(ix) ***Better Information for People with a Learning Disability and their Families and Carers***
Purchasers and providers should provide better information in various media about the range of services available, and the functions and responsibilities of the different bodies involved in their provision.

(x) ***Children with Complex Disabilities***
Trusts should cooperate with education authorities to ensure comprehensive provision within daily travelling time is made for children with complex disabilities during and out of school hours. This should include provision for children with complex needs who are at present having to board at specialist hospitals during the week, and children for whom absence of support during school holidays creates problems.

(xi) ***Adults with Complex Needs***
Boards and Trusts should cooperate in making specialist provision for people with a learning disability who have additional complex needs. The numbers and location of such people make it impractical for each Trust to provide specialist care for them.

11 CHAPTER ELEVEN MENTAL HEALTH

HEALTH
& WELLBEING:
INTO THE NEXT
MILLENNIUM

The Issues

11.1 Mental health services are in a period of change. There is considerable potential for development to meet the assessed needs of patients and clients more effectively. In recent years there has been significant progress in the development of community-based mental health services and detailed evaluation has concluded that the policy of relocating long-stay patients outside hospital has been worthwhile for those people discharged to date.

11.2 The key challenge for the next strategic planning period is to build on the advances which have been made and establish a framework which will enable the pace of development to continue into the next century. This framework should take account of recent guidance on the development of mental health services, including the Clinical Standards Advisory Group report *Schizophrenia*[1] and the Audit Commission's *Finding a Place: Review of Mental Health Services for Adults*[2].

11.3 Mental health problems are leading causes of illness, distress and disability in Northern Ireland. It is estimated that:-

- over 100,000 people seen by GPs each year will be diagnosed as having some form of mental illness; and
- over 11,000 will be referred to outpatient clinics in psychiatry.

11.4 *Targets*

By 1998 an agreed approach to outcomes measurement should be in place for mental health services within Northern Ireland and all services in the statutory and independent sectors should be monitored against common quality standards.

By 1998 Boards should assess the needs of their population and determine the future requirements for specialist hospital services for people with a mental illness. The strategic goal should be that long-term, institutional care should no longer be provided in traditional psychiatric hospital environments.

By 2002 a medium secure unit should be established in Northern Ireland and comprehensive arrangements should be in place so that, where appropriate, people with mental illness can be diverted from the criminal justice system.

11.5 **Action**

(i) *Involving Users and Carers*

People with mental illness and their families need to be involved in the process of planning the services they will use. Purchasers and providers should build on the experience of initiatives already under way in involving users and carers in the design of services for the future.

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[1] CLINICAL STANDARDS ADVISORY GROUP.
Schizophrenia.
HMSO, 1995.

[2] AUDIT COMMISSION.
Finding a Place: Review of Mental Health Services for Adults.
HMSO, 1994.

(ii) *Assessment of Need*

There is a lack of basic information on the size of the burden of mental illness in Northern Ireland and the Department should support research to address this gap as part of a comprehensive strategy of research on mental health issues.

(iii) *Health Promotion*

By 1997 a regional working group on mental health promotion should be established as indicated in paragraph 3.18. It should be a multi sectoral group tasked with developing a framework for action on mental health. It should aim to increase understanding about mental health, develop education programmes and plan a media strategy to support the framework.

(iv) *Primary Care*

The primary care team has an important role to play in the management of mental illness. Professional members of primary care teams should be aware of the structure and delivery of community mental health services in their areas and should seek to develop a working relationship with members of community mental health service teams responsible for delivering services in their practice areas. Purchasers should determine what actions could be taken to support primary care teams and increase their effectiveness in carrying out their role. Purchasers and providers should develop close integration between primary and secondary care services in the delivery of mental health care.

(v) *Community Mental Health Services*

In future the main focus for delivery of secondary mental health services should become the community mental health team. Purchasers and providers should determine the state of development of community mental health services in localities within their area, identify gaps and deficiencies and establish plans to build a comprehensive pattern for services for the future.

(vi) *Medication*

Particular attention needs to be given to those individuals with profound and enduring mental illness who are prescribed complex treatment regimes. Patients and carers need to have access to credible, intelligible information and advice regarding their medication.

(vii) *Hospital Services for Mental Illness*

The continuing reduction in the long-stay component of hospital care, together with the potential for devolution of acute services to more accessible local settings, inevitably brings into question the future of existing mental illness hospitals.

(viii) *Specialist Services*

A comprehensive pattern of mental health services requires the development of specialist services to run in parallel with the build up in community mental health services. Purchasers should assess the need for further development in specialist services including child and adolescent, forensic and psychotherapy services and services for people with sensory disability.

12 CHAPTER TWELVE CIRCULATORY DISEASES

HEALTH
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The Issues

12.1 Diseases of the circulatory system, mainly coronary heart disease and stroke, remain the commonest cause of death in males and females, accounting for 38% of all deaths and 34% of deaths of people under 75 years of age. While death rates from these conditions are falling in Northern Ireland, variations in mortality persist between different parts of the province and between different social classes. During the period of the last strategy, major progress was made in reducing waiting times for cardiac surgery, so that by the end of December 1994 only 40 people were waiting longer than 12 months for cardiac surgery compared to 639 in September 1991. There are currently over 1,300 cardiac operations performed in Northern Ireland each year. As indicated in the Chief Medical Officer's 1992 report on cardiac surgery[1], the demand for cardiac surgery in Northern Ireland will be kept under continuing review.

12.2 Peripheral vascular disease shares the same underlying pathological process as coronary heart disease and similar preventive measures apply. While it is unusual for peripheral vascular disease to cause death directly, patients with this condition have a greater risk of dying from other circulatory diseases such as coronary heart disease and stroke. It is also associated with significant ill health such as intermittent claudication, aneurysms and renal artery disease.

12.3 A combination of measures is required to tackle circulatory diseases. These include:-

- preventive programmes for the general population and individuals at high risk of developing disease;
- treatment strategies, including effective medication management, compliance monitoring and advice and therapeutic outcome monitoring to ensure the effective treatment of illness when it occurs; and
- effective liaison arrangements between hospital and community services.

12.4 The primary care team is central to any strategy for reducing death and ill health through a combination of health promotion, risk factor detection and treatment and slowing the progress of the disease in an affected individual. The increasing numbers of elderly patients will result in increasing demand for secondary prevention services and therapeutic interventions such as thrombolysis, coronary artery bypass grafts and femoral popliteal bypass grafts.

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[1] DHSS.
Review of Cardiac Surgery in Northern Ireland.
Department of Health and Social Services, 1992.

12.5 *Targets*

By 2002 to reduce the death rate from coronary heart disease among 35-64 year olds by 40%.

By 2000 to reduce the death rate from coronary heart disease among 65-74 year olds by 30%.

By 2000 to reduce the death rate from stroke among 15-74 year olds by 40%.

Objective

To ensure that all stroke patients have a multidisciplinary assessment either before discharge from hospital or in the community.

12.6 Action

(i) *Health Promotion and Disease Prevention*

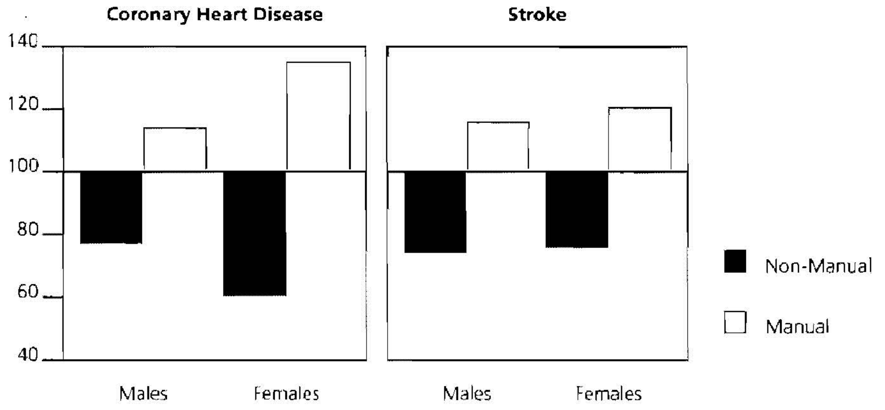
Health promotion and disease prevention are central to any strategy for reducing death and ill health from circulatory diseases. These include providing information and support for individuals who wish to choose healthy lifestyles, developing public policies which support an environment conducive to health and improving preventive services which identify and treat individuals with risk factors for coronary heart disease and stroke. Training in simple cardiopulmonary resuscitation for relatives and the general population has been shown to be effective in improving survival following a cardiac arrest in the community.

(ii) *Variations in Mortality Rates*

The known variations in mortality between Health and Social Services Boards in Northern Ireland and different social classes should be recognised and addressed by all purchasers. For instance, death rates from coronary heart disease and stroke are higher in manual than in non-manual socioeconomic groups (Figure 12.1). Purchasers should therefore ensure that interventions, including health promotion measures, are designed to secure **both** absolute improvements in the health of the population as a whole **and** reductions in inequalities within the population. The process of taking action against coronary heart disease and stroke in specific geographical areas and for high risk groups should be monitored and evaluated by commissioners (see paragraph 4.20) as part of their purchasing strategies for achieving the targets set out in the Regional Strategy.

Figure 12.1

***STANDARDISED DEATH RATES BY GENDER AND *SOCIOECONOMIC GROUP 1989-1994**



Source: REGISTRAR GENERAL NI

*See Glossary

(iii) *Developing Clinical Standards*

Purchasers and providers of services should develop by 1998 explicit agreement on clinical standards governing:-

- investigations which should be carried out prior to referral to regional cardiology services;
- guidelines for angiography and angioplasty; and
- guidelines for assessing the severity of cardiac disease and the clinical urgency of patients requiring coronary artery bypass surgery.

This will be facilitated by the ongoing work of the Clinical Resource Efficiency Support Team (CREST).

(iv) *Cardiac Rehabilitation*

Cardiac rehabilitation improves patients' quality of life and can significantly lower the risk of death following a heart attack. Effective communication arrangements should be in place between hospital services and primary care following the discharge of patients after a coronary event. This is particularly important in the area of cardiac rehabilitation, where increasingly this task will be undertaken by the primary care team. Cardiac rehabilitation programmes are carried out by multidisciplinary teams and focus on three main areas:-

- exercise training and activity prescription;
- risk factor modification, including secondary prevention, drug therapy and treatment adherence; and
- psychosocial and vocational evaluation and counselling.

The content of cardiac rehabilitation programmes should be standardised across primary and secondary care. They should include a common dataset developed by a multidisciplinary group which would then form the basis of an annual audit which is forwarded to the purchaser.

(v) *Effective Response*

Patients with an obvious acute heart attack should expect to receive thrombolytic treatment within ninety minutes of alerting medical and paramedical services. This will require an integrated response from GPs, ambulance personnel and hospital staff. Aspirin therapy should be started promptly and as soon as a heart attack is suspected. If confirmed, aspirin should be continued as long-term therapy. Purchasers will expect unnecessary delays in receiving thrombolysis to be monitored through medical audit.

(vi) *Coordinated Care*

Coordinated stroke care has been shown to improve outcomes for patients and their carers. Purchasers should ensure that guidelines are in place to identify arrangements for the admission, treatment, rehabilitation, discharge and follow up in the community of stroke patients. The needs of young stroke patients ie those under 65, should be clearly outlined in contracts. Purchasers should ensure that arrangements are in place for the urgent assessment of acute cerebrovascular events such as stroke and transient ischaemic attacks.

13

CHAPTER THIRTEEN CANCERS

HEALTH
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The Issues

13.1 There are approximately 8,000 new cases of cancer diagnosed in Northern Ireland each year and the incidence is rising, mainly because of the increasing number of elderly people in the population. If this is taken into account by age standardisation, only tobacco-related cancers are increasing. It is estimated that tobacco will kill one in six of the population unless its consumption is controlled. Other cancers, such as stomach cancer, are decreasing due to better availability of fresh produce. Cancer is second only to heart disease as a major cause of death, accounting for 3,595 deaths in I994 - 1,854 in men and 1,741 in women.

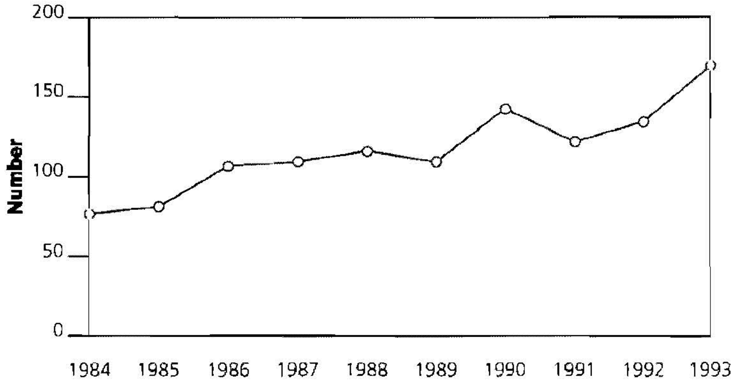
13.2 Tobacco smoking has been clearly identified as the greatest single contributing factor to cancers, causing 30% of all cancer deaths and 90% of lung cancer deaths. There were 766 deaths from lung cancer in 1994, 510 males and 256 females. The rate of new cases and death is increasing in females. Survival time with lung cancer is short. Of those with lung cancer diagnosed before the age of 45 only one in six will be alive five years later. For those aged 75, only one in twenty will survive five years. Discouraging the use of tobacco is the way to control tobacco-related cancers.

13.3 Breast cancer is the commonest cause of death in women aged 30 to 64. Of the 338 female deaths from breast cancer in 1994, 158 occurred in women in this age group. Cancer of the cervix is the twelfth most common cause of cancer death in women in Northern Ireland and accounted for an average of 37 deaths each year between 1989 and 1993. Colorectal cancer is also a major cause of death in men and women. Each year over 300 men and 265 women are diagnosed as having colorectal cancer. Each year this disease causes between 400 and 500 deaths; in 1994 there were 438 deaths from this type of cancer.

13.4 Many hundreds of people have skin cancers removed each year. Most of these are cured. One form of skin cancer, malignant melanoma, however has a high death rate. The numbers of this serious cancer have increased, from 77 cases in 1984 to 171 in 1993. (Figure 13.1).

Figure 13.1

INCIDENCE OF CUTANEOUS MALIGNANT MELANOMA IN NORTHERN IRELAND



Source: WOLSSON FOUNDATION REPORT

13.5 There are approximately 60 new cases of oral cancer diagnosed in Northern Ireland each year. Early diagnosis is important. The five year survival rate for all oral cancers is 40% but increases to 80% with early diagnosis.

13.6 Cancer of the prostate gland accounts for almost 190 deaths each year in Northern Ireland. This cancer occurs mainly in older men. Increasing numbers of prostatic cancer are being diagnosed as the population ages and as a result of better diagnostic techniques. This results in some small non-life threatening cancers being discovered. A multinational trial is under way to determine whether a blood test for prostatic specific antigens (PSA) is useful for screening. This test has been found to assist with therapeutic decision making and long term management of patients, but the issue of screening men without symptoms is still controversial, with a high level of false positives. There is no evidence at this stage that there would be improved life expectancy from widespread adoption of this test.

13.7 Testicular cancer is a highly treatable often curable cancer occurring mainly in young and middle-aged men. Information on deaths is a poor indication of numbers of cancers.

13.8 Health gain in cancer will be achieved by an increased emphasis on:-

- Prevention, by addressing lifestyle factors.
- Early diagnosis, by screening and raised community awareness of symptoms.
- Enhancing treatment outcomes through ensuring a high level of expertise and a well-organised service.
- Enhancing quality of life through a high quality palliative care service in the community, hospitals and hospices. This includes increased emphasis on counselling and support services which are locally responsive and available outside of normal working hours.

Research plays an important role in uncovering new causes of disease, evaluating methods of prevention and measuring effects of new treatments and quantifying outcomes.

13.9 Recent developments will provide opportunities for enhancement of health and social wellbeing in relation to cancer. These include:-

- The re-establishment of the Northern Ireland Cancer Registry in the Department of Epidemiology and Public Health at Queen's University, Belfast.
- The debate on the delivery of cancer services prompted by the report *A Policy Framework for Commissioning Cancer Services* (see paragraph 13.11(iv)).
- Research into genetic causes of cancer is promising for approximately 10% of patients with selected cancers, eg breast cancer. At this stage the benefits for therapy are doubtful. The genetic service has received regional monies to provide an enhanced service.
- Therapy advances such as pre-surgical treatment and high dose therapies with autologous stem cell transplantation in selected cases.
- Northern Ireland is now covered by a mammographic breast screening service for women aged 50-64 and a population based call and re-call cervical screening service for women aged 20-64.

13.10 ***Targets***

By 1998 an integrated strategy for the prevention of cancer should be developed.

By 1998 a strategy for the prevention, diagnosis and treatment of malignant melanoma should be developed.

By 2010 to reduce the death rate from lung cancer by at least 30% in men aged under 75 and 15% in women aged under 75.

By 2002 to reduce the death rate from breast cancer in women aged 50-69 by at least 25%.

By 2002 to reduce the incidence of invasive cervical cancer by at least 20% in women aged 20 and over.

13.11 Action

(i) An *Integrated Strategy for the Prevention of Cancer*

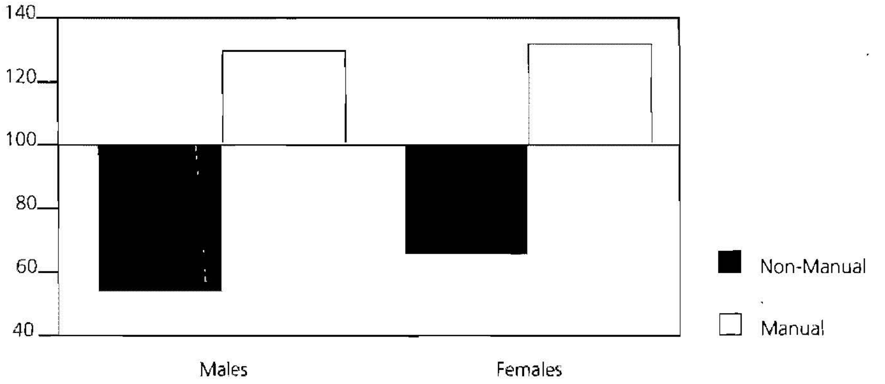
The Department should commission a group of experts to liaise with professionals to develop, by 1997, an integrated strategy for the prevention of cancer.

(ii)*Variations in Mortality Rates*

There are geographic and socioeconomic variations in death rates for cancer. For example, death rates for most cancers, including lung cancer (Figure 13.2), are higher in manual than in non-manual socioeconomic groups and mirror the variations in associated risk factors outlined in Chapter 3. However, death rates for breast cancer and, to a lesser extent, skin cancer are unusual in that they are higher in non-manual groups. In any event, purchasers should ensure that interventions, including health promotion measures, are designed to secure **both** absolute improvements in the health of the population as a whole **and** reductions in inequalities within the population. The interventions should be monitored and evaluated as in paragraph 4.20.

Figure 13.2

***STANDARDISED DEATH RATES FOR LUNG CANCER BY GENDER AND *SOCIOECONOMIC GROUP 1989-1994**



Source: REGISTRAR GENERAL NI

*See Glossary

(iii) *Controlling Tobacco Use*

Tobacco control should remain on the agenda of the Inter-Departmental Group on Health. Research to monitor tobacco use and identify strategies for its control should be promoted, especially among young people. Active health promotion programmes should be pursued which address prevention of smoking in young people, smoking cessation and control of environmental tobacco smoke.

(iv) *Commissioning Cancer Services*

In April 1995, following consultation, the Government accepted the report entitled *A Policy Framework for Commissioning Cancer Services*. The report, which was produced by the Expert Advisory Group on Cancer set up by the Chief Medical Officers of England and Wales, recommended a number of fundamental changes to the way in which cancer services are organised. In July 1995 DHSS set up a Cancer Working Group, under the chairmanship of the Chief Medical Officer, to consider the implications of the report for the development of cancer services in Northern Ireland and, amongst other things, to make recommendations as to how cancer services can be improved. The Group's report was published for consultation in May 1996.

(v) *Participation in Audit and Involvement in Clinical Trials*

Quality of care can be enhanced by participation in audit and involvement in clinical trials. From 1997 onwards, purchasers should require providers to audit participation in clinical trials and should ensure that information about such trials and their outcomes is widely disseminated.

(vi) *Counselling and Support for People with Cancer*

Evidence has shown the benefits of counselling and support for people with cancer in terms of survival and quality of life. Counselling and support for families and carers are also important. Purchasers should therefore include in contracts from 1997 onwards the provision of counselling and support, including anxiety relieving techniques, for people with cancer and their families and carers.

(vii) *Screening Programmes*

The Department should commission work to assure the quality of breast cancer and cervical cancer screening programmes and should endeavour to reach out to women by raising awareness of screening services.

(viii) *Preventing and Controlling Malignant Melanoma*

There has been a worrying increase over the past twenty years in the incidence of this type of cancer. If this trend is to be reversed it is vital that the Department takes the lead in developing a strategy for preventing and controlling malignant melanoma. Providers, for their part, should offer advice about care in the sun as part of their health promotion services and should ensure that protocols for the early detection and early referral of suspected cases are adhered to. The postgraduate programmes for health professionals should address training in relation to the prevention, detection and treatment of malignant melanoma.

13.13 The table below highlights the levels and main causes of seven common forms of cancer, details preventive steps to avoid occurrence and describes methods which assist in early diagnosis and assessment and treatment.

COMMON TYPES OF CANCER

Type of Cancer	Levels & Causes	Prevention & Promotion	Diagnosis & Assessment	Treatment
Lung 28% male cancer deaths. 510 in 1994 15% female cancer deaths. 256 in 1994.	Most commonly occurring cancer in NI. Almost 90% of all lung cancer is smoking related. 5 year survival is low at 5-20% depending on age and stage. Environmental tobacco smoke also contributes to lung cancer.	Adopt comprehensive measures to reduce smoking. Address smoking in women, especially low income groups. Stopping smoking would result in 600 fewer deaths from lung cancer and 3,000 lives overall. Reduce environmental tobacco smoke.	The majority of patients should be assessed by a chest physician as good control of symptoms can enhance quality of life.	Specialist treatment accessible to patients. Encourage enrolment in clinical trials.
Breast 338 deaths in 1994	Lifestyle factors, such as diet, have been identified as probable causal factors. Hereditary factors, such as the breast cancer gene, may account for some cases (less than 10%).	Possibly reduce dietary fat intake. Possible prevention by adjuvant therapy eg Tamoxifen	Encourage population awareness. Compliance with Breast Screening Programme in excess of 75%.	Encourage treatment by specialists. Encourage counselling and support. Encourage enrolment in clinical trials.
Colo-Rectal 438 deaths in 1994	A proportion of all colo-rectal cancer arises in people with heredity or familial dispositions. Evidence also suggests links with high fat - low roughage diet.	Increase fibre, fruit and vegetable consumption in diet. Raise awareness of symptoms	Document family histories in all new cases. Surveillance programmes for those at high risk. Diagnosis and assessment should take account of the recognised proximal shift in this disease.	Encourage treatment by specialists. Encourage enrolment in clinical trials.
Cervix 38 deaths in 1994	Sexual behaviour is a major cause of the cancer. Female smokers are also more likely to develop an abnormal smear.	Modification of sexual behaviour. Improvement in sex education in schools. Stop smoking.	Compliance with cervical cancer screening programme. Training in diagnosis.	Adherence to protocols.
Malignant Melanoma 36 deaths in 1994	Incidence is rising rapidly. Caused by exposure to ultra-violet light. People with fair hair, fair skin and multiple moles are particularly at risk.	Avoid sunburn. Barrier creams and protective clothing help.	The public should be made aware of abnormal symptoms and encouraged to seek immediate medical advice. Training of GPs.	Encourage treatment by specialists. Encourage enrolment in clinical trials.
Oral Cancers 51 deaths in 1994	Death rates rising. Tobacco, alcohol and poor oral hygiene are main risk factors. Occurs in males twice as often as females.	Control of tobacco use as above. Maintaining alcohol consumption within the recommended sensible drinking limits. Increase awareness of symptoms	Encourage attendance at dentist and continuing registration. Training in diagnosis.	Encourage treatment by specialists. Encourage enrolment in clinical trials.
Ovarian Cancers 90 deaths in 1994	5 year survival is 30%. Germ cell type which occurs in early life has an improved prognosis with early management.	Means of early detection not yet selective or specific enough for general population screening but appropriate for those with high familial risk.		Encourage treatment by specialists. Encourage enrolment in clinical trials.

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14 CHAPTER FOURTEEN OTHER NON-COMMUNICABLE DISEASES

HEALTH
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The Issues

14.1 As well as adding years to life by preventing premature death, this strategy seeks to add life to years by improving the quality of life for people in Northern Ireland, including those who suffer from long-term illnesses. This key area concentrates on three specific conditions - diabetes, respiratory diseases and back pain - which account for a substantial proportion of long-term illness in Northern Ireland, but many of the messages apply equally to other chronic conditions.

14.2 The organisation of services for people with long-term illnesses is complex, involving both hospital and primary care teams, the patients themselves and their families. It is essential that services are coordinated to ensure effective continuity of care with appropriate access to specialist services.

14.3 **Diabetes mellitus** and its complications can cause severe problems for affected individuals, who constitute 1.5-2% of the population, and their families. The impact of diabetes on people's daily life and the chances of complications can be reduced through the provision of well-organised integrated care, the education of patients and their families and the early detection and treatment of complications. The main complications of diabetes are:-

- eye disease;
- complications within the nervous system;
- kidney disease;
- peripheral vascular disease; and
- cardiovascular disease.

Under the chronic disease management scheme, GPs receive payment for providing diabetes management programmes[1] within their practices. In 1995, 75% of Northern Ireland GPs qualified for payment. The St Vincent Declaration (1989) set targets for the reduction of complications of diabetes. A taskforce on diabetes has been set up to consider how the targets can be addressed in Northern Ireland.

14.4 **Respiratory diseases** are the fourth most common cause of long standing illness and are also a major contributor to premature death. They are the most common cause for consulting a GP and are a major component of childhood illness. There is significant potential for disease prevention and health promotion, and treatments are generally effective. Respiratory diseases include:-

- serious, non-reversible illness such as chronic bronchitis, cystic fibrosis, emphysema and pneumoconiosis;
- treatable and reversible conditions such as asthma, acute bronchitis and pneumonia; and
- minor self-limiting episodes including coughs and colds.

Under the disease management scheme mentioned in paragraph 14.3, GPs also receive payment for providing asthma management programmes. In 1995, 85% of GPs in Northern Ireland qualified for payment.

14.5 **Back pain** is a major cause of avoidable ill health, and one of the most frequent causes of work loss, particularly during the productive middle years of adult life. This in turn impacts on the community as a whole, on employers and on the economy. There is growing evidence to show that the problem is amenable to preventive and curative action, particularly during the first few months following onset, and that early effective action will prevent disability and incapacity.

14.6 *Objectives*

Purchasers should ensure that treatment protocols are developed for major chronic illnesses.

The Department, purchasers and providers should seek to promote best practice based on professional standards and on evidence from research and clinical audit.

The Department, the Health Promotion Agency, purchasers and providers should work with other relevant agencies to ensure a healthier and safer environment.

14.7 Action

(i) *Diabetes*

- Information is essential for measuring and monitoring the health of people with diabetes and the effectiveness of services for them. Purchasers should coordinate the development of Board-wide diabetes registers which collate information from primary and secondary care to assist in monitoring the health of patients with diabetes.

- Purchasers should develop local strategies for diabetes care in consultation with health professionals and people with diabetes to ensure a coordinated approach to diabetes care.

- Purchasers should ensure that local guidelines are developed to ensure timely referral to specialist services.

- A retinal screening policy for diabetes mellitus should be developed in Northern Ireland to ensure that all patients with diabetes have effective annual screening carried out. By 1999, all patients known to have diabetes mellitus should have annual screening carried out.

- Purchasers and providers should work together to ensure that the recommendations for the care and treatment of diabetes made by the Clinical Standards Advisory Group and the targets set out in the St Vincent Declaration are achieved.

(ii) *Respiratory Diseases*

- The major social factor causing respiratory diseases is smoking, which, it is estimated, accounts for 90% of deaths from chronic obstructive pulmonary diseases as well as 90% of deaths from lung cancer. Targets to address smoking are set in the chapter on Promoting Health and Social Wellbeing.

- Asthma clinics should be established for sufferers under locally agreed guidelines developed in conjunction with local specialists and Boards. Opportunity exists for multidisciplinary working in this field. Asthma clinics should have protocols for:-

  - drug treatment;

  - symptom monitoring;

  - referral procedures; and

  - shared care arrangements.

- Purchasers should develop policies for rehabilitation for those suffering from chronic obstructive pulmonary diseases. This should be concentrated at primary care level but close liaison with local specialists is necessary. Areas covered should include:-

  - provision of local nurses and therapists whose activity in pulmonary rehabilitation has been shown to reduce hospital admissions and raise quality of life of those suffering from these diseases;

  - smoking cessation policies;

  - exercise; and

  - mobile oxygen to allow increased mobility for those suffering from chronic obstructive pulmonary disease.

- Purchasers should ensure close liaison between local and regional specialists so that people with cystic fibrosis have better access to more appropriate local services.

- Purchasers and providers should consider developing and purchasing services from a regional referral centre which offers adequate facilities for the investigation and treatment of sleep apnoea sufferers.

Back Pain

- The Department should encourage other departments and their agencies to ensure access to appropriate occupational health services with the aim of improving staff health and providing safe systems of work.

- Purchasers should seek to establish a regional data base for back pain, including primary care data.

- Purchasers and providers should work together to ensure that the standards for care and treatment of back pain set by the Clinical Standards Advisory Group are achieved.

- Through local clinical consensus, purchasers should develop guidelines and measures for clinical outcomes in the areas of effectiveness, appropriateness and value for money.

- Resources should be directed to primary care settings to secure early effective physical therapy and patient education.

- Professional and educational bodies in Northern Ireland should consider developing multidisciplinary training programmes, at pre- and postgraduate level, for all professions involved in the management of back pain.

Appendix 1

HEALTH
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REGIONAL STRATEGY 1997-2002: QUANTITATIVE TARGETS

Reference		Target	Baseline Data	Target Data	Data Source
3.25	**Accidents, Trauma and Violence**	By 2002 the annual number of deaths from accidents should be reduced by 15%. Special emphasis should be placed on preventing accidents to children and older people.	26.3 per 100,000 (1994)	22.4 per 100,000 (2002)	Registrar General NI E800-E949[1]
3.33	**Smoking**	By 2002 the proportion of the adult population aged 16+ who do not smoke cigarettes should have increased from 72% to 74%.	72% (1994/95)	74% (2002/03)	Continuous Household Survey (CHS)
		By 2002 the proportion of the population aged 11-15 years who do not smoke cigarettes should have increased from 83% to 85%.	83% (1994)	85% (2002/03)	'The Health Behaviour of School Children in NI', The Health Promotion Agency for Northern Ireland.
3.35	**Nutrition**	By 2002 the proportion of women breastfeeding during the first two or three days after birth should be increased to 50%.	30% (1994)	50% (2002)	Boards' Child Health Systems
		By 2002 the proportion of women breastfeeding at 6 weeks should be increased to 35%.[2]	17% (1990)	35% (2002)	Baseline: 1990 Infant Feeding Survey Target: Boards' Child Health Systems
3.41	**Physical Activity**	By 2002 the proportion of men and women aged 16+ who are classified as sedentary should be reduced from 20% to 15%[2].	20% (1992)	15% (2002)	Baseline: NI Health and Activity Survey 1992 Target: NI Survey of Health and Social Wellbeing
		By 2002 the proportion of men and women aged 16+ who achieve recommended age-related activity levels should be increased from 30% of men and 20% of women to 35% of men and 25% of women[2].	Men 30% (1992) Women 20% (1992)	Men 35% (2002) Women 25% (2002)	Baseline: NI Health and Activity Survey 1992 Target: NI Survey of Health and Social Wellbeing

Reference	Target	Baseline Data	Target Data	Data Source
3.43 **Sexual Health**	By 2002 there should be a further fall in unplanned births to mothers aged under 20, with the effect that the overall number of births to teenage mothers is reduced by 10%.	17 per 1,000 women aged 12-19 (1992-94)	15.3 per 1,000 women aged 12-19 (2002)	Registrar General NI
3.47 **Immunisation**	By 2002 each Board should have an uptake rate of 97% for all primary immunisations.	Diphtheria 95% Polio 95% Tetanus 95% MMR 94% HIB 94% Whooping Cough 93% (1993)	97% for all primary immunisations (2002)	Boards' Child Health Systems
5.30 **Needs of Elderly People**	During the period of this strategy the target remains that at least 88% of people aged 75 and over will be supported in their own homes.[2]	87% (1995)	88% (2002)	Baseline: DHSS Target: The NI Census of Population 2001
8.12 **Family and Child Health and Welfare**	By 2002 there should be a 10% reduction in stillbirths and deaths in children under one year old.	6.3 stillbirths per 1,000 births (live and still) registered (1994) 6.1 infant deaths per 1,000 live births registered (1994)	5.7 stillbirths per 1,000 births (live and still) registered (2002) 5.4 infant deaths per 1,000 live births registered (2002)	Registrar General NI
	By 2002 there should be a reduction of at least 25% in the total number of acute hospital bed days occupied per annum by children aged 0-15 years.	185,000 occupied bed days (1993/94)	140,000 occupied bed days (2002/03)	Hospital Inpatient System[4]
	By 2002 there should be a 50% reduction in the number of children abused or reabused who are on child protection registers.	1,560 (December 1995)	780 (2002)	Child Protection Registers
10.4 **Learning Disability**	By 2002 long-term institutional care should no longer be provided in traditional specialist hospital environments.[3]	734 persons (February 1995)	0 persons (2002)	Mental Illness/Learning Disability Annual Census

Reference	Target	Baseline Data	Target Data	Data Source
	By 2002 the number of adults with a learning disability admitted to specialist hospitals should be reduced by 50% and the number of children, other than in exceptional cases, to zero.[3]	Adults: Plan to base on 1996/97 data Children: Plan to base on 1996/97 data	Adults: N/A pending setting of baseline (2002) Children: 0 (2002)	Mental Health Inpatient System
12.5 Circulatory Diseases	By 2002 to reduce the death rate from coronary heart disease among 35-64 year olds by 40%.	202.7 per 100,000 (1988)	121.6 per 100,000 (2002)	Registrar General NI 410-414[1]
	By 2000 to reduce the death rate from coronary heart disease among 65-74 year olds by 30%.	933.2 per 100,000 (1994)	653.2 per 100,000 (2000)	Registrar General NI 410-414[1]
	By 2000 to reduce the death rate from stroke among 15-74 year olds by 40%.	46.3 per 100,000 (1990)	27.8 per 100,000 (2000)	Registrar General NI 430-438[1]
13.10 Cancers	By 2010 to reduce the death rate from lung cancer by at least 30% in men aged under 75 and 15% in women aged under 75.	Men 49.8 per 100,000 (1990) Women 22.4 per 100,000 (1990)	Men 34.9 per 100,000 (2010) Women 19.0 per 100,000 (2010)	Registrar General NI 162[1]
	By 2002 to reduce the death rate from breast cancer in women aged 50-69 by at least 25%.	90 per 100,000 (1990)	67.5 per 100,000 (2002)	Registrar General NI 174[1]
	By 2002 to reduce the incidence of invasive cervical cancer by at least 20% in women aged 20 and over.	12.8 per 100,000 (1989)	10.2 per 100,000 (2002)	The 5 screening laboratories

Notes:

In order to take account of changes in the population structure, standardised death rates have been used for all mortality baselines and targets (apart from stillbirths and infant deaths). For the calculation of standardised death rates see Glossary of Terms at Appendix 2.

1 International Classification of Diseases - 9th Revision.

2 It is important to bear in mind that the target and baseline data sources are not precisely the same. This may have an effect on comparisons and should be borne in mind when monitoring the target.

3 It is highly likely, for clinical reasons, that there will always be a small number of patients who require long-term treatment in hospital.

4 Excluding 'well babies' specialties 540-550.

Appendix 2

HEALTH
& WELLBEING:
INTO THE NEXT
MILLENNIUM

GLOSSARY OF TERMS

Care Manager

The care manager takes responsibility for designing and assembling a package of social care tailored to the client's needs and, for ensuring that the services provided are effectively coordinated, delivered and monitored.

Carer

A carer is someone who provides or intends to provide a substantial amount of care on a regular basis.

Clinical Audit

The appraisal of clinical procedures with regard to the effective, efficient and economical use of resources and achievement of the required outcome.

Clinical Effectiveness

The successful outcome of a patient's clinical treatment.

Clinical Outcomes Group

A committee which advises the Department of Health in England on how it may improve outcomes of clinical care. Members include managers, patients' representatives and academics as well as the clinical professions.

Clinical Resources Efficiency Support Team

A small committee of doctors established under the auspices of the Central Medical Advisory Committee to promote clinical efficiency in the health service in Northern Ireland while ensuring the highest possible standards of clinical practice is maintained.

Clinical Standards Advisory Group

The Clinical Standards Advisory Group was set up in 1991 as an independent source of expert advice to the UK Health Ministers and to the NHS on standards of clinical care for, and access to and availability of service to, NHS patients.

Clinical Trial

A study which is carried out on human beings in order to compare the usefulness and safety of two or more different methods of managing or treating a disease. Such studies are often used to evaluate promising new treatments by comparing them with a standard treatment.

Health and Social Services Councils

The Councils' role is to represent the interest of the public in their Board's area and to review the proposals for changes in the provision of services. Membership is drawn from nominees of district councils, nominations made by voluntary organisations, and other interested bodies and individuals.

Health and Social Services Trust
A hospital or other unit which, whilst remaining fully within the Health and Personal Social Services, is run by its own Board of Directors, is independent of Health and Social Services Board management and has a wide range of freedoms which were not available to the former directly managed units.

Locally Sensitive Purchasing
A process of purchasing (or commissioning) services which takes account of the differing health and social care needs of the various local communities within a Health and Social Services Board area. This involves actively seeking and taking into account the views of: local communities: Health and Social Services Councils; GPs and other primary professionals; and service providers.

Purchaser
Any body within the Health and Personal Social Services purchasing health or social care on behalf of its resident population or patient/client list.

Provider
Any body providing health or social care under contract arrangements with a purchasing body.

Medium Secure Unit
Hospital facility providing appropriate services for mentally disordered patients who require treatment under conditions of special security.

Outreach Clinic
Clinic provided by a hospital consultant in a community setting.

Palliative Care
The treatment of incurable diseases, the aim being to relieve suffering.

Polyclinic
Clinic in a community setting providing a wide range of health and social services.

Royal Colleges
The Medical Royal Colleges are autonomous professional bodies which set and monitor the standard of postgraduate medical education and promote the maintenance of the skills and competences of trained doctors through continuing medical education, and clinical audit.

Socioeconomic Groups

Manual

Comprising skilled (manual), partly skilled and unskilled. Married women whose husbands are in the household are classified according to their husband's occupation.

Non-Manual

Comprising professional, managerial and technical and skilled (non-manual). Married women whose husbands are in the household are classified according to their husband's occupation.

Standardised Death Rate

A standardised death rate is used to compare the mortality of a particular sub-group of the population relative to a standard, adjusting for differences in population age structures. It is calculated by applying the age-sex specific rates from the standard population to the sub-group to obtain the 'expected' number of deaths and comparing the actual number of deaths in the latter with the expected number.

Unit (of alcohol)

A unit is 8 grammes of alcohol. A unit is equivalent to a half pint average strength beer or lager or a small glass of wine. A Northern Ireland pub measure of spirits (35ml) is 1.5 units.

Appendix 3

HEALTH
& WELLBEING:
INTO THE NEXT
MILLENNIUM

PROGRESS ON REGIONAL STRATEGY 1992-1997

Target	**Target and Target Date**	**Baseline**	**Current Position**	**Progress Rating**
Water supply fluoridated	65% by 1997	7% (1991)	7% (March 1995)	No Change
Proportion of the population aged 12-64 who do not smoke cigarettes	75% by 1997	68% (CHS 1988)	72% (CHS 1994/95)	4
Proportion of 12-64 year olds exceeding the sensible drinking limits:	Male 25% Female 7% by 1997	Male 33% Female 11% (Change of Heart '87)		
(i) Male (ii) Female		16% 5% (CHS 1988)	21% (18-64) 7% (18-64) (CHS 94/95 prov.)	5 5
Cardiac operations	1,100 by 1993	738 (1990)	1,303 (September 1995)	1
People 75+ in own homes	88% by 1997	86% (1990)	87% (March 1995)	2
People in psychiatric hospitals	1,500 by 1997	2,359 (December 1991)	1,771 (September 1995)	3
People in specialist hospitals for learning disability	700 by 1997	954 (December 1991)	774 (September 1995)	2
Births to teenage mothers (Based on 3 year rolling average)	1,600 by 1997	1,939 (1988-90)	1,674 (1992-94)	2
Primary Immunisations	95% by 1997	Polio 95% Diphtheria 95% Tetanus 95% Pertussis 84% MMR 91% (1990)	Polio 97% Diphtheria 97% Tetanus 97% Pertussis 93% MMR 89%* (March 1994)	1 1 1 2 3
Children in care in family placements	75% by 1997	73% (1990)	81% (September 1995)	1

APPENDIX THREE

Target	Target and Target Date	Baseline	Current Position	Progress Rating
Deaths from accidents (Based on 3 year rolling average)	380 by 1997	485 (1988-90)	399 (1992-94)	2
Deaths from ischaemic heart disease in the 35-64 age group (Based on 3 year rolling average)	700 (by 1997) 600 (by (2002)	918 (1987-89)	725 (1992-94)	2 3
Deaths from stroke in population under 75 (Based on 3 year rolling average)	316 by 2000	527 (1989-91)	486 (1992-94)	4
GP cervical cancer screening (L= lower target; H=higher target)	L 80% H 50% by 1997	L 77% H 26% (Jan. 91)	L 95% H 56.5% (July 1995)	1 1
Deaths from breast cancer in women aged 50-64 (Based on 3 year rolling average)	72 by 2000	96 (1989-91)	106 (1992-94)	5
Incidence of invasive cervical cancer (Based on 3 year rolling average)	20% by 2000	35 (1986-88) [Number of deaths used as proxy for incidence]	35 (1992-94)	No Change
Deaths from lung cancer in the population aged under 75 (Based on 3 year rolling average) (i) Male (ii) Female	270 128 by 2010	387 151 (1989-91)	361 178 (1992-94)	4 5

Notes:
* Closure of 2 suppliers affected EHSSB's stock of vaccine in 93/94

Progress Rating:
1 Achieved
2 Substantially achieved
3 On course
4 Movement in right direction but not fast enough
5 Movement in wrong direction

DHSS

Department of Health and Social Services

SSI Social Services Inspectorate

REVIEW OF CARE IN THE COMMUNITY

FEBRUARY 2000

DHSS&PS

Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteacht Phoiblí

Social Services Inspectorate

Ms Bairbre de Brún MLA
Minister for Health, Social Services & Public Safety

Minister

On the 7th January you asked me to undertake an urgent review of the provision of care in the community and the relationship which it has with the admission and discharge of patients into and from hospitals and to report to you by the end of January.

I am pleased to present to you my report. The report draws on information gathered from Boards, Trusts and Organisations representing the voices of users of services.

The completion of report within the short timescale available would not have been possible without the full co-operation of many people within the Department and in outside bodies. I would like to thank all who contributed to the process and to pay tribute to the many staff working in community care who have shown great commitment in striving to meet the many pressures which have been placed upon them.

I hope that consideration of the findings of the review will lead to improved arrangements for the provision of high quality care services to some of the most vulnerable people in our community.

K. McCoy.

KEVIN McCOY
Chief Inspector

4th February 2000

INVESTOR IN PEOPLE

REPORT FOR MINISTER ON THE REVIEW OF CARE IN THE COMMUNITY

1. OBJECTIVE

In light of the growing pressures on Health and Social Services (HSS) Boards and Trusts to meet "winter pressure" demands, and the increase in the number of patients awaiting discharge from hospitals in Northern Ireland, to provide for Minister "an urgent review of the provision of care in the community and the relationship which it has with the admission and discharge of patients into and from hospital".

1.1 This report provides:

- the background to current policy and practice on discharge arrangements;
- an analysis of statistical data on care management, adult services and unmet need as at 14 January 2000;
- the views collated from meetings held with Boards, Trusts and user representatives; and
- key findings and an agenda for further action.

2. BACKGROUND

2.1 The policy paper "People First: Community Care in Northern Ireland for the 1990s" sets out the framework for the management and delivery of good quality community care services. The aim was to enable vulnerable people to live as independently as possible in their own homes or in a homely setting in the community.

