bedded Crisis House in Belfast this year is expected to contribute to reductions in admissions to Mental Health Hospitals in the Belfast Area over the three-year period. This is in effect the removal of inappropriate admissions to Mental Health Hospitals. Where a person in crisis who cannot benefit from crisis response and home treatment, requires a period away from their home to stabilise, this can be provided in the crisis house thus avoiding a hospital admission.

Crisis response & Home Treatment

The enhancement of the crisis response and home treatment service across Belfast this year will also have an impact on admissions to Mental Health hospitals.

The phased enhancement of Mental Health Community infrastructure and Psychological services over the next three year period is also expected to have a positive effect on the reduction of admissions to hospital.

Trust response: Strengthen community mental health teams

The HWIP allocation to the Belfast Trust over the 3 years of the plan is set out below:

	Year 1	Year2	Year3
Belfast Trust Allocation	**£1.021m**	**£0.0 £**	**0.79m**

The Trusts plans to strengthen its community Mental Health services in the following ways:

The Trauma Resource centre.

This service is currently operating in North & West Belfast has an existing funding shortfall in the region of £130,000 per annum, which the Trust needs to address.

The Trust is also developing a proposal to expand this service city -wide. The Trust envisages the service as being based in the existing Everton complex and providing in reach to the South and East Belfast and Castlereagh areas. The service would continue to focus on working with and through community victim's' groups. This expansion, including the existing shortfall would be in the region of £200,000 per annum.

The Self-Harm Team.

This service currently takes its referrals from the Mater Hospital emergency department. As with the Trauma resource centre the Trust would wish to widen the scope of this service. The aim would be to embrace all emergency departments in the City of Belfast and to reach into all communities across the city of Belfast. Ideally the Trust would aspire to Mainstream this service within an appropriate service delivery model.

The Trust is currently considering how this aspiration links in with Primary Mental Health teams, Hospital liaison services, the Crisis Response & Home Treatment team (CRHT), Personality Disorder services and Psychotherapy, in order to develop a proposal that ensures clarity of the role and function of all aspects of these services in respect of self harm and to identify the extent of any overlaps and remove any potential for the duplication of services.

The extension and remodelling of the existing service will have funding implications.

Young Carers.

In principle the Trust favours the provision of services to carers through the community sector and voluntary sectors but this does not negate the value of professional advocates.

The current service supporting young carers of people with Mental Health difficulties is provided by LAMP and is being independently evaluated. The evaluation is expected to provide the Trust with recommendations as to whether this type of service should be provided in-house or otherwise and whether there are benefits associated with more generic provision of carer support and advocacy.

The existing Mental Health young carers Co-ordinator is currently funded by the Belfast Regeneration Office but this funding ceases on the 31st March 2008.

Should a more generic response be recommended, a pathway would have to be created for the existing 25 young carers to transfer. Either way, funds will be required to sustain and expand this service across the city of Belfast and into schools where it should be linking with individual teachers and those responsible for pastoral care in schools.

Expert Patient Project

This project has proved to be very effective in delivering anxiety management on a co-ordinated volunteering basis. The Trust is keen that this project should be supported into the future and believes that the additional costs required would be minimal.

Single point of Referral.

It is clear to the Trust that its ability to maintain 13-week access targets and to move towards 9-week access targets will require additional resources to achieve. The Trust believes that additional resources will be required to support administrative, clinical and professional staff. The Trust is currently developing a model/pathway towards a single point of referral for the City of Belfast Mental Health Services. The Trust is committed to introducing new ways of working for admin, clinical and professional staff but the need for additional resource is clearly emerging as part of the modernisation process.

Discharge Co-ordination

It is imperative for the Trust to have a focused resource/ driver in order to comply with the renewed discharge targets.

Currently the Trust has discharge co-ordinators for the Belfast City Hospital (Windsor) and Mater hospitals employed through existing resources. The discharge co-ordinator for the Knockbracken site was funded on a non-recurring basis on the back of slippage on the Crisis Response and Home Treatment.

The Trust is considering how best to maximise the impact of the existing resource across the three in patient sites. However, in the context of the Mc Cleary report and the planned decant of the 35 Windsor inpatient beds, as the CRHT comes up to its full staffing complement, the Trust may require additional resource.

Reshaping of Addiction services

The Trust is currently modelling the reshaping of its addiction services, to include a potential Eastern Area service. Whilst the Trust will endeavour to reshape its service from retraction of current services there may be an additional cost.

Trust response: Personality Disorder Services

The HWIP allocation to the Belfast Trust over the 3 years of the plan is set out below:

	Year 1	**Year2**	**Year3**
Belfast Trust Allocation	**£0.00m**	**£0.136m**	**£0.425m**

It is noted by the Trust that there is no specific allocation for the development of Personality Disorder services in year one. The Trust would expect to draw funding from the Enhanced community services or Psychotherapy streams in year one in order to further develop services for this group.

It is the Trust's aspiration to increase its investment in the voluntary and community sector around psychological services. The Trust recognises real problems in current equity of access to these services. In response the Trust will either bring these community services under the control of its single point of referral and triage system, governed by eligibility criteria and objectives or direct access governed by agreed access criteria. A significant number of people presenting with self harm also have a recognised personality disorder.

Personality disorders and self harm are clearly linked and there are potential efficiencies in considering both services together.

The Self-Harm Team

This service currently takes its referrals from the Mater Hospital emergency department. As with the Trauma resource centre the Trust would wish to widen the scope of this service. The aim would be to embrace all emergency departments in the City of Belfast and to reach into all communities across the city of Belfast. Ideally the Trust would aspire to Mainstream this service within an appropriate service delivery model.

The Trust is currently considering how this aspiration links in with Primary Mental Health teams, Hospital liaison services, the Crisis Response & Home Treatment team (CRHT), Personality Disorder services and Psychotherapy, in order to develop a proposal that ensures clarity of the role and function of all aspects of these services in respect of self harm and to identify the extent of any overlaps and remove any potential for the duplication of services.

The extension and remodelling of the existing service will have funding implications.

Trust response: Role of clinical staff to deliver psychological therapies

The HWIP allocation to the Belfast Trust over the 3 years of the plan is set out below:

	Year 1	**Year2**	**Year3**
Belfast Trust Allocation	**£0.667m**	**£0.113m**	**£0.806m**

The Trust is in the process of scoping capacity and demand in respect of its Psychological services including CBT and through this process will begin to identify gaps in service capacity and begin redesigning and populating the stepped care model. See paragraph below.

Trust response: Evidence based psychological therapies

Currently Psychological services in the Belfast Trust for adults with Mental Health difficulties are managed through two distinct service groups, namely Clinical Services and the Mental Health and Learning Disability service group. Mental Health & Learning Disability service group manage the cognitive behavioural therapists, Psychotherapy services, the Trauma centre and the self-harm team and Clinical services manage the Psychology input to adult Mental Health Services, the community at large and the Acute hospital sites.

Within Mental Health Managed Psychological services there are 422 patients waiting a first appointment for CBT in the Belfast Trust and there are a total of 220 patients currently waiting over 13 weeks for their first appointment.

However, the ongoing phased implementation of a single point of referral and the introduction of a stepped care model of psychological services, will require mental Health services to work across service group boundaries especially with Clinical services and Psychology services and will require funding to populate the new model.

The Trust needs to establish the communication s, data collection, referral criteria, systems and protocols to effect the smooth implementation of the stepped care model as well as identify the service gaps, redesign and populate the model.

This role will be fundamental in an environment where the Trust is both implementing a phased introduction of the single point of access, developing a stepped care model of psychological therapies and having to manage service improvements within psychology, psychotherapy, CBT teams, the trauma centre and self harm teams in order to meet the 13 week waiting time target for 31st March 2009. This role will be pivotal in ensuring the latter while ensuring good interface with the broader agendas of single point and stepped care model.

Trust response: Eating Disorder Services

The HWIP allocation to the Belfast Trust over the 3 years of the plan is set out below:

	Year 1	Year2	Year3
Belfast Trust Allocation	**£0.198m**	**£0.00**	**£0.196m**

The Trust has begun a process of developing a needs analysis and development/ action plan for eating disorder services in conjunction with the Regional eating Disorders group. Early indicators suggest the need to further develop tier 3 day services to improve the overall functionality of the Eating disorder service.

Whilst the Trust(s) continue to have ECR referrals to St George's in England, it is evident that these referrals are primarily to access the tier 3 support services available there as opposed to re-feeding beds per se.

The Trust is increasingly minded that re-feeding beds in England do not function in the absence of strong supportive tier 3 - day services, and it is in fact that aspect of services, available at St George's that the Trust will probably wish to develop further on a local basis.

The Trust is not convinced that the Region requires re-feeding beds but that it does require strengthened tier 3 eating disorder day services. The Trust is of the view that persons who are so seriously ill that they require admission to an inpatient ward for "re-feeding" should in effect be admitted to a general hospital ward.

The Trust is concerned that if any available resources for Eating Disorder services in the region are channelled towards "re-feeding" beds, that this will not have the desired effect of reducing the number of ECR referrals and not in effect improve the local response to persons with eating disorders. Furthermore the Trust would wish to open up discussions immediately on the potential to use the HWIP investment in the further development of tier 3 day support services.

Trust response: Developing and reforming services

The Trust will give full consideration to the Departmental of Health's "New Ways of Working for Everyone" best practice guide.

Trust response: Advice and information services

It is the Trust's aspiration to increase its investment in the voluntary and community sector. It is the Trust's view that the community and voluntary sector are true partners in the delivery of high quality Mental health services and will work in collaboration with the community and voluntary sector, user groups and advocates to effect improvements in existing information and advice services.

The Trust wishes to expand its existing service provision for carer's support and advocacy across the City of Belfast. As part of this remodelling the Trust will be reviewing the function and scope of its existing three staff.

The Trust also wishes to further develop the participation of service users in service planning, implementation and monitoring and will be bringing forward proposals rooted in the community/ voluntary sector that will promote user participation.

PRIORITY AREA 6: IMPROVING MENTAL HEALTH SERVICES

Ref : BT 36
PSA 6.2: By 2011, ensure a 10% reduction in the number of long stay patients in mental health hospitals

1. Related Ministerial target:
    - Resettlement – Trusts should, by March 2009, resettle 30 patients from hospital to appropriate places in the community compared to the March 2006 total (and a further 60 by March 2011)

Trust response:

Trust milestones and actions related to the targets are set out below:

March 2009	March 2010	March 2011
3.3%	6.6%	10% reduction in the number of long stay patients in mental hospitals

The HWIP allocation to the Belfast Trust over the 3 years of the plan is set out below

	Year 1	Year2	Year3
Belfast Trust Allocation	**£1.032m**	**£0.068m**	**£0.391m**

The Belfast Trust has recently constituted a Modernisation Project Board chaired by the Chief Operating officer to oversee and steer the modernisation of Mental Health & Learning Disability services in the City of Belfast. The project Board is supported by four sub groups including a group focusing on Recovery services which will include a remit to develop strategic and operational plans to effect the resettlement of a significant number of adults from long-stay psychiatric wards into the community. This exercise is driven by the Trust's commitment to the rights of all to experience ordinary living in a community setting.

In the first instance the Belfast Trust has plans to rationalise four wards on the Knockbracken site into two wards and resettle those who do not require continuing inpatient treatment.

This process will involve the need to create an internal catalyst to effect this change and drive the resettlement process in a person centred and effective manner. The Trust is in the process of considering how best to achieve this shift and the type of model / team required to produce a successful outcome for patients. There will be a resource implication of creating this resettlement team/ change agent.

In addition, for the resettlement process to be any way successful, the Trust will need to enhance its existing community supported accommodation schemes in order to improve their ability to meet the complex needs of the individuals being considered for resettlement.

Ref : BT 37

PRIORITY AREA 6: IMPROVING MENTAL HEALTH SERVICES

PSA 6.3: By 2009, ensure a 13 week maximum waiting time for defined psychotherapy services

1. Related Ministerial target:
    - Assessment and treatment: Trusts should ensure that, from April 2008, no patient waits longer than 13 weeks from referral to assessment and commencement of treatment for mental heath issues, other than psychological therapies where the 13-week maximum waiting time is to be achieved by March 2009.

Trust response:

Single Point of Referral

The Trust is currently introducing a single point of referral for all Mental Health services.

The aim of the single point of referral is to ensure that the needs of clients referred to the Mental Health Service are assessed by the most appropriate person, to meet their needs most effectively. The process endeavours to avoid duplication and allow the sharing of information to enable appropriate decision making to be made within the team to meet the needs of the clients referred to the service. The Single point of referral process will also aim to screen referrals for appropriateness, whilst ensuring that the information received is of a good standard and provides adequate information required prior to an initial assessment. Non-urgent referrals will be prioritised following a multi-disciplinary discussion around the content and needs. Services to be included will include Consultant Psychiatric outpatients, Primary and Secondary care, CBT, Psychotherapy, self-harm and Psychology. The Trust would also wish to the SPOR team to have the capacity to provide its own evaluative function as it develops thus providing a continuous review and formative and summative evaluation function.

