

**MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT**

Statement of Jan McGall

Date: 6th June 2023

I, Jan McGall, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

The statement is made on behalf of Southern Health and Social Care Trust (the Trust) in response to a request for evidence by the Inquiry Panel.

This is my second statement to the Inquiry. My first statement to the Inquiry was dated 25th January 2023 and my verbal evidence to the Inquiry was provided on 5th April 2023.

In exhibiting any documents I will use my initials "JMcG" so my first document will be "JMcG/2" (JMCG/1 was exhibited as part of my first statement to the Inquiry dated 25th January 2023).

Section 1: Qualifications and Position

1.1 Qualifications:

Master of Public Administration (MPA) (UUJ)

Bachelor of Science Occupational Therapy (UUJ)

HCPC Registered Occupational Therapist

1.2 Position:

Director of Mental Health and Disability, Southern Health and Social Care Trust.

Appointed March 2022.

Section 2: Module 2: Health Care Structures and Governance, Section (g): Inter-relationships between the Trusts re patients admitted to Muckamore and Module 2: Health Care Structures and Governance, Section (i): Outline of provision for community based services

2.1 This supplementary statement aims to respond to issues raised during my verbal evidence of 5th April 2023 to the Inquiry in respect of Module 2 (g) and (i).

2.2: Transcript Page 82/83, Question 159 and Question 161: Structure or policy or both in respect of multi-agency meetings, specifically for individuals with forensic needs.

2.2.1: The Care Pathway and Model for Community Forensic Teams in Northern Ireland, October 2011 (Exhibit JMcG2) was the policy followed by the Southern Trust Community Learning Disability Forensic Team in supporting both individuals in the community and those in low secure facilities transitioning to the community.

2.3: Transcript Page 88, Question 171: Date of last admission of Southern HSC Trust patient to Muckamore Abbey Hospital and dates of resettlement of six individuals from 1999 – 2021; Transcript Page 109, Question 212: Resettlement of Southern HSC Trust patients from Muckamore Abbey Hospital.

2.3.1: Date of last admission of Southern HSC Trust patient to Muckamore Abbey Hospital was on 16th December 2016 and this was an individual with a learning disability and forensic history. Over the period 2007 – 2013 there were 5 individuals discharged from Muckamore Abbey Hospital to the Southern Trust Community Learning Disability Team under the Resettlement Agenda (Table 1).

Table 1: Dates of admission to and resettlement from Muckamore Abbey Hospital, 2007-2013

Patient	Date of Admission	Date of Discharge
A	September 1977	April 2009
B	July 1998	September 2011
C	July 2006	November 2011

D	July 1963	December 2011
E	January 1994	July 2012

2.4: *Transcript Pages 96 and 98: Supervision Policies for Inpatient Staff*

2.4.1: Current Trust supervision policies for each profession within the multi-disciplinary team in Dorsy Learning Disability Inpatient Assessment and Treatment Unit, Bluestone Unit, Southern HSC Trust are exhibited with this statement of evidence:

- Exhibit 'JMcG3': SHSCT: Reflective Supervision Policy for Nurses and Midwives
- Exhibit 'JMcG4': SHSCT: Medical Appraisal and Engagement Procedure
- Exhibit 'JMcG5': SHSCT: Supervision Policy, Standards and Criteria for Social Workers and Social Care Workers. A Regional updated policy 2021 remains in draft format.
- Exhibit 'JMcG6': SHSCT: Procedure for AHP Supervision in the Southern HSC Trust
- Exhibit 'JMcG7': The British Psychological Society, Division of Clinical Psychology Policy on Supervision (under review)

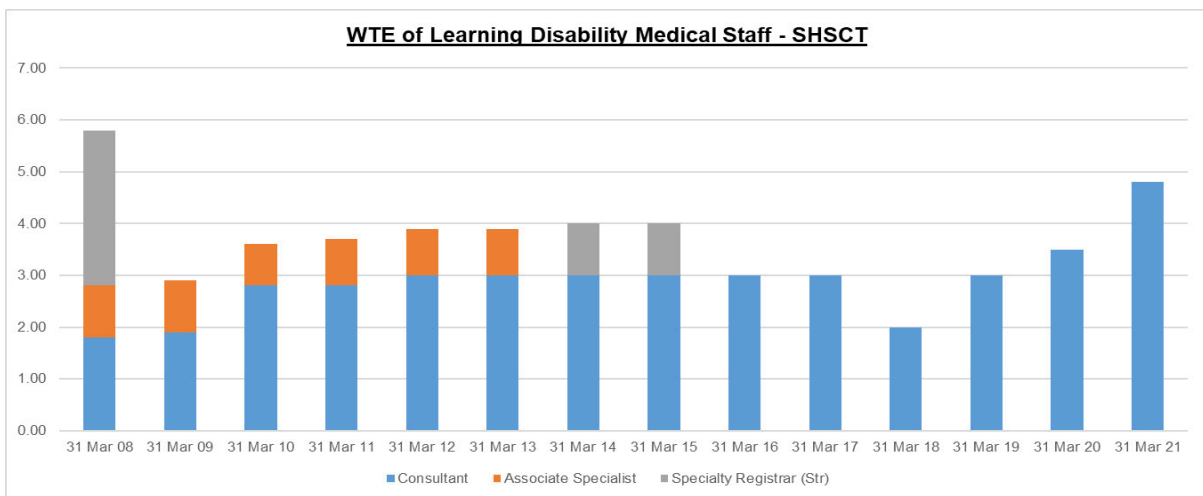
2.4.2: In addition to the supervision guidelines above, on Dorsy Ward, annual appraisals are also completed and there are a variety of opportunities for registered and non-registered staff to engage in clinical supervision, reflection and case discussion:

- Operational supervision with all staff every 4-weeks
- Psychology-led, Balint style reflective groups 1-2 monthly
- Hot and cold post incident debriefs as required
- Structured Early Learning process completed with input from all staff involved post-incidents
- Daily staff and patient safety huddles and briefs with a focus on Gibb's advisory on reflection

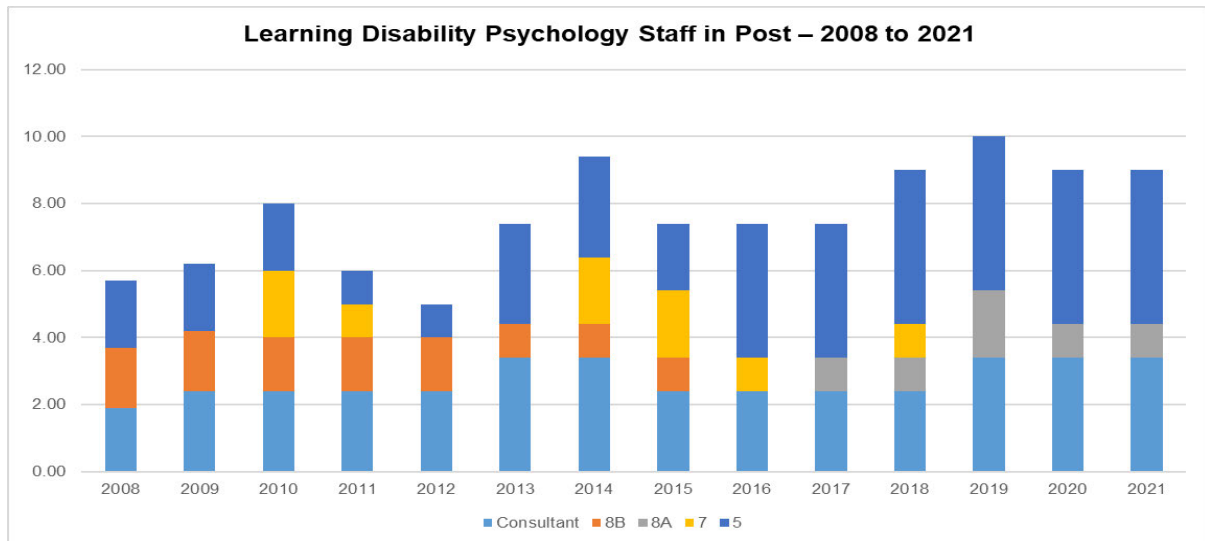
2.5: Transcript Page 101, Question 191: Commissioning/Provision of Psychiatry and Psychology to Community Learning Disability Services; Transcript Page 115, Question 237 and Question 238: Information on Psychology/Psychiatry Staffing

2.5.1: On review of information provided to me, from the period 2007, there was development of multi-disciplinary teams across community learning disability services and psychiatry and psychology professions were included in this way of working. There appears to have been a mixture of integration and location of psychologists within multi-disciplinary teams, for example, in the community learning disability forensic team and also a model of an aligned psychologist, who would attend community team meetings, offer consultation and advice on formulation, case management and interventions. For psychiatry, there was provision of input to both the Longstone Hospital, community teams and outpatient services. Table 2 shows staff in post reports for learning disability psychology and psychiatry to compliment those provided in my first statement of evidence for the other professions in the multi-disciplinary team.

2.5.2: Table 2: Summary Data: Whole Time Equivalent (WTE) Medical Staff in Learning Disability Division 2008-2021 (SHSCT Human Resources Department, June 2022)



2.5.3: Table 3: Summary Data: Whole Time Equivalent (WTE) Psychology Staff in Learning Disability Division 2008-2021 (SHSCT Human Resources Department, June 2022)



2.6: *Transcript Page 114, Question 235: Commissioning Statements for the development of Community Learning Disability Services.*

2.6.1: Investment proposal templates for resettlement and community learning disability services that have been made available are exhibited as detailed below:

- Exhibit 'JMcG8': Learning Disability Accommodation Based Services in the Community (Resettlement) (Draft) March 2013
- Exhibit 'JMcG9': SHSCT Learning Disability Community Infrastructure March 2013
- Exhibit 'JMcG10': Area Supporting People Partnership Business Case Capital Finance: capital finance business case to support the development of accommodation for individuals resettled from Longstone Hospital long stay wards
- Exhibit 'JMcG11': Demographics Funding: Learning Disability Transitions July 2014
- Exhibit 'JMcG12': Community Learning Disability Infrastructure April 2014

- Exhibit 'JMcG13': SHSCT Resettlement of Learning Disability and Delayed Discharges April 2014
- Exhibit 'JMcG14': Demographics Funding: Community Learning Disability Transitions 2015
- Exhibit 'JMcG15': SHSCT Learning Disability Community Forensics October 2015
- Exhibit 'JMcG16': SHSCT Children with Learning Disability Transitioning to Adult Services January 2016
- Exhibit 'JMcG17': SHSCT Day Opportunities April 2016
- Exhibit 'JMcG18': Demographics Funding: SHSCT AHP Support to Learning Disability Day Opportunities 2016
- Exhibit 'JMcG19': SHSCT Learning Disability Complex Discharges from Hospital 2017
- Exhibit 'JMcG20': SHSCT Learning Disability Day Opportunities 2017
- Exhibit 'JMcG21': SHSCT Learning Disability Community Infrastructure for Crisis/Out of Hours 2017
- Exhibit 'JMcG22': SHSCT Learning Disability Forensic Day Opportunities 2018
- Exhibit 'JMcG23': SHSCT Complex Care Nursing 2018
- Exhibit 'JMcG24': SHSCT Additional Investment for Community Infrastructure for crisis/out of hours LD 2019
- Exhibit 'JMcG25': SHSCT Enhance Adult Learning Disability Psychiatry Service 2018
- Exhibit 'JMcG26': SHSCT Adults with Learning Disability whose Family Care Arrangements break down 2019
- Exhibit 'JMcG27': SHSCT Complex Discharges from Hospital 2020


2.7: Transcript Pages 119 and 120, Questions 247 and 248: Reason for rise in nursing/residential placements from 2017/2018

2.7.1: On review of available information, there is a reasoned view that the spike in placements numbers in nursing/residential accommodation from 2017/2018/2019 was due to a) a number individuals coming back from specialist placements outside of Northern Ireland requiring nursing/residential accommodation on return; b) loss of

respite bed capacity with the closure of Longstone Hospital and the impact on carer/family stress and ability to manage individuals at home leading to higher demand for placement.

Section 3: Declaration of Truth

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

Signed: 

Date: 6th June 2023

List of Exhibits (Jan McGall)

JMcG2: The Care Pathway and Model for Community Forensic Teams in Northern Ireland, October 2011

JMcG3: SHSCT: Reflective Supervision Policy for Nurses and Midwives

JMcG4: SHSCT: Medical Appraisal and Engagement Procedure

JMcG5: SHSCT: Supervision Policy, Standards and Criteria for Social Workers and Social Care Workers. A Regional updated policy 2021 remains in draft format.

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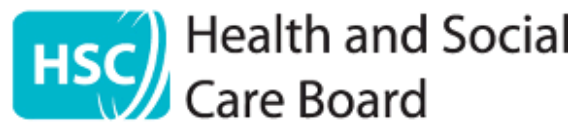
JMcG8': Learning Disability Accommodation Based Services in the Community (Resettlement) (Draft) March 2013

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- JMcG14: Demographics Funding: Community Learning Disability Transitions 2015
- JMcG15: SHSCT Learning Disability Community Forensics October 2015
- JMcG16: SHSCT Children with Learning Disability Transitioning to Adult Services January 2016
- JMcG17: SHSCT Day Opportunities April 2016
- JMcG18: Demographics Funding: SHSCT AHP Support to Learning Disability Day Opportunities 2016
- JMcG19: SHSCT Learning Disability Complex Discharges from Hospital 2017
- JMcG20: SHSCT Learning Disability Day Opportunities 2017
- JMcG21: SHSCT Learning Disability Community Infrastructure for Crisis/Out of Hours 2017
- JMcG22: SHSCT Learning Disability Forensic Day Opportunities 2018
- JMcG23: SHSCT Complex Care Nursing 2018
- JMcG24: SHSCT Additional Investment for Community Infrastructure for crisis/out of hours LD 2019
- JMcG25: SHSCT Enhance Adult Learning Disability Psychiatry Service 2018
- JMcG26: SHSCT Adults with Learning Disability whose Family Care Arrangements break down 2019
- JMcG27: SHSCT Complex Discharges from Hospital 2020

<u>JMcG2 Care Pathway and Model for Community Forensic Teams in NI Oct 2011</u>	10
<u>JMcG3 Reflective Supervision Policy for Nurses and Midwives</u>	38
<u>JMcG4 Medical Appraisal Engagement procedure Jan 2023</u>	71
<u>JMcG5 Social Work Social Care SupervisionPolicyOctober2009ReviewedandamendedJune2012</u>	95
<u>JMcG6 AHP Supervision Procedure</u>	139
<u>JMcG7 DCP Supervision May2014</u>	181
<u>JMcG8 SHSCT IPT LD Resettlement revised 300413</u>	204
<u>JMcG9 SHSCT LD Community Infrastructure revised 260413</u>	217
<u>JMcG10 SSAP LD Longstone Revised 031210 B</u>	228
<u>JMcG11 SHSCT IPT LD Transitions 2014</u>	297
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<u>JMcG13 SHSCT IPT Learning Disability Resettlement PTL and Delayed Discharge IPT - 2014</u>	328
<u>JMcG14 SHSCT IPT Demography 2015'16 POC6 Learning Disability</u>	341
<u>JMcG15 SHSCT Final scanned IPT for Learning Disability forensics</u>	377
<u>JMcG16 SHSCT Transitioning IPT 130116</u>	397
<u>JMcG17 SHSCT IPT - Day opps ST 2016</u>	419
<u>JMcG18 SHSCT AHP Support to learning Disability Day Opportunities</u>	436
<u>JMcG19 SHSCT IPT L2 LD Complex discharges from Hospital</u>	450
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<u>JMcG21 SHSCT IPT LD Additional Community Infrastructure for crisis out of hours L2 SH _V1</u>	480
<u>JMcG22 SHSCT LD Forensics Day Opportunties V1 - 21-05-2018 (3) final</u>	493
<u>JMcG23 SHSCT Complex Care Nurses IPT FINAL Signed</u>	504
<u>JMcG24 SHSCT Signed Copy LD Crisis Out of Hours 18-19</u>	522
<u>JMcG25 SHSCT Enhance Adult LD Psychiatry Service IPT FINAL signed</u>	540
<u>JMcG26 SHSCT Signed Copy LD Family Care Arrangements Break down 19-20</u>	556
<u>JMcG27 SHSCT IPT LD Complex Discharges from Hospital 2018-costed080120v4-signed</u>	570



**CARE PATHWAY AND MODEL FOR
COMMUNITY FORENSIC
TEAMS IN
N. IRELAND**

OCTOBER 2011

Acknowledgements

The authors Hugo Kelly (SHSCT), Terry Mc Cabe (NHSCT), Dr Paul Devine (BHSCT) & Brian Simpson (WHSCT) wish to acknowledge the significant contribution and support received from all members of the Bamford Forensic Services sub-group. The completion of this document was achieved through the collaboration of the various agencies involved in the management and care of Mentally Disordered Offenders.

Membership of the Bamford Forensic Sub Group:

- Molly Kane, Public Health Agency (Forensic, Joint Chair)
- Hugo Kelly, SHSCT (Forensic, Joint Chair)
- Dr Ian McMaster, DHSSPS (Low Secure Lead)
- Jackie Scott, BHSCT
- Dr Ian Bownes, WHSCT
- Terry McCabe, NHSCT
- Paul McMonagle, BHSCT (Patient Advocate,
- Paul Devine, BHSCT (Shannon Clinic)
- Noel McDonald, BHSCT
- Jackie Elliott, BHSCT (Shannon Clinic)
- Barry Mills, BHSCT (Learning Disability)
- Calum McDonald, HM Prison & Young Offender's Centre
- Helen Kennedy, HSCB (Prison)
- Adrian East, Shannon Clinic
- Jane Reynolds, NHSCT (AHP)
- Pat Conway, NIACRO
- Geraldine O'Hare, Probation Board for NI
- Maura Harper, CAUSE
- Mary Donaghy, HSCB (Social Work)
- Yvonne McWhirter, WHSCT
- Brian Simpson, WHSCT

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SECTION 1: INTRODUCTION & BACKGROUND

Introduction

The main purpose of this paper is to provide a composite regional care pathway for community forensic mental health and learning disability services. It outlines the links needed with probation, prison and police services as an integral element to provide streamlined access to community forensic services. In addition this paper provides an overview of current arrangements and processes within forensic mental health and learning disability services in place across Northern Ireland.

The paper makes reference to Community Forensic Teams (CFT's) as defined in Bamford 2006, for ease of reading. CFT's covers both Community Forensic Mental Health Teams (CFMHT) and Community Forensic Learning Disability Teams (CFLDT), with each service, where available, working within their own specialisms. In Trusts where there is no CFLDT established, the CFMHT will provide advice on such issues as offending behaviour and risk management where appropriate. It is recognised that this arrangement is not endorsed in every Trust area; however a Forensic Learning Disability proposal is being taken forward to address this deficit.

Background

The Public Health Agency and Health & Social Care Board established the Mental Health and Learning Disability Taskforce in 2010 to take forward the implementation of the Bamford Action Plan 2009-11 which was the DHSSPSNI response to the Bamford Review of Mental Health and Learning Disability Services (2007).

The Mental Health & Learning Disability Commissioning Team is responsible for planning and commissioning services through the Board and Agency, and for supporting and assisting the overall constituent elements of the service team structure i.e. Project Board/Commissioning Board and the range of sub groups. Membership of the sub groups includes a wide range of stakeholders, including the voluntary and community sector, service users and carers (appendix 1).

The Bamford Specialist High Support Services Sub-Group forms one of the work streams that are responsible for taking forward specific work packages within a number of workstreams, of which the Bamford Forensic Sub Group is one. Members of the Bamford Forensic Sub Group identified the need to

review the community forensic services care pathway document that was produced in 2006 to more accurately reflect and inform on current community forensic health care provision.

Definition of a Care Pathway

An integrated care pathway is a multi-disciplinary outline of anticipated care, placed in an appropriate timeframe to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes (www.evidence-based-medicine.co.uk, 2001)

The purpose of a forensic health care pathway is to ensure that service users are receiving a quality service that is accessible and appropriate to their needs.

The formation of a care pathway allows for better monitoring and streamlining of the care process, this is of particular relevance where there are a range of professionals/agencies involved in the management of the client. This in turn helps to ensure a high degree of efficiency and consistently delivered care regionally, thus reducing unnecessary variations in treatment and outcomes. The care pathway also supports the development of care partnerships, a vital component of interagency collaborative working, whilst at the same time empowering clients and their carers to participate and contribute to their specific care needs.

The development and implementation of a care pathway informs outcome measures and is an integral part of both Quality and Modernisation agendas across health communities. *“They are key to reducing variations in healthcare... are crucial to ensuring the delivery of care that is safe, effective, patient centred, timely, efficient and equitable.”* (Davis 2004).

Strategic Context

There are a number of significant strategic drivers that underpin the need for a co-ordinated and streamlined care pathway for community forensic mental health and learning disability services. Further detail can be found at Appendix 2.

SECTION 2: CURRENT SERVICE PROVISION

Mental Health

High Secure Services

Currently in Northern Ireland there is no provision for high secure services; this service is provided by the State Hospital Carstairs in Scotland (male) and Rampton in England (female). In exceptional circumstances male patients may also be located in any of the 3 High Secure Hospitals in England.

Medium Secure Services

Shannon Clinic, on the Knockbracken site in Belfast, provides regional medium secure inpatient services. The Unit is made up of 34 beds spread across 3 wards:

- Ward 1: Admission/Assessment and Intensive Care
- Ward 2: Continuing Care Services
- Ward 3: Rehabilitation

Ward two has five beds that can be made available for female patients, although this is not a dedicated provision. The Unit is supported by the four Community Forensic Mental Health Teams across the region who each deliver services to their respective Trust population.

Low Secure Services

There is currently no dedicated low secure provision for forensic mental health patients in Northern Ireland.

Community Forensic Mental Health Services / Teams

There is a Community Forensic Mental Health Team (CFMHT) in each of the Trusts across the region, with the exception of the South Eastern Trust which is covered by the Belfast Trust's CFMHT.

Learning Disability

High secure Services

Within Northern Ireland there is currently no high secure service provision for forensic learning disability clients. Currently forensic learning disability services for male clients are accessed through The State Hospital, Scotland, with services for female clients again being provided by Rampton Hospital.

Medium Secure

There is currently no dedicated medium secure provision for this client group, causing individuals to remain in high secure settings for longer than necessary or to be inappropriately placed in a low secure setting.

Low Secure

Learning Disability in-patient forensic services are provided by the Sixmile Low Secure Unit on the Muckamore site. This unit caters solely for male clients and there is currently no low secure provision for females, although they may be admitted to Cranfield Unit, Muckamore. The Sixmile Unit is comprised of two elements, a 4 bed assessment unit and a 15 bed treatment unit. The Unit is predominantly supported by generic learning disability community teams which include senior social work practitioners who act as designated risk managers as defined by PPANI, and where available Community Forensic Learning Disability practitioners and Community Forensic Learning Disability psychologists.

Community Forensic Learning Disability Services / Teams

Three out of the five Trusts, Northern, Southern and Belfast, currently provide dedicated community forensic services for their respective learning disability populations. These services are delivered via two service models. The Northern Trust CFLDS is integrated within the CFMHS infrastructure working to the same protocols and operational policies, and availing of the same training and supervision as their forensic mental health colleagues. The alternative existing approach is a stand alone model, as is the case in the Southern Trust (the senior Forensic Practitioners in the mental health team however have dedicated time devoted to the Community Learning Disability Team to promote an integrated model) and more recently the Belfast Trust. In January 2011, the Belfast Trust commissioned a community forensic learning disability post (Forensic Psychologist) with the intention of developing a comprehensive service. Current arrangements mitigate against delivery of services at level 4 although clients requiring complex and specialist assessments and interventions can be facilitated.

For both CFMHS and CFLDS the underpinning rationale for service delivery is the need to support the smooth transition from secure provision towards community integration. In addition their role is to support adult mental health and learning disability services in the risk assessment and safe management of those clients who meet the defined criteria as laid out in Section 3. Collaborative working with the Criminal Justice Service is paramount in the contribution to the assessment, treatment and management of Mentally Disordered Offenders whilst promoting recovery and being mindful of public safety (appendices 6 & 7).

This care pathway recommends that community forensic teams should work within the four level model outlined below:

Level 1 - A specialist consultation, education and training role which may include, for example, CFT attendance at case reviews to offer advice and support to generic teams, and a service co-ordination role or liaison between health and criminal justice. This will also include initial assessments following referral to determine immediate needs and decrease response time to referring agent.

Level 2 - An in-depth assessment (which may include a standardised risk assessment and management plan) prepared by the CFT with the referring team retaining responsibility.

Level 3 - An agreed period of shared responsibility for any or all of a variety of reasons including to assess risk; to evaluate the interplay/operation of known risk factors; to offer a specialist piece of therapeutic work; and to assess the efficacy of risk reducing strategies.

Level 4 – CFT taking full responsibility for the duration of need with referral back to the appropriate services when deemed appropriate. This will be particularly evident for clients being discharged from secure environments into the community (MSU, NIPS).

It would be assumed that the majority of the CFT's work would be at level 1 with only a small minority at level 4. (Bamford 2006).

Forensic mental health and learning disability services aim to uphold the underlying philosophy of recovery focused services in line with the Departmental Guidelines on Promoting Quality Care (2010) and the service development standards as defined in Bamford (2006). The Bamford High Support Services Sub Group supports the implementation of the Bamford standards in principle considering the current resource limitations.

Team structure and Multi-disciplinary working

The multi-disciplinary team (MDT) across the scope of forensic services consists of a range of professionals including Forensic Psychiatry, Forensic/Clinical Psychology, Nursing, Social Work and Occupational Therapy. These professionals work in support of each other to ensure best outcomes for the clients, being mindful of their own accountability and the way in which they practice.

The MDT approach to care delivery is best evidenced and supported through the implementation of the Department of Health's New Ways of Working for

Everyone, (NWW) (2007). This document gives clear indicators of effective multi-disciplinary team working, and should be evidenced in the delivery of forensic healthcare regardless of the setting (appendix 3).

In order to ensure a regionally consistent evidence based approach to care delivery, training needs analysis and subsequent commissioning should be undertaken at a regional level on an annual basis. This will ensure that all forensic practitioners have equal access to training, thus minimising the potential for inequalities in service delivery.

Quality and safety:

Key priorities for CFTs are to ensure a focus on safety and continuous improvement in the quality of services. CFTs will foster a culture of openness and learning where staff will feel supported and concerns about safety and care can be openly discussed. Training, personal development and supervision for all staff will be the cornerstone of the strategy to deliver safe, high quality care.

CFTs will provide care and treatment that is evidence based. Regular audit and evaluation processes will enable CFTs to assess their performance using a range of audit measures to evaluate clinical outcomes, service level outcomes, patient reported outcomes and patient reported experiences.

As national standards for community forensic services are developed it is anticipated that CFTs will aspire to benchmark their service against these standards.

Where disputes arise between agencies relating to their respective roles and responsibilities resolution should be sought through local senior management structures in the first instance.

SECTION 3: DEFINITION OF CLIENT GROUP

Patients suitable for referral to a CFT are usually (but not exclusively) between the ages of eighteen and sixty-five, currently suffering from a mental disorder (as defined in the 1986 Northern Ireland Mental Health Order) and who require a forensic service on the basis of either (i) risk, (ii) specialist need or (iii) continuity of care. The service will also provide advice/guidance to referring agents where the level of risk is not clearly defined but there are ongoing concerns. The categories are further explored below:

Risk: The patients will have behaviour that may bring them into contact with the Criminal Justice system and are a cause for concern, either because of the seriousness of their offending or their significant risk (that which is sufficiently serious to warrant a response) of causing serious harm to others.

Serious offending would include serious violence (such as murder, manslaughter, attempted murder, threats to kill or malicious wounding with intent, arson, kidnapping and any offence against a vulnerable adult) or a history of serious sexual offence against an adult or any sexual offence against a child.

Serious harm is defined in the Public Protection Arrangements for Northern Ireland Manual of Practice as “Harm (physical or psychological) which is life threatening and/or traumatic and from which recovery is usually difficult or incomplete”.

Specialist need: The patients should have forensic needs, which cannot be met by other available Mental Health or Learning Disability Services.

For example as personality disorder services continue to develop at primary, secondary and tertiary levels, the CFT, in line with NICE guidance, may offer for people with complex needs and challenging behaviours a structured assessment of personality functioning, and where appropriate specialist risk assessment to inform the delivery of treatment interventions (see Section 5).

Continuity of care: It is expected that all conditionally discharged restricted patients and those patients who have been discharged from high or medium secure mental health services will require advice to be sought from forensic services regarding the prospective management of the case.

Exit criteria conversely should apply as risk diminishes or is reasonably reduced/managed to an acceptable level. This will be after an agreed period

of observed stability and may coincide for example with the absolute discharge of a restriction order or the reduction in risk category by Public Protection Arrangements for Northern Ireland to category 1.

SECTION 4: REFERRAL PROCESS

Community Forensic Team's (CFT's) ideally function as a tertiary level service within the spectrum of both mental health and learning disability services. It is therefore important to ensure that the referral process is compatible with the current structures already in place across services.

Mental health services have /are in the process of implementing the regionally agreed 'stepped care model'. The implementation of this model follows the strategic vision of a system that ensures the most effective, yet least resource intensive, treatment is delivered to the patient (CSIP 2006). In essence, this means, having the right service in the right place, at the right time delivered by the right person.

A number of principles underpin the delivery of an effective and efficient stepped care model of service delivery, see appendix 4 for further detail.

Appendix 5 sets out the diagrammatic version of the Care Pathway.

Referrals from generic mental health and learning disability services:

The aim of CFT's is to provide an inclusive and equitable service that is underpinned by the multi-disciplinary team making decisions which are based on client need and the teams' expertise to address those needs.

Each service will have an operational policy that clearly outlines the systems and processes in operation to facilitate robust governance in the management of referrals into the service. These governance arrangements must take cognisance of the Health and Social Care Boards (HSCB) 2010 Mental Health Services Integrated Elective Access Protocol Addendum (IEAP). The key principles underpinning the referral process are:

- All referrals should be on the prescribed proforma i.e. a Community Services Referral Form including an up to date Comprehensive Risk Assessment (in line with Promoting Quality Care guidelines) and a case summary review letter from the referring agent (Team Leader / Consultant).
- All referrals are made to the Multi-disciplinary team and not individuals within the team.
- Referrals will be accepted from both community based services and inpatient services.

- On receipt all referrals are screened by a member of the forensic team to determine urgency, this should be done by the end of the next working day.
- All referrals are discussed at the Multi-disciplinary forensic team meeting, no more than seven working days from receipt, where consensus is reached on the appropriateness of the referral.
- If the referral is deemed appropriate, the referral will be allocated to a team member at that meeting.
- The Multi-disciplinary forensic team will communicate the outcome of their discussions to the referring agent and the GP as soon as practical following the close of the meeting but no later than three working days.
- Patients who require interventions will be seen within 15 working days from the date of acceptance by the team.
- For cases accepted at level 2 the appointed practitioner will contact the referral agent to update on initial findings within fifteen working days.
- The decision to intervene at level 3 & 4 will be decided by CFS following consultation with the referral agent.

Forensic Patients moving across Trust Boundaries:

- Where a patient, who is known to CFT, moves to/plans to move to another Trust area, it is the responsibility of the originating Trust to convene a transfer of care meeting with the receiving Trust within 15 working days prior to relocation.
- If the move is unplanned, the originating Trust should coordinate a transfer of care meeting with the receiving Trust within 7 working days of move becoming known.
- The originating Trust will provide a minimum data set which will include the case summary report, referral form and up to date comprehensive risk assessment in line with Promoting Quality Care Guidelines, as part of the transfer process.
- The responsibility for care resides with the Trust coordinating the transfer until such time as the transfer is complete.

Forensic Patients released from prison to non-originating Trust locality:

- When released from prison a forensic patient may through choice relocate to another Trust catchment area so that their care will be the responsibility of the receiving Trust. Where these arrangements are temporary (e.g. as part of Bail conditions) care will be temporarily coordinated by the receiving Trust CFT, with support and input from the originating Trusts CFT in line with Promoting Quality Care Guidelines.

- The Prison Healthcare Discharge Liaison Team (DLT) will coordinate with the originating Trust to ensure that Promoting Quality Care Guidelines are implemented in relation to this patient group.

Patients returning to N. Ireland following a period of care and treatment in the UK (Extra Contractual Referrals).

- Where forensic health services are involved in the repatriation of ECR patients, the role of the Care Coordinator remains with the originating Trust, regardless of where the patient is relocating to.
- This duty of care remains in force for a period not exceeding 6 months by which time the duty of care rests with the receiving Trust.
- The originating Trust will ensure that the Promoting Quality Care Guidelines are adhered to through the transfer process, facilitating and coordinating an appropriate number of meetings to ensure smooth transition of care.
- The originating Trust care co-ordinator will liaise with the receiving Trust to identify appropriate services prior to repatriation and will work collaboratively during the six month transition period.

Interface with Secure Units (Shannon Clinic/Sixmile Unit):

- The CFT will allocate a named professional to each patient from their Trust residing in these secure units.
- The named professional will attend secure unit review meetings regularly and report back to the CFT multi-disciplinary team.
- The named professional will endeavour to establish a therapeutic relationship with the patient prior to discharge.
- The named professional will actively participate in the discharge process for patients who will be returning to their respective Trust area.

Referrals from the Criminal Justice Services:

All referrals into forensic services are predicated by the need to adhere to each respective Trust's single point of access and the referral criteria as defined earlier in this document. To facilitate this process the CFT will act as a conduit/facilitator to ensure that the referred client, if required, has access/is known to core services.

Probation Board NI:

- Community forensic health services will accept referrals for initial assessment from Probation Services via the Probation Psychology Dept.

- Community Forensic Learning Disability Teams can only accept referrals via tier two services at this time i.e. PBNI need to refer to generic LD services in the first instance.
- Should the client require input from secondary mental health services and is not currently known/open to them the CFT will work in collaboration with the referring agent to ensure safe seamless engagement.
- All referrals from PBNI will be discussed at pre-arranged multi-agency/multi-disciplinary meetings. These discussions will be informed by the appropriate documentation to include referral form and a written risk formulation report.
- If at initial assessment it is evident that CFT or core mental health/learning disability services have no input to deliver, the case will be returned to the referring agent.
- A client who is currently open to CFT and who has a Probation Order in place will be managed via a joint agreement between the respective agencies, being mindful of PBNI statutory functions and responsibilities.
- The PBNI psychologist should, following agreement, attend the CFT team meetings on a regular basis (approx 8-12 weekly) to discuss currently opened cases and where appropriate new cases for consideration by the team. This timeline is by nature flexible and will be dictated by level of need and urgency.
- Reaching consensus/agreement on case management responsibilities will be facilitated through a multi-agency meeting coordinated by the CFT, being mindful of the PBNI statutory function and responsibilities.

Prison Services: (pathway out)

Forensic Needs:

- The CFT will work closely with the Discharge Liaison Team (DLT) to facilitate the smooth transition from prison into the community of those prisoners deemed to be suffering from a mental disorder who fall under the remit of “Promoting Quality Care”. This is because of the risk to others, with identified forensic needs and in need of on-going secondary level mental health/learning disability care.
- Prior to discharge the DLT will make contact with the relevant CFT to coordinate a pre-discharge meeting to facilitate the transfer of care from prison health care to community services for those individuals who fall under the PQC Guidelines.
- All such meetings should be compliant with the PQC Guidelines and referrals to CFT should be on the prescribed proforma.

Non Forensic Needs:

- Where the prisoner requires secondary mental health/learning disability services CFS will liaise with the appropriate Community Team to facilitate discharge from the prison to the appropriate service.
- This transition process will be informed by the client's response to treatment and evidence of ongoing manageable levels of risk.

Prison Services: (pathway in)

- The CFT will inform the DLT when a forensic patient (managed at level 3/4) is committed to prison. They will provide a minimum data set comprising of case summary report in line with PQC Guidance and a up to date comprehensive risk assessment within two working days.
- The CFT will, if required, act as a contact point to support effective communication between the DLT and core mental health/learning disability services. The DLT will link with appropriate NIPS mental health services.

Police Service of N. Ireland:

The development of a composite regional care pathway, and supporting protocols, is required to manage the day to day interface with the PSNI in particular for the effective and timely management of vulnerable adults and offenders with mental health and learning disability needs who fall outside of the CFT criteria. CFT's are primarily concerned with those patients subject to PPANI, and as such the PSNI do not have a direct referral route into CFT's. This does not preclude the PSNI referring into each Trusts respective single point of access.

- Where a mental health/learning disability patient is managed though PPANI the CFT may act as care providers where appropriate.
- The Trust representative in PPANI will liaise with the CFT where the patient is open to mental health/learning disability services.
- There is an expectation that all mental health/learning disability patients under PPANI should be allocated to a forensic practitioner. This will be facilitated through regular communication between the CFT and the respective Trust's representative on the Local Area Public Protection Panel.

SECTION 5: Risk Assessment/Management & Therapeutic Interventions.

CFT's provide care and treatment for individuals who have a major mental disorder and demonstrate serious offending behaviours or present a significant risk to others. The CFT offers assessment, consultation, care and treatment, which is proportionate to the situation and underpinned by risk assessment/management and treatment of offending behaviours. Where deemed appropriate and to assist in the formulation of treatment needs, psychological assessments are also undertaken, for example, personality assessments (IPDE), Psychopathy Checklist (R) (PCLR) etc .

Interventions by the CFT are preceded by the timely, comprehensive and professional completion of evidenced based assessments of risk. CFT's use a varying range of evidence based risk assessment tools for this purpose.

The completion of informed detailed risk assessments facilitates the formulation of robust multi-disciplinary risk management strategies, which in turn inform the therapeutic process whilst promoting public safety and emphasising a strong recovery based ethos to service delivery.

Interventions are predominantly based on the cognitive behavioural model, and delivered at both an individual and group level. Group interventions use a Cognitive Behaviour Therapy (CBT) approach and include psychosocial and life skills training such as Motivational Enhancement, Good Thinking Skills and Anger Management. Depending on the assessed needs, group interventions can be delivered on a one to one basis, if it is not appropriate for the client to participate in group work, or as booster sessions following group participation.

Although these groups predominantly target community clients, in-patients can also attend following assessment. Alternatively the CFT may in-reach into acute facilities to deliver one to one interventions.

Other treatment approaches include.

- Pharmacotherapy
- Use of positive behavioural management approaches
- Offence and offending type related work
- Sex offending related work
- Substance misuse work
- Medication concordance therapy
- Relapse prevention therapy
- Psychosocial interventions with families
- Developing contingency plans for crises and relapses.

SECTION 6: Evaluation measures.

Having identified the objectives of CFS as outlined in appendix 6, CFS recognises the need to ensure robust systems and processes are in place against which the service delivery can be measured and held accountable. This is a key component in ensuring a safe and effective service given that CFS is delivered across a range of interfaces and agencies.

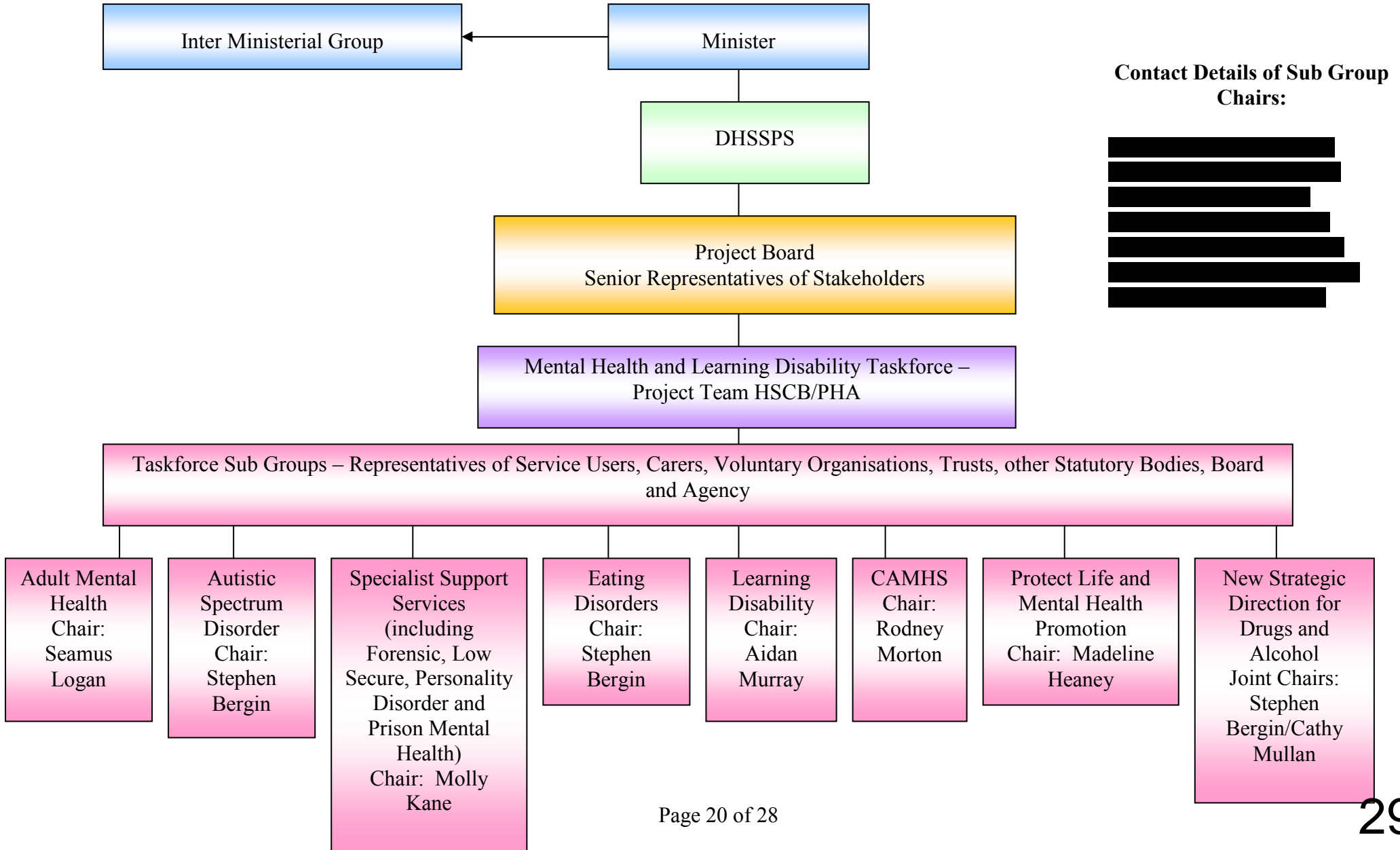
CFS will by March 2013 developed a range of standards and performance indicators encompassing Lord Darzi's 2008 'High Quality Care for All' definition of quality. Lord Darzi's review sets out a vision of high quality care, in which quality is defined as: clinically effective, personal and safe. The main themes of the standards will focus on:

- Primary focus on delivery of high quality care for patients
- Reducing variation in quality of care delivered
- Empowering patients to make their own choices
- Safe care - getting the basics right
- Preventative care, measures to improve health and well being

Glossary

CFT	Community Forensic Team
CFMHT	Community Forensic Mental Health Team
CFLDT	Community Forensic Learning Disability Team
CFMHS	Community Forensic Mental Health Services
CFLDS	Community Forensic Learning Disability Services
PPANI	Public Protection Arrangements Northern Ireland
BHSCT	Belfast Health & Social Care Trust
NHSCT	Northern Health & Social Care Trust
SHSCT	Southern Health & Social Care Trust
WHSCT	Western Health & Social Care Trust
MDT	Multidisciplinary Team
NWW	New Ways of Working
RcPsych	Royal College of Psychiatrists
CSIP	Care Services Improvement Partnership
IEAP	Integrated Elective Access Protocol
DLT	Discharge Liaison Team
ECR	Extra Contractual Referral
PBNI	Probation Board Northern Ireland
LD	Learning Disability
PQC	Promoting Quality Care
PSNI	Police Service Northern Ireland
IPDE	International Personality Disorder Examination
PCLR	Psychopathy Check List-Revised
STAR	Salford Tool for Assessment of Risk
HCR20	Historical Clinical Risk 20
RSVP	Risk of Sexual Violence Protocol
ARMADILO	Assessment of Risk and manageability of Intellectually Disabled individuals who Offend
RAMAS	Risk Assessment Management and Audit Systems
CBT	Cognitive Behaviour Therapy
DRAMS	Dynamic Risk Assessment & Management System
START	Short Term Assessment of Risk

APPENDIX 1 - Mental Health/Learning Disability Bamford Taskforce – Project Structure



Appendix 2 – Literature Review

- **The Reed Principles (1991)** as aspired to in the Bamford Review (2005), stated that patients, including Mentally Disordered Offenders should be cared for ‘as far as possible in the community rather than institutional settings’.
- **The Bamford Forensic Services Report (2006)** http://www.dhsspsni.gov.uk/forensic_services_report.pdf makes a total of 169 recommendations relating to the care and treatment of Mentally Disordered Offenders with several recommendations to the on-going development and operational capacity of community forensic services.
- **Bamford Action Plan (2009)** http://www.dhsspsni.gov.uk/bamford_action_plan_2009-2011.pdf recommends the establishment of a N. Ireland Forensic Mental health and Learning Disability Steering Group, to ensure better joined up services for people who need forensic services.
- **Priorities for Action (2010/11)** http://www.dhsspsni.gov.uk/microsoft_word_-_priorities_for_action_2010-11.pdf require Commissioners and Trusts to maintain the staged developments of specialist services, including forensic mental health and learning disability services.
- **Health and Social Care (Reform) (N. Ireland) Act 2009** <http://www.legislation.gov.uk/ukpga/2009/21>, Sections 19 and 20 place a statutory duty on HSC organisations to ensure that there are structures in place where individuals and local communities are actively engaged in their own health and wellbeing and in improving and shaping local services, thus ensuring services are person centred, responsive and meet the individuals assessed needs appropriately.
- **Not a Marginal Issue, Criminal Justice Inspectorate Report (2010)** <http://www.cjini.org/CJNI/files/24/24d6cd45-20bb-4f81-9e34-81ea59594650.pdf>, findings point to the need for a more coordinated and focused approach to the delivery of mental health services that concentrates on the need to divert people away from custody where appropriate and provide the right care in the right setting. Furthermore, the need to improve the interface between justice and health, whilst strengthening linkages with care in the community.
- **Promoting Quality Care (2010)** <http://www.dhsspsni.gov.uk/good-practice-guidance-and-risk-assessment.pdf>. Departmental guidelines describing the principles of best practice in making decisions about managing risk and potential risks that service users may cause harm to themselves or others. The broad principles of this guidance are to be

applied to any individual receiving care and treatment from learning disability and specialist mental health services, including forensic services.

Appendix 3

The following excerpts are drawn from the NNW document as indicators of effective MDT working:

Leadership: should be based primarily on competence rather than profession, with the focus on the team rather than the individual professions. The teams' ethos will be of developing the competence of all its members rather than one or two professions dominating the proceedings, this in turn makes the team more effective and stronger.

Team working and attitude: The team culture is one where by each individual takes personal responsibility for the governance of their work in an atmosphere of openness. Those with the most experience and clinical skills will deal with people with the most complex needs whilst supporting and developing the less experienced team members, thus building their competence, which in turn impacts positively on the overall teams' capabilities.

User and carer focus: Care is delivered through the sharing of capabilities within the team and blending them to the needs of the individual service user. Care is also delivered on a clear service pathway by the most competent practitioner to provide it, regardless of profession. Users and carers believe that their individuality is being responded to and therefore can engage more effectively with the service.

Innovation and efficiency: Services are underpinned by a system of care coordination, in which interventions are organised and delivered when required, this leads to more effective and efficient service delivery. This approach frees up practitioners, allows for even distribution of the workload, facilitating the timely management of increasing demands that can be placed on the service.

The intelligent use of information: Service structures and processes facilitate transparent and open caseload management. Through the processes of supervision and dynamic team meetings, everybody is challenged to consider what progress is occurring. Adopting this approach allows team members to know the bigger picture and see beyond the clinical work they are engaged in. This in turn creates a service that is dynamic and there is clear evidence of clinical movement, benefiting not only the team but also service users and carers.

The fundamental principle underpinning the decision making processes within the multi-disciplinary team is the concept of Recovery and Strengths based practice. This approach recognises that clients often feel powerless and disenfranchised, that these feelings can interfere with initiation and maintenance of mental health care, and that the best results come when the client feels that treatment decisions are made in ways that suit their cultural, spiritual, and personal ideals. The Recovery approach focuses on wellness and resilience and encourages clients to participate actively in their care.

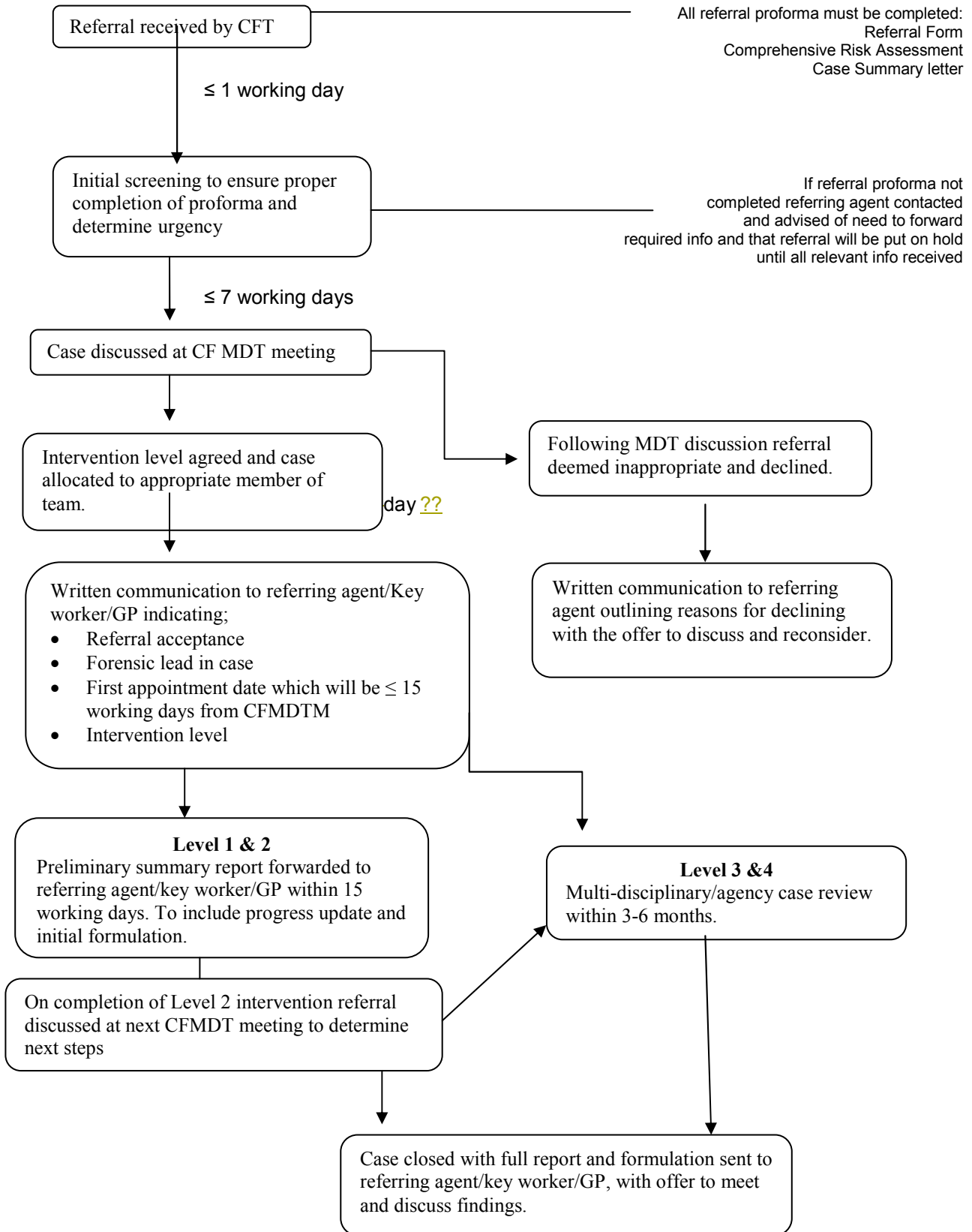
Appendix 4

A number of principles underpin the delivery of an effective and efficient stepped care model of service delivery:

- Treatment should always have the best chance of delivering positive outcomes while burdening the patient as little as possible.
- A system of scheduled review is in place that detects and acts on non-improvement to enable stepping up to more intensive treatments or stepping down where a less intensive treatment becomes appropriate.
- The establishment of a single point of access in association with robust screening, triage and assessment function.
- A focus on early intervention and signposting people to the most appropriate care and services which are provided by the Trust and/or voluntary/community/independent sector organisations.

The stepped care model creates structures that facilitate a single point of access to all mental health and learning disability services, offering pre-referral advice, screening assessment and treatment or onward referral. The model provides a clear pathway which sets out how people will move through the service, ensuring they get the most appropriate care by the right part of the service.

APPENDIX 5 – Care Pathway Diagram
 Referral pathway into Community Forensic Teams:



Appendix 6 – Objectives of Forensic Mental Health and Learning Disability Services

- To develop a service which is safe, secure and supportive, with skilled, confident staff who aim to manage risk effectively, within a framework of organisational managerial support.
- To promote patient, carer and whole family approaches in the development of treatment plans, through choice, negotiation and person centred approaches.
- To integrate closely with existing services.
- To facilitate the integration and maintenance of the individual into society, as far as is possible.
- To work in partnership with other relevant agencies for the benefit of patients, facilitating, establishing and maintaining a team knowledgeable of local, statutory and independent services.
- To monitor the changing needs of the forensic caseload (by developing a case register and routinely assessing need) and bring unmet need to the attention of the mental health and learning disability senior management team and commissioners.
- To regularly evaluate service and facilitate ongoing improvements - from patient, carer, referrer and staff perspectives.
- To promote awareness of forensic mental health and learning disability issues, including the valuable work of other agencies involved in the delivery of services to this complex population.
- To provide a training resource for other professionals.
- To contribute to the Bamford Action Plan for Forensic services.

Appendix 7 – Forensic Team composition (as of April 2011)

Team composition		
Trust	Post	WTE
Belfast Trust* and South Eastern Trust	Band 7 Nurse	3.0
	Band 7 Social Worker	3.0
	Band 8A Social Work Locality Manager	1.0
	Band 6 OT (not funded)	1.0
	Consultant	1.0
	Consultant Psychotherapist	0.25
	Band 8c Psychologist	0.5
	Band 4 Admin	1.0
	Band 3 Admin	1.0
	Band 2 Admin (not funded)	1.0
Southern Trust	Band 7 Practitioners	3.0
	Band 6 (vacant)	2.0
	Band 3 Admin	1.0
	Forensic Consultant	0.5
	Forensic Psychologist	0.8
Western Trust	Consultant	0.5
	Junior Doctor	0.5
	Band 8A	1.5
	Band 7 Practitioners	1.0
	Band 6	4.0
	Band 4	1.0
	Band 3	1.50
Northern Trust	Nurse Practitioners	4.0 (2 vacant)
	OT	1.0
	Forensic Team Leader	1.0
	Clinical Psychologist	0.75
	Forensic Psychiatrist	0.5
	Personal Secretary	1.0
Forensic Learning Disability Team Composition		
Trust	Post	WTE
Belfast Trust	Band 8B	1.0
Southern Trust	Forensic Psychiatrist	0.2
	Forensic Psychologist	0.2
	Band 7 Practitioners	2.0
Western Trust	No Forensic Learning Disability Service	
Northern Trust	Learning Disability Nurse Practitioner	1.0
	Learning Disability Social Work Practitioner	1.0
South Eastern Trust	No Forensic Learning Disability Service	

* Belfast Trust was commissioned by the legacy Eastern Health & Social Services Board to provide Community Forensic Services to both Belfast and South Eastern Trust areas.



Southern Health
and Social Care Trust

Quality Care - for you, with you

Reflective Supervision Policy for Nurses and Midwives

Lead Policy Author & Job Title:	Maggie Davison Senior Manager Appraisal and Revalidation
Directorate responsible for document:	Corporate Nursing, Midwifery & AHPs Directorate
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Policy name:	Reflective Supervision for Nurses and Midwives
Lead Policy Author & Job Title:	Maggie Davison, Senior Appraisal and Revalidation Manager
Director responsible for Policy:	Heather Trouton Executive Director of Nursing, Midwifery and AHP's
Directorate responsible for Policy:	Corporate Nursing, Midwifery & AHPs Directorate
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Policy Implementation Plan included?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
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Nurses and Midwives, as the largest health related workforce in Northern Ireland, have a vital part to play in achieving the transformation agenda set out in our local policy *Health and Wellbeing 2026: Delivering Together*. The Nursing and Midwifery Task Group report provides a roadmap to help secure this agenda and enhance nursing and Midwifery roles across a wide spectrum of sectors, services, settings and areas of practice.

The Northern Ireland Practice education Council (NIPEC) undertook a review of Nursing Supervision and as a result NIPEC have reproduced a **new** Reflective Supervision framework. [DoH Reflective Supervision - A Framework to Support Nursing and Midwifery Practice](#)

The framework is defined within a context of lifelong learning and professional development starting with practice supervision in pre-registration nursing and midwifery, through preceptorship, to reflective supervision thereafter. Reflective Supervision is a means by which staff may be supported to develop greater confidence & competence by providing the opportunity to discuss and reflect upon work/practice in a supportive and challenging environment.

The Reflective Supervision Model is based upon the model for Restorative Resilience Supervision that focuses on our emotional response to everyday threats we all experience, these can be **Personal**, **Professional** or **Practice** related. Reflective Supervision is defined as a participative process of supported reflection that enables individual nurses and midwives to develop personally and professionally to improve the quality, safety and person-centredness of their practice.

The three main functions of Supervision are:

- **Normative (Effectiveness)**
- **Formative (Learning)**
- **Restorative (Support)**

These align with Proctor's functions of supervision (Proctor 1998) each function has a separate purpose, these are outlined in (Appendix 1). Examples of the three main functions of Supervision and how they may be used in practice are highlighted in (Appendix 2).

NMC Revalidation encourages a culture of sharing, reflection and improvement and highlights the benefits for Nurses and Midwives as well as those they care for. Reflective Supervision can, in turn, provide the practitioner with support in: their practice; the acquisition of new knowledge, skills and abilities; and promoting staff wellbeing and positive relationships.

2.1 Reflective supervision should:

- Enable registrants to reflect on personal, professional and service provision topics to support improved safety, quality and person-centred practice for health and care services.
- Be used to identify what motivates registrants and provide recommendations to enhance and sustain their motivation. Maintaining a positive relationship with registrants can increase staff engagement, collaboration, inclusiveness and participation.
- Not be confused with performance management or with the client focussed elements of safeguarding supervision.
- Be defined within a context of lifelong learning and professional development
- Be used as part of the NMC revalidation process for Nurses and Midwives.
- Be defined within a context of lifelong learning and professional development starting with practice supervision in pre-registration nursing and midwifery, through preceptorship, typically regarded as in the first six months of registration with the Nursing and Midwifery Council (NMC), to reflective supervision thereafter.

Reflective Supervision is a part of the learning and development experience for Nurses and Midwives, commencing with: **Practice Supervision** for Student Nurses and Student Midwives; moving onto **Preceptorship** [SHSCT Preceptorship Procedure Nov 2022.pdf](#) in the early stages of registered practice; and when employed as a Registered Nurse or Registered Midwife, they can access **Reflective Supervision** supporting lifelong learning in practice throughout their career

Time will be set aside to have the reflective supervision session aside from daily work activities which are confidential to the participants unless a concern is raised that requires escalation.

Reflective supervision can be used as part of the revalidation process for Nurses and Midwives. The Nursing and Midwifery Council (NMC) has recognised the importance of reflection and subsequent discussion as integral to professional development of nurses and midwives.

3.0 Purpose

3.1 The purpose of the policy is to:

- Describe how the Reflective Supervision Standards required will be implemented and monitored
- Provide Registered Nurses and Midwives with guidance on the process of Reflective Supervision
- Outline the role of supervisors and supervisees
- Provide supporting templates for recording supervision activities in order to comply with the four reflective standards
- Outline how Reflective Supervision session will be evaluated

3.2 Aim of the policy is

The aim of this policy is to ensure that a culture of Nursing Supervision is embedded in the trust and that the processes through which Reflective Supervision is carried out are integral to the organisational arrangements for delivery of safe and effective care.

It is the duty of the Trust to establish and keep in place processes for the purposes of monitoring and improving quality of health and social care. This policy identifies Reflective Supervision in Nursing and Midwifery as a key organisational objective.

The implementation of an effective system of Reflective Supervision for Nursing and Midwifery will help ensure:-

- The promotion and maintenance of Nursing Care Standards i.e. NIPEC Standards for person centred nursing and midwifery record keeping practice, NMC (2015), The Code: Professional standards of practice and behaviour for nurses and midwives.
- A competent and skilled workforce,
- Delivery of safe and effective care; and
- A supportive professional environment for Nursing and Midwifery staff.

Senior management teams in the SHSC must ensure that appropriate measures are in place to enable Reflective Supervision activities for both clinical and non-clinical teams.

4.0 Standards for Reflective Supervision

Regional agreed standards for supervision have been developed to articulate the expectations of what would be expected of a nurse or midwife undertaking the process of reflective supervision, and the support to be provided by employing organisations.

- 1 Enable supervisors and supervisees to prepare for and acknowledge their role within the reflective supervision process.
- 2 Provide a guideline for organisations to ensure effective implementation.
- 3 Guide the development of education programmes for reflective supervision focusing on agreed best practice.
- 4 Provide service users and the public with a contemporary description of the standards for reflective supervision.

4.1 Standard 1 - Supervisors

- Supervisors of Nurses and Midwives must be a NMC Registered Nurse or Registered Midwife.
- A Supervisor should have a minimum of three years' experience as a Registered Nurse or Registered Midwife, this requirement might be challenging for some areas, however this is the preferred length of experience to enable the Supervisor to fulfil the role effectively.
- Supervisors must, as a minimum, have undertaken a Supervisor preparation programme [Programmes | Clinical Education Centre \(hscni.net\)](https://www.hscni.net/programmes/clinical-education-centre) and have an understanding of Reflective Supervision. The Supervisor should be on the organisation's Register of Supervisors of Nurses and Supervisors of Midwives. (The Register of Supervisors will be reviewed and updated by the Nursing Revalidation Team).
- A Supervisor should have knowledge and skill specific to the composition of the Supervisee's role, taking account of any particular specialised and expert requirements. For example, where the purpose of the Reflective Supervision session is related to a specialised area of clinical practice then the Supervisor

would require a certain level of knowledge in relation to this area. However, if the Supervisee wished to use the supervision session to reflect on feedback from a person receiving care or a recent activity of learning, then the Supervisor could be chosen from a wider area of practice (see Appendix 5).

- Each Supervisor must facilitate the Supervisee to complete their Reflective Supervision record and must retain copies of all Reflective Supervision sessions, with the exception of any records relating to an issue of concern for escalation, raised during a supervision session. Reflective Supervision records are discoverable and may be called upon for legal reasons.
- Supervisors must record the number of sessions they engage in on a quarterly basis and make these returns available to Line Managers for collation. Line Managers will be requested to return completed quarterly reflective supervision data collection to the Trust Nursing Supervision department.
- Supervisors must seek their own Reflective Supervision sessions (Appendix 7).
- A Supervisor must be available to provide at least two formal sessions of Reflective Supervision annually for each Supervisee. The sessions may be provided as a one-to-one or group format.
- A Supervisor should only provide a maximum of sixteen Reflective Supervision sessions annually.

4.2 Standard 2 - Supervisees

- Supervisees are NMC Registered Nurses or Registered Midwives. They should participate in two formal Reflective Supervision sessions a year, keeping personal reflective accounts including relevant actions.
- Supervisees should choose an appropriate Supervisor from the organisation's list and agree this with their line manager
- Supervisees will need to prepare for each supervision session. As a guideline this preparation time should be between **30** and **60 minutes**, prior to each Reflective Supervision session (Appendix 6).
- Supervisees should actively identify a focus for the meeting and be open to constructive feedback.

- Supervisees should evaluate the perceived benefit of the session to their personal and professional life, reflecting on the opportunity to impact on safety, quality, experience of those they care for or staff experience. This can help registrants meet NMC requirements for revalidation (Appendix 7).
- Supervisees can contribute to their appraisal and Personal Development Plan process through identification of learning and development needs in partnership with their Supervisor.
- Each Supervisee should consider a range of factors that might trigger the need for the review of frequency and type of Reflective Supervision: They might include:
 - Risks that could compromise the quality of services.
 - Risks that could compromise the experience of the person being cared for.
 - Risk of negative impact to the staff experience.
 - Reported personal stress.

4.3 Standard 3 - Structure of Reflective Supervision Sessions

Reflective Supervision sessions can be delivered via a range of formats, for example face-to-face sessions in person or using video-conferencing on a one-to-one basis. Alternatively a Supervisor may provide Reflective Supervision for a number of people.

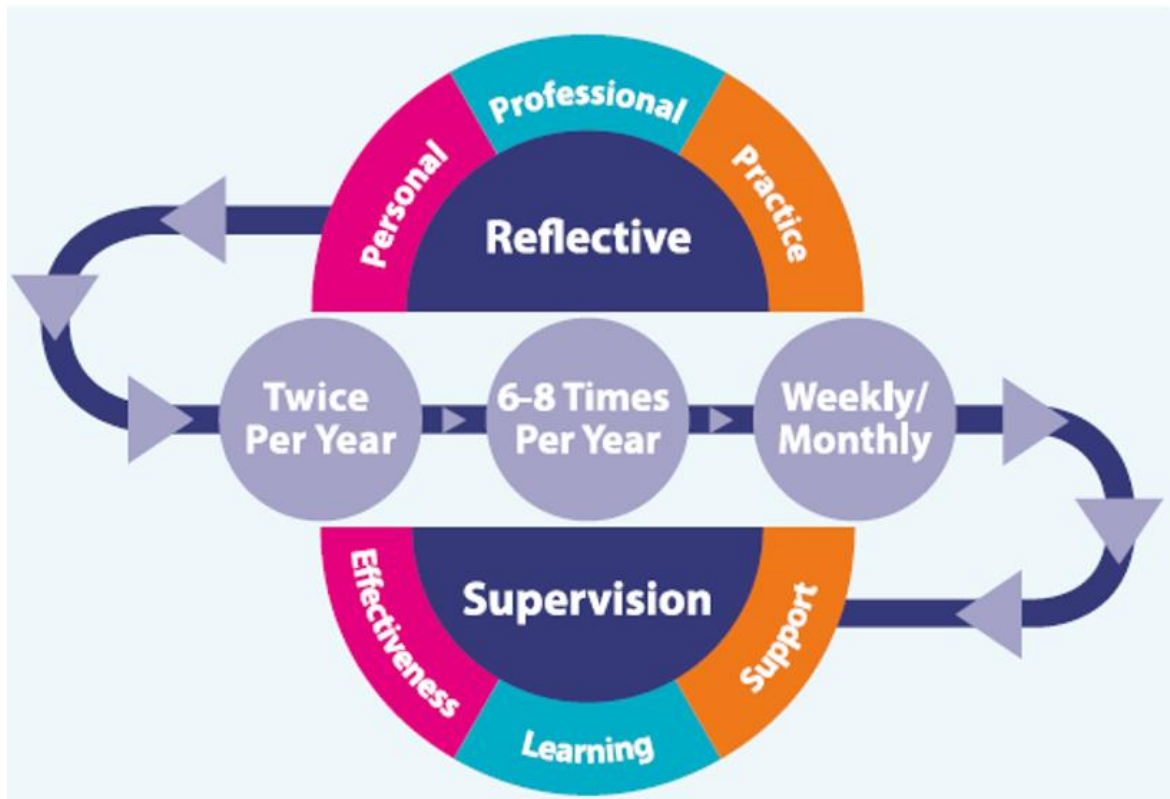
As a guide, a one-to-one session should typically last up to one hour. This time should be ring fenced and where possible Reflective Supervision should be carried out in an environment which is free from disturbance. Group sessions should typically last up to two hours. Sessions can be extended at the discretion of the Supervisor as required. The time for Reflective Supervision is generally calculated as 4 percent of the funded establishment for each post, which also includes study leave.

Each Supervisor must agree ground rules (Appendix 4), with the Supervisee and undertake the following responsibilities in each session:

- Protect the allocated time and maintain an environment conducive to supervision.
- Appropriate exploration of the Supervisee's expectations.
- Follow the focus identified by the Supervisee(s) and allow the Supervisee(s) to express their individuality.
- Provide clear constructive feedback.

- Evaluate the perceived benefit of the Reflective Supervision session including identification of agreed action plans.
- Manage areas of conflict, including onward action

Nurses and Midwives work in challenging environments and in circumstances that might, on occasion, require an increased level of support for practitioners. This may mean that the mode and/or frequency of Reflective Supervision will change depending on circumstances



4.4 Standard 4 - Governance Structure

The Trust has a Nursing and Midwifery Assurance Framework in place which includes Reflective Supervision recording, reporting and monitoring assurance framework in place to support organisational accountability for Nurses and Midwives. The Assurance Framework is aligned with existing governance and escalation processes and includes raising and escalating concerns and the management and escalation of third-party risks.

A quarterly and annual report of assurance regarding the provision of Reflective Supervision for Nurses and Midwives, will be provided by the Senior Revalidation and Appraisal Manager to the Executive Director of Nursing, Midwifery, AHP's.& Functional Support Services

The Senior Revalidation and Appraisal Manager will retain a register of appropriately prepared and updated Supervisors.

The Senior Revalidation and Appraisal Manager will provide quarterly Supervisor network meetings, all meetings will be facilitated by the Senior Revalidation and Appraisal Manager.

5.0 Policy Statement

The Trust acknowledges the importance of Reflective Supervision in ensuring the delivery of safe and effective nursing care and the essential role it plays in protecting the public.

All registered nurses and midwives employed in the trust should have access to and avail of, a minimum of two Reflective Supervision sessions per year. The Trust will ensure effective systems are in place to support Reflective Supervision processes. All supervisors will be supported to acquire the appropriate knowledge and skills to competently undertake this role.

6.0 Scope of Policy

The content of the policy applies to all registered nurses and midwives with substantive bank contracts employed by trust.

7.0 Responsibilities

In the SHSCT there are key individuals in posts with responsibility for ensuring Reflective Supervision is implemented. They are: -

7.1 Chief Executive

The Chief Executive of the trust is responsible and accountable for quality service provision at Trust Board level which includes systems, such as Reflective Supervision in Nursing, which support Clinical and Social Care Governance.

7.2 Executive Director of Nursing, Midwifery, AHP's & Functional Support Services

The Executive Director of Nursing, Midwifery, AHP's & Functional Support Services in conjunction with the Operational Directors in the SHSCT is accountable to the Chief Executive for the implementation and maintenance of Reflective Supervision in Nursing. The Executive Director of Nursing presents Reflective Supervision report to both the

Trust Board and the Chief Nursing Officer for Northern Ireland on an annual basis. In addition, s/he may act as a supervisor for Assistant Directors and other senior professional roles when appropriate.

7.3 Directors

All Directors have responsibility for ensuring that arrangements are in place within their directorates to evidence compliance with this policy and that resources are available to support Reflective Supervision, monitoring and reporting processes.

7.4 The Assistant Director of Nursing for Patient Safety, Quality and Experience of Nursing, Midwifery and AHP's

Has responsibility to co-ordinate, facilitate, evaluate and maintain a system of Supervision in the Nursing workforce. S/he is accountable to the Executive Director of Nursing, Midwifery, AHP's & Functional Support Services for presenting information relevant to the quantity and quality of SHSCT Reflective Supervision activity in Governance reports and Accountability/Assurance meetings.

7.5 Operational Assistant Directors

Operational Assistant Directors have responsibility to co-ordinate and facilitate implementation and maintenance of Reflective Supervision for nurses and midwives within their divisions. They are responsible for agreeing the models of Reflective Supervision to be employed within their division and must ensure appropriate resources are in place to enable nurses to undertake at least two formalised sessions of Reflective Supervision annually.

They are responsible for monitoring the ongoing level of Reflective Supervision activity within their division supporting the Assistant Director of Nursing for Patient Safety, Quality and Experience of Nursing, Midwifery and AHP's as requested in collation of reports.

7.6 Nursing and Midwifery Heads of Service/Nursing and Midwifery Managers/ Lead Nurses

Nursing and Midwifery Heads of Service/Nurse Managers/ Lead Nurses have a responsibility to promote, co-ordinate and facilitate implementation and maintenance of Reflective Supervision for nurses within their individual directorates/divisions. They are accountable to the Operational Assistant Director and can act as supervisors for Ward

Managers/Team Leaders within their own division/directorate.

7.7 Senior Revalidation and Appraisal Manager

The Senior Revalidation and Appraisal Manager is responsible and accountable for hosting meetings, local learning events and disseminating relevant information, generating Reflective Supervision Assurance reports and supporting and providing guidance to Supervisors. They are accountable to the Assistant Director of Nursing for Patient Safety, Quality and Experience of Nursing, Midwifery and AHP's

7.8 Ward Sisters/Charge Nurses/Team Leads

Ward /Team Leaders have a responsibility to role-model and facilitate implementation and maintenance of Reflective Supervision for nurses and midwives within their staff teams. They are accountable to the Heads of Service. They can act as supervisors for other members of staff, either within or outside their own team. Ward Sisters/Charge Nurses/Team Leads are accountable to The Assistant Director of Nursing for Patient Safety, Quality and Experience of Nursing, Midwifery and AHP's and will review quarterly returns received from supervisors within their team e.g. quarterly reflective supervision data collection spreadsheet.

7.9 Supervisors (Registered Nurses and Midwives)

Supervisors have a responsibility to maintain and develop their own skills and competencies relative to Reflective Supervision activity, contribute to the models of learning and to the approaches used.

They must seek and undertake Reflective Supervision themselves, maintaining records for both their personal Reflective Supervision and Reflective Supervision of others. They must provide at least two formal sessions of Reflective Supervision annually for each supervisee, whether group, individual or video conferencing.

They must adhere to ground rules identified and conduct Reflective Supervision sessions within the principles and process identified in these procedures. They are accountable to their line managers for this activity.

7.10 Supervisees (Registered Nurses/Midwives)

Supervisees have a responsibility to engage fully in the nursing reflective supervision process, adhering to identified ground rules. They have a responsibility to prepare for,

and participate in, a minimum of two formal Supervision sessions per year, keeping accurate records of relevant actions. Activities undertaken between sessions should be used to inform Reflective Supervision sessions. Supervisees are accountable to their line Manager to engage in a minimum of two Reflective supervision sessions annually.

8.0 Frequency of Reflective Supervision

Formalised Reflective Supervision sessions for nursing staff should take place at least twice per year. Registrants will have one Reflective supervision session within their first 6 months of taking up their post. Registrants who are in post over one year should have one reflective supervision session by 30th September and their second session by 31st March. All Registered nurses and Midwives should reflect on their own practices as they engage in ongoing learning and development activities in their working environment. This experience should be used to inform the Reflective Supervision sessions. There are many ways to reflect on practice and approach supervision-some examples are included in (Appendix 4).

In order to benefit from Reflective Supervision, nurses and Midwives should prepare appropriately. Preparation will include becoming familiar with and agreeing to, the Ground Rules for the Reflective Supervision session. (Appendix 4). Preparation will also include a review of the current Reflective Supervision action plan and reflection on the learning activities that have been undertaken between sessions. A Reflective Supervision Preparation template to help structure this process can be found at (Appendix 6).

General information and guidance on Reflective Nursing Supervision is available via the following link [Reflective Supervision. A Framework to Support Nursing and Midwifery Practice.](#)

9.0 Processes for Supporting Reflective Supervision

The following additional elements are important to support the effective implementation of Reflective Supervision.

9.1 Confidentiality

Confidentiality is pivotal to the success of supervision and should be maintained through a trustful relationship, an appropriate choice of environment, and dedicated time. Supervisors and Supervisees should adhere to the responsibilities articulated within the

Standards for Reflective Supervision as a ~~acknowledgement~~ ~~of~~ trust and expectations.

In setting up Reflective Supervision, it is important that the boundaries of the supervisory relationship are established, including the agreement of ground rules between the parties to support and protect confidentiality at the start of Reflective Supervision sessions (see Appendix 4). This process of agreement enables identification of potentially conflicting roles and development of mutual understanding. The agreement may be reviewed at any stage at the request of either Supervisor or Supervisee; however, frequent review should not normally be necessary.

9.2 Recording Reflective Supervision

Good record keeping is fundamental to high quality Nursing and Midwifery practice and is essential for the provision of safe, effective, person and family centred care. Registrants must keep clear and accurate records relevant to their practice. For the purpose of Reflective Supervision, Supervisors and Supervisees must ensure that they maintain adequate records of the supervision session adhering to the principles of confidentiality for storage. Supervisors will be required to keep record of the number of sessions provided by them annually for each Supervisee, with the exception of any records required relating to issues of concern for escalation. The NMC's guidance on reflection for revalidation advised the following:

'In meeting the revalidation requirements and keeping your evidence, you must not record any information that might identify an individual, whether that individual is alive or deceased. This means that all information recorded must be recorded in a way that no patient, service user, colleague or other individual can be identified from the information'.

9.3 Raising and escalating concerns

A positive working environment is vital in supporting the professional practice and behaviours of Nurses and Midwives. This includes being able to raise concerns if issues arise that could for example: compromise the safety, quality and experience of people receiving care.

During a Reflective Supervision session, a Supervisee may divulge an issue of concern in relation to practice. If so, the issue identified should be dealt with supportively via appropriate organisational and/or regulatory procedures.

Although generally rare, where practice is raised that is below the expected standard, the Supervisor will advise the registrant and an agreement should be made to put in place an appropriate improvement plan with regular review, including any appropriate supervised practice.

The Supervisor must inform the line manager of the Nurse or Midwife, identifying how far short the practice falls from the expected standard and the level of support required in line with the NMC Code. The Supervisee should be kept fully informed at each stage of the process and the organisation's processes should be followed in relation to support, capability and if necessary fitness to practice procedures. (Appendix 8) examples of issues that may be presented within a supervision session that might require escalation.

9.4 Use of Patient /Client Records

If necessary, patient/client records may be used for the purposes of Supervision activity. The NMC states that where this happens, principles of access and confidentiality apply. The NMC no longer have standalone guidance on record keeping, this has been incorporated into the NMC Code. [NMC standards and code](#). The SHSCT Records Management Policy and associated procedures should be adhered to.

9.5 Storage of Records

Reflective Supervision Records are discoverable documents. The SHSCT Records Management Policy and disposal schedules for records, as per principles of Good Management Good Records (GMGR) and associated procedures should be adhered to each registrant should also be mindful of his/her professional accountability with regard to the principle of confidentiality of information. Nurses and Midwives must, therefore, take responsibility for making sure that the system used is managed in such a way that it is appropriately protected to ensure the security of confidential information.

10.0 Monitoring and Evaluation

The Senior Revalidation and Appraisal Manager will seek qualitative information periodically from individual registrants to assist in the ongoing evaluation of Supervision processes. This information will be shared with the Executive Director of Nursing, Midwifery, AHP's & Functional Support Services. Regular feedback will be obtained from staff by a range of methods including active feedback following the supervision session for example via the use of surveys or questionnaires to analyse utility following

implementation. Social media will also be considered as a means to collect feedback from staff through closed groups.

11.0 Legislative Compliance, Relevant Policies, Procedures and Guidance

This policy should be read in conjunction with the:-

- Department of Health (2014). Good Management Good Records. DOH. www.health-ni.gov.uk/articles/introduction-good-management-good-records
- DHSSPS Safeguarding Children Supervision Policy for Nurses and Midwives (2011) - currently under Regional review [Safeguarding children supervision for nurses and midwives | Department of Health \(health-ni.gov.uk\)](http://www.health-ni.gov.uk/Safeguarding%20children%20supervision%20for%20nurses%20and%20midwives)
- DoH Reflective Supervision - A Framework to Support Nursing and Midwifery Practice. [DoH Reflective Supervision - A Framework to Support Nursing and Midwifery Practice](http://www.health-ni.gov.uk/DoH%20Reflective%20Supervision%20-%20A%20Framework%20to%20Support%20Nursing%20and%20Midwifery%20Practice)
- Records Management Policy <http://sharepoint/pr/informatics/Policies%20%20Procedures/20210303>
- Safeguarding Board for Northern Ireland (SBNI) Regional Core Child Protection Policy and Procedures (2017). [Safeguarding Board for Northern Ireland Procedures Manual \(proceduresonline.com\)](http://www.proceduresonline.com/Safeguarding%20Board%20for%20Northern%20Ireland%20Procedures%20Manual)
- SHSCT, Performance and Personal Development Review Policy Based on the Knowledge and Skills Framework (KSF) [Performance and Personal Development Review Policy Based on the Knowledge and Skills Framework \(KSF\)](http://www.health-ni.gov.uk/Performance%20and%20Personal%20Development%20Review%20Policy%20Based%20on%20the%20Knowledge%20and%20Skills%20Framework%20(KSF))

12.0 Equality & Human Rights Considerations

This policy has been screened for equality implications as required by Section 75, Schedule 9, of the Northern Ireland Act, 1998. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. This policy will therefore not be subject to an Equality Impact Assessment. This policy has been considered under the terms of the Human Rights Act 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

This policy will be included in the Trust's Register of Screening Documentation and maintained for inspection whilst it remains in force. This document can be made available on request in alternative formats, e.g. Braille, disc, audio cassette, and in other languages to meet the needs of those who are not fluent in English. The SHSCT audit this Policy every two years and make appropriate changes where necessary.

