Northern Ireland
Assembly

PUBLIC ACCOUNTS COMMITTEE

OFFICIAL REPORT
(Hansard)

‘Resettlement of Long-Stay Patients from Learning Disability Hospitals’

25 February 2010

NORTHERN IRELAND ASSEMBLY

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‘Resettlement of Long-Stay Patients from Learning Disability Hospitals’

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Members present for all or part of the proceedings:
Mr Paul Maskey (Chairperson)
Mr Roy Beggs (Deputy Chairperson)
Mr Jonathan Craig
Mr John Dallat
Mr Jeffrey Donaldson
Mr Trevor Lunn
Mr Patsy McGlone
Mr Mitchel McLaughlin
Ms Dawn Purvis
Mr Jim Shannon

Witnesses:

Mr Martin Bradley	)	
Dr Maura Briscoe	)	Department of Health, Social Services and Public Safety
Dr Andrew McCormick	)	

Also in attendance:

Mr Kieran Donnelly	)	Comptroller and Auditor General
Ms Fiona Hamill	)	Treasury Officer of Accounts

The Chairperson (Mr P Maskey):

We move on to the evidence session. Do any members wish to express an interest?

Ms Purvis:

I express an interest as a member of the all-party Assembly group on learning disability.

The Chairperson:

Dr Andrew McCormick, the accounting officer for the Department of Health, Social Services and Public Safety (DHSSPS), is here to respond to the Committee. Members will be aware that his colleague Ms Browne is unable to attend today and that Mr Martin Bradley has kindly taken her place. You are all very welcome to the meeting. I will pass over to Dr McCormick to say a few words of introduction, and I remind everyone of the sensitivity of the subject that we are covering.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):

Thank you, Chairman. We appreciate the opportunity to give evidence today. Dr Maura Briscoe is the director of mental health and learning disability in the Department and is responsible for the local policy area, and Martin Bradley is the Chief Nursing Officer. It is perhaps most important to point out that we approach this issue with care and sensitivity because it concerns a group of individuals, each of whom has the right to be treated as an individual and with dignity and full respect. I apologise in advance in case, inadvertently or accidentally, any of us says anything that is in any way undignified. We respect the dignity of each individual, and we want to ensure that the issue is handled with great care and sensitivity.

The issue is complex and very challenging and is one of the most sensitive with which we deal. How we move forward with it is not at all straightforward. We have known for many years what the right thing to do is, and we have been seeking to pursue that agenda. That was familiar to us long before the Bamford review, but it was confirmed very strongly in the review report ‘Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland’, which was part of the Bamford review, and, indeed, it was confirmed in the Bamford review conclusions. The issue involves working with colleagues from several Departments to make sure that the best possible way forward is secured. The issue is government-wide, and the other Departments have taken a very supportive attitude to it.

The resettlement programme is a key action in the Government's response to the Bamford review. The important thing is that people should not be defined by disability or by illness. They are people with the same rights as everyone in our society, and equality and disability discrimination legislation exists to ensure that vulnerable groups are afforded the same rights as everyone else. Every person should be able to call somewhere other than an institution their home. We recognise that, and we recognise the importance of the issue. Therefore, we will work in partnership with the other relevant Departments to continue to ensure that that happens.

We need to respect fully the wishes and views of each person and their families. Resettlement is never imposed. However, the process is difficult. In our population, around 16,500 people with a learning disability are known to social services. We need to be particularly sensitive to the needs of the group that falls into the resettlement category in long-stay hospitals.

I want to give a few examples of the range of issues with which we are dealing. The list is generalised and will help to paint a picture of the way in which we are taking the issue forward. The group of people concerned range in age from their early 20s to their 70s. That means that the full range of health and social care issues that apply to any group in the population also apply to those individuals. Some people are physically able-bodied, and others have limited movement and need to use a wheelchair. Some individuals are able to understand what is being said and to communicate and make decisions. Others have difficulties in that area, and some have a limited understanding of danger and, therefore, need close supervision at all times to avoid accidental self-harm. Some have limited communication skills, and some exhibit behaviours that are challenging whenever they are unhappy, frightened or uncertain. The care that is provided must address those issues and be aware of and sensitive to them.

I am sure that there will be an opportunity today to pay tribute to the staff who work sensitively and thoughtfully with those patients. They give tremendously dedicated care in institutions, hospitals and the community so that each person can have the best possible quality of life.

Returning to the facts, a significant proportion of those concerned have autistic spectrum disorder, and a substantial number have physical as well as learning disabilities. Epilepsy, ranging from mild to severe, is quite common in the group, and the people concerned face other conditions, just as any individual does. Individuals with certain conditions may be more represented in that group than other people.

A small number of people have offending histories, and that requires support from staff so that they and others can be kept safe. Occasionally, there are those who have complex mental health issues in addition to learning disabilities. That means that skilled support is important to ensure that we provide the best way forward.

It is vital that the resettlement programme proceeds and that we get people out of hospital when it is right for them, when it is clinically the right thing to do and when it is what their families want. We must get those patients into placements that they can call home. That is what the Department is trying to achieve. However, that has been very difficult to do over the years. I do not want to pre-empt any questions that Committee members may ask; I merely want to give some background information to draw those points out. It is crucial that we find the right placement for each individual and that it is tailored to suit their particular needs. Those patients have the same rights and dignity as any other individual in our society.

The resettlement programme is among the Minister's top priorities for service development, and he made it a particular priority after the 2008 spending review. The resettlement programme is in place, but the Department can and must do better.

We have a great deal to acknowledge this afternoon, but I want to underline our commitment to do the best that we can in the current context. The resettlement programme is not only an obligation but absolutely the right thing to do. I thank the Committee for giving us the opportunity to make those points.

The Chairperson:
I appreciate that Dr McCormick. It is obvious that sensitive issues are involved.

I am aware that relatives and family members of those who are involved are in the Public Gallery today. They have been joined by a study group from Romania. I thank everyone for showing an interest in our Committee meeting today. You are all very welcome.

I will begin by asking some questions, and other Committee Members will then follow suit. I ask that you keep your our answers succinct and that you do not leave out any of the major points. I would appreciate it if you would speak up, as the sound system in the Senate Chamber is not very good.

Paragraph 2.2 of the report indicates that the Department set an initial target date of 2002 for the full resettlement of long-stay patients in learning disability hospitals. Eight years later, over 250 people with learning disabilities can still give a hospital as their permanent address. Will you give the Committee some background on that and tell us why that target has not yet been met?

Dr McCormick:

It is important to acknowledge that the resettlement process has been very difficult and that for many years the programme did not receive the priority status and attention that it deserved. The Department has let people down. I acknowledge that and apologise for it. The matter could and should have received more attention over the years. However, the truth is that it has been a difficult programme to manage, because identifying and delivering the right placement for each individual has required a lot of work, time and attention. It has been a challenging thing to do.

Furthermore, during the past decade, and, as a result of the Bamford review, there was a pause in the way that things were handled. However, the direct rule Minister gave a fresh commitment to the process in early 2007, and, when he took office, the current Minister of Health, Social Services and Public Safety gave such a commitment to give new impetus to the programme. A specific target date of 2013 was set to ensure that anyone with a learning disability should be promptly treated in the community and that no one should remain unnecessarily in hospital. That commitment was confirmed in the Programme for Government, but that was a result of work that the direct rule and current Ministers carried out the previous year.

It is important to note that alongside that, we have an additional target to prevent the build-up of a new resettlement population. As well as that specific target that is highlighted in the report, an additional target on delayed discharge states that trusts should ensure:

> “75 per cent of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days”.

Achieving the long-term target to ensure that the existing resettlement population is resettled and avoiding a new build-up would ensure that we are doing our best. It is very challenging area, and, although we have been able to keep the number of delayed discharges to a minimum, there have been some such cases. In fact, 38 people have been added to the list since the target was set, because it was difficult to secure the right placement for them.

We have a major issue to deal with, and it is important that it is addressed. It is also important that we continue with the commitment that exists. The resettlement of patients is among the targets that are managed strongly by the Department and by the Health and Social Care Board on the Department's behalf. The Minister made firm commitments that the resettlement of patients would be made as high a priority as possible in the present climate. We need to do the very best that we can for the people who are involved.

The Chairperson:

Have lessons been learned?

Dr McCormick:

Yes, very much so.

The Chairperson:

Paragraph 4.9 states that the Department believes that people who have been living in learning disability hospitals can have improved lives if they are able to live in the community. What steps has your Department taken to enhance the lives of those who still await resettlement and who are still in hospital?

Dr McCormick:

The important point to note is that the care that is given in those hospitals is the best that can be provided. We do our best to support and encourage that. It is also important to ensure that, as they are planned, discharges deliver genuine betterment. That is the key factor in making resettlements worthwhile. Therefore, placements and resettlements are carried out only when we are confident that they are clinically appropriate, that the families of the patients support such action and that the environment will be appropriate.