The key objectives of the policy paper were:

- to promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever possible;

- to ensure that service providers make practical support for carers a high priority;

- to make proper assessment of need and good case management the cornerstone of high quality care;

- to promote the development of a flourishing independent sector alongside good quality public services;

- to clarify the responsibilities of agencies and so make it easier to hold them to account for their performance; and

- to secure better value for taxpayers' money by introducing a new funding structure for community care.

As part of the new community care reforms, Boards and Trusts, from 1st April 1993, took on new responsibilities for assessing health and social care needs and funding residential and nursing home placements. These new arrangements attached a particular importance to ensuring that effective hospital discharge procedures were established. Professionals and administrators working in hospitals, and those with responsibility for care in the community, were required to work closely together to ensure that best practice was developed. This had to be undertaken in a way to ensure that there was a comprehensive assessment of patients' needs, whilst avoiding premature discharge, and minimising the potential impact on hospital resources of undue delay. The implementation of these new arrangements and their impact on hospital discharge procedures has had significant implications for Health and Social Services Boards, Hospital and Community Trusts, providers of services, users and their carers.

2.2 The Department of Health, Social Services and Public Safety (the Department) continues to monitor and evaluate the progress being made in implementing the community care reforms. This includes monitoring, inspection and the collection and analysis of statistical data. Results of this work provide important information for the Department, Boards and Trusts, on how the reforms are working out in practice. A Multi-Disciplinary Inspection of Assessment and Care Management Arrangements was conducted by the Department and led by the Social Services Inspectorate (SSI) in 1994. The findings were published in a report in 1995 and disseminated across all Trusts in Northern Ireland.

A Multi-Disciplinary Inspection of Hospital Discharge Arrangements of Older People To their own Home/Residential Nursing Home Care was undertaken in 1997. The findings of this inspection were published in the report "From Hospital to Home", (DHSS 1997) and the information disseminated across all Trusts in Northern Ireland.

2.3 The policy on discharge arrangements in Northern Ireland was set out in the Departmental Circular "Procedures for Admission and Discharge of Hospital Patients" (HSS (OS3) 5/74). This circular emphasised the importance of ensuring that all disciplines are aware of the relevant procedures and their respective responsibilities and was reinforced in "People First". The implementation of the assessment and care management arrangements required Trusts, when undertaking needs-based assessments for community and residential care, to ensure those patients leaving hospital are provided with the necessary support. Both "A Charter for Patients and Clients", and the later "Charter Standards for Community Services", gave an undertaking that no-one will be discharged from hospital until suitable arrangements have been made to meet their continuing health or social care needs. Equally, it must be the aim that no one remains in hospital after he or she has been assessed as medically fit for discharge.

A more recent Circular, ECCU 1/98, issued as a result of the " From Hospital to Home" report, required Trusts to draw up arrangements for the discharge of patients in consultation and collaboration with appropriate hospital and community personnel, and to ensure that these were fully integrated, as necessary, with assessment and care management arrangements. Trusts were also required to ensure that there was clarity with regard to the roles and responsibilities of all professionals involved in discharge arrangements and the relevant procedures so that timely and effective intervention is provided in accordance with the patients assessed needs.

2.4 The report "From Hospital to Home" stressed the importance of joint arrangements for the discharge of patients from hospital in order to ensure that beds are not occupied by patients who no longer need hospital care. "It is important that patient discharge is planned in order to provide adequate and effective support systems and alleviate the risk of further deterioration to the patient's health, or re-admission to hospital. Effective discharge arrangements depend on effective liaison, not only with the patient and carer but with all relevant community and hospital professionals involved in the assessment and ongoing care of the patient.” In seeking to improve the effectiveness and efficiency of hospital discharge arrangements, Trusts were asked to address a number of major recommendations which if implemented would have assisted in addressing a number of the current problems facing the hospital and community trusts.

These included the need to:

- develop a collaborative and integrated approach to assessment, care management and discharge arrangements so as to ensure roles and responsibilities of both hospital and community staff are clarified and agreed;

- disseminate information to all professional staff on the identification and collation of unmet need and devise systems to effectively inform service planning;

- agree on a strategy to reduce the number of patients awaiting discharge due to the lack of available funding for the agreed care package; and

- ensure greater participation of and support to users and carers in the assessment, care management, discharge process and implement the agreed care package.

3. METHODOLOGY

3.1 Information was sought from Boards and Trusts as to the extent of unmet need as of 14 January 2000. Discussions were held with the Association of Directors of Social Services and the Executive Directors of Social Work in Trusts and meetings were held in six Trust areas. In addition, the four Health and Social Services Councils and a number of voluntary organisations representing the views of users were consulted, namely Age Concern, Help the Aged and Carers National Association, regarding their experience of the effects of “winter pressures” and the delivery of community care.

This exercise focused on a number of issues including:

- the pattern of winter pressures in relation to the provision of community care and the responses of Boards and Trusts to these;
- the financial and resource pressures facing Boards and Trusts;
- the level of unmet need in the provision of community care;
- the effect of the “winter pressures” on the provision of quality care; and
- recommendations for future policy and practice.

4. KEY FINDINGS

One of the principles of "People First" is that people should be maintained in their own homes with support wherever possible. Information provided by the Boards and Trusts highlighted that at the 31st March 1999, 43% of all packages of care across Northern Ireland, were provided to people in their own homes. The two largest programmes of care, elderly and mental health are close to having only one third of their care packages delivered at home.

There are variations between programmes of care. As would be expected, most care packages in the physical disability/sensory impairment programme are domiciliary. In 1995, 80% of packages to this client group were for home care and this remains the same (81%) in 1999. All other programmes have experienced a reduction over the past five years. In 1995, 48% of care packages in the elderly programme of care were home based. This has fallen to 38% in 1999. For mental health the respective figures are 48%, falling to 35% and for learning disability 70% falling to 56%.

Trends in community care for each programme are set out below.

Elderly People

Between 1995 and 1999, the number of care packages in effect in the elderly programme of care increased by over 60%, from 6,849 to 11,052 packages of care. In 1995, 52% of all elderly care packages were in residential/nursing care. By 1999 this figure had increased to 62% of all care packages. The numbers of elderly people in independent sector residential and nursing homes who have "preserved rights" continues to decline. This has resulted in reducing expenditure on residential and nursing home care within the social security budget. There is also evidence of a higher level of unmet need which is reflected in delayed discharge from hospital and inadequate care packages to meet assessed care needs.

Physical Disability

A total of 1,163 people with a physical disability had care packages in effect at 31 March 1999, an increase of 64% from 1995. Almost 81% of people with a physical disability were maintained at home through care management arrangements (941 clients), a similar picture as in 1995 (80%). Although numbers are small, the cost of individual packages can be extremely high. The effect of this is that a number of Trusts are indicating higher levels of unmet need within this programme of care.

Pressures on the provision of wheelchairs and adaptations have also added to the financial difficulties experienced within this programme resulting in long waiting lists for both assessment of need and provision of equipment.

Mental Health

Over the past five years, the total number of people being care managed has remained constant at around 1100, although the proportion being supported at home has fallen. The trend towards increasing use of residential care has continued.

In line with the Regional Strategy, Boards and Trusts are reviewing the role of specialist psychiatric hospitals. It is anticipated that more patients could be cared for more appropriately outside hospital.

Learning Disability

Between 1995 and 1999, the number of care packages in effect in the Learning Disability programme of care almost doubled from 683 to 1317. In 1999, 56% of care packages in effect were in residential or nursing care compared to 70% in 1995.

As with the mental health programme, the drive to resettle individuals from hospital, in line with the Regional Strategy, is underway.

4.1 Community Care Pressures

The term "winter pressure" is a misnomer, as discharge delays and waiting lists for provision of care packages are a problem throughout the year and are not confined to the winter months.

There are a range of pressures facing Boards and Trusts which include:

4.1.1 Unmet Need

Shortfall in service provision measured against assessed need has been identified in all aspects of community care provision. This is reflected in all aspects of community care:- delayed discharge from hospital; waiting lists for day care and respite care; people maintained at home when residential care is considered to be the most appropriate care option; people with disabilities inappropriately placed in homes for the elderly; and the inability of Trusts to provide holistic assessment of individual need and meet Community Care Charter standards for occupational therapy assessments for adaptations.

A significant concern raised was the fact that at this critical period the only option open to elderly people was institutional care. The value base and principles underlining the community care reforms of increasing choice for users was ignored.

The eleven Community Trusts were asked to complete a short questionnaire detailing the level of unmet need at 14 January 2000. All eleven Trusts responded. Analysis is presented at Health and Social Services Board Level and Northern Ireland level (Table 1).

In response to the growing "winter pressures" in acute hospitals additional funding was made available to the Trusts to facilitate hospital discharges. By way of illustration, between the 20 December 1999 and 10 January 2000, 160 people were discharged in the Eastern Board area. The acute position would obviously have been much worse had this not occurred.

Table 1. Unmet Need on 14 January 2000 by Boards

Question	EHSSB	SHSSB	NHSSB	WHSSB	Northern Ireland
No of Adults in Hospital waiting for care management type services (institutional care or home packages)	72	55	50	24	201
No of adults waiting at home for Intensive Home Care package	207	71	286	228	792
No of adults waiting at home for admission to Institutional Care	69	26	205	13	313
No of people (adults and children) waiting for specialist equipment to support them or their carers	164	1,333 [1]	240	1,079	2,816
No of adults waiting for Home Help Service	38	58	82	45	223
No of adults waiting for Day Care provision	116	56	84	59	315
No of adults waiting for Respite Care	32	6	59	20	117

1. *Includes clients waiting for OT assessments on aids and adaptations, and those already assessed and waiting for equipment in two of the Trusts within the Southern Board.*

Key Points

- A total of 201 adults in Northern Ireland were waiting to be discharged from hospital on 14 January. Three times as many adults were awaiting discharge from hospital in the Eastern Board (72) than in the Western Board (24).

- Some 792 adults in Northern Ireland were waiting at home for an Intensive Home Care package. The Northern Board had the largest number of adults waiting for an Intensive Home Care package (286), the Southern Board the lowest (71).

- Over 310 adults in Northern Ireland were waiting at home for admission to Institutional Care. More than two thirds of these adults were from the Northern Board.

- About 2,800 adults and children in Northern Ireland were awaiting specialist equipment on 14 January 2000. Almost half of these cases were in the Southern

Board, although the majority of these clients were awaiting OT assessments for aids and adaptations.

- A total of 223 adults were waiting for home help services, with the largest number waiting in the Northern Board. 315 adults were waiting for Day Care provision, and 117 adults were waiting for respite care provision.

4.1.2 Resource Pressures

The four Boards were also asked to provide details outlining the pressures within community care and to detail how the additional £25m made available through Comprehensive Spending Review (CSR) was allocated. This analysis reflects the position at January 2000.

Although £25m was identified by the HSS Executive for community care, Boards were given flexibility to deal with local pressures when utilising all CSR monies for 1999/2000. Boards have reported severe pressures this year. These include recurring deficits and over commitments from previous years together with capitation funding losses. The HSS Executive has now instructed Boards/Trusts to defer CSR funded growth schemes to the extent required to fund inescapable pay pressures in-year.

The funding of these pressures has to a large extent curtailed the application of the CSR funds in-year for their original purpose; i.e. increased community care provision. Table 2 provides a breakdown of how the £25 million is being applied in 1999/2000. Just over £13.2 m of the £25 million allocated for community care has been spent on additional community care services in 1999/2000. About £8.6m was used by Boards to fund over commitments from previous years and to fund the 1999/00 pay shortfall, while just over £2.1m was used to fund services that Boards state would have otherwise ceased due to capitation losses. The pattern of application may be different in the next financial year.

In addition preliminary estimates from Boards and Trusts suggest that, within the learning disability programme of care, they are likely to require funding for between 70 - 90 community placements per annum for each of the next four years. With average placement costs currently running at £30,000 per annum this would suggest a total cost of between £2.1 and £2.7 million.

Within the mental health programme of care there is a need for additional funding to promote care in the community and to tackle the increase in drug abuse.

The Boards also indicate that resources in excess of £50m would be required over a 2 year period to meet the increasing demand in services and as a consequence maintain that an additional £30m is needed to meet the shortfall.

Table 2: Utilisation of 1999/2000 CSR Funds by Boards

	EHSSB	WHSSB	NHSSB	SHSSB	TOTAL
	£m	£m	£m	£m	£m
HSSE allocation 1999/00	10.585	4.117	5.893	4.405	25.000
Funding of over commitments to services made in previous years	3.104		0.140		3.244
Continued funding of services that would otherwise cease due to 1999/00 Capitation loss [1]	0.744		0.639	0.750	2.133
Funding of additional community care services in 1999/00	4.353	2.064	3.564	2.687	13.233
Contribution to 1999/00 pay shortfall	2.384	0.501	1.550	0.968	5.403
Moved to Acute		1.228			1.228
Other pressures		0.324			0.324
Total applications in 1999/00	10.585	4.117	5.893	4.405	25.000

1. *This refers to baseline services that would have been cut had money not become available.*

Board's have been encouraged by the HSS Executive's assurance that the growth funds need only be diverted on a once-off basis in relation to 1999/2000 pay pressures and that additional recurrent funds will be made available in 2000/2001 to meet these costs.

4.1.3 Additional Pressures

Since last year's bid for additional community care funding there have been a number of developments which have had a direct impact on the cost of providing community care services. These include:

Staffing

Boards and Trusts are reporting insufficient staff and resources to cope with the increase in the demand for services.

Demographic changes

Demographic change will place increasing pressure on health and social care resources. Per capita spending on health and social services rises markedly with age so that on average far more is spent per person in the over 65 age group than on people in lower age groups. The Government Actuary Department are projecting a significant increase in the elderly population such that the proportion of people over 65 years will increase from 13% in 1998 to 21% in 2031. Those over 75 years will account for 10% of the population compared with 6% in 1998 and the number over 85 years will double from 23,000 to 45,000. These changes will impact on a wide range of health and social services and , in particular, on long term care.

Waiting Lists

Whilst additional funds to cope with "winter pressure" have helped to alleviate hospital discharge difficulties there has been a significant increase in the number of clients living in the community awaiting delivery of care packages. There is evidence to suggest that individuals, with high levels of risk, are being placed in positions where they feel they have no option but to present themselves at Accident and Emergency units or are being admitted at a critical point to hospital due to care packages not being available.

In addition to this there are lengthy waiting lists in Trusts of clients awaiting occupational therapy assessments and provision of equipment. The implications of this are that clients are not receiving a holistic assessment of individual need and Trusts are not meeting the Community Care Charter Standards for occupational therapy assessment and provision of equipment.

Integrated Services

There has been a failure on the part of Trusts to fully develop integrated professional arrangements, resulting in poor integration in the delivery of services.

The Introduction of the Minimum Wage

This will particularly affect contracts with the independent sector for residential/nursing home care and domiciliary care services.

Working Time Directive

The extension of employee rights, both in terms of the length of a working week and entitlement to holidays and maternity leave, are likely to force up the cost of care provided by the independent sector. Trusts have indicated that they have been forced to increase contract prices in line with the revised rates set by the private sector.

Recent Pay Settlements

Recent pay awards for nurses and PAMS in 1999/2000 will impact on the cost of all sectors.

Single Status Agreement

This agreement reduced the working week of many social care staff from 39 hours to 37 hours. Estimates from the Eastern Board suggest that the effect of this change will cost in the order of £1.5 million per year. The four Boards estimate that this will cost in the region of £3-£4 million.

Some elements of these pressures may be addressed by way of additional pay award funding next year.

Independent Sector Pressures

A number of nursing homes are experiencing difficulty in recruiting qualified nurses. This will undoubtedly effect their ability to deliver care to required standards and may ultimately impact on the continued viability of some units. This problem is likely to be exacerbated with the announced pay increases for nurses. Home owners are currently seeking increases in tariffs generally. A Departmental led working group is currently reviewing pricing arrangements. The recommendations of this working group may have funding implications.

Similarly, nursing homes and residential care homes are experiencing difficulties in recruiting unqualified staff. The opening of larger supermarkets (i.e. Tesco, Sainsbury's and Safeway) has attracted employees who might otherwise have been recruited to posts in residential or domiciliary care. This is particularly affecting home care providers in rural areas.

DHSS Reports

The approach to the implementation of the recommendations contained in "From Hospital to Home" (1997), the report produced by the Social Services Inspectorate "Community Care – From Policy to Practice: The Case of Mr Frederick Joseph McLernon (deceased)" and the "Audit of Assessment and Care Management" (1998) has varied across the hospital and community trusts. These reports highlighted many deficits that needed to be addressed in the current arrangements which included a review of the infrastructure arrangements for the delivery of services and additional training for staff.

Carers Separate Assessment

The entitlement of carers to a separate assessment has created an additional pressure on resources. In response to current trends of earlier discharge from hospital, increasingly patients with Traumatic Brain Injury or neurological conditions require residential care and regular respite care following discharge to the community. Recently private providers have expressed an interest in providing specialist accommodation for this group. This will begin to address the problem of inappropriately placing these people in homes for the elderly, as is the current practice. The cost of specialist residential provision for this group will be greater than current nursing home costs.

Preserved Rights

The numbers of elderly people in independent sector residential and nursing homes who have "preserved rights" continues to decline. This has resulted in reducing expenditure on residential and nursing home care within the social security budget.

Training Organisation for the Personal Social Service (TOPSS) Training Strategy

More than 80% of the social care workforce hold no qualifications relevant to their jobs. In order to improve the quality of the service a major investment in training is needed.

4.2 Issues Raised by User Representatives and Health & Social Service Councils

Issues arising from the discussions with user representatives regarding their experience of the "winter pressures" and the delivery of community care included:

- the lack of a co-ordinated approach to assessment, care planning and discharge arrangements and insufficient information on discharge;

- assessing need, planning and providing individual packages of care is finance rather than needs led;

- an increase in the number of complaints to voluntary organisation's telephone helplines and referrals for advocacy support;

- lengthy waiting lists for OT assessments and provision of equipment;

- due to the funding pressures, standards were not being implemented.

- variations across Boards and Trusts in the eligibility criteria and charging policy for services;

- families paying for services whilst those assessed as requiring services are on waiting lists;

- substantial waiting lists and cuts in services such as chiropody, night sitting and home help services have been in existence for some time and are not the result of the current ‘winter pressures’; and

- individuals receiving services well below assessed requirements, placing increased pressure on carers and staff to provide for the additional services needed and a sense of weariness and dejection about raising complaints.

5. CONCLUSIONS AND RECOMMENDATIONS

Evidence submitted by Boards, Trusts and user representatives suggest major pressures impacting on the provision of community care services. The significant increase in funding by the Department to the Boards since 1993 has resulted in the provision of an increased range of quality community care services. However, evidence from this review suggests that the additional allocations for community care have fallen short of the amount required to develop and provide community services in line with assessed need and Department policy.

In conclusion, the Minister may wish to commission a comprehensive review of the implementation of community care policy, to include funding and arrangements for the delivery of services in Northern Ireland. Current policy has now been operational for almost 7 years and a review may now be deemed timely and appropriate. In undertaking such a review, account should be taken of the important interfaces between hospital, primary and community care. Account should also be taken of the following:

- the most effective method of funding and strategic planning to deliver community care;

- the infrastructure which facilitates all year round planning and resourcing in order to deliver the most effective use of resources;

- standards set by the Department regarding assessment, care management and discharge arrangements and recommendations of previous inspection reports;

- the need for greater collaboration across Hospital, Primary and community care so as to develop a co-ordinated approach to the planning and management of hospital admissions and discharges to ensure care pathways for patients and clients with appropriate thresholds and settings meet the needs of carers;

- schemes such as “Home From Hospital” and “Rapid Response Service” which prevent unnecessary hospital admissions and facilitate early and appropriate discharges;

- the eligibility criteria and charging policy to provide consistent and fair access to care services for all people in Northern Ireland.

- outcome measures which demonstrate the impact and effectiveness of schemes to address emergency pressures and their impact on the quality of care for patients and clients;

- information systems to enable the Department to more effectively monitor community care and care management arrangements and to inform resourcing decisions. Information on waiting times, costs of referrals, assessments and packages of care in the community should be developed as a matter of priority.

- accountability arrangements which are sufficient to ensure that all recommendations made as a result of inspections are fully implemented.

APPENDIX

KEY TRENDS IN CARE MANAGEMENT

An Overview - All Programmes

One of the main principles of People First is that, where possible, people should be supported in their own homes with appropriate levels of care. Recent trends however, are at variance with this principle. The figures below (provided by the Boards) show a steady decrease in the percentage of total People First funds committed to domiciliary care across the four Boards. In 1998/99, no Board spent more than 45% of its People First funds on domiciliary care. (Table 1).

Table 1: Percentage of Total People First Funds Committed to Domiciliary Packages

Year	% of People First Funds Invested in Domiciliary Packages			
	EHSSB	NHSSB	SHSSB	WHSSB
1993/94	51%	51%	68%	58%
1994/95	51%	35%	58%	60%
1995/96	48%	41%	49%	44%
1996/97	45%	46%	41%	40%
1997/98	44%	45%	40%	40%
1998/99	41%	45%	43%	39%

Source: People First Financial Returns provided by each Board.

This level of funding is reflected in the information on activity which shows that by 31 March 1999 only 43% of all packages of care, across Northern Ireland, were provided to people in their own homes. The two largest programmes of care, elderly and mental health are close to having only one third of their care packages delivered at home.

There are variations between programmes of care. As would be expected, most care packages in the physical disability/sensory impairment programme are domiciliary. In 1995, 80% of packages to this client group were for home care and this remains the same (81%) in 1999. All other programmes have experienced a reduction over the past five years. In 1995, 48% of care packages in the elderly programme of care were home based. This has fallen to 38% in 1999. For mental health the respective figures are 48%, falling to 35% and for learning disability 70% falling to 56%.

Care Management Trends in the Elderly Programme of Care

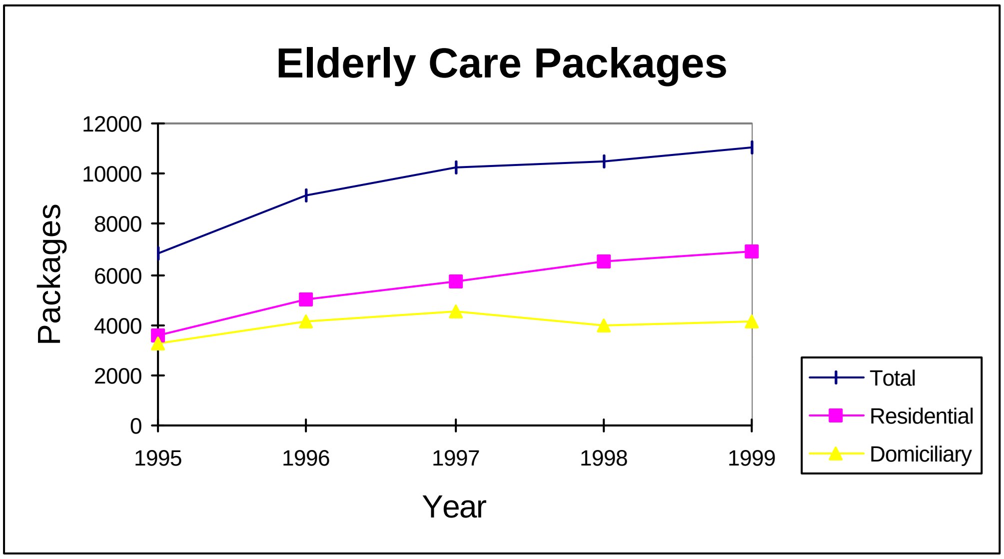
Between 1995 and 1999, the number of care packages in effect in the elderly programme of care increased by over 60%, from 6,849 to 11,052 packages of care. In 1995, 52% of all elderly care packages were in residential/nursing care. By 1999 this figure had increased to 62% of all care packages. During this period of time, the number of domiciliary care packages had increased by 27%, compared to a 92% increase in residential/nursing care packages over the same period. Table 2 and Figure 1 shows the trends within this programme since March 1995.

Table 2: Elderly Care Packages in Effect by Type of Care (Quarter Ending 31 March)

Elderly	**1995**	**1996**	**1997**	**1998**	**1999**
Residential	3585	5011	5726	6498	6894
Domiciliary	3264	4135	4501	3959	4158
Total	6849	9146	10227	10457	11052

- Latest figures show a further increase of 205 care packages at September 1999.

Figure 1: Care Packages in Effect by Type of Care (Quarter ending 31 March)



The pressure within the elderly programme of care is clearly on the need for institutional care. Table 3 shows the type of long term institutional care provided by each Board.

Table 3: Long Term Residents in Institutional Care for the Elderly Funded by Boards - March 1999

Type of Long Term Care	EHSSB	NHSSB	SHSSB	WHSSB	NI TOTAL
Statutory Residential – Elderly & EMI	804	436	144	233	1617
Independent RH & NH[1] – Elderly & EMI (Care Mgd)	2,868	1,295	1,167	866	6196
Hospital Based Geriatric Continuing Care	62	48	100	108	318
Hospital Based Long Stay EMI Care	169	72	48	45	334
Total Residents funded by the Board*	3,903	1,851	1,459	1,252	8,465
Population aged 75 years and over (1998 MYE)	45,458	23,583	15,230	13,000	97,271
Number Funded as % of Population aged 75+	**8.6%**	**7.8%**	**9.6%**	**9.6%**	**8.7%**

Source: CC7 Care Management Returns and SHSSB People First and Contract Information.

1. *Paid for from People First Funds or through core contracts with Provider Trusts (internal and external).*

The percentage of those aged 75 and over supported in institutional care varies across the four Boards. At March 1999, both the Southern and Western Boards were funding 9.6% of their age 75+ population as long term residents in institutional care. The slightly lower figures of 8.6% for the Eastern Board and 7.8% for the Northern Board may be explained by a number of factors, including the level of funding available for community services in each Board. Many older people with high levels of dependency, are also being supported by Community Care services in their own homes.

The Government Actuary Department are projecting a significant increase in the elderly population such that the proportion of people over 65 years will increase from 13% in 1998 to 21% in 2031. Those over 75 years will account for 10% in the population compared with 6% in 1998 and the number over 85 year will double from 23,000 to 45,000. These changes will impact on a wide range of health and social services and , in particular, on long term care.

Recent reports have also highlighted pressures within this programme. The Health and Social Care Research Unit produced a draft final report in May 1999 following a survey of 10,857 residents. Nearly two thirds (63.7%) were funded by Trusts; 14.9% were completely self financing and the remainder, 17.6%, had all or part of their costs met by "preserved rights" allowances.

Preserved Rights

The numbers of elderly people in independent sector residential and nursing homes who have "preserved rights" continues to decline. Table 4 shows the decrease in the number of "preserved rights" residents over the last three years.

Table 4: No. of Preserved Rights Residents in RH/NH for the Elderly

Year	Number of Preserved Rights Residents
1996	4,983
1997	2,791
1998	2,052

Source: Annual surveys of residential and nursing homes undertaken by each Board.

Although the 1999 Preserved Rights figures are not available for all Boards, early indications suggest a further reduction of 20%.

Care Management Trends in the Physical and Sensory Impairment Programme of Care

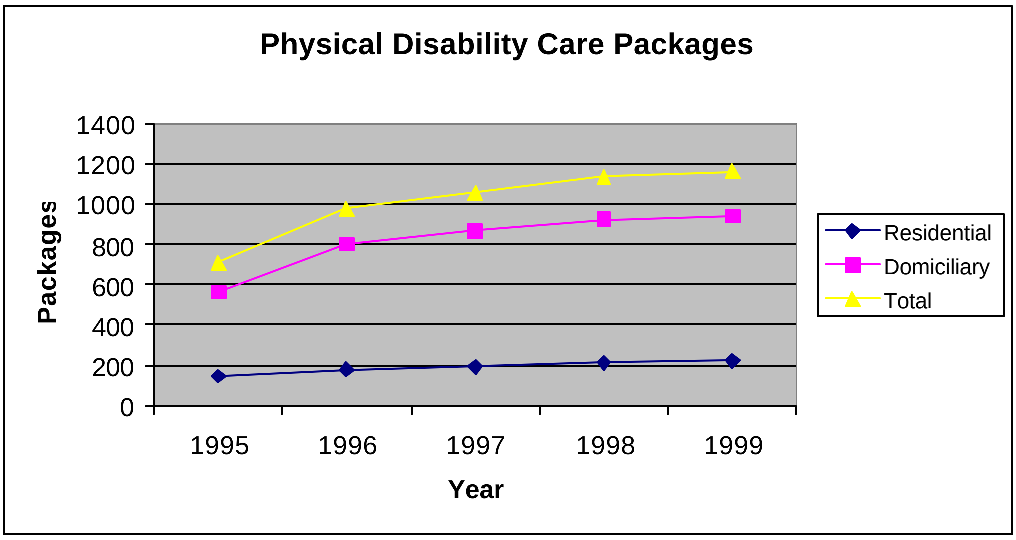
A total of 1,163 adults with a physical disability had care packages in effect at 31 March 1999, an increase of 64% from 1995. Almost 81% of adults with a physical disability receiving a care package were maintained at home through care management arrangements (941 clients), a similar picture as in 1995 (80%) (Table 5). The number of people with physical disabilities or sensory impairment care managed at home is greater than the number in Mental Health and Learning Disability programmes of care. This, in part, is due to the preferred choice of young people with disabilities to remain at home and to lack of suitable residential accommodation for this group.

Table 5: Physical and Sensory Impairment Care Packages in Effect by Type of Care (Quarter Ending 31 March)

Physical and Sensory Impairment	**1995**	**1996**	**1997**	**1998**	**1999**
Residential	144	178	190	212	222
Domiciliary	564	801	869	924	941
Total	708	979	1059	1136	1163

- At September 1999 care packages in this Programme had increased by a further 58 packages.

Figure 2: Physical and Sensory Impairment Care Packages in Effect by Type of Care (Quarter Ending 31 March)



Adaptations/Wheelchairs

A Health and Social Services Executive Review of Occupational Therapy Assessments for Housing Adaptations, in December 1998 highlighted the following numbers on waiting lists (Table 6).

Table 6: Number on Waiting Lists for Adaptations (December 1998)

EHSSB	5092
SHSSB	1521
NHSSB	2782
WHSSB	1102

Board's also report pressures on Board budgets for wheelchairs with a noted rise in referrals for specialist wheelchairs, special cushioning and chairs for children. In meeting these referred needs Boards and Trusts report a significant overspend on their wheelchair contracts. Despite an allocation given in 1999/2000 for specialist wheelchairs, Boards indicate that this has not been sufficient to meet demand.

Care Management Trends in the Mental Health Programme

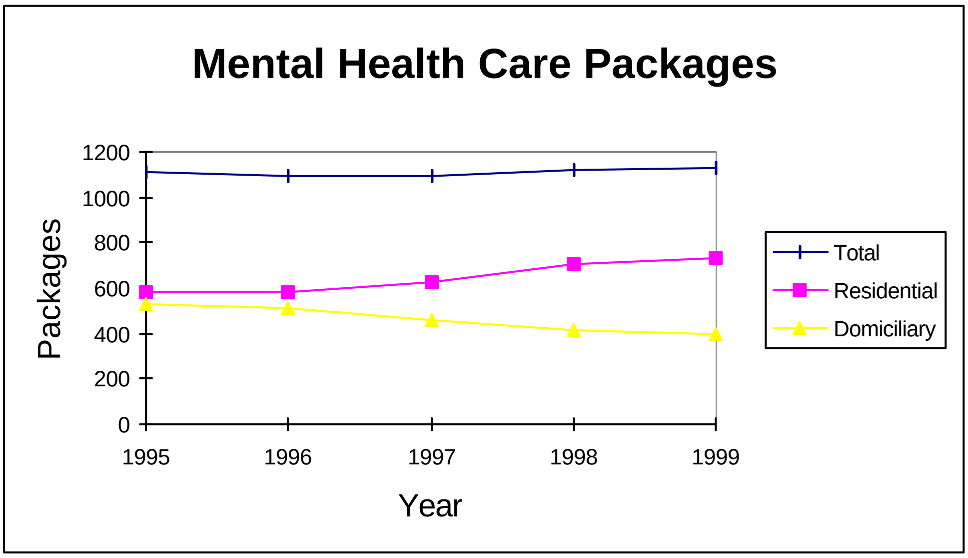
In March 1999, the total number of packages in effect in the Mental Health programme of care (1,128) was little changed from the position in 1995 (1,112). However, the trend towards increasing use of residential care has continued. Although in the last five years, the total number of people being supported has remained constant at around 1,100, the proportion being supported at home has fallen. In 1995, 531 people (48%) were supported at home. By March 1999 this number had fallen to 398 (35%). (Table 7)

Table 7: Mental Health Care Packages in Effect by Type of Care (Quarter Ending 31 March)

Mental Health	**1995**	**1996**	**1997**	**1998**	**1999**
Residential	581	581	627	706	730
Domiciliary	531	513	463	413	398
Total	1112	1094	1090	1119	1128

- At September 1999 care packages in this Programme had increased by a further 37 packages.

Figure 3: Mental Health Care Packages in Effect by Type of Care (Quarter Ending 31 March)



Care Management Trends in Learning Disability Programme of Care

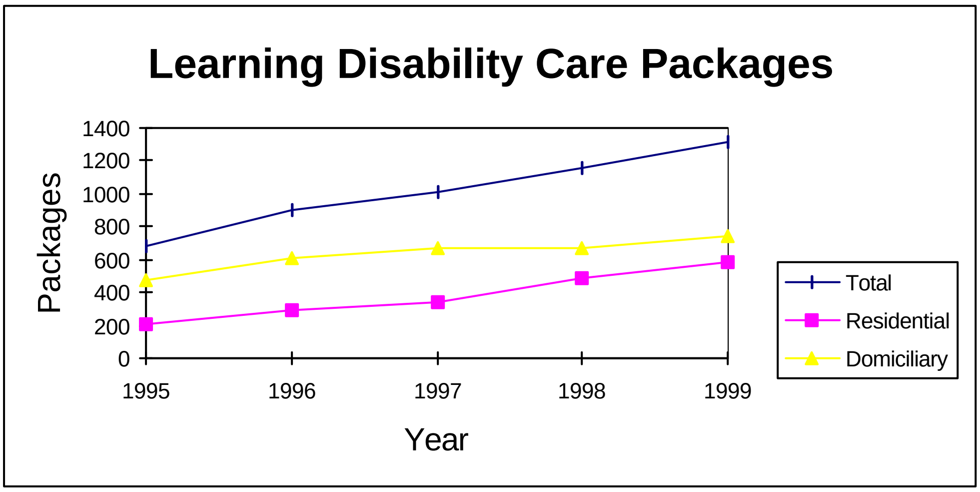
Between 1995 and 1999, the number of care packages in effect in the learning disability programme of care almost doubled from 684 to 1,317. In 1999, 56% of the care packages in effect were residential or nursing home care packages compared to 70% in 1995. (Table 8)

Table 8: Learning Disability Care Packages in Effect by Type of Care (Quarter Ending 31 March)

Learning Disability	**1995**	**1996**	**1997**	**1998**	**1999**
Residential	205	294	344	481	579
Domiciliary	479	603	667	671	738
Total	684	897	1011	1152	1317

- By September 1999 care packages in this programme had dropped slightly by 8 packages.

Figure 4: Learning Disability Care Packages in Effect by Type of Care (Quarter Ending 31 March)



REVIEW OF COMMUNITY CARE

FIRST REPORT

Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

April 2002

FOREWORD

Following the pressures on health and social services during the outbreak of the flu-like illness in the winter of 1999-2000, two of my first actions as Minister were to ask the Chief Medical Officer to review intensive care provision and the Chief Inspector of Social Services to review community care.

“Facing the Future: Building upon the lessons of Winter 1999/2000” recommended a comprehensive review of community care policy and I endorsed that recommendation in October 2000.

As a first stage an extensive consultation exercise was carried out through July, August and September of 2001 to take the views of statutory and independent sector providers, voluntary organisations and the health and social care professions. The objective was to identify barriers to the delivery of good community care services, to identify good practices and to bring forward recommendations for improvements. I have considered the findings in the report and now wish to make it available for your information and consideration.

Section 5 of the report identifies improvements that can be introduced in the short term. I have been encouraged by, for example, the number of innovative schemes in place aimed at preventing admission to hospital and to providing safer and faster discharge for those considered medically fit for discharge from hospital. The use of such schemes shows a widespread recognition of the changing face of community care and the need to further develop and improve the way in which community care services are delivered across health and personal social services. One of the next steps will be to make available detailed information on the range of innovative practices to all service providers, to encourage the sharing of experience across Trusts and to ensure that good practice is replicated elsewhere. That work is now in hand.

Section 6 of the report includes a number of recommendations of a more long-term nature and my Department is now considering how best these can be progressed. In the meantime, it is important that specific elements of the review are taken forward without delay and that an appropriate amount of the new investment in community care is targeted at the recommendations in this report. With new investment and the ideas emerging from this phase of the review I would expect to see improvements in service delivery happen quickly.

Minister for Health, Social Services and Public Safety

RÉAMHRÁ

I ndiaidh an oiread sin brú ar na seirbhísí sláinte agus sóisialta le linn an ráig tinneas fliú le linn gheimhreadh 1999-2000 ba iad an chéad dá rud a rinne mé mar Aire ná a iarraidh ar an Príomh-Oifigeach Liachta athbhreithniú a dhéanamh ar an soláthar dianchúraim agus ar an bPríomhchigire Seirbhísí Sóisialta athbhreithniú a dhéanamh ar an an gcúram pobail.

Mhol “Facing the Future: Building upon the lessons of Winter 1999/2000” athbhreithnniú cuimsitheach ar pholasaí chúram pobail agus d'aontaigh mise leis an moladh sin i nDeireadh Fómhair 2000.

Mar chéad chéim rinneadh obair chomhchomhairle leathan le linn Iúil, Lúnasa agus Mheán Fómhair 2001 chun tuairimí soláthróirí san earnáil statúideach agus san earnáil neamhspleách, eagraíochtaí deonacha agus na gairmeacha sláinte agus cúram sláínte a ghlacadh san áireamh. Is é an aidhm a bhí leis sin na constaicí maidir le seachadadh seirbhísí maithe chúram pobail a sheachadhadh a aithint, chun deachleachtais a aithint agus moltaí faoi fheabhsúcháin a thabhairt chun cinn. Bhreithnigh mé na torthaí sa tuarascáil sin agus is mian liom í a chur ar fáil anois mar eolas daoibh agus le go bhféachfaidh sibh uirthi.

Aithníonn Roinn 5 san tuarascáil feabhsúcháin is féidir a thabhairt isteach sa ghearrthéarma. Údar misnigh dom mar shampla an líon scéimeanna nuálacha atá bunaithe agus atá dírithe ar chosc a chur ar iontráil chuig ospidéil agus a sholáthródh scaoileadh amach níos tapúla agus níos sábháilte ina measc sin a bheadh oiriúnach, ó thaobh liachta, le scaoileadh amach as an ospidéal. Léiríonn an leas a bhaintear as na scéimeanna sin an t-aitheantas fairsing a thugtar don athrú atá ar chúram pobail agus an gá atá le tuilleadh forbartha agus feabhsúcháin a chur ar an tslí a ndéantar seirbhísí cúraim pobail a sheachadadh feadh seirbhísí sláinte, sóisialta agus pearsanta. Ceann de na chéad chéimeanna eile ná mioneolas a chur ar fáil ar an raon cleachtas nuálach chuig gach soláthróir seirbhísí chun roinnt na taithí a spreagadh feadh Iontaobhas agus a chinntiú go ndéantar aithris ar dheachleachtas gach áit. Tá an obair sin ar bun anois.

Áirítear i Roinn 6 den tuarascáil roinnt moltaí níos fadtéarmaí agus tá mo Roinn anois ag féachaint ar an mbealach is fearr chun iad a chur chun cinn. Idir an dá linn tá sé tábhachtach go ndéanfaí gnéithe sonracha den athbhreithniú a thabhairt chun cinn gan mhoill agus go ndíreofaí méid chuí den infheistíocht nua ar na moltaí sa tuarascáil seo. Le hinfheistíocht nua agus leis na smaointe atá ag teacht chun cinn ón gcéim seo den athbhreithniú bheinn ag súil feabhsúcháin a fheiceáil ag tarlú go tapa maidir le seachadadh seirbhíse.

Minister for Health, Social Services and Public Safety

CONTENTS

Annexes

SECTION 1

INTRODUCTION

1 The Minister of Health, Social Services and Public Safety commissioned a review with the following Terms of Reference:

- "to review the implementation of the community care policy with a view to ensuring that adequate levels of service are available, and preventing inappropriate hospital admissions and discharge arrangements", and

- "to consider the effectiveness of the current arrangements for delivering community care services and to make recommendations to Minister by September 2001 about the levels and type of community care provision appropriate for the future, identifying areas for possible improvement in the light of likely need of these services".

2 A Project Board was established during April 2001 under the chairmanship of Mr Brian Coulter, Chief Executive of the Fold Housing Association. The membership of the Project Board (Annexe 1) was selected to give an independent and informed direction to the review.

3 A multi-disciplinary Project Team (Annexe 2) was set up to carry out the review. Initially they were asked to speak to all those involved in the planning and delivery of community care services within the voluntary, statutory and private sector. Planners and professional advisors, doctors, pharmacists, the professions allied to medicine, care managers, nursing and social care staff, were to be consulted to give everyone concerned with the delivery of community care services the opportunity to comment on how they think future services should be provided. In June 2001, following initial discussions, the Minister agreed that in this early phase the review should concentrate on investigating the hospital/community interface, with a particular focus on services for older people.

4 Over the summer months, therefore, there was an extensive consultative exercise with a wide range of service users and providers across all Board areas (Annexe 3).

5 Section 3, which forms the main part of this report, presents the findings of the consultation exercise. This consultation process was a very worthwhile exercise as the service providers and users gave the review team a great deal of useful information about the current problems in delivering community care. They also

gave their views on a wide range of innovative approaches and initiatives that have been, or might be used, to resolve identified problems.

6 In Section 4 the findings of the consultation exercise are analysed and the Project Board, using their collective experience of community care, have agreed the key problem areas on which action is now urgently required. The next phase of the review process will require these areas to be examined in detail. The consultation demonstrated a consensus about many of the key problem areas and their possible solutions. However, the review will need to independently assess potential solutions so as to ensure that any changes to the system eventually recommended will be balanced, realistic and achievable.

7 Section 5 identifies areas in the Community Care Service where there is room for real and immediate improvement. It identifies and describes examples of schemes and innovative practice that the Project Board believes could, if implemented in a pragmatic and evolutionary way, enable Boards and Trusts to have a realistic and positive impact throughout the service.

8 Section 6 presents the Project Board's view on the best way forward to complete the full review of community care services. This proposed work programme is, in effect, an evaluation of the implementation of the 'People First' policy. This policy continues to provide a focus for actions designed to ensure that all users of community care services have access to high quality and responsive care in the setting most appropriate to their needs. These services should optimise choice, promote independence and ensure fairness and equity. Section 6 gives an outline of the tasks that need to be taken to complete the review and we intend, as our next step, to develop a more detailed plan that will reflect the full complexities of the issues to be addressed.

9 As an aide to understanding the background to this review, we have included a statistical profile of the current state of community care (Annexe 4) which illustrates the main demographic and operational pressures within the system.

10 As part of the analysis of the strategic context for this review, a literature review was also commissioned, which sought to analyse any documents and reports relevant to the implementation of the key objectives of 'People First'. This literature review can be obtained as a separate document.

SECTION 2

THE CONSULTATION PROCESS – THE APPROACH

1 A range of stakeholders were consulted, including health and social services staff, representatives from the voluntary and private sector, and users of the service and their carers. The Project Board would like to take this opportunity to record their thanks to all those who contributed to the review.

2 Six workshops were held at different locations throughout the four Board areas. A range of professionals attended these workshops and all Trusts, Boards and Health and Social Services Councils were represented. Further workshops were held specifically for the voluntary sector, Registered Homes Confederation and General Practitioners. Over 230 people attended these workshops. The aims of the workshops were to:

- Identify barriers to the effective implementation of the community care policy;
- Identify initiatives which work well in the delivery of community care and in reducing the instances of unnecessary admissions to hospital, and
- Identify key short and long-term measures to improve the attainment of the objectives of the community care strategy.

3 Site visits were also made to a number of Community and Hospital Trusts. The aims of these visits were:

- To focus on hospital/community interface issues, with particular reference to older people;
- To investigate further examples of good practice which had been identified by participants at workshop sessions, and
- To gain further understanding from the Trusts involved about how we might prevent inappropriate admissions to hospital and reduce the incidence of delayed discharge.

4 The user consultation consisted of two focus groups, the North Belfast Community Forum for Elderly People and the Omagh Elderly Forum. The Health and Social Services Councils arranged these focus groups. The Northern HSS Council also provided the Team with the results of a user satisfaction survey it had carried out.