13.0 Sources of Advice & Further Information

Department of Health (2016) Health and Wellbeing 2026: Delivering Together. Belfast: DoH. [Health and Wellbeing 2026 - Delivering Together | Department of Health \(health-ni.gov.uk\)](https://www.health-ni.gov.uk/health-and-wellbeing-2026-delivering-together)

Department of Health (2020) Nursing and Midwifery Task Group Report. Belfast: DoH. [Nursing and Midwifery Task Group \(NMTG\) Report and Recommendations | Department of Health \(health-ni.gov.uk\)](https://www.health-ni.gov.uk/nursing-and-midwifery-task-group-report)

Department of Health (2022) Northern Ireland Preceptorship Framework for Nursing and Midwifery. Belfast: DoH. [NI Preceptorship Framework 2022 | NIPEC \(hscni.net\)](https://www.hscni.net/northern-ireland-preceptorship-framework)

Nursing and Midwifery Council (2018) The Code: Professional standards. [The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council \(nmc.org.uk\)](https://www.nmc.org.uk/standards/the-code)

Nursing and Midwifery Council (2019) *Revalidation*. London: NMC. [Revalidation - The Nursing and Midwifery Council \(nmc.org.uk\)](https://www.nmc.org.uk/revalidation)

Nursing and Midwifery Council [Reflective-practice-guidance.pdf \(nmc.org.uk\)](https://www.nmc.org.uk/standards/reflective-practice)

Nursing and Midwifery Council [Revalidation resources and templates - The Nursing and Midwifery Council \(nmc.org.uk\)](https://www.nmc.org.uk/revalidation-resources)

Proctor, B. (2010) Training for the supervision alliance: Attitude, skills and intention. In Routledge handbook of clinical supervision (pp. 51-62). Routledge.

Wallbank, S. (2016) *The Restorative Resilience Model of Supervision* A reader exploring resilience to workplace stress in health and social care professionals. London: Pavilion Publishing and Media.

ELEMENTS OF REFLECTIVE SUPERVISION Supervisors and Supervisees take part in Reflective Supervision understanding the elements of Reflective Supervision and their role and responsibilities in maximising the effectiveness of the experience. Registrants may select an appropriate element of depending on the focus of the reflective supervision session. The following elements of Reflective Supervision align with Proctor’s Supervision Model (Proctor 1993) and emphasise how each element has a separate purpose and can be used separately or interchangeably depending on the purpose of the Reflective Supervision session.



Appendix 2 Examples in practice exemplifying how each element could be used during the reflective supervision session

EXAMPLES IN PRACTICE EXEMPLIFYING HOW EACH ELEMENT COULD BE USED DURING THE REFLECTIVE SUPERVISION SESSION

EFFECTIVENESS (NORMATIVE)	LEARNING (FORMATIVE)	SUPPORT (RESTORATIVE)
<p>A newly qualified nurse has received positive feedback from one of his patients in relation to the care they have received during a hospital stay. He wishes to reflect on the experience with his supervisor endeavouring to continue to uphold high values and personal accountability in his practice.</p>	<p>A nurse has attended a leadership programme and wishes to use the Reflective Supervision session to reflect on the skills and knowledge that she has gained and how she may utilise this in practice to work collaboratively with teams and support improvements in practice.</p>	<p>A midwife attends a delivery where the baby is born with an undiagnosed cardiac defect. She wishes to attend Reflective Supervision to reflect on her emotional response to the event and consider ways where she could offer support to parents if a similar situation arises in future</p>
<p>A midwifery team leader has received a complaint that there were communication failings during and following delivery of her baby which affected her experience during and after her baby's delivery. She wishes to use the Reflective Supervision session to reflect on the care delivered and to identify personal and professional objectives that could change or improve communication processes within her team.</p>	<p>A newly qualified staff member has completed a preceptorship programme and wishes to use the Reflective Supervision session to reflect on the skills and knowledge that they have acquired during the process and how these skills can provide the foundation to continue their journey of personal and professional development.</p>	<p>A registered staff member is experiencing a situation where she perceives a colleague is treating him unfavourably in comparison to other staff. She wishes to discuss these concerns with her supervisor as it is now affecting his job performance and causing a level of personal stress.</p>
<p>A medication error has resulted in a patient not receiving a critical medication as part of her plan of care. The patient has not come to any harm but this has been reported through the appropriate governance processes and ensuring confidentiality the ward manager has given feedback to the team. A group of staff wish to discuss this event during a group Reflective Supervision session and reflect on ways that they could improve practice and minimise medication error risks in the future.</p>	<p>A team leader has successfully completed a Quality Improvement initiative and has been nominated for an award for her work. She wishes to reflect on the learning gained through this process and identify how she could provide support to colleagues and peers in their Quality Improvement journey.</p>	<p>A nurse has been asked by her manager to prepare a presentation for a regional conference. She is content to prepare the work but does not feel confident to deliver the presentation as this would be the first time she has presented to groups outside of the organisation. This is causing her concern and she is experiencing a moderate level of stress. She wishes to discuss this in confidence with her supervisor and identify strategies that could help build her confidence and self-esteem prior to the event.</p>
	<p>A midwife has completed a piece of research in her field of practice which is due for publication in a peer reviewed journal. She wishes to reflect on the learning acquired with her supervisor and how she could use this to develop her career pathway.</p>	<p>A staff nurse working in a regional Emergency Department is struggling with the emotional demands of the clinical role. She wishes to discuss this at her Reflective Supervision session and identify coping strategies to minimise stress and foster resilience in this role.</p>

Think about

- Facilitating supervision sessions – setting the supervision agenda, engagement, boundaries, timing and frequency, supervision contracts, expectations of supervision, supervision, dealing with feedback, endings, keeping records of supervision.
- Relationship factors – how the supervisee makes you feel and how you manage this, promote and enhance engagement.
- Use of verbal and non-verbal communication, Facilitation skills and questioning
- Think formulation and action planning – in order to determine the most appropriate actions for action plans.
- Professional issues – working within codes of conduct, awareness of power issues, prioritising workload and self-care, taking advantage of learning opportunities, professional relationships, working within levels of competence, maintaining appropriate documentation, awareness of legal obligations.
- Personal issues – In practice, personal issues can be defined as any personal problem that affects a certain individual. Typical personal issues could relate, among others, work, career pressure, to family, finance, addiction, disability or health.
- Practical issues – A nurse and midwives daily clinical work includes performing several different practical skills - Practical issues relate to time, use of equipment, or technical skills such as how to safely administer medication via a PICC Line, in order to provide adequate care, maintain patient safety, and feel confident and competent in the profession.



GROUND RULES FOR FACE-TO-FACE SESSIONS IN PERSON OR USING VIDEO-CONFERCING ON A ONE-TO-ONE BASIS

Prior to Reflective Supervision session the SUPERVISEE will have: -

- Read all relevant/associated policies, procedures and guidance
- Prepared for the session and will have considered and identified practice areas for open discussion
- Undertaken relevant action(s) as agreed at previous Supervision session(s) have an attitude of open learning.

Where face-to-face sessions in person or using video-conferencing on a one-to-one basis one-to-one meeting is taking place between a supervisor and supervisee all parties should:

- Have an attitude of open learning.
- Deal appropriately with areas of disagreement positively approaching conflict in an attitude of mutual respect.
- Ensure that practice that could compromise patient safety, quality and experience if identified, is dealt with supportively via appropriate procedures.
- Where such an issue arises, ensure all parties are informed of the intention to disclose, before revealing confidential information.
- Ensure that all relevant records are kept securely in an appropriate place

During each Supervision session both SUPERVISOR and SUPERVISEE will: -

- Agree to share within a group setting.
- Be sensitive to the needs of individuals and the overall dynamics within the group.
- Maintain confidentiality by not disclosing or discussing information provided by any other members of a group - they should not be discussed with anyone outside the group e.g. other team members, family or friends.
- Be supportive of other members of the group.
- Listen to other members of the group when they are speaking and allow them to finish before beginning to speak themselves.
- Ensure that unsafe, unethical or illegal practice, if identified, is dealt with supportively via appropriate procedures.

- Where such an issue arises, ensure all parties are informed of the intention to disclose, before revealing confidential information.
- Ensure that all relevant records are kept securely in an appropriate place.

After the session the SUPERVISEE will: -

- Engage in learning and development activities that will inform subsequent supervision sessions
- Record and reflect on significant activities using a portfolio approach
- Evaluate the perceived benefit of the session
- Maintain and store records in line with Trust Policy

After the session the SUPERVISOR will: -

- Facilitate if appropriate to assist with the completion of the Reflective Supervision record sheet
- Maintain and store records in line with Trust policy
- Provide the supervisee with a copy of the session if not already provided
- Evaluate the perceived benefit of the session to the supervisee

Supervisee Name: [Click here to enter Name](#) Signature: [Click here to enter signature](#)

Supervisor Name: [Click here to enter Name](#) Signature: [Click here to enter signature](#)

Section 5 of the NMC Code (7) states clearly that registrants must respect people’s right to privacy and confidentiality. This includes sharing necessary *‘information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality’*.



Reflective Supervision Questions

Open-ended questions are likely to feature the typical "who, what, where, when, why, and how" used in good journalism. These questions draw out different kinds of responses that can be useful for both Supervisee and Supervisor.

- **Who:** Elicits insight into the event/situation/experience
- **What:** Most often leads to facts
- **Where:** Enables discussion about the place the environment took place
- **When:** Brings about the timing of a problem, including what happened immediately before and after it
- **Why:** Most often brings about reasons
- **How:** Enables a person to talk about feelings and/or processes

Reflective Questions

- What is going well for you at the minute?
- How are you feeling at the minute?
- What were your thoughts and feelings regarding this situation?
- What abilities did you discover in yourself?
- What in the future will enable these abilities to grow and thrive?
- What assumptions did you make about the situation beforehand? Have these changed or shifted?
- How might your own history and experiences influence your thoughts, feelings and assumptions about the issue?
- What perspectives might the person you are working with have about the situation?
- What appears to be most important to you?
- What new insights came from thinking this through?
- How might you implement these new insights into practice?

Summarise

- How are you feeling right now?
- Let's summarise where you are now?
- What I'm hearing is?

Dealing with Emotions

- How does that make you feel?
- Do you need a break?
- What can the set do at this moment to help you?

End Questions

- What do you need to do to move this forward?
- What is your learning from today's session?



PREPARATION FOR SUPERVISION

The model is based upon the NMC reflective account form and should help to focus and critically reflect on your strengths, areas for development and potential actions in preparation for your Reflective Supervision session.

Reflective Title

Click here to enter text.

What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?

Click here to enter text.

2.0 Feelings: what were you thinking and feeling?

Click here to enter text.

3.0 What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?

Click here to enter text.

4.0 How did you change or improve your practice as a result?

Click here to enter text.

5.0 How is this relevant to the Code? Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust

Click here to enter text.

Name: Click here to enter Name

Date: Click here to enter Date

Appendix 7 Supervision Group / 1-1 Record Template



Supervision Group / 1-1 Record Template

The 1-1 supervision session was carried out between:			
Supervisee Name -	Click here to enter Name	Supervisor Name -	Click here to enter Name
Date -	Click here to enter a date.		
Venue -	Click here to enter Venue		
Date of previous supervision meeting -	Click here to enter a date.		

Supervision Component:	<u>Learning in Practice (example: reflection on learning from Incidents, SIA's M&M's or specific clinical experience etc)</u>			
Key Issues	Action Plan	By Whom	Date to be completed by	Review from previous session
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.

Supervision Component:	<i>Professional Development (All examples of reflection on courses/training/conferences, learning to practice, training needs, career progression etc.)</i>			
Key Issues	Action Plan	By Whom	Date to be completed by	Review from previous session
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.

Supervision Component:	<i>Personal/ Interpersonal Issues (In practice, personal issues can be defined as any personal problem that affects a certain individual. Typical personal issues could relate, among others, to family, finance, disability or health etc)</i>			
Key Issues	Action Plan	By Whom	Date to be completed by	Review from previous session
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.

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Supervision Component:	Opportunity to Raise Concerns (i.e. Patient Safety, Culture, Organisational Issues)			
Key Issues	Action Plan	By Whom	Date to be completed by	Review from previous session
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.

Supervision Component:	Any Areas of Disagreement (if applicable)			
Key Issues	Action Plan	By Whom	Date to be completed by	Review from previous session
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.

Date & Time of Next Supervision Session:			
Date -	Click here to enter a date.	Time -	Click here to enter Time
Session Evaluation – please comment			
Click here to enter text.			

If a significant issue requires onward reporting, record below outline of issues for onward reporting, to who and when it will be reported		
Issue	Report to	Timescale
Click here to enter text.	Click here to enter text.	Click here to enter text.

Signatures				
Supervisee -	Click here to sign		Supervisor -	Click here to sign
Copy to Supervisee -	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Click here to enter a date.	Click here to enter a date.

Appendix 8 Examples of Issues for Escalation

EXAMPLES OF ISSUES FOR ESCALATION

Prioritise people	Inappropriate behaviour or language when discussing an issue with diversity implications e.g. racism, homophobia, ageism.	Evidence of treatment being forced on a person without their consent.	Evidence that confidentiality has been breached.
Practise Effectively	Refusal to apply current evidence in practice.	Evidence of threatening behaviours towards colleagues and/or service users.	Refusal to keep accurate records.
Preserve Safety	Evidence that an adverse incident was not escalated appropriately at the time of occurrence.	Evidence that there are significant competence issues within a specific area of practice.	Evidence that the Nurse or Midwife has actively discouraged colleagues/ service users to raise concerns.
Promote Professionalism and Trust	Evidence of inappropriate or unprofessional behaviour via social media.	Evidence of bullying other members of staff.	Evidence of professional boundaries being breached, including inappropriate expression of political, religious or moral beliefs.

MEDICAL APPRAISAL & Revalidation

ENGAGEMENT PROCEDURE

Jan 2022

1. Background
2. Duty of Doctor to Engage in Revalidation Process
3. Employer Responsibilities
4. Definition of Non-Engagement
5. Extenuating Circumstances
6. Processes of Non-Engagement and Local Processes
7. Local Support and Engagement Process
8. Engagement Process
9. Doctors new to the Trust
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1. Background

All doctors with a licence to practice are required to participate in Annual Appraisal towards Revalidation in accordance with regulation 4(3)(a) of the [Click here to access General Medical Council \(Licence to Practise and Revalidation\) Regulations 2012](#).

In the majority of cases, most doctors participate actively in the system. For a small minority who do not participate, clear processes are in place to handle such non-participation under:

- [Click here to access General Medical Council \(Licence to Practise and Revalidation\) Regulations 2012](#)
- [Click here to access Dept. of Health Appraisal for doctors and dentists \(excluding GPs\)](#)

In some cases, a process of dialogue between the doctor and Responsible Officer (RO) may be necessary to establish agreement about what constitutes meaningful appraisal within the terms of the guidance that exists. This protocol will identify the sequence of actions (Appendix 1) that will be taken to encourage and support participation in the appraisal process when there is apparent non-participation by a doctor. It is recommended to document all meetings using the Engagement Meeting Template (Appendix 2).

- Reminding practitioners of their professional and contractual obligations and responsibilities.
- Advising medical practitioners as to the potential implications of non-participation:
 - regarding revalidation and their licence to practise
 - in relation to their contract of employment

Doctors should note that, ultimately, failure to participate in the appraisal and revalidation process will place a doctor's employment and their General Medical Council (GMC) licence to practise at risk.

2. Duty of Doctor to engage in the revalidation process

The GMC (Licence to Practise and Revalidation) Regulations 2012 (see regulation 6) place duties on licenced doctors in respect of their own revalidation and state that doctors must 'take reasonable steps' to arrange a recommendation about their revalidation (see regulation 6(4)). In practice this means that licensed doctors must:

- Participate in annual appraisals with Good Medical Practice (GMP) at their core, which consider the whole of their practice;
- Collect supporting information that meets the requirements of the GMC's [Click here to access Supporting information for appraisal and revalidation](#).

In addition the doctors must comply with the Southern Health & Social Care Trust [Medical Staff Appraisal Scheme](#).

As an employer, the Trust has developed and implemented robust systems for appraisal and clinical governance to support our doctors with their revalidation. The systems that are in place include:

- Appraisal & Revalidation Structure, including the Responsible Officer and the Delegated Responsible Officer roles
- Trained Appraisers
- Regional Appraisal System Programme (RASP) [Click here to access RASP](#)
- Appraisal & Revalidation Team
- Formal Appraisal Training Programme
- [Medical Staff Appraisal Scheme \(Policy\)](#)

3.1 Appraiser Responsibilities

It is required that the Appraiser engages in a timely manner (suggested timeframe is 10 days from date of verbal/email request) with the Appraisee when requested. If there are difficulties with this process the Appraisee should highlight through to the Medical Revalidation Team in the first instance.

Following satisfactory completion of the appraisal, the Appraisee and Appraiser should sign off the Appraisal. It will then go for the Second Sign off Quality Assurance (QA) process.

3.2 Medical Leads Appraisal & Revalidation Responsibilities

The Medical Leads will review appraisal and supporting information to ensure this is of the standard required by the GMC and Trust.

The RO has a statutory duty to make sure that these systems are in place.

4. Definition of Non-Engagement

A doctor is not engaging in revalidation when, in the absence of reasonable circumstances, they do not participate in the local systems and processes that support revalidation on an ongoing basis and/or do not participate in the formal revalidation process (see paragraph 5.1.1. of [Click here to access the GMC Protocol for making revalidation recommendations](#)).

A non-engagement recommendation will be made once all local systems and processes, including use of the Appraisal Policy and the Engagement Protocol, to facilitate the doctor to engage have been exhausted.

5. Extenuating Circumstances

- It is for the Responsible Officer to determine whether there are reasonable circumstances that explain why a doctor is not engaging in revalidation. Where there is a reasonable circumstance it may be appropriate for the Responsible Officer to request that the doctor is deferred.
- The doctor is responsible for engaging with the Responsible Officer to determine if extenuating circumstances exist.

- Further to advice, a doctor can request a deferral by submitting a 'Deferment Application Form' (Appendix 3) to the Responsible Officer.

6. Processes of Non-Engagement and Local Processes

There are two processes for non-engagement, depending on when it occurs:-

- Non-engagement where doctor is **outside** their notice period
- Non-engagement where doctor is **within** their notice period

6.1 Non-engagement where doctor is out with their notice period

If a doctor is not engaging in the process but has yet to receive notice that a recommendation about their revalidation is due, it is still possible to inform the GMC. In this instance the RO will notify the GMC requesting that the Early Concern Procedure is initiated. When informed of a doctor's failure to engage, the GMC non-engagement concern letter will remind the doctor that they are obliged to participate in order to maintain their licence to practise. If a doctor does not begin to engage with the processes that support revalidation, the GMC can bring forward the issue of notice to a doctor which will effectively bring forward their revalidation due date and the Responsible Officer will then be able to make a formal non-engagement recommendation (see 6.2 below).

6.2 Non-engagement where doctor is within their notice period

A notification of non-engagement is a formal recommendation about a doctor's revalidation and can only be made once the doctor has been issued notified by the GMC, that a recommendation about their revalidation is due (i.e. 4 months prior to the revalidation due date). During the notice period, non-engagement can only be communicated to the GMC through a formal notification of non-engagement by the Responsible Officer. On receipt of a notification of non-engagement, the GMC will commence the [Click here to access GMC Licence Withdrawal Process](#).

7. Local Support and Engagement Process

7.1 Local Support

To support its doctors through appraisal and revalidation the Trust has put in place:

- Appraisal & Revalidation Team
(The Appraisal & Revalidation Team can be contacted on extensions 61987 and 61993 or via email on medical.revalidation@southerntrust.hscni.net)
- Medical Appraisal tile on Sharepoint [Click here to access Medical Appraisal info on SharePoint](#)
- Appraisal Training Program
- Medical Appraisal & Revalidation Policy

The Appraisal & Revalidation Team supports doctors locally by:

- Providing support and advice
- Collating and circulating appraisal supporting information annually

- Monitoring and reporting on appraisal progress
- Providing annual appraisal reminders
- Providing appraisal training
- Facilitating Colleague and Patient Feedback
- Facilitating revalidation file management and revalidation readiness reminders.

8.0 Engagement Process

For appraisals not completed at the end 31st May in the following year, as per the Southern Health & Social Care Trust Policy, the Appraisal & Revalidation Team, on behalf of the Responsible Officer, will commence the Engagement Protocol by issuing reminder letters, medical appraisal engagement timeframes (Appendix 4) and offering support.

The Engagement Protocol will provide periodic reminders until engagement has been established or a non-engagement recommendation/early concerns letter is required

Stage 1

Gentle Reminder Letter forwarded to all Doctors by 7th January, detailing actions required for completion of Medical Appraisal by 30th April. (Appendix 5).

Stage 2

If, by the end of April, the doctor has not completed their appraisal then they will receive a **first reminder letter 1st May**. (Appendix 6).

This letter will:

- Remind them to complete their Medical Appraisal
- Request an update on progress with your appraisal, along with your scheduled appraisal meeting date.
- Remind them of support available locally via the Appraisal & Revalidation Team.
- ***Ask if there are circumstances that exist that might explain why the doctor is not engaging in appraisal.***
- This letter will be copied to Divisional Medical Director, Appraiser and Medical Workforce Office Administrator
- Appraisee should have appraisal at completion level two weeks prior to appraisal meeting
- Appraiser Role is to contact the Appraisee to set date/time for appraisal meeting and ascertain issues/concerns as to why appraisal has not progressed to completion level this will be required for Clinical Directors completion of engagement template.

Stage 3

If, by the 1st September, the doctor has not completed their appraisal then they will receive a **second reminder letter 1st September** (Appendix 7).

This letter will:

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This letter will be copied to Deputy Medical Director for Appraisal and Revalidation, Appraiser and Medical Workforce Office Administrator

- Outline Professional responsibility for all doctors to fully engage in the appraisal and revalidation process
- Remind them of support available locally via the Appraisal & Revalidation Team
- ***Ask if there are circumstances that exist that might explain why the doctor is not engaging in appraisal.***

Stage 4

If, by the 1st November, the doctor has not completed their appraisal then they will receive a **final reminder letter 1st November** (Appendix 8).

This letter will:

- Highlight the General Medical Council (Licence to Practise and Revalidation) Regulations **with a view to submitting a request to the GMC to initiate the Early Concern Procedure which may result in your license to practice being withdrawn by the GMC.** Non-completion of appraisal will be considered under **the Maintaining High Professional Standards Framework**
- Advise the doctor that the matter will be discussed with the GMC Employer Liaison Advisor (NI) if meaningful engagement is not demonstrated within 28 days of the letter being dispatched.
- Remind them of support available locally via the Appraisal & Revalidation Team.
- ***Ask if there are circumstances that exist that might explain why the doctor is not engaging in appraisal.***
- This letter will only be copied to Medical Director | Responsible Officer, Divisional MD, Clinical Director and Appraiser
- Divisional MD to confirm with the Medical Director the position in relation to individual doctors and dentists, including any mitigating circumstances

Stage 5

On the 15th December the Medical Director will liaise with Divisional MDs confirming the position in relation to individual doctors and dentists, including any mitigating circumstances.

Stage 6

If no response or no appraisal submitted by 31 December (final cut-off date), and if no appropriate mitigating circumstances, the Medical Director / Responsible Officer will discuss action with the GMC Employer Liaison Adviser in context of non-engagement with the processes that support

revalidation. This could lead to a process which may result in the withdrawal of a doctor's licence to practise.

9.0 Doctors new to the Trust

For doctors who join the Trust and who have a revalidation date within 12 months of taking up post, a recommendation for revalidation/Deferral will be submitted through to the GMC, this will be based on the following:-

1. **Revalidation** – provided the Doctor meets the requirements for revalidation and the RO is satisfied with the level of information provided. (See appendix 7 Medical Revalidation Flowchart).
2. **Deferral** – If Doctor is unable to provide sufficient relevant information required for revalidation within the notice period, the Revalidation Team will advise RO and Doctor of the requirements to bring their portfolio up to the standard. The RO will make an informed decision of a recommendation for deferral through to the GMC based on this. The deferral period will facilitate the completion of an appraisal and supporting information.

In addition, the Trust 'Revalidation Reminder Process' will be used to ensure readiness for revalidation, (Appendix 1).

10.0 Other Local Processes

10.1 Internal Disciplinary Processes

At the same time as notifying the GMC of a doctor's non-engagement the Trust will engage the doctor through local disciplinary processes. This is on the basis that the individual is in breach of contract for failing to comply with their contractual obligations. [Click here to access Guidelines for Handling Concerns about Doctors](#)

10.2 Fitness to Practice

Notifications of non-engagement are not a mechanism through which concerns about doctors' fitness to practise can be raised with the GMC. Concerns about fitness to practise raised at any point during the revalidation cycle should be referred to the GMC through the existing processes for raising concerns. [Click here to access Guidelines for Handling Concerns about Doctors](#)

11.0 GMC Processes

11.1 Early Concern Procedure

The Responsible Officer will make a judgement as to whether there are reasonable grounds that account for a doctor's failure to engage and may wish to discuss any concerns about a doctor with the GMC Employer Liaison Advisor for Northern Ireland. Further to these actions the Responsible Officer may initiate the 'GMC Early Concern Procedure'.

11.2 Licence Withdrawal Process ~~Page~~ STM - 126 - 79

When a non-engagement recommendation is accepted by the GMC then the licence withdrawal process will commence. See paragraph 5.2.4. [Click here to access GMC Protocol for making revalidation recommendations](#)

The GMC will communicate with the doctor advising that their licence is at risk because they have failed to meet the requirements of revalidation. The doctor has 28 days to respond and explain why their licence should not be removed.

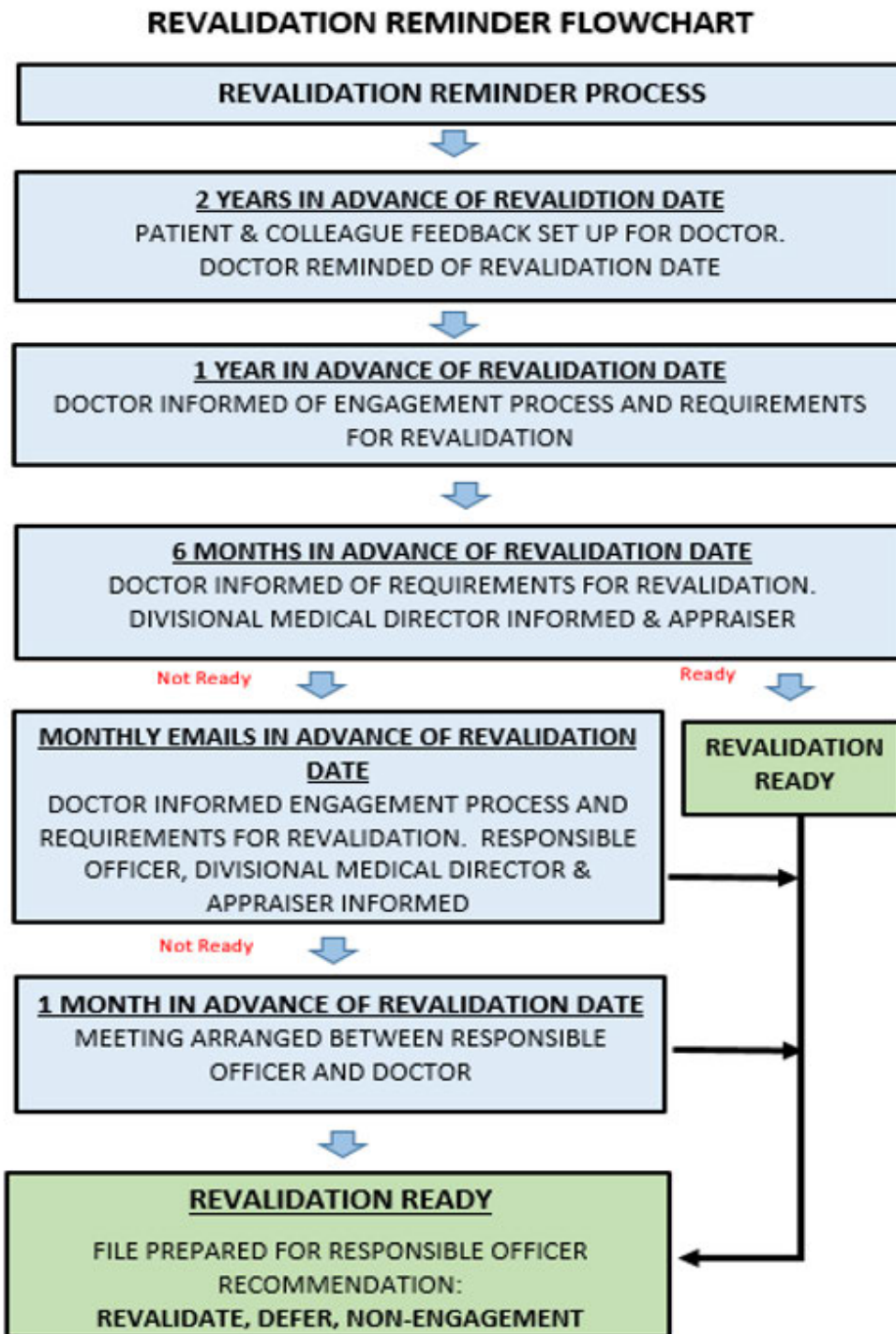
At this stage, if the doctor agrees, the GMC may share the response with the RO to gain more information before a final decision is made.

If the GMC decides to remove the doctor's licence, the doctor will be given notice and advised of their right to appeal within 28 days.

The GMC will advise the RO on the date of removal, barring any appeal. If the doctor doesn't appeal the GMC will email the RO again on the date of removal.

If the doctor appeals, the GMC will not take any action until the appeal process is complete.

If a doctor's appeal is unsuccessful, the GMC will remove their licence and email the RO.



ENGAGEMENT MEETING TEMPLATE			
Date:	Time:	Venue:	
Appraisee			
PRINT NAME:		SIGNATURE:	
Clinical Director / Divisional Director			
PRINT NAME:		SIGNATURE:	
PRINT NAME:		SIGNATURE:	
Issues / Topics for Discussion:			
Key Points from Discussion:			
Agreed Action Plan for Appraisee			
Actions	Timescale	Date	Progress

Deferment Request Form

To be returned to Revalidation Team medical.revalidation@southerntrust.hscni.net

Demographics	Comments
Name:	
Address	
Telephone numbers :	
Email	
GMC number	
Please indicate the dates of your last 4 appraisals: (Month and year) and names of the appraisers	
Name of appraiser	

Deferment details	Comments
Please indicated WHY you wish to request a deferment of your appraisal and WHEN you would next like to be appraised	
Do you anticipate having any breaks in practice in the next 2 years?	
If you have missed any appraisals in the last 4 years please: indicate the reasons why	
Are you currently under investigation by your employer, NCAS, or GMC for any issue regarding your clinical performance?	
Any further comments	

Deferral Reason (please tick relevant boxes)			
1. Missing Appraisal Activity		6. Missing Patient Feedback	
2. Interruption to practice		7. Missing Quality Improvement Activity	
3. No Colleague Feedback		8. Missing Significant Events	
4. Missing Compliments/Complaints		9. Missing Other Evidence	
5. Missing Continuing Personal Development			

Applicant Name: _____ **Date:** ____/____/____

Signature: _____

Divisional Medical Director / Clinical Director

Name: _____ **Date:** ____/____/____

Signature: _____

Deferment Application Process

- The applicant must complete the application form and submit to their Divisional Medical Director for approval.
- Associate Medical Director approved application forms must then be forwarded to the Medical Directors Office for final approval.
- The applicant will be informed of the outcome by the Medical Directors Office.

Appendix 4- Medical Appraisal Engagement Timeframes

MEDICAL APPRAISAL ENGAGEMENT TIMEFRAMES

Appraisal Info	Action	Rationale
7 th Jan	Gentle Reminder issued by Medical Directorate Appraisal office	Reminder Letter forwarded to all Doctors by 7 th January, detailing actions required for completion of Medical Appraisal by 30 th April
Appraisal not completed by		
1 st May	First reminder issued by Medical Directorate Appraisal office	Copied to the Divisional MD, the Appraiser, and the Service Directorate Medical Workforce Office.
1 st September	Second Reminder issued from the Divisional MD	Copied to the Appraiser, and the Service Directorate Medical Workforce Office. If no response or appraisal submitted, and due to the absence of a current PDP, further study leave may not be funded.
1 st November	Final Reminder issued by Medical Director	If no response or appraisal submitted, formal letter from Medical Director / Responsible Officer. Copied to the Divisional MD, the Appraiser, and the Service Directorate Medical Workforce Office.
15 th December	Check Updates from Divisional MDs	Divisional MD to confirm with the Medical Director the position in relation to individual doctors and dentists, including any mitigating circumstances.
1 st January	No appraisal completed Discuss with GMC Employer Liaison Adviser	If no response or no appraisal submitted by 31 December (final cut-off date), and if no appropriate mitigating circumstances, the Medical Director / Responsible Officer will discuss action with the GMC Employer Liaison Adviser in context of non-engagement with the processes that support revalidation. This could lead to a process which may result in the withdrawal of a doctor's licence to practise.



Appraisal & Revalidation Office
Medical Directorate
Southern Health & Social Care Trust

ADDRESS

Appraisal for Practice Year Ending December

DATE

Dr

Medical Grade

Specialty

Dear *(Name)*

I am writing to you as I take up the position as the Responsible Officer for doctors working in Southern Trust. The “winter pressures” this year have been a challenge for you and colleagues in providing care for our patients. It is also important that, as medical professionals, we reflect on practice as part of annual appraisal to provide assurance that practice is up to date and also to reflect on your aspirations and development needs.

Online information to support appraisal and update training on appraisal is available at [Medical Appraisal Toolkit](#). The link to the Regional Appraisal System is <http://rasp.hscni.net/> and the link to RASP PowerPoint Presentation is [RASP Presentation](#)

If you feel you would need specific support (e.g. if you are new to the system), please contact medical.revalidation@southerntrust.hscni.net (or Medical Revalidation Senior Managers directly on extensions 61987 and 61993) and this will be organized for you.

Your appraiser for the practice year 2022 is *(appraiser)*.

I would suggest that you make an appointment with your appraiser now for a convenient time, for example in March or early April to get the meeting in diaries, as hopefully the service pressures will have eased somewhat by this time.

To assist with your preparation for appraisal, you will receive an email over the next few weeks containing information on complaints, litigation, incidents and coronial

cases to which you may be linked. You will also receive a summary of your clinical activity (e.g. CLIP reports / TMS reports / etc).

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In the interim, I would suggest gathering your thoughts, reflections and any other relevant information and use this to gradually update your appraisal documentation on the online

Regional Appraisal System over the next number of weeks in preparation for the appraisal meeting. You should consider updating your required training - mandatory (fire safety, information governance, etc), and clinical training (e.g. Hyponatraemia, Right Patient, Right Blood, etc) to update your training passport.

As your appraisal must cover the whole of your medical practice, you should provide information about work undertaken external to the Trust and also a Letter of Good Standing from external bodies for which you undertake medical work e.g. private providers, NIMDTA, Royal College etc. External bodies are usually able to provide this for you.

I would ask that you ensure that your appraisal (which is a contractual obligation) is completed and uploaded to the Regional Appraisal System **by the 30th April**. If there are any reasons why this may not be possible, please let us know. The appendix outlines the Trust's Appraisal and Revalidation Engagement and Escalation process.

Yours sincerely

Dr Stephen Austin

Medical Director and Responsible Officer

cc Medical Workforce Office Administrator

Appendix Appraisal Engagement and Escalation

The GMC requires the Trust to inform them of any non-engagement concerns in relation to appraisal and revalidation at an early stage as outlined in the March 2018 [Recommendations Protocol](#). This may lead to:

- A non-engagement recommendation for Doctors who are under notice for revalidation, **or**
- A Rev 6 submission for Doctors not yet under notice, which is a request to the GMC to send a non-engagement concern letter to a doctor.

Both of these will begin a GMC process that can result in a doctor's licence to practise being withdrawn. The Medical Director (Responsible Officer), with involvement of your Divisional MD, will inform you if either process has been activated with the GMC.

In the unlikely event that this process is activated, your Divisional Medical Director will meet with you about this. It is however intended that this process will not be necessary following completion of your appraisal. The Trust will apply an absolute cut-off date of 31 December. This means that:

- Appraisals received after this date will not be included for Trust / Directorate / Divisional reporting purposes, and will be considered incomplete.
- Appraisals received after this date may not be accepted as evidence for revalidation.
- Appraisals received after this date cannot be considered as compliant with the local appraisal process.

Appraisal Engagement and Escalation Arrangements

Appraisal Engagement and escalation arrangements are outlined in the Southern Trust Appraisal Policy. If a completed appraisal is not received by the 30th April, the following process will be followed:

Appraisal not completed by	Action	Rationale
1 st May	First Reminder issued by Medical Directorate Appraisal office	Copied to the Divisional MD, the Appraiser, and the Service Directorate Medical Workforce Office.
1 st September	Second Reminder issued by Divisional Medical Director	If no response or appraisal submitted, formal letter from Divisional Medical Director. Copied to the Deputy Medical Director, Clinical Director and the Appraiser.
1 st November	Final Reminder issued by Medical Director	If no response or appraisal submitted, formal letter from Medical Director Responsible Officer. Copied to Divisional Medical Director, Clinical Director and Appraiser.
31 st December	Discussion with GMC-ELA	If no response or appraisal submitted, formal letter from Medical Director Responsible Officer will discuss with GMC –ELA / Consideration under MHPS Framework.

Any special circumstances (e.g. sickness, parental leave, etc) relating to a particular doctor will be considered and the above timetable adjusted as appropriate.

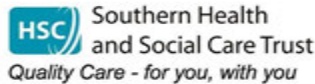
The GMC requires the Trust to inform them of any non-engagement concerns at an early stage as outlined in the [March 2018 Recommendations Protocol](#). This may lead to:

- A non-engagement recommendation for Doctors who are under notice for revalidation, **or**
- A Rev 6 submission for Doctors not yet under notice, which is a request to the GMC to send a non-engagement concern letter to a doctor.

Both of these will begin a GMC process that can result in a doctor's licence to practise being withdrawn. The Medical Director, with involvement of your Divisional MD, will inform you if either process has been activated with the GMC.

Should the need arise, your Divisional MD will meet with you about this. It is however intended that this process will not be necessary following urgent completion of your appraisal. The Trust will apply an absolute cut-off date of 31 December 2023. This means that:

- Appraisals received after this date will not be included for Trust / Directorate / Divisional reporting purposes, and will be considered incomplete.
- Appraisals received after this date may not be accepted as evidence for revalidation.
- Appraisals received after this date cannot be considered as compliant with the local appraisal process.



Appraisal & Revalidation Office
Medical Directorate
Southern Health & Social Care Trust

ADDRESS

DATE
Dr
Medical Grade
Specialty

Dear Dr

Completion of Appraisal for Practice Year Ending December 2022

Our records indicate that the Trust has not yet received your completed appraisal for the Practice Year Ending December 2022. You will be aware that appraisal must be completed annually and **by the end of April** each year, unless there are exceptional circumstances. The appendix outlines the Trust's Appraisal and Revalidation Engagement and Escalation process.

Actions Required

We need you to confirm the current status of your appraisal for 2022 even if you have previously informed us or your Directorate Medical Workforce Office.

- Contact [redacted] in the Medical Director's Appraisal & Revalidation Office **by 31 May 2023** to provide an update on progress with your 2022 appraisal, along with your scheduled appraisal meeting date.

Please advise if there are any exceptional circumstances which are preventing you from progressing your appraisal that need to be brought to the attention of the Medical Director.

- If you have not yet completed your appraisal for 2022, please ensure your appraisal meeting takes place as soon as possible, and that your appraisal is signed off no later than **31st August 2023**.

If you require any general advice or support regarding appraisal and revalidation please contact me directly on extensions 61987 and 61993 or via email on medical.revalidation@southerntrust.hscni.net, or the Service Directorate Workforce Office, or your Appraiser depending on the nature of the advice required.

Yours sincerely

Maggie Davison
Appraisal & Revalidation Manager

Cc Divisional Medical Director
Appraiser
Medical Workforce Office Administrator

The GMC requires the Trust to inform them of any non-engagement concerns at an early stage as outlined in the March 2018 [Recommendations Protocol](#). This may lead to:

- A non-engagement recommendation for Doctors who are under notice for revalidation, **or**
- A Rev 6 submission for Doctors not yet under notice, which is a request to the GMC to send a non-engagement concern letter to a doctor.

Both of these will begin a GMC process that can result in a doctor’s licence to practise being withdrawn. The Medical Director, with involvement of your Divisional MD, will inform you if either process has been activated with the GMC.

Should the need arise, your Divisional MD will meet with you about this. It is however intended that this process will not be necessary following urgent completion of your appraisal. The Trust will apply an absolute cut-off date of 31 December 2023. This means that:

- Appraisals received after this date will not be included for Trust / Directorate / Divisional reporting purposes, and will be considered incomplete.
- Appraisals received after this date may not be accepted as evidence for revalidation.
- Appraisals received after this date cannot be considered as compliant with the local appraisal process.

Appraisal Engagement and Escalation arrangements

Appraisal Engagement and escalation arrangements are outlined in the Southern Trust Appraisal Policy. If a completed appraisal is not received by the 30th April, the following will apply:

Appraisal not completed by	Action	Rationale
1 st May	First reminder issued by Medical Directorate Appraisal office	Copied to the Divisional MD, the Appraiser, and the Service Directorate Medical Workforce Office.
1 st September	Second Reminder issued by Medical Director	If no response or appraisal submitted, formal letter from Medical Director / Responsible Officer. Copied to the Divisional MD, the Appraiser, and the Service Directorate Medical Workforce Office.
1 st November	Final Reminder issued by Medical Director	Medical Director Responsible Officer, Divisional MD, Clinical Director and Appraiser. Divisional MD to confirm with the Medical Director the position in relation to individual doctors and dentists, including any mitigating circumstances

15 th December	Check Updates from Divisional MDs	Divisional MD to confirm with the Medical Director the position in relation to individual doctors and dentists, including any mitigating circumstances.
1 st January	No appraisal completed Discuss with GMC Employer Liaison Adviser	If no response or no appraisal submitted by 31 December (final cut-off date), and if no appropriate mitigating circumstances, the Medical Director / Responsible Officer will discuss action with the GMC Employer Liaison Adviser in context of non-engagement with the processes that support revalidation. This could lead to a process which may result in the withdrawal of a doctor's licence to practise

**Appraisal & Revalidation Office
Medical Directorate
Southern Health & Social Care Trust**

Date

Dear Dr

Appraisal for Practice Year Ending December 2022 – Second Formal Reminder

You will have received correspondence regarding submission of your 2022 appraisal in a first reminder letter in August 2023. Our Appraisal and Revalidation Office have also been in contact with you to assist in progressing your 2022 appraisal. I have attached, for reference, a copy of the August correspondence which provides an overview of the importance of appraisal, the process for non-engagement, and a detailed timetable for subsequent required actions. The Trust requires appraisal to be completed and submitted by the end of June each year, unless there are exceptional circumstances. The Trust extended the deadline for receipt of your completed appraisal to 20 September 2023. However, this deadline has passed and we have still not received a copy of your completed 2022 appraisal.

The Chief Medical Officer, Dr Michael McBride, has previously advised that there is a clear professional responsibility for all doctors to fully engage in the appraisal and revalidation process and that any failure to do so must be treated very seriously and escalated immediately. I should also ask you to note that completion of annual appraisal is required as part of your contract.

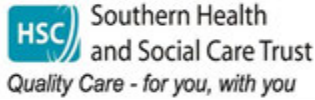
It is therefore important that you now complete and submit your 2022 appraisal without further delay. I would be grateful for an update on your plans, including the planned meeting date and estimated submission date (if not already submitted). Please let me know any circumstances which have contributed to this delay, or if you require additional support. This is necessary to formally establish your current status even if you have previously informed one of our offices. In addition, my office will be in touch shortly to arrange a meeting with you to discuss progress on completing your 2023 appraisal.

If there is continued delay without reasonable circumstances, I will raise the matter with the Medical Director/Responsible Officer, Dr Stephen Austin, who is required in such circumstances to speak with the GMC Employer Liaison Adviser. Please remember that the Appraisal & Revalidation Team is available to provide support and advice, and can be contacted on extensions 61987 and 61993 or via email on medical.revalidation@southerntrust.hscni.net

I look forward to hearing from you within **two weeks** of the date of this letter.

Yours sincerely
Dr XXX, Divisional MD

Cc Dr Damian Scullion, Deputy Medical Director for Appraisal and Revalidation
XXX, Appraiser
XXX, Medical Workforce Office



Appraisal & Revalidation Office
Medical Directorate
Southern Health & Social Care
Trust

DATE

Private and Confidential

ADDRESS

Dear Dr

**Final Reminder re Completion of Appraisal for Practice
2022**

I have been informed by the Appraisal and Revalidation Office that the Trust has not yet received your completed appraisal for the Practice Year Ending December 2023. You will be aware that appraisal must be completed annually and by the end of June each year, unless there are exceptional circumstances.

You will be aware that the General Medical Council (Licence to Practise and Revalidation) Regulations 2012 requires that you participate in local annual appraisal processes that support your revalidation. Failure to engage could lead to a recommendation of non-engagement and impact on your licence to practise. It is also a requirement of your contract that annual appraisal is undertaken and failure to do so may result in potential disciplinary processes.

As Medical Director and Responsible Officer, I must advise you to ensure that your appraisal is complete by 31st December 2022.

If your appraisal is not complete by the 31st December 2023, I will have to discuss your case with the GMC Employer Liaison Advisor for Northern Ireland, with a view to submitting a request to the GMC to initiate the Early Concern Procedure which may result in your license to practice being withdrawn by the GMC. In addition, non-completion of appraisal will be considered under the Maintaining High Professional Standards Framework.

If there are any reasons why you cannot comply with the revalidation process please contact my office immediately so that your circumstances can be considered.

Please remember that the Appraisal & Revalidation Team is available to provide support and advice, and can be contacted on extensions 61987 and 61993 or via email on medical.revalidation@southerntrust.hscni.net

Regards

Dr Stephen Austin
Medical Director | Responsible Officer
cc Divisional MD
Clinical Director
Appraiser



Southern Health
and Social Care Trust

Quality Care – for you, with you

**Supervision Policy, Standards, and Criteria
for Social Workers and
Social Care Workers
in
Acute Services Directorate
Mental Health & Disability Directorate
Older Persons & Primary Care Directorate**

**October 2009
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This document is based on the on the document 'Supervision Policy, Standards and Criteria' for social work staff in children's services which was published by DHSSPSNI Reform Implementation Team (RIT) in February 2008.

The Trust Social Work Forum established a working group to produce a social work supervision policy for use in adult's services Directorates. A further working group was established to review the policy in December 2012. Appreciation is extended to the members of these groups for their work on its development and review.

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1.0 Supervision Policy

1.1 Introduction

This policy sets the framework and minimum standards for Health and Social Care Trusts to implement an effective and consistent approach to social work and social care supervision practice.

Supervision and appraisal are the most important ways of ensuring staff deliver a high standard of service, carry out their duties according to policy and procedures and meet departmental and corporate targets. Supporting staff through supervision improves working practices and contributes to better service delivery and outcomes.

1.2 Purpose and Aims

The aims of this policy are to define:

- The menu of supervision models to be adopted for all social work and social care posts within adults services Directorates in order to support high quality practice and develop the professional competencies of all those involved
- The rights and responsibilities of these staff in respect of supervision
- The standards to be met
- The means by which the practice of supervision will be qualitatively assessed and monitored.

1.3 Policy Statement

The Trust will provide supervision to social work and social care staff in accordance with the professional standards as detailed in this Policy. For social work, the policy will apply where a social worker is employed in a social care post which requires a professional qualification and the worker is maintaining their NISCC registration as a social worker. This is recognized as a key method of ensuring that the Trust delivers its statutory responsibilities as outlined in the Scheme for the Delegation of Statutory Functions (March 2008). It is also critical in ensuring the delivery of safe, high quality care and plays an important part in the ongoing development of a competent workforce.

1.4 Scope

This is a mandatory policy. It applies to the supervision of all social work and social care staff in the undernoted Directorates within the Southern Trust:

- Acute Services
- Mental Health & Disability
- Older People & Primary Care ¹

These social work/social care staff include:

- All social work staff (including social workers on the assessed year in employment)
- All social care staff (except domiciliary care staff¹)
- Senior social work practitioners
- Team managers (where social work by profession)
- Heads of Service (where social work by profession)
- Senior managers (where social work by profession).

This Policy should be read in conjunction with:

Northern Ireland Social Care Council, Code of Practice for Social Care Workers (September 2002)

Northern Ireland Social Care Council, Code of Practice for Employers of Social Care Workers (September 2002)

Northern Ireland Social Care Council, Registration and Regulation of the Social Care Workforce: Guidance for Employers (May 2006)

Southern Health & Social Care Trust, Capability Procedure (September 2008)

1.5 Definition and Functions

Morrison (2001) defines supervision as:

'a process in which one worker is given responsibility by the organisation to work with another worker(s) in order to meet certain organizational and professional objectives.'

¹ See also Supervision Policy For Domiciliary Care Workers in Older People and Primary Care Directorate

The aim of supervision is to improve the quality of work in order to optimise service users' capacity to lead independent and fulfilling lives.

The functions of supervision are:

- Management (ensuring competent and accountable performance)
- Development
- Support
- Engagement (engaging the individual with the organisation).

1.6 Literature/ Research

There is now a substantial body of literature and research into the practice of supervision within social care that demonstrates that in many cases supervision has not met minimum standards or been of the requisite quality. A key theme is that of the four functions (see above) the management function takes precedence over the others, especially the development and support functions – with the unfortunate consequence that the latter two functions are given insufficient attention. This is a significant shortcoming as a competent and confident workforce is central to the provision of quality services and to the efficient operation of social work/care services. In addition few social care organisations have audited supervision to ensure that it is of the requisite frequency and quality.

The McLernon Report (1998)² which examined the suicide of Mr Frederick McLernon and the role of health and social services in his life made four recommendations (Numbers 14, 22, 43 and 46) in relation to professional supervision based on deficits in care practice. These recommendations focused on the necessity of professional supervision, the monitoring of assessment practice, the identification of unmet need, the importance of relevant theoretical knowledge and social work principles and the adequacy of decision making.

More recently the O'Neill Inquiry Report³ (2007) into the circumstances of Mrs Madeleine O'Neill who took her daughter Lauren's life and then killed herself reinforced the requirement that Trusts have supervision policies in place that, among other things, have arrangements to monitor the effectiveness of practice interventions and appropriate record keeping.

² Social Services Inspectorate (1998) Community Care: From Policy to Practice – The case of Mr Frederick McLernon (deceased), Social Services Inspectorate, Belfast, September 1998.

³ Department of Health, Social Services and Public Safety (2007) Report of the Independent Inquiry Panel to the Western and Eastern Health and Social Services Boards, DHSSPSNI, Belfast, May 2007.

In addition a range of policies and reports in the field of adult protection emphasize the role of supervision in supporting staff involved in reporting, investigation and working with victims of adult abuse.

The DHSSPSNI regional child protection report (2007)⁴ made similar observations including there being:

- Inconsistencies in the frequency and quality of social work supervision
- Few formal processes whereby senior managers agreed targets for supervision
- Little evidence of alternative arrangements being made where supervisory arrangements were disrupted e.g. managers were on sick leave
- A weakness in helping social workers to apply theoretical concepts and models
- Inconsistent recording of decisions made in supervision
- Little formal auditing of supervision.

1.7 Core Values and Principles

These are the core values which underpin the policy and the ensuing standards and criteria:

1. Supervision must ensure the effective management of practice, develop and support staff and promote their engagement with the organisation.
2. The quality of supervision has a direct bearing on the quality of service delivery and outcomes.
3. All staff, irrespective of their role, have the right to receive high quality supervision which meets the standards of this policy.

⁴ Department of Health, Social Services and Public Safety (2006) Our Children and Young People - Our Shared Responsibility Overview Report, SSI, December 2006.

4. All staff have responsibility for the quality of their own work and, to this end, should prepare for and make a positive contribution to the supervisory process. They are not passive recipients.
5. Senior managers have a responsibility to promote good supervision by implementing this policy and ensuring mandatory training is provided for both supervisors and supervisees.
6. Senior managers need to conduct regular audits to ensure that this policy and standards are being implemented.
7. Supervision must promote anti discriminatory practice and respect for the privacy and dignity of service users and carers.
8. All practice must be consistent with the Northern Ireland Social Care Council Codes of Practice.
9. Effective supervision must promote adherence to the corporate governance framework and is an important element of risk management.

1.8 Responsibilities

Overall responsibility for ensuring the implementation and quality of social work and social care supervision rests with the Executive Director of Social Work. Social Work Leads in each Directorate are responsible for ensuring the effective implementation of the policy within their respective Directorates including the identification of a named professional supervisor for each member of social work and social care staff. Heads of Service are responsible for implementing the policy within Teams and for conducting regular audit of compliance. Operational and Professional supervisors are responsible for co-operating to ensure delivery of all aspects of the supervision policy to practitioners.

Supervision is a process not an event. It entails preparation, open discussion and the implementation of decisions. Both supervisors and supervisees have a responsibility to contribute positively to this process. Supervisors should ensure adherence to the standards outlined in this policy.

Supervisees will make a substantial contribution to the quality of their own supervision by:

- Making suitable preparation for meetings through preparation of an agenda
- Ensuring that actions agreed within supervision are carried out in a timely manner and evidenced in the case file
- Notifying the supervisor of any difficulties in implementing decisions or plans
- Identifying development and support needs
- Understanding and implementing policy
- Ensuring diversity is integrated into all work and records
- Highlighting areas of learning in relation to his/her own professional development

Where the supervisee is a practitioner s/he will also contribute to the supervision process (and promote high quality service delivery) by, for example, ensuring that:

- Where required, there is a written care plan for each service user
- Service user's care plans are in place identifying care objectives, intervention provided, programme agreed and review dates
- Case files contain clear assessments, risk assessments, plans and summaries
- Case records and all social care records are available for supervision
- Issues of a child protection or vulnerable adult nature are discussed with reference to the procedures, including agreed interventions
- The supervisee outlines processes re multi-disciplinary assessment and discharge planning/case closure
- The supervisee highlights unmet need
- The supervisee highlights areas of concern for example issues with own professional performance or that of other

professionals, or cases which may present professional or organisational challenges.

The supervisee has a responsibility to keep the supervisor informed of urgent developments or concerns re staff or service users, and to seek out advice and guidance outside of formal supervision meetings when required and to record the outcome of same. In addition, the supervisee has responsibility to implement guidance given on such occasions.

Supervisors will make a substantial contribution to the quality of supervision by adhering to the standards set out in Section 2.

Neither supervisors nor supervisees are likely to maximise the benefit of supervision unless they are adequately trained to understand their responsibilities and the supervision process. To this end an outline of supervision, its purpose, responsibilities and processes will be provided in the Social Services Induction Programme for social work students and newly employed social work and social care staff. Training for supervisors will be provided on an annual basis in the Social Services training programme.

Where a professional qualification is not required for a post, it will be the individual's responsibility to maintain their registration with NISCC. This should be negotiated with line management.

1.9 Methods

- **Social Work**

The principal method of professional supervision for social workers within the Trust is one-to-one supervision by a professionally qualified social worker— where one worker is given the responsibility to work with another worker to meet certain organisational, professional and personal objectives. Where the operational manager is not a social worker, this supervision policy will be delivered by the operational manager and an identified professional supervisor⁵. All grades of social worker should receive professional supervision in the organisation up to Assistant Director level.

However, it may be unrealistic to expect one-to-one supervision to meet all four supervision functions for all staff all of the time. There is a menu of options which can be considered for use in certain settings. These are as follows:

⁵ Good Practice Guidance: Professional and Operational management Interface within the Integrated Care Teams SHSCT 28 October 2009

- One-to-one supervision: This is best suited to staff carrying their own individual caseloads
- Joint supervision: This is most suitable when two staff are engaged in the same piece of work eg co-working a case or running a group
- Group supervision: This best suits the needs of staff working in group care settings or where team working/development is a priority
- Peer group/mutual support supervision: This might be used with an experienced group of staff undertaking a specific piece of work where they monitor and review progress and provide one another feedback on their performance
- Consultation: This is where specialist expertise outside the team is utilised as an additional resource
- Live supervision: This is where direct observation is used as a form of supervision
- Support groups: In certain areas of practice it may be appropriate for support groups to operate eg practice teaching, approved social work. When these groups examine practice issues they can be categorised as group or peer supervision and can incorporate a training and development aspect
- Mentoring: This can be used in any work situation to supplement the formal supervision arrangement.

Where these methods of supervision are used, there should be agreed arrangements with the manager for the recording of the supervision and any decisions reached. These should be available in the staff member's personal file and where appropriate in the service user file.

- **Social Care**

In Residential Units and Day Care and Supported Living settings in particular, the above models may have relevance. Given that the work often takes place in a group setting and the observations of skills and competence is inherent in the work, the workplace itself can be an evidence base for supervision. It is acknowledged that, with the other methods available, individual supervision may be of shorter duration. The guiding principle, irrespective of which methods are used, is that

the line manager is responsible for ensuring that all four functions of supervision are formally addressed.

1.10 Knowledge and Skills Framework

All staff in Health and Social Care are now required to complete the Knowledge and Skills Framework (KSF) Performance Development Review (PDR) on an annual basis.

The KSF Performance Development Review provides an opportunity for the staff member to reflect on their knowledge, skills and values in a structured way, focusing on the knowledge and skills required for their job outline. The manager completes the performance review form at the PDR meeting. Individuals will be assessed on their examples of practice and the worker and manager will need to identify the most relevant examples in order to meet the requirements. Professional supervision will make a valuable contribution to the PDR.

It has been agreed by the Northern Ireland Social Care Council (NISCC) that the KSF Performance Development Review form may be used for meeting the post registration requirements for NISCC. The Personal Development Plan (page 8 of the KSF Performance and Development Joint Review) will suffice as the Training Plan required for the NISCC post registration requirements (Training and Learning Plan). Staff can photocopy the Personal Development Plan and put this in their NISCC folder, to be presented to the NISCC on request.

1.11 Quality Standards

The Quality Standards for the Health and Personal Social Services (HPSS in Northern Ireland) identifies corporate leadership and accountability as key themes for all health and social care organisations.

The standards state that “HPSS organisations and professionals must provide effective leadership and clear direction to make the most of its people, skills, time and money so as to deliver safe, sustainable and high quality services in health and social care”.

The ability of the organisation to reach and maintain the standard will be dependent on the workforce and the opportunities for support and continuous improvement.

A key component which will measure the quality of services provided is staff supervision. Supervision provides an opportunity to reflect on standards of practice and also consider the needs of the individual in terms of support and continuous professional development. This is prescribed within the following standards.

1.12 Confidentiality

Supervision sessions are, in general confidential exchanges between supervisor and supervisee. However, the supervision record is an organisational document which may be seen by others for e.g. audit, reviews of practice, inspection purposes, where there are grievances or disciplinary proceedings, without the consent of the parties involved. The supervision agreement should clarify the constraints upon confidentiality. As the keeping of these records will eventually involve electronic recording, security access levels will need to be agreed. It should be noted that the personal file will move within the organisation with the individual.

1.13 Recording

Supervision should always be recorded in a timely manner and in such a way that the content and decisions can be readily understood and audited. All notes of individual supervision should be signed as agreed records at the end of a session or within 10 working days (appendix 2(a)). Personal information will only be recorded where it is causing concern in relation to the individual's work performance. The supervision agreement should state how supervision will be reviewed, including feedback about quality and helpfulness (see appendix 1).

Written notes should be maintained by the supervisor with a copy for the staff member. Where other staff are providing aspects of supervision/mentoring this should also be recorded and forwarded to the supervisor. The supervisor will hold a copy of all supervision records in the supervisee's personal file along with the supervision agreement, the PDR and the PDP. In addition, records of cases discussed in supervision will be retained on the client file. Where peer, group or joint supervision occurs there should be clear arrangements for recording same and adding the record to the supervisee's personal file.

It is the supervisor's responsibility to record any case-related decisions on the case file. The record should outline the issues discussed, advice/direction given and actions agreed. They should make it clear

with whom they have consulted, especially if a decision is made outside a formal supervision meeting (an 'impromptu' consultation) or involves another manager. The record should be agreed and signed by supervisor and supervisee.

Supervision records are subject to a retention period of five years except where they form part of the client file when they will be subject to the same retention period as the file. When a supervisee moves within the Trust, the supervisor should forward the personal file to the new supervisor. When a supervisee leaves the Trust, the supervisor is responsible for forwarding the personal file to the closed record store as per closed records policy.

1.14 Quality Assurance/Audit

Quality assurance is the responsibility of supervisee, line manager and senior management.

The line manager should always include discussion on record keeping with all staff who are being supervised by them. Records of all such discussions should be available to senior management for audit purposes.

The line manager should read a sample of the supervisee's case records regularly to ensure adherence to policy and the quality of work undertaken. From this s/he should select a number of cases to review in supervision. Records selected should always include cases involving the protection of vulnerable adults and where appropriate the protection of children.

Where a manager or senior manager views records as part of supervision or audits s/he should countersign the case file.

Senior managers are also responsible for assuring the quality of supervision and the performance of their staff. To this end they should regularly audit small random samples of case files and supervision records to ensure adherence to policy and the provision of high-quality supervision. Appendix 3 has a template pro forma for this.

It is not realistic for senior managers to review all case/ supervision records. The key is regular audit of small samples – maybe six or eight such records. It may be productive to review case records thematically i.e. to examine assessments of new referrals, case closure decision making and adult protection processes.

These processes are described in standard 12 (in addition see the proforma for case file audit in appendix 3).

2.0 Supervision Standards and Criteria

Standards are used in many different areas of life. They describe the basic level of performance or ability that is required for a product or service to be effective and do the job it was designed to do.

In this case the standards define what needs to be in place in order for agencies to ensure a consistent approach to supervision at all levels and across the Trusts. Under each standard are a number of criteria – indicators that will help decide whether this standard has been met.

Standard 1

All staff are provided with formal and regular supervision.

Criteria for qualified Social Worker	Criteria for Social Care Workers
<ul style="list-style-type: none"> • Qualified practitioners receive formal one to one operational supervision at least every four to six weeks. • AYE staff receive formal one to one professional supervision by a qualified social worker at least fortnightly for a minimum of the first 6 months and thereafter on a monthly basis. • Where the operational manager is not a social worker, one in every three supervision sessions will be provided by a registered social worker who has responsibility to undertake the professional supervisory role. • Of the four specific professional supervision sessions in the year: <ul style="list-style-type: none"> - 1 can be group supervision. - 3 must be one to one and should include review of KSF. - Additional sessions can be requested as and when required. 	<ul style="list-style-type: none"> • Social care workers in group care (Day Care, Supported Living, Residential Care): <ul style="list-style-type: none"> - Live observation of practice on on-going basis. - Formal group supervision should occur bi-monthly and must address 4 functions of supervision. - Twice per year formal one to one supervision should be provided by the line manager, should include KSF review. • Social care workers who are lone workers: <ul style="list-style-type: none"> - Monthly operational supervision, must address 4 functions of supervision, provided by line manager. - One in 3 sessions can be group where appropriate.

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Standard 2

All forms of supervision are arranged and conducted in such a way as to permit proper reflection and discussion.

Criteria:

- Supervision is not subject to cancellation and is only postponed in exceptional circumstances. Any postponed session is reconvened at the earliest opportunity and in all cases within 6 weeks of the cancelled session
- Where the supervisor is absent long-term from work (because of e.g. sick leave) alternative arrangements should be made by senior management to provide supervision
- Supervision takes place in an environment which affords privacy and where arrangements have been made to avoid interruptions (other than in circumstances described in the supervision agreement)
- Supervisors should follow the protocol for staff debriefing following joint video evidence interviews
- A record is kept of any cancellation and the reason noted.

Standard 3

All supervisory relationships are subject to a written agreement to be drawn up within the first six weeks of the start of the relationship, (see appendix 1).

Criteria:

The agreement addresses:

- Respective roles and responsibilities
- The frequency of supervision
- How agendas are to be drawn up

- How the supervision sessions are to be recorded
- How confidentiality is to be maintained – and what the limits are to this
- How KSF Performance Development Review requirements are to be met
- How differences in the working relationship are to be managed
- How the principles of diversity (within the supervisor/ supervisee relationship and in service delivery) are to be handled
- How and when the agreement is to be reviewed.

Standard 4

Supervision is a planned and purposeful activity.

Criteria:

- Both supervisor and supervisee prepare for supervision by identifying issues to be addressed
- An agenda will be drawn up in advance of any supervision meeting. Both supervisor and supervisee may contribute to this
- Decisions made at the previous supervision meeting are reviewed to ensure actions have been taken, (see appendix 2 pro forma).

There is a further criterion under this standard in relation to the protection of adults and where appropriate the protection of children. This is:

- The supervisor reads a sample of the supervisee's case records regularly in line with Trust policy. S/he must sign and date the records to indicate they have been read. From this s/he selects a number to review in supervision.

Standard 5

All supervision sessions should be recorded promptly, competently and stored properly.

Criteria:

- The supervision record is recorded on the relevant pro forma, signed by the supervisor and supervisee and placed on the supervisee's file by the former within, other than in exceptional circumstances, 10 working days. A copy should be handed to the supervisee. This record would normally only be read by more senior management for the purposes of auditing the quality of work and supervision
- All records relating to cases (whether individual or joint supervision or 'impromptu' discussions) are recorded on the relevant file/pro forma (see appendix 2b) by the supervisee, signed by the supervisor other than in exceptional circumstances in 10 working days. The supervisee should place these on the case file
- Records demonstrate that issues of dignity and diversity have been addressed both in the supervisory relationship and service delivery
- All supervision records should be legible and clearly signed and dated by supervisor and supervisee.

Standard 6

Supervisors and supervisees are trained to carry out their role.

Criteria:

- Professional induction of all staff addresses the supervision policy and standards
- All social services Team Leaders and managers will complete training in supervision and appraisal within two years of appointment (PSS Development & Training Strategy 2006-2016, page 15)
- For social workers, the Regional Professional Supervision course linked to the NI Post Qualifying Framework is the appropriate vehicle to meet this requirement

- For social care supervisors an in-house course in supervisory skills should be accessed within one year of appointment
- Refresher training is available to supervisors (e.g. peer discussions, action learning, critical reflective practice workshops) to consolidate skills and is discussed within the supervisor's annual appraisal
- Supervisors receive regular feedback from their managers regarding their performance and from supervisees as part of their appraisal process
- Supervisees attend training in first year in practice to ensure continuing professional development. This is provided in the Social Services Professional Induction Programme
- All social work/social care staff should have regular refresher awareness raising on the supervision policy.

Standard 7

The supervisor ensures that the management (competent, accountable performance) function is met.

Criteria:

Supervision meets this function by ensuring that:

- Agency policies and procedures both professional and corporate, are understood and adhered to
- The supervisee's workload is managed and priorities are set
- Cases are assessed, services allocated and decisions made about closure in line with Trust policy and procedure
- The quality of the supervisee's performance (including anti-discriminatory practice) is measured. Where staff are under performing, further action may need to be considered in accordance with the Trust Capability Procedure and NISCC Codes of Practice
- Statutory responsibilities are addressed

- Risks are identified, assessed in line with policy
- Work is allocated according to the experience and skill of the practitioner and the team's/ agency's business plan
- Case recording, including daily records are of the requisite standard
- Case files are audited as per Trust requirements
- Case plans are devised, implemented, reviewed and recorded on the case file
- Any advice/consultation on case work given outside formal supervision by the line manager or other manager should be recorded by the supervisee and countersigned by the manager and placed on the case file
- The needs and desirable outcomes of service users and carers are understood; and that risks are identified and countered
- Appraisals take place, supervisees have opportunities to meet objectives set in these and that the objectives are reviewed on a regular basis.

Standard 8

The supervisor ensures that the continuing professional development function (including the post registration training and learning requirement (PRTL) set down by NISCC) is met.

Criteria:

Supervision addresses this function by:

- Helping staff to develop their professional competence
- Enabling relevant staff to achieve NISCC Induction Standards and registration
- Enabling staff to complete the KSF Performance Development Review

- Enabling staff to meet their post qualifying requirements where appropriate, and training requirements related to their ongoing registration with NISCC
- Helping staff to initiate fresh ways of working in response to changing needs, including through the use of technology
- Enabling staff to relate theory and research to practice
- Assessing training and development needs
- Developing skills and knowledge
- Helping workers to reflect on their work and interaction with service users and carers
- Providing feedback on performance
- Discussing knowledge and skills gained in training events and identifying opportunities to integrate these into the supervisee's work.

Standard 9

The supervisor ensures the support function is met.

Criteria:

Supervision addresses this function by:

- Supporting staff to cope with the stresses that the work entails
- Offering advice on the help available to cope with stress arising from work related and personal issues
- Creating a safe climate for workers to examine their practice
- Helping workers explore the effect of the work on them, both personally and professionally
- Helping workers explore emotional blocks to the work
- Monitoring the overall functioning of workers, especially with regard to the effects of stress, team dynamics and relationships.

N.B. It is important to distinguish between support and counselling. Whilst the impact of the work on the supervisee is an appropriate focus of supervision, seeking to resolve the personal problems of the supervisee is not. Staff support services should be easily accessible for all staff.

Standard 10

The supervisor ensures the engagement (of the individual with the organisation) function is met.

Criteria:

Supervision addresses this function by:

- Communicating effectively with staff about organisational changes and initiatives
- Briefing management about resource deficits
- Representing staff needs to management
- Seeking policy clarification
- Consulting with staff and feeding back to management on how organisational policies/practice is perceived
- Arbitrating between team members when required
- Negotiating on differences which may arise between supervisors and other professionals, teams or services.

Standard 11

Supervision promotes a commitment to diversity in all aspects of work (i.e. that all service users and carers are entitled to the same quality of service irrespective of ethnicity, culture, religion, language, gender, age, disability or sexual orientation).

Criteria:

Supervision addresses this function by ensuring that:

- All assessments, plans and interventions address the implications of the client's ethnicity etc (see list above)
- That staff show appropriate attitudes and behaviours towards service users, respecting their right to clear and appropriate communication and to privacy and dignity.
- The potential vulnerabilities of specific user groups (e.g. disabled/ deaf)are identified and countered
- Discrimination that service users and their carers may experience is acknowledged and, in so far as this is possible, countered by service provision
- There is effective communication with all service users and their carers (this to include e.g. those for whom English is a second language or who are disabled)
- All children and vulnerable adults receive an appropriate level of protection
- Service users and their carers receive appropriate services irrespective of ethnicity etc (see list above).

Standard 12

Managers assure the quality of supervision.

Criteria:

- If any functions of supervision are undertaken by a third party, the manager coordinates the process and ensures effective communication
- Senior management ensures there is an audit, at least once every 6 months of a small sample of:
 - Case files to track the decision making process, actions and outcomes
 - Supervision records placed on casework files and on supervision files
- Senior management conducts an annual audit of supervision practice.



3.0 Supporting Documents

3.1 Appendix 1 - Supervision Contract

[NB: This document can be amended for use in specific settings e.g .group care]

This document should be read in conjunction with the Trust's supervision policy and standards document. All staff you supervise should be given a copy of this. It is designed to help the supervisor and supervisee construct a contract in which expectations are clear. It should act as a template rather than be simply copied. However, in amending it staff should be careful to adhere to the policy and standards. Where a member of staff has different operational and professional supervisors, both should meet with the supervisee to agree the contract.

This contract is between supervisor _____ and supervisee _____

Frequency, Length and Location

We will normally meet at _____ intervals. Our supervision session will last on average for _____. We will meet in a location which is private. Interruptions will be kept to a minimum.

Agenda and Structure

There should be a statement about the structure of supervision for the particular setting e.g. combination of 1:1 and group supervision.

We will both prepare for supervision by identifying cases/issues to be addressed. We will notify each other of any major issues to be addressed in advance (in writing if applicable). An agenda will be drawn up at the start of the supervision session. This will always include:

- Oversight of new referrals and assessments
- Decisions about service provision and closure
- Cases involving the protection of children and vulnerable adults
- Audit of selected files.

Functions

Supervision will cover⁶:

- a) Management (ensuring competent/accountable performance, case guidance, decision making)
- b) Development
- c) Support
- d) Engagement (engaging the individual with the organisation).

Additional requirements for KSF and professional development.

The supervisee has a personal development plan detailing the learning and development taking place in the coming months. This will be addressed in supervision along with any requirements emerging from regulation e.g. assessed year in employment, NISCC continuous professional development.

The KSF Review is a separate function from supervision. The KSF Review may take place following a supervision session but will be distinct.

The supervisor will support the above processes in supervision by e.g.:

- Considering how the supervisee is applying his/her knowledge and skills
- Reviewing progress against the development plan and identifying opportunities
- Providing feedback around the skills and performance of the supervisee (thus making a transparent and ongoing input into Gateway Reviews).

Equalities Issues

Supervision will be based on anti-discriminatory principles and respect for the dignity of the persons involved and sensitive to differences

between our backgrounds and experiences. We will deal with these differences by _____

Record Keeping

All supervision sessions will be recorded on a pro-forma (see appendix 2) by (the supervisor) and passed to the supervisee within stipulated timescales (see policy and standards).

Confidentiality

The recording of personal information will be treated sensitively and the record will contain only that information deemed necessary for effective supervision. There are however constraints on confidentiality in that supervision records may be accessed by senior management for e.g. audit and inspection, grievances and disciplinary purposes without the consent of the parties involved.

Disagreements

Areas of disagreement between us will be recorded on the supervision records. In the first instance we will seek to resolve differences within supervision. However, if they cannot be resolved either of us may refer these to the supervisor's line manager.

Review of Supervision

Supervision session process, content, length, frequency, format and style should be reviewed by the supervisor and the supervisee on a six monthly basis.

Feedback on the quality of the supervision will be given by the supervisee to the supervisor by the following method _____(please state frequency too).

Absence of Supervision

Trust policy requires that supervision be provided at stipulated minimal intervals. We will only postpone supervision in exceptional circumstances. In all cases supervision should be rearranged within 6 weeks.

Should supervision not take place e.g. long-term sickness, failure to adhere to the supervision timetable, we will refer this to (the supervisor's line manager).

Specific Expectations

Our expectations of each other are as follows:⁷

If anyone other than the line manager is going to take responsibility for some part of the supervision process (mentoring, action learning etc) then this should be clearly recorded below and the process specified for regular review and communication.

Signed: Supervisor _____ Date _____

Supervisee _____ Date _____

3.2 Appendix 2a and 2b: Staff Supervision Record Pro-Forma

It is very important that supervision is recorded in a structured way. The following examples (2a for Social Work staff and 2b for Social Care staff) can be adapted to meet local needs and managers are advised to use them as models when designing their supervision record-keeping system.

Supervision should address the following five themes:

- Management (competent and accountable performance)
- Development
- Support
- Engagement (with organisation)
- Caseload management/weighting

The table below should be used to record briefly what was discussed and any decision and actions.

When discussing cases, only record minimal information on this form. All case decisions and actions should be fully recorded on pro-forma (c) and a copy placed on the client file.

The supervision record should demonstrate that issues of respect, dignity and diversity have been addressed in the supervisory relationship and service delivery.



**SUPERVISION RECORD PRO-FORMA
SOCIAL WORK STAFF SUPERVISION RECORD**

Supervisee: _____ Supervisor: _____

Date: _____

Items Discussed	Action by Whom/Timescale
<p>Management (ensuring competent/ accountable performance) (Standard 7) (eg. Case Management, Staffing, Budget, Time Management, Risk, Adult Safeguarding, Child Protection)</p>	
<p>Professional Development (Standard 8) (eg. Training, Courses attended, KSF)</p>	

/continued overleaf....

This Form must be copied to Supervisee

(Continuation Sheet)

Items Discussed	Action by Whom/Timescale
<p>Support (Standard 9) (eg. Personal issues, Annual Leave, Work Life Balance, Sick Leave, TOIL, Lone working)</p>	
<p>Engagement (Standard 10) (eg. Organisational changes, Resource deficits, Policy and Procedures, Service User issues, Team working)</p>	
<p>Other relevant issues might include:</p>	
<p>Annual Leave:</p>	
<p>T.O.I.L:</p>	
<p>Team Work:</p>	
<p>Satisfaction with Supervision:</p>	
<p>NISCC Registration:</p>	
<p>Car Insurance and mileage claim:</p>	

Date of Next Supervision: _____

Supervisee's signature: _____ Date: _____

Supervisor's signature: _____ Date: _____



SOCIAL CARE STAFF SUPERVISION RECORD

Supervisee: _____ Supervisor: _____

Date: _____

Items Discussed	Action by Whom/Timescale
<p>Client specific issues (Management, refer to Standard 7)</p> <p>Risk issues (Management, refer to Standard 7)</p>	
<p>Staff Development (identifying training needs/record) (refer to Standard 8)</p>	

/continued overleaf....

This Form must be copied to Supervisee

(Continuation Sheet)

Items Discussed	Action by Whom/Timescale
Support (Personal Issues, Leave etc) (refer to Standard 9)	
Engagement (engaging and individual with the organisation – refer to Standard 10) eg. E-brief, Continuous Improvement newsletter.	
Other relevant issues might include:	
Annual Leave:	
T.O.I.L:	
Time-keeping:	
Case Load/Work Load:	
Team Work:	
Satisfaction with Supervision:	
Hours of Work:	
Date of Next KSF Review:	
Risk Management:	
Sick Leave:	
NISCC Registration:	
Car Insurance and mileage claim:	

Date of Next Supervision: _____

Supervisee's signature: _____ Date: _____

Supervisor's signature: _____ Date: _____

Appendix 3: Case Supervision Record Pro-Forma

This form should be used to record any case actions and decisions made in either formal supervision or impromptu consultation. It does not replace other methods of recording formal decisions such as reviews and planning meetings.

Once completed a copy should be placed on the client file.



3.3 Case Supervision Record

CASE SUPERVISION RECORD	
Name of client:	_____
Date:	_____
Discussion:	_____ _____ _____ _____ _____ _____ _____
Decisions and actions agreed:	_____ _____ _____ _____ _____ _____ _____
Supervisor:	_____
Supervisee:	_____
Supervision file: Copy to client file	



3.4 Sample Supervision Agenda

SUPERVISION AGENDA SAMPLE

Staff Member: _____

Date of Supervision: _____

CASE DISCUSSION/PROFESSIONAL DEVELOPMENT	PRIORITY
Case Managed Cases	
Level 11	
Hospital Admission	
Drafts/Closures	
Bank Holiday List	
Case Load Report for Audit	
Home Help Issues	
Training	
Sick Leave	
Annual Leave	
I.C.S	
Reviews	
Carers Assessments	
Direct Payments	
Contact Details	
A.O.B	
Next Date	



3.5 Case File Audit Sheet

This form should be used as a tool for first line managers for a random sampling of case files. It does not replace larger audit processes that the Trust may administer.

Service delivery area for audit.....

Client Name: File No:

Address: Soscare No:
.....
.....

Keyworker:

	Yes	No
- Fronting sheet on file fully completed and up to date	<input type="checkbox"/>	<input type="checkbox"/>
- Assessment and Risk Assessment Documents dated and signed by Keyworker and Team Leader	<input type="checkbox"/>	<input type="checkbox"/>
- Planning Documents dated and signed by the Keyworker	<input type="checkbox"/>	<input type="checkbox"/>
- Review Documents dated and signed by the Keyworker	<input type="checkbox"/>	<input type="checkbox"/>
- Evidence that Direct Payments were considered	<input type="checkbox"/>	<input type="checkbox"/>
- Evidence that Carers Assessment was offered	<input type="checkbox"/>	<input type="checkbox"/>
- Daily records signed and dated and filed in order	<input type="checkbox"/>	<input type="checkbox"/>
- All records completed in a legible manner	<input type="checkbox"/>	<input type="checkbox"/>
- Evidence of decision making on file, e.g. case Supervision/consultation or evidence of Team Leader auditing file.	<input type="checkbox"/>	<input type="checkbox"/>

- Evidence of adherence to Policies and Procedures e.g. timescales, etc.
- Evidence of adherence to Safeguarding of Vulnerable Adults Procedures
- Evidence of adherence to Child Protection Procedures

Team Leader Comments:

Signature of Person doing audit:.....

Date:

Date discussed with Keyworker:

Keyworker Signature:

Copy: Client file
Keyworker supervision record

3.6 Supervision Audit Tool

This tool is designed to assist managers to audit supervision (see standard 12) with a view to establishing whether supervision policy has been adhered to.

It is intended that this tool can generally be completed with reference to supervision notes recorded on the pro forma (appendix 2a) and placed on the supervision file. However, auditing of case-specific supervision records (appendix 2b) will present a fuller picture.

Standard 1 – Formal and regular supervision

	Yes	Partially	No
Has supervision been provided at the stipulated intervals?			

Comment

Standard 2 – Permitting proper reflection and discussion

	Yes	Partially	No
Was supervision postponed only in exceptional circumstances—and sessions reconvened asap?			
Where the supervisor was absent long-term, were alternative arrangements made?			