That is why careful planning is required; the time between someone being ready for the idea of being resettled and the right place being found can be many months. Time and planning are required, and the trusts have been working very hard to do the best that they can to deliver betterment. We can say more about that issue if you wish.

The Chairperson:
The issue is about enhancing the lives of those who await resettlement but who are still in the hospital. Has the Department taken any specific measures to tackle that issue?

Dr McCormick:
In providing that care, the trusts seek to ensure that the provision that is available is the best that they can provide in that setting. Trusts can take a range of different actions to try to ensure that that is the case. There is a clear responsibility on the system to deliver the best provision possible.

Dr Maura Briscoe (Department of Health, Social Services and Public Safety):
Each patient has a care plan that seeks not only to give care in the hospital setting but, where appropriate, to promote further integration into the community. For example, the Society of Parents and Friends of Muckamore Abbey values the swimming pool and the access to the cinema and bowling facilities, for example. Such activities are part of the care-planning process to promote social inclusion and are part of a philosophy of purposeful living and enhancement of opportunities on a day-to-day basis in the care-planning process.

The Chairperson:
Am I right in saying that care plans are worked out with relatives as well as with patients?

Dr Briscoe:
The involvement of parents, families and, indeed, carers themselves is an integral part of the care-planning process.

Mr Martin Bradley (Department of Health, Social Services and Public Safety):
Maura may want to elaborate on what she said, but as well as that, each trust has a resettlement team that looks regularly at the progress that the trust is making on resettlement. Indeed, that is overseen through regular reports back to Department.

The Chairperson:

Thank you. My questions aimed to set the scene; other members will delve into those areas in more detail.

Mr Dallat:

Paragraph 2.5 states that the latest target date for full resettlement is 2013. Paragraph 2.31 states that community care packages for patients with the most complex needs can cost well over £100,000. With more than 200 patients still to be resettled, costs could potentially run to £26 million. Have you secured that level of funding?

Dr McCormick:

The position is that funding is available under the current plans. The Executive set those as of January 2008 to provide for completion of targets up to the planned funding programme, which goes up to March 2011. No Department has any firm budgetary allocations from the Department of Finance and Personnel (DFP) for 2011-12 or 2012-13. That process is still forthcoming, and it will probably not begin until after the Westminster general election.

Therefore, funding is in place for the short-term resettlement programme for 2010-11 to ensure that there is a programme that provides for a further 30 resettlements in that period. That is provided for, but we estimate that additional cost is required. However, that will be subject to consideration in the next set of spending plans.

That will be challenging, given the context that we all face in applying public expenditure. It would be wrong to say that it will be easy, because the spending context is so fraught. We will seek to secure resources in that spending round because we have a clear responsibility to do so. However, the context is not propitious.

Mr Dallat:

With all due respect, Dr McCormick, there have been many general elections since it was first discovered that people should be resettled in the community. Can I ask you a personal question? When was your most recent visit to Muckamore Abbey Hospital?

Dr McCormick:

I was there in January.

Mr Dallat:

I was there on Thursday 18 February 2010. Let me make my position clear: it is an absolutely splendid place. I would describe it as out of this world. However, during my tour of the place, three patients asked when they would get home. One of them had been there for 30 years.

During the two or three hours that I spent there, I found the staff's work to be absolutely faultless. They want to deliver the plans that were put in place. At the end of the day, I have come to the conclusion that Muckamore Abbey Hospital, despite its excellence, has been treated shabbily. That is not to say that the people who ought to stay there should be resettled; I met some of those people, too. However, it seems that it is a centre of excellence that is not put to its best use because of what we call bed-blocking; in other words, it is not able to provide the kind of services that, in the short term, would allow people not to become institutionalised. I must say that I find it difficult to attribute the term "institution" to Muckamore. It is not an institution; it is a good place.

I listened to your introduction. Can any Department explain why there has been a delay in allowing people who are supposed to have the same rights and equality as everyone else to be confined to a place for 30 years — perhaps longer — and not to be provided for in the community? Can you give us an honest answer?

Dr McCormick:

The honest answer is that that is not and was not acceptable. We need to hold our hands up and acknowledge that. The matter has not been given the priority that it has merited over the years. The impetus that came from ministerial intervention in 2007 was genuine and has been sustained. It is incumbent on us all to ensure that that continues through the forthcoming difficult times.

Some thought was given to the matter in previous years. The Department initiated the Bamford review, because it realised back in 2002 that the matters of mental health and learning disabilities as whole areas had been neglected. Indeed, they are often referred to as the Cinderella services. That has left us with some deep issues to deal with, and it will be difficult to change that quickly. I have to simply hold my hands up and acknowledge that the system has let the people concerned down. We need to acknowledge that openly.

Mr Dallat:

You certainly seem sincere, and I do not question that. However, I came away from my visit feeling very guilty about the fact that we had let those people down badly.

Ms Purvis:

Paragraph 2.14 refers to the publication of an action plan. The ‘Equal Lives’ report was published in 2005, and the Bamford review was concluded two years later. However, the action plan to implement the recommendations of the ‘Equal Lives’ report and the Bamford review was not published until October 2009. Successful implementation of a policy requires strategic commitment. Why did it take so long for an action plan to be produced?

Dr McCormick:

It is important to say that after the completion of the ‘Equal Lives’ report, there was a clear consensus on the right thing to do. There was no doubt about what the right policy direction in that period was. That is why, when the Ministers became involved in the issue in 2007, action was taken then and there to accelerate resettlement and to give it fresh commitment. The delay in producing the response to Bamford and getting the action plan through the Executive did not hold back either the work that was being done or the fresh attention that was being given to the issue.

There was a need for the Department to work with other Departments to draw together a consultation paper on action following the Bamford review and for that to be progressed through the other Departments and, ultimately, through the Executive. That process took the time that is set out in the report; that is a matter of fact. However, at no stage was that standing in the way of action on the resettlement programme. It is simply that the consultation processes, the consideration of the consultation responses and the advice to the Minister on the drawing up of the action all took time, including time for Executive clearance.

Ms Purvis:

Are you saying that had the Minister not taken up his post in 2007, we might not be looking at an action plan even now?

Dr McCormick:

Undoubtedly, there would have been an action plan and another parallel way forward. However, I am not sure how long that would have taken. In the reality of the processes that unfolded and that we were working with, it took quite a few months to complete each stage. Nevertheless, it was always the intention to move forward with certain things, including the action plan and the resettlement programme, which were happening anyway.

Dr Briscoe:

We need to remember that 10 reports were produced in the Bamford process. The 'Equal Lives' report was produced in 2005. However, the final Bamford reports were finished around 2007. The Department produced its 'Delivering the Bamford Vision' consultation document in 2008, and, in the summer of 2008, that was subject to full public consultation, including engagement with many of the groups represented here today. Subsequently, the three-year Bamford action plan was issued, following a post-consultation period, in 2009. However, that does not mean that all work in relation to resettlement stopped. Clearly, it did not. As you can see from the NIAO report, specific action was taken to re-emphasise the importance of resettlement in 2007, and that continued throughout the CSR period, into 2008 and beyond.

Ms Purvis:

I am well aware of the timescale. I am asking why it took so long after the publication of 'Equal Lives' in 2005 to produce an action plan. Dr McCormick has answered that. However, you must accept that there was frustration among families, carers and patients that, when 'Equal Lives' — a commissioned report, which produced recommendations that people wanted to see implemented — was published, it took from 2005 until October 2009 to produce an action plan. I accept that work did not stop and that it was ongoing, but people want to see action.

I take it that you made detailed costings for the delivery of the action plan that was based on the Bamford vision. When I read the action plan, I expected to see included in it a detailed financial plan with estimated costs against each target and proposed action. If you do not have detailed costs to back up the action plan and deliver the vision, do you consider the action plan to be a useful working document?

Dr McCormick:

It is important to say that the action plan covers the activities not only of the Health Department but of others as well. Some of that financial planning is for those other Departments to do. It is a cross-government response. The individual elements are each in their own context and have their own implications. The action plan is made up of many strands of response, all of which will have different timetables and different associated implications. That is the context. Maura may want to say more about that.

Dr Briscoe:

Let me reiterate that the Bamford action plan, as published, does not just include the action plan in respect of learning disability. It is a much wider document than that, and it includes the mental health action plan and a number of related actions and the learning disability action plan. The Bamford action plan was designed on a three-year basis to coincide with the money that was secured within the respective Departments for the CSR period 2008-2011. As such, the Bamford action plan was designed to deliver actions within that time period.