The rationale behind introducing a single point of access is to:

- Simplify and streamline the system,
- Ensure appropriateness of referrals,
- Screen and refer to the relevant service,
- Improve accessibility for all,
- Assessment equity,
- Identify areas of need,
- Provide information for planning and service development.

Its purpose is to create an uncomplicated process for accessing adult community mental health and social care services within the community.

Where the needs of those referred can be best met by another service they will be passed onto the relevant service and the referrer informed.

The system will assist the trust in meeting access targets through improving service access and duty protocols.

Stepped Care Model for Psychological Services

It is important to note that the single point of referral cannot in itself be considered as the solution to compliance with access targets. It is the front door to the service where triage will be carried out, but the services populating the upper tiers need to be critically analysed and reviewed. The Trust is in the process of scoping capacity and demand in respect of its Psychological services including CBT and through this process will begin to identify gaps in service capacity and begin redesigning and populating the stepped care model.

Psychotherapy

The Trust is currently developing a proposal to modernise the Psychotherapy service in Belfast, which it expects to be able to share with The Eastern Board in the very near future.

The Trust has an existing cost pressure in respect of the transfer of a half time psychotherapist to full time which it needs to respond to in 2008/09.

CBT

This service will be modernised in the context of a single point of referral and a stepped care model. The modernisation process will analysis and improve the interfaces between psychological therapies to ensure an efficient use of the whole resource including psychology and psychotherapy.

Ref : BT 38
PRIORITY AREA 6: IMPROVING MENTAL HEALTH SERVICES

1. Ministerial target (no PSA target):

- Discharge: Trusts should ensure that, by March 2009, 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days. In exceptional circumstances where patients are delayed in hospital beyond 90 days the Department will expect the relevant Trust to have robust plans in place to work towards the provision of appropriate care for the patient in a non-hospital setting, with that care plan beginning not later than 12 months after the original discharge date.

Trust response:

- Currently the Trust has in place discharge co-ordinators for the Belfast City Hospital (Windsor) and Mater hospitals employed through existing resources. The discharge co-ordinator for the Knockbracken site was funded on a non-recurring basis on the back of slippage on the Crisis Response and Home Treatment. The role of the co-ordinators is to facilitate discharge arrangements within the acute mental health wards.

- The Trust is considering how best to maximise the impact of the existing resource across the three in patient sites. However, in the context of the Mc Cleary report and as the CRHT comes up to its full staffing complement, the Trust may require additional resource to achieve its target.

- Achieving the target will also be dependent on capacity being available within community services, including independent sector care and accommodation services.

Ref : BT 39
PRIORITY AREA 6: IMPROVING MENTAL HEALTH SERVICES

1. Ministerial target (no PSA target):

   - Trusts should, by March 2009, provide an additional 500 dementia respite places a year (increasing to 2,000 by March 2011)

Trust response:

The Trust share of the above target and monitoring arrangements will need to be clarified.

March 2009	March 2010	March 2011
To be confirmed with the EHSSB	To be confirmed with the EHSSB	To be confirmed with the EHSSB

The Trust will take forward the following actions in response to the target:

- The Trust will be taking forward a complete a review of existing respite services available to people with dementia and their carers. This will include the views of users and carers. A baseline report will be developed. This report will capture current provision, usage and any quality issues.

- The Trust will develop or commission an additional respite places based, as far as possible, on the preferences of users and carers by March 2009.

- The EHSSB HWIP has identified the Belfast Trust share of the March 2009 target as 115 weeks of respite, increasing to 455 by March 2010/2011. Related investment has been identified within the Boards HWIP. The Trust wishes to further discuss this with the EHSSB.

- The Trust will also put in place a monitoring system to measure usage and quality of dementia respite services for people with dementia.

Ref : BT 40
PRIORITY AREA 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY

PSA 7.1: By March 2011, ensure a 25% reduction in the number of long stay patients in learning disability institutions

1. Related Ministerial target:
   - Resettlement: Trusts should, by March 2009, resettle 60 patients from hospital to appropriate places in the community compared to the March 2006 total (and a further 60 by March 2011).

2. Trusts should detail below their proposed plans for ensuring the achievement of the above milestones and PSA / Ministerial targets. Plans should include proposals (as per allocation letter) for:
   - extending community based support by provision of access to specialist treatment through the extension of the range of community alternatives to hospital admission, and
   - improved diagnosis and provision of interventions for children and adults with autism in line with the recommendations of the Independent Review of Autism (Learning Disability)

Trust response: Resettlement target

12.5%	0%	25% reduction in the number of long stay patients in learning disability institutes

	Year 1	Year2	Year3
Belfast Trust Allocation	**£0.625m**	**£0.m**	**£0.913m**
No:	**5 children** **6 adults**	**0**	**11 adults**

The Total allocation for resettlement for the Belfast Trust over the CSR period is £1.538 m.

The current PTL list for Muckamore Abbey Hospital stands at 209 patients. The number of Belfast residents in the PTL is 88, 25% of which is 22 patients.

As in the previous year the Belfast Trust will work closely with the SE Trust and EHSSB to ensure the resettlement target for the two Trusts is met in collaboration and taking account of the choices and needs of those being resettled.

As the children on the Muckamore Abbey site are expected to move into the community towards the end of 08 / 09, the Trust's first call in 2008/09 in respect of resettlement will be for the three people whose resettlement plans have been developing this year. They were identified as possible "reserves" for the 07/08 targets. We believe that each of them will have a resettlement cost of at least £120k.

There will be 7 Belfast children requiring resettlement packages. All but one of these will be well under 18 years when they leave. The Trust wishes to highlight the fact that the money to fund their packages will therefore be lost to adult learning disability services. In addition these children will create a future cost pressure within adult services when they become 18. One will be a young adult and the Trust would hope to plan for him within adult services.

This situation is further complicated by the shortfall in revenue funding for the Iveagh Community Treatment unit for children with a Learning Disability.

The financial pressures of the above combined factors are likely to extend into the Trust's 2009/10 allocations

Resettlement costs continue to increase year on year as a result of the increasing complexity of need of those people being considered for resettlement and so the Trust would expect to agree uplift in the funding of packages in year three period

Trust response: Community based support

	Year 1	Year2	Year3
Belfast Trust Allocation	**£0m**	**£0.444m**	**£0m**
Speech and Language Therapy	**£0m**	**£0.045m**	**£0.066m**

The Belfast Trust is committed to extending the range of its community alternatives to hospital admission by the provision of specialist treatment services.

However whilst these developments have been partially funded for children with Learning Disability in terms of the development of the Iveagh community treatment unit and associated residential units, no specific funding has been made available to adult services.

The Trust continues to negotiate with the Eastern Board towards a position that the Trust can re invest any efficiencies it can make in HWIP to developing further elements of specialist community treatment.

Under the mantle of the Trust's mental Health & Learning Disability Modernisation Board the Trust will be developing a strategic plan to reduce the number of inpatient beds, increase the capacity of community infrastructure and supports and enhance the development of community treatment services.

The Trust will be considering the development a Multi-disciplinary treatment team and the development of forensic, Mental Health, epilepsy, Dementia, complex health and addictions services as well as the need for community treatment beds.

Trust response: Autism services improved diagnosis and interventions

	Year 1	Year2	Year3
Belfast Trust Allocation	**£0.203m**	**£0.00m**	**£0.241m**

Total allocation £0.444m

The population split would indicate that one third of this resource should be for children and two thirds for adults. The Trust would propose one of two options for the use of this funding. –

a) The total resource is used to support cross programme work to co-ordinate services and to involve families and other stakeholders in planning, developing and re-engineering services. Work completed previously indicated a need for an individual to undertake this,

Or

b) Two thirds of the funding is used to increase the capacity in community teams by creating three psychology / speech and language therapy assistant posts.

Plans should provide sufficient detail (including milestones) to facilitate monitoring by the Department of progress with proposed service developments and associated resource utilisation. This should clearly indicate the scale of resources per annum being invested to achieve this target, analysed by commissioner.

PRIORITY AREA 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY

Ref : BT 41

PSA 7.2: By March 2011, improve access to physical / sensory disability care by providing an additional 200 respite packages a year

1. Related Ministerial target:

    - Trusts should ensure that, by March 2009, access to physical/sensory disability care is improved by providing an additional 50 respite packages a year (increasing to 200 by March 2011).

Trust response:

March 2009	March 2010	March 2011
12 additional respite packages	4 additional respite packages	. 29 additional respite packages

- The Belfast Trust share of the regional target identified within the EHSSB HWIP is outlined in the table above.

- The BHSCT will improve access to Physical and Sensory Disability care through working directly with individuals and/or their carers to identify daytime opportunities in their own communities, appropriate to their respite needs and in accordance with their wishes. Residential respite will also be provided. Due to demand for respite services BHSCT is confident of meeting this target.

- The Trust has invested in additional staffing in the Care Management Team and appointed a Care Manager Co-ordinator which has enhanced the capacity and effectiveness of the team to respond to respite needs of clients.

PRIORITY AREA 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY

Ref : BT 42
PSA 7.3: By March 2011, ensure a 13 week maximum waiting time for specialised wheelchairs

1. Related Ministerial target:

    - Trusts should ensure that, by March 2009, 35 additional specialised seats/wheelchairs have been provided compared to the position at March 2008.

Trust response:

- The current waiting time for referral to delivery of equipment is approximately 52 weeks. This timescale incorporates Referral to assessment appointment, then prescription report to Commissioner for approval, ordering/receipt of equipment, then delivery appointment.

- The BHSCT has been involved in the Regional Review of wheelchairs and as part of this review has worked with the Department and SHSSB pilot scheme in the application of the 'Lean Methodology' exercise which has assisted in the identification of contributing factors and strategies to reduce current waiting times through redesigning and improving systems within the wheelchair service.

- The Trust has invested in employing one additional WTE Occupational Therapist wheelchair specialist.

Key Milestones in the 2008-2009 Year are:

- The Trust is hosting a two day Rapid Improvement Event Workshop on 6th and 7th May.

- The Trust is establishing a Working Group, commencing on 12th May, which aims to meet the 2011 target.

The 3 year milestones are outlined in the table below.

March 2009	March 2010	March 2011
Maximum 45 week waiting time	Maximum 26 week waiting time	Maximum 13 week waiting time for specialist wheelchairs

While the BHSCT recognises that the timely provision of specialised wheelchairs is important and key to the attainment of the above waiting targets and is committed to attaining this target, our capacity to attain it is dependent on the presentation of this level of need in the 2008-09 year. Hence we will commit to purchasing up to 7 of these wheelchairs in line with the demand, in the course of the year. The cost of this investment will be in the region of £25K, dependant on the specific design of each chair. (EHSSB HWIP identified 8 in 2008/09 and a further 14 in 2010/11 for the Belfast Trust).

PRIORITY AREA 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY

Ref : BT 43

PSA 7.4: By March 2011, improve access to learning disability care by providing an additional 200 respite packages a year

1. Related Ministerial target

    - Trusts should ensure that, by March 2009, access to learning disability services is improved through the provision of an additional 50 respite packages a year (increasing to 200 a year by March 2011).

Trust response :

March 2009	March 2010	March 2011
To be confirmed	0	45 additional respite packages provided

	Year 1	Year2	Year3
Belfast Trust Allocation	**£0.585m**	**£0.00m**	**£0.767m**

Total allocation £1.352m

The Trust is in the process of developing its own proposals to use the available resource in a way that addresses the greatest needs of the citizens of Belfast.

The Trust has plans to incrementally increase the available overnight residential respite places available to its population over the three- year period.

The Trust is reviewing its existing Residential respite care stock in order to improve accessibility and dignity for all.

The Trust is looking into ways of extending Non-residential respite services such as Caring Breaks across the city of Belfast.

PRIORITY AREA 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY

Ref : BT 44

1. Ministerial target (no related PSA target)

  - Discharge: Trusts should ensure that, by March 2009, 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days. In exceptional circumstances where patients are delayed in hospital beyond 90 days the Department will expect the relevant rust to have robust plans in place to work towards the provision of appropriate care for the patient in a non hospital setting, with that care plan beginning not later than 12 months after the original discharge date.

Trust response:

The Trust has already implemented discharge-planning protocols, which ensure the commencement of discharge planning from the date of admission.

The Trust has set up a system to monitor discharge waiting times to ensure that 75% are discharged within 7 days.

The Trust has carried out research over the last year that highlighted the numbers of discharges where difficulties are experienced when discharging patients with learning Disability and Complex needs, particularly when it is not possible to discharge to their admission address.

In some instances of this nature the target of 100% discharge within 90days will be difficult if not impossible to meet. These are circumstances where the individual assessed as medically fit for discharge requires a bespoke community package of care that may require the development of specialist housing.

PRIORITY AREA 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY

Ref : BT 45

1. Ministerial target (no related PSA target)

    - Trusts should ensure that, by March 2009, all children are resettled from hospital to appropriate places in the community.

Trust response:

The Trust is taking forward the following actions in response to the target:

- The individual children involved have been identified and the process of detailed holistic care planning and matching of children to existing and proposed community facilities is underway. There are seven children/young people involved.