Comment

Standard 3 – Written agreement

	Yes	Partially	No
Was a written agreement drawn up within the stipulated timescale?			
Did the agreement address the stipulated issues?			
Has the agreement been reviewed as described in the agreement?			

Comment

Standard 4 – Planned and purposeful activity

	Yes	Partially	No
Is there evidence that supervision was planned?			
Were decisions made at the previous session reviewed?			

Comment

Standard 5 – Recording and storage

	Yes	Partially	No
Were all records made on the correct pro forma and signed within the stipulated timeframe?			
Do records demonstrate that issues of respect, diversity/ anti-discriminatory practice have been addressed?			
Are all records legible, signed and dated?			

Comment

--

Standard 6 – Training

	Yes	Partially	No
Has the supervisor received training/ refresher training in their role (as outlined in this standard)?			

Comment

--

Standard 7 – Management Function

	Yes	Partially	No
Has the workload been managed and work allocated as specified in the standard?			
Has supervision ensured that case plans are devised, implemented, reviewed and recorded?			
Has supervision ensured that outcomes and risks are identified?			
Has supervision reviewed all new referrals, assessments, decisions and case closures?			

Comment

--

Standard 8 – Professional Development Function

	Yes	Partially	No
Has supervision provided opportunities to staff to develop their skills, knowledge and competence?			
Have training needs and opportunities been identified?			
Has feedback on performance been provided?			

Comment

Standard 9 – Support Function

	Yes	Partially	No
Is there evidence that the supervisee has received appropriate support?			

Comment

Standard 10 – Engagement

	Yes	Partially	No
Has supervision enabled staff needs to be represented to management?			
Has supervision enabled negotiation of differences (within and outside of the agency)?			

Comment

Standard 11 – Diversity/ anti-discriminatory practice

	Yes	Partially	No
Has supervision promoted the integration of diversity principles into assessments, plans and interventions?			
Has supervision helped to identify specific vulnerabilities?			
Has discrimination been acknowledged and (in so far as this is possible) countered by service provision?			
Has supervision ensured respect for the dignity of service users and carers?			

Comment

Signature _____ Date _____

Equality

This policy/proposal has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998, and it was found that there were no negative impacts on any grouping.

Human Rights

This policy has been considered under the terms of the Human Rights Act 1998 and was deemed compatible with the European Convention Rights contained within the Act



Southern Health
and Social Care Trust

Procedure for AHP Supervision within the Southern Trust

Revised June 2017



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1. PURPOSE OF AHP SUPERVISION

The main purpose of AHP supervision is to:

- a. Support the development of knowledge and skills within a role or clinical area, the focus being safe and effective practice and benefit to service users and carers.
- b. Support AHP's in non-clinical roles through providing an opportunity to discuss issues pertinent to the delivery of safe and effective care and / or professional issues.
- c. Support AHP's through difficult circumstances such as challenging and complex client caseloads or difficult interpersonal contact with other team members.
- d. Support the development of competence, knowledge and skills through facilitation of personal and professional growth.
- e. Support reflective practice and clinical reasoning taking account of professional standards, the legislative context and eligibility criteria for service delivery.
- f. Provide professional supervision to those AHPs in generic and HSC leadership roles where the eligibility criteria for their post has specified a requirement to:-
 - hold a professional qualification
 - be registered with the relevant Regulatory body.
- g. For post holders who are AHPs, where an AHP professional background and maintaining their registration with HCPC is not a requirement of their Trust role the Prof HOS are not required to provide professional supervision as this is outside their remit. If an issue arose relating to the practice of that registrant that might leave the supervising Prof HOS or their delegated supervisor in a vulnerable position where they have no professional supervision remit for that registrant.

2. ISSUES RELATED TO SUPERVISION

Core Values and Principles

The following are the core values which underpin the supervision policy and procedures documents:

- Supervision must ensure the effective management of practice, develop and support staff and promote their engagement with the organisation.
- The quality of supervision has a direct bearing on the quality of service delivery and outcomes.
- All staff members, irrespective of their role, have the right to receive high quality supervision.
- All staff members bear responsibility for the quality of their own work and are required to prepare for and make a positive contribution to the supervisory process. They are not passive recipients.

- Senior managers have a responsibility to promote good supervision by implementing this policy and ensuring training is provided for both supervisors and supervisees.
- Senior managers need to conduct regular audits to ensure that this policy and standards are being implemented.

2.2. Knowledge and Skills Framework

All staff in Health and Social Services are now required to complete the Knowledge and Skills Framework (KSF) Performance and Development Joint Review on an annual basis. The KSF Performance Review provides an opportunity for the staff member to reflect on their knowledge, skills and values in a structured way, focusing on the knowledge and skills required for their job profile. The line manager completes the performance review form at this meeting. Individuals will be assessed on their examples of practice and the AHP staff and manager will need to identify the most relevant examples in order to meet the requirements. To support the interface with KSF and supervision processes appendix N can be applied.

2.3 Quality Standards

The Quality Standards for the Health and Personal Social Services (HPSS in Northern Ireland) identify corporate leadership and accountability as key themes for all health and social care organisations.

The standards state that “HPSS organisations and professionals must provide effective leadership and clear direction to make the most of its people, skills, time and money so as to deliver safe, sustainable and high quality services in health and social care”.

The ability of the organisation to reach and maintain the standard will be dependent on the workforce and the opportunities for support and continuous improvement.

A key component which will measure the quality of services provided is staff supervision. Supervision provides an opportunity to reflect on standards of practice and also consider the needs of the individual in terms of support and continuous professional development.

3. SUPERVISION PROCESSES

Frequency of Supervision

Formal supervision should be available on a regular basis, the minimal requirement being that supervision takes place **at least once a month for full time staff and bi monthly for part time staff (0.50WTE or less)**. This includes therapeutic radiographers who hold caseloads. For all other radiography services the frequency will be bi monthly as these staff members do not carry caseloads.

The main form of supervision will be in the form of one to one supervision but professional managers may deploy team or group supervision techniques where appropriate. It is likely that a combination of both types of supervision will be used.

Supervision session lasts on average between one to one and a half hours. In addition, time will be needed for preparation and recording. The frequencies stipulated here refer to staff members who are in full time employment. There may need to be an adjustment where staff members are employed on a part-time basis.

Other activities AHPs engage in throughout the year may impact on the process of supervision. Registered AHPs should reflect on their own practices as they engage in ongoing learning and development activities in their working environment. This experience should be used to inform the supervision sessions. AHPs can access guidance on reflection and keeping a portfolio at www.hcpc-uk.org which can assist with this process. The range of activities that are encompassed within and support supervision are outlined in Appendix A.

Training

The provision of supervision carries training implications for all practising AHPs. Supervisors and supervisees must be trained to carry out their roles within the supervision process and profession specific induction of all staff must address the supervision policy and procedures. Supervisors will attend designated training in supervision within an agreed timescale of taking up their first supervisory/management post.

Refresher training will be available to supervisors to consolidate skills and is discussed within the supervisor's annual appraisal. Supervisors will receive regular feedback from their managers regarding their performance and from supervisees as part of their appraisal process.

Where supervision training is not yet complete, AHPs new to the supervisory role should sit in for a number of sessions with an experienced supervisor to gain some experience of the process as deemed appropriate and with consent of all involved. Time should be made available for supervisors to attend appropriate introductory and advanced training courses.

The skills and competence of a supervisor is crucial to the effective supervision of AHPs. The skills required for supervision will build on existing communication and facilitation abilities learned through initial training, post-registration professional development and experiential learning.

3.3 Receiving Supervision

All AHP staff should be in receipt of formal and regular supervision. For newly qualified staff into post there will be a need for weekly supervision activities as part of a **preceptorship model** as distinct from this policy and procedure for supervision.

Supervision should be available to all AHP staff in four areas of professional activity: **Clinical, Professional, Managerial/Operational and Personal**. Appendix E can be used to agree the list of supervision topics to be discussed within the supervision process.

Although the four types of supervision may be provided to an individual AHP staff member by the same supervisor from within their profession, within the Integrated Team Structures this will not be the case for many staff.

Where managerial/operational supervision is carried out by a supervisor from a different professional background there will be a need for the professional line manager to undertake clinical and professional supervision separately to ensure that sufficient time is afforded to all functions of supervision and that all four types are fully addressed.

The professional and operational managers should ensure that there is an appropriate balance in terms of the time given to each form of supervision and will need to share information and work in partnership to achieve this. (Reference: Good Practice Guidance for Professional Interface Issues within and across Care Directorates).

Joint supervision sessions with the OM, PM and the supervisee may be an efficient way of agreeing overlap areas and the supervision agreement. These processes will be agreed with the professional and operational line managers.

The principal method of supervision within the Trusts is **one-to-one** supervision – where one worker is given the responsibility to work with another worker to meet certain organisational, professional and personal objectives. Supervision as defined in this policy should operate at all professional levels in the organisation up to assistant director level.

However, in some instances as advised by the professional head of service it may be necessary and appropriate to use other methods of supervision. These include **group supervision, team supervision** and mentoring by senior practitioners or the use of other expertise and skills. The guiding principle, irrespective of which methods are used, is that the professional and operational line managers are jointly responsible for ensuring that all four functions of supervision are addressed.

The Supervisee and Supervisor must prepare for Supervision sessions using the proforma (*Appendices H and I*) and adhere to the ground rules for 1:1 and Group Supervision (*Appendices A and B*).

It is recognised that all AHPs engage in the process of informal supervision and whilst acknowledging the importance, and indeed necessity of this activity, this should not in any way replace the formal supervisory requirement. Where advices are given in informal supervision processes these can be captured in

Appendix M and revisited for further discussion or review at formal supervision session/s.

3.4 Providing Supervision

All qualified AHP staff may regularly be expected or asked to provide supervision to a range of grades of staff within their own discipline. If AHPs are team leaders or senior managers responsible for other HPSS staff they may need to supervise these staff members also and reference the Good Practice Guidance for Professional Interface Issues across Care Directorates. The time and frequency of supervision for **non** AHP staff may be variable depending upon the guidelines and rules for those professional groups.

Supervision must be arranged and conducted in such a way as to permit proper reflection and discussion and is not subject to cancellation and is only postponed in exceptional circumstances. Any postponed session is reconvened at the earliest opportunity.

Where a supervisor is absent long-term from work (because of e.g. sick leave) alternative arrangements should be made by senior management to provide supervision.

Supervision takes place in an environment which affords privacy and where arrangements have been made to avoid interruptions

All supervisory relationships are subject to a written agreement to be drawn up at the start of the relationship (see *Appendix D*).

This agreement will address the **respective roles and responsibilities**, frequency of supervision sessions, how **the agendas** will be drawn up, **recording** of supervision, how **confidentiality** is to be maintained – and what the limits are to this, the arrangements to meet **KSF performance and development review** requirements. Also how **differences in the working relationship** are to be managed and how and when the agreement is to be **reviewed**.

Since supervision is a planned purposeful activity the following activities must be addressed;

- Both supervisor and supervisee prepare for supervision by identifying issues to be addressed using the proforma (*Appendix E, J and K*)
- Agreed items for discussion are drawn up at the start of each supervision meeting using *Appendix E*. Both supervisor and supervisee contribute to this
- Decisions made at previous supervision meetings are reviewed to ensure agreed actions have been taken (*Appendices F, G, H & I*).

3.5 Clinical Supervision

The fundamental aim of clinical supervision is to promote best clinical practice through the process of reflection, discussion and review of all aspects of the clinical task and client/therapist relationship.

For the purpose of this policy clinical supervision is defined as **that supervision that relates to all clinical activity; the processes involved in case management, assessment, clinical reasoning, formulation, therapeutic intervention, decision making, consultation, consideration of legislative context and statutory functions, case evaluation/case review status and other wider and more systemic clinical activities.**

In the case of clinical supervision the AHP staff providing supervision should be working within the same area of specialty and should preferably be from within the same organisation.

If no suitably qualified member of AHP staff within the same specialism is available to provide clinical supervision within the organisation then it will be necessary to seek and to ensure supervision is provided, preferably by a suitably qualified Allied Health Professional from within the same specialism, outside the organisation. This will be particularly pertinent for those staff in extended/new roles and regional posts.

In instances where no such suitable qualified AHP staff are available to provide supervision either within or external to the organisation the practitioner should seek competent supervision from another AHP staff member or recognised and accredited Professional, in agreement with his or her Professional Head or Service.

The professional line managers will agree streamlined approaches to the supervision of AHP staff in rotational posts/split posts to avoid the need for multiple supervisors and ensure clarity of approach.

In keeping with the professional body guidelines, Specialist AHP Practitioners should ensure their supervisory requirements are met using the following:

- Attendance at Special Interest Groups
- Regional Forums
- Peer Support
- Peer Supervision

The nature of some of the above activities is such that the time requirement for supervision may not necessarily be met on a monthly basis but will be met through longer sessions held less regularly throughout the year.

3.6 Professional Supervision

All AHPs should have access to a Professional Line Manager of the same profession for issues relating to the following:

- Scope of practice
- Continued Professional Development

- Their role as one of the AHP professionals as defined in their job description
- Professional Guidelines
- Ethical obligations
- Other broader Professional issues

Within supervision, the supervisor ensures that the continuing professional development function (including the post registration training and learning requirement (PRTL) set down by HCPC is met by:

- Helping staff to develop their professional competence
- Enabling staff to complete the KSF performance and development review
- Enabling staff to meet their post qualifying and training requirements related to their ongoing registration with HCPC
- Helping staff to initiate fresh ways of working in response to changing needs
- Enabling staff to relate theory and research to practice
- Assessing training and development needs
- Developing skills and knowledge
- Helping workers to reflect on their work and interaction with service users
- Providing feedback on performance
- Discussing knowledge and skills gained in training events and identifying opportunities to integrate these into the supervisee's work.

3.7 Managerial / Operational Supervision

Managerial/Operational Supervision involves ensuring that the processes, procedures and objectives of the organisation and the wider health service are understood, observed and followed and furthermore that the supervisee is supported and guided with regard to all of the above.

Within supervision, the supervisor ensures that the management (competent, accountable performance) function is met by ensuring that:

- Trust/Professional policies and procedures are understood and adhered to
- The supervisee's workload is managed and priorities are set
- The quality of the supervisee's performance is measured
- Statutory responsibilities are addressed
- Work is allocated according to the experience and skill of the practitioner and the team business plan in keeping with profession specific guidelines
- Case recording, including daily records meet the Trust/professional standards
- Case files are audited as per Trust requirements, a minimum frequency of bi-annually.
- Intervention plans are devised, implemented, reviewed and recorded on the case file
- Any advice/consultation on case work given outside formal supervision by the professional line manager or other manager should be recorded on the case file

- Any advice/consultation on case work given **outside formal supervision** by the professional line manager or other manager should be recorded by the supervisee on the file or in *Appendix H, G and/or Appendix H* in the case of Mental Health services.
- The needs and desirable outcomes of service users are understood; and that risks are identified and countered
- Appraisals take place, that supervisees have opportunities to meet objectives set in these and that the objectives are reviewed on a regular basis.

Within Supervision, the supervisor ensures the **engagement** (of the individual with the organisation) by:

- Communicating effectively with staff about organisational changes and initiatives.
- Briefing management about resource deficits.
- Representing staff needs to management.
- Seeking policy clarification.
- Consulting with staff and feeding back to management on how organisational policies/practice is perceived.
- Arbitrating between team members when required.
- Negotiating on differences which may arise between supervisors and other professionals, teams or service

The application of the Good Practice Guidance for Professional Interface Issues across care Directorates will apply to this function of supervision.

3.8 Personal Supervision

It is important that there is recognition taken for AHP staff as practitioners to be aware of how working with varying client groups can impact upon staff and to be mindful of the implications of this for our work as clinicians. In light of the above AHP clinicians should have access to ways and means that allow them to reflect upon and to process such issues.

Within Supervision, the supervisor ensures the personal supervision support function is met by:

- Enabling staff to cope with the stresses that the work entails
- Offering advice on help available to cope with stress and personal issues
- Creating a safe climate for workers to examine their practice
- Helping workers explore the effect of the work on them, both personally and professionally
- Helping workers explore emotional blocks to the work
- Monitoring the overall functioning of workers, especially with regard to the effects of stress, team dynamics and relationships.

N.B. It is important to distinguish between support and counselling. Whilst the impact of the work on the supervisee is an appropriate focus of supervision, seeking to resolve the personal problems of the supervisee is not. Staff support services should be easily accessible for all staff.

While it may be possible for AHPs providing clinical supervision to another AHP to offer this kind of supervision the opportunity to do so, however, will be influenced by a range of factors, including:

- a. The personal relationship between supervisor and supervisee.
- b. Level of experience of the supervisor.
- c. The nature of the specific issues(s) arising for the person in clinical practice.

There may be times when personal experiences and issues cannot be dealt with appropriately within the existing clinical or other supervisory relationships. In such instances there may be a need for some additional personal supervision. Where this is considered necessary the AHP concerned should discuss the requirement with his/her Line Manager or Professional Head of Service.

4. RECORDING SUPERVISION

Documentation

The written agreement for all supervisory relationships must be completed as outlined under providing supervision using *Appendix D*.

All supervision sessions should be recorded promptly, competently and stored properly, using the relevant proforma (*Appendices D, E, F, G, H & I*).

- All records relating to cases (whether individual or joint supervision or unplanned discussions) are recorded on the relevant proforma (*Appendix G* or *Appendix H*) the latter is in relation to mental health services by the supervisee and signed by the supervisor. The supervisee should place these on the client case and supervision files.
- Records relating to other matters are recorded in the relevant proforma (*Appendices F & I*), signed by the supervisor and placed on the supervisee's supervision file by the former. This record would normally only be read by more senior management for the purposes of auditing the quality of work and supervision
- All supervision records should be either typed or written in clear print.
- The date of and time of each supervision session should be recorded along with a brief outline of areas discussed. Both supervisor and supervisee should agree and sign the supervision records (*Appendices D, F, G, H, I, M and N*).
- Where clinical supervision involves the discussion of specific clinical cases a brief summary of the issues discussed and any recommendations or actions agreed, should be included in the case file by the clinician bringing the case to supervision using the appropriate proforma (*Appendix G*) or (*Appendix H*) for Mental Health cases.
- Both supervisor and supervisee should record time involved in informal/unplanned supervision along with a brief summary of the content of this, on the supervision record in *Appendix M*. Where this has involved case supervision this should be recorded in *Appendix E, G* or *Appendix H* for Mental Health programme of care.
- If any functions of supervision are undertaken by a third party, the professional line manager coordinates the process, ensuring effective communication and organises relevant tripartite meetings.
- Professional Senior management should ensure there are planned audits of a small sample of case files and supervision records within the case or supervision files, to inform supervision evaluation and client outcome, a minimum frequency of bi-annually.
- Professional Senior management should conduct an annual audit of supervision practice.

It is essential that written notes of individual sessions are taken, remain confidential and record clearly any agreed actions, using the relevant proforma (*Appendices D, F, G, H, I, M and N*). Individual sessional notes are the responsibility of the supervisee. (Copies of the Record of Supervision forms can be found in *Appendices D & G*).

4.2 Confidentiality

Supervision sessions are, in general confidential exchanges between supervisor and supervisee. However, the supervision record is an organisational document which may be seen by others for e.g. audit and inspection purposes, where there are grievances or disciplinary proceedings, without the consent of the parties involved. The supervision agreement process should clarify the constraints upon confidentiality and where records are kept in electronic format security access levels will need to be agreed.

Where there are Issues of **concern regarding unsafe, unethical or illegal practice this should be dealt with supportively via appropriate procedures. All parties must be informed of the intention to disclose, before revealing confidential information.**

4.3 Use of Patient/Client Records

Where supervision is focused on case discussions/review or application of clinical reasoning patient/client records may be used to support this activity. This will be particularly relevant to new graduates and to aid complex case discussions.

Where this happens, staff's code of ethics and confidentiality will apply.

The Southern HSC Trust Records Management Policy and associate procedures should be adhered to.

Organisations employing professional staff members who make such records are the legal owners of those records.

4.4 Storage of Records

The Southern HSC Trust has its own policy for the safe storage of records. However, each registrant should be mindful of his/her professional accountability with regard to the principle of confidentiality of information. AHPs must, therefore, take responsibility for making sure that the system used is managed in such a way that it is appropriately protected to ensure the security of confidential information. Supervision files for staff who have left SHSCT should be retained as Leavers dossiers for 6 years after the subject has left the service. After 6 years the file can be destroyed.

5. IMPLEMENTATION PLANS

Each professional Head of Service will have an agreed implementation plan for their service which will be agreed and shared with the operational line manager if AHP staff members have separate professional and operational line managers.

6. MONITORING AND EVALUATION

Monitoring and evaluation of supervision activity is essential to ensure that Supervision Policies and Procedures are implemented and that they are meeting all four functions of Supervision. It is also necessary to monitor the benefit to individual registrants, clients and the organisation, since the quality of supervision activities can influence effectiveness, reduce risk and promote safe and effective care.

At an organisational level monitoring will take place in governance reports or accountability reviews. The quantity and quality of supervision activity may be included in the Southern HSC Trust performance indicators for the AHP Workforce.

Individual supervisors must comply with information gathering regarding the number of sessions they engage in and make this data available to professional line managers for collation. This information will, in turn, be collated by AHP Heads of Service and communicated to the Assistant Director AHP Governance, Workforce Development & Training who is responsible for monitoring AHP supervision within the Trust and reporting on this activity to the Trust Governance Committee on a quarterly basis

In order to ensure that the quarterly AHP supervision activity figures are available for presentation to the Trust's Governance Committee *Appendix L* must be completed by the Professional Heads of Service and returned to the Assistant Director AHP Governance, Workforce Development & Training no later than 15 working days of the first month of the next quarter.

Given the centrality of supervision to the clinical and governance tasks, this supervision policy should be reviewed every two years and amended in accordance with Clinical Governance Standards and relevant Professional Guidelines.

Range of Supervision Activities

Appendix A

<p>One to One Supervision</p> <p>This is where an identified supervisor meets an individual member of staff (or supervisee) for a session of one to one protected time to fulfil some or all of the functions of supervision. This is best suited to staff carrying their own individual caseloads.</p>	<p>Joint Supervision</p> <p>This is most suitable when two or more staff are engaged in the same piece of work; eg co-working a case, running a group.</p>	<p>Group Supervision</p> <p>This is a valuable learning activity as it helps to develop critical thinking and collaborative working and brings about improvements in practice. Group supervision best suits the needs of staff working in group care settings or where team working and team development is a priority.</p>
<p>Reflective Practice</p> <p>Reflective practice is the process of thinking about one's own practice and that of others in a structured way. It aims to lead to new and better ways of working and helps develop new levels of knowledge and competence. It is about thinking critically about practice and about what is needed to improve the care we provide.</p>	<p>Journal Clubs</p> <p>Can be uni disciplinary or multi disciplinary or inter agency in nature where staff come together to present research or best practice papers in a related field / speciality on a team / individual rotational basis.</p>	<p>Special Interest Groups (local / regional)</p> <p>Many services have specialist sections to share and promote best practice at local/regional or national level. This may be required for highly specialised services that need to outreach to access peer review/supervision.</p>
<p>Opportunistic Experiences / Direct observation</p> <p>Opportunistic experiences or direct observations provide opportunities for staff to learn from one another. These experiences may or may not be planned and examples include direct patient care activities, working with new equipment, new treatments or supporting a colleague who has experienced challenging behaviour from a client. All of these situations provide learning which staff often reflect on without recording.</p> <p>Supervisors may also carry out direct observation of a supervisee's performance to assess competence and development needs.</p>	<p>Preceptorship / Mentoring</p> <p>A mentor is someone who has skills of working with individuals who can provide guidance and support to help staff achieve your potential. The purpose of the mentoring process is to enable staff to recognise their own skills and capabilities and maximise the development opportunities available. Mentoring is a process of relationship building between yourself and your mentor and takes place over a period of time.</p>	<p>Action Learning Sets</p> <p>The term refers to a group of people who meet regularly to work and learn together, using a structured format. The learning set can comprise of uni- or multi-professional groups and the focus is on self-directed learning with participants deciding on the particular issue to be explored. Each member of the group is facilitated and supported by the others in the solving of issues and problems.</p>
<p>Supervised Practice for Competency Development</p> <p>This is a negotiated period of supervised practice, with agreed learning and competency outcomes. It is likely to be arranged if there are concerns about clinical competence in an area of practice. The length of time and the expected outcomes, are set before the period begins and supervision is provided by an experienced practitioner.</p>	<p>Post Incident Review</p> <p>A post-incident review involves the review of specific incidents, either individually or as a team, within a setting that provides emotional support to each person. The incident is analysed with your involvement and the involvement of all team members, using reflection, self-evaluation and/or facilitated learning to establish how the incident happened and how it could be avoided in the future</p>	<p>Work Shadowing</p> <p>Spending time observing/working alongside another Trust colleague or a staff member in a different Trust or agency may provide the most effective learning method in some scenarios.</p>



GROUND RULES for 1:1 SUPERVISION

Prior to supervision session the SUPERVISEE will have: -

- Read all relevant/associated policies, procedures and guidance
- Prepared for the session and will have considered and identified practice areas for open discussion
- Undertaken relevant action(s) as agreed at previous supervision session(s)

During each supervision session both SUPERVISOR and SUPERVISEE will: -

- Maintain mutual respect
- Have an attitude of open learning
- Maintain strict confidentiality
- Be open to constructive feedback
- Engage in reflective practice
- Deal appropriately with areas of disagreement according to the ground rules
- Ensure that identified unsafe, unethical or illegal practice is dealt with supportively via appropriate procedures.
- All parties must be informed of the intention to disclose, before revealing confidential information
- Explore the supervisee's expectations appropriately using appropriate knowledge, skills and experience

At the end of the supervision session both SUPERVISOR and SUPERVISEE will: -

- Agree a suitable time and venue for the next session

After the session the SUPERVISEE will: -

- Engage in learning and development activities that will inform subsequent supervision sessions
- Record and reflect on significant activities using a profession specific approach
- Evaluate the perceived benefit of the session
- Maintain and store records in line with Trust policy

After the session the SUPERVISOR will: -

- Maintain and store records in line with Trust policy
- Provide the supervisee with a copy of the session if not already provided
- Evaluate the perceived benefit of the session to the supervisee



GROUND RULES for GROUP SUPERVISION

Prior to supervision session the SUPERVISEES will have: -

- Read all relevant/associated policies, procedures and guidance
- Prepared for the session and will have considered and identified practice areas for open discussion
- Undertaken relevant action(s) as agreed at previous supervision session(s)

During each supervision session both SUPERVISOR and SUPERVISEES will: -

- Be sensitive to the needs of individuals and the overall dynamics within the group
- Maintain strict confidentiality by not disclosing or discussing information provided by any other members of a group
- Be supportive of other members of the group
- Listen to and allow other members of the group to speak.
- Maintain mutual respect
- Have an attitude of open learning
- Be open to constructive feedback
- Engage in reflective practice
- Deal appropriately with areas of disagreement according to the ground rules
- Ensure that identified unsafe, unethical or illegal practice is dealt with supportively via appropriate procedures
- All parties must be informed of the intention to disclose, before revealing confidential information.
- Explore the supervisee's expectations appropriately using appropriate knowledge, skills and experience

At the end of the supervision session both SUPERVISOR and SUPERVISEES will: -

- Agree a suitable time and venue for the next session

After the session the SUPERVISEES will: -

- Engage in learning and development activities that will inform subsequent supervision sessions
- Record and reflect on significant activities using your profession specific approach
- Evaluate the perceived benefit of the session
- Maintain and store records in line with Trust policy

After the session the SUPERVISOR will: -

- Maintain and store records in line with Trust policy
- Provide the supervisees with a copy of the session if not already provided
- Evaluate the perceived benefit of the session to the supervisees



SUPERVISION AGREEMENT

Supervisee Name		Supervisor name	
Supervisee Job Title		Supervisor Job Title	
Professional Line Manager		Operational Line Manager	

Professional Activities to be addressed in Supervision:	
Clinical	<input type="checkbox"/>
Professional	<input type="checkbox"/>
Managerial/Operational	<input type="checkbox"/>
Personal	<input type="checkbox"/>

Frequency of Supervision Sessions - _____

Duration of Supervision Sessions - _____

Venue for Supervision Sessions - _____

- Supervision will be primarily in the form of one to one supervision. Where appropriate, Group and informal supervision techniques may also be employed. It is likely that a combination of supervision techniques will be used. (Appendices 1&2)
- Both supervisor and supervisee will prepare for Supervision by identifying issues/cases to be addressed. Priority areas for discussion will be drawn up at the start of the Supervision sessions (*Appendices G & H*). Major issues/ concerns to be discussed will be communicated by either supervisor or supervisee in advance.
- All Supervision sessions will be documented on the attached templates (*Appendix D or F*), by the Supervisor and signed (either manually or electronically) and dated by all parties. Case discussions and agreed action plans will be recorded on proforma (*Appendix E or Appendix I*) in relation to the Mental Health Programme of Care.
- **Limits to Confidentiality** Personal information will be treated confidentially and not recorded. Supervision records can be accessed by Senior Manager for audit, inspection, grievances and disciplinary processes.

- **Conflicts/Disagreements in the Supervision Relationship** will be recorded within Supervision documentation. A resolution to these differences will be sought within the Supervision Process and where this is not achieved, either party can refer to the Supervisor’s line manager.
- **Informal Contact Arrangements between Supervision Sessions.** A note will be kept in the supervision record or all relevant discussions that occur within the informal supervision process. (Appendix K)
- **Personal Development Plans and KSF** All Supervisees will have a Personal Development Plan and a KSF Outline, the objectives from such can be discussed and reviewed within Supervision Sessions. This will be supported by the Supervisor by using Appendix L
KSF Review meetings will be undertaken separately from Supervision Sessions.

- **Review of Supervision**

A 12 monthly review of the Supervision Process and agreement including content, frequency, length, format and style will be undertaken by the Supervisor and Supervisee.

Feedback on the quality of the Supervision will be given by the Supervisee either at the 12 monthly review or at any stage throughout the Supervision Process

- **Postponement of Supervision** 1:1 or Group Supervision as deployed by Professional Head of Service will occur once monthly or bi monthly for 0.50wte staff. Postponement of Supervision will only occur in exceptional circumstances. Lack of adherence to Supervision timetable due to non-compliance or staff vacancies will be referred to the Supervisor’s Professional Line Manager.
- Any other arrangements to support the Supervision Process in addition to the line manager (mentor/coach, peer support group, action learning, special interest group, regional forum) should be noted and agreed mechanism for review, communication or any tripartite meetings.

Declaration:

We agree to adhere to the terms of this Supervision Agreement as agreed by the Trust’s Senior Management Team and incorporated into the AHP Supervision Policy and Procedures.

Supervisee Signature		Supervisor Signature	
Date		Date	

Section 1: CLINICAL - Caseload Management/Review

- Clinical Caseload** – assessment skill, clinical reasoning, treatment planning, use of outcome measures, decision making, case evaluation/review, reflective practice, etc
- Activity planned for coming months.**
- Health Promotion activity**
 - Sessions run/evaluations
 - Activities planned.
- Training**
 - Training run/evaluations
 - Training planned
- Projects/Audits/Service Improvements**
- Communication skills** – MDT, colleagues, patients, carers

Section 2: PROFESSIONAL – Professional Development

- CPD** –log,reports/reflections/formal training.
- Training needs**
- HCPC**
- Professional guidelines** - Update on standards/protocols/guidelines etc
- Feedback from groups/meetings attended**
- Service developments**
- Update from KSF** – requires minimum of 6 monthly review
- Incidents/accidents/complaints**

Section 3: MANAGERIAL/OPERATIONAL

- Mandatory Training**
- Supervision of students**
- Delegation to assistants**
- Staff cover**
- Complaints/compliments**
- Audit Activity**
- Discussion of any feedback/information from operational managers (if applicable)**

Section 4: PERSONAL

Support as arises eg health issues, work life balance, team/colleague Relationships, annual leave, emotional aspects of role

January 2014

Record of 1:1 Supervision

The 1:1 Supervision Session was carried out between	
Name of Supervisee	Name of Supervisor
Date:	
Venue:	
Date of previous Supervision Meeting	

Supervision Component:		CLINICAL – Caseload Management/Review & Discussion		
Key Issues	Action Plan	By Whom	Completion Date	Review from previous session

--	--	--	--	--

Case Discussion – Refer to Appendix E

Supervision Component: PROFESSIONAL – Professional Development

Key Issues	Action Plan	By Whom	Completion Date	Review from previous session

Supervision Component:		MANAGERIAL / OPERATIONAL		
Key Issues	Action Plan	By Whom	Completion Date	Review from previous session

Supervision Component:		PERSONAL		
Key Issues	Action Plan	By Whom	Completion Date	Review from previous session

--	--	--	--	--

Supervision Component:		OTHER		
Key Issues	Action Plan	By Whom	Completion Date	Review from previous session

Risk Issues that require onward reporting – please record details below:			
Key Risk Issues	Action Plan / Report To	By Whom	Timescale

Areas of Concern / Disagreement

Date & Time of next Supervision Session			
Date:		Time:	

Session Evaluation [Please Comment]

Signatures:

Supervisor		Supervisee	
-------------------	--	-------------------	--

Copy to Supervisee	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date	
---------------------------	------------	--------------------------	-----------	--------------------------	-------------	--

AHP Supervision Procedures – APPENDIX G

CASE SUPERVISION RECORD

Name of Supervisee			
Name of Supervisor			
Date of Supervision Session		<i>Time of Supervision Session</i>	
Name of Client			
Client's Date of Birth			
Client's Health & Care Number			

Record of Key Discussion Points				
Key Issues	Action Plan	By Whom	Date to be Completed by	Review from previous session

Record of Key Discussion Points				
Key Issues	Action Plan	By Whom	Date to be Completed by	Review from previous session

Signatures:			
Supervisor		Supervisee	
Date:		Date:	

NOTE: Completed records are to be filed in the client's case record and a copy held on the Supervision File



CASE DISCUSSION/SUPERVISION RECORD

Date:

Time:

Staff Name:

Designation:

Face to Face/Telephone Contact

Client Details

Concerns/Queries/Information

See Overleaf

Issues Discussed/Risk Identified

Action Agreed/To Be Taken

Supervisor:

Supervisee:

Designation:

Designation:

Signed:

Signed:

To be filed in clients' records and copied to staff supervision file



RECORD of GROUP OR PEER SUPERVISION

The Group Supervision Session took place on:

Date:	
Time:	
Venue:	
Date of Previous Group Supervision Session:	

Attendance List:

SUPERVISEES	SIGNATURE
SUPERVISOR(S)	SIGNATURE

Supervision Component: CLINICAL

Review of Action Points from Previous Supervision Session:

Key Issues	Action Plan	By Whom	Date to be Completed by	Review from previous session

Case Discussion – Refer to Appendix E

Supervision Component:		PROFESSIONAL – Professional Development		
Review of Action Points from Previous Supervision Session:				
Key Issues	Action Plan	By Whom	Date to be Completed by	Review from previous session

Supervision Component:			MANAGERIAL / OPERATIONAL	
Review of Action Points from Previous Supervision Session:				
Key Issues	Action Plan	By Whom	Date to be Completed by	Review from previous session

Supervision Component:		OTHER		
Review of Action Points from Previous Supervision Session:				
Key Issues	Action Plan	By Whom	Date to be Completed by	Review from previous session

Risk Issues that require onward reporting – please record details below:			
Key Risk Issues	Action Plan / Report To	By Whom	Timescale

Areas of Concern / Disagreement

Date & Time of next Supervision Session

Date:		Time:	
--------------	--	--------------	--

Session Evaluation [Please Comment]

--

Copy to all Supervisees	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date	
--------------------------------	------------	--------------------------	-----------	--------------------------	-------------	--



SUPERVISEE PREPARATION FORM FOR SUPERVISION

Name of Supervisee:			
Date		Time	
Venue			

Agreed actions from previous session	Progress on action points

Reflection on Learning and implementation of this from Previous Session

--

Issues to be brought forward and discussed at next meeting

--

Signature:	
-------------------	--



SUPERVISOR PREPARATION FORM FOR SUPERVISION

Name of Supervisor:			
Date		Time	to
Venue			

<i>Agreed actions from previous session</i>	<i>Progress on action points</i>

Review of Learning and implementation of this from Previous Session

Issues to be brought forward and discussed at next meeting

Signature	
Length of time for preparation:	



Quarterly AHP Supervision Activity Return *(Registrant & Support Staff Only)*

***NOTE: The total number of supervision sessions that required need to be calculated using the demand / capacity ratio for 42 working weeks. This will equate to 1.3 sessions per quarter for staff contracted for less than or equal to 0.5WTE and 2.6 sessions per quarter for staff contracted more than 0.5WTE. (Supervision can be facilitated as a 1:1 session or group session).**

AHP Discipline										
Financial Year										
Quarter Ending										
Care Directorate										
	Acute Services		CYP		HR&OD		MHD		OPPC	
	≤0.5 WTE	> 0.5 WTE	≤0.5 WTE	> 0.5 WTE	≤0.5 WTE	> 0.5 WTE	≤0.5 WTE	> 0.5 WTE	≤0.5 WTE	> 0.5 WTE
Total Headcount										
Total Number of staff within Directorate										
Number of required Supervision sessions per WTE										
Total Number of supervision sessions that are required										
Number of Completed Supervision Sessions per WTE										
Total Number of supervision sessions that have been completed										



Directorate Compliance with Trust AHP Supervision Policy & Procedures (%)					
Overall Trust Compliance with Trust AHP Supervision Policy & Procedures (%)					
Any Additional Comments					

Signature of Professional Head of Service	
Date:	

Please return this proforma (Appendix J) to: AHP.governance@southerntrust.hscni.net

In order to make sure that this information is available for presentation to the Trust's Governance Committee this form must be submitted to the office of AD Governance, WFD and Training no later than **15 working days** of the first month of the next quarter.



INFORMAL SUPERVISION RECORD

Date:

Staff name:.....
.....

Staff Number

Supervisors name:.....
contact:.....

Name of person who initiated

Supervision Component (tick) –

Clinical___ Professional ___ Managerial/Operational ___ Personal ___
Other_____

ISSUES DISCUSSED AND OUTCOMES/ACTIONS TO BE TAKEN

Signature of Supervisor _____

Signature of Supervisee _____



PDP/KSF Update Record

Appendix N

Staff Name _____ Date PDP Completed ___/___/___				PDP Review Date ___/___/___	
	Identified Learning or Development Need	Agreed Action	Target Date	Outline action taken	Completed YES/NO
Corporate Mandatory Training	1. 2. 3.				
Essential for the Post	1. 2. 3.				
Best practice/ Development	1. 2. 3.				



The British
Psychological Society
Promoting excellence in psychology



Division of
Clinical Psychology

DCP Policy on Supervision



This document was written on behalf of the Division of Clinical Psychology Professional Standards Unity by:

Dr Catherine Dooley Director, Division of Clinical Psychology Professional Standards Unit
Thomas Peyton-Lander DCP Publications Assistant

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- South West London & St George’s Mental Health Trust for allowing us to use their examples of ‘Supervision Contracts’ in Appendix A.

We would also like to thank the following people who contributed to the development and production of this document.

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Wandsworth Psychological Therapies and Wellbeing Service
(IAPT)

If you have problems reading this document and would like it in a different format, please contact us with your specific requirements.

Tel: 0116 252 9523; E-mail: P4P@bps.org.uk.

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DCP Equality and Diversity Statement

The British Psychological Society's *Code of Ethics and Conduct* (2009) is based on the four ethical principles of respect, competence, responsibility and integrity. This code is the basis for the Division of Clinical Psychology's work and is the foundation for the Division's diversity statement.

The Health and Care Professions Council (HCPC) as the regulatory body for the profession set out their statements in relation to equality and diversity in the *HCPC Equality and Diversity Scheme* (2007).

The Division of Clinical Psychology expects members to deliver services fairly in response to individual needs, and to behave with respect and decency to all. Members of the DCP do not discriminate based on a person's age; ability or disability; family circumstance; gender; political opinion; race, nationality, ethnic or national origin; religion or belief; sexual orientation; socio-economic background; or other distinctions. Such forms of discrimination represent a waste of human resources and a denial of opportunity.

The DCP recognises that discrimination, harassment and bullying does occur and expects members to challenge inappropriate behaviour and discriminatory practice either directly, or through working within cultures and systems to establish changes to practice.

Supervision is a critical element of clinical practice since it links scientific research to the realities of clinical work, and is the means by which theory becomes linked to practice (e.g. Fleming & Steen, 2012; Scaife 2001; Bernard & Goodyear, 1998).

Introduction

Supervision is one strand of clinical governance for professions within health services, alongside continuing professional development (CPD) and life-long learning to ensure safe and accountable practice and high quality clinical and professional services.

Supervision is identified within a range of documents in relation to the governance of professional practice, for instance the Care Quality Commission's *Essential Standards of Quality and Safety* (2010) and the Health and Care Professions Council's Standards of Practice 2c.2 (HCPC, 2011).

The Department of Health (1993) defines supervision as, 'A formal process for professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in complex situations. It is central to the process of learning and scope of the expansion of practice and should be seen as a means of encouraging self-assessment, analytical and reflective skill.'

Supervision within clinical psychology can be defined as 'the formal provision, by approved supervisors, of a relationship-based education and training that is case-focused and which manages, supports, develops and evaluates the work of junior colleagues'. (Milne, 2007)

This document updates and replaces previous guidance from the DCP on this area, namely *Policy Guidelines on Supervision in the Practice of Clinical Psychology* (2003) and *Continued Supervision* (2006). Reference should also be made to the BPS *Code of Ethics and Conduct* (2009), the BPS *Generic Professional Practice Guidelines* (2008), *DCP Continuing Professional Development Guidelines* (2010) and *DCP Guidelines on Activity for Clinical Psychologists* (2012). The BPS's *Register for Supervisors* (RAPPS) contains standards for knowledge, skills, experience and understanding for the provision of effective supervision and these would be recommended as good practise for those offering supervision. (See Appendix D for RAPPS learning outcomes.)

This document confines itself primarily to the supervision needs of qualified clinical psychologists; supervision of trainee clinical psychologists is determined by additional guidance for clinical psychology training programmes: *Guidelines on Clinical Supervision* (BPS 2010). Supervising of assistant psychologists is addressed within the *Guidance on the Employment of Assistant Psychologists* (DCP, in preparation).

1. Aim of this document

The aim of this policy is to:

- Describe managerial, professional and clinical supervision.
- Set out standards for best practise in supervision for and by clinical psychologists.
- Outline responsibilities for the line/operational manager, supervisor and supervisee within this process. In particular, to demonstrate that the supervisee has a proactive role to bring concerns and issues to supervision and engage openly and honestly with the process.
- Reference how supervision, CPD and appraisal work together to provide a system for clinical governance and staff development.
- Provide guidance on the delivery, development and audit of supervision – such as contracts, recording, monitoring and audit.

1.1 Purpose and function of supervision

The primary purpose of supervision is to ensure the safety and quality of care and treatment for service users.

Supervision also supports professional development, developing and embedding new skills and ensuring adherence to good practice both in clinical and professional areas.

Where clinical psychologists work with more complex/transdiagnostic clients there is a particular role for supervision to support them to develop and refine (and re-refine) formulation and intervention plans.

Effective supervision also has a role in providing support for the individual and maintaining morale. This can be of particular value when psychologists are working in highly complex and sensitive areas – such as trauma or child sexual abuse – where the need to establish sufficient time to take issues to a safe and confidential place away from the normal work setting may need to be factored into the job plan.

At a time of ongoing change within services, the supervisory function has a particular role to allow the individual practitioner to reflect on the personal impact of their work and manage concerns in order to assist them in maintaining their level and standard of functioning.

Several models of supervision (see Beinart, 2012 for a review), identify supervision tasks and functions such as: education; support; quality assurance/monitoring; conceptualisation/formulation and consultation. These may occur in the broader service/team context and models such as Hawkins and Shohet (2012) and Holloway (1995) stress the importance of the broader context. Current theory and research also emphasises the centrality of the supervisory relationship to effective supervision, e.g. Beinart (2012) and Watkins (2013).

2. Standards and recommendations for good practise

These standards apply to all members of the DCP and provide a good practice benchmark for all clinical psychologists, although it is recognised that there may be different approaches within different organisations. Individuals in independent practice, either as sole practitioners or within an organised service, will require robust supervision arrangements that meet these standards and the underlying principles that underpin them.

1. All clinical psychologists, at all stages of their career and in all work contexts, will engage in regular planned supervision of their work.
2. All aspects of a clinical psychologist's work including clinical, consultancy, supervisory, research, educational, or managerial, will be subject to supervision.
3. The amount and frequency is dependent on context, experience and work demands:
 - 3.1 An absolute minimum will be one hour per month, one to one supervision with a psychologist, for all staff, however part time.
 - 3.2 It is recommended that a full time newly qualified clinical psychologist will have weekly clinical supervision for a minimum of one hour.
 - 3.3 It is recommended that a full time mid career clinical psychologist will have clinical supervision for a minimum of one hour per fortnight.
 - 3.4 It is recommended that a senior psychologist would have clinical supervision for a minimum of one hour per month.
4. It is recommended that a supervision contract (see Appendix A for examples), agreed and signed by supervisor and supervisee be established, and reviewed regularly, at least annually. The annual review will identify the amount of supervision required and incorporate supervision time in relation to the demands of the work and may be reflected in a work plan (DCP, 2012).
5. All clinical supervisors will be appropriately trained for the role.
6. All supervision will be documented and records kept (see Appendix B).
7. The individual has a responsibility to identify the need for and to seek access to supervision within their work situation.
8. Supervisors apply supervision models and best evidence to their supervisory practice and attend carefully to their supervisory relationships.
9. Supervisors demonstrate ethical practice and are respectful of diversity in all its forms.

3. Types of supervision

It is important conceptually to separate out:

- Line management supervision
- Professional supervision
- Clinical supervision.

In practise, in some services these three areas will each be dealt with within different supervisory arrangements, with an individual meeting with their team manager (a non-psychologist) on perhaps a monthly basis, meeting with their professional supervisor monthly and with the clinical supervisor on a weekly basis.

However, at times two or even all three may be combined within one supervisory relationship. In these situations it may be particularly important to ensure that all aspects are appropriately addressed. There are examples of matrices illustrating how and where the different elements may be met (Appendix C).

It should be noted that at times a particular issue will be and should be addressed in all three areas; one example would be a clinical issue concerning safeguarding of a vulnerable adult which may need to be discussed with the line manager (to support formal reporting), within professional supervision in terms of how the individual managed the situation and within clinical supervision to refine the clinical intervention.

3.1 Operational/line management supervision

Line management structures are determined by the employing organisation and line managers are responsible for developing systems for the managerial supervision of staff within their service. Line management supervision has a focus on appraisal and monitoring of performance, and is specifically concerned with operational issues and quality of service. This complies with clinical governance requirements, and addresses the need for accountability. Line management supervision ensures that staff perform the tasks they are paid to perform as part of the services that the organisation is commissioned to deliver. A key aim is to ensure that there is consistency between the individual's work and the objectives of the service.

3.2 Professional supervision

Professional supervision is a distinct function but may be combined with other roles. It has the overall focus on the individual as a professional within a professional role and its key function is to ensure that professional practice standards, ethics and codes of conduct are met.

Such supervision will address issues such as

- team working and relationships;
- progress against personal development plan (PDP) goals and organisational objectives from the appraisal;
- CPD needs and priorities;
- use of broader competencies, in particular leadership skills (DCP, 2010);

- professional and ethical issues and concerns; and
- longer term career development.

This offers a confidential (in so far as there are no concerns regarding fitness to practice and/or competence) reflective space for clinical psychologists to think and talk about their work, and their responses to the work.

Supervisors will need to possess solid understanding and expertise in key areas of professional competence for clinical psychologists, and have had appropriate preparation for their role of supervisor of qualified professional staff members. In most situations this would be provided by a psychologist in a more senior position; however, for senior psychologists peer supervision could be acceptable although this should be monitored within the appraisal system and access to a more senior psychologist should be available, even if external and in some circumstances necessitating providing funding to receive this from an external supervisor.

The frequency and duration of professional supervision will be of a standard that allows all aspects of work to be discussed, and enables the development of a beneficial supervisory relationship. This will be negotiated with, and agreed by all involved parties: supervisee, supervisor and line manager. A minimum standard is one professional supervisory session per month.

The focus, content, and process of supervision will be negotiated between supervisee and supervisor. The focus and content of supervisory discussions will shift and vary from individual to individual, over different work contexts, and over time.

Professional supervision may incorporate clinical supervision wholly or partly depending on the individual's need and/or the organisational context. Ideally the two would be kept separate or have clearly defined times as in practise one can easily be neglected in favour of the other.

3.3 Clinical supervision

Clinical supervision has the specific purpose to maintain, update and develop clinical skills in assessment, formulation and interventions. This may address clinical work from various orientations – complex cases, based on diagnoses/conditions, interventions or model specific.

Regular clinical supervision within the model of care that the clinician uses is a prerequisite for clinical practice. Such supervision also requires integration of clinical material with theoretical perspectives. There is a particular focus on the need to ensure that the work is evidence based and relates to most recent research and theoretical literature, as well as guidance from National Institute for Health and Care Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN) and other formal guidance.

The function is to ensure safe and effective practice within a respectful and trusting relationship. As there may be a high level of personal disclosure, strong emotions and also at times a high amount of challenge from the supervisor it is crucial that a good relationship is engendered and supported.

Clinical supervision will allow reflective space to review on-going clinical work where the individual practitioner can step back and critique this with a view to addressing biases or errors within work and learning new skills, having access to fresh ideas and new perspectives. It is invaluable in helping to deal with 'stuckness'. In particular it would allow the exploration of challenging attitudes and mind sets or particular mental frameworks.

This would also offer a 'safe space' to allow recognition of the personal impact of the work both generally and particularly at times with individual cases.

Traditionally the emphasis has been on the provision of reflective space but increasingly the formative and normative component is becoming stronger as demonstrated by clear guidance from NICE, SIGN and local protocols; in addition to the focus on payment by results (PBR) and the requirements for more immediate information on clinical activity. There is also the statutory aspect to the work, e.g. where a psychologist is working with a case where there is child sexual abuse or financial abuse of a vulnerable adult and safeguarding issues. The supervisor may need to give a clear message or other direction and this will be recorded formally.

In some areas of work, clinical supervision will be highly structured and model specific, such as within IAPT services. At times there may be supervision focusing on specific areas, such as development disorders/neuropsychology, trauma.

Where the clinician is working to develop clinical skills (and/or qualification) within a particular modality, such as cognitive, interpersonal, psycho-dynamic or systemic therapy, there may be externally determined standards required for accreditation for both the supervisor and supervisee. In this case there will be an expectation to prioritise time for such supervision (including possible travel), CPD opportunities or even to pay for external supervision.

Supervision is usually hierarchical with a more experienced supervisor providing supervision to a less experienced supervisee. However, clinical supervision is more competency based so it is possible that a more 'junior' staff member could provide clinical supervision to a more 'senior' member of staff. This may provide particular challenges to the supervisory relationship which need to be carefully negotiated and managed. With an increasingly wider range of clinical areas of work, and the need to be more self directed, individual practitioners are more likely to seek this collaborative, co-creative model. Regular supervision may be supplemented with ad hoc sessions (for instance where there is a recognised expert, e.g. in trauma, who colleagues utilise for specific cases). Increasingly, no one supervisor can meet all clinical supervision needs. Consultation is considered to be the term for ad hoc or one off use of supervision.

The status of any advice from the supervisor will vary given the level of qualification and autonomy of the practitioner – for newly qualified clinical psychologists or supervisees undertaking initial training in a new clinical areas, the supervisee might be advised to follow the advice of their supervisor. Once qualified, generally the psychologist is autonomous and decides whether to take advice; they would then be accountable as an individual for that judgement.

3.4. Alternative approaches to the provision of supervision

Supervision, especially clinical supervision, is normally considered to be provided one-to-one and face-to-face. However, there are many examples of alternative types of provision. Clinical supervision could be group based, with an identified lead, or peer based, with all members sharing expertise. It can be conducted by telephone (such as is common within Mindfulness-based CBT); Skype or other instant messaging solutions as well as email. Some models (e.g. systemic) use reflective teams or live supervision, where the supervisor is in the room with the clinician and client. Good practice would indicate the use of recorded or observed material within supervision at times.

These approaches all have benefits, even if primarily pragmatic, but there would also be disadvantages and a situation where a psychologist did not receive face-to-face and one-to-one supervision with reasonable frequency would not be considered acceptable practise.

3.5. Informed consent from clients in relation to supervision

Clinical psychologists will inform clients and supervisees of their own supervisory arrangements. Clients undertaking a course of formal psychological therapy will be informed of the fact that all therapists use clinical supervision as part of their work. Clinical psychologists will attempt to gain a general and informed consent from clients and supervisees for those occasions where potentially identifiable case or supervisory material needs to be part of supervisory discussions.

4. Complex issues that might arise in supervision

4.1 Aspects of the supervisory relationship

There can be a number of issues that arise in supervision that require careful management. The prime concern for all practitioners should be patient safety and well-being; this will also include concern about the wider governance of the service and the provision of safe and effective care, as well as professional ethics.

Some examples are:

- concerns about confidentiality, breaches of information governance;
- reporting of safeguarding issues;
- whistle blowing;
- personal issues – for instance, managing carer responsibilities;
- concerns about own fitness to practise;
- concerns about others fitness to practise;
- addressing capability issues within one’s position, for instance being asked to take on work that is outside current skill range;
- ethical dilemmas within the local team/service; and
- managing boundary violations or dual relationships.

These issues could arise within different areas of supervision and may require different

courses of action. Most organisations have policies and procedures in relation to these areas, and the human resources department may be able to assist; in some areas the Health and Care Professions Council (HCPC) might need to be involved.

It needs to be stressed that supervision should not be viewed as ‘personal therapy’ for the supervisee; it could be easy for boundaries to be affected. In such situations it may be valuable for the supervisor to take this to their own professional supervision to ensure that they provide the right balance, for instance where a staff member brings an issue such as their own substance misuse to supervision.

Supervisory space needs to be a safe space for the individual but there can be times when organisational changes threaten this. Increasingly, as work roles change, there may be boundary issues that affect the supervisory relationship, such as for instance in a reorganisation where two psychologists were originally peers but now one is in a more senior position than the other. A supportive and contained relationship between supervisor and supervisee are cited as factors promoting satisfaction with supervision. In order to achieve these goals a supervisor and supervisee should have an explicit agreement about the circumstances under which issues discussed in supervision will be discussed with a third party. This should be reflected in the supervision contract, e.g. under ‘boundaries’ and should include reference to third party discussion where:

- concerns about the supervisee’s work with service users are not being resolved through supervision;
- concerns about the supervisee’s well-being are not being resolved through supervision;
- there appears to be a breach of the HCPC’s *Standards of Proficiency*, BPS *Code of Conduct, Ethical Principles and Guidelines*, the DCP’s *Professional Practice Guidelines* or the DCP’s *Core Purpose and Philosophy of the Profession* on the part of the supervisee or supervisor; and
- behaviour on the part of the supervisor or supervisee where disciplinary proceedings might apply.

4.2 Sociocultural aspects to consider in supervision

The relationship between the supervisor and supervisee must be built on mutual trust and respect to ensure safe and effective practice. As there may be a high level of personal disclosure, strong emotions and also at times a high amount of challenge from the supervisor it is crucial that a good relationship is engendered and supported.

It is therefore important to recognise that people who have grown up in sexist, homophobic, racist or other discriminatory cultures may have problems building a trustful relationship between themselves and a supervisor or supervisee who comes from a very different cultural background. In such instances, if this cannot be resolved by discussion and internal mediation, the reallocation of the supervisor or supervisee without prejudice may be the only possible solution to ensure a good outcome.

4.3 Diversity impact assessment in relation to supervision

Category	Impact	Solution
1. Age	Differences in experience, values, knowledge and understanding.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.
2. Disability (including long-term physical health problems)	Access, travel, time commitment, impact of sensory impairment.	Deal with practical issues, including reducing travel and ensuring accessible facilities. Possible reallocation of supervisor or supervisee without prejudice. Ensure aids and adaptations are provided.
3. Religion/ 4. Culture	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.
5. Pregnancy and maternity	Possible gaps in continuity, maternity leave, childcare.	Need to ensure standards are met, especially around continuity of supervision.
6. Marriage and civil partnerships	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.
7. Sexual orientation and 8 Gender re-assignment	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.
9. Gender	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.

5. Quality, aspects of effective supervision

5.1 Expertise in the provision of effective supervision

The Society's Register for Supervisors (RAPPS) contains standards for knowledge, skills, experience and understanding for the provision of effective supervision at an introductory level and is recommended as good practise for those offering supervision. These are attached in Appendix F.

5.2 Training and CPD for supervisors

The supervisor will ensure that they have attended core supervision skills training and undertake further regular training relating to supervision over the course of their career. There are introductory and advanced training available from most of the training courses for placement supervisors. The BPS and many training courses provide training that is BPS approved and confers eligibility for the Register for Applied Psychology Practitioner Supervisors.

5.3 Problems in accessing supervision

There may be some settings where it is difficult to access suitable supervision to meet these standards, where, for instance, a psychologist is the only psychologist working in an organisation, for example, the sole clinical psychologist within an district general hospital or in an independent or third sector provider. In these situations, the individual and their manager will need to ensure they meet the standards of the HCPC and BPS and use this document to ensure the supervision needs are met. It would be advised to liaise with local DCP branch chairs for professional advice.

5.4 Monitoring and audit

All services employing clinical psychologists will ensure that effective supervision is provided and received. This can be monitored in a variety of ways, including formal audit and via annual appraisals.

The outcomes of supervision will be systematically reviewed and evaluated on a regular basis (at least annually). A minimum audit would be to ensure that psychologists all have this at the minimum frequency and more detailed analysis of qualitative aspects, such as the content and purpose. An ideal would be annual monitoring of the quality of supervision via a survey of supervisees associated with annual appraisal.

6. Conclusion

This document updates the guidance from the DCP for members and builds on that provided by earlier documents.

It sets clear standards in terms of supervision in relation to grades, quality aspects of supervision and for the supervisors in providing supervision.

It has become clear during the process of writing this document that supervision within clinical psychology is very much an area in development in terms of:

- the emergent literature on theoretical aspects of supervision;
- the work on a competency framework for supervisors; and
- the current plans to take forward the RAPPS system to accredit supervisors.

It is hoped that the guidance within this document will be relevant over a reasonable timescale; it had been written, where appropriate, quite broadly to ensure that the increasingly diverse work contexts within the delivery of psychological services are addressed within it.

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Appendix A. Two examples of supervision contracts

SAMPLE CONTRACT FOR INDIVIDUAL AND GROUP CLINICAL SUPERVISION OF PSYCHOLOGICAL THERAPY

For use by all qualified practitioners within

Name of Supervisee (s):

Name of Supervisor:

Work Base:

Place of Supervision:

The supervision contract is a commitment by the supervisor and the supervisee to enable the supervisee, as a qualified practitioner of psychological therapy, to discuss in confidence issues relating to their clinical work with clients/patients, to ensure safe practice and to enable the development and maintenance of clinical therapeutic skills.

- 1) Supervision will take place on a weekly basis for hours.
- 2) Supervision will usually be provided individually unless otherwise agreed and reviewed at least annually.
- 3) The supervisor has the responsibility of ensuring that a private venue (as free from interruption as possible) is available and booked for each session.
- 4) Sessions cancelled unavoidably due to annual leave, sick leave, etc, should be re-booked as soon as convenient to both parties.
- 5) Notes will be taken by the supervisor and a copy given to the supervisee.
- 6) Subjects discussed will be treated as confidential as set out by the Trust's guidelines on supervision.
- 7) The supervisee has the responsibility to highlight in supervision concerns, pressures and information they feel the supervisor should be aware of.
- 8) The supervisor has responsibility to use supervision to provide structure, support and exploration to maintain, enhance and/or develop the supervisee's clinical skills.
- 9) is the qualified clinician who will act as third party, in a consultative role, if difficulties and conflicts arise between supervisor and supervisee.
- 10) When requested the supervisor will provide feedback for the supervisee's appraisal.

Date agreed: Review date:

Signed:

Supervisor: Supervisee:

PROFESSIONAL SUPERVISION CONTRACT

Supervisor: Supervisee:

Date contract agreed: Contract to be reviewed:
(Minimum annually)

Frequency of supervision: Monthly Duration of each session: 1–1.5 hours

Focus:

The professional supervisor ensures that the individual clinician is working within appropriate professional boundaries, and is adhering to appropriate professional standards, in line with the objectives of the service and the Trust. They also contribute to appraisals, identification of training needs and reviewing of objectives in the personal development plan.

The primary focus of professional supervision will therefore be on the development and maintenance of professional and clinical skills appropriate to the role of the supervisee.

Clinical caseload/workload will be reviewed routinely to monitor the types of clinical work undertaken, the caseload mix, waiting times and the development of clinical expertise.

Appraisal objectives will be routinely reviewed.

CPD activities will be reviewed and objectives discussed/recorded.

The supervisee will take responsibility for highlighting areas of need for further support in relation to specific aspects of clinical work, professional roles or managerial tasks.

Issues discussed and agreed outcomes will be recorded and agreed by both parties for each supervision session. The notes will be emailed to the supervisee who will then be able to comment or amend if necessary

Boundaries:

Regular supervision will be scheduled by agreement at the frequency specified with a commitment to good time keeping and avoidance of interruption.

Where issues of personal well-being are of concern to either party and appear to fall outside of the supervisory relationship, a third party (within the department) may be consulted with the permission of the supervisee/supervisor. We have identified XX.

The content of supervision and associated written records are confidential unless there are concerns raised about competence or risk.

Material from supervision/related records, specific to either party, is only to be discussed outside of supervision with the agreement of the supervisee and/or supervisor except where it is necessary to consult with a third party in the event of concerns regarding clinical or professional misconduct on the part of either the supervisor or supervisee.

Signed:

Supervisor: Supervisee:

Date:

Appendix B: Recording of supervision sessions

Good practise would indicate that the recording of supervision sessions should include:

- a. Copies of all supervisory contracts and updates to the contract.
- b. The date and duration of each session.
- c. A supervision logbook should be kept, and include at least minimal notes on the content of supervision, decisions reached, agreed actions.
- d. A written record should be made of all regular reviews, including outcomes, of supervision. This would normally be the responsibility of the supervisor to ensure that a record is kept.
- e. In some situations (e.g. risk issues) it would be good practice to also record a discussion and/or agreement within the relevant case file or as part of the clinical record; this is the responsibility of the supervisee. It would be good practise to record within the clinical case record, in particular any clinical decisions. The supervisee will record in the clinical record any risk issues and how they are addressed.

Appendix C: Psychology and Psychological Therapies: Responsibilities of psychology and psychological therapy managers in multiprofessional managed services

1. This document sets out the responsibilities of psychology professional management in multi-professionally managed services and teams. The majority of NHS services are multi-professional and managed through general service managers and/or clinical directors. Professional management supplements service management, with responsibility for managing and advising on profession specific areas where general managers may not have expertise. This paper clarifies the respective responsibilities of service and professional managers where these may be unclear.
2. Service management involves all aspects of managing the service/team. It includes:
 - Strategic direction for the service
 - Operational policies
 - Clinical governance of the service
 - Workload allocation
 - Supervision of staff in relation to their work in the service.
3. Professional management involves ensuring the professional standards and continuously improving the professional quality of work of professional staff. It includes:
 - Appointment of professionally competent and skilled staff
 - Profession specific elements of clinical governance – professional standards assurance and quality improvement
 - Profession specific clinical supervision
 - Continuing professional development.
4. Responsibility for hiring, appraisal and disciplinary matters can rest with either service or professional management. Line management is the term often used for this ‘hiring and firing’ responsibility. Sometimes there is a degree of vagueness as to which of service or professional manager has the line responsibility or it may be stated that this responsibility is shared.
5. As there can be different understandings as to what is the responsibility of service management and what of professional management, it can be useful to set out and agree the specific responsibilities of each. The Appendix is a suggested matrix of the respective responsibilities of service/team managers and psychology/psychological therapy professional managers in relation to psychologists and psychological therapists working in a multi-professional team. In this example, the psychology professional manager takes the line management responsibilities.
6. Job descriptions should include that the post holder is responsible to both service manager and professional manager. The precise form of wording will vary depending on the balance of responsibilities. In the example in the Appendix where the psychology/psychological therapy manager undertakes line management responsibilities for a psychologist who is working in two different teams, the job description should set out the relationship with regard to line management arrangements for both teams.

	Service/team manager	Psychology/psychological therapy manager
Recruitment	Contributes to writing and agreeing job description, recruitment procedures and selection of candidates.	Leads on recruitment, ensuring team/service manager(s) agree job description and procedures for selection of candidates.
Induction	Lead for induction is by agreement between service/team manager(s) and psychology manager, with the other contributing. Where psychologist is to work full-time in a team, the service/team manager will usually be responsible for induction; where the psychologist will work in more than one team, the psychology manager will usually be responsible.	
Work allocation	Responsible for allocation of work within the team/service.	Advises service/team manager(s) on parameters of appropriate kind of work/roles for psychologist in the team.
Standards, quality monitoring and clinical governance	Responsible for monitoring and ensuring work of the psychologist is within the policies and standards of the team/service.	Responsible for standards, quality monitoring and clinical governance of specialist psychology work in the team, within overall clinical governance arrangements of the team.
Appraisal/ IPR	Where a psychologist is full-time in a team/service, the service/team manager and psychology manager jointly carry out the annual IPR/appraisal. Where the psychologist works in more than one team/service, the psychology manager leads on the annual appraisal/IPR and ensures the relevant team/service managers contribute and agree IPR objectives.	
Training and CPD	Contributes to setting CPD goals as part of the IPR process and scheduling and facilitation of CPD.	Responsible for agreeing annual CPD plan and facilitating psychologist in undertaking agreed CPD, with involvement of team/service manager(s) in setting CPD goals and scheduling of CPD.
Annual leave/ absence monitoring	Lead responsibility for agreeing annual leave and ensuring absence reporting and monitoring is by agreement between service/team manager and psychology manager, with the other contributing. Where psychologist works full-time in a team, the service/team manager will usually be responsible for leave arrangements; where the psychologist works in more than one team, the psychology manager will usually be responsible.	
Disciplinary	Ensures matters that might require formal disciplinary procedures are brought to the attention of the psychology manager. Liaises with psychology manager in taking forward disciplinary procedures where these relate to the performance of the psychologist in the team/service.	Responsible for any needed disciplinary procedures, with involvement of service/team manager(s) as needed.

While in principle, these respective responsibilities can be detailed in the job description of the post, in most cases a summary of line management and reporting arrangements for both teams should be sufficient.

Appendix D: RAPPS learning outcomes

Understanding and application

1. Have knowledge of the context (including professional, ethical and legal) within which supervision is provided and an understanding of the inherent responsibility.
2. Have an understanding of the importance of modelling the professional role, e.g. managing boundaries, including protecting time), confidentiality, accountability.
3. Have knowledge of developmental models of learning which may have an impact on supervision.
4. Have knowledge of a number of supervision frameworks that could be used for understanding and managing the supervisory process.
5. Have an understanding of the importance of a safe environment in facilitating learning and of the factors that affect the development of a supervisory relationship.
6. Have skills and experience in developing and maintaining a supervisory alliance.
7. Have knowledge of the structure of supervised professional experience including assessment procedures at different levels of qualification up to Chartered status level, and the changing expectations regarding the supervisor's role.
8. Have skills and experience in contracting and negotiating with supervisees.
9. Have an understanding of the transferability of professional skills into supervision and the similarities and differences.
10. Have an understanding of the process of assessment and failure, and skills and experience in evaluating supervisees.
11. Have skills and experience in the art of constructive criticism, on-going positive feedback and critical feedback where necessary.
12. Have knowledge of the various methods to gain information and give feedback (e.g. self report, audio and video tapes, colleague and client reports).
13. Have skills and experience of using a range of supervisory approaches and methods.
14. Have knowledge of ethical issues in supervision and an understanding of how this may affect the supervisory process, including power differentials.
15. Have an understanding of the issues around difference and diversity in supervision.
16. Have an awareness of the on-going development of supervisory skills and the need for further reflection/supervision training.
17. Have knowledge of techniques and processes to evaluate supervision, including eliciting feedback.

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Investment Proposal Template (IPT3)

Revenue funding > £500,000 < £1,500,000

*(unless in exceptional circumstances and approved by Commissioner for >£1,500,000)***Commissioner's Statement**

Reference Number	
Commissioner Representative	<u>Aidan Murray</u>
Title	Assistant Director, Mental Health and Learning Disability
Contact Tele No. & Email	
Date	

1. **Strategic Context – (if provider requires to add any further information for strategic context this should be added to box 14 in the main proposal attached)**

Southern Trust - Learning Disability Accommodation Based Services in the Community. (Resettlement)

The Commissioning Plan Direction and Transforming Your Care require that there should be no long-stay patients in learning disability hospitals by March 2015.

Proposals should be drawn up by Trust for provision of a range of accommodation with support in the community to meet the needs of 33 long stay hospital patients. The accommodation should be planned and developed in partnership with the NIHE, Housing Associations and the voluntary sector. Proposed schemes should make full use of the Supporting People Programme where possible.

2. **Description of Services – (if provider requires to add any further information for strategic context this should be added to box 14 in the main proposal attached)**

- **Supported Living Schemes**
- **Registered Nursing Homes**
- **Registered Residential Homes**

3. **Funding –**

A total of £2.805m recurrent funds (£2.805m for CYE in 2013/14) will be made available to the Southern Trust to provide the accommodation with support in the community for the 33 long stay hospital patients

Note: Board Finance Officers will be meeting with Trust Finance Officers to confirm the actual FYE funding requirement for resettlements up to 31st March 2013 and the CYE and FYE requirements for 2013/14 resettlements.

4. **Timescale and process for submitting**

Trust to submit completed investment proposal to Aidan Murray [REDACTED]
by 22nd March 2013.

PROVIDER SECTIONS

Provider	Southern Health and Social Care Trust	Submission date	22 March 2013
Scheme Title	Resettlement of Learning Disability Long-stay Patients from Hospital to the Community		
Responsible Officer - including title	Mr Miceal Crilly, Acting Director of Mental Health and Disability		
Contact Details – Tele no. & Email	[REDACTED]		

- This business case should be prepared in line with the Green Book and NIGEAE Guidance
- Please complete this template with proportional effort, i.e. detail provided should be commensurate with the size of the bid.

1) Explain how this proposal specifically meets the needs for this investment (linked directly to the Commissioner statement)

Introduction

Transforming Your Care – December 2011 - A review of Provision of Health and Social Care (HSC) services in Northern Ireland was undertaken to provide a strategic assessment across all aspects of health and social care services, examining the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and communities are being met resulting in bring forward recommendations to shape future services. One of the key proposals within TYC is the closure of long stay institutions and complete resettlement by 2015. Trusts are urged to give absolute commitment to resettlement and to ensuring the required community services are in place to prevent a new long stay population. Also within the Commissioning Plan Direction one of the key strands is the resettlement of all long stay patients in learning disability hospitals by 2015.

Current Service Provision

In the past people with extreme challenging behaviours and complex learning disability who could not live with families had to live in long stay hospital accommodation. However such reports as the Equal Lives and the Bamford Review recommended that all adults with a learning disability residing in long stay hospital accommodation be resettled within the community. In recent years the Southern Trust has developed and taken forward its resettlement plan which has resulted in 100+ people being successfully resettled into alternative community living.

The Southern Trust still have a long stay hospital population however this is reducing year on year. These include patients living in Longstone Hospital, Armagh and Muckamore Abbey Hospital in Antrim.

These individuals have spent the major part of their lives in a hospital setting due to their complex needs and for some, their forensic histories. As such they have not experienced the skills required to enable them to live in a community setting. Therefore it is acknowledged that these individuals will require a high level of supervision care and support to be resettled, rehabilitated and maintained in the community.

Aim and Objectives:

- To provide suitable alternative community placements for long stay patients which meet their individual and collective needs and provide for them an improved quality of life based on the principle of betterment.
- Provision of a living environment that as far as possible reflects general home living.
- The service should offer a permanent whole life care option that minimises the possibility of re-admission to hospital by managing risk and preventing re-offending.
- By being resettled the person is offered a range of services which supports community living and also supports better health and social wellbeing.
- Person centred approach which provides improved flexibility to account for changes in individual care needs.
- Resettlement provides local community integration and is located close to other public sector facilities which enables promotion of social inclusion.
- To meet strategic direction such as the Bamford Action Plan and Ministerial PfA Targets for resettlement.
- The Trust proposes to resettle learning disability patients from long-stay hospitals into facilities in the community which appropriately meet their needs. The selected providers will provide 24/7 care and support which will include day time opportunities for the individuals (some individuals will attract additional costs for their day time opportunities due to the levels of supervision required to meet their needs). The provider will ensure staffing levels according to the profile of the individual to be resettled in order to provide the maximum support and care and manage risk. Again for some individuals the SHSCT will be required to provide input from Specialist services to support their placement to the required level.

Anticipated Outcomes

It is proposed to resettle 23 individuals to the new supported living scheme in Granville Dungannon, a scheme developed in partnership with the NIHE, Supporting People and Apex Housing. Trust staff will provide the care and support within this scheme. One individual will be accommodated within the Heathers Supported Living Scheme in Armagh. This scheme has been developed in partnership with NIHE, Supporting People, Oaklee Housing and the Trust. The Care and Support will be provided by Oaklee Housing.

The patients identified below will be accommodated in Granville and the Heathers in Armagh. The one remaining patient in Muckamore will be required to be resettled under licence due to the nature of his crime. The following table details where these patients are currently resident and their proposed location.

It must be noted that the amount of funding required is less than the amount stipulated by the Commissioner.

Client	Currently Resident	Status	Proposed Location
BT	Donard	PTL	Granville
SS	Sperrin	PTL	Granville
AOC	Mourne	PTL	Granville
MB	Mourne	PTL	Granville
EH	Mourne	PTL	Granville
EMCC	Mourne	PTL	Granville
MD	Mourne	PTL	Granville
AC	Mourne	PTL	Granville
TD	Donard	PTL	Granville
KMCG	Donard	PTL	Granville
ED	Sperrin	PTL	Granville
KE	Donard	PTL	Granville
GP	Sperrin	PTL	Granville
MMCC	Sperrin	PTL	Granville
TC	Sperrin	PTL	Granville
PC	Sperrin	PTL	Granville
KMCC	Sperrin	PTL	Granville
NI	Sperrin	PTL	Granville
GS	Donard	PTL	Granville
AC	Donard	PTL	Granville
GM	Cherryvilla	PTL	Granville
TM	Donard	PTL	Granville
FMCK	Donard	PTL	Granville
GH	Six Mile Unit, Muckamore	PTL	(no identified facility as yet, needs to be outside Trust area due to the nature of his crime)
KT	Mourne	PTL	Heathers

A detailed patient profile and needs assessment was completed for each individual. The total cost of all patients to be resettled in 2013/14 will be in the region of 2.125M with an average of £85,000 per client. Some of these individuals will require much more management and supervision due to their forensic and/or behavioural histories, therefore an enhanced level of community staffing is required to support and maintain their placements.

2a) Objective(s) of this development - these will be examined in more detail in section 10 and 11)

*Please complete the list below - please note that this list is not exhaustive but is a **minimum requirement***

OBJECTIVES	DATE/ACTIVITY	EXPLANATORY TEXT IF REQUIRED
Development implemented by what date?	To be fully implemented by 31 March 2014	Compliance with the 2013/14 PfA target Long Stay Patients in learning disability hospitals
Target met by what date?	31 March 2014	
Activity increased by? (Further detail in Section 12)	N/A	
Qualitative Benefits?	The further resettlement of 25 long stay learning disability patients into alternative community placements	
Other		
Other		
Other		

2b) What are the Constraints of the Project?

Availability of staff, recruitment difficulties, Constraints in, space, time and funding etc.

Constraints include the availability of suitable community placements (All have identified placements except GH in Muckamore who will require a placement outside of the SHSCT area due to the nature of his crime) and the skills and numbers of staff in the community to provide the appropriate level of care, support and management of risk which is required to successfully resettle and rehabilitate these individuals. Another constraint is the timeframe for resettling these individuals within this financial year and the time associated with preparing both them and their families for the transition from hospital to the community.

The Trust is confident that all will be successfully overcome.

3) Option one: Status Quo or Base Case

This section must be completed in all instances

Current activity levels must be detailed in the appropriate currency as well as current access timescales and numbers waiting.

A Costing sheet must be completed for this option – Appendix 1

Option 1 - Base Case - Learning disability patients will continue to be cared for in long stay hospitals.

Advantages

Individuals will continue to reside in hospital accommodation and continue to be cared for within the hospital environment by staff who are familiar with their individual needs and the management of risk.

Disadvantages

If the individuals remain in hospital there are limited opportunities for betterment. The Trust will not be working towards the achievement of ministerial target for the resettlement of long stay patients from hospital wards. The Trust will fail to meet strategic recommendations such as the Bamford Review and Equal Lives.

4) Option Two

Changes to base activity levels must be detailed in the appropriate currency as well as impact on current access timescales and numbers waiting where appropriate

A Costing sheet must be completed for each new option – Appendix1

Option 2 – Resettlement of 25 long stay patients in a community setting

All learning disability patients will be resettled into a range of community facilities appropriate to their needs and wishes, following a Person Centred assessment of their needs. The selected provider will provide 24/7 care and support which includes day time opportunities appropriate to each of their individual needs. The selected provider will provide the appropriate level of staffing required to support these placements to ensure that these individuals will be safely maintained, supported and managed in the community. Providers will be supported in this by directly provided services from the Trust, where the provider cannot reasonably be expected to have the required skill and knowledge to meet an individual's needs from within their own service.

Advantages

It provides an alternative community placement which will cater for the individual needs of the patients and providing 24/7 care and day time opportunities. Resettlement provides an improved quality of life and betterment for these individuals. All 25 patients can be resettled which assists the Trust in working towards its PfA target for resettlement and complying with the mental health directive for the resettlement of certain long stay hospital patients.

Disadvantages

Many of these individuals have very complex needs, including some Forensic histories, which will be challenging in terms of appropriately managing this risk to ensure the protection of them and others.

5) Option Three

Changes to base activity levels must be detailed in the appropriate currency as well as impact on

*current access timescales and numbers waiting where appropriate
A Costing sheet must be completed for each new option – Appendix1*

Option 3 – Placement of Long-stay Patients in private and statutory nursing homes

The Trust will seek places for all patients in private and statutory nursing homes.

Advantage

The level of care provided would be to a high standard.

Disadvantage

A nursing home setting would be similar to a hospital setting and there would be limited opportunities for betterment. These placements may not be appropriate due to the nature of the clients already resident in these facilities. Staff may not be appropriately trained to support these individuals in these settings. This option would not be in line with the Bamford Review and Transforming Your Care recommendations.

6) Option Four – if deemed necessary

*Changes to base activity levels must be detailed in the appropriate currency as well as impact on current access timescales and numbers waiting where appropriate
A Costing sheet must be completed for each new option – Appendix 1*

N/A

7) Identify and evaluate the overall benefits of all of the options

Consider costs and benefits to other parts of the public and private sectors

Criterion	Weight	Option 1 - Base Case		Option 2 - Resettle all patients in a community setting		Option 3 – Private and Statutory Nursing Homes	
		Score	Score x weight	Score	Score x weight	Score	Score x weight
Quality of Support and Care to provide betterment to the individual	40	3	120	6	240	3	120
Appropriate staffing levels to meet the need of the individuals and manage risk	30	6	180	6	180	5	150
Improved quality of living accommodation	30	3	90	8	240	5	150
Total	100		390		660		420

Robustness/Bias Test (Sensitivity Analysis)	<p><u>If benefits are not delivered as expected above would the ranking change?</u></p> <p><u>How much would costs increase before VFM (Ref Box 9 is impacted?)</u></p>
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<p>8) Financial Quantification of chosen option <i>Express Costing in total rather than incremental terms to expose full resource consequences</i></p> <p><u>Please note which option is the preferred option -</u></p>			
OPTION NUMBER AS ABOVE	Option Name	Total £ (Rec)	Total £ (Non-Rec)
OPTION 1 - STATUS QUO	25 individuals remain as long-stay hospital patients	<u>TBC</u>	
OPTION 2	25 individuals to be resettled in the community	<u>£2.125M</u> See attached costing sheet	
OPTION 3	25 individuals to be placed in statutory and private nursing home placements	<u>TBC</u>	
OPTION 4			
Additional Cost (Marginal Increase: Preferred Option less Status Quo Option)			
<p>Note: Detail to be contained in costing appendix. <i>(Where cost savings or efficiency improvements are projected these must be further detailed in Section 9 below)</i></p>			
<p>9) Value for Money A) Efficiency Savings (Where applicable) - Provide an accurate costing of any savings. Are these savings to be cash released or redeployed? If redeployed please provide full details of redeployment (cost, activity, outcomes etc).</p>			
<p>B) Further demonstrate overall Value for Money by including benchmarking evidence B1) Breakdown the elements of the option and compare cost and activity to Status Quo option and</p>			

benchmarking statistics eg Community Statistical Indicators, Reference Costs, Specialty Costs, HRGs etc.

B2) Please explain the reason for any positive or negative variances that exist when the preferred option is compared to B1 above.
Positive Variances: eg Better working practices, more efficient use of resources etc. These will indicate VFM.
Negative Variances: eg Increased complexity of services etc. These will not initially indicate VFM – More information required below in B3.