I recognise that the resettlement target in the Programme for Government was 2013, but we took the opportunity in the Bamford action plan to re-emphasise and refocus all Government targets on the Programme for Government action plan that was endorsed by the Executive and which included the target 2013. In summary, our Department secured an additional £17 million of recurrent funding over the CSR period for learning disability over and above what is invested in learning disability services. The Bamford action plan was designed to coincide with the investment in the CSR period.

Ms Purvis:

I will ask the question again: have you made detailed costings for delivering your part of the action plan?

Dr Briscoe:

Yes. We know exactly what the spend on resettlement, respite and community infrastructure will be.

Ms Purvis:

Have you secured those resources to deliver the action plan?

Dr Briscoe:

Our level of resource has been determined by the CSR process, and £17 million of recurrent funding was secured for the three-year period that began in 2008. As we move forward to deliver the 2013 target for resettlement, we, along with our partners in the Housing Executive, the Department for Social Development, the boards and the trusts, have done detailed analysis. We know that to deliver the 2013 target will cost approximately £9 million in revenue for health and social care, over and above our additional investment, and it will require a substantial investment from the Department for Social Development (DSD).

Mr Shannon:

I am pleased to see you again and to be discussing the final report. The Bamford review comes up regularly in my office and, I suspect, in the offices of all the members in this Chamber. Carers come to us with questions about what is going on in respite care, and that is a concern.

The Bamford review suggested that there was an absence of suitable housing options, and it reiterated that the lack of support services in the community was one reason that the Department had failed to resettle all patients. Is the required community infrastructure now in place, and will it be sufficient to meet the needs of a further 250 patients?

We all have been contacted on that issue, and it worries me. As Mr Dallat said, resettlement has the longest waiting list in the Health Service. Some people are forgotten about and some have been on the waiting list for decades. For some that has been similar to a prison sentence, and for some that sentence has been a life term. The passion with which Mr Dallat asked his question is shared by a great many of us. My question was very clear, and I want a very clear answer.

Dr McCormick:

Community infrastructure needs to be put in place step by step as the resettlement programme goes forward. The process can sometimes involve staff transferring from the hospital to stay with clients as they move into the community. We do not create community infrastructure for a large number of people and then carry out the resettlement programme, it is done step by step. Therefore, the simple answer is that community infrastructure is not yet in place, but it will be put in place as the programme unfolds.

As part of what is already a very long process, the intention is to ensure that, as each resettlement is planned, the physical environment, care package, and partner support from other agencies — whether the housing sector or the voluntary sector — is built up step by step as the programme is made. Therefore, it is only as we continue with the programme that the community infrastructure will be built up. There are significant advantages to doing it that way. I have seen some very good examples, in different parts of Northern Ireland, of support arrangements, where, for example, groups of staff, who primarily support clients with learning disabilities, are based with the clients, who are living in their own properties. Clients are provided with the support and care that they need on a one-to-one basis or in whatever form is appropriate for them. The same group of staff will be available to work in the wider community as well.

That is a much better way forward for everyone concerned, because it provides a better quality of life. That is what we are trying to do, and the vision and intention is very clear. We share that sense of guilt and frustration, and, indeed, I saw the paper that Mr Shannon has when it was sent to our office. The sense of responsibility gets to us as well. The situation is unsatisfactory, and it is unacceptable. We have to work faithfully to make the right things happen as far as possible.

Mr Shannon:

Dr McCormick, do you think that most people will be resettled by 2013? It is all very well to have a stated target, and I take your answer to the last question as being an honest one. However, we need assurance that the 2013 target is achievable. As set out in paragraph 2·9 of the NIAO report, the Bamford review concluded that:

> "the failure to fully achieve the aspirations of the 1995 policy review was due to the absence of sufficient resources … the lack of robust implementation … a misplaced belief that learning disability needs can only be met by the health and social services sector … and a failure to fully involve patients".

Have the lessons been learned?

Dr McCormick:

Absolutely; the lessons have been learned. The approach is dependent fundamentally on partnership with the family and respect for their wishes. Resettlement is never imposed. We work family by family and individual by individual to find the right solution. It is undeniable that the 2013 target is, at best, very challenging. What I can say is that everyone in the Department, the Health and Social Care Board and the trusts will do everything possible to deliver that target. However, it is only honest to say that it is a very challenging target.

Mr Shannon:

I know that it is not always possible to say definitively that you will achieve a target, but the Department has said that it will achieve that target by 2013. As a spokesman for the Department, I assume that you agree that that challenging target can be met.

Dr McCormick:

We will do the very best that we can to meet the target; that is the best that I can say.

Mr Shannon:

Elected representatives constantly come across the issue of respite care. We all recognise the importance of respite care for carers. Respite care gives those carers who look after people 24/7 a break. Do you agree that it is highly cost effective to have good respite care readily available for the families and carers of people with learning disabilities? I know people in that situation.

Dr McCormick:

That is absolutely the right thing to do; it is essential for the well-being of families and individuals. Imaginative use has been made of both existing and new facilities to develop that possibility. Some of the new developments that have been part of the resettlement programme have built-in provision for respite as part of their design, and the support staff can use that as part of their work programme. The provision is planned and geared, and we recognise it as an important measure as we seek to do better, despite the limitations in and frustrations with the programme.

Mr Martin Bradley (Department of Health, Social Services and Public Safety):

I want to take this opportunity to acknowledge the contribution that carers make to the client group. Without the care that they have given over many years, often unpaid, we would not even be as successful as we are at the moment. Respite services support carers, but they also support the individuals who are being cared for. Respite care gives those individuals an opportunity to get out of their normal environment and to have richer experiences. That is extremely important, and we need to build it in to all our systems. As we move further and further into the community, the capacity to provide a range of opportunities for individuals, and relief for carers, is increasing slowly but surely.

Dr Briscoe:

Your question is pertinent. For us, respite care is a fundamental part of the broader community infrastructure that needs to be in place not only for individuals who are being resettled but for the wider population. To support that, we have made additional investment in respite. Members will note that it is a target in the Minister's priorities for action to increase respite care for those with learning disability in the community.

For us, respite care can take many forms. It can take the form of residential care, but it can also take the form of different types of domiciliary care in an individual's home or, for example, through host families. Another element of respite care is respite through leisure or recreational opportunities. A fundamental part of that is to enhance the relationship between the carer and the individual. Therefore, respite can take many guises. There is a respite care target in the priorities for action, and we absolutely agree that respite is fundamental to the service that is provided to individuals in the community.

Mr Shannon:

I accept the point that you are making and your response to the questions. However, through its questions, the Committee is keen to find out whether sufficient resources are being made available. You may agree with the principle, as everybody in the room does; however, there has to be more than that. Sufficient resources must be available. The people who come to my office and to the offices of all Committee members are aware of that. Sometimes, we have to struggle to get a response. Therefore, I am asking whether there is sufficient availability and appropriate targeting of respite care, and whether resources are available for that.

Dr McCormick:

There are many things in health and social care for which it is difficult to find sufficient resources to address the needs of the community. That applies not only to respite care, but across a range of issues. Undeniably, there is unmet need. We do not have the resources to do all that could be done, or all that we want to do, or to cover all that should reasonably be provided for. That is the nature of having to manage health and social care as a public service that is funded in the way that it is. That is the nature of the issue that we are dealing with, and it is very challenging. Our responsibility is to ensure that we make the very best use of all available resources and meet as much need as possible. That is mainly done through the allocation of resources to the Regional Health and Social Care Board and, hence, to the trusts, so that they can address the needs of their communities. However, the trusts face rising demand in all aspects of health and social care and that is why, in the present context, the provision of respite care is so challenging.

Mr Shannon:

We are seeking flexibility in respite care. That flexibility does not always exist, and that can be frustrating. If a carer goes on holiday, is it not possible for an individual with a learning disability to stay in his or her home and have someone come in to look after them? Have you considered that? I am aware that requests have been made for that service but that is has not happened. That is one example of the sort of flexibility that should be in the respite care system but is not.

Dr Briscoe:

There are different models of respite care. Where it is possible to achieve overnight respite care, we do that. We aim to enhance respite care through some of the supported-living schemes for resettlement. However, if, for example, a carer is away for a long period of time, such as a week or more, that may mean that an individual has to come into a community setting outside his or her own home. That would mean that the programme and the multidisciplinary team that looks after that person within the respite facility would be shared with those in the supported living environment. There are benefits to doing that, such as the social re-integration of the individual in the community. Sometimes, flexibility is difficult to achieve due to the pressures on the service, but we encourage a broader, more socially inclusive model of respite to enhance the re-integration of individuals into the community.

In respect of the additional funding secured for learning disability within the comprehensive spending review, the second-largest proportion of additional resource, after that for resettlement, was secured for respite.

