

10 RECOMMENDATIONS FOR THE WAY FORWARD

10.1 Introduction

This section and section 11 of our report seek to address the aspects of the evaluation associated with “Where do we want to be?” and “How can we get there?”.

This section of our report outlines the future vision of HSS services to victims of the conflict and identifies our recommendations for change in order to realise the future vision. Section 11 addresses action planning of the recommended changes

Many of the recommendations are interlinked and on this basis have been categorised under broad headings.

10.2 Future Service Vision for HSS Services to Victims of the Conflict

During Stages 7 and 8 of the evaluation the Capita team facilitated a workshop with the Project Board. The purpose of the workshop was to address the way forward for future HSS services to victims of the conflict. The workshop was structured into three main activities:

- SWOT (*Strengths, Weaknesses, Opportunities and Threats*) analysis of current HSS service provision to victims; and
- Developing the vision of future HSS service provision to victims of the conflict.

Reflecting on the work conducted during Phase 1 of this evaluation and with cognisance to the SWOT analysis, the Capita team and Project Board identified the main characteristics of future HSS services to victims of the conflict to be:

- Integrate specialist services with mainstream service provision, facilitating the provision of specialist services which are able to meet the needs of both conflict and non-conflict related victims in a flexible manner.
- Services should be based on a ‘cradle to grave’ approach, capable of meeting the needs of children, families and adults, with a focus on progression of individuals from victims to survivors.
- As part of the service integration processes it is essential that mainstream services also become more sensitive to the needs of victims, with the ability to respond to the particular needs of various groups within the population.

- The service vision should be realised through the development of one regional centre of excellence with equitable outreach services. The future service delivery model must be needs based, with transparency in service planning and provision decisions.
- Services must also possess the flexibility to respond to changing needs and demonstrate value for money.
- In order to achieve the future service vision a long-term service plan is required, complemented by long-term funding and supported by a funding monitoring and evaluation framework.
- The service delivery structures which underpin the service vision must be easy to understand and capable of improving coordination and collaboration.

10.3 Structure

In section 4 Figure 1 we provided an outline of the current HSS services delivery structure to victims of the conflict. The findings of the evaluation indicate a lack of clarity surrounding the existing service delivery structures, and an easily understood structure is one of the desirable characteristics of the future service delivery model. On this basis we recommend the implementation of a new service delivery structure as identified in Figure 2. The main structural aspects influenced by our recommended changes in respect of the current structure are identified under 10.3.1 to 10.3.2.

10.3.1 TAPs

We recommend relocation of TAPs from the DHSSPS as the ‘parent’ NICS department to the Victims Unit in OFMDFM. This recommendation is in line with the current funding of TAP coordinator posts provided by the Victims Unit. It is our view that there is a need to raise cross-departmental awareness of victim issues, reinforcing the fact that victim issues are not confined to ‘health’, but rather that all departments share collective responsibility for victims’ issues. We believe that resiting the TAPs under the accountability of OFMDFM may add additional impetus to cross-departmental collaboration. Under this arrangement TAPs would be ultimately accountable to the Victims Unit, but could retain their own local line management responsibilities and accommodation and support agreements with Trusts/HSS Boards. It is our recommendation **that line management, accommodation, support arrangements and resourcing are subject to agreement between the DHSSPS, Boards, Trusts and the Victims Unit.** In order to ensure clarity under the proposed new arrangements **we recommend that TAPs, DHSSPS, Boards, Trusts and OFMDFM jointly sign-off on agreed accountability and resourcing arrangements.** We also recommend the **renaming of the TAPs to more readily reflect their coordination role in the provision of services to victims of the conflict.**

In section 4.7.2 we identified the current gap that exists in respect of the TAP in the WHSSB area (i.e. the Foyle Area TAP does not include coverage for the geographical areas of Omagh and Enniskillen). Sperrin Lakeland Trust had originally expressed the desire to establish a TAP to cover the geographical areas of Omagh and Enniskillen. However, to date this has not been possible due to resource constraints. It is our view that in the interests of service coordination and equity that one TAP exists for each HSS Board geographical area. This view is also in line with the original recommendations of the Bloomfield Report. It is therefore our recommendation **that the WHSSB work with both Foyle and Sperrin Lakeland Trusts to develop a TAP with WHSSB area-wide representation.** We believe that such actions are necessary in order to improve coordination and collaboration of WHSSB area and regional TAP activities.