B3) If there are negative variances shown in B2 above explain how are these offset by, for example Qualitative benefits and the context of the project.

10) Preferred Option (Insert option number _____)
 Please rank costs and benefits and summarise reasons for selection.

Criterion	Weight	Option 1 - Base Case		Option 2 - Resettle all patients in a community setting		Option 3 – Private and Statutory Nursing Homes	
		Score	Score x weight	Score	Score x weight	Score	Score x weight
Quality of Support and Care to provide betterment to the individual	40	3	120	6	240	3	120
Appropriate staffing levels to meet the need of the individuals and manage risk	30	6	180	6	180	5	150
Improved quality of living accommodation	30	3	90	8	240	5	150
Total	100		390		660		420
Rank			3		1		2

Option 2 – This is the preferred option and scored highest. This option meets all the project objectives and individual needs of each client. This option will enable 25 clients to be resettled within the community with the appropriate package of care and support. These clients will be provided with individual choice and will have access to support and care to their level of need. This will provide betterment to all individuals identified.

Both Option 1 and Option 3 have been rejected as they do not provide an opportunity of improved quality of life and betterment for the individuals as they will either continue to live in

a hospital setting or a nursing home setting. Option 3 was ranked higher than the base case, as the quality of living accommodation would be improved.

11) What are the Specific Outcomes of the preferred option

Quality, Timescales, Quantity (detailed in box 11)

The preferred option will enable the Trust to resettle 25 long-stay patients into the Community. These places will be provided in both Armagh and Dungannon. These placements will provide each individual with a better quality of life while meeting each of their needs.

The number of Southern Trust long stay patients will be significantly reduced which will enable the Trust to meet its PfA resettlement targets for long stay patients.

Quantity Outcomes

- 25 long stay patients who currently reside in an institutionalised Hospital setting will be resettled into more appropriate placements in the community which will provide for their individual needs and improve their quality of life by March 2014.
- The resettlement of all patients will guarantee that the Trust will achieve the 2013/14 PfA Resettlement Target.

Quality Outcomes

- Reduction in the number of patients inappropriately placed in long stay hospital beds.
- Improved care environment that is non-clinical care, and replicates a home environment in so far as is possible.
- Privacy, dignity and respect for resident
- Promotes social inclusion
- Promotes recovery
- Provides an infrastructure where recovery is more achievable
- Flexibility, privacy and a non-institutionalised environment for family and carers to visit.
- Greater flexibility to reflect individual needs and choice

12) Activity Outcomes

Activity, contacts, placements, procedures etc, please identify

SBA Activity		
Original Baseline Activity	New Baseline Activity	Currency (FCE/IP/OP/DC/ Contacts/Caseload etc.)
Additional Baseline Activity		
New Baseline Activity		

If approved, activity will be added to Indicative volumes in Organisation’s Service and Budget Agreement (if applicable)

The above table must be completed for each discreet element of the service in question, please replicate as required. If activity is for more than one LCG please detail separately.

13) Assess Risks and Uncertainties

Identify the main risks associated with the proposal and how can these be mitigated – these should be scored using the Providers recognized risk scoring method

Low Risk

This risk has been assessed using the Trust’s scoring methodology:

Consequence	Likelihood
1 Insignificant	1 Rare
2 Minor	2 Unlikely
3 Moderate	3 Possible
4 Major	4 Likely
5 Catastrophic	5 Almost certain

The consequence and likelihood are combined to provide a risk rating

Risk Rating

- H** Red Risk - High = 20 - 25
- M** Amber Risk - Moderate = 12 -19
- L** Yellow Risk - Low = 6 - 11
- VL** Green Risk - Very Low = 1 - 5

Table : Assessment of Risks for Option

Description of Risk	Consequence	Likelihood	Risk Rating
<i>Failed community placements. There is a risk that those clients placed in either Granville or the Heathers will not settle nor will they be compatible with the other residents</i>	3	3	L

To mitigate the risk the Trust will provide detailed individual profiles of each patient to the before the placement, to assess the suitability to meet the individual’s needs. Put in place a transitional transfer package involving trust staff, carers and advocates to smooth the process. Patients will be assessed and placed in accommodation along with those patients they are most compatible with.

Medium Risk

High Risk

14) Monitoring and Post Implementation Evaluation Process – please also refer to detail contained within the Commissioner’s Statement

Who will manage the implementation of this scheme? When will the development be fully

implemented, when will full benefits and outcomes be realised?
 What post evaluation arrangements are in place, these evaluations are also subject to test drilling should be available 12 months after full implementation of the scheme if approved.

Miceal Crilly, Acting Director of Mental Health and Disability will be the Trust responsible officer working alongside the appointed resettlement officer. Monitoring and evaluation of the success of the placements

15) Other relevant information
 Please note any other appendices or attachments

16) Signature of individuals responsible for this bid – Provider Section

Trust Authorising Officer	Mr Miceal Crilly	Date 22 March 2013
Title	Acting Director of Mental Health and Disability	
Trust Director of Finance Signature		Date
Trust Chief Executive Signature		Date

17) Approval or rejection (Local/Regional Commissioning Use only-HSCB and PHA)

	Approved	Rejected (if yes detail reasons)	Approved in Principle (if yes detail reasons)
Yes/No			

Responsible Person

Signature	Date	Position

Authorising Person

Signature	Date	Position

Director of Finance Authorisation or delegated officer

Signature	Date	Position

Chief Executive Authorisation

Signature	Date	Position

SUMMARY OF FUNDS APPROVED – IF THIS DIFFERS FROM PREFERRED OPTION PLEASE DETAIL			
TO BE UPDATED BY THE RESPONSIBLE OFFICER FOR TRAFFACS	FYE of project (£)	CYE of project (£)	Non Recurrent (£)
SOURCE OF FUNDS			

DRAFT

Commissioner's Statement

Reference Number	
Commissioner Representative	Aidan Murray
Title	Assistant Director Mental Health and Learning Disability, HSCB
Contact Tele No. & Email	████████████████████ ████████████████████
Date	

1. [Strategic Context – \(if provider requires to add any further information for strategic context this should be added to box 8 in the main proposal attached\)](#)

SHSCT Learning Disability Community Infrastructure

As outlined in the HSCB Commissioning Plan, and in accordance with the principles of Citizenship and Human Rights enjoyed by all, people with a learning disability are entitled to live in their own homes in the community with a range of support services to meet their assessed needs.

In line with the Commissioning Plan Direction and Transforming Your Care, the HSCB seeks to ensure that no-one with a learning disability should be living in hospital by March 2015. It is essential therefore that, in addition to the ongoing resettlement programme from hospitals, Trusts should take all necessary action to prevent the admission of people to hospital due to the possibility of breakdown of their residential placements in the community.

The Trusts are now invited to submit proposals aiming at enhancing the capacity of community learning disability teams and associated specialist services to:

- Prevent inappropriate hospital admissions and ensure that all discharges from hospital take place no more than 28 days from the fit for discharge date as required under the 2013/2014 Commissioning Plan Direction (DHSSPS).
- To develop services that can respond outside of the traditional 9-5 Monday to Friday model.
- Develop step up/step down facilities where people may be accommodated on a short term, time limited basis in order to de-escalate placement problems, provide a period of intensive support or provide respite for carers.
- Develop a model of in reach services to support individuals remain in the community when family and/or carers are under significant strain.

The HSCB recognizes that in looking at the need to develop such facilities, the Trust may propose to use funding that the HSCB may make available over the current CSR period. The HSCB has advised the Trust of its indicative funding allocations for learning disability services in 2013/14 and 2014/15. It should be stressed however that these are indicative allocations at this stage which have not yet had formal confirmation by the HSCB.

Community infrastructure funding has been indicated for 2013-14-2015 therefore Trust proposals should incrementally reflect service developments over this period.

2. [Description of Services - \(if provider requires to add any further information for strategic context this should be added to section 8 in the main proposal attached\)](#)

See 1 above

3. [Funding](#)

A total FYE of £0.450m (CYE £0.225m) is available for 2013/14 to fund learning disability community infrastructure. An indicative FYE amount of £0.136m is also available for 2014/15.

4. [Timescale and process for submitting](#)

Trust to submit completed investment proposal to Aidan Murray [REDACTED] by 22nd March 2013.

Provider Sections

Provider	Southern Health and Social Care Trust	Submission date	22 March 2013
Scheme Title	Learning Disability Community Staffing and Support		
Responsible Officer - including title	Mr Miceal Crilly, Acting Director of Mental Health and Disability		
Contact Details – Tele no. & Email	[REDACTED]		

- This business case should be prepared in line with the Green Book and NIGEAE Guidance.
- Please complete this template with proportional effort, i.e. detail provided should be commensurate with the size of the bid.

1) Explain how this proposal specifically meets the need for this investment

(Must link directly to the Commissioner statement)

Introduction

Transforming Your Care – December 2011 - A review of Provision of Health and Social Care (HSC) services in Northern Ireland was undertaken to provide a strategic assessment across all aspects of health and social care services, examining the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and communities are being met resulting in bring forward recommendations to shape future services. One of the key proposals within TYC is the closure of long stay institutions and complete resettlement by 2015. Trusts are urged to give absolute commitment to resettlement and to ensuring the required community services are in place to prevent a new long stay population. Also within

the Commissioning Plan Direction on the key standards 1.26 and 2.10 of all long stay patients in learning disability hospitals by 2015.

From April 2013 specific ministerial targets are to ensure that 99% of all learning disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge with no discharge taking more than 28 days.

Background

In 2011 the Trust held a series of workshops involving senior staff, carers and advocates, LCG representation and professional representatives from the Learning Disability programme to review services within Learning Disability within the Southern Trust for the period 2011-2015. These workshops examined:

- Current demand
- Projected additional demand over the next 5 years, including known transitions
- The reduction in IATU beds from 15 to 10
- The closure of long-stay hospital beds at Longstone and Muckamore Abbey
- The need to modernise services in line with recommendations set out in the Bamford Action Plan

In conclusion, the workshops identified a required investment of £2.5million in community infrastructure within the next 5 year period. This funding would be in addition to any allocation made to resettlement. The Trust has been applying this investment in a planned way and prioritising need against identified funding on a yearly basis to enable community infrastructure to be developed and will continue to do so.

Alongside the above the Trust has agreed the following:

- Agreement on the need to develop robust community treatment and intervention services to underpin the closure of long stay beds and reduced capacity in hospital based assessment and treatment provision, as part of the above investment.
- Agreement on the need to review and modernize Day Services and Respite Care
- Agreement on a revised Gateway process.
- Plans to develop a specification for Advocacy Services

Proposal

It is proposed to continue the process of developing an enhanced and modernised community infrastructure in line with the 5 year vision for community services for learning disability. The above investment would be used as follows:

- Appoint 0.5 wte Epilepsy Nurse. – There is currently a service provided in the community and this would be further enhanced to provide a service for the learning disability population including the learning disability clients who have been resettled. £25K Epilepsy - 0.5WTE Band 5. This additional investment will offer a new development in the Epilepsy Service as it will introduce in partnership with the Consultant a Nurse Led Epilepsy Clinic working to NICE Guidelines. This will provide a localized service catering for larger numbers in a more efficient way, offering a more immediate service with improved communication. This will result in two additional monthly clinics for 12 patients per clinic, which will equate to an additional 288 appointments per annum. This will

enhance localized services. **MAHI - STM - 126 - 220**

- Invest part of the funding in developing and enhancing the community team to maximise the impact on preventing admission, facilitating discharge and to manage and support those resettled in the community. This will increase the professional staff capacity within the community team to support those who are being resettled in the community. £125K. This will be made up of a skill mix of Bands 4, 5 and 6 staff across the teams and will be proportional dependent on the current make-up of the teams. This will employ 2.85 wte Band 5 staff to support keyworkers on community teams by enabling them to dedicate more professional time to service users and carers. It is anticipated that this will lead to enhanced support to 50 cases per team per annum, that is 150 cases being supported across the Trust.
- Investment in focused domiciliary care packages to enhance community options for all learning disability service users. This investment will enhance and build self-help skills to promote independent living and assist with transitions to assist these people to remain in the community and prevent hospital/nursing home admission. **£100k**. Allocation of 33.5K per team to develop community care options which will support and facilitate hospital discharges and service users who are being resettled into the community. This will equate to approximately 7,500 hours of care and support.
- Enhancement of the home treatment crisis response to provide an extended service and introduce skill mix. Crisis Response **50k** - This will provide an extension in the hours the service will be delivered to prevent hospital admission for clients with challenging behaviour and forensic presentation residing in the community including those PTL patients who have been resettled as part of the Community Integration process. It is proposed to introduce a skill mix by appointing a Band 5 and a Band 3 staff (between the hours of 9pm – 1am) to provide support to the multi-disciplinary integrated team.
- Improving transition and to explore the process of sensory integration in the assessment process to assist. This will assist with transition at a critical point of the patient's life, e.g. leaving school or transferring from hospital. **£50K required**. Employment of Band 6 Occupational Therapist to provide specialist support to 38 young people in the transition process including training for 12 staff x 12 sessions per annum.
 - In 2011/12 60 young people transferred from children's services to adult services within Learning Disability and it is expected that a further 38 young people will transfer during 2012/13, 47 in 2013/14 and a further 42 individuals in 2014/15.
 - A significant number of young people within the transition phase are presenting with challenging behaviors and complex sensory issues, requiring greater levels of support. With increasing numbers accessing the service and the volume of complex cases, these factors place increasing pressures on the existing service where the priority is the AHP 9 week access target. Transition becomes arduous and stressful for the individuals, their carers and Trust staff.
 - The Trust will use this additional investment to develop an 'Understanding Sensory

Experiences in Transition (USEIT) programme to assist in providing client specific assessments for individualised care plans for individuals with a learning disability transitioning from children's services to adulthood. An Band 6 specialist occupational therapist with advanced knowledge of sensory integration working with individuals aged 15 years to 20 years in partnership with the Transition Worker will provide valuable client specific information to improve staff understanding of the client's needs and how they interact with their environment. The occupational therapist will provide a detailed assessment, intervention and training including sensory integration assessment, on every client in preparation for their transition into adult services. They will support the transition into day care and day opportunities and provide an ongoing supportive role for 2 years post leaving school. The occupational therapist may work with the clients in school, at home, at their work or day opportunities placement. This new USEIT service can target one locality area initially to ensure targets set can be achieved. In addition, investment will provide extensive client specific sensory integration assessments for all individuals entering adult services. It will enable sensory integration awareness training to be offered to many key stakeholders such as carers, day care staff, day opportunities staff, staff working with adults with clients who avail of forensic services and other relevant staff who require awareness training on the principles of sensory integration.

- The Learning Disability Service Framework (LDSF, Dec 2011) identifies a number of Key Performance Indicators (KPI) for individuals entering adulthood. The accuracy of these transition plans and their capacity to be properly implemented, in addition to the long-term success of work placements or a smooth transition into meaningful day opportunities is influenced by how well understood the individuals needs and abilities are.
 - Development of this post will establish baselines and determine performance baselines in line with the LDSF KPI.
 - The CYPSP have set an objective of by March 2014, to increase the number of care leavers aged 19 in education, training or employment to 75%. Identification of these individual's sensory needs at an early stage will improve understanding of client need and help match client need and abilities with appropriate work placements supporting a seamless transition.
 - The number of sensory integration awareness training sessions presented and staff attendance at these sessions will be recorded across the various adult learning disability venues. It is proposed to fund clerical support for this proposal also at Band 3.
- Investment in Respite – By enhancing the current respite service this will minimise the risk of possible breakdown in the carer support to the service user. The Trust will also consider flexibility for specialist respite services for forensic services in order to manage risk. £50k of this will provide funding for Staff in Sensory Integration, assessment and training **£100k** support will be provided through a combination of direct payments cash grant and domiciliary support to innovative flexible opportunities are made available to meet assessed need. (a) 2x0.5 Band 5 Respite Co-ordinators to facilitate support to carers through timely and appropriate short break provision – £40K. (b) 45 one-off Direct Payments for up to £500 per allocation = £22,500 (15 per community team). (c) 1 wte to facilitate community integration by developing evening opportunities. This equates to 48 sessions x 2 staff x 3 evenings x 3 hours per week = 864 hours of evening activity.

Aims and Objectives

- To provide support to individuals to enable them to live in an accommodation that as far as possible reflects general home living.
- The service should offer a permanent whole life care option that minimises the possibility of re-admission to hospital by managing risk.
- By being resettled the person is offered a range of services which supports community living and also supports better health and social wellbeing.
- Person centred approach which provides improved flexibility to account for changes in individual care needs.
- The support provided to individuals will enable them to avail of local community amenities and to be part of the local community. This will promote social inclusion.
- To meet strategic direction such Bamford Action Plan and Ministerial PfA Targets for resettlement/delayed discharges
- Meet strategic direction as outlined within TYC and the Commissioning Plan.

Implication to the service if funding is not provided

If the requested investment is not successful it will be unlikely that the Trust will meet the specific ministerial targets for discharge from hospital and resettlement. Nor will the Trust deliver against the Commissioning Plan Direction and Transforming your Care Plan that no person with a learning disability should remain unnecessarily in hospital by 2015.

Without support in the community, resettlement placements may break down and individuals may be readmitted to an inappropriate environment and continue to rely on hospital care provision.

This proposal will promote local community integration and social inclusion for clients. In addition a person centred approach will provide more flexibility to account for changes in individual care needs and both age and mental health related issues will be addressed. Greater independence and choice will be available and Pressure on families and carers will be reduced. By providing support and accommodation for these clients with a learning disability, the Trust in will be meeting recommendations set out within the Bamford Review and the Bamford Action Plan.

2a) Options Considered and Benefits

*Identify and describe all options considered including base case (**requirement** is that at **least 2** further options considered)*

*Identify and evaluate the benefits of **all** the options considered.*

Option 1 – Base Case – No enhancement to the existing Community Services.

Option 2 – Procure and purchase care and support packages from the independent/private sector

Option 3 – Develop an enhanced and modernised community infrastructure.

Continue the process of developing an enhanced and modernised community infrastructure in line with the 5 year vision for community services for learning disability. The above investment would be used as

follows:

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- Appoint 0.5 wte Epilepsy Nurse. – There is currently a service provided in the community and this would be further enhanced to provide a service for the learning disability population including the learning disability clients who have been resettled.
- Invest part of the funding in developing and enhancing the community team to maximise the impact on preventing admission, facilitating discharge and to manage and support those resettled in the community. This will increase the professional staff capacity within the community team to support those who are being resettled in the community.
- Investment in focused domiciliary care packages to enhance community options for all learning disability service users. This investment will enhance and build self-help skills to promote independent living and assist with transitions to assist these people to remain in the community and prevent hospital/nursing home admission.
- Enhancement of the home treatment crisis response to provide an extended service and introduce skill mix
- Improving transition and to explore the process of sensory integration in the assessment process to assist. This will assist with transition at a critical point of the patient’s life, e.g. leaving school or transferring from hospital.
- Investment in Respite – By enhancing the current respite service this will minimise the risk of possible breakdown in the carer support to the service user. The Trust will also consider flexibility for specialist respite services for forensic services in order to manage risk.

2b) Reasons for rejection of options described and identification of preferred option from box 2a

Option 1 – Base Case – This has been discounted as this option proposes that the current staffing level remains unchanged. Therefore, no additional provision to assist with the increased pressures and demands within the service to prevent hospital admissions/readmissions and facilitate early discharge.

Option 2 — This option has been rejected as it is not in line with the Trust’s five year plan for the development and enhancement of community infrastructure. This option is too narrow a focus and all needs cannot be fully met nor could a full service be provided by this sector.

Preferred Option

Option 3 - Develop an enhanced and modernised community infrastructure. Option 3 has been identified as the preferred option as it facilitates the continuation of development of a robust community infrastructure, which focuses on improving support and intervention which relates directly to many of the current reasons for hospital admission and delayed discharges.

3) Financial Quantification of chosen option - STM - 126 - 224

Option Type	Option Name	Total £ (Rec)	Total £ (Non-Rec)	Overall Total £
Option 1	<i>Base Case – No enhancement to the existing community services</i>			
Option 3	<i>Develop an enhanced and modernised community infrastructure</i>	See attached costing sheet.		
Additional Cost (Marginal Increase: Preferred Option less Base Case)				

*Express costing in total rather than incremental terms to expose full resource consequences
 Note: Detail to be contained in costing appendix and where cost savings or efficiency improvements are projected these will be further detailed in the VFM Section 6.*

4) What are the Specific Outcomes of the preferred option

Quality, Timescales, Quantity – (detailed in box 11 below)

The preferred option will deal with additional in year pressures, allow for the commencement of modernising key community services and begin to enhance community treatment services, all in line with a strategic 5 year vision for Learning Disability. Learning Disability clients will be supported within the community providing more choice and the ability to live more independently. The aim is to provide these clients with betterment in their everyday living. As outlined in the HSCB Commissioning Plan, and in accordance with the principles of Citizenship and Human Rights enjoyed by all, people with a learning disability are entitled to live in their own homes in the community with a range of support services to meet their assessed needs. By enhancing the community support infrastructure the Trust will be supporting people with a learning disability to do this.

5) Activity Outcomes

Contacts, placements, procedures etc, please identify

SBA Activity		
Original Baseline Activity	New Baseline Activity	Currency (FCE/IP/OP/DC/ Contacts/Caseload etc.)
Additional Baseline Activity		
New Baseline Activity		

If approved, activity will be added to Inpatient Services in 126 Service 2025 and Budget Agreement (if applicable), further sub analysis may be required by LCG/LGD please refer to Commissioner Statement.

The above table must be completed for each discreet element of the service in question and by hospital site if appropriate, please replicate if necessary. If activity is for more than one LCG, please also replicate this table.

6) Value for Money

A) Efficiency Savings (Where applicable)

- Provide an accurate costing of any savings. Are these savings to be cash released or redeployed? If redeployed please provide full details of redeployment (cost, activity, outcomes etc).

N/A

B) Further demonstrate overall Value for Money by including benchmarking evidence

B1) Breakdown the elements of the option and compare cost and activity to Status Quo option and benchmarking statistics eg Community Statistical Indicators, Reference Costs, Specialty Costs, HRGs etc.

N/A

B2 Please explain the reason for any positive or negative variances that exist when the preferred option is compared to B1 above.

Positive Variances: *eg Better working practices, more efficient use of resources etc. These will indicate VFM.*

Negative Variances: *eg Increased complexity of services etc. These will not initially indicate VFM – More information required below in B3.*

N/A

B3) *If there are negative variances shown in B2 above explain how are these offset by, for example Qualitative benefits and the context of the project.*

N/A

7) Assess Risks and Uncertainties of achieving the Objectives and Outcomes

Identify main risks associated with the proposal and how can these be mitigated – these should be scored using the Providers scoring tool

Low Risks

There is a risk that the Trust will continue to have delayed hospital discharges, admissions/readmissions for individuals with more complex/Challenging needs. To mitigate against the risk the additional staff resource will provide more regular assessments and evaluations of patients within a shorter timeframe to help prevent admissions and facilitate earlier discharges and maintain individuals in their own homes.

Medium Risks

The additional staffing complement may not be sufficient to manage the small number of complex/challenging individuals with high level needs to be managed and supported in the community. However, to mitigate this risk, there will be more monitoring, assessment and evaluation of individual behaviours on an ongoing basis.

High Risks

None

8) Monitoring and Post Implementation Evaluation Process – please also refer to detail contained within the Commissioner’s Statement

Who will manage the implementation of this scheme? When will the development be fully implemented, when will benefits and outcomes be realised?

What post evaluation arrangements are in place, these evaluations are also subject to test drilling and should be available 12 months after full implementation of the scheme if approved.

Miceal Crilly, Acting Director of Mental Health and Disability, supported by the Heads of Service will manage and monitor the implementation of this additional resource. The recruitment process will commence as soon as funding is received from HSCB and will take approximately 2-3 months for implementation. Monthly returns will be provided to the HSCB via the delayed discharge proforma and other agreed community contact returns.

9) Other relevant information

Please make note of appendices or attachments

10) Signature of individuals responsible for this bid (Provider section)

Trust Authorising Officer	Mr Miceal Crilly	Date: 22 March 2013
Title	Acting Director of Mental Health and Disability	
Trust Director of Finance Signature		Date
Trust Chief Executive Signature		Date

11) Approval or rejection ((Local/Regional Commissioning Use only-HSCB and PHA)

	Approved	Rejected (if yes detail reasons)	Approved in Principle (if yes detail reasons)
Yes/No			
<u>Responsible Officer</u>			
Signature	Date	Position	
<u>Authorising Officer</u>			
Signature	Date	Position	

Director of Finance Authorisation or delegated officer - 126 - 227

Signature Date Position

Chief Executive Authorisation or delegated officer

Signature Date Position

SUMMARY OF FUNDS APPROVED – IF THIS DIFFERS FROM PREFERRED OPTION PLEASE DETAIL SHOULD BE PROVIDED

TO BE UPDATED BY THE RESPONSIBLE OFFICER FOR TRAFFACS	FYE of project (£)	CYE of project (£)	Non Recurrent (£)
SOURCE OF FUNDS			

Area Supporting People Partnership

Business Case Pro Forma

For Capital Investment Schemes (HAG – DSD) and/or Revenue Funding (HSSB/NIHE) over £250,000

Area Board: Southern

Sponsor Agency: Southern Health & Social Care Trust
(Trust* / Probation Board* / Housing Executive*)

Responsible Officer: Mr Bryce McMurray

Designation: Assistant Director of Learning Disability

Scheme Name: Supporting People – Learning Disability Longstone Hospital

Location: Dungannon

Target Resident Group: Learning Disability

Number of Units of Accommodation 24

Existing Service no

Submitted to NASPP* / WASPP* / SASPP* / EASPP*

Date: submitted

Approved by NASPP* / WASPP* / SASPP* / EASPP*

Date: TBC

*Delete as appropriate

“The essential content of a Full Business Case is a complete economic appraisal covering the 10 standard appraisal steps in accordance with section 2 of the NI Practical Guide. However, DFP will accept variations in the style of presentation...,provided all the necessary information is still covered.”

3 December 2010

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Appendix 1 – Proposed Schedule of Accommodation

Appendix 2 – Proposed Staffing

Appendix 3-7 Finance Sections

1.0 Introduction

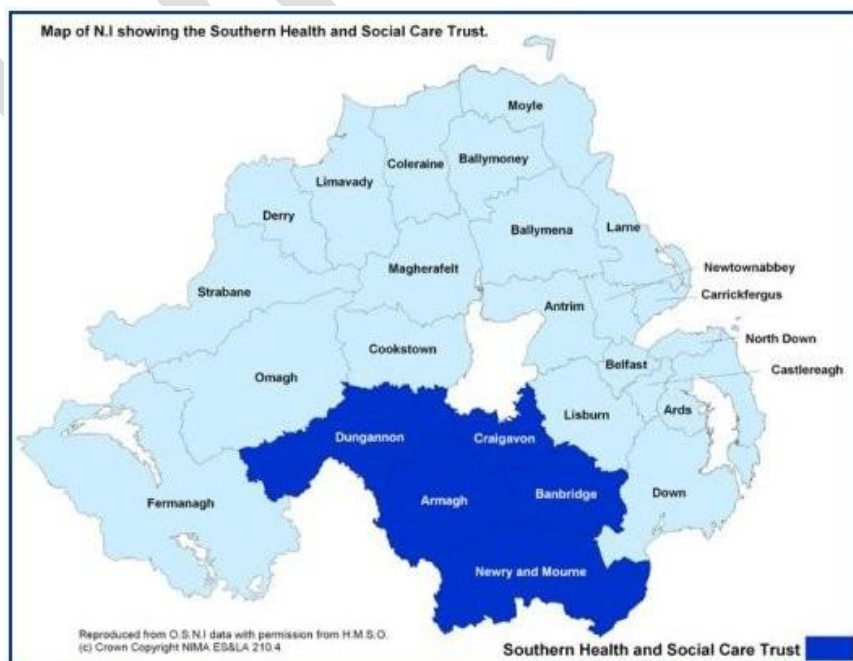
This business case has been produced by the Southern Health and Social Care Trust (SHSCT) to seek capital finance to put in place accommodation which will enable the Trust to resettle 24 long stay individuals from Mourne Donard and Sperrin Wards which are located in Longstone Hospital, Armagh. This is one phase in a programme of resettlement of adults with a learning disability from long-stay hospital accommodation.

1.1 Background

The Southern Health and Social Care Trust, was established on 1 April 2007, as a consequence of the changes in HPSS Structures under the Northern Ireland Review of Public Administration (RPA). The Southern Trust is the result of a merger of four previous Trusts as listed below:

- Craigavon and Banbridge Community Health and Social Services Trust
- Armagh and Dungannon Health and Social Services Trust
- Craigavon Area Hospital Group Trust
- Newry and Mourne Health and Social Services Trust

The map below details the geographical area covered by the Southern Health and Social Care Trust.



The new Trust provides a wide range of health and social care services in hospital, community and primary care settings. The hospital services provided by the Trust are also used by people from many other areas in Northern Ireland. The Trust covers a population of 342,000.

The SHSCT currently provides for individuals with a learning disability through the three community areas – Craigavon and Banbridge, Newry and Mourne and Armagh and Dungannon. The Trust hosts Longstone Hospital, which provides short-term assessment and treatment, sub acute rehabilitation, complex physical needs, elderly care and specialist challenging behaviour, including autism and epilepsy. The hospital provides these services for people with a learning disability throughout the SHSCT area in keeping with regional strategy. There are ongoing plans to further enhance the community treatment services available to facilitate both resettlement and reduction in the inpatient treatment capacity.

1.2 Strategic Vision

This section will consider the implications of national, regional, and local strategies, and legislation which provide strategic direction regarding long-stay hospital residents.

The former Southern Health & Social Services Board as host commissioner has invested significantly in resettlement schemes for people with learning disabilities, and in an area-wide crisis intervention service to avoid hospital admission.

Priorities for Action 2007/08 sets out the planning priorities and actions for Boards and Trusts.

Refer to: http://www.dhsspsni.gov.uk/pfa_2007-08.pdf

Southern Health and Social Care Trust Corporate Plan 2007/08 sets out

the long term aspirations for the Trust.

Refer to:

<http://www.southerntrust.hscni.net/pubinfo/Corporate%20Plan%202007.pdf>

Equal Lives – Review of Policy and Services for People with a Learning Disability in Northern Ireland September 2005.

Refer to: <http://www.rmhdni.gov.uk/equallivesreportchpt6.pdf>

The Equal Lives Review under Chapter 6 Accommodation and Support proposed principles and aspirations which should guide the development of future housing and support options for people with a learning disability such as:

- People should not live in hospital accommodation.
- People with disability have the same rights as non-disabled peers and should have access to the same range and standards of accommodation.

N.I. Review of Mental Health & Learning Disability Services –

Refer to: <http://www.rmhdni.gov.uk/index.htm>

The strategic direction and service re-engineering requirements for the Mental Health programme are supported by Departmental Policy. The strategic priorities of the review are:

- Resettlement from long stay hospital.
- Development of community based services to support people with Mental Health problems in their own homes or community settings.
- Development of crisis intervention services to prevent hospital admission.
- Enable people with learning disability to access mainstream services through the promotion of person centred planning

approaches.

A Healthier Future a Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005 – 2025 presents a vision of how Health and Social Care Services will develop in Northern Ireland over the next 20 years. It focuses on a number of targets and objectives.

Refer to: http://www.dhsspsni.gov.uk/show_publications

SHSSB Strategic Review (2000) “Service for People with a Learning Disability” provides a summary of proposals for future service provision.

- the right to ordinary patterns of life within the community
- the right to be treated as an individual
- the right to the appropriate help and support to develop personal potential.

Building the Way Forward in Primary Care – A Consultation Paper 2000

Refer to: <http://www.dhsspsni.gov.uk/resp.pdf>

“It is proposed that new arrangements in primary care should:

- promote equity of access and service quality
- adopt a locality based approach to needs assessment and service delivery

The Disability Discrimination Act (1995) makes it unlawful to discriminate against people with disabilities. All Trust premises must comply with DDA regulations in that they must be fully accessible by disabled persons.

Refer to: http://www.opsi.gov.uk/acts/acts1995/ukpga_19950050_en_1

Northern Ireland Act (1998) Section 75 relates to all public sector organisations across Northern Ireland. The Act states that all public authorities shall in all its functions have due regard to the need to promote

equality of opportunity.

Refer to: http://www.ofmdfni.gov.uk/section_75

The **Mental Health Foundation** identified issues of particular relevance to the Government's Learning Disability Strategy:

- Consideration of the friendships and relationships of people with learning disabilities should be a key factor in making plans with them
- Local authorities should quantify the need for homes and daytime opportunities.

DRAFT

2.0 Scheme Needs

2.1 Current Service Provision

In the past people with a learning disability who could not live with their families had to live in long-stay hospital accommodation or residential facilities. As demonstrated within the Strategic Vision section of the business case, reports such as the Equal Lives and the Bamford Review recommend that all adults with a learning disability residing in long-stay hospital accommodation be resettled within the community.

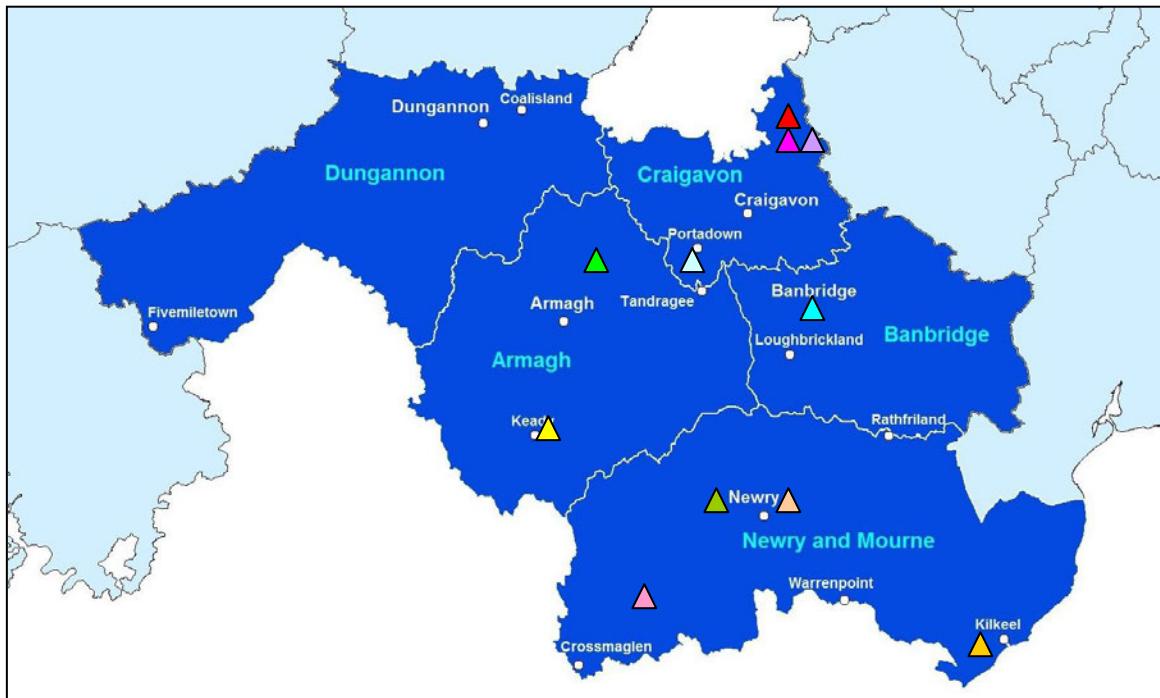
In recent years, the Southern Health & Social Services Board as host commissioner has invested significantly in resettlement schemes, the development of an Assessment and Treatment Unit and the expansion of community services for this resident group. Since 2004, 80 people have been resettled from Longstone Hospital with no new admissions to long term hospital care through the development of alternative services in the community. Of the last 29 people resettled only 2 placements proved unsuccessful and new arrangements had to be made. As at 31st March 2010 there was a long stay population of 51 in Longstone Hospital. Following this 6 residents with challenging behaviours have been resettled in a new supported living facility in Bessbrook in partnership with Belfast Improved Housing (2008).

Currently adults with a learning disability living in long-stay hospital in the Southern Trust area are accommodated in Longstone Hospital. Longstone Hospital is made up of Cherry Villa, Cedarwood, Rosewood and the IATU. This business case will focus on those individuals remaining in Cedarwood which contains the Mourne, Donard and Sperrin Wards. Mourne is a dedicated female ward and Donard and Sperrin are dedicated male wards.

2.2 Current Support Living Schemes for Learning Disability Residents

The following map details current supported living schemes within the Southern Trust area.

Southern Trust Area



In house provision

- Bowens Close, Lurgan ▲
- Lilburn Hall, Lurgan ▲
- Teach Sona, Mullaghbawn ▲
- Glanree House, Newry ▲
- Shanlieve, Killeel ▲
- Ardaveen Manor, Bessbrook ▲
- Orchard House, Loughgall ▲

Partnership arrangements

- Riversley, Banbridge (partnership with Mencap/Fold) ▲
- Knock Eden, Portadown (partnership with Fold) ▲
- Castle Lane, Lurgan (partnership with Praxis) ▲
- Fair Green, Keady (partnership with Mencap) ▲

2.3 Current Accommodation

Longstone hospital is situated adjacent to the St Luke’s Hospital site in Armagh. The Mourne, Donard and Sperrin wards are contained within Cedar

Wood Villa. The building was constructed in 1975, a single story building of traditional construction with solid concrete floors, cavity walls and a combination of flat and pitched roofs. The total area of the building 1223m² divided into four areas.

Sperrin	329m ²
Donard	327M ²
Mourne	300M ²
Entrance and ancillary area	267M ²

The following Estates Code Criteria were applied to determine the current conditions of the buildings:

- Physical Condition (PC)
- Functional Suitability (FS)
- Space Utilisation (SU)
- Statutory Standards and Safety Requirements (SS/F)
- Energy Performance (EP)

The overall condition of each element was then estimated in categories A-D. Broadly, the interpretation of the ranking is:

Table 2.3.1 Interpretation of ranking – Estates Code Criteria

A	The element is as new can be expected to perform adequately to its full normal life
B	The element is sound operationally safe and exhibits only minor deterioration
C	Below Standard – Minor Expenditure Required
CX	Below standard and improvement may be uneconomical or impossible
D	The element is unsatisfactory
DX	The element is unsatisfactory and impossible or uneconomic to improve

The scoring system for space utilisation is:

Table 2.3.2 Space Utilisation Scoring:

1	Empty or grossly underused
2	Underused
3	Adequate in both provision and use
4	Overcrowded

Under the Ceri Davies Appraisal the accommodation, Mourne, Donard and Sperrin score as follows:

Table 2.3.3 Current Accommodation Ceri Davis Scores

Condition	Ranking
Functional suitability	D
Space Utilisation	3
Energy Performance	B
Statutory Standards	C
Physical Condition	C

The upgrade costs to obtain a Ceri Davies B rating for physical condition and statutory standards is £150,000.

2.4 Current Resident group within Longstone Hospital to be resettled

There are 8 females aged between 37 and 65 years of age accommodated within the Mourne ward. Within Donard there are 9 males aged between 21 and 71. The Sperrin ward accommodates 10 males aged between 30 and 61.

There are currently 24 adults with a learning disability in the Mourne, Donard and Sperrin wards.

2.5 Profile of Adults with a Learning Disability based in Longstone Hospital

Adults accommodated in Mourne, Donard and Sperrin present with complex physical and behavioural needs. Some of these are very challenging with

episodes of aggressive unpredictable behaviours. A number of these individuals have been resident in Longstone for 20 to 30 years and have a low level of basic life skills. Risk Assessments are carried out for all of these individuals when considering going on outings due to the high levels of aggression and inappropriate behaviours. When an individual has to attend a hospital appointment, they may require to be accompanied by two members of staff. When attending church services each person is accompanied by a member of staff.

All individuals require high levels of supervision and support with input from Allied Health Professional (AHP) services. This includes a high level of support from Speech and Language Therapy regarding feeding and communication. Also a high percentage of residents have autistic tendencies such as very obsessive ritualised behaviours and any changes to their routines can have an adverse effect on their day to day activities.

All individuals require full assistance with all aspects of personal hygiene and dressing. Quite a number are doubly incontinent and all require assistance and support with toileting needs.

2.6 Staffing levels

There are four to five staff on each ward on a daily basis and two of these are qualified staff. At night there are two waking staff and one of these will be specifically trained. The staffing ratio can be increased to three if required depending on behaviours presented.

Table 2.6.1 demonstrates staff in post by Band as at October 2010 – MDS Longstone Hospital

Table 2.6.1 Funded Posts

Qualified Staff	Mourne	Donard	Sperrin	Shared Staff	Support Services *	Grand Total
	Posts	Posts	Posts	Posts	Posts	Posts
Non-qualified	7.00	8.28	8.00	1.00	9.00	33.28
Qualified	6.09	9.00	6.00	3.00	0.00	24.09
Total	13.09	17.28	14.00	4.00	9.00	57.37

* Service provided by Hotel Services Function (Domestic and Catering Services)

Table 2.6.2 demonstrates the skill mix on each ward and the number of individuals on each ward as at October 2010.

Table 2.6.2 Staff Skill Mix

Ward	Housing Support Skill Mix	No of Individuals	Bed Complement
Mourne	54% qualified 46% non-qualified	9 1 respite	91 respite
Donard	47% qualified 53% non-qualified	11	12.....1 respite
Sperrin	53% qualified 47% non-qualified	12 ...1 respite	13
Total	51% Qualified 49% non-qualified		

The new scheme will not provide respite services.

2.7 Needs Assessment

The following section identifies the number of adults with a learning disability for future resettlement and their requirements. It also looks at the spatial requirements and the staff requirements.

2.8 Adults with a Learning Disability Identified for future Resettlement Projects and their need

Table 2.8.1 details each individual, their current location and the accommodation best suited to those identified for future supported living projects. All individuals have been grouped according to compatibility.

All of those identified will require supervision and support with all aspects of supported living. Each individual identified will require a high level of support from staff. All of those identified will require a safe secure environment with plenty of personal space both inside and outside the facility.

Table 2.8.1 Adults with a Learning Disability identified for Resettlement

Resident Number	SEX	Current Location	Suggested Accommodation
2	F	Mourne House	Shared Supported Living
4	F	Mourne House	Shared Supported Living
5	F	Mourne House	Shared Supported Living

Resident Number	SEX	Current Location	Suggested Accommodation
6	F	Mourne House	Shared Supported Living
7	F	Mourne House	Shared Supported Living
34	F	Knock Eden	Shared Supported Living
12	M	Donard	Shared Supported Living
13	M	Donard	Shared Supported Living
20	M	Donard	Shared Supported Living
14	M	Donard	Shared Supported Living
17	M	Donard	Shared Supported Living
11	M	Donard	Shared Supported Living
35	M	IATU	Shared Supported Living
18	M	Donard	Single Supported Living
21	M	Sperrin	Shared Supported Living
27	M	Sperrin	Shared Supported Living
29	M	Sperrin	Shared Supported Living
30	M	Sperrin	Shared Supported Living
22	M	Sperrin	Single Supported Living
25	M	Sperrin	Shared Supported Living
26	M	Sperrin	Shared Supported Living
28	M	Sperrin	Shared Supported Living
31	M	Sperrin	Shared Supported Living
33	M	Sperrin	Single Supported Living
Total			

The majority of individuals to be resettled have spent the major part of their lives in a hospital setting. As such these individuals have not experienced the skills required to enable them to live a more independent life in the community. These individuals require a high level of support to enable them to experience real life opportunities within their own tenancy.

Areas in which individuals require care and support are listed below:

- ▢ Appointments such as G.P. appointments dental, podiatry.
- ▢ Communication - All have limited or no verbal communication. They use facial expressions and gestures to demonstrate if they are happy or sad. Speech and Language Therapists have been involved in identifying methods of communication for this resident group.
- ▢ Feeding and Nutritional requirements (some are on specialised diets)
- ▢ Socialisation
- ▢ Personal activities of daily living with input from occupational therapists where appropriate
- ▢ Mobilisation - Most of these residents can mobilise independently

with input from physiotherapists where necessary. However some require the use of a wheelchair for outings or journeys which involve walking for long periods

- ▢ Relationships
- ▢ Recreational/Leisure
- ▢ Behavioural – supported by psychology and occupational therapy
- ▢ Spiritual
- ▢ Medication
- ▢ Financial budgeting, shopping, buying items for personalising their own rooms, food etc.

Ardaveen Manor, in Bessbrook which opened in 2008, has been a very successful resettlement scheme for adults with a learning disability. Individuals successfully resettled with no requirement for an inappropriate hospital admission.

2.9 Future Need

This outline business case is one part in a resettlement scheme for individuals based in Longstone Hospital and it is anticipated that there will be at least one other phase of resettlement. As stated there are 24 individuals remaining in Mourne, Donard and Sperrin who are planned for resettlement and this business case focuses on their need. However there are still approximately 27 long stay individuals based within Longstone Hospital and the Trust does plan to resettle these individuals also. The latter group of individuals would be considered if any placements become available within this scheme in the future. Also demand will be placed on these resettlement schemes from children who will be moving from Children and Young Peoples Services into Adult Services.

2.10 Location

The Project Team considered a range of factors when deciding on the location of the accommodation. These are listed as follows:

- Travel time for relatives/family and friends who visit.
- Geographical spread – After examining the location of other Learning Disability Supported Living Schemes throughout the Southern Trust as demonstrated in Section 2.2, there is little availability within the Armagh and Dungannon area.
- Cost effectiveness if the accommodation is grouped in clusters in terms of staffing and communal areas
- Providing equitable supported living schemes within the Southern Trust area.

As demonstrated in Section 2.2, there are no supported living schemes within the Dungannon area and two within the Armagh area. A benefit in providing accommodation in these areas is that it will assist the Trust in equitable spread of supported living accommodation for Learning Disability residents within the Southern Trust area, in particular the Dungannon area. This will assist the Trust in an even geographical spread for current need and future need. If it is not possible to locate all 24 individuals within Dungannon, the Trust will split the units over two sites but these will remain within the Armagh and Dungannon area.

The project team have identified those individuals who are compatible and would be capable of living with others. This is demonstrated in Table 2.8.1.

2.11 Capacity and Spatial Requirements

The following section provides a draft outline of capacity and spatial requirements to meet the needs of those currently residing in Mourne, Donard and Sperrin. This can be fully explored at design stage.

- (a) The number of persons accommodated in each house
- (b) The staffing levels required within each house
- (c) The level of “visiting” services to each house.

As stated previously there will be 24 units required within the Dungannon area. However if there is not sufficient space to accommodate all 24 units within the Dungannon area the Trust will consider splitting the units between Armagh and Dungannon with 11 units in the Dungannon area and 13 units in the Armagh area. These units will be in a cluster with a core area containing communal facilities.

Single storey accommodation is preferable for this group of individuals but the Trust would consider a mix of single and two storey accommodation if required.

Communal facilities will accommodate an area for staff changing, storage, general administration. The units will not require sleep over accommodation for staff.

The number of Trust services visiting the house will be kept to a minimum as the ethos around supported living is to provide a homely environment with no clinical aspects. It was felt by the team that if a tenant requires a GP or any other service the consultation can take place in their bedroom. It was felt by the Project Team that it may be beneficial to have a quiet room within the communal area which can be used for a number of functions.

Circulation space within the house and garden would be a priority as a number of individuals require space to walk around. Solutions to reduce noise levels and disturbance to neighbouring residents will be necessary and will be explored further at design development stage.

The complex range of physical and behavioural needs of this group of individuals requires a need for increased internal and external physical space. On occasions when two attending support staff are assisting an individual, circulation space is important. This is also necessary to accommodate wheelchair access and use of a hoist.

There is a catering requirement and a central kitchen will be provided within each house. Some tenants will be able to prepare snacks therefore there is a requirement for a smaller kitchen area which will allow tenants, supported by staff, to develop basic kitchen skills.

Ensuites will be included however; if a member of staff requires assistance with a tenant a shared bathroom would be easier to access. Some tenants may require more than one member of support staff to assist with their personal hygiene during certain periods and by having shared bathrooms this will allow for more space to be allocated to these areas creating more spacious conditions for both staff and tenants.

Appendix 1 details the requirements for a 3, 5 and 6 bedded bungalow; however this is only a guide and can be fully explored at the design development stage to provide a solution which meets the needs of the individuals who are to be accommodated.

2.12 Staffing Requirements

The number of staff required for both a single and split site option is detailed in table 2.12.1 below. If a split site option is chosen the levels of staff will increase. Staffing levels for both a split and single site are detailed within the table.

There will be intensive multi-disciplinary input when these individuals are resettled. The Allied Health Professional element of staffing is also referred to in Appendix 2.

Table 2.12.1 Staffing Requirements

Band of Staff Required	Single Site Option	Split Site	
	24 residents	Armagh 13 residents	Dungannon 11 residents
Deputy Manager Band 6	1.0	1.0 shared between sites	
Admin/Clerical	1.0	1.0 shared between sites	
Senior Support Worker	22.5	15.0	10.0
Support Worker	35.0	17.5	20.0
Cooks	3.0	2.0	2.0
Catering Assistants	3.0	2.0	2.0
Domestic Assistants	3.0	1.5	1.5
Total	68.5	75.5	

As demonstrated in Table 2.12.1, the split site option would require increased levels of staffing due to the residents being split between two sites.

There is an increase in staffing from the current staffing complement due to a number of factors. Current sleeping accommodation is in a dormitory with up to four individuals sharing. Within the proposed supported living scheme single ensuite bedrooms have been identified as a requirement to allow individuals to become more independent. This would require additional support as most individuals would have very basic life skills and time and support would be required to allow them to adjust and develop. The current accommodation does not allow for a great deal of separation from other residents as there is only one living area which is shared by all within that ward, however the new accommodation will offer individuals the opportunity to use different rooms such as the quiet room or the small kitchen area. This will require more staff to support the tenants in the various areas. Also tenants will have more opportunity to develop their life skills and increase their independency through kitchen skills. Meals are currently provided ready prepared and plated and individuals do not have any input into the purchase or preparation of their food. Support will be provided by staff to develop these basic skills.

This new accommodation and supported living will offer these individuals much more life opportunities. These individuals will require a high level of support as some have lived within a hospital style setting for more than 20 years. Their needs currently are met by nursing staff. Supported living will be a totally new experience to all of the individuals.

Staffing for this new provision of supported living accommodation for these individuals has been calculated based on the fact that each house has been assessed and the required staffing levels assigned according to the complexity of the residents. Individuals needs have been assessed and the requirement to cover 24 hour shift patterns, 7 days per week. However, it would obviously be of benefit of having a larger pool of staff within a defined singular site which would allow the Trust to consider reducing staffing in particular areas. This will be further explored when a design solution has been finalised.

There will be a requirement to train nursing staff to enable them to offer support to individuals to enable these individuals to become more independent and more able to do basic everyday things for themselves. Current staff work within a hospital setting and training and development is necessary if they are to provide support and care in a community setting.

3.0 Project Objectives

Section one of the business case set out the Strategic Vision and identified the main drivers for change. The following section describes the work undertaken to identify the objectives to be fulfilled by any option for future service provision and the constraints which are likely to be faced when developing these options.

3.1 Project Objectives

The Project Team has defined the following service specific objectives which are listed in order of priority with Quality of Service being the overriding objective.

a) Quality of Service

To provide suitable supported living accommodation and support to modern standards which meet individual collective needs of current individuals from Mourne Donard and Sperrin, Longstone Hospital by 2011.

The service delivery model should offer a permanent whole life support option and replicate the existing supported living ethos within the Trust area. The option must offer flexibility to account for changes in individual needs and ensure individuals receive access to a full range of support available to the wider community. The option must contribute to the ethos of supported living and the views expressed by the former Southern Board's vision for people with a learning disability. A pro-active approach to service provision will allow the specific personal development and the needs of the tenants to be met. This will enable them to achieve their maximum potential through the establishment of individual support/care plans, which incorporates assessment and active programme planning in a person centred fashion.

The option must comply with the recommendations of recent reviews such as N I Review of Mental Health and Learning Disability and SHSSB Strategic Review of Services for People with a Learning Disability. This will enable the Trust to meet the needs of a more dependant resident group. Tenants will therefore be able to remain in the community rather than in a hospital setting.

(Measure: Ongoing evaluation of the service is essential and this should include the views of users, their advocates and family carers. Assessment of how service configuration has changed; that all services required are provided for. Measure: - Meet standards set by the Regulation and Quality improvement Authority, (Northern Ireland 2007)).

b) Quality of Accommodation

To provide a building which is functional and meets the needs of a complex and disabled group of tenants. This accommodation must comply with legislative requirements and will exceed wheelchair standards.

The preferred option should provide accommodation which is fit for purpose and provides an enhanced quality of life for people with a learning disability that promotes independent living. The option must provide an environment that is as domestic and 'ordinary' in respect of size and design as far as possible. Space requirements will be based on assessed need which may exceed DDA specifications. Accommodation should provide a safe and suitable environment. Accommodation should provide an environment which enables the Trust to deliver a person centred service. The quality of accommodation will provide adequate resources and facilities to support a more complex and disabled group of service users with a therapeutic input to live in the community.

(Measure: Improvement in estate condition to Grade A level as a minimum for all Ceri Davies categories; use of modular design principles to maximise flexibility in design. Feedback from staff and service users as to the

accessibility of services and the quality of the environment.) Measure: - Meet standards set by the Regulation and Quality Improvement Authority)

c) Accessibility

To facilitate local community integration.

The service should be locally based, close to public sector facilities and on or close to public transport networks. This will promote social inclusion and meet local tenant needs.

(Measure: Distance to public services and public sector facilities).

d) Staffing

Staff must possess the necessary skills to deliver a high quality support and care service to meet the needs of a very complex group of individuals living in the community.

The preferred accommodation solution must be staffed by an appropriate level of suitable skilled staff. The preferred option must promote integrated team working.

(Measure: Feedback from residents, carers and advocates.) (Measure: continuous evaluation of development and impact on key stakeholders).

4.0 Options

This chapter describes the process undertaken to identify the long and short list of options for the project, based on the objectives and constraints previously identified.

Long- list of Options

Option 1 – Status Quo – Individuals would remain in Longstone Hospital in long stay accommodation.

Option 2 – Refurbish Alternative Trust Accommodation – The Trust would provide alternative Trust accommodation suitable to the residents needs.

Option 3- New Build provided by DHSSPSNI – The Trust would submit a business case to the DHSSPS for capital funding for supported housing accommodation to provide for this resident group.

Option 4 - New Build provided by Social Housing Provider – split site – The Trust would secure capital through engagement with a Social Housing Provider and the care and support will be provided by Trust staff.

Option 5 – New Build provided by Social Housing Provider – single site – The Trust would secure capital through engagement with a Social Housing Provider and the care and support will be provided by Trust staff.

Option 6 – Trust Provide a Site for a Housing Provider – The Trust would provide a suitable site from existing Trust estate which would enable a provider to build suitable accommodation.

Option 7 – The Trust will acquire a number of existing satisfactory private properties adjacent to each other within the stipulated locations and refurbish to HMO and DDA standards

Discounted Options

<p>Option 2 – Alternative Trust Accommodation – The Trust would provide alternative Trust</p>	<p>This option has been discounted as there is no suitable accommodation within the Trusts Estate.</p>
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accommodation suitable to the residents needs.	
Option 3- New Build provided by DHSSPSNI – The Trust would submit a business case to the DHSSPS for capital funding for a new build to provide housing for this resident group.	This option has been discounted as the DHSSPS does not have responsibility for providing supported living accommodation The Department of Social Development has responsibility for this.
Option 6 – Trust Provide a Site for a Housing Provider –The Trust would provide a suitable site from existing Trust estate which would enable a provider to build suitable accommodation.	This option has been discounted as there is no suitable accommodation within the Trusts Estate.
Option 7 – The Trust will acquire a number of existing satisfactory private properties adjacent to each other within the stipulated locations and refurbish to HMO and DDA standards.	This option was explored through local Estate Agents; however this has been discounted as there are no suitable accommodations adjacent to each other available for purchase in either the Armagh or Dungannon area.

Short-List of Options

The Trust fully explored a long list of options and considered and examined each thoroughly on how the options would meet the objectives. Three options have progressed to the short list stage , Option 1 Status Quo, Option 4 New Build provided by Social Housing Provider, split site and Option 5 New Build provided by Social Housing Provider, single site . Option 1 has been retained as a base case and all options are detailed below.

Option 1 – Status Quo – Individuals would remain in Longstone Hospital in long stay accommodation.

By remaining in the existing accommodation the quality of life for these residents will not be improved.

Option 4 – New Build provided by Social Housing Provider – Split site –

The Trust would secure capital through engagement with Social Housing Provider and the care and support will be provided by Trust staff. The 24 units will be split between two sites.

Under Option 4 accommodation will be provided for 24 tenants through a new build of five dwellings to accommodate those adults with a learning disability who currently reside in Mourne, Donard and Sperrin. The number of tenants to be accommodated in each house will be between 3 and 6. Outside space is also important for the needs of the tenants and should be accessible from various areas within the house. The following table 4.0.1 details the number of dwellings, the possible locations and the number of individuals within each dwelling. The individuals were grouped according to compatibility and location by the Project Team.

Option 5 – New Build provided by Social Housing Provider – single site

– The Trust would secure capital through engagement with Social Housing Provider and the care and support will be provided by Trust staff. All units will be based on one site.

Under Option 5, five dwellings are required to accommodate those adults with a learning disability who currently reside in Mourne, Donard and Sperrin. The number of tenants to be accommodated in each house will be between 3 and 6. Outside space is also important for the needs of the tenants and should be accessible from various areas within the house. The following table details the number of dwellings, the possible locations and the number of individuals within each dwelling. The individuals were grouped according to compatibility by the Project Team.

Table 4.0.1 Residents identified for Resettlement

Resident Number	SEX	Current Location	Suggested Accommodation	Housing	House No
2	F	Mourne House	Shared Supported Living	1 six bedded unit	1
4	F	Mourne House	Shared Supported Living		
5	F	Mourne House	Shared Supported Living		
6	F	Mourne House	Shared Supported Living		
7	F	Mourne House	Shared Supported Living		
34	F	Knock Eden	Shared Supported Living		
12	M	Donard	Shared Supported Living	1 three bedded unit	2
13	M	Donard	Shared Supported Living		
20	M	Donard	Shared Supported Living		
14	M	Donard	Shared Supported Living	1 five bedded unit	3
17	M	Donard	Shared Supported Living		
11	M	Donard	Shared Supported Living		
35	M	IATU	Shared Supported Living		
18	M	Donard	Shared Supported Living		
21	M	Sperrin	Shared Supported Living		
27	M	Sperrin	Shared Supported Living		
29	M	Sperrin	Shared Supported Living		
30	M	Sperrin	Shared Supported Living		
22	M	Sperrin	Shared Supported Living		
25	M	Sperrin	Shared Supported Living	1 five bedded unit	5
26	M	Sperrin	Shared Supported Living		
28	M	Sperrin	Shared Supported Living		
31	M	Sperrin	Shared Supported Living		
33	M	Sperrin	Shared Supported Living		

4.1 Benefit Criteria

The Project Team met to establish and agree the benefits and benefit criteria for the non-financial appraisal options. The benefit appraisal is a process for quantifying and comparing the potential benefits of the options in terms of non- financial criteria.

The approach used to evaluate the non-financial benefits of the options is the weighted-score method, which includes;

- ▢ Listing and describing each of the benefit criteria against which each option can be examined and scored
- ▢ Identifying the weight of each benefit criteria in accordance to its relative importance
- ▢ Scoring each option against the benefit
- ▢ Totalling the weighted scores for the options

Each of the options is assessed against four benefit criteria detailed below in Table 4.1.1 Benefit Criteria

Table 4.1.1 Benefit Criteria

	Benefits	Description of Criteria	Weighted Score (Total 100)
1.	Quality of Support and Care	<ul style="list-style-type: none"> ➤ The service should offer a permanent whole life living experience that minimises the possibility of inappropriate re-admission to hospital. ➤ Gain meaningful life experience through being supported to maintain own tenancy through appropriate levels of housing support. ➤ Enhanced quality of life ➤ Offer a range of services which support independent living ➤ Better health and social wellbeing ➤ Improved flexibility to account for changes in individual support needs and changes in tenants. 	40
2.	Quality of Accommodation	<ul style="list-style-type: none"> ➤ Provides a modern, warm, clean, homely environment ➤ Provides a safe and secure environment ➤ Provides an environment to deliver a person centred service ➤ Space requirements meet the needs of more complex individuals. ➤ Application of electronic assistive technology to enhance care and support ➤ Comply with DDA and Section 75 Equality Legislation ➤ Comply with health and safety and fire regulations ➤ Comply with building control standards/planning services. 	30
3.	Accessibility	<ul style="list-style-type: none"> ➤ To provide local community integration. ➤ Be close to public sector facilities ➤ Be close to public transport networks ➤ Promote social inclusion ➤ Meet local resident needs 	20
4.	Appropriate Staffing	<ul style="list-style-type: none"> ➤ Supported Living Schemes require the appropriate skilled support/care staff who are appropriately trained to meet 	10

	Benefits	Description of Criteria	Weighted Score (Total 100)
		various needs of tenants. ➤ Single cohesive staff structure	
	Total		100

The weighting of the individual benefit criteria determines their relative importance with the more significant benefits achieving a higher weighting and those of lower impact achieving a lower rating. Weighting is apportioned to the benefit criteria as follows in Table 4.1.2.

Table 4.1.2 Allocation of Weighting

	Benefits	Weighted Score (Total 100)
1.	Quality of Support and Care	40
2.	Quality of Accommodation	30
3.	Accessibility	20
4.	Appropriate Staffing	10
	Total	100

4.2 Rationale for Weighting

The rationale for the weighting of the benefit criteria is explained below:

Criterion 1 – Quality of Support and Care – The Project Team placed Quality of Support and Care as the most important benefit as it underpins all other benefits and is the over-riding objective of service delivery.

This criterion considers the safe and clinical effective delivery of high standards of care required to meet the nursing needs of mental health care.

Criterion 2 – Quality of Accommodation – Quality of Accommodation has been ranked of second of importance as the Project Team decided that the

quality of support and care requires the appropriate accommodation/environment for the delivery of care. Without the necessary supportive/appropriate facilities in suitable environments, the Trust will have difficulty in ensuring that services meet recommended standards of care. Quality of Support and Care is enabled by quality accommodation.

Criterion 3 – Accessibility – This criterion was ranked to be of third importance by the Project Team. Services must provide local community integration and be close to other public sector facilities.

Criterion 4 – Appropriate Staffing – The Project Team ranked appropriate staffing fourth as Supported Living Schemes require the appropriate skilled Support and Care staff who possess specific skills to help individuals to maintain a level of independence through support provided.

4.3 Benefit Analysis

Each of the options was rated on a score between 1- 10, with 10 meaning that the option fully met the non-financial criteria. The results of this analysis are recorded in table 4.3.1 below.

Table 4.3.1 Benefit Analysis

Benefit Criteria	Weight	Option 1 – Status Quo		Option 4 – New Build provided by DSD – Split site		Option 5 – New Build provided by DSD – Single site	
		Weight	Score	Weight	Score	Score	Weight
Quality of Support and Care	40	7	280	9	360	10	400
Quality of Accommodation	30	2	60	10	300	10	300
Accessibility	20	2	40	7	140	9	180
Appropriate Staffing	10	9	90	7	70	9	90
Total	100		470		870		970

Rationale for Scoring

Quality of Support and Care – Option 1 scored lowest under this criterion as staff are limited in delivering support/care due to the current accommodation. Options 4 and five scored higher than Option 1 as smaller groups of individuals would be accommodated with more living space and individual bedrooms allowing more scope when working with the tenants. Staff would be able to resolve a situation quicker and easier by separating individuals and using different areas of the accommodation. Individuals would receive more support to develop life skills. Option 5 scored slightly higher than option 4 due to the units all being on one site, therefore all staff will be placed on one site with tenants having optimum support.

Quality of Accommodation –Option 1 scored the lowest as the current accommodation is extremely poor with inadequate space for the individuals. Also there are insufficient rooms with only one main living area for each ward and no single bedrooms. Also the current accommodation has been brought in line with DDA standards but only to the minimum requirements. Options 4 and 5 scored higher as the Trust will be involved in the design development with the Housing Provider and as this is a new build it will be built to specification. Options 4 and 5 will meet all building standards and regulations including HMO and contain the latest technology.

Accessibility – Option 1 scored lowest as the current accommodation does not promote social inclusion. Options 4 and 5 scored higher as a joint decision with the Trust and provider will be made regarding location, and the Trust will not agree to the accommodation being in an isolated area. The decision on location will be based around, proximity to public transport and other public sector facilities. The preferred option will promote social inclusion, and local community integration. Option 5 scored slightly higher than Option 4 as with all units being based on one site there is more scope for communal activities and outings among the tenants, due to more staff being available and also better efficiencies regarding transport.

Staffing – Both options 1 and 5 scored equally regarding staffing as staff would all be based on the one site providing a better utilisation of staff. Option 4 scored slightly lower as the units will be split across sites as will staffing. Also more staffing will be required for a split site arrangement.

Preferred Option

The Short-List scores are as follows:

Option		Score
Option 1 – Status Quo	Individuals would remain in Longstone Hospital in long stay accommodation.	470
Option 4 – New Build provided by Social Housing Provider – Split Site.	The Trust would secure capital through engagement with Social Housing Provider and the care and support will be provided by Trust staff. Split site.	870
Option 5 – New Build provided by Social Housing Provider – Single Site.	The Trust would secure capital through engagement with Social Housing Provider and the care and support will be provided by Trust staff. Single site.	970

As can be seen from the above score the preferred option is Option 5 – The Trust would secure capital through engagement with **Social Housing Provider** and the support and care will be provided by Trust staff on one single site with the preferred location being the Dungannon area.

5.0 Financial Analysis

This section assesses the financial merit of each option. The short-listed options have been appraised in terms of the relevant costs as prescribed by the Northern Ireland Guide to Expenditure Appraisal (NIGEA) are outlined under the following headings,

- Optimism Bias
- Capital Costs
- Opportunity Costs
- Capital Charges
- Revenue Consequences
- Economic Costs (NPC's)

5.1 Optimism Bias

There is a demonstrated, systematic tendency for project appraisers to be overly optimistic. To redress this tendency appraisers should make explicit, empirically based adjustments to the estimates of a project's costs, benefits, and duration.

The NIGEA on Optimism Bias recommends that these adjustments be based on data from past projects or similar projects elsewhere, and adjusted for the unique characteristics of the project in hand. The Guidance also identifies adjustment ranges for generic project categories including standard and non-standard building projects.

In compliance with the NIGEA, this business case has been reviewed to ensure that it allows for optimism bias with respect to the following short-listed options:

Option 4: New Build provided by Social Housing Provider – split site – the Trust would secure capital through engagement with Social Housing provider and the care and support will be provided by Trust staff.

Option 5: New Build provided by Social Housing Provider – single site – the Trust would secure capital through engagement with Social Housing provider and the care and support will be provided by Trust staff.

Note:

For the purposes of this Business Case, the other shortlisted Option i.e. Option 1: Status Quo, where residents would remain in Longstone Hospital in long-stay accommodation, is not included in the Optimism Bias section.

The first stage of optimism bias adjustment is to give careful consideration to the characteristics of the project in order to determine the project type. A “non-standard” building project is one that involves the construction of buildings requiring special design considerations due to space constraints, complicated site characteristics, specialist innovative buildings or unusual output specifications.

With specific reference to the current sites for Option 4, the Project Group decided that the option does not require special design considerations and therefore is classed as a “standard” building project.

The Optimism Bias adjustment ranges for a “standard” building project as per the NIGEA are as follows:-

	Capital Expenditure	Capital Expenditure	Works Duration	Works Duration
	Upper Limit	Lower Limit	Upper Limit	Lower Limit
Standard	24%	2%	4%	1%

5.2 Capital Works Expenditure: **Options 4 and 5**

1. Project Type

The developments would be considered to be standard building projects as described in Clause 3.10 of the NIGEA supplementary guidance.

2. The Upper Bound

The maximum capital expenditure uplift for a standard building is 24%.

3. Consider whether the Optimism Bias Upper Bound can be reduced.

The elements of optimism bias in the following table apply to a standard building. Mitigation factors are also provided.

Table 5.2.1 : Optimism Bias – Capital Works Expenditure (Options 4 & 5)

	OPTIMISM BIAS	Capital Expenditure Option 4 (Split Site) & Option 5 (Single Site):		
		% Contribution to Optimism Bias	Mitigation Factor	Total
Procurement				
	Late Contractor Involvement in Design	2	0.70	1.40
	Poor contractor capabilities	9	0.70	6.30
	Disputes	29	0.70	20.30
Project Specific	Design Complexity	1	0.80	0.80
	Degree of Innovation	4	0.80	3.20
Resident Specific	Inadequacy of business case	34	0.70	23.80
	Project Team Management	1	0.80	0.80
	Poor Project Intelligence	2	0.70	1.40
Environment	Site Characteristics/Others	2	0.60	1.20
	Public Relations	2	0.70	1.40
External Influences	Economic	11	0.60	6.60
	Legislation/Regulations	3	0.70	2.10
	TOTAL	100		69.30

The reduction in optimism bias is 69.30%. Therefore the capital expenditure optimism bias uplift factor is: $(100 - 69.30) \times 24\% = 7.368\%$

4. Apply Optimism Bias Factor

Capital works costs (excluding contingency) + 7.368%

Table 5.2.2: Capital Works Expenditure: Optimism Bias Uplift

Option 4 (Split Site): New Build provided by Social Housing Provider	$£ 2,120,000 + 7.368\% = £2,276,202$
Option 5 (Single Site): New Build provided by Social Housing Provider	$£ 2,120,000 + 7.368\% = £2,276,202$

5. Capital Works Expenditure : Review of Optimism Bias Adjustment
(Options 4 & 5)

The following comments explain the mitigation factors:

Procurement:

Late Contractor Involvement in Design: Established tendering procedures ensure that a reliable and reputable contractor is appointed. However there remains scope for probable error. Therefore, a mitigation factor of 0.70 has been used for Options 4 and 5.

Poor Contractor Capabilities:

The Trust is assuming that the Housing Association will have a formal project management structure in place which will have the relevant technical/professional representatives who will oversee the building project. Nevertheless, the scope for problems exists. A mitigation factor of 0.70 has therefore been used for Options 4 and 5.

Disputes: It is the responsibility of the Housing Association in conjunction with the Housing Provider to ensure that the contract specification and terms and

conditions are clear and unambiguous and that the project brief, as outlined by the Trust, is specific to the needs of residents. Also, if the Trust is involved at an early stage with the above parties in developing the project brief, the likelihood of disputes and claims for interim payments will be minimised. An experienced project team will ensure the project is properly scoped from the outset. However, experience suggests that unforeseen delays and inflationary factors will occur. Therefore, a factor of 0.70 has been used for Options 4 and 5.

Project Specific:

Design Complexity: The development involves a standard approach to the design and construction of new builds on two sites in different geographical locations. The designs will be sufficiently standard to enable many contractors to carry out the project. A mitigation factor of 0.80 has been used for Options 4 and 5.

Degree of Innovation: Precise accommodation requirements will be stipulated. Also, Options 4 and 5 involve standard building designs with limited scope for innovative features and the builds will have to comply with building control standards/planning services; DDA; Health & Safety and Fire Regulations. Therefore, a mitigation factor of 0.80 has been used for Options 4 and 5.

Resident Specific:

Inadequacy of business case: The business case has been completed in accordance with the principles contained in the Capital Investment Manual: Management of Construction Projects issued by the DHSSPS whilst taking into account the guidance contained in the new edition of the NIGEA. Each of the appropriate sections have been addressed and the options have been based on a strategic review of the development of services for resettling Learning Disability residents from long-stay hospital wards. However, a more detailed financial analysis of the capital costs will be provided by the selected Housing Provider at a later stage.

A mitigation factor of 0.70 has therefore been used for Options 4 and 5.

Project Management Team: The Trust is assuming that the Housing Association will have a formal project management structure in place which will have the relevant technical/professional representatives who will oversee the building project. A mitigation factor of 0.80 has been used for Options 4 and 5.

Poor Project Intelligence: The Trust has already carried out a Needs Assessment profiling the needs of the specific residents to be resettled and has indicated the accommodation requirements. However, the exact sites within the two geographical locations will only be known after the Housing Provider has been appointed. Therefore, a factor of 0.70 has been used for Options 4 and 5.

Environment:

Site Characteristics: The exact locations of the sites within the two geographical areas remain unknown at this time. However, the Trust is assuming that the Housing Provider will begin the appropriate investigations and surveys on site before construction commences. As with any site, there remains the possibility of risk in terms of the unknown. A mitigation factor of 0.60 has therefore been used for Options 4 and 5.

Public Relations: Generally, the resettlement of long-stay hospital residents has been accepted by the local community. However, there is still a risk of resistance from the general public if, for instance, the new builds are within/close to existing Housing Developments. Therefore, a mitigation factor of 0.70 has been used for Options 4 and 5.

External Influences:

Economics: Given current cost constraints/ pressures within Public Sector organisations, there is a significant risk of other housing pressures being prioritised within the Social Housing environment which may well see this project becoming less of a priority. Therefore, a mitigation factor of 0.60 has

been used for Options 4 and 5.

Legislation/Regulations: The project will adhere to all relevant legislation/regulations. For Options 4 and 5, which would be more medium to long term, future legislative changes are unknown, therefore a mitigation factor of 0.70 has been used for both Options 4 and 5.

5.3 Works Duration : Options 4 and 5

1. Project Type

The Development would be considered to be a standard building project.

2. The Upper Bound

The maximum works duration uplift for a standard building is 4%.

3. Consider whether the Upper Bound can be reduced

The elements of optimism bias in the following table apply to a standard building. Mitigation factors are also provided.

Table 5.3.1 : Optimism Bias : Options 4 and 5 - Works Duration

	OPTIMISM BIAS	Works Duration Option 4 (Split Site) & Option 5 (Single Site):		
		% Contribution to Optimism Bias	Mitigation Factor	Total
	Contributory Factors			
Procurement	Complexity of Contract Structure	3	0.90	2.70
	Late contractor involvement	6	0.70	4.20
	Poor contractor capabilities	9	0.70	6.30
	Disputes	29	0.70	20.30
Project Specific	Design Complexity	1	0.80	0.80
	Degree of Innovation	4	0.80	3.20
Resident Specific	Inadequacy of business case	34	0.70	23.80
	Project Team Management	1	0.80	0.80
	Funding availability			
	Other			
	Poor Project Intelligence	2	0.70	1.40

Environment	Site Characteristics/Other	2	0.60	1.20
	Public Relations	2	0.70	1.40
External Influences	Economic	4	0.60	2.40
	Legislation/Regulations	3	0.70	2.10
	TOTAL	100		70.60

The reduction in optimism bias is 70.60%. Therefore the works duration optimism bias uplift factor is $(100 - 70.60\%) \times 4\% = 1.176\%$

4. Apply the Works Duration Optimism Bias

Table 5.3.2 : Works Duration Optimism Bias:

Option 4 (Split Site): New Build provided by Social Housing Provider	14 months + (1.176% x 14 months) = 14.16 months
Option 5 (Single Site): New Build provided by Social Housing Provider	14 months + (1.176% x 14 months) = 14.16 months

5. Works Duration : Review of Optimism Bias Adjustment (Options 4 and 5)

The following comments explain the mitigation factors:

Procurement:

Complexity of Contract Structure: It is anticipated that this will be a basic contract. The duration of works is agreed from the outset depending on the size and scale of the project. A mitigation factor of 0.90 has been used for Options 4 and 5.

Late Contractor Involvement in Design: Established tendering procedures ensure that a reliable and reputable contractor is appointed. However there remains scope for probable error. Therefore, a mitigation factor of 0.70 has been used for Options 4 and 5.

Poor Contractor Capabilities: The Trust is assuming that the Housing Association will have a formal project management structure in place which will have the relevant technical/professional representatives who will oversee the building project. Assessment and selection criteria will be established by the Housing Association and Housing Provider which considers whether the contractor can deliver the project brief on time and within budget. Nevertheless, the scope for problems remains. A mitigation factor of 0.70 has therefore been used for Options 4 and 5.

Disputes: It is the responsibility of the Housing Association in conjunction with the Housing Provider to ensure that the contract specification and terms and conditions are clear and unambiguous and that the project brief, as outlined by the Trust, is specific to the needs of residents. Also, if the Trust is involved at an early stage with the above parties in developing the project brief, the likelihood of disputes and claims for interim payments will be minimised. An experienced project team will ensure the project is properly scoped from the outset. However, experience suggests that unforeseen delays and inflationary factors will occur. Therefore, a factor of 0.70 has been used for Options 4 and 5.

Project Specific:

Design Complexity: The development involves a standard approach to the design and construction of new builds on two sites in different geographical areas. The designs will be sufficiently standard to enable many contractors to carry out the project. A mitigation factor of 0.80 has been used for Options 4 and 5.

Degree of Innovation: Precise accommodation requirements will be stipulated. Also, Options 4 and 5 involve standard building designs with limited scope for innovative features and the builds will have to comply with building control standards/ planning services; DDA; Health & Safety and Fire Regulations. Therefore, a mitigation factor of 0.80 has been used for both Options 4 and 5.

Resident Specific:

Inadequacy of business case: The business case has been completed in accordance with the principles contained in the Capital Investment Manual: Management of Construction Projects issued by the DHSSPS whilst taking into account the guidance contained in the new edition of the NIGEA. Each of the appropriate sections have been addressed and the options have been based on a strategic review of the development of services for resettling Learning Disability residents from long-stay hospital wards. A more detailed financial analysis of the capital costs will be provided by the selected Housing Provider at a later stage. A mitigation factor of 0.70 has therefore been used for Options 4 and 5.

Project Management Team: The Trust is assuming that the Housing Association will have a formal project management structure in place which will have the relevant technical/professional representatives who will oversee the building project. A mitigation factor of 0.80 has been used for Options 4 and 5.

Poor Project Intelligence: The Trust has already carried out a Needs Assessment profiling the needs of the specific residents to be resettled and has indicated the accommodation requirements. However, the exact sites within the two geographical locations will only be known after the Housing Provider has been appointed. Therefore, a factor of 0.70 has been used for Options 4 and 5.

Environment:

Site Characteristics: The exact locations of the sites within the two geographical areas remain unknown at this time. However, the Trust is assuming that the Housing Provider will begin the appropriate investigations and surveys on site before construction commences. As with any site, there remains the possibility of risk in terms of the unknown. A mitigation factor of 0.60 has therefore been used for Options 4 and 5.

Public Relations: Generally, the resettlement of long-stay hospital residents

has been accepted by the local community. However, there is still a risk of resistance from the general public if, for instance, the new builds are within/close to existing Housing Developments. Therefore, a mitigation factor of 0.70 has been used for Options 4 and 5.

External Influences:

Economics: Given current cost constraints/ pressures within Public Sector organisations, there is a significant risk of other housing pressures being prioritised within the Social Housing environment which may well see this project becoming less of a priority. Therefore, a mitigation factor of 0.60 has been used for Options 4 and 5.

Legislation/Regulations: The project will adhere to all relevant legislation/regulations. For Options 4 and 5 which would be more medium to long term, future legislative changes are unknown, therefore a mitigation factor of 0.70 has been used for both Options 4 and 5.

5.4 General Equipment : Options 4 and 5

1. Project Type

The Development would be considered to be a standard building project.

2. The Upper Bound

The maximum uplift for general equipment is 24%.

3. Consider whether the Upper Bound can be reduced

The elements of optimism bias in the following table apply to equipment. Mitigation factors are also provided.

Table 5.4.1 : Optimism Bias : Options 4 and 5 - Equipment

	OPTIMISM BIAS	Equipment Option 4 (Split Site) & Option 5 (Single Site)		
	Contributory Factors	%		

		Contribution to Optimism Bias	Mitigation Factor	Total
Procurement	Complexity of Contract Structure	7	0.90	6.30
	Late contractor involvement	7	0.70	4.90
	Poor contractor capabilities	4	0.70	2.80
	Information Management	5	0.70	3.50
Project Specific	Design Complexity	10	0.80	8.00
	Degree of Innovation	17	0.80	13.60
Resident Specific	Inadequacy of business case	18	0.70	12.60
	Project Team Management	5	0.80	4.00
	Poor Project Intelligence	4	0.70	2.80
External Influences	Legislation	5	0.70	3.50
	Technology	18	0.80	14.40
	TOTAL	100		76.40

The reduction in optimism bias is 76.40%. Therefore the equipment optimism bias uplift factor is $(100 - 76.40) \times 24\% = 5.664\%$

4. Apply the Equipment Optimism Bias

Capital cost of Equipment + 5.664%

Table 5.4.2 : Capital Equipment Expenditure: Optimism Bias Uplift

Option 4 (Split Site): New Build provided by Social Housing Provider	$£30,000 + 5.664\% = £31,699$
Option 5 (Single Site): New Build provided by Social Housing Provider	$£30,000 + 5.664\% = £31,699$

5. Review of Optimism Bias Adjustment

The following comments explain the mitigation factors:

Procurement:

Complexity of Contract Structure: It is anticipated that the Trust will use a standard contract to procure the general equipment required; thereby avoiding

any complex issues in relation to the complexity of the structure of the contract. A mitigation factor of 0.90 has been used for Options 4 and 5.