Mr Martin Bradley:

It is obvious that there is a resource issue, as Dr Briscoe said. It is also a matter of using our imagination to get the best out of what we have. I have met people with learning disability and carers on holiday. There is a societal change to be effected as well, and we must make sure that we all have an opportunity to contribute fully in society, and that involves allowing individuals and their carers to take a holiday. We must use our imaginations and work within the available resources. If we had more resources, respite care would be much more available than it is at present.

Let me pick up on something that Mr Dallat said. One cannot but agree with everything he said in relation to Muckamore Abbey Hospital. There is no lack of willingness on the part of staff to try to make resettlement happen. There is no lack of willingness on our part to get the policy right and to have the right vision. We now need to work to make absolutely sure that we have the resources to make it happen, and we continue to work on that. That is where we are at present.

Mr Shannon:

You used the word “imagination” in responding to that question. However, imagination is not always used. We all know carers and the work that they put in. We see how great the need is for respite care. I suspect that the imagination to provide that flexibility is not there. We can point to many cases where people have had to fight tooth and nail to get flexibility. The imagination that you refer to, and that I would like to see, is not there. I am sorry that that is more of a statement than a question, to be fair.

Ms Purvis:

Mitchel McLaughlin and I attended the Finance and Personnel Committee yesterday, and we heard evidence from Carers NI that the informal cost of carers is approximately £3·1 billion. That is the saving that informal carers provide every year to society. It is important to recognise that. Respite is, therefore, among the least that can be provided to help those carers.

Families and carers may have very complex needs. Some require residential respite care, and I am concerned about continuity of care. The Northern Health and Social Care Trust has lost one residential respite bed this year and will lose another by the end of June. Continuity of care is central to mental health and learning disability. Do you think that continuity is important in relation to residential respite care?

Dr McCormick:

Yes. It is a very important aspect of planning. That applies specifically to a group of clients where familiarity, continuity and a pattern of life is central to their quality of life, and where disruption or disturbance has serious consequences. It is the right thing to seek to do. However, it is difficult to always deliver it, and there can be constraints on imagination, partly through the need to consider the right balance of issues. In other words, finding something that is acceptable, workable and safe for all concerned can be quite difficult. I take the point that we need to apply imagination to ensure that rules, procedures and protocols are applied sensitively, thoughtfully and properly. However, it is very challenging for the clients that you are talking about.

Mr Martin Bradley:

It may be slightly off the point, but I am conscious of the theme of working things through and being sensible. If people with learning disabilities have to come into hospital, to the A&E or outpatients' departments, in the Craigavon area, they have a passport that allows them to move forward quickly in the system, so that their needs are recognised much more quickly and are dealt with in a much more timely manner. We are beginning to take a fresh look at how we meet the needs of people with learning disabilities in society in general and in the whole Health Service, so that we can make life easier for them and their carers. That is just one small example. Nevertheless, it is an example of something that did not cost anything but was about us trying to look at how we deal with some of those issues more imaginatively.

Mr McLaughlin:

I want to associate myself with the remarks made about Muckamore Abbey Hospital. I visited that facility some time ago and had an extensive tour. The significant commitment to the care and well-being of the patients is evident. The staff display professionalism and dedication over and above the responsibilities of their day-to-day employment. However, we must be concerned about the missed targets.

Resettlement has been identified as one of the key priorities, and that is set out in paragraphs 2.15 and 2.16 of the report. I am pleased to meet Dr Briscoe today. However, there have been some delays in making that appointment. There was a five-year delay in establishing the resettlement team, and the Bamford review was used as some sort of explanation for that. Does that demonstrate that there is a systemic problem, in that people with learning difficulties have not been given the strategic priority that they deserved, despite the Minister's public commitment and the statements of priority on that matter?

Dr McCormick:

That is not true now. The Minister and the Department have a clear commitment to the whole health and social care system to respect the issue and to give it the priority that it merits. That is the current determination. We acknowledge the Audit Office's concerns in paragraph 2.15. We must recognise that there was insufficient focus, drive and determination in that period to pursue the resettlement programme as vigorously as we should have.

There is no doubt that work was ongoing on the Bamford review at that time. I pay tribute to the team that produced the 'Equal Lives' report, and I should say that that work is going well.

Sufficient priority was not given to the matter for a number of years, but the commitment stands, and the current Minister has expressed a strong determination that, notwithstanding the significant challenges arising from the Assembly's draft Budget, as much as possible should be secured and maintained for the resettlement programme. However, a sudden and substantial reduction in funding of approximately £100 million in 2010-11, compared with the plans that were in place from January 2008, is worrying and challenging. The Minister consistently tells us that we must continue to give priority to the resettlement programme alongside mental health and some other priorities. The matter is one of the Minister's top priorities.

Mr McLaughlin:

A resettlement strategy is a complex challenge in any circumstance. It involves a considerable amount of interaction and co-operation with other Departments, including the Department for Regional Development (DRD) for transport options and the Department for Social Development for supported housing provision. Are you saying that such issues are not in any way an impediment? You referred to the current efficiency drive and to the impact that that is having on your Department. As you go into 2010-11, have the issues of co-operation and the release of resources from other Departments for the resettlement strategy been addressed and resolved?

Dr McCormick:

We have good co-operative working relationships with the main Departments in question. I am sure that there are as many concerns in DSD, for example, which holds the other main budget that has significant relevance for the resettlement programme. If the Supported Living projects and the housing programme are subject to any reductions, it will more challenging for the Department to provide its planned contribution to the programme. I am aware that there is good co-operation and a sense of common purpose, but those are becoming increasingly difficult to sustain.

Dr Briscoe:

A regional resettlement team exists that includes representatives of all the stakeholders, including DSD, and it oversees active multi-disciplinary discharge teams in each of the relevant trusts. An integrated structure exists in which the Housing Executive and DSD are the main bodies that are involved in prioritising business cases for the Supporting People programme and Supported Living projects. We have worked closely with the Housing Executive and DSD to map out the provisions that might be required to meet the 2013 target.

Mr McLaughlin:

That is reassuring, but I could couple that response with the answers that you gave to Dawn Purvis about the business plan and the resources that are required to deliver the resettlement strategy. I do not want to identify anyone, but a visitor is in the Public Gallery, and I know that his treatment at Muckamore Abbey Hospital was completed five years ago. He has been identified as being suitable for resettlement, and he is willing to be resettled. As we sit here this afternoon, that person does not know where he is going or when he is going. How does that match? How can that be? He has been waiting for five years.

Dr McCormick:

It does not match —

Mr McLaughlin:

We are being told that there is a plan that has been resourced and that will deliver. That person has no reason to be in Muckamore Abbey Hospital other than that there is nowhere to send him. How does that match with the information that we have just been given?

Dr McCormick:

Over 200 people are due for resettlement, and, in a perfect world, they would be resettled immediately. However, we are not in a perfect world, and the resources are not there to resettle them.

Mr McLaughlin:

Before we begin to worry about the cuts and the pressures on resource levels, you must accept that that is another example of failure. You have told the Committee that the Department has a plan and the resources, yet that person is trapped in the system, he does not want to remain in Muckamore Abbey Hospital, he has completed his treatment successfully, and he could and should be in the community.

Dr McCormick:

The resources are available for the additional 30 resettlements in 2010-11 of the total of over 200 people who are due for resettlement.

Mr McLaughlin:

Is it correct that if that patient were one of the 30 people who are due for resettlement, he would know by now, and, therefore, he is not one of those people?

Dr McCormick:

I am not sure exactly when those people will be resettled, because it takes a considerable time for the plans to be worked out. Some of the 30 people who are scheduled for resettlement in 2010-11 will know by now, but others may not. It takes a considerable time to plan each resettlement.

For example, 16 people are in Longstone Hospital in Derry. A new facility is being built, and the plan is to open it this spring. That group of 16 people will move into that new facility as the spring unfolds. That is specific, planned and definite. However, current resource levels mean that there are other people for whom the Department is unable to provide resettlement during 2010-11. The determination is to complete the programme as quickly as possible, but the Department must pursue it properly.

I apologise; I am getting mixed up. Longstone Hospital is, of course, in Armagh. I meant that there are 16 patients in Lakeview Hospital in Derry who will be resettled when the new facility is opened. Forgive me for that mistake.

The Department is determined to see the resettlement programme through. However, the programme is very challenging, and the resource plans take time to unfold.

No UK Government Department in 2011-12 or 2012-13 has firm plans for resource levels. Indeed, all the signals are that resource levels will be significantly constrained. That is the economic context that we are in. We must recognise that and plan in the best possible way.

Mr McLaughlin:

If we were to compare the level of learning disability funding for each person in the population here in the North, we would find that it is lower here than it is in any other UK region. Is that not the case?

Dr McCormick:

That is correct.