In section 4 we identified that each of TAP's were at varying degrees of development. However, now that all of the coordinators are in post we believe that opportunities exist for increased collaboration across the four TAPs. On this basis we recommend that **TAP coordinators and chairs meet on a quarterly basis to share information, experience of lessons learned, service evaluation feedback etc. and explore opportunities for joint service coordination and development initiatives.** In addition, we recommend that the TAPs ensure that their focus is on identifying 'grass roots' issues and providing the link between local victim service issues and the development of policy and strategy at Interdepartmental Group level. In order to ensure a more robust funding base for TAP activities we recommend that each of the TAPs develop a funding strategy, covering the lifetime of TAP business plans/strategies.

Many stakeholders consulted during this evaluation expressed the view that TAP membership was still weighted towards the statutory sector. We recommend that **each of the TAP's conduct a review of their current membership with a view to encouraging more active participation by the voluntary sector.** In addition, we recommend that a representative from the Family Trauma Centre is included within the membership of each of the four TAPs. We also recommend regular review of TAP membership with re-election of membership at least every 3 years. However, should circumstances and/or need alter during this 3 year period, new TAP members should be co-opted onto the TAP as deemed necessary. TAP members should be elected based on appropriate skills and expertise. In addition, TAP members should be subject to induction training.

The original terms of reference for the TAPs were derived from the recommendations for the Bloomfield report and the 1998 DHSSPS Circular. As previously highlighted each of the TAPs and the TAP coordinators has evolved at a different rate. In light of this we therefore recommend that as part of the resiting of the TAPs under OFMDFM that **the Victims Unit (in conjunction with the TAPs) review the terms of reference for the TAPs and the job descriptions for each of the coordinators.**

10.3.2 Cross-departmental Collaboration

As previously highlighted responsibility for victim issues is not merely a health issue, but the collective responsibility of all NICS departments and agencies. For example, research demonstrates the link which exists between academic achievement and mental health (research demonstrates that students who are undertaking exams obtain better results if their mental health is ‘good’). If adequate support for mental health i.e. timely and effective counselling, is provided to children and young people in an educational setting who are victims of the conflict, it is possible that the potential of such individuals presenting to the health and social care sector for treatment may be reduced.

In section 4.6 we outlined the original function of the Interdepartmental Group (IDG) for Victims. **It is our view that the membership of this group should be reviewed in order to ensure that all appropriate departments/agencies are represented and that each representative is the appropriate individual (i.e. possessing the correct skill set and of a suitable level of seniority in order to represent their department and make decisions on behalf of their department). In addition, the terms of reference for the group should reflect the importance of interdepartmental collaboration to achieve the aims of the Victims Strategy, the requirement for the IDG is to provide advice in the development of policy (including HSS policy) that impacts on victims and to identify funding for services to support victims of the conflict. The IDG should also ensure that they link with TAPs via OFMDFM. In this respect communication between OFMDFM and the TAP’s should be top-down and bottom-up. It should be noted that these recommendations are outside the scope of this evaluation. It is our view that these recommendations should be taken forward under the umbrella of OFMDFM (the IDG is currently chaired by two junior OFMDFM ministers).**

10.4 Roles and Responsibilities

Our findings indicate that one of the main reasons that collaboration between all stakeholders involved in HSS services to victims of the conflict has not always been maximised is due to lack of clarity surrounding the roles and responsibilities of all stakeholders³ with a responsibility for HSS services for victims of the conflict. We therefore recommend that **future stakeholder roles and responsibilities be clearly defined. As a mechanism to facilitate this process we recommend that individual stakeholders each formally sign up to this definition of roles and responsibilities. It is our view that this process should be jointly led by DHSSPS and the Victims Unit. The service delivery model identified under section 10.5 provides our broad recommendations in respect of future roles and responsibilities for each service delivery layer.**

³ Stakeholders include – NICS departmental representatives, members of IDG, members of TAP’s, specialised services, mainstream services and HSS Boards and Trusts.