The aims of these focus groups were:

- To listen to users' first hand experience of community care;
- To identify elements of good practice, and
- To identify areas where improvements could be made.

5 Advertisements inviting comments and views from the general public were placed in local newspapers.

6 Professional journals were provided with a copy of an article requesting a personal or professional opinion on current service delivery, possible improvements, and examples of 'Good Practice', or more effective ways of working.

7 A letter was issued to all 1,080 General Practitioners, and 77 Geriatricians and Psycho-geriatricians, inviting them to make their views known on what they saw as the main issues in the delivery of community care services. The Medical Practitioners were also asked to put forward their suggestions for improvements in the service.

8 There were also individual meetings with Jane Graham from the Eastern HSS Council, Dr Brian Patterson of the BMA, representatives from the Royal College of General Practitioners and the Advisory Committee of the Therapeutic Professions Allied to Medicine.

9 In total, approximately 350 people participated in the consultation. The consultation report (Section 3) does not ascribe particular views to individuals or organisations since a very wide range of topics was covered in these meetings and it would have been quite difficult, and not particularly helpful, to attempt this. Instead, the responses from consultees are presented under a series of broad headings, to provide a potential focus for future actions on our part. This is not a verbatim report of what was said, but an attempt to give as objective an account as possible of the essential points made, grouped and summarized where appropriate.

SECTION 3

CONSULTATION REPORT – THE FINDINGS

Introduction

1 The main messages during the consultation were that people believed they had a Community Care system which was under severe pressure. They believed that there was a general lack of resources, and that the ageing community were generally not well provided for.

The Views Of Older People

2 During the consultation older people expressed the following views:

- They were often made to feel a burden on society.
- They felt that the system militated against families who wanted to keep their loved ones at home.
- They were concerned for their carers who they felt required more help.
- An increasing number of carers were also elderly and frail. This was worrying for users and carers who feared a crisis that would, almost inevitably, lead to admission into care.
- They were dissatisfied with the means testing system as older people did not want to have to sell their homes to pay for residential care.
- They believed care packages were not sufficient to maintain people in their own homes and that they had to depend on the good will of care assistants and home helps for the extra service they need. One home help described how she regularly worked one to two hours unpaid per day.
- They were concerned at the insecurity of community care packages that are often cut back without warning. One 87 year-old gentleman caring for his 85 year old wife had recently had his home help service reduced on the day following her discharge from hospital.
- They believed that services such as social centres and clubs, which increased social contact and helped keep older people active, required more support. A significant theme identified during the consultation was loneliness.

Many expressed feelings of loneliness and isolation, where the only visitor is often the home help.

3 Overall the responses from the consultation process indicated that there was widespread commitment to the original aspirations and principles of 'People First: Community Care in Northern Ireland for the 1990s', amongst professionals and users alike. However, there were many concerns arising from the experience of implementing the community care reforms since 1993. In particular there was concern about what the future will hold in relation to the increasing demands, expectations and pressures that are anticipated to increasingly affect the service.

4 The views expressed throughout the consultation process were wide-ranging but consistent. Many echoed and built on issues that had been raised in the February 2000 SSI Report, 'Review of Care in the Community', and evidenced in the literature review. There was considerable enthusiasm amongst those consulted to engage with these complex and difficult issues and to share the experience that they had gained over the previous seven years.

5 Many participants expressed the view that while this review of Community Care was much needed, its focus on the care of older people and hospital discharge was too narrow. It was widely felt that the care of older people should not simply be viewed in the context of the interface between acute hospitals and community care. Indeed one view frequently expressed was that it was quite inappropriate that major decisions about the long-term care of older and vulnerable people were regularly being taken in such a pressurized context. Many participants felt strongly that a review of community care should not solely look at the needs of one group of service users.

6 Consultees drew attention to many examples of new and innovative practice that they felt could be used as a basis for developing community care. They believed these concrete examples of action could improve the effectiveness of the arrangements for community care in the short-term. However, at the same time they also said that the answer did not lie in "*quick-fixes*". They urged that an in depth review be undertaken to look at the considerable body of experience and practice that was now available, both locally and from further afield.

7 They continually drew attention to the difficult decisions that would have to be taken in light of the ever-increasing demands on the health and social care system. There was a consensus that to develop a high quality care system that effectively promoted independence and choice for service users would need a strong, shared vision and significant investment. They expected demand for services to continue to increase and there was a strong feeling that as a society

we all needed to look now at how we want to see our community care system develop over the next 20 to 30 years.

The Hospital Community Interface

8 It became clear during the consultation that there were considerable variations across Northern Ireland in the arrangements with regard to hospital community interfaces and, in particular, the extent to which liaison procedures and protocols had been developed between hospital and community Trusts. This appeared to be more complex in those situations where hospitals had to relate to a number of different Trusts, each of which had uniquely different arrangements and procedures.

9 It appeared that systems worked best where there was face-to-face contact amongst hospital and community staff and a shared commitment to common goals and procedures. It was felt by many that this was difficult to achieve in an environment where there was often competition between hospital and community priorities. Many felt that there was an imbalance in power, with acute hospitals having a much higher public and political profile, and therefore more power in attracting resources.

10 There was some concern about the extent to which community care and, in particular, care management, had become driven by the pressure on hospital discharge. It was claimed that service users were being discharged "*quicker and sicker*" than in the past. A number of participants expressed the view that this placed additional pressures on community resources, a trend which had not been taken into account in planning and resource allocation.

11 Concern was expressed during the consultation that discharges were often being processed much faster than previously was the case and that in some cases this might be inappropriate, leading to re-admission. It was felt that not enough was known about re-admission rates. It was also felt that there was a need to look at the point of admission as well as the point of discharge, and to ask why there were such high rates of admission to acute care in the first place.

12 Many participants in the consultation workshops felt that there was much that could be done to improve integrated working across hospital/community interfaces. They supported the view that face-to-face approaches worked best and they gave specific examples of more effective ways of working. These included discharge co-ordinators, home from hospital schemes and joint planning groups.

13 Discussion of issues around acute care was highly emotive. While those consulted were very mindful of the press coverage that was given to people waiting on hospital trolleys for a hospital bed for lengthy periods, many realised that this tended to mask a situation whereby Northern Ireland continues to have higher rates of admission than elsewhere in the UK. There was concern that even short stays in hospital and institutional environments could result in increased dependency and loss of resilience in older people. Many focused attention on the admission stage and gave examples of schemes designed to prevent inappropriate admission to hospital.

14 Consultees described initiatives which recognised the risk of infection and disruption to social well being that acute hospital settings bring. They suggested that there was scope for increased use of an approach that delivered expert services in domestic settings. Examples given included schemes aimed at sharing specialist expertise in Chronic Obstructive Pulmonary Disease (COPD) and in wound management.

15 Widespread concern was expressed by professional staff that assessment in a pressurised, unfamiliar, clinical environment could not give an accurate picture of a service user's full ability and potential. There were worries that while a person may be judged medically fit, they may not yet have made a full recovery from illness. There was a widespread belief that assessment in an acute hospital environment could lead to admissions to institutional care that, with a different approach, might have been avoided. They also felt, for the same reason, that some patients may leave hospital with inflated care packages that could be difficult to reduce at a later date.

16 Hospital Community Interface - Ideas for Change

- Common discharge planning policy and procedures on a multi-disciplinary basis and standardised across all hospital and community Trusts;
- Regular review and update of discharge policies and procedures;
- Increased and meaningful face-to-face contact between staff in hospital and community Trusts at senior management and operational levels;
- Increased use of working arrangements that bridge the interface between hospital and community. For example, discharge co-ordinator, liaison staff etc;
- Making permanent decisions about a person's future care in an acute hospital setting should be avoided wherever possible;
- Hospital staff should have access to budgets for services for people with less complex needs, e.g., home helps, to ensure that service users are not unduly delayed in hospital for minor reasons;
- Improved and speedier communication between hospital consultants and GPs is needed. This should be possible with the better use of electronic mail;
- There should be shared access by hospital and community staff to aids and equipment;
- More focus should be placed on the extent of inappropriate hospital admission and the development of suitable preventative strategies, and
- Increased use of pre-admission screening and assessment for service users facing elective surgery. This is aimed at shortening hospital stay by identifying in advance those service users who will be likely to require additional support on discharge so that planning can begin sooner.

BETTER PRACTICE

Innovative Schemes and Good Practice Models

17 Trusts demonstrated to us a number of schemes and models of innovative practice that they had developed. The majority of these focused on bridging the gap between acute hospital and primary care. Many had been developed using the funding that had been made available to relieve winter pressures on acute care. They included various hospital-at-home schemes, rapid response schemes, intermediate care schemes and rehabilitation schemes. Many were focused on the premise that increased investment in care in the short-term could be more cost-effective in the long-term by:

- Preventing inappropriate admission or re-admissions to hospital;
- Facilitating early discharge and recovery once a person in hospital is medically fit; or
- Preventing admission to institutional care.

The key features of these schemes were:

- Having dedicated multi-disciplinary teams
- Being user focused
- Targeting specific patients
- Having clear admission and discharge criteria
- Setting measurable outcomes

It was argued that these innovative developments offered working examples of best practice that, if developed into core mainstream working, could provide solutions to many of the difficulties that were highlighted during the consultation.

18 The main issue raised by Trusts about these schemes was their non-recurrent funding which had led to stop-start planning arrangements and had resulted in difficulties in recruiting temporary staff to work on these schemes.

Prevention

19 Consultees emphasised the need for a philosophical shift which would re-affirm the value of prevention in the care of older people. They said that in the current climate there had been little focus on the role of prevention, with most efforts focused at the sharp end of provision. Many felt that the end result of this was counterproductive, both in cost terms, and in health and social well-being

outcomes for older people. It was their opinion that, in the long run, screening and early detection of unmet need was the more cost effective option.

20 They also pointed out that the vast majority of people being cared for by community care services were not within the formal care management process. There was a strong view that there should be an increased focus on the needs of this group if the issue of prevention was to be seriously tackled. It was suggested that targeting resources on those in most urgent need had led to a decline in support for less complex need, such as the traditional home help service, and that the vital role of these services in prevention should be recognised.

21 Consultees believed that if more could be done to develop primary care services less people would need to go into hospital beds for treatment since it was now increasingly possible to deliver quite complex treatment in service users' own home, or in GP surgeries.

22 They also stated that supported housing schemes and technological aids had a much greater potential than was presently employed, and their wider use would significantly contribute to preventing the need for more disruptive and expensive forms of institutional care.

Rehabilitation

23 Many expressed the view that there was little or no effective rehabilitation for older people, either in the community, or before service users were discharged from hospital. They felt that the effect of recent developments had been to focus professional time disproportionately on assessment activity. They also stated that where rehabilitation is started in hospital it is not generally carried on when service users move into residential or nursing care homes. They said that this wasted the valuable input already made and prevented older people from regaining their full potential. A number supported the view that institutional environments are often "*de-habilitating*" in that they actually lead to increased dependency, loss of individual resilience and ability to cope independently.

24 They gave a number of examples of innovative developments that they believed supported the view that investing in rehabilitation in the short to medium term could have considerable long-term benefits in terms of quality of life and cost of care. They claimed that in these cases a significant proportion of service users made good recoveries and were consequently much less dependent on long-term services. One example given of such an innovative community-based rehabilitation scheme was the delivery of person-centred stroke rehabilitation in the service users' own homes following their discharge from hospital.

Other Intermediate Care Schemes

25 Consultees discussed a number of intermediate care schemes which were focused on bridging the gap between acute hospital and primary care. These had also been developed using winter pressures funding. They included various rapid response schemes and step-down arrangements. They believed that these underpinned the idea that increased investment in care in the short-term could lead to more cost-effectiveness in the long-term by:

- Preventing inappropriate admission or re-admission to hospital;
- Facilitating early discharge and recovery once a person in hospital is medically fit, and
- Preventing admission to institutional care.

Evaluation, Research And Sharing Of Good Practice

26 Many examples were cited of new and innovative practice in the area of intermediate care in Northern Ireland. It appeared, however, that these had been developed in isolation. Indeed, frustration was expressed about the lack of sharing, both between Trusts and at regional level. It was claimed that there were few forums or opportunities for staff to share the development of good practice either within or between Trusts, and they welcomed the opportunity given by the consultation workshops to share ideas and concerns.

27 It was stated that there was a general lack of bench marking or evaluation of what works. Although some of these schemes had been evaluated or audited, there was no clear consensus about how this information could be effectively shared.

Sustaining Innovative Developments

28 One particular cause of frustration for health and social care staff was the difficulty of sustaining innovative projects that had been developed with short-term project funding. This was the case for both the statutory and voluntary sectors. Many in the voluntary sector expressed the view that the flourishing independent sector that was envisaged in People First had not developed as intended. They also felt that partnership working was underdeveloped and voluntary sector providers often felt that they were effectively "*sub-contracted*", rather than working in partnership. There were particular concerns from some voluntary sector providers that in certain cases costs were being driven too low to provide care at the quality they would wish.

29 They clearly expressed the view that a way of adequately funding and sustaining schemes that can be shown to work effectively should be found. A strong strategic lead was required to determine if such funding could be released from existing sources, or whether additional, recurrent, funding was required.

30 **Better Practice - Ideas for Change**

- Collective experience of new, innovative work that has developed should be reviewed to draw out the lessons that could be applied across the board;
- The feasibility of focusing less professional therapy time on assessment, and more into rehabilitation, prevention and treatment, to achieve maximum independence for service users, should be considered;
- New and innovative practice should be evaluated and audited on a more regular and widespread basis.
- Opportunities for sharing of good practice should be increased;
- When examining good practice there should be an emphasis on comparative costs and resources, avoiding duplication and ensuring consistency;
- Effective means of rolling out and mainstreaming successful working models of practice must be found;
- The current patchy and stop-start provision of funding should be addressed;
- Access to, and choice of, opportunities for prevention, rehabilitation and recovery to all people who can avail of them, irrespective of age and disability, should be increased, and
- Partnership with the independent sector should be given further investment and development.

RESOURCING COMMUNITY CARE

Funding Uncertainties

31 Widespread concern was expressed that the funding available to the community care system to cope with the present needs of service users was already insufficient and that this was likely to be compounded in the future by increased demand and expectations from the public.

32 Explanations were given as to why resources are currently under pressure. Primarily, they said, that since the outset of the community care reforms in 1993 the predicted turnover in care had not been as high as had been expected. They said that this was because the average life expectancy of service users receiving community care was now significantly longer than the average of three years anticipated in 1993. This meant that the total number of people needing support at any one time tended to be significantly higher than first predicted. They believed that there were other factors that led to increased pressures on community care systems, such as the reduction in acute sector beds that had occurred. Another explanation put forward was that, since "*preserved rights*" monies were not recycled into the community care budget, this effectively meant a decrease in the resources available.

33 They also believed that costs had risen in other ways not anticipated at the outset of the 1993 reforms. As well as the implications of changes in the labour market, which had already been raised, they drew attention to the SSI report, ‘Review of Community Care’. They stated that more attention should be paid to what it had to say on the impact of recent changes in pay and working conditions such as the minimum wage, the working time directive, and increased public sector pay awards.

34 Other cost increases cited were those associated with increased regulation, such as the guidance on lifting and handling. They said that these had added substantially to the cost of care packages. They also said that there would be additional costs associated with the pending regulation of the social care workforce.

35 In every consultation session with staff, three areas emerged where resource difficulties are giving particular cause for concern and seen as needing urgent attention:

- Recruitment and retention of skilled care staff;
- Supply of private sector bed places, and
- Supply of aids to daily living and housing adaptations.

Recruitment And Retention Of Skilled Care Staff

36 Attention was repeatedly drawn to the often very poor pay and conditions still experienced by many frontline care workers. As one participant stated, *"Why would someone go out on a cold winter's night for two hours to drive through icy country lanes for half-an-hours pay?"* Managers reported that this situation had been further exacerbated by the growth within other sectors of the economy, for example, in the retail sector, with supermarkets often offering much better pay and conditions for easier, less stressful jobs. It appeared that this problem was worse in rural areas with their higher travel costs. It was stated that this high turnover of staff meant that there were often many workers, some new and inexperienced, involved with an individual service user and this made it difficult to provide continuous quality care. Managers felt that these issues needed to be tackled urgently and that care workers should be more highly valued and better rewarded both by employers and by society.

37 While recruitment and retention of staff was a general issue across all grades of staff, we were told that there was a definite lack of skilled staff to carry out assessments, treatment and rehabilitation. There was a widespread feeling that there needed to be improved long-term planning to tackle these issues based on realistic predictions of the future need for care staff.

39 Consultees believed that there was scope for improved efficiencies in this area and they drew attention to the potential duplication of effort arising from systems and structures they believed to be overly complex. They expressed a firm view that there was room for improvement in the general skills mix, in particular with the better targeting and sharing of the time and expertise of skilled specialist staff. It was stated that streamlining of systems and structures and development of new ways of working were required to make all this possible and that this would require a strong strategic lead. Without this, they said, the scope for local improvement remained very limited.

Independent Beds

40 The independent sector indicated that they were fast approaching a time when the residential and nursing home business would no longer be profitable. Although it had been argued by others that this sector is over used, they told us that that demand for their services is still growing. They discussed whether this situation might not provide an opportunity to develop a new service for older people, in partnership with the independent sector, which would enable a shift of emphasis from residential accommodation to rehabilitation and prevention. The main points the private sector representatives made were that:

- The independent sector had not been fully involved as equal partners in the development of community care;
- Their relationship with the statutory sector had become quite strained, and
- The contract prices for basic levels of care needed to be agreed.

41 Many of the staff consulted were deeply concerned about the decline in availability of independent sector beds. They reported that demand was beginning to outstrip supply in some areas, with particular problems emerging in the supply of EMI beds. While staff accepted that the use of nursing home and residential beds in Northern Ireland is still relatively high compared to usage in Great Britain and the rest of Ireland, there was some feeling that this difficulty had arisen here because there had been insufficient growth of alternatives to nursing home and residential care.

42 Consultees said that there was a need to provide more choice and diversity in future arrangements, including more use of rehabilitation in nursing and residential settings. They recognised that independence would be at the centre of future practice development. However, it was their expectation that in all likelihood there would continue to be significant numbers of frail people who would continue to need considerable support. They believed that a wider range of supported living situations should be developed which would give better choices for frail older people.

43 Another view expressed was the need for more transparency in the actual cost of provision of private care. Other consultees said that there needed to be better working arrangements between the statutory and independent sectors, with clearer arrangements about what the private sector was expected to provide, and how much they would be paid for it. There was broad agreement on the scope for improved working relationships and sharing of expertise.

Equipment And Housing Adaptations

44 In talking to Trusts, widespread variations in arrangements for housing adaptations were revealed. Evidence offered showed that in many areas, while minor work was not an issue, major work could be slow and fraught with bureaucracy. Examples were cited where, apparently, on a number of occasions, the service user was placed in residential care before the home adaptation was completed.

45 It also appeared that in many areas there are long waiting lists for equipment. Instances were reported where service users were delayed in hospital while waiting for relatively small and inexpensive items. This situation was apparently

exacerbated in areas where there was no distinction made in the waiting lists between small and large pieces of equipment.

46 Another problem reported was the ever-faster development of newer, more modern appliances. This meant equipment becomes obsolete faster, further increasing overall equipment costs. Desirable "*state of the art*" equipment was reported as being increasingly costly, subjecting funding to even greater pressures.

47 Particular concern was expressed that, once purchased, equipment is frequently not adequately tracked and that expensive pieces of equipment that had ceased to be required by the service users to whom they had been allocated were often lost in this way.

48 **Resourcing Community Care - Ideas for Change**

- A planned approach to the resourcing of community care should be developed which would allow key decisions to be made now about how the future needs should be resourced;

- It should be implicitly recognised when resource planning that good quality care is expensive. It should also be recognised that providing poor quality care is even more expensive;

- The issue of increasing costs should be addressed, in relation to:
  - The upward trend in demand for community care services;
  - The pressure for improved pay and conditions for care staff, and
  - The new costs associated with regulation and training needs.

- It should be recognised that better management of resources is needed in terms of:
  - Workforce planning;
  - Better targeting of expensive professional time and more appropriate use of skill mix, and
  - More efficient systems for tracking equipment.

- The position of the private sector vis-a-vis costs, profitability and increased demand for managing more complex care should be reviewed, and

- More choice should be offered to service users through the development of a wider range of supported care options.

MULTI-DISCIPLINARY AND MULTI-AGENCY WORKING

49 It appeared that there were considerable variations in the arrangements for multi-disciplinary and multi-agency working. Attention was frequently drawn to the demise of collaborative working. Consultees said that this was as a result of the development of the competitive market based culture that had been encouraged in the delivery of public sector services through the late 1980s and part of the 1990s.

50 Managers and staff said that at a strategic level they would like to see improved working and collaboration between the following:

- Government Departments;
- Professional disciplines;
- Trusts;
- Hospital and Community based staff;
- Statutory sector and the voluntary and community sectors; and
- Statutory sector and the private sector.

51 Managers believed that at an operational level there was often relatively successful collaboration, especially where staff had good day-to-day working relationships. They also believed that effective community care needed dedicated multi-disciplinary teams and gave a number of good working examples where multi-disciplinary teams, based in primary care settings, were working well. However, they also said that there were still too many barriers in place. A number of those consulted expressed the view that there was insufficient integrated team working. They believed that in some areas there was still a uni-discipline team culture, and situations with multi-disciplinary working *"getting lip service only"*. They believed that cultural and attitudinal change was required, otherwise professional jealousy and competition would continue to undermine care provision.

52 A note of caution was also sounded about the extent to which we actually have a specialised and professionalised care service. Some said that this sometimes "*fragmented"* care delivery and worked against a "*holistic*", person-centred, approach. They believed that it was important that individual service users should not be “*bombarded*” by too many professionals and that there should be collective staff agreement on the key personnel who would interact directly with service users. They also said that it was vital that service users should be at the centre of goal setting in regard to their own care plans and that this should not be taken over by professionals. Otherwise, they said, there was a risk that professionals might have differing goals and perspectives, either from each other or from the service user.

53 **Multi-disciplinary and Multi-agency Working - Ideas for change**

- There should be a cultural shift towards more collaborative working;
- Approaches should be encouraged that ensure lack of duplication through development of closer links;
- The use of common assessment tools amongst professions should be encouraged, and
- There should be an increase in the use of person centred approaches, where service users set goals in consultation with profession staff.

MEDICINES MANAGEMENT

54 A number of issues around the area of medicines management surfaced during the consultation. Concerns were expressed about the following issues:

- Service users and informal carers were often confused about medicines and when they should be taken;
- Undesirable side effects and inappropriate use of medicines were major factors leading to increased admissions to hospital and increased risk of falls;
- Ineffective systems for reviewing medicines led to "*polypharmacy*", and
- The difficulty of obtaining drugs out of hours, particularly for palliative care.

They stated that more effective medicines management should have an enormous impact in cost savings and improved quality of life, reduction in falls, and inappropriate admissions due to side effects.

55 There was a strong view amongst those consulted that pharmacists, particularly community pharmacists, had an important role to play in improving medicines management. This requirement appeared to exist not only at primary care level, but also in residential homes, nursing homes and domiciliary care situations, and also at the hospital-community interface. Our attention was drawn to a wide body of evidence based on recent research in this area which should be taken into account if the need for improved medicines management is being looked at.

56 As well as identifying a role for the increased involvement of community pharmacists in community care, we heard expressed the general need for a higher awareness of these issues to be achieved right across the care spectrum, including qualified and unqualified health and social care staff, service users, carers and the general public.

57 **Medicines Management - Ideas for Change**

- Increasing involvement of community pharmacy in primary and community care systems;
- Increasing awareness of the issues around medicines management across all staff;
- Making medicines review a routine part of the care review process, especially for older people and those in residential and nursing settings;
- Updating repeat prescribing systems and dispensing repeat prescriptions monthly, rather than three monthly, to increase review and decrease medicines wastage;
- Educating and training of carers on the safe use and administration of medicines;
- Improving hospital admission and discharge arrangements with routine medicines review;
- Giving better information and advice to patients and/or before hospital discharge, and
- Giving consideration to increasing the current three day prescribing period at discharge as an increased convenience for people leaving hospital and their carers.

STRUCTURES AND SYSTEMS

58 Some participants in the workshops felt that overall there were simply too many Trusts. Others argued forcefully that there was a need for a more common focus on community care across all Trusts, and particularly between hospital and community Trusts. It was reported that there were considerable variations both in working arrangements and in the extent of collaboration between community and hospital trusts. It was also made plain that the continuing competition for scarce resources led to a lack of collaboration and that those in the community sector often felt that excessive resources are targeted at acute provision.

59 Consultees said that within community Trusts the relationship between primary and community care, care management, conventional services and programmes of care is subject to complicated systems and structures. Some expressed the view that differences in multi-disciplinary and single-disciplinary practices between Trusts often added to this complicated situation. It was also made clear that the sheer number of systems, and the many interfaces between them, often present difficulties for service users and for those who are attempting to support them.

60 There was a general opinion that there was a great deal of scope to simplify the bureaucracy and paperwork that accompanies the different arrangements in working practices, policies and procedures. They believed that all this resulted in unnecessary pressure on staff time. One idea that surfaced frequently during these discussions was the idea of moving towards a standardised assessment tool.

61 They also identified communication systems as having considerable scope for rationalisation and simplification. In particular, they saw shared information systems as highly desirable. One popular view expressed identified a core problem as "*IT systems which don't talk to each other and professionals who don't talk to each other*".

62 Structures and Systems - Ideas for Change

- Communication between professionals and between systems, particularly IT systems, should be improved:
- There should be further development of approaches to improve integration and reduce duplication, such as one-stop shops, joint working between hospitals and communities, and service-user held records;
- Service users should be provided with information describing the structures and systems in place and detailing the range of community care services potentially available to them;
- There should be more use of regional approaches in terms of development of practice and procedures for working;
- Staff should be encouraged to work in collaborative, rather than competitive ways, and
- There should be rationalisation to reduce the number of systems and structures that exist.

CARE MANAGEMENT PROCESSES

63 Considerable concern was expressed that care management had not developed in the way that was originally envisaged whereby service users would be offered greater choice and access to innovative care options. Consultees said that there was too much emphasis on assessment activity and discharge from hospital and that this led to a strong focus on residential and nursing home solutions. They saw this as creating perverse incentives within the systems which resulted in most placements becoming long-term. It was claimed that if review was not timely or meaningful – which was often not the case – then the decisions made rarely change so that, even if the user initially had the potential to return home, most people did not move out of care again.

64 We were told that large caseloads meant staff did not always know clients well enough with, in some cases, perhaps only one visit per year. They said that at times care management and its associated underdevelopment of real alternatives to residential and nursing care was driving a culture of dependency rather than independence. They forcefully put to us that the current system was

maintaining and accommodating service users, doing things “to them” and “for them” rather than with them.

65 Developing this theme, some consultees highlighted the emphasis on giving priority to people with complex needs. This tendency, they alleged, had now become disproportionate. Participants often expressed concern that the emphasis and priority on complex needs resulted in borderline service users being pushed into the "*complex category*" in order to receive a service. They said that this was because the system had become service-led rather than person-centred, resulting in assessments that were too mechanical and clinical. This was, they said, because the model of care provision that dominated was medical rather than social.

66 Care Management Processes - Ideas for Change

- Common assessment tools should be developed;
- The balance between demand and resources should be fundamentally reviewed;
- There should be a move in emphasis from assessment towards increased use of review;
- More intermediate care options should be developed;
- There should be investment in those approaches which, although more expensive in the short-term, are more cost effective in the long-term;
- A wider range of innovative care options should be developed, and
- There should be an increased use of Direct Payments.

BUDGETS

67 A particular issue raised by participants during the consultation was the inflexibility of budgets. An example quoted was where Trusts’ budgets for institutional care and domiciliary care were separate and inflexible. It appeared that under this system the numbers who stay at home and the numbers who go

into care are pre-determined in the budget allocation. The general view was that, overall, domiciliary care is under funded.

68 It was also reported that when speed of hospital discharge became the main performance indicator, tensions could surface between hospital and community staff over budgetary issues, with each tending to feel that the other is placing pressure on their budget. Consultees said that there were considerable variations in practice, with some areas giving total priority to service users seen as at risk in the community while others give their priority to those being discharged from hospital.

69 They also believed that financial and budgetary incentives worked against the development of alternatives to institutional care. Since moving service users into residential and nursing home settings can be charged for, unlike domiciliary care which is free, some said that this was creating a perverse incentive to do the former. They also pointed out a tendency for formal, or informal capping of domiciliary care costs by Trusts as a response to financial pressures.

70 **Budgets - Ideas for Change**

- There should be more flexibility in budgets to facilitate greater innovation and creativity in response to need;
- Alongside increased flexibility there should be a degree of ring fencing, especially for new money or finance, that can be easily "raided" to pay for overspends elsewhere;
- There should be clear guidance in specific areas about who pays for what, for example, non-drug tariff items;
- There should be some funding that could be spent very flexibly to alleviate unforeseen difficulties that are causing major delays;
- Additional funding should be made available to pump-prime innovative work, and
- Long-term funding streams should be identified to sustain and mainstream new approaches, either through new resources or re-allocated resources.

CHARGING POLICIES AND USE OF SOCIAL SECURITY BENEFITS

71 A widespread view was that there were untapped sources of funding already in the system in terms of service user contributions. They debated existing charging policies and focused on the use, or non-use, of relevant social security benefits in purchasing care, such as Disability Living Allowance (Care Component) and Attendance Allowance,

72 Their discussion around these issues confirmed that it was a difficult and controversial area and the debate revealed that very disparate views were held. There appeared to be widespread uncertainty over present legislation and policy. It was also clear that not all participants were aware of the Departmental guidance that already exists in the area of Disability Living Allowance and Attendance Allowance. While others seemed aware of it, some of them clearly disagreed with it.

73 They also discussed the use of Direct Payments. Some of the consultees saw this as generally underdeveloped and a potential alternative source of funding for innovative service development. Others saw it as a barrier to further development, citing issues around infrastructural support for service users.

74 It was stated that since residential care is subject to means assessment, while the bulk of domiciliary care is provided free of charge irrespective of income, this situation led to inequity between those who go into care and those who stay at home. They suggested that, in some instances, formal or informal capping takes place in terms of the cost of domiciliary care once it exceeds the cost of residential or nursing care. They made the criticism that those who cannot afford to buy extra help are disadvantaged over more wealthy service users who can afford to pay. Some also commented on other anomalies, such as the inability of Trusts to charge for services where service users had received high compensation claims, part of which have been based on their care needs.

75 Charging Policies and Use of Social Security Benefits - Ideas for Change

- Steps should be taken to ensure that existing guidance to Disability Living Allowance and Attendance Allowance which has already been clarified, is widely known, and

- There should be continued support for development of Direct Payments and the necessary infrastructure to support this.

- There should be a review of charging policy, with particular reference to work already completed by the Department in 1997;

STRATEGIC PLANNING AND DIRECTION

76 Consultees were still in broad agreement with the original vision for community care, which had the development of choice and independence for service users at its core. However, there was also a strongly held view that service development was not always driven by this vision and that managers at local level were often struggling to develop services without clear direction. They believed that there was a need for improved strategic planning and direction to replace approaches that are based on crisis management and reactive working. They said that staff and managers often felt that they could not *"get their heads above water".*

77 Across the board they expressed a definite view that the Community Care policy needed to be looked at again, especially given that it was ten years since ‘People First’ was produced. Many believed that policy and planning had not been sufficiently evaluated to take account of actual experience and that this contributed, to some extent, to the resource problems that have subsequently emerged. They said that it must be recognised that costs have risen in ways that could not have been anticipated at the outset of the policy and they instanced unforeseen economic, legislative and demographic changes during the intervening years.

78 They said that in a climate where it was known that the pressures over the next ten years were certain to increase, the Community Care Review needed to develop a strong regional vision and strategy for the future and that the Department should take the lead in this. They also said that all future strategic planning in community care needed to adopt a multi-professional, user-centred, and collaborative approach.

79 **Strategic Planning and Direction - Ideas for Change**

- There should be a review of the existing community care policy to give a new, up-to-date vision for community care, taking into account changes in the policy and legislative climate, new best practice and the vast body of experience that has been gained in recent years both within Northern Ireland and beyond;
- Links should be made to ensure that the interim findings of the community care review are taken into account in the development of the new Regional Strategy. Links should also be made between the review of community care and other recent reviews such as the Acute Hospitals Review and the 'Way Forward' consultation report on Primary Care;
- Mechanisms should be developed to give a strong regional lead to the future development of community care;
- Targets and performance indicators for community care should be linked to the revised vision for community care, and
- Full consideration should be given to resource implications when developing future strategy.

OTHER KEY ISSUES

80 During the consultation workshops consultees repeatedly raised three other important issues. Although they did not develop these in-depth, they made it clear that they regarded these as vital issues which they felt must be picked up and developed more comprehensively as part of the review and any subsequent consultation work that takes place. These three issues were:

- Quality assurance;
- Equality; and
- Involving people and communities.

Quality Assurance

81 During the consultation workshops participants raised a number of issues about Quality Assurance. They said that:

- In a situation where resources are constantly under pressure and over-stretched, the aspiration to deliver high quality community care services was constantly being undermined.

- There was a need for improved staff development, training and supervision, particularly where there was a high turnover of unqualified staff working at first-hand with service users.

- There was a need for improved regulation of aspects of the service, although it was acknowledged that, to some extent, this was being picked up through the improvements for regulation of the social care workforce that are already underway.

- There was a need for clear regional standards for community care provision. They felt that although much work had already been done in this area it needed to be given a much higher profile.

- The National Service Framework for Older People, whilst not adopted here, may provide a valuable source to be drawn on for further development of local standards.

82 A particular debate that was raised in many consultation sessions was the difficulty that existed with regard to risk-taking in an increasingly regulated working environment. In general, experienced staff held the view that there needed to be an accepted degree of risk taking if older people are to be allowed a reasonable quality of life. Many believed that they were working in a "blame culture" with an increasing likelihood of litigation if they were to get it wrong. They frequently expressed the view that ways needed to be found to allow older people to take risks, if that is what they desire, in order to maintain a reasonable quality of life. They said that there was a need to move from a *“blame*” to a “*learning*” or “*educative*” culture.

Equality

83 Consultees raised a number of issues in regard to inequalities that they believed existed within the present system. They said that these would need to be tackled in light of the current statutory equality duties on service providers. Highlighting the need to ensure that all future community care policy and practice development takes equality fully into account they said that:

- The equity issue in funding arrangements between Trusts has not been fully addressed and this has led to unacceptable differences in the range and level of services available across Trusts' areas.

- The different priorities and different eligibility criteria that exist between Trusts means that service users in different Trust areas experience inequalities in provision.

- There are particular equity difficulties in regard to rural areas, since it can be easier and cheaper to develop innovative provision in urban areas where staff supply is better and economies of scale are more possible.

- In our society general attitudes to ageing and elderly care are often negative or subject to ageism and that, as a consequence, many older people experience considerable social exclusion from everyday life.

- Older people are often less vocal or radical than other groups of service users and some are unlikely, or simply unable, because of disability or isolation, to participate in consultation. There is a need to address these missing voices in any consultation work.

Involving People And Communities

84 Consultees saw a pressing need for involving service users, carers and communities in the improvement of care policy and delivery. They said that:

- There was a need for a more person-centred approach to the care of older people.

- Although service user and carer involvement are vital to future planning and policy development, we do not know enough about what older people want.

- There has been less capacity building for involvement of older people than in other groups of service users.

- As people become older their care seems to be increasingly located in a medical model of care. This needs to be redressed and it should be acknowledged that older people do not wish to be viewed solely in the context of their health status, but as adult human beings with the same emotions and feelings as younger, fitter people.

- Carers’ needs should always be considered in service provision and planning and, in particular, the needs of the growing number of older carers need to be heard.

- At community level participation and involvement is still underdeveloped and there was concern that we are often not listening to communities. In part this was attributed to a system that is still driven by a strong medical model, whereby "professionals know best".

- Consumer expectation amongst younger age groups is rising. In the future, as they age, there will be increased numbers of older people requiring care and these people will demand higher standards. There was a need for a debate about how younger people could be encouraged to make better plans for their own old age.

SECTION 4

THE CONSULTATION PROCESS – OUR RESPONSE

1 The members of the Project Board have carefully considered what was said during the consultation process. While much of what we were told was not supported by direct evidence, from our collective experience of community care, and from the variety of information sources that we do have access to, it seems to us indisputable that significant weight must be attached to the comments and criticisms we have received to date.

2 Before we give our response we wish to take this chance to express our admiration and support for those who endeavour and, to a remarkable degree in difficult circumstances succeed, in delivering community care services to those in need.

3 While Community Care has had some successes, as evidenced in many SSI Inspections, the pressures that impact on community care, rising expectations, demographics, funding conflicts, and inter-agency and inter-disciplinary failures are indisputable and well rehearsed. We recognise that these pressures will continue to intensify in the future.

4 In starting the second phase of this work we believe that a systemic review of the community care services should have, at its core, a re-evaluation of the ‘People First’ policy. While there was a clearly expressed opinion that the objectives of ‘People First’ remain valid and desirable, there was considerable disquiet about the way in which they had been implemented over the last seven or eight years. Indeed there was a view that as we have moved into the new Millennium, and given the major changes being considered in other areas of the Health and Social Services system, it would be wrong if this opportunity to revisit ‘People First’ was not taken.

5 How we would propose to take this work forward is the purpose of the next two sections. In the remainder of this section we give a summary of our response to the issues raised in the consultation and attempt under the headings used during the consultation, to present our view of what the problems are and what needs to be done to deal with them.

The Hospital/Community Interface

6 We agree that the community care system works best where there is face-to-face contact amongst hospital and community staff, with a shared commitment to common goals and procedures. However, there are obviously significant variations in how individual delivery systems work in practice and much could be done to improve integrated patterns of working across hospital/community interfaces.

Better Practice

7 Good practice, improved standards and innovation should be the cornerstones of a developing community care service in a changing environment. There are many excellent examples of new schemes and approaches, the initial findings from the vast majority indicate positive outputs and outcomes. However, we noted that few have been independently audited. Many of these are small in scale and many are subject to short-term funding arrangements. There are no obvious mechanisms to publicise and, where appropriate, roll out these schemes regionally. We feel the service is severely inhibited by the failure to share good practice among Trusts, which have very few opportunities for staff to share the development of good practice. The Department and Trusts need to establish mechanisms and processes to remove these barriers.

8 Preventative services, targeted at those at risk, should make it possible to maintain people in their own homes for longer. There is a clear need to begin to identify, evaluate and promote schemes which are not simply crisis interventions, but involve a more long-term approach to identifying people at risk and supporting them before they require crisis interventions.

9 Rehabilitation is fundamental to enabling older people to recover from illness or accident and to continue to enjoy the later stages of life. The consultation process confirmed our view that effective rehabilitation can help people stay at home, provide a direct alternative to hospital, facilitate early discharge and reduce readmission to hospital. We share the widely expressed concern that the balance has shifted from rehabilitation to maintenance. There is also evidence of a reluctance to put in intensive help in the early stages of a person’s return home in case they become dependent on this. However, if an older person was able to receive adequate help on discharge this could facilitate their rehabilitation. There are many examples of innovative schemes based on a rehabilitation model and we must ensure that steps are taken to redress this imbalance. We need to initiate a process that will benchmark models of good practice to ensure there is sound evidence that schemes are achieving their desired outcomes, and then ensure that this good practice is rolled out.

10 The contribution carers make towards helping people remain in their own homes and staying independent cannot be over stated. This level of service could not be delivered by the formal care system and this important fact should be recognised and supported. We need to think of ways in which the system can recognise the valuable role of carers and provide more comprehensive support for them. In considering this issue, we will need to work closely with the development of the Carer's Strategy.

Resourcing Community Care

11 We accept that the resourcing of Community Care is highly problematic, with a number of prominent pressure points. For instance, the cost of domiciliary care packages has risen sharply, due mainly to the increasing complexity of care packages and the introduction of new working rules. Additionally, the terms and conditions for domiciliary care employment have become uncompetitive with other sectors of the economy, causing acute recruitment and retention problems. We also accept, with some concern, that there has been a decline in the availability of independent sector beds, even though we note that the use of nursing home and residential beds in Northern Ireland is still relatively high compared to usage elsewhere in the UK. Finally, we recognise that waiting lists for equipment and housing adaptations are increasing and, in some instances, this is contributing to delaying discharge from hospital. We accept that there are further problems surrounding retrieval of re-usable equipment and meeting the demand for "state of the art" equipment.

12 A principal objective of "People First" was that older people should receive services to enable them to live as full and independent a life as possible within their own homes. There has been a decline in the ratio of people receiving care packages in their own home, compared to people receiving care in residential or nursing homes. Where users are receiving care at home, it is often inadequate in quantity and unsatisfactory in quality. However, we believe that at this time we do not have a comprehensive explanation of why this is happening. This issue must be properly explored so that meaningful proposals to effectively reverse the trend can be developed.

13 The availability of a well-trained and committed workforce is obviously essential if both the volume and quality of care services are to be increased from current levels. The sector is labour intensive and will remain so, in spite of some technological advances. Furthermore, labour market trends suggest that today's problems will be exacerbated in the future as women become better qualified and therefore less likely to fill the gaps left in the service by retirements. Any planned expansion in the service will worsen this position. To rectify the

situation we need first to accurately establish the scale of this problem by working closely with the DHSSPS Workforce Planning project.

14 We acknowledge that there are obvious problems in the provision of residential and nursing home places, which are overprovided in some areas and underprovided in others. We also accept that there is a trend to rely on nursing home provision rather than domiciliary care. The current residential and nursing home provision needs to change to provide a wider range of services to meet increasingly complex need. We know that the independent sector has a valuable role to play in the provision of community care to people who can no longer remain in their own home. We must work with the independent sector to determine how the residential and nursing home market is currently operating and identify what changes are required to bring greater confidence and stability into this sector.

Multi-Disciplinary and Multi-Agency Working

15 Multi-disciplinary and inter-agency working has long been recognised as the best way of delivering good community care to older people. It is also clear that such professional collaboration is optimised where staff have close day-to-day working relationships. We believe that while multi-disciplinary teams based in primary care settings are often working well, there are still many barriers to overcome. Indeed, overall, it is our view that there is insufficient integrated team working within the system. We need to ensure a better skills mix in community care provision. There should be an evaluation to determine whether dedicated multi-disciplinary teams have better outcomes for service users than the traditional uni-disciplinary approach and to identify transferable models of good integrated team working.

Medicines Management

16 We accept that medicine related problems are frequently encountered in the delivery of community care and that there are particular needs for carers and patients in residential and nursing homes. Effective medicine management strategies should form an integral part of community care provision. We learnt that there were many examples of innovative practice already in place and that we need to explore the introduction of integrated management systems, in particular the role of community pharmacists in community care. This could best be done in conjunction with the planned Community Pharmacy Strategy.

Structures And Systems

17 We need to consider seriously the potential for rationalisation of the overall community care management, both between and within Trusts, looking to simplify where possible. We also need to look at the existing communication systems with a view to rationalising and simplifying them, and, where possible, to develop new systems which can readily pool and exchange information. This is particularly important when we are developing a more accurate way of recording unmet need.

Care Management Processes

18 We heard and sympathised with the view that care management has contributed to a service-led rather than person-centred service, with the result that assessments are often too mechanical and clinical. The concern that the system does not offer appropriate choice and often fails to identify an appropriate "*exit*" point for users seems to us well-founded. We recognise that the system may be creating perverse incentives leading to inappropriate long-term solutions. In practice, this results in too much focus on residential and nursing homes. We also accepted that there was a tendency for border-line service users to be pushed into the "*complex*" category in order that they might access care management. This tendency highlighted the fact that assessments and services are targeted at those with most complex needs while those with less complex needs are often left without service. We are also concerned that the present system of service delivery has led to inequity. There is some evidence to support the view that the level and type of service can very much depend on your geographical area or postcode.

Budgets

19 We know that people are living longer and that the costs of community care are rising. Good quality community care is expensive and costs are increasing at a rapid rate and, while there are a lot of very positive developments taking place to improve services for older people, these also cost money. There was an understandable demand for community care budgets to be ring-fenced or protected.

20 Currently there are a number of funding sources underpinning community care and it is not always clear how these are spent. We need to examine the current use of resources from all funding streams, core funding, People First funding, Belfast Regeneration Office, and European funding including Peace monies. We will also need to consider the level of personal funding by individuals and the

independent sector. Finally, any future work in this area should be linked to the current Needs and Effectiveness study.