- The Trust is finalising a business case for two, four bedded community units and a two bed extension to Willow Lodge (July 2008). The plans include:

    - A four bedded home to provide long term care/shared care for children currently in Muckamore,
    - A four bedded respite unit to support families and help prevent avoidable hospital admissions (Muckamore is currently used for respite),
    - Willow Lodge is currently a two bedded children's home providing one permanent place and two shared care places for 5 – 19 year olds with a severe learning disability and challenging behaviour. The additional two beds will be an option for the Muckamore children.

- The Trust has an established Muckamore Resettlement Group which co-ordinates all the resettlement projects. For children this includes those outlined in the business case (above) and the Iveagh Project. It will be an eight bedded unit for the assessment, treatment and rehabilitation of children. This will replace the provision in Muckamore for children. It is planned to be open in September 2009.

- The Muckamore Resettlement Group will also oversee the prioritisation and the allocation of funding for the children and if necessary bid to the EHSSB for additional funding above the 125K per child.

- The Trust with collaboration between Children's and Adult Learning Disability services has plans to move two young people from Willow Lodge to another community setting. Funding has been agreed with the EHSSB and it is planned that the children should have moved by the end of September 2008. This will provide immediate options for the relocation of some of the Muckamore children.

- The Trust is looking at a number of possible options for a suitable interim facility for the children whose permanent community arrangements are not in place by

March. In conjunction with this the Trust will begin to recruit staff and introduce them to the children in hospital.

- The Trust will renovate the property when it is confirmed to ensure it is fit for purpose.

- The Trust already has a user (parental) involvement in the Resettlement Programme and the Iveagh Project. Others will be identified and involved in the new projects and all the arrangements regarding the children. There will also be engagement with local communities and detailed parental involvement regarding individual care plans.

The milestones detailed above are not necessarily sequential.

PRIORITY AREA 9: IMPROVING PRODUCTIVITY

Ref : BT 46
PSA 9.1: Improve productivity, efficiency and effectiveness in the HSC as measured by such indicators as:

- **Patient throughput per bed**
- **Ratio of day cases to inpatient cases**
- **Use of more effective drug therapies**
- **Greater use of generic drugs**
- **Improved procurement practice**
- **Proportion of people with community care needs supported at home**
- **Staff absenteeism**

1. Related Ministerial targets:
   - Hospital productivity: each Trust will be expected to achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.
   - Cancelled operations: Trusts should ensure that, by March 2009, no more than 2% of operations are cancelled for non-clinical reasons on the day of admission or later.
   - Each Trust should ensure that, during 2008-09, levels of absenteeism are reduced to 10% below average 2006-07 levels in its legacy Trusts, working towards a regional target of 5.2% in 2010-11.
   - Each Trust should ensure that, by March 2009, the number of admin and clerical staff as a proportion of all Trust staff is reduced to (target to be confirmed)
   - Each Trust should ensure that, by March 2009, its ratio of qualified to unqualified nurses is increased (target to be confirmed)
   - Each Trust should ensure that, by March 2009, its ratio of qualified to unqualified AHPs is increased to (target to be confirmed)
   - Each Trust should ensure that, during 2008-09, staff turnover (excluding admin and clerical staff) is reduced by 5% compared to the position in 2007-08.

Trust response: Productivity

Section 4 of the TDP sets out the Trust plans to achieve the required efficiency savings over the next 3 years. As part of this process the Trust plans to deliver productivity improvements in a range of areas utilising benchmarking data from agreed peer group analysis. The Trust will be focusing on improvements in defined specialties in areas such as:

- Length of stay
- Pre-operative length of stay
- Daycase rates
- Outpatient new to review ratios
- Reductions in DNA rates

Performance in the above areas will be monitored on a continual basis.

Trust response : Cancelled Operations

The Trust is waiting on the definition guidance from the Service Delivery Unit to enable detailed data reports to be provided. The Trust will be reviewing performance at site and speciality level and take actions necessary in relation to the achievement of the target.

Trust response: Absence

Absence

The PfA Target relating to attendance management is:

- Each Trust should ensure that, during 2008-09, levels of absenteeism are reduced to 10% below average 2006-07 levels in its legacy Trusts, working towards a regional target of 5.2% in 2010-11.
- The Belfast Trust target for 2008/09 is being validated at present pending confirmation of the methodology to be used by Trusts to calculate absence figures. (DHSSPS have been requested to provide clarification).

In response to the target the Trust is and will be:

- working with other HSC employers and Trade Unions to develop a new regional Attendance Management policy. It is planned that this will be agreed and implemented from 1 September 2008.
- developing a set of internal targets for Service and Corporate aimed at securing a 10% reduction on absence levels in 2008/09.
- developing a set of performance management reports which will enable specific areas and individuals with poor attendance patters to be targeted by Management.
- developing attendance management forums within each Service and Corporate Group area to allow Human Resources, Occupational Health and Service Managers to come together specific cases and to agree future action and monitoring.
- developing training programmes and a toolkit for managers to enable more consistent and effective attendance management at both team and individual level.

Trust response: Admin / Nursing / AHP ratios

The improving productivity skill mix and staff ratios have been incorporated into the Trust's response to the C.S.R. The Trust is waiting on clarification on the targets to be achieved in 2008/09. Each of the areas has been allocated to a project workstream.

Specific comments are provided below:

- Ratio of Admin staff to all staff (excluding bank staff). All recruitment requisitions in the Trust are scrutinised at Service Group Director or Co-Director level before forwarding to the HR Department for recruitment to proceed. The Trust would comment however that at present we are relying on a large number of admin agency and temporary staff and in order to provide some stability it is likely that a number posts will be filled on a permanent basis (increasing rather than reducing numbers). Overall numbers of admin staff will continue to be monitored to ensure that relevant control is maintained.

- Skill mix ratios.

    - A project with nurse management has now commenced in the Trust with a review of all acute, adult nurse staffing. This review has covered over 100 ward areas and provides the basis upon how skill mix adjustments in this significant area can be made. By way of example, it is not possible to introduce significant numbers of untrained staff into Intensive Care Areas therefore the ratios in more general areas have had to be adjusted. Data collection in Specialist Nursing has commenced. Starting in May, Service Group Directors will receive monthly monitoring reports. The Trust has appointed a specific team of HR staff who will work with managers to deliver the changes.

    - Within AHP services the Trust faces a significant challenge. Many of the services provided by the Trust do not easily lend themselves to skill mix adjustments, e.g. Therapeutic Radiology. To seek to address this project the Trust has identified the current skill mix ratios and is presently developing targets for each profession.

Trust response : Staff Turnover

Staff turnover 2007/09 = 10.67% (excluding admin and clerical and doctors in training).

With regard to the target of a 5% reduction for 2o08/09, the Trust would highlight that this is at odds with the strategic direction associated with the CSR savings that the Trust is required to achieve over the next 3 years. All staff will be impacted by CSR and the Trust will be seeking to reduce the number of posts within the organisation in a managed way while maintaining services.

The Trust will therefore require an increase in staff turnover to facilitate the service changes required to achieve the CSR saving and re-deployment of staff where necessary.

The Trust therefore cannot accept any turnover target as a appropriate indicator in the circumstances presented by the CSR. A high turnover rate is the main method by which the Trust hopes to achieve the workforce reductions required.

PRIORITY AREA 10: MODERNISING THE INFRASTRUCTURE

Ref : BT 47
PSA 10.1: Ensure the timely modernisation of the HSC infrastructure to include:

- **By 2009, Downe Enhanced Local Hospital due to be completed**
- **By 2010, Ulster Hospital A due to be completed**
- **By 2011, first stage of Altnagelvin Phase 3 due to be completed**
- **By 2011, Royal Phase 2B due to be completed**
- **By 2008, Craigavon Crisis Resource Centre due to be completed**
- **By 2009, Castlereagh Community Treatment and Care Centre due to be completed**
- **By 2010, Portadown Health & Care Centre due to be completed**
- **By 2010, Gransha Mental Health Crisis Centre due to be completed**
- **By 2010, Regional Adolescent Psychiatric Unit & Child and Family Centre due to be completed**
- **By 2011, Health & Wellbeing Centres Phase 2 due to be completed**
- **By 2011, delivery of PACS to be completed**

Trust response:

The Capital Redevelopment Team is currently leading on the major redevelopment projects across the Belfast Trust that will:

- enhance the delivery of patient and client services
- ensure safer, better quality services through modernising of the Trust's infrastructure.

The Trust will take forward relevant capital schemes within agreed timescales. Details of major capital schemes over the period of the plan are outlined below eg.

The Critical Care building, The Royal Hospitals (phase 2B)

Advance and enabling works started on site. Main contract programmed to commence Sept 08.
Completion date Nov 2011.
Capital cost of project £100 K

Wellbeing & Treatment Centres

- Castlereagh Wellbeing and Treatment Centre

Contractor on site and on programme. Centre due for handover Sept 08.
Commissioned and operational by Nov 09.
Completion date Sept 09
Capital cost of project £ 4.2m

- Shankhill & Beechhall Wellbeing and Treatment Centres

GMP to be agreed by July 08 contractor due on site Sept 08
Completion date November2010
Total capital cost of project £ 29 million

Conicar project at Iveagh

An 8 bedded Assessment and Treatment unit for children with learning disabilities. This project is part of the ministerial priority for the resettlement of children from Muckamore abbey
GMP to be agreed by July 08. Enabling works to commence June 09
Contractor due on site Sept 08
Completion date Sept 09
Capital cost of project £ 3.6

Adolescent Psychiatric Unit (18 beds)and Child and Family unit (15 beds)are designed to provide two distinct units with shared administrative and support services facilities on the Forster Green site
Preferred Bidder appointed for Adolescent unit. GMP to be agreed by May 08 contractor on site June 08. (pending planning permission)
Completion date Sept 09
Capital cost of project £5.7

Child & Family unit currently in design phase to be completed by
Completion date Dec 09
Capital cost of project £ 8.7

Muckamore Phase II, III, IV

Muckamore II is a 33 bedded unit for adults with learning disabilities
Contractor on site and on programme. Centre due for handover July 08.
Commissioned and operational by Sept 08
Completion date July 08
Total capital cost of project £ 6.7
Muckamore III
Refurbishment and extension to current day centre for clients with learning disabilities based in Muckamore Abbey
Contractor on site and on programme. Centre due for handover Feb09.
Commissioned and operational by April09
Completion date Feb09
Capital cost of project £3.2
Muckamore IV
Refurbishment of current administration and support services facilities and improvements to site infrastructure
Design stage to be completed June 08 contractor on site August 08
Completion date Aug08
Capital cost of project £1.2

Victoria Pharmaceuticals

A pharmacy manufacturing unit that produces a number of products that is not commercially available
Contractor appointed May 08 contractor onsite Aug 08

Completion date   Sept 2009
Capital cost of project £ 6.5 million

Decant Unit for Neurology Patients

A decant building to allow the transfer of patients from Forster Green to Musgrave Park
Completion date   April 09
Capital cost of project £1.9

Enler

A Multiagency regeneration project in Ballybeen Estate consisting of an older persons day centre, lesiure facilities, community spaces and shops. The project is funded by DSD, the Trust, IFI, & NIHE
Completion date   Dec09
Capital cost of project £ 2.2 million

Ref : BT 48
PRIORITY AREA 10: MODERNISING THE INFRASTRUCTURE

1. Ministerial target (no related PSA target):

- Trusts should ensure that, by December 2008, in line with the schedule agreed with the Department, they dispose of surplus assets to the value of at least £55m.

Trust response:

In order to achieve the regional target of £55m, the Belfast Trust, in agreement with DHSS is taking the following action.

The Trust, in partnership with the Department, SIB and Land and Property Services**,** have tendered for, recruited and engaged a consultancy firm to prepare Belvoir Park Hospital for disposal on the open market. In 2007 this complex site, including listed buildings, an ancient rath, Trust laundry and temporary location for an integrated school,

In addition to this disposal the Trust Board has agreed to the sale of the following properties.

- McCartney House
- 92 University avenue
- 98/98a Templemore avenue
- 53-57 Davaar Avenue
- Land at Whiterock Health Centre
- Land at BCH gate

The realisation of these assets is however subject to the current economic climate which is out with the Trust's control

The Director with responsibility for Capital Planning reports on the progress of assets disposal twice yearly through the Trust's accountability review process. The Co Director for Capital Planning reports six weekly on progress to the Strategic Investment Group.

3. RESOURCE UTILISATION

3.1 Income and Expenditure and Capital Investment

3.1.1 Introduction

Trusts are held directly accountable by the Department for the effective deployment of all the resources at their disposal. This includes income, expenditure, capital, workforce and estate. The Department's *Priorities for Action* circular requires each Trust to produce a Trust Delivery Plan reflecting the summation of the service and budget agreements reached with Commissioners, capital investment plans and relevant management objectives.

This section provides details of the financial plan for the Belfast Trust for 2008/09. It sets out the strategic context and financial parameters within which the Trust is bound to operate for 2008/09. The income and expenditure positions are summarised and key areas of risk are highlighted.