Late Contractor Involvement in Design: The Contractor will be appointed at the start of the procurement process. Established tendering procedures will ensure that a reliable and reputable contractor is appointed. However, there remains scope for probable error. Therefore a mitigation factor of 0.70 has been used for Options 4 and 5.

Poor Contractor Capabilities: The Trust will engage with RSS who have expertise in procurement and who will ensure the correct equipment is acquired from reputable contractors. However, the scope for problems remains. A mitigation factor of 0.70 has been used for all Options 4 and 5.

Information Management: The Trust expects to be able to manage information interfaces effectively. Therefore a mitigating factor of 0.70 has been used for Options 4 and 5.

Project Specific:

Design Complexity: The development involves standard approaches to the design of accommodation. The designs will be sufficiently standard to enable many contractors to carry out the project. A mitigation factor of 0.80 has been used for Options 4 and 5.

Degree of Innovation: This project involves standard equipment for use in any supported living accommodation unit with minimal innovative features. A mitigation factor of 0.80 has been used for Options 4 and 5.

Resident Specific:

Inadequacy of Business Case: The Trust has taken all possible steps at this stage to ensure that the revenue and capital cost drivers have been identified. A mitigation factor of 0.85 has been used.

Project Management Team: A project team will be appointed which will have responsibility for ensuring that the necessary equipment is procured. As the risk for this factor is minimal, a mitigation factor of 0.70 has been used for Options 4 and 5.

Poor Project Intelligence: The Trust has been involved in a number of new build projects and procurement of equipment and has established processes in place. A mitigation factor of 0.70 has been used for Options 4 and 5.

External Influences:

Legislation/Regulations: The project adheres to all relevant legislation/regulations. A mitigation factor of 0.70 has been used as future legislative changes are unknown at present.

Technology: It is currently envisaged that there should not be unexpected technological advancements which would impinge on the procurement of general equipment. A mitigation factor of 0.80 has been used.

5.5 Capital Costs

A summary of the capital costs associated with each option is shown in Table 5.5.1 below. See Appendix 4.

	Option1 £	Option 4 £	Option 5 £
Land	0	745,000	670,500
Construction Cost	200,000	1,700,000	1,700,000
On Costs	0	420,000	420,000
Equipment	15,000	30,000	30,000
Total	215,000	2,895,000	2,820,500

In Option 1 it is recognised that some capital expenditure will be required over the 25 year appraisal period to maintain buildings and to replace equipment at Mourne, Donard and Sperrin wards. For this purpose capital costs to buildings of £200k have been included at year 15 and for on-going

equipment requirements of £15k for each replacement cycle and these costs have been provided by the Trust Estate Services Department.

For the new build Options 4 and 5, indicative capital costs were provided by the Northern Ireland Housing Association for the development of housing accommodation in Armagh and Dungannon under the split site option and Dungannon for the single site option. It is recognised that a detailed analysis of capital requirements has still to be undertaken, but at this point the indicative land and capital costs (excluding VAT) are analysed over each location in Table 5.5.2 below:

Element	Option 4 : Split-Site			Option 5 : Single Site
	Armagh £	Dungannon £	Total £	Dungannon £
Land	390,000	355,000	745,000	670,500
Works	890,000	810,000	1,700,000	1,700,000
On-Costs	220,000	200,000	420,000	420,000
Equipment	15,000	15,000	30,000	30,000
Total	1,515,000	1,380,000	2,895,000	2,820,500

5.6 Opportunity Costs

In line with the NIGEA, opportunity costs have been included in respect of those options that make use of existing land and buildings belonging to the Southern Health and Social Care Trust. In all options, the value of land and buildings at 1st April 2010 as stated in the Trust Capital Asset Register have been used as the opportunity cost for land and buildings.

In Option 1 the Trust will continue to use the land and buildings which make up the Mourne, Donard and Sperrin wards at Longstone Hospital and these are included as an opportunity cost in this option.

Also, for Options 4 and 5 there will be the continued use of the land and buildings which make up Mourne, Donard and Sperrin wards until they are replaced by the new build unit and therefore they are also included as an opportunity cost in these options.

Table 5.6.1 below sets out the opportunity costs for each option.

Table 5.6.1 Opportunity Costs

	Option 1 £	Option 4 £	Option 5 £
<u>Opportunity Costs</u>			
Existing Land:			
Mourne, Donard and Sperrin Wards	513,591	513,591	513,591
Existing Buildings:			
Mourne, Donard and Sperrin Wards	653,005	653,005	653,005
Total Opportunity Costs	1,166,596	1,166,596	1,166,596

5.7 Depreciation Charges

Depreciation charges have been calculated for the purpose of determining the residual values of assets for the Net Present Costs (NPC) calculations as set out at Table 5.7.1 below; these are included at Appendix 5. Depreciation Charges costs in Options 4 and 5 will accrue to the Housing Association who will build and own the premises when complete.

In calculating depreciation charges, the following working assumptions have been used for length of asset life,

New Build	50 Years
Refurbishment	25 Years
General Equipment	10 Years

ICT Equipment

5 Years

The average annual depreciation charges associated with each of the short-listed options are detailed in Table 5.7.1 below.

Table 5.7.1 Depreciation Charges

	Option 1 £	Option 4 £	Option 5 £
Depreciation Charges – Excluding Optimism Bias	30,962	44,944	44,944
Depreciation Charges – Including Optimism Bias	30,962	48,182	48,182
Increased Depreciation Charges (Excluding Optimism Bias)	0	3,238	3,238

5.8 Revenue Costs

5.8.1 Summary Revenue Costs

The summary revenue costs of each option are shown in Table 5.8.1.1 below. The detailed cost of all options are shown in Appendix 3.

Costs are stated at 2010-11 price levels.

Table 5.8.1.1 Summary Revenue Costs

	Option 1 £000's	Option 4 £000's	Option 5 £000's
Payroll Costs	1,428	2,140	1,965
Goods and Services Costs	44	129	129
Total Costs	1,472	2,269	2,094
Increased Costs		797	622

5.8.2 Funding of Revenue Costs

Tables 5.8.2.1 and 5.8.2.3 below set out the normal revenue funding package under supporting people arrangements. An assumed funding split between care and support respectively of 70:30 for the main cost elements has been assumed, with care costs being funded by SHSCT and support costs being funded through the Northern Ireland Housing Executive.

The indicative costs below identify the financial commitment that the Trust and Supporting People would have to spend recurrently, to deliver the required level of service, at a 70% care and 30% support split, for the supporting housing facilities as outlined in this business case. All costs are set at 2010/11 price levels and will require an inflationary uplift, in due course, to reflect 2012/13 costs in the year of opening.

5.8.2.1 Funding of Revenue Costs : Option 4 Split Site

The SHSCT will incur additional care costs of £355k under Option 4 and will have to bid against funds held centrally under dowry arrangement, for the resettlement of residents from long stay hospital accommodation.

Table 5.8.2.1 Funding of Revenue Costs (Option 4 : Split Site)

		Northern Ireland Housing Executive			SHSCT
		Total Support	Housing	Support	Care
		30%	5%	95%	70%
	£	£	£	£	£
Total Annual Recurring Costs – (Excluding Night Staff)	1,255,875	441,269	95,210	346,059	814,606

		Northern Ireland Housing Executive			SHSCT
	Total Costs	Total Support	Housing	Support	Care
		30%	5%	95%	70%
	£	£	£	£	£
+ Night Staff	1,013,003				1,013,003
Totals	2,268,878	441,269	95,210	346,059	1,827,609

The costs as set out in Table 5.8.2.1 above translate into the following weekly cost per resettlement in Table 5.8.2.2 below.

Table 5.8.2.2 Weekly Revenue Costs per Resettlement (Option 4 : Split Site)

		Northern Ireland Housing Executive			SHSCT
	Total Costs	Total Support	Housing	Support	Care
	£	£	£	£	£
Cost per bed per week	£1,813	£353	£76	£277	£1,460

5.8.2.2 Funding of Revenue Costs : Option 5 Single Site

The SHSCT will incur additional care costs of £211k under Option 5 and will have to bid against funds held centrally under dowry arrangement, for the resettlement of residents from long stay hospital accommodation.

Table 5.8.2.3 Funding of Revenue Costs (Option 5 : Single Site)

		Northern Ireland Housing Executive			SHSCT
	Total Costs	Total Support	Housing	Support	Care
		30%	5%	95%	70%
	£	£	£	£	£
Total Annual Recurring Costs – (Excluding Night Staff)	1,155,014	411,011	93,697	317,314	744,003
+ Night Staff	938,561				938,561
Totals	2,093,575	411,011	93,697	317,314	1,682,564

The costs as set out in Table 5.8.2.3 above translate into the following weekly cost per resettlement in Table 5.8.2.4 below.

		Northern Ireland Housing Association			SHSCT
	Total Costs	Total Support	Housing	Support	Care
	£	£	£	£	£
Cost per bed per week	£1,673	£328	£75	£254	£1,345

Supporting people advise that this proposed weekly cost of £259 (support) is the above the provincial average of £210.24. In addition when compared to the NI benchmark for similar sized accommodation schemes this weekly cost is closer to the upper quartile of £263/ week for learning disability providers.

5.9 Economic Costs (Net Present Cost before Optimism Bias adjustment)

Discounted cash flows for each of the options are presented in Appendix 7

and 8. They include opportunity costs and the residual values at the end of the appraisal period as appropriate.

Table 5.9.1 below gives the net present cost (NPC), before adjusting for optimism bias for each option. NPC are “full life” costs and, therefore, reflect equipment replacement at the end of the equipments useful life during the appraisal period. It has been assumed that 50% of the equipment cost is for general equipment and 50% for ICT equipment, with general equipment having a 10 year life and ICT equipment a 5 year life.

Table 5.9.1 – Net Present Costs			
Option	Option Description	Net Present Cost £000's	Variance from Baseline £000's
1	Status Quo (Do Nothing)	26,142	
4	New Build (split site)	39,438	13,296
5	New Build (single site)	36,749	10,607

The following assumptions have been used in calculating net present costs,

The appraisal period for the cost analysis is 25 years

The discount rate used is 3.5%

5.10 Economic Costs (Net Present Cost after Optimism Bias adjustment)

In accordance with the new NIGEA all capital and revenue costs associated with each option are subject to an optimism bias uplift. Discounted cash flows, including optimism bias for each of the options, are presented in Appendix 7 and 8 and Table 5.10.1 below summarises the optimism bias adjusted Net Present Costs.

Table 5.10.1 – Net Present Costs adjusted for Optimism Bias			
Option	Option Description	Net Present	Variance from

		Cost £000's	Baseline £000's
1	Status Quo (Do Nothing)	26,142	
4	New Build (split site)	39,594	13,452
5	New Build (single site)	36,869	10,727

The preferred new build option from the financial analysis is Option 5 : New Build of 24 places for the resettlement of residents from Mourne, Donard and Sperrin Wards at Longstone Hospital on a single site at Dungannon.

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6.0 Assessment of Risks/Uncertainty

Risk management is a structured approach to identifying, assessing and controlling risks that emerge during the course of the policy, programme or project lifecycle. Its purpose is to support better decision-making through understanding the risks inherent in a proposal and their likely impact. The presence of risks e.g., risk of a capital cost overrun, may influence the choice of option, therefore the implications must be thoroughly explored. Using the table below give details of any risks and uncertainties and the countermeasures that will be put in place to minimise their impact. Also indicate whether the level of risk is low medium or high for each option by allocating a score of 1, 2 or 3 respectively. This will determine the overall level of risk for each option and enable a comparison to be made.

Risk Detail	Risk Probability			Countermeasure
	Option 1	Option 4	Option 5	
	Status Quo	New Build provided by Social Housing Provider – Split site	New Build provided by Social Housing Provider – single site	
Timeframe Unable to complete by 2011	3	3	3	Phased incremental approach can be applied. Risk of revenue not being available.
Unable to meet strategic recommendations	3	2	2	With a phased approach the Trust can demonstrate that they are working towards departmental recommendations
Unable to secure capital funding	1	2	2	DSD will explore all avenues to secure capital funding.
Unable to secure recurring revenue funding	1	3	3	Supporting People has responsibility to provide revenue to be approved and agreed at a later stage.
OVERALL RISK LEVEL	8	10	10	(Low, Medium or High)

7.0 Conclusion and Recommendations

On the basis of the information provided in this business case the Trust has identified the need for the provision of accommodation of 5 units of accommodation for people with a learning disability currently residing in Longstone Hospital. The Trust has determined the preferred option for this development as **Option 5 - New Build provided by Social Housing Provider - single site** – The Trust would secure capital through engagement with Social Housing Provider and the care and support will be provided by Trust staff.

The Trust is already engaged with its lead Commissioner, the Health and Social Care Board, on this proposal and careful consideration has been given to the financial aspects associated with this process. It is the view that the revenue resources required for the care component, as set out in Table 10.1, can be realised over the proposal planning period to 31st March 2011 from a combination of funding as follows,

- i) development money already earmarked for the normal level of planned resettlement to 31st March 2011 and
- ii) through investment of additional centrally held resettlement funding which will accrue to the Trust in respect of resettlements which are over and above the normal planned level, as proposed under this accelerated resettlement process.

In order to progress this development there is a need for support from funding streams such as Supporting People for the support element of the costs, so as to enable the provision of a range of alternative accommodation across the Southern Trust area. This business case therefore sets out current need and proposes that initial funding be made available by Supporting People for the 24 identified individuals.

8.0 Post Project Evaluation

A Post Project Evaluation (PPE) is the process of assessing the impact of projects while they are in operation or after they have come to an end. It is an essential part of improving project performance, achieving best value for money from public resources and improving decision making.

The post project evaluation will be undertaken under the auspices of the Project Team. It is anticipated that an initial part of the review concerned with inputs and outputs will be undertaken on completion and occupation of the building. Review of the achievement of service objectives will follow after approximately six months and reported to Trust Board, the Commissioner and SASSP as necessary.

8.1 Capital Project Monitoring

Monitoring of the capital development will be conducted throughout the construction period and at completion. The key issues that will be addressed will be:

- Was the project completed on time?
- Was it completed at budget cost?
- What were the reasons for any delay?
- What action would management recommend to prevent future problems?
- What are the functional relationships of the key services?
- What is the functional suitability of the building/ system? (This will require initial evaluation and subsequent evaluation once the building has been occupied and operational for a reasonable period).

9.0 Post Benefit Evaluation Plan

Following the implementation Post Benefit Evaluation (PBE) will be carried out. The main objective of the PBE will be to assess the benefits that have been derived from the Project, compared with those that were envisaged. A summary of the planned PBE is illustrated in Table 9.1.1 overleaf.

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Table 9.1.1 Post Benefit Realisation Plan

Aim	Objective	Specific Indicator	Performance		Activity to Confirm Realisation	Lead Responsibility	Key Date for Realisation
			Baseline	Target			
Quality of Support and Care	Improved quality of service which meets standards stipulated by NI Review of Mental Health and Learning Disability and other statutory standards	Future service model	Number to be resettled 24 individuals	24 individuals	Number of Individuals resettled.	Head of Learning Disability RQIA Inspection Supported Living	1 year from residents be resettled
Quality of Accommodation/ Compliance with Legislative Requirements	Fit for Purpose Buildings which provide a safe and secure environment, makes full use of the space available and which offers	An accommodation support solution that provides a safe and secure environment that meets the needs of learning disability tenants	Ceri Davis Score – Longstone Hospital		Meets Health Building Notes Provides Safe and Secure Environment. Meets all legislative requirements.	Housing Executive Housing Provider	1 year from buildings being operational
			Condition	Ranking			
			Functional suitability	D			
			Space Utilisation	3			
			Energy Performance	B			
			Statutory Standards	C			
Physical Condition	C						
Accessibility	Improved physical accessibility to facility	The benefits of improving physical access to service and	DDA levels/Target compliance	compliance is 100%	DDA Audit Relatives/Staff	Housing Executive Housing	1 year from buildings being

Aim	Objective	Specific Indicator	Performance	Activity to Confirm Realisation	Lead Responsibility	Key Date for Realisation
		meeting compliance levels with statutory standards and responsibilities include improvements to resident environments and the quality of their resident every day experiences	Ongoing satisfaction survey to begin while still in old facility.	Satisfaction Surveys	Provider	operational
Accessibility	Facility located in close proximity to public transport networks and road infrastructure	The benefits of locating facility close to public transport networks will include reduced travel times	Distance from Public transport.	Ensure traffic impact assessment report is completed and outcomes from this considered and implanted where appropriate as the project evolves.	Head of Learning Disability	To be confirmed once approval date agreed
Accessibility	Facility located close to public amenities	Public amenities must be within close proximity to the centre.	Current accommodation is situated close to local amenities and town centre.	Measure distance from the new accommodation to public amenities	Head of Learning Disability	To be confirmed once approval date agreed
Staff Utilisation	Implement appropriate staffing and skill mix levels that enable staff to provide high standards of care.	Promote a person centred approach to supported living. To promote a single cohesive staff structure with better	Current Staffing levels will be used as a base line. Staff to resident ratios. Sickness and Absenteeism rates will be monitored.	Assessment and feedback from staff and service users as to the quality of the	Head of Learning Disability	1 year from buildings being operational

	Aim	Objective	Specific Indicator	Performance	Activity to Confirm Realisation	Lead Responsibility	Key Date for Realisation
		Continued use of existing integrated teams, AHP, Social Work and Nursing	utilisation of staff resources.	<p>Staff Turnover will be monitored.</p> <p>Established multi-disciplinary teams will continue to support residents.</p>	working environment and how it supports service adjacencies and sharing of space; a retrospective audit to assess if partnerships have materialised and the benefits arising from this.)		

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Appendix 1
Proposed Schedule of
Accommodation

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Housing Requirements

House 1	1 six bedded bungalow
House 2	1 three bedded bungalow
House 3	1 five bedded bungalow
House 4	1 five bedded bungalow
House 5	1 five bedded bungalow

6 bedded accommodation

Room Type
Entrance/porch
General Staff area
Bedroom x 6 and ensuites
WC
Assisted Bathroom
Quiet Room
Lounge/Quiet Room and Dinning/living area both with access through patio doors to safe outdoor area (with landscaping appropriate to needs)
Central Kitchen where meals will be prepared for all residents – also included within the central kitchen an area where residents can prepare a snack. Dining space to be included in kitchen.
Linen Store/Hot press
General Store
Utility Room/Sluice

3 bedded accommodation

Room Type
Entrance/porch
General Staff area
Bedroom x 3 and ensuites
WC
Assisted Bathroom
Quiet Room
Lounge/Quiet Room and Dinning/living area both with access through patio doors to safe outdoor area (with landscaping appropriate to needs)
Central Kitchen where meals will be prepared for all residents – also included within the central kitchen an area where residents can prepare a snack. Dining space to be included in kitchen.
Linen Store/Hot press
General Store
Utility Room/Sluice

5 bedded accommodation

Room Type
Entrance/porch
General Staff area
Bedroom x 5 and ensuites
WC
Assisted Bathroom
Quiet Room
Lounge/Quiet Room and Dinning/living area both with access through patio doors to safe outdoor area (with landscaping appropriate to needs)
Central Kitchen where meals will be prepared for all residents – also included within the central kitchen an area where residents can prepare a snack. Dining space to be included in kitchen.
Linen Store/Hot press
General Store
Utility Room/Sluice

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Appendix 2
Allied Health Professional
Staffing

AHP Staffing Requirements

The following table details AHP requirements to support the residents in the community.

Staff	WTE
Psychologist	0.5
Speech and Language Therapy	0.4
Podiatrist	0.2
Occupational Therapist	0.6
Occupational Therapist Assistant	0.4
Physiotherapist	0.5

Speech and Language Therapy

All 24 individuals to be re-settled that have been referred to our SLT will require:

1. Ongoing assessment/treatment/review/advice re Dysphagia management (eating/drinking difficulties) to minimise the risk of aspiration choking incidents and swallowing problems, and to make onward referrals as required
2. Communication programmes to be implemented involving individual assessment and treatment incorporating both individual therapy sessions and group therapy sessions.

Programmes to include:

- Intensive interaction
- Individualised sensory environment
- Improving and maintaining augmentative/alternative communication systems re Makaton signing, symbols, objects of reference, communication wallets/books/boards
- Picture Exchange Communication system
- Social Skills programmes
- Reminiscence work

- Expressive and receptive language work
3. Hearing Screening Assessments and reviews to be carried out to identify and hearing difficulties or reduction in hearing levels which could have a detrimental impact on communication and/or behaviour, with onward referrals being made as required.
 4. New environments to facilitate our residents communication abilities; this will include:
 - Symbolising the environment
 - Ensuring choice is available at resident's level re: choice boards at symbol/photographic/object level re food/drink/activities/personal care etc.
 - Ensuring information is accessible to our resident group following RQIA guidelines e.g. visual menus, visual schedules etc.
 5. Staff training will be imperative. Training will include:
 - Total Communication Training – promoting all forms of communication
 - Awareness Training re eating/drinking – to ensure all staff are aware of clinical signs/symptoms of aspiration and/or eating/drinking difficulties and know referral procedure
 - Facilitating Communication – general awareness training re hearing/environmental considerations
 - Makaton Training
 - Boardmaker/symbol training
 - Intensive Interaction Training
 - Individualised Sensory Environment Training
 - Picture Exchange Communication System (PECS) Training
 6. Staff will require ongoing support to implement and maintain programmes and will need assistance in ensuring all relevant information is shared with significant people. This will require the Speech & Language

Therapist supporting staff in compiling personal passports, communication wallets, hospital passports and using tools e.g. Talking Mats to clarify our residents' opinions, wants and wishes.

Occupational Therapy

Baseline assessments of the 24 individuals in Mourne, Donard and Sperrin who will be resettled into community location have identified the following needs:-

- Risk and environmental management both within home and community to promote development of appropriate day time activity (in relation to daily occupation) to facilitate social integration (24 individuals)
- Sensory issues (15 individuals)
- Development of personal care skills (12 individuals)
- Development of domestic skills (9 individuals)
- Prevocational skills development (4 individuals)

Ongoing sessions to support above needs would require 38 hours face to face weekly contact

With additional capacity for:-

- Additional assessments/monitoring
- Treatment planning and documentation
- Staff training and support
- Additional travel time

Providing face to face contacts across two weeks would allow additional activities above to be achievable in 37.5 hours of Band 6 OT. However in consideration of skill mix this could be more cost effective if modified to:-

0.6 WTE Band 6 OT

0.4 WTE Band 3 OT assistant

Physiotherapy

Provision of physiotherapy to individuals who are currently on site will be somewhat more difficult after resettlement. This aging population will benefit from a proactive health promoting physiotherapy service.

An additional 0.5 WTE band 6-7 physiotherapist would enable us to provide rehabilitation when required and to establish and deliver a continuous exercise and activity based health promotion programme for individuals. We would complete assessments of physical exercise and fitness needs and provide regular physical activity to enhance social integration. This would involve use of local fitness and leisure facilities including leisure centres, swimming pools, fitness suites, local parks and walks and provision of general physical activity.

Podiatry

Currently these individuals receive and require regular Podiatry treatment for a variety of interventions i.e.

- Annual Diabetic Assessment- (Crest Guidelines)
- P.V.D. Assessment
- Biomechanical Assessment- for orthotics and insoles
- Footwear Assessment-ongoing
- Nail Surgery
- Range of podiatric conditions –athletes foot, thickened nails, corns, callous, acute infections.

This more complex group require more time for treatments and training would be required for staff, carers and families to enable us to maintain mobility and encourage independence.

Therefore I recommend that an additional 0.2wte Band 6 Podiatrist would be required to maintain this level of care to these residents in a community setting.

LEVEL 3 Investment Proposal Template**REVENUE FUNDING £250k - £1m**

HSCB IPT Ref No	BC/SHSCT/368
Source of Funding (Year / ref)	Demographics SLCG 2014/15
Allocation value	£334,149 Cash FYE / £197,234 CYE Productivity £197,234 CYE/FYE
HSCB Representative name and contact details	Mr Iolo Eilian, Social Care Commissioner ████████████████████ ████████████████████
Trust Representative name and contact details	Francis Rice, Director of Mental Health and Disability Services / Executive Director of Nursing & AHPs
Project Title	POC6 – Learning Disability (Transitions)
Total Cost	£344,149
Start date	
Completion date	

Complete this section if bid is for new funding i.e. funding is not currently in the Trust baseline

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Yes
How much total funding required?	£344,149
How much funding required per year?	

Is this funding to be made recurrent?	
--	--


Complete this section if funding available within existing allocation i.e. funding is currently in the Trust baseline

Funding available within existing allocation (Y/N)	
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	

Is this business case	Y/N
(a) Standard	Y
(b) Novel	
(c) Contentious	
(d) Setting a precedent	
If "yes" to (b) or (c) or (d), requires Departmental & DFP approval	
Is Departmental / DFP approval required	

Approval & submission by Trust/s

This section to be completed by Trusts for all submissions

Prepared by (required)	
Name Printed Mr Miceal Crilly	(signed) 
Grade/ Title Acting Director of Mental Health and Disability	
Date July 2014	

<u>Trust Director of Finance Signature (required)</u>		
Name printed	Stephen McNally	(signed)
Date		
<u>Trust Chief Executive Signature (required)</u>		
Name printed	Mairead McAlinden	(signed)
Date		

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – required for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.

Approved by

Name printed (signed)

Grade / Title

Date

Approval of Investment Proposal Template by HSCB Director(s) / Chief Executive Officer – required for all submissions

<u>Responsible Director Signature (required)</u>		
Name printed	(signed)	
Grade / Title:		
<u>HSCB Director of Finance Signature (required)</u>		
Name printed:	Stephen McNally	(signed)

Date
<u>HSCB Chief Executive Signature</u> (required)
Name printed: Mairead McAlinden (signed)
Date

Approval of Investment Proposal Template by Commissioning Board (required for all submissions)

<u>Date approved by Commissioning Board</u>
Date

Complete this section if Department / DFP approval required

Date submitted to Department
Department/ DFP approval (y/n) N
Date approved

SECTION 1(a): Commissioner specification to include strategic context and need (to be completed by the Commissioner).

The Transition from school to adulthood is a time to celebrate, change and challenges for all young people. For many disabled young people having access to timely and comprehensive information, advice and guidance can be enough to help them reach their goals. For others, more support may be needed from a range of services to enable them reach their full potential. It is essential that joined up and comprehensive services are available throughout the transition process that will enable disabled young people to grow up and live the lives they want, to fully participate and be active members of their community.

Equal Lives (Sept 2005) highlights the need for commissioners and providers to ensure that the move from childhood to adulthood for young people with a learning disability supports their access to equal opportunities for continuing education, employment and training and that they and their families receive continuity of support during the transition period.

Transforming Your Care (2011) highlights the increasing population of young people with complex needs surviving into adulthood, who will require more complex care particularly during transition to adult services.

The Department of Health's "Transition Guide for All Services" (2007) recognizes that providers often struggle to provide timely support to young people with disabilities in transition to adult services as the range and availability of services locally may not always meet their needs and aspirations.

The DHSSPS Learning Disability Framework considers that "the manner in which young people are supported at the time of transition from adolescence to adulthood is a crucial component in determining the degree to which they are enabled to live full and valued lives in their communities" and suggests that many young people have unsatisfactory experiences during the move from school towards adulthood. In relation to transition plans for young people with learning disabilities, it sets a key performance indicator as the percentage of young people who express satisfaction that their transition plan has been implemented within 2 years of leaving school.

In 2014/15, the Southern Local Commissioning Group wish to direct demographic funding to address specific pressures in:

- a) The Transition of two complex individuals from Children to Adult Services during 2014/15.
- b) The recruitment of a Band 6 Transition Coordinator.

A total of £334,149 (FYE) / £197,234 (CYE) is available to the Southern Trust to deliver on this commissioning intent. Posts should be in place not later than 3 months from confirmation of funding.

A productivity target of £197,234 will be applied to the learning disability programme of care. The SLCG would request a productivity plan from the Trust detailing how this target will be achieved.

SECTION 1(b): DEMONSTRATE THE NEED FOR THE PROJECT

Transforming Your Care recognises the increasing number of young people with complex needs surviving into adulthood who require more complex care through transition from children's to adult services.

This investment will be used to support the smooth transition of 2 young people with complex needs into Adult Services and provide appropriate care and support to meet their long term needs in the Community.

The Trust recognises the importance of timely engagement at an early point in the transition process with carers and families in the development of personalisation agendas to provide appropriate and fitting care packages.

It is recognised that people with Learning Disabilities who have complex needs may at times throughout their lives require access to specialist health services. They may have a broad range of health needs that will often require additional services and support to those available from mainstream services, including primary and secondary health care.

Across the SHSCT a range of in-patient and specialist health supports services are in operation. These include Community Learning Disability Team, In-patient Assessment and Treatment Services, Epilepsy Service, Behaviour Support, Community Access, Day Opportunities, Forensic Services and Crisis Response. All these services are accessed by a single point of entry through the integrated Learning Disability Teams.

Following the Longstone Hospital Closure in March 2014 and the completion of the resettlement programme a range of approaches and specialist services were developed to provide support to people with learning disabilities that have complex support needs including those individuals with a dual diagnosis and associated challenging behaviours.

In-patient Assessment and Treatment Services transferred to Bluestone in June 2014 and in-patient beds were decreased from 15 to 10 with no hospital respite provision. Complex cases will therefore be required to be managed in a community setting which may be at a higher cost given our experience from the resettlement process. It is clear from the Equal Lives Policy that a hospital bed should not be someone's home.

It is therefore essential to capitalise on the skills and knowledge that providers have and look to work in partnership with them and Trust services to explore the development of more robust, community based and social care focused living options that can better support people with additional complex needs, who require longer term support in particular those with challenging behaviour who are not suited to community living.

Therefore it is essential to ensure that the high level of support packages provided to children who are transitioned to adult services with the same continued level of care in a community setting.

This funding will be used to further develop and enhance community support and cohesion throughout the transition process.

SECTION 2(a): OBJECTIVES

Project Objectives	Measurable Targets
1. Secure long term placements to support 2 very complex young people within the Community and prevent hospital admissions.	<ul style="list-style-type: none"> • Aim to transition one young person by the end of August 2014 • Aim to secure long term placement for a second young person by November 2014. • Successful placement of both individuals enabling Community based care.
2. Appointment of 1 x WTE Band 6 Transition Co-ordinator to enable earlier intervention by Adult Services to Young People in the transitions process.	<ul style="list-style-type: none"> • Appointment of 1 x WTE Band 6 Transition Co-ordinator by October 2014

SECTION 2(b): CONSTRAINTS

Constraints	Measures to address constraints
1. Availability of appropriate/suitable placements within the Community and the ability the maintain these.	<ul style="list-style-type: none"> - This constraint will be addressed through early engagement with providers and the involvement of Crisis Response and the Behaviour Support Team to assist with the transition.

SECTION 3: IDENTIFY AND SHORTLIST OPTIONS

Option Number/ Description	Shortlisted (S) or Rejected (R)	Reason for Rejection
1. Status Quo - continue with existing arrangements	S	
2. Transition of 2 complex individuals from Childrens to Adult Services and appointment of Band 6 Transition Co-ordinator as per Commissioner statement.	S	

SECTION 4: MONETARY COSTS AND BENEFITS OF OPTIONS

Option 1: Status Quo	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5 ..	Totals
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs							
Include details	28,884,996	28,884,996	28,884,996	28,884,996	28,884,996	28,884,996	173,309,976
(b) Total Revenue Cost	28,884,996	28,884,996	28,884,996	28,884,996	28,884,996	28,884,996	173,309,976
(c) Total Cost = (a) + (b)	28,884,996	28,884,996	28,884,996	28,884,996	28,884,996	28,884,996	173,309,976
(d) Disc Factor @ 3.5%pa	1.0000	.9662	.9335	.9019	.8714	.8420	
(e) NPC = (c) x (d)	28,884,996	27,908,683	26,964,144	26,051,138	25,170,386	24,321,167	159,300,514

COST ASSUMPTIONS:

(Expand as appropriate)

Baseline costs are LD Community Nursing and Social Work Teams, Statutory and Independent domiciliary care and direct payments and Independent nursing/residential beds from TFR 12-13 uplifted by 1.6% inflation to 13-14 pay & prices; and 2013-14 cost of Independent and Statutory supported living services.

Option 2: Demographic Development	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5 ..	Totals
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs							
Include details	28,884,996	28,884,996	28,884,996	28,884,996	28,884,996	28,884,996	173,309,976
Additional Revenue Costs							
Payroll	0	21,933	37,153	37,153	37,153	37,153	170,545
Goods and Services	0	175,301	296,996	296,996	296,996	296,996	1,362,285
(b) Total Revenue Cost	28,884,996	29,082,230	29,219,145	29,219,145	29,219,145	29,219,145	174,843,806
(c) Total Cost = (a) + (b)	28,884,996	29,082,230	29,219,145	29,219,145	29,219,145	29,219,145	174,843,806
(d) Disc Factor @ 3.5%pa	1.0000	.9662	.9335	.9019	.8714	.8420	
(e) NPC = (c) x (d)	28,884,996	28,099,251	27,276,072	26,352,747	25,461,563	24,602,520	160,677,149

COST ASSUMPTIONS:**(Expand as appropriate)**

Full detail of additional revenue costs and associated cost assumptions are included in Appendix 2

SECTION 5: NON MONETARY COSTS AND BENEFITS

Weighting method

			1 Status Quo		2 Transition of 2 complex individuals from Children's to Adult Services and appointment of Band 6 Transition Co-ordinator	
	Criterion	Weight	Score	Score x Weight	Score	Score x Weight
1	Compliance with strategic direction	30	5	150	9	270
2	Timely and earlier intervention to Young People and families during transition to identify appropriate community placement.	40	4	160	8	320
3	Improved multi-agency working	30	3	90	9	270
Totals				400		860
RANKING				2		1

Or Impact assessment

Rationale for weighting and scoring

Compliance with strategic direction- Option 2 scored the highest as the transition of 2 individuals with complex needs, through the support of a Transition Co-ordinator will better enable the Trust to adhere to strategic guidance such as 'Equal Lives (Sept 2005)', 'Transition Guide for All Services (2007)' and 'DHSSPS Learning Disability Framework'. Option 1 to maintain the status quo will not see any enhancement to Trust services and therefore will not enable adherence to strategic direction.

Timely and earlier intervention to Young People and families during transition to identify appropriate community placement.- Option 2 through enhanced transition processes and the establishment of a Transition Co-ordinator will better inform the timely development of appropriate care packages based within a Community setting. Option 1 will not enhance the appropriate and timely placement of individuals encouraging the move from Acute to Community care alongside the transition from Children's to Adult Services.

Improved multi-agency working – Option 2 through the over-arching role of the Transition Co-ordinator will, inherently, reassure the development of multi-agency working thereby enhancing community support throughout the transition process. Option 1 will maintain current working procedures and thereby will not result in any enhancement to multi-agency working which is necessary to ensure a smooth and cohesive transition process.

SECTION 6: ASSESS RISKS AND UNCERTAINTIES

Risk Description	Likely impact of Risk H/M/L		State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	
1. Allocation of Funding	N/A	M	<ul style="list-style-type: none"> Option 2 - If funding is not allocated in an appropriate and timely manner this will negatively impact the Trust's ability to ensure the transition and placement of 2 complex individuals within the Community and therefore may result in further hospital admissions. Mitigation – ensure forward planning in place close liaison with LCG regarding urgency of funding
2. Inability to appoint staff	N/A	M	<ul style="list-style-type: none"> Option 2 – inability to appoint 1 x WTE Band 6 Transition Co-ordinator may negatively impact/delay the ability to smoothly transition and ensure the placement of 2 complex individuals Mitigation - ensure forward planning in place and close liaison with HR regarding recruitment process
3. Availability of appropriate accommodation to meet the needs of each individual's personalisation agenda	N/A	M	<ul style="list-style-type: none"> Option 2 – Delays or difficulty may be experienced in the availability of appropriate and suitable accommodation as per personalisation agenda. This may result in hospital admissions or longer stays within an Acute setting. Mitigation – Earlier multi-agency engagement by Transition Co-ordinator to ensure the readiness and timely availability of accommodation
4. Breakdown of placement	N/A	M	<ul style="list-style-type: none"> Option 2 – As these individuals present with varying and particularly challenging behaviour there is a risk that placements may break down which could result in an Acute admission.

			Mitigation – Earlier intervention multi-agency intervention from for example Crisis Response to resolve break down issues.
Overall Risk (H/M/L):	N/A	M	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

The preferred option is Option 2: The Transition of two complex individuals from Children to Adult Services during 2014/15 and the recruitment of a 1 x WTE Band 6 Transition Coordinator.

There are currently 2 complex individuals in care :

- Client 'A' : who will requires placement in the community via a care package that best meets his needs in a nursing home or supported living unit at an estimated cost of £146,250
- Client 'B': who requires placement in the community via a care package that best meets his needs through the continuation and enhancement of Direct Payment and a placement in Ardaveen at an estimated cost of £145,670
The successful placement of these 2 individuals is essential to progress their transition from Children's to Adult Services.

As per strategic guidance, including; 'The Equal Lives Policy' (2005) and 'Transforming Your Care' (2011) care for these individuals should be provided within the Community setting thereby reducing inappropriate and unnecessary, often prolonged Acute hospital admissions.

The establishment of a Band 6 Transition Co-ordinator is therefore a fundamental role in the transition process by ensuring, aiding, enhancing and improving transition to ensure, not only, the transition/placement of 2 complex individuals but to work with all individuals progressing through the transition from Children's to Adult services.

Therefore Option 2 has been identified as the preferred option.

SECTION 8: ASSESS AFFORDABILITY AND FUNDING ARRANGEMENTS

	Yr 0	Yr 1	Yr 2	Yr 3	Totals
	£000's	£000's	£000's	£000's	£000's
Required:					
Capital	0	0	0	0	0
Resource	28,885	29,373	29,806	30,105	117,285
Existing Budget:					
Capital	0	0	0	0	0
Resource	28,885	29,174	29,466	29,760	117,285
Additional budget Required:					
Capital	0	0	0	0	0
Resource	0	199	340	345	883

Affordability narrative

[expand as necessary]

7 months additional budget requirements assumed in Yr. 1 – start date of September 2014.
 1% inflation assumed on recurrent requirements per annum from Yr. 1 – Yr. 3.
 Note: rounding's on the above values.

SECTION 9: PROJECT MANAGEMENT (Please see Benefits Realisation Plan in Appendix A)

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management. The following key roles have been identified:

Project Owner: Miceal Crilly, Acting Director of Mental Health and Disability Services

Project Director: Noreen McComiskey, Acting Assistant Director of Disability Services

Project Manager: Donna Curley, Head of Community Services for Adults with a Physical Disability

A review of this investment in relation to the stated objective will be undertaken in 12 months after full implementation.

A Benefits Profile is attached as Appendix A.

SECTION 10: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

				Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains
PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	I - Investment P - Productivity
N/A							

SECTION 11: MONITORING AND EVALUATION

As per Section 9 the named personnel will be:

Project Owner: Miceal Crilly, Acting Director of Mental Health and Disability Services

Project Director: Noreen McComiskey, Acting Assistant Director of Disability Services

Project Manager: Donna Curley, Head of Community Services for Adults with a Physical Disability

Target	Date to be achieved by (estimated)
Transition of 1 Young Person with complex needs	End of August 2014
Secure long term placement for 1 Young Person with complex needs	November 2014
Commence Recruitment of Transition Co-ordinator post	September 2014
Have post in place	October 2014

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

As per strategic direction including; 'Equal Lives (2005)' and 'Transforming Your Care (2011)', implementation of the preferred Option 2 will ensure Young People with complex needs are maintained within a Community environment with appropriate care packages in place.

Appendix A: Benefits Profile

- **Benefit Owner:** This is the name of the actual benefit owner, not the person responsible for reporting on it. This might be the SRO, but could also be someone else senior in the organisation;
- **Baseline Value:** The Baseline value can be estimated at OBC stage (This should be firmed up and accurate by the time the business case reaches FBC if applicable);
- **Target Value:** Insert the target value you hope to attain for the benefit
- **Measurement:** Explain how and when you hope to measure and report on the benefit;
- **Timing:** Details of how often you intend to report on the realisation of the benefits;
- **Responsibility:** Who has responsibility for measuring and reporting on the benefit.

For large expenditure decisions where FBC is required, i.e. >£1m, please complete the benefit profile as detailed at the following link:

http://www.dfpni.gov.uk/benefit_profile_template.doc

Revenue Expenditure £250k - £1m

Appendix 1 - Benefit Profile

Signed off by:	Date:
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Benefit Owner	Benefit	Baseline value	Target Value	Measurement	Timing	Responsibility
Noreen McCoomiskey (Acting) AD of Disability Services	Transition of 2 individuals with complex needs from Childrens to Adult Services	N/A	<ul style="list-style-type: none"> Transition 2 individuals 	N/A	<ul style="list-style-type: none"> 1 x August 2014 1 x November 2014 	Donna Curley, Head of Community Services for Adults with a Physical Disability
Noreen McCoomiskey (Acting) AD of Disability Services	Appointment of Band 6 Transition Co-ordinator	N/A	1 x WTE Band 6 Transition Co-ordinator	N/A	October 2014	Donna Curley, Head of Community Services for Adults with a Physical Disability

LEVEL 2 Investment Proposal Template

REVENUE FUNDING £50k - £250k

HSCB IPT Ref No	S3
Source of Funding (Year / ref)	<i>Funding identified in 2014/15 Financial Plan</i>
Allocation value	£0.136m FYE; (CYE = £0.034m). CYE 14/15 has been received. The Trust only seeks the FYE of £136k for 15/16.
HSCB Representative name and contact details	Aidan Murray, Assistant Director of mental health & Learning Disability Aidan.murray@hscni.net 02895363003
Trust Representative name and contact details	Noreen McComiskey, Assistant Director of Learning Disability Services Noreen.mccomiskey@southerntrust.hscni.net
Project Title	SHSCT Learning Disability Community Infrastructure 2014/15,
Total Cost	An indicative FYE amount of £0.136m is available for 2015/16 (CYE 14/15= £0.034m). CYE 14/15 of £34k has already been received and therefore this IPT is only seeking to secure the FYE of £136k for 2015/16
Start date	1 st April 2014
Completion date	31 st March 2015

Complete this section if bid is for new funding i.e. funding is not currently in the Trust baseline

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	YES
How much total funding required?	An indicative FYE amount of £0.136m is

	required for 2015/16 (CYE = £0.034m). IPT seeks to secure the FYE of £136k with effect from 1 st April 2015.
How much funding required per year?	See above
Is this funding to be made recurrent? (Y/N)	YES

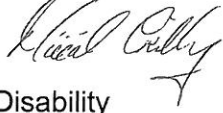
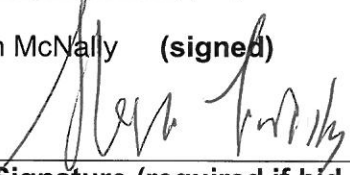
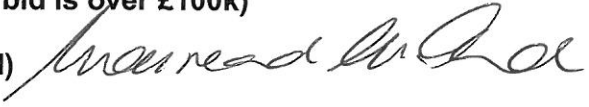
Complete this section if funding available within existing allocation i.e. funding is currently in the Trust baseline

<i>Funding available within existing allocation (Y/N)</i>	
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	

<i>Is this business case</i>	Y/N
<i>(a) Standard</i>	YES
<i>(b) Novel</i>	
<i>© Contentious</i>	
<i>(d) Setting a precedent</i>	
<i>If yes to (b) or (c) or (d) , requires Departmental & DFP approval</i>	
<i>Is Departmental / DFP approval required</i>	

Approval & submission by Trust

This section to be completed by Trusts for all submissions

<u>Responsible Director Signature</u> (required for all submissions)		
Name Printed	Miceal Crilly	(signed) 
Grade/ Title	Acting Director of Mental Health and Disability	
Date:	12 February 2015	
<u>Trust Director of Finance Signature</u> (required if bid is over £100k)		
Name printed	Stephen McNally	(signed) 
Date	13/2/15	
<u>Trust Chief Executive Signature</u> (required if bid is over £100k)		
Name printed	Mairead McAlinden	(signed) 
Date	16/2/15	

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – required for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.

Approved by

Name printed (signed)

Grade / Title

Date

Approval of Investment Proposal Template by HSCB Director(s) and/or Chief Executive

Director Signature (required for all bids)

Name printed (signed)

Grade / Title

Date

HSCB Director of Finance Signature (required if bid is over £100k)

Name printed (signed)

Date

HSCB Chief Executive Signature (required if bid is over £100k)

Name printed (signed)

Date

Approval of Investment Proposal Template by Commissioning Board (required if bid is over £100k)

Date of approval at Commissioning Board

Date

Complete this section if Department / DFP approval required

Date submitted to Department

Department/ DFP approval (y/n)

Date approved

SECTION 1: Commissioner specification to include strategic context and need (to be completed by the Commissioner)

SHSCT Learning Disability Community Infrastructure

As outlined in the HSCB Commissioning Plan, and in accordance with the principles of Citizenship and Human Rights enjoyed by all, people with a learning disability are entitled to live in their own homes in the community with a range of support services to meet their assessed needs.

In line with the Commissioning Plan Direction and Transforming Your Care, the HSCB seeks to ensure that no-one with a learning disability should be living in hospital by March 2015. It is essential therefore that, in addition to the on-going resettlement programme from hospitals, Trusts should take all necessary action to prevent the admission of people to hospital due to the possibility of breakdown of their residential placements in the community.

The Trusts are now invited to submit proposals aiming at enhancing the capacity of community learning disability teams and associated specialist services to:

- Prevent inappropriate hospital admissions and ensure that all discharges from hospital take place no more than 28 days from the fit for discharge date as required under the 2013/2014 Commissioning Plan Direction (DHSSPS).
- To develop services that can respond outside of the traditional 9-5 Monday to Friday model.
- Develop step up/step down facilities where people may be accommodated on a short term, time limited basis in order to de-escalate placement problems, provide a period of intensive support or provide respite for carers.
- Develop a model of in reach services to support individuals remain in the community when family and/or carers are under significant strain.

The HSCB had advised the Trust in 2013/14 of its indicative funding allocations for learning disability services in 2013/14 and 2014/15. Trust proposals should therefore incrementally reflect service developments over this period.

An indicative FYE amount of £0.136m is available for 2015/16 (CYE 14/15 = £0.034m). CYE has already been received.

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. Offering individuals with learning disabilities an enhanced infrastructure in the community which meets their needs providing them with betterment.	To further increase the number of successful community placements, reduce the number of delayed discharges.
2. To work towards targets and strategic direction as outlined in: <ul style="list-style-type: none"> • Transforming Your Care • Bamford Action Plan • Commissioning Plan • Ministerial PfA targets. 	The numbers of learning disability clients in hospital, resettled, community placements etc will assist in evidencing meeting with strategic direction.

SECTION 2 (b) : CONSTRAINTS

<p>The following constraints must be considered in line with this investment;</p> <ul style="list-style-type: none"> • The availability of suitable community placements which meet with the needs of learning disability clients. The Trust will continually evaluate the availability and suitability of placements with a view to successful resettlement and discharge. • If funding was unsuccessful, the ability for the SHSCT to meet specific ministerial targets for discharge from hospital and resettlement may be compromised. • The timeframe as outlined in the commissioning plan and Transforming Your care indicates that there should be no patients in long stay learning disability hospitals by March 2015 is imminent and every effort is being taken to work towards this.
--

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	<p>Status Quo - continue with existing arrangements.</p> <p>This option would involve no change to current service delivery to learning disability clients nor see any additional investment provided this year for the service.</p>

<p>2</p>	<p>Develop an enhanced community infrastructure for learning disability clients via recruitment of additional staff.</p> <p>It would be anticipated to appoint the following staff would be appointed to work within Crisis Response and further develop the Home Treatment team;</p> <table border="1" data-bbox="320 416 1099 521"> <thead> <tr> <th>WTE</th> <th>Band</th> <th>Post</th> </tr> </thead> <tbody> <tr> <td>1.0</td> <td>Band 5</td> <td>Nurse</td> </tr> <tr> <td>4.3</td> <td>Band 3</td> <td>Support Workers</td> </tr> </tbody> </table> <p>This option builds upon the work carried out in previous years to develop services in the community for individuals with a learning disability. The investment would include enhancement of;</p> <ul style="list-style-type: none"> • Developing community teams to help prevent hospital admission, facilitate discharge and to manage and support those resettled in the community. • Offer a direct response into the clients own home or facility to help maintain placements thus minimising the risk of breakdown in packages. • Skill mix within the Crisis response team through appointment of Band 3's and Band 5 to provide support to the multi-disciplinary integrated team. 	WTE	Band	Post	1.0	Band 5	Nurse	4.3	Band 3	Support Workers
WTE	Band	Post								
1.0	Band 5	Nurse								
4.3	Band 3	Support Workers								
<p>3</p>	<p>Procure and purchase care and support packages from the independent/private sector.</p> <p>This would involve the purchase of care for SHSCT learning disability clients to be provided from the independent and private sector organisations.</p>									

SECTION 4: PROJECT COSTS - Finance to complete

Option	Year 1 (£'000)	Year 2 (£'000)	Year 3 (£'000)	Total (£'000)
1. Status Quo - continue with existing arrangements	29,511	29,806	30,105	89,422
2. Develop an enhanced community infrastructure for learning disability clients via recruitment of additional staff	136	137	139	412
3 Procure and purchase care and support packages from the independent/private sector	136	137	139	412

COST ASSUMPTIONS:

Year 1 is 15/16 and is Full Year Effect costs for all options.

All Costs are from the HSCB Costing template and include 10% Goods & Services..

1% inflation on costs has been assumed.

Recurring baseline revenue costs are the in year 14/15 Budgeted costs for Learning Disability community services.

Option 3 will cost the same as Option 2.

SECTION 5: NON-MONETARY BENEFITS

The non-monetary benefits associated with this investment are;

- To provide support to individuals to enable them to live in an environment that as far as possible reflects general home living.
- Offering a whole life care option that minimises the possibility of re-admission to hospital by appropriately managing risk.
- Offering the individual a range of services which supports community living, social inclusion and better health and wellbeing.
- To meet with strategic direction as outlined in Transforming Your Care, Bamford Action Plan, Ministerial PfA targets and Commissioning Plan.

SECTION 6: PROJECT RISKS & UNCERTAINTIES

There remains a possibility that the SHSCT could always have delayed hospital discharges or admissions for learning disability clients to hospital. This can be due to many factors including new clients moving to the area, deterioration in current clients health and insufficient community placements available in the future. This risks are being mitigated by forward planning, and more regular assessments and evaluation of clients.

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

The preferred option for this investment is **Option 2 Develop an enhanced community infrastructure for learning disability clients via recruitment of additional staff.** This option has been selected as the

preferred option as;

- It builds upon work already carried out within the SHSCT to enhance the community infrastructure for learning disability clients.
- Support in the community will help to ensure that resettlement placements are effective, reducing breakdown and possible re-admission to hospital.
- Enhancing community infrastructure promotes local community integration and social inclusion for clients.
- Meets with Strategic direction as outlined within Transforming Your Care, Bamford Action Plan, Ministerial Pfa targets and the Commissioning Plan.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS – Finance to Complete

AFFORDABILITY STATEMENT	Yr 0 £000's	Yr 1 £000's	Yr 2 £000's	Yr 3 £000's	Totals £000's
Required					
Capital required					
Revenue required	29,253	29,649	29,945	30,245	119,092
Existing budget :					
Capital					
Revenue	29,219	29,511	29,806	30,105	118,641
Additional Allocation Required:					
Capital					
Revenue	34	137	139	140	450

AFFORDABILITY ASSUMPTIONS

Year 0 is 14/15 and shows current year effect, already received.

Recurring baseline revenue costs are the in year 14/15 Budgeted costs for Learning Disability Community Services.

1% Inflation is assumed for years 1 to 3.

SECTION 9: MANAGEMENT ARRANGEMENTS

Miceal Crilly, Acting Director of Mental Health and Disability, supported by Heads of Service and

Scheme Managers will oversee the management of this investment. This will take the form of regular communication via reporting, meetings and monitoring.

SECTION 10: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains
				Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	
Acute	Gen Surgery	Vascular	FCE	1200	500	2000	I - Investment P - Productivity

SECTION 11: MONITORING AND EVALUATION

Who will manage the implementation?	Mrs Noreen McComiskey, Acting Director of Disability Services will be the Project Owner. Mrs McComiskey will be supported by relevant Heads of Service and Scheme Managers – all of whom will report as necessary to Mr Miceal Crilly, Acting Director of Mental Health and Disability.
Who will monitor and evaluate the outcomes?	The monitoring and evaluation of the outcomes as a result of this investment will be carried out by Mrs Noreen McComiskey, Acting Director of Disability Services. Information from the Crisis Response Team on referrals, interventions etc will be provided and activity recorded is reviewed against the statement of purpose. Admission and discharges to the Dorsy Unit, Bluestone are reviewed regularly.
What other factors will be monitored and evaluated?	
When will this take place?	This reporting will take place monthly

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

The preferred option is to enhance community infrastructure for learning disability clients through processes which include resettlement of long stay clients and delayed discharge patients to the community, along with developing services that are responsive, and timely. These factors are outlined and supported in strategic direction as detailed in Transforming Your Care, the Commissioning Plan, Ministerial Pfa targets and the Bamford Action plan.

LEVEL 2 Investment Proposal Template

REVENUE FUNDING £50k - £250k

HSCB IPT Ref No	S1
Source of Funding (Year / ref)	<i>Funding identified in 2014/15 Financial Plan</i>
Allocation value	<i>FYE = £0.085m plus £0.085m = £0.170m</i> <i>CYE = £0.0m</i>
HSCB Representative name and contact details	Aidan Murray, Assistant Director of mental health & Learning Disability [REDACTED] [REDACTED]
Trust Representative name and contact details	Noreen McComiskey, Assistant Director of Learning Disability Services [REDACTED]
Project Title	SHSCT - Resettlement of Learning Disability PTL and Delayed Discharge (DD) patients in 2014/15
Total Cost	<i>FYE = £0.085m plus £0.085m = £0.170m</i> <i>CYE = £0.0m</i>
Start date	1 st April 2014
Completion date	31 st March 2015

Complete this section if bid is for new funding i.e. funding is not currently in the Trust baseline

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Yes
How much total funding required?	<i>FYE = £0.085m plus £0.085m = £0.170m</i> <i>CYE = £0.0m</i>
How much funding required per year?	<i>As above</i>

Is this funding to be made recurrent?	Yes
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<i>Is this business case</i>	<i>Y/N</i>
<i>(a) Standard</i>	<i>Yes</i>
<i>(b) Novel</i>	
<i>© Contentious</i>	
<i>(d) Setting a precedent</i>	
<i>If yes to (b) or (c) or (d) , requires Departmental & DFP approval</i>	
<i>Is Departmental / DFP approval required</i>	

Approval & submission by Trust

This section to be completed by Trusts for all submissions

<p><u>Responsible Director Signature (required for all submissions)</u></p> <p>Name Printed Mr Miceal Crilly (signed)</p> <p>Grade/ Title Acting Director of Mental Health and Disability Services</p> <p>Tel: ██████████</p> <p>Date</p>
<p><u>Trust Director of Finance Signature (required if bid is over £100k)</u></p> <p>Name printed Mr Stephen McNally (signed)</p> <p>Date</p>
<p><u>Trust Chief Executive Signature (required if bid is over £100k)</u></p> <p>Name printed Mrs Mairead McAlinden (signed)</p> <p>Date</p>

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – required for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.

Approved by

Name printed (signed)

Grade / Title

Date

Approval of Investment Proposal Template by HSCB Director(s) and/or Chief Executive

Director Signature (required for all bids)

Name printed (signed)

Grade / Title

Date

HSCB Director of Finance Signature (required if bid is over £100k)

Name printed (signed)

Date

HSCB Chief Executive Signature (required if bid is over £100k)

Name printed (signed)

Date

Approval of Investment Proposal Template by Commissioning Board (required if bid is over £100k)

Date of approval at Commissioning Board

Date

Complete this section if Department / DFP approval required

Date submitted to Department

Department/ DFP approval (y/n)

Date approved

SECTION 1: Commissioner specification to include strategic context and need (to be completed by the Commissioner)

The Commissioning Plan Direction and Transforming Your Care require that there should be no long-stay patients in learning disability hospitals by March 2015. This is also a Ministerial and Departmental policy. The key stakeholders are the Department of Health, Social Services and Public Safety, The Health & Social Care Board, Health and Social Care Trusts, the Housing Executive, Housing Associations and the Voluntary Sector. Since 2011/12, the HSCB has been operating a Community Integration Project to achieve the target that there should be no long-stay patients in learning disability hospitals by March 2015

The ultimate goal of the Community Integration Programme is to improve the quality of life for those with learning disabilities by providing a range of services that will support personal choice; move away from a service-led to needs-led approach and challenge and change mind-sets that may affect the individual's potential to become an integral and valued member of their community.

Proposals should be drawn up by Trust for provision of a range of accommodation with support in the community to meet the needs of 1 PTL long stay hospital patient and 2 delayed discharge hospital patients. The accommodation should be planned and developed in partnership with the NIHE, Housing Associations and the voluntary sector. Proposed schemes should make full use of the Supporting People Programme where possible.

The FYE indicative funding available for the 1 PTL long stay hospital patient is £0.085m (CYE = £0.0m)

The FYE indicative funding available for the 2 delayed discharge patients is £0.085m (CYE = £0.0m). The FYE indicative funding of £0.085m is for 1 of the 2 delayed discharge patients and this reflects that the Trust has already received £0.085m FYE funding for the other named delayed discharge patient in 2013/14 under the heading 'New delayed discharges, 12 months or more before 31st March 2012'.

Note: Board Finance Officers will continue to meet with Trust Finance Officers and Trust Service Officers in 2014/15 and 2015/16 to confirm the actual FYE funding requirement for 2014/15 resettlements up to 31st March 2015. This on-going process will also determine the overall FYE requirements for the whole resettlement programme (2011/12 to 2014/15).

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. Resettle 1 PTL long stay hospital patient and 2 delayed discharge hospital patients to the community.	1.1 This PTL is the last remaining patient the Southern Trust needs to resettle to the community. 1.2 These 2 remaining Delayed Discharges will complete the resettlement agenda for the Southern Trust under the criteria for DD
2. To provide suitable alternative community placements for delayed discharge patients which meets the individuals collective needs and provides a greater quality of life and betterment.	2.2 The resettlement of 1 PTL long stay hospital Patient and 2 delayed discharge hospital patients to suitable placements in the community.
3. To meet with strategic direction in terms of Transforming your care and the requirement that there should be no long-stay patients in learning disability hospitals by March 2015.	3.3 When these 3 patients are successfully discharged to the community the Resettlement process for the Southern Trust LD population in long stay hospital will be complete

SECTION 2 (b) : CONSTRAINTS

<p>The following constraints must be considered in line with this investment;</p> <ul style="list-style-type: none"> • The availability of suitable community placements which meet with the needs of individuals identified for resettlement and discharge. The Trust will continually evaluate the availability and suitability of placements with a view to successful resettlement and discharge. • Deterioration of individual’s health which may prevent or further delay resettlement or discharge. • New individuals being admitted/re-admitted with complex/challenging needs. To mitigate this risk the staff will provide more regular assessments and evaluation of patients with a view to preventing admission where possible and maintain individuals in their own homes. The Trust has recently established a Crisis Response/Home Treatment Team in Adult Learning Disability which should also help prevent admissions to hospital and enable patients to be cared for in their own homes. • The timeframe as outlined in the commissioning plan and Transforming Your care indicates that there should be no patients in long stay learning disability hospitals by March 2015 is imminent and every effort is being taken to work towards this.

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION																				
1	<p>Status Quo - continue with existing arrangements</p> <p>This option involves the continuation of services within current accommodation and there would be no change to the delivery and type of care given to these patients. The 1 long stay patient and delayed discharge patient would remain in care as they currently exist.</p>																				
2	<p>Placement in private or statutory nursing homes</p> <p>This option would see learning disability individuals, long stay and delayed discharge patients placed in a private nursing home. There would be the requirement for consideration to be given as to whether the facilities have staff which are suitably trained to care for learning disability individuals and the compatibility of clients already resident in these facilities.</p>																				
3	<p>To resettle 1 long stay patient and 2 delayed discharge patients in the community</p> <p>This option would involve the long stay and delayed discharge patients being resettled to a placement in the community setting as outlined below;</p> <table border="1" data-bbox="316 1037 1364 1482"> <thead> <tr> <th data-bbox="316 1037 512 1111">Identifier</th> <th data-bbox="512 1037 815 1111">Cost of Placement per Week</th> <th data-bbox="815 1037 1139 1111">Cost of Placement per Annum</th> <th data-bbox="1139 1037 1364 1111">Placement</th> </tr> </thead> <tbody> <tr> <td data-bbox="316 1111 512 1375">PC</td> <td data-bbox="512 1111 815 1375">Currently detained in Dorsy – no plans to discharge until he is medically fit</td> <td data-bbox="815 1111 1139 1375">Funds already received from Board via baseline as he was resettled to Seeconnell, however following a serious assault was re-admitted to Dorsy</td> <td data-bbox="1139 1111 1364 1375"></td> </tr> <tr> <td data-bbox="316 1375 512 1413">PN</td> <td data-bbox="512 1375 815 1413">£1634</td> <td data-bbox="815 1375 1139 1413">£85,000</td> <td data-bbox="1139 1375 1364 1413">Ardaveen</td> </tr> <tr> <td data-bbox="316 1413 512 1451">GH</td> <td data-bbox="512 1413 815 1451"></td> <td data-bbox="815 1413 1139 1451"></td> <td data-bbox="1139 1413 1364 1451">TBC</td> </tr> <tr> <td data-bbox="316 1451 512 1482">Total</td> <td data-bbox="512 1451 815 1482"></td> <td data-bbox="815 1451 1139 1482">£170K</td> <td data-bbox="1139 1451 1364 1482"></td> </tr> </tbody> </table>	Identifier	Cost of Placement per Week	Cost of Placement per Annum	Placement	PC	Currently detained in Dorsy – no plans to discharge until he is medically fit	Funds already received from Board via baseline as he was resettled to Seeconnell, however following a serious assault was re-admitted to Dorsy		PN	£1634	£85,000	Ardaveen	GH			TBC	Total		£170K	
Identifier	Cost of Placement per Week	Cost of Placement per Annum	Placement																		
PC	Currently detained in Dorsy – no plans to discharge until he is medically fit	Funds already received from Board via baseline as he was resettled to Seeconnell, however following a serious assault was re-admitted to Dorsy																			
PN	£1634	£85,000	Ardaveen																		
GH			TBC																		
Total		£170K																			

SECTION 4: PROJECT COSTS

Option	Year 1 (£'000)	Year 2 (£'000)	Year 3 (£'000)	Total (£'000)
1. Status Quo - continue with existing arrangements	323	326	329	978
2 Placement in private or statutory nursing homes	170	172	173	515
3 Resettle learning disability client and delayed discharge clients in the community	170	172	173	515

COST ASSUMPTIONS:

It is assumed that the investment of £170,000 will adequately cover the cost of the resettlement of 1 long stay patient and 1 delayed discharge patient. This does not take into account any requirements which may be associated with deterioration in patient health and wellbeing which can increase the level of care needed for these individuals.

Option 3 is the combined total of £85k for 1 Long Stay Patient and £85k for 1 delayed discharge patient. Total of £170k.

At present GH, Muckamore is refusing to allow the SHSCT to share his information with potential providers. The Trust is liaising with DLS regarding this. However the SHSCT is of the opinion that the costs will be in excess of £85K per annum.

Status Quo funding is based on the 2013-14 TFR In-patient bed cost for 'Mental Handicap – Adults – Long Stay', increased by 1.6% for pay and prices to provide a 2014-15 annual baseline cost per bed of £159,832.

1% inflation is assumed on additional years.

Year 1 is 15/16. Costs in this year are Status Quo costs uplifted by 1% for Inflation.

SECTION 5: NON-MONETARY BENEFITS

The non-monetary benefits associated with this investment are;

- Provision of a permanent whole life care option that minimises the possibility of re-admission to hospital.

- Promote improved health and social wellbeing through community based service provision.
- Increase social inclusion, with greater access to the community, family and carers.
- Enhance human rights of dignity, privacy, choice and family life.
- Deliver person centred, individualised care with reflects family and community ties, personal interests and hopes for the future.
- Provision of a living environment that reflects general home living i.e warm, clean, homely, safe and secure.
- Meets strategic direction recommendations.

SECTION 6: PROJECT RISKS & UNCERTAINTIES

In working towards the resettlement of all long stay patients and delayed discharge it is potential risk that there may be new admissions/readmissions to hospital, this could be the result of a new learning disability patient moving into the area or deterioration in health of a patient which could result in further delay.

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 3 – To resettle 1 long stay patient and 1 delayed discharge patient in the community is the preferred option as it is expected that the placement will offer an improved quality of life and betterment for the patient. It also offers the opportunity to move away from historic ‘institutional’ type care. This option will assist the Trust in working towards it PfA target for resettlement and is in keeping with strategic direction.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Yr 0	Yr 1	Yr 2	Yr 3	Totals
	£000's	£000's	£000's	£000's	£000's
Required					
Capital required					
Revenue required	320	493	498	503	1,813
Existing budget:					
Capital					
Revenue	320	323	326	329	1,298
Additional Allocation Required:					
Capital					
Revenue	0	170	172	173	515

AFFORDABILITY ASSUMPTIONS

Yr. 0 (2014-15) used as baseline and 1% inflation assumed on recurrent requirements per annum for Yrs. 1, 2 and 3.



SECTION 9: MANAGEMENT ARRANGEMENTS

Miceal Crilly, Acting Director of Mental Health and Disability, supported by Heads of Service and Scheme Managers will oversee the management of this investment. This will take the form of regular communication via reporting, meetings and monitoring.

SECTION 10: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

				Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains
PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	I - Investment P - Productivity

SECTION 11: MONITORING AND EVALUATION

Who will manage the implementation?	Mrs Noreen McComiskey, Acting Director of Disability services will be the Project Owner. Mrs McComiskey will be supported by relevant Heads of Service and Scheme Managers – all of whom will report as necessary to Mr Miceal Crilly, Acting Director of Mental Health and Disability.
Who will monitor and evaluate the outcomes?	The monitoring and evaluation of the outcomes as a result of this investment will be carried out by Mrs Noreen McComiskey, Acting Director of Disability Services.
What other factors will be monitored and evaluated? –	<p>This will take the form of reporting via specialist letters which are place with the provider, clearly identifying the requirement to report to the keyworker on staff inputs etc. Annual contract meetings with the provider are also held.</p> <p>For resettlement, quality of life questionnaires are completed at 3 months, 6 months and 12 months, followed then by an annual review. In addition to this each client resettled has been offered the services of an independent advocate.</p>
When will this take place?	As above

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

The preferred option to resettle long stay and delayed discharge patients to the community is outlined in Strategic Direction as detailed in Transforming Your Care, Commissioning Plan.

LEVEL 3 Investment Proposal Template**REVENUE FUNDING £250k - £1m**

HSCB IPT Ref No	BC/SHSCT/403
Source of Funding (Year / ref)	Demographics SLCG 2015/16
Allocation value	£ 354,500 FYE / £31,000 CYE
HSCB Representative name and contact details	Mr Iolo Eilian, Social Care Commissioner ████████████████████ ████████████████████
Trust Representative name and contact details	Mr Francis Rice, Director of Mental Health and Disability Services
Project Title	POC6 – Learning Disability (Transition & Community Team Pressures)
Total Cost	£354,500 FYE / £31,000 CYE (only 9 months Band 6 Transition team for CYE)
Start date	
Completion date	

Complete this section if bid is for new funding i.e. funding is not currently in the Trust baseline

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Yes
How much total funding required?	£354,500 FYE / £31,000 CYE (only 9 months Band 6 Transition team for CYE)
How much funding required per year?	£354,500 FYE / £31,000 CYE (only 9 months Band 6 Transition team for CYE)
Is this funding to be made recurrent?	Yes

Complete this section if funding available within existing allocation i.e. funding is currently in the Trust baseline

Funding available within existing allocation (Y/N)	
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	

Is this business case	Y/N
(a) Standard	
(b) Novel	
(c) Contentious	
(d) Setting a precedent	
If "yes" to (b) or (c) or (d), requires Departmental & DFP approval	
Is Departmental / DFP approval required	

Approval & submission by Trust/s

This section to be completed by Trusts for all submissions

<u>Prepared by (required)</u>	
Name Printed: Francis Rice	(signed)
Grade/ Title: Director of Mental Health & Disability Services/ Executive Director of Nursing and AHPs	
Date	
<u>Trust Director of Finance Signature (required)</u>	
Name printed: Stephen McNally	(signed)
Date	
<u>Trust Chief Executive Signature (required)</u>	
Name printed: Paula Clarke	(signed)
Date	

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – required for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.

Approved by

Name printed (signed)

Grade / Title

Date

Approval of Investment Proposal Template by HSCB Director(s) / Chief Executive Officer – required for all submissions

Responsible Director Signature (required)

Name printed (signed)

Grade / Title

Date

HSCB Director of Finance Signature (required)

Name printed (signed)

Date

HSCB Chief Executive Signature (required)

Name printed (signed)

Date

Approval of Investment Proposal Template by Commissioning Board (required for all submissions)

Date approved by Commissioning Board

Date

Complete this section if Department / DFP approval required

Date submitted to Department

Department/ DFP approval (y/n)

Date approved

SECTION 1(a): Commissioner specification to include strategic context and need (to be completed by the Commissioner).

People with learning disabilities have a variable range of health and social care needs and often experience greater health and wellbeing inequalities than the general population and can experience difficulty in accessing services. They are also at risk of social exclusion, affecting their quality of life through exclusion from employment, relationships and other life opportunities. People with learning disabilities are now living longer thanks to the medical advancements in their care and as a result there is therefore an increase in numbers and complexities. Both Transforming Your Care and the DHSSPS Learning Disability Service Framework highlight the needs of the increasing numbers of young people with complex needs surviving into adulthood and the importance of the right support at transition stage to adult services focusing on promoting their independence through use of supported living and day opportunities models.

In 2013/14 there were 2,123 people identified on the Southern LCG GP Practice registers for learning disability, and it is expected that there will be at least 50 young people who will transition into adult learning disability services during 2015/16.

The SLCG and SHSCT have made significant progress in the completion of the resettlement programme, with the closure of Longstone Hospital in March 2014 and the transfer of In-patient Assessment and Treatment Services to Bluestone in June 2014. However, in line with the HSCB/PHA Commissioning direction to continue to work with the Regional Bamford Team to support the shift from hospital based services to community services regionally, has added to the local pressures within the specialist Assessment & Treatment Unit in Bluestone and subsequently on the local community learning disability services.

In 2015/16, the southern Local Commissioning Group wish to direct demographic funding of £354,500 to address specific pressures identified by the SHSCT.

- a) Provision of support for high cost packages in transition to adult services estimated at £165,000. (This is in addition to a regional allocation of £768,400 for high cost packages)
- b) Enhancement to the existing Transition Team with a Band 6 Transition Post (Est. £41,133)
- c) Enhancement to the existing Community Team to address pressures due to resettlement of non-Trust clients in the Southern area (Est. £85,823)
- d) To continue to develop the Day Opportunities following the endorsement of the Learning Disability Day Opportunities Model in 2014 (£62,544)

A total of £354,500 (FYE) /£31,000 (CYE) is available to the Southern Trust to deliver on this commissioning intent. Posts should be in place not later than 3 months from confirmation of funding.

SECTION 1(b): DEMONSTRATE THE NEED FOR THE PROJECT**Introduction:**

It is recognised that the transition period from childhood to adulthood for those with a Learning Disability is a particularly significant time in their lives, which for the young person, can impact greatly on determining the degree of which they are enabled to live their lives to the fullest.

A number of strategic documentation including:

Transforming Your Care 2011
 Department of Health – Transition Guide for all services 2007
 Equal Lives 2005
 DHSSPSNI Learning Disability Framework
 Bamford Review

recognise how essential it is for Trusts to ensure smooth transition for young people with a learning disability into adult services. The need to provide support which is timely and personalised along with providing a range of opportunities including social, leisure, and educational remains challenging for the Trust.

The Trust continues to witness a significant increase in complexity of young adults with a Learning Disability in transition. Coupling this with the increase in birth rate within the area over the last 20 years continues to put pressure on existing resources in both children's and disability services. In some cases, the needs being presented cannot be met within the current range of available services and it is therefore essential that a wider range of opportunities are created, which are based on assessed and personalized needs.

A. Provision of support for high cost packages in transition to adult services estimated at £165,000.

Transforming Your Care recognises the increasing number of young people with complex needs surviving into adulthood who require more complex care through transition from children's to adult services.

The Trust recognises the importance of timely engagement at an early point in the transition process, with carers and families, in the development of personalisation agendas to provide appropriate and fitting care packages to meet their individual needs.

It is recognised that people with Learning Disabilities who have complex needs may at times throughout their lives require access to specialist health and/or care services. They may have a broad range of health and/or social care needs that will often require additional services and support to those available from mainstream services, including primary and secondary health care.

Proposal:

This investment will be used to support the smooth transition of 3 young people with complex needs into Adult Services and provide appropriate care and support to meet their long term needs in the Community.

There are currently 3 young people in care who this investment will support:

- Client A: Is an 18 year old male, currently residing in Glenraig. Client A has autism and challenging behaviours. Client A has been assessed for placement in Seaconnell requiring 24 hour specialist residential care including day opportunities. (£1,700 per week x 52 = £88,400 per annum)

- Client B: Is an 18 year old female, currently residing at home with her parents. Client B has been diagnosed with bi-polar illness and experiences acute bi-polar episodes. Client B requires 24 hours of Direct Payment at £320.16 per week (£320.16 per week x 52 weeks= £16,648) and 7.5 weeks respite care (7.5 weeks x £1750 = £13,125)
- Client C: Is an 18 year old male, who until recently resided at home with his mother. Client C has mild Learning Disability, Autism and presents with challenging behaviour. Due to on-going behavioural issues Client C is now an occupant of Praxis Accommodation. It proposed to use the remaining £46,827 from this allocation towards providing care through the transition process to Client C. Estimated care package costs for Client C are £60,000, the Trust intend to fund the outstanding requirement from regional allocation for high cost packages.

B. Enhancement to the existing Transition Team with a Band 6 Transition Post £41,133

The SHSCT seeks to ensure that young people in transition to adulthood are identified at an early stage, their needs are assessed and they receive appropriate services in a timely manner. Additionally, it is imperative that services not only meet the impending demands but also plan for future needs in line with strategic drivers such as Transforming Your Care (DoH, 2011) and the Equal Lives Review (DoH, 2008). The Transition Team is a new multi-disciplinary service that is essential to meet the needs of this diverse group of young people as they transition to adulthood.

Proposal:

Further to the establishment of the Transition Team the Trust seeks to appoint a 1 x WTE Band 6 Social Worker. In conjunction with the Transition Team Leader, the Social Worker will facilitate the implementation of the SHSCT Transition Protocol by planning, co-coordinating and evaluating transition services into the SHSCT adult disability services, in conjunction with other Trust professionals, service users, carers, external agencies, and community/voluntary agencies.

Duties will include (See Appendix B for full job description):

- Work with young people leaving school and provide support and guidance to young people, their families/ carers and relevant others in the development of future planning for adulthood.
- Interface with the transition workers funded under Children & Young Peoples Directorate and Education Transition Co-Ordinators as required
- Carry out continuous transition planning based on formal and informal assessments with clear outcomes for young people, with those young people and their carers
- Develop and encourage interagency collaboration to strengthen working relationships between SHSCT and other relevant partners in the transition process based on a person centred ethos and approach

This post has currently been circulated for Expression of Interest. It is anticipated that the post will be successfully appointed by 20th November 2015.

C. Enhancement to the existing Community Team to address pressures due to resettlement of non-Trust clients in the Southern area

In 2013/14 there were 2,123 people identified on the Southern LCG GP Practice registers for learning disability, and it is expected that there will be at least 50 young people who will transition into adult learning disability services during 2015/16.

In line with the HSCB/PHA Commissioning direction to continue to work with the Regional Bamford Team to support the shift from hospital based services to community services regionally, has added to the local pressures within the specialist Assessment & Treatment Unit in Bluestone and subsequently on the local

community learning disability services.

Proposal:

In line with Commissioning direction, 26 individuals have been resettled into SHSCT, who are owned by other Trusts. It is acknowledged that more individuals may be enroute to resettlement within SHSCT and that further individuals will present who are, as yet, unknown.

As each of the individuals resettled within SHSCT from other Trusts, present as unknown (reports do not usually follow individuals upon entry to SHSCT), each individual, therefore, requires input and assessment from a range of professionals to establish the level of care and package required. These individuals are not captured under SHSCT demographic at presentation. Additional assessments are being undertaken within current resources which are resulting in additional pressures to existing services. The additional pressures are evident from initial assessment of individuals throughout their care within the Community services.

In order to continue to provide safe and effective care and to fully meet the needs of individuals resettled within the SHSCT, the Trust seeks additional funding to enhance capacity within existing community teams to meet the additional need.

The Trust proposes to use the demography allocation of £85,823 to support individuals from other Trusts resettled in SHSCT. As noted, a number of individuals from other Trusts are, as yet, unknown to SHSCT therefore the Trust is unable, at this time, to detail the exact distribution of the allocation. The Post Project Evaluation (which will be carried out in 12 months) will reflect the final distribution of spend.

D. To continue to develop the Day Opportunities following the endorsement of the Learning Disability Day Opportunities Model in 2014 (£62,544)

The Trust is developing its Community Access Service within the Trust area for Adults with a Physical/Learning Disability and Sensory Impairment. This service works to support individuals in a holistic manner focusing on a person centered approach within the community taking into account individuality and promoting social inclusion within the wider community. Staff will provide a catalogue of services supporting the capacity to develop skills. The aim is to provide everyday experiences, opportunities and choices to support and enable individuals to live ordinary lives based on their assessed individual need and to promote empowerment to enable individuals to make informed decisions in relation to their daily lives.

Proposal:

In line with development of the Community Access Service it is necessary to appoint 2 x WTE Band 3 Community Access Support Workers.

Support workers will assist the Community Access Service in the everyday delivery of the service, ensuring a high standard of Care/Support is provided. They will facilitate ongoing communication with all relevant professionals and a commitment to partnership working between Health, Social Care and other agencies in both organizing and providing a Community Access Service.

Duties will include (See Appendix C for full job description):

- To advocate and support Service Users to maximize their potential and to make full use of suitable community provision which promotes the independence of each individual in a person centered way according to their assessed needs and choices.
- To provide and enable Service Users to develop practical informal access to networks and to discover better links between existing services tailored to individual needs.
- To support individuals in a positive, person centered way to participate (if required) in Service User

Multi-Disciplinary meetings and to support Service Users when making decisions.

- To support Service Users to become active citizens in their local community and avail of activities of their choice.
- To support Service Users on outings either individually or in groups, as and when required and to support the integration of Service Users irrespective of their disability into the community and by promoting the use of public transport if applicable.

In order to provide safe and effective care the Trust appointed, at risk, 2 x WTE Band 3 Community Access Support Workers since 1st July 2015. The Trust proposes to use the allocation (£62,544) to maintain these posts.