Charging Policies

21 It seems sensible to us that, where it is appropriate and fair, Social Security benefits should be used to complement the objectives of Community Care policy. We need to develop ways in which this can be done, in a manner that is equitable and non-discriminatory. We see a need to revisit our existing charging policies to help achieve this outcome.

Strategic Planning and Direction

22 Community Care needs a strategic vision that all sectors can give commitment to and feel ownership of, and which could be the driver for collaborative practice across the service sectors. To ensure that it is given appropriate priority throughout the service it will need to be clearly expressed and presented. We will require a clear understanding of current provision, its trends, projections and resources. We will also need to identify all gaps, deficiencies, and duplications to develop such a Strategy. It needs a firm understanding of the service's priorities and the implications for funding of the expected growth in services. We, therefore, need to examine current service provision to form a comprehensive and evidenced picture of how services are currently planned and delivered, how they have changed, and how they need to be developed to meet local needs and circumstances.

User involvement

23 We know service user and carer involvement are vital to future planning and policy development. However, we accept we do not know enough about what older people want. We also accept that older people are often not given enough information to make informed choices. Information is quite often restricted to a generic leaflet which many older people find difficult to understand. There is a need for simpler and more personalised information exchange within the community care system.

SECTION 5

SHORT-TERM IMPROVEMENTS

1 This section aims to identify areas in the community care service where there is room for real and immediate improvement. It identifies and describes examples of schemes and innovative practice that the Project Board believes could, if implemented in a pragmatic and evolutionary way, enable Boards and Trusts to have a realistic and positive impact throughout the service.

Innovative Schemes And Models

2 The review highlighted that there are now very many good working examples of new and innovative practices in the area of community care. However, the extent to which most of these have been developed in isolation is striking. Staff frequently expressed frustration at the lack of sharing that occurs between Trusts and at the regional level. Many believe this is a by-product of the competitive environment within which Trusts previously operated. As a result there are few opportunities for staff to share the development of good practice, either within or between Trusts.

3 Trusts will be actively encouraged to work collaboratively with each other to share learning and develop new ways of working which will help shape the future strategic direction of community care. The Project Board recognised that some of the schemes and practices cited in this report may not have been independently evaluated or scrutinised to the extent that they would have wished.

4 The section will report under the following headings:

(A) Strategic Planning And Direction
(B) Integrated Health And Social Care
(C) Hospital/Community Interface
(D) Hospital Discharge Arrangements
(E) Rehabilitation Approaches
(F) Involving Users And Communities
(G) Providing Support For Carers

(H) Medicines Management
(I) Independent Sector Provision
(J) Human Resource Planning
(K) Equality

(A) STRATEGIC PLANNING AND DIRECTION

5 It is clear that we need to look again at the Community Care policy in the light of the ten years experience since the "People First" policy was introduced. There is evidence that the implementation of the policy has not been sufficiently reviewed in recent years to reflect the actual experience and practice on the ground. This lack of strategic planning and direction has contributed to approaches that are sometimes based on crisis management and reactive working and have, in the view of many, contributed to some of the difficulties service users are experiencing. Trusts, voluntary organisations and professionals on the ground have responded to these difficulties with a variety of innovative schemes and practice designed to meet their local needs. While some of these schemes have yet to be independently evaluated and verified, there is already some evidence to suggest they can provide a basis for deciding what future community care should look like.

6 The Community Care Project Board has therefore formed the view that the Department should now give a strong regional lead in the future development of community care provision. This requires a long-term planning process which reflects the needs of the population as it is now, and takes on board the changes that have occurred during the last decade. Only then can the Department, Boards, Trusts and professionals begin working collectively towards implementing a modern, shared vision for community care.

7 There is an awareness that effectively shaping an "integrated" approach to community care will involve ensuring the review establishes a close alignment with the prospective developments within primary care and the acute hospitals sector. Evidence gathered during the consultation process suggests the design and development of a vision and regional strategy for community care should be based on the following principles:

- Future strategic planning in community care needs to adopt a multiprofessional, user-centred, collaborative approach;
- Promotion of inclusion, independence and helping users realise their potential as the drivers of strategic thinking;
- An integrated vision for secondary, primary and community care is essential; Strategic planning needs to be bottom up as well as top down;
- Users and communities need to be centrally involved in the development of a modern vision for community care;
- All Government Departments need to be involved in creating a healthier population using the widest definition of health;

- The statutory, voluntary and independent sector all have significant and integral roles to play in the development of regional community care vision and strategy; and
- All new strategy and subsequent policy should be developed with regard to issues around equality, discrimination, inclusion and human rights.

Recommendation

8 A review of the existing community care policy is required to give a new, up-to-date vision for community care which takes into account changes in the policy and legislative climate, new best practice and the cumulative body of experience that has been built up over recent years.

Action

9 The next phase of the community care review will revisit the objectives of “People First”, with the aim of developing a new community care vision based on the principles identified above. This phase will use as its starting point the many examples of good practice already identified during the first phase. Attention will be paid to building a seamless service, with proper linkages between primary, secondary and community care. It will develop effective partnerships with other public sector bodies, Government Departments and with the independent sector which has a unique contribution to make in addressing individual and community expectations. The overall goal is to develop a new vision that uses innovative and creative ways of working for the benefit of the community.

(B) INTEGRATED HEALTH AND SOCIAL CARE

10 Although Health and Social Services have been the responsibility of a single Department since 1973, the review has found evidence that in many Trusts separate systems of primary health care and community care have been maintained. This has reduced the seamlessness of the service and at times has led to duplication of effort. It is clear people requiring community care have a diversity of needs which require a diversity of responses from across the spectrum of Health and Social Services. In order that the best outcomes can be achieved for service users and carers we need an informed approach to service commissioning, development and delivery, which results in the appropriate skills mix. The review's findings confirm that the current skills mix, at all levels, requires review and re-engineering.

Recommendation

11 An integrated and multi-disciplinary approach to community care delivery is required, involving improved working and collaboration between the:

- Professional disciplines within Trusts;
- Hospital and community based staff;
- Statutory sector and the voluntary and community sectors; and
- Statutory sector and the independent sector.

The next phase of the community care review will explore ways in which multi-disciplinary and collaborative working can be improved. One of the projects proposed will look specifically at the prospect of developing common assessment tools to ensure a holistic approach, encouraging person centred care, where goals will be set by service users in consultation with professional staff.

Immediate action

12 Trusts should begin to identify models designed to reduce the number of interfaces a user has to negotiate after initial contact with the community/ primary care service. They should explore models of integrated primary health and social care teams appropriate to their local infrastructure and needs. Once established, these multi-disciplinary, integrated teams will then require considerable capacity /team building to ensure that professionals are empowered to work in a more collaborative way. Down Lisburn Trust have developed such a model, which other Trusts may find a useful starting point.

13 An Integrated Primary Health And Social Care Model: Down Lisburn Trust

Down Lisburn Trust have put forward a model of working that could be used as a template for more effective and accessible community care. The model involves Primary Care Teams, encompassing health and social care practitioners, built around common groups of service users. Teams are organised around GP practice lists as a common group of clients and patients and include the GP, district nurses, social workers, care managers and support staff.

This model was the subject of a piece of research carried out by Mr Brian Dornan (Director of Community Services) in 1999. His research established that there was overwhelming support in all disciplines for integrated primary/community care teams attached to primary care practices. Practitioners preferred to work in multi-disciplinary rather than uni-disciplinary teams. Services provided were judged to have improved. Shared buildings and team rooms, alongside team effectiveness training, were identified as significant in promoting team working. It is understood that this team model could be extended to include other professionals including professions allied to medicine (PAMs).

(C) HOSPITAL/COMMUNITY INTERFACE

14 During the first phase of the community care review most health and social care staff expressed concern at the ongoing (and highly publicised) difficulties at the hospital community interface. Delays in discharging patients from hospital or delays getting patients admitted to hospital wards are viewed, by almost everyone consulted, as a symptom of a much wider and complex problem in the funding, planning and delivery of community care. Many also believe that the recent focus on moving patients out of hospital to nursing and residential homes has only had a limited effect on the hospital problems and has led to an overuse of this provision. The Project Board believes that the solution lies in a fundamental shift in thinking, away from the outdated belief that acute care should always be synonymous with hospital care. There is a growing body of evidence to support the view that the chronic illness often associated with older people can and should be treated in the community. Evidence suggests such treatment is much less disruptive for older people, allowing them to stay at home and thereby avoiding the risks of cross infection and cognitive deterioration.

Recommendation

15. The solution to this problem requires the development of a community infrastructure and services that will gradually facilitate the movement of traditional hospital based services into the primary/community care setting. This solution will not only involve a shift in thinking but will need significant investment or re-engineering to increase the capacity of primary/community care, including GPs. It is only when this issue is addressed that the stress caused to the system by delayed discharges will be alleviated and the number of patients who are admitted unnecessarily to hospital in the first place will begin to reduce. How such a long-term strategic objective can be achieved will be addressed in a comprehensive way in the second phase of the community care review.

Immediate action

16 Trusts should begin to move forward in a pragmatic way testing out some of the ideas, which have been generated by professionals on the ground. The Community Care Project Board have identified a number of innovative schemes and practices which may provide some guidance to Trusts attempting to develop local solutions to the pressures they are experiencing. The majority of schemes and practices cited have focused on bridging the gap between acute hospital care and primary care. They are designed to either prevent hospital admission or facilitate early and appropriate discharge. Many have been set up using funding that has been made available to relieve winter pressures on acute care or the re-engineering of existing services. They include various one-stop assessment schemes, hospital at home schemes, rapid response schemes, intermediate care schemes and some fall prevention initiatives.

17 These schemes have the common themes of being user-orientated, offering users more choice and have a clear independence focus. The key features of these schemes are that they:

- Are user focused
- Are targeted at specific patients
- Have dedicated multi-disciplinary teams
- Set clear admission and discharge criteria
- Have measurable outcomes

18 One-Stop Assessment Centre – Ulster Community and Hospitals Trust

Elderly patients make up the majority of emergency admissions and may be admitted to an acute hospital for non-specific reasons, such as “gone off their feet”. Such an admission may have been avoided if the patient had been assessed promptly prior to admission and alternatives considered.

This one-stop assessment centre provides a consultant-led, multi-professional resource for GP referrals within an agreed protocol. The service can cope with up to 3-4 multi-disciplinary assessments per day and has immediate access to laboratory services, ECG, pharmacy etc. Admission is viewed as a last resort and alternatives are sought by the Ulster Hospitals Discharge Team and the Community Care Department.

This service, through the referral protocol, targets older patients where GPs feel there is the likelihood of referral for acute admission within 48-72 hours that might be preventable. Conditions include exacerbation of chronic obstructive airways disease, congestive heart failure, cardiac arrhythmia’s, anaemia, etc. Statistics presented indicated there were 230 referrals between November 2000 and September 2001, resulting in 140 patients being treated outside hospital; only 40 patients were admitted to an acute hospital bed.

This project provides a patient-centred service with prompt assessment leading to rapid intervention. It also gives GPs more confidence to manage patients for short periods in the community while awaiting assessment by experienced clinicians. The outcome of the evaluation indicates the potential for fewer patients being referred for emergency admission, particularly out-of-hours.

19 Specialist Chronic Obstructive Pulmonary Disease Nurse – Ulster Community and Hospitals Trust

This project aims to support patients with chronic respiratory conditions in the community through a proactive approach to prevent deterioration, which has often led to hospital admission. A specialist COPD nurse provides clinics in hospital settings, health centres, and occasionally the patient’s home. The COPD nurse performs respiratory function tests and advises on interventions such as alterations to the patient’s drug regimes. This specialist nurse links with a consultant chest physician to provide an efficient proactive monitoring of chronic respiratory conditions. The scheme has the potential to both prevent admissions and improve patient-centred care.

20 Tissue Viability Project – Ulster Community and Hospitals Trust

Leg ulcers, especially in older patients, can deteriorate if not managed appropriately and can lead to an admission to hospital. By ensuring local access to early treatment and regular review by specialist staff this project aims to prevent a hospital admission, which can often be quite lengthy. The project involves a specialist nurse as well as district nursing services. Clinics are held in Ards and Bangor Community Hospitals. Patients are reviewed and treated according to best practice guidelines. The nurses link with a dermatologist and a vascular surgeon. The specialist nurse also contributes to the development of good practice standards throughout the Trust.

21 A&E Diversion Scheme – Homefirst Community Trust

This scheme consists of nurses employed by Homefirst Trust who are located in Antrim Hospital A&E. Consultants in A&E can refer patients to the scheme if they feel the patient could be managed at home rather than being admitted. The nurses assess patients and draw up a community based care plan. This care plan is then implemented in the most appropriate setting, which may be in the patients own home, with the support of a domiciliary care package, or in a nursing or residential home. This scheme is aimed at preventing avoidable admissions to hospital by offering A&E staff an alternative, which at times of pressure they may have not otherwise been able to explore.

22 A Regional Falls Audit

A Regional Falls Audit, funded by the Regional Multiprofessional Audit Group, is currently being conducted as part of a National Audit involving the College of Occupational Therapists and the Chartered Society of Physiotherapists. The purpose of the audit is to identify older people at risk and to minimise that risk through appropriate preventive measures in order to enable people to remain safely at home. Such measures will aim to prevent hospital admissions and/or dependency on expensive packages of care. It is intended that the Audit findings and agreed guidelines will soon be published and shared with all relevant staff in both the statutory and independent sectors to help promote awareness and collaborative practice with a view to minimising risk of falls

23 North And West Falls Project Team

This project identifies people aged over 65, resident within North and West Belfast, who attend the local A&E Department following a fall. The project comprises of a multi-disciplinary team undertaking a comprehensive domiciliary assessment of the circumstances surrounding the fall. The aim of the scheme is to: reduce a number of hospital admissions as a result of a fall; complete a Risk Assessment of the home environment; identify the cause of the fall and any potential hazards; complete a nursing assessment to identify any underlying medical cause for the fall; ensure appropriate management of any identified need is undertaken by referral to an appropriate provider in the statutory/independent sectors; notify the patients in writing of the completed assessment; ensure there is awareness among professions about falls, prevention and appropriate intervention; educate older people about home safety, and improve quality of life by reducing the fear of falling.

24 Rapid Response Scheme South And East Belfast Trust

This is an example of a community/primary care service operating at the sharper end of treating acute illness at home. The scheme operates with a multi-disciplinary team responding to patients providing early intervention, 24 hours a day, 7 days a week. The South and East Belfast Trust rapid response team had 3,579 referrals between December 1997 and February 2001 which prevented the same number of people being admitted to hospital.

25 Hospital At Home Scheme Down Lisburn Trust

Hospital at home provides care in the patient's home as an alternative to hospital admission or through early discharge from hospital. It was originally piloted in GB (Peterborough) to provide a service to patients with fractures. In Down Lisburn Trust the idea has been developed and expanded to include patients from a variety of specialties, including general medicine, surgery, orthopaedics, gynaecology and palliative care. The scheme not only facilitates early discharge, but accepts direct admissions onto the scheme from GPs for intravenous fluids, intravenous antibiotics, and blood transfusions. Where patients cannot be accepted onto the scheme because of home conditions, arrangements can be put in place for patients to be managed on the scheme in the local elderly person's resource centres. While the hospital at home scheme is nurse led, it is a dedicated multi-disciplinary team.

The success of the Hospital at Home Service in Down Lisburn Trust has been documented in two independent evaluations and has also been the research subject of a Masters thesis in Health and Social Service Management at the University of Ulster. During the 12 months July 2000 to July 2001, there were 380 admissions to the scheme saving an estimated 3,430 bed days. The Down Lisburn Trust scheme has also attracted visits from a number of other HPSS Trusts and at least one other Trust is beginning to replicate this service.

Home From Hospital Schemes

26 Home from Hospital schemes are in operation in a number of Trusts. Homefirst, Down Lisburn, Ulster Community and Hospitals, and South and East Belfast HPSS Trusts all provide excellent examples. These schemes are designed to provide intensive short-term domiciliary support / convalescence to patients leaving hospital to help prevent unnecessary re-admissions.

Intermediate Care

27 Intermediate care beds facilitate the transition from hospital to home and provide more intense medical, nursing and PAM intervention, than can be provided within an individual's home. These beds may also be used to prevent admission to acute hospital by admitting patients where the required level of care and monitoring by healthcare staff cannot be provided in the patient's normal place of residence. Generally patients suitable for intermediate care have conditions such as respiratory infections, urinary tract infections, recovering stroke,

palliative care, leg ulcers, heart failure, top-up blood transfusions, rehabilitation following acute hospital stay, routine post-operative patients.

28. Intermediate Care Beds – Whiteabbey Hospital

This has been provided since December 1997 by GPs from 4 local practices in collaboration with United Hospitals Trust. The project had a review of activity between March 1998 and April 1999 which showed bed occupancy of 75% and an average length of stay of 8.5 days. Their evaluation also showed admissions to be appropriate when judged by a panel of GPs and consultants against the standard of care equivalent to hospital care. This would appear to be an effective targeted scheme.

29 Intermediate Care Beds – Donard Commissioning Group

The beds are located in 2 nursing homes in Castlewellan and allow patients to be managed closer to home, facilitating visits by relatives and allowing patients to be cared for by staff known to them (their own GP and district nurse). Occasionally care can also be provided locally for patients in the last days of their lives. Patients are not required to contribute to the cost of care in the nursing home as these beds are seen as an alternative to hospital admission. Donard Commissioning Group carried out an audit of the service between November 2000 and April 2001 showing overall patient satisfaction and lower cost of intermediate care beds compared with acute beds in the Downe Hospital.

30 Step-Down/Intermediate Care Scheme – Craigavon & Banbridge Community Trust

This scheme aimed to free up acute and assessment/rehabilitation beds and provide intensive rehabilitation outside the acute sector. The scheme takes referrals of patients aged over 65 years who would either remain in or be admitted to hospital if not on the scheme. The scheme accepts referrals from GPs, community personnel and A&E. The scheme offers time-limited (total approximately 6 weeks) interventions in the form of domiciliary packages and/or within local residential or nursing homes. This model provides more flexible local care than using a hospital site and enhances skill development within residential home/nursing homes. The emphasis on time-limited intervention and rehabilitation allows efficient use of resources.

31 Northern Board Contract With Healthcare At Home

Healthcare At Home is a private company, which supplies nursing staff. Currently the Northern Board uses the staff for two innovative schemes. The first scheme allows patients to receive treatment, usually blood transfusion or intravenous chemotherapy, at home, given under the supervision of a nurse rather than the patient having to attend haematology unit or rheumatology as a day patient or even as an inpatient. The relevant hospital consultant maintains responsibility for the patient during this period. The second scheme involves the treatment at home by a nurse of various conditions (varicose ulcers, pneumonia and other infections) for approximately a 3-4 day period and routinely would include the use of intravenous antibiotics. If required, the patients attend the A&E unit to be reviewed by the consultant. Both these projects increase the role for nurse specialists as well as providing appropriate care for the patients in their home. The second project in particular is innovative and has been submitted to a national journal for publication.

Support services

32 Trusts should also explore the scope for earlier support services which may help older people remain healthy, active and socially included. Low level core services were cited as a lifeline to people wishing to remain at home. However, in recent years many of the low level services such as day centres, home help services etc have tended to be the target of efficiency savings. This situation needs to be reviewed to ensure people do not develop complex needs prematurely. Health promotion initiatives should also get added emphasis. The Project Board believe there is a long-term educative issue for the general public e.g. anti smoking campaigns, promotion of physical activity, preventing loneliness, isolation and depression. They believe that public health should be promoted in the wider context of social services, housing, leisure services, and social security.

(D) HOSPITAL DISCHARGE ARRANGEMENTS

33 While many professionals have expressed concern at the undue emphasis placed on the issue of patients delayed in hospital, which they believe may result in expedient decision making for vulnerable people leaving hospital, there is evidence of room for improvement around the hospital discharge process. While acknowledging the need for a longer term strategic solution and increased investment in community infrastructure, the Project Board have identified a number of initiatives/practices which may help Trusts develop a more user

responsive discharge process. In 1997 the Social Services Inspectorate carried out a multidisciplinary inspection of hospital discharge arrangements entitled "From Hospital to Home". The Project Board believe the recommendations of this report can provide Trusts with reliable guidance on how to improve this process.

Recommendation

34 The next phase of the Community Care review will seek to develop a long-term strategy for dealing with the pressures on acute hospitals caused by patients remaining in beds long after they have been deemed medically fit for discharge. This will involve research into alternative service provision, identification of preventative measures, and seeking ways to implement the "culture change" required if more acute care is to continue to move into the community. Another project proposed for the next stage will also specifically examine the various funding streams for community care to ensure value for taxpayers' money. It will also consider how the "new" service should be paid for and if there is scope for significant resources to be redirected to develop the necessary infrastructure to treat people in the community who traditionally have been treated in hospital. It will consider the key sources of funding and track how it is spent right across the entire spectrum of health and social care services. Recommendations should emerge about the appropriate use of funds, revised targets, desired outcomes and value for money.

Immediate action

35 Trusts should revisit the SSI report "From Hospital to Home" 1997 to ensure recommendations contained therein have been given due consideration and appropriate implementation. Trusts should embark upon a continuous quality improvement process to ensure proper ongoing evaluation and improvement of their hospital discharge procedures. Issues to be explored should include an evaluation of users and carers experience. Many users reported dissatisfaction around their discharge from hospital. They said they often felt as if they were on a conveyer belt and a burden to those providing the service. Trusts should seek to develop mechanisms that would positively address these issues, reduce delays in assessments, improve effectiveness of communication between hospital, community and primary care services and hold professionals to account for practice.

36 These recommendations are based on the premise that patients being discharged from hospital must be treated with respect and dignity, that their human rights must be protected and that they should receive the most appropriate treatment and service to ensure the fullest recovery possible. They

are further based on the premise that all policy procedures and practice are free of ageist or discriminatory language and undertones. Every organisation and professional involved in planning or providing services for older people should reaffirm the positive value of older people to our society.

37 The Project Board were informed of a number of initiatives/schemes that had been developed in some Trusts which may help inform those wishing to seek ways of improving the service provided to users at this very vulnerable time.

38 Discharge Co-ordinator Post

This hospital-based post was in place in Sperrin Lakeland, Altnagelvin, Foyle and City Hospital Trusts. The main aims of this post are to: facilitate the provision of a seamless service in relation to the discharge of patients back into the community from hospital; one point of contact for multi disciplinary hospital and community staff; maximise the potential for effective working relationships and communication between multi-disciplinary hospital primary and community care teams; improve communication of service details to patients and carers; act as a key link person in the co-ordination of services to highly vulnerable patients being discharged from hospital; provide a dedicated person to focus on particular discharge issues and allow other medical and nursing staff to carry on with their duties; and provide consistency of approach specifically in relation to resource allocation.

The review team had the opportunity to meet some of the personnel involved in these schemes. These staff are convinced of the merits of a single point of contact in the hospital and were able to demonstrate some of the benefits of ensuring a collaborative, patient-led approach to the assessment and care planning of patients in hospital settings. They were also able to demonstrate that the establishment of this service has served to promote a culture of joint working between the acute and community sector professionals in their area. While many of the schemes identified have not been independently evaluated in terms of the long-term benefits to the patient, this post would appear to be worth investing in to ensure that because of poor processes, or a lack of a co-ordinated approach, patients do not remain in hospital long after they are medically fit to go home.

39 **Discharge Co-ordination Team: Ulster Community and Hospitals Trust**

The Ulster Community and Hospitals Trust have taken the concept of discharge co-ordination a step further and established a discharge Team in the Ulster Hospital Dundonald. This team serves as a single contact point for referrals for patients with health and social care needs from the Ulster Community and Hospitals Trust and ensures an efficient and effective discharge process. All patients requiring health and social care should have this arranged through the Discharge Team, which is made up of 5 whole time equivalent nursing and social work staff. The care is arranged on the basis of assessed need and the services provided include:

- Home From Hospital Scheme (six week, time-limited rehabilitative service);
- Step down Services (for patients with less complex care needs) in residential, nursing home or community hospital settings for conditions such as patient rehydration and convalescence post fracture;
- Care Management Services;
- Intensive domiciliary services, and
- Nursing/residential placements.

The aims and key features of the discharge team are:

- To improve the channels of communication between hospital and community staff;
- To make the discharge process more efficient for the client and to safeguard service to clients already in the community;
- To decrease the delay days due to care arrangement process for those being placed in nursing/residential accommodation or those who require care managed domiciliary packages;
- To actively promote the use of current community rehabilitation options such as community hospital, step down facilities and fracture beds in statutory elderly persons' home, and
- The Discharge Team could also be a vehicle for developing the use of time limited domiciliary packages, more appropriate for people with less complex needs

An independent pre-discharge team and post-discharge team evaluation was carried out. On comparison of the pre- and post-discharge team evaluations it is evident that the team has had some success. It has improved communication between hospital and community staff, reduced the number of delay days for those awaiting placement into nursing or residential care, and has increased the number of clients being stepped down into community hospital, statutory homes and fracture beds. The Discharge Team also made effective use of time-limited, domiciliary packages, accessed through Home From Hospital. This focus on rehabilitation has eased the current care management workload, “freeing up” care managers in the community to give appropriate attention to current community clients. The evaluation also highlighted the positive opinions and feelings of the clients and carers that received a service. It concluded that there was a clear increase in satisfaction of information provided and services received.

(E) REHABILITATION APPROACHES

40 The review team heard concerns from a wide range of professionals and users that community care had developed into a service which “did things for users”, rather than helping users achieve their potential in terms of independence. Many believe, and there is evidence to support the claim, that we have created a culture of dependence rather than independence. People are being given less rehabilitation and are therefore less able to make a full recovery, resulting in more demand for residential and nursing home provision. There is also evidence that even within the accommodation provision more users are requiring the higher dependency nursing home care.

41 There is strong evidence of the positive effects of rehabilitation in a variety of key areas. Examples include stroke rehabilitation and geriatric assessment of older people. The evidence suggests rehabilitation effects often exceed drug-assisted improvements. Assessment and appropriate rehabilitation reduces the risk of older people being readmitted to hospitals or placed in long-term care. It also improves survival rates and physical and cognitive functioning. It should therefore follow that investing in rehabilitation in the short to medium term will have considerable long-term benefits in terms of quality of life and cost of care. This is because a significant proportion of service users are ultimately able to make good recoveries and are consequently much less dependent on long-term services.

Recommendation

42 The next phase of the review will examine how we can develop a culture of rehabilitation within community care. One of the specific projects proposed is entitled “Enabling people to live in their own homes”. It is proposed that the review team will build upon the examples of good practice found during phase one and examine how people can be maintained in their own homes or other community setting. This project will involve an examination of a range of rehabilitation methods to determine whether it is an appropriate, person-centred and cost effective approach to addressing need. This project will not only focus upon best practice schemes here, but will research, and hopefully learn from rehabilitation schemes in the Republic of Ireland, Great Britain and further afield.

Immediate action

43 Trusts should begin to make the shift from the maintenance and accommodation model of community care to a more rehabilitative model. Trusts should revisit the vast wealth of experience, knowledge and skill within their own staff teams, to develop a culture where everyone involved in individual care planning and service delivery is focused on helping the user achieve maximum levels of independence. The overall objective must be to rehabilitate and therefore empower people to live for as long as possible in their own homes. The Project Board identified some initiatives which may prove useful models for Trusts wishing to develop specific rehabilitation schemes to meet their local needs. These schemes are based on the view that increased investment in care and therapeutic intervention in the short-term can be more beneficial to the user in the long-term, and is consequently more cost-effective.

44 South and East Belfast Stroke Rehabilitation Scheme

This Stroke Rehabilitation Scheme is a good example of the benefits of helping people achieve their potential after serious illness. This particular scheme has enabled 98 people to receive their acute rehabilitation at home and initial findings from a study carried out by Queens University Belfast suggest that people receiving community based rehabilitation spent on average 20 days less in hospital. The same findings indicate that carers in the community appeared to have a significantly lower level of self reported stress and strain.

Results also showed that users of the service expressed significantly higher levels of satisfaction, due to the fact they could be treated in their own home.
The scheme, if funded recurrently, could make it possible for 50 people per year to receive their post stroke rehabilitation at home. In terms of cost, results show that on average this scheme costs £1,500 less per person than an equivalent hospital based service.

45 South and East Belfast Community Rehabilitation Scheme

This scheme offers older people meeting care management criteria (people with complex needs) the choice to have a combined intensive rehabilitation/care package for up to 13 weeks before making any decisions about their long-term care. Rehabilitation plans are developed using a person-centred goal setting approach. The scheme aims to maximise the patients potential thereby helping them become less dependent on care services. This pilot is currently being evaluated by researchers from Queens University Belfast. The initial findings are positive evidence that a rehabilitation model can offer realistic alternatives to intensive care management services. This evaluation will be ongoing during the next 3 years.

46 North and West Belfast Community Fracture Rehabilitation Scheme

This scheme was developed in response to the Eastern Board's guidelines for "Management of Elderly People with Fracture of the Proximal Femur". The scheme offers rehabilitation in the community for patients normally aged over 65 years, with any fracture, though younger patients are considered. A maximum of 10 patients on a 7-day a week basis can be treated at any one time. Suitable patients identified at ward level are referred by the fracture rehabilitation co-ordinator through to community rehabilitation team. The team comprises of 1 full time Occupational Therapist, 1 full time Physiotherapist, and 2 nursing home beds normally available for 2 weeks co-ordinated by the care manager. There are regular meetings between the Community Rehabilitation Team members and the Fracture Rehabilitation Co-ordinator to monitor the patient's progress and resolve any issues which may arise.

(F) INVOLVING USERS AND COMMUNITIES

47 Community/user participation is about involving people, most especially the disadvantaged, in making decisions about changes to their lives which they identify as important and which use and develop their skills, knowledge and experience. For community/user participation to have any real meaning in community care there requires to be a tremendous cultural shift from a service where traditionally the decisions about the allocation of scarce resources have been in the hands of expert professionals - where expectations about health improvements have been linked to inputs and outputs of services and where users are usually the passive recipients of treatments and services. Community development approaches are widely viewed as a more appropriate vehicle to deal with complex health and social service provision, where the

community/users are actively involved in the planning, design, provision and evaluation of services.

48 While many of the Trusts we visited were keen to tell us about their many user groups and consultation processes, the reality is that bottom up planning is limited. Most Trust resources are tied up in infrastructure, staff and buildings, therefore community care tends to be more service led rather than needs led. The community care review team, recognise that at this time of change there is an opportunity to actively involve communities in reshaping their community services.

49 The review team also recognize, for example, that the significant movement of acute care services into the community would require confidence building among the general public. To do so we need to involve the public in this process. The public need to be actively involved in the design and systematic evaluation of initiatives and schemes to demonstrate positive outcomes. This is a significant step beyond the consultation and information giving, which many public bodies currently engage in.

Recommendation

50 At the next stage of the review it is planned to involve users and their representatives in each of the projects proposed. In this way communities will have an active role to play in shaping the future of community care.

Immediate Action

51 Trusts need to:

- Actively listen to what users of the service are saying, and not assume that professionals, carers or advocates always speak on their behalf.
- Encourage capacity building, particularly with the older population, to enable them to participate more effectively.
- Think beyond the concept of a consultation group or forum to ensure the voice of older people is heard, particularly those users with complex needs.
- Take cognisance of the fact that activist users emerge who dominate every committee and perhaps actually limit the opportunity for other users to participate.
- Identify personnel within each programme of care to drive forward the user participation agenda.
- To ring fence resources to ensure adequate time is given to allow the process of community participation to progress.

During the consultation process the review team had the opportunity to meet a number of service users and learned of some of the methods Trusts are using to involve users in service design and evaluation. We have described a few of these initiatives as examples of how this agenda might be moved forward.

52 **Sperrin Lakeland Senior Citizens Forum**

This forum was established in partnership with Western Health and Social Services Board; Sperrin Lakeland Trust; Age Concern; the Western Health and Social Services Council and the Rank Foundation. The key aim of the consortium is to promote the interests of senior citizens in the Sperrin Lakeland Trust area.

Its main achievements are:

- Development of a partnership with voluntary, community and statutory organisations to improve the assessment of needs of older people;
- Participation in the setting up of a cross-party group of MLA’s to promote issues affecting older people;
- Responding to policy initiatives; and
- Representing the views of older people to public agencies.

The Chairman of Sperrin Lakeland Trust has commented that he hopes to constructively use the infrastructure created by the establishment of the consortium and its cluster groups to consult with users and carers about the planning and provision of services.

53 **Mid Ulster Commissioning Pilot - Elderly Needs Assessment**

The aim of the pilot was to bring together primary care based professionals from GP practices and local H&SS Trusts to work in partnership with the NHSSB and the local community to plan how best to deliver services to that community. This exercise drew on existing information across the complete range of health and personal social services provision, including mental health services, district nursing, podiatry, home help service, occupational therapy, residential and nursing home care etc. A user involvement group was established to take on board the views of local older people and their carers. Improving care in the community for older people and supporting carers was identified as the top priority and a series of recommendations were made as to how improvements could best be made.

These included the:

- Provision of additional community based PAMs resources e.g. occupational therapy assessments;
- Enhancement of the home help service;
- Provision of additional specialist training for care providers, and
- Consideration of community-based services such as Hospital at Home and
- Intermediate Care beds

The report and recommendations went out for consultation and decisions will now be taken on how the NHSSB will take forward the recommendations specifically relating to health and personal social services.

54 **Down Lisburn Trust Disability Network Scheme**

This scheme was developed in response to the needs of people living in the Twinbrook and Poleglass areas of Belfast. It was developed as a response to local research which suggested many of those with a disability living in the area did not have access to, or wish to avail of, the traditional services on offer. The target group is doubly disadvantaged by living in an area that experiences marked social exclusion and poverty, as well as facing the typical barriers that confront all people with disabilities in accessing services, facilities and employment. Since it was first established in March 1997, the Disability Network Scheme has received over 207 referrals from people aged between 5 and 65 who have a physical, learning or sensory disability. The Disability Network Scheme’s main areas of activity include:

- Research that highlights the needs of people with disabilities in the area;
- Provision of a one-to-one support service;
- Development of a number of self help support groups;
- Awareness raising activity;
- Development of a user forum;
- Advice and information giving;
- Extensive networking;
- Increasing access to training and employment, and
- Increasing access to facilities and services

The scheme has been independently evaluated as having a positive impact on peoples’ lives. It was described by the evaluation team as

“at the leading edge of community development approaches to health and social care delivery”.

(G) PROVIDING SUPPORT FOR CARERS

55 ‘People First’ stated as one of its six key objectives

> “To ensure that service providers make practical support for carers a high priority”

Clearly this objective has only been partially met and sadly, in some situations, not met at all. The users that the review team met expressed concern for their carers who they feel require more help. An increasing number of carers are also elderly and frail: this is worrying for users and carers who fear a crisis and the inevitable admission to care. Carers we met also expressed concern at the insecurity of their practical support which they claim is often cut back without warning. One 87 year old gentleman caring for his 85 year old wife had recently had his home help service reduced on the day following her discharge from hospital.

Recommendation

56 At the next phase of the community care review the review team will take full account of the proposals for a carers strategy and any plans in place to implement. This will ensure all the issues raised during the review are taken into consideration. One of the projects proposed is specifically aimed at developing a range of services which would provide practical support for carers. It will build upon the work carried out to produce the Carer’s Strategy. It will examine the potential for developing an extensive range of community based services, e.g. respite services, sitting services etc in line with what is recognised as good practice here, in GB and the Republic of Ireland. It aims to establish whether existing schemes and initiatives are cost effective and if they are provided in the correct location. The desired outcome will be models of good practice that fall within a developed set of key principles for carers support.

Immediate action

57 Trusts need to make support for carers a high priority to ensure that the many valuable and over worked carers in the community are provided with the support they need to maintain their loved ones at home. Services such as respite and sitting services should be protected and developed to ensure carers have access to them at short notice and times of stress or illness. Regular respite should be built into care plans to ensure the carers have planned breaks at times appropriate to their needs. Personal care services, including home help services, should involve as few changes as possible to enable carers to plan the rest of their lives outside of their caring role. Trusts should also give

consideration to the development of a support group for carers. Such a group could have the potential for not only self help initiatives and mutual support but could develop into a carers lobby and advocacy group. Such groups require practical support to enable carers to participate fully.

There are many good examples of such groups within the disability programme. One example of note is:

58 **Down Lisburn Trust Learning Disability Carers Forum**

This forum has been in existence for ten years, providing a means for carers of people with a learning disability to make their voice heard. Although the Trust support the group financially, they also benefit from administrative support from Mencap. The Carers Forum is a very active group, lobbying on behalf of all carers in the Trust. They are also very much involved in helping carers with the task of caring through support, advice and education. They have recently been involved in organising an international conference which has given parents and carers access to the latest ideas and innovation in the world of learning disability.

(H) MEDICINES MANAGEMENT

59 Medicine-related illness is often an overlooked element of community care. In reality however, it is a significant problem, particularly in older people. Adverse drug reactions have been implicated in between 3% to 17% of hospital admissions (rates vary according to patient group), costing the health service well in excess of £13m annually. A significant proportion of these admissions could be prevented with effective medicines management systems. The need to provide support for targeted patients and their carers in taking and administering medicines is now acknowledged. The perceived benefits of such support include optimisation of treatment, minimisation of adverse events and a reduction in wastage. It is clear that one of the key issues is the patient’s failure to take their medication appropriately. Research has shown that as many as 50% of older people may not be taking their medicines as intended. Older people and their carers need to be more involved in decisions about treatment and to receive more information than they currently do about the risks and benefits of treatment.

Recommendation

60 The next phase of the community care review does not have a specific project relating to the issue of medicine management. However, it will be an ongoing theme in the development of good practice, particularly within projects which are

reviewing assessment and care management processes and examination of prevention of admissions.

Immediate Action

61 There is a vast body of research and local knowledge on this subject available to Trusts. Trusts should make use of this research in partnership with their pharmacy colleagues to identify schemes and innovative initiatives which have been shown to have significant benefits to the patients. Trusts should ensure that:

- Community pharmacists are more involved in primary and community care systems;
- The issues around medicines management are brought to the attention of all community staff involved in the care of older people;
- A medicines review becomes a routine part of the care review process especially for older people and those in residential and nursing settings;
- Education and training is provided to carers on the safe use and administration of medicines; and
- patients and/or carers receive written information and advice on their medicines before leaving hospital.

Consideration should also be given to:

- increasing the current 3 day discharge prescribing period to enhance the convenience for people leaving hospital and their carers.

62 Many good practice initiatives were described during the consultation process. While in the main these may be at an early stage in their development and are not routinely available, they may provide Trusts with a template/guide to dealing with the significant medicine issues identified by this review.

63 Medication Review Schemes -“Managing your Medicines”

This is a new service, funded by the Department through the Boards, for a medicines management initiative delivered by community pharmacies. In this scheme eligible patients who are either taking multiple medicines, have a history of poor compliance, or recently discharged from hospital, can have their complete medication history (prescribed, OTC and complementary medicines) reviewed by their local pharmacist. During a one-to-one private consultation, the pharmacist reviews the suitability of each medicine for the patient and identifies any drug interactions or potential side effects. This also presents an opportunity to identify any particular needs a patient may have in managing their medicines, such as difficulties in self-administration, and the pharmacist is able to identify potential compliance problems and provide drug charts or other compliance aids where necessary. The service was launched over the winter period 2000-2001, with a target of 20% of pharmacies actively providing the service. The recruitment target for community pharmacy has since been exceeded, although only a minority of contractors have actually commenced patient reviews. These early adopters have however shown a high level of commitment and have been positive about the service, both in terms of the improvements in patient care and the professional rewards.

64. **Practice Based Medication Review - ABC Commissioning Pilot**

Pharmacists were employed to work with eight GP practices on a sessional basis. A detailed medication review of over 700 patients on multiple medication was undertaken. Suggested amendments to therapeutic regimes were discussed between the pharmacist and a nominated GP and actioned by administrative staff. Evaluation of the scheme indicated that following the review approximately 95% of patients screened had at least one change made to their medication. The quality of prescribing had improved, education of nursing home carers was extremely well received, pharmacists and GPs had collaborated well and ultimately the quality of patient care had improved. Overall cost implications for changes to individual patient's medication were not calculated, but savings resulting from the implementation of agreed therapeutic switches in those screened indicate the programme was cost effective, off-setting the employment costs of the pharmacists.

65 **Falls Prevention Initiative - Armagh Primary Care Commissioning Pilot**

This scheme was set up as part of a fall prevention initiative. A dedicated nurse undertook assessment of patients referred by local GPs, or through the A&E department, who were at risk of falls, or further falls. Those visited who were on 6 or more medications were referred to the Pilot's Prescribing Advisor for a medication review. This review entailed the identification of any potential side-effects of the patient's current drug therapy, drug-drug or drug-disease interactions, which placed the patient at increased risk of fall. Where appropriate, recommendations were made for changes to drug therapy to minimise such risks. In total, 29 (20%) of those screened were referred for a medication review. Outcomes from this scheme demonstrated that 52% of referrals assessed had actual or potential medicine associated problems and had resulted in a medical intervention. This initiative demonstrates clear patient care benefits.

66 Domiciliary Pharmaceutical Care for Elderly Housebound Patients

In 1998 NHSSB commissioned a project to determine the scale of pharmaceutical care issues occurring with elderly housebound patients and to examine whether domiciliary visits by a pharmacist would be of benefit to them. GPs from 5 practices referred 36 patients for enrolment, 21 of whom met the inclusion criteria and agreed to participate in the project. Results from the project indicated that some 90.5% of the enrolled patients had medication problems on assessment. These problems included:

Compliance problems, 52.3%;
Medication not synchronised, 52.3%;
Inappropriate use of medication, 38.1%;
Incorrect dosage, 23.8%;
Adverse drug reaction, 23.8%, and
: Unable to open CRC, 23.8%.

Where compliance problems were identified, these were further classified as unintentional (65%), or intentional (35%): Management plans were produced for all patients (n=21) and implemented in 81% of cases (n=17). GPs approved 92% of proposed interventions. Pharmacists, GPs and patients all indicated high levels of satisfaction with the scheme and hoped that it would be rolled out in the future.

67 Medication Review in Nursing Homes

There have been a number of schemes set up across NI involving pharmacists undertaking medication review in Nursing Homes. All have been well evaluated and have demonstrated effectiveness in reducing the number of drugs taken by patients, identifying medicine-related problems and improving medication administration systems in the nursing homes. Examples of such schemes are found in Western Health and Social Services Board (projected annual cost saving of £2,300), Lisburn Commissioning Pilot (projected annual cost saving of £12,450) and Armagh Commissioning Pilot (projected annual cost saving of £12,671). This is a key target area for future development.

68 Schemes operating at the Hospital-Community Interface -Dedicated Interface Pharmacists

A recent study carried out in Antrim Area Hospital demonstrated that 61% of patients had an incomplete medication history on admission, 21% of patients who brought their own drugs were not dealt with appropriately and 33% of discharged patients had medication-related problems. The study also found that a Trust-based community liaison pharmacist produced benefits in terms of patient medication management, reduced readmission rates (by 2.4%) and reduced wastage of patients' own drugs. There is increased recognition that a dedicated interface role is necessary to achieve more pro-active liaison between all the relevant practitioners in primary and secondary care and so improve understanding, promote seamless care for patients and reduce risk. One such pharmacist has already been appointed in WHSSB as a result of concerns identified with the increased use of more specialised drugs in the community setting. Key tasks for this role include:

- Development of shared care protocols and clear guidelines on prescribing responsibility between primary and secondary care;
- Development of guidelines for the introduction of new drugs or existing drugs with major new indications;
- Providing guidance on the prescribing interface between hospital and primary care including the supply of medication to patients on discharge, return of medication brought into hospital and the development of communication links with hospital and primary care;

- Development of a single formulary, through integrating the current formularies, for use by the local GPs and provider units and primary care;
- Development of guidelines for improving patient compliance and understanding of medication;
- Development of guidelines for effective medication reviews, and
- Development of a means of liaising with the Local Medical Council; Area Medical Advisory Committee; Area pharmacy Committee, and other relevant agencies to help inform and shape local action plans

(I) INDEPENDENT SECTOR PROVISION

69 The private sector indicated that they were fast approaching a time when the residential and nursing home business would be no longer profitable. While there may be an argument that that this sector is over used, demand for this provision is still growing. Many of the staff consulted are deeply concerned about the decline in availability of all independent sector beds, with demand beginning to outstrip supply in some areas, and particular problems emerging in the supply of EMI beds. While staff accept that the use of nursing home and residential beds is still relatively high compared to usage elsewhere, there is some feeling that the difficulty here has arisen because there has been insufficient growth of alternatives to nursing home and residential care. While it is not clear why this situation has developed, there is a view within the voluntary sector that the contract culture has significantly damaged relationships and has resulted in less partnership working and joint planning.

