The Regulation and Quality Improvement Authority

# Review of the Regional Emergency Social Work Service

## January 2017

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Assurance, Challenge and Improvement in Health and Social Care

## The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews and reporting against four key stakeholder outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

These stakeholder outcomes are aligned with Quality 2020[1], and define how RQIA intends to demonstrate its effectiveness and impact as a regulator.

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[1] Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - http://www.dhsspsni.gov.uk/quality2020.pdf

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## Executive Summary

Mainstream community social work services operate during the traditional office hours of 9am to 5pm, Monday to Friday. However, access to services may be required 24 hours a day, seven days a week.

It is not feasible to provide a full range of social work services during the out-of-hours period. In the past, crises were dealt with by an out-of-hours duty social worker. It was not uncommon for them to have little or no knowledge of the individual or their circumstances.

Since 2013, emergency social work interventions are provided by the Regional Emergency Social Work Service (RESWS). The Belfast Health and Social Care Trust manage the RESWS, providing the service to the other trusts during the out-of-hours period.

Stakeholders reported significant improvements in accessing social work services during the out-of-hours period, since the establishment of the RESWS. However, some stakeholders have yet to accept that the service only provides emergency interventions.

The RESWS was considered to be delivering a good service; however, it faces some significant challenges that must be addressed. Action must be taken in the following areas:

- All staff must have appropriate access to the various IT systems to allow them to obtain an individual's information to inform their assessment.
- A continuation of the programme of training for approved social workers, and vulnerable adults training.
- A return to normal management staffing levels.
- A review and development of an appropriate protocol in relation to staff safety.

Further improvements that could be made to the service were identified in the following areas:

- A review of the call management arrangements with the aim of reducing the amount of inappropriate referrals.
- A reviewing of the arrangements for dealing with referrals in relation to homelessness.
- Develop more robust mechanisms for exchanging information between the RESWS and daytime services, the GP out-of-hours service, the NIHE and the PSNI.
- Develop mechanisms for engagement with individuals who have used the service, to obtain their views about the service.
- Strengthen the relationships with other organisations, in particular, the GP out-of-hours service, the NIHE and the PSNI.
- Develop better mechanisms for monitoring the performance of the service.

This report makes seven recommendations to improve the Regional Emergency Social Work Service.

## Section 1 - Introduction

### 1.1 Context for the Review

Mainstream community based social work services operate during the traditional office hours of 9am to 5pm, Monday to Friday. However, access to services may be required 24 hours a day, seven days a week. Evidence suggests that access to services to deal with cases, such as, emergency mental health assessments, emergency admissions of children into care, attempts at self-harm, and applications for secure accommodation for young people, frequently happen at night or weekends.

In the past, crises were usually dealt with by an out-of-hours duty social worker. It was not uncommon for them to have little or no knowledge of the individual or their circumstances. However, this situation was not unique to Northern Ireland, with similar arrangements in place in other parts of the United Kingdom.

Following the Lord Laming Inquiry (2003)[2], the Social Services Inspectorate in Northern Ireland responded by carrying out an inspection of child protection. A report was published in 2006 entitled "Our Children and Young People - Our Shared Responsibility". The report identified issues in relation to the provision of social care services, particularly for child protection, during the out-of-hours period. It was recommended that a comprehensive review of the social care out-of-hours system in Northern Ireland be undertaken.

Subsequently, in 2008, a review[3] was carried out by members of the out-of-hours teams in the respective trusts. The review focused on the structure, staffing, expertise and resources of the out-of-hours services, and proposed a number of options that could improve the service.

At the same time, out-of-hours social work was the subject of a number of recommendations contained within the independent review conducted in 2008, by Mr. Henry Toner (the Toner report)[4], into the death of Mr McElhill and his family. It was recommended that the then Department of Health, Social Services and Public Safety (DHSSPS) should conduct an independent review in order to professionalise, modernise and upgrade the service.

In recent years, DHSSPS prioritised out-of-hours social services and included it as a strategic priority within the social work strategy, Improving and Safeguarding Social Wellbeing - A Strategy for Social Work in Northern

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[2] The Victoria Climbié Inquiry: Report by Lord Laming. January 2003 - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273183/5730.pdf

[3] Regional Review of Emergency Out of Hours Social Work Provision in Northern Ireland. December 2008

[4] DHSSPS Independent Review Report of Agency Involvement with Mr Arthur McElhill, Ms Lorraine McGovern and their children. Henry Toner June 2008 - https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/independentreview2008.pdf

Ireland 2012 – 2022[5]. A recommendation in the strategy was that a regional out-of-hours social work service should be developed.

During 2010-11, the Health and Social Care Board undertook a review to identify the potential options for a regional model for out-of-hours social work. A position paper was shared with the HSC Trusts and work to oversee the reform of out-of-hours social work provision commenced. In 2012, a formal consultation was conducted, which identified a new model for an emergency social work service during the out-of-hours period.

The new model, the Regional Emergency Social Work Service (RESWS) commenced on 29 May 2013. The service model is based on having staff working at all times that the service is operational. Emergency social work response is provided between 5pm and 9am daily and over each weekend and public holiday. Emergency social work staff work from a number of offices across Northern Ireland.

The RESWS has been operational for over three years, and no reviews of this service have been undertaken. RQIA has carried out this review to determine whether the interventions of care carried out by the RESWS are safe, effective and compassionate, and that the service is well led.

## 1.3 Terms of Reference

The terms of reference for this review are:

1. To review the Regional Emergency Social Work Service to determine whether the provision of emergency interventions of care is safe, effective and compassionate, and the service is well led.

2. To assess the views of key stakeholders in relation to the provision of emergency social work services.

3. To report on the findings, identify areas of good practice and, where appropriate, make recommendations for improvements.

## 1.4 Exclusions

Other services that may be required by the public during the out-of-hours period, such as General Practitioner (GP) out-of-hours, or Mental Health Emergencies are not included in the scope of this review.

[5] Improving and Safeguarding Social Wellbeing - A Strategy for Social Work in Northern Ireland 2012 – 2022 - https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/social-work-strategy.pdf

Circulars, guidance, standards, reviews and reports which arise during the course of this review will not be assessed as part of this review and will be highlighted for consideration in the future.

## 1.5 Review Methodology and Scope

The review included the following stages, designed to gather information on the Regional Emergency Social Work Service (RESWS).

- A review of relevant literature set out the context for the review and identified appropriate lines of enquiry.

- Meetings with a range of stakeholders to obtain their views about the RESWS, to help inform the review.

- Validation visits to meet with staff, managers and representatives who have responsibility for the operation or the oversight of the RESWS.

The findings from questionnaires, meetings with staff and management, along with feedback from stakeholders, were collated. This information has been used to inform this report.

## Section 2 – Findings from the Review

### 2.1 Engagement with Interested Stakeholders

This section reflects the views expressed by interested stakeholders of the RESWS during the focus group meetings. RQIA has not made any formal recommendations based solely on the comments; however, the comments were used to inform the review process and to develop lines of discussion with the RESWS. Where required, relevant issues raised during the discussions were passed onto the RESWS for their consideration and any necessary follow up.

In assessing the RESWS, it was necessary to hear stakeholders' views of the service. The stakeholders were identified as those services or organisations that interacted directly with the RESWS, and included:

- mainstream daytime social work services
- other hospital services
- GP out-of-hours services
- the Police Service of Northern Ireland (PSNI)
- the Northern Ireland Housing Executive (NIHE)
- the Northern Ireland Public Service Alliance (NIPSA)

There were two stakeholder groups with whom no engagement took place. They were the Social Security Agency (SSA) and individuals[6].

The RESWS provides a service on behalf of the SSA, which is a legacy arrangement to provide emergency financial aid. With the modernisation of SSA payments, the need for emergency payments has significantly reduced, and no interventions on behalf of the SSA were made within the last year. As a result, it was considered that engaging with the SSA would not provide any meaningful input into the review.

Individual engagement was considered as part of the review; however, given the nature of the work of the RESWS and the associated challenges, meaningful engagement could not be guaranteed. The challenges were identified to be:

- Direct engagement with individuals accessing the service on a particular night would be inappropriate, as they would be accessing the service at time of crisis.
- Many individuals may only have one interaction with the service, so any follow up would require extensive administration by the RESWS on behalf of RQIA.
- From information obtained at the focus groups, it was identified that there are a group of repeat individuals using the service who may be easier to contact. However, it was considered that they would not be a representative sample.

[6] For consistency, anyone who accesses the service is referred to as an individual rather than a service user, client or patient.

- The RESWS had advised of plans to conduct a survey of individuals, so another survey would possibly be counterproductive.

**Feedback from daytime social work services and other hospital services**

Meetings were held with representatives from the mainstream daytime services in each of the trusts, including social work disciplines representing mental health, learning disability, older people, children's, integrated care, gateway teams, acute services, crisis response, family support services, and hospital social work. Representatives from some of the Emergency Departments and the Acute and Community Midwifery teams attended some of the meetings.

Changes since the establishment of the RESWS

Staff in all focus groups highlighted that, prior to the establishment of the RESWS, it was often difficult to contact a social worker during the out-of-hours period. Since the establishment of the RESWS this scenario no longer exists. Following the initial call, it was reported that a social worker would usually call back within 15 minutes.

Staff considered that the success of the new service was a direct result of the preparation and planning undertaken prior to the transfer. This had facilitated a smooth transition to the RESWS. Although there was an initial period when staff were getting used to the new service, it was reported that things were now more established, the service is better structured, good relationships exist, and there is better collaboration between the RESWS and other services.

Staff in all groups spoke about an improved service, where support and advice was much more accessible and responsive. Representatives from the Emergency Department highlighted that they were now getting responses to their queries a lot quicker than prior to the establishment of the RESWS.

Even though most staff considered the RESWS was performing well, there were a few that thought the local knowledge associated with individuals and the local environment had been lost, once the service started to be provided regionally. They highlighted cases where the engagement with individuals was being carried out by social workers from different trusts who were located many miles away.

Operation of the Emergency Social Work Service

During focus group discussions, staff demonstrated differing levels of understanding of the workings and operation of the RESWS, and the services they offered. However, all staff were able to identify the single contact number for the service, and the different handover arrangements currently in place.

All staff discussed the arrangements for handover from day time to the out-of-hours period. They advised that the RESWS would not accept referrals for cases that had been commenced by the daytime teams; however, an alert system was in place. The alert system allowed daytime staff to flag up any potential cases that might escalate during the out-of-hours period and subsequently require an intervention.

Staff advised that the alert system worked well; however, they advised of having to submit the alerts by 3:30pm, although in practice, many staff still submitted alerts right up to 5pm. Despite the RESWS not accepting referrals known to the daytime teams, some staff stated that depending upon the complexities of the case, they would still ring the RESWS and negotiate whether the referral could be accepted.

Some staff raised a point in relation to the RESWS having a higher threshold for accepting referrals than was present during the day time. They thought the threshold was not always clear and asked if more clarity could be provided.