SECTION 2(a): OBJECTIVES

Project Objectives	Measurable Targets
<p>High Cost Packages</p> <p>1. To support the transition to adult services for 3 placements of very complex young people within the Community and prevent hospital admissions</p>	<p>1.1 Successful transition to adult services by placement of 3 individuals enabling Community based care.</p>
<p>Band 6 Transition Post</p> <p>2. Appointment of 1 x WTE Band 6 Social Worker to the Transitions Team</p>	<p>2.1 Appointment of 1 x WTE Band 6 Social Worker by 20th November 2015.</p>
<p>Community Team</p> <p>3. To increase capacity within Community Teams to support non-Trust clients.</p>	<p>3.1 Support a number of individuals resettled into SHSCT area from other Trusts for the period 2015/16</p>
<p>Day Opportunities</p> <p>4. Maintain 2 x WTE Band 3 Community Access Support Workers</p>	<p>4.1 Confirmed recurrent funding for posts to secure 2 x WTE Band 3 Community Access Support Workers</p>

SECTION 2(b): CONSTRAINTS

Constraints	Measures to address constraints
<p>High Cost Packages</p> <p>1. Availability of appropriate/suitable placements within the Community and the ability the maintain these.</p>	<p>This constraint will be addressed through early engagement with providers and the involvement of Crisis Response and the Behaviour Support Team to assist with the transition.</p>
<p>Band 6 Transition Post</p> <p>2. Ability to appoint post within timescales</p>	<p>Complete recruitment documentation as soon as possible.</p>
<p>Community Team</p> <p>3. Funding not made available to enhance current services to support Non-Trust clients</p>	<p>Submit IPT within the agreed timescales with all relevant data included</p>
<p>Day Opportunities</p> <p>4. Recurrent funding not made available to support 2 existing Band 3 Community Access Support Workers</p>	<p>Submit IPT within the agreed timescales with all relevant data included to secure funding and posts.</p>

SECTION 3: IDENTIFY AND SHORTLIST OPTIONS

Option Number/ Description	Shortlisted (S) or Rejected (R)	Reason for Rejection
<p>1. Status Quo - maintain existing services with no recurring investment</p>	<p>S</p>	
<p>As per Commissioners Statement</p> <p>2. Funding will be used to deliver the following enhancements in Learning Disability:</p> <p>a) Use demography allocation of £165,000 to support the transition of 3 young people with complex needs into</p>	<p>S</p>	

<p>Adult Services and provide appropriate care and support to meet their long term needs in the Community</p> <p>b) use demography allocation of £41,133 to appoint 1 x WTE Band 6 Social Worker to the Transition Team</p> <p>c) use of demography allocation of £85,823 to support individuals from other Trusts resettled into SHSCT in 15/16</p> <p>d) use of demography allocation of £62,544 to maintain the appointment of 2 x WTE Band 3 Community Access Workers</p>		
<p>3. Procure and Purchase care and support packages from the independent /private sector for the total funding allocated for all areas.</p>	<p>S</p>	

SECTION 4: MONETARY COSTS AND BENEFITS OF OPTIONS

Option 1: Status Quo	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5 ..	Totals
	15/16	16/17	17/18	18/19	19/20	20/21	
	£000's	£000's	£000's	£000's	£000's	£000's	
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs							
Budgeted Baseline	52,718	52,718	52,718	52,718	52,718	52,718	316,308
(b) Total Revenue Cost	52,718	52,718	52,718	52,718	52,718	52,718	316,308
(c) Total Cost = (a) + (b)	52,718	52,718	52,718	52,718	52,718	52,718	316,308
(d) Disc Factor @ 3.5%pa	1.0000	.9662	.9335	.9019	.8714	.8420	
(e) NPC = (c) x (d)	52,718	50,936	49,212	47,546	45,938	44,389	290,739

COST ASSUMPTIONS:

- Year 0 is current financial year 2015/16;
- Baseline Budget is 2015/16 Disability budget of £52,717,545;
- No other revenue costs associated with this option;
- Discount factor @ 3.5% pa has been applied;
- Please note all figures above have been rounded to thousands;
- Total NPC £290,739k

Option 2: Enhance Transition Services, Integration of Individuals resettled from other trusts and enhance day opportunities.	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5 ..	Totals
	15/16	16/17	17/18	18/19	19/20	20/21	
	£000's	£000's	£000's	£000's	£000's	£000's	
<u>Capital Costs</u>	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
<u>Revenue Costs</u>							
Budgeted Baseline	52,718	52,718	52,718	52,718	52,718	52,718	316,308
Payroll	29	167	167	167	167	167	864
Payroll related G&S	2	15	15	15	15	15	77
Goods & Services	0	172	172	172	172	172	860
(b) Total Revenue Cost	52,749	53,072	53,072	53,072	53,072	53,072	318,109
(c) Total Cost = (a) + (b)	52,749	53,072	53,072	53,072	53,072	53,072	318,109
(d) Disc Factor @ 3.5%pa	1.0000	.9662	.9335	.9019	.8714	.8420	
(e) NPC = (c) x (d)	52,749	51,278	49,543	47,866	46,247	44,687	292,370

COST ASSUMPTIONS:

- Year 0 is current financial year 2015/16;
- Baseline Budget is 2015/16 Disability Budget of £52,717,545;
- All posts costed to 15/16 HSCB Costing template;
- Payroll costs include employers costs for national insurance and superannuation;
- Payroll related G&S costed to 10% of basic pay per HSCB costing template per band;
- All posts applied part year effect in 15/16 as detailed in Payroll Option 2 schedule;
- All posts applied full year effect from 16/17;
- No capital costs identified with this case;
- Additional revenue costs associated with this option attached as per G&S option 2;
- Service dependant on recurrent revenue funding;
- Discount factor @ 3.5% pa has been applied;
- Please note all figures above have been rounded to thousands;
- Total NPC £292,370k

SECTION 5: NON MONETARY COSTS AND BENEFITS

Weighting method

Non-Monetary Factor	Weighting (%)	Score Option 1 Status Quo		Score Option 2 As per Commissioner's statement		Score Option 3 Procure via independent sector	
			Weighted score		Weighted Score		Weighted Score
1. Enhance Learning Disability Services to meet demographic changes within SHSCT	40	1	40	8	320	3	120
2. Enhance transition services to meet increasing complex needs	20	1	20	8	160	3	60
3. Integration of individuals resettled from other Trusts	20	1	20	8	160	3	60
4. Enhancement of day opportunities	20	1	20	8	160	3	60
Total	100%		100		800		300

Or Impact assessment

Non-Monetary Factor	Option 1	Option 2	Option 3 ...

1.			
2.			
3. etc			

Rationale for weighting and scoring

Enhance Learning Disability Services to meet demographic changes within SHSCT – Option 1 scored lowest under this criterion as by maintaining existing services, demands on services will continue to face increasing pressures causing risk to service provision. Without additional funding the Trust will not be able to transition complex young individuals appropriately from children’s services to adult services therefore resulting in inappropriate placements. The Trust will be unable to meet the increasing demand to resettle individuals from other Trusts. Unable to further enhance day opportunities without the appointment of Community Access Workers. Option 2 scored the highest under this factor as it will enable the transition of young individuals with complex needs from children’s services to appropriate adult placements. This option will allow enhancement of the Transition team through appointment of a social work to address this need. Option 2 will further enable the Trust to support the resettlement of individuals from other Trusts. This option will enhance day opportunities through the appointment of Community Access Support Workers. Option 3 scored low due to the timescales associated with procuring and purchasing services from independent/private providers and also the unavailability of these services. A full service could not be provided by this sector.

2. Enhance transition services to meet increasing complex needs – Option 1 scored lowest, as above as by maintaining existing services, demands on services will not be met. Without additional funding the Trust will not be able to appropriately transition complex young individuals from children’s services to adult services therefore resulting in inappropriate placements. Option 2 scored highest under this factor as additional funding will ensure and support the transition of complex young individuals from children’s to adult services through appropriate placement. Option 3 scored low due to the timescales associated with procuring and purchasing services from independent/private providers and also the unavailability of these services. A full service could not be provided by this sector.

3. Integration of individuals resettled from other Trusts - Option 1 scored lowest, as above as by maintaining existing services, demands on services will not be met. Without any enhancement to existing services the Trust will be at risk regarding the integration of individuals from other Trusts

resettled within the SHSCT area. Option 2 scored highest as additional funding will enable the Trust to provide appropriate assessment and packages to individuals enabling integration within SHSCT. Option 3 scored low due to the timescales associated with procuring and purchasing services from independent/private providers and also the availability of these services. A full service could not be provided by this sector.

4. Enhancement of day opportunities - Option 1 scored lowest, as above as by maintaining existing services there would be no enhancement to Day Opportunities within Learning Disability. Option 2 scored highest as this will enable enhancement to Day Opportunities through the appointment of Community Access Support Workers. Option 3 scored low due to the timescales associated with procuring and purchasing services from independent/private providers and also the unavailability of these services. A full service could not be provided by this sector.

SECTION 6: ASSESS RISKS AND UNCERTAINTIES

Risk Description	Likely impact of Risk H/M/L				State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	Opt 3	Opt 4	
1. Failure to appoint staff within the timescale of the IPT	L	M	L	N/A	The likely impact of risk on Options 1 & 3 is low as the Trust would not appoint staff for any of the services. Option 2 risk level is medium as although there may be risk in appointing staff, the service will take forward any necessary procedures to enable staff to be appointed as quickly as possible. In addition some of these posts have been filled on a temporary basis.
2. Reduced ability to maintain operational capacity due to demand exceeding capacity of the service within available resources	H	L	M	N/A	Option 1 carries a high risk as there would be considerable reduction in operational capacity without funding for posts within the Transition Team, Day Opportunities and the continued demand faced in the transition of high cost packages and resettlement of non-Trust patients within Trust services. The impact on Option 3 is medium as there may be risk for the Trust in procuring and securing services from the private/independent sector. Option 2 has a low risk as through the appointment of additional staff, as detailed, and the enhancement of transition services (high cost packages) and support for resettlement of non-Trust Patients the service will be able to maintain operational capacity.
3. Reduction in service resulting in risk to patient safety which may give rise to incidents and complaints, reducing patient satisfaction	H	L	M	N/A	Option 1 would be impacted as by maintaining existing services without funding being allocated would lead to a reduction in service which could impact on all services identified within the Commissioners statement. Pressure would be placed on the Transitions Team and Community Access Service. This may lead to additional admissions to hospital and increases the risk of incidents occurring within the service. Option 2 presents the lowest risk as the provision of additional funding will mean no reduction in services and the expectation of patients/carers will be

					met.
Overall Risk (H/M/L):	H	L	M		

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 1 was shortlisted as a base case for comparison with the other options. This option has been rejected as with no funding secured there would be no enhancement to any of the services identified within the Commissioners Statement. Without funding being secured the service provided would be inconsistent and costly to the Trust and would not meet the demographic changes in the Southern Trust population. Additional pressure will be placed on community services and clients may experience inappropriate placements.

Option 3 was rejected due to the timescales and cost associated with procuring and purchasing services from independent/private providers and the unavailability of these services. A full service complement could not be provided by this sector.

Preferred Option:

Option 2 has been identified as the preferred option as it will enable the demography funding to be allocated in the following ways to meet service demand within Learning Disability:

- Enable the Trust to facilitate and support the smooth transition of 3 young people (as detailed in this paper) with complex needs into Adult Services and provide appropriate care and support to meet their long term needs in the Community.
- Enhancement of the Transitions Team through the appointment of 1 x WTE Band 6 Social Worker. This will ensure the social needs of individuals are addressed through Transition.
- Enable the Trust to successfully and fully support individuals, from other Trusts, to resettle in SHSCT.
- Enhance the Community Access Service through the continued appointment of 2 x WTE Community Access Support Workers.

This option scored highest in benefits realisation and had the lowest risk impact. It further meets strategic direction.

SECTION 8: ASSESS AFFORDABILITY AND FUNDING ARRANGEMENTS

	Yr 0	Yr 1	Yr 2	Yr 3	Totals
	£000's	£000's	£000's	£000's	£000's
Required:					
Capital	0	0	0	0	0
Resource	52,749	53,842	54,622	55,414	216,627
Existing Budget:					
Capital	0	0	0	0	0
Resource	52,718	53,482	54,257	55,044	215,501
Additional budget Required:					
Capital	0	0	0	0	0
Resource	31	360	365	370	1,126

Affordability narrative

- Year 0 is current financial year 2015/16;
- Baseline budget is 2015/16 Disability Budget;
- Recurring revenue baseline uplifted by 1.45% annually from 16/17 – 18/19 within section 8 only for inflation;
- Additional recurring revenue costs uplifted by 1.45% annually from 16/17 – 18/19 within section 8 only for inflation;
- All posts applied part year effect in 15/16 as detailed in Payroll costing option 2 schedule;
- All posts applied full year effect from 16/17;
- Please note all figures above have been rounded to thousands.

SECTION 9: PROJECT MANAGEMENT (Please see Benefits Realisation Plan in Appendix A)

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management. The following key roles have been identified:

Project Owner: Mr Francis Rice, Director of Mental Health & Disability Services/ Executive Director of Nursing and AHPs

Project Director: Mr Miceal Crilly, Assistant Director of Disability Services.

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation. A Benefit Profile is attached as Appendix 1.

SECTION 10: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

				Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains
PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	I - Investment P - Productivity

SECTION 11: MONITORING AND EVALUATION

As per Section 9 the named personnel will be:

Project Owner: Mr Francis Rice, Director of Mental Health & Disability Services/ Executive Director of Nursing and AHPs

Project Director: Mr Miceal Crilly, Assistant Director of Disability Services.

Project Manager: Noreen McComiskey, Learning Disability Specialist Services Manager; John McEntee, Head of Community Disability Service; Donna Curley, Head of Community Services for Adults with a Physical Disability; Bronagh McKeown, Head of Physical and Sensory Disability Support Services

Service	Responsible	Timeframe
High Cost Packages	Noreen McComiskey	Successful transition of Clients as below: <ul style="list-style-type: none"> • Client A: April 2015 • Client B: April 2015 • Client C: June 2015
Transition Service Ensure Band 6 Social Worker in post	Noreen McComiskey	20 th November 2015
Community Team Continued resettlement of non-Trust Clients within SHSCT	Miceal Crilly	August 2016 (Post Project Evaluation will detail spend and number of non-Trust Clients received in 2015/16)
Day Opportunities Ensure all staff are in post Community Access Worker	Bronagh McKeown	1 st July 2015

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

[expand as necessary]

Appendix A: Benefits Profile

- **Benefit Owner:** This is the name of the actual benefit owner, not the person responsible for reporting on it. This might be the SRO, but could also be someone else senior in the organisation;
- **Baseline Value:** The Baseline value can be estimated at OBC stage (This should be firmed up and accurate by the time the business case reaches FBC if applicable);
- **Target Value:** Insert the target value you hope to attain for the benefit
- **Measurement:** Explain how and when you hope to measure and report on the benefit;
- **Timing:** Details of how often you intend to report on the realisation of the benefits;
- **Responsibility:** Who has responsibility for measuring and reporting on the benefit.

For large expenditure decisions where FBC is required, i.e. >£1m, please complete the benefit profile as detailed at the following link:

http://www.dfpni.gov.uk/benefit_profile_template.doc

Appendix A - Benefit Profile

Signed off by:

Date:

Benefit Owner	Benefit	Baseline value	Target Value	Measurement	Timing	Responsibility
Noreen McComiskey Donna Curley John McEntee	Enhance Transition Services to meet increasing complex needs through the transition of 3 complex young individuals from children's to adult services	N/A	3 individuals successfully transitioned to adult services	3 individuals transitioned by August 2016	2015/16	Noreen McComiskey Donna Curley John McEntee
Noreen McComiskey	Enhance Transitions Team by recruiting 1 x WTE Band 6 Social Worker	N/A	1 x WTE Band 6 Social Worker	No of staff in post	2015/16	Noreen McComiskey
Miceal Crilly	Resettlement of individuals from other Trusts within SHSCT	N/A	Support a no. of individuals resettled within SHSCT with full care packages	No. of individuals resettled from other Trusts.	2015/16	Miceal Crilly
Bronagh McKeown	Enhance Day Opportunities by recruiting 2 x WTE Band 3 Community Access Support Workers	N/A	2 x WTE Band 3 Community Access Support Workers	No. of staff in post	2015/16	Bronagh McKeown

APPENDIX B: Transition Team Social Worker Band 6 Job Description**SOUTHERN HEALTH & SOCIAL CARE TRUST****JOB DESCRIPTION**

JOB TITLE	Transition Coordinator (Adult Services)
BAND	Band 6 Social Worker
DIRECTORATE	Mental Health & Disability
INITIAL LOCATION	To be agreed
REPORTS TO	Transition Team Leader
ACCOUNTABLE TO	Assistant Director Disability Services

JOB SUMMARY

The SHSCT seeks to ensure that young people in transition to adulthood are identified at an early stage, their needs are assessed and they receive appropriate services in a timely manner. Additionally, it is imperative that services not only meet the impending demands but also plan for future needs in line with strategic drivers such as Transforming Your Care (DoH, 2011) and the Equal Lives Review (DoH, 2008). The SHSCT recognises the role of the transition coordinator as a critical variable in the development of an Adult Transition Service. Accordingly, this post as Transition Coordinator in Adult Services has been established.

In conjunction with the Transition Team Leader the postholder will facilitate the implementation of the SHSCT Transition Protocol by planning, coordinating, and evaluating transition services within the SHSCT adult disability services, in conjunction with other Trust professionals, service users, carers, external agencies, and community/voluntary agencies.

KEY DUTIES / RESPONSIBILITIES

- In conjunction with the Transition Team Leader implement agreed systems and procedures to achieve effective transition planning for young people in the 16 – 21 age group
- In conjunction with the Team Leader produce and keep up to date information leaflets on transition service

- In conjunction with the Team Leader facilitate use of existing information systems to identify young people with disability from age 16 to 21 years entering adult services and monitor the transition process for them
- In conjunction with Team Leader maintain an up to date database of young people in transition
- Work with young people leaving school and provide support and guidance to young people, their families/carers and relevant others in the development of future planning for adulthood
- Operate as a Trust wide service, conjoining specialist teams in all 3 localities, has a commitment to acquiring new skills and knowledge, and the resilience to deal with constantly changing priorities.
- Interface with the transition workers funded under Children & Young Peoples Directorate and the Education Transition Co-ordinators as required.
- Carry out continuous transition planning based on formal and informal assessments with clear outcomes for young people.
- Interagency collaboration to strengthen working relationships between the SHSCT and other relevant partners in the transition process based on a person centred ethos and approach.
- Liaise with other Professionals as required
- Coordinate meetings in conjunction with Transition Team Leader, Adult Community Team Leaders and Managers/Head of Services for Day Care/Day Opportunities/Community Access and liaise with other team members to access appropriate, additional support for clients internal or external to the SHSCT service provision.
- Collect and collate data relating to service users journey from children's services into adult services.
- To audit the impact of services and track the progress of service users into adult services
- Establish effective methods of service user/carer involvement
- Attend transition planning meetings
- Review young people annually or more often if required
- Participate in personal and professional training and skills development
- Provide written reports on work carried out as requested
- To manage a designated caseload as agreed with Line Manager

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
6. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
7. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximize his/her potential and continue to meet the demands of the post.
8. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.
9. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.
10. Understand that this post may evolve over time, and that this Job Description *will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.*

This Job Description will be subject to review in the light of changing circumstances

and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Transition Coordinator (Adult Services) Band 6 Social Worker

DIRECTORATE Mental Health & Disability

SALARY

HOURS 37.5

Ref No: <to be inserted by HR>

<Month & Year>

Notes to applicants:

1. You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.
2. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.

ESSENTIAL CRITERIA – these are criteria all applicants **MUST** be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

Essential Criteria

1. Social Work Qualification with two experience
2. On the NISCC Live Register
3. Knowledge, understanding and application of relevant legislation pertaining to adults and children
4. Understand the needs/rights of people with a disability
5. Knowledge of a variety and range of opportunities and services for young people
6. Hold a full current driving licence valid for use in the UK and have access to a car on appointment
7. The person appointed will be Community professional based and will be required to work across the Trust area.
8. The person appointed will be able to work effectively within a multidisciplinary service provision.
9. Good communication and organisational skills.

10. Prepared to take on a student placement
11. Effective Planning & Organizational skills with an ability to prioritize own workload.
12. Effective Communications skills to meet the needs of the post in full.
13. Ability to identify solutions to problems and implement them effectively.
14. Ability to work to tight timescales whilst meeting targets.
15. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement

DESIRABLE CRITERIA – *these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted*

1. Have two years' experience in the last five years working with children/adults with a disability
2. The person appointed will be expected to attain relevant training / development during their employment

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

**Successful applicants may be required to attend for a Health Assessment
All staff are required to comply with the Trusts Smoke Free Policy**

APPENDIX C: Community Access Support Worker Band 3 Job Description

Ref No:

(DMHD)
First trawl - Staff in Daycare**JOB DESCRIPTION**

JOB TITLE	Community Access Support Worker
BAND	3
INITIAL LOCATION	SHSCT
DIRECTORATE	Mental Health and Disability Services
RESPONSIBLE TO	Head of Service
REPORTS TO	Manager for Daycare and Day Opportunities

JOB SUMMARY

The Trust is developing its Community Access Service within the Trust area for Adults with a Mental Health / Physical/ Learning Disability and Hearing Impairment. Staff will be required to support individuals in a holistic manner focusing on a person centered approach within the community taking into account individuality and promoting social inclusion within the wider community. Staff will provide a catalogue of services supporting the capacity to develop skills. The aim is to provide everyday experiences, opportunities and choices to support and enable individuals to live ordinary lives based on their assessed individual need and to promote empowerment to enable individuals to make informed decisions in relation to their daily lives.

Support workers will be expected to assist Community Access Officers in the everyday delivery of the service, ensuring a high standard of Care/Support is achieved. There should be ongoing communication with all relevant professionals and a commitment to partnership working between Health, Social Work and other agencies in both organizing and providing a Community Access Service.

KEY DUTIES / RESPONSIBILITIES

1. To support Community Access Officer in the everyday Operational Delivery of a Community Access Service within the SHCST.
2. To advocate and support Service Users to maximize their potential and to make full usage of suitable community provision which promotes the independence of each individual in a person centered way according to their assessed needs.

3. To provide and enable Service Users to develop practical informal access to networks and to discover better links between existing services tailored to individual needs.
4. To support individuals in a positive, person centered way to participate (if required) in Service User Multi-Disciplinary meetings and to support Service Users when making decisions.
5. To support Service Users to become active citizens in their local community and avail of activities of their choice.
6. To observe Service Users behavior i.e. change of mood or feeling unwell and attend to same, ensuring accurate documenting and reporting immediately action taken to the Community Access Officer/Manager.
7. To support Service Users on outings either individually or in groups, as and when required and to support the integration of Service Users irrespective of their mental health/ disability into the community and by promoting the use of public transport if applicable.
8. To participate fully in the team approach by contributing to staff meetings, supervision and appraisal (KSF) etc. and ensure that good communication and co-operation is kept to a high level at all times.
9. Community Access Support Staff will contribute alongside the Community Access Officer to the preparation, implementation and review of existing services that are provided and be involved in the sourcing of new initiatives.
10. Community Access Support Staff will be required to contribute to appropriate risk assessments relating to all aspects of the service and will ensure that activities are delivered with due regard for the health and safety of the Service User and staff in accordance with good practice and risk assessed guidelines. Community support staff will bring to the attention of community access officers any risk factors they identify which may have a bearing on support provided to service users when accessing activities in the community. Community support staff will be responsible for the implementation of a risk management plan developed in collaboration with community access officers who will monitor the implementation of same from a governance perspective.
11. To liaise with families/carers, members of the Multi-disciplinary team and other relevant organisations when required and work in a positive manner at all times.

- 13 Community Access Support Staff will be required to undertake specific duties required under the direction of the Community Access Officers to assist in the provision of both individual and group activities provided. They may be required to undertake delegated tasks unsupervised. As at 10 above these tasks will be subject to appropriate risk assessment/ risk management processes on an ongoing basis.
- 14 To adhere to Trust policy & procedures and Legislative requirements.
- 15 Community Access Support Staff will be required to be flexible in their working day and on occasions may be required to ensure the personal care needs of service users are appropriately met.
- 16 Community Access Support Staff will maintain personal and professional development to meet the changing demands of the service and participate in appropriate training activities.
- 17 Community Access Support Staff will act in a professional manner and maintain confidentiality at all times.
- 18 To ensure good Community Access practice the following values should be applied:
 - The Support of the Service Users right to privacy
 - The respect of a Service Users dignity
 - The understanding of the Service users need for independence
 - The consideration of the Service Users preferences and personal choice
 - The recognition of the Service Users Human Rights
 - The provision of opportunity for fulfillment and inclusion
 - The acceptance of the Service Users free expression

GENERAL REQUIREMENTS

The post holder will be required to:

2. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
3. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
4. Adhere at all times to all Trust policies/codes of conduct, including for example:

- Smoke Free policy
 - IT Security Policy and Code of Conduct
 - Standards of attendance, appearance and behaviour
5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
 6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
 7. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including Service Users, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Act 1998. Employees are required to be conversant with the Trust's policy and procedures on records management and to seek advice if in doubt.
 8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
 9. Represent the Trust's commitment to providing the highest possible standard of service to Service Users and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.
 10. Available/able to work any 5 days out of 7 immediately on appointment or at a later stage following commencement in response to changing demands of the service.
 11. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location

within the Trust's area, as needs of the service demand.

PERSONNEL SPECIFICATION Internal redeployment only (first trawl to daycare staff)

Please note that the agreed generic criteria used for all band 3 posts will be used when this post is trawled more widely (second trawl)

JOB TITLE Community Access Support Worker Band 3

DIRECTORATE Mental Health and Disability Services

SALARY £16,110 - £19,077 per annum pro rata

HOURS Full-time

Ref No:

Notes to applicants:

- 3. You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
- 4. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA – these are criteria all applicants **MUST** be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

1. You must be an employee of the Southern Health & Social Care Trust in DMHD Day Care facilities (first trawl)

You must therefore clearly demonstrate your eligibility on your application form. **Please note that failure to do this will result in you not being shortlisted.**

2. Six months experience working in a care capacity which includes either hospital, statutory, voluntary or private sector setting.
3. Hold a full current driving license valid for use in the UK and have, on appointment, access to a car¹

¹ This criterion will be waived in the case of applicants who are prevented from driving due to a disability, providing the applicant can organise suitable alternative arrangements in order to meet the requirements of the post in full.

The following are essential criteria which will be measured during the interview stage.

4. Effective communication skills to meet the needs of the post in full.
5. Ability to work flexibly to meet the needs of the service which may require working a range of shifts.
6. Sensitive to the needs of service users with a disability
7. Highly committed to a person centered approach in the delivery of care and support.
8. Ability to work well as part of a team and to assist community access officers in providing a high standard of care and support.
9. Ability to use own initiative.
10. An understanding of the care needs of people with a disability.

DESIRABLE CRITERIA – these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted

1. NVQ Level II or III in Care

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

MAHI - STM - 126 - 376

Summary Costing schedule for Investment Decision Making Templates

Provider	SOUTHERN
Hospital Site or Community development	COMMUNITY
Scheme Title	POC6 Learning Disability (Transition & Community Team Pressures)
Pay and Price Levels	2015/16

Commissioner Use only
Sign and Date for TRAFFACS update

Pay Costs	Description	Base Case - option 1				Option 2				Option 3				Option 4			
		months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye
	Revenue Baseline			52,717,545	52,717,545			52,717,545	52,717,545								
	Enhancement of Transition Team:																
BAND 6	Social Worker - 1.0wte					9.00	1.00	38,057	28,543								
	Day Opportunities																
BAND 3	Community Access Support Workers - 2.0wte					0.00	2.00	44,492									
	Enhancement of Community Team:																
	Support resettlement of Individuals from other trusts					0.00		78,021									
	Non-AFC posts please detail below																
	Allowances for posts noted above - please detail below																
	Band 3 Community Access Support Worker (Unsocial Hours)					0.00		6,896									
	Exceptional Recruitment and Retention costs for posts above the mean plus x% (please provide detail)																
	TOTAL PAY COSTS			52,717,545	52,717,545	8.00		52,885,011	52,746,088			0.00	0	0		0.00	0
	Non-Pay Costs - please detail below																
	Goods & Services associated with Social Worker post @ 10% of basic					9.00	1.00	3,076	2,437								
	Goods & Services associated with Community Access Support Workers posts @ 10% of basic					0.00	2.00	3,658									
	Goods & Services associated with Support resettlement of Individuals from other trusts posts @ 10%					0.00		7,802									
	Provision of Support of High cost packages in transition to adult services, Client A, B & C (various transition dates within FY15/16)							165,000									
	Day Opportunity Activities					0.00		7,498									
	TOTAL NON-PAY COSTS			0	0			187,034	2,457			0	0		0	0	
	GRAND TOTAL			52,717,545	52,717,545			53,072,045	52,748,545			0	0		0	0	
	Phasing/Timescale	<i>(Can development be phased, if so provide details in this box)</i>				<i>(Can development be phased, if so provide details in this box)</i>				<i>(Can development be phased, if so provide details in this box)</i>				<i>(Can development be phased, if so provide details in this box)</i>			
	PROGRAMME OF CARE	learning disability				learning disability											
	SUB-SPECIALTY INFORMATION eg inpatients, outpatients, daycases if known																
	LCG	Southern				Southern											
	If more than one LCG in option above please give details																
	LGD																
	If more than one LGD in option above please give details																

LEVEL 2 Investment Proposal Template

REVENUE FUNDING £50k - £250k

HSCB IPT Ref No	SCCD 2015/LD8
Source of Funding (Year / ref)	2015/16
Allocation value	£109,020FYE recurring; £9,085 CYE - 1 month (Trust has this funding already non-recurrently)
HSCB Representative name and contact details	Aidan Murray Assistant Dir MH&LD Social Care and Children's Dir 12-22 Linenhall Street Belfast BT2 8BS Aidan.murray@hscni.net
Trust Representative name and contact details	Micéal Crilly, Assistant Director of Learning Disability Services miceal.crilly@southerntrust.hscni.net
Project Title	SHSCT Learning Disability Community Forensics
Total Cost	£109,020FYE recurring ; £9,085 CYE (1 month – 15/16)
Start date	1 st October 2015
Completion date	31 st March 2016

Complete this section if bid is for new funding i.e. funding is not currently in the Trust baseline

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Yes
How much total funding required?	£109,020 FYE recurring; £9,085 CYE (1 Month – 15/16)(Trust has this funding already non-recurrently)

How much funding required per year?	<i>£109,020 FYE recurring; £9,085 CYE (1 Month – 15/16)(Trust has this funding already non-recurrently)</i>
Is this funding to be made recurrent? (Y/N)	

Complete this section if funding available within existing allocation i.e. funding is currently in the Trust baseline

<i>Funding available within existing allocation (Y/N)</i>	<i>No</i>
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	

<i>Is this business case</i>	<i>Y/N</i>
<i>(a) Standard</i>	<i>Yes</i>
<i>(b) Novel</i>	<i>No</i>
<i>© Contentious</i>	<i>No</i>
<i>(d) Setting a precedent</i>	<i>No</i>
<i>If yes to (b) or (c) or (d) , requires Departmental & DFP approval</i>	<i>No</i>
<i>Is Departmental / DFP approval required</i>	

Approval & submission by Trust

This section to be completed by Trusts for all submissions

Responsible Director Signature (required for all submissions)

Name Printed: Francis Rice (signed) *Francis Rice*

Grade/ Title: Director of Mental Health and Disability

Date 08.01.2016

Trust Director of Finance Signature (required if bid is over £100k)

Name printed: Stephen McNally (signed)

Date 12/01/16

Trust Chief Executive Signature (required if bid is over £100k)

Name printed Paula Clarke (signed) *P Clarke*

Date

Approval & submission by Trust

This section to be completed by Trusts for all submissions

<p><u>Responsible Director Signature</u> (required for all submissions)</p> <p>Name Printed: Francis Rice (signed)</p> <p>Grade/ Title: Director of Mental Health and Disability</p> <p>Date</p>
<p><u>Trust Director of Finance Signature</u> (required if bid is over £100k)</p> <p>Name printed: Stephen McNally (signed)</p> <p>Date</p>
<p><u>Trust Chief Executive Signature</u> (required if bid is over £100k)</p> <p>Name printed Paula Clarke (signed)</p> <p>Date</p>

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – required for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.

Approved by

Name printed (signed)

Grade / Title

Date

Approval of Investment Proposal Template by HSCB Director(s) and/or Chief Executive

Director Signature (required for all bids)

Name printed (signed)

Grade / Title

Date

HSCB Director of Finance Signature (required if bid is over £100k)

Name printed (signed)

Date

HSCB Chief Executive Signature (required if bid is over £100k)

Name printed (signed)

Date

Approval of Investment Proposal Template by Commissioning Board (required if bid is over £100k)

Date of approval at Commissioning Board

Date

Complete this section if Department / DFP approval required

Date submitted to Department

Department/ DFP approval (y/n)

Date approved

SECTION 1: Commissioner specification to include strategic context and need (to be completed by the Commissioner)

Strategic Context

The relevant regional drivers for this service development are :

- All components of The Bamford Review of Mental Health and Learning Disability (2006), including 'Equal lives: Review of Policy and Services for People with a Learning Disability Northern Ireland';
- The specific Learning Disability targets that the Board and Trusts are expected to deliver on which are expected to extend to community based support by provision of specialist treatment through the extension of the range of community alternatives to hospital admission;
- The Board's Learning Disability Community Integration programme. As outlined in the HSCB Commissioning Plan, and in accordance with the principles of Citizenship and Human Rights enjoyed by all, people with a learning disability are entitled to live in their own homes in the community with a range of support services to meet their assessed needs.

Background:

Chapter 8 of 'Equal Lives' recommended that action be taken considering prevention and continuity of care as well as specialist assessment and treatment for clients with a learning disability with forensic histories and for those with the potential to offend. The Review advocated for the establishment of a range of services including specialist community services for clients with forensic or offending behaviour .

The Bamford Review Report on Forensic Services (2006) advocated the establishment of a regional community forensic learning disability service with the development of locally based and regionally co-ordinated community forensic learning disability teams linked to an inpatient assessment and treatment service. Consequently in 2009 a proposal was developed by the Health and Social Services Boards and relevant Trust staff and this was submitted by the Regional Forensic Network Group (now stepped down) to the Department of Health, Social Services and Public Safety (DHSSPS) for consideration.

It was subsequently recognised that service developments needed to be considered in a more flexible and innovative manner to ensure available resources are targeted

towards providing care and support for those patients and clients most in need and ensuring that these services are delivered efficiently and effectively consistent with best available evidence. A revised proposal was therefore submitted to and accepted by the Department in April 2012. This proposal included an interim model which would see the provision of community forensic learning disability services within all Trusts.

There are approximately 15 to 20 people in Muckamore Abbey Hospital with forensic and offending behaviour histories who are delayed discharge and who would benefit from living in the community if community learning disability forensic services were available to support them. Currently, this gives rise in inequitable service provision for this learning disability client group as forensic services are available for the rest of the Adult population.

There is therefore a need to incrementally develop a community based forensic learning disability service that will support discharge from Muckamore Abbey Hospital and other secure/semi secure units, and which will enable the development of services for supporting those already living within the community. There would be an overall requirement to reduce the dependency on hospital /inpatient based provision and reduce the risk for recurring forensic behaviours.

The objectives would be to:

- Develop client contact and monitoring in the community to reduce admission rates and facilitate discharge.
- Research and actively seek out accommodation /housing for clients with forensic and offending behaviour issues
- Increase activity in the specialist assessment and management of risk by developing support to community learning disability teams
- Support the development of day services for people with forensic needs through engagement in social activities and employment opportunities.
- Develop access to specialist assessment and formulation treatments and interventions of more complex cases.
- Develop and support treatments and supervision for other staff delivering interventions
- Improve the quality of the patient's experience by providing input to meet the needs of our client by supporting discharge from hospital setting by sourcing and supporting appropriate supported housing/living
- Develop risk assessment and action plan strategies

It is envisaged that there will be 4 levels of support offered to clients with a learning disability similar to the model developed by mental health as follows:

Level 1

A one off assessment/consultation with the Community Forensic learning disability practitioners

Level 2

A short period of assessment by the Community Forensic learning disability practitioners with the referring team retaining responsibility.

Level 3

Agreed period of shared responsibility - (a) to assess risk, (b) to evaluate interplay/operation of known risk factors, and (c) to assess efficacy of risk reducing strategies.

Level 4

Community Forensic learning disability practitioners taking full responsibility for duration of need.

To this end the HSCB will make **£ 109,020 FYE ; £54,510 CYE** available to the SHSCT. However, the Trust requires **£9,085 only in year and full recurrent sum of £109,020 from 1st April 2016.**

The Trust should bring forward proposals to develop and augment Community Learning Disability Forensic teams to include proposal to provide Consultant Forensic Psychiatrist and Clinical/Forensic Psychologist input alongside other appropriate community Forensic Staff.

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. To use the investment within the Learning Disability community team who have in the past committed £147k to forensic service to assist in areas where pressures within the service has been identified.	£109,020 increase in community learning disability budget, to enhance staffing on CLDTs
2.	

SECTION 2 (b) : CONSTRAINTS

No constraints have been identified.

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	<p>Status Quo</p> <p>Continue with existing arrangements in community learning disability service delivery with no increase in funding.</p>
2	<p>Use of funding to support the community Learning Disability teams</p> <p>This funding would be used to support community learning disability teams who over previous years have committed resources to forensic services with no increase in budget. This has inevitably put pressure on the community learning disability team budget which cannot be sustained. The funding of £109,020 will be used to help finance additional staff on the CLDTs..</p>

SECTION 4: PROJECT COSTS

Option 1: Status Quo	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5 ..	Totals
	15/16	16/17	17/18	18/19	19/20	20/21	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs							
Budgeted Baseline	52,718	52,718	52,718	52,718	52,718	52,718	316,308
(b) Total Revenue Cost	52,718	52,718	52,718	52,718	52,718	52,718	316,308
(c) Total Cost = (a) + (b)	52,718	52,718	52,718	52,718	52,718	52,718	316,308
(d) Disc Factor @ 3.5%pa	1.0000	.9662	.9335	.9019	.8714	.8420	
(e) NPC = (c) x (d)	52,718	50,936	49,212	47,546	45,938	44,389	290,739

COST ASSUMPTIONS:

- Year 0 is current financial year 2015/16;
- Baseline Budget is 2015/16 Disability budget of £52,717,545;
- No other revenue costs associated with this option;
- Discount factor @ 3.5% pa has been applied;
- Please note all figures above have been rounded to thousands;
- Total NPC £290,739k

Option 2: Use of funding to support the community Learning Disability Teams	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5 ..	Totals
	15/16	16/17	17/18	18/19	19/20	20/21	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs							
Budgeted Baseline	52,718	52,718	52,718	52,718	52,718	52,718	316,308
Payroll	8	95	95	95	95	95	483
Payroll related G&S	1	8	8	8	8	8	41
Goods & Services	1	6	6	6	6	6	31
(b) Total Revenue Cost	52,728	52,827	52,827	52,827	52,827	52,827	316,863
(c) Total Cost = (a) + (b)	52,728	52,827	52,827	52,827	52,827	52,827	316,863
(d) Disc Factor @ 3.5%pa	1.0000	.9662	.9335	.9019	.8714	.8420	
(e) NPC = (c) x (d)	52,728	51,041	49,314	47,645	46,033	44,480	291,241

COST ASSUMPTIONS:

[expand as appropriate]

- Year 0 is current financial year 2015/16;
- Baseline Budget is 2015/16 Disability Budget of £52,717,545;
- All posts costed to 15/16 HSCB Costing template;
- Payroll costs include employers costs for national insurance and superannuation;
- Payroll related G&S costed to 10% of basic pay per HSCB costing template per band;
- All posts applied part year effect in 15/16 as detailed in Payroll Option 2 schedule;
- All posts applied full year effect from 16/17;
- No capital costs identified with this case;
- No additional revenue costs associated with this option;
- Service dependant on recurrent revenue funding;
- Discount factor @ 3.5% pa has been applied;
- Please note all figures above have been rounded to thousands;
- Total NPC £291,241k

SECTION 5: NON-MONETARY BENEFITS

Option 1: Status Quo – continue with existing arrangements

This option will not enable any benefit.

Option 2: Use of funding to support the community Learning Disability teams

This funding will be utilised within the community learning disability teams to enhance staffing levels. This will help with equitable service provision.

SECTION 6: PROJECT RISKS & UNCERTAINTIES

Risk of IPT not being submitted within agreed timescales.

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Preferred Option:

Option 2 has been identified as the preferred option as it will enable the pressures currently experienced within the community learning disability teams to be alleviated. An investment of £109,020 will be welcomed into the Learning disability budget to fund additional staff on the CLDTs.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	15/16 Yr 0 £000's	16/17 Yr 1 £000's	17/18 Yr 2 £000's	18/19 Yr 3 £000's	Totals £000's
Required					
Capital required	0	0	0	0	0
Revenue required	52,728	53,593	54,369	55,157	215,847
Existing budget :					
Capital	0	0	0	0	0
Revenue	52,718	53,482	54,257	55,044	215,501
Additional Allocation Required:					
Capital	0	0	0	0	0
Revenue	10	111	112	113	346

AFFORDABILITY ASSUMPTIONS

- Year 0 is current financial year 2015/16;
- Baseline Budget is 2015-16 Disability Budget of £52,717,545;
- Recurring Revenue Baseline uplifted by 1.45% annually from 16/17-18/19 within section 8 only for inflation;
- All posts applied part year effect in 15/16 as detailed in Payroll costing option 2 schedule;
- All posts applied full year effect from 16/17;
- Please note all figures above have been rounded to thousands.

SECTION 9: MANAGEMENT ARRANGEMENTS

The following key roles have been identified:

Project Owner: Mr Francis Rice, Director of Mental Health & Disability Services/ Executive Director of Nursing and AHPs

Project Director: Mr Miceal Crilly, Assistant Director of Disability Services.

A review of investment in relation to the stated objectives will be undertaken 12 months after full implementation.

SECTION 10: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains I - Investment P - Productivity
				Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	
Acute	Gen Surgery	Vascular	FCE	1200	500	2000	P

SECTION 11: MONITORING AND EVALUATION

Who will manage the implementation?	Project Director: Mr Miceal Crilly, Assistant Director of Disability Services.
Who will monitor and evaluate the outcomes?	Project Director: Mr Miceal Crilly, Assistant Director of Disability Services.
What other factors will be monitored and evaluated?	Increased outcomes from the Community Teams as evidenced by more timely assessments and improved recording.
When will this take place?	12 months after full implementation.

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

[expand as necessary]

Summary Costing schedule for Investment Decision Making Templates		Ref Number
Provider	SOULTHERN COMMUNITY	
Hospital Site or Community development	SHSCT Learning Disability Community Forensics	
Scheme Title	2015/16	
Pay and Price Levels	Commissioner Use only Sign and Date for TRAFFACS update	

Pay Costs	Description	Base Case - option 1			Option 2			Option 3			Option 4			
		months claimed	wtc	fyc	months claimed	wtc	fyc	months claimed	wtc	fyc	months claimed	wtc	fyc	
BAND 1	BASELINE			52,717,545			52,717,545			0			0	
BAND 2				0			0			0			0	
BAND 3				0			0			0			0	
BAND 4				0			0			0			0	
BAND 5				0			0			0			0	
BAND 6				0			0			0			0	
BAND 7				0			0			0			0	
BAND 8A				0			0			0			0	
BAND 8B				0			0			0			0	
BAND 8C				0			0			0			0	
BAND 8D				0			0			0			0	
Non-AFC posts please detail below														
Allowances for posts noted above - please detail below														
G&S - Band 5 (3.0wre) - 10% as per HSCB Costing Template														
Exceptional Recruitment and Retention costs for posts above the mean plus x% (please provide detail)														
TOTAL PAY COSTS				52,717,545	0.00	52,717,545	52,717,545	6.00	52,820,517	52,726,127	0.00	0	0.00	0
Non-Pay Costs - please detail below														
Goods & Services														
TOTAL NON-PAY COSTS				0		0	0		6,048	503			0	0
GRAND TOTAL				52,717,545		52,717,545	52,726,630		52,826,565	52,726,630			0	0

Phasing/Innescale	(Can development be phased, if so provide details in this box)	(Can development be phased, if so provide details in this box)	(Can development be phased, if so provide details in this box)	(Can development be phased, if so provide details in this box)
PROGRAMME OF CARE				
SPECIALTY INFORMATION eg inpatients, outpatients, daycases if LCG	Southern	learning disability	Southern	
If more than one LCG in option above please give details LGD				
If more than one LGD in option above please give details				

LEVEL 3 Investment Proposal Template

REVENUE FUNDING £250k - £1m

HSCB IPT Ref No	SCCD 2015 LD3
Source of Funding (Year / ref)	2015/16
Allocation value	
HSCB Representative name and contact details	Aidan Murray
Trust Representative name and contact details	Miceal Crilly, Assistant Director of Learning Disability Services miceal.crilly@southerntrust.hscni.net
Project Title	SHSCT Children with learning disability transitioning to adult services
Total Cost	£790,800 FYE Recurrently ; £244,000 CYE (2015/16)
Start date	17 th August 2015
Completion date	31 st March 2016

Complete this section if bid is for new funding i.e. funding is not currently in the Trust baseline

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Y
How much total funding required?	£790,800 FYE Recurrently; £244,000 CYE (2015/16)
How much funding required per year?	£790,800 FYE Recurrently; £244,000 CYE (2015/16)

Is this funding to be made recurrent?	Y
---------------------------------------	---

Complete this section if funding available within existing allocation i.e. funding is currently in the Trust baseline

<i>Funding available within existing allocation (Y/N)</i>	
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	

<i>Is this business case</i>	<i>Y/N</i>
<i>(a) Standard</i>	<i>Y</i>
<i>(b) Novel</i>	<i>N</i>
<i>(c) Contentious</i>	<i>N</i>
<i>(d) Setting a precedent</i>	<i>N</i>
<i>If "yes" to (b) or (c) or (d), requires Departmental & DFP approval</i>	<i>N</i>
<i>Is Departmental / DFP approval required</i>	

Approval & submission by Trust/s

This section to be completed by Trusts for all submissions

<u>Prepared by (required)</u>	
Name Printed : Francis Rice (signed)	<i>Francis Rice</i>
Grade/ Title –Director of Mental Health and Disability	
Date: 6 January 2016	
<u>Trust Director of Finance Signature (required)</u>	
Name printed Stephen McNally (signed)	<i>Stephen McNally</i>
Date 08/01/16	
<u>Trust Chief Executive Signature (required)</u>	
Name printed Paula Clarke (signed)	<i>P Clarke</i>
Date 11/1/16	

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – required for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.

Approved by

Name printed (signed)

Grade / Title

Date

Approval of Investment Proposal Template by HSCB Director(s) / Chief Executive Officer – required for all submissions

Responsible Director Signature (required)

Name printed (signed)

Grade / Title

Date

HSCB Director of Finance Signature (required)

Name printed (signed)

Date

HSCB Chief Executive Signature (required)

Name printed (signed)

Date

Approval of Investment Proposal Template by Commissioning Board (required for all submissions)

Date approved by Commissioning Board

Date

Complete this section if Department / DFP approval required

Date submitted to Department

Department/ DFP approval (y/n)

Date approved

SECTION 1(a): Commissioner specification to include strategic context and need (to be completed by the Commissioner).

Each year a number of children transfer from Children’s Disability Community Services to Adult Learning Disability Community Services. Increasingly, this can present a number of challenges to adult learning disability community services, such as the number of children transferring in any one year, the complexity of their needs and the capacity within existing services to meet these needs.

Trusts have already submitted anonymised details of children transferring in 2015/16 from high cost Children’s Disability services to high cost Adult Learning Disability services. These are all children who are in the statutory care of the Trusts and for whom lifelong care arrangements will be required. Previously these children would likely have become long term residents of Adult Learning Disability hospital wards, an inappropriate option which is no longer available

Funding has been identified from cost pressure funding to address these issues. Trusts are therefore asked to bring forward proposals to identify or develop services that will meet the needs of these children and which also take into account all funding opportunities around vacancies in existing services that are already within existing baseline funding. Children should not be identified by name but by initials and date of birth.

SECTION 1(b): DEMONSTRATE THE NEED FOR THE PROJECT

Introduction

People with learning disabilities have a variable range of health and social care needs and often experience greater health and wellbeing inequalities than the general population and can experience difficulty in accessing services. They are also at risk of social exclusion, affecting their quality of life through exclusion from employment, relationships and other life opportunities. People with learning disabilities are now living longer thanks to the medical advancements in their care and as a result there is therefore an increase in numbers and complexities. Both Transforming Your Care and the DHSSPS Learning Disability Service Framework highlight the needs of the increasing numbers of young people with complex needs surviving into adulthood and the importance of the right support at transition stage to adult services focusing on promoting their independence through use of supported living and day opportunities models.

It is recognised that the transition period from childhood to adulthood for those with a Learning Disability is a particularly significant time in their lives, which for the young person, can impact greatly on determining the degree of which they are enabled to live their lives to the fullest.

A number of strategic documentation including, Transforming Your Care 2011 and Equal Lives 2005 recognise how essential it is for Trusts to ensure smooth transition for young people with a learning disability into adult services. The need to provide support which is timely and personalised along with providing a range of opportunities including social, leisure, and educational remains challenging for the Trust. Transforming Your

Care recognises the increasing number of young people with complex needs surviving into adulthood who require more complex care through transition from children's to adult services.

The Trust continues to witness a significant increase in complexity of young adults with a Learning Disability in transition. Coupling this with the increase in birth rate within the area over the last 20 years continues to put pressure on existing resources in both children's and disability services. In some cases, the needs being presented cannot be met within the current range of available services and it is therefore essential that a wider range of opportunities are created, which are based on assessed and personalized needs.

Timely engagement at an early point in the transition process with carers and families is vital in the development of personalisation agendas in order to provide appropriate and fitting care packages to meet their individual needs.

It is recognised that people with Learning Disabilities who have complex needs may at times throughout their lives require access to specialist health and/or care services. They may have a broad range of health and/or social care needs that will often require additional services and support to those available from mainstream services, including primary and secondary health care.

Proposal:

This investment will be used to support the smooth transition of 11 young people with complex needs into Adult Services and provide appropriate care and support to meet their long term needs in the Community. There is also a requirement for funding for 8wte Band 3 Health Care Assistants Post who will assist clients and their carers in daily living and activities. Funding has also been identified for short breaks for those clients with severed challenging behaviour needs.

There are currently 11 young people in care who this investment will support detailed in the following table:

Initials	Locality	DOB	Assessed Need	Cost
LM	C&B	14.09.1997	Equipment	£5,000
PA	C&B	05.01.1995	Specialist supported Living	40000
SC	A&D	27.07.1998	Adult Placement	15000
AC		24.09.1998	Equipment	£8,000
RB	C&B	30.12.1997	Flexible Respite	£10,000
PS	C&B	14.02.1998	Equipment	£10,000
AC	A&D	21.2.1998	May require out of home placement as currently in Foster Care	40000
LMCK	A&D	22.04.1998	Will require placement – currently on ECR in Scotland until age 18	125000
GMCK	A&D	22.04.1998	Will require placement - currently on ECR in Scotland until age 18	125000
BMCC	C&B	08.07.1998	Will require placement – currently on ECR in Scotland. Will require client specific training	150000

DMCC	C&B	09.12.1998	Equipment costs	£10,000
Respite Provision for Challenging Behaviour			To be used across the Trust area to spot purchase two challenging behaviour beds	60208
Health Care Assistant Posts band 3 x 8				192592
				£790,800

The total level of investment required is £790,800 which will be used to support the smooth transition of 11 young people with complex needs into Adult Services and provide appropriate care and support to meet their long term needs in the Community.

SECTION 2(a): OBJECTIVES

Project Objectives	Measurable Targets
1. Successful transition from children’s care to adult Learning Disability services	1.1 Number of children successfully transitioning.
2. Young adults are supported to enable them to continue to live in a community setting	2.1 Number of admissions to hospital

SECTION 2(b): CONSTRAINTS

Constraints	Measures to address constraints
1. Availability of appropriate/suitable placements including short breaks within the community and the ability to maintain these.	This constraint will be addressed through early engagement with providers and the involvement of Crisis Response and the Behaviour Support Team to assist with the transition
2. Availability of funding	Submit IPT within the agreed timescales with all relevant data included

SECTION 3: IDENTIFY AND SHORTLIST OPTIONS

Option Number/ Description	Shortlisted (S) or Rejected (R)	Reason for Rejection
1. Option 1 - Status Quo - continue with existing arrangements	S	
2. Option 2 - support the smooth transition of 11 young people with complex needs into Adult Services and provide appropriate care and support to meet their long term needs in the Community.	S	

SECTION 4: MONETARY COSTS AND BENEFITS OF OPTIONS

Option 1: Status Quo	15/16	16/17	17/18	18/19	19/20	20/21	Totals
	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5 ..	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs							
Budgeted Baseline	52,718	52,718	52,718	52,718	52,718	52,718	316,308
(b) Total Revenue Cost	52,718	52,718	52,718	52,718	52,718	52,718	316,308
(c) Total Cost = (a) + (b)	52,718	52,718	52,718	52,718	52,718	52,718	316,308
(d) Disc Factor @ 3.5%pa	1.0000	.9662	.9335	.9019	.8714	.8420	
(e) NPC = (c) x (d)	52,718	50,936	49,212	47,546	45,938	44,389	290,739

COST ASSUMPTIONS:

- Year 0 is current financial year 2015/16;
- Baseline budget is 2015-16 Disability Budget of £52,717,545;
- No other revenue costs associated with this option;
- Discount factor @ 3.5% pa has been applied;
- Please note all figures above have been rounded to thousands;
- Total NPC £290,739

Option 2: Support the smooth transition of 11 young people with complex needs into Adult Services and provide appropriate care and support to meet their long term needs in the Community.	15/16	16/17	17/18	18/19	19/20	20/21	Totals
	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5 ..	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's

Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs							
Budgeted Baseline	52,718	52,718	52,718	52,718	52,718	52,718	316,308
Goods & Services (Care Packages & Equipment)	244	791	791	791	791	791	4,199
(b) Total Revenue Cost	52,962	53,509	53,509	53,509	53,509	53,509	320,507
(c) Total Cost = (a) + (b)	52,962	53,509	53,509	53,509	53,509	53,509	320,507
(d) Disc Factor @ 3.5%pa	1.0000	.9662	.9335	.9019	.8714	.8420	
(e) NPC = (c) x (d)	52,962	51,700	49,951	48,260	46,628	45,055	294,556

COST ASSUMPTIONS:

- Year 0 is current financial year 2015/16;
- Baseline budget is 2015-16 Disability Budget of £52,717,545;
- Part Year Effect in 15/16 as detailed in G&S Option 2 Schedule;
- Full Year Effect recurrent from 16/17;
- No capital costs associated with this option;
- Service dependant on recurrent revenue funding;
- Discount factor @ 3.5% pa has been applied;
- Please note all figures above have been rounded to thousands;
- Total NPC £294,556k

SECTION 5: NON MONETARY COSTS AND BENEFITS

Weighting method

Non-Monetary Factor	Weighting (%)	Score Option 1		Score Option 2	
		Score	Weight	Score	Weight
1. Enhance Learning Disability Packages to meet the needs of those transitioning to adult services	40	2	80	8	320
2. Provide specialist equipment required to enable those transitioning to remain in the community.	20	2	40	8	160
3. Provide support to those transitioning to enable clients to continue to attend daily activities.	20	2	40	8	160
4. Provide short breaks to those transitioning to support carers.	20	2	40	8	160
Total	100%		200		800

Or Impact assessment

Non-Monetary Factor	Option 1	Option 2	Option 3 ...
1.			
2.			
3. etc			

Rationale for weighting and scoring

Option 1 scored low as if the correct packages are not put in place for those clients identified this may result in a breakdown in the clients current living arrangements. Option 2 will enable clients to remain living in the community as they will have the necessary care and support. This option will also enable the appropriate specialist equipment to be purchased which will also enhance the care and support of those clients who have been identified as requiring equipment. By not providing the necessary daily support clients will no longer be able to attend daily activities. Option 2 will provide the means for this to continue. Therefore Option 2 scored higher than Option 1.

Short breaks are an essential part of the care package and enable carers to continue in their role and mitigates breakdown in the care arrangements. Option 1 does not provide this. Option 2 scored highest as it will enable the necessary short breaks to continue which not only benefits the client but also those caring for the client.

SECTION 6: ASSESS RISKS AND UNCERTAINTIES

Risk Description	Likely impact of Risk H/M/L				State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	Opt 3	Opt 4	
1. Reduced ability to maintain operational capacity due to demand exceeding capacity of the service within available resources.	H	L	N/A	N/A	Option 1 carries a high risk as there would be a considerable reduction in operational capacity without funding for those existing packages and care and support identified as being required. Option 2 has a low risk as the funding will enable the necessary care and support to be provided for those clients therefore enabling these clients to remain in the community.
2. Reduction in service resulting in risk to patient safety which may give rise to incidents and complaints and reduce client and carer satisfaction.	H	L	N/A	N/A	Option 1 would be impacted as by maintaining existing services without funding being allocated would lead to a reduction in service which would impact on all clients identified. Pressure would be placed on the community teams. This may lead to admissions to hospital and also this may lead to a number of incidents occurring within the community. Due to a reduction in service carers may be unable to upkeep the level of care which will place additional pressures on Trust community services. Option 2 poses the lowest risk as providing additional funding there will be no reduction in services and expectations of patients/carers will be met.
3. Risk that patients will be admitted to hospital	H	L	N/A	N/A	Option 1 would be impacted as by maintaining existing services without funding being allocated would lead to a reduction in service which would impact on all clients identified. Pressure would be placed on the community teams. This may lead to admissions to hospital and also this may lead to a number of

					<p>incidents occurring within the community. Due to a reduction in service carers may be unable to upkeep the level of care which will place additional pressures on Trust community services.</p> <p>Option 2 poses the lowest risk as providing additional funding there will be no reduction in services and expectations of patients/carers will be met.</p>
Overall Risk (H/M/L):	H	L	N/A	N/A	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 1 - Status Quo - continue with existing arrangements has been discounted as it will not provide the required level of care and support for those clients identified.

Preferred Option

Option 2 - support the smooth transition of 11 young people with complex needs into Adult Services and provide appropriate care and support to meet their long term needs in the Community has been identified as the preferred option. This option will enable those children identified to transfer from Children’s Disability Community Services to Adult Learning Disability Community Services with the necessary care and support required in place. This will present a number of challenges to adult learning disability community services however the funding identified will support existing services to enable them to meet these needs. Option 2 will enable clients to remain living in the community as they will have the necessary care and support and the purchase of the appropriate specialist equipment will also enhance their daily routines.

SECTION 8: ASSESS AFFORDABILITY AND FUNDING ARRANGEMENTS

	15/16	16/17	17/18	18/19	Totals
	Yr 0	Yr 1	Yr 2	Yr 3	
	£000's	£000's	£000's	£000's	£000's
Required:					
Capital	0	0	0	0	0
Resource	52,962	54,284	55,071	55,870	218,187
Existing Budget:					
Capital	0	0	0	0	0
Resource	52,718	53,482	54,257	55,044	215,501
Additional budget Required:					
Capital	0	0	0	0	0
Resource	244	802	814	826	2,686

Affordability narrative

- Year 0 is current financial year 2015/16;
- Baseline Budget is 2015-16 Disability Budget of £52,717,545;
- Recurring Revenue Baseline uplifted by 1.45% annually from 16/17 – 18/19 within section 8 for inflation;
- Part year effect in 15/16 as detailed in G&S Option 2 Schedule;
- Full Year effect from 16/17 recurrently;
- Please note all figures above have been rounded to thousands

SECTION 9: PROJECT MANAGEMENT (Please see Benefits Realisation Plan in Annex B)

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management. The following key roles have been identified:

Project Owner: Mr Francis Rice, Director of Mental Health and Disability

Project Director: Mr Miceal Crilly, Assistant Director of Learning Disability Services

Project Manager: Noreen McComiskey, Head of Learning Disability Specialist Services

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation. A Benefit Profile is attached as Appendix 1.

SECTION 10: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains I - Investment P - Productivity
				Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	

SECTION 11: MONITORING AND EVALUATION

Project Owner: Mr Francis Rice, Director of Mental Health and Disability

Project Director: Mr Miceal Crilly, Assistant Director of Learning Disability Services

Project Manager: Noreen McComiskey, for Learning Disability Specialist Services

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

[expand as necessary]

Appendix 1 Benefit Profile

Appendix 4 Benefit Profile Benefit Owner	Benefit	Baseline Value	Target Value	Measurement	Timing	Responsibility
Miceal Crilly	Enable the smooth transition of those clients identified from children's learning disability services to adult learning disability services	No of children identified for transition	As identified in Option 2	Care and support packages delivered to those clients identified	2015/16	Noreen McComiskey
Miceal Crilly	Provide support to those transitioning to enable clients to continue to attend daily activities.	No of current Health Care Assistants	Appointment of 8wte Band 3 Health Care Assistants	No of band 3 health care assistants	2015/16	Noreen McComiskey

Summary Costing Schedule for Investment Decision Making Templates

Provider	Ref Number
Hospital Site or Community development	SOUthern COMMUNITY
Scheme Title	Single Children with Learning Disabilities Transitioning to Adult Services
Pay and Price Levels	2011 to

Commissioner Use only
Sign and Date for TRAFFACS update

Pay Costs	Description	Base Case - option 1			Option 2			Option 3			Option 4		
		months claimed	w/c	f/y	c/y	months claimed	w/c	f/y	c/y	months claimed	w/c	f/y	c/y
BAND 1	BASELINE:			52,717,545	52,717,545			52,717,545	52,717,545				
BAND 2				0	0			0	0				
BAND 3				0	0			0	0				
BAND 4				0	0			0	0				
BAND 5				0	0			0	0				
BAND 6				0	0			0	0				
BAND 7				0	0			0	0				
BAND 8A				0	0			0	0				
BAND 8B				0	0			0	0				
BAND 8C				0	0			0	0				
BAND 8D				0	0			0	0				
Non-AFC posts please detail below				0	0			0	0				
Allowances for posts noted above - please detail below				0	0			0	0				
Exceptional Recruitment and Retention costs for posts above the HRA pay % (please provide detail)				0	0			0	0				
TOTAL PAY COSTS			0.00	52,717,545	52,717,545		0.00	52,717,545	52,717,545		0.00	0.00	0
Non-Pay Costs - please detail below													
Goods & Services - Car Packages & Equipment								700,800	911,000				
TOTAL NON-PAY COSTS								700,800	911,000				
GRAND TOTAL				52,717,545	52,717,545		52,717,545	53,508,345	52,961,545		0	0	0

Phasing/Timeline	(Can development be phased, if so provide details in this box)
PROGRAMME OF CARE	(Can development be phased, if so provide details in this box)
SUBSPECIALTY INFORMATION eg inpatient, outpatient, daycase, if LCC	(Can development be phased, if so provide details in this box)
If more than one LCC in option above please give details	(Can development be phased, if so provide details in this box)
If more than one LCD in option above please give details	(Can development be phased, if so provide details in this box)

LEVEL 2 Investment Proposal Template

REVENUE FUNDING £50k - £250k

HSCB IPT Ref No	
Source of Funding (Year / ref)	Funding identified in 2016/17 Financial Plan (June Monitoring)
Allocation value	£99,140
HSCB Representative name and contact details	Iolo Eilian - HSCB ████████████████████ ████████████████
Trust Representative name and contact details	Miceal Crilly - SHSCT ██ ████████████████
Project Title	Day Opportunities
Total Cost	£99,140 – PART YEAR EFFECT - NON RECURRING
Start date	1 st April 2016
Completion date	31 st March 2017

Complete this section if bid is for new funding i.e. funding is not currently in the Trust baseline

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	YES
How much total funding required?	£99,140 – PART YEAR EFFECT - NON RECURRING
How much funding required per year?	<i>See above</i>

Is this funding to be made recurrent? (Y/N)	No

Complete this section if funding available within existing allocation i.e. funding is currently in the Trust baseline

Funding available within existing allocation (Y/N)	
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	

Is this business case	Y/N
(a) Standard	YES
(b) Novel	
© Contentious	
(d) Setting a precedent	
If yes to (b) or (c) or (d) , requires Departmental & DFP approval	
Is Departmental / DFP approval required	

Approval & submission by Trust

This section to be completed by Trusts for all submissions

<u>Responsible Director Signature</u> (required for all submissions)		
Name Printed	Bryce McMurray	(signed)
Grade/ Title	Acting Director of Mental Health and Disability	
Date		
<u>Trust Director of Finance Signature</u> (required if bid is over £100k)		
Name printed	Stephen McNally	(signed)
Date		
<u>Trust Chief Executive Signature</u> (required if bid is over £100k)		
Name printed	(signed)	
Date		

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – required for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.

Approved by

Name printed (signed)

Grade / Title

Date

Approval of Investment Proposal Template by HSCB Director(s) and/or Chief Executive

Director Signature (required for all bids)

Name printed (signed)

Grade / Title

Date

HSCB Director of Finance Signature (required if bid is over £100k)

Name printed (signed)

Date

HSCB Chief Executive Signature (required if bid is over £100k)

Name printed (signed)

Date

Approval of Investment Proposal Template by Commissioning Board (required if bid is over £100k)

Date of approval at Commissioning Board

Date

Complete this section if Department / DFP approval required

Date submitted to Department

Department/ DFP approval (y/n)

Date approved

SECTION 1: Commissioner specification to include strategic context and need (to be completed by the Commissioner)

Day Opportunities

The Service Framework for Learning Disability published in September 2012, sets out clear standards of care that people can expect. This Framework aims to improve the health and wellbeing of people with a learning disability, their carers and families, by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.

The 2012-2015 Bamford Action Plan continues to progress the enhancement of mental health and learning disability services started through the previous plan. The evaluation of the 2009-2011 Action Plan, published in May 2012, established that over the last two years the joint working across Government Departments and the HSC sector has achieved much, and 80% of the actions have been delivered. It also highlights areas where services can still be improved and the need for more of a focus on outcomes rather than outputs.

The strategy entitled "A strategy to improve the lives of disabled people – 2012 to 2015 also sets out the key priorities that OFMDFM believe will be crucial in addressing the barriers that disabled people face.

Promoting Social Inclusion (PSI) Disability presented to the first minister in December 2009 recommendations are also firmly anchored around the principles of the United Nations Convention on the Rights of Persons with Disabilities, which aim to promote dignity, independence and access.

Following the endorsement of the Regional Day Opportunities Model in 2014 this gave the Trusts direction on the desired Model for the delivery of day opportunities.

The HSCB requires the Trust to invest this non recurrent investment in the further development of the Day Opportunities Model within their locality.

Trust Proposal

The Southern Trust has been developing and extending the options for supporting people with disabilities to participate as active members within their communities for many years. These options are referred to as 'day opportunities'. This direction of travel is in line with key national and local strategies, Transforming Your Care, A Review of Health and Social Care in Northern Ireland, The Bamford Review and also the Physical and Sensory Disability Strategy for Northern Ireland. All of these strategies focus on improving the lives of those with disabilities.

Transforming Your Care outlined as one of its key proposals for individuals with a learning disability a commitment to continue to develop creative and age appropriate day opportunities to promote independence and choice, such as access to employment, leisure and educational activities. Transforming Your Care also indicated a review of the provision of day-care services.

Currently each Day Care locality has 25+ ageing service users with a learning disability and/or declining mental/physical health that are increasingly in need of less active Day Care services closer to their home. The Trust proposes to implement a new service GOLD (Growing older with a learning disability) where the appointment of 2wte band 3 community support workers will help transition those individuals who are aged 75+ into individualised age appropriate community based Day Services. The vision for the future is to ensure that all adults with a disability have the individualised support they need to be as independent as possible.

(5months £20,628)

The Trust proposes to use the investment to provide 1wte band 5 nurse based in Linen Bridge Day Care Centre to assist with those clients with complex health care needs. This service will alleviate pressure on support workers who will then be freed up to support other clients within the centre. **(6 months £17,682)**

The Trust also proposes to use the remaining investment to fund contracts with independent/private providers. These contracts will concentrate on the delivery of Community Mapping Programmes to support adults with learning and/or physical disabilities to utilise community services; improve engagement, and to empower them to become valued members of their communities.

These programmes should provide a range of stimulating, innovative, flexible, and person centred activities which are structured and specific to the individual needs and capabilities of the participants.

They will explore all assets within each community;

- Individual
- Community
- Statutory

The participants will be supported to access; facilities such as libraries and community/sports centres, local businesses, parks and forests. They should be provided with the opportunity to engage with local people; organised community groups or individuals who have skills and talents. All of which can be mapped to create a picture of the community which demonstrates capacity and potential in supporting this Service User group. (£60,830).

The Trust proposes to deliver 48 community mapping sessions (Defined as 6 hours) 16 weekly sessions for eight participants with disabilities in each geographical area outlined below:

- Armagh/Dungannon – Mondays or Wednesdays
- Craigavon/Banbridge - Thursdays
- Newry/Mourne – Fridays 9.30am

Sessions should be delivered within working hours identified as 9.30 am -3.30 pm in community venues. The Trust requires one Service Provider to deliver the whole service across the Trust geographical area.

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. Develop community based alternatives to day care in partnership with voluntary and statutory partners (stimulate market development with an emphasis on partnership working developing a diverse range of activities).	Day Opportunities” to mean a package of community-based day time activities which will engage adults with a learning disability in areas such as accredited further education; volunteering; paid supported employment; social enterprise activity and opportunities to meet and make friends and use local leisure and recreational facilities.
2. Remodel in-house services to focus on meeting more complex support needs and support the reshaping of the	No of in house services remodelled

Project Objectives	Measurable Targets
current in-house day service provision and staffing to the new model of working as necessary.	
4. Ensure cross-project and cross departmental objectives are noted and tracked to deliver desired outcomes	Evidence of cross department working
5. Support individuals to engage with both the development and uptake of new opportunities promoting social inclusion, flexibility and maximising independence	No of users to benefit from new day opportunities/ activities.

SECTION 2 (b): CONSTRAINTS

<p>The following constraints must be considered in line with this investment;</p> <ol style="list-style-type: none"> 1. The availability of suitable day opportunities which meet with the needs of learning disability clients. The Trust will continually evaluate the availability and suitability of placements with a view to successful placements for individuals. 2. If funding was unsuccessful the proposed GOLD service would not be able to be implemented. 3. Timescales to recruit staff and to have in post within the timeframe
--

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	Status Quo - continue with existing arrangements with no investment to Learning Disability for Day Opportunities
2	<p>Increase staffing levels to provide the following to further develop Day Opportunities with Learning Disability Services:</p> <ul style="list-style-type: none"> • 1 wte band 5 nurse to input into Linen Bridge Day Care Centre to assist with those clients with complex health care needs (6 months) • 2.0 wte band 3 Support Workers to input into Gold Services in providing support for sampling of various day opportunities. This will be a temporary service until the end of the 16/17 financial year. (5 months) • Remainder of allocation to fund contracts for Community Mapping Contracts.
3	N/A

SECTION 4: PROJECT COSTS

Option 1: Status Quo	Year 0 16/17 £ 000	Year 1 17/18 £ 000	Year 2 18/19 £ 000	Year 3 19/20 £ 000	Totals £ 000
<u>Capital Costs</u>					
(a) Total Capital Cost	0	0	0	0	0
<u>Revenue Costs</u>					
Baseline Costs	1,290	1,290	1,290	1,290	5,160
(b) Total Revenue Cost	1,290	1,290	1,290	1,290	5,160
(c) Total Cost = (a) + (b)	1,290	1,290	1,290	1,290	5,160
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	
(e) NPC = (c) x (d)	1,290	1,246	1,204	1,163	4,903

FINANCIAL ASSUMPTIONS:

- Year 0 is current financial year 2016/17
- Baseline costs are recurring revenue baseline budget for Mental Health & Disability Day Opportunities 15/16 TFR costs uplifted by 2% for 16/17 of £1,290,379
- No proposed works associated with this option
- No additional capital or revenue / non-recurring revenue costs associated with this option
- Discount factor @ 3.5% pa has been applied
- Please note all figures above have been rounded
- Total NPC £4,903k

Option 2: Day Opportunities	Year 0 16/17 £ 000	Year 1 17/18 £ 000	Year 2 18/19 £ 000	Year 3 19/20 £ 000	Totals £ 000
<u>Capital Costs</u>					
(a) Total Capital Cost	0	0	0	0	0
<u>Revenue Costs</u>					
Baseline Costs	1,290	1,290	1,290	1,290	5,160
Payroll	35	0	0	0	35
Payroll related goods & services	3	0	0	0	3
Contract Community Mapping	61	0	0	0	61
(b) Total Revenue Cost	1,389	1,290	1,290	1,290	5,259
(c) Total Cost = (a) + (b)	1,389	1,290	1,290	1,290	5,259
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	
(e) NPC = (c) x (d)	1,389	1,246	1,204	1,163	5,002

FINANCIAL ASSUMPTIONS:

- Year 0 is current financial year 2016/17
- Baseline costs are recurring revenue baseline budget for Mental Health & Disability Day Opportunities 15/16 TFR costs uplifted by 2% for 16/17 of £1,290,379
- All posts costed to 16/17 draft HSCB costing template
- Payroll costs include employers costs for national insurance and superannuation
- All posts costed at basic with no enhancement for overtime or rota according to working rota of Monday-Friday 9am-5pm
- Payroll related goods and services costed to 10% of basic pay per HSCB costing template per band
- Contract for Community Mapping programme costs of £60,830
- No other consumables, maintenance or revenue costs identified for this project
- Band 5 post applied part year effect in 16/17 by 6/12 in post from 1st October 2016
- Band 3 post applied part year effect in 16/17 by 5/12 in post from 1st November 2016
- Non recurring 16/17 funding allocation of £99,140
- No capital costs identified with this case
- Detailed payroll costings attached
- Discount factor @ 3.5% pa has been applied
- Please note all figures above have been rounded to thousands
- Total NPC £5,002k

SECTION 5: NON-MONETARY BENEFITS

- Increase the range and availability of person centred community based opportunities for people with a learning disability
- To refocus day care provision on the needs of individuals with significant challenging behaviours and/or complex healthcare needs.
- To deliver therapeutic programmes to support rehabilitation and ongoing support for individuals with continuing complex care needs.
- Provision of person centred, age appropriate day services support to ageing service users.
- Creation of capacity within day centres to cater for the needs of young persons in transition from special schools with complex needs.
- Continued provision of respite to ageing carers.

SECTION 6: PROJECT RISKS & UNCERTAINTIES

There is a risk that the Trust will not be able to identify a further range of day opportunities which are age appropriate.

There is also a risk that the number of clients with complex health care needs will increase and 1wte nurse will not be sufficient to meet the need.

There is also a risk that the day opportunity does not meet the need of the client and the client requires an alternative day opportunity or placement in a day centre.

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

The preferred option is as follows:

Option 2 - Increase staffing levels to provide the following to further develop Day Opportunities with Learning Disability Services:

- 1 wte band 5 nurse to input into Linen Bridge Day Care Centre to assist with those clients with complex health care needs
- 2.6 wte band 3 Support Workers to input into Gold Services on a temporary basis until the end of the current financial year.
- Remainder of allocation to fund Community Mapping Contract.

A new service GOLD (Growing older with a learning disability) will be implemented. With the appointment of 2.6wte band 3 community support workers who will support individuals who are aged 75+ transition into individualised age appropriate community based Day Services and provide support for clients to sample various day opportunities. The vision for the future is to ensure that all adults with a disability have the individualised support they need to be as independent as possible.

The appointment of the 1wte nurse who will be based in Linen Bridge Day Care Centre will assist with those clients with complex health care needs. This will alleviate pressure on support workers who will then be

freed up to support other clients within the centre.

The Community Mapping Programme will provide a range of stimulating, innovative, flexible, and person centred activities which are structured and specific to the individual needs and capabilities of the participants.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Year 0 16/17 £ 000	Year 1 17/18 £ 000	Year 2 18/19 £ 000	Year 3 19/20 £ 000	Totals £ 000
Required					
Capital required	0	0	0	0	0
Revenue required	1,389	1,316	1,342	1,369	5,416
Existing budget :					
Capital	0	0	0	0	0
Revenue	1,290	1,316	1,342	1,369	5,317
Additional Allocation Required:					
Capital	0	0	0	0	0
Revenue	99	0	0	0	99

AFFORDABILITY ASSUMPTIONS

- Year 0 is current financial year 2016/17
- Baseline costs are recurring revenue baseline budget for Mental Health & Disability Day Opportunities 15/16 TFR costs uplifted by 2% for 16/17 of £1,290,379
- Additional recurring revenue costs uplifted by 2% to account for inflation
- Band 5 post applied part year effect in 16/17 by 6/12 in post from 1st October 2016
- Band 3 post applied part year effect in 16/17 by 5/12 in post from 1st November 2016
- Non recurring 16/17 funding allocation of £99,140
- No capital costs identified with this case
- Discount factor @ 3.5% pa has been applied
- Please note all figures above have been rounded to thousands

SECTION 9: MANAGEMENT ARRANGEMENTS

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management. The following key roles have been identified:

Project Owner: Mr Bryce McMurray, Director of Mental Health and Disability

Project Director: Mr Miceal Crilly, Assistant Director of Physical and Sensory Disability Services

Project Manager: Bronagh McKeown, Head of Disability Day services

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation.

SECTION 10: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

				Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains
PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	I - Investment P - Productivity

SECTION 11: MONITORING AND EVALUATION

Who will manage the implementation?	The implementation of this investment will be overseen by Bronagh McKeown, Head of Physical and Sensory Disability Support
Who will monitor and evaluate the outcomes?	Bronagh McKeown, Head of Physical and Sensory Disability Support will be responsible for overseeing the project
What other factors will be monitored and evaluated? –	Number of day care places made available to other clients
When will this take place?	During 2016/17

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

The preferred option is to implement the GOLD service which will enable the Trust to provide support to those clients aged 75+ to sample various day opportunities as they are currently inappropriately placed. By finding suitable day opportunities for these clients further day opportunities and day care placements will be made available to those clients transitioning or those clients who are no longer suitable for their current placement.

The Trust proposes to deliver 48 community mapping sessions (Defined as 6 hours) 16 weekly sessions for eight participants with disabilities in each geographical area outlined below:

- Armagh/Dungannon – Mondays or Wednesdays
- Craigavon/Banbridge - Thursdays
- Newry/Mourne – Fridays 9.30am


Sessions should be delivered within working hours identified as 9.30 am -3.30 pm in community venues. The Trust requires one Service Provider to deliver the whole service across the Trust geographical area.

MAHI - STM - 126 - 434

Summary Costing schedule for Investment Decision Making Templates		Ref Number	
Provider		SOUTHERN	
Hospital Site or Community development		COMMUNITY.	
Scheme Title		DAY OPPORTUNITIES	
Pay and Price Levels		2016/17	
			Commissioner Use only
			Sign and Date for TRAFFACS update

Pay Costs	Description	Base Case - option 1				Option 2				Option 3				Option 4			
		months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye
	BASELINE BUDGET 16/17	12.00		1,290,379	1,290,379	12.00		1,290,379	1,290,379								
BAND 1				0	0			0	0								
BAND 2				0	0			0	0								
BAND 3				0	0	5.00	2.00	45,814	19,089								
BAND 4				0	0			0	0								
BAND 5				0	0	6.00	1.00	32,760	16,380								
BAND 6				0	0			0	0								
BAND 7				0	0			0	0								
BAND 8A				0	0			0	0								
BAND 8B				0	0			0	0								
BAND 8C				0	0			0	0								
BAND 8D				0	0			0	0								
BAND 9				0	0			0	0								
Non-AFC posts please detail below																	
Allowances for posts noted above - please detail below																	
	Band 3 Payroll related goods and services			0	0	5.00		3,694	1,539								
	Band 5 Payroll related goods and services			0	0	6.00		2,604	1,302								
				0	0			0	0								
				0	0			0	0								
				0	0	0.00		0	0								
				0	0			0	0								
Exceptional Recruitment and Retention costs for posts above the mean plus x% (please provide detail)																	
TOTAL PAY COSTS				0.00	1,290,379	1,290,379		3.00	1,375,251	1,328,689			0.00	0	0	0.00	0
Non-Pay Costs - please detail below																	
	Contract for community mapping programme							60,830	60,830								
TOTAL NON-PAY COSTS					0	0		60,830	60,830				0	0			0
GRAND TOTAL				1,290,379	1,290,379			1,436,081	1,389,519			0	0			0	

Phasing/Timescale	<i>(Can development be phased, if so provide details in this box)</i>	<i>(Can development be phased, if so provide details in this box)</i>	<i>(Can development be phased, if so provide details in this box)</i>	<i>(Can development be phased, if so provide details in this box)</i>
PROGRAMME OF CARE	learning disability	learning disability		
SUB-SPECIALTY INFORMATION eg inpatients, LCG	Southern	Southern		
If more than one LCG in option above please give details				
LGD				
If more than one LGD in option above please give details				

 Southern Health and Social Care Trust						
Financial Management - Capital Services & Business Cases						
Financial Appraisal						
Section 8: Affordability Table						
IPT Project: MHD Day Opportunities						
Date Prepared: 3rd November 2016						
		16/17	17/18	18/19	19/20	
		YEAR 0	YEAR 1	YEAR 2	YEAR 3	TOTAL
		000	000	000	000	
		£	£	£	£	£
TOTAL BUDGET REQUIRED						
	Capital Required	0	0	0	0	0
	Revenue Required	1,389	1,316	1,342	1,369	5,416
	Total Budget	1,389	1,316	1,342	1,369	5,416
EXISTING BUDGET						
	Capital Required	0	0	0	0	0
	Revenue Required	1,290	1,316	1,342	1,369	5,317
	Total Existing Budget	1,290	1,316	1,342	1,369	5,317
ADDITIONAL BUDGET REQUIRED						
	Capital Required	0	0	0	0	0
	Revenue Required	99	0	0	0	99
	Total Add Budget Required	99	0	0	0	99
Financial Assumptions:						
1. Year 0 is current financial year 2016/17.						
2. Baseline costs are recurring revenue baseline budget for Mental Health & Disability Day Opportunitie						

LEVEL 2 Investment Proposal Template**REVENUE FUNDING £50k - £250k**

HSCB IPT Ref No	
Source of Funding (Year / ref)	Demography 2016/17
Allocation value	£42,412
HSCB Representative name and contact details	
Trust Representative name and contact details	Miceal Crilly - SHSCT Miceal.crilly@southerntrust.hscni.net 028 3883 3248
Project Title	AHP Support to Learning Disability Day Opportunities
Total Cost	£42,412 fye (17/18) £21,206 cye
Start date	TBC
Completion date	31st March 2017

Complete this section if bid is for new funding i.e. funding is not currently in the Trust baseline

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Y
How much total funding required?	£42,412
How much funding required per year?	£42,412
Is this funding to be made recurrent? (Y/N)	Y

Complete this section if funding available within existing allocation i.e. funding is currently in the Trust baseline

Funding available within existing allocation (Y/N)	
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	

Is this business case	Y/N
(a) Standard	Y
(b) Novel	
© Contentious	
(d) Setting a precedent	
If yes to (b) or (c) or (d) , requires Departmental & DFP approval	
Is Departmental / DFP approval required	

Approval & submission by Trust

This section to be completed by Trusts for all submissions

<u>Responsible Director Signature</u> (required for all submissions)	
Name Printed	(signed)
<i>Carroll Henry</i>	
Grade/ Title	
Date	
<u>Trust Director of Finance Signature</u> (required if bid is over £100k) - N/A	
Name printed	(signed)
Date	
<u>Trust Chief Executive Signature</u> (required if bid is over £100k) - N/A	
Name printed	(signed)
Date	

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – required for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.