Recommendation

70 "People First" Policy stated as one of its central objectives to

"Promote the development of a flourishing independent sector alongside good quality public services"

In the second phase of the Community Care Review a project is proposed which will carry out an examination of this objective. The project will review the potential for improved partnerships between the statutory, voluntary and independent sectors to ensure the development of a range of high quality services giving value for money. The aim is to review the effectiveness and efficiency of current partnerships to the benefit of the individual, the community and the service providers. It will also seek to identify solutions that meet everyone's needs in the short and long-term and which develops planning approaches that reflect all interests and are of mutual benefit for all parties. An aim of this review will be to ensure that there is an equal status between all parties that builds and fosters trust and good relationships. The desired outcome is a set of recommendations that will create a stable and sustainable independent sector that works with the HPSS and which promotes innovative, diverse, flexible solutions, providing value for money and choice.

Immediate Action

71 An immediate resolution of the contract price issue is required if we are to ensure stability in the nursing and residential home sector in the short-term. This will allow space for more long-term planning in partnership with both the private and voluntary sector. This should reflect a desire to develop more appropriate levels of nursing home provision and domiciliary support.

72 Throughout the consultation process the review team heard many concerns expressed around the reduction in support type services. These services are often provided by the voluntary and community sector and grant aided by the Trusts. They include day centres, social clubs, meals on wheels etc., which are seen by users and carers as a means of respite and social inclusion. Trusts should seek to support and protect such services to ensure older people have access to the community and remain an active part of it.

73 During the consultation process the review team met with the voluntary sector to hear first hand some of the initiatives they are involved in. They were keen to share examples of good practice which they had direct experience of. Examples included:

Actively Ageing Well Project (Age Concern and The Health Promotion Agency)
This scheme is designed to allow older people to take part in social activities which will alleviate isolation and boredom both of which have a detrimental effect on people’s lives.

Warm Home Scheme (Help the Aged)
For older people on income support, this scheme attempts to deal with the issue of older people currently waiting for heating.

Freephone Advice Service “Senior line” (Help the Aged)
This is a free welfare rights advice service for older people and their carers. The service offers advice or information about a wide range of issues including community and residential care, welfare/disability benefits and housing issues.

Preventative Adaptations Scheme (NIHE)
Which aims to prevent falls etc in older people

Assisted Living Schemes (Cedar Foundation)
Examples of which are in North and West Belfast and Ulster Hospitals Trusts.

Angel Watch Project (Partners in Care)
Provides personal and domestic care to older and disabled people in their own homes and at the same time provides support and relief for their carers. The service operates 24 hours a day throughout the year and the “Angel Watch” provides a special service in the clients home throughout the night.

(J) HUMAN RESOURCE PLANNING

74 Recruitment and retention of staff is an issue across all grades, with a particular lack of skilled staff in some areas to carry out assessment, treatment and rehabilitation. There is a widespread feeling that there needs to be improved long-term planning to tackle these issues, based on prediction of future staffing needs.

75 The review team's attention was also drawn to the very poor pay and conditions still experienced by many frontline care workers. As a result it is difficult to attract high quality committed staff. This situation has been further exacerbated by the growth within other sectors of the economy, for example, in the retail sector, with supermarkets often offering much better pay and conditions for easier, less stressful jobs. High turnover of staff means that there are often many workers involved with individual service users and it is difficult to provide high quality care with new inexperienced staff. The problem is often further complicated in rural areas where populations are less dense, leading to increased costs of travel and a smaller potential recruitment pool of staff. It was felt that the issue needs to be tackled urgently to improve the situation for care workers so that they are more highly valued and rewarded by employers and by society.

Recommendation

76 At the next phase of the community care review the review team will work alongside the Departmental working party who are currently developing the new Health and Social Services Workforce Plan. This will ensure all the issues raised during the review are taken into consideration.

Immediate action

77 Undoubtedly there is scope for improved efficiency in the area of providing skilled staff to carry out assessment, treatment and rehabilitation, particularly regarding the duplication of effort that occurs because of the complexity of systems and structures and lack of integration that are highlighted elsewhere in this report. There would appear to be room for improvement in skill mix and, in particular, with the better targeting and sharing of the time and expertise of skilled specialist staff. Almost all of the schemes and practice highlighted during the report are based on the principle of dedicated multi-disciplinary teams. Trusts should review their method of service delivery to identify scope for improved skill mix and multi-disciplinary working.

78 In relation to the issues of shortages of care staff Trusts need to begin to urgently address this issue. Trusts, in conjunction with staff representatives, need to develop policies and practice which begin to value the essential service provided by this group of staff. Policies which are family friendly, training intensive and which begin to develop career structures in this sector are urgently required. Best Practice – Best Care, the consultation paper which describes the Framework for Setting Standards, delivering services and improving, monitoring and regulation in the HPSS, offers Trusts a starting point for improvement in this area. The National Service Framework for Older People is a valuable source that could also be drawn on for further development of local standards.

79 Experienced staff generally feel that there needs to be an accepted degree of risk taking if older people are to be allowed a reasonable quality of life. However, many feel that they are working in a "blame culture", with an increasing likelihood of litigation if they get it wrong. There was a frequently expressed view that we need to find ways to allow older people to take risks, if that is what they desire to do in order to maintain a reasonable quality of life. There is a need to move from “blame” to “learning” or “educative” culture.

(K) EQUALITY

80 During the consultation process a number of issues were raised with regard to inequalities that exist within the present system. Many Trusts feel that the equity issue in funding arrangements between Trusts has not been fully addressed, leading to unacceptable differences in the range and level of services available across Trusts' areas. There is insufficient clarity around this issue to determine if this claim is legitimate and further work is therefore required. There was evidence, however, of different priorities and different eligibility criteria being applied in various Trusts. Evidence also emerged relating to levels of service in rural areas as well as increased costs due to travelling. Older people also face many attitudes which are negative or subject to ageism. This can lead to older people experiencing considerable social exclusion from everyday life.

Recommendation

81 The next phase of the community care review will consist of a number of projects which will provide a comprehensive review of the community care policy. All of these projects will be based on the premise that any new policy must be developed with regard to issues around equality, inclusion and anti-discrimination. They need to be based on the policy of targeting social need and promoting social inclusion as well as ensuring they are fully compliant with equality and human rights legislation. They must be based on the principle of promoting independence and helping users realise their potential. It is proposed that a particular project in the next phase will examine how community care is funded. This should help identify any inequalities which relate to different funding levels in different areas.

Immediate Action

82 Trusts need to ensure the eligibility criteria for service is applied equally and fairly across their entire service provision. Older people and their families need to be given clear information on their rights and responsibilities vis-a-vis community care provision. The Equality Officer in each Trust should be actively involved in the development and updating of all community care policies and systems to ensure equity and human rights issues are fully addressed.

SECTION 6

FUTURE WORK PROGRAMME

Introduction

1 “People First: Community Care in Northern Ireland in the 1990s” set out six central objectives. The Project Board has used each of these objectives as a framework for setting out the future work programme for the next phase of the community care review. It incorporates projects relating to each of the People First objectives, identifying the likely outcomes from each piece of work designed to produce practical solutions to the issues raised in phase one. Presented in this section is a short description of each project, its purpose and expected outcome.

2 The aim is to improve services to give users and carers real choice over the how, and where of service delivery to meet their needs. Attention will be paid to building a seamless service with proper linkages between primary, secondary and community care and which develops effective partnerships with other public sector bodies, government departments and the independent sectors who have unique contributions to make in addressing individual and community expectations. Account will also be taken of other programmes of care where there is the potential for learning or read across to improve the services for the benefit of users and carers. The overall goal is to develop a new vision that uses innovative and creative ways of working for the benefit of the community.

Second Phase Plans – Community Care Review

3 A number of projects will be taken forward based on the ‘People First’ objectives.

(People First - Objective 1)

“To promote the development of domiciliary care day and respite services to enable people to live in their own homes wherever possible”.

Project 1 – Enabling people to live in their own homes

4 Building upon the examples of good practice found during phase one, this project will examine how people can be maintained in their own homes or other community setting. It will comprise 3 elements:

- An examination of a range of rehabilitation methods to determine whether it is an appropriate and cost effective approach to addressing need. This project will not only focus upon best practice schemes in Northern Ireland but will identify how similar schemes are delivered in the Republic of Ireland, Great Britain and further afield.

- A review to identify ways of preventing people from being inappropriately admitted to residential and nursing homes or hospital. This project will examine the range of preventative services and other innovative approaches to meeting the needs of the community before they become dependent on care management services. It will build upon the findings from phase one and consider best practice from other countries.

- A review to identify the scope for developing a range of services in the community/service user's home which would previously be provided in an acute hospital setting. This will include an examination of existing schemes and schemes trawled from further afield.

5 All three elements will involve desk research, meetings with staff and consultation with users and carers (or their advocates), to obtain the information required to produce sound recommendations and actions that can be implemented. These actions will be based upon best practice principles for meeting people's needs using a range of well developed preventative, rehabilitative and other innovative schemes, (or by providing acute services where people feel more secure and less vulnerable in their own homes).

Project 2 – Spreading Best Practice

6 The aim of this review is to identify and propose effective methods to spread best practice across the Health and Personal Social Services. The findings from the phase one revealed that there is little or no sharing of best practice across Boards and Trusts. All too often good work that has been carried out in one place is not known about elsewhere, so similar work is redone and duplicated

throughout the HPSS. This review will identify the strengths and weaknesses of different dissemination techniques and how they need to be adjusted to suit the HPSS. Its outcome will be the development of effective knowledge management systems and a database for sharing best practice that reduces waste and transfers knowledge to the point where it is needed. The Review will use local and international research about knowledge management and, as necessary, will seek expert academic and operational advice to develop solutions. It will also utilise other pieces of research such as The Cabinet Office's research project: "The effectiveness of different mechanisms for spreading best practice" which contains examples of mechanisms currently in use in UK Health sectors.

(People First - Objective 2)

"To ensure that service providers make practical support for carers a high priority".

Project 3 – Developing services to provide practical support for carers

7 This project is aimed at developing a range of services which would provide practical support for carers. It builds upon the work carried out to produce the Carer's Strategy. It will examine the potential for developing an extensive range of community based services e.g. respite services, sitting services etc., in line with what is recognised as good practice appropriate to N.I. and establish if existing schemes and initiatives are cost effective and provided in the correct location. The desired outcome will be models of good practice that fall within a developed set of key principles for carers.

(People First - Objective 3)

"To make proper assessment of need and good case management the cornerstone of high quality care"

Project 4 – Care management processes and assessment tools

8 The purpose of this project is to identify the most effective and efficient care management process that enables sound operational and planning decisions to be taken for the benefit of the individual and the community as a whole. It will examine best practice multi-disciplinary models with a focus on the most appropriate skill mix and the possibility of developing a single assessment tool that can be used to meet all levels of need whether in the hospital or in the community setting. It will pay particular attention to the current processes, to identify weaknesses in how information is gathered, communicated and used, not only in the context of the individual, but also in the assessment of need within

the overall planning context in light of its implications on the financial and performance management of services.

(People First - Objective 4)

"To promote the development of a flourishing independent sector alongside good quality public services"

Project 5 – Promoting the development of a flourishing independent sector alongside good quality public services

9 This project will review the potential for partnership between the statutory, voluntary and private sectors to ensure the development of a range of high quality services and value for money. The aim is to review the effectiveness and efficiency of current partnerships to the benefit of:

- the individual
- the service user
- all other stakeholders

It will also seek to identify solutions that meet stakeholder needs in the short and long-term and which develops planning approaches that reflect all stakeholder interests and are of mutual benefit for all parties. An aim of this review will be to ensure that there is an equal status between all parties that builds and fosters trust and good relationships. The desired outcome is a set of recommendations that will create a stable and sustainable independent sector that works with the HPSS and which promotes innovative, diverse, flexible solutions that provide value for money and choice.

(People First - Objective 5)

"To clarify the responsibilities of agencies and so make it easier to hold them to account for their performance"

Project 6 – Accountability of Agencies

10 The aim of this project is to clarify the responsibilities of agencies and so make it easier to hold them to account for their performance. The review will identify how quality and standards are currently set, how and by whom they are monitored, and establish if the processes are in place to hold the various agencies to account if they are not continually improving performance, or are not focusing on the most appropriate measures to successfully run their business. The review aims to develop recommendations for monitoring performance and

give a greater clarity about roles, responsibilities and the processes that gives a greater focus on outcomes and continuous improvement.

(People First - Objective 6) –

"To secure better value for taxpayers' money by introducing a new funding structure for community care"

Project 7 – Funding Structure for Community Care

11 This review will examine the various funding streams for community care to ensure value for taxpayers' money. It will consider the key sources of funding, how it is spent, and whether funding levels are adequate to address need. To do this the reviewers will establish how funding is planned for, targeted and monitored to determine whether there is clarity about how HPSS funding objectives fit with each other and with wider Government objectives.

12 Recommendations should be made about the appropriateness of, and use of funds, and the adequacy and effectiveness of short and long-term planning and monitoring processes. Other recommendations should emerge, for example, around the possible need for redirecting funding, revised targets, and around the need to give greater attention to outcomes and value for money.

ANNEXE 1

COMMUNITY CARE REVIEW

PROJECT BOARD MEMBERS

Brian Coulter, Chief Executive, Fold Housing Association (Chair)

Les Allamby, Law Centre N.I.

Hazel Baird, Director of Nursing, Homefirst Community HSS Trust

Dominic Burke, Director of Social Work, Western HSS Board

Laura Collins, Carers National Association

Robert Ferguson, Chief Executive, South & East Belfast HSS Trust

Leslie Frew, Director, Child and Community Care Directorate, DHSSPS

Brian Grzymek, Director, Secondary Care Directorate, DHSSPS

Paul Martin, Chief Social Services Inspector, DHSSPS

John McGrath, Director, Planning and Performance Directorate, DHSSPS

Dr Brian Patterson, British Medical Association

ANNEXE 2

COMMUNITY CARE REVIEW

PROJECT TEAM MEMBERS

Bernie McNally, Project Team Leader, Down and Lisburn Trust (Project Team Leader)

Robbie Saulters, Policy Development and Review Unit, DHSSPS (Project Manager)

Charlie Bamford, Social Services Inspectorate, DHSSPS

Fergal Bradley, Regional Information Branch, DHSSPS

Greg Campbell, Economics Branch, DHSSPS

Dr Vanessa Chambers, Pharmaceutical Officer, DHSSPS

Peter Deazley, Elderly and Community Care Unit, DHSSPS

Gary Fair, Developments Unit, DHSSPS

Nuala McArdle, Officer for the Professions Allied to Medicine, DHSSPS

Dr Ian McMaster, Medical Officer, DHSSPS

John McKeown, Elderly and Community Care Unit, DHSSPS

Francis Rice, Nursing Officer, DHSSPS

Alan Urquhart, Policy Development and Review Unit, DHSSPS

ANNEXE 3

COMMUNITY CARE REVIEW

CONSULTATION PROCESS

The consultation process comprised:

1 A letter from the Project Board Chairman, Mr Brian Coulter, issued to all service staff on 14 May, to gather early views and comments on the review

2 Six workshops held at different locations throughout all Board Areas and attended by a range of professionals from all the Trusts, Boards and Health and Social Services Councils. Further workshops held specifically for the voluntary sector, Registered Homes Confederation and General Practitioners. Over 230 people attended this series of workshops.

3 A series of visits with the following Trusts to establish current practice and gain further views and suggestions:

Craigavon Hospitals HSS Trust.
Ulster Community Hospitals HSS Trust.
Craigavon and Banbridge Community HSS Trust.
Down Lisburn Trust HSS Trust.
Armagh and Dungannon HSS Trust.

4 Further meetings with:

Jane Graham, Eastern HSS Council.
Dr Brian Patterson, BMA Advisory
Committee of the Therapeutic Professions Allied to Medicine.
Royal College of Practitioners

5 Two focus groups with the North Belfast Community Forum for Elderly People and the Omagh Elderly Forum, arranged by the Health and Social Services Councils. The Northern HSS Council provided the Team with the results of a user satisfaction survey that they had recently carried out.

6 An advertisement placed in the following newspapers inviting comments and views from the general public:

Belfast Telegraph
Coleraine Chronicle
Irish News
Ballymena Guardian
Belfast Newsletter
CountyDown Spectator

Newtownards Chronicle
Larene/Carrickfergus/Newtownabbey Times
Ulster Star
Down Recorder
Down Democrat
Newry Reporter
Portadown Times
Lurgan Mail
Impartial Reporter
Ulster Herald
Tyrone Constitution
Tyrone Courier
Dungannon Observer
Mid Ulster Mail
Mid Ulster Observer
Derry Journal
Londonderry Sentinel

7 An article in the following professional journals requesting a personal or professional opinion on current service delivery, possible improvements, examples of 'Good Practice' or more effective ways of working:

British Medical Journal
Community Care
Doctor
GP Magazine
GP Newspaper
Health Service Journal
Hospital Doctor
Northern Ireland Medical Review
Northern Ireland Medicine Today
Nursing Standard
Nursing Times
Pulse Magazine

8 A letter to all 1,080 General Practitioners and 77 Geriatricians and Pyscho-geriatricians giving them an opportunity to make their views known on what they see as the main issues in the delivery of community care services and to put forward suggestions for improvements in the service.

9 Alphabetical List of Organisations and Individuals Consulted

Advisory Committee of the Therapeutic Professions Allied to Medicine
Age Concern
Altnagelvin Hospital HSS Trust
Armagh and Dungannon HSS Trust
Arthritis Care

Bangor Citizens Advice Bureau
Belfast City Hospital HSS Trust
British Medical Association
Bryson House

Causeway HSS Trust
Cedar Foundation
Church of Ireland Board for Social Responsibility
Laura Collins
Craigavon Area Hospital Group HSS Trust
Craigavon and Banbridge Community HSS Trust
Crossroads

Down Lisburn HSS Trust

Eastern Health and Social Services Board
Eastern Health and Social Services Council
Extracare

Foyle HSS Trust

(All) General Practitioners
Green Park Healthcare Trust

Homefirst Community HSS Trust
Help the Aged

Law Centre NI

Mater Infirmorum HSS Trust

Newry and Mourne HSS Trust
North Belfast Community Forum for Elderly People
North and West Belfast HSS Trust
NI Federation of Housing Associations
Northern Health and Social Services Board
Northern Health and Social Services Council
Northern Ireland Housing Executive
Northern Ireland Public Service Alliance

Omagh Elderly Forum

Registered Homes Confederation
Royal Group of Hospitals HSS Trust
Royal College of GPs
RNIB

Simon Community
Southern Health and Social Services Board
Southern Health and Social Services Council
South and East Belfast HSS Trust
Sperrin Lakeland HSS Trust

Triangle Housing Association

Ulster Community and Hospitals HSS Trust
United Hospitals HSS Trust

Voluntary Service Belfast

Western Health and Social Services Board
Services Council
Western Health and Social
Services Board

10 Submissions Received During Course Of Review

1. Mr J Compton, Deputy Chief Executive, Down Lisburn Trust.
2. Brian Dornan, Director of Community Services, Down Lisburn Trust.
3. Chris Williamson, Director, NI Federation of Housing Associations.
4. Dominic Burke, Western Health and Social Services Board.
5. Dr Jean McClune, Skegoneill Health Centre.
6. Christie Colhoun, Chief Executive, Homefirst HSS Trust.
7. Hilary Boyd, Chief Executive, Greenpark Healthcare Trust.
8. Dr M G Scott, Chief Pharmacist, Pharmacy Department, United Hospitals Trust.
9. Helen Creighton, Prescribing Advisor, Lisburn Commissioning Pilot.
10. Teresa O’Neill, Senior Manager, Social Care Services, Bryson House.
11. Dr B Farrell, Acting Primary Care Medical Adviser, Southern Health and Social Services Board.
12. John McGrath, Project Manager, Mid-Ulster Primary Care Commissioning Pilot.
13. Dr Paula Cobain, Senior Pharmaceutical Prescribing Advisor, NHSSB.
14. Dr Kathryn Booth, GP Unit, EHSSB
15. Emer McPhelimy, NHSSB.
16. Pat Haines, Director of Planning, Belfast City Hospital Trust.
17. Cavan Weir, Deputy Chief Executive, Extra Care.
18. Dr Michael Steele, GP Principal, Ballywalter Health Centre.
19. Marie Doherty, Primary Care Pharmacist, Boots the Chemist.
20. Stuart MacDonnell, Chief Executive, NHSSB
21. Fiona McConnell, NHSSB.
22. Dr Kevin McCoy, Social Services Inspectorate, Review of Care in the Community Report (February 2000).
23. Down Lisburn Trust/Lisburn Commissioning Pilot.
24. Stephen O’ Brien, South and East Belfast HSS Trust.
25. Brian Coulter, Foldgroup, Notes from meeting of Pressure Group.
26. Mrs E Cavan, Director of Professions Allied to Medicine.
27. Dr D Boyd, Medical Adviser (Primary Care) NHSSB.
28. Joe Brogan, FPSU, WHSSB.
29. Age Concern NI.
30. Prof. James C. McElnay, President of the Pharmaceutical Society of NI.
31. J P Ferguson, Chief Executive, Ulster Community Hospitals Trust.
32. Dr Peter Beckett, Chair of the Armagh GP Forum.
33. Angela Costello, Fracture Rehabilitation Co-ordinator, Musgrave Park Hospital.
34. B P Cunningham, Chief Executive, SHSSB.
35. Brian Dornan, Research Report “Teamwork in Integrated Primary Health and Social Care Teams”.
36. Irene Duddy, Director of Nursing, Altnagelvin Hospitals HSS Trust.
37. J P Loughrey, Director Child and Community Care, Causeway HSS Trust.
38. Dr H Curran, Chairman, South & East Belfast Primary Care Group.

39. Chris Williamson, Director, The Northern Ireland Federation of Housing Associations.
40. Fiona McConnell, Pilot Prescribing Adviser, Mid-Ulster Commissioning Pilot.
41. Dr D H Gilmore, Consultant Physician in Geriatric Medicine, The Royal Hospitals.
42. Dr Peter Flanagan, Consultant Geriatrician, Braid Valley Hospital.
43. Ricky Stewart, Project Manager, North & West Locality Consortium.
44. F G McCafferty, Consultant Psychiatrist, South & East Belfast Trust.
45. Gerard Finnegan, Training and Development Manager, S.T.E.E.R.
46. B J Hampson, Derry.
47. Liz Cuddy, Business Development Manager, Threshold.
48. Joanne Murphy, JCM Training Services, County Derry.
49. D & P Maguire, Ballycastle, County Antrim.
50. Eleanor Duff, Ballycastle, County Antrim.
51. Dr J S Burnham, Newtownards Health Centre.
52. Dr G M Crawford, Chairman GP Executive Ards and Bangor Community Hospitals.
53. Dr G D O'Neill, Springfield Road Surgery.
54. Dr Eamonn McMullan, Omagh Health Centre.
55. Dr I C Steele, Consultant Physician in Geriatric Medicine, Royal Hospitals.
56. Dr T R O Beringer, Dr DH Gilmore, Dr IC Steele, Dr MI Wiggam, Royal Hospitals.
57. Dr M A Jones, Consultant Physician, South Tyrone Hospital.
58. W H Moffatt, Greenisland.
59. M Dowse, Peterborough, Cambridgeshire.

ANNEXE 4

COMMUNITY CARE REVIEW

DEMOGRAPHIC AND OPERATIONAL PROFILE

Demographics

1 In the 1991 census the demographic picture showed that the elderly population accounted for 13.6 % of the total population in Northern Ireland, which then stood at 1.57 million. Of this 13%, 7.4% were between 65 and 74 and 5.2% were 75 or over. The mid year estimates for 1999 show that while the total population had grown to almost 1.70 million, the proportion of those between 65 and 74 had reduced by 0.21% and now made up 7.2% of the population. Conversely, those aged over 75 had increased by 0.6% and now accounted for 5.8% of the total population.

2 From our point of view, the most important demographic trend is that people are living longer. The generally accepted reasons for this are:

Improved living standards – housing, sanitation and environment;

Developments in medical technology leading to improved diagnosis and treatment; and

Increasing emphasis on health promotion and health education.

3 The direct consequence of people living longer is an increased demand on a range of both health and personal social services. As well as the direct effect of increased numbers, there are a number of other factors that are responsible for increasing demand. These are:

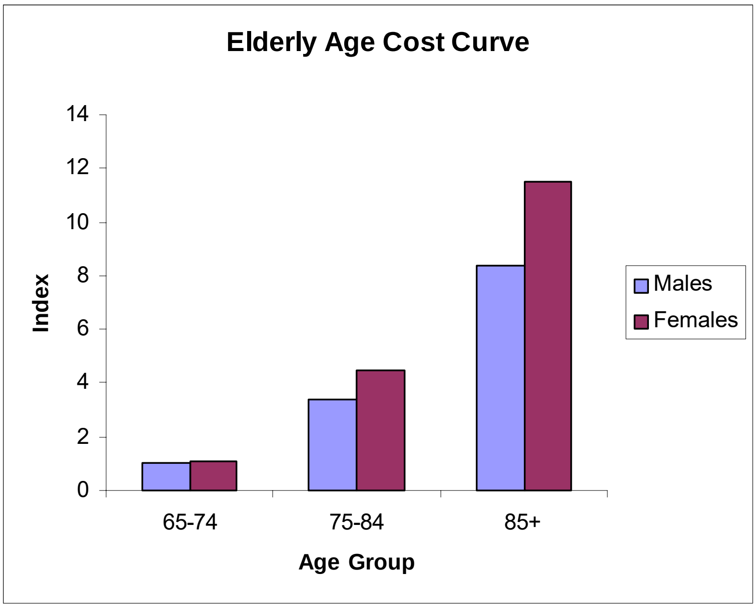
Higher expectations of the level and range of services which are available, increased by the high profile publicity surrounding all health and social care developments;

A reduction in community and family infrastructure support, forcing more people to depend on the support and intervention of the state, and

Increased public awareness of their rights to health and social services.

4 The following diagram illustrates how the cost of service provision increases with the age of the client.

Figure1: Age Cost Curve for Elderly Programme



Assessed and Met Need

5 Since the “People First” policy was first introduced in 1993, many people are now being maintained in their own homes who would otherwise have been in residential care or, perhaps, in a long stay hospital ward. The number of care packages in place to support these people can be taken as a direct measure of the success of the community care policy. There are three main types of care package – residential care, nursing care and domiciliary care. The following table shows the numbers of residential and domiciliary care packages in place for each of the years from 1995 to 2001.

Table 1: Numbers of Residential Care Packages 1995-2001

Year	1995	1996	1997	1998	1999	2000	2001
Total Care Packages	6849	9146	10027	10457	11067	11502	12622
Residential Care Packages*	3585	5011	5726	6498	6894	7179	7985
As % of Total Care Packages	52%	55%	57%	62%	62%	62%	63%
% Increase of Residential Care Packages Since 1995		40%	60%	81%	92%	100%	123%

(* Both residential homes and nursing homes)

Table 2 Numbers of Domiciliary Care Packages 1995-2001

	1995	1996	1997	1998	1999	2000	2001
Total Care Packages	6849	9146	10027	10457	11067	11502	12622
Domiciliary Care Packages	3264	4135	4501	3959	4173	4323	4637
As % of Total care Packages	48%	45%	45%	38%	38%	38%	37%
% Increase of Domiciliary Care Packages Since 1995		27%	38%	21%	28%	32%	42%

6 As can be seen, between 1995 and 2001 the numbers of residential care packages in effect increased by 123% whilst the numbers of domiciliary care packages increased by only 42%.

(NB: During the review staff from a number of Trusts argued there is a major incentive to place people in residential care since some of the costs are defrayed by access to Social Security benefits, while the costs of more expensive domiciliary care packages must be met in full by the Trusts themselves)

The view that more people are going into residential care than is necessary is supported by evidence of the comparative provision of community care.

Table 3: Comparative Provision of Community Care (1999)

	NUMBERS PER 1000 OF POPULATION OVER 75				
Service Area	N. Ireland	England	Scotland	Wales	R o I
Number Of Nursing Home Beds	99.5	54.9	68.1	49.2	35.6
Number Of Residential Places	71.4	93.7	70.7	72.9	62.8
Total Number Of Care Home Places	170.9	148.6	138.7	122.0	98.4
Numbers State Supported In Nursing Homes	51.9	19.9	35.5	22.1	N/a
% Of Care Home Places Provided In Residential Homes	58%	37%	49%	40%	36%
Numbers State Supported In Residential Homes	34.0	50.8	20.2	48.3	N/a
Total supported	85.9	70.8	55.8	70.4	N/a

Source: DHSSPS

7 In comparison to other areas, Northern Ireland has the highest number of residential care places in the UK. Of these places 58% are within a nursing home environment, compared to 37% in England, 49% in Scotland, 40% in Wales and 36% in the Republic of Ireland.

(NB: While these figures may seem to indicate a greater propensity to use nursing home accommodation we should be cautious with this explanation; the figures may simply reflect a greater level of need (for whatever reason) in Northern Ireland)

Assessed But Unmet Need

We are not clear about the relationship between our current service provision and potential, i.e., as yet unassessed need

(NB: work is currently being undertaken which may clarify this somewhat viz., the Needs and Effectiveness Working Group and the Review of Business Information Needs project).

Pressures on services are often measured only in terms of provision and met and unmet (identified) demands, whereas establishing the appropriate level of provision of health and social services would require the identification of total need, both met and unmet as well as all need in the community yet to be assessed. Since we lack direct and reliable data we have had to develop alternative ways to assess the appropriate level of provision. Hospital and community waiting list information and delayed discharge figures are therefore used as crude proxy measures.

Delayed Discharge

8 The number of patients remaining in hospital, after they have been deemed medically fit for discharge, has become the yardstick for measuring community care pressures. In July 2001, there were 365 patients who had had their discharge delayed. Of these, 91% were aged 65 or over and 77% were 75 or older. 66% of patients had had their discharge delayed by more than 3 weeks, 15% by more than 12 weeks and 2% by more than 6 months.

Table 4 identifies the numbers in each of the Board areas.

Table 4: Numbers With A Delayed Discharge At July 2001

	Total	Eastern HSS Board	Northern HSS Board	Southern HSS Board	Western HSS Board
July 2001	365	129	112	102	22

Source: Regional Information Branch, DHSSPS

9 Although a simple reading of Table 4 would seem to indicate a marked inequity between Board Areas, there figures require more detailed explanation. It would be necessary to look as well at the number of bed days lost, community waiting lists and the reporting criteria used. The straight figures are not meaningful unless examined within the context of the total services demands.

Table 5 below supports this, in particular by highlighting the significant numbers of people waiting outside for services outside the hospitals sector.

Table 5: Unmet Need in the Community (All Boards)

Number Of Adults Waiting At Home For A Nursing Home Placement	107
Number Of Adults Waiting At Home For A Residential Home Placement	174
Number Of Adults Waiting At Home For A Home Care Package	456
Number Of People (Adults Or Children) Awaiting At Home Specialist Equipment To Support Them Or Their Carers	907
Number Of People Waiting For Home Help Service	281
Number Of People Waiting For Day Care Provision	343
Number Of Adults Awaiting Hospital (As A Result Of Financial Deficits)	3
TOTAL	2271

10 Table 5 above shows the estimated numbers of people, in all of the relevant categories of assessed but unmet need, at October 2000

(NB: The table shows cases where no package is in place and does not account for cases where part of the assessed need is being met).

The 365 people identified as awaiting discharge in Table 4 will also require community care services but are not included in the Table 5 figures.

(NB: the numbers waiting in the community is therefore more then 6 times the number waiting in hospital for services to be provided).

Table 6 below provides information on the reasons why patients remain in hospital after they have been deemed medically fit for discharge.

Table 6: Reasons For Delayed Discharge

Reason for Delay	Number Delayed	% of Total Delayed
Hospital Process Not Complete	61	17%
Care Planning In Process	48	13%
Patient/Relative Choice Not Available	28	8%
No Funding Available	146	40%
No Provision Available For Place/Care Package	43	12%
Patient Self Funding	16	4%
Essential Equipment/Adaptations Not Available	13	4%
Other	10	3%
Not Specified	0	0%
TOTAL	365	100%

11 On these figures, a significant number (40%) are the result of a general lack of funding for community care services. While this means that the majority of delays are not primarily funding related, we have evidence that funding issues are much more complex problems to resolve.

12 Patients remaining in an acute hospital bed long after they have been deemed medically fit for discharge has a number of ramifications.

- Patient’s human rights may be infringed as many would choose not to remain in hospital;

- It increases risk, as vulnerable patients may be exposed to other contagious illness;

- Patient's recovery may be delayed as people tend to recover more quickly in their own homes;

- Patients may become more dependent and institutionalised;

- An acute hospital bed is the most expensive way of accommodating a person who does not require hospital treatment;

- Patient care in hospital is free therefore client contributions to accommodation are lost to service providers, and

- Inappropriate use of hospital beds results in a reduction in acute treatment capacity.

Produced by: Department of Health, Social Services & Public Safety
Castle Buildings
Belfast
BT4 3SL

Telephone: (028) 90 524322

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Review of Community Care 'First Report' is also available on the Department's website: www.dhsspsni.gov.uk

Further copies may be obtained by writing to John McKeown, Elderly & Community Care Unit, Room 115, Dundonald House, Upper Newtownards Road,
BELFAST BT4 3SF or by e-mail [redacted]

NEWS RELEASES
THE DEPARTMENT OF HEALTH, SOCIAL SERVICES & PUBLIC SAFETY

30 January 2007

GOGGINS OUTLINES ACTION FOR LEARNING DISABILITY HOSPITALS

Health Minister Paul Goggins has announced an action plan to discharge all patients from learning disability hospitals, including Muckamore.

Key elements of the plan include:

- An end to the permanent placement of children in learning disability hospitals. This will begin immediately with no children permanently resident by March 2009;
- A new community-based, £3.5 million 8-bedded unit for children and adolescents will be fast-tracked. In the meantime, more appropriate accommodation will be provided for children as quickly as possible;
- Increase the numbers of patients who are resettled from 25 to 40 each year;
- No learning disabled patient to stay in hospital for longer than 12 months depending on the level of treatment and assessment they need;
- By 2014 no learning disabled patient will have a hospital as a permanent address;
- New protocols to be drawn up so there is clear guidance on patients only being kept in locked wards if they pose a risk to themselves or others;
- Care plans to be developed for every learning disabled patient in Hospital.

The Minister said: **"Less than two weeks ago I asked officials to draw up, as a matter of urgency, an action plan to address the problems in Muckamore Abbey Hospital. In particular, I wanted a plan which would set out how we would move those patients who have been staying in Muckamore, and other learning disability hospitals, for too long back into the community.**

"I am confident that the plan I have announced today will move people, as quickly as possible, out of learning disability hospitals and back into the community where they belong. The plan seeks to ensure that patients are provided with the most appropriate accommodation, tailor-made for their individual needs, and, that families have access to support and respite care to help them look after their relative.

"It is important that we move forward as quickly as possible, however, we must remember that many of these patients have very complex needs and challenging behaviours that require very specialist and intensive care. We must also ensure that patients who have been living in learning disability hospitals for many years are moved in a sensitive way and that this is not too rushed."

Health Trusts will now be required to draw up individual care plans for patients upon admission which will consider arrangements for their discharge.

The Minister said: **"Learning Disability hospitals, such as Muckamore, still have a key role to play in assessing and treating people with a learning disability or mental health problem. Last year, the first phase of new assessment and treatment facilities was opened at Muckamore at a cost of nearly £9 million. Progress on the second phase of this project is well underway, bringing a total capital investment of around £14 million in Muckamore alone. In 2006, I also**

opened the new Lakeview learning disability hospital in Londonderry at a cost of nearly £5 million.

"However, we need to move away from a situation where patients end up in a learning disability hospital with no plan for when they should return to the community. That is why I am requiring health trusts to draw up clear plans for all patients who need treatment in hospital. I am asking trusts, from day one, to have a set date as to when patients will be returned to the community.

"I also want to acknowledge the dedicated care that staff have been providing to patients in learning disability hospitals, such as Muckamore, for many years. A great deal of progress has already been made in resettling patients back into the community. For example, over the last 20 years the numbers of patients in Muckamore has reduced from 800 to under 300 – more than 500 people are now living back in the community."

NOTES TO EDITORS:

Action Plan for Discharge of Patients from Learning Disability Hospitals

- The Department will strengthen the learning disability services available to support people and their families to remain in the community, prevent inappropriate admissions and facilitate early discharge. This will include dealing with challenging behaviour, short break respite for families and carers and day opportunities for improved social integration and occupation.
- An end to the permanent placement of children in learning disability hospitals. This will begin immediately with no children permanently resident by March 2009. This will include the provision of an 8-bedded assessment and treatment centre in Belfast for children with a learning disability. There are plans for four children to be resettled in the community in the next few months using funds from the Children and Young People's funding package. In addition, the intention is to place a further six children in the community before the end of the year.
- The Department will accelerate the rate of resettlement and discharge of patients from Learning Disability Hospitals, from 25 to 40 each year, so that the programme will be complete by 2014 at the latest and no-one will have a hospital as their permanent address. Discharge planning will begin immediately upon admission for patients as part of their care plan so that they have a date for discharge back into the community.
- Steps will be taken to separate those patients who need to be kept in a secure ward from other patients. If necessary a vacant ward within Muckamore will be re-opened by June 2007 for two years to allow this to be achieved. Care plans must be in place to ensure that no-one is held in a secure ward inappropriately.
- A Regional Resettlement Team will be established to oversee the discharge of patients across learning disabled hospitals. The Team will bring together all of the Departments and agencies needed to ensure adequate planning is being carried out. This Team should also include representatives from groups such as the Friends of Muckamore and Housing Associations.

Media queries to Clare Baxter, DHSSPS Press Office on 02890 520571 or 07919 400248.

Click here to print this press release.

Terms of Reference

Regional Resettlement Team

Background

A Regional Resettlement Team, announced as part of an Action Plan in January 2007, is being established to oversee the discharge of patients across the three learning disabled hospitals Muckamore Abbey, Longstone and Lakeview. The team will drive and monitor the development of appropriate accommodation and support in the community. Active Discharge Teams, which have been set up at each of the three hospitals, will be responsible for the discharge of patients from Learning Disability Hospitals and development of appropriate associated accommodation. Progress will be monitored on a monthly basis and the Regional Team will report to the Department on a quarterly basis.

The Team will be chaired by Dr Bernie Stuart, Director of Disability Policy, and will comprise members from a range of stakeholders and organisations who are involved in the provision of accommodation and support. It will normally meet quarterly. The team will meet monthly during the months of October, November and January.

The Team’s remit will be to work across organisational boundaries to:

- Oversee, drive and monitor the work of the Active Discharge Teams;

- Drive the development of appropriate community infrastructure and alignment of hospital capacity;

- Identify and highlight issues which need to be addressed and facilitate resolution, and

- Liaise, as required, with the (future) Equal Lives Implementation Team and the Panel of Experts on Mental Health and Learning Disability.

- The Team may use focus groups of users/carers for reference purposes, as required.

PRIORITIES FOR ACTION

2007-08

January 2007

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PRIORITIES FOR ACTION 2007-08

Foreword by the Minister

In presenting last year's **Priorities for Action**, I explained exactly where and how I wished to raise our standards of health and social care. Already I have observed some significant improvements – especially in waiting times for hospital assessment and treatment. But we still have a long way to go, and we need to ensure that all of our health and personal social services are delivered to a standard that matches legitimate expectations.

I believe that goal is within sight. We have embarked on the most profound and far-reaching process of reform and modernization, a process that embraces the way our system is organized and how HPSS professionals organize themselves to provide services. We must maintain that momentum, with no loss of focus on the several facets of improving and protecting the health and well-being of the public (including emergency planning and preparedness), and taking the opportunity presented by the Review of Public Administration to better integrate such activities into mainstream health and social care.

Let me restate three themes of the HPSS reform programme that are especially important in delivering our core purpose – safe, effective care:

- Managing the demand on hospital services by promoting healthier ways of living, and by providing more responsive and accessible alternative services in the community so as to prevent unnecessary hospital admissions and facilitate prompt discharge
- Managing patient flows within a safe hospital system, to allow for swifter and more effective access to services
- Improving outcomes for all children who are, or have been, in public care.

It is such changes in the frontline of care that are of direct value to those who rely on the HPSS – a group that, sooner or later, includes all of us. But we must also see to it that essential backroom services, such as HR and finance, and the physical infrastructure itself, are able to sustain and increase the capacity for improvement.

In last year's Priorities for Action I accordingly specified 10 key priorities that underpin the reform programme, and I am now endorsing further action in those 10 areas. I wish to see, by March 2008, that the HPSS is moving to meet improved, guaranteed, standards in all the major programmes of care. The key standards and targets, set out in Section One of this document, will be subject to robust monitoring and performance management throughout the coming year. Performance against the standards and targets will receive close Ministerial attention – but the critical point is that the public will be able to judge how well the HPSS is doing.

In Section Two are listed 40 supplementary targets and actions. These are, for the most part, of less significance for the generality of patients and others, but they make an indispensable contribution to improved service delivery. Their achievement, too, will be closely monitored.

We have to recognize that the statutory services sector cannot, on its own, meet all of these challenges. There must, for example, be strategic partnerships with the independent sector. The HPSS should focus on the complex, integrated services required around the hospital/community interface, while the wider independent sector plays a bigger role in the delivery of continuing care. And the voluntary and community sectors are particularly well placed at local level to deliver the flexible and responsive services we need in prevention and in less intensive support. We all have a part to play.

Priorities for Action 2007-08 is a much shorter document than its predecessors, but it is – I believe – more relevant to the health and well-being of people in Northern Ireland. That is why it is vital that its standards and targets are met. I am confident that the HPSS will meet them.

Paul Goggins

Minister for Health, Social Services & Public Safety.

SECTION ONE: PRINCIPAL STANDARDS AND TARGETS

1. The overall aim of the Department of Health, Social Services and Public Safety is to improve the health and well-being of the people of Northern Ireland.

   In pursuing this aim, the key objectives of the Department are:

   - To improve health and well being outcomes through a reduction in preventable disease and ill-health by providing effective, high quality, equitable and efficient Health, Social and Public Safety Services to the people of Northern Ireland

   - To create a safer environment for the community by providing an effective fire fighting, rescue and fire safety service.

2. The previous Priorities for Action provided a planning framework for Health and Personal Social Services 2006-08. In presenting that document, the Minister dwelt on the transformation that the HPSS was undergoing. He made it plain that, as a result of this programme of change, he expected the Boards and Trusts to be more effective in promoting the public's health and well-being and, in pursuit of ever-improving quality of service, to provide treatment and care more promptly and efficiently. To add weight to his message, Mr Goggins announced that he would be giving personal attention to 10 priority areas where progress was critical to the reform process.

3. In his foreword to Priorities for Action 2007-08, Mr Goggins has confirmed the approach adopted in June 2006. This document is, therefore, structured around those same 10 areas. While the challenges remain the same, however, the Minister is determined that further, demonstrable improvements are made to services in the course of 2007-08.

4. The specific targets relating to these 10 priorities are designed to secure real improvements for patients and other service-users; that must be the touchstone. The targets are to be regarded as a means to improved services, not as ends in themselves. Those listed below will be subject to particularly detailed performance management and reporting arrangements during the year.

5. The Minister's expectation is that the public will see continuing improvement to services in the following 10 areas:

(1) Improving health and well-being

The 20-year strategy *A Healthier Future*, the organisational changes in the Review of Public Administration, and the detailed outworking of reform are all designed to change the nature of the health and social care system, to put first the aims of promoting good health and well-being, the prevention of illness and injury, early intervention and good long term care. It is estimated that preventable ill health accounts for over 6,500 avoidable deaths per annum in Northern Ireland. There are, moreover, unacceptable inequalities in health often associated with socio-economic status and disadvantaged areas. Addressing this, for example through the delivery of the *Investing for Health* strategy, remains a key priority for the Department and the HPSS.

Specific actions planned for 2007-08 in support of the *Investing for Health* aims and objectives, and which contribute to that strategy, are set out in Section Two.

The principal target for this priority is:

> **Smoking prevalence**: by March 2008, smoking prevalence by Board area should be reduced by 7% across Northern Ireland to 24%.

(2) Safer, better quality services

For all aspects of health and social care, there is a duty to deliver a quality service. Patient safety must come first and must not be compromised. There has always been a due emphasis on the quality and safety of the health and social services commissioned or delivered in Northern Ireland. But the continual change in circumstances, expectations and modes of treatment means that unremitting attention must be given to this priority; our aim is continuous, measurable improvement, based on the principles of professional excellence, the management of risk, and continued implementation of such strategies as *Cleanliness Matters.*

It is important to adopt evidence-based interventions that are known to save lives. These include: reducing health care associated infection; preventing harm from medication with specific but not exclusive focus on high hazard medications; preventing surgical errors, including wrong site, wrong procedure and wrong person errors; reliable recognition of a response to patient deterioration via early warning score systems and rapid response; and proactive enhancement of quality improvement knowledge and skills across managers and clinical teams (see p17 for relevant target).