3.1.2 Financial Context

The allocation letter from DHSS&PS was issued to the HPSS on 15 February 2008 and set out the formal outcome of the Comprehensive Spending Review 2007. The recurrent sum available to Boards for HPSS expenditure in 2008/09 to 2010/11 was reported as £2,769m, £2,809m and £2,893m although these amounts have been reduced since the allocation letter to reflect a reduction in the amount which the DHSS&PS feel is required in respect of the new superannuation rate.

In overall terms this settlement amounts to an increase, year on year, of 4.4% (including a baseline adjustment to fund an increase in the employer's contribution rate to the HPSS Superannuation Scheme from 7% to 15.7%), 1.6% and 2.9% and £355 million from 2007-08 to 2010-11. In particular it reflects:

- the removal of resource releasing efficiency savings equating to 3.0% per annum (£70.8m/£158m/£263m);
- new service developmental resources totalling £56m, £86m and £166m in 2008-09, 2009-10 and 2010-11 respectively.

As in previous years the allocation letter emphasises the strict requirement for organisations to contain expenditure within the annual expenditure limit for each financial year.

It is clear from the allocation letter that the Department expects Trusts to continue to focus their efforts on containing costs within the income levels established at the beginning of the year. If deficits develop, early contact must be made with Commissioners and the Department and contingency arrangements should be put in place to address the matter. The Department has also re-emphasised the need for compliance with the principles set out in circular HSS(F)29/2000 'Promoting Financial Stability within HPSS Organisations'. In particular, no service development should be initiated without the prior securing of recurrent funding from Commissioners.

As in previous years there is an expectation at Department level that the Service will itself manage the inevitable (and inescapable) cost pressures which emerge, through improved efficiency or other measures, within the resources currently available. Whilst the Trust will continue to pursue any unnecessary increase in costs, it would appear to be unrealistic in the current financial climate to expect that all cost pressures can be managed without additional resources or a detrimental impact on patient care.

Limited additional funding has been made available in 2008/09 to meet the costs of existing commitments and unavoidable pressures including the revenue costs of capital schemes, expanding renal capacity, the costs of new nurse mentoring schemes, the increased cost associated with children with complex needs and integrated medicines management. New monies have also been provided for blood safety and for hospital and community acquired infection.

Investment has been provided for areas which have historically been less well provided for such as mental health and learning disability and to improve services for people with chronic diseases. In the acute sector there is additional investment in cancer and cardiovascular services and, as in the last few years, funding has been earmarked for a range of specialist drugs.

In the Eastern Board's financial plan, they have identified funding to support the development of further intermediate care services to reflect demographic issues and to continue the programme of reform and modernisation commenced in the EHSSB locality in 2005/06.

Although actual amounts have not been indicated, funding has been signalled for access targets including A&E, fractures and cancer targets; further work is required to identify the costs involved and to determine whether available funding will be sufficient.

Several funding streams have been removed from the HPSS recurrent baseline allocation and presented as separate ring-fenced allocations, notably funding for new pay contracts, EPF/RRI revenue consequences and Health Development expenditure. Ring fencing or earmarking allocations means that where resources allocated for a particular purpose are not required in full for that purpose, they must be returned to DHSS&PS for potential redistribution. However, in a change from previous years, Boards now have flexibility to redeploy resources to similar areas of expenditure where resources are required to meet existing outcome targets.

3.1.3 Capitation

Both equity and clinical and social care considerations demand that HPSS resources be distributed in line with the population's need for services. To that end the Department employs the Weighted Capitation Formula to take account of such relevant factors as population size, the age/sex profile of each Board area and the level of additional, largely deprivation-related, need.

Actual funding allocations should accord with the Formula's findings, but this has not proved feasible because of the potential consequences of sudden changes from historic patterns of spending. The latest projections increase the divergence from equity and the funding gap is projected to grow by around £3m-£5m a year (at current prices) for the foreseeable future. Capitation adjustments have therefore been made to reduce the three smaller Boards to the same percentage gap from their target shares by 2010/11 and bring the EHSSB to within 1% of the distance from its target share; the impact of the EHSSB's 'capitation skew' on the Belfast Trust is £21m. In order to help facilitate this transition, non-recurrent managing reform monies have been provided on a reducing balance basis by the EHSSB. This means that the capitation withdrawal is covered in full in 2008/09 but the Trust and its commissioners will have to work together to ensure that further financial pressures are not levied on the Trust when the bridging reduces after 2008/09.

Recent work by the HSC had also identified a number of areas where Trusts were failing to accurately attribute activity and costs to Commissioners and the allocation letter provides a basis for correcting this for 2008-09 and beyond. The net effect is a baseline reduction of £6m in the Eastern Board and £1m in the Western Board with resources transferred to the Northern and Southern Boards of £6m and £1m respectively. The adjustment is to be cost neutral for providers in 2008/09.

3.1.4 Trust Financial Position 2008/09

The Department's planning assumption is that it will have to live within its 2008/09 allocation and its expectation is that Boards and Trusts will take a similar approach. The 2008/09 financial plan for the Belfast Trust would therefore be expected to achieve a breakeven position.

The Trust has produced a consolidated income and expenditure position, based on Commissioner Service and Budget Agreements (SBAs), assumed income from Commissioners not yet confirmed, and anticipated income from DHSS&PS and other sources, against expected recurrent expenditure for the Trust in 2008/09.

The Belfast Trust had identified an underlying deficit of £48m in 2007/08. As a result of robust financial management arrangements and tight workforce controls, the Trust was able to address around half of this deficit in 2007/08, most of which was delivered from non-recurrent vacancies. Non-recurrent income from Commissioners and DHSS&PS enabled the Trust to address the remaining gap and a balanced financial position was achieved in 2007/08.

Current Commissioner SBAs would suggest that around £17m of the 2007/08 opening deficit has now been addressed which should result in an underlying deficit of approximately £31m. However, significant shortfalls in funding in relation to the increased cost of superannuation and the loss of investment income in the main mean that the projected deficit for 2008/09 is in the region of £36m, prior to the application of CSR efficiency targets.

A summary of the initial financial position is shown in Table 3.1 below.

Table 3.1: Summary Initial Income and Expenditure Position 2008/09

	2008/09 Expected Position £'m
Total Income	***988***
Pay expenditure	*645*
Non-pay expenditure	*379*
Total operating expenditure	***1,024***
Operational Surplus/(deficit)	***(36)***

In arriving at this position, the Trust has assumed income of £61m in addition to amounts formally approved and confirmed for 2008/09. This includes income which has historically been awarded annually on a non-recurrent basis such as SUMDE and R&D subvention monies, development/investment income which should be confirmed pending HWIP approval, and income received in 2007/08 which is being held centrally but which the Trust believes will be released by DHSS&PS during 2008/09 such as red drug and junior doctor funding.

Other income assumptions made are that excess pay awards (above the 2.3% funded) will be covered in full and that costs incurred to meet access targets will be fully addressed.

A breakdown of the current income shortfall along with an assessment of the associated risk of each item is provided in Table 3.2 below.

Table 3.2: Risk Assessment of Projected Income Deficit 2008/09

	High £'m	***Medium £'m***	***Low £'m***	***Total £'m***
Pay Reform	*10*	*2*	*1*	*13*
Superannuation	*3*			*3*
Cost Pressures	*6*	*2*	*1*	*9*
EHSSB Re-engineering 2007/08	*11*			*11*
Potential Shortfall	***30***	***4***	***2***	***36***

The breakdown of the anticipated income deficit by Commissioner is shown in Table 3.3 below.

Table 3.3: Anticipated Income Deficit by Source 2008/09

		Income Budget £'m	***Expected Income £'m***	***Expected Deficit £'m***
Boards	*EHSSB*	*666*	*636*	*30*
	NHSSB	*127*	*125*	*2*
	SHSSB	*67*	*65*	*2*
	WHSSB	*41*	*39*	*2*
Other HPSS		*3*	*3*	*0*
DHSS&PS	*R&D/RRG*	*11*	*11*	*0*
	SUMDE	*31*	*31*	*0*
	Other	*6*	*6*	*0*
NIMDTA		*17*	*17*	*0*
Other Income		*55*	*55*	*0*
TOTAL		***1,024***	***988***	***36***

3.1.5 Commissioner Income Positions 2008/09

There have been ongoing negotiations with Commissioners over the past year but significant shortfalls against anticipated expenditure remain. The positions as summarised in Table 3.3 above reflect the income included in Commissioner Service and Budget Agreements (SBAs) and revenue funding identified for service developments included within HWIPs. In addition to notified SBA values, as discussed in section 3.1.4 above, additional income has been assumed in relation to a number of 'low risk' elements.

EHSSB Position

The EHSSB deficit comprises pay reform pressures of £9.3m, superannuation of £3m, a 2007/08 reengineering shortfall of £11.3m and other cost pressures totalling £6.4m.

Pay Pressures and Maintaining Existing services (MES)

A substantial element of the EHSSB's opening 2007/08 shortfall remains. The main deficits are attributable to consultants contract, AFC, junior doctors and superannuation which are discussed in more detail in sections 3.1.6 and 3.1.7 below. There are also significant cost pressure deficits in relation to energy, rates, water and waste (£1.7m), drugs (£0.8m), high cost procedures (£0.7m), investment income (£.5m) and a range of other cost pressures (£2.7m). The latter includes £0.3m in respect of social care procurement savings which are expected to be achieved through re-negotiation of nursing home prices. This is likely to depend on the Trust's ability to source alternative homes and is therefore expected to be difficult to achieve in 2008/09; non-recurrent support was provided in 2007/08 to address this.

2007/08 Re-engineering Retraction (Capitation/Appleby Related)

Due to the unavailability of maintaining existing services funding and the top-slicing of an additional £12m to the three smaller Boards in 2007/08 to close capitation differentials, the EHSSB made a strategic decision to re-profile their funding, removing funding from the acute sector in order to fund a number of local strategic investment priorities. This resulted in a baseline funding reduction of £11.4m across the four acute hospitals in Belfast.

The Eastern Board used the apparent Trust cost differentials identified by both the Department and the Appleby report as a basis for targeting most of the reduction across the Trusts.

This strategy was identified in the 2006/07 EHSSB Financial Plan but the effective date for the majority of the recurrent reduction was 1 April 2007 as non recurrent monies were made available in 2006/07. No funding was provided in 2007/08 and the reduction is rolled forward into the 2008/09 EHSSB position.

In addition to the above, capitation related baseline reductions were also applied by EHSSB in 2007/08 to areas where they believed that EHSSB residents appeared to use in excess of their equitable share of NI services. This resulted in a total reduction of £0.9m across three of the four acute Belfast hospitals.

There had been no prior engagement with the Belfast Trust to agree a mechanism for reducing demand to generate the required cost reductions.

If a further financial deficit is to be avoided it is imperative that the material capitation loss to the EHSSB and the Trust referred to in paragraph 3.1.3 is dealt with differently and early indications would suggest that this is the case. Whilst the financial impact is neutral in 2008/09 due to the availability of bridging monies, work has commenced in the acute arena to identify specific areas where the EHSSB feel they are utilising excess levels of service given the size of their population. Once identified the Trust will fully engage with the Board to assist them in their development of a demand management strategy in these areas.

Retraction of Activity-related Income

In 2007/08, EHSSB withdrew £10.1m from the Royal Hospitals and Mater Trust baselines; a further £0.4m has been withdrawn from the Belfast Trust baseline in relation to the Green Park legacy Trust in 2008/09. The Board's rationale for these reductions is that historical activity levels for EHSSB had not been achieved by those legacy Trusts and the amounts withdrawn represented the full cost of the perceived activity shortfalls. The £10.1m shortfall was funded non-recurrently in 2007/08.

In its 2008/09 SBA, EHSSB has provided recurrent funding of £2m to reflect case mix changes and £3.6m in lieu of activity increases towards the £10.5m shortfall. Furthermore, recent work by the HSC identified a number of areas where Trusts failed to accurately attribute activity and costs to Commissioners and the allocation letter provides a basis for correcting this for 2008-09 and beyond. The net effect is a baseline reduction of £6m in the Eastern Board and £1m in the Western Board with resources transferred to the Northern and Southern Boards of £6m and £1m respectively. As a result of this, £4.9m has been provided by the Northern and Southern Trusts in 2008/09.

The £10.5m shortfall has therefore been addressed in 2008/09.

Other Commissioning Boards

In addition to pay reform and superannuation shortfalls, the projected deficits for NHSSB, SHSSB and WHSSB are attributable in the main to unfunded cost pressures including energy, rates and water (£0.6m), drugs and high cost procedures (£0.7m), investment income (£0.3m), revenue consequences of capital schemes (£0.3m) and other pressures (£0.4m).

3.1.6 Pay Reform Issues

Despite additional funding in 2008/09 for consultants contract and AFC (though not at the level provided non-recurrently in 2007/08) and a revision of AFC estimates by the Trust, significant shortfalls remain in relation to pay reform issues in 2008/09. Table 3.4 below shows the likely shortfall position in relation to junior doctors, consultants contract and Agenda for Change. In arriving at this position, junior doctor funding of £1.3m has been assumed from ISG in line with the 2007/08 allocation. Whilst it has been confirmed that funding is being held centrally by ISG for this purposes the Trust's actual allocation has not yet been communicated.