Approved by

Name printed (signed)

Grade / Title

Date

Approval of Investment Proposal Template by HSCB Director(s) and/or Chief Executive

Director Signature (required for all bids)

Name printed (signed)

Grade / Title

Date

HSCB Director of Finance Signature (required if bid is over £100k)

Name printed (signed)

Date

HSCB Chief Executive Signature (required if bid is over £100k)

Name printed (signed)

Date

Approval of Investment Proposal Template by Commissioning Board (required if bid is over £100k)

Date of approval at Commissioning Board

Date

Complete this section if Department / DFP approval required

Date submitted to Department

Department/ DFP approval (y/n)

Date approved

SECTION 1: Commissioner specification to include strategic context and need (to be completed by the Commissioner)

[expand as appropriate]

The number of people with a learning disability and the levels of accompanying complex physical and mental health needs continues to grow in NI. A lifelong service response is required to support people to live as healthy, fulfilling and independent lives as possible. Crucial to this is the support for families and other carers who continue to provide the bulk of care and support which people need.

By 2020 there is expected to be a 6% increase in the total Southern LCG/Trust population. Prevalence data estimates that people with a Learning disability make up 1% to 2% of the total population of Northern Ireland. These population changes will impact on the demand for Learning Disability services. In line with the HSCB Commissioning Plan, the Trust will be required to demonstrate how the change in population need and demand for Learning Disability services will be managed in 2016/17, to include specific arrangements to address each of the regional Learning Disability service priorities and as part of this allocation to ensure:

- Effective arrangements are in place to increase the number of individuals availing of community based Day Opportunities.

Trust proposal:

The Southern Trust has been developing and extending the options for supporting people with disabilities to participate as active members within their communities for many years. These options are referred to as 'day opportunities'. Transforming Your Care outlined as one of its key proposals for individuals with a learning disability a commitment to continue to develop creative and age appropriate day opportunities to promote independence and choice, such as access to employment, leisure and educational activities.

The Trust proposes to use this investment to enhance AHP support, increasing the Trust's capacity to assess individuals for a range of Day Opportunities. The Trust plans to take this forward through appointment of a 1wte Band 6 Occupational Therapist who will work as part of a multi-disciplinary team providing specialist occupational therapy assessments and interventions for service users aged 18 YRS+

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. To increase the Trust's AHP capacity through the appointment of 1wte Band 6 Occupational Therapist	<ul style="list-style-type: none"> • Appointment of a wte Band 6 OT by 31st March 2017 • Provision of 6 specialist assessments per week. • Reduction in waiting times for clients needing assessed for day opportunities

<p>2. Support service users to engage in a range of suitable community opportunities promoting social inclusion, flexibility and maximizing their independence through:</p> <ul style="list-style-type: none"> • the assessment of their skills • provision of travel training to and from community venues • assessment of their occupational skills for employment 	<ul style="list-style-type: none"> • Increase in the number of service users who benefit from new day opportunities/ activities. • Release of day care places for those more complex individuals.
<p>3. [add more objectives as appropriate]</p>	

SECTION 2 (b) : CONSTRAINTS

<p>The following constraints must be considered in line with this investment;</p> <ol style="list-style-type: none"> 1. The availability of suitable day opportunities which meet with the needs of learning disability service users. The Trust will continually evaluate the availability and suitability of placements with a view to successful placements for individuals. 2. Timescales to recruit staff and to have in post within the timeframe

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	Status Quo - continue with the existing arrangements with no investment in AHP services to support the development of Day Opportunities
2	Increase AHP staffing levels to further develop Day Opportunities within Learning Disability Services: <ul style="list-style-type: none"> • Appointment of 1wte Band 6 Occupational Therapist
3	N/A

SECTION 4: PROJECT COSTS

Option	Year 0 (£'000)	Year 1 (£'000)	Year 2 (£'000)	Total (£'000)
1 Status Quo				
2 – Enhanced AHP Capacity with appointment of 1wte Band 6 OT				
3 - N/A				

COST ASSUMPTIONS:

[expand as appropriate]

SECTION 5: NON-MONETARY BENEFITS

1. Increased OT capacity to the multidisciplinary team thus reducing the waiting time for OT assessment for this client group.
2. Increased capacity in day centres for more complex client group
- 3.

SECTION 6: PROJECT RISKS & UNCERTAINTIES

1. There is a risk that the Trust will not be able to appoint staff within the timeframe.
2. There is also a small risk that the number of clients requiring assessment will increase and as a result waiting times for client assessments will not reduce.

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

The preferred option is as follows:

Option 2 - Increase AHP staffing levels to provide the following to further develop Day Opportunities for service users within Learning Disability Services:

- 1 wte Band 6 Occupational Therapist

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Yr 0 £000's	Yr 1 £000's	Yr 2 £000's	Yr 3 £000's	Totals £000's
Required					
Capital required					
Revenue required					
Existing budget :					
Capital					
Revenue					
Additional Allocation Required:					
Capital					
Revenue					

AFFORDABILITY ASSUMPTIONS



SECTION 9: MANAGEMENT ARRANGEMENTS

The following key roles have been identified:

Project Owner: Mr Bryce McMurray, Director of Mental Health and Disability

Project Director: Mr Miceal Crilly, Assistant Director of Physical and Sensory Disability Services

Project Manager: Bronagh McKeown, Head of Disability Day services

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation. The following key roles have been identified:

SECTION 10: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains I - Investment P - Productivity
				Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	
Acute	Gen Surgery	Vascular	FCE	1200	500	2000	P
POC6	Learning Disability	Occupational Therapy		Lynn Lappin to provide baseline info	Lynn Lappin to provide baseline info		

PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains
				Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	
							I - Investment P - Productivity

SECTION 11: MONITORING AND EVALUATION

<p>Who will manage the implementation?</p>	<p>Project Director: Mr Miceal Crilly, Assistant Director of Disability Services.</p>
<p>Who will monitor and evaluate the outcomes?</p>	<p>Project Director: Mr Miceal Crilly, Assistant Director of Disability Services.</p>
<p>What other factors will be monitored and evaluated? –</p>	
<p>When will this take place?</p>	<p>12 months after full implementation.</p>

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

[expand as necessary]

LEVEL 2 Investment Proposal Template

REVENUE FUNDING £50k - £250k

HSCB IPT Ref No	SCCD/2017/18/LD 28
Source of Funding (Year / ref)	Inescapable Service Developments 2017/18 Non-recurrent
Allocation value	£198,281 CYE
HSCB Representative name and contact details	Joyce McKee, Tower Hill, Armagh BT61 9DR
Trust Representative name and contact details	Miceal Crilly Asst. Director, Learning Disability Services Southern Health & Social Care Trust [REDACTED]
Project Title	Learning Disability – Complex Discharges from Hospital
Total Cost	£198,281 CYE
Start date	1 st October 2017
Completion date	31 st March 2018

Complete this section if bid is for new funding i.e. funding is not currently in the Trust baseline

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Y
How much total funding required?	
How much funding required per year?	

Is this funding to be made recurrent? (Y/N)	N
---	---

Complete this section if funding available within existing allocation i.e. funding is currently in the Trust baseline

Funding available within existing allocation (Y/N)	
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	N

Is this business case	Y/N
(a) Standard	Y
(b) Novel	N
© Contentious	N
(d) Setting a precedent	N
If yes to (b) or (c) or (d) , requires Departmental & DFP approval	
Is Departmental / DFP approval required	

Approval & submission by Trust

This section to be completed by Trusts for all submissions

<u>Responsible Director Signature</u> (required for all submissions)	
Name Printed	(signed)
Grade/ Title	
Date	
<u>Trust Director of Finance Signature</u> (required if bid is over £100k)	
Name printed	(signed)
Date	
<u>Trust Chief Executive Signature</u> (required if bid is over £100k)	
Name printed	(signed)
Date	

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – required for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.

Approved by

Name printed (signed)

Grade / Title

Date

Approval of Investment Proposal Template by HSCB Director(s) and/or Chief Executive

Director Signature (required for all bids)

Name printed (signed)

Grade / Title

Date

HSCB Director of Finance Signature (required if bid is over £100k)

Name printed (signed)

Date

HSCB Chief Executive Signature (required if bid is over £100k)

Name printed (signed)

Date

Approval of Investment Proposal Template by Commissioning Board (required if bid is over £100k)

Date of approval at Commissioning Board

Date

Complete this section if Department / DFP approval required

Date submitted to Department

Department/ DFP approval (y/n)

Date approved

SECTION 1: Commissioner specification to include strategic context and need (to be completed by the Commissioner)

From 1/4/2013 the standard for complex discharges (Commissioning Direction letter DHSSPS) is that 99% of people in LD and MH hospitals are discharged 7 days after being declared fit for discharge and 100% after 28 days.

In recognition of the pressures on Trusts to meet and maintain this target additional discharge packages should be provided to avoid any breaches of the 28 day target.

The investment is based on the Trust's capitation share of funds available to the HSCB for this purpose and reflects a whole population approach rather than the individual patient specific funding approach employed to date.

The Trust should also take account of the community infrastructure investment into LD to make best effect of the total funding available in terms of achieving the target.

The Trust should bring forward proposals that clearly set out the packages of care for the complex delayed discharge patients that are being funded within each programme of care, together with initials and dates of births.

Trust Proposal

The Trust proposes to allocate the funding identified for three clients who are currently in the Dorsy Unit on the Craigavon Hospital site.

Below is a list of individuals identified by initials, date of birth and the corresponding costs a nursing/residential home placement, supported living or care and support package. These individuals' needs are of a complexity that if we were not able to resource the required level of care, then the person would require long term hospital admission to meet their needs.

Initials	Date of Birth	Package	Annual Cost £
RK	23/06/97	Care and Support Package	£88,920
DK	21/03/91	Specialist Placement	£93,600
AD		Bespoke supported living package	£16,000
			£198,520

Please note that the package required for AD is £250 and there is a shortfall of £234,000 required to fund a supported living packaged for this individual which cannot be met within this investment proposal.

This cohort of people if not supported in the community may be readmitted to hospital and will then receive care in an inappropriate environment with a continued reliance of hospital care provision. Pressure on acute admission beds will continue to cause major problems and the proposed objectives for patients will not be

progressed.

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. To work towards targets and strategic direction <ul style="list-style-type: none"> • Transforming Your Care • Bamford Action Plan • Commissioning Plan • Ministerial PfA targets. 	<ul style="list-style-type: none"> • All admissions will have a discharge plan in place within 7 days and home treatment will attend all planned multi-disciplinary meetings and discharges will be effected earlier for those who require changing medication which will be undertaken by the Home Treatment Team • The resettlement of long stay hospital Patient to suitable placements in the community.
2. To provide suitable alternative community placements for complex delayed discharge patients which meets the individuals collective needs and provides a greater quality of life and betterment.	<ul style="list-style-type: none"> • The number of long stay patients in learning disability inpatient services by 31 March 2016.
3. Promote recovery, maintain and/or build family and social connections/networks.	<ul style="list-style-type: none"> • Enhanced level of support to patients reducing the need to be admitted to hospital. • No of re-admissions.
4. Minimize the need for hospital care through earlier intervention.	<ul style="list-style-type: none"> • Reduction in the number of readmissions
5. Enables earlier discharge and prevents delays in discharge from acute inpatient care.	<ul style="list-style-type: none"> • 99% of all Learning disability discharges take place within 7 days of the patient being assessed as medically fit for discharge with no discharge taking more than 28 days.
6. Provide care and support packages to those clients with a learning disability to enable them to remain in the community.	<ul style="list-style-type: none"> • The number of clients who are able to remain in the community.

SECTION 2 (b) : CONSTRAINTS

The following constraints must be considered in line with this investment;

- The availability of suitable community placements which meet with the needs of learning disability clients. The Trust will continually evaluate the availability and suitability of placements with a view to successful resettlement and discharge.
- If funding was unsuccessful, the ability for the SHSCT to meet specific ministerial targets for discharge from hospital and resettlement may be compromised.

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	<p>Status Quo - continue with existing arrangements –</p> <p>This option would involve no change to current service delivery to mental health clients nor see any additional investment provided this year for the service.</p>
2	<p>Option 2 - Resettle those individuals identified to placements within the community with the appropriate packages of care and support</p>

SECTION 4: PROJECT COSTS

Option	Year 1 (£'000)	Year 2 (£'000)	Year 3 (£'000)	Total (£'000)
1				
2				
3				

COST ASSUMPTIONS:

[expand as appropriate]

SECTION 5: NON-MONETARY BENEFITS

To provide community placements for those individuals with a learning disability who can no longer remain in a hospital setting and to prevent readmission to hospital. Provide support to those individuals to enable them to live in a community setting and to support those individuals to enable them to attend daily activities.

SECTION 6: PROJECT RISKS & UNCERTAINTIES

- Failed community placements
- Re-admission to hospital
- Breakdown in client living arrangements resulting in a risk to the client

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

The Preferred Option is - Option 2 - Resettle those individuals identified to placements within the community with the appropriate packages of care and support

This option meets all the project objectives and individual needs of each client. It will provide consistency in the package of care and support to be delivered. This option offers individual choice and a betterment that is person centred and recovery based to meet the individual assessed needs. If the correct packages of care and support and placements are not put in place for those clients identified this may result in a breakdown in the clients living arrangements and re-admission to hospital.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

	Yr 0	Yr 1	Yr 2	Yr 3	Totals
AFFORDABILITY STATEMENT	£000's	£000's	£000's	£000's	£000's
Required					
Capital required					
Revenue required					

Existing budget :					
Capital					
Revenue					
Additional Allocation Required:					
Capital					
Revenue					

AFFORDABILITY ASSUMPTIONS

SECTION 9: MANAGEMENT ARRANGEMENTS

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management. The following key roles have been identified:

Project Owner: Mr Bryce McMurray, Director of Mental Health and Disability

Project Director: Mr Miceal Crilly, Assistant Director of Learning Disability Services/Mr Bryce McMurray, Assistant Director of Mental Health

Project Manager: Mr John McEntee, Head of Service Community Disability Services

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation.

SECTION 10: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

				Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains
PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	I - Investment P - Productivity

SECTION 11: MONITORING AND EVALUATION

Who will manage the implementation?	The implementation of this investment will be overseen by John McEntee, Head of Learning Disability Services
Who will monitor and evaluate the outcomes?	John McEntee, Head of Learning Disability Services will be responsible for overseeing the project
What other factors will be monitored and evaluated? –	*****
When will this take place?	During 2017/18

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

- | |
|--|
| <ul style="list-style-type: none"> • The Trust benchmarks the cost and the quality of placements across providers to ensure value for money and quality outcomes for individuals. • Contracts are monitored bi-annually. |
|--|

LEVEL 3 Investment Proposal Template

REVENUE FUNDING £250k - £1m

HSCB IPT Ref No	SCCD 2016/17 LD 44
Source of Funding (Year / ref)	June Monitoring 2016/17 Recurrent
Allocation value	£297,421 & £8,750 CYE £306,171 FYE £297,421
HSCB Representative name and contact details	Joyce McKee, Tower Hill, Armagh BT61 9DR
Trust Representative name and contact details	Miceal Crilly Asst. Director, Learning Disability Services Southern Health & Social Care Trust [REDACTED]
Project Title	June Monitoring Round – Learning Disability – Day Opportunities
Total Cost	£306,171 CYE and £297,421 FYE
Start date	1 st April 2017
Completion date	31 st March 2018

Complete this section if bid is for new funding i.e. funding is not currently in the Trust baseline

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Y
How much total funding required?	
How much funding required per year?	

Is this funding to be made recurrent?	Y

Complete this section if funding available within existing allocation i.e. funding is currently in the Trust baseline

<i>Funding available within existing allocation (Y/N)</i>	
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	Y

<i>Is this business case</i>	
<i>(a) Standard</i>	Y
<i>(b) Novel</i>	N
<i>(c) Contentious</i>	N
<i>(d) Setting a precedent</i>	N
<i>If "yes" to (b) or (c) or (d), requires Departmental & DFP approval</i>	
<i>Is Departmental / DFP approval required</i>	

Approval & submission by Trust/s

This section to be completed by Trusts for all submissions

<u>Prepared by(required)</u>	
Name Printed Bronagh Mc Keown	(signed)
Grade/ Title Head of Disability Day services	
Date 13/11/17	
<u>Trust Director of Finance Signature(required)</u>	
Name printed	(signed)
Date	
<u>Trust Chief Executive Signature(required)</u>	
Name printed	(signed)
Date	

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – required for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.	
<u>Approved by</u>	
Name printed	(signed)
Grade / Title	
Date	

Approval of Investment Proposal Template by HSCB Director(s) / Chief Executive Officer – required for all submissions

<u>Responsible Director Signature (required)</u>	
Name printed	(signed)
Grade / Title	
Date	
<u>HSCB Director of Finance Signature(required)</u>	
Name printed	(signed)
Date	
<u>HSCB Chief Executive Signature(required)</u>	
Name printed	(signed)
Date	

Approval of Investment Proposal Template by Commissioning Board (required for all submissions)

<u>Date approved by Commissioning Board</u>
Date

Complete this section if Department / DFP approval required

Date submitted to Department
Department/ DFP approval (y/n)
Date approved

SECTION 1(a): Commissioner Specification to include strategic context and need (to be completed by the Commissioner).

The Trusts should bring forward proposals which will outline how a range of Day Opportunities will be developed and or enhanced to meet the needs of individuals within their Trust locality.

Within this IPT the term “Day Opportunities” reflects the expectations that the Bamford review places in relation to Equal Lives which states:-

- 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” (Equal Lives).

Therefore we are using the terms “Day Opportunities” to mean a package of community-based day time activities which will engage adults with a learning disability in areas such as accredited further education; volunteering; paid supported employment; social enterprise activity and opportunities to meet and make friends and use local leisure and recreational facilities. These services should be discrete from traditional buildings-based day care facilities and access to the Day Opportunities services should be in non-segregated general transport provision.

To secure this investment, proposals will need to be in line with the Regional Learning Disability Day Opportunities Model and include the options to:-

- a. Develop community based alternatives to day care in partnership with voluntary and statutory partners
- b. Support the reshaping of the current in-house day service provision and staffing to the new model of working as necessary.
- c. Remodel in-house services to focus on meeting more complex support needs.
- d. Support and work to stimulate market development with an emphasis on partnership working developing a diverse range of activities.
- e. Make any necessary adjustments to contract arrangements arising out of the introduction of Self-Directed Support (SDS) /Personal Budgets (PB) for day services.
- f. Ensure cross-project and cross departmental objectives are noted and tracked to deliver desired outcomes
- g. Support individuals engage with both the development and uptake of new opportunities promoting social inclusion, flexibility and maximising independence.
- h. Reflect the adoption of best practice in development plans with particular reference to rurality.
- i. Demonstrate the financial model, sustainability and deliverability of the new service model.
- j. Demonstrate commitment to the principles and values inherent in Bamford
- k. Ensure relevant stakeholder engagement.

Social Farming Element – Non Recurrent Business case

Social Farming is an innovative use of agriculture to promote therapy, rehabilitation, social inclusion, education and Day Opportunities in rural areas. Central to the concept is the farm, which remains a typical working farm where people in need of support can benefit from participation in farm activities in a non-clinical environment and the farmer, who is remunerated for the provision of the service.

The Social Farm Referral Fund would be allocated across Trusts on a pro-rata basis to take into account current Social Farming provision as follows:

Heath and Social Care Trust	Percentage (%)
Northern	20.83
South Eastern	16.67
Belfast	16.67
Southern	12.5
Western	33.33

Flexibility is recommended in relation to the number of farms and associated days per week in order to meet farmer availability, service user referrals and transport considerations.

Part of the £297,421 CYE allocation should be used to fund the Social Farming element. The SHSCT share of this element is 12.5% which equates to £3,126 for this specific non-recurrent project. A further £70,000 regionally is being provided non-recurrently by DAERA and PHA in 2017/18 for the Social Farming element. The SHSCT share of this additional non-recurrent funding is 12.5% which equates to £8,750 and this has been added to the £297,421 CYE allocation for SHSCT for 2017/18.

The total CYE funding for SHSCT in respect of the non-recurrent Social Farming element is therefore £11,876 for 2017/18.

SECTION 1(b): DEMONSTRATE THE NEED FOR THE PROJECT

Day Opportunities

The Service Framework for Learning Disability published in September 2012, sets out clear standards of care that people can expect. This Framework aims to improve the health and wellbeing of people with a learning disability, their carers and families, by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.

The 2012-2015 Bamford Action Plan continues to progress the enhancement of mental health and learning disability services started through the previous plan. The evaluation of the 2009-2011 Action Plan, published in May 2012, established that over the last two years the joint working across Government Departments and the HSC sector has achieved much, and 80% of the actions have been delivered. It also highlights areas where services can still be improved and the need for more of a focus on outcomes rather than outputs.

The strategy entitled “A strategy to improve the lives of disabled people – 2012 to 2015 also sets out the key priorities that OFMDFM believe will be crucial in addressing the barriers that disabled people face.

Promoting Social Inclusion (PSI) Disability presented to the first minister in December 2009 recommendations are also firmly anchored around the principles of the United Nations Convention on the Rights of Persons with Disabilities, which aim to promote dignity, independence and access.

Following the endorsement of the Regional Day Opportunities Model in 2014 this gave the Trusts direction on the desired Model for the delivery of day opportunities, and to review its daycare provision and ensure that those individuals who do not meet the criteria for daycare are supported to avail of a wider choice of day time activities as recommended in Equal Lives / Bamford report

The HSCB requires the Trust to invest this recurrent investment in the further development of the Day Opportunities Model within their locality.

Trust Proposal

The Southern Trust has been developing and extending the options for supporting people with disabilities to participate as active members within their communities for many years. These options are referred to as ‘day opportunities’. This direction of travel is in line with key national and local strategies and all of these strategies focus on improving the lives of those with disabilities.

Transforming Your Care outlined as one of its key proposals for individuals with a learning disability a commitment to continue to develop creative and age appropriate day opportunities to promote independence and choice, such as access to employment, leisure and educational activities. Transforming Your Care also indicated a review of the provision of day-care services.

In theory this modernisation agenda had significant potential in that it would have been reasonable to assume that if a wider range of more person centred alternatives to day care in the community were developed disabled persons would transition from day care to community options, or transition directly to Day opportunities from school thereby retaining ‘building based’ day care for those service users assessed as in greatest need. In practice however this transition has not taken place as originally envisaged .

There have been a number of factors which have had a significant impact on the lack of progress of service users from day care to community alternatives over the past 3 to 4 years. Consequently many day care centres now have no physical capacity to accept new referrals. Many are exceeding and are in breach of RQIA space standards. This therefore places significant restrictions on the Directorate’s ability to be responsive to the needs of young persons leaving school over the next 5 years who have been assessed as having very complex needs requiring ‘building based’ day care placements. To address these strategic and operational challenges it was therefore agreed that the need for a Day Services Review is urgent and critical to clearly identify a modernised day services model within the Southern Trust. The aim of the project is to review the current model of Day care and Day opportunities within Disability services in the Southern Health and Social Care Trust and identify inherent strengths; areas for development and make recommendations for a Modernised day services model.

The key objectives of the project are as follows:

- To describe the current day services model in the Southern Health and Social Care Trust and

on the basis of recommendations define a future fit for purpose Model which will address and meet projected need.

- To identify service users who have the potential to progress from day care to alternative day opportunities in the community.
- To scope existing provision, highlighting planning issues in terms of:
 - i. Number of attenders and their assessed level of dependency.
 - ii. Projection of young people assessed as needing day care within the next 5 years and also those who will require day opportunities.
 - iii. To identify required staffing levels within centres and day opportunities teams.
 - iv. To identify environmental issues across day care taking cognisance of RQIA space standards, business cases for new builds and status of same.
 - v. To review registered numbers of attenders in day centres in accordance with attendance levels, space standards and statutory requirements.

In order for the Trust to review the service and define its service model the Trust proposes to use the investment identified within this IPT non recurrently for the timeframe of this review, to put in place a structure and dedicated resource to focus on the assessment of day care and day opportunity placements. This will be through appointing the following team:

- 3wte band 3 Support workers and 1wte band 5 Care Worker– these support staff are already in place on a temporary basis and it is proposed to continue the funding for this posts for the next year.
 - 1wte band 7 Project Manager for Day Services Review – This post holder will focus on the assessment of day care and day opportunity placements throughout the Southern Trust. They will provide a detailed report on client numbers requiring day opportunities and Day Care and will lead on the assessment process of all individuals availing of day services.
 - 0.5wte band 6 Project Support for Day Services Review – This post holder will support and facilitate the review
 - 0.5wte Band 5 Nurse - This post holder will be part of the assessment team and will contribute to the assessment process of all individuals
 - 0.5wte Band 5 Physiotherapist - This post holder will be part of the assessment team and will contribute to the assessment process of all individuals
 - 0.5wte band 7 Speech and language therapist - This post holder will be part of the assessment team and will contribute to the assessment process of all individuals
- The following will also be funded through this investment proposal.
- 8% funding will be £24,000 and will be allocated to Self Directed Support and to Social Farming Element of the funding
 - £15,000 Brokerage Licence – required for data base for Day Opportunities

The desired outcome is to design and implement a Modernised Disability Day Services which is fit for purpose, affordable and meets the needs of adults with a disability. The review will progress with full stakeholder engagement including representatives from relevant Trust departments, service users advocates, carers and independent sector organisations.

This funding will be utilised as above for an interim period until the review is finalised and recommendations put in place. The Trust will then be in a position to outline how the identified funding for Day Opportunities will be allocated.

SECTION 2(a): OBJECTIVES

Project Objectives	Measurable Targets
1. To describe the current and future day services model in the Southern Health and Social Care Trust and to develop community based alternatives to day care in partnership with voluntary and statutory partners (stimulate market development with an emphasis on partnership working developing a diverse range of activities).	Day Opportunities” to mean a package of community-based day time activities which will engage adults with a learning disability in areas such as accredited further education; volunteering; paid supported employment; social enterprise activity and opportunities to meet and make friends and use local leisure and recreational facilities.
2. Remodel in-house services to focus on meeting more complex support needs and support the reshaping of the current in-house day service provision and staffing to the new model of working as necessary.	Number of staff appointed to progress the review of day services within the Southern Trust area. The dependency needs of all service users will be assessed in accordance with eligibility criteria for service provision.
4. To scope existing provision, highlighting planning issues	Appoint a Project Team to lead on the assessment of individuals
5. Support individuals to engage with both the development and uptake of new opportunities promoting social inclusion, flexibility and maximising independence	No of users to benefit from new day opportunities/ activities.

SECTION 2(b): CONSTRAINTS

Constraints	Measures to address constraints
<p>The following constraints must be considered in line with this investment;</p> <ol style="list-style-type: none"> 1. The availability and accessibility of suitable day opportunities which meet with the needs of adults with a disability living in the southern trust locality. 	<p>The Trust will continually evaluate the availability and suitability of placements with a view to successful placements for individuals.</p>
<ol style="list-style-type: none"> 2. Timescales to recruit staff and to have in post 	<p>Complete recruitment documentation as soon as</p>

within the timeframe	possible
3. Uptake of non-recurrent funding to implement Social Farming aspect taking cognisance of travel requirements and affordability constraints	Exploration of potential for sustainable shared affordable transport arrangements
4. Funding not made available to enhance current services	Submit IPT within the agreed timescales with all relevant data included

SECTION 3: IDENTIFY AND SHORTLIST OPTIONS

Option Number/ Description	Shortlisted (S) or Rejected (R)	Reason for Rejection
1. Option 1 - Status Quo - continue with existing arrangements with no investment to Learning Disability for Day Opportunities	S	
2. Option 2 - Contract with statutory and private providers to provide day opportunities	S	
<p>3. Option 3 – Support the Review of Day Services in the Southern Trust by focusing on the assessment of individuals and ensuring all individuals are correctly placed. Funding will be allocated as follows:</p> <ul style="list-style-type: none"> • 8% funding will be £24,000 will be allocated to Self Directed Support and to Social Farming Element of the funding • 3wte band 3 Support workers • 1wte band 5 Care Worker • 1wte band 7 Project officer for Day Services Review – This post holder will focus on the assessment of day places and day opportunity placements throughout the Southern Trust. They will provide a detailed report on client numbers requiring day opportunities and Day Care and implementation plan based on outcome and recommendations of day services review • 0.5wte band 6 Social worker for Day Services Review – This post holder will support and facilitate the review and collate assessment 	S	

information across teams and localities as required <ul style="list-style-type: none"> • 0.5wte Band 5 Nurse • 0.5wte Band 5 Physiotherapist • 0.5wte band 6 Speech and language therapist • £15,000 Brokerage Licence – required recurrently for data base currently being developed to support Day Opportunities Brokerage model 		
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SECTION 4: MONETARY COSTS AND BENEFITS OF OPTIONS

Option 4	Yr 0 £k 16/17	Yr 1 £k	Yr 2 £k	Yr 3 £k	Yr 4 £k	Yr5 £k	Totals £k
<u>Capital Costs</u>							
(a) Total Capital Cost							
<u>Revenue Costs</u>							
Day Opportunities							
(b) Total Revenue Cost							
(c) Total Cost = (a) + (b)							
(d) Disc Factor @ 3.5%pa							
(e) NPC = (c) x (d)							

COST ASSUMPTIONS:

Costing are been based on business cases and placements that the Trust has already identified.

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SECTION 5: NON MONETARY COSTS AND BENEFITS

Weighting method

Non-Monetary Factor	Weighting (%)	Score Option 1		Score Option 2		Score Option 4	
1. Strategic alignment	25	2	50	7	175	8	200
2. Speed of implementation	25	2	50	7	175	8	200
3. Stakeholder acceptability	25	2	50	8	200	8	200
4. Integration within Community	25	2	50	8	200	8	200
TOTAL	100		200		750		800

Or Impact assessment

Non-Monetary Factor	Option 1	Option 2	Option 3 ...
1.			
2.			
3. etc			

Rationale for weighting and scoring

Option 1 scored lowest as by doing nothing the Trust will not be utilising the funding for day opportunities and therefore will not be making any improvements to the service.

While Option 2 scored equally with Option 3 under Stakeholder Acceptability and Community Integration it scored slightly lower under Strategic Alignment and Speed of Implementation. Although there will be further enhancement to day opportunities the number of clients attending day centres will

exceed capacity. The Trust needs to take forward its review of day service provision to ensure all individuals are suitably placed. Option 3 scored highest as by implementing a project team to focus on the assessment of all individuals availing of day services, the Trust will be in a better position to go forward in the future and be able to provide a Modernised Disability Day Service which is fit for purpose, affordable and meets the needs of adults with a disability.

SECTION 6: ASSESS RISKS AND UNCERTAINTIES

Risk Description	Likely impact of Risk H/M/L				State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	Opt 3	Opt 4	
1. Acceptance by clients, families and carers	H	M	L		Option 1 scored high as to do nothing would not be acceptable. Option 3 is a lower risk than Option 2 as through communication with service users, the review of current day services is acceptable as the outcome will lead to a modernised service with clients being placed in suitable placements.
2. Delays in recruitment of staff	n/a	M	M		Both Options 2 and 3 have a medium risk associated with them as there will be process in place for both. The Trust will endeavour to begin all process as soon as possible and complete recruitment documentation as soon as possible.
3. Missed opportunity to Improve day services	H	M	L		Option 3 scored lowest as by taking forward Option 1 and reviewing day service provision the Trust will implement recommendations which will lead to a service which is meets all client needs.
4. There is a risk that the number of clients with complex health care needs will increase and there will not be capacity within day services	H	M	L		Option 3 scored lower under this risk as by taking forward the review the Trust will identify any gaps in service provision and implement recommendations and changes.

Risk Description	Likely impact of Risk H/M/L				State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	Opt 3	Opt 4	
for these clients					
Overall Risk (H/M/L):	H	M	L		

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

The preferred option is as follows:

Option 3 – Support the Review of Day Services in the Southern Trust by focusing on the assessment of individuals and ensuring all individuals are correctly placed. This option scored highest as by implementing a project team to focus on the assessment of all individuals availing of day services, the Trust will be in a better position to go forward in the future and be able to provide a Modernised Disability Day Service which is fit for purpose, affordable and meets the needs of adults with a disability.

Following the review the Trust can then refocus day care provision on the needs of individuals with significant challenging behaviours and/or complex healthcare needs and deliver therapeutic programmes to support rehabilitation and ongoing support for individuals with continuing complex care needs. The Trust will aim to provide person centred, age appropriate day services support to all users and younger service users in transition from school to adult services. The Review will work towards creating capacity within day centres to cater for the needs of young persons in transition from special schools with complex needs.

The desired outcome is to design and implement a Modernised Disability Day Services which is fit for purpose, affordable and meets the needs of adults with a disability.

SECTION 8: ASSESS AFFORDABILITY AND FUNDING ARRANGEMENTS

	Yr 0 £000's	Yr 1 £000's	Yr 2 £000's	Yr 3 £000's	Totals £000's
Required:					
Capital					
Resource					

Existing Budget:					
Capital					
Resource					
Additional budget Required:					
Capital					
Resource					

Affordability narrative

SECTION 9: PROJECT MANAGEMENT (Please see Benefits Realisation Plan in Annex B)

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management. The following key roles have been identified:

Project Owner: Mr Bryce McMurray, Director of Mental Health and Disability

Project Director: Mr Miceal Crilly, Assistant Director of Disability Services

Project Manager: Bronagh McKeown, Head of Disability Day services

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation.

SECTION 10: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

				Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains
PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	I - Investment P - Productivity

MAHI - STM - 126 - 478

				Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains
PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	I - Investment P - Productivity

SECTION 11: MONITORING AND EVALUATION

The Trust will continue to care manage these packages and review placements closely to ensure that they achieve the objectives outlined above and that all risks are managed.

Who will manage the implementation?	The implementation of this investment will be overseen by Bronagh McKeown, Head of Disability day services
Who will monitor and evaluate the outcomes?	Bronagh McKeown, Head of Disability Day services will be responsible for overseeing the project
What other factors will be monitored and evaluated? –	Number of day care places made available to service users assessed as having high dependency needs
When will this take place?	During 2017/18

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

**The Trust benchmarks the cost and the quality of placements across providers to ensure value for money and quality outcomes for individuals.
Contracts are monitored bi-annually.**

LEVEL 2 Investment Proposal Template**REVENUE FUNDING £50k - £250k**

HSCB IPT Ref No	SCCD/2017/18/LD/33
Source of Funding (Year / ref)	Inescapable Service Developments 2017/18 non-recurrent
Allocation value	£74,355 CYE
HSCB Representative name and contact details	Joyce McKee, Tower Hill, Armagh BT61 9DR
Trust Representative name and contact details	Miceal Crilly Asst. Director, Learning Disability Services Southern Health & Social Care Trust ████████████████████
Project Title	Learning Disability Additional Community Infrastructure for Crisis/Out of Hours
Total Cost	£74,355 CYE
Start date	1 st October 2017
Completion date	31 st March 2018

Complete this section if bid is for new funding i.e. funding is not currently in the Trust baseline

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Y
How much total funding required?	£74,355
How much funding required per year?	£74,355
Is this funding to be made recurrent? (Y/N)	N

Complete this section if funding available within existing allocation i.e. funding is currently in the Trust baseline

Funding available within existing allocation (Y/N)	N
Total cost of proposal	£74,355
Cost of proposal per year	£74,355
Is this cost within recurrent allocation?	N

Is this business case	<u>Y/N</u>
(a) Standard	Y
(b) Novel	N
© Contentious	N
(d) Setting a precedent	N
If yes to (b) or (c) or (d) , requires Departmental & DFP approval	N
Is Departmental / DFP approval required	

Approval & submission by Trust

This section to be completed by Trusts for all submissions

<u>Responsible Director Signature</u> (required for all submissions)	
Name Printed Bryce McMurray	(signed)
Grade/ Title Acting Director Mental Health & Disability	
Date 20.10.2017	
<u>Trust Director of Finance Signature</u> (required if bid is over £100k)	
Name printed	(signed)
Date	
<u>Trust Chief Executive Signature</u> (required if bid is over £100k)	
Name printed	(signed)
Date	

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – required for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.

Approved by

Name printed Iolo Ealian **(signed)**

Grade / Title

Date

Approval of Investment Proposal Template by HSCB Director(s) and/or Chief Executive

Director Signature (required for all bids)

Name printed Bryce McMurray **(signed)**

Grade / Title Acting Director Mental Health & Disability

Date

HSCB Director of Finance Signature (required if bid is over £100k)

Name printed **(signed)**

Date

HSCB Chief Executive Signature (required if bid is over £100k)

Name printed **(signed)**

Date

Approval of Investment Proposal Template by Commissioning Board (required if bid is over £100k)

Date of approval at Commissioning Board

Date

Complete this section if Department / DFP approval required

Date submitted to Department

Department/ DFP approval (y/n)

Date approved

SECTION 1: Commissioner specification to include strategic context and need (to be completed by the Commissioner)

As outlined in the HSCB Commissioning Plan, and in accordance with the principles of Citizenship and Human Rights enjoyed by all, people with a learning disability are entitled to live in their own homes in the community with a range of support services to meet their assessed needs.

In line with the Commissioning Plan Direction and Transforming Your Care, the HSCB seeks to ensure that no-one with a learning disability should be living in hospital since March 2015. It is essential therefore that, in addition to the on-going resettlement programme from hospitals, Trusts should take all necessary action to prevent the admission of people to hospital due to the possibility of breakdown of their residential placements in the community.

The Trusts are now invited to submit proposals aiming at enhancing the capacity of community learning disability teams and associated specialist services to:

- Prevent inappropriate hospital admissions and ensure that all discharges from hospital take place no more than 28 days from the fit for discharge date as required under the 2013/2014 Commissioning Plan Direction (DHSSPS).
- To further develop services that can respond outside of the traditional 9-5 Monday to Friday model.
- Develop step up/step down facilities where people may be accommodated on a short term, time limited basis in order to de-escalate placement problems, provide a period of intensive support or provide respite for carers.
- Develop a model of in reach services to support individuals to remain in the community when family and/or carers are under significant strain.

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1.To assist with drawing up and implementing a bespoke re-enablement care plan for Adults with a Learning Disability leaving hospital after a long stay	Four Adults with a Learning Disability in the financial year to March 2018
2. Upskilling three band 3s (one existing staff member and two new recruits) to be able to complete the monitoring of vital signs, administering medications, monitor medication compliance and taking blood	By the end of financial year 3 staff will be trained

samples (staff to complete phlebotomy course).	
3. To provide in home medication administration and monitoring of prescribed psychotropic medications. To monitor vital statistics and any side effects as an alternative to hospital admission	By the successful medication regime being established By audit of recordings

SECTION 2 (b) : CONSTRAINTS

BSO recruitment process can be lengthy. To counteract this we will take off established waiting list from recent interviews held in Specialist Services
--

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	Clients remain in hospital and become delayed discharges
2	Discharge to the community with no support
3	<p style="text-align: center;"><i>To recruit one band 5 staff and two band 3 staff</i></p> <hr/> <p>To deliver enablement programme in clients own home. One young person will be transferring from Iveagh on 1st Dec 2017 and the other 3 will be discharges from Dorsy (two of whom are transition clients who were previously in Iveagh)</p> <p>To identify and release band 3 staff to attend relevant training in the Acute setting and have their new role monitored by a qualified nurse in undertaking delegated nurse duties. Backfill will need to be recruited from the waiting list/bank for band 3 staff</p>

SECTION 4: PROJECT COSTS

Option	Year 1 (£'000)	Year 2 (£'000)	Year 3 (£'000)	Total (£'000)

1	£150,000			
2	N/a			
3	£74,355			

COST ASSUMPTIONS:

[expand as appropriate]

£74,355 for recruitment of oneband 5s and two band 3s to take forward objectives The funding is not sufficient for this level of employment

SECTION 5: NON-MONETARY BENEFITS

[expand as appropriate]

Betterment for the clients

Free up acute LD psychiatric beds

Support for carers

Liaison with GP, Pharmacy will raise awareness of LD clients living in the community

SECTION 6: PROJECT RISKS & UNCERTAINTIES

[expand as appropriate]

Recruitment of staff in a timely manner

Potential delayed discharge due to person deteriorating

Lack of community placements

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

[expand as appropriate]

Option 3 – Given that three of the four people are young people in the transition process leaving LD psychiatric hospital it would be very important to invest time and effort to offer a programme of intensive bespoke rehabilitation to settle them into the community. In the long term this should be betterment for the person and also minimise the need for services. Part of the work would also improve community awareness of the needs of Adults with a Learning Disability and offer training and support to carers to enable them to better manage psychiatric/challenging behaviour episodes at home

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Yr 0 £000's	Yr 1 £000's	Yr 2 £000's	Yr 3 £000's	Totals £000's
Required					£74,355
Capital required					
Revenue required					
Existing budget :					
Capital					
Revenue					
Additional Allocation Required:					
Capital					
Revenue					

AFFORDABILITY ASSUMPTIONS

This is an affordable service as it will be a bolt on to the existing Crisis Response/ Home Treatment Service

SECTION 9: MANAGEMENT ARRANGEMENTS

[expand as appropriate]

As this service will be a further development in line with the vision of the service it can be absorbed by the current management arrangement

SECTION 10: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

				Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains
PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	I - Investment P - Productivity
Adult Learning Disability							

MAHI - STM - 126 - 491

				Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains
PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	I - Investment P - Productivity

SECTION 11: MONITORING AND EVALUATION

<p>Who will manage the implementation?</p> <p>Joe McGivern, Manager Crisis Response, Home Treatment Service</p>	<p>[expand as appropriate]</p>
<p>Who will monitor and evaluate the outcomes?</p> <p>Noreen McComiskey, Specialist Services Manager, Adult Disability</p>	<p>[expand as appropriate]</p>
<p>What other factors will be monitored and evaluated? –</p> <p>Impact on bed occupancy in Dorsy Unit/Iveagh House.</p> <p>Benefit to Carers</p> <p>Engagement of client and impact of service/outcome for them</p>	<p>[expand as appropriate]</p>
<p>When will this take place?</p> <p>End March 2018</p>	<p>[expand as appropriate]</p>

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

<p>[expand as necessary]</p> <p>Reduce current hospital population and length of stay/ readmission to LD psychiatric hospital</p>
--

LEVEL 2 Investment Proposal Template

REVENUE FUNDING £50k - £250k

HSCB IPT Ref No	
Source of Funding (Year / ref)	Demography 2017-18
Allocation value	£70,000
HSCB Representative name and contact details	
Trust Representative name and contact details	Miceal Crilly Asst. Director, Learning Disability Services Southern Health & Social Care Trust [REDACTED]
Project Title	Learning Disability Forensic Day Opportunities
Total Cost	£70,000 FYE
Start date	1 st April 2018
Completion date	

Complete this section if bid is for new funding i.e. funding is not currently in the Trust baseline

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	<i>N- funded from Demography 2017/18</i>
How much total funding required?	<i>£70,000 FYE 2018/19</i>
How much funding required per year?	<i>£70,000 FYE 2018/19</i>
Is this funding to be made recurrent? Y/N)	<i>Y</i>

Complete this section if funding available within existing allocation i.e. funding is currently in the Trust baseline

<i>Funding available within existing allocation (Y/N)</i>	<i>Y</i>
Total cost of proposal	<i>£70,000 FYE 2018/19</i>
Cost of proposal per year	<i>£70,000 FYE</i>
Is this cost within recurrent allocation?	<i>Y- within Demography allocated for 2017/18</i>

Is this business case	Y/N
(a) Standard	Y
(b) Novel	N
© Contentious	N
(d) Setting a precedent	N
If yes to (b) or (c) or (d) , requires Departmental & DFP approval Is Departmental / DFP approval required	

Approval & submission by Trust

This section to be completed by Trusts for all submissions

<u>Responsible Director Signature</u> (required for all submissions)	
Name Printed : Mrs Carmel Harney	(signed) 
Grade/ Title : Interim Director of Mental Health and Disability Services	
Date: 22.05.2018	
<u>Trust Director of Finance Signature</u> (required if bid is over £100k)	
Name printed	Helen O'Neill (Acting) (signed)
Date	
<u>Trust Chief Executive Signature</u> (required if bid is over £100k)	
Name printed	Stephen McNally (Acting) (signed)
Date	

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – required for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.

Approved by

Name printed (signed)

Grade / Title

Date

Approval of Investment Proposal Template by HSCB Director(s) and/or Chief Executive

Director Signature (required for all bids)

Name printed (signed)

Grade / Title

Date

HSCB Director of Finance Signature (required if bid is over £100k)

Name printed (signed)

Date

HSCB Chief Executive Signature (required if bid is over £100k)

Name printed (signed)

Date

Approval of Investment Proposal Template by Commissioning Board (required if bid is over £100k)

Date of approval at Commissioning Board

Date

Complete this section if Department / DFP approval required

Date submitted to Department

Department/ DFP approval (y/n)

Date approved

SECTION 1: Commissioner specification to include strategic context and need (to be completed by the Commissioner)

Strategic Context for Day Opportunities

The Service Framework for Learning Disability published in September 2012, sets out clear standards of care that people can expect. This Framework aims to improve the health and wellbeing of people with a learning disability, their carers and families, by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.

The 2012-2015 Bamford Action Plan continues to progress the enhancement of mental health and learning disability services started through the previous plan. The evaluation of the 2009-2011 Action Plan, published in May 2012, established that over the last two years the joint working across Government Departments and the HSC sector has achieved much, and 80% of the actions have been delivered. It also highlights areas where services can still be improved and the need for more of a focus on outcomes rather than outputs.

The strategy entitled "A strategy to improve the lives of disabled people – 2012 to 2015 also sets out the key priorities that OFMDFM believe will be crucial in addressing the barriers that disabled people face.

Promoting Social Inclusion (PSI) Disability presented to the first minister in December 2009 recommendations are also firmly anchored around the principles of the United Nations Convention on the Rights of Persons with Disabilities, which aim to promote dignity, independence and access.

Following the endorsement of the Regional Day Opportunities Model in 2014 this gave the Trusts direction on the desired Model for the delivery of day opportunities, and to review its daycare provision and ensure that those individuals who do not meet the criteria for daycare are supported to avail of a wider choice of day time activities as recommended in Equal Lives / Bamford report.

Trust Proposal

The Southern Trust has been developing and extending the options for supporting people with disabilities to participate as active members within their communities for many years. These options are referred to as 'day opportunities'. This direction of travel is in line with key national and local strategies and all of these strategies focus on improving the lives of those with disabilities.

Transforming Your Care outlined as one of its key proposals for individuals with a learning disability a commitment to continue to develop creative and age appropriate day opportunities to promote independence and choice, such as access to employment, leisure and educational activities. Transforming Your Care also indicated a review of the provision of day-care services.

The Trust plans to use this recurrent funding for the appointment of 2 X Band 5 Support Workers to assist in the provision of day opportunities for Learning Disability Forensic clients.

It is envisaged that the Support Workers will work as a member of a peripatetic team under the supervision of the Specialist Services Manager in the provision of individual and group daytime opportunities. They will work closely with the Forensic Practitioners, Probation Service, Public Protection Unit, PSNI, Community groups, partner organisations and other professionals to assist the offender to prepare and source community

opportunities in their local area.

These daytime opportunities will be designed to enhance and maximize the capabilities and independence of the individuals. The Support Worker will match the client with a suitable type of activity based on their individual needs. These types of activities vary in nature and may include programmes in a community setting, manual tasks, outdoor pursuits, environmental projects, art, music, horticulture, working with animals etc.

Primarily it is intended that the 2 Support Workers associated with this investment will provide bespoke individualized work to 10 clients (5 clients per staff member) who are leaving a secure setting i.e. prison or hospital. There are already a number of clients identified for whom these Support Workers could support. These identified clients are mostly younger in age, do not see themselves as having a learning disability and are deemed difficult to engage with, particularly in a group setting and it is therefore anticipated that they would benefit from 1 to 1 engagement with a support worker.

Service needs and demand will dictate the evolving duties carried out by the Support Workers.

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. Increase the support staff within the remit of Forensic Day Opportunities to meet service needs.	Appointment of 2 additional Band 5 Support Workers.
2. To assist in meeting service demand for provision of individualised and personalised work for forensic day opportunity clients.	Attendance returns compiled and provided to the informatics teams. Feedback on the number of clients receiving support.

SECTION 2 (b) : CONSTRAINTS

The following constraints must be considered in line with this investment;

- Timeliness of appointing staff. A waiting list of suitable qualified staff already exists and staff members could be recruited promptly, however this will expire in the Summer 2018
- Risks of offending behaviour and community acceptance.

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	Status Quo - continue with existing arrangements with no investment to Forensic Learning Disability clients for Day Opportunities.
2	Recruit 2 additional Band 5 Forensic Day Opportunities Support Workers to work with this client group in order to engage them in a meaningful way

SECTION 4: MONETARY COSTS AND BENEFITS OF OPTIONS

Option 1: Status Quo	Year 0 17/18 £000's	Year 1 18/19 £000's	Year 2 19/20 £000's	Year 3 20/21 £000's	Year 4 21/22 £000's	Year 5 22/23 £000's	Totals £000's
Capital Costs Works	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs							
Recurring revenue baseline	60,142	60,142	60,142	60,142	60,142	60,142	360,852
(b) Total Revenue Cost	60,142	60,142	60,142	60,142	60,142	60,142	360,852
(c) Total Cost = (a) + (b)	60,142	60,142	60,142	60,142	60,142	60,142	360,852
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	60,142	58,109	56,143	54,242	52,408	50,640	331,684

COST ASSUMPTIONS:

Finance Assumptions

1. Year 0 is 2017/18 Financial Year.
2. Baseline costs refer to the recurring revenue budget for Disability Services for 2017/18.
3. No other revenue or capital costs are associated with this option.
4. A discount factor @3.5% pa has been applied to calculate the NPC.
5. Please note all figures above have been rounded to thousands.
6. Total Net Present Cost (NPC) equates to £331,684k for this option.

Option 2:- Recruit 2.00 WTE additional Band 5 Forensic Day Opportunities Support Workers to work with this client group in order to engage them in a meaningful way	Year 0 17/18 £000's	Year 1 18/19 £000's	Year 2 19/20 £000's	Year 3 20/21 £000's	Year 4 21/22 £000's	Year 5 22/23 £000's	Totals £000's
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs							
Recurring revenue baseline	60,142	60,142	60,142	60,142	60,142	60,142	360,852
Payroll	0	66	66	66	66	66	330
Payroll related G&S	0	4	4	4	4	4	20
(b) Total Revenue Cost	60,142	60,212	60,212	60,212	60,212	60,212	361,202
(c) Total Cost = (a) + (b)	60,142	60,212	60,212	60,212	60,212	60,212	361,202
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	60,142	58,177	56,208	54,305	52,469	50,699	332,000

COST ASSUMPTIONS:

Finance Assumptions

1. Year 0 is 2017/18 Financial Year.
2. Baseline costs refer to the recurring revenue budget for Disability Services for 2017/18
3. The 2.00WTE Band 5 have been costed according to the HSCB – General Costings - 2017/18 (Including 1% pay award), an allowance has been made for employee related G&S.
4. Costs will accrue from 1st April 2018.
5. No capital costs are identified in this case.
6. A discount factor @3.5% pa has been applied to calculate the NPC.
7. Please note all figures above have been rounded to thousands.
8. Total Net Present Cost (NPC) equates to £332,000k for this option.

SECTION 5: NON-MONETARY BENEFITS

The recruitment of 2 additional staff members will assist in providing one to one support for a list of already identified forensic learning disability clients. By providing bespoke individualised work to a number of identified forensic learning disabled clients will enhance the outcomes for the clients. This will improve the patient/client experience and the quality of care delivered to individuals, families and carers.

SECTION 6: PROJECT RISKS & UNCERTAINTIES

1. Failure to appoint staff within the timescale of the IPT.
2. Reduced ability to maintain operational capacity due to demand exceeding capacity of the service within available resources.
3. Risk of offending behaviour and how the clients are perceived in their local area

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 1: Status Quo
 This option will not enable any enhancement to the current service or recruitment of staff to the service.

Preferred Option : Option 2
 Recruitment of 2 x Band 5 Support Workers who will support and enhance the Forensic Day Opportunities Service. Additional staffing will assist in:

- supporting those clients who are deemed difficult to engage with and who benefit from 1 to 1 support rather than group settings
- Providing clients with timely access to support.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Year 0 2017/18 £000's	Year 1 2018/19 £000's	Year 2 2019/20 £000's	Year 3 2020/21 £000's	Totals £000's
Required					
Capital required	0	0	0	0	0
Revenue required	60,142	61,115	62,032	62,962	246,251
Existing budget :					
Capital	0	0	0	0	0
Revenue	60,142	61,044	61,960	62,889	246,035
Additional Allocation Required:					
Capital	0	0	0	0	0
Revenue	0	71	72	73	216

AFFORDABILITY ASSUMPTIONS

Finance Assumptions

1. Year 0 is 2017/18 Financial Year
2. Baseline costs refers to the recurring revenue budget for Disability Services for 2017/18
3. The 2.00 WTE Band 5 have been costed according to the HSCB – General Costings - 2017/18 (Including 1% pay award), an allowance has been made for employee related G&S.
4. Costs will accrue from 1st April 2018.
5. Recurring revenue costs have been uplifted by an Inflationary rate of 1.5%.
6. No capital costs are identified in this case
7. Please note all figures above have been rounded to thousands

SECTION 9: MANAGEMENT ARRANGEMENTS

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management. The following key roles have been identified:

Project Owner: Mrs Carmel Harney, Acting Director of Mental Health and Disability

Project Director: Mr Miceal Crilly, Assistant Director of Disability Services

Project Manager: Noreen McComiskey, Head of Specialist services

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation.

SECTION 10: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

				Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains
PoC	Service line descriptor 1	Service line descriptor 2	Currency use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	Full Year Effect Total	Current Year Effect Total	Full Year Effect Total	I - Investment P - Productivity
LD	Adult Forensic LD Team		Day Opportunities	Up to 10 clients			

SECTION 11: MONITORING AND EVALUATION

Who will manage the implementation?	The implementation of this investment will be overseen by Noreen McComiskey, Specialist Services Manager
Who will monitor and evaluate the outcomes?	The implementation of this investment will be overseen by Noreen McComiskey, Specialist Services Manager
What other factors will be monitored and evaluated? –	Number of clients supported by the Supported Workers. Needs and outcomes of the clients are discussed on a regular basis.
When will this take place?	<p>Monitoring will take place via;</p> <ul style="list-style-type: none"> • Weekly Forensic meetings. • Promoting Quality Care review • Peer supervision meetings between Band 3 and Band 5 Support Workers. • Quarterly staff meetings between all staff and the Specialist Service Manager • Returns of attendances are compiled and returned to the informatics department.

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

Supporting offenders coming out of prison or secure hospital or those who are beginning the Judicial process.

REVENUE BUSINESS CASE PROFORMA COVER

(To be submitted with every business case)

Name of organisation	SHSCT
Project Title	Demography: Complex Care Nursing
Total Cost	2018/19 £37,500 CYE 2019/20 £90,000 FYE
Start date	1st November 2018
Completion date	Recurring

Complete this section if bid is for new funding

BID FOR NEW FUNDING	Y
Is this bid for new funding (Y/N)	Y
How much total funding required?	2018/19 £37,500 CYE 2019/20 £90,000 FYE
How much funding required per year?	2018/19 £37,500 CYE 2019/20 £90,000 FYE
Is this funding to be made recurrent?	Y

Complete this section if funding available within existing allocation

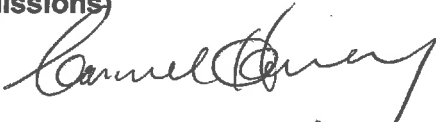
Funding available within existing allocation (Y/N)	No
Total cost of proposal	2018/19 £37,500 CYE 2019/20 £90,000 FYE
Cost of proposal per year	2018/19 £37,500 CYE 2019/20 £90,000 FYE
Is this cost within recurrent allocation?	

Is this business case	Y/N
(a) Standard	Y
(b) Novel	
© Contentious	
(d) Setting a precedent	

<p><i>If yes to (b) or (c) or (d) , requires Departmental & DoF approval Is Departmental / DOF approval required</i></p>	
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Approval & submission by Trust

This section to be completed by Trusts for all submissions

<u>Responsible Director Signature</u> (required for all submissions)	
Name Printed	CARMEL HARNEY (signed) 
Grade/ Title	Interim Director Mental Health & Disability
Date	12.10.2018
<u>Trust Director of Finance Signature</u> (required if bid is over £100k)	
Name printed	(signed)
Date	
<u>Trust Chief Executive Signature</u> (required if bid is over £100k)	
Name printed	(signed)
Date	

Complete this section if Department / DOF approval required

Date submitted to Department
Department/ DOF approval (y/n)
Date approved

BUSINESS CASE TEMPLATE**REVENUE FUNDING £50k - £250k****SECTION 1: PROJECT BACKGROUND, STRATEGIC CONTEXT & NEED****Background:**

The Complex Care Nursing Service provide services to adults with a learning disability, physical disability or acquired brain injury aged 18 years and over who present with complex physical health care needs and require input from a trained professional in specific areas of their care working in collaboration with both acute and community specialist services.

Complex Care Nursing provides a service working within the context of the client, family and carer working to support and promote optimum quality of life for clients with complex needs and their families. The Complex Care Service works to enhance mental, emotional and physical health by empowering individuals to manage their conditions, partake in daily activities within the community and through the provision of continuity of care. The Complex Care Service engages clients and their families/carers in a collaborative, client focused process, based on Royal Marsden clinical guidelines.

Clients and families/carers using Complex Care Services can expect:

- To be treated with respect and dignity
- To receive treatment and evidence-based care that is appropriate to their needs and directed by standards such as the Royal Marsden (Respiratory Care) 2015
- To have their privacy and right to confidentiality respected in line with Southern Trust policies and procedures
- To be collaborative partners in their treatment and care especially relating to key decision making
- To receive a high quality service
- The service to be responsive to local need, as accessible as possible, reflect inter-agency working, be equitable in terms of the individual and the area served, and be effective and efficient in operation
- A high-quality and responsive service aimed at helping clients manage their condition and meet their immediate needs, but also to generate long-term outcomes that will help individuals and families/carers through effectively managing their care in community settings.
- To avoid preventable admissions to acute hospital thereby reducing the risk of hospital acquired infections.

Referral Process

Referrals can be made by General Practitioners, Consultant Neurologists, Consultant Psychiatrists, Trust AHPs, Transition Team Learning, Physical or Sensory Disability Community or Hospital based services.

Referral criteria

- Clients with complex care needs being discharged from hospital
- Clients with complex health needs transitioning into adult services
- Clients who have complex health needs living in the community.

Proposal:

The Trust proposes to use funding of £90,000 recurrently to fund **2 x WTE Band 5 Complex Care Nurses** aligned to specific clients in order to facilitate their on-going care in the community. One post

will work with a client with physical disability and the other post will work with a client with learning.

Complex Care services provide specific interventions including:

- Enteral feeding care and support such as PEG, Gastrostomy
- Tracheostomy and respiratory care and support
- Epilepsy care and support
- Client specific care based on assessed need.
- Colostomy, ileostomy
- Cystectomy
- Nasogastric intubation
- Intermittent urinary catheterisation
- Supports with dialysis
- Non healing/debilitating surgical/non-surgical wound management

The needs of the proposed Clients are detailed below:

<p>Client A Physical Disability</p>	<ul style="list-style-type: none"> • Tracheostomy in place • fed via a RIG (Radiologically inserted Gastrostomy) • Requires the assistance of two carers and hoist to transfer from A-B • Requires Complex Care Nurse to attend Daycare Centre. The nurse also assists Client A on transport to and from daycare centre.
<p>Client B Learning Disability</p>	<ul style="list-style-type: none"> • Client B is fully dependent on others to attend to all care needs • Client B is doubly incontinent • Client B has no purposeful movement and requires others to ensure they are safe and comfortable • Requires hoist for all moves by two people and uses a wheelchair, propelled by others • Uses a symmetric chair during the day and sleeps in a bed which has full length bedrails with bumpers and specialised mattress maintain good skin integrity. • Has a tracheostomy used for suctioning and is prone to chest infections

The level of care required by both Client A and Client B cannot be met within traditional nursing provision therefore dedicated specialist care provided by Complex Care Nurses is required. Provision of Complex Care Service further enables these Clients to be maintained and cared for within a community setting in line with strategic direction.

SECTION 2 (a): OBJECTIVES

Project	Measurable Targets
1. Provide Complex Care support Client A, Physical Disability, to remain within the community.	<ul style="list-style-type: none"> • Appoint 1.0 x WTE Band 5 Complex Care Nurse by 1st November 2018
2. Provide Complex Care support Client B, Learning Disability, to remain within the community.	<ul style="list-style-type: none"> • Appoint x 1.0 WTE Band 5 Complex Care Nurse by 1st November 2018
3. Promote recovery, maintain and/or build family and social connections/networks.	<ul style="list-style-type: none"> • Enhanced level of support to patients reducing the need to be admitted to hospital. • No of re-admissions.
4. Minimise the need to hospital care through earlier intervention and through provision of a collaborative care approach across specialties.	<ul style="list-style-type: none"> • Reduction in the number of hospital admissions and readmissions • The number of clients who are able to remain in the community

SECTION 2 (b) : CONSTRAINTS

The following constraints must be considered in line with this investment:

Constraints	Measures to address constraints
1. Delay in the recruitment of posts	<ul style="list-style-type: none"> - Trust will commence the recruitment process as soon as funding is made available
2. Allocation of funding on a recurrent basis	<ul style="list-style-type: none"> - Trust will submit the IPT within agreed timescales and inclusive of all relevant information

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	Status Quo - continue with existing arrangements
2	Appoint 2 x WTE Band 5 Complex Care Nurses aligned to specific clients in order to facilitate their on-going care in the community on a recurrent basis. One post will work with a client with physical disability and the other post will work with a client with learning disability.
3	Appoint 1 x WTE Band 5 Complex Care Nurse to provide care to 2 Clients; one Learning Disability and one Physical Disability.

SECTION 4: PROJECT COSTS

Option 1: Status Quo	18/19 Yr 0 £000's	19/20 Yr 1 £000's	20/21 Yr 2 £000's	21/22 Yr 3 £000's	22/23 Yr 4 £000's	23/24 Yr 5 .. £000's	Totals £000's
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs							
Revenue Baseline	2,412	2,412	2,412	2,412	2,412	2,412	14,472
(b) Total Revenue Cost	2,412	2,412	2,412	2,412	2,412	2,412	14,472
(c) Total Cost = (a) + (b)	2,412	2,412	2,412	2,412	2,412	2,412	14,472
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	2,412	2,330	2,252	2,175	2,102	2,031	13,302

COST ASSUMPTIONS:

1. Year 0 is 2018/19 Financial Year.
2. The baseline costs for this case is the 2018/19 recurrent budget for Disability Specialist Services.
3. No other revenue or capital costs are associated with this option
4. A discount factor @3.5% pa has been applied to calculate the NPC.
5. Please note all figures above have been rounded to thousands
6. Total Net Present Cost (NPC) equates to £13,302k for this option

Option 2:- Recruit 2wte Band 5 Nurses	18/19 Yr 0 £000's	19/20 Yr 1 £000's	20/21 Yr 2 £000's	21/22 Yr 3 £000's	22/23 Yr 4 £000's	23/24 Yr 5 .. £000's	Totals £000's
<u>Capital Costs</u>							
(a) Total Capital Cost	0	0	0	0	0	0	0
<u>Revenue Costs</u>							
Revenue Baseline	2,412	2,412	2,412	2,412	2,412	2,412	14,472
Payroll	28	66	0	0	0	0	94
Payroll Related G&S	10	24	0	0	0	0	34
(b) Total Revenue Cost	2,450	2,502	2,412	2,412	2,412	2,412	14,600
(c) Total Cost = (a) + (b)	2,450	2,502	2,412	2,412	2,412	2,412	14,600
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	2,450	2,417	2,252	2,175	2,102	2,031	13,427

COST ASSUMPTIONS:

1. Year 0 is the financial year 2018/19.
2. The baseline costs for this case is the 2018/19 recurrent budget for Disability Specialist Services.
3. Posts costed according to the HSCB - Costing Template - 2017/18
4. Posts costed: 2wte Band 5 Nurses.
5. Enhancements included @ 23.09% in costing for 24hr Service.
6. Payroll related Goods & Services costed at 10% of basic as per HSCB Costing Template Plus Excess Travel.
7. Posts: CYE 2018/19 (5 months wef 1st November 2018).
8. Service dependant on recurrent funding
9. To be funded from 2018/19 Demography funding
10. A discount factor @3.5% pa has been applied to calculate the NPC.
11. Please note all figures above have been rounded to thousands.
12. Total Net Present Cost (NPC) equates to £13,427k for this option.

Option 3:- Recruit 1wte Speciality Doctor	18/19 Yr 0 £000's	19/20 Yr 1 £000's	20/21 Yr 2 £000's	21/22 Yr 3 £000's	22/23 Yr 4 £000's	23/24 Yr 5.. £000's	Totals £000's
Capital Costs							
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs							
Revenue Baseline	2,412	2,412	2,412	2,412	2,412	2,412	14,472
Payroll	14	33	0	0	0	0	47
Payroll Related G&S	5	12	0	0	0	0	17
(b) Total Revenue Cost	2,431	2,457	2,412	2,412	2,412	2,412	14,536
(c) Total Cost = (a) + (b)	2,433	2,457	2,412	2,412	2,412	2,412	14,538
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	2,433	2,374	2,252	2,175	2,102	2,031	13,367

COST ASSUMPTIONS:

1. Year 0 is the financial year 2018/19.
2. The baseline costs for this case is the 2018/19 recurrent budget for Disability Specialist Services.
3. Posts costed according to the HSCB - Costing Template - 2017/18
4. Posts costed: 1wte Band 5 Nurse
5. Enhancements included @ 23.09% in costing for 24hr Service.
6. Payroll related Goods & Services costed at 10% of basic as per HSCB Costing Template Plus Excess Travel.
7. Posts: CYE 2018/19 (5 months wef 1st November 2018).
8. Service dependant on recurrent funding
9. To be funded from 2018/19 Demography funding
10. A discount factor @3.5% pa has been applied to calculate the NPC.
11. Please note all figures above have been rounded to thousands.
12. Total Net Present Cost (NPC) equates to £13,367k for this option.

SECTION 5: NON-MONETARY BENEFITS

Impact Key:	
✓✓✓	Extremely positive impact
✓✓	Significant positive impact
✓	Some positive impact
X	No impact

Non - Monetary Factor	Impact of Option 1	Impact of Option 2	Impact of Option 3	Commentary
Provide support to maintain clients in the community	X	✓✓✓	✓	<p>Option 1 will have no impact on helping to maintaining these clients within the Community setting as it does not enhance/enable service provision.</p> <p>Option 3 has some positive impact on the ability to maintain these clients in the Community as complex care nursing will be provided, however provision of 1 x WTE Complex Care Nurse is not sufficient to fully meet the needs of 2 Clients, thereby leaving a potential care gap which increases the risk of clients being readmitted to hospital.</p>
Compliance with strategic direction	X	✓✓✓	✓	<p>Option 1 'do nothing' does not enable the Trust to comply with strategic direction.</p> <p>Option 3 has some positive impact, however appointment of 1 x WTE Complex Care Nurse is not sufficient to fully meet the needs of 2 Clients and therefore will not enable the Trust to fully comply with strategic direction (NICE Guideline 14 and Royal Marsden Clinical Guidelines).</p>
Empower Clients with physical and learning disability	X	✓✓✓	✓	<p>Option 1 'do nothing' will not enhance the current service provision and therefore will not further empower clients with physical and learning disability.</p> <p>Option 3 has some positive impact however appointment of 1 x WTE Complex Care Nurse is not sufficient to fully meet the needs of 2 Clients and therefore cannot fully capitalize on the opportunity to empower clients with physical disability and learning disability.</p>
Improved collaborative approach to care	X	✓✓✓	✓✓	<p>Option 1 'do nothing' will not enhance the current service provision and therefore will not enable/improve a collaborative approach to care.</p> <p>Option 3 has significant positive impact as allocation of a Complex Care Nurse will provide a collaborative approach to care; liaising across specialties to provide a full health approach to care. However as stated appointment of 1 x WTE Complex Care Nurse is not sufficient to fully meet the needs of 2 x Clients.</p>

SECTION 6: PROJECT RISKS & UNCERTAINTIES

Risk Description	Likely impact of Risk H/M/L			State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	Opt 3	
1. Inability to appoint staff	N/A	L	L	<p>Option 1 – Do nothing – no enhancement to the service. <i>Mitigation Measure:</i> N/A</p> <p>Option 2 – Appoint 2.0 WTE Band 5 Complex Care Nurses This is deemed a low risk as it is envisaged staff will be in post by 1st November 2018. <i>Mitigation Measure:</i></p> <ul style="list-style-type: none"> Continue to liaise with Human Resources throughout the recruitment process <p>Option 3 – Appoint 1.0 WTE Band 5 Complex Care Nurse This is deemed a low risk as it is envisaged staff will be in post by 1st November 2018. <i>Mitigation Measure:</i></p> <ul style="list-style-type: none"> Continue to liaise with Human Resources throughout the recruitment process.
2. Allocation of recurrent funding	N/A	L	L	<p>Option 1 – Do nothing – no improvements would be undertaken. <i>Mitigation Measure:</i> N/A</p> <p>Option 2 – Appoint 2.0 WTE Band 5 Complex Care Nurses If recurrent funding is not allocated in a timely manner this will negatively impact the Trust’s ability to maintain the Client A & Client B in the community. Further Client A & Client B have life-long conditions whereby it is deemed care will be required indefinitely, therefore recurrent funding is imperative. <i>Mitigation measure:</i></p> <ul style="list-style-type: none"> Ensure forward planning in place Submitt IPT within agreed timescales and inclusive of all relevant information <p>Option 3 - Appoint 1.0 WTE Band 5 Complex Care Nurse If recurrent funding is not allocated in a timely manner this will negatively impact the Trust’s ability to maintain the Client A & Client B in the community. Further Client A & Client B have life-long conditions whereby it is deemed care will be required indefinitely, therefore recurrent funding is imperative. <i>Mitigation measure:</i></p> <ul style="list-style-type: none"> Ensure forward planning in place Submitt IPT within agreed timescales and inclusive of all relevant information

3. Stakeholders not in agreement with proposal	N/A	L	L	<p>Option 1 – Do nothing – no improvements would be undertaken.</p> <p><i>Mitigation Measure:</i> N/A</p> <p>Option 2 – Appoint 2.0 WTE Band 5 Complex Care Nurses There is a low risk stakeholders will not agree with this proposal. Inclusive and person centered approach is fundamental to this proposal therefore stakeholders will be engaged with throughout the development of care plan.</p> <p><i>Mitigation measure:</i></p> <ul style="list-style-type: none"> Engage with stakeholders throughout development of proposal Ensure communication processes in place to keep stakeholders informed <p>Option 3 - Appoint 1.0 WTE Band 5 Complex Care Nurse There is a low risk stakeholders will not agree with this proposal. Inclusive and person centered approach is fundamental to this proposal therefore stakeholders will be engaged with throughout the development of care plan.</p> <p><i>Mitigation measure:</i></p> <ul style="list-style-type: none"> Engage with stakeholders throughout development of proposal Ensure communication processes in place to keep stakeholders informed
Overall Risk (H/M/L):	N/A	L	L	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 1 – Do nothing. This option has been discounted as this will not enable any change/improvement to service provision. No change to the existing service will not enable the Trust to maintain/support Client A & Client B in the community.

Option 3: Appoint 1.0 WTE Band 5 Complex Care Nurse, has been discounted. While this option goes some way to meet the needs of Client A & Client B it cannot fully address the care requirements of these individuals. In order to remain within a community setting Client A & Client B require input from a full time Complex Care Nurse each. Appointment of 1 x WTE Complex Care Nurse will not address the service gap, this increases the risk of readmission to an acute facility.

The preferred option has been identified as **Option 2: Appoint 2 x WTE Band 5 Complex Care Nurses aligned to specific clients in order to facilitate their on-going care in the community on a recurrent basis. One post will work with a client with physical disability**

and the other post will work with a client with learning disability. This option will enable the Trust to provide sufficient service to fully meet the care needs of Client A & Client B. Further this will enhance the care provision of Client A & Client B by maintaining and providing their care within a community setting, in line with strategic direction. This option provides a person centred approach to care provision, it engages clients, their families/carers in the development of care programmes. Provision of a Complex Care Nurse individually, to Client A and Client B will ensure a collaborative interface between specialties to ensure a whole health approach to care provision.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Yr 0 £000's	Yr 1 £000's	Yr 2 £000's	Yr 3 £000's	Total s
Required					
Capital required	0	0	0	0	0
Revenue required	2,449	2,546	2,501	2,547	10,043
Existing budget :					
Capital	0	0	0	0	0
Revenue	2,411	2,456	2,501	2,547	9,915
Additional Allocation Required:					
Capital	0	0	0	0	0
Revenue	38	90	0	0	128

AFFORDABILITY ASSUMPTIONS

1. Year 0 is 2018/19 Financial Year.
2. The baseline costs for this case is the 2018/19 recurrent budget for Disability Specialist Services .
3. Posts: CYE 2018/19 (5 months wef 1st November 2018).
4. Service dependant on recurrent funding
5. To be funded from 2018/19 Demography funding
5. Baseline revenue costs only uplifted for inflation by 1.83% per annum from 2019/20 onwards.
6. Please note all figures above have been rounded to thousands.

SECTION 9: MANAGEMENT ARRANGEMENTS

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management. The following key roles have been identified:

- Project Owner: Mrs Carmel Harney, Acting Director of Mental Health and Disability
- Project Director: Noreen McComiskey, Acting Assistant Director of Physical & Sensory Disability Services
- Project Manager: Bernie McNaughton, Team Leader Complex Care Service

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation.

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation? (please provide the name of the	Bernie McNaughton, Team Leader Complex Care Service
Who will monitor and evaluate the outcomes? (please provide the name of the responsible individual where	Bernie McNaughton, Team Leader Complex Care Service
What other factors will be monitored and evaluated?	N/A
When will this take place? (preferably 4 to 12 months after project closure)	12 months after full implementation

SECTION 11: ACTIVITY OUTCOMES (TRUSTS ONLY)

Specify activity, e.g. IP, DC OPN, OPR, Contacts etc

	IP	DC	OPN	OPR		
Baseline						
Additional activity						
New Baseline Activity						

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

[expand as necessary]

Summary Costing schedule for Investment Decision Making Templates
 Provider: SOUTHERN COMMUNITY.
 Hospital Site or Community development: Demography - Complex Care Nursing
 Scheme Title: 2017/18
 Pay and Price Levels

Ref Number: SOUTHERN COMMUNITY.
 Demography - Complex Care Nursing
 2017/18

Commissioner Use only
 Sign and Date for TRAFFACS update

Pay Costs	Description	Base Case - option 1			Option 2			Option 3			Option 4		
		months claimed	wte	eye	months claimed	wte	eye	months claimed	wte	eye	months claimed	wte	eye
BAND 1				2,411,768	2,411,768	2,411,768							
BAND 2													
BAND 3													
BAND 4													
BAND 5	Nurses				2.00	66,447	27,686	5.00	1.00	35,224	13,843		
BAND 6													
BAND 7													
BAND 8A													
BAND 8B													
BAND 8C													
BAND 8D													
BAND 9													
Non-AEC posts please detail below													
Allowances for posts noted above - please detail below													
Salary Related 6&S: @ 10% / Excess Travel													
Band 5 Nurse					5.00	5,260	2,192	5.00		2,630	1,096		
Band 5 Nurse Excess Travel					5.00	2,950	1,229	5.00		2,000	833		
Band 5 24hr Service Costs					5.00	15,343	6,393	5.00		7,671	3,196		
Exceptional Recruitment and Retention costs for posts above the mean plus 3% (please provide detail)													
TOTAL PAY COSTS			0.00	0	2.00	2,503,768	2,449,268		1.00	2,457,293	2,430,737	0.00	0
Non-Pay Costs - please detail below													
TOTAL NON-PAY COSTS			0	0		0	0			0	0	0	0
GRAND TOTAL			0	0		2,503,768	2,449,268			2,457,293	2,430,737	0	0
Phasing/Timescale						90,000	37,500			45,525	19,969		
PROGRAMME OF CARE													
SUB-SPECIALTY INFORMATION eg Inpatients, outpatients, daycases if known													
LCG													
if more than one LCG in option above please give details													
LGD													
if more than one LGD in option above please give details													

BUSINESS CASE TEMPLATE
Level 3
REVENUE FUNDING £250k-£1m
REVENUE BUSINESS CASE PROFORMA COVER

HSCB Reference Number	SCCD/2018/19 LD19ST
Source of Funding	2018/19 LD Inescapable Cost Pressures
Year	2018/19
HSCB representative name, job title and contact details	Valerie McConnell, Programme Manager MH and LD Valerie.mcconnell@hscni.net Cc Lorna Conn, Commissioning Lead MH and LD Cc Sophie Lusby, SLCG
Provider representative name, job title and contact details	SHSCT Aldrina Magwood, Director of Planning Cc Carmel Harney, Director of MH and LD Cc Noreen McComsky, Acting Assistant Director LD
Project Title	Additional Community Infrastructure for crisis/out of hours - LD
Start date	01/01/18
Completion date	Recurrent




Cost of proposal per year:	18/19: £74,355 (RRL Notification 008 - 17 October 2018 Traffacs ID 109898 recurrently) 19/20 CYE: £297,420
	*19/20: £297,420(made up of £74,355 already received under Commitment ID 109898 + £74,355 + £148,710 from indicative alloc yet to be received); * = Amount is conditional on funding being made available in 2019/20 and beyond

Funding required:	18/19 £74,355 CYE (RRL Notification 008 - 17 October 2018 Traffacs ID 109898 recurrently) 19/20 FYE £297,420
	*19/20: £297,420(made up of £74,355 already received under Commitment ID 109898 + £74,355 + £148,710 from indicative alloc yet to be received); * = Amount is conditional on funding being made available in 2019/20 and beyond

<i>Is this business case</i>	<i>Y/N</i>
<i>(a) Standard</i>	<i>Y</i>
<i>(b) Novel</i>	<i>N</i>
<i>© Contentious</i>	<i>N</i>
<i>(d) Setting a precedent</i>	<i>N</i>
<i>If yes to (b) or (c) or (d) , requires Departmental & DoF approval</i>	
<i>Is Departmental / DOF approval required</i>	

Approval & submission by Trust

This section to be completed by Providers for all submissions

Responsible Director Signature (required for all submissions) Name printed Barney McNeany (signed)  Title Director of Mental Health & Disability Services Date 08.11.19	
Provider Director of Finance Signature (required if bid over £100k) Name printed HELEN O'NEILL (signed)  Date 26/11/19	
Provider Chief Executive Signature (required if bid over £100k) Name printed Shane Devlin (signed)  Date 28/11/19	

Approval & submission by HSCB/PHA

Responsible Director Signature (required for all submissions up to £1m)

Name printed: Marie Roulston (signed)

Title: Director of Social Care and Children's Directorate

Date

SECRET

SECTION 1(a): PROJECT BACKGROUND AND STRATEGIC CONTEXT

Given the strategic objective of supporting adults with a learning disability to live in the community, and the associated reduction in availability of long term hospital care there is a need to continue to develop the range of services available for adults with a learning disability and complex needs in community settings.

SECTION 1(b): DEMONSTRATE THE NEED FOR THE PROJECT

Trends would indicate that people with complex needs due to learning disability and physical health conditions are living longer. HSC Trusts are asked to provide ongoing support packages for young people with complex needs transitioning to adult health and social care services to sustain them with their families / substitute carers, or move on to live independently if appropriate.

People with learning disabilities have a variable range of health and social care needs and often experience greater health and wellbeing inequalities than the general population and can experience difficulty in accessing services. They are also at risk of social exclusion, affecting their quality of life through exclusion from employment, relationships and other life opportunities. People with learning disabilities are now living longer thanks to the medical advancements in their care and as a result there is therefore an increase in numbers and complexities. Both Transforming Your Care and the DHSSPS Learning Disability Service Framework highlight the needs of the increasing numbers of adults with a learning disability with complex needs surviving well into adulthood. Transforming your Care recognises the need to provide support for families and carers including short breaks and day opportunities to enable people with a learning disability to remain at home with appropriate support.

Many individuals with a learning disability have associated physical health conditions including complex mobility or personal care needs. As individuals age these conditions may become more severe and the level of care and support required may increase. Also family and carers are also ageing and the ability to provide the care and support for individuals is becoming more difficult. Many individuals require higher levels of care and support needs which the family/carer cannot provide. Some individuals, known to adult disability are assessed as requiring residential or nursing care and are placed in a residential or nursing home placement.

Previously these people would likely to have been admitted to long stay learning disability hospital wards, an option which is no longer appropriate. Equal Lives and the Bamford Review recommended that all adults with a learning disability be resettled within the community.

A number of adults with learning disability live at home with their parents or other adults, rather than in residential and nursing facilities or supported living schemes. As the parent or other carers providing care age, it may not be possible for them to continue to care for their adult relatives with learning disability at home and Trusts are required to source alternative appropriate community packages for the adults with learning disability. There are times when the caring arrangements breakdown due to an episode or if the carer/parent themselves is not able to continue care for a short time. These are times of crisis and require intervention.