By May 2007, the Regulation and Quality Improvement Authority will have completed governance reviews in HPSS organisations with a particular emphasis on 'corporate leadership and accountability' and 'safe and effective care'. HPSS organisations need to learn from their governance reviews and adopt action plans to improve systems accordingly.

The principal target for this priority is:

> **Health care associated infection:** by May 2007, Trusts must submit to the Department, for approval and monitoring, Infection Reduction Plans that include Trust-specific targets for prevention and control of health care associated infection. Progress in meeting these targets must be robustly monitored and reported monthly by the Infection Prevention and Control lead to the Trust Board.

(3) Reductions in Hospital Waiting Times

Excellent progress has been made to reduce the number of people waiting for hospital inpatient or day case treatment. By the end of March 2007, the HPSS should have met its target that no-one on the inpatient/day case list should have been waiting more than six months. At April 2006 there were nearly 74,000 people who had been waiting longer than six months to be seen at outpatients. Over the course of 2006-07 a significant programme of outpatient reform, augmented by additional clinic sessions and independent sector capacity, has brought about much improvement; the HPSS is expected to meet its end of March 2007 target that no-one is waiting longer than six months for a first outpatient appointment. Further improvement is required for 2007-08, coupled with more exacting standards for life-threatening conditions where speed of access is of the essence. In addition, maximum waiting time targets will be set for access to services provided by Allied Health Professionals (AHPs) such as physiotherapy and occupational therapy.

The principal targets for this priority are:

Elective care (consultant-led): by March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment.

Elective care (AHP): by May 2007, with a view to improving access to AHP services, Boards and Trusts must submit to the Department, for approval and monitoring, proposed targets and associated reform plans for March 2008 and beyond.

Cancer: by March 2008, at least 98% of patients diagnosed with cancer should commence treatment within 31 days of the decision to treat, and at least 75% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days (increasing to 95% by March 2009).

(4) Significant Improvements in Emergency Care

Patients in many parts of Northern Ireland have to wait too long in emergency care departments before receiving treatment and being admitted or sent home. Lengthy waits in emergency care are unacceptable, particularly for elderly and vulnerable patients, and represent a failing in quality of care. Too often they are the product of inefficient management of patient flows. Working with Boards and Trusts, the Department is taking forward a major programme of reform to improve emergency access. Improving the patient experience must focus on the complete patient journey through emergency services, beginning with the ambulance journey, if required, continuing through the emergency care department and the hospital system itself and ending when the patient is discharged.

The principal targets for this priority are:

A&E: from April 2007, no patient should wait longer than 12 hours in A&E and, by March 2008, 95% of patients who attend A&E should be either treated and discharged home, or admitted within four hours of their arrival in the department.

Fractures: by March 2008, at least 75% of patients should, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment (increasing to 98% by March 2009).

Ambulance services: for 2007-08, the Northern Ireland Ambulance Service should respond to an average of 65% of Category A (life-threatening) calls within eight minutes, with performance improving to 70% for the month of March 2008.

(5) Fully Integrated Care and Support in the Community

The development of fully integrated primary and community care services is central to the overall reform programme. These must be designed to focus on people most at risk, providing alternative services and ways of delivering services that help ensure that people can live independently at home for as long as possible. The key components of this reform are person-centred planning approaches such as individually designed services, direct payments, case management for people with long-term conditions and the development of intermediate care services as a bridge between the community and hospital. These must be underpinned by fully integrated multi-disciplinary working and the expansion of nurse-led discharge, non-medical prescribing arrangements and the development of responsive community-based services.

Commissioners will also need to work with providers to develop self-care and self-management programmes, and clinical networks, to help people manage their own conditions more effectively. Critical to the achievement of Ministerial objectives for independent living is support for carers. Commissioners and providers must develop flexible and responsive support services for carers in line with the *Caring for Carers* strategy. Assessment of complex continuing care needs should take place outside an acute setting and in the context of appropriate opportunities for rehabilitation. Health and Well-being Investment Plans must fully reflect these strategic changes by establishing the baseline for the local health and social care economy and by setting out a firm plan and timeline for transition to the new arrangements.

The principal targets for this priority are:

> **Timely discharge:** from April 2007, 50% of complex discharges from an acute setting should take place within 72 hours of the patient's being declared medically fit, rising to 100% by March 2008. From April 2007, all other discharges should take place within 12 hours, reducing to six hours by March 2008.

Primary care access: from April 2007, Boards should ensure that all patients have 48-hour access to a GP or other appropriate practice-based primary care practitioner. In cases where the patient has an acute condition (including exacerbation of an existing condition), access must be within 24 hours.

Elderly: by March 2008, older people with continuing care needs should wait no longer than eight weeks for assessment to be completed and should have the main components of their care needs met within a further 12 weeks.

(6) Improvements in Children's Services

While the Children and Young People's Package provides welcome support to mainstream services for children, the basic policy challenge — a better start in life for each looked-after child — has yet to be overcome. There is strong evidence of better outcomes for children in care living in stable placements and for children who have left care but who continue to live with their former carers. At present, however, too many children and young people in care undergo multiple placements with different foster carers and into different residential homes during their time in care. Too many young people leaving care end up living alone in isolated placements without family support.

The principal target for this priority is:

Children: by March 2008, an additional 175 foster carers (as compared to the March 2006 total) should be in place across Northern Ireland.

(7) Better Mental Health and Learning Disability Services

In the wake of the Bamford review of mental health and learning disability, the task for the HPSS is to establish a strategic framework for mental health promotion and suicide prevention, and to reform and modernize mental health and learning disability services. Those who provide the mental health and learning disability services should see each as a whole system, made up of a number of linked services where targeted action can have more than one beneficial effect. The HPSS should continue to strengthen the mental health and learning disability services available to enable people and their families to remain in the community, to prevent inappropriate admission to hospital, and to facilitate early discharge. Service users and carers should be involved in developing, delivering and evaluating services, and the voluntary sector should be encouraged to deliver a higher proportion of services. The particular needs of people affected by the Troubles should be taken into account when planning mental health services. Many of the definitive policies and targets in the fields of mental health and learning disability will be decided in the context of the inter-departmental action plan that will be drawn up by July 2007 in response to the Bamford Review.

The principal targets for this priority are:

> **Mental health:** by July 2007, with a view to improving regional access to mental health services on foot of the Bamford Review, Boards and Trusts should submit to the Department, for approval and monitoring, proposed targets and associated reform plans for improving the response to, and support for, people with mental health problems presenting at primary care level.
>
> **Learning Disability:** by March 2008, Boards and Trusts should have resettled 40 people currently being cared for in learning disability hospitals to appropriate places in the community. In addition, Boards and Trusts should ensure that, from April 2007, all patients admitted for assessment and treatment are discharged when treatment is complete, according to the care plan created for each new patient on admission.

(8) Effective financial control and improved efficiency

Financial control is integral to the proper provision of health and social care. A weakening of such discipline would mean that the Minister's service priorities would become distorted, and the public would lack assurance that the most infirm and vulnerable were receiving their needful treatment. It is important that the existing degree of control (resulting in, among other things, the delivery of planned efficiency savings) continues into 2007-08. In addition, as the RPA changes take effect, Boards and Trusts are expected to provide realistic, timely and fully considered information on the resource implications of operating the new structures, ensure that properly resourced project management arrangements control all aspects of the re-structuring process, and prepare for the introduction from April 2008 of a tariff-based system for the allocation of funds.

The principal target for this priority is:

> **Finance:** the Department and all HPSS organisations should live within the resources allocated and achieve financial balance.

(9) Reforming the Workforce

There needs to be sustained investment in the education and training of the future HPSS workforce, continuous professional development of the existing teams, and action to safeguard the interests of staff within the context of the organisational changes and reductions in corporate functions as a result of the Review of Public Administration. Failing such investment, patients and other service users will not benefit to the full from Agenda for Change and the other reforms in HPSS terms and conditions.

Government has shown its commitment to the workforce and to service-users by significant funding injections for Agenda for Change, the consultant's contract and the new General Medical Services contract, modernizing their terms and conditions and increasing (by 16% over the last four years) the numbers of frontline staff working in the HPSS. It is expected that improvements in productivity, as expressed in both throughput and effectiveness of care, will result from the changed professional working practices etc made possible by that investment. Drawing on the recommendations of its Productivity Working Group, the Department will issue guidance in April 2007 on measuring change in the level of HPSS workforce productivity. The Trust plans referred to in the target below will be drawn up in light of that guidance.

The principal target for this priority is:

> **Productivity:** by May 2007, Trusts must submit to the Department, for approval and monitoring, productivity improvement plans to meet the requirements set out in the Department's guidance on HPSS productivity.

(10) Infrastructure investment

A high quality service demands modern, fit-for-purpose facilities and equipment. Action is under way to renew many of the key facilities for health and social care across Northern Ireland, rolling out the decisions taken in *Developing Better Services* and moving forward the planned programme of investment in primary and community care to support the strategy of *A Healthier Future* and *Caring for People Beyond Tomorrow*. In support of this, Trusts will be expected to comply with new Service-wide programme management requirements for infrastructure investment, including the provision of timely and complete information on business case development and project management, and timely provision of business cases themselves. Trusts must also engage effectively with the Department in the management of the capital budget, implementation of the strategy for identification, use and disposal of surplus assets, and taking forward plans for reducing the total HPSS estate backlogs.

Section Two amplifies the point.

Conclusion

6. The major service improvements listed above entail some changes to last year's Public Service Agreement. A revised version of the PSA will be issued once it has been agreed with DFP.

7. As with every Northern Ireland Department, the established policies and commitments to targeting social need and promoting equality of opportunity are expected to permeate all policies and strategies.

SECTION TWO: SUPPLEMENTARY OBLIGATIONS AND TARGETS

In support of, or alongside, the standards and targets specified in Section One, a further 40 obligations and targets must be met in 2007-08. These supplementary actions are grouped under the Minister’s 10 key priorities.

PRIORITY 1: IMPROVING HEALTH AND WELL-BEING

Boards should continue to take the lead in co-ordinating the implementation, monitoring and review of the cross-sectoral Health Improvement Plans developed by each of the Investing for Health Partnerships. Trusts should support this process and ensure that their work in this area is clearly within the *Investing for Health* framework:

- Boards and Trusts should begin rolling out a diabetic retinopathy screening programme from April 2007, with full coverage being achieved across Northern Ireland by March 2008;
- Board plans should include specific action and appropriate outcome targets to ensure that the Government’s PSA targets are achieved in relation to increased life expectancy and reduced health inequalities ie:
    - By March 2008, reducing by 10% the rate of births to mothers under 17 years of age (the Northern Board achieving a rate of 2.8 births per 1,000 females, the Southern 2.2, the Eastern 3.4 and the Western 2.1);
    - By March 2008, reducing the percentage of adult drinkers who binge drink to 30% in the Northern Board area, 30% in the Southern, 40% in the Eastern and 41% in the Western;
    - By March 2008, reducing the incidence of illicit drug taking among 15-64 year-olds, to 5.9% in the Northern Board area, 4.8% in the Southern, 6.9% in the Eastern and 5.5% in the Western;
    - From September 2007, collecting and recording BMI measurements through the School Nursing Service, which will offer to record the height and weight of all year 8/9 pupils (with analysis of the data being used to assess the need for further interventions, to be

  implemented within a public health model in partnership with relevant stakeholders);
  - By March 2008, ensure that each GP practice has an appropriate professional trained in depression awareness or suicide awareness in line with the Suicide Prevention Strategy; and
  - By March 2008, achieve 92% coverage for MMR uptake, with efforts to increase uptake rates focused on identified socially excluded groups and communities with high deprivation indices.

PRIORITY 2: SAFER, BETTER QUALITY SERVICES

Boards and Trusts should ensure that:

- By April 2007, each organization has a specified lead person responsible for ensuring that staff health and safety and support are properly and consistently managed – with a view to, among other things, reducing the incidence of attacks on, and abuse of, staff;
- By September 2007, an action plan is in place to address the recommendations from the forthcoming RQIA governance reports;
- By September 2007, arrangements are in place to learn from at least three major interventions which, based on international evidence, are known to save lives;
- By December 2007, systems are in place for the post-discharge surveillance of surgical site infections following Caesarean Section;
- By December 2007, the Department’s Safety First framework action plan has been fully implemented and that safer, high quality, care is included as a standing agenda item for board meetings;
- By March 2008, 95% of all staff shall have received training in infection prevention and control;
- By March 2008, there is full implementation of the relevant recommendations in *Improving Patient Safety, Building Public Confidence* (the NI response to Shipman); and

- By March 2008, self assessments have been completed against the emergency planning controls assurance standard and moderate compliance attained with both the Civil Contingencies Framework and the Emergency Planning Functions Directions.

PRIORITY 3: REDUCTIONS IN HOSPITAL WAITING TIMES

Boards and Trusts should ensure that:

- From April 2007, all breast referrals deemed urgent according to regionally agreed guidelines for suspected breast cancer should be seen within 14 days of the receipt of the GP referral;
- By September 2007, the capacity of paediatric and neonatal intensive care (including retrieval service) is increased by one cot and one bed;
- By March 2008, all patients with severe inflammatory arthritis who, at 31 March 2006, were on the waiting list for treatment with biologic therapies, have commenced their treatment;
- By March 2008, no patient with MS, who has been assessed as eligible for disease modifying treatment under the ABN guidelines, should wait more than 13 weeks to start treatment;
- Patients have timely access to renal dialysis services, three times weekly, with overall capacity (haemodialysis and peritoneal dialysis) being increased by 10% year on year to March 2008, in line with the expected growth in demand as outlined in the Renal Services Review 2002; and
- By March 2008, all patients assessed as clinically urgent are able to access specialist Genito-Urinary Medicine/Sexual Health services within two working days.

PRIORITY 4: SIGNIFICANT IMPROVEMENTS IN EMERGENCY CARE

- Boards and Trusts should ensure that, from April 2007, any patients waiting in an emergency care department for more than 12 hours are classified as Serious Adverse Incidents and reported to the Department.

PRIORITY 5: FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

- By October 2007, Boards should ensure that the new, more regional, out-of-hours service is in operation; and,

- Boards and Trusts should ensure that people can live independently at home for as long as possible, in particular so that, by March 2008:
    - Forty-three per cent of people receiving care-managed support receive it in their own homes; and
    - The number of direct payment cases increases to 750.

PRIORITY 6: IMPROVEMENTS IN CHILDREN'S SERVICES

Boards and Trusts should ensure that:

- Throughout 2007-08, 50% of all young people coming into care participate in a family group conference to try to identify alternative or kinship/familial fostered living arrangements;
- By September 2007, 150 young people aged 18-20, who have left care, should be living with their former carers;
- By September 2007, a regional recruitment, marketing and training team for foster care has been put in place, together with a round-the-clock support service for foster carers; and
- By March 2008, all relevant recommendations of the Child Protection Overview Report have been implemented.

PRIORITY 7: BETTER MENTAL HEALTH AND LEARNING DISABILITY SERVICES

Boards and Trusts should ensure:

- By March 2008, community mental health and learning disability services are further developed, augmenting existing community teams (including an additional 25 staff for crisis response, home treatment and assertive outreach teams and 25 community learning disability staff), to provide appropriate, responsive services, promote access to round-the-clock support, and reduce waiting times;
- By March 2008, specialist eating disorder posts are created in each Board area (a regional total of 12), to facilitate early detection and intervention for children and young people and so prevent cases becoming more severe in adult life;
- Community facilities continue to be developed to allow resettlement of people from long stay hospitals – by March 2008 a further 50 people should be resettled from mental health and learning disability hospitals – while long stay facilities should be reconfigured to better reflect patients' care needs; and
- Services for people with autism continue to be developed reflecting, in due course, the recommendations of the review of autism services to be completed by September 2007.

PRIORITY 8: EFFECTIVE FINANCIAL CONTROL AND IMPROVED EFFICIENCY

- During 2007-08, Boards and Trusts should achieve the efficiency targets specified in the Department's financial allocation letter; and
- As part of this, throughout 2007-08 Boards and Trusts are required to implement the agreed action plan (including support arrangements) to meet the targets set in the Pharmaceutical Services Improvement Programme.

PRIORITY 9: REFORMING THE WORKFORCE

- During 2007-08, Boards and Trusts should ensure that, leaving aside administrative and clerical staff, there will be a 5% reduction in staff turnover, vacancy rates and the costs of locum staff as compared to 2006-07;
- For 2007-08, each Trust should ensure that its absenteeism rate is 10% lower than the 2006-07 average absenteeism rate across its constituent former Trusts; and
- During 2007-08, consistent with the Minister's medium term intention to bring HPSS productivity into line with that of the NHS (ie an improvement of 7-10%), Trusts must produce evidence of new more flexible working patterns, and the delivery of more routine work in the evenings and weekends. Trusts should submit, at 6-monthly intervals, a report that links workforce modernisation with service redesign. The report should demonstrate how the benefits are being realised from pay reform.

PRIORITY 10: DELIVERING ON THE INVESTMENT STRATEGY

As outlined in Section One, during 2007-08 Trusts are required to:

- Co-operate fully with the implementation of the Department's strategy for the identification, use and disposal of surplus assets, with the monthly finance returns to the Department reflecting actual and proposed disposals; and

- Develop and implement plans for reducing the total estate backlogs in respect of such statutory and other standards as the Disability Discrimination Act, health & safety, fire safety, physical condition, replacement of ageing equipment and compliance with decontamination policy and standards.

Appendix

PRIORITIES FOR ACTION 2007-08: RING-FENCED FUNDING

While reform and the wider adoption of best practice do not necessarily require more money, there are service developments and increases in HPSS capacity which cannot take place without such resources. Some of the standards, targets etc in Priorities for Action 2007-08 fall into the latter category. This appendix lists the recurrent ring-fenced funding relevant to each priority. For the most part, the amounts in question are directly associated with particular targets or obligations and are described accordingly. In some instances, however, the ring-fencing relates to a broader field of activity or to the priority as a whole; again, and where relevant, that point is brought out. The ultimate authority in this matter is the 2007-08 financial allocation letter to Boards, which amplifies the Department's requirements for the deployment of all ring-fenced amounts.

PRIORITY 1: IMPROVING HEALTH AND WELL-BEING

- Ring-fenced funding of £0.35m has been issued for the purpose of rolling out a diabetic retinopathy screening programme.
- Funding for suicide prevention (£1.2m), pandemic 'flu (£1.0m), smoking cessation (£0.8m) and bowel screening (£0.3m) is centrally retained.

PRIORITY 2: SAFER, BETTER QUALITY SERVICES

- Ring-fenced funding of £0.25m has been set aside to allow for the implementation of the recommendations contained in the NI response to Shipman, together with £0.3m to maintain safety and quality of service in certain regional specialities.

- Additional funding is being retained centrally for combating health care associated infection (£0.2m), liquid based cytology (£0.2m) and full implementation of the Hine Review (£0.5m).

PRIORITY 3: REDUCTIONS IN HOSPITAL WAITING TIMES

- £18.0m has been ring-fenced to ensure continuing progress in the provision of elective care services and ICATS.
- Funding of £3.5m (including £2.0m for drugs) has been allocated to facilitate full implementation of the Cancer Control Programme by March 2008, while an additional £0.1m is being held centrally in respect of the Wilson Review.
- Increased capacity in Paediatric and Neonatal intensive care is being funded by an addition of £0.8m.
- Ring-fenced funding of £0.5m has been set aside to enable the Regional Lymphoedema Services Implementation Group, during 2007-08, to create a regional lymphoedema network, provide educational and training materials for healthcare professionals, develop specialist clinics for the treatment of both primary and secondary lymphoedema, and develop a regional register of patients.
- To help ensure that the inflammatory arthritis target is met, £4.75m has been allocated.
- A ring-fenced sum of £1.25m has been made available to help meet the target that, by March 2008, no patient with MS who is eligible for treatment should wait more than 13 weeks for the treatment to begin.
- £2.5m has been set aside to give patients timely access to Renal Dialysis Services.
- An allocation of £5.0m has been made to fund the adoption or increase the uptake of hospital and specialized drugs.
- In support of elective care reform, £1.0m has been made available to improve the care of patients with cardiac disease, including greater sustainability of paediatric cardiac services and the introduction of new technological approaches (consistent with best practice).

PRIORITY 5: FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

- A total ring-fenced addition of £4.0m has been made to help modernize primary and community care through expansion of flexible and responsive integrated community health and social care services, focused on older people and aimed at reducing inappropriate admissions to hospital, facilitating prompt discharge when admission is unavoidable and supporting people to continue living independent lives in their own homes for as long as possible. This investment comprises £1m for the primary care management of respiratory conditions and diabetes (including the development of a managed clinical network for children with diabetes), and £3m for community care services such as intermediate care, flexible and responsive domiciliary care services (including support for carers), the expansion of assistive technology in community care and the expansion of supported living schemes (working with NIHE). Improvements in primary and community care services are expect to make a significant contribution to the achievement of the Ministerial priority on delayed discharge. Further guidance on enhancing primary and community care may be found in Circular HSS (EPCC) 1/2007.
- Funding of £0.25m has been set aside to support the Alternative Medicines Integration Scheme.

PRIORITY 6: IMPROVEMENTS IN CHILDREN’S SERVICES

- As part of the Children and Young Persons Package, there is an £8.0m ring-fenced addition for such children’s services as child protection, foster care support, young carers and parenting skills.
- An allocation of £0.5m has been made to fund the legislative requirement to appoint personal advisers.

- There is a ring-fenced addition of £0.8m for the modernization of children's residential care homes.
- To support the regional expansion of foster care there is a ring-fenced allocation of £2.0m.

PRIORITY 7: BETTER MENTAL HEALTH AND LEARNING DISABILITY SERVICES

- £2.0m has been ring-fenced to augment existing community teams and otherwise help with the further development of Community Mental Health and Learning Disability Services.
- £0.5m has been set aside for the creation of 12 specialist eating disorder posts.
- A sum of £1.0m has been ring-fenced to forensic mental health services, for supporting in the community higher risk mental health clients.
- Funding of £5.0m has been allocated for the resettlement of 50 people from mental health and learning disability long stay hospitals and for learning disability patients to be accommodated, in line with their care plans, in unlocked wards.
- An additional £0.5m (first provided on a non-recurrent basis in October 2006) will be made available to support the development of services for people with Autism.
- Children and Young Persons Package funding of £8.1m will be channelled towards services (including wheelchair provision) for children with special needs and physical and sensory disabilities, extension of speech and language therapy services for these children, and children with mental health problems at times of crisis.

PRIORITY 9: REFORMING THE WORKFORCE

- Ring-fenced allocations in respect of Agenda for Change, the consultants' contract and for junior doctors, and the conditions surrounding their deployment, are set out in the Department's financial allocation letter of 22 December 2006.

PRIORITY 10: DELIVERING ON THE INVESTMENT STRATEGY

- The revenue consequences of bringing into commission capital schemes are recognized by a ring-fenced addition of £9.0m for 2007-08.
- The ring-fenced funding for the revenue consequences of EPF/RRI schemes amounts to an additional £4.4m for 2007-08.

Permanent Secretary apologises to Muckamore families

Date published: 17 December 2018

Department of Health Permanent Secretary Richard Pengelly today apologised to families of Muckamore Abbey Hospital patients at a meeting with them at the Co Antrim facility.

Mr Pengelly also made a series of firm commitments to the families, as regards future care provision.

He was accompanied at the meeting by Chief Social Worker Sean Holland and Chief Nursing Officer Charlotte McArdle.

Commenting after the meeting, Mr Pengelly said: "It was important to me to apologise to families face-to-face for what happened to their loved ones while in the care of Muckamore Abbey Hospital - rather than through a press statement. I am both appalled and angered that vulnerable people were let down.

"At the same time, action is urgently needed by the HSC system as a whole in response to the recommendations of the Serious Adverse Incident (SAI) review.

"I fully endorse the view of the SAI panel that no one should have to call Muckamore their home in future, when there are better options for their care – I am now confirming to the families that this will be the case.

"That means Muckamore returns to being a hospital providing acute care, and not simply a residential facility.

"To make that happen will require investment in both specialised accommodation and staff training to meet the complex needs of people who no longer need to be in hospital."

Mr Pengelly said he expects the resettlement process to be completed by the end of 2019. That means finding suitable alternative accommodation for patients who have been living at Muckamore on a long-term basis, despite not requiring in-patient hospital care.

The separate issue of delayed discharge will also be addressed as a top priority, with the HSC system tasked to provide an action plan to the Permanent Secretary in January. Delayed discharges involve patients staying longer than medically required due to difficulties securing appropriate alternative arrangements.

Mr Pengelly added: “I fully recognise that the December 2019 deadline for the resettlement process will be challenging, but the Department owes it to patients and their families to be demanding.”

The Permanent Secretary continued: “I also know that, while this report has highlighted appalling behaviours that fell well short of what is acceptable, there are many working in the HSC who work tirelessly to deliver high quality and safe services to families and people with learning disability, and will rise to this challenge. We have seen this as recently as this weekend in the actions of those staff who have provided much needed support and flexibility to ensure the safe and effective care of our most vulnerable patients in Muckamore. It is important in the midst of this not to overlook the dedicated and compassionate care that families have also experienced.

“I will be holding the HSC system to account and closely monitoring progress.”

During the meeting, Mr Pengelly also directly addressed the call from some of the families for a public inquiry. “I want to take this opportunity to reassure the families that I have not ruled out any options regarding further scrutiny of the serious failings at Muckamore.

“Active investigations into wrongdoing are ongoing by both the PSNI and the Belfast Trust as employer. The ongoing police investigation clearly takes primacy over any other process at present.

“The HSC system will continue to cooperate fully with the PSNI inquiry while also rigorously pursuing its own disciplinary procedures.”

Mr Pengelly also took the opportunity to update the families on plans for a new model of acute care for people with learning disability through the transformation agenda, saying: “This work will now be prioritised as part of a wider project already initiated to transform learning disability services, and will take account of the findings of the SAI report which states very clearly that the current model is not working. We need urgently to find pragmatic solutions to the issues laid out in stark terms in this report.”

Addressing the core purpose of the SAI, to review safeguarding practice at the hospital, Mr Pengelly confirmed that, in addition to closely scrutinising the actions now required by the Trust to address the findings of the report, the Department is actively considering a proposal to introduce adult safeguarding legislation in Northern Ireland. He said: “Any new legislative proposals will have to take account of lessons learned in other jurisdictions, and would be subject to a full public consultation and ministerial approval."

Mr Pengelly expressed his thanks to the families for taking the time to meet with him, and for sharing their concerns and issues. He also thanked the SAI independent panel for their work.

He added: "I remain very concerned about the HSC system's current structures and attitudes regarding concerns and complaints from service users and their families. All too often, it seems the onus is on citizens to persuade the system that something is wrong.

"While important work is already underway on establishing advocacy rights and arrangements that empower citizens, I will want to pay close attention that this has the desired impact.

"In the interim, the Patient Client Council has been tasked with enhancing its complaints helpline for patients, families and other service users."

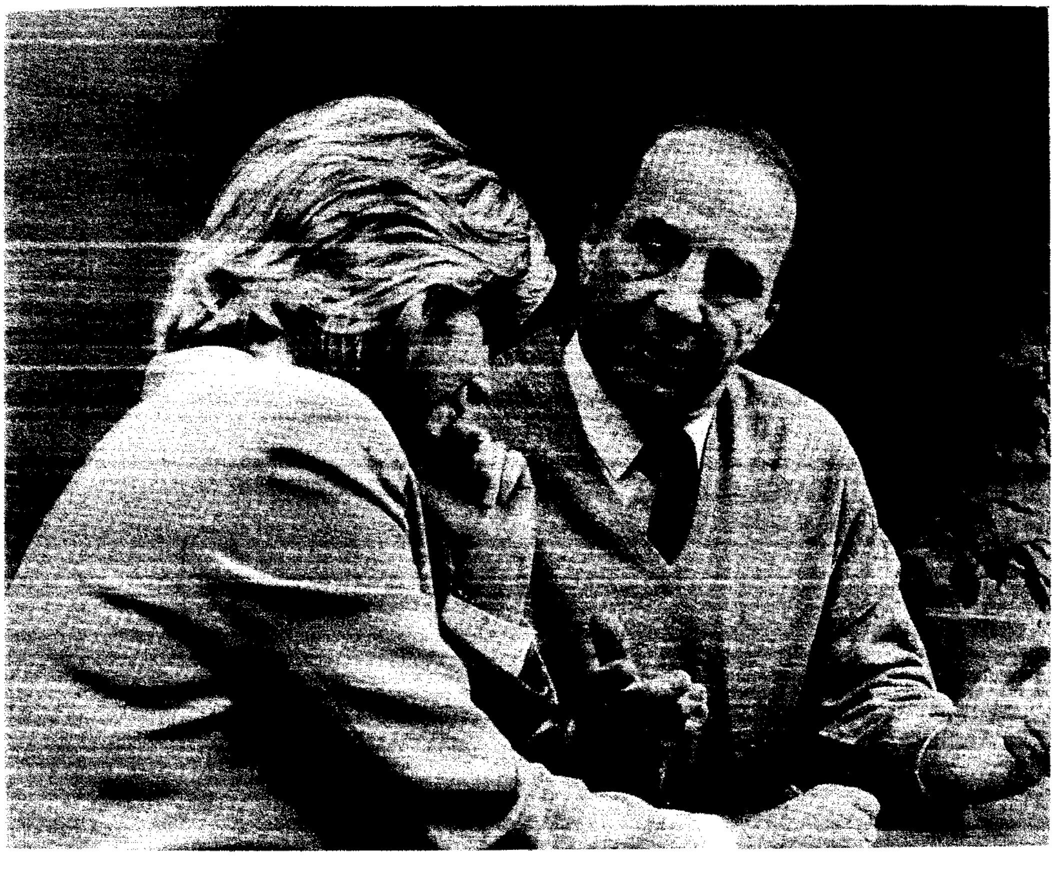
Finally, Mr Pengelly stated that it was his intention to have regular meetings with the families to keep them updated on developments and to listen to any new concerns that they may have.

The Northern Ireland Health and Personal Social Services

Complaints

Listening...Acting...Improving

Guidance on Implementation of the HPSS Complaints Procedure



March 1996

HPSS Executive

Guidance on Implementation of the HPSS Complaints Procedure

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Appendices

1 Background

1.1 *Being Heard*, the report on NHS complaints procedures by a Review Committee, chaired by Professor Alan Wilson, Vice Chancellor of Leeds University, was published in May 1994.

1.2 The health services in Northern Ireland were included within the remit of the review. Complaints procedures for community care and child care, which are the responsibility of local authorities in Great Britain, were outside the scope of the review.

1.3 Following formal public consultation on the conclusions and recommendations of the Review Committee, the HPSS Executive published *Acting on Complaints*, its revised policy and proposals for a new unified HPSS complaints procedure, in March 1995. Complaints on child care will **not** be incorporated within the new procedure but will be dealt with under the procedures in the *Children (Northern Ireland) Order 1995*.

1.4 Nationally, the NHS Executive took forward the initial work in developing guidance on implementation of the new procedure. In Northern Ireland, the HPSS Executive set up a Steering Group to take account of the decisions which have been emerging nationally and, in turn, to produce guidance and oversee implementation. The Steering Group comprised representatives from the professions, Health and Social Services Boards and Trusts, Health and Social Services Councils and other key interests.

1.5 Interim Guidance was published in December 1995.

2 Purpose of the Guidance

2.1 This Guidance complements the Directions and Regulations (see paragraphs 4.1 and 4.2) which provide the statutory and therefore the mandatory framework of the complaints procedure. Implementation will be on 1 April 1996. It aims to provide advice for those tackling the practical details of how the policy objectives of *Acting on Complaints* are to be achieved. It updates the earlier advice contained in the Interim Guidance.

2.2 The Guidance is not designed to be all-embracing. Trusts and Boards, and Family Health Service (FHS) practitioners are expected to design and operate their complaints procedure within the spirit of the Guidance, while adhering to the legal requirements of the appropriate Directions and Regulations. It is recognised that the size and complexity of the various organisations will result in different models emerging for the management of complaints. It is hoped that in due course different experiences will be exchanged so that lessons can be learnt.

3 Policy Objectives

3.1 The outcome of the formal consultation on *Being Heard* revealed broad agreement on the objectives for change that had been outlined by the Review Committee. The key objectives for introducing the new procedure remain:

- ease of access for patients and clients;
- a simplified procedure, with common features;
- separation of complaints from disciplinary procedures;
- more rapid, open processes, with an emphasis on early resolution;
- fairness for staff and complainants alike;
- an approach which is honest, thorough, and with the prime aim of resolving the problem and satisfying complainants concerns; and
- making it easier to learn from complaints, in order to improve services and standards.

3.2 The Department is committed to achieving all these objectives. They are a key part of the programme of action flowing from the Charter for Patients and Clients.

3.3 Great emphasis is placed on resolving complaints as quickly as possible. This may be through an immediate informal response by a front-line member of staff or practitioner, or by subsequent investigation and conciliation by staff who are empowered to deal with complaints in an open and non-defensive way. Boards, Trusts and FHS practitioners are therefore urged to concentrate on developing the awareness of front-line staff to the value of satisfying complainants early on, and to establish protocols for an open, positive response to complaints. The successful handling of Local Resolution is the key to the success of the new procedure.

4 Framework

Legal Framework

4.1 The following Directions are being made to implement the new complaints procedure:

- Directions to Health and Social Services Boards on Procedures for Dealing with Complaints about Family Health Services Practitioners;
- Directions to Health and Social Services Trusts and Boards on HPSS Complaints Procedures;
- Directions to Health and Social Services Boards on Miscellaneous Matters Concerning Complaints.

4.2 The following Regulations are being made and will affect the implementation of the new complaints procedure:

- The General Medical and Pharmaceutical Services (Amendment) Regulations (NI) 1996;
- The General Dental Services (Amendment) Regulations (NI) 1996;
- The General Ophthalmic Services (Amendment) Regulations (NI) 1996;
- The Health and Personal Social Services (Fundholding Practices) Amendment Regulations (NI) 1996;

Access to Health and Social Services Records

4.3 Any patient who has a complaint about any aspect of an application to obtain access to health records under the *Access to Health Records (Northern Ireland) Order 1993* may now make a complaint under this complaints procedure **as an alternative** to making an application to the courts. Patients still have the right to take matters to a court if they remain dissatisfied with the outcome of an investigation. Where the complaint relates to a decision to withhold access to all or part of the record the panel's role is to advise the record holder of their opinion. It remains the responsibility of the record holder to decide whether access should be granted. Care must be taken to ensure that in reporting the outcome of an investigation into a complaint about access to health records, the patient does not obtain information to which he or she is not entitled under the Order. This is particularly important when access has been denied on the grounds that it would cause serious harm to the physical or mental health of the patient or any other individual; or the information relates to or was provided by a third party who could be identified from that information and who had not consented to its disclosure.

4.4 Where the patient has sought access to his/her health records without the formality of an application under the Order, any complaint should be dealt with in the same way as if a formal application had been made. Access to health records compiled before 30 May 1994 (other than on computer) is at the discretion of the record holder, having regard to the fact that such records were not compiled in the expectation that they would be disclosed to the patient. This is an additional factor to bear in mind when considering whether to grant access to such records. It remains current policy that patients should be allowed to see what is written about them in their health record whenever possible. Complaints records should be kept separate from health records, subject to the need to record any information which is strictly relevant to the patient's health in their health records.

4.5 The new complaints procedure will also subsume the complaints procedure for access to social services records. Access to social services records is currently provided for under Departmental circular *Client's Access to Non-computerised Personal Social Services Records About Themselves (HSS SP1/87)*, and *The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991*. Legislation to give clients access to social services records, similar to that given to patients under the Access to Health Records Order, has been enacted but is awaiting implementation.

Confidentiality

4.6 The use of the patient's/client's personal information to investigate a complaint is a purpose for which it is not necessary to obtain the patient's/client's express consent. Care must be taken at all times throughout the complaints procedure to ensure that any information disclosed about the patient/client is confined to that which is relevant to the investigation of the complaint, and only disclosed to those people who have a demonstrable need to know it for the purpose of investigating the complaint. Even so, it is good practice to explain to the complainant that information from his or her health or social services records may need to be disclosed to the complaints officer, clinical assessors, and panel members. If the patient/client objects the effect on the investigation will need to be explained. The patient's/client's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

4.7 Where a complaint is made on behalf of a patient/client who has not authorised someone to act for him or her (*see paragraph 5.10*) care must be taken not to disclose personal health or social services information to the complainant, unless the patient has expressly consented to its disclosure.

4.8 The duty of confidence applies equally to third parties who have given information or who are referred to in the patient's/client's records. Particular care must be taken where their records contain information provided in confidence, by, or about a third party who is not a health or social services professional. Only that information which is relevant to the complaint should be considered for disclosure and then only to those within the HPSS who have a demonstrable need to know it in connection with the investigation. It must not be disclosed to the patient/client unless the person who provided the information has expressly consented to the disclosure.

4.9 Disclosure of information provided by a third party **outside** the HPSS also requires the express consent of the third party. If the third party objects then it can only be disclosed where there is an overriding public interest in doing so.

4.10 Draft guidance on '*The Protection and Use of Public Information*' is due to be issued shortly for consultation.

Use of Anonymised Information

4.11 Where anonymised information about patients/clients and/or third parties would suffice, identifiable information should be omitted. Anonymisation does not of itself remove the legal duty of confidence but, where all reasonable steps have been taken to ensure that the recipient is unable to trace the patient/client and third party identity, it may be passed on for a justifiable purpose. Where a patient/client or third party has expressly refused permission for the use of information, then it can only be used where there is overriding public interest in doing so.

4.12 Complaints about non-disclosure of other information which may be requested should not be dealt with under the HPSS complaints procedure. Such requests should be considered under the proposed Code of Practice on Openness in the HPSS. Draft guidance on the Code of Practice on Openness will be issued for consultation by the HPSS Executive shortly.

4.13 Where part of a complaint about services is that information has been refused - maybe in pursuit of the original complaint - and provided the Chief Executive has been given the opportunity first to review the circumstances, complainants should be advised of their right to pursue this aspect separately with the NI Commissioner for Complaints (the Commissioner). They should not have to wait for the outcome of investigations into the rest of the complaint.

Complaints about Purchasing

4.14 Boards will **not** be involved in resolving complaints about services provided by Trusts. There will, however, need to be both Local Resolution and Independent Review arrangements for dealing with complaints about purchasing decisions by Boards or GP Fundholders, and services for HPSS patients/clients purchased from the independent sector by Trusts, Boards or GP Fundholders. Boards will also need to have in place arrangements to deal with complaints about their administrative functions, particularly in relation to providing family health services. While most of this guidance is focused on complaints against Trusts and family health services practitioners, as these constitute the vast majority of complaints, similar mandatory provisions and guidance will apply to complaints about purchasing decisions and about services purchased from the independent sector. (*See Section 9 - Complaints about Purchasing.*)

Mixed Sector Complaints

4.15 Where a complaint involves more than one HPSS provider or one or more other body, such as a purchaser, there should be full cooperation in seeking to resolve the complaint through each body's local complaints procedure. Where a complaint is solely concerned with services provided by another provider or a body outside the HPSS, the complaint should be referred to the Complaints Officer. The officer should ensure that it is passed immediately to the correct body, after consulting with the complainant and provided that the complainant wishes this to be done. The complainant and the body concerned should both then be formally advised in writing.

4.16 In cases of mixed complaints relating to the actions of two HPSS bodies - for example two Trusts, or a FHS practitioner and a Trust - where a complainant wishes to pursue related complaints to Independent Review and is content with the arrangement, the convenors involved should liaise with the aim of establishing close cooperation with the respective bodies. While, legally, separate panels would need to be established, they may nonetheless comprise the same panel chairman, and in some cases the same third panel member. The chairman could establish close working arrangements for the two or more panels - possibly meeting in the same place and on the same day. While each panel would make its own separate report the chairmen may be able to ensure commonality of findings and that appropriate advice was given, possibly by the same assessors.

4.17 It is important to recognise that the review procedure for continuing care is not a complaints procedure. If a complainant decides instead to complain directly to the Commissioner, he will have discretion to waive the normal requirement that, before there is an investigation by the Commissioner, the HPSS complaints procedure should have been exhausted. As with all complaints, the Commissioner will need to be convinced that there are prima facie grounds for an investigation related to hardship or injustice.

4.18 The fact that a death has been referred to the Coroner's Office does not mean that all investigations into a complaint need to be suspended. It is important for the Trust or FHS practitioner to initiate proper investigations regardless of the Coroner's inquiries, and where necessary to extend these investigations if the Coroner so requests.

Private Pay Beds

4.19 The complaints procedure will cover any complaint made about the Trust's staff or facilities relating to care in private pay beds, but not to the private medical care provided by the consultant outside his HPSS contract. The procedure applies in similar fashion to any private places provided in residential homes operated by Trusts.

Note: Some sections of the Interim Guidance are reproduced in ***bold/italics*** indicating ***mandatory requirements*** of the new procedure, most of which will be established in ***Directions and Regulations*** (*see paragraphs 4.1 - 4.2*). Other mandatory requirements arise from existing legislation and/or common law.

Formal Procedure

5.1 ***Trusts, Boards and FHS practitioners must establish a complaints procedure and take steps to publicise the arrangements.***

5.2 It will be a requirement for all Trusts/Boards to have a formally adopted written complaints procedure for complaints against themselves.

5.3 FHS practitioners will be required to establish and operate a Board approved complaints procedure within their practices. This applies to all individuals, and public or private companies who appear on the Board's list of contractors and practitioners undertaking to provide family health services.

Grievance Procedure

5.4 It is important to recognise that the HPSS complaints procedure is designed to address patients and clients complaints, not staff grievances, which will continue to be handled separately. Local procedures will also cover more general grievances. Disputes on contractual matters between Boards and FHS practitioners should not be handled through the complaints procedure. Staff of Boards and Trusts may complain about the way they have been dealt with under the complaints procedure and, provided they have exhausted the local grievance procedure, may complain to the Commissioner for Complaints. FHS practitioners may complain to the Commissioner about the way they have been dealt with under the complaints procedure.

Publicity

5.5 ***Trusts, and Boards must ensure well publicised advice is available to all users of their services, visitors, staff, and their local HSS Council, about:***

- ***the arrangements for dealing with Local Resolution and the Independent Review of complaints;***
- ***how to refer a complaint to the Complaints Officer or the Chief Executive;***
- ***how to make a request for an Independent Review panel;***
- ***under what circumstances a complainant may approach a Board with a complaint about a FHS practitioner;***
- ***the role of the HSS Council in giving individuals advice and support on making complaints;***
- ***the right to complain, and the means of making a complaint to the Commissioner.***

(*See paragraph 6.14 for FHS practitioners.*)

Trusts and Boards

5.6 ***Complainants will be existing or former users of a Trust's or Board's services and facilities. People may complain on behalf of existing or former patient's/clients provided they have their consent. If the patient/client is unable to act then consent is not needed. Where the Complaints Officer, or Convenor at the Independent Review stage, does not accept the person as a suitable representative of a patient/client who is unable to give consent, they may refuse to deal with the representative, and may nominate another person to act on the patient's/client's behalf.***

Family Health Services Practitioners

5.7 ***Complainants will be existing or former patients of a practitioner who has arrangements with a Board to provide family health services. Complaints may be made on behalf of existing or former patients by anyone who has the patient's consent. If the patient is unable to act then consent is not needed. Where the Board's Complaints Officer, or the Board's Convenor at the Independent Review stage does not accept the person as a suitable representative, they may refuse to deal with the representative, and may nominate another person to act on the patient's behalf.***

5.8 Complaints can be made about the purchase or provision of any services, treatment and care for a patient/client. A person who has been refused any services, treatment and care can also complain under the complaints procedure.

5.9 A FHS practitioner may also complain to the Board about a patient. In the event of a complaint being made by a FHS practitioner about a patient, the Complaints Officer from the Board will make a written report to the practitioners with a copy, if appropriate, sent to the complainant.

5.10 The question of whether a complainant is suitable to represent a patient/client who is unable to give consent depends in particular on the need to respect the confidentiality of the patient/client, and to any known wishes expressed by the patient/client that information should not be disclosed to third parties.

5.11 Trusts, Boards and FHS practitioners should, as a matter of good practice, ensure that they deal sensitively and effectively with complaints by visitors, contractors and other users of their facilities.

Time Limits on Initiating Complaints

5.12 ***Normally a complaint should be made:***

- ***within six months of the incident that caused the problem, or***
- ***within six months of the date of discovering the problem, provided that this is within twelve months of the incident.***

There is discretion to extend this time limit where it would be unreasonable for the complaint to have been made earlier; and where it is still possible to investigate the facts of the case.