Some staff spoke about the timing of accepting referrals. They stated that when it was nearing the end of shift, there were times when the RESWS would not accept a referral. However, several staff advised that their experience of the RESWS during this time was that staff would respond by telephone and assess the risk before deciding on whether to undertake a call out visit, or leave the case for the daytime service.

Staff from all groups advised that social workers from the RESWS would undertake call out visits when required. They stated that call out visits included child protection issues and mental health assessments. Most staff advised that the level of visits was sufficient; however, some staff thought that more call out visits should be undertaken, as this would have more of an impact in relation to appropriate interventions and subsequent care.

Staff did not raise any issues in relation to call out visits relating to child protection issues; however, some comments were made in relation to call out visits relating to mental health assessments. It was noted that during the meetings in the Western Health and Social Care Trust (Western Trust), staff were more vocal in relation to the need for more call out visits. They told us that they felt there was a perceived reluctance to conduct call out visits within their trust area in comparison to other trusts, and queried whether the RESWS had sufficient provision in place to appropriately cover the Western Trust area.

In some of the meetings, a number of staff spoke about cases where individuals had been expecting a visit from the daytime social worker. This was stated to be a result of the RESWS staff signposting them to daytime services or advising them of a follow up visit by a social worker the next day.

Staff stated that the process for advising daytime services, of any interventions and engagement during the out-of-hours period, was through the

submission of RESWS referral forms. These referral forms were submitted to a single point of entry in each of the trusts and subsequently disseminated to the appropriate staff.

It was stated that referral forms were always received early in the morning, usually by 9:30am, but always by 10:30am. There were exceptions that were received later in the day, but these were usually related to complex cases, or cases that were not closed until later in the day. Staff considered that the timeliness of the receipt of referrals was good.

While many staff raised no particular issues in relation to the content of the referral forms, several staff in each group considered the amount of information on some referral forms was either too much or too little. Staff commented that a lot of information that was not relevant was included and they spent time reading it only to find that it was unnecessary.

Many staff advised that some of the referral forms lacked clarity in relation to the outcome of the interventions or the follow up actions required. They stated that such forms did not have a conclusion, and it was difficult to determine what had been done or what still needs to be done, often resulting in the daytime staff starting the interview process again. Staff advised that the lack of clarity also meant it was difficult to determine to whom the referral should be passed on to, or if it was indeed a referral.

Staff questioned whether the referral forms could be shortened, to include only specific information, an analysis of the outcome, and some proposals for the next steps.

In a few meetings, staff highlighted that on many referral forms the individual's contact details were not included, and this made it difficult to follow up with them. Staff queried why this information was not included on referral forms.

Staff in several focus groups highlighted a potential issue with the referral forms relating to a specific set of individuals. Usually, over the weekend period, there are instances where individuals may access the services of the RESWS more than once. When this happens, they are not assessed by the same social worker each time. In these cases, staff advised that a new referral form is generated for each time the individuals contacted the service. When the forms are forwarded to the daytime services they have to spend time identifying the sequence of the forms.

Staff queried whether there was an opportunity to use a standardised assessment form that linked more directly with existing systems. The examples proposed related to the potential use of NISAT (Northern Ireland Single Assessment Tool) for adults and UNOCINI (Understanding the Needs of Children in Northern Ireland) for children. Staff advised that information was subsequently copied from referral forms into the existing NISAT and UNOCINI assessment forms.

Although these areas in respect of the referral forms were highlighted, most staff advised that the amount and quality of information detailed on the referral forms was adequate.

Staff also noted that there was limited opportunity to get feedback from the RESWS social workers, in relation to following up on specific cases. They advised that there was no face to face handover and they did not have any contact details which they could use to contact the RESWS social workers. A number of staff stated that some social workers from the RESWS would contact the daytime services to get feedback on progress of cases and to follow up; however, this practice was not widespread.

Access to information

Staff discussed the access that the RESWS staff had to each trust's patient information system. They advised that most trusts had different systems and limitations to access might have an impact on the assessments, decision making, and interventions for individuals.

Some staff suggested that if the RESWS had full access to each trust's patient information system they could see the entire individual's history and also input data directly into an individual's file.

Several staff also told us that on occasions the names and addresses of individuals were sometimes misspelled. This often led to the daytime teams not identifying a known individual, or having to take time to find the correct information. Staff felt that such issues could be minimised if the RESWS staff had access to each trust's patient information system.

A few staff stated that the issue of access to patient information systems had been raised with the RESWS. During several group meetings it was acknowledged that there was no regional patient information system and limited access to an individual's files was an issue that was not peculiar to the RESWS alone.

Governance Arrangements

Not all staff were familiar with the governance arrangements associated with the RESWS. The majority of practitioners indicated they were not familiar with the Operational Management Group or the Consortium Board, and their respective roles. However, they expressed an interest in finding out more about these groups.

In the main, it was the more senior staff and managers that gave their opinions about the arrangements.

Staff that were aware of them stated that they thought the governance arrangements were much better under the RESWS, with better structures in place. It was stated that the RESWS had put personnel in place with experience and knowledge of governance.

Staff highlighted that when day to day issues were identified, managers would deal directly with the respective staff in the RESWS. Issues that could not be resolved were raised at Operational Management Group meetings. It was stated that further oversight was provided by the Consortium Board. Staff considered that under the current arrangements the RESWS was not an isolated service and each trust had appropriate input at various levels.

Most staff advised that they did not know what was being reported on by the RESWS; however, managers at the various meetings spoke about regular reporting. While staff made little reference to the type, level and amount of reporting, there was one meeting where a number of staff thought the information provided was generic, and that more information specific to their trust should be provided.

Challenges for the Service

Staff identified several challenges that they thought impacted upon the RESWS.

Staff in most meetings highlighted that there were a small number of individuals within their area that accessed the RESWS on a regular basis. They advised that these individuals often over used the service and on many occasions the contact was not warranted. It was stated that this contact was often an attempt to get something they felt they could not get from the daytime service.

Staff reported that there were many inappropriate calls to the RESWS, in particular, calls from supported living and residential care providers and from home care workers. Staff highlighted that many of these calls would be recorded by the RESWS team and subsequently received by the daytime teams. Some examples included calls from:

- domiciliary care providers reporting that they could not access an individual's house
- providers to confirm changes to an individual's medication
- home care workers to advise that individuals were not taking their medication or to provide updates on a person's condition or progress

Staff in the Western Trust considered that there was a gap in the service, particularly in terms of geography, in relation to the rural areas of Fermanagh and around the Omagh area. They queried whether people in those areas were getting the same level of service in comparison to people in other parts of Northern Ireland. It was further suggested that there was a need for the RESWS to establish a base in the Enniskillen area.

Staff from each of the trusts identified a challenge in relation to the number of Approved Social Workers (ASW), linked to their availability to undertake call out visits. However, it was stated that the number and availability of ASWs was not unique to the RESWS and affected many daytime services too. This

was also an issue for services throughout the National Health Service. It was stated in one meeting, that trusts were already investigating the numbers of ASWs and looking at different models of service provision to best utilise the ASW provision.

Areas of good practice

During all meetings, staff were asked to identify areas of good practice carried out by the RESWS. Many suggestions were highlighted, and included:

- The responsiveness of the service, and the advice that is provided.
- Confidence in the RESWS staff experience and knowledge.
- There are good links between the RESWS and daytime services, with identified named leads for different parts of the service who can be contacted in relation to issues, or for advice.
- The RESWS is engaging with the daytime teams to provide information and improve areas of practice. Several workshops have been set up to review different work areas.
- The development of guidance for adults in need of assessment for emergency residential/ nursing placements.
- The service is very open to suggestions and regularly links back with daytime services about any issues raised.
- The service is well structured with good governance arrangements in place.
- Some of the RESWS social workers would follow up with the daytime service during the day to discuss cases.
- The RESWS was fully involved in previous crisis response cases.

Suggestions for improvements to the service

In all meetings staff were asked to suggest any improvements they thought could be made to the RESWS. The suggestions were:

- On referral forms, provide more information about the case, an analysis, and a judgement about the next steps. The referral forms should also be prioritised or highlighted for immediate action.
- Minimise the number of referral forms for repeat callers, with the aim of a single referral form that was updated with each call.
- Include the contact details for the individual on the referral form, to make it easier for daytime services to contact them.
- Provide access for the RESWS staff to each trust's patient information system.
- Allow the RESWS staff to input notes directly into an individual's files.
- Allow time for a face to face or telephone handover.
- Reduce the amount of inappropriate calls by further advertising and promotion of the services offered by the RESWS.
- Increase the provision of ASWs during the out-of-hours period, particularly during busy periods.

**Feedback from the GP Out-of-Hours Service**

The GP Out-of-Hours service has links with the RESWS, and engagement with them helped to inform the review. Meetings were held with the providers of the GP Out-of-Hours services in the Southern Health and Social Care Trust, Northern Health and Social Care Trust (Dalriada Urgent Care) and the Western Trust (Western Urgent Care). The providers for the Belfast Health and Social Care Trust (Belfast Trust) and South Eastern Health and Social Care Trust (South Eastern Trust) did not provide an input.

Staff advised that the GP out-of-hours service had only limited interaction with the RESWS. They stated that the main interactions were in relation to providing input for dual assessments for people with a mental illness. It was only on rare occasions that they would involve the RESWS in children's cases. The only other times that they have contacted the RESWS were in relation to homeless people, once it had been established there was no medical issue.

Staff commented that the service worked well, particularly the single telephone number, and they now felt confident their case was being dealt with. After the initial call, they highlighted the responsiveness of the service as a social worker would always ring back.

Staff stated that the advice provided was professional and accurate and that it was good to get their opinion. These conversations allowed them to discuss the case and the appropriateness of a call out visit. Since the establishment of the RESWS, staff advised that they could not recall any times that the RESWS staff did not attend a call out visit.

Staff highlighted that there were some times when the call out time could be up to two hours, but overall the timeliness of the responses was acceptable. Staff stated they would usually negotiate with the RESWS staff in relation to call out times, and try to coordinate the visits. Staff stated that coordinating the visits of both the GP and the ASW was difficult, as both could be subject to delays.

Staff queried whether the coordination of the activities associated with dual assessments could be improved, as the function of the social worker took much longer to complete than that of the GP. Staff highlighted that social workers took a lead role in the assessments, checked that everything was correct, and would remain with the individual until a bed became available.

Staff were questioned about any cases where the GP may not contact the RESWS and discuss, with a family member, the possible admission of their relative due to a mental illness. Staff advised that this was not common practice; it was strongly discouraged and they had only been aware of a limited number of cases. Staff advised that it is still possible that this practice may be undertaken by GPs operating outside the out-of-hours service. However, staff admitted that in a very particular set of circumstances, such as

when the individual was in danger of harm, this approach may still be taken by staff from the GP out-of-hours service.