10.5 Service Delivery Model

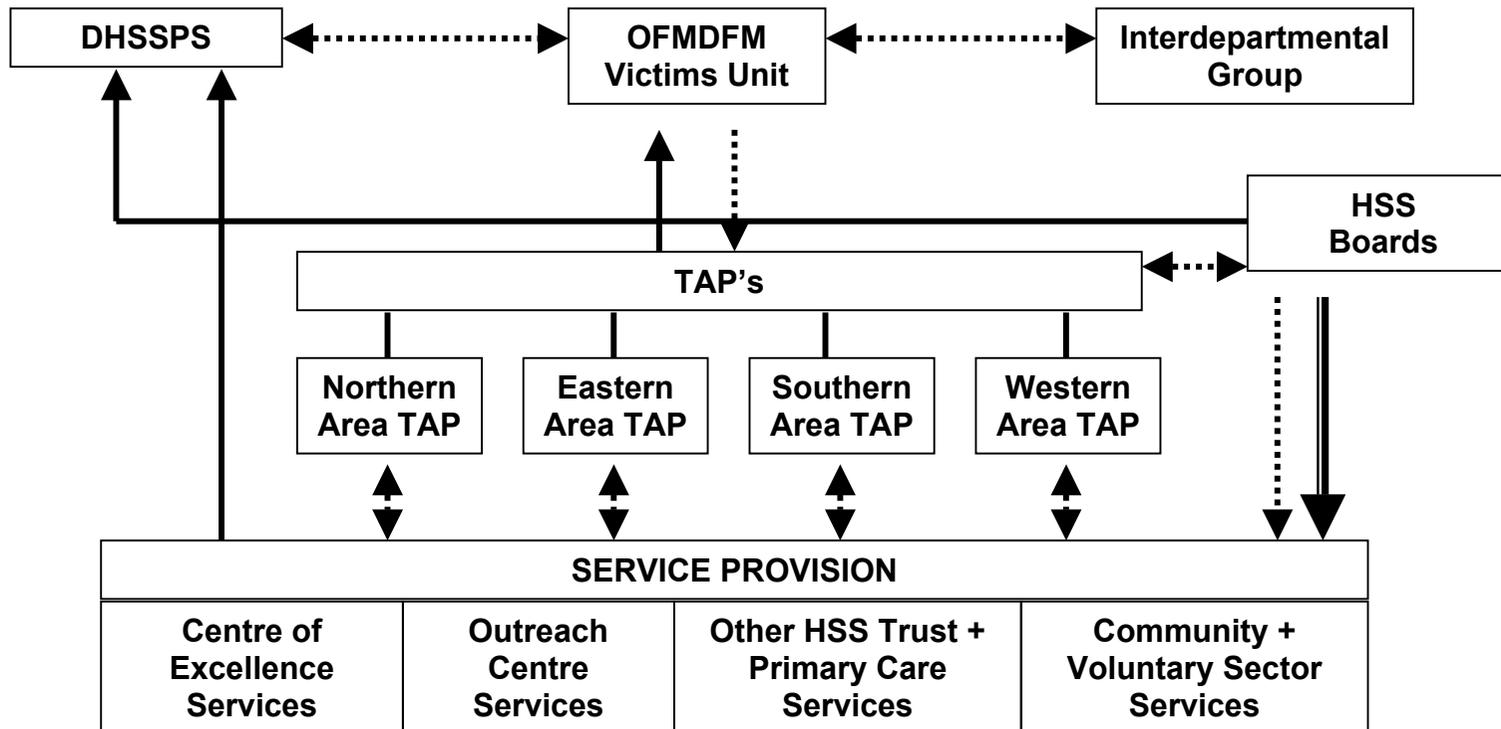
In order to achieve the future vision of services to victims of the conflict we recommend the implementation of the service delivery model as tabulated overleaf and illustrated in Figure 2.