Table 3.4: Pay Reform and Modernisation Position 2008/09

	Income Budget 2008/09 £'m	***Anticipated Income 2008/09 £'m***	***Expected Deficit £'m***
Agenda for Change	*32.92*	*23.23*	*9.69*
Consultant Contract	*14.24*	*13.11*	*1.13*
Junior Doctors	*10.92*	*8.96*	*1.96*
Total	***58.09***	***45.31***	***12.78***

This anticipated deficit represents a reduction of almost £7m against the 2007/08 opening shortfall of £19.6m.

The Trust continues to engage with Commissioning and Departmental colleagues with regard to the significant pressures expected as a consequence of the pay reform agenda but it is unlikely that further assistance will be provided in 2008/09. Further information on each issue is detailed in the paragraphs below.

Consultant Contract

As a result of additional funding this year, the basic pay element of the consultant contract has now been funded in full. The additional funding has also contributed £0.5m towards the on-call and APA deficits of £0.7m and £0.9m respectively.

On-call allocations were based on assumed average on-call intensity and frequency rates across all English Trusts but no adjustments were made to individual Trust's allocation to reflect the regional and complex nature of the services performed which would have skewed funding in favour of the Royal Hospitals and the Belfast City Hospital Trust. As a result, the on-call problem is perceived to be greater in the Belfast Trust than other Trusts in Northern Ireland. The Trust is looking at on-call with a view to exploiting the opportunities provided by its new structure but it is unlikely that substantial savings will be made, particularly in the short term.

The final element of the shortfall is additional programmed activities (APAs). Whilst the Trust will endeavour to reduce its total to the number of APAs funded, this remains a significant risk given the challenging elective care reform agenda, and a deficit is anticipated in 2008/09.

Agenda for Change (AFC)

The anticipated shortfall in respect of AFC in 2008/09, determined largely on the outcomes of the regional financial model, is likely to be almost £10m. In arriving at this position adjustments have already been made to the model to reflect staff turnover and reduced annual leave cover made possible by service redesign. Nevertheless, despite the best efforts of the Trust to accommodate an average increase of 4 days annual leave per person and a substantial reduction in total contracted hours, it is clear that it has not been possible to implement AFC within the current financial envelope.

Junior Doctor Compliance

The expected shortfall on junior doctors is £2m, based on anticipated spend in this year compared with funding provided. This assumes that £1.3m additional funding will be provided in-year by ISG who are holding funds centrally, in line with the level of funding allocated non-recurrently to the Trust during 2007/08.

3.1.7 Superannuation

The rate of superannuation payable by employers increased from 7% to 15.7% with effect from 1 April 2008 and Trusts were advised that this would be funded in full. However, funding has been provided on the basis of actual payroll costs in 2006/07 adjusted to take account of inflation, AFC and growth. As a result, funding has not been awarded on £24m of funded posts covered by agency staff in 2007/08 or on the £22m of funded posts held vacant non-recurrently in 2007/08 as part of the Trust's contingency plan to facilitate the achievement of breakeven. This equates to a shortfall of circa £3m.

An element of the superannuation allocation is non-recurrent and will be withdrawn as the Trust's CSR savings are achieved; in reality this means that CSR savings must be achieved at the new superannuation rate. In contrast, investment provided to facilitate the achievement of CSR efficiency savings has not been adjusted for the increase in superannuation which means that the investment is worth less in real terms than before.

3.1.8 Change in Finance Regime/Interest Receivable

Changes in the HSC finance regime in 2008/09 mean that Trusts will no longer be able retain the investment income earned as a result of the cash balances it held. Instead Trusts will draw down cash on a regular basis to meet liabilities as they fall due. The expected loss of investment income for the Belfast Trust is in the region of £2.8m. A £6m allocation has been provided regionally for this purpose of which the Belfast Trust share is £2.1m, resulting in an anticipated shortfall of £0.7m.

3.1.9 DHSS&PS Income 2008/09

Although no formal allocation has been received at this stage, the Trust has assumed no new DHSS&PS deficits will emerge in 2008/09.

The opening position for SUMDE income is the 2007/08 outturn uplifted by inflation, although it is assumed that the actual costs of SUMDE and joint appointments in 2008/09 will be met in full. The SUMDE income figure includes subvention funding of £2.5m and historic pay awards of £1.1m.

It is also assumed that R&D subvention monies of £4.5m will also be provided to the Trust from DHSS&PS as in previous years.

In terms of other DHSS&PS income it is assumed that red drugs funding of £1m will be provided to Boards for the Belfast Trust, that the costs of merit awards and junior doctor protection will be met in full and that the in-year costs of maintaining the Belvoir Park site prior to its closure will be funded.

In previous years, funding has been provided non-recurrently for district nursing/health visiting replacement staff and for personal social services training courses and it is assumed that this funding, expected to be in the region of £1.4m, will be available again in 2008/09.

3.1.10 CSR/Trust's Efficiency Programme

Stringent efficiency targets have been set for the Belfast Trust by the Department of Health, Social Services and Public Safety for the next three financial years, 2008/09 to 2010/11, as a consequence of the Government's 2007 Comprehensive Spending Review. The efficiency target for the Belfast Trust for each of the next three financial years is £26m, £57m and £93m, representing savings of 2.5%, 5.5% and 9% of the Trust's financial budget over the three year period.

In addition to the Trust having to deliver against this demanding CSR efficiency agenda it also has to address the £36m recurrent funding deficit, most of which was inherited from its six legacy organisations as discussed above. The collective effect of these financial issues on the Trust is a total deficit of £129m for the period to 2010/11 (£62m in 2008/09).

In order to address the major organisational reforms, resource utilisation and performance management imperatives necessary to deliver the CSR targets and the underlying deficit, the Trust has established the MORE programme (Maximising Outcomes, Resources and Efficiencies) which will be discussed in more detail in section 4 of the TDP. This programme is designed to address the strategic, clinical, operational and financial performance issues which will ultimately drive service improvement, productivity and efficiency.

The Trust's efficiency proposals have been categorised into three broad headings within the MORE programme as follows:-

- Workforce
- Non-pay Economies and Efficiencies
- Health and Social Care Process Improvements and Service Redesign.

Workforce

The main focus of the workforce initiatives is around productivity improvements and robust workforce management across all staff groups and service areas of the Trust.

NON-PAY ECONOMIES AND EFFICIENCIES

It is assumed that the Trust will receive approximately 40% of the efficiencies which are projected to be delivered from the regional procurement and pharmacy workstreams. The Trust anticipates savings of £4m, £7m and £11m over the three year period.

In addition, non-pay efficiency targets have been applied to each service and corporate group of ½%, 1% and 2% of non-pay funding over the three year period 2008/09 to 2010/11. Efficiencies in this category will centre around product and service standardisation across the Trust, the review and effective management of contracts, exploiting the Trust's enhanced purchasing power, the elimination of waste (particularly around energy, stock holding etc), and the increased use of recycling.

The Trust anticipates efficiencies of £2m, £4m and £8m, over the three year period 2008/09 to 2010/11.

HEALTH AND SOCIAL CARE PROCESS IMPROVEMENTS AND SERVICE REFORM

The third strand of the MORE programme focuses on service reform and modernisation. Under this strand the Trust and its Service Groups will fundamentally review the systems, processes, activities and resources that have traditionally been used to provide health and social care to its patients and clients. The Trust's approach is principally centred on thinking differently and taking new and innovative approaches to service delivery, particularly in the use of technology, thereby increasing efficiency and productivity, and maximising outcomes.

The MORE programme will concentrate on clinical activities that offer the greatest scope for improvement. In light of this the Trust has identified four overarching themes and organisational workstreams, within which a multiplicity of proposals and schemes will be programme and performance managed.

- Hospital/Institutional Process Reform
- Hospital/Community Interface Reform and Enhancement of Community Based Services
- Strategic Service Reform
- Impact of Technology

Further detail is provided on each of these themes in section 4 of the TDP.

A financial summary of the total savings anticipated through the MORE programme is provided below.

Table 3.5 – Summary of MORE Targets

MORE Efficiency Savings	**2008/09 £m**	**2009/10 £m**	**2010/11 £m**
Workforce	31.0	41.1	44.8
Non-pay	6.0	11.0	19.0
Service Group Initiatives: Process Improvement/Service Reform	7.0	30.0	59.0
TOTAL	**44.0**	**82.1**	**122.8**

A comprehensive risk assessment is currently being completed with regard to the MORE programme.

3.1.11 Other Financial Risks

In addition to the income deficits discussed above and the risks associated with achieving CSR efficiency targets , there are a number of other financial risks which may cause additional pressures for 2008/09.

There is a clear expectation at Ministerial level that the Service will manage cost pressures within existing resources through improved efficiency. Given the significant pressures which already exist within the HPSS it is extremely unlikely that this will be deliverable without an impact on services. Significant pressures are expected in goods and services in areas such as water, waste and energy in line where prices have and continue to rise far above the cost of inflation.

Expenditure on high cost drugs and expenditure such as cardiology implants increased again in 2007/08 and is expected to rise further in 2008/09 and beyond. The Trust will work closely with Commissioners to manage expenditure to funded levels where possible, or to identify at an early stage where financial pressure is appearing and agree what action the Commission would wish the Trust to take if additional resources are not available.

In 2007/08 the Trust incurred a significant deficit in children's services particularly in relation to article payments and boarded out services. No deficit has been assumed for 2008/09 but this assumes that spend will fall substantially or that Boards will cover the specific costs incurred.

Based on current allocations for 2008/09, there will be a relatively small shortfall in funding in respect of the revenue costs of capital schemes and this will probably be covered from slippage. However, the shortfall is projected to rise significantly to well above £1m by 2010/11 based on current allocations, much of which falls to EHSSB. Additional funding has been earmarked for this issue by EHSSB and the Trust is currently engaging with its commissioner colleagues to prioritise schemes and agree the allocation of this funding across EHSSB Trusts.

Funding has been provided in Board SBAs for nurse mentoring and for the new pay arrangements for staff grades and associated specialists. It has been assumed that all costs will be fully funded. This constitutes a financial risk to the Trust given current shortfalls in relation to previous pay reforms.

Departmental led cash release

There are a number of Departmental-led initiatives which are projected to deliver significant elements of the cash release required by DFP; this includes the G&S savings target set in 2006/07 and a substantial element of the Trust's non-pay CSR efficiency savings for 2008/09. If these central initiatives to reduce the HPSS cost base are not achieved it is imperative that the Department identify alternative measures since in the current climate, requiring a further cash release from individual organisations probably late in the CSR period is wholly inappropriate.

Access Targets 2008/09

As part of the continuation of the NI Elective Reform Initiative, DHSS&PS has set further patient journey improvement targets for inpatients and day cases, outpatients, diagnostics, emergency care and discharge in 2008/09 as well as targets for fracture and cancer patients.

In order to meet these targets the Trust has identified potential capacity issues and developed action plans aimed at overcoming these. The scale of the problem is vast and in many cases targets will only be achieved if patients are treated outside the Trust. Consequently, the cost of achieving the targets is substantial. Work is ongoing at Trust level to provide a definitive cost for 2008/09 and the Trust is working closely with Commissioners to identify the scale of the potential funding gap.

In the absence of any details regarding agreed levels of funding to be made available to the Trust, and until the extent of the capacity shortfall for the Trust is fully understood, the impact of access targets has been excluded from the Trust's financial plan.

3.1.12 Summary 2008/09 Position

Assuming no further funding is available from Commissioners, and based on DHSS&PS income assumptions above, the Trust anticipates an underlying operational deficit of approximately £36m in 2008/09. This is in addition to the 2008/09 CSR efficiency target of £26m.

In order to address the shortfall the Trust has embarked upon a robust and comprehensive efficiency programme which sets out to modernise and reform services and reduce the cost base of the Trust without impacting on the level of service provided.

Given the nature of the fundamental service changes required to reduce the cost base of the organisation by circa 13% it is clear that this will not be achievable on a year by year basis and the Trust has, therefore, set out to deliver its full CSR efficiency requirement and cover its underlying deficit position by the end of 2010/11.

It is anticipated that efficiencies of £44m will be achieved in 2008/09. This will have the effect of meeting CSR efficiency targets and reducing the Trust's underlying deficit of £36m by £18m. A net deficit of £18m is therefore anticipated in 2008/09.

The Trust acknowledges its responsibility with regard to breakeven and will work closely with Commissioners and the Department to address this issue.

3.1.13 Summary of Financial Position 2009/10 -2010/11

Commissioners have provided limited information in relation to 2009/10 and 2010/11. Apart from inflationary uplifts, there are planned increases in income relating to the FYE of 2007/08 developments, new developments and the revenue consequences of new capital schemes. Funding has been reduced to reflect the impact of additional CSR savings in 2009/10 and 2010/11. Furthermore, non-recurrent bridging towards the 'capitation skew' withdrawal discussed in section 3.1.3 above has been reduced by £3.1m in 2009/10 and by a further £4.1m in 2010/11.

In terms of the impact on the Trust's deficit, the reduction in capitation bridging presents a financial risk to the Trust and there will have to have detailed discussions and negotiations with all Commissioners to ensure that activity is funded and that appropriate reductions in patient services are properly planned and implemented. Until further clarity is provided the Trust will assume that its underlying deficit will increase by £3.1m in 2009/10 and £7.2m in total by 2010/11.