Staff indicated that there were no written protocols in place between the GP out-of-hours service and the RESWS. They advised that documents and leaflets about the RESWS were distributed throughout their premises, and all staff were aware of the RESWS and the contact number. Staff considered that they did not need written protocols and were happy with the current arrangements, referencing that they would always get a response after contacting the RESWS.

Suggestions for improvements to the service

In all the meetings staff were asked to suggest any improvements they thought could be made to the RESWS. The suggestions were:

- Redistribute information leaflets about the RESWS to promote and remind people about the service.
- Increase the provision of ASWs during the out-of-hours period, particularly during busy periods.
- Review the process for dual assessments of people with a mental illness, to determine if the coordination of the GP and the social worker attending could be improved.
- Facilitate access to the Electronic Care Records system for the RESWS staff.

**Feedback from the Police Service of Northern Ireland**

The RESWS interacts on a regular basis, with both the Public Protection Unit (PPU) and Central Referral Unit of the PSNI. Representatives from the PPU met with the review team to share their experiences of working with the RESWS.

The PSNI advised of a good relationship with the RESWS and its social workers. It was stated that prior to the establishment of the RESWS, it was often difficult to get in contact with a social worker to deal with a referral. However, the current arrangements provide a much easier access to the service and appropriate social work response.

It was advised that the response time following referrals is good. However, at weekends, it can sometimes take a few hours to get a response. It can also be a problem getting in contact with a social worker who is appropriately trained in the protocol for the joint investigation of alleged and suspected cases of abuse of a vulnerable adult. It was felt this was having an impact on some cases involving vulnerable adults, and had the potential to lose the opportunity to secure best evidence.

The PSNI stated there was a good response from the RESWS in relation to child protection referrals.

The PSNI questioned the current contact arrangements. They stated they would only contact the RESWS when it was required and still had to go through the call handlers and be allocated to a social worker. In some cases the allocated social worker was unable to assist due to their lack of experience. They queried whether there could be alternative arrangements established where they could have direct contact with an Assistant Service Manager (ASM). It was felt this could speed up the referral process.

The PSNI considered that they have a substantial amount of sensitive and confidential information which should be transferred to the RESWS. However, many of the RESWS staff did not have a Criminal Justice Secure email (CJSM)[7] account. It was stated that in some cases, information was not transferred as a result of this.

A final issue related to the follow up of referrals. When a referral was made to the RESWS, and the PSNI wanted to follow it up, there was no way to confirm what had happened to it. Even when contacting the daytime services it was difficult to identify the status of the referral.

The PSNI advised that meetings with the RESWS had taken place to discuss the working arrangements and more were planned. They welcomed the meetings and hoped to strengthen the relationship between the PSNI and the RESWS.

**Feedback from the Northern Ireland Housing Executive**

The RESWS provides an out-of-hours service, for the emergency response to homelessness, on behalf of the NIHE. Referrals are received from individuals requesting accommodation.

The NIHE considered that the service worked well and they had good relationships with the RESWS. They stated that the arrangements for responding to homelessness had greatly improved since the establishment of the RESWS. In particular, individuals now only had to contact a single telephone number, and were able to speak with someone more readily.

The NIHE stated that information about the RESWS was available in their offices and on their website.

The NIHE advised that a list of available accommodation places was forwarded to the RESWS each day. A list of individuals who had refused accommodation during the day was also provided. It was advised that the approach to be undertaken when providing accommodation was to err on the side of caution and work out the details the following day.

We were told that an ASM from the service has met with the NIHE to develop arrangements for managing referrals. The NIHE stated that they were also

[7] The Criminal Justice Secure eMail service allows people working in the Criminal Justice System and other public, private and voluntary organisations, to send emails containing sensitive or confidential information in a secure way.

working towards addressing some issues relating to the management of referrals, such as a mechanism for providing real time accommodation availability.

The NIHE confirmed that the main challenges they face in relation to managing homelessness were the availability of accommodation, and finding appropriate accommodation for people with special needs, a mental illness or a learning disability.

**Feedback from the Northern Ireland Public Service Alliance**

The Belfast branch of NIPSA asked to meet with RQIA as part of the review process, as many of the RESWS staff are members of NIPSA. The meeting was intended to share information and express concerns in relation to the RESWS.

NIPSA considered that the RESWS delivers a good service, particularly when compared to the level of service prior to its it was establishment. They did however, have some reservations about the service, these included:

- Staffing levels – whether the staffing levels on each shift were appropriate to meet the demand, particularly during the 1am-9am shift and at the weekends.
- Training – whether staff had sufficient training across the different areas of care to respond appropriately to referrals. The lack of training in relation to vulnerable adults was also highlighted.
- Information technology (IT) systems – difficulties and limitations in accessing the different IT systems across the trusts to obtain an individual's information.
- Lack of standardisation – different trusts operate in different ways in relation to services, such as referral pathways and structures of care. This was a challenge for staff that were not familiar with these.
- Performance management – appears to be a lack of performance management information and analysis to support potential changes to practice.
- Call handlers – whether they were appropriately supported for working in an emergency environment.
- Lone working – the current arrangements are not appropriate, and there are potential risks to staff.
- Service identity – the RESWS needs to be clear in relation to what services it does and does not offer, and this should be clearly communicated.

NIPSA welcomed the opportunity to be involved in the review and would welcome any future involvement with helping to improve the RESWS.

## 2.2 The Structure of the Service

The RESWS is a regionally managed service that operates from 5pm-9am seven days a week, and also from 9am-5pm at weekends and bank holidays.

The service is staffed by 28.75 whole time equivalent, permanently employed senior social work practitioners, who are supported by 70 locum staff when required. A team of call handlers answer all calls coming into the service. Two full time and two part time administrative staff provide support to the staff and managers, and the two part time staff also provide a back-up service to the call handlers up until 9pm Monday to Friday.

Management of the service is provided by a service manager, supported by four assistant service managers. To cover annual leave and absence, the RESWS has employed ten locum shift managers.

All permanent staff are employed by the Belfast Trust and deliver the service on behalf of the other health and social care trusts. Staff are based across four service offices throughout Northern Ireland, in Belfast, Ballymena, Londonderry and Armagh.

Oversight of the RESWS is provided by a Consortium Board and an Operational Management Group. Membership of the Consortium Board includes the Executive Directors of Social Work from each of the five trusts, which facilitates clear lines of accountability back to each trust. The Consortium Board meets on a quarterly basis.

The Operational Management Group consists of a range of senior managers from each of the five trusts, and across all service areas. The Operational Management Group meets on a bi-monthly basis.

The RESWS reports to the Consortium Board and the Operational Management Group on a regular basis.

## 2.3 Is Care Safe?

The care provided to individuals may be considered safe when the interventions and support intended to help them do not cause harm.

The services offered by the RESWS are considerably different to the services provided by daytime social work teams. Interventions should only be provided in response to emergency need, and aimed at reducing risk or stabilising an emergency. However, on occasions the service is still operating in a similar manner to a duty system and would appear to be accepting some referrals that are non-emergency in nature.

To provide interventions for individuals, the RESWS has arrangements in place for staff to access and exchange information and access training and other resources. However, there are challenges, which are outlined below,

that may affect these arrangements. These subsequently impact on the ability of staff to provide the most appropriate interventions.

**Call management**

When individuals access the service, a call handler takes their details prior to forwarding them to a social worker. At this point, many of the calls are from people in crisis, which often results in conversations that are emotive and challenging. This can be demanding for call handlers. Although training and support was provided to call handlers, it was not clear whether specific training and support was provided in relation to the types of calls they would be receiving or the content of the calls. This is an area that should be reviewed to maximise the resilience of the call handlers in dealing with continuous crisis or emergency calls.

Call handlers sometimes identify referrals that are not within the remit of the RESWS, and signpost the caller to a more appropriate service. However, inappropriate referrals are being passed onto the social workers. A new recording template is been developed for the call handlers, to more accurately record referral information. It is hoped this will contribute to better identification of inappropriate referrals. The RESWS planned to pilot this in September 2016.

While it is not the role of call handlers to triage referrals, the review team considered that this was an area that could improve the service, by reducing the level of inappropriate referrals that are passed onto social workers. Appropriate training for call handlers would be key to such an improvement.

| **Recommendation 1** | **Priority 1** |
|---|---|
| The Belfast Trust should review the call management arrangements for the service and should include:<br>• the training and support provided to the calls handlers in relation to dealing with continuous crisis or emergency calls<br>• the training requirements to ensure the call handlers can identify and have the confidence to redirect inappropriate referrals | |

**Assessment of referrals**

The service has clear thresholds, outlined in the RESWS Operational Policy. These must be met before a referral is passed onto a social worker for subsequent interventions. However, information was provided that would suggest this policy is not always followed and non-emergency referrals were being passed onto the teams.

The review team identified that the level of inappropriate referrals into the service was an ongoing challenge, and had a significant impact on the workload of the social workers. Assessing inappropriate referrals was diverting already pressured resources from the real emergency cases.

Access to IT systems and an individual's information to inform assessments

Upon receipt of a referral, the social worker checks all relevant IT systems, such as SOSCARE, PARIS, EPEX or MAXIM, to determine whether the individual is known to social services and if there is an up-to-date history that could help inform the assessment.

Access to IT systems and an individual's information is a significant challenge for the RESWS staff. Although any lack of access did not have a bearing on the overall status of the referral, it could have an impact on how the referral was managed.

Prior to the establishment of the RESWS, individual trusts managed their own out of hours provision. The only exception was that the Belfast Trust provided cover for the South Eastern Trust. Within these arrangements, staff covering out of hours in the Northern Health and Social Care Trust (Northern Trust), Southern Health and Social Care Trust and Western only had access to their own IT systems and databases. There was limited access to the IT systems and databases between the Belfast and South Eastern trusts.

From the outset of the service, it was the intention that all staff would have full access to all information held about individuals. Given the complexity of the IT systems across trusts, it was anticipated that this would be achieved incrementally over time. However, progress has been very slow, and is a particular frustration for both managers and staff. This was also a significant area of concern for the review team, as there was a lack of confidence that social workers had access to the necessary information they required to respond appropriately to some referrals.

It was found that staff had varying levels of access and permissions to the different IT systems within trusts. Some staff had only limited access, while others had extensive access. As an interim arrangement, a list of staff with permissions for each IT system was created. If required, staff can cross reference the list with the duty rota, to check whether a colleague is available in another trust that could obtain an individual's information. However, this was often time consuming.

The review team was informed that regionally all staff have access to SOSCARE for family and childcare cases, although again, levels of access varied depending on the trust and the staff member.

RESWS staff have access to the Child Protection Register via SOSCARE, as well as case conference reports and child protection plans. Access to the Regional Child Sexual Exploitation List was also available, along with information in relation to sexual and violent offenders who are subject to review arrangements under the Public Protection Arrangements Northern Ireland.

The level of access to information to help inform adult assessments was not as comprehensive as it should be.