Mr McLaughlin:

I know that the Department and the Minister have been very vociferous in arguing for more resources, and fair play to them for that. I understand that the case for that will be taken forward. Generally, the per capita funding for the Health Service here is the same as that in other regions. Does that not indicate that the historic lower priority that is given to this issue, for which people have said they have so much commitment and good will, means that we have not actually changed our thinking over the years? The Department has a responsibility to prioritise spending, so why has it not done so?

Dr McCormick:

The Minister has given that area the highest priority that he can from within the limited resources that are available for service development following the January 2008 financial settlement. The Minister agreed that settlement, but he was not satisfied with it. He would have liked to have had a far better settlement, but he said that it was "as good as it gets" at that time. However, that was the basis on which it was agreed, and it involved a level of service development funding for 2010-11 as planned. Mental health and learning disability was, and remains, the Minister's top priority for the use of those resources.

However, the nature of planning finance for health and social care means that before people can do the things that they want to do, they have to pay for the things that they have to do. Essential life-saving services and providing contractual obligations, as well as the pay and conditions of existing staff, consume the vast majority of the money that is available to the Minister. Even that depends on the delivery of £300 million recurrent of efficiency savings a year by 2010-11. A total of £700 million of efficiency savings were required in the CSR period. That was immensely challenging.

Within the available service funding, the Minister is prioritising mental health and learning disability. As you said, per capita expenditure is comparable. Indeed, HM Treasury's latest public expenditure statistical analysis indicates that health spend per capita is 2% higher in Northern Ireland than it is in England. Our best estimate for the differential in relative need for health expenditure is 10%. Therefore, the allocation does not match the need.

That is a matter of historical record, and the facts remain the same. Under the devolved

Administration that existed at the start of the previous decade, the then Health Minister and Finance Ministers argued that point very strongly. John Appleby highlighted that the most conspicuous part of the differential with England has been in mental health and learning disability. You made that point very strongly, and it is a reflection on the pattern of prioritisation of services over many years. It has not built up suddenly; it is a long-term trend.

It is an issue for our entire society and for the Department. We accept our responsibility, but others also have responsibilities for the matter. The situation that we face is a fundamental consequence of the significant underfunding of health and social care in Northern Ireland compared with other parts of the United Kingdom and compared with the identified evidence-based analysis of the needs and demands on the services.

That is documented very clearly, but I should give an update on the figures. The Audit Office report refers to the differential as the familiar £600 million figure. Strictly speaking, however, a change in the English allocation in a previous Budget round means that the current differential is probably about £540 million. However, that does not make a big difference, and the point stands that we face significant underfunding that will be made much worse by the £92 million cuts that have been proposed in the current draft of the Budget. That is a major issue for the Department, but I suggest respectfully that it is also an issue for the Assembly.

Mr McLaughlin:

That would take us well beyond the remit of this meeting, but it is a strong case. However, any additional resources that are allocated to the Department of Health, Social Services and Public Safety will have to be taken away from another Department. That is just the way it is, because the cake remains basically the same as it was at the start of the process.

I am concerned by the report's reference to the £100 million deficit that has to be addressed. Does that mean that we face the possibility of the action plan being torn up and revised and targets being reset?

Dr McCormick:

The Minister is determined to give the maximum possible sustained priority to mental health and learning disability, even in the current context. Some decisions are still to be taken, but the Minister is determined to continue to prioritise and protect those services and the resettlement programme in particular.

The Chairperson:
Before I invite Jonathan Craig to ask a question, I ask the witnesses to speak up. Some people are finding it difficult to hear the responses. Thank you.

Mr Craig:
Dr McCormick, I want to explore the statement that you made to my colleague that you feel that the resettlement programme has the resources necessary to meet the 2013 target. I have some difficulty with that statement. I have been involved personally in two re-housing building projects in Lagan Valley. The housing associations involved had to dig into their own pockets to deliver those projects, because not enough funding was available. Ultimately, the choice for the housing associations was to either drop the projects completely or to dig into their own pockets and take a long-term hit. In fairness to both of them, that is what they did. When you say that the programme is properly funded, what exactly do you mean by that? Will it meet the delivery date?

Dr McCormick:
It is important to emphasise how challenging it will be. However, the important point is that we remain determined to do the best that we possibly can to deliver the target. The funding is in place for the present plans in 2010-11 for the 30 additional resettlements that are scheduled for that period. I assume that we will continue to deliver what has been targeted for the current financial year to complete that programme, which, based on our figures, was on track as of December 2009. However, we need to look at the resourcing for DSD and the housing programme alongside our resourcing so that the housing association cases such as that that you referred to will be an issue with the housing funding. I am not familiar with the full details, but the plans that are in place for resettlements in 2010-11 depend on the partnership approach and the regional resettlement team, which Maura mentioned earlier, working together to deliver the programme case by case and plan by plan. I am aware that there have been some difficulties in securing that.

However, what I can take away from this session is the need to engage further with colleagues in DSD and to explore what is possible. If there are obstacles that we need to apply ourselves to, we need to do that and see what we can do to overcome them, subject, ultimately, to the resources that the Assembly makes available to make those things possible.

Mr Craig:

I think that you would agree with me that a joined-up approach has to be taken, otherwise there will be no delivery.

Dr McCormick:

Absolutely.

Mr McGlone:

To pick up on your last point, are you saying that your resettlement programme is entirely reliant on DSD making housing available? A project that is going on not far away from me has adequately and successfully used private sector housing. Indeed, I pay tribute to the Northern Trust for that work. Perhaps you were not aware that that was going on, because the entire focus here has been on people saying that they cannot do something because something else needs to be done. Is a bit more creativity needed so that people can say that housing is available that could be used? There may be other ways of feeding into the budget.

Mitchel referred to people having to wait five years to move into accommodation, be that supported living, nursing homes or residential homes, whatever that might be. Forgive me, I am not an accountant, but figure 3 on page 21 states that there is an increase — as one would rightly expect — in expenditure on nursing homes, supported living and residential homes. However, has a person, who, because of circumstances, has been forced to stay in hospital for a long stay of five years more than they should have, pushed up the figures in one of those graphs when that money could have been better utilised? I do not expect instant answers, but that example springs to my mind. If no housing association homes were available but private sector housing were available that could be adequately used, perhaps some of that money would be better utilised going towards that housing. You might like to answer that question first.

Dr McCormick:

We will do our best. I am sure that my colleagues may have points to add. The key thing is to design a resettlement that is tailored to the needs and requirements of each individual. If that is done through the different categories that are shown in figure 3, that is what is done. If it is best done in a private sector context, we should be seeking to explore that option.

As the graph shows, the truth is that expenditure on supported living is growing. There is partnership with DSD and the housing associations in that area because it often involves specially designed arrangements. Through that partnership, we can get something that is tailored very specifically to the complex and very challenging needs of many of our clients. That is why there has been a drive to proceed in that way. However, we should explore all opportunities and options, although they rarely turn out to be easy.

I do not think that we are missing any major tricks in the ways in which supported living can be pursued. People have applied imagination and dedication to try to make it work. Obviously, if there are other ideas, we are more than willing to explore them and to take them further.

Dr Briscoe:
I am familiar with the project that you described — I think that it is in the Northern Trust area. We must remember that, and to the best of my knowledge, the individuals involved have their own tenancies, and, therefore, their housing benefit covers the cost of the rent to the private developer. That sort of scheme is not always possible. For example, property in the greater Belfast area would have higher rents, and, therefore, housing benefit would not necessarily cover a tenancy arrangement. Even in that case, health and social care would provide the care element of supported living, and the predominant investment by the trusts is in that care element. Individuals in the trusts — in the Belfast Trust, for example, and, as my colleagues mentioned, at Muckamore — have looked at other options. Those include perhaps putting out to tender a project that would engage with a range of providers, including those in the voluntary sector. Nonetheless, the housing element has to have its own funding mechanism.

Mr McGlone:
You mentioned that you had looked at the possibilities of tendering. What happened with that? Did that succeed or fail?

Dr Briscoe:
You mentioned the Northern Trust —

Mr McGlone:
You referred to Belfast.

Dr Briscoe:

Yes. The Belfast Trust has looked at tendering arrangements and at whether it could consider using existing accommodation. However, in addition to the points that I made about rent and tenancy, it must be said that some property would need substantial adaptations to accommodate individuals with very complex disabilities. That could mean multiple adaptations to accommodate hoists, lifts, specialised wheelchairs and so on. That would be quite a substantial piece of work. My understanding is that the Belfast Trust has looked at that. However, the cost of property in the area means that it would be difficult for housing benefit to maintain tenancies.

Mr McGlone:

You said that it would be costly to carry out adaptations. However, if that person were living at home, would the trust not recommend those adaptations anyway as of right?