As discussed in section 3.1.11, revenue costs associated with capital schemes are expected to rise significantly by 2010/11 as a number of larger capital schemes such as the regional adolescent psychiatry and child and family unit are due to commence in 2009/10. On the basis of current indicative allocations it would appear that funding will be considerably lower than that required. However, the Trust understands that further funding has been earmarked by Boards which may reduce the eventual shortfall. The Trust will work closely with Boards to get clarity on this issue but will assume at this stage that no deficit will emerge.

It is inevitable that additional cost pressures will emerge over the next few years although at this point it is assumed that any pressures will be funded.

It is likely that some form of tariff based system of commissioning will be introduced over the next few years although the details of this have not been determined at this stage. This poses a significant financial risk to the Trust for 2009/10 and beyond.

On the basis of the assumptions above, and subject to greater clarity around the impact of tariff, the Trust is projecting an underlying income deficit of 39.1m in 2009/10, increasing to £43.2m by 2010/11.

It has been assumed that the implementation of the Trust's MORE programme will ensure that the 2009/10 and 2010/11 CSR efficiency targets are achieved. The programme should also provide a contribution of approximately £30m towards the Trust's underlying deficit by the end of 2010/11 as shown in Table 3.5 above.

3.2 CAPITAL INVESTMENT PLAN

3.2.1 Introduction

The Belfast Trust, as with all other Trusts, is required to live within the Capital Resource Limit (CRL) that is established by the Department. The CRL provides the budgetary cover to enable the Trust to incur capital expenditure.

The CRL for the Trust normally comprises a general capital approval together with specific capital allocations for major schemes including those identified under the RRI and EPF initiatives.

The following table shows the CRL allocation indicated by DHSSPS Capital Resource Unit for 2008/09 in its letter dated 14 May 2008. This allocation refers to contractually committed amounts only. Remaining CRL allocations are to be issued by the end of June 2008.

Table 3.2.1- CRL Allocation for 2008/09 at 14 May 2008

Category	***CRL Allocation 2008/09 £'m***
Muckamore – design fees	*2.878*
West Belfast Health & Care Centre – design fees	*0.800*
Conicar – design fees	*0.150*
Castlereagh Health & Care Centre	*3.305*
RGH – Phase 2B	*6.000*

Regional Adolescent Unit	*0.300*
Mater – Fairview	*0.027*
Somerton Road	*0.015*
Total	***13.475***

3.2.2 General Capital Allocation

The CRL issued on 14 May 2008 does not include any amount in respect of General Allocation. Significant funding will be required to maintain existing services and to address deminimis firecode and statutory standards across the Trust's estate. The Trust is currently assessing the quantum of general capital investment required within these areas along with other calls upon general capital and will prioritise required schemes within the available allocation when it becomes available.

It has been the Trust's experience that additional general capital has become available in the latter part of the last few financial years and the Trust would intend to be in a position to avail of as much of that additional resource as is possible. The capital strategy will therefore identify additional priority investments above its initial allocation, which can be developed to tender stage potentially allowing expedient progress in the final quarter of 2008/09, should this funding become available. The precise timing and level of investment will be dependent on the scale of additional funds notified.

3.2.3 Approved Capital schemes

Redevelopment schemes continue at pace throughout all the facilities of the Trust. The 2008/09 capital programmes cover a wide area of service provision and are in line with previously agreed investment priorities.

In addition to the contractually committed amounts shown above, a number of projects are ongoing. The following expenditure on projects is anticipated, subject to CRL cover.

Category	***Projected Spend 2008/09 £'m***
Muckamore Phase 4	*4.878*
West Belfast Health & Care Centres	*5.000*
Conicar	*0.592*
RGH – Phase 2B	*9.000*
Regional Adolescent Unit	*6.850*
Victoria Pharmaceuticals	*6.224*
MPH decant	*2.000*
Enler Complex	*2.000*
General Allocation	*10.800*
Total	***47.344***

In 2008/2009, a Trust wide strategic service planning review and comprehensive capital investment plan will be completed. This, in turn, will inform future capital redevelopment investment priorities for the Belfast Trust.

3.3 Workforce Strategy

The Belfast Health and Social Care Trust since its establishment has sought to engage with staff in developing its strategic vision, values and objectives. The Belfast vision document sets out a very clear picture of the type of employer we wish to be in order to both ensure we provide the best service we can for our patients and clients as well as meeting the aspirations of our staff through initiatives such as improving working lives and IIP.

The workforce strategy will seek to incorporate the objectives of the vision and the requirements by the Department of Health through Priorities for Action and other initiatives and in that way ensure that the Trust has the workforce required to meet its needs.

Workforce productivity indicators will seek to improve the utilisation and efficiency of the workforce with emphasis being placed on skill mix, harmonisation of numbers and improved attendance records. In this way the Trust can ensure that it is as efficient as possible with regard to the utilisation of its workforce. The Agenda for Change initiative has largely been to date about pay reform however benefits realisation is now a priority given the financial, productivity and modernisation challenges.

Recruitment will be undertaken in a way to ensure we identify best future employees and will be done in line with safe employment practices and governance. It is envisaged over the next 3 years that there will be more limited recruitment externally given the challenges of CSR and indeed the turnover rate experienced by the Trust at the moment may mean the need for VER/VR in the future in order to meet CSR challenges.

Targets have been set both corporately and within service groups to reduce absenteeism. A new policy relating to this matter is being developed in partnership with Trade Unions and training will be rolled out in order to ensure its proper application. It is imperative that the Trust reduces the number of absentees and while this means there is a need for management of absenteeism there is also a need to recognise the role that Occupational Health can play in helping to rehabilitate workers back into employment who have had a period of illness.

As an organisation that has commenced the journey to reach IiP in 2009 various initiatives are up and underway. A learning and development strategy is being finalised having consulted widely with staff at all levels in the organisation. Team effectiveness initiatives have been rolled out throughout the Trust and clinical leadership programmes have already commenced. A leadership and management strategy is being developed as the Trust recognises the importance of leadership particularly in the environment we are working in. An NVQ and widening participation strategy will feature this year which will help deliver on the skill mix issues required as part of the utilisation and productivity of the workforce initiative.

A major staff survey has commenced within the Belfast Trust and will be reported on this year with comprehensive action plans being developed with relevant partners in answer to the survey outcomes. In this way the Trust will be genuinely engaging with staff and also seek staff suggestions on improving services around health and safety, control of infection, adverse incidents etc. Outcomes will include initiatives that will help improve working lives and this annual survey can also be benchmarked against national survey outcomes.

The MORE programme has various HR strands which will not only seek to utilise and make the workforce more productive but will also assist in the modernisation of services. Specific HR areas being considered are agency staffing, harmonisation skill mix and absenteeism levels. We will seek to engage staff in the change process of modernising services so that they can not only contribute and therefore make the change better but will understand and accept the need for the change.

A new appraisal system is being rolled out in the Trust which links to KSF to ensure that staff are appropriately developed and get an opportunity to receive and give feedback on their work. This appraisal system this year will seek to ensure all staff receive this opportunity and that the outcomes of engagement of this type will improve the service for our patients and clients.

These change initiatives will need the co-operation and support of our Trade Union colleagues. The Belfast Trust holds the view that it is right to inform and involve staff and their representatives at the early stage of change.

All of these HR approaches are in order to deliver safe, high quality and effective care as well as modernising and reforming our services. Belfast as a major organisation will use its staff to help improve health and well being through engagement with our services users, local communities and partner organisations. We will develop leadership initiatives and attain excellence through organisational and workforce developments and while making the best use of our resources to improve performance and productivity.

3.4 Collaborative Working

The Belfast Trust has established, at the centre of its purpose, the objective of working in partnership with the full range of voluntary, statutory, community and independent sector providers to provide integrated, high quality, modern and cost-effective health and social care.

1.0 The Trust is currently working with a wide range of partners to maximise service benefits and uses a range of structures and processes to achieve this, for example:

- Community and user groups
- Section 75 consultation and user groups
- Disability Steering Group
- Minority Ethnic Forum
- Participation in Belfast-wide conflict transformation project; to promote good relations
- Participation in the Health Action Zones

- Participation in Investing for Health programmes
- Participation in Employability Initiatives, in targeting social needs areas, to increase employability and reduce unemployment and poverty
- The Belfast Health & Social Care Trust Joint Negotiating Forum
- The development of an Employment Equality Plan
- The development and approval of an Equality Scheme and Plan
- The creation of Health and Well-Being Centres in targeting social needs areas

1.1 Some of these examples of partnership working are detailed below:

The Trust has a close working relationship with EHSSB Investing for Health with whom it is working on a number of initiatives alongside the Trust's community development, health improvement and health inequality teams which target disadvantaged areas and groups.

1.1.2 A Health Economy is currently being established to link the Trust, the EHSSB and LCG and other agencies to work together on the reform and development of hospital/community/patient home interfaces.

1.1.3 The Trust is working closely with the Common Services project group to progress the development of efficient, regional and semi-regional services across finance, HR, legal and other shared services.

1.1.4 Following on from developments across some of the Legacy trusts, the Belfast Trust has continued to support and expand the Employability Projects. The Health Employment Project is in partnership with the Community, the Trade Unions and the Employee, targeting social need in West Belfast and Greater Shankill with employability and career progression programme.

Participation in Employability Initiatives has included the long-term unemployed, the local community, other public bodies including the Belfast City Council, the Housing Executive, Education, and Trade Unions.

1.1.4 The Trust has developed and is consulting on an Employment Equality Plan to promote Equality of Opportunity and Social Inclusion within the workforce.

1.1.5 In addition, a wide range of region-wide and local representative groups were consulted during the production of the Trust Disability Action Plan.

2.0 In addition, there is a wide range of other active partnership arrangements with HPSS and other bodies:

2.1 The Trust is working with commissioners and other Trusts to standardise the payment arrangements for services provided across residential, nursing homes, and domiciliary care across mental health, learning disability, older person services and physical disability. This will also enable a more efficient contracting process for the relevant service areas and financial teams in the Trust.

2.2 The Trust's MORE project (Maximising Outcomes, Resources & Efficiencies) was established to develop and deliver plans for the sustained improvement, modernisation and reform of patient and client services across the Trust area.

The Trust has attempted to adopt a comprehensive, "whole systems" approach to the challenging efficiency agenda faced within the Health and Social Care sector, focusing on the reform and modernisation of our services. As part of this approach the Trust is seeking to work in partnership with our commissioners to reach common objectives and maximise the value of new investments to facilitate this significant change. We particularly see opportunities for a joint approach around services delivered for older people as we attempt to shift the delivery of care from acute and institutional settings to a community based model which provides better outcomes for clients and enhances choice and independence.

2.3 The Trust has launched "Involving You – a Framework for Community Development, Health Improvement and User Involvement" following a 9-month development and consultation process with community, voluntary and statutory groups across Belfast and Castlereagh. The Framework affirms the Trust's commitment to addressing health inequalities and identifies the means by which its partners can be more involved in health improvement.

2.4 The Social Services, Family & Childcare has participated in the Trust's User Involvement Strategy. The Social Services, Family & Childcare has participated in local Neighbourhood Renewal and Partnership Boards in South and West Belfast. The Social Services, Family & Childcare has been fully engaged in the ongoing initiative in the Ballymurphy area. It has been substantially involved in the Integrated Development Fund Initiative in West Belfast and the Shankill areas.

2.5. A performance management system is being established in order to ensure the Framework delivers on its set of objectives and targets.

- The Trust is participating in a Belfast-wide Conflict Transformation Project with the Belfast City Council and other public agencies.

- The Trust has a Disability Steering Group that has members from within the Trust and from a number of disability groups.

- The Trust has an approved Equality Scheme and Plan for 2008/09 including initiatives with Travellers, Ethnic Minority Grouping, Targeting Social Needs initiatives.

2.6 The Trust works in partnership with Voluntary Service Belfast.

4.REFORM, MODERNISATION AND EFFICIENCY

Context

The Department of Health, Social Services and Public Safety has set challenging efficiency targets for the Belfast Trust over the next three years (2008/09 to 2010/11) as a result of the 2007 Comprehensive Spending Review. In addition to this demanding efficiency agenda there are a number of underlying deficits which have been inherited by the Trust from its six legacy organisations. The background and detail of these financial issues have been discussed in Section 3 – Resource Utilisation.

Recent proposals in respect of capitation and the shift of funds by the Department across the region will have a significant impact on the volume of services the Trust delivers over the next five years and the associated funding streams. Lastly the Department has indicated that it intends to introduce a tariff based funding regime commencing in 2008/09, on a pilot basis, which will increase the uncertainty and risks around the Trust's funding regime.

Reform and modernisation agenda

The Trust recognises that the combined impact of the above changes is considerable and will result in a material reduction in the funding baseline of the organisation. The scale of the challenge is such that the traditional cost efficiency/cash releasing projects which have been delivered in the past will not be sufficient. The Trust has therefore embarked on an organisational reform programme which focuses on resource utilisation, performance improvement and effective service delivery.