Managers advised that they have attempted to keep these issues live, and discuss them at both the operational management group and consortium board meetings. However, it was advised that there has been no significant change. The review team was advised that work is ongoing with the individual trusts to secure improved access to some of the IT systems for all staff. Meetings were also held with the Business Services Organisation to obtain access to all IT systems; however, again no resolution has been achieved.

Limited access to IT systems and an individual's information did not have a bearing on whether the assessment was completed; however, it can have an impact on the comprehensiveness of the assessment and subsequent level of intervention.

The limited access to information was a concern for the review team, particularly as this was highlighted as a problem, and was the subject of a recommendation, in the Toner Report of June 2008. It is imperative that all RESWS staff have full access to the required IT systems across all trusts.

It should be noted that the challenges associated with the IT systems are not within the power of the RESWS to resolve. The RESWS is subject to the overall IT strategy across health and social care.

The review team was informed that the Department of Health and the HSC Board have embarked on a development programme to improve IT systems and access to information. Two initiatives include the development of an electronic care record, and the development of community information systems in each trust. Both initiatives will facilitate the transfer and access to information across trusts. However, these are long term developments and would not improve the current issues associated with access to IT systems and information.

The RESWS management has undertaken work to try and improve access to IT systems; however, they have been unable to make any progress. The review team considers that a joint approach from all organisations should be now be undertaken. The review team considered that the Consortium Board should take a lead role in driving this forward as a matter of priority, until the implementation of the regional initiatives.

| **Recommendation 2** | **Priority 1** |
|---|---|
| In the interim period until the implementation of regional IT initiatives, the Consortium Board should examine local measures for providing better access to the various IT systems with the aim of achieving appropriate access for RESWS staff. | |

Referrals are prioritised and responded to, based on an initial assessment of need, urgency and risk. The experience and knowledge of staff in relation to

legislation, crisis intervention, and emergency social work practice, provides the framework for them to make these initial assessments. The focus of the service is to intervene and provide support where there is an immediate or significant protection or welfare concern, relating to a child or adult at risk or in need of protection.

On receipt of a referral, social workers either advise on the appropriateness of the referral, to provide advice or support, or to obtain further details to ascertain if further intervention is required. The response times to referrals varied depending upon the workload at the time and the availability of a specific social worker to respond to a specific type of referral.

Referrals in relation to homelessness

Referrals received from individuals requesting accommodation are managed in the same way as other referrals. Call handlers will record the details of the referral before it is allocated to a social worker.

Staff advised that these referrals are quite labour intensive and take up a considerable amount of their time. On some shifts, several referrals could be received, utilising all duty staff and compromising their availability to deal with further referrals.

Both the NIHE and RESWS have thresholds in relation to referrals. These are often discussed with the individuals in an attempt to establish expectations and ensure that social workers do not spend too much time looking for accommodation.

A further issue that was frustrating for staff, related to the number of referrals that are not completed. These are referrals that the individuals decline, either because they did not like or want the accommodation found, or they had already made alternative arrangements. Such cases utilise the time of a social worker for no reason.

Based on the experience of the review team, it was considered that a significantly large number of referrals, in relation to homelessness, are being received by the RESWS.

The social workers considered these referrals were not the best use of their time and it was questioned whether this work could be done by someone other than a social worker. The review team considered that using senior social workers to find accommodation was utilising a very expensive time resource.

The review team would recommend that this is an area that needs to be reviewed, in particular:

- benchmarking the number of referrals received, with similar jurisdictions across the United Kingdom, in relation to their appropriateness
- determining whether the work associated with the referrals should be undertaken by a social worker

- confidentiality of information exchanged
- determining the appropriateness of the RESWS in providing such as service

| **Recommendation 3** | **Priority 1** |
|---|---|
| The Belfast Trust should review the arrangements in relation to referrals associated with homelessness, in particular:<br>• benchmarking the number of referrals received, with similar jurisdictions across the United Kingdom, in relation to their appropriateness<br>• determining whether the work associated with the referrals should be undertaken by a social worker<br>• confidentiality of information exchanged<br>• determining the appropriateness of the RESWS in providing such as service | |

Based on the outcome of the review, appropriate action should be taken in relation to referrals associated with homelessness.

Referrals from the PSNI

There is a two way relationship between the RESWS and the PSNI. The RESWS staff would frequently request the assistance of the PSNI when dealing with particular cases. Similarly, the PSNI would make referrals to the RESWS for assistance in child protection and vulnerable adult cases.

During the daytime period of the weekend, the PSNI's Public Protection Unit would make referrals to the RESWS. For other out-of-hours periods, referrals would be received from the PSNI's Central Referral Unit.

**Exchange of information**

Information about individuals is exchanged between the RESWS and daytime services, as well as the PSNI and NIHE. This contributes to the assessment process for referrals. The limitations of the IT systems do not facilitate easy exchange of information, resulting in alternative arrangements being established.

An alert system is in place between daytime services and the RESWS. This allows practitioners to advise the team about particular individuals who they have concerns about, or who may require an emergency intervention during the out-of-hours period. The alerts provide information on contingency arrangements should they be required.

The alert system also allows the RESWS staff to be informed about various risks associated with particular individuals. Information exchanged through the alert system contributes to the assessment of referrals.

All referrals received by the RESWS are recorded onto PARIS, and at the end of the out-of-hours period, they are forwarded onto the daytime services for

appropriate follow up. With referrals covering several programmes of care and specialisms, arrangements are in place to forward them to a single point of contact for each programme of care within each trust. It is the responsibility of the contact person to allocate them to the appropriate daytime social worker.

For referrals that require specific ASW input, the ASW completes a written report of the assessment and leaves it with the hospital before they leave. This is followed up by a more detailed report which is completed within five working days, and forwarded to the relevant day service professionals.

The arrangements for the exchange of information between the RESWS and daytime services were discussed during the review. Some staff advised of using different approaches to exchanging information, and not all staff were fully familiar with the arrangements in place. Stakeholders also raised many points in relation to the arrangements, and also the practice of exchanging information, which are outlined in Section 2.1.

The review team considered that this was an area that should be considered by the RESWS management. In particular, all staff should be familiar with the arrangements for exchanging information, and there may be opportunities for improving the arrangements through engagement with staff in daytime services.

With the number of referrals being passed between the RESWS and daytime services, the review team also considered that a more robust process should be put in place. The RESWS needs to be sure that all referrals are collated and appropriately passed to the daytimes services, with someone within the service having responsibility for this.

| **Recommendation 4** | **Priority 2** |
|---|---|
| The Belfast Trust should ensure that all staff are familiar with the arrangements for exchanging information between the RESWS and daytime services, and that a more robust process should be put in place for collating, recording and tracking referrals. | |

To assist with the assessment of referrals relating to homelessness, the NIHE forwards up-to-date lists of available accommodation to the RESWS. Details of individuals who have declined accommodation options are also provided to the RESWS, and these are saved onto PARIS for staff to refer to. The review team was advised that the NIHE is currently developing an electronic database of bed availability, which will be made available to RESWS staff once completed.

All referrals relating to homelessness are sent via email to the relevant NIHE office, at the end of each shift.

Confidentiality

The need for confidentiality is of the utmost importance, as it maintains the security of an individual's information. The issue of confidentiality was not identified as a problem; however, there were some instances identified where improvements could be made.

The exchange of information between trusts was primarily carried out by email. Confidentiality was maintained as the communications were conducted using the secure HSC IT infrastructure, along with adherence to the HSC information governance policies and procedures.

The email addresses for the points of contact in each trust are stored on the email system. This ensures information is forwarded to the correct individuals, minimising the possibility of an unauthorised person receiving it.

All ASMs and locum shift managers have a CJSM email account for the secure transfer of information between the RESWS and the PSNI. In light of the comments raised by the PSNI, it was evident this information may not have been fully communicated to them. Details of the arrangements associated with CJSM email accounts should be shared with the PSNI.

Staff that are required to transmit confidential information, such as joint protocol forms, to the PSNI, do so via the manager on duty. An evident gap in this process was the period between 2am and 9am, when there is no manager on duty.

The review team considered that the arrangements for the period where no ASM was on duty should be reviewed by the RESWS management, to identify potential solutions for ensuring that access to CJSM was available.

The RESWS and the NIHE also exchanged information on a regular basis. While most of the information relates to the availability of accommodation, some individual's information is also transferred. The existence of secure email facilities between the organisations was not evident. The review team considered that assurance of the confidentiality of information exchanged, should be included in the review of the arrangements in relation to referrals associated with homelessness.

**Staffing and Training**

Maintaining safe practice requires staff to be trained to ensure they have the appropriate skills, knowledge and qualifications. Having suitably trained staff ensures that responses can be provided to all types of referrals.

The RESWS is staffed by experienced social workers, with backgrounds in either children's or adult practice. There was a relatively low turnover of staff within the RESWS, with recruitment mainly focusing on new locums. The RESWS has developed a specific induction programme for new staff, although it was utilised mostly by new locum staff.

RESWS staff are experienced senior practitioners with many years of practice and training. Their current training requirements are typically limited to updates and refresher training. The permanent staff considered they had sufficient training to carry out their job; however, locums expressed varying levels of satisfaction in respect of training.

Locums received training from both the RESWS and their own trust. It was unclear as to the areas in which locums felt their training needs are not being met, or who should have been meeting them. It was also identified that the arrangements for locums' training, which were put in place between the RESWS and the trusts, in some instances may not be fully adhered to. Some locums had to complete RESWS training in their own time. The review team considered that training arrangements should be reviewed to ensure that agreements between the RESWS and trusts are being adhered to.

Along with the scheduled training, the RESWS has provided training days for all staff. These are bespoke training opportunities to address issues that specifically affect their practice, such as personal safety and disengagement, and child sexual exploitation. It was advised that further training days have been scheduled.

Arrangements are also in place which allows RESWS staff to avail of training from the trust where they are located. This reduces the need for travel to the Belfast Trust to attend training.

The review team considered that staff with a background in children's practice, are appropriately trained to respond to child protection issues. Staff are familiar with the Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected cases of child abuse in Northern Ireland[8]. Additional information was also available in guidance documentation developed by the RESWS. Twenty six staff are trained in the Pre-interview Assessment[9] of children. This contributed to provision of suitable responses to children's issues.

Over the course of the review, the number of references in relation to the provision of ASWs would indicate there is a challenge in this area. However, it must be noted that this is a challenge across all services, and not specific to the RESWS.

The RESWS management had identified this and has already put measures in place to improve the provision of ASWs within the service. In responding appropriately to the different types of referrals, the RESWS tries to maintain a

[8] The Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected cases of child abuse in Northern Ireland - http://www.rqia.org.uk/cms_resources/Protocol%20for%20joint%20investigation%20of%20child%20abuse,%20April%202013.pdf

[9] Pre-Interview Assessment is used to determine the child's understanding, willingness and ability to engage with the investigative process. The Pre-Interview Assessment is not part of the Investigative Interviewing process.

level of 50 per cent of staff on duty on all shifts that are qualified as ASWs. To further enhance this, a programme of ASW training is in place.