Proposal

The Learning Disability Crisis Response and Home Treatment Service provides specialist support for adults with a learning disability who present with mental ill health or behaviour that challenges them and their carers enabling them to stay in their own homes and avoid unnecessary admission to acute psychiatric hospital where possible. Their aim is to provide safe and supportive intervention to clients, carers and the wider public, whilst working with other statutory, community and voluntary agencies.

All referrals to The Adult Learning Disability Crisis Response and Home Treatment Service are screened by the practitioner who receives the call.

Interventions may include:

- Advice and support given via telephone
- Home visit to assist with management of a crisis situation
- Consultation with external agencies for guidance, advice and support
- Consultation with learning disability for guidance, advice and support
- Facilitation of early discharge from hospital through structured home visits
- Support in home environment up to a maximum of 48 hours to manage crisis

The Adult Learning Disability Crisis Response and Home Treatment Service endeavour to respond to referrals within one hour. The team assess service users who present with mental ill health or behaviour that challenges them and their carer's. Interventions are person centred and endeavour to promote the rights of people with a learning disability while maintaining the safety of all parties involved. The team encourages shared decision making and ownership of decisions and responsibility for actions. This is achieved by client specific interventions, interagency working and involving other community learning disability services.

The Adult Learning Disability Crisis Response and Home Treatment Team actively recognise the important and invaluable role played by carers and the team provides a point of contact for support, assessment and intervention, risk management planning, and ongoing contact with the referring agent.

All assessments and interventions will be person-centred in their approach based on partnership working with service users and carers.

The Southern Trust's Learning Disability Crisis Response Service was set up in June 2017 and is currently staffed by 2.00 WTE band 5 nurses.

The Service works with other health and social care staff including the Behavior Support Team, GPs, psychiatrist and social worker to provide the best care for the individual during their time of difficulty.

It is proposed to extend the service by enhancing the current team with the following members of staff:

- 2.00 WTE band 6 practitioner (1.00 WTE Nurse Prescriber and 1.00 WTE social worker)
- 1.00 WTE band 6 OT
- 2.00 WTE band 5 Nurses
- 2.00 WTE band 3 Home Treatment Support workers
- 1.00 WTE band 8a Psychologists

SECTION 2(a): OBJECTIVES

Project Objectives	Measurable Targets
<p>1. To work towards targets and strategic direction</p> <ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • All admissions will have a discharge plan in place within 7 days and home treatment will attend all planned multi-disciplinary meetings and discharges will be effected earlier for those who require changing medication which will be undertaken by the Home Treatment Team • The resettlement of long stay hospital Patient to suitable placements in the community.

<p>2. Appointment of the following posts by 1 January 19:</p> <ul style="list-style-type: none"> • 2.00 WTE band 6 practitioner • 1.00 WTE band 6 OT • 2.00 WTE band 5 Nurses • 2.00 WTE band 3 Home Treatment Support workers • 1.00 WTE band 8a Psychologists 	<ul style="list-style-type: none"> • Appointment of all posts by 1 January 2019
<p>3. To respond to all crisis out of hours calls within the target time</p>	<ul style="list-style-type: none"> • All crisis calls are responded to within one hour
<p>4. To provide suitable alternative community placements those clients who require crisis intervention to avoid admission</p>	<ul style="list-style-type: none"> • The number of admission to hospital
<p>5. Promote recovery, maintain and/or build family and social connections/networks.</p>	<ul style="list-style-type: none"> • Enhanced level of support to patients reducing the need to be admitted to hospital. • No of re-admissions.
<p>6. Minimize the need for hospital care through crisis intervention</p>	<ul style="list-style-type: none"> • Reduction in the number of readmissions
<p>7. Provide care and support packages to those clients with a learning disability to enable them to remain in the community.</p>	<ul style="list-style-type: none"> • The number of clients who are able to remain in the community.

SECTION 2(b): CONSTRAINTS

Constraints	Measures to address constraints
<p>1. Appointment to posts within acceptable time frame</p>	<ul style="list-style-type: none"> • Complete and submit IPT within agreed timeframes • Work with HR throughout recruitment process
<p>2. Funding not made available to enable full rollout</p>	<ul style="list-style-type: none"> • Complete and submit IPT within agreed framework

SECTION 3: IDENTIFY AND SHORTLIST OPTIONS

Option Number/ Description	Shortlisted (S) or Rejected (R)	Reason for Rejection
1. Status Quo - continue with existing arrangements	S	
2. Enhancement of the Crisis Response Home Treatment Service for Learning Disability by appointing the following staff: <ul style="list-style-type: none"> • 2.00 WTE band 6 practitioner • 1.00 WTE band 6 OT • 2.00 WTE band 5 Nurses • 2.00 WTE band 3 Home Treatment Support workers • 1.00 WTE band 8a Psychologists 	S	
3. Enhancement of the Crisis Response Home Treatment Service for Learning Disability by appointing the following staff: <ul style="list-style-type: none"> • 2.00 WTE band 6 practitioner • 1.00 WTE band 6 OT • 3wte band 5 Nurses • 3wte band 3 Home Treatment Support workers • 1.00 WTE band 8a Psychologists 	S	

SECTION 4: MONETARY COSTS AND BENEFITS OF OPTIONS
(to be completed by the Trust)

Option 1: Status Quo	18/19 Year 0 £000's	19/20 Year 1 £000's	20/21 Year 2 £000's	21/22 Year 3 £000's	22/23 Year 4 £000's	23/24 Year 5 £000's	Totals £000's
Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(a) Total Capital Cost	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Revenue Costs							
Revenue Baseline	61,886.4	61,886.4	61,886.4	61,886.4	61,886.4	61,886.4	371,318.4
(b) Total Revenue Cost	61,886.4	61,886.4	61,886.4	61,886.4	61,886.4	61,886.4	371,318.4
(c) Total Cost = (a) + (b)	61,886.4	61,886.4	61,886.4	61,886.4	61,886.4	61,886.4	371,318.4
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	61,886.4	59,794.6	57,771.0	55,815.3	53,927.8	52,108.3	341,303.4

COST ASSUMPTIONS:

Finance Assumptions:

1. 1. Year 0 is 2018/19 Financial Year.
2. The baseline costs for this case is the MHD AD Disability Services Recurring Revenue Baseline Budget for 2018/19 .
3. No other revenue or capital costs are associated with this option
4. A discount factor @3.5% pa has been applied to calculate the NPC.
5. Please note all figures above have been rounded to thousands and shown to one decimal point.
6. Total Net Present Cost (NPC) equates to £341,303.4k for this option

Option 2 - Enhancement of the Crisis Response Home Treatment Service for Learning Disability by staff identified in Section 3.2.	18/19 Year 0 £000's	19/20 Year 1 £000's	20/21 Year 2 £000's	21/22 Year 3 £000's	22/23 Year 4 £000's	23/24 Year 5 £000's	Totals £000's
<u>Capital Costs</u>	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(a) Total Capital Cost	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<u>Revenue Costs</u>							
Revenue Baseline	61,886.4	61,886.4	61,886.4	61,886.4	61,886.4	61,886.4	371,318.4
Payroll	73.5	293.9	293.9	293.9	293.9	293.9	1,543.0
Payroll related G&S	0.9	3.5	3.5	3.5	3.5	3.5	18.4
(b) Total Revenue Cost	61,960.8	62,183.8	62,183.8	62,183.8	62,183.8	62,183.8	372,879.8
(c) Total Cost = (a) + (b)	61,960.8	62,183.8	62,183.8	62,183.8	62,183.8	62,183.8	372,879.8
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	61,960.8	60,082.0	58,048.6	56,083.6	54,187.0	52,358.8	342,720.8

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2018/19 Financial Year.
2. The baseline costs for this case is the MHD AD Disability Services Recurring Revenue Baseline Budget for 2018/19 .
3. The costs have been based on the 2018/19 HSCB General Costings.
4. Payroll G&S have been capped at £435.50 per WTE due to funding constraints.
5. No allowance has been made for unsocial hour's enhancements or annual leave/sickness cover.
6. There is 3 months effect for all posts in Year 0 (2018/19).
7. No other capital or revenue costs are identified in this option.
8. A discount factor @3.5% pa has been applied to calculate the NPC.
9. Please note all figures above have been rounded to thousands and shown to one decimal place.
9. Total Net Present Cost (NPC) equates to £342,720.8k for this option.

Option 3 – Enhancement of the Crisis Response Home Treatment Service for Learning Disability by staff identified in Section 3.3.	18/19 Year 0 £000's	19/20 Year 1 £000's	20/21 Year 2 £000's	21/22 Year 3 £000's	22/23 Year 4 £000's	23/24 Year 5 £000's	Totals £000's
Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(a) Total Capital Cost	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Revenue Costs							
Revenue Baseline	61,886.4	61,886.4	61,886.4	61,886.4	61,886.4	61,886.4	371,318.4
Payroll	87.8	351.2	351.2	351.2	351.2	351.2	1,843.8
Payroll related G&S	1.1	4.4	4.4	4.4	4.4	4.4	23.1
(b) Total Revenue Cost	61,975.3	62,242.0	62,242.0	62,242.0	62,242.0	62,242.0	373,185.3
(c) Total Cost = (a) + (b)	61,975.3	62,242.0	62,242.0	62,242.0	62,242.0	62,242.0	373,185.3
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	61,975.3	60,138.2	58,102.9	56,136.1	54,237.7	52,407.8	342,998.0

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2018/19 Financial Year.
2. The baseline costs for this case is the MHD AD Disability Services Recurring Revenue Baseline Budget for 2018/19.
3. The costs have been based on the 2018/19 HSCB General Costings.
4. Payroll G&S have been capped at £435.50 per WTE due to funding constraints.
5. No allowance has been made for unsocial hour's enhancements or annual leave/sickness cover.
6. There is 3 months effect for all posts in Year 0 (2018/19).
7. No other capital or revenue costs are identified in this case.
8. A discount factor @3.5% pa has been applied to calculate the NPC.
9. Please note all figures above have been rounded to thousands and shown to one decimal place.
10. Total Net Present Cost (NPC) equates to £342,998.0k for this option.

SECTION 5: NON MONETARY COSTS AND BENEFITS

Weighting method

Non-Monetary Factor	Weighting (%)	Score Option 1 Status Quo		Score Option 2 Enhancement of the Crisis Response Home Treatment Service for Learning Disability		Score Option 3 Enhancement of the Crisis Response Home Treatment Service for Learning Disability	
1. Meets strategic direction	25	2	50	9	225	9	225
2. Provide support to those individuals living in the community.	25	2	50	9	225	9	225
3. Acceptability of service user, parents and carers	25	2	50	9	225	9	225
4. Prevent admission/re-admission to hospital	25	2	50	7	175	8	200
Total	100%		200		850		875
Rank			3		2		1

Or Impact assessment

Non-Monetary Factor	Option 1	Option 2	Option 3 ...
1.			
2.			
3. etc			

Rationale for weighting and scoring

Option 1 scored low as it will not provide any benefits to the service.

Option 2 and 3 scored equally under the first three criteria as they both meet current strategic direction as clients will be supported to remain in the community. Also in times of crisis, support will be available to the clients and their families and carers to enable them to remain in their own home or to put the necessary support packages in place. With the Enhancement of the Crisis Response Home Treatment Service for Learning Disability the number of admissions and re-admissions may reduce. Admission to hospital can be stressful and upsetting for the client therefore if the additional support can be provided in their home setting this would be more acceptable to clients, their family and carers. Option 3 scored higher as with a full complement of staff a more enhanced service will be provided.

Option 3 scored highest however due to insufficient funding it is not possible to implement this option. This option has been rejected as there is insufficient funding to provide the full complement of staff. Therefore Option 2 is the preferred option.

SECTION 6: ASSESS RISKS AND UNCERTAINTIES

Risk Description	Likely impact of Risk H/M/L				State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	Opt 3	Opt 4	
1. Failure to appoint staff within the timescale of the IPT	L	M	M	N/A	The likely impact of risk on Options 1 is low as the Trust would not appoint staff. Option 2 risk level is medium as although there may be risk in appointing staff, the service will take forward any necessary procedures to enable staff to be appointed as quickly as possible. In addition some of these posts have been filled on a temporary basis. Option 3 is a higher risk due to the availability of staff with the short timescale.
2. Availability of funding	L	M	H		Option 1 scored low, as no additional funding is required to maintain the current service provision which means no service change. Option 2 scored medium as additional funding is required to expand the service. The Trust will submit the IPT within agreed timeframes and will liaise closely with the HSCB to mitigate this risk. Option 3 is a high risk as funding allocated within the IPT is not sufficient for this option.
3. Re-admission to hospital	H	L	L	n/a	Option 1 scored high as there will be no enhancement to the service. Both Options 2 and 3 scored low as the service will aim to reduce the number of re-admissions
4. Acceptance by clients, families and carers	H	L	L		Teams will meet with both service users/parents/carers to discuss the level of care and support being offered. Agreed support plans will be put in place and all will be fully informed.
Overall Risk (H/M/L):	H	M	M	n/a	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 1 has been rejected as this option would not provide any enhancement to the current service. This option has been retained as a base case for comparison.

Option 3 scored highest however due to insufficient funding it is not possible to implement this option. This option has been rejected as there is insufficient funding to provide the full complement of staff. Therefore Option 2 is the preferred option.

Option 2, Enhancement of the Crisis Response Home Treatment Service for Learning Disability scored highest and is the preferred option as it will provide the following benefits to the service:

- Provides assessment and short term treatment in the community for people who might otherwise need admission to hospital
- Offers support to those who have been in hospital and are ready for early discharge
- While the service user is receiving support from the Home Treatment Team, they and their carers can contact the team 24 hours / seven days week
- The team will provide intensive support and care during a crisis, according to an agreed plan of care
- The care plan will include the location where the team will meet the individual, how often the visits will happen, interventions needed, contact details for the CRHTT, medication/treatment information, needs of families/carer's.
- Treatment is home based to keep disruption to everyday life to a minimum

SECTION 8: ASSESS AFFORDABILITY AND FUNDING ARRANGEMENTS

	2018/19 Year 0 £000's	2019/20 Year 1 £000's	2020/21 Year 2 £000's	2021/22 Year 3 £000's	Totals £000's
Required:					
Capital	0.0	0.0	0.0	0.0	0.0
Resource	61,960.7	63,321.7	64,480.5	65,660.5	255,423.4
Existing Budget:					
Capital	0.0	0.0	0.0	0.0	0.0
Resource	61,886.3	63,018.9	64,172.1	65,346.5	254,423.8
Additional budget Required:					
Capital	0.0	0.0	0.0	0.0	0.0
Resource	74.4	302.8	308.4	314.0	999.6

Affordability Narrative

Finance Assumptions:

1. Year 0 is 2018/19 Financial Year.
2. The baseline costs for this case is the MHD AD Disability Services Recurring Revenue Baseline Budget for 2018/19.
3. The costs have been based on the 2018/19 HSCB General Costings.
4. Payroll G&S have been capped at £435.50 per WTE due to funding constraints.
5. No allowance has been made for unsocial hour's enhancements or annual leave / sickness cover.
6. There is 3 months included for all posts in Year 0 (2018/19)
7. Costs have been uplifted by 1.83% for inflation from 2019/20.
8. No capital costs are identified in this case.
9. Please note all figures above have been rounded to thousands and shown to one decimal point.

SECTION 9: PROJECT MANAGEMENT (Please see Benefits Realisation Plan in Annex B)

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management. The following key roles have been identified:

- **Project Owner:** Barney McNeany, Director of Mental Health & Disability Services
- **Project Director:** Miceal Crilly , Assistant Director of Physical and Sensory Disability Services
- **Project Manager:** Noreen McComisky, Learning Disability Specialist Manager

A review of investment in relation to the stated objectives will be undertaken 12 months after full implementation.

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation?	<ul style="list-style-type: none"> • Noreen McComisky, Learning Disability Specialist Manager
Who will monitor and evaluate the outcomes?	<ul style="list-style-type: none"> • Noreen McComisky, Learning Disability Specialist Manager
What other factors will be monitored and evaluated? –	<ul style="list-style-type: none"> • Referrals and the number of interventions and outcomes. A baseline will be established.
When will this take place?	<ul style="list-style-type: none"> • 6 Monthly Performance Report

Revenue Expenditure £250k - £1m - APPENDIX A

Benefit Profile (Small Projects)			Signed off by:		Date:	
Benefit Owner	Benefit	Baseline value	Target Value	Measurement	Timing	Responsibility
Miceal Crilly	To provide care and support packages to those clients with a learning disability to enable them to remain in the community	2.00 WTE band 5 Nurses	<ul style="list-style-type: none"> 2.00 WTE band 6 practitioner 1.00 WTE band 6 OT 2.00 WTE band 5 Nurses 2.00 WTE band 3 Home Treatment Support workers 1.00 WTE band 8a Psychologists 	Number of staff in post	March 2020	Noreen McComiskey

Summary Costing schedule for Investment Decision Making Templates		Ref Number	Commissioner Use only Sign and Date for TRAFFACS update											
Provider		SOTTHERY CRAIGAVON	Option 1			Option 2			Option 3			Option 4		
Hospital Site or Community development		Additional Community Infrastructure for crisis out of hours - 2018.19 L1D Inevitable Cost Pressure	months claimed	wte	fyf	cye	months claimed	wte	fyf	cye	months claimed	wte	fyf	cye
Scheme Title		2018.19	Base Case - option 1			Option 2			Option 3			Option 4		
Pay and Price Levels			months claimed	wte	fyf	cye	months claimed	wte	fyf	cye	months claimed	wte	fyf	cye
Pay Costs														
BAND 3	Home Treatment Support workers		3.00	2.00	61,886,332	61,886,332	3.00	2.00	47,128	11,782	3.00	2.00	47,128	11,782
BAND 5	Nurses		0	0	0	0	0	0	67,402	16,851	0	0	67,402	16,851
BAND 6	Practitioner - Nurse Practitioner		0	0	0	0	0	0	40,437	10,109	0	0	40,437	10,109
BAND 6	Practitioner - Social Worker		0	0	0	0	0	0	40,437	10,109	0	0	40,437	10,109
BAND 6	OT		0	0	0	0	0	0	40,437	10,109	0	0	40,437	10,109
BAND 8A	Psychologists		0	0	0	0	0	0	58,095	14,524	0	0	58,095	14,524
Additional Staff - Option 3 Only														
BAND 3	Home Treatment Support workers		0	0	0	0	3.00	1.00	23,564	5,891	3.00	1.00	23,564	5,891
BAND 5	Nurses		0	0	0	0	3.00	1.00	33,701	8,425	3.00	1.00	33,701	8,425
Non-AYC posts please detail below.														
Allowances for posts noted above - please detail below.														
Unsocial Hours payments														
GG&S Costs associated with the above posts														
Employee Related GG&S														
BAND 3	Home Treatment Support workers		3.00	3.00	871	218	3.00	3.00	871	218	3.00	3.00	871	218
BAND 5	Nurses		3.00	3.00	871	218	3.00	3.00	871	218	3.00	3.00	871	218
BAND 6	Practitioner - Nurse Practitioner		3.00	3.00	436	109	3.00	3.00	436	109	3.00	3.00	436	109
BAND 6	Practitioner - Social Worker		3.00	3.00	436	109	3.00	3.00	436	109	3.00	3.00	436	109
BAND 6	OT		3.00	3.00	436	109	3.00	3.00	436	109	3.00	3.00	436	109
BAND 8A	Psychologists		3.00	3.00	436	109	3.00	3.00	436	109	3.00	3.00	436	109
Additional Staff - option 3 & Only														
BAND 3	Home Treatment Support workers		0	0	0	0	0	0	436	109	0	0	436	109
BAND 5	Nurses		0	0	0	0	0	0	436	109	0	0	436	109
Exceptional Recruitment and Retention costs for posts above the mean plus x% (please provide detail)														
TOTAL PAY COSTS			0.00	61,886,332	61,886,332	61,886,332	3.00	65,188,772	61,960,707	61,960,707	10.00	65,241,908	61,975,241	0.00
Non-Pay Costs - please detail below														
OTHER GOODS & SERVICES														
TOTAL NON-PAY COSTS			0	0	0	0	0	0	0	0	0	0	0	0
GRAND TOTAL			0	61,886,332	61,886,332	61,886,332	3.00	65,188,772	61,960,707	61,960,707	10.00	65,241,908	61,975,241	0
Phasing/Timescale														
PROGRAMME OF CARE														
SUB-SPECIALITY INFORMATION of Impairments, LCG														
If more than one LCG in option above please give details														
LCG														
If more than one LCG in option above please give details														

REVENUE BUSINESS CASE PROFORMA COVER

(To be submitted with every business case)

Name of organisation	SHSCT
Project Title	Enhance Adult Learning Disability Psychiatry Service
Total Cost	£125,952 FYE, £31,488 CYE 18/19
Start date	1 January 2019
Completion date	Recurrent

Complete this section if bid is for new funding

BID FOR NEW FUNDING	N
Is this bid for new funding (Y/N)	N
How much total funding required?	£125,952 FYE, £31,488 CYE (2018/19)
How much funding required per year?	£125,952 FYE
Is this funding to be made recurrent?	Y

Complete this section if funding available within existing allocation

Funding available within existing allocation (Y/N)	Y
Total cost of proposal	£125,952 FYE, £31,488 CYE (2018/19)
Cost of proposal per year	£125,952 FYE
Is this cost within recurrent allocation?	Y

Is this business case	Y/N
(a) Standard	Y
(b) Novel	N
© Contentious	N
(d) Setting a precedent	N
If yes to (b) or (c) or (d) , requires Departmental & DoF approval's	N/A
Departmental / DOF approval required	

Approval & submission by Trust

This section to be completed by Trusts for all submissions

Responsible Director Signature (required for all submissions)	
Name Printed Mrs Carmel Harney	(signed) <i>Carmel Harney</i>
Grade/ Title Interim Director Mental Health + Disability	
Date 12.10.2018	

Trust Director of Finance Signature (required if bid is over £100k)	
Name printed	(signed) <i>Umarah</i>
Date 22/10/18	

Trust Chief Executive Signature (required if bid is over £100k)	
Name printed S. Debn	(signed) <i>JD</i>
Date 28/10/2018	

Complete this section if Department / DOF approval required

Date submitted to Department
Department/ DOF approval (Y/N)
Date approved

BUSINESS CASE TEMPLATE**REVENUE FUNDING £50k - £250k****SECTION 1: PROJECT BACKGROUND, STRATEGIC CONTEXT & NEED****Background:**

The Service Framework for Learning Disability published in September 2012, sets out clear standards of care that people can expect. This framework aims to improve the health and wellbeing of people with a learning disability, their carers and families by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.

People with Learning Disabilities have a variable range of health and social care needs; often experiencing greater health and wellbeing inequalities than the general population, this can also lead to difficulty in accessing services. Individuals with Learning Disability are also at risk of social exclusion, affecting their quality of life through exclusion from employment, relationships and other life opportunities.

Due to medical advancements, individuals with learning disabilities are now living longer, meaning an increase in the number of clients and the complexity of cases. Transforming your Care recognises the need to provide support for families and carers including short breaks and day opportunities to enable people with a learning disability to remain at home with appropriate support.

The landscape of Learning Disability services has changed in the last four years with the resettlement of patients into the community. In line with strategic direction hospitals no longer provide respite care; this has resulted in an increase in demand on psychiatric services to liaise with families and Multi-Disciplinary Teams (MDT) to fully manage individuals with challenging behaviour in the community. Requests for day care placements, respite care and 24 hour care facilities have increased beyond capacity. This has resulted in an increased work load for LD psychiatrists to work with community services in maintaining the placement, particularly in the family home. The life expectancy of patients with learning disability is increasing although concerns still remain that their survival rates are well below the general population. Therefore it has become necessary to undertake a review to consider developing the workforce and psychiatry provision in order to meet increasing demographic demands.

Drivers for Change:

There have been a number of strategic changes and increases in standards to the provision of LD Psychiatric Care which have impacted how the service is and should be delivered. Some of these changes are detailed below:

Standards:

- Assessment of medications requiring Best Interest Meetings
- Epilepsy - requirement to carry out joint clinics with Neurologists to adhere to the National Epilepsy Care Pathway
- Psychotropic monitoring requirements
- Dementia – completion of assessment tools, memory assessment
- Need to increase outpatient clinic review times per patient

Interfacing with teams:

- Increased requirement to interface and input with specialist teams including; epilepsy, crisis and home treatment, dementia, health facilitation service, transition service and complex care teams

Patients outside catchment area:

- Patients from outside the Trust have been resettled within SHSCT which creates additional pressure that does not sit within SHSCT projections.

Home Visits:

- Requests have increased from 1 per week to 3-4 per week.
- Additional requests to hold clinics in residential care facilities, supported living facilities and to see patients in these facilities on an urgent basis have increased.
- Approximately 250 patients reside in facilities that require LD Psychiatry input.

Medical Reports:

- PIP Consultants complete 2-3 reports per month
- Increase in requests for court reports
- Previously increase from 3-4 court reports from acute hospitals for serious interventions per year to 10 per year

Prescribing:

- Increasing demand to prescribe medications over the phone

Inpatient:

- Quality Network for Inpatient Services for People with Learning Disabilities (QNLND)

Current Provision:

Within the SHSCT Learning Disability Psychiatry services are provided through a Consultant delivered service model. Currently there are 3.0 WTE Consultants within Adult LD Psychiatry, providing consultant cover to each locality. Further to this each consultant has responsibility for 3-5 inpatients at any given time.

As at August 2018, the current case load is 990 patients. Each Consultant is seeing around 450-500 patients per year, including an additional 20-40 new referrals each year. Consultants are also required to attend MDT meetings which include; care plan meetings, risk management meetings, vulnerable adult protection meetings and best interest meetings. Currently each Consultant holds 3 clinics per week across their localities including within care facilities.

The table below details the caseload and breakdown:

SHSCT LD Psychiatry Service	
Caseload at August 2018	990
3 x Consultants (1 per locality)	390 patients Craigavon & Banbridge 350 patients Armagh & Dungannon 250 patients Newry & Mourne Additional 20- 40 new referrals each year 3-5 inpatients 3 clinics per week in each locality

With increasing demographic pressures the demands for routine and urgent home visits has also increased. Since 2010 there has been less than a 10% increase in the psychiatry resource and in the last four years there has been no expansion of psychiatry despite growing demographic demands. In the next 2 years there are an estimated 200 patients transitioning to Adult LD services with many requiring input for mental health and behavioural problems.

Proposal:

This business case sets out a proposal to appoint an additional **1.0 WTE LD Psychiatry Consultant**. Appointment of an additional consultant within the service will enable provision of a further 8 sessions, a caseload reallocation of approximately 200 patients. It is envisaged that this additional Consultant will work closely within the community setting to help discharge patients with complex care needs and work to sustain community placements and reduce the occurrence of hospital readmissions. Increasing capacity within the service through the appointment of a further Consultant will enable the service to take forward a number of additional clinics and Multi- disciplinary Team working including:

- STOMP clinics
- Epilepsy Care Pathway Joint Meetings Neurology & Psychiatry
- Autism Management
- Respite Support
- PARIS and Mental Capacity Act
- Dementia Pathways
- Forensic Pathways
- Liaison Support Acute Hospitals
- Acute Care At Home

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. Appointment of 1.0 WTE Consultant LD Psychiatrist working closely with community	- Appointment of Consultant by 1 st January 2019
2. Increase capacity within LD Psychiatry Services	- Provision of 8 additional sessions - No. of Patient contacts undertaken
3. Reduction in Consultant caseloads	- Uptake of a caseload of 200 by additional consultant - Reallocation in individual caseloads overall in line with increased capacity
4. Adhere to standards and guidelines for the safe provision of care	- Care provided within frameworks as established in standards and guidelines

SECTION 2 (b) : CONSTRAINTS

There is currently a shortage of LD Psychiatry Consultants in Northern Ireland. This is further exasperated as Psychiatry Consultants can't be recruited from overseas due to limited availability of LD specialist training outside of the UK.

Mitigation:

Continue to work with and liaise with HR throughout the recruitment process. Ensure the opportunity for professional development is included within the post to appeal to candidates.

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	Status Quo - continue with existing arrangements
2	Appoint 1.0 WTE Consultant LD Psychiatrist
3	Appoint 1.0 WTE Staff Grade to Psychiatry Service

SECTION 4: PROJECT COSTS

Option 1: Status Quo	Year 0 18/19 £000's	Year 1 19/20 £000's	Year 2 20/21 £000's	Year 3 21/22 £000's	Year 4 22/23 £000's	Year 5 23/24 £000's	Totals £000's
<u>Capital Costs</u>							
Works	0	0	0	0	0	0	0
Equipment	0	0	0	0	0	0	0
Design team Fees & Professional Fees	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
<u>Revenue Costs</u>							
Recurring revenue baseline	4,581	4,581	4,581	4,581	4,581	4,581	27,486
(b) Total Revenue Cost	4,581	4,581	4,581	4,581	4,581	4,581	27,486
(c) Total Cost = (a) + (b)	4,581	4,581	4,581	4,581	4,581	4,581	27,486
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	4,581	4,426	4,276	4,132	3,992	3,857	25,264

COST ASSUMPTIONS:

Finance Assumptions:-

1. Year 0 is 2018/19 Financial Year.
2. The baseline costs for this case is the recurrent 2018/19 Medical Payroll Budget for MHD Associate Medical Director.
3. No other revenue or capital costs are associated with this option
4. A discount factor @3.5% pa has been applied to calculate the NPC.
5. Please note all figures above have been rounded to thousands
6. Total Net Present Cost (NPC) equates to £25,264k for this option

Option 2:- Appoint 1.00 WTE Consultant LD Psychiatrist	Year 0 18/19 £000's	Year 1 19/20 £000's	Year 2 20/21 £000's	Year 3 21/22 £000's	Year 4 22/23 £000's	Year 5 23/24 £000's	Totals £000's
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs							
Recurring revenue baseline	4,581	4,581	4,581	4,581	4,581	4,581	27,486
Payroll	29	117	117	117	117	117	614
Payroll related G&S	2	9	9	9	9	9	47
(b) Total Revenue Cost	4,612	4,707	4,707	4,707	4,707	4,707	28,147
(c) Total Cost = (a) + (b)	4,612	4,707	4,707	4,707	4,707	4,707	28,147
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	4,612	4,548	4,394	4,245	4,102	3,963	25,864

COST ASSUMPTIONS:

Finance Assumptions:-

1. Year 0 is 2018/19 Financial Year.
2. The baseline costs for this case is the recurrent 2018/19 Medical Payroll Budget for MHD Associate Medical Director.
3. The Consultant LD Psychiatrist identified in Section 3 has been costed at the rate of a Consultant (1:9 rota or less Cat A - incl 3% allows) according to the HSCB - General Costings - 2017/18 (Including 1% pay award)
4. An allowance has been included for Employee related G&S and for Excess Travel as per HSCB Costings.
5. The expected start date for funding is 01/01/2019 so 3 months funding is being sought for this year.
6. No capital costs are identified in this case.
7. A discount factor @3.5% pa has been applied to calculate the NPC.
8. Please note all figures above have been rounded to thousands.
9. Total Net Present Cost (NPC) equates to £25,864k for this option

Option 3:- Appoint 1.00 WTE Staff Grade to LD Psychiatry Service	Year 0 18/19 £000's	Year 1 19/20 £000's	Year 2 20/21 £000's	Year 3 21/22 £000's	Year 4 22/23 £000's	Year 5 23/24 £000's	Totals £000's
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs							
Recurring revenue baseline	4,581	4,581	4,581	4,581	4,581	4,581	27,486
Payroll	20	80	80	80	80	80	420
Payroll related G&S	2	6	6	6	6	6	32
(b) Total Revenue Cost	4,603	4,667	4,667	4,667	4,667	4,667	27,938
(c) Total Cost = (a) + (b)	4,603	4,667	4,667	4,667	4,667	4,667	27,938
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	4,603	4,509	4,357	4,209	4,067	3,930	25,675

COST ASSUMPTIONS:

Finance Assumptions:-

1. Year 0 is 2018/19 Financial Year.
2. The baseline costs for this case is the recurrent 2018/19 Medical Payroll Budget for MHD Associate Medical Director.
3. The Staff Grade doctor identified in Section 3 has been costed at the rate of a Specialty Doctor (1:1 rota to 1:4 rota - incl 6% allowance) according to the HSCB - General Costings - 2017/18 (Including 1% pay award)
4. An allowance has been included for Employee related G&S and for Excess Travel as per HSCB Costings.
5. The expected start date for funding is 01/01/2019 so 3 months funding is being sought for this year.
6. No capital costs are identified in this case
7. A discount factor @3.5% pa has been applied to calculate the NPC.
8. Please note all figures above have been rounded to thousands
9. Total Net Present Cost (NPC) equates to £25,675k for this option

SECTION 5: NON-MONETARY BENEFITS

- To provide support in the community for those individuals with a learning disability and their families and carers to enable these individuals to remain within the community
- Improved access to care and services
- Enhance Learning Disability Medical Team to respond to growing demands within the service
- Facilitate early discharge from hospital
- Enhance multi-disciplinary working

SECTION 6: PROJECT RISKS & UNCERTAINTIES

Risk Description	Likely impact of Risk H/M/L			State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	Opt 3	
1. Inability to appoint suitable staff	N/A	M	M	<p>Option 1 – Do nothing – no enhancement to the service. Mitigation Measure: N/A</p> <p>Option 2 – Appoint 1.0 WTE Consultant LD Psychiatry This is deemed a medium risk due to current regional shortage LD specialists. Mitigation Measure:</p> <ul style="list-style-type: none"> • Continue to liaise with Human Resources throughout the recruitment process • Include opportunities for professional development within post to attract candidates <p>Option 3 –Appoint 1.0 WTE Staff Grade to LD Psychiatry Service This is deemed a medium risk due to current regional shortage LD specialists. Mitigation Measure:</p> <ul style="list-style-type: none"> • Continue to liaise with Human Resources throughout the recruitment process.
2. Failure to achieve project objectives	N/A	L	M	<p>Option 1: there is no enhancement to the existing service so the project objectives will not be achieved. Mitigation Measure: N/A</p> <p>Option 2: Appoint 1.0 WTE Consultant LD Psychiatry This has been deemed low risk and the appointment of an additional Consultant will increase the service capacity thereby reducing service gaps/risk to LD Service users Mitigation Measure:</p> <ul style="list-style-type: none"> • Continue to monitor and evaluate project objectives • Put a reporting mechanism in place if there are any issues that need addressed <p>Option 3 Appoint 1.0 WTE Staff Grade to LD Psychiatry Service This has been deemed medium risk as appointment of a staff grade will not enable the Trust to fully enhance the service. A staff grade does not have the qualification specification to fully address the current capacity issues and service gaps. A staff grade will require supervision from a Consultant.</p>

				<p>Therefore there is a medium risk that this appointment would not achieve the project objectives.</p> <p>Mitigation Measure:</p> <ul style="list-style-type: none"> • Continue to monitor and evaluate project objectives • Put a reporting mechanism
Overall Risk (H/M/L):	N/A	L	M	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 1: Status Quo. This option has been discounted as it will not address current issues. Continuing with existing arrangements will not enable the Trust to address current service gaps which will continue alongside increasing demand.

Option 3: Appoint 1.0 WTE Staff Grade to LD Psychiatry Service. This option has been discounted. While this option would go some way to addressing existing service provision issues through additionality, a staff grade does not have the appropriate qualifications to undertake the full duties necessary. Further a staff grade will require supervision and input from a Consultant thereby placing additional duties on Consultants whose clinical roles are currently beyond capacity adding to their workload.

The preferred option has been identified as **Option 2: Appoint 1.0 WTE Consultant LD Psychiatry**. Appointment of a Consultant will create additional capacity within the LD Psychiatry Service. This will enable the service to address existing service gaps and meet increasing demographic pressures. Appointment of an additional consultant within the service will enable provision of a further 8 sessions, a caseload of approximately 200 patients. It is envisaged that this additional consultant will work closely within the community setting to help discharge patients with complex care needs and work to sustain community placements and reduce the occurrence of hospital readmissions. Increasing capacity within the service through the appointment of a further consultant will enable the Service to take forward a number of additional clinics and MDT working in line with strategic direction. Enhancement of the LD Psychiatry service will reduce inequalities experienced by Learning Disability Patients.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Year 0 £000's	Year 1 £000's	Year 2 £000's	Year 3 £000's	Totals £000's
Required					
Capital required	0	0	0	0	0
Revenue required	4,612	4,793	4,880	4,970	19,255
Existing budget :					
Capital	0	0	0	0	0
Revenue	4,581	4,664	4,750	4,837	18,832
Additional Allocation Required:					
Capital	0	0	0	0	0
Revenue	31	129	130	133	423

AFFORDABILITY ASSUMPTIONS**Finance Assumptions:-**

1. Year 0 is 2018/19 Financial Year.
2. The baseline costs for this case is the recurrent 2018/19 Medical Payroll Budget for MHD Associate Medical Director.
3. The Consultant LD Psychiatrist identified in Section 3 has been costed at the rate of a Consultant (1:9 rota or less Cat A - incl 3% allows) according to the HSCB - General Costings - 2017/18 (Including 1% pay award)
4. An allowance has been included for Employee related G&S and for Excess Travel as per HSCB Costings.
5. The expected start date for funding is 01/01/2019 so 3 months funding is being sought for this year.
6. No capital costs are identified in this case
7. Costs have been uplifted by 1.83% for inflation from 2019/20.
8. No capital costs are identified in this case.
9. Please note all figures above have been rounded to thousands.

SECTION 9: MANAGEMENT ARRANGEMENTS

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management.

The following key roles have been identified:

Project Owner: Mrs Carmel Harney, Director of Mental Health and Learning Disability (Acting)

Project Director: Miceal Crilly, Assistant Director of Learning Disability

Project Manager: Mr Arun Subramanian, Consultant Psychiatrist

In order to ensure the project delivers its objectives and achieves implementation within timescales and budget, progress will be monitored on a regular basis.

A full review of the project in relation to the stated objectives will be undertaken 12 months after full implementation.

SECTION 10: MONITORING AND EVALUATION

<p>Who will manage the implementation? (please provide the name of the responsible individual where possible)</p>	<p>Mr Arun Subramanian, Consultant Psychiatrist</p>
<p>Who will monitor and evaluate the outcomes? (please provide the name of the responsible individual where possible)</p>	<p>Mr Arun Subramanian, Consultant Psychiatrist</p>
<p>What other factors will be monitored and evaluated?</p>	<p>N/A</p>
<p>When will this take place? (preferably 4 to 12 months after project closure)</p>	<p>12 months after full implementation</p>

SECTION 11: ACTIVITY OUTCOMES (TRUSTS ONLY)

Specify activity, e.g. IP, DC OPN, OPR, Contacts etc

	IP	DC	OPN	OPR		
Baseline						
Additional activity						
New Baseline Activity						

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

As per the Royal College of Psychiatrists Report 204/ CR 174; Safe Patients and High Quality Care for Adults with Learning Disability, psychiatrists should have a working caseload of 150 patients including up to 20 new patients per year. Within the SHSCT LD Psychiatrists have an average annual caseload of 330 patients per year, well in excess of the standards set out by the Royal College of Psychiatrists.

Appendix A:

The table below details the job plan of the additional LD Psychiatry Consultant:

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total	Prem
				DCC	SPA	APA	EPA		
Mon	09.00 – 13.00	Review of Dorsy complex discharge patients in community	Community facility	4				8	
	13.00 – 17.00	Crisis and Home treatment Discussion/Consultant Meeting	Dorsy Unit	4					
Tues	09.00 – 13.00	Outpatient Clinic	24 hour supported living facility	4				8	
	13.00 – 17.00	Outpatient Clinic	Armagh community hospital	4					
Wed	09.00 – 13.00	Acute Liaison work with Craigavon area hospital	Banbridge day centre	4				8	
	13.00 – 17.00	Medical management / Governance	CAH		4				
Thurs	09.00 – 13.00	Adult Learning Disability Team Meetings	Community team	4				8	
	13.00 – 17.00	Review of Dorsy complex discharge patients in community	Community facility	4					
Fri	09.00 – 11.00	Meeting with Behavioural services on complex behavioural issues	St Luke's Hospital	2				8	
	11.00 – 13.00	Academic Meeting	CAH		2				
	13.00 – 17.00	Emergency appointments	Dorsy Unit	4					
TOTAL HOURS				34	6			40	
TOTAL PROGRAMMED ACTIVITIES				8.5	1.5			10	

Summary Costing Schedule for Investment Decision Making Templates

Provider: SOUTHERN CRAIGAVON

Hospital Site or Community development: 2018/19 Enhance Adult Learning Disability Psychiatry Service

Scheme Title: 2017/18

Pay and Price Levels: Commissioner Use only
Sign and Date for TRAFFACS update

Pay Costs	Description	Base Case - option 1			Option 2			Option 3			Option 4			
		months claimed	wte	fye	months claimed	wte	fye	months claimed	wte	fye	months claimed	wte	fye	
BAND 1	BAND 1			4,580,579		4,580,579		4,580,579		4,580,579		4,580,579		4,580,579
BAND 2	BAND 2			0		0		0		0		0		0
BAND 3	BAND 3			0		0		0		0		0		0
BAND 4	BAND 4			0		0		0		0		0		0
BAND 5	BAND 5			0		0		0		0		0		0
BAND 6	BAND 6			0		0		0		0		0		0
BAND 7	BAND 7			0		0		0		0		0		0
BAND 8A	BAND 8A			0		0		0		0		0		0
BAND 8B	BAND 8B			0		0		0		0		0		0
BAND 8C	BAND 8C			0		0		0		0		0		0
BAND 8D	BAND 8D			0		0		0		0		0		0
BAND 9	BAND 9			0		0		0		0		0		0
Non-AFC posts please detail below														
	LD Psychiatrist - Consultant (1:9 rota or less Cat A - incl 9% allow)			0		0		0		0		0		0
	Specialty Doctor (1:1 rota to 1:4 rota - incl 6% allowance)			0	1.00	115,056		28,764		0		0		0
	Allowances for posts noted above - please detail below			0		0		0		0		0		0
	Unsocial Hours payments			0		0		0		0		0		0
	Excess Travel			0		0		0		0		0		0
	G&S Costs associated with the above posts			0		0		0		0		0		0
	Enhance Related G&S			0		0		0		0		0		0
	WTE Consultant LD Psychiatrist			0		8,896		2,224		0		0		0
	Specialty Doctor (1:1 rota to 1:4 rota - incl 6% allowance)			0		0		0		6,090		1,528		0
	Excisional Recruitment and Retention costs for posts above the mean plus x% (please provide detail)			0		0		0		0		0		0
TOTAL PAY COSTS				0.00	4,580,579	4,580,579		4,612,067		1.00	4,667,078	4,609,804		0.00
Non-Pay Costs - please detail below														
OTHER GOODS & SERVICES														
TOTAL NON-PAY COSTS				0		0		0		0		0		0
GRAND TOTAL				4,580,579	4,580,579	4,580,579		4,612,067		4,667,078	4,609,804	4,609,804		0
Phasing/Timescale														
PROGRAMME OF CARE														
SUB-SPECIALTY INFORMATION - eg inpatients, outpatients,														
LCG														
If more than one LCG in option above please give details														
If more than one LGD in option above please give details														

(Can development be phased, if so provide details in this box)

Learning Disability Southern

(Can development be phased, if so provide details in this box)

Learning Disability Southern

(Can development be phased, if so provide details in this box)

Learning Disability Southern

(Can development be phased, if so provide details in this box)

Learning Disability Southern

(Can development be phased, if so provide details in this box)

Learning Disability Southern

BUSINESS CASE TEMPLATE	REVENUE FUNDING up to £250,000
LEVEL 2	

REVENUE BUSINESS CASE PROFORMA COVER

(To be submitted with every business case)

HSCB Reference Number	SCCD2019/20LD16ST
Source of Funding (Reference/Year)	2019/20 Inescapable Pressures Learning disability
Allocation Value (CYE/FYE, recurrent/non-recurrent, if non-recurrent please provide details of investment timescale)	19/20: £44,180 CYE (RRL Notification 006 - 27 September 2019 Traffacs ID 114713 non-recurrent) 20/21: £132,541 FYE
HSCB representative name, job title and contact details	Valerie McConnell, Programme Manager MH & LD, 12-22 Linenhall Street, Belfast, BT2 8BS. Copy: Lorna Conn, Social Care Commissioning Lead MH & LD
Provider representative name, job title and contact details	Aldrina Magwood, Director of Planning Cc Barney McNeaney, Director of MH and LD Cc John McEntee, Assistant Director LD
Project Title	Adults with learning disability whose family care arrangements break down
Total Cost	19/20: £44,180 CYE (RRL Notification 006 - 27 September 2019 Traffacs ID 114713 non-recurrent) 20/21: £132,541 FYE
Start date	1 December 2019
Completion date	31 March 2020

Complete this section if bid is for new funding

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Y
How much total funding required?	19/20: £44,180 CYE (RRL Notification 006 - 27 September 2019 Traffacs ID 114713) 20/21: £132,541 FYE
How much funding required per year?	19/20: £44,180 CYE 20/21: £132,541 FYE
Is this funding to be made recurrent?	Yes 2019/20 amount of £44,180 is recurrent, balance of FYE for 2020/21 is subject to funding being confirmed for 2020/21.


Complete this section if funding available within existing allocation



Funding available within existing allocation (Y/N)	N
Total cost of proposal	N/A
Cost of proposal per year	N/A
Is this cost within recurrent allocation?	N/A

Is this business case	Y/N
(a) Standard	Y
(b) Novel	N
(c) Contentious	N
(d) Setting a precedent	N
If yes to (b) or (c) or (d) , requires Departmental & DoF approval Is Departmental / DOF approval required	

Approval & submission by Provider

This section to be completed by Providers for all submissions

Responsible Director Signature (required for all submissions)	
Name Printed	Barney McNeany (signed) 
Grade/ Title	Director of Mental Health & Disability Services
Date	08.11.19
Provider Director of Finance Signature (required if bid is over £100k)	

Name printed HELEN ONEILL (signed) 
Date 26/11/19
Provider Chief Executive Signature (required if bid is over £100k)
Name printed Shane O'Neill (signed) 
Date 28/11/19

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – required for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.
Approved by
Name printed (signed)
Grade / Title
Date

Approval of Investment Proposal Template by HSCB Director(s) and/or Chief Executive

Director Signature (required for all bids over £25k)
Name printed Marie Roulston (signed)
Grade / Title Director of Social Care & Children's Directorate
Date
HSCB Director of Finance Signature (required if bid is over £100k)
Name printed HELEN ONEILL (signed)
Date
HSCB Chief Executive Signature (required if bid is over £100k)

Name printed	(signed)
Date	

Approval of Investment Proposal Template by SMT – Required for all Transformation based investments

<u>Director Signature</u>	
Name printed	(signed)
Grade / Title	
Date of SMT approval	

SHCST Family Breakdown

BUSINESS CASE TEMPLATE REVENUE FUNDING up to £250,000**LEVEL 2****SECTION 1: PROJECT BACKGROUND AND STRATEGIC CONTEXT**

Given the strategic objective of supporting adults with a learning disability to live in the community, and the associated reduction in availability of long term hospital care there is a need to continue to develop the range of services available for adults with a learning disability and complex needs to support people with learning disability and their family carers in community settings. It is anticipated that the current review of acute assessment and treatment will highlight the need for increased capacity within intensive home support services.

Ultimately this should provide informal carers with additional support to continue to care as well as assist in the development of alternative community care options to avoid inappropriate inpatient admissions and ensure that people with learning disability are well supported within their communities of origin.

Proposal

The Trust proposes to allocate the funding identified for one client who was discharged from Iveagh into a community placement in April 2019. This individual's needs are of a complexity that if the Trust were not able to resource the required level of care, then the person would require long term hospital admission to meet their needs. Please note the total cost for the package of care required for this client is £300,000 per year leaving a shortfall of £167,459 which will be met with Transition funding.

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. To work towards targets and strategic direction <ul style="list-style-type: none"> • Transforming Your Care • Bamford Action Plan • Commissioning Plan 	<ul style="list-style-type: none"> • All admissions will have a discharge plan in place within 7 days and home treatment will attend all planned multi-disciplinary meetings and discharges will be effected earlier for those who require changing medication which will be undertaken by the Home Treatment Team • The resettlement of long stay hospital Patient to suitable placements in the community.
2. To provide suitable alternative community placements for complex patients which meets the individuals collective needs and provides a greater quality of life and betterment.	<ul style="list-style-type: none"> • The number of long stay patients in learning disability inpatient services by 31 March 2020.
3. Promote recovery, maintain and/or build family and social connections/networks.	<ul style="list-style-type: none"> • Enhanced level of support to patients reducing the need to be admitted to hospital. • Number of re-admissions.
4. Minimize the need for hospital care through earlier intervention.	<ul style="list-style-type: none"> • Reduction in the number of readmissions
5. Enables earlier discharge and prevents delays in discharge from acute inpatient care.	<ul style="list-style-type: none"> • 99% of all Learning disability discharges take place within 7 days of the patient being assessed as medically fit for discharge with

	no discharge taking more than 28 days.
6. Provide care and support packages to those clients with a learning disability to enable them to remain in the community.	<ul style="list-style-type: none"> The number of clients who are able to remain in the community.
7. Successful transition from home setting to appropriate alternative care arrangements	<ul style="list-style-type: none"> Number of Adults with Learning Disability in alternative care arrangements.
8. Adults with a learning disability are supported to enable them to continue to live in a community setting	<ul style="list-style-type: none"> Number of admissions to hospital

SECTION 2 (b): CONSTRAINTS

Constraints	Measures to address constraints
1. Availability of appropriate/suitable placements and the ability to maintain these.	This constraint will be addressed through early engagement with providers and Behaviour Support Team to assist with transition
2. Availability of funding	Submit IPT within the agreed timescales with all relevant data included

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	<p>Status Quo - continue with existing arrangements</p> <p>This option would involve no change to current service delivery to clients with a learning disability whose family care arrangements have broken down.</p>
2	<p>Fund community package for one client who has been discharged from hospital.</p>
3	<p>Client is admitted to Dorsy as an inpatient.</p>

SECTION 4: PROJECT COSTS

Option 1: Status Quo – Do nothing	Year 0 2019/20 £ 000	Year 1 2020/21 £ 000	Year 2 2021/22 £ 000	Year 3 2022/23 £ 000	Year 4 2023/24 £ 000	Year 5 2024/25 £ 000	Totals £ 000
Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(a) Total Capital Cost	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Revenue Costs							
Revenue Baseline	67,368.7	67,368.7	67,368.7	67,368.7	67,368.7	67,368.7	404,212.2
(b) Total Revenue Cost	67,368.7	67,368.7	67,368.7	67,368.7	67,368.7	67,368.7	404,212.2
(c) Total Cost = (a) + (b)	67,368.7	67,368.7	67,368.7	67,368.7	67,368.7	67,368.7	404,212.2
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	67,368.7	65,091.6	62,888.7	60,759.8	58,705.1	56,724.4	371,538.3

COST ASSUMPTIONS:

1. Year 0 is 2019/20 Financial Year.
2. The baseline costs for this case is the MHD AD Disability Services Recurring Revenue Baseline Budget for 2019/20.
3. No other revenue or capital costs are associated with this option
4. A discount factor @3.5% pa has been applied to calculate the NPC.
5. Please note all figures above have been rounded to thousands and shown to one decimal point.
6. Total Net Present Cost (NPC) equates to £371,538.3k for this option

Option 2: Community Care Package for 1 client	Year 0 2019/20 £ 000	Year 1 2020/21 £ 000	Year 2 2021/22 £ 000	Year 3 2022/23 £ 000	Year 4 2023/24 £ 000	Year 5 2024/25 £ 000	Totals £ 000
Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(a) Total Capital Cost	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Revenue Costs							
Revenue Baseline	67,368.7	67,368.7	67,368.7	67,368.7	67,368.7	67,368.7	404,212.2
Care Package	44.2	132.5	132.5	132.5	132.5	132.5	706.7
(b) Total Revenue Cost	67,412.9	67,501.2	67,501.2	67,501.2	67,501.2	67,501.2	404,918.9
(c) Total Cost = (a) + (b)	67,412.9	67,501.2	67,501.2	67,501.2	67,501.2	67,501.2	404,918.9
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	67,412.9	65,219.7	63,012.4	60,879.3	58,820.5	56,836.0	372,180.8

COST ASSUMPTIONS:

1. Year 0 is 2019/20 Financial Year.
2. The baseline costs for this case is the MHD AD Disability Services Recurring Revenue Baseline Budget for 2019/20.
3. Care Package cost for one client identified at £300k per annum.
4. Funding of £44,180 CYE available in 2019/20 thus leaving a shortfall of £255,820 in 2019/20.
5. Funding of £132,541 FYE available in 2020/21 thus leaving a shortfall of £167,459 in 2020/21.
6. No other capital or revenue costs are identified in this option.
7. A discount factor @3.5% pa has been applied to calculate the NPC.
8. Please note all figures above have been rounded to thousands and shown to one decimal place.
9. Total Net Present Cost (NPC) equates to £372,180.8k for this option.

Option 3: Long stay resettlement (Dorsy)	Year 0 2019/20 £ 000	Year 1 2020/21 £ 000	Year 2 2021/22 £ 000	Year 3 2022/23 £ 000	Year 4 2023/24 £ 000	Year 5 2024/25 £ 000	Totals £ 000
Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(a) Total Capital Cost	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Revenue Costs							
Revenue Baseline	67,368.7	67,368.7	67,368.7	67,368.7	67,368.7	67,368.7	404,212.2
Care Packages	85.2	255.5	255.5	255.5	255.5	255.5	1,362.7
(b) Total Revenue Cost	67,453.9	67,624.2	67,624.2	67,624.2	67,624.2	67,624.2	405,574.9
(c) Total Cost = (a) + (b)	67,453.9	67,624.2	67,624.2	67,624.2	67,624.2	67,624.2	405,574.9
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	67,453.9	65,338.5	63,127.2	60,990.3	58,927.7	56,939.6	372,777.2

COST ASSUMPTIONS:

1. Year 0 is 2019/20 Financial Year.
2. The baseline costs for this case is the MHD AD Disability Services Recurring Revenue Baseline Budget for 2019/20 .
3. Long term resettlement costed @ £700 per bed day 17/18 TFR uplifted for pay & prices ie £255,500 per annum.
4. No other capital or revenue costs are identified in this option.
5. A discount factor @3.5% pa has been applied to calculate the NPC.
6. Please note all figures above have been rounded to thousands and shown to one decimal place.
7. Total Net Present Cost (NPC) equates to £372,777.2k for this option.

SECTION 5: NON-MONETARY BENEFITS

Weighting method

Non-Monetary Factor	Weighting (%)	Score Option 1 Status Quo		Score Option 2 Resettle ? within the Community		Score Option 3 Resettle ? in Dorsey as an inpatient	
1. Meets strategic direction	25	2	50	8	200	2	50
2. Provide support to those individuals living in the community.	25	2	50	8	200	2	50
3. Acceptability of service user, parents and carers	25	2	50	8	200	2	50
4. Prevent admission/readmission to hospital	25	2	50	7	175	8	200
Total	100%		200		775		350
Rank			3		1		2

Rationale for weighting and scoring

Option 1 and Option 3 scored low under the criterion of Meeting Strategic Direction as it will not promote community integration or social inclusion. Option 2 scored highest as the client is not in a hospital and would be able to have a care package to enable them to live within their own community. Transforming Your Care and the DHSSPS Learning Disability Service Framework promote community integration with a focus shift to community care, promote social inclusion and reduce inequalities in health and social wellbeing and improve the quality of health and social care services, by supporting those most vulnerable in our society.

Again Option 1 scored low under the criterion support the client to remain in the community as by doing nothing there will not be the necessary care and support packages to allow the client to remain in the community. Option 3 scored low as the client would not remain within their own community. Option 2 scored highest as one client will be provided with support to remain in the community.

All options must be acceptable to the clients, their parents and carers therefore Option 1 and Option 3 scored lowest as neither of these options would be to the betterment of the client. Option 2 scored highest as it offers more support.

Again option 1 scored lowest as it would not provide the necessary care and support to enable the client to remain within a community setting and would not prevent re-admission to hospital. Options 2 and 3 again were higher because they offered higher support.

SECTION 6: PROJECT RISKS & UNCERTAINTIES

Risk Description	State how the options compare & identify relevant risk management/mitigation measures			
	Opt 1	Opt 2	Opt 3	
1. Acceptance by clients, families and carers	M-H	L	H	Option 1 is deemed to be assessed as medium to high risk as no change to current services mean that there are limited support mechanisms in place to facilitate clients whose family care arrangements have broken down. Option 2 will offer client a personalised proposal to support them in the community. Option 3 is high risk as admitting client to long stay resettlement may not be accepted by client, family and carers.
2. Breakdown or failed community placements resulting in a risk to the client	M-H	H	L	Option 1 is deemed to be assessed as medium to high risk as no change to current services mean that there are limited support mechanisms in place to facilitate clients whose family care arrangements have broken down. Options 2 will offer client a personalised proposal to support them in the community. Option 3 is low risk as client will be admitted to long term care therefore will not require community placements. The clients will be continually assessed and regular meetings held to discuss their progress in order to prevent a breakdown in placements.
3. Re-admission to hospital	M	L	L	Option 1 would be impacted as by maintaining existing services without funding being allocated would lead to a reduction in service which would impact on all clients identified. Pressure would be placed on the current services. It is anticipated that Option 2 will provide betterment for the client and therefore reduce the risk of readmission to hospital. Option 3 is low risk due to client being in long term resettlement.
Overall Risk (H/M/L):	M	L	M	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 2 fund community package for one client is the preferred option. This option is the most acceptable to the service user, parents and carers. This option will promote community integration and social conclusion. Pressure on families will be reduced with the knowledge that their relative is placed in a suitable community placement with the necessary care and support packages in place.

This option meets all the project objectives and individual needs of the client. It will provide consistency in the package of care and support to be delivered. This option offers individual choice and a

betterment that is person centred and recovery based to meet the individual assessed needs.

Please note the total cost for the package of care required for this client is £300,000 per year leaving a shortfall of £167,459 which will be met with Transition funding.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	19/20 Yr 0 £000's	20/21 Yr 1 £000's	21/22 Yr 2 £000's	22/23 Yr 3 £000's	Totals £000's
Required:					
Capital required	0.0	0.0	0.0	0.0	0.0
Revenue required	67,412.9	71,976.6	76,748.6	81,837.0	297,975.1
Existing Budget:					
Capital	0.0	0.0	0.0	0.0	0.0
Revenue	67,368.7	71,835.2	76,597.9	81,676.4	297,478.2
Additional Allocation Required:					
Capital	0.0	0.0	0.0	0.0	0.0
Revenue	44.2	141.4	150.7	160.6	496.9

AFFORDABILITY ASSUMPTIONS

1. Year 0 is 2019/20 Financial Year.
2. The baseline costs for this case is the MHD AD Disability Services Recurring Revenue Baseline Budget for 2019/20.
3. The costs have been based on the 2019/20 HSCB General Costings dated 16.09.19.
4. No allowance for enhancements, annual leave, sickness cover has been included.
5. Costs have been uplifted by 6.63% for inflation from 2020/21.
6. No capital costs are identified in this case.
7. Please note all figures above have been rounded to thousands and shown to one decimal point.

SECTION 9: MANAGEMENT ARRANGEMENTS

The following key roles have been identified:

Project Owner: Mr Barney McNeaney, Director of Mental Health and Disability

Project Director: Mr John McEntee, Assistant Director of Disability Services

Project Manager: To be confirmed

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation? (please provide the name of the responsible individual where possible)	John McEntee, Assistant Director of Learning Disability Services
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Who will monitor and evaluate the outcomes? (please provide the name of the responsible individual where possible)	John McEntee, Assistant Director of Learning Disability Services
What other factors will be monitored and evaluated?	As per objectives
When will this take place? (preferably 4 to 12 months after project closure)	12 months after project implementation

SECTION 11: ACTIVITY OUTCOMES (TRUSTS ONLY)

Specify activity, e.g. IP, DC OPN, OPR, Contacts etc

	IP	DC	OPN	OPR		
Baseline						
Additional activity						
New Baseline Activity						

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

[expand as appropriate]

Summary Costing schedule for Investment Decision Making Templates		Ref Number											
Provider		SOUTHERN CRAIGAYON											
Hospital Site or Community development		19/20 Inescapable Pressures - Adults with Learning Disability whose family care arrangements break down 19/20											
Scheme Title		Commissioner Use only											
Pay and Price Levels		Sign and Date for TRAFFACS update											
Pay Costs	Description	Base Case - option 1			Option 2			Option 3			Option 4		
		months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye
	BASELINE -			67,368,695	67,368,695		67,368,695	67,368,695	67,368,695		67,368,695	67,368,695	0
	Exceptional Recruitment and Retention costs for posts above the mean plus 5% (please provide detail)			0	0	4.00	132,541	44,180	255,500	85,167	0	0	0
	TOTAL PAY COSTS		0.00	67,368,695	67,368,695	0.00	67,368,695	67,368,695	67,368,695	0.00	67,368,695	67,368,695	0
	Non-Pay Costs - please detail below			0	0	0	0	0	0	0	0	0	0
	OTHER GOODS & SERVICES			0	0	4.00	132,541	44,180	255,500	85,167	0	0	0
	Option 2: Community Care Package			0	0	0	0	0	0	0	0	0	0
	Option 3: Long Term Resettlement			0	0	0	0	0	0	0	0	0	0
	TOTAL NON-PAY COSTS		0	0	0	4.00	132,541	44,180	255,500	85,167	0	0	0
	GRAND TOTAL		67,368,695	67,368,695	67,368,695	4.00	132,541	44,180	255,500	85,167	0	0	0
	Phasing/Timescale						132,541	44,180	255,500	85,167			
	PROGRAMME OF CARE						learning disability	learning disability	learning disability	learning disability			
	SUB-SPECIALTY INFORMATION eg inpatients,												
	LGD												
	If more than one LCC in option above please give details												
	LGD												
	If more than one LGD in option above please give details												

BUSINESS CASE TEMPLATE Level 2	REVENUE FUNDING £50k-£250k
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REVENUE BUSINESS CASE PROFORMA COVER


HSCB Reference Number	SCCD2018/19LD39ST
Finance Transformation Reference Number	Not applicable
Source of Funding	2018/19 Inescapable Pressures
Year	2018/19
HSCB representative name, job title and contact details	Valerie McConnell, Programme Manager MH and LD Cc Lorna Conn, Commissioning Lead MH and LD Cc Iain Deboys, BLCG
Provider representative name, job title and contact details	Aldrina Magwood, Director of Planning Cc Barney McNeaney, Director of Mental Health and Learning Disability Cc John McEntee, Assistant Director of Disability Services
Project Title	Adult Learning Disability – Complex Discharges from Hospital
Start date	01/04/19
Completion date	Recurrent

Cost of proposal per year:	18/19: £99,140
	19/20: £99,140
	20/21 and beyond: £99,140
Funding required:	18/19 £99,140
	19/20 £99,140

<i>Is this business case</i>	Y/N
<i>(a) Standard</i>	Y
<i>(b) Novel</i>	N
<i>© Contentious</i>	N
<i>(d) Setting a precedent</i>	N
<i>If yes to (b) or (c) or (d) , requires Departmental & DoF approval Is Departmental / DOF approval required</i>	

Approval & submission by Trust

This section to be completed by Providers for all submissions

Responsible Director Signature (required for all submissions)	
Name printed:	Mr Barney McNeany (signed) 
Title:	Director of Mental Health & Disability Services
Date:	13 January 2020
Provider Director of Finance Signature (required if bid over £100k)	
Name printed	(signed)
Date	
Provider Chief Executive Signature (required if bid over £100k)	
Name printed	(signed)
Date	

Approval & submission by HSCB/PHA

Responsible Director Signature (required for all submissions up to £1m)	
Name printed	MARIE ROULSTON (signed)
Title	Director of Social Care & Children
Date	

SECTION 1: PROJECT BACKGROUND, STRATEGIC CONTEXT & NEED

Admissions to hospital should be reserved for those who are acutely unwell and whose needs cannot be catered for appropriately within their community of origin. There is a need to enhance both the capacity and skill set of community based services to enable them to provide placements for people with both complex health and learning disability needs in order to prevent hospitalisation but also where appropriate admission taken place, to support a timely return to the community once a person's assessment and treatment needs have been addressed.

Given the strategic objective of supporting adults with a learning disability to live in the community, and the associated reduction in availability of long term hospital care, there is a need to continue to develop the range of services available for adults with a learning disability and complex needs in community settings.

Trust Proposal

Further develop community infrastructure to support people with a learning disability in the community. This may include additions to the multi – disciplinary community learning disability teams and/or extend availability of crisis resolution / behavioural support services out of normal office hours.

The Trust proposes to allocate the funding available to appoint 2.73 wte band 5 nurses to provide nursing support to clients with a learning disability who are being discharged from hospital to the community.

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. To work towards targets and strategic direction <ul style="list-style-type: none"> • Transforming Your Care • Bamford Action Plan • Commissioning Plan • Ministerial PfA targets. 	<ul style="list-style-type: none"> • All admissions will have a discharge plan in place within 7 days and home treatment will attend all planned multi-disciplinary meetings and discharges will be effected earlier for those who require changing medication which will be undertaken by the Home Treatment Team • The resettlement of long stay hospital Patient to suitable placements in the community.
2. To provide suitable alternative community placements for complex delayed discharge patients which meets the individuals collective needs and provides a greater quality of life and betterment.	<ul style="list-style-type: none"> • Reduction in the number of long stay patients in learning disability inpatient services by 31 March 2019.
3. Promote recovery, maintain and/or build family and social connections/networks.	<ul style="list-style-type: none"> • Reduction in the number of admissions to hospital by 31 March 2019. • Reduction in the number of re-admissions

	by March 2019.
4. Minimize the need for hospital care through earlier intervention.	<ul style="list-style-type: none"> Reduction in the number of readmissions by March 2019.
5. Enables earlier discharge and prevents delays in discharge from acute inpatient care.	<ul style="list-style-type: none"> 99% of all Learning disability discharges take place within 7 days of the patient being assessed as medically fit for discharge with no discharge taking more than 28 days.
6. Provide care and support packages to those clients with a learning disability to enable them to remain in the community.	<ul style="list-style-type: none"> An increase in the number of clients living in the community at 31st March 2019.

SECTION 2 (b): CONSTRAINTS

Constraints	Measures to address constraints
<ul style="list-style-type: none"> The availability of suitable community placements which meet with the needs of learning disability clients. 	<ul style="list-style-type: none"> The Trust will continually evaluate the availability and suitability of placements with a view to successful resettlement and discharge.
<ul style="list-style-type: none"> If funding was unsuccessful 	<ul style="list-style-type: none"> The ability for the SHSCT to meet specific ministerial targets for discharge from hospital and resettlement may be compromised.

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	<p>Option 1 - Status Quo - continue with existing arrangements</p> <p>This option would involve no change to current service delivery to learning disability clients nor see any additional investment provided this year for the service.</p>
2	<p>Option 2 – Appoint 2.73 wte Band 5 nurses</p> <p>This option offers nursing support to clients with a learning disability who are being discharged from hospital to the community.</p>
3	<p>Option 3 – Appoint 5 wte Band 5 nurses</p> <p>This option offers nursing support to clients with a learning disability who are being discharged from hospital to the community.</p>

SECTION 4: PROJECT COSTS

	Year 0 18/19 £ 000	Year 1 19/20 £ 000	Year 2 20/21 £ 000	Year 3 21/22 £ 000	Year 4 22/23 £ 000	Year 5 23/24 £ 000	Totals £ 000
Option 1: Status Quo							
<u>Capital Costs</u>							
Capital Cost	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(a) Total Capital Cost	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<u>Revenue Costs</u>							
Baseline Costs	63,170.2	63,170.2	63,170.2	63,170.2	63,170.2	63,170.2	379,021.2
(b) Total Revenue Cost	63,170.2	63,170.2	63,170.2	63,170.2	63,170.2	63,170.2	379,021.2
(c) Total Cost = (a) + (b)	63,170.2	63,170.2	63,170.2	63,170.2	63,170.2	63,170.2	379,021.2
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	63,170.2	61,035.0	58,969.4	56,973.2	55,046.5	53,189.3	348,383.6

COST ASSUMPTIONS:

<p><u>Financial Assumptions:</u></p> <ol style="list-style-type: none"> 1. Year 0 is 2018/19 Financial Year. 2. The baseline costs for this case is the 2018/19 funding for Disability Services with the MHD directorate of SHSCT. 3. No other revenue or capital costs are associated with this option 4. A discount factor @3.5% pa has been applied to calculate the NPC. 5. Please note all figures above have been rounded to thousands and shown to one decimal point. 6. Total Net Present Cost (NPC) equates to £348,383.6k for this option
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Option 2: - 2.73 wte Band 5	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
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	18/19 £ 000	19/20 £ 000	20/21 £ 000	21/22 £ 000	22/23 £ 000	23/24 £ 000	£ 000
Capital Costs							
(a) Total Capital Cost	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Revenue Costs							
Recurring revenue baseline	63,170.2	63,170.2	63,170.2	63,170.2	63,170.2	63,170.2	379,021.2
Payroll	91.8	91.8	91.8	91.8	91.8	91.8	550.8
Payroll Related G&S	7.3	7.3	7.3	7.3	7.3	7.3	43.8
(b) Total Revenue Cost	63,269.3	63,269.3	63,269.3	63,269.3	63,269.3	63,269.3	379,615.8
(c) Total Cost = (a) + (b)	63,269.3	63,269.3	63,269.3	63,269.3	63,269.3	63,269.3	379,615.8
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	63,269.3	61,130.8	59,061.9	57,062.6	55,132.9	53,272.8	348,930.3

COST ASSUMPTIONS:

Financial Assumptions:

1. Year 0 is 2018/19 Financial Year.
2. The baseline costs for this case is the 2018/19 funding for Disability Services with the MHD directorate of SHSCT.
3. The cost of supporting each of the three patients with a nursing/residential home placement, supported living or care and support package is set out in Section 1(b).
4. The start date is 01/04/2018 so there will be 12 months effect in Year 0 (2018/19).
5. No capital costs are identified in this case.
6. A discount factor @3.5% pa has been applied to calculate the NPC.
7. Please note all figures above have been rounded to thousands and shown to one decimal point.
8. Total Net Present Cost (NPC) equates to £348,930.3k for this option

Option 3:- 5 WTE Band	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
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5.	18/19 £ 000	19/20 £ 000	20/21 £ 000	21/22 £ 000	22/23 £ 000	23/24 £ 000	£ 000
Capital Costs							
(a) Total Capital Cost	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Revenue Costs							
Recurring revenue baseline	63,170.2	63,170.2	63,170.2	63,170.2	63,170.2	63,170.2	379,021.2
Payroll	168.5	168.5	168.5	168.5	168.5	168.5	1,011.0
Payroll Related G&S	13.3	13.3	13.3	13.3	13.3	13.3	79.8
(b) Total Revenue Cost	63,352.0	63,352.0	63,352.0	63,352.0	63,352.0	63,352.0	380,112.0
(c) Total Cost = (a) + (b)	63,352.0	63,352.0	63,352.0	63,352.0	63,352.0	63,352.0	380,112.0
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	63,352.0	61,210.7	59,139.1	57,137.2	55,204.9	53,342.4	349,386.3

COST ASSUMPTIONS:

Financial Assumptions:

1. Year 0 is 2018/19 Financial Year.
2. The baseline costs for this case is the 2018/19 funding for Disability Services with the MHD directorate of SHSCT.
3. The start date is 01/04/2018 so there will be 12 months effect in Year 0 (2018/19).
4. No capital costs are identified in this case.
5. A discount factor @3.5% pa has been applied to calculate the NPC.
6. Please note all figures above have been rounded to thousands and shown to one decimal point.
7. Total Net Present Cost (NPC) equates to £349,386.3k for this option

The following non-monetary benefits have been identified:

- Promote community integration and social inclusion and reduce inequalities in health and social wellbeing.
- Improve the quality of health and social care services by supporting those most vulnerable in our society.
- Meet strategic direction as set out in Transforming your Care and DHSSPS Learning Disability Service Framework.
- Acceptability of service user, parents and carers

Option 1 – Option 1 - Status Quo - continue with existing arrangements

This option will not provide any of the non-monetary benefits as detailed above and has been retained as a base for comparison only.

Option 2 - Appoint 2.73 wte Band 5 nurses

This option will provide all of the above non-monetary benefits. With the appointment of extra nurses, service users will be further supported to live within their own community which will promote community integration and social inclusion and improve the quality of health and social care services.

Option 3 - Appoint 5 wte Band 5 nurses

This option will provide all of the above non-monetary benefits. This Option provides the most support by having 5 additional band 5 nurses to support service users to live within their own community which will promote community integration and social inclusion and improve the quality of health and social care services.

SECTION 6: PROJECT RISKS & UNCERTAINTIES

Risk Description	Likely impact of Risk H/M/L			State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	Opt 3	
1. Failed community placements	N/A	L	L	<p>Option 1 - Status Quo - continue with existing arrangements</p> <p>In option 1 there is no additionality so the current situation will not change.</p> <p>Option 2 - Appoint 2.73 wte Band 5 nurses</p> <p><i>Mitigation Measure for Option 2</i></p>

				<p>For Option 2 the additional nursing staff will ensure the necessary care and support is provided to enable the service user to remain within the community.</p> <p>Option 3 – Appoint 5 wte Band 5 nurses</p> <p><i>Mitigation Measure for Option 3</i></p> <p>For Option 3 the higher level of nursing would result in more sustained community placements.</p>
2. Re-admission to hospital	N/A	L	L	<p>Option 1 - Status Quo - continue with existing arrangements</p> <p>In option 1 there is no additionality so the current situation will not change.</p> <p>Option 2 - Appoint 2.73 wte Band 5 nurses</p> <p><i>Mitigation Measure for Option 2</i></p> <p>For option 2, care and support packages will be tailored to meet each individual's needs and support will be provided from the additional nursing to prevent re-admission to hospital.</p> <p>Option 3 – Appoint 5 wte Band 5 nurses</p> <p><i>Mitigation Measure for Option 3</i></p> <p>For option 3, additional nursing support will further enhance the amount of care and support provided to individual clients which will result in more clients being able to live in the community.</p>
3. Breakdown in client living arrangements resulting in a risk to the service user	N/A	L	L	<p>Option 1 - Status Quo - continue with existing arrangements</p> <p>In option 1 there is no additionality so the current situation will not change.</p> <p>Option 2 - Appoint 2.73 wte Band 5 nurses</p> <p><i>Mitigation Measure for Option 2</i></p> <p>For Option 2, through provision of additional funding there will be additional care and support outside of the family home and expectations of service users/parents/carers will be met.</p> <p>Option 3 – Appoint 5 wte Band 5 nurses</p> <p><i>Mitigation Measure for Option 3</i></p> <p>For Option 3, funding for the additional number of</p>

				nurses will further enhance the outside support provided to service users and their carers which will in turn reduce the number of breakdowns in the living arrangements of service users.
4. Acceptance by clients, families and carers	N/A	L	L	<p>Option 1 - Status Quo - continue with existing arrangements</p> <p>In option 1 there is no additionality so the current situation will not change.</p> <p>Option 2 - Appoint 2.73 wte Band 5 nurses</p> <p>Mitigation Measure for Option 2</p> <p>With the additional funding in option 2 nurses will be able to meet with both service users/parents/carers to discuss the level of care being offered. Agreed support plans will be put in place and all will be fully informed.</p> <p>Option 3 – Appoint 5 wte Band 5 nurses</p> <p>Mitigation Measure for Option 3</p> <p>In option 3 the risk is lower as there will be additional nurses available to advise and support service users and their carers as agreed plans are put in place and implemented.</p>
Overall Risk (H/M/L):	N/A	L	L	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 1 Status Quo – do nothing has been discounted as it doesn't provide any change to current service delivery to learning disability clients. Option 1 will not meet the objectives and has been retained as a base case for comparison.

Option 2 - Appoint 2.73 WTE Band 5 nurses - Option 2 meets all the objectives and offers nursing support to clients with a learning disability who are being discharged from hospital to the community. If the correct package of care and support is not put in place for clients this may result in a breakdown in the client's living arrangements and re-admission to hospital.

Option 3 - Appoint 5 WTE Band 5 nurses - Option 3 meets all the objectives and offers nursing support to clients with a learning disability who are being discharged from hospital to the community. If the correct package of care and support is not put in place for clients this may result in a breakdown in the client's living arrangements and re-admission to hospital. However, there is insufficient funding available to appoint 5 WTE nurses therefore it has been discounted.

Preferred Option

Option 2 is the preferred option as it is within the funding envelope available and meet all the

objectives in section 2. This option will continue to promote community integration and social conclusion. Pressure on families will be reduced with the knowledge that their relative is placed in a suitable community placement with the necessary care and support packages in place.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Year 0 18/19 £ 000	Year 1 19/20 £ 000	Year 2 20/21 £ 000	Year 3 21/22 £ 000	Totals £ 000
Required					
Capital required	0.0	0.0	0.0	0.0	0.0
Revenue required	63,269.3	64,427.1	65,606.2	66,806.7	260,109.3
Existing budget :					
Capital	0.0	0.0	0.0	0.0	0.0
Revenue	63,170.1	64,326.2	65,503.3	66,702.1	259,701.7
Additional Allocation Required:					
Capital	0.0	0.0	0.0	0.0	0.0
Revenue	99.2	100.9	102.9	104.6	407.6

AFFORDABILITY ASSUMPTIONS

Financial Assumptions:

1. Year 0 is 2018/19 Financial Year.
2. The baseline costs for this case is the 2018/19 funding for Disability Services with the MHD directorate of SHSCT.
3. The cost of supporting each of the three patients with a nursing/residential home placement, supported living or care and support package is set out in Section 1(b).
4. The start date is 01/04/2018 so there will be 12 months effect in Year 0 (2018/19).
5. Costs have been uplifted by 1.83% for inflation from 2019/20.
6. No capital costs are identified in this case.
7. Please note all figures above have been rounded to thousands and shown to one decimal point.

SECTION 9: MANAGEMENT ARRANGEMENTS

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful

project management. The following key roles have been identified:

- Project Owner: Mr Barney McNeaney, Director of Mental Health and Disability
- Project Director: Mr John McEntee, Assistant Director of Learning Disability Services
- Project Manager: Donna Curley, Head of Service Community Disability Services

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation.

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation? (please provide the name of the responsible individual where possible)	John McEntee, Assistant Director of Disability Services
Who will monitor and evaluate the outcomes? (please provide the name of the responsible individual where possible)	John McEntee, Assistant Director of Disability Services
What other factors will be monitored and evaluated?	As per Project Objectives in section 2.
When will this take place? (preferably 4 to 12 months after project closure)	A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation.

SECTION 11: ACTIVITY OUTCOMES (TRUSTS ONLY)

Specify activity, e.g. IP, DC OPN, OPR, Contacts etc.

	IP	DC	OPN	OPR		
Baseline						
Additional activity						
New Baseline Activity						

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

[expand as necessary]

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Summary Costing schedule for Investment Decision Making Templates		Ref Number	
Provider	SOUTHERN		
Hospital Site or Community development	CRAIGAVON		
Scheme Title	SHSCT Learning Disability - Complex discharges from hospital - 2018/19 LD Inescapable Pressures		Commissioner Use only
Pay and Price Levels	2018/19		Sign and Date for TRAFFACS update

Pay Costs	Description	Base Case - option 1				Option 2				Option 3				Option 4			
		months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye
BAND 1	BASELINE -			63,170,166	63,170,166			63,170,166	63,170,166			63,170,166	63,170,166				0
BAND 2				0	0			0	0			0	0				0
BAND 3				0	0			0	0			0	0				0
BAND 4				0	0			0	0			0	0				0
BAND 5				0	0	12.00	2.73	91,836	91,836	12.00	5.00	168,506	168,506				0
BAND 6				0	0			0	0			0	0				0
BAND 7				0	0			0	0			0	0				0
BAND 8A				0	0			0	0			0	0				0
BAND 8B				0	0			0	0			0	0				0
BAND 8C				0	0			0	0			0	0				0
BAND 8D				0	0			0	0			0	0				0
BAND 9				0	0			0	0			0	0				0
Non-AFC posts please detail below					0			0	0			0	0				0
Allowances for posts noted above - please detail below																	
<i>Unsocial Hours payments</i>																	0
BAND 5								0	0			0	0				0
<i>G&S Costs associated with the above posts</i>																	
<i>Employee Related G&S</i>																	
BAND 5						12.00		7,304	7,304	12.00		13,348	13,348				
Exceptional Recruitment and Retention costs for posts above the mean plus x% (please provide detail)					0				0				0				0
TOTAL PAY COSTS			0.00	63,170,166	63,170,166		2.73	63,269,306	63,269,306		5.00	63,352,020	63,352,020		0.00	0	0
Non-Pay Costs - please detail below					0				0				0				0
OTHER GOODS & SERVICES					0				0				0				0
TOTAL NON-PAY COSTS					0				0				0				0
GRAND TOTAL				63,170,166	63,170,166			63,269,306	63,269,306			63,352,020	63,352,020				0

Phasing/Timescale	(Can development be phased, if so provide details in this	(Can development be phased, if so provide details in	(Can development be phased, if so provide details in
	99,140	99,140	181,853