5.13 A complaint should be made as soon as possible after an event. The discretion to vary the time limit should be used flexibly, and with sensitivity. Wherever possible the complainant's concerns should be addressed, while remaining scrupulously fair to staff. An example of where discretion should be exercised in favour of extending the time limit would be where the complainant has suffered particular distress or trauma which prevented them from making their complaint at an earlier stage.

5.14 When a complaint is made outside of the time limit the Complaints Officer or appropriate FHS practitioner will be responsible for considering an extension of the time limit.

5.15 If the discretionary extension of the time limit is rejected by the Complaints Officer then the procedure will be as follows:

- the complainant may complain about the refusal to exercise discretion to waive the time limits;
- if the refusal is maintained, the complainant may request the convenor to consider setting up a panel for Independent Review of the complaint about refusal to waive the time limit: the normal requirements as to convening decisions will apply - including the time limit for a convening request;
- the convenor may then decide to take no further action; or
- to refer the complaint back for Local Resolution, or
- to set up a panel to consider the complaint.

5.16 If the convenor decides to refer the complaint about the time limit back to the Trust/Board, the Complaints Officer - or Chief Executive if it is referred specifically to him/her - should review very carefully the decision not to accept the complaint in the light of the convenor's conclusion that further action through Local Resolution is possible.

5.17 If the Convenor rejects the request, then the complainant has the right to complain to the Commissioner for Complaints.

Complaints Officer

5.18 ***The Trust/Board must have a designated Complaints Officer, who is readily accessible to the public.*** The prime role of the Complaints Officer is to oversee the complaints procedure. The detailed role and functions should be decided by the Trust or Board. The functions of the Complaints Officer may be performed personally, or by a person authorised by the Trust/Board to act on his/her behalf.

5.19 The Complaints Officer may be:

- the Chief Executive,
- a senior manager reporting directly to the Chief Executive; or
- particularly in large Trusts a senior manager reporting to the Chief Executive through a Director, but with personal access to the Chief Executive when appropriate.

While it is not essential for the title to be used, it is nevertheless important that the person with the role of Complaints Officer should be easily identifiable to the public and staff alike. (*See paragraph 5.21 for equivalent role for FHS practices.*)

5.20 It is for the Trust and Board to decide on the Complaints Officer's exact role. This may be either to investigate or advise, or both. He/she will need access to all relevant records which are essential for the investigation of a complaint referred to him/her. He/she should also be able to investigate and resolve complaints under the Local Resolution process where the complainant does not wish to raise their concerns with the people directly involved with their care, or where front-line staff are unable to deal with the complaint. The Complaints Officer should also provide support and help to staff who respond to complaints.

5.21 *FHS practices must nominate one person to administer the complaints procedure and to identify that person to patients.*

5.22 FHS practices will decide who is most appropriate to be responsible for the practice complaints procedure, together with an alternative to act if this person is the subject of the complaint. Complainants may be unhappy at the prospect of having their complaint dealt with by someone who is already involved in their care and who may be the subject of the complaint. If contacted by a complainant, the Board should be ready to provide assistance to both the complainant and the practitioner to resolve the complaint at practice level, bearing in mind the Board may become formally involved if the decision is made to proceed to Independent Review. (*See paragraphs 6.15 and 6.16.*)

Role of Health and Social Services Councils

5.23 The staff of Health and Social Services Councils have a very important role in assisting complainants at each stage of the process in both the hospital and community services, and family health services. Trust and Board Chief Executives should ensure that advice on how to contact the local HSS Council for assistance in making a complaint is well publicised, and that HSS Councils are fully aware of the complaints procedures in operation.

Appointment of Convenor

5.24 ***The Board must appoint at least one person to act in the role of convenor, who may not be one of its own employees. At least one of the persons appointed must be a non-executive director of the Board.***

5.25 The convenor will consider requests by complainants for Independent Review panels to be set up. The discretion to appoint more than one non-executive director to this function allows the role to be shared, and a successor or understudy to be trained. It also provides for the possibility of an alternate convenor to represent the Board on the panel, if it is established. This will also relieve pressure on the original convenor who may be involved in more than one convening request. The concept of a 'lead' convenor, or 'convenor's office', may be useful. The convenor will need support staff. In organising this the Board will need to demonstrate impartiality, for example, where the remaining grievance relates in some way to the handling of the complaint during Local Resolution. (*See paragraph 8.47.*)

5.26 Convenors may be appointed from any of the non-executive directors, although chairmen are not recommended to take on this role other than in exceptional circumstances. Convenors will be indemnified for this duty in the same way as for their other non-executive director duties.

5.27 Boards should be sensitive to concerns about bias and the appointment of practising clinicians, or recently retired HPSS staff, should be exceptional. The convenor should be fully appraised of guidance and issues relating to their role. Boards may wish to appoint additional people on a 'consultancy' basis, specifically to act as convenors. People appointed to take on this task may act in the role of convenor, including serving on the panel. Their terms of appointment by the Board should ensure that their role is explicit and they have appropriate indemnity cover. (*See paragraph - 8.48.*)

5.28 It is suggested that appointments be for an initial period of at least two years, but where more than one convenor is designated, the appointments might be staggered.

Separation of Complaints and Disciplinary Procedures

5.29 ***The complaints procedure must be kept separate from disciplinary procedures.***

5.30 Policy is firm on the need for the new complaints procedure to be concerned **only** with resolving complaints and **not** with investigating disciplinary matters. The purpose of the complaints procedure is **not** to apportion blame amongst staff. It is to investigate complaints to the satisfaction of complainants (while being scrupulously fair to staff) and to learn any lessons for improvements in service delivery. Inevitably some complaints will reveal information about serious matters which indicate a need for disciplinary investigation.

5.31 In hospital and community/ambulance services, a case for considering disciplinary action can be suggested at any point during the complaints procedure. Consideration on whether or not disciplinary action is warranted is, however, a separate matter for management outside the complaints procedure and must be subject to a separate process of investigation.

Trusts/Boards

5.32 In the case of Trusts/Boards, papers that have accumulated during the investigation of the complaint may be passed to the appropriate person in the Trust/Board who will be considering the need for a disciplinary or other form of investigation (*see paragraph 5.35 for other relevant forms of investigation*). The papers can be made available for a disciplinary investigation.

FHS Practitioners

5.33 In the case of family health services, the Service Committee procedure will not be used to investigate complaints made on or after 1 April 1996. Formal complaints already under investigation before that date will be completed under the service committee procedures. From 1 April 1996 complaints will be investigated using the new procedure and the need for local disciplinary action will only be considered after the handling of a complaint has been concluded. Only if action is necessary to protect patients, for example, involving the police, professional registration body, or the HPSS Tribunal, will disciplinary action interrupt the handling of a family health services complaint.

5.34 Information gathered as part of the Local Resolution process by the practitioner belongs to the practice. The information will be kept separate from the patient's health record. Therefore the Board has no right of access to it. The Commissioner for Complaints does, however, have wide-ranging powers which can be used, if necessary, to require the production of information and documents.

Hospital and Community Health Services

5.35 ***If any complaint received by a member or employee of a Trust/Board indicates a possible need for referral to:***

i ***an investigation under the disciplinary procedure;***

ii ***one of the professional regulatory bodies; or***

iii ***an independent inquiry into a serious incident under Article 54 of the Health and Personal Social Services (Northern Ireland) Order 1972;***

iv ***an investigation of a criminal offence.***

the person in receipt of the complaint should immediately pass the relevant information to the Complaints Officer. The officer will pass it on to a suitable person who can make a decision on whether or not to initiate such action. *This referral may be made at any point during any stage of the complaints procedure.*

Neither the Complaints Officer nor the convenor shall be responsible for deciding whether or not to initiate any of the action referred to in the above paragraph and they should refer such circumstances to the person designated in the Trust/Board for dealing with such matters.

Whenever these circumstances arise, a full report of the investigation thus far should be made available to the complainant.

The complaints procedure will not deal with matters relating to that part of the complaint which is currently the subject of disciplinary investigation. If action is initiated under i or ii above, the complainant should be advised accordingly. Where there are other matters raised in the complaint which do not relate to disciplinary investigation appropriate action should then be pursued under the complaints procedure.

If any action is initiated under iii or iv above, the complaints procedure should be similarly modified until such action is concluded.

When any action as set out above has been concluded, that part of the original complaint which has been referred to a different procedure should only recommence where there are matters in the complaint which have not been dealt with through that action.

5.36 When a decision is made to embark upon a disciplinary investigation, the processing of the complaints procedure ceases in respect of all matters that are the subject of disciplinary proceedings. There may well be other aspects of the original complaint not covered by the disciplinary inquiry which will continue to be investigated. It is essential for the person handling the complaint to make clear to the complainant that a disciplinary inquiry is now under way, particularly if the complainant is likely to be asked to take part in this process.

5.37 If there are no outstanding issues from the original complaint to be investigated the complainant should be advised that no further action will be taken, other than that taken through the disciplinary procedure.

5.38 The complainant may well ask at this point to be informed of the outcome of the disciplinary inquiry. A judgement will need to be made on how to reassure the complainant that the matter complained about has been dealt with seriously and satisfactorily, while protecting the confidentiality of the member of staff.

5.39 The guiding principle should be that, when the disciplinary procedure is invoked, the complainant receives the same consideration and level of information as if the matter had been dealt with through the complaints procedure. The complainant should be able to understand what happened, why it happened, and what action has been taken as a consequence to ensure that it does not happen again. The complainant should be informed in general terms of any disciplinary sanction imposed on any staff member.

5.40 It is most important that the complainant is satisfied with the action being taken by the Trust/Board. If a referral for disciplinary investigation has been made during the period of Local Resolution then this part of the complaints procedure should be rounded off with a formal written explanation of the action taken by the Trust/Board. Where the referral is made later during the Independent Review process, then a similar written explanation needs to be given on completion. Within the context of the complaints procedure, the overall consideration must be that, even if the investigation has been moved into the disciplinary procedure, the complainant is not left dissatisfied, and feeling that their grievance has only been partially dealt with.

5.41 A similar approach will need to be adopted in a case which has indicated the need for a referral to one of the professional regulatory bodies. A Trust/Board has no control over what then happens and over what period. The complainant should be informed of this decision and at that point given as full a response as possible to the complaint. It should be made clear that any information obtained during the complaints investigation may need to be passed on to the regulatory body. Those parts of the original complaint not included in the referral to the professional regulatory body should continue to be investigated under the complaints procedure.

Possible Claims for Negligence

5.42 ***The complaints procedure should cease if the complainant explicitly indicates an intention to take legal action in respect of the complaint.***

5.43 If a complainant reveals a prima facie case of negligence, or if it is thought that there is a likelihood of legal action being taken, the person in receipt of the complaint should inform the persons in the Trust/Board responsible for dealing with risk and claims management. Even if a complainant's initial communication is via a solicitor's letter, the inference should not necessarily be that the complainant has decided to take formal legal action. A hostile, or defensive, reaction to the complaint is more likely to encourage the complainant to seek information and a remedy through the courts.

5.44 In the early part of the process it may not be clear whether the complainant simply wants an explanation and apology, with assurances that any failures in service will be rectified for the future, or whether the complainant is in fact seeking information with formal litigation in mind. It may be that an open and sympathetic approach will satisfy the complainant. Where there is a prima-facie case of clinical negligence, the person dealing with the complaint should seek advice appropriately. This should not prevent a full explanation being given and, if appropriate, an apology offered to the complainant as appropriate. An apology is not an admission of liability. If formal legal action has been instigated, the complaints procedure should be brought to an end, with the complainant and the complained against being appropriately advised in writing.

5.45 In all prima facie cases of negligence, or where the complainant has indicated that they propose to start legal proceedings, the principles of good claims management and risk management should be applied. There should be a full and thorough investigation of the events. In any case where the Trust/Board accepts that there has been negligence, a speedy settlement should be sought.

6.1 *As part of its complaints procedure, the Trust/Board must establish a clear Local Resolution process. In the case of family health services, Local Resolution is the responsibility of the practitioner*

6.2 The primary objective of Local Resolution is to provide the fullest possible opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances. Complaints procedures of Trusts/Boards must therefore have a well-defined Local Resolution process, which lays emphasis on complaints being dealt with quickly and, wherever possible, by those on the spot - see Appendix 1. The intention of Local Resolution is that it should be open, fair, flexible, and conciliatory. The complainant should be given the opportunity to understand all possible options for pursuing the complaint, and the consequences of following any of these. This explanation should indicate that it might be necessary to look at the patient's/client's health/social services records.

6.3 The process should encourage communication on all sides. The aim should be to resolve a complaint during this stage to the satisfaction of the complainant while being fair to staff. Local Resolution should not be seen simply as a run-up process to Independent Review: its primary purpose being a comprehensive response that satisfies the complainant. The process of Local Resolution should provide for a range of different options for response to the complainant. Rigid, bureaucratic, and legalistic approaches should be avoided at all stages of the procedure, but particularly during Local Resolution. It is for Trusts/Boards to consider whether there would be an advantage in offering access to conciliation. (*See paragraph 6.17.*)

Role of Front-Line Staff

6.4 Complaints are most likely to be made to front-line staff on hospital wards, in clinics, at reception desks, or in social services departments. Management need to empower front-line staff to deal with complaints on the spot. Local guidance needs to assist front-line staff in distinguishing serious issues which need reference elsewhere, and in knowing when to refer complaints for fuller investigation by the Complaints Officer. Steps need to be taken to ensure effective arrangements are in place for dealing with complaints that are received over the telephone. Steps should also be taken to ensure that complainants are made aware of the role of HSS Councils in assisting them to pursue complaints and how to contact them.

6.5 The first responsibility of a recipient of a complaint is to ensure - before doing anything else - that the patient's/client's immediate health and social care needs are being met. This may require urgent action before any matters relating to the complaint are tackled. Whoever within the organisation receives the complaint should seek to understand the nature of the complaint and any nuances that are not immediately obvious.

6.6 If the recipient is unable to investigate the complaint adequately, or feels unable to give the assurances that the complainant is clearly looking for, then the complaint should be referred to the Complaints Officer for advice or for handling. Complainants should be encouraged to speak openly and freely about their concerns. And they should be reassured that whatever they may say will be treated with appropriate confidentiality and sensitivity.

6.7 Some complainants may prefer to make their initial complaint to someone who has not been involved in their care. In these circumstances they should be counselled to address their complaints to the Complaints Officer or, if they prefer, to the Chief Executive. While front-line staff should always encourage complainants to be forthcoming in expressing their concern and anxiety, particularly where they are disappointed with the care they have received, this should never be done at the expense of overriding the right of complainants to make their complaint to the Complaints Officer or the Chief Executive.

6.8 When deciding whether or not to pass the complainant on to the Complaints Officer, front-line staff will need to take into account the seriousness of the oral complaint and the possible need for more independent investigation and assessment. While an important role of the Complaints Officer is to investigate complaints and to satisfy complainants, this must not preclude the Complaints Officer from advising front-line and other staff in the resolution of complaints.

6.9 Front-line staff also need to be empowered to use the information they gain from complaints to improve service quality, particularly oral complaints or criticisms which are not actually complaints where people want something put right, but not investigated. Mechanisms for achieving this can be agreed at team level and will be particularly important for sharing information relevant to the work of other teams, for example, those responsible for hotel services.

Role of the Chief Executive

6.10 The Citizen's Charter Complaints Task Force defined a complaint as 'an expression of dissatisfaction requiring a response'. In the majority of cases, complaints are made orally. All complaints, whether oral or written, should receive a positive and full response, with the aim of satisfying the complainant that their concerns have been heeded, and offering an apology and explanation as appropriate, referring to any remedial action that is to follow.

6.11 ***All written complaints must receive a response in writing from the Chief Executive. Some oral complaints are sufficiently serious, or difficult to resolve, that they should be recorded in writing by the Complaints Officer. These complaints should also receive a written response from the Chief Executive.*** The reply might take the form of a full personally signed response or a shorter letter covering a fuller report from another member of staff which the Chief Executive has reviewed and is content with.

6.12 Anyone handling a complaint, and particularly complaints officers handling written complaints, must ensure that any response given to a complainant which refers to matters of clinical judgement is agreed by the clinician concerned and, in the case of medical care, by the consultant concerned.

6.13 There may be occasions when a communication is critical of a service or the quality of care, but is not intended as a complaint. Chief Executives will wish to ensure that their organisations are receptive to comments and suggestions, whether critical or positive, as well as to complaints. Such communications are a useful form of feedback from patients/clients, which can be used to improve the quality of service, and also to give encouragement to staff when they are doing well.

Family Health Services Practitioners

6.14 From 1 April 1996 there will be a term of service obligation on family health services practitioners to have in place and to operate practice-based complaints procedures which comply with minimum agreed criteria. For general practitioners, it has been agreed that the minimum criteria will be:

- administration of practice-based procedures must be practice-owned and managed entirely by the practice - the Board will only become involved if the practice procedure does not appear to meet the criteria;
- the Board will only become involved in an individual complaint if asked to do so by the complainant and/or the practitioner;
- one person will be nominated by the practice to be responsible for overseeing

the administration of the procedure;

- practices must give the procedures publicity;
- practices must ensure it is clear how to lodge a complaint, and to whom;
- an acknowledgement or initial response should normally be made within two working days;
- the person nominated to investigate the complaint should make all necessary inquiries such as interviews, if appropriate, of the complainant, general practitioner(s) and practice staff;
- an explanation should normally be provided within two weeks (ie ten working days).

Action by the Board

6.15 There are two roles for Boards in the family health services Local Resolution process. Where, for example, a complainant does not wish to have a complaint dealt with by the practice, or is having difficulty in having the complaint dealt with by the practitioner Boards will, if both parties agree, act as '*honest broker*' between the complainant and the practitioner to resolve the complaint at practice level. Boards will also make lay conciliators available as a service to complainants and practices. Arrangements for appointing lay conciliators and, where appropriate, professional advisors to the lay conciliators are matters for the Board.

6.16 Patients and FHS practitioners need to feel confident in the new complaints procedure. When a Board is acting as intermediary between patient and practitioner by providing conciliation or arranging Independent Review it is essential that clear lines of communication are established between Board, patient and practitioner. This might be done via the Complaints Officer in the Board who can give information on the progress of the complaint. Within the Board only those who need to be involved in handling a complaint should be aware of its existence. Complaints about treatment provided under FHS arrangements may involve a statutory charge payable to the complainant. Boards will need to ensure that conciliators who may become involved fully understand the nature of such charges.

Family Health Services Conciliation

6.17 Conciliation is essentially a process of facilitating agreement between the complainant and practitioner, and may prove essential if complaints are to be handled successfully at practice level. It is most effective when used as early in the complaints resolution process as possible Boards should therefore continue to make conciliators available to practices where a conciliator's assistance is requested, either by the complainant or the practice. Confidentiality must be strictly observed during the process and conciliators should **never** be required to report to the Board the details of cases in which they are involved. Nor should conciliators provide information which might be used by the Board if there is an Independent Review of the complaint.

Trusts and Boards

6.18 It may be appropriate for the entire process of Local Resolution to be conducted orally, without any written communication, leaving the complainant completely satisfied with the outcome. However, where for example:

- the person dealing with the complaint suspects that the complainant may wish to take the matter further; or
- the complainant is satisfied with the oral response but has expressed the wish for a formal response to close the case;

it is recommended that Local Resolution may be best rounded off with a letter to the complainant. Any letter concluding the Local Resolution stage (whether signed by the Chief Executive because it was a written complaint, or by some other appropriate person) should indicate the right of the complainant to seek Independent Review of the complaint, or any aspect of the response to it with which the complainant remains dissatisfied, and that the complainant has twenty-eight days from the date of the letter to make such a request.

FHS Practitioners

6.19 Guidance to FHS practitioners does not differentiate between the handling of oral and written complaints. In both cases practices are advised to round off the complaint by giving a written summary of the investigation and its conclusions to the complainant, also indicating their right to seek an Independent Review and that the complainant has twenty eight days to make that request. Local Resolution will end at this point. Practices have been advised to keep records of complaints handling - which should be kept separate from patients health records - both for using complaints to improve procedures and services, and in case they are needed to enable the practice to cooperate with later stages of the complaints procedure, including Independent Review.

6.20 It should be borne in mind that the right of the complainant to request the convenor to set up an Independent Review panel is not a right to proceed automatically to Independent Review. The subtlety of this distinction may often be lost on complainants who may well be angry at the time as a result of their dissatisfaction with the outcome of Local Resolution - whether or not a final letter has been sent to the complainant - will assist with reducing the time the convenor may have to spend researching the background of the complaint, in the event of an application by the complainant to proceed to Independent Review.

Performance Targets for Local Resolution

6.21 Recognising that the primary purpose of Local Resolution is to satisfy the complainant whenever possible, while being scrupulously fair to staff, the following targets should be used with discretion. Where these targets are not being met, it is very important for the complainant to be informed of the delay and the reasons for it, as well as the likely revised timetable for dealing with the complaint. Similarly, where a complainant withdraws a complaint, it is important that the persons complained against (in the case of family health services, the practitioner) are informed immediately.

Trusts and Boards

6.22 Most oral complaints will be resolved on the spot or within two working days. Where this is not possible, and where there is a formal written complaint, the Trust/Board should aim to make either an initial acknowledgement to the complainant **within two working days** or, if they are able to resolve the complaint fully within this time, a response **in five working days**. For written complaints, and oral complaints recorded in writing, acknowledgements should always be in writing.

6.23 Full investigation and resolution of all types of complaints should be sought **within twenty working days**, while recognising that there is likely to be great variation in the nature of complaints and in the ability of complainants to cope with their part of the process. Given the complexity that arises in some complaints, a clear referencing and dating system is needed for all communications with patients and FHS practitioners. First class post or, exceptionally special delivery mail, should be used. All communications should be marked 'Private and Confidential' and/or 'Personal'.

Family Health Service Practitioners

6.24 The aim should be for FHS practitioners to complete the Local Resolution process within **ten working days**. The possibility, however, of the Board being asked to provide support or conciliation (*see paragraphs 6.15 - 6.17*) will inevitably extend the period of Local Resolution. In these cases it would not be unreasonable for the performance target to be extended.

Action by the Complainant

7.1 ***Complainants who are dissatisfied with the response from the Trust/Board or FHS practitioner as a result of the Local Resolution process may refer a request for an Independent Review panel to the convenor either orally or in writing. This request should be made within twenty eight working days from the completion of the Local Resolution process. Any request for an Independent Review panel received either orally or in writing by any other member or employee of the Trust/Board should be passed on to the convenor immediately.***

7.2 The twenty eight calendar day time limit for making the request applies to the period from the date when the letter was sent to the complainant at the conclusion of Local Resolution, including conciliation where it is used (*see paragraph 6.15 - 6.17*). The time limit for making the request applies to the initial request and not to the making of the subsequent written statement to the convenor (*see paragraph 7.4*).

Action by the Convenor

7.3 The request for a panel should be followed up by the appointed convenor immediately. The convenor should make arrangements so that a complainant's request for an Independent Review panel can be acknowledged in writing.

7.4 ***Before deciding whether to convene a panel, the convenor must obtain a statement signed by the complainant setting out their remaining grievances and why they are dissatisfied with the outcome of Local Resolution.***

7.5 The convenor will need to understand as quickly as possible why the complainant remains dissatisfied. It is important for the convenor to obtain the complainant's statement, in as explicit and detailed a form as possible, before starting his/her inquiries. The complainant should be encouraged to submit the written statement as quickly as possible so that a response can be made within the twenty-eight day time limit. Experience shows that complainants frequently do not set out clearly what their grievances actually are, or set out clearly why they are dissatisfied. The convenor should ensure complainants are aware of how to seek independent help in drawing up statements if they wish, for example from HSS Councils or patients' advocates. Alternatively, the convenor, or member of staff, may prepare the statement for the complainants approval. If the complainant has already clearly set out their remaining grievances, and there is no need to amend this, then the convenor should not require a new statement to be drawn up. Complainants need to be advised of the various options that are open to the convenor for dealing with the complaint at this stage.

7.6 Those who are complained against, including the FHS practitioner, should always be advised in writing of what the complainant has formally stated as his/her grievance. the initial communication to the practitioner advising that there is a request for Independent Review of a complaint involving them might contain details of the secretary of other individual nominated by the local representative committee to help practitioners deal with complaints.

7.7 When dissatisfied with the outcome of Local Resolution, a complainant does **not** have an automatic right to move to Independent Review (*see paragraph 6.20*). There may be occasions when the convenor feels that Local Resolution has been adequately pursued - in that the complaint has been properly investigated and an appropriate explanation given - and that nothing further can be done, although the complainant remains dissatisfied. The safeguard for the complainant lies in the right to put their case directly to the Commissioner should a convenor decide not to establish a panel. The Commissioner will be able to consider whether to recommend that:

- the initial decision of the convenor should be reconsidered; or
- it seems to him more appropriate to investigate the complaint himself.

Role of the Convenor

7.8 The role of the convenor is crucial to triggering events under Independent Review (*see Appendix 2*). It is important that the convenor distances him or herself from those involved in the complaint. The convenor's role is to ensure the complaint is dealt with impartially at the convening stage. It is not the convenor's function to defend those complained against, but rather to ascertain whether all opportunities for satisfying the complainant during Local Resolution have been explored and fully exhausted. And what issues, if any, should be referred to a panel. To this end the convenor will need to obtain a full picture of the events relating to the complaint. It is not the convenor's role to try to resolve the complaint on his/her own.

7.9 Before the convenor decides to convene a panel he or she will consult with the independent lay chairman on the Board's list. This should **not** be the same person who will chair the panel, if it is convened. The purpose of this contact is to provide the convenor with an external independent view and to aid him or her in assessing the grievance. It is, however, ultimately the convenor's decision as to whether or not to recommend proceeding with the establishment of a panel and to explain why he or she made this decision. (*For role of independent lay chairmen - see paragraphs 8.9 - 8.10*).

7.10 The convenor will decide on the panel's terms of reference. He/she should advise the complainant of the matters which the panel will **not** investigate, for example which the Trust/Board has decided should be subject to disciplinary investigation - except for FHS practitioners, where consideration of disciplinary action is not an option at this stage. - or matters that have already been dealt with adequately as well as those which **will** be dealt with. The convenor's statement to the panel of its terms of reference should not be an interpretation or embellishment of the complainant's written grievance, but set out clearly what are the issues he or she believes the panel should investigate. Similarly, the convenor should make it clear in writing the reasons for deciding why a panel should not be established. Failure to do so will be criticized by the Commissioner for Complaints if the complaint is subsequently referred to him.

Criteria for Establishing a Panel

7.11 **In deciding whether to convene a panel, the convenor will consider, in consultation with an independent lay chairman from the Board's list, whether:**

- ***the Trust/Board/FHS practitioner can take any further action*** *(short of establishing a panel) to satisfy the complainant;*
- ***the Trust/Board/FHS practitioner has already taken all practical action*** *and therefore establishing a panel would add no further value to the process.*

The convenor will need to take fully into account the advice of the independent lay chairman, although ultimately it is for the convenor alone to decide whether or not to direct the establishment of a panel.

7.12 The convenor should not consider the potential cost of setting up a panel as being a factor in his or her decision to recommend moving to Independent Review.

Clinical Advice to the Convenor

Clinical Complaints

7.13 ***Where the convenor considers that a complaint relates in whole or part to action taken in consequence of the exercise of clinical judgement, he or she must take appropriate clinical advice in deciding whether to convene a panel.***

7.14 The convenor must take appropriate clinical advice in deciding whether to convene a panel when he or she considers a complaint relates in whole or in part to action taken in consequence of the exercise of professional clinical judgement - ie any judgement that is made by a member of the clinical professions in the HPSS by virtue of their knowledge and skill, which a layman could not make. These will be known as 'clinical complaints'.

7.15 This process will be important in informing the convenor about any particular clinical considerations which he or she should take into account, and whether, for instance, there is any further practical action which could still be taken through the Local Resolution process. The key lies in the concept of action taken in consequence of clinical judgement.

7.16 Clinical judgement can be exercised by any of the recognised clinical professions working within the HPSS to provide care: doctors, nurses, midwives, health visitors, dentists, pharmacists, optometrists, clinical psychologists, members of professions allied to medicine, paramedics and ambulance technicians, laboratory and other scientific and technical staff. It is for the convenor to decide whether a complaint appears to be a clinical complaint and from whom to seek appropriate clinical advice. Such advice is expected to come at least initially from within the Board, but not from anyone who is in any way associated with the complaint. Advice may need to be sought from outside the Board.

7.17 Where medical or other clinical advice is needed, convenors are recommended to seek this initially from the Board's Director of Public Health, or equivalent professional officer, who in turn can direct the convenor to a suitable nominee from the list of clinical assessors. Where the Director of Public Health, or other professional officer, is the subject of the complaint, or where possible conflict of interest arises, some other appropriate independent medical, or other clinical opinion, such as the Department's Chief Medical Officer, should be sought. In those cases where an area officer for each of the professions allied to medicine does not exist the convenor should approach the particular service manager in the first instance, who in turn can direct the convenor to a suitable nominee from the list of clinical assessors.

7.18 In the case of family health services, the convenor should seek initial clinical advice from the Board's relevant Adviser, who in turn can direct the convenor to an independent practitioner from the same profession as the practitioner who is being complained about. The practitioner's name will come from a list of practitioners nominated by the relevant local professional representative committee, or as otherwise agreed with the professions or, in the case of GP fundholders, by the local GP fundholding groups within the Board or, by agreement, by local medical committees working with local GP fundholding interests.

7.19 ***Where the convenor considers that a complaint relates in whole or part to action taken in consequence of the exercise of professional social work judgement, he or she must take appropriate professional advice in deciding whether to convene a panel.***

7.20 The convenor must take appropriate professional social work advice in deciding whether to convene a panel when he or she considers a complaint relates in whole or in part to action taken in consequence of the exercise of professional social work judgement - ie any judgement that is made by a member of the social work profession in the HPSS by virtue of their knowledge and skill, which a layman could not make.

7.21 In the case of personal social services the convenor is recommended to seek professional advice initially from the Board's Director of Social Services who in turn may suggest who else would be qualified to advise. Where the Director of Social Services is the subject of the complaint, or where possible conflict of interest arises, some other appropriate independent social services opinion, such as that of the Department's Chief Social Services Inspector should be sought.

Decision of the Convenor

7.22 Convenors are advised that they should not recommend the setting up of an Independent Review panel where:

- any legal proceedings have commenced, or there is an explicit indication by the complainant of the intention to make a legal claim against a Trust/Board, or one of their employees, or against a family health services practitioner; or
- it is considered that the Trust/Board, FHS practitioner has already taken all practicable action and therefore establishing a panel would add no further value to the process: consideration of the cost of instituting an Independent Review is not an appropriate reason for refusing to proceed; or
- it is believed further action as part of Local Resolution is appropriate and practicable:
    - either referral back to the Trust/Board Chief Executive, for consideration is thought preferable to beginning the Independent Review process; or
    - an invitation by the convenor to the FHS practitioner to reconsider Local Resolution, possibly with conciliation, as preferable to instituting the Independent Review process;
- for Trust/Board employees, it is considered that there is a prima facie case for a disciplinary investigation (*see paragraphs 5.31 - 5.32*) and referral by the convenor to the responsible officer in the Trust/Board is appropriate. The setting up of an Independent Review panel would follow automatically if no disciplinary investigation was pursued.

7.23 ***The convenor must inform the complainant, and any person alleged in the complaint to have taken any part in the action complained of, in writing of his or her decision as to whether or not a panel should be appointed, setting out clearly the terms of reference or the reasons for any decision to refuse a panel, and whether or not he or she believes there is further action the Trust/Board/FHS practitioner could take.***

7.24 ***Where a panel has been refused, the complainant should be advised of the right to complain to the Commissioner.***

7.25 ***The convenor must inform the Chief Executive of the Trust/Board of his or her decision as to whether or not a panel should be set up, or whether he or she believes there is further action which the Trust/Board could take as part of Local Resolution.***

7.26 Both the complainant and the respondent must be informed in writing of the convenor's decision as to whether or not an Independent Review panel is to be set up. The convenor should send to the Chief Executive of the Trust/Board, and the FHS practitioner concerned a copy of his/her communication which explains the decision to the complainant.

7.27 The convenor must set out the reasons for any decision to refuse a panel as fully as possible so that the convenor's views are clearly available should the complainant decide to exercise the right to refer the complaint to the Commissioner. This right should be recorded in the letter from the convenor to the complainant. The intention is to ensure that the complainant is fully informed of the reasons for not convening a panel and, if appropriate, why the convenor believes there should be a reference back to Local Resolution.

7.28 ***If the complainant remains dissatisfied following the reference back to the Trust/Board/FHS practitioner he/she may refer the complaint once again to the convenor to reconsider whether an Independent Review panel should be convened.***

Action by the Board

7.29 In order to avoid delay, Boards are advised to arrange for delegated powers to be given to the Chief Executive and an alternate executive director to formally establish a panel as soon as the advice of its convenor is known. The convenor will likewise advise the Trust/Board when he/she has decided against establishing a panel. If the recommendation of the convenor is that Local Resolution should be reactivated, this should be expedited by the Chief Executive.

Performance Targets for Convening

7.30 The convenor will arrange for acknowledgement of the complainant's request for an Independent Review panel **within two working days**.

7.31 Convening should not be a re-run of the action taken during Local Resolution. While recognising that assimilation of written and oral facts, and the conduct of adequate consultation, all need time if they are to be exercised thoroughly, the period required for a decision to be made as to whether to convene an Independent Review panel should **not normally exceed twenty working days** (ie four weeks) from the date of the complainant's request being received by the convenor.

Purpose of the Panel

8.1 The purpose of an Independent Review panel is to consider the complaint according to the terms of reference provided by the convenor, and in the light of the written complaint or statement provided to him or her by the complainant. The panel will investigate the facts of the case, taking into account the views of both sides. It will set out its conclusions, with appropriate comments and suggestions, in a written report.

Establishing the Panel

8.2 ***Independent Review panels will be composed of three members:***

- ***an independent lay chairman appointed by the Board;***
- ***a convenor (non-executive director of the Board) or appointed person; and***
- ***an independent person appointed by the Board.***

Where the convenor decides, after consultation with the independent lay chairman and after taking appropriate clinical advice, that the complaint is a clinical complaint, the panel will be advised by at least two independent clinical assessors nominated by the Board following advice from the relevant professional representative bodies. In the case of social services complaints two independent assessors will be nominated by the Board following advice from the BASW (NI).

The panel is to be established as a committee of the Board and the assessors are to be appointed by the Board to advise the panel.

8.3 In considering a complaint from, or on behalf of, a person suffering from mental disorder, and where the complaint relates to the care and treatment of that mental disorder, the convenor should consider co-opting a member of the Mental Health Commission onto the panel.

8.4 In order to avoid accusations of bias members or officers of HSS Councils will be excluded from panel membership.

Appointment of Panel Members

8.5 Boards will be responsible for recruiting independent lay chairmen and lay panel members. Criteria for selecting panel members should include:

- interest in the subject,
- impartiality and judgmental skills and,
- experience in working in small groups tasked with producing reports, where possible.

8.6 The names of persons held on the lists for the role of independent lay chairman and the third panel member will all be those of lay people. Only exceptionally will they be recently retired HPSS staff or lay non-executive directors of other Trusts/Boards. Practising or retired members of the clinical professions should not be chosen for this role. No panel member - other than the convenor or alternative person - should have any past or present links with the Board establishing the panel. The chairman and third panel member will always be lay people. Recruitment will be in accordance with equal opportunities policy.

8.7 Boards are responsible for putting in place arrangements for holding lists of independent chairmen and lay panel members. It will be the responsibility of Boards to organise access to broad training for independent chairmen and panel members and to decide their appropriate allocation to panels. Boards may find it helpful in liaising with each other in finding an appropriate chairman and panel members, where circumstances demand a wider trawl. Call-off from these lists should be organised in a balanced, independent way, so that no one panel member becomes regularly linked with a particular Trust/Board.

8.8 It is for Boards to issue formal letters covering the appointment of panel members to serve on a specific panel, including indemnity cover, and to ensure that arrangements are made to let panel members have appropriate background and briefing papers, together with the names of the assessors who have been appointed to assist their particular panel. The complainant should be informed of the panel members and assessors appointed to conduct the Independent Review. Respondents should similarly be advised of the panel members and assessors appointed to conduct the Independent Review.

Role of Independent Lay Chairman

8.9 There are two roles for the independent lay panel chairman (*see Appendix 4*):

- helping convenors, by providing independent advice and support during the convening period; and
- chairing panels when established.

The Board will formally appoint the panel chairman, bearing in mind the need for indemnity cover in respect of the advice given to the convenor by the chairman during the convening period.

8.10 Once the convenor's decision to establish an Independent Review panel has been made and the convenor has set out the panel's terms of reference, responsibility for leading the organisation of the panel's business falls to its independent lay chairman.

Function of the Panel

8.11 ***The function of the panel is to:***

- ***investigate the aspects of the complaint as set out in the convenor's terms of reference, taking into account the complainant's grievance as recorded in writing to the convenor;***
- ***make a report setting out its conclusions, with appropriate comments and suggestions.***

The panel will have no executive authority over any action by the Trust/Board, or family health services practitioner, and may not make any suggestion in its report that any person should be subject to disciplinary action or referred to any of the professional regulatory bodies.

8.12 The panel should be proactive in its investigations, always seeking to resolve the complainant's grievance in a conciliatory manner, while at the same time taking a view on the facts it has identified. The panel should be flexible in the way it goes about its business, choosing a method or procedure appropriate to the circumstances of the complaint. It should not act in a confrontational manner. Resolution of the complaint may be sought by the full panel, with its assessors, through separate meetings with the complainant and the person complained against. It is a matter for the panel to decide whether the complainant and the person complained against should be brought together at the same meeting; similarly whether smaller meetings involving, say, any one member of the panel, with or without assessors, are appropriate in the circumstances.

8.13 ***The panel will decide how to conduct its proceedings, having regard to guidance issued by the HPSS Executive, within the following rules:***

- ***the panel's proceedings must be held in private;***
- ***the panel must give both the complainant and any person complained against a reasonable opportunity to express their views on the complaint;***
- ***if any of the panel members disagree about how the panel should go about its business, the chairman's decision will be final;***
- ***when being interviewed by any members of the panel or the assessors, the complainant and any other person interviewed may be accompanied by a person of their choosing, who may speak to the panel members/assessors - except that no person interviewed may be accompanied by a legally qualified person acting as an advocate.***

8.14 The panel will have access to all the records held by the Trust/Board relating to the handling of the complaint. FHS practitioners will be asked to make available their records of the handling of the complaint. If the complaint is a clinical complaint, the panel must have access to the relevant parts of the patient's health records.

8.15 The panel has discretion as to how it should operate. It has a duty to keep records, bearing in mind the possibility of future investigation by the Commissioner for Complaints. Panels should work informally and be flexible in their approach, so that they can respond appropriately to differing kinds of complaint. The panel chairman will be the final arbiter. The panel should not act as a tribunal involving formal cross-examination of witnesses, nor should it operate in a confrontational, adversarial, or legalistic way.

8.16 Neither the complainant nor the respondent may be legally represented. The complainant may, however, be supported on all occasions by a person of their choosing who, even if legally qualified, may not act in a legal capacity. This could be an adviser, say from the HSS Council, who may speak on behalf of the complainant. It may also be appropriate for the complainant to be accompanied by a second person, such as a relative, for emotional support.

8.17 Any person mentioned in the complaint who is interviewed may be similarly supported by a representative of their trade union or professional organisation, or appropriate manager or colleague, who can act in the capacity of personal adviser.

Identification of Assessors

8.18 ***Where the complaint is wholly or partly related to clinical matters, panels must be advised by at least two independent clinical assessors. The independent clinical assessors' role is to advise and make a report, or reports, to the panel on the clinical aspects of complaints. The assessors should decide, in consultation with the panel, how to exercise their responsibilities having regard to guidance issued by the HPSS Executive and their professional bodies.***

8.19 The role of an assessor is to advise the panel or its individual members. Assessors should not act independently to resolve a complaint. Where a complaint raises issues about more than one medical specialty or health and social care profession, at least one assessor for each medical specialty or health or social care profession should be available to advise the panel. In cases where only one discipline is under scrutiny there will be two assessors from the relevant discipline. In some cases it may be appropriate for there to be more than two assessors and it will be for the convenor and independent lay chairman of the panel to make this decision.

8.20 Boards will hold copies of the lists of assessors for hospital and community health services, family health services and social services complaints, and assessors with experience of exercising clinical judgement in a purchasing context.

8.21 The professional bodies' role in ensuring that lists of appropriate independent assessors, who are acceptable to the profession concerned, are kept up to date (and revised at least annually), will be crucial to the general standing and efficacy of the assessor system:

- the BMA has undertaken to continue this role for hospital medical and dental staff;
- the Central Committee for Community Dental Services of the British Dental Association will undertake this role for community dentists;
- Nursing professional bodies will ensure that appropriate independent nursing assessors, acceptable to the profession, are identified;
- local medical committees will make arrangements for preparing lists of appropriate assessors from general medical practitioners;
- assessors for GP fundholding complaints will be nominated by recognised local fundholding groups working in conjunction with local medical committees;
- Boards will nominate clinicians with experience in exercising clinical judgement in a purchasing context;
- the British Association of Social Workers (NI) will undertake this role for social services;
- Those professional bodies who represent other professions which might be involved will ensure that lists are available.

8.22 Boards will select assessors to serve individual panels. Normally assessors will be selected from names of those working outside the geographical area of the Trust/Board concerned, but there will be discretion on this point. If the Board has any difficulty in determining appropriate assessors they should consult the appropriate professional body. Boards will also have access to the lists held in Great Britain, where it is appropriate to appoint an assessor from outside Northern Ireland.

8.23 Boards will need to ascertain the availability of assessors before making formal appointments. Normally assessors for hospital and community health services and social services complaints will be selected from outside the Board area concerned. In the case of FHS panels assessors should be chosen from a list held by the Board and nominated by the local representative committees or, in the case of GP fundholders, by recognised local GP fundholding groups working in conjunction with local medical committees. FHS assessors should not come from within the Board area of the practice or practitioner against whom the complaint was made. When selecting assessors it is important that they have no connection with any of the parties to the complaint. This might call into question their independence or objectivity in respect of the complaint. When there is doubt about the choice of an assessor the Board should contact the appropriate professional body.

Appointment of Assessors

8.24 Responsibility for formally appointing and communicating with the chosen assessors will rest with Boards, who should issue letters covering their appointment to assist a specific panel, including indemnity cover. They will ensure that arrangements are made to let the assessors have appropriate documentation.

Release of Assessors

8.25 The role of the assessor is crucial to the success and impartiality of the new complaints procedure. If the role is to be carried out thoroughly and successfully, then assessors will need to be granted prompt release from their commitments. Trusts and other employers are encouraged to recognise that the system of assessors will only work successfully if there is recognition that release needs to be granted quickly, so that delays can be avoided (*see paragraphs 8.20 - 8.23*).

Role of Assessors

8.26 The role of the assessors is to advise the panel, as and when required, on those aspects of the complaint involving clinical (or other professional) judgements (see Appendix 5).

8.27 ***At least one assessor must be present when the panel, or a member of the panel interviews either or both of the parties on occasions when matters relating to the exercise of clinical (or other professional) judgement are under consideration.***

8.28 The assessors must have access to all the patient's/client's health and social services records held by the Trust/Board/FHS practitioner which together with information about the handling of the complaint. Assessors will need to acquaint themselves with any circumstances where a patient or client might be denied access to information on the record, or where the patient has asked for personal information to be withheld from other parties.

8.29 Assessors may interview/examine complainants, who may have a person of their choosing present. Assessors should check if the patient/client has ever been denied access to all or part of their health or social services record. Where the complainant is not the patient/client, care must be taken not to breach patient/client confidentiality. Care must also be taken not to breach third party confidentiality. Assessors should not normally explain their findings to either the patient/client or complainant at this stage, before advising the panel of their views.

8.30 Assessors may also interview any person complained against, who may have a person of their choosing present. They should not normally explain their findings to the person complained against before advising the panel of their views.

8.31 There may be occasions when a patient's/client's health/social services record is no longer in the possession of the person complained against. In these circumstances, every effort should be made by the Trust/Board to provide the person complained against with access to it for the purpose of framing a response. In the case of a FHS practitioner, if it is appropriate to return the record then the whole, or relevant part of the record might be photocopied or inspected at the Trust's/Board's premises.

Assessors' Reports

8.32 It will be open to assessors to provide combined or individual reports. The assessors' reports should **not** be made available to the complainant - or the consultant/clinician/other professional complained about - in advance of the reports being made available to panel members. The panel may decide, in consultation with the assessors, to release their reports to the complainant and the complained against if it is believed this will aid resolution of the complaint. Otherwise assessors' reports will only become accessible to them as part of the panel's final report, initially as a draft.