Each year since 2013, the RESWS has provided ASW training for two senior practitioners, and provided a further two staff with practice assessor training, to guide, assist, and assess staff for their capacity to practice. At the time of the review, two staff were due to finish their ASW training, and a further two about to commence training in September.

Appropriately responding to cases involving vulnerable adults was identified as a gap in the service. Based on the experience of the review team, it was considered that the number of referrals being categorised as vulnerable adult cases was disproportionately low.

A comment made during the review that concerned the review team, was in relation to the cumbersome paperwork associated with vulnerable adult referrals. This had allegedly influenced some staff to manage the referral through a different route. Referrals may have been responded to, but not necessarily as a vulnerable adult's referral. This may contribute to the low number of recorded vulnerable adult referrals.

It was considered that the low number of referrals may be directly related to the limited amount of vulnerable adults training received by staff. It was found that only one permanent member of staff and two locums have undertaken training in achieving best evidence[10] (ABE).

Insufficient training reduces the possibility of identification of alleged or suspected cases of abuse of vulnerable adults. The outcome of discussions with staff, and the comments raised by the PSNI in relation to challenges with accessing a practitioner with joint protocol training for vulnerable adults, confirmed the need for further training in relation to both vulnerable adults and ABE.

The RESWS management has already recognised the challenges in relation to vulnerable adults and has plans in place to address this. Further training has been scheduled for later in the year.

The review team welcomed the plans that were in place, but would suggest a review of these to ensure that areas highlighted within this report are covered and that the arrangements for managing vulnerable adult referrals are robust.

The RESWS management reported on the recent development of a central training matrix, which will assist with recording and monitoring training needs and requirements, along with recording completed training.

[10] Achieving Best Evidence describes the good practice when interviewing vulnerable victims and witnesses, and in preparing them to give their best evidence in court.

**Support and resources for staff**

The support and resources provided for staff are crucial in ensuring they can carry out their work effectively. The managerial, professional, administrative and technological support and resources all contribute towards staff conducting appropriate assessments and providing appropriate interventions.

Managerial support, to discuss cases or to get advice, was available to staff from an ASM, for the majority of the shift. The only period when managerial support is not immediately available, is between 2am and 9am. However, staff can contact the service manager or the co-Director during this period if required.

Professional support, such as working with colleagues and other professionals, occurs on a daily basis. RESWS staff work closely together, and with the GP out-of-hours service, the Northern Ireland Ambulance Service (NIAS), and the PSNI.

RESWS staff regularly discuss cases, providing advice and support to colleagues. However, the review team considered that the availability of resources may have a potential impact on the service. It did not have an impact on the effectiveness of the assessment process or the interventions provided to individuals, but rather a potential risk to the safety of staff was identified.

Within the team, there was limited resource for a second person to attend a site visit or an assessment. In light of the unpredictable nature of the work, the locations, and the times of night that staff undertake visits, in some cases lone working is a potential risk for staff. The RESWS has a lone working policy in place.

Further risks to staff, as a result of lone working, were identified in relation to the transport of individuals. Due to the nature of the work, staff are often left with the responsibility for transporting individuals, exposing themselves to potential abuse or harm. Staff also advised that there were occasions when they had transported minors. This practice was concerning for the review team, as staff were putting themselves in situations where allegations could be made against them, which could affect their future registration to practice.

The review team recommends that staff should more frequently consider the possible risks associated with their work, and assess the potential for harm before taking action.

While carrying out their functions, RESWS staff work closely with other professionals. Although the resources of the GP out-of-hours service, NIAS, and the PSNI were available, it was often difficult to coordinate availability to facilitate joint working.

The review team acknowledged the challenges of joint working, but would suggest that some collaborative work is undertaken to further formalise these

relationships. Understanding the pressures affecting each organisation and identifying ways to strengthen closer working arrangements would be beneficial to all organisations.

Administrative support and resources were available to staff. Information to facilitate the work of the RESWS was maintained and accessible to staff, such as:

- policies and procedures relating to the RESWS
- legislation, service protocols and procedures relating to Family and Child Care, and Mental Health
- relevant information about child sexual exploitation
- alerts from daytime services
- up to date lists associated with fostering placements, accommodation availability, on-call managers, and interpreting services

Supporting information is changed and updated on a regular basis.

Technological support and resources are available to staff. As outlined earlier, staff have access to the PARIS system, which facilitates access to information held by the RESWS. However, access to other IT systems and an individual's information varied considerably.

The review team was of the opinion that the interventions provided to individuals in response to emergency need could be considered to be safe, as they were undertaken by suitably qualified and trained staff. The service seemed to be successful in reducing the risks, stabilising any emergency and assuring that no further harm was caused. There are challenges impacting the RESWS especially in terms of information available to the service and the transfer of information to daytime services that if resolved, could further improve the service.

## 2.3 Is Care Effective?

Care may be considered effective when interventions and support are appropriate, provided at the right time, in the right place, with the best possible outcome.

As the RESWS is an emergency service, the type of support and interventions provided are distinctly different to those provided by the daytime social work service. This needs to be kept in mind when considering the effectiveness of care.

During the course of the review, it was evident that this distinction was not entirely clear to all individuals and stakeholders. Although many did recognise the difference, some did not, which influenced their expectations of the service.

Given the type of service, the RESWS should only provide support and interventions in response to cases of emergency. Non-emergency cases

should be redirected to daytime services. The review team considered the service was still had work to do to fully achieve this approach. The identity of the service needed to be strengthened to reflect this as an absolute approach.

The review team would suggest that further promotion of the service should be undertaken to ensure that individuals, other services, and professionals fully understand the role of the RESWS and the emergency focus of the service it provides.

The accessibility of the service was considered as one of the strengths. This was also confirmed by stakeholders. Prior to the establishment of the RESWS, it was often difficult to get access to a social worker. Within the current arrangements, there is now a single point of contact into the service for everyone. This is clearly identified and communicated.

A benefit of the single point of contact is that it allows individuals to get support at the time of crisis, rather than having to wait, possibly until the next day. Receiving care at the right time increases the potential for better outcomes for them.

There is a consistent approach to handling referrals from the public and other professionals. All calls are answered immediately, and then responded to promptly by a social worker, unless the service is experiencing an unusually high demand, when there may be delays.

With the types of cases being referred to the RESWS, providing care in the right place is potentially difficult to accomplish for an emergency service. The best that can often be achieved is an intervention to minimise risk or prevent further harm, until the appropriate care is available and can be provided.

An area of good practice identified during the review, was associated with care being provided at the right time, in particular, the emergency admission of older people into residential and nursing placements. The RESWS, in conjunction with the trusts and RQIA, has developed a framework for managing these out-of-hours admissions. The document, Practice Guidance for Adults in Need of Assessment for Emergency Residential/Nursing Placements, is available to all staff.

The decision as to whether a call out visit should be undertaken was an area raised several times during the review. It was apparent that many stakeholders considered the RESWS should undertake more call out visits. Stakeholders stated that better assessments can be carried out through face to face conversations, and they considered that call out visits can improve outcomes. While there may be merit in such an approach, there was little evidence available to justify an increase in numbers of call out visits.

The review team considered that a better understanding of the RESWS may alleviate the perception of the need for call out visits.

RESWS staff had a clear understanding of the need for a call out visit, and told us that many were undertaken. It was also apparent that they would like to undertake more visits; however, they were conscious of their threshold for a visit and their capacity to do so.

Many of the call out visits undertaken require input from other services or organisations, such as, the GP out-of-hours, NIAS, or the PSNI. The review team was satisfied that RESWS staff had a good understanding of the roles and responsibilities of these services and organisations, and the input they provided as part of joint visits.

The most challenging aspect of joint visits was the coordination of the different individuals. It was rare that everyone was available at the same time, and this sometimes resulted in delays in assessments or interventions. The extent of the delays could not be accurately quantified, but it was not considered to be significant. However, each agency equally expressed a sense of frustration when they were available and the others were not.

The review team would again suggest that some collaborative work is undertaken to understand the pressures affecting each organisation and identify ways to strengthen closer working arrangements.

The review team was advised of an initiative by the Northern Trust to develop a protocol for the co-operation and joint working between trusts, GP out-of-hours, NIAS, and the PSNI. It outlined a framework for the safe management of people with a mental disorder by agencies and professional staff, when discharging their duties under the Mental Health (NI) Order 1986. Representatives from the RESWS were involved in its development.

Although the protocol was not specifically designed for the out-of-hours period, it could be applied to cases referred to the RESWS. The RESWS management should consider disseminating the protocol to their staff.

The nature of the RESWS means there is no follow up of the outcome of the support or interventions provided by their staff. All referrals are passed onto daytime services for further care, with no additional input from the RESWS staff. It was noted that some of the RESWS staff would occasionally contact the daytime teams to follow up on cases, however, this is not normal practice and usually if further clarification regarding cases is required, an ASM is available during the day to assist.

The effectiveness of care is further supported through the established links between the RESWS and other services and organisations. These links facilitate the exchange and sharing of information, which contributes towards effective assessments and interventions. However, these are subject to the limitations of the IT systems.

The ASMs are the key people in terms of interfaces, with each allocated to a specific area of care or organisation. They maintain links with daytime services by attending their team meetings and other relevant regional

meetings. The leads use the meetings to increase awareness and understanding of the RESWS, as well as gathering information to bring back to the teams.

The ASW lead attends the quarterly regional ASW forum, while staff are encouraged to attend the ASW staff forums in the trust area where they practice. The ASW lead also attends trust ASW forums, along with meetings with nursing staff and out-of-hours medical staff to facilitate awareness and enhanced communication between their services.

The lead for joint protocol investigations into child abuse, attends regional multi-agency safeguarding meetings. The RESWS has recently agreed to participate in the Regional Adult Safeguarding group.

Meetings with PSNI and NIHE were less frequent; however, discussions were taking place to establish more regular meetings. The review team considered this should be a priority in order to strengthen relationships and joint working arrangements.

It was noted that practitioners were not usually involved in meetings outside of the RESWS. Working on a permanent out-of-hours shift did not provide them with regular access to information about changes or updates to practice. The review team considered this has the potential to limit their continuing professional development, and would suggest that the RESWS management consider ways to improve this. For example, require the permanent staff to attend a minimum number of regional forums, to keep up to date with new developments and changes to practice.

Based on the information provided to the review team, the care could be considered to be effective, as the interventions and support are appropriate for an emergency service, and they are provided at the time of crisis.

The challenges identified as impacting on the provision of safe care, such as the IT systems, support and resources, also have an impact on the provision of effective of care. Addressing these challenges would further improve the service.