This comprehensive programme has been named the MORE programme, reflecting the aims of the programme in terms of Maximising Outcomes, Resources and Efficiencies.

The programme will address strategic, clinical, operational and financial performance within the Trust, drive improvements in services and address productivity and operational inefficiency.

Strategic approach

The Trust has adopted a strategic approach to the programme which is grounded in the vision and strategic direction of the organisation. The programme aims to achieve the best possible care for patients and clients and deliver maximum value for money.

Benefits management approach

The Trust has developed a Benefits Management approach to oversee the reform and transformation of services. Under this approach the focus is on the benefits for

the patient, client and citizen, in addition to efficiency and productivity benefits for the organisation. This Benefits Management approach also takes into account and

stresses the critical importance of early recognition and management of the associated risks of service change and the full range of stakeholder interests.

In addition to the Benefits Management approach, the Trust has developed a Communications Strategy which outlines the rationale for, and direction of travel of the MORE programme. This strategy outlines the requirement and necessity of doing MORE (for less), promotes the key message of ‘doing the right thing’ and emphasises the need for effective engagement from the full range of stakeholders in the design and implementation of the new service models.

The programme has been established as a core element of the Trust’s business and performance management framework. It is not seen as a stand alone project but a methodology and way of working which is totally mainstreamed.

Governance arrangements

The Trust has established a robust and ‘fit for purpose’ programme infrastructure to support and performance manage the delivery of the MORE programme. The governance, accountability and reporting arrangements have been established and agreed within the context of the Trust’s overall codes of conduct and accountability.

Accountability is clear and unambiguous, with clear lines of reporting from Project Managers through to Workstream Leads, to the MORE Steering Group, the Senior Executive Team and ultimately the Trust Board.

The Chief Executive is the Senior Responsible Officer (SRO) for the MORE programme, and is committed to providing leadership to deliver the programme’s objectives.

Two key organisational bodies have been established with clear responsibility for the MORE programme:

- The MORE Steering Group has responsibility for the planning and delivery of the MORE programme, and

- The MORE Programme Assurance Board has responsibility for overseeing the programme, ensuring that its plans are robust and that the required objectives are achieved.

  The Programme Assurance Board has an independent Chair and both Non-Executive and commissioner representation.

Appendix 1 outlines the governance arrangements for the programme in a diagrammatical format.

Terms of reference and roles and responsibilities have been clearly established and implemented for all groups and specific staff within the teams and groups.

Performance management framework

The Trust has developed a robust performance management methodology and framework to ensure the successful delivery of the MORE programme.

Comprehensive templates which meet PRINCE 2 and OGC's Managing Successful Programmes principles have been specifically designed for the programme.

Completion of these templates by Project Managers will provide assurance that the projects are being sufficiently scoped and that all aspects are given due attention e.g. monetary and non-monetary benefits, risks, interdependencies, resources, stakeholders, quality etc.

Under the MORE methodology highlight reports, and where necessary exception reports, must be completed monthly and reported to the Workstream Leads and the MORE Steering Group. This monitoring and escalation process will ensure that the various activities and processes required to successfully deliver the MORE projects are on target.

The Trust intends to conduct independent reviews of the delivery of the projects, and the associated planning, implementation and reporting tools, at key points in the programme to ensure that the schemes are being effectively project managed.

The MORE performance management framework will form an integral part of the Trust's overall performance management framework.

The MORE programme

The Trust's combined target for the Department's efficiency savings under CSR, and its underlying deficit, is in the region of £125m, which has been scheduled for delivery over the three years as follows; £44m (2008/09), £82.1m (2009/10) and £123.3m (2010/11(.

The MORE programme proposals to achieve these targets fall under three high level themes:

- Workforce
- Non Pay Economies and Efficiencies
- Health and Social Care Process Improvements and Service Redesign.

Workforce

A significant proportion of the efficiency savings identified within the MORE programme will come from workforce initiatives, in line with the cost profile of the Health and Social Care sector.

The main focus of the workforce initiatives centres around productivity improvements and robust workforce management across all staff groups and service areas of the Trust.

The Trust has identified four specific workforce initiatives;

- RPA
- Absence Controls
- Vacancy Controls
- Harmonisation of staffing levels, grades and skill mix.

The split of the overall workforce target across the above four headings is identified below.

Target Action Area	**Indicative 2008/09 Target £'m**	**Indicative 2009/10 Target £'m**	**Indicative 2010/11 Target £'m**
RPA	**6.4**	13.1	13.4
Absence Controls	**1.5**	3.0	4.5
Vacancy Controls	**19.0**	16.0	13.0
Harmonisation of Staffing Levels Grades & Skill mix	**4.1**	9.0	14.0
Total	**31.0**	**41.1**	**44.9**

Although these four areas constitute major areas of work in their own right, there are significant interdependencies between the areas and therefore the Trust will programme manage their delivery through a cross-cutting workstream which is co-ordinated corporately from a Human Resources and Finance perspective.

RPA

Under the RPA initiative a total of 499 posts will be removed from the organisation over the three year CSR period, ending 31 March 2011.

The efficiencies will be delivered across the following categories of staff;

- Senior Management – Board level
- Administrative and Clerical – Corporate/Managerial level posts below Board level and related administration
- Professional/Clinical administration
- Professional (Clinical) management
- Shared Services

Absence Controls

The Trust will implement a targeted approach to the management of those individuals in the organisation who are deemed to have the most significant impact as a result of sickness absence. (2008/09 circa 100 staff, 2009/10 circa 200 staff, 2010/11 circa 300 staff).

On the assumption of the Trust’s current estimates for cover it is projected that the actions undertaken under this initiative will have the effect of decreasing costs by £1.5m, £3m, £4.5m respectively over the three year period. This will be achieved through reductions in overtime, agency and additional hours and therefore will not have a detrimental impact on the level of staff employed by the Trust.

It is expected that the savings will be achieved mainly amongst nursing, allied health professionals and ancillary and general staff categories.

Vacancy Controls

A target of 3%, 2½% and 2% has been applied to each Service and Corporate Group over the three year period, with projected savings of £19m, £16m, and £13m respectively.

Under this initiative the Trust will deliver the same level of activity and care, with no detrimental impact to patients and clients, whilst at the same time increasing the Trust’s productivity indicators. The whole time equivalents impacted by this work is in the region of 610 (2008/09), 511 (2009/10), and 409 (2010/11).

The Trust recognises that there are different categories of workforce expenditure, i.e. expenditure relating to permanent and temporary staffing, bank, agency, additional hours and overtime, and therefore this initiative will be managed through a combination of stringent internal control measures and a timely ‘joined up’ performance management approach.

Skill Mix/Harmonisation

Targets have been applied to each Service and Corporate Group of £4.1m, £9m, £14m over the three year period 2008/09 to 2010/11.

The Trust plans to achieve the above targets by critically assessing staffing levels and skill mix across all staff groups and service areas within the Trust.

This initiative will incorporate a number of the targets which have been set for the Trust by the Department as part of its regional Productivity project. In addition the Trust will carry out comparative analysis against stretch targets from a number of top performing organisations, as part of its ongoing performance management work.

The indicative WTE impact of harmonisation of staffing levels is projected as 295, and the indicative WTE impacted by skill mix changes is in the region of 600.

Non-Pay Economies and Efficiencies

Regional Goods & Services Procurement and Pharmacy workstreams

It is assumed that the Trust will receive approximately 40% of the efficiencies which are projected to be delivered from the regional procurement and pharmacy workstreams.

The Trust anticipates savings of £4m, £7m and £11m over the three year period.

The Trust is keen to engage fully with the regional workstreams to facilitate and drive these initiatives forward.

Internal Non-Pay Efficiencies

Non-Pay Efficiency targets have been applied to each Service and Corporate Group of ½%, 1% and 2% of non-pay funding over the three year period 2008/09 to 2010/11.

The Service and Corporate Groups have brought forward a number of initiatives to meet these targets. The initiatives centre around product and service standardisation across the Trust, the review and effective management of contracts, exploiting the Trust’s enhanced purchasing power, the elimination of waste (particularly around energy, stock holding etc), and the increased use of recycling.

The Trust anticipates efficiencies of £2m, £4m and £8m, over the three year period 2008/09 to 2010/11.

Health and Social Care Process Improvements and Service Reform

The third strand of the MORE programme focuses on service reform and modernisation.

Under this strand the Trust and its Service Groups will take a radical review of the systems, processes, activities and resources that have traditionally been used to provide health and social care to its patients and clients. The Trust's approach is principally centred on thinking differently and taking new and innovative approaches to service delivery, particularly in the use of technology, increasing efficiency and productivity, and maximising outcomes.

The MORE programme will concentrate on clinical activities that offer the greatest scope for improvement. It hopes to maximise effective evidence based treatments and review those treatments that have been researched and shown to be clinically ineffective or inefficient. The approach also aims to focus on removing unnecessary processes, steps and interventions from the patient and client journey and pathways, using service improvement methodologies such as LEAN and Six Sigma.

Within the overarching category of Health and Social Care Process Improvement and Service Reform the Trust has identified four overarching cross cutting themes and organisational workstreams, within which a multiplicity of proposals and schemes will be programme and performance managed.

The key themes are:

- Hospital/Institutional Process Reform
- Hospital/Community Interface Reform and Enhancement of Community Based Services
- Strategic Service Reform
- Impact of Technology

The table below outlines the projected efficiencies which will be achieved under the four broad themes over the three year CSR period, together with an indication of the reduction in posts.

	Indicative 2008/09 Target £'m	**Indicative 2009/10 Target £'m**	**Indicative 2010/11 Target £'m**	**Indicative Reduction in Posts**
Hospital/Institutional Process Reform	3.750	12.700	21.950	674
Hospital/Community Interface Reform	1.825	7.350	18.150	518
Strategic Service Reform	0.675	5.950	10.900	329
Impact of Technology	0.750	4.000	8.000	224
Total	**7.000**	**30.000**	**59.000**	**1745**

Hospital/Institutional Process Reform

The Trust's overarching theme within this area is to improve productivity and efficiency through better utilisation of resources from staffing to physical infrastructure and estate.

The Trust aims to improve productivity within its hospitals through utilising less inpatient beds to deliver the same quantum of patient care. It is projected that the main reductions in bed requirements will result from reductions in pre-operative length of stay, admission on day of surgery, and through more effective theatre utilisation, the reduced need for beds at weekends.

It is recognised that the actions required to deliver the reduction in bed requirements will be different across Service Groups and hospitals, and therefore the Trust will co-ordinate this work within its institutions in a way which maximises the benefits delivered.

In addition occupancy and activity levels will be reviewed within non acute programmes of care within the Trust's institutions and facilities, with the potential to move the provision of services from a number of locations and increase productivity levels on other sites, without impacting on the quantum of services or how the services are delivered.

Hospital/Community Interface Reform and Enhancement of Community based services

The Trust is committed to the delivery of health and social care services which promote better experiences and outcomes for its patients, clients and the citizens of Belfast.

Within this overarching area the Trust has adopted a number of key principles:

- Early Intervention and the Promotion of Preventative Care - producing a delivery model that supports and develops a culture of self assessment and self care.

- Personalisation of Services – where clients and patients have more choice and personal control of the services they require, leading to enhanced independence, inclusion and well being, and less reliance on institutional based care.

- Community Engagement and strong Inter-sectoral/Agency Partnership Working.

Strategic Reform

The creation of the Belfast Trust from its six legacy predecessors provides the opportunity to reconfigure, reform and modernise services across the city of Belfast for the benefit of its citizens, and also the wider Northern Ireland population.

The Trust's new organisational structures which are focused around the totality of a patient/client journey or experience has facilitated the strategic review of services and identified the potential for rationalisation.

There are numerous examples of duplication across the Trust as services have traditionally been organised around hospitals or institutions. As a consequence there are significant opportunities to deliver an improved quality of service to patients and clients by reviewing and rationalising services whilst improving productivity and realising a significant level of resource release.

The Trust recognises the significant challenges posed internally and externally by changing the locations of service provision. However these strategic service reviews will be set within the wider vision and strategic direction established by the Belfast Trust.