8.33 Assessors should take care - since their reports may be made available at a later date to others than just panel members - that their reports contain no information which may cause serious harm to the physical or mental health of the patient/client or of any individual. Nor should they contain information about, or provided by, a third party (other than a health or social care professional) who can be identified from the information - unless he/she has consented to its disclosure.

8.34 ***The assessors' reports must be attached to the panel's final report when it is issued. If the panel disagrees with the assessors reports it must state why it has disagreed.***

8.35 If the chairman of the panel finds it appropriate to meet the complainant - for example, as a way of rounding off resolution of the complaint - at least one of the assessors should be present if the complaint relates to a clinical matter. The assessor should be able to give a personal explanation to the complainant of any clinical findings.

Panel's Final Report

8.36 The panel may find it helpful to provide the complainant and the person complained about, with the opportunity to check a draft report for factual accuracy within, say, a period of **fourteen days** before it is formally issued in its final form. The assessors' reports should be made available in time for their preliminary circulation with the panel's draft report. Those receiving the draft report should be reminded that the report is confidential to them and the panel members. The complainant, and anyone complained about, should be asked to inform the panel if he or she wishes to consult on the content of the draft report with an adviser who has not been previously involved in the complaint, such as the HSS Council. The responsibility for ensuring the panel completes its report within the target time limit rests with the panel chairman.

8.37 *The panel's final report must be sent to:*

- ***the complainant;***
- ***the patient/client if a different person from the complainant and alive and competent to receive it;***
- ***any person named in the complaint;***
- ***any person interviewed by the panel;***
- ***the clinical assessors or other professional assessors, as appropriate;***
- ***the Trust/Board Chairman and Chief Executive;***
- ***the practitioner, where the complaint is about FHS practitioners/GP fundholders;***
- ***the Director of Performance Review and Secondary Care in the HPSS Executive;***
- ***in the case of GP Fundholder complaints the Director of Primary Care and Purchasing Development in the HPSS Executive;***
- ***the Chairman and Chief Executive of the independent provider, where the complaint is about services provided by the independent sector.***

The report will have a restricted circulation. The panel will not send it to any other person or body. The panel chairman has the right to withhold any part of the report and all or part of the assessor's report in order to ensure confidentiality of clinical information.

8.38 The panel's final report should set out the results of its investigations, outlining its conclusions, with any appropriate comments or suggestions. The panel may **not** make any recommendations or suggestions relating to disciplinary matters.

8.39 The complainant may wish to show the report to a representative of the HSS Council or other appropriate adviser. The Chief Executive may need to show the report, or sections of it, to Board members and a FHS practitioner may need to show it to colleagues in their practice. These, and any other similar arrangements, will need to protect the overall confidentiality of the report.

Follow-up Action by Trusts/Boards

8.40 ***Following receipt of the panel's report, the Chief Executive must write to the complainant informing them of any action the Trust/Board is taking as a result of the panel's deliberations. And of the right of the complainant to take their grievance to the Commissioner if they remain dissatisfied.***

8.41 Trusts/Boards should consider what arrangements are necessary for ensuring that action is taken on the outcome of Independent Review panel reports, and that action in individual cases has been taken where it had been earlier agreed to do so. Trusts/Boards will also be responsible for ensuring that the action taken is communicated quickly and clearly to the complainant.

Completion of the Complaints Procedure

8.42 It needs to be made very clear to the complainant when the complaints procedure has been completed. The Commissioner for Complaints will normally only embark on an investigation when the procedure has been exhausted.

Trusts/Boards/GP Fundholders (*see Appendix 6a*)

8.43 Completion of the complaints procedure for Trusts/Boards - except in the case of FHS practitioners (*see paragraph 8.46*) - will be when the Chief Executive writes to advise the complainant of the outcome of the Board's consideration of the panel's report and the complainant's right to complain to the Commissioner. It is recognised that it may take a Trust/Board some time to consider how to respond to a panel's report, particularly if there are policy review or changes which need consultation with others before a final decision can be made. Nevertheless, the Chief Executive should strive to communicate to the complainant in writing - **within twenty working days** from the publication of the panel's report - any matters such as a formal apology, approval of a ex-gratia payment, or an indication of the timescale in which the Board has agreed to consider policy issues, plus information about their right to complain to the Commissioner if they are still dissatisfied. If, following this action, the Board takes any further decisions relating to the outcome of the case, then the complainant should be appropriately informed by the Chief Executive.

8.44 Completion of the complaints procedure for complaints about services purchased by Boards or GP Fundholders from the independent sector, is when the panel's report is sent to the complainant by the Board Chief Executive. The Chief Executive should send the panel's report to the complainant and the independent provider under suitable cover letters as soon as possible after receiving it. The covering letter must advise the complainant of the right to refer their complaint to the Commissioner if still dissatisfied. If the panel has commented about the possibility or desirability of making changes to the services purchased by a Board, which are the subject of the complaint, the Chief Executive should consider, in consultation with the provider as necessary, how those services can be improved and the implications for the Board's purchasing policy. The Chief Executive will then wish to follow up the panel's report with a further letter setting out any changes which have been decided on.

8.45 In cases of care purchased by a GP Fundholder, the Chief Executive will also send the panel report to the fundholder. Where suggestions have been made about improvements to a service which has been purchased by a GP Fundholder, the Chief Executive will want to tell the complainant that he is inviting the fundholder to respond personally to the complainant on those matters. Likewise, when the Chief Executive is writing to the fundholder, he will want to suggest that a response goes from the practice direct to the complainant.

8.46 For services purchased by Trusts from the independent sector, the normal Trust complaints procedure will apply.

FHS Practitioners *(see Appendix 6b)*

8.47 Completion of the complaints procedure for family health services is when the panel's report is sent to the complainant by the Board's Chief Executive. The Chief Executive should send the report to the complainant and the practitioner under suitable covering letters as soon as possible after receiving it. The covering letter must advise the complainant of the right to complain to the Commissioner. If the panel has commented about the possibility of making changes to a practitioner's services or organisation the Chief Executive will want to tell the complainant that he/she is inviting the practitioner to respond personally to the complainant on these matters. Likewise, when the Chief Executive is writing to the practitioner, he will want to suggest that a response goes from the practice directly to the complainant.

Administrative Support, Fees and Expenses

8.48 The Board will provide any administrative support which the convenor, the independent lay chairman, the panel and its assessors need. All the expenses arising out of the Independent Review process, including any fees or expenses paid to panel members and assessors, will be met by the Board establishing the panel. Boards will need to determine the level of administrative support that will be necessary for the convening and Independent Review processes, bearing in mind the fluctuating nature of the demand for this support.

Panel Members

8.49 Panel members, including convenors, will be eligible to receive travel expenses, subsistence, and loss of earnings allowances. Boards should indicate in appointment letters that the particular panel chairman and third panel member will be appropriately indemnified.

Assessors

8.50 Arrangements for payments to independent assessors of all professions while advising a particular panel, together with eligibility for travel expenses and subsistence allowances, will be advised separately by the HPSS Executive.

8.51 Arrangements for funding locum expenses of certain FHS practitioners, and the responsibility for the payment of locums in respect of other assessors, will be advised separately by the HPSS Executive.

8.52 Assessors will be formally appointed by Boards to a particular panel and as such will be covered for indemnity while carrying out their role as advisers.

8.53 Where assessors find it more convenient to make their own arrangements for, say, typing their reports, they should agree a rate of payment with the Board in advance.

Performance Targets for Panels

8.54 For complaints against Trusts/Boards the formal appointment of the panel members and assessors should be made **within four weeks** of the convenor's formal letter to the complainant confirming his or her decision to recommend that a panel should be set up. While complaints are bound to vary in complexity, a panel should aim to complete its work **within twelve weeks** of the formal appointment of the panel members and assessors. The Chief Executive of a Trust/Board should write to the complainant **within four weeks** of the panel's final report informing them of any action the Trust/Board is taking as a result of the panel's report and of their right to complain to the Commissioner. The overall target for the Independent Review process is **six months** from the date when the complainant first requests a panel to the date when the Chief Executive writes following the panel's report.

8.55 In the case of family health services complaints, the aim is for panels to complete their work **within three months** of the date on which the complainant approached the convenor with the request for a panel to be set up.

Summary of Time Limits and Performance Targets

8.56 Time limits and performance targets have been summarised in APPENDIX 7.

Complaints about Purchasing Decisions by Boards

9.1 Complaints about Boards purchasing decisions may be made by, or on behalf of any individual personally affected by a purchasing decision taken by the Board. The complaints procedure may not deal with complaints about the merits of a decision where the Board has acted properly and within its legal responsibilities. Of course, the public or the HSS Council may wish to raise general issues about purchasing issues with the Board and they should receive a full explanation of the Board's policy. These are **not**, however, issues for the new complaints procedure. Panels may criticise the way in which a purchasing decision has been reached - for example on the grounds that the Board did not consult properly or take appropriate clinical advice - but where a purchasing decision has been taken properly and reasonably, panels will not be able to suggest an alternative decision.

9.2 The Board must have a Local Resolution process and a designated Complaints Officer to deal with purchasing complaints and other complaints about the Board's own actions and decisions. It must appoint at least one or more of its non-executive directors to act as a convenor for the Independent Review of complaints about the Board. (*See paragraph 5.26 - 5.27 for guidance on the appointment of additional convenors.*) The Board will nominate an independent lay chairman to link with the convenor and to chair the panel, if one is established. The third member of the panel will be another independent lay person nominated by the Board.

9.3 Where a complaint concerns the exercise of clinical judgement, the Board will nominate at least two clinical assessors (or other professionals as appropriate) with experience of exercising clinical judgement in a purchasing context.

Complaints about Purchasing Decisions by GP Fundholders

9.4 Complaints about purchasing decisions by GP Fundholders, and about all uses of the allotted sum paid to the practice, may be made by, or on behalf of any existing or former patient of the fundholding practice concerned, from the time when it joined the fundholding scheme, subject to the time limit for making complaints. Complaints will only be dealt with through the new complaints procedure if they are made by, or on behalf of a specific individual personally affected by a purchasing decision made by the GP Fundholder.

9.5 GP Fundholders will be required as a condition of remaining in the fundholding scheme to set up and run a practice-based complaints procedure to deal with purchasing complaints. In practice this is likely to be subsumed within their practice procedures for dealing with family health services related complaints. They will also be required to cooperate with the complaints review procedures organised on their behalf by their Board.

9.6 Panels may criticise the way in which a purchasing decision has been reached - for example on the grounds that the fundholder allowed concerns about their budget to interfere with a clinical decision about the needs of an individual patient - but where a purchasing decision has been taken properly and reasonably, panels will not be able to suggest an alternative decision.

9.7 The Independent Review for complaints about purchasing decisions by GP Fundholders will follow the same structure as those for the review of family health services complaints.

9.8 Where a panel is convened to consider a complaint which relates wholly or partly to a purchasing decision by a GP fundholder, the Board must **always** appoint assessors with experience of exercising clinical judgement in a purchasing context. These will normally be a GP fundholder chosen in consultation with local fundholding groups, working in conjunction with local medical committees and the Board's Director of Public Health. If a panel is to consider a complaint which relates partly to a GP Fundholder purchasing decision and partly to the provision of family health services, one of the assessors should be a GP Fundholder and one a GP assessor nominated by the Board from a list of names put forward by the local medical committees in the Board's area.

Complaints about Services Purchased from the Independent Sector

9.9 Services for patients/clients may be purchased from the independent sector by Trusts, Boards, or GP Fundholders. The new complaints procedure will apply equally to services provided by the independent sector. Complaints about the actual services purchased from the independent sector must be treated as such and **not** as complaints about purchasing decisions (although a complainant may also wish to complain about the related purchasing decision at the same time and may pursue this through the same procedure in parallel).

9.10 Trusts will need to ensure that their contracts with independent providers specify that the provider will cooperate with the Trust's own Local Resolution and the Independent Review process. Boards, and GP Fundholders, should specify in their contracts with independent providers that the provider must set up and run a local complaints procedure as far as possible identical to, and as effective as the Local Resolution which HPSS providers are required to provide. Independent providers must cooperate with the Independent Review procedure. Contracts made by Trusts/Boards/GP Fundholders should include a requirement on the independent provider and their staff to cooperate with any Independent Review process that is set up, and to indemnify them for the costs of setting up and running the arrangements.

9.11 Where a Trust has purchased the service concerned, it will be responsible for ensuring Local Resolution by the independent provider in the same way as for complaints about services the Trust provides direct.

9.12 Where the Board or GP Fundholder has purchased the service concerned, the convening and panel stages of the review process will be organised by the Board in the same way as for reviews of complaints against purchasing decisions. The questions to be addressed will, however, be about the services concerned. Complaints may be pursued in this way by, or on behalf of existing or former users of services purchased from the independent sector by either the Board or any fundholding practice within the Board's area. Such complaints must relate to the services in question.

9.13 If a complaint concerns the exercise of clinical judgement, the Board will nominate at least two clinical assessors (or other professionals as appropriate) to advise the panel. If the complainant wishes to pursue a complaint both about the actual services, and the purchasing decision involved, the assessors must represent between them the appropriate experience for both aspects.

9.14 A complaint under the procedures of the Registered Homes (NI) Order 1992 (through the Inspection Unit Manager of the relevant Board) if the independent provider is registered under that Order does not preclude a complainant pursuing a separate complaint under the HPSS complaints procedure.

9.15 If a complaint against an independent provider (registered under the Registered Homes Order) is not resolved locally, the convenor may, with the complainant's consent, delay the instigation of Independent Review until the Inspection Unit Manager of the Board registering the independent provider has had the opportunity to attempt to resolve the complaint.

9.16 HSS Councils will continue to assist patients and clients who wish to complain about purchasing decisions, and to pursue general issues arising from these complaints with the Board concerned. The complaints procedure does not affect existing requirements to consult extensively with HSS Councils and others on policy decisions.

10 Role of the NI Commissioner for Complaints (The Commissioner)

10.1 *Acting on Complaints* confirmed that the jurisdiction of the NI Commissioner for Complaints would be extended to all complaints by HPSS patients and clients. A Bill amending and widening his powers in the *Commissioner for Complaints Act (NI) 1969* is expected to become law later this year.

10.2 For the first time the Commissioner will be able to investigate complaints about:

- HPSS services provided by FHS practitioners, their staff, or their deputies or locums;
- actions taken wholly or partly as the result of the exercise of clinical judgement;

10.3 It is intended that the new legislation should put beyond doubt the Commissioner's power to investigate complaints about any HPSS-funded care or treatment provided in whole, or in part, by non-HPSS providers.

10.4 The Commissioner will continue to investigate complaints about services provided, or not provided, and about maladministration where actual hardship or injustice has been caused to the complainant or to the person on whose behalf the complaint is made. These will include complaints about the way the HPSS has handled complaints - currently the biggest single cause of grievances referred. The Commissioner will, for example, be able to investigate a complaint that a convenor has refused to recommend the setting up of an Independent Review panel, or that the Local Resolution or Independent Review investigations have been mishandled.

10.5 It is intended that complainants should have exhausted the new complaints procedure before referring a complaint to the Commissioner save that the Commissioner should have discretion in any individual case to override that requirement where he or she decides that it would not be reasonable for it to apply.

10.6 In deciding whether to investigate a complaint under the new jurisdiction, the Commissioner will expect to have access to all papers relating to both Local Resolution and Independent Review investigations. Where a case has been the subject of an Independent Review panel, these papers will include the report of the panel and the associated independent assessors' reports. In deciding whether to investigate a case, the Commissioner will wish to satisfy him or herself that there are grounds for intervention. The Commissioner will obtain independent professional advice as necessary to help him or her with cases involving clinical (or other professional) issues. The legislation defining the bodies and persons to whom the Commissioner must send the reports of his investigations will be amended to take account of his or her new jurisdiction.

10.7 Trusts/Boards will need to ensure that appropriate references are made to the role of the Commissioner when publicising their new complaints procedure, and in the responses they make to individual complainants. Family health services practitioners and independent providers of services will need to take similar action.

10.8 The Commissioner proposes to publish a revised leaflet about these new powers for the public, HPSS staff and family health services practitioners who will operate the new system.

10.9 Transitional provisions relating to the Commissioner's new powers are referred to in Section 11.

11 Transitional Arrangements

11.1 The new complaints procedure will become operational from 1 April 1996. It is recognised that there will need to be a transitional period during which existing complaints procedures will run in parallel with the new procedure. Complaints received before 1 April 1996 should be dealt with under old procedures. Any complaint first made on or after 1 April 1996 - notwithstanding whether the action concerned took place before or after 1 April 1996 - should be dealt with under the new complaints procedure.

11.2 The following rules will apply in relation to complaints against hospital consultant medical and dental staff of Trusts under the previous clinical complaints procedure:

- if, by 1 April 1996, a complaint has not been referred on by the Trust to the Board's Director of Public Health, under the second stage of the old clinical complaints procedure, then the complaint should be dealt with under the new complaints procedure;
- if, however, the complaint has been referred to the Board's Director of Public Health before 1 April 1996, but a decision has not been made to set up an independent professional review, the Director of Public Health will, refer the complaint back to the convenor of the Board originally receiving the complaint, for consideration in accordance with the new complaints procedure. This will be as if a request for a panel had been made by the complainant to that convenor;
- if, on the other hand, before 1 April 1996, the Director of Public Health has made a decision on the complaint, including a decision to set up an independent professional review, then the complaint should be followed through under the old procedure by the relevant Board.

Costs of appointing assessors under the old procedure will be passed on by the Board to the originating Trust.

11.3 For FHS practitioners complaints, if, **on or after 1 April 1996** a complaint is made relating to events which took place before that date, it will be investigated as follows:

- complaints relating to events which occurred **on, or after 1 January 1996** will be investigated using the new procedure;
- complaints relating to events which occurred **before 1 January 1996** will be investigated under the new arrangements **only** where the complainant can show that he or she had good cause for not making the complaint within the appropriate period under the service committee procedures.

11.4 Legislation to extend the powers of the NI Commissioner for Complaints to mirror that of the GB Health Service Commissioner Bill will be introduced as soon as possible. Complainants will not be able to refer complaints, in respect of clinical matters and about family health services, to the Commissioner until the legislation is enacted.

12 Performance Management and Data Collection

Local Monitoring and Recording of Complaints

12.1 *Management Boards of Trusts/*Boards must receive quarterly reports on complaints, in order to:*

- *monitor arrangements for local complaints handling;*
- *consider trends in complaints;*
- *consider any lessons which can be learned from complaints, particularly for service improvement;*
- *Trusts/*Boards must publish annually a report on complaints handling and send copies to all Trusts/Boards and GP Fundholders with which it has contracts, all relevant HSS Councils and the HPSS Executive. This information should be included in Boards' Annual Reports.*

Reports must avoid any breaches of patient/client confidentiality.

** (Only relevant to complaints about Boards themselves. Complaints against FHS practitioners, GP fundholders, and independent providers will not be included.)*

12.2 In their role in monitoring implementation of the Charter for Patients and Clients, Boards are required to monitor the arrangements made by providers for dealing with complaints and action taken to improve performance as a result of complaints. An increase in the number of complaints is not, in itself, a reason for thinking that a service is deteriorating. It could mean that the organisation is becoming more responsive to complaints. The important point is to handle complaints well and to feed the lessons learnt into quality improvement.

Collection of Complaints Statistics

12.3 The HPSS Executive will continue to monitor the number and type of complaints made in Northern Ireland. Arrangements for the collection of information on hospital and community services/family health services complaints will be through the completion by Trusts/Boards of the CH8 central return, which has been revised to take into account the new procedures. There will be a revised central return CHB to be completed by Boards for FHS complaints.

12.4 General medical practitioners and dentists will be required by their terms of service to provide Boards with information on the number of complaints received in each practice or surgery, to be included in this return. However, detailed information on Local Resolution will not be required. Boards will be required to provide information on cases which proceed to Independent Review, including those where the convenor decides that a panel investigation is not appropriate.

13 Training

13.1 Training will be the key to making the new complaints procedure effective. All HPSS bodies will need to take action now to ensure that staff understand the intentions that lie behind the new procedure and how the new processes will work.

13.2 All staff and non-executive directors of Trusts/Boards should know how to react and what to do if approached by a complainant. The initial response to someone who feels aggrieved can be crucial in establishing the confidence of the complainant that their grievance will be treated appropriately. Steps should be taken to improve the awareness of staff to the fundamental importance of responding well to complaints. Improving the communications skills of staff throughout the organisation must be a priority to ensure that complaints handling is improved.

13.3 All FHS practitioners will be required to operate Local Resolution procedures within their practices. The intention is to create a channel for constructive discussion and information-seeking so that, wherever possible, the relationship between a patient and their practitioner can be maintained, or saved. Family health services practitioners, who have until now dealt with service committee procedures, will perhaps be facing the greatest cultural change of all. Boards will need to work positively with local representative committees to assist practices, particularly in the early stages, and to ensure that training and support is available for practitioners, practice managers, and staff who are introducing Local Resolution into their practices.

Regional Initiatives

13.4 The HPSS Executive has distributed a training pack for Trusts/Boards to prepare their staff to undertake the Local Resolution complaints process.

13.5 Guidance booklets for Family Health Service practitioners on practice-based complaints procedures have been distributed for every FHS practitioner, with particular emphasis on Local Resolution.

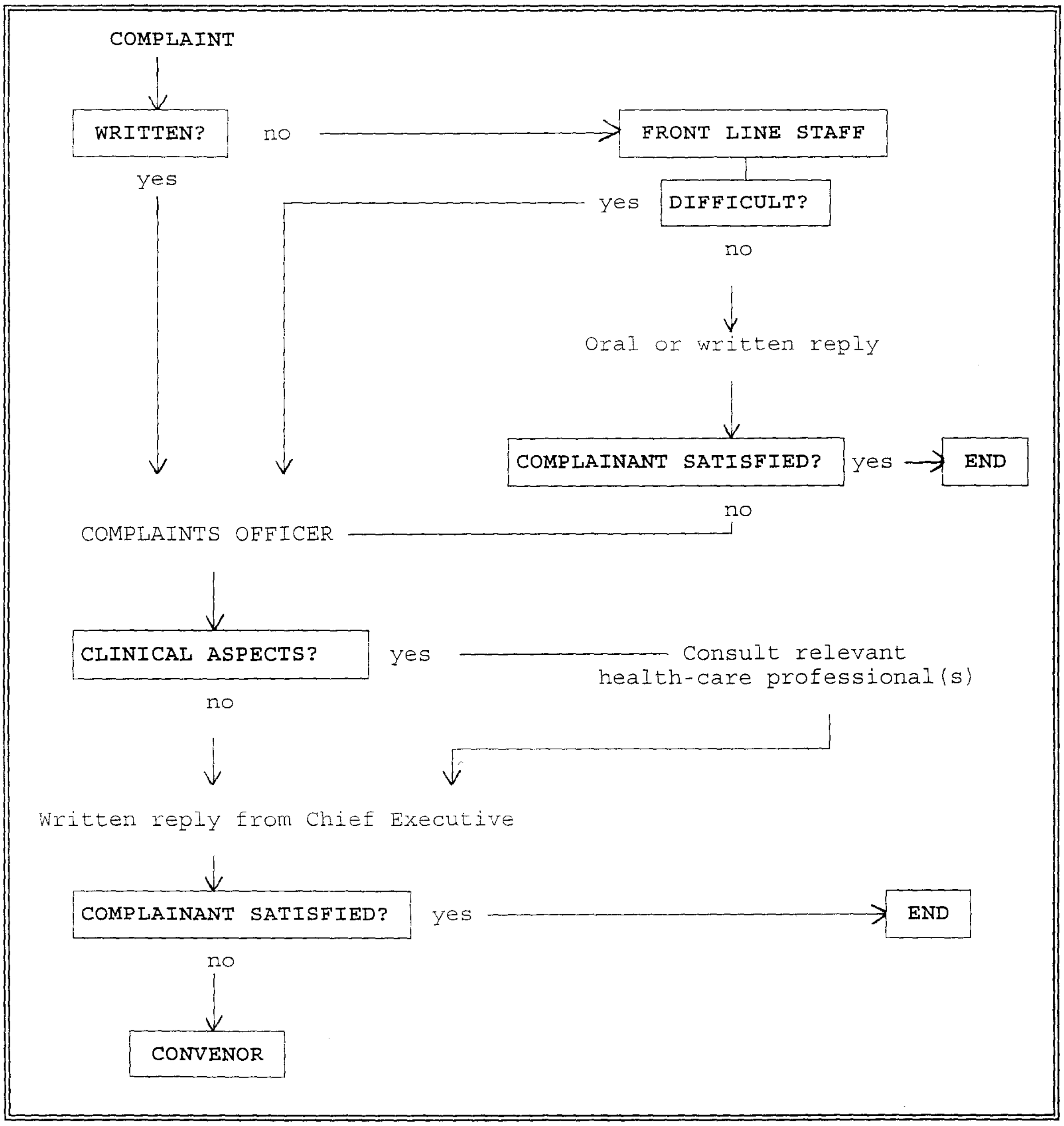
13.6 A further training pack covering the Independent Review panels will be available in April/May 1996.

13.7 Briefing material is being prepared for clinical assessors and will be distributed in June 1996.

APPENDIX 1

LOCAL RESOLUTION FOR TRUSTS/BOARDS

(Local Resolution for family health services practitioners - see practice-based guidance booklets)



ROLE OF THE CONVENOR

The convenor will be a non-executive director of the Board, or a person specifically charged by the Board to act in this role, who will:

- respond to an oral or written request by a complainant who is dissatisfied with the outcome of Local Resolution (the complainant's request should be made within twenty-eight days of completion of the Local Resolution process: the convenor has discretion to extend this period if there are exceptional circumstances why there has been delay);
- formally acknowledge the request within two working days (the convenor will be appropriately assisted in his/her task by a manager appointed by the Board);
- immediately consult with one of the independent lay panel chairmen on the Board's list in order to consult over a decision as to whether or not to convene a panel;
- call for all papers and documents relating to the Local Resolution;
- advise any person who is complained against;
- request the complainant to provide a written statement to elucidate exactly why he/she remains dissatisfied, if the initial request is either not clear or not full enough (the convenor should ensure the complainant is aware of the help that is available from the HSS Council or other sources);
- seek appropriate independent clinical (or other professional) advice, where the convenor considers there is a clinical element to the complaint, initially approaching either local head of the profession concerned or obtaining advice from an appropriate person on the list of assessors, accessed through the Board;
- in consultation with the prospective independent lay panel chairman, decide whether or not a panel should be set up, within twenty working days of receiving the complainant's request;
- liaise with other convenors if the complaint involves more than one body.

The convenor will decide **not** to establish a panel if:

- the complainant has commenced any legal proceedings, or proceedings explicitly threatened;
- the Trust/Board/family health services practitioner has already taken all action that is reasonably possible, so that a panel is unlikely to add anything to the outcome;
- further action is believed to be appropriate and practicable by the Trust/Board/family health services practitioner.

If the convenor decides to refuse a request for Independent Review, he/she must inform the following, in writing, of the reasons for the decision, and whether he/she believes that Local Resolution should be reactivated:

- the complainant, with advice of the right to appeal to the Commissioner of Complaints;
- the Chief Executive;
- any person who is complained against;
- the independent lay panel chairman with whom he/she has consulted;

- anyone else with whom he has consulted.

If the convenor decides that a panel should be convened, he/she will:

- decide the terms of reference for the panel, outlining the issues to be excluded from its consideration, eg any matters where the Trust/Board has instituted disciplinary investigation or referred on to a professional regulatory body;

- advise the complainant in writing of his decision and the terms of reference for the panel, the issues to be excluded from its consideration and why, and when the panel is likely to be set up;

- advise any person who is complained against in writing of his decision and the terms of reference for the panel, the issues to be excluded from its consideration and why, and when the panel is likely to be set up;

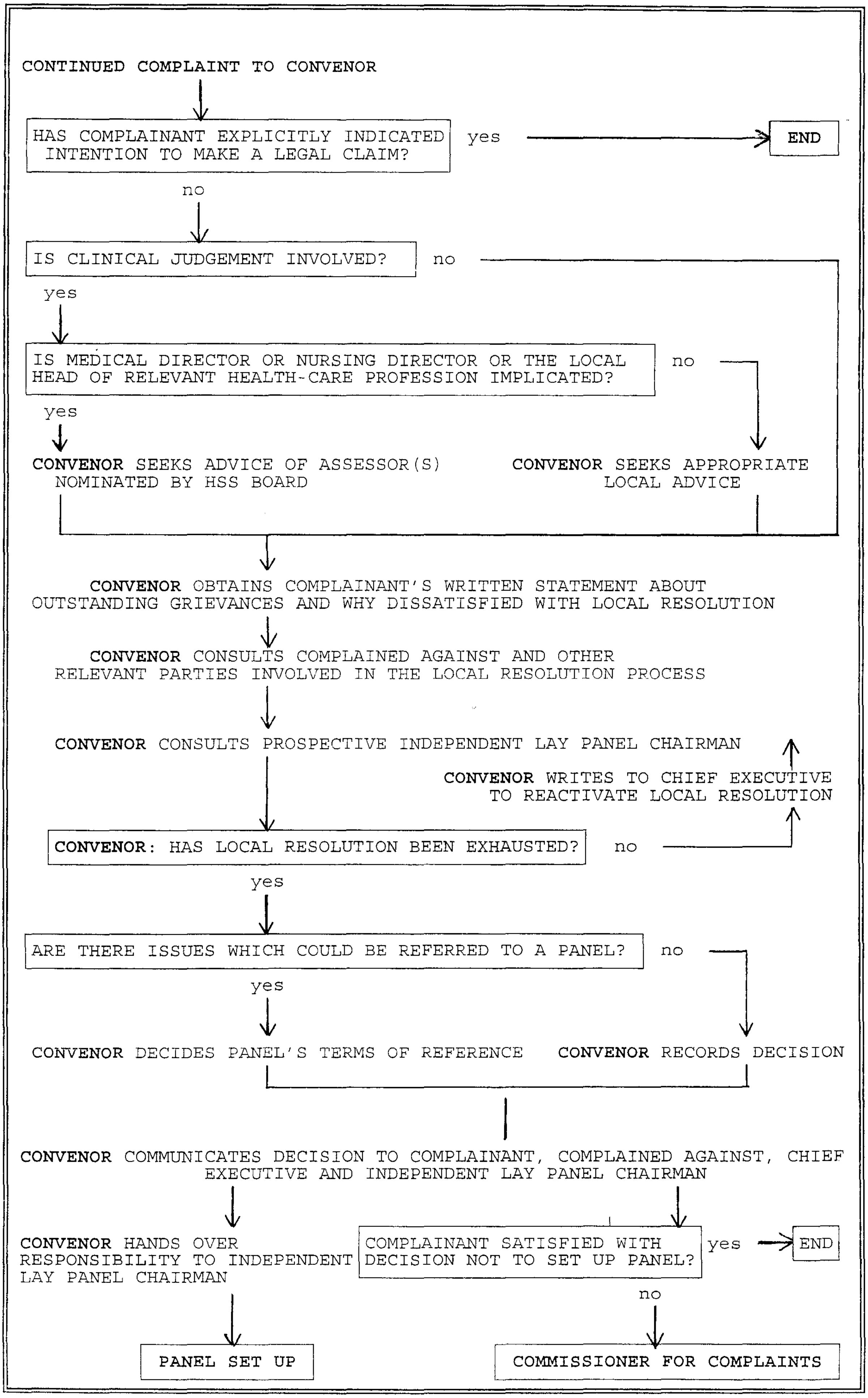
- advise the independent lay panel chairman of his decision, with the terms of reference and the complainant's written grievance, thereby handing over responsibility for the next stage;

- advise the Chief Executive in writing of:

    - the decision and terms of reference of the panel;
    - the need for a further member of the panel;
    - whether there is a need to appoint assessors to assist the panel, and that appropriate arrangements should be made for their formal appointment;
    - the need for administrative assistance to support the panel.

APPENDIX 3

CONVENING ROLE



APPENDIX 4

ROLE OF THE INDEPENDENT LAY CHAIRMAN

The role of the independent lay chairman is in two parts:

First

- to help convenors, by providing independent advice and support during the convening period: prospective panel chairmen may need to read reports and documents that are passed to him/her by the convenor, but it is not for the convenor to make the ultimate decision as to whether or not a panel is to be convened;
- to keep a personal record of the part they have played in the convening process, in case of need for future reference, for example investigation by the Commissioner for Complaints.

Second

- once the decision has been made by the convenor to establish an independent review panel, to ensure that he/she understands the terms of reference being provided for the panel and to decide on arrangements for the panel's business;
- to decide with the other panel members how the panel should operate, and to make appropriate arrangements to ensure full records of the panel's activities are kept bearing in mind a possible subsequent investigation by the Commissioner for Complaints (the Board appointing the panel has responsibility for providing appropriate administrative support for the panel and its assessors);
- to ensure members of the panel and assessors have received appropriate documentation, including the convenor's report and the complaint's grievance as recorded in writing to the convenor;
- in the light of discussion with panel members and also, where appropriate, the assessors, to decide the way in which the panel will proceed with its business, always bearing in mind its objective is to resolve and satisfy the complainant's grievance, while at the same time being fair to staff who are involved in the complaint;
- to exercise discretion as chairman of the panel as to how the panel should operate if any of the panel members disagree about how the panel should go about its business: the chairman's decision will be final;
- to decide, with the panel, arrangements for meeting the complainant and those who are complained against, together with those chosen to accompany them;
- to agree with the panel and its assessors the way in which the latter will meet with the complainant and the complained against, and how they should make their report;
- to lead the panel in shaping its report, setting out the results of its investigations, outlining its conclusions, with any appropriate comments or suggestions;
- to ensure there are no recommendations or suggestions relating to disciplinary matters

contained in the report;

- to decide, with the panel and, when appropriate, its assessors, what parts of the draft report are to be shown to the complainant and any person complained against;
- to ensure the work of the panel maintains momentum and as far as possible meets the target time limit for the panel to make its final report and, where this is likely to be exceeded, that an appropriate explanation is forthcoming to the complainant and those involved in the complaint;
- to send the report as formally required under the complaints procedure, ensuring its confidentiality.

APPENDIX 5

ROLE OF THE ASSESSOR

The role of the assessors is to advise the panel as and when required, on those aspects of the complaint involving clinical (or other professional) judgements.

The following set of questions is meant to be a framework within which all health care professions can operate. The questions are meant to be an *aide memoire*; they will not all be relevant in a particular complaint, so they will need to be tailored to the individual complaint; and they will need to be adapted for each profession.

1. Were the actions of the health care professional(s) based on a reasonable and responsible exercise of clinical judgement of a standard which could reasonably be expected of his/her/their peers by patients in similar circumstances?

2. Did the health care professional(s) respect the right of the patient (and the relatives/carers with the patient's consent) to influence decisions about his/her care?

3. Did the actions of the health care professional(s) conform with the codes of practice and/or rules of his/her/their profession(s)?

4. Was the necessary information and/or support expert professional advice available to the health care professional(s) to enable him/her/them to form a proper judgement and offer appropriate care?

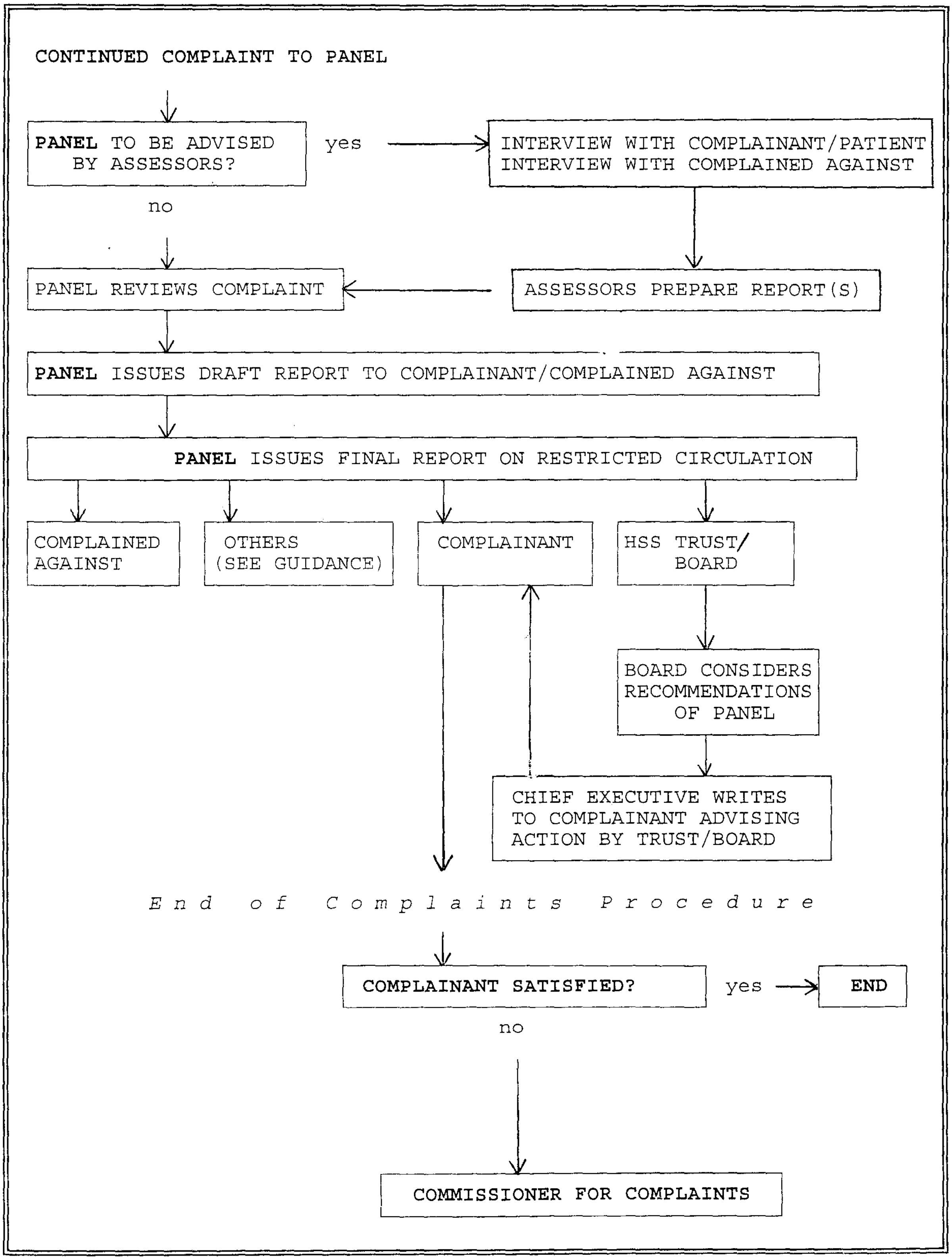
5. Did the health care professional(s) fail to recognise the limits of his/her/their professional competence?

6. If there was delegation to a junior (or subordinate) member of staff of responsibility for the care of the patient, was it agreed? and did the health care professional satisfy himself/herself that the junior (or subordinate) member of staff was competent to undertake that care?

7 Was there failure to refer the patient to another health care professional?

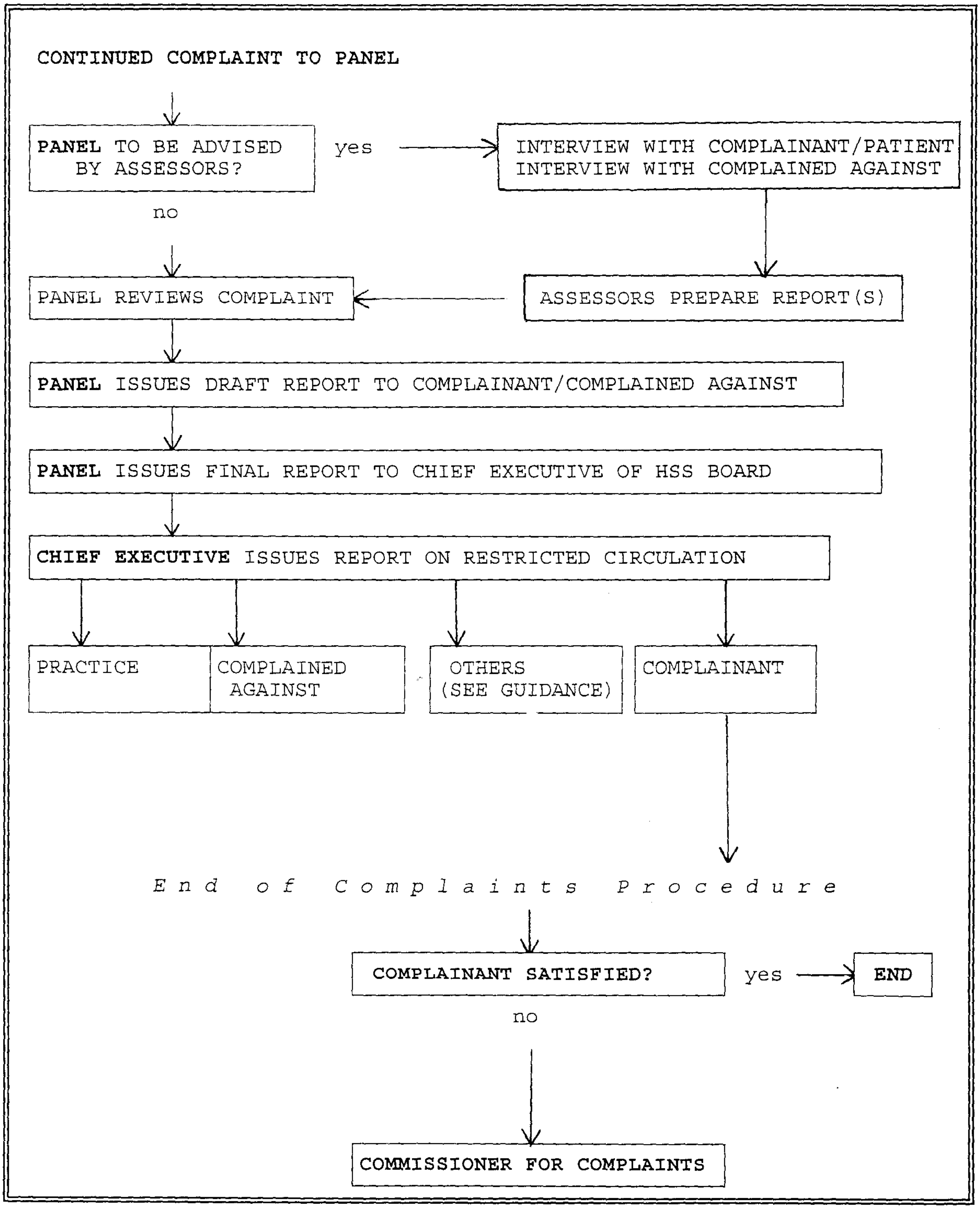
APPENDIX 6a

INDEPENDENT REVIEW FOR TRUSTS AND BOARDS



APPENDIX 6b

INDEPENDENT REVIEW FOR FHS PRACTITIONERS



APPENDIX 7

SUMMARY OF TIME LIMITS/PERFORMANCE TARGETS

EVENT	TIME ALLOWED	PARAGRAPH
Original complaint	6 months from event, *or* 6 months of becoming aware of a cause for complaint, but no longer than 12 months from event: discretion to extend	5.12
Local Resolution		
Oral complaint	Dealt with on the spot or referred	6.22
Acknowledgement	2 working days of receipt, *or* full reply within 5 working days	6.22
Full response, by trust/Board, *or* family health services practitioner	20 working days of receipt, *or* normally 10 working days for practice-based complaints or, if this is not possible, as soon as reasonably practicable thereafter.	6.23 6.24
Complainant to apply for Independent Review	28 calendar days of receipt of response to Local Resolution	7.1
Independent Review for Trust/Board complaints		
Acknowledgement by convenor of request for Independent Review	2 working days of receipt	7.30
Decision by convenor to set up panel, or not	20 working days of receipt of request	7.31
Appointment of panel members	20 working days of decision by convenor to establish a panel	8.53
Draft report of panel	50 working days of formal appointment of panel and assessors	8.53
Final report of panel	10 further working days	8.53
Response to complainant by Board	20 working days of receipt of panel's report	8.53
Independent Review for family health services practitioner complaints		
Acknowledgement by convenor of request for Independent Review	2 working days of receipt	7.30
Decision by convenor to set up panel, or not	10 working days of receipt of request	8.54
Appointment of panel members	10 working days of decision by convenor to establish a panel	8.54
Draft report of panel	30 working days of formal appointment of panel and assessors	8.54
Final report of panel	10 further working days	8.54
Final report sent to complainant by chief executive of Board	5 working days of receipt of panel's report	8.54