## 2.4 Is Care Compassionate?

Care may be considered compassionate when individuals are treated with dignity and respect, and are fully involved in decisions affecting their treatment, care and support. However, this is a particular challenge for staff providing a service in an emergency environment, as it may not always be possible to fully involve individuals in decisions affecting their treatment, care or support.

RESWS staff were seen to be dedicated and passionate about the job they do.

The review team was informed that all staff have undertaken mandatory equality training, to assist them with the provision of compassionate care.

Information about the RESWS and how to access the service is available from a number of sources. Details of the service are available on trust websites, and other government websites. Information leaflets, posters and business cards were printed and widely circulated to a wide range of stakeholders and public places, such as, GP surgeries and health and wellbeing centres.

The information leaflets advise that information is available in alternative languages or formats; however, this is only advised in English. The RESWS should consider including the advice information in alternative languages.

The RESWS has access to the regional interpreting service, which includes access to sign language interpreters and the Big Word telephone interpreting service. Information regarding interpreting services is available in the RESWS folders. Although this service is available to assist people with hearing impairments and the service advertises communication by text or email, the details about the interpreting service were not evident in the promotional material. The RESWS should consider including information about the interpreting service on their promotional material.

If individuals have any complaints or compliments in relation to the service, they have access to the Belfast Trust complaints process. Details of how to access this are included on the promotional material provided by the service, and on the Belfast Trust website. Staff are aware of the complaints process and can advise individuals about the process.

The complaints departments in the other trusts are aware that if they receive a complaint about the RESWS, it is to be passed on to the Belfast Trust for investigation. For complaints that relate to both the RESWS and a daytime service in another trust, a joint response will usually be agreed.

The review team was informed that only a small number of complaints had been received by the service. All complaints were addressed in line with trust's complaints process. It was found that some of the complaints did not relate to the RESWS, and an analysis of the others did not identify any trends that required changes to practice.

At the time of the review, the RESWS had not engaged significantly with individuals to obtain their views about the service. However, they had developed a questionnaire, based on similar questionnaires used by GP out-of-hours and other emergency services in the United Kingdom. This was being piloted with a small sample of individuals. The RESWS plans to review the results of the pilot and amend the questionnaire before a more comprehensive engagement with individuals is carried out.

The review team acknowledged the challenges associated with obtaining individuals' feedback for an emergency service, and would suggest that the RESWS also considers some face to face engagement with individuals.

The review team considered this was a difficult area to assess, without input from individuals. However, the review team was of the opinion that based on the findings from the review, the care could be considered as compassionate. Further work is required in this area, in particular, obtaining the views of individuals and using it to shape the service.

## 2.5 Is Service Well Led?

The service may be considered to be well led when it demonstrates effective leadership, management and governance, which creates a culture focused on the delivery of safe, effective and compassionate care.

Prior to the establishment of the RESWS, it was clear that a significant amount of planning and work had been undertaken in developing this service. This is reflected in the current service, and those involved should be commended for this.

At the time of the review, the RESWS had been in operation for approximately three years. In comparison to the previous service model, what has been achieved in this short time is significant. During this time, the focus of the work has been on getting the service established and delivering care. However, it is now at a point when that focus needs to shift, towards identifying improvements to the service and its long term sustainability. A key requirement for the long term sustainability of this service is filling the vacant service manager post. It was subsequently advised that this post had been filled from September 2016.

**Policies and procedures**

The Belfast Trust has operational responsibility for the management of the RESWS; subsequently all trust policies and procedures apply to staff. The RESWS has also developed specific policies and procedures for the service. An operational policy is the overall governing document for the service. This is kept up to date to reflect emerging or changing practice, the development of new protocols or agreements and changes to legislation.

Area specific policies, such as, family and child care, mental health, and admissions to nursing homes have also been developed for the service. The specific family and childcare procedures and guidance were developed as a manual for managing child protection and children's services procedures. Although this was a comprehensive document, the review team considered it could be improved by making specific reference to other child protection guidance and procedures, and the forms used at different stages of the process.

The review team did not see any evidence of a similar manual for managing vulnerable adult cases. The RESWS should also include this in the overall review of vulnerable adults.

All documentation is available to staff, either on the trust intranet or in the RESWS folders.

Information from the operational policy was used to develop an information guide about the service. This was supplied to all trusts upon the establishment of the service.

**Standards**

Surprisingly, there are no current standards available for emergency social work. The RESWS adheres to the National Emergency Social Services Standards along with service specific standards developed from best practice guidance. The review team considered this approach to be adequate, providing the standards were kept up to date with emerging practice.

**Staffing**

All staff working in the RESWS, including locum staff and locum shift managers, have clearly defined job descriptions. These were developed specifically for the service, and matched with Agenda for Change guidance. Staff understood the requirements and responsibilities associated with their job.

Staffing levels were an area that was referenced frequently during the review. Some stakeholders held a perception that not enough staff were allocated to certain areas or to particular shifts. Limited access to social workers and delays in response times were quoted as examples. While these issues did occur in the service, they are not a definitive indication of staffing shortages.

Prior to the establishment of the RESWS, activity levels in relation to out-of-hours services were collated in each of the trusts. This information was used to inform the new service model and calculate the number of staff required to be on duty for each shift. These activity data were also used to identify the locations for the offices, based on the percentage of referrals by location.

Ensuring appropriate staffing levels is always a challenge for an emergency service, due to the nature of the work. Since the start of the service, activity levels have been tracked, but it was difficult to identify any patterns in relation to why some periods were busier than others. However, it was identified that the daytime period of the weekend, and also on bank holiday weekends, was consistently busy. As a result the staffing levels for these periods were increased.

The duty rota for permanent staff consists of four nine hour shifts per week, with a rota pattern operating on a 6 week basis. The rota takes account of the need for staff breaks and rest periods. However, it was noted that staff frequently did not get breaks due to the nature of the work. The RESWS management acknowledged this and encourages staff to take ad-hoc breaks when possible.

All staff, whether permanent or locum staff, are expected to manage any additional shifts in line with the European Union Working Time Directive (WTD), and applicable health and safety legislation. Managers oversee the rota and remove staff form the rota if they have been allocated additional shifts that may impact on the WTD.

The management and administration of the staff rota had been an ongoing challenge for the managers and administration staff since the commencement of the service. A rota was being managed for each of the four locations, which was time consuming. A single rota has now been developed for the service, which allows managers and administration staff to view, track and identify resources more easily.

Some staff were not totally satisfied with the current rota pattern; however, the exact reasons for this were not determined. The RESWS management was aware of concerns in relation to the rota patterns and a working group had been established, including staff and staff side representatives, to consider alternative working patterns, and also the use of e-rostering. The review team welcomed the plans in place, but would stress that any changes to the rota, need to be clearly focused around the needs of the service and the legislative working time directives.

Administrative staff provide support for the service. There are two full time administration staff who work 9am-5pm Monday to Friday, and two part time staff who work 1pm-9pm Monday to Friday. The number of staff has increased since the start of the service due to an increase in the workload. The administrative staff are flexible, and come in over busy periods to assist. The level of administrative staff was not raised as an issue during the review; however, it is always kept under review.

Providing appropriate staffing levels is likely to remain a challenge for the service. Based on the findings from the review, the review team would suggest that the RESWS management consider looking at alternative staffing models for delivering the service. Some possible examples may include:

- **On-call staff** – retaining a number of social workers or locums on-call, to assist when the service is experiencing high demand, or when interventions may require the assistance of more than person.
- **Support workers** – support workers may be non-social work staff who would undertake work on specific cases, so as to free up the social workers. They could assist with NIHE referrals, transport individuals, or act as a chaperone if social workers are transporting children.

**Supporting staff**

An ASM is available during most shifts to provide support and advice to staff. The ASM is usually available until 2am. However, if a member of staff was working on a complex case beyond this time, the ASM would remain in contact to support them if required.

From 2am-9am there is no managerial cover on shift, although staff are aware that they can contact either the service manager or Co-Director if they need to discuss a particular issue or concern. Locum shift managers provide cover for the ASMs when they are on annual leave or sick leave, ensuring a managerial presence during the busiest shifts.

An area of concern for the review team, related to recent long term absences within the management team. These absences had an impact on the support provided to staff, particularly in the Belfast Trust area, in terms of staff meetings and supervision happening less frequently. At the time of the review, action was being taken to return the service to normal management staffing levels.

Regular team meetings are held in each of the four office locations, to which both permanent and locum staff are invited. Staff confirmed that meetings take place; however, stated that the frequency of meetings varied between locations. The Belfast Trust area was identified as a location where meetings were not held regularly. However, this was a consequence of the long term absences within the management team. Steps were being taken to ensure that regular meetings took place.

Attendance of locums at team meetings is inconsistent; however, this is attributed to the times of the meetings and them having other responsibilities. The RESWS management is currently reviewing how to facilitate the attendance of locums at team meetings.

The review team considered that the attendance of locums at team meetings was a necessary step towards fostering good working relationships and strengthening the identity of the service. The RESWS should consider placing an expectation on locums, for a minimum number of attendances at team meetings. The scheduling of meetings should be reviewed to accommodate this.

For staff that are unable to attend meetings, the minutes should be distributed to them to ensure they are kept up to date.

Although the RESWS is a regional service and all staff work for the Belfast Trust, the review team got a sense that some staff still maintained a mind-set of working in separate locations/ services. If the RESWS is to develop its identity with individuals and stakeholders, the mind-set of staff needs to be clearly focused as a regional service. To strengthen the identity of the service, more joint working between locations should be considered.

The RESWS management had already recognised that support for ASW staff needed to be strengthened, and had identified actions to address this. A programme for ASW training is in place and, arrangements are in place to commence quarterly peer supervision. ASW staff are being encouraged to attend ASW forums.

**Supervision and appraisal**

Supervision is an important management tool for engaging with staff in relation to reflective practice, development, and for identifying and discussing work related problems. A supervision policy is available for the service; however, there are plans to update it.

The review team was informed that all practitioner staff should receive supervision on a six weekly basis, with management receiving monthly supervision. Staff however, advised that supervision was not always conducted as regularly as stated, especially in the Belfast Trust area. The review team identified that the recent long term absences within the management team and the coordination of rotas contributed to the reduced supervision for some staff.

Locum staff do not receive supervision through the RESWS; however, should receive it from their primary employer. In the absence of supervision, the ASM has responsibility for overseeing the practice of locum staff in their office and providing support as required. Locum shift managers also meet with the ASMs and the service manager on a bimonthly basis to discuss practice issues.

Locum staff raised the absence of supervision as a concern, as it did not provide them with an opportunity to get feedback on their practice. For locum staff employed in one of the trusts, their primary supervision did not cover their work for the RESWS. Locum staff not employed in one of the trusts received no supervision. Providing supervision for locum staff is a significant challenge for the RESWS, particularly in terms of resources to carry it out. However, the RESWS management were currently looking at ways to address this.