Dr Briscoe:

No. Some of the smaller adaptations would be done through the trust and others would be done through the Housing Executive.

Mr McGlone:

That is what I mean; it is doable.

Dr Briscoe:

It would still require substantial resources that could fall primarily to health and social care, DSD or the Housing Executive.

Mr McGlone:

I do not expect you to answer on behalf of the trusts. However, it would be useful if we could get that information from the Belfast Trust. It sounds as though there is some positive thinking on the matter that needs to be translated into action.

Paragraph 3.4 of the report says that three quarters of people who were waiting to be resettled had been in hospital for 10 years or more and that almost 10% had been in hospital for 50 or more years. Paragraph 4.4 gives an example of two friends named Mary and Jane — I presume that those are not their real names — who, after Mary had been in hospital for over 50 years, were resettled together into a supported living setting. That brings us back to the nub of the matter. I am sure that there are many success stories, as Mitchel said, but given the success of that example, how are patients being prioritised and selected for resettlement in the community? Someone's being in hospital the longest does not make them a priority, otherwise they would not have stayed as long in hospital. In cases such as those that Mitchel mentioned, another five years are added. As someone in the ordinary five eighths, I am anxious to know what method is used to prioritise people for resettlement.

Dr McCormick:

It is a matter of using a range of criteria, but in effect, it is about identifying resettlement opportunities and matching what is possible in building community infrastructure, as we talked about earlier. It is also about providing the relevant housing that is matched to the particular needs and contexts of individuals. It is a complex matching process; one cannot simply use a formulaic set of numbers that includes the length of the delayed discharge. It is a much more human process than that, because it takes into account the dignity and aspirations of each individual. It is difficult to do.

Mr McGlone:

It is right that there should be a proper assessment of needs, but in layman's terms, could you give me a flavour of how that is done? I want to understand how the problems that have arisen can be averted and resolved.

Dr Briscoe:

It goes back to the principle of betterment. First and foremost, is it clinically appropriate for the person to be resettled? Secondly, does immediate resettlement provide a better outcome for the individual? Thirdly, does the individual wish to be resettled and do parents and carers believe that their loved one should be resettled? Lastly, as Dr McCormick said, is the accommodation and community infrastructure there to support that individual? At the end of the day, resettlement is about individuals. It may be that there is a variation in the length of time that a person is in hospital. I do not work at trust level, but all trusts have criteria to go through a process that determines the need and nature of the resettlement process.

Mr McGlone:

It might be useful for the Committee to have sight of those criteria. Is there a points system? How are people prioritised for resettlement?

Dr Briscoe:

It is determined by the principle of betterment.

Mr McGlone:

Yes, but it would be useful to have sight of those criteria.

Mr Martin Bradley:

Further to what Dr Briscoe said, criteria are applied, but there will also be a conversation with the individual concerned. The individual has quite a say in their readiness for resettlement. We discussed the example of someone who has been told that they are ready for resettlement but who has not yet left the hospital. I accept that, but the decision is based on the human condition. The conversation is between the professionals, the individual and his or her family so that the individual's needs can be matched with the facilities that are available in the community. If the required facilities are not available, there will be a delay until they are available.

Mr McGlone:

I am not a clinician, but when a person has gone through a criteria-based application process, has spoken to medical staff and believes that they are at the point of returning to the community, it is wrong for them to be told that they will be resettled in a relatively short time. Do you accept that that does not help, to use your terminology, the "betterment" of individuals?

Mr Martin Bradley:

I agree; that is not the way to do it. However, it is a complex process that involves people talking to each other, and it is one in which criteria are used to assess the preparedness of someone to make the move.

One must plan, but it is not good practice to raise someone's expectations that they might move into the community within a relatively short period and not deliver on that promise. That is obvious.

Mr McGlone:

Will the outcome from today's meeting mean that that should not happen?

Mr Martin Bradley:

It is not good practice. One needs to plan, but it would be wrong to raise a person's expectation that he or she would move into the community in a reasonably short time and then not deliver that.

The Chairperson:

I have a supplementary question on that issue that may provide some clarity. However, I will bring Mitchel in first.

Mr McLaughlin:

I want to see the criteria that Dr Briscoe has described in such detail. I also want more information on the principle of betterment.

I will not identify anyone, but, within the past fortnight, I have been made aware of a patient who accepted a resettlement offer to be placed in an old people's home, even though he by no means fitted into the recognised age category of other residents. He was told that he was a suitable client for resettlement and that the treatment and the care package provided would allow him to be resettled. The anxiety to be resettled is obviously very strong in such an individual.

I have examined the statistics on residential and nursing homes and they are quite strong. However is resettling individuals in those establishments an easy option that does not stick rigidly to the principle of betterment? Why would a relatively young man be offered the option of resettlement in an old people's home?

The Chairperson:

Before the witnesses answer those questions, John Dallat wants to make a comment.

Mr Dallat:

I am aware of people who have committed the most horrendous crimes, yet unlimited energy and resources are put into their resettlement in the community. I am not against resettlement for offenders, but I cannot see how they can be compared to people who have been in Muckamore Abbey Hospital for 30 years. Those people are intelligent enough to know their rights; they have expressed their wish to be resettled, yet they have not been resettled. That is terrible.

Dr Briscoe:

I am very sorry to learn of the case highlighted by Mr McLaughlin. I am not familiar with individual cases, but what I would say is —

Mr McLaughlin:

The records will show that the individual agreed to his offer of resettlement. However, you will need to drill down into the reasons why he was offered a place in an old people's home in the first place.

Dr Briscoe:

Once the process is underway, generally individuals are brought to the environment in which they are to be settled, and they are encouraged to make one or more overnight stays to ensure that they are comfortable and at ease. The process is a long one, and when individuals are formally transferred they will still be under the care of specialist providers, such as those at Muckamore Abbey, for as much as two or three months after resettlement.

Figure 8 of the report reflects the growing trend in supported living for those individuals who have been resettled, and the Department recognises that it is important to place individuals in an age-appropriate environment. Figure 8 shows, as Dr McCormick indicated, that there is a huge increase in demand for the supported-living projects under the Supporting People initiative. The principle of betterment applies, even for individuals who have been resettled in residential homes or nursing homes.

Mr Beggs:

I, too, appreciate the work that is done by the staff of Muckamore Abbey Hospital. The changes that are being brought about are no reflection on the quality of their work or on their potential to make individuals' lives better.

Following on from the previous discussion, paragraph 3.7 of the report states that the majority of people who have been resettled in the past six years have been moved to nursing homes or a residential home setting. Figure 7 shows that approximately 70 people have been moved to residential homes, approximately 47 to residential homes and approximately 74 to supported living. The vast majority have gone to nursing homes or residential homes. Are those homes age-appropriate or are they just old people's homes? Do nursing homes and residential homes fulfil a niche requirement?

Dr Briscoe:

When I was a community GP and worked in some long-stay hospital wards, I became aware that the level of privacy that was afforded individuals in a nursing home or in residential accommodation was far superior to that of ward environments. People can bring their own furniture to residential-care and nursing-home accommodation and they have en suite facilities. The level of dignity and privacy that is afforded an individual in a nursing home or residential environment is far better than that which is available in a traditional long-stay hospital.

Mr Beggs:

I do not disagree with that. Whether they are receiving quality care is another matter. I want to know whether those environments are age-appropriate and can offer other activities. Committee members were given a DVD that described the supported-living programme in Orchard House in Loughgall, which seems to offer exemplary care. The quality of care for individuals in those environments is vastly superior to that which is offered in a nursing home where there is very little interaction. Potentially, people might sit alone in their rooms in nursing homes or use communal rooms in which there is no interaction with other people. There is potential for isolation in such situations. I want to know whether nursing homes or residential accommodations are age-appropriate and offer related activities.

Dr McCormick:

The trusts plan activity programmes for clients who are in a community setting, whether in a nursing home or a supported-living environment. The care package is the most important thing, so that individuals can take part in social activities and are not stuck in their rooms, as Mr Beggs characterised it. That risk exists, but it is managed by having an appropriate care programme for the individual in the community setting, using various aspects of day care activities that are planned and tailored according to individual need and context. We are very sensitive to that need, but, of course, there are some people in the older age groups for whom we have to find the best available setting.

Mr Martin Bradley:

I take Mr Beggs’s point. I want to be careful not to generalise too much. Placements will be made not only on the basis of age considerations but on clinical considerations.

We must accept that there will be a proportion of clients with learning disabilities who also have complex physical healthcare needs. Those needs must also be catered for, very often in a much more nursing-orientated environment, simply because that is what the client requires.