Impact of Technology

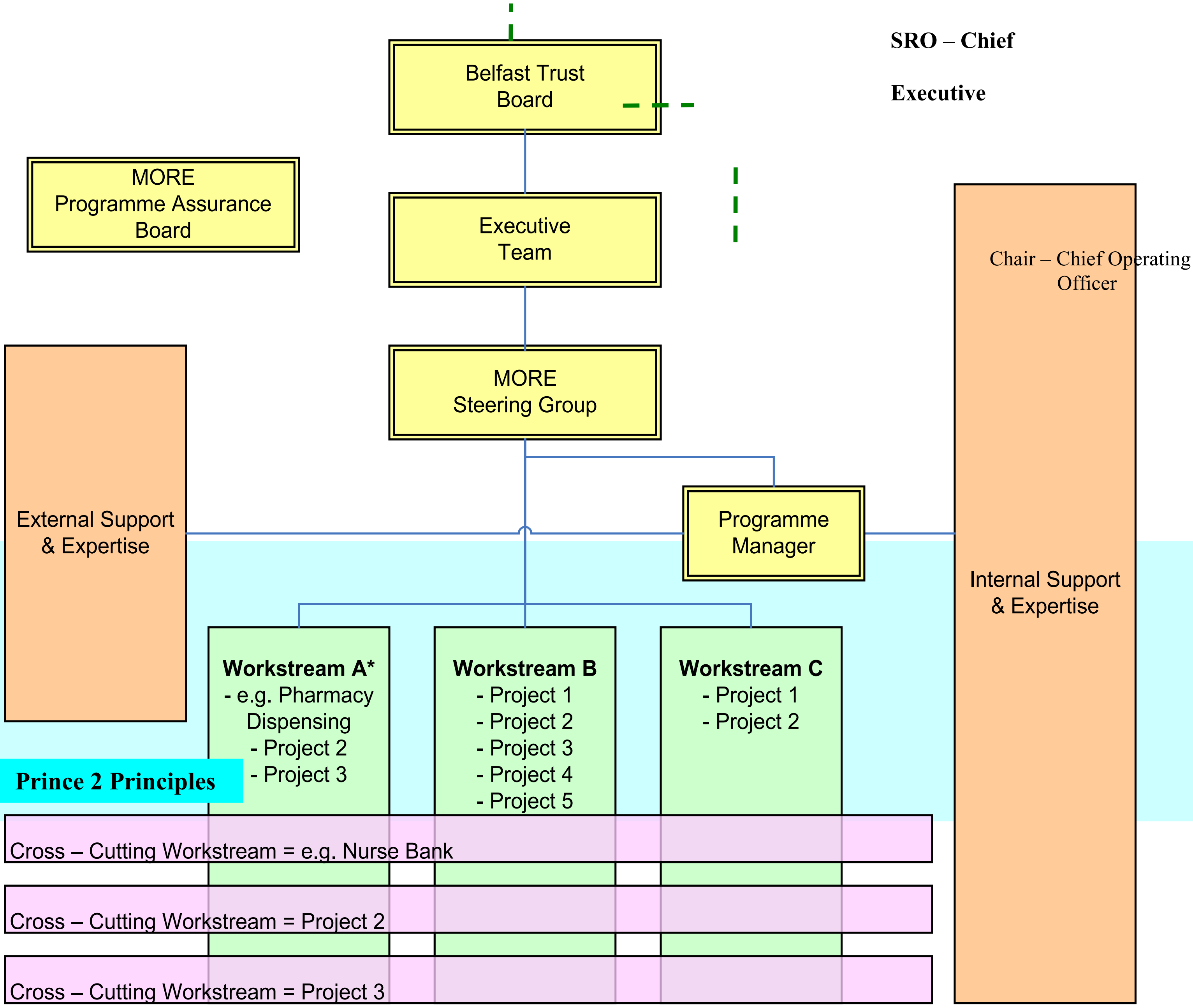
The Trust intends to deliver productivity improvements through the use of technologies to support its business and operational processes. It is expected that by working smarter the Trust will release staff time and resources, reduce duplication of effort, avoid unnecessary manual processes and ultimately improve services.

The Trust expects that the establishment of the European Centre for Connected Health will assist the Trust with its development plans in the above areas.

OGC Managing Successful Programmes Principles

MORE Programme

Governance and Accountability Arrangements



SRO – Chief

Executive

Belfast Trust Board

MORE Programme Assurance Board

Executive Team

Chair – Chief Operating Officer

MORE Steering Group

External Support & Expertise

Programme Manager

Internal Support & Expertise

Workstream A*
- e.g. Pharmacy Dispensing
- Project 2
- Project 3

Workstream B
- Project 1
- Project 2
- Project 3
- Project 4
- Project 5

Workstream C
- Project 1
- Project 2

Prince 2 Principles

Cross – Cutting Workstream = e.g. Nurse Bank

Cross – Cutting Workstream = Project 2

Cross – Cutting Workstream = Project 3

5. GOVERNANCE

Board of Trust

The Board of Directors of the Trust is responsible for ensuring it has effective systems in place for governance, essential for the achievement of the organisational objectives.

The Assurance Framework is an integral part of the governance arrangement for the Belfast HSC Trust, together with the Risk Management Strategy and Corporate Risk Register and the Corporate Management Plan.

The Assurance Framework

The Assurance Framework describes the organisational objectives, identifies potential risks to their achievement, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls.

The Directors of the Belfast Trust have:

- Defined Corporate Objectives
- Identified principal risks
- Controls in place to manage the risks, underpinned by controls assurance standards and
- Explicit arrangements for obtaining assurance on the effectiveness of baseline controls

Risk Management

The Belfast Trust has a risk management strategy that is underpinned by its policy on risk.

Processes for managing and learning from adverse incident, complaint and litigation are a priority.

Organisational Arrangements

The Board of Directors has established an Assurance Committee and an Audit Committee. A range of Clinical and Social Care Governance and Controls Assurance Committees are identified within the Assurance Framework.

An Assurance Group Co-ordinates the work of the Assurance/scrutiny committees.

Further details of the Trust Assurance Framework are available on request.

6.USER EXPERIENCE

6.1 Investing for Health

Delivery of the IfH Strategy

The Belfast Trust is committed to the full implementation of the IfH strategy. The work established by the legacy Trusts is continuing and Trust staff have been fully engaged in the Board wide Investing for Health Partnerships. Staff from the Health Improvement Department and other service groups are contributing to the locality Health Improvement Plan through all the Community of Interest structures and Health Improvement Planning seminars. The Trust has also established Senior Manager working groups to liaise with the locality IfH Managers in order to plan and agree joint actions. The Trust are committed to embedding the aims and objectives of the IfH strategy into its core business and this will be facilitated through the Health Improvement Department. This can only be achieved by working in partnership and the Trust continually demonstrates its commitment to this way of working through its participation in a range of local partnership groups. The Trust is also in the process of developing a comprehensive Community Development and User Engagement Framework which has the explicit aim of improving health and wellbeing and we envisage the implementation of the framework to play a significant role in the Trust business.

Trust As A Health Promoting Organisation

Recently the Trust has made 2 new senior appointments to ensure that Health Improvement is a central aspect of the Trusts business. The posts are an Associate Medical Director (Public Health) and a Senior Manager for Health Improvement. Both staff along with the Health Improvement staff from the 6 legacy Trusts are continuing to develop the wide range of initiatives that have existed around the issues of Smoking, Physical Activity, Nutrition, Home Accidents, Drugs & Alcohol, Screening etc.

All these initiatives are delivered in partnership with a range of staff and other organisations from the Community, Voluntary and Statutory sectors.

Workforce Promoting and Protecting Health

With 22,000 staff the opportunity to address staffs' health and wellbeing is significant. The Trust are in the process of establishing a workplace health group that will bring together a wide range of staff groups to develop a specific workplace Health Action Plan.

With the Trust newly developed purpose of "improving health and wellbeing and reducing health inequalities" the organisation has committed itself to a greater emphasis on a preventative approach.

Staff at all levels are being encouraged through the support of the Health Improvement Department to adopt this approach and this is being built on through Training, Advice & Support and initiatives such as the Chairman's Awards and the MORE initiative.

6.2 User Engagement / 6.3 User Experience

The Trust is taking forward a number of initiatives in relation in support of our commitment to engage with service users, patients, carers and relatives. Some of the initiatives are outlined below:

Picker Institute

During 2008/09, the Picker Institute will be used to carry out a Patient Satisfaction Survey with 750 patients across the Clinical Services, Older People, Medicine and Surgery, Specialist Services, and Head and Skeletal Service Groups. The survey will be carried out proportionately (based on bed numbers) across these Service Groups, and will be used to measure patient experience using a postal questionnaire to patients discharged during November 07 to gain feedback on a range of issues.

This survey will complete the contract with Picker previously held with the Royal Group of Hospitals. Following this the Trust will carryout its own patient satisfaction survey work to assess views over a wide range of specific issues.

Future Patient Satisfaction Survey work in BHSCT

Future patient satisfaction work will be developed and taken forward by the Assurance Committee's of each Service Group with support from the Senior Manager for Patient and Public Involvement. A standard questionnaire will be developed and representatives from service users / patients groups will be involved in the development of this questionnaire. This questionnaire will be piloted, using those service users / patients involved in its development, and will then be adopted for use across the Trust. Whilst it is recognised that in areas such as learning disability services and mental health services, a standard questionnaire may not be appropriate, but the aim is to have as little variance as possible in relation to issues/ themes addressed in patient satisfaction survey work.

Service Group assurance committees will develop a rolling calendar for the administration of patient satisfaction surveys, targeting different areas of their service periodically.

Any service areas wishing to carryout additional patient satisfaction surveys (over and above those detailed in the rolling calendar) will be required to liaise with the Service group governance leads / assurance committees. Guidelines for staff on the Patient Satisfaction Survey process will be development.

In the long term, a model will be developed to support service user / patient involvement in the administration and ongoing review of patient satisfaction survey work.

Service User Engagement

The Trust's Community Development and User Engagement Framework (copy available on request) has been developed and will guide the Trust's work in relation to PPI in the coming year. As part of the implementation of this framework, Service Groups will be required to develop action plans detailing how they will develop PPI in year. The Senior Manager For PPI will be actively involved in supporting the implementation and evaluation of this framework.

As a result of consultation sessions held to inform the development of the Community Development and User Engagement Framework, the Senior Manager for Patient and Public

Involvement will be working with the Long Term Conditions Alliance to organise a workshop facilitate dialogue about ongoing involvement with relevant Trust staff. A similar process will be facilitated between the Belfast Woman's Centres and relevant Trust staff. The Senior Manager for PPI is also supporting the Chronic Pain Liaison Nurses to develop a Patient Support / Involvement Group for people who use the Chronic Pain Clinics.

A model will be developed to support user involvement in "corporate" issues such as infection control and environmental cleanliness. PPI guidelines for staff will be developed to challenge staff thinking in relation to service user involvement, for example, in relation to the purpose of the involvement and the methods / approaches used to engage with people.

The Senior Manager for PPI will participate in relevant Trust initiatives as they develop, for example, the review of unscheduled care, to ensure that effective PPI is developed as part of the process.

Staff awareness raising / training for PPI will be developed in partnership with other relevant Trust staff to support the development of PPI initiatives within Service Groups.

Mental Health & Learning Disability Management Plan 2008 – 2000

Learning Disability Specific

Quality and Safety

Corporate Theme	Key Objective	Actions	November update	Actions
Quality and Safety	Harmonisation of policies/standards/ guidelines	Ensure harmonisation of policies/ standards & guidelines across the service group in line with corporate harmonisation.		
	Management of aggression & violence	Implement Trust policy & procedures. Address untoward incidents.		
	Develop a confident & competent Workforce	Ensure staff access relevant training in line with development of training needs analysis for the service group.		
	Develop a confident & competent Workforce	Ensure all staff receive training on PCF & KSF and have a completed PCP & PDP.		

Modernisation

Corporate Theme	Key Objective	Actions	November update	Actions
Modernisation	Develop modernisation strategy for learning Disability	Bring forward working papers in respect of Hospital Services, Community Treatment and Day Support services.		
	Refocus on the Resettlement Project for Muckamore Abbey	Achieve corporate 'buy in' as a priority project Develop a strategy to take this forward that clearly sets out how it will be achieved		
	By March 2011, ensure a 25% reduction in the number of long stay patients in learning disability institutions	Reconvene Resettlement Project Board.		
	Trusts should ensure that, by March 2009, all children are resettled from hospital to appropriate places in the community.	Support Children's services in development of 2 Bc's. Assist in the identification of interim RQIA community facilities.		

Partnerships

Corporate Theme	Key Objective	Action	November update	Actions
Partnerships				
	Review role of ACET consortium			

People

Corporate Theme	Key Objective	Action	November update	Actions
People	During 2008 09	levels of absenteeism are reduced to 10% below average 2006		
	Develop a confident & competent Workforce	Ensure staff access relevant training in line with development of training needs analysis for the service group.		
	Develop a confident & competent Workforce	Ensure all staff receive training on PCF & KSF and have a completed PCP & PDP.		

Resources

Corporate Theme	Key Objective	Action	November update	Actions
Resources				
	MORE: delivery programme & key principles & work streams & KPI's & milestones contained within that programme	Identify Operational Impact of Proposals. Undertake relevant Consultation.		
Resources PFA				
	By 2011, ensure a 25% reduction in the number of long-stay patients in learning disability institutions.			
	By 2011, improve access to learning disability care by providing an additional			

	200 respite packages a year.			
	Resettlement (PSA 7.1): Trusts should, by March 2009, resettle 60 patients from hospital to appropriate places in the community compared to the March 2006 total (and a further 60 by March 2011).			
	Ensure that, by March 2009, 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days			

Corporate Theme	Key Objective	Action	November update	Actions
Resources (continued)	Ensure that, by March 2009, access to learning disability services is improved through the provision of an additional 50 respite packages a year (increasing to 200 by March 2011).			
	Ensure that, by March 2009, all children are resettled from hospital to appropriate places in the community.			
Resources (Capital)	Manage and deliver Phase II Muckamore Abbey			
	Annadale Ave BC development			