The review team was informed that an audit of supervision files had been conducted; however, at the time of the review, the results had not been distributed. A follow up review of the supervision arrangements was planned, pending the outcome of the audit.

Staff appraisal was an area that was not well developed. It was also surprising that staff did not raise it during the review. The review team was subsequently informed that staff appraisals are currently being introduced for staff this year, with this included as an area identified for development in the Service Plan.

The review team welcomed the plans, but would recommend that the RESWS management, as a matter of urgency, continues to prioritise development of the arrangements for staff supervision and appraisal.

| Recommendation 5 | Priority 1 |
|---|---|
| The Belfast Trust should, as a matter of urgency, prioritise the development of arrangements for staff supervision and appraisal within the Regional Emergency Social Work Service. | |

**Staff safety**

The nature of the services provided by the RESWS potentially makes it one of the more hazardous services within healthcare. Staff are frequently required to work alone during the out-of-hours period, visit locations that may be described as precarious, and provide interventions in often unpredictable circumstances. In many cases, the assistance of the police is required as part of the interventions, although sometimes unavailable. The safety of staff is therefore of paramount importance.

All staff commence their shift at their designated office, and their presence in the office is checked by the manager covering the shift. Issues in relation to staff safety do not present until there is a need for them to undertake a call out visit.

Staff expressed differing views in relation to the safety aspect of call out visits. Some expressed concerns about such visits with a clear realisation of the risks, while other perceived fewer risks and did not think it was a concern.

If a decision is made to undertake a call out visit, it is understood that this has to be discussed with the ASM prior to going. All available information is taken into consideration in assessing the risks and potential safety issues for the staff member. The limitations of access to the IT systems and an individual's information can have an impact on the decision making process. If any potential safety issues are identified, consideration is given to whether two staff should visit, or whether the PSNI should be contacted and asked for assistance. Cooperation from the PSNI in these cases is reported to be good; however, the coordination of their attendance and their involvement can be impacted by resource availability. It was identified that a formal protocol for the allocation of a second worker to call out visits was currently not available.

During the review, it was reported that there have been instances when some staff do not discuss a call out visit with the ASM prior to going. This has the potential for staff to put themselves at risk, with further potential consequences for the trust. While there may be no perceived risks associated with some visits, staff should not be able to choose when they will or will not follow protocol.

A further risk identified was in relation to discussions between the ASM and the staff member. It was noted that there was no record kept of any discussions, including risk factors, the outcome, or any actions taken to mitigate risks. It is imperative that this information is documented, in case there are any incidents of harm involving staff.

When the service was established, the Guardian24 safety system[11] was available for staff; however, the system did not work as anticipated and is no longer in use. At the time of the review, there was no third party safety system available for staff to use.

In the interim, staff are expected to liaise with the ASM to keep them updated as to their status while on call out visits. During the 1am-9am shift, a colleague should be notified. The review team identified that this practice varied among staff, and that it was not always adhered to. There did not appear to be a formal process for communicating information, about staff members, between shifts.

The service has undertaken risk assessments in relation to the working environment in each office, risks associated with driving long distances and lone working. Advice to mitigate some of the risks has been communicated to staff.

All staff have received personal safety and disengagement training to assist them in managing challenging and aggressive situations.

During discussions with staff, many examples were cited about situations that `developed during call out visits. Based on this information, the review team concluded that the desire of some staff to provide help sometimes put them at risk, as they did not remove themselves from a potentially hazardous situation.

The review team was concerned about the level of risk associated with the work and the need for improved safety of staff. Additionally, staff also need to take more responsibility for their safety when carrying out their work. With due cognisance to statutory duties relating to health and safety, the review team would recommend a review of the current safety arrangements for staff.

| **Recommendation 6** | **Priority 1** |
|---|---|
| The Belfast Trust should review of the current safety arrangements for staff within the Regional Emergency Social Work Service, and establish appropriate arrangements to minimise risks. | |

**Arrangements with other organisations**

Working with other services and organisations is essential, to ensure that individuals receive appropriate care. The relationship the RESWS has with each service is different, depending upon the organisation. For the other trusts and the NIHE, the RESWS provides a service on their behalf. For the GP out-of-hours service and the PSNI, the RESWS does not provide a service but works collaboratively with them when dealing with referrals.

[11] Guardian24 - http://guardian24.co.uk/

The RESWS has a Service Level Agreement (SLA) in place with the four other trusts, which details the nature of the service provided and expectations in relation to accountability and monitoring. At the time of the review, the RESWS was finalising an SLA with the NIHE.

The RESWS has a legacy arrangement with the SSA; however, it has not provided any services for them for a considerable time. The RESWS had initial discussions prior to the establishment of the service with the SSA regarding the need for an SLA. At that time, the SSA did not view it as a necessary requirement. The review team would recommend a review of the legacy arrangements with the SSA to determine the future need for this service. Appropriate action should be taken in relation to the findings.

| **Recommendation 7** | **Priority 2** |
|---|---|
| The Belfast Trust should review the legacy arrangements with the Social Security Agency, to determine the future need for the service provided by the Regional Emergency Social Work Service. | |

There are no specific protocols in place, with either the GP out-of-hours service or the PSNI, regarding the working relationships between them and the RESWS. However, there are protocols covering the specific working arrangements for investigations into alleged cases of abuse against children and vulnerable adults. Neither the GP out-of-hours service nor the PSNI saw any merit in developing any further formal protocols.

There is extensive communication between the RESWS and the trusts. Regular meetings take place to discuss the performance of the service, and to discuss and resolve any issues that arise. These are further supported by the Operational Management Group and Consortium Board meetings. Several stakeholders from the trusts spoke about the benefits of the meetings and workshops with the RESWS, and would welcome more.

Based on the information obtained during the review, the review team considered that it would be beneficial if the RESWS was to strengthen and formalise the relationships with other services and organisations, in particular, the GP out-of-hours service, the NIHE and the PSNI.

**Monitoring the service**

Since the formation of the RESWS, a key focus for management has been on getting the service established and delivering care. Many of the monitoring activities to identify key performance data that could inform improvements to the service have received less attention.

During the review, several references were made to aspects of the service that needed to be improved. These references were somewhat anecdotal

however, as the service lacked the factual data to provide a definitive response.

The RESWS is now at a point where improvements to the service are necessary, if its long term sustainability is to be maintained.

When the service commenced, all information was collated on the emergency duty team's database. This provided information on the number of referrals received by the service. With the move onto PARIS, it had been anticipated that more information would be available to the service, such as, numbers of referrals per shift, per staff member, number of home visits undertaken, and who the referrals were received from.

Due to the design of their templates, this information was not being consistently collected and. it was not until 2015 that this was detected. Further work was undertaken by IT staff, to ensure that all key information became mandatory on recording proformas.

The service is satisfied that key management information is now being recorded; however, it will be later in the year before the improved quality data is available for analysis. It is anticipated that the information will be used to better inform the referral statistics, and the requirements for staffing levels and resource locations.

**Reporting**

The governance arrangements for the service dictate the reporting requirements. A service report is provided to the Operational Management Group and the Consortium Board for each meeting. These reports outline the service activities, and include updates in relation to inter-agency working.

An annual report on the service is provided to all trusts and the HSC Board, which details information about the service, activity levels in relation to referrals, challenges and future developments.

The RESWS completes an annual delegated statutory functions report on behalf of each trust, covering the out-of-hours period. This report is forwarded to the HSC Board and the Department of Health.

The review team considered that there was a reasonable level of reporting in relation to the service. Improvements to the monitoring and recording of activities should deliver an increased level of detail in future reports.

The review team was of the opinion that this was a well led service. Leadership was being provided, and well-structured management and governance arrangements were in place. These contributed to creating a culture that focused on the delivery of safe, effective and compassionate care to individuals. However, the service was experiencing some challenges in this well led domain. In particular, the vacant service manager post had an impact on maintaining regular staff meetings and supervision within the Belfast office.

While limited robust policies and procedures in relation to lone working, and protocols for undertaking call out visits, were contributing to increased potential safety risks for staff.  If these can be addressed, further improvements to the service could be achieved.

## Section 3 – Conclusion and Recommendations

### 3.1 Conclusion

Prior to the establishment of the RESWS, access to social work services during the out-of-hours period could often be erratic. The RESWS has improved access to services, which are provided in a more professional manner.

The RESWS aims to offer an emergency service, which is distinctly different to the services offered by the daytime social work services. During the course of the review, there were many instances when it was apparent that this distinction was not clearly understood, especially by stakeholders. This contributed to people having wrong expectations of the service leading to inappropriate referrals being made.

There is a need to strengthen the identity of the RESWS and for more promotion of the service, clearly outlining its role as an emergency service.

The emergency status of this service must be kept in mind when assessing the care provided to individuals. The context of safe, effective and compassionate care during the out-of-hours period should not be compared with the care provided by daytime services.

The review team was of the opinion that generally the RESWS could be considered as providing safe, effective and compassionate care to individuals. However, there were some significant concerns to be addressed.

The review team considered that the interventions carried out by the RESWS in response to emergency need could be considered to be safe, as they were undertaken by suitably qualified and trained staff. The service seemed to be successful in reducing the risks, stabilising any emergency and assuring that no further harm was caused.

Interventions and support could be considered effective, as they are appropriate for an emergency service, and they are provided at the time of crisis.

Interventions and support could be considered compassionate, as individuals are treated with dignity and respect. However, as a consequence of providing a service in an emergency environment, it may not always be possible to fully involve them in decisions affecting their treatment, care or support.

The review team was of the opinion that this was a well led service. Leadership was being provided, and well-structured management and governance arrangements were in place. These contributed to creating a culture that focused on the delivery of safe, effective and compassionate care to individuals. However, at the time of the review, the vacant management post was contributing to a gap in the management structure and putting pressure on the governance arrangements.

While the overall assessment found this to be a much improved service to the provision prior to 2013, it does face many challenges. If not addressed, some of these challenges could impact on the long term sustainability and safety of the service.

The key challenges that affect the service are:

- **Call management** - The arrangements for call handling should be reviewed to see if there is an opportunity to reduce the amount of inappropriate referrals, and look at the support provided to the staff.

- **Access to IT systems and an individual's information to inform assessments** - In relation to access to an individual's information, staff had varying access and permissions to the IT systems. This had an impact on the assessment of referrals. Work was ongoing in an attempt to improve IT access; however, this needs to be a priority and should be driven via a regional approach by the Consortium Board.

- **Exchange of information** - The exchange of information between the RESWS and other services was an area where there may be an opportunity for improving these arrangements including, engagement with staff in daytime services, as well as with the GP out-of-hours service, the NIHE and the PSNI.

- **Referrals in relation to homelessness** - It was considered that a significantly large number of referrals in relation to homelessness, are being received by the RESWS. These referrals are time consuming and divert the social work resource from other emergencies. A review of this area is recommended.