There will also be situations in some homes and supported housing developments in which a number of people who have lived together for a considerable time will often want to move as a group. That causes some issues with one of the Bamford recommendations about maintaining living units of no more than five people. In a perfect world that would be fine, but there will be groups of people who will decide that they would prefer to remain together, particularly those who are moving out of Muckamore Abbey Hospital and other hospitals. In some cases the staff will also move with them.

Mr Beggs:
The Bamford review considered the dangers of moving individuals from one institutional setting to another. It indicated that it was important that the quality of care was improved and that an opportunity was provided for those individuals to integrate with the rest of the community. Can the witnesses provide an example of the sort of interaction and social care that is provided for those who are placed in residential or nursing homes, so that they are not left isolated?

Mr Martin Bradley:
There will be opportunities for integration in the rest of the community through individuals' use of local community entertainment and recreational facilities and by their going on trips and holidays together.

The current situation is not perfect, and the Department must continue to work at it. There are also issues in society generally about how people with learning disability are viewed, and a job of work must be done by us all to ensure a greater acceptance of those individuals. However some improvements are being made, and in my local community many more people who live in residential accommodation attend church and use local facilities than before.

Mr Beggs:
The witnesses indicated that the Orchard House project in Loughgall was initiated through supported housing — one of the functions that DSD is responsible for — and that, if the

Department is to meet its 2013 target, another £9 million of recurrent funding will be required. If that project is to be delivered, the Committee must know what the total package will cost. Do the witnesses have an idea of how much money will be required to provide that all-encompassing service, which is reliant on other Departments, such as DSD?

Dr McCormick:
To achieve the 2011-12 and 2012-13 targets, the Department of Health, Social Service and Public Safety will require £30 million worth of capital investment and £9 million a year recurrent funding, over and above its existing planned health and social care expenditure. DSD will also need to contribute an additional £4 million for supported-living expenditure.

Mr Beggs:
It is helpful to have that full picture. It is the first time that I have really been aware of it.

Mr Donaldson:
Given other commitments today, I will not be able to stay to hear all of the evidence. I apologise for that, but I will read the Hansard report of the session.

I declare an interest. My younger brother, who is over 40 years old, is learning disabled, and this issue will have to be considered at some stage by my family.

Paragraph 3.26 of the report refers to the Bamford review's estimate that there could be as many as 1,600 people with learning disabilities living with their families. Bamford suggested that they are likely to require alternative accommodation in the next five to 10 years. What are the cost implications of that, and how will the Department secure the required additional funding?

Dr McCormick:
That major challenge lies ahead, and we will need to address it in the forthcoming spending rounds — not just the one to come through in the next few months. It is a societal trend, and the numbers will increase. I am very conscious of the concerns of families who need to know that the care that they can currently give to their loved one will be there for their lifetime. It is a significant challenge, and we must ensure that we plan carefully for it. The regional resettlement team has been considering that issue, and we need to continuously go from the broad concept that Bamford mentions, which is the estimated long-term trend, to specifics that will come through the

detailed working of trusts and commissioners as they look at the needs of their communities and become aware of the care. That links to the enormous contribution from carers in our society that was mentioned earlier. That is very significant, and it needs to be planned for and built into the spending plans going forward, and that will be challenging.

Dr Briscoe:

I want to emphasise that considerable work has been done in the South Eastern Trust in relation to succession planning. It has carried out detailed work in respect of its broader learning disability community in its area. A number of things have come out of that: the importance of respite to promote the establishment of a pathway to permanence; the development of independent living skills and planned activities that we talked about; and the focus on supporting individuals through the formal process. Exemplar work has been done in relation to succession planning in that area.

In addition, the Department has issued guidance and put in place a carers' assessment tool as a fundamental part of the work that is being taken forward on the needs of carers. Guidance has been produced, and there is now a regional tool for the assessment of not only the individual but the carers.

Mr Donaldson:

In the constituency that Mr Lunn, Mr Craig and I represent, the absence of respite support and facilities is a matter of great concern to families. I accept what you say about the work that is being done, but I have not yet seen any evidence of firm proposals to provide respite facilities, particularly for elderly carers in the South Eastern Trust, and I am sure that that extends to other parts of Northern Ireland. The evidence that is coming through shows that the lack of respite support is a major issue for the families of individuals who are being resettled from Muckamore Abbey Hospital or other facilities and for those families whose loved ones have remained with them in the community.

I have met elderly carers who are their wits' end, frankly, and whose mental and physical health has been damaged significantly by the stress and pressure that comes from looking after an ageing child with learning disabilities — someone who is, in effect, and adult. It is an enormous challenge for them, yet very few respite facilities are available.

To what extent have trusts and the Department carried out periodic surveys to assess carers' needs to ensure that sufficient respite care is being delivered for them. At the moment, although there may be planning, there is a huge gap, and the actual provision is very poor.

Dr Briscoe:
I acknowledge what you say about the importance of respite. From a ministerial point of view, respite has a priority, and it has been embedded in our priorities for action over the past three years. Those priorities for action outline specific targets for the provision of respite care.

We have done considerable work with the Health and Social Care Board to standardise definitions of respite and the environments in which respite can take place to ensure that there is clear understanding of the way in which investment changes services on the ground. The Health and Social Care Board will continue to monitor that work regularly as we move forward with the priorities for action target.

Mr Donaldson:
Could you provide the Committee with an assessment of the current respite provision in each of the trusts in Northern Ireland?

Dr Briscoe:
As a consequence of its status as a priority for action, the first returns on respite will be available within the next couple of weeks.

Mr Donaldson:
It would be helpful for the Committee to have that information.

Paragraph 3·26 of the NIAO report also refers to Bamford's assessment that there could be an additional 1,600 people with learning disabilities living at home with families or carers. What is your assessment of the way in which respite care will be shaped and resourced to best meet the needs of the carers and families who already need the provision, in addition to the people who may need to be resettled in the future? I accept your point that the Department has embedded respite care as a priority, and the Committee welcomes that. Priorities can be set, but resourcing is crucial. What work has the Department done in response to that Bamford assessment?

Dr Briscoe:

We talked previously about the level of additional investment for learning disability that was secured through the comprehensive spending review process. Respite care receives a higher level of additional investment than every other aspect of the learning disability programme apart from resettlement. I acknowledge that respite care can take many different forms, such as residential or domiciliary respite care and recreational or leisure respite care.

The model of respite care will change as we move forward. There will be no one-size-fits-all approach, of course, but the predominant emphasis will be on securing respite that promotes social inclusion. Martin talked about people with learning disabilities engaging with the community, through attending leisure centres and so on, to give carers a break. However, that recreational or leisure respite care must provide a meaningful experience for the individual with learning difficulties. In general terms, that approach has to be about purposeful living.

Mr Donaldson:

I accept and endorse the good intention behind that approach. However, to what extent can you take forward social inclusion for people who may have been in a residential facility for many years and for whom going back into the community is a major challenge? The extent to which you can deliver the aspired-to social inclusion remains to be seen.

Having read the NIAO report and the Bamford review, it strikes me that there is a big gap between the Department's policy to resettle long-stay patients from learning disability hospitals in the community and the level of respite support that is provided to the families who receive those individuals back into the family home. There seems to be a huge gap between the Department's policy of reintegration and rehabilitation and the provision of the means and support that families need to be able to cope in those circumstances. That is without prejudice to whether or not resettlement is the right thing to do in the first place, which is a whole other story.

Dr McCormick:

This issue relates to the process by which resettlement is handled sensitively and thoughtfully, individual by individual, as Maura said in answer to previous questions, to allow the family to be sure that it is the right thing to do through trialling the new placement for several nights as a way of getting used to the change. That requires investment, time and attention over many months to prepare the way.

You are absolutely right to say that there are gaps between what we know to be the right thing to do, the full extent of planning for both resettlement and respite and the ultimate level of need in the community. There is a major issue there. We will have to find imaginative solutions and the best way to use available resources to draw on every sector that can contribute to resettlement. That is our absolute responsibility: to advance this, together with other agencies and Departments, and find a solution that is acceptable to society. What we have at present is deficient, and that is a major issue for us.

Mr Martin Bradley:
This is still very much work in progress. However, as we move more resources into the community, there will be more infrastructure to provide more realistic respite care. In addition to that, some of the hospitals are now seriously considering the allocation of beds for respite.

You also raise another issue: how good our resettlement schemes are, and whether families are prepared for resettlement. All those issues have to be dealt with sensitively, and we have to take this work forward one step at a time. We will get there over time, even though it will be very challenging.

Mr Lunn:
You referred to paragraph 3.18, which relates to the supported-living schemes. It says that out of the 36 schemes in development for people with learning difficulties, 16 of them are designed to provide for 10 people, whereas the Bamford review recommends five as the optimum number. Will those schemes progress regardless of Bamford's recommendation, or have you taken the decision to abandon them?