- **Training** - RESWS staff are experienced practitioners with many years of practice and training. Their current training provision is typically limited to updates and refresher training. However, the areas identified as requiring further development included:
  - training in achieving best evidence
  - vulnerable adults training
  - the continuation of the programme of training for ASWs

- **Engagement with individuals** - At the time of the review, the RESWS had not engaged significantly with individuals to obtain their views about the service. However, a process for engagement had begun. This engagement needs to continue.

- **Supporting staff** - Support for staff was good; however, there were a few areas that could benefit from improvements, including:
  - a return to normal management staffing levels
  - improving team meetings and more involvement of locums
  - improving staff supervision and appraisal

- **Staff safety** - The nature of the service makes it potentially one of the more hazardous services within healthcare. Staff safety was an area that needs to be improved significantly. Both staff and management have a responsibility for improvement in this area. A review of safety arrangements has been recommended.

- **Arrangements with other organisations** - While there are good working relationships with other organisations, there is a need to strengthen these relationships, in particular, with the GP out-of-hours service, the NIHE and the PSNI.

- **Monitoring the service** - Management needs to focus their attention on developing better mechanisms for monitoring the performance of the service. Better data could inform improvements to the service, and allow management to better respond to criticisms of the service.

This report makes seven recommendations to improve the Regional Emergency Social Work Service.

RQIA wishes to thank the management and staff from the HSC organisations for their cooperation in taking forward this review, and the contributions from the other stakeholders for their input.

## 3.2 Summary of Recommendations

The recommendations identified during the review have been prioritised in relation to the timescales in which they should be implemented.

Priority 1 - completed within 6 months of publication of report
Priority 2 - completed within 12 months of publication of report
Priority 3 - completed within 18 months of publication of report

Implementation of the recommendations will improve the services delivered by the Regional Emergency Social Work Service.

| Rec. Number | Recommendation | Priority |
|---|---|---|
| 1 | The Belfast Trust should review the call management arrangements for the service and should include:<br>• the training and support provided to the calls handlers in relation to dealing with continuous crisis or emergency calls<br>• the training requirements to ensure the call handlers can identify and have the confidence to redirect inappropriate referrals | Priority 1 |
| 2 | In the interim period until the implementation of regional IT initiatives, the Consortium Board should examine local measures for providing better access to the various IT systems with the aim of achieving appropriate access for RESWS staff. | Priority 1 |
| 3 | The Belfast Trust should review the arrangements in relation to referrals associated with homelessness, in particular:<br>• benchmarking the number of referrals received, with similar jurisdictions across the United Kingdom, in relation to their appropriateness<br>• determining whether the work associated with the referrals should be undertaken by a social worker<br>• confidentiality of information exchanged<br>• determining the appropriateness of the RESWS in providing such as service | Priority 1 |
| 4 | The Belfast Trust should ensure that all staff are familiar with the arrangements for exchanging information between the RESWS and daytime services, and that a more robust process should be put in place for collating, recording and tracking referrals. | Priority 2 |

| | | |
|---|---|---|
| 5 | The Belfast Trust should, as a matter of urgency, prioritise the development of arrangements for staff supervision and appraisal within the Regional Emergency Social Work Service. | Priority 1 |
| 6 | The Belfast Trust should review of the current safety arrangements for staff within the Regional Emergency Social Work Service, and establish appropriate arrangements to minimise risks. | Priority 1 |
| 7 | The Belfast Trust should review the legacy arrangements with the Social Security Agency, to determine the future need for the service provided by the Regional Emergency Social Work Service. | Priority 2 |

## Appendix 1 - Abbreviations

| | |
|---|---|
| ABE | - Achieving Best Evidence |
| ASM | - Assistant Service Manager |
| ASW | - Approved Social Worker |
| Belfast Trust | - Belfast Health and Social Care Trust |
| CJSM | - Criminal Justice Secure eMail |
| DHSSPS | - Department of Health, Social Services and Public Safety |
| GP | - General Practitioner |
| HSC | - Health and Social Care |
| IT | - Information Technology |
| NIAS | - Northern Ireland Ambulance Service |
| NIHE | - Northern Ireland Housing Executive |
| NIPSA | - Northern Ireland Public Sector Alliance |
| NISAT | - Northern Ireland Single Assessment Tool |
| Northern Trust | - Northern Health and Social Care Trust |
| PPU | - Public Protection Unit |
| PSNI | - Police Service of Northern Ireland |
| RESWS | - Regional Emergency Social Work Service |
| RQIA | - Regulation and Quality Improvement Authority |
| SLA | - Service Level Agreement |
| South Eastern Trust | - South Eastern Health and Social Care Trust |
| SSA | - Social Security Agency |
| UNOCINI | - Understanding the Needs of Children in Northern Ireland |
| Western Trust | - Western Health and Social Care Trust |
| WTD | - Working Time Directive |

## RQIA Published Reviews

| Review | Published |
|---|---|
| Review of the Lessons Arising from the Death of Mrs Janine Murtagh | October 2005 |
| RQIA Governance Review of the Northern Ireland Breast Screening Programme | March 2006 |
| Cherry Lodge Children's Home: Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities | September 2007 |
| Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland | February 2008 |
| Review of Assessment and Management of Risk in Adult Mental Health Services in Health and Social Care Trusts in Northern Ireland | March 2008 |
| Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children | April 2008 |
| Clostridium Difficile – RQIA Independent Review, Protecting Patients – Reducing Risks | June 2008 |
| Review of the Outbreak of Clostridium Difficile in the Northern Health and Social Care Trust | August 2008 |
| Review of General Practitioner Appraisal Arrangements in Northern Ireland | September 2008 |
| Review of Consultant Medical Appraisal Across Health and Social Care Trusts | September 2008 |
| Review of Actions Taken on Recommendations From a Critical Incident Review Within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust | October 2008 |
| Review of Intravenous Sedation in General Dental Practice | May 2009 |
| Blood Safety Review | February 2010 |
| Review of Intrapartum Care | May 2010 |
| Follow-Up Review: Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children | July 2010 |
| Review of General Practitioner Out-of-Hours Services | September 2010 |
| RQIA Independent Review of the McDermott Brothers' Case | November 2010 |
| Review of Health and Social Care Trust Readiness for Medical Revalidation | December 2010 |
| Follow-Up Review of Intravenous Sedation in General Dental Practice | December 2010 |
| Clinical and Social Care Governance Review of the Northern Ireland Ambulance Service Trust | February 2011 |
| RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland | February 2011 |
| Review of General Practitioner Out-of-Hours Services | September 2010 |

| Review | Published |
|---|---|
| RQIA Independent Review of the McDermott Brothers' Case | November 2010 |
| Review of Health and Social Care Trust Readiness for Medical Revalidation | December 2010 |
| RQIA's Overview Inspection Report on Young People Placed in Leaving Care Projects and Health and Social Care Trusts' 16 Plus Transition Teams | August 2011 |
| Review of Sensory Support Services | September 2011 |
| Care Management in respect of Implementation of the Northern Ireland Single Assessment Tool (NISAT) | October 2011 |
| Revalidation in Primary Care Services | December 2011 |
| Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults | February 2012 |
| RQIA Independent Review of Pseudomonas - Interim Report | March 2012 |
| RQIA Independent Review of Pseudomonas - Final Report | May 2012 |
| Mixed Gender Accommodation in Hospitals | August 2012 |
| Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home | October 2012 |
| Review of the Implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services | October 2012 |
| Review of the Northern Ireland Single Assessment Tool - Stage Two | November 2012 |
| Review of the Implementation of the Cardiovascular Disease Service Framework | November 2012 |
| RQIA Baseline Assessment of the Care of Children Under 18 Admitted to Adult Wards In Northern Ireland | December 2012 |
| Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report | February 2013 |
| Independent Review of the Governance Arrangements of the Northern Ireland Guardian Ad Litem Agency | March 2013 |
| Independent Review of the Management of Controlled Drug Use in Trust Hospitals | June 2013 |
| Review of Acute Hospitals at Night and Weekends | July 2013 |
| National Institute for Health and Care Excellence Guidance: Baseline Review of the Implementation Process in Health and Social Care Organisations | July 2013 |
| A Baseline Assessment and Review of Community Services for Adults with a Learning Disability | August 2013 |

| Review | Published |
|---|---|
| Review of Specialist Sexual Health Services in Northern Ireland | October 2013 |
| Review of Statutory Fostering Services | December 2013 |
| Respiratory Service Framework | March 2014 |
| Review of the Implementation of NICE Clinical Guideline 42: Dementia | June 2014 |
| Overview of Service Users' Finances in Residential Settings | June 2014 |
| Review of Effective Management of Practice in Theatre Settings across Northern Ireland | June 2014 |
| Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast Health and Social Care Trust and Related Regional Considerations | July 2014 |
| Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House | July 2014 |
| Review of Actions Taken in Response to the Health and Social Care Board Report Respite Support (December 2010) and of the Development of Future Respite Care/Short Break Provision in Northern Ireland | August 2014 |
| Child Sexual Exploitation in Northern Ireland - Report of the Independent Inquiry | November 2014 |
| Discharge Arrangements from Acute Hospital | November 2014 |
| Review of the Implementation of the Dental Hospital Inquiry Action Plan 2011 | December 2014 |
| Review of Stroke Services in Northern Ireland | December 2014 |
| Review of the Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings | December 2014 |
| Baseline Assessment of Access to Services by Disadvantaged Groups in Northern Ireland (Scoping Paper) | December 2014 |
| RQIA Quality Assurance of the Review of Handling of all Serious Adverse Incidents Reported between January 2009 and December 2013 | December 2014 |
| Review of the Care of Older People in Acute Hospitals | March 2015 |
| Review of the Diabetic Retinopathy Screening Programme | May 2015 |
| Review of Risk Assessment and Management in Addiction Services | June 2015 |
| Review of Medicines Optimisation in Primary Care | July 2015 |
| Review of Brain Injury Services in Northern Ireland | September 2015 |
| Review of HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services | December 2015 |

| Review | Published |
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| Review of Eating Disorder Services in Northern Ireland | December 2015 |
| Review of Advocacy Services for Children and Adults in Northern Ireland | January 2016 |
| Review of the Implementation of the Palliative and End of Life Care Strategy (March 2010) | January 2016 |
| Review of Community Respiratory Services in Northern Ireland | February 2016 |
| Review of the Northern Ireland Ambulance Service | March 2016 |
| Review of HSC Trusts' Readiness to Comply with Allied Health Professions Professional Assurance Framework | June 2016 |
| Overview of Quality Improvement Systems and Processes in Health and Social Care | June 2016 |
| Review of Governance Arrangements Relating to General Practitioner Services in Northern Ireland | July 2016 |
| Review of the Operation of the HSC Whistleblowing Arrangements | September 2016 |
| Review of Adult Learning Disability Community Services Phase II | October 2016 |
| Review of Perinatal Mental Health Services in Northern Ireland | January 2017 |
| Review of Governance Arrangements in HSC Organisations that Support Professional Regulation | January 2017 |


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