Dr McCormick:
This has come up in previous discussion. It is important to go back to the reason underlying Bamford's reference to living units of no more than five individuals. That ensures that a clear distinction is drawn between the institutional setting in the hospitals — and that is a more significant difficulty in the two older hospitals, Longstone Hospital and Muckamore Abbey Hospital — and the community resettlement environment that is proposed.

There are examples of where provision for more than five people with learning difficulties works well. Orchard House works well; I visited it earlier this month, and it is a working model. The clients to whom I spoke in Orchard House were content in that environment. It provides a combination of privacy and identity. The residents have space that is clearly theirs, and there is also a social context. As members will have seen from the DVD, and some may have visited it, Orchard House provides a working model. Bamford made it clear that such accommodation should be as close to a normal community environment as is possible. If we accommodate more than five people with learning difficulties, we must question whether we are exchanging one institution for another. Orchard House will say that that is not the case.

However, we need to be careful. If we are to take those projects forward, any proposed schemes must be worked on in conjunction with DSD and the housing sector. Maura may have specific details on how those schemes are being progressed.

Dr Briscoe:

It is important that I point out that I understand your question. First, some supported housing schemes may not be newbuilds but refurbishments. Secondly, one has to highlight that, for some individuals, it is appropriate to have more than five people in a scheme. Those individuals may have lived for many years on a ward with their friends and colleagues, and, therefore, it may be in their best interests to have more than five people in a scheme.

How a scheme is defined is also important. For example, there are three houses plus a couple of flats in Rigby Close. That scheme provides support for around 19 people. However, those people are spread throughout three houses and a number of flats. Indeed, in that scheme, some individuals live in their own house and are supported by carers. Therefore, you are right to say that not all schemes comply with the requirement to have five people in a house. As we move forward, the trend will be to commission schemes on the basis that there would be no more than five people in a house. However, that does not mean that a scheme as a whole may not include more people, as is the case, for example, in Orchard House, Rigby Close and Ralph Close.

Mr Lunn:

Five-person units for a group of 15 or 20 people could be provided, and that would not prejudice anybody’s privacy or living conditions. However, have you decided to abandon any of the 36 proposed schemes?

Dr Briscoe:

I do not know the details of the 16 schemes to which the report refers.

Dr McCormick:

I do not think that we have, but we can check that and come back to the Committee. I am sorry that we do not have that information to hand.

Mr Lunn:

You have perhaps already answered this question. Paragraph 3.24 refers to the need for a greater range of housing to meet the diverse community care needs of long-stay patients. It also notes that the Bamford review points out that there is a low level of home ownership among people with learning disability. That does not really surprise me. Do you have any comment to make on that?

Dr McCormick:

In visits that I have made, I have seen some good examples of situations in which a learning disability client has a tenancy and, therefore, has a sense of identity that results. In that sense, it is their tenancy and their property. However, as you pointed out, the Bamford review states that not many of our learning disability clients own their homes. The aim is to provide as independent and normal a life as possible for the individuals concerned. We should be trying to ensure that the full range of an individual's health and social care needs are addressed by the support package, the placement, and their environment. There are distinct advantages to some of the tenancy arrangements that have been put forward. However, the process has to be done carefully and thoughtfully and according to the needs of, and opportunities for, each client.

Mr Lunn:

Patsy referred to the involvement of the private sector in at least one scheme. Is that a relatively rare arrangement? To what extent do you try to involve the private and voluntary sectors?

Dr Briscoe:

The voluntary sector is involved, and, indeed, many schemes are carried out with housing associations. The use of the private sector is relatively uncommon.

Mr Lunn:

Given the present rate of progress, is there any possibility that the resettlement programme could be completed within a reasonable timescale?

Dr McCormick:

The rate of progress is not as fast as we would want it to be. We have a target to complete the programme by 2013 and to reach the steady situation whereby hospitals will be available almost exclusively for assessment and treatment. We want to continue to apply every possible effort to achieve that as soon as possible. The 2013 target is challenging, but we are clear that it is the right thing to do. We are also clear that that has to be done in accordance with the identified and considered needs of each individual and with great involvement, consultation and engagement with families to ensure that the right thing is done for their family member. We are not imposing solutions. We never take the view that one size fits all or that we have predetermined ways of doing things. Work on the programme must be done thoughtfully and genuinely.

Mr Martin Bradley:

I know that progress has been slow. However, even the Audit Office's report acknowledges that in the 10 years prior to 2002, the number of clients who were in hospital as long-stay patients fell by 50%. I am not saying that that is a rip-roaring success, but I should point out that work to that end has been on the go for quite some time. Indeed, the numbers fell from 872 to 453 prior to 2002. Since 2002, we have been trying to keep on moving and to reduce the numbers further.

Mr Craig:

By and large, we have been looking at how to get people resettled. I want to look at another touchy subject, which may be the other side of the matter. Paragraph 4.5 highlights the fact that some people believe genuinely and strongly that the level of care that Muckamore Abbey Hospital provides at present cannot be replicated or bettered in any way in the community. They are a strong band of people, and they have lobbied just about every MLA at one time or another. What steps has the Department taken to try and allay those genuine fears?

Dr McCormick:

I understand and respect the views of families and friends who see the status quo as being the best situation for their loved one. That is understandable, given the efforts, commitment and quality of care that is provided. It is recognised and understood that there are advantages in the facilities that are available at Muckamore Abbey Hospital. Reassurance has been given that there is no question of imposing change. That will not be considered. However, we have a responsibility to try to provide the very best for each individual. Having visited several community facilities that were developed, designed and implemented over the past few years, the clear view is that there are better opportunities for each and every client who is in a long-stay hospital. Successful resettlements have resulted from some very challenging cases; it is not impossible for any client. However, that is not to say that resettlement is the best thing. We must look carefully at the client's wishes, the wishes of their families and at the clinical view to see what is best in a particular context. We engage fully with the Friends of Muckamore in the resettlement work, they are full participants in that work, and their views are respected and understood.

It has been recognsied that that view is entirely reasonable, legitimate and understandable. It is the Department's responsibility to stand over its obligation to provide equal lives and equal rights. The equal rights issue means that the resettlement policy must be firm and clear and that the Department must accept its obligation to deliver the policy. However, resettlement must be done through consultation, not imposition, and it must always be done in conjunction with families. It is clear that that is the right way forward.

That is an important assurance to give. Undoubtedly, there will need to be some persuasion, and people will be encouraged to look at and consider the options. However, the Department can cite some very successful examples that show what is possible in a community context. Maura mentioned the example of Rigby Close, in which a gentleman with very challenging needs has been successfully resettled. Additionally, the build at Ralph Close, which is nearly finished, on the Gransha site in Londonderry will provide 16 new units. It is a very well-designed facility, and it will enable the right level of support from staff and ensure that staff have the correct environment for their working lives. That model will present great opportunities, and if we could only reproduce it quicker and more extensively, resettlement could be addressed more fully.

In the meantime, the Department will respect and work with those who feel that hospitals are the best place for the people in question. That view exists as a result of the high levels of commitment and care that hospital staff provide. My colleagues paid tribute to those staff today, and it is right to acknowledge their efforts.

Mr Craig:

Paragraph 4.9 considers the issue of undue pressure being put on individuals to resettle. What genuine assurances can you give me that no undue pressure is placed on anyone to force them to resettle? How careful is the Department in addressing that issue? I am aware that whenever we are dealing with the learning disabled, they have a much lower tolerance threshold and they will accept things much more easily than a tough old hack like me.

Dr McCormick:

I can give an absolute commitment that no undue pressure will be put on individuals to resettle, and there will not be any imposition. There will be a genuine persuasion to identify the value of the different opportunities that are available, but that is the limit. No health and social care organisation would go as far as imposing on people or putting undue pressure on them. That is the Department's guarantee.

Mr Craig:

My last question deals with something that is a bit of a conundrum for the Department. Paragraph 4.9 indicates that a guarantee was given to the families concerned that no one would be forced to resettle against their wishes. That does not fit with the Department's wish to resettle everyone. How will the Department ultimately find a solution to or a balance for that?

Dr McCormick:

The Department has not yet reached that stage, because more people are eager and willing to be resettled than it can currently provide for. There may come a point when only those who remain in hospital are those who want to stay, and the Department will need to consider what to do at that point. However, I stand by what I said earlier: there will be no imposed solution, because the first and most important principle is the rights of the individual. They should be treated and respected as individuals. That involves respecting their wishes absolutely.

The Chairperson:

OK. Thank you. It has been a long session, and you will be pleased to know that that brings an end to the questions. Progress has been made, and the Committee has requested some further information from the Department. It will be keeping a focus on the issue in the time ahead.

I also thank all those in the Public Gallery for their attendance today; they all obviously have a great interest in this issue. I also thank Hansard.