Service Layer	Service Model Role and Responsibilities
DHSSPS	<ul style="list-style-type: none"> • Development of regional strategy and policy with reference to victim needs • Provision of mainstream (and mainstream specialist services) funding • Coordination and leadership of HSS services to support the needs of victims of the conflict • Responsible for the Regional Centre of Excellence • Membership of IDG
Victims Unit	<ul style="list-style-type: none"> • Accountability for TAP Coordinators • Development of victims policy/strategy • Development and monitoring of Victims Strategy • Management of core funding of victims groups • Management of Victim Strategy Implementation Fund • Management of Memorial Fund • Membership of IDG
Interdepartmental Group	<ul style="list-style-type: none"> • Appropriate cross-departmental/agency representation to advise on policy that will impact on victims of the conflict • Identification of funding for health and social services to support victims of the conflict • Link to 'grass roots' via TAP's accountability to Victims Unit
TAPs	<ul style="list-style-type: none"> • Needs assessment and advice on commissioning of victim related services to HSS Boards • Top-down and bottom-up link between victim related policy levels (i.e. Victims Unit and IDG) and 'grass roots' • Partnership building across sectors • Developing service delivery partnerships • Helping support groups to develop • Local coordination (i.e. HSS Board-wide) of service developments and service delivery • Regional coordination (i.e. NI-wide collaboration across TAP's) of service developments and service delivery
HSS Boards	<ul style="list-style-type: none"> • Commissioning services • Raising staff awareness of victim needs
Primary Care	<ul style="list-style-type: none"> • Service provision

Service Layer	Service Model Role and Responsibilities
Centre of Excellence	<ul style="list-style-type: none"> • Raising staff awareness of victim needs • 1 regional centre of excellence for specialist services • Services provided by coordination of local trauma outreach centres • Provision of services to support children, families and adults • Provision of conflict and non-conflict related specialist trauma services • Integrated with mainstream services • Flexible and needs based services • Provision of specialist training, training placements and professional development support • Provision of professional development links with dedicated services to victims provided by HSS Trust service providers • Facilitation of research and research dissemination, development of standards (with reference to Regulation and Improvement Authority) and evidence based practice • Membership of TAPs
Local Trauma Outreach Centres	<ul style="list-style-type: none"> • Provision of local specialist trauma services to meet need. Such services should be based in existing statutory or non-statutory accommodation facilities • Provision of services to support children, families and adults. • Provision of conflict and non-conflict related trauma services • Development of partnerships to provide a more comprehensive range of locally provided trauma services i.e. provision of alternative therapies • Links with centre of excellence for training, professional development, research and development of standards
Community/Voluntary Sector	<ul style="list-style-type: none"> • Augment services provided by HSS • Provision of services as defined within agreed service boundaries (i.e. befriending, counselling etc.) and within Service Level Agreements (SLA's) • Development of partnerships with statutory and non-statutory sector to provide a more comprehensive range of locally provided services to victims • Delivery of services for victims not accessible elsewhere

Figure 2

FUTURE SERVICE PROVISION MODEL



Accountable To
 Liaison with Co-ordination
 *Members of Interdepartmental Group
 Commissioning Services

10.6 The Role of the Family Trauma Centre

The findings of stakeholder consultation during this evaluation indicated that the majority of stakeholders viewed the services provided by the Family Centre as high quality, evidence based and effective. The main issue of concern for stakeholders is the location of services and equity of service access regionally. In addition the current location of the centre does not reinforce the requirements of New Targeting Social Need (NTSN). The referral patterns to the centre also demonstrate that it is not utilised on an equitable basis across the population of Northern Ireland.

The future service vision for HSS services to victims identified the need for one regional centre of excellence, able to respond to demand in a flexible manner and facilitated by local trauma outreach centres. In section 9 we identified the original scope and objectives of the Family Trauma Centre. The centre was originally developed on the principal that it would provide a regional specialist trauma service for children and families, primarily to victims of the conflict. In addition, the centre is currently the only HSS funded regional specialist service. The centre also has access to highly skilled professionals across a range of disciplines, experienced in trauma treatment. Our evaluation of the efficacy of the Family Trauma Centre demonstrated that it provides a high-quality service and has significant progress towards meeting its objectives. However, the centre has not been able to attract referrals on a province-wide basis.

We recommend that the original principal of the centre is fully recognised, through the provision of an equitable, regional specialist trauma service. It is our view that this regional role be extended to formally include provision of specialist trauma services to clients who have suffered either conflict related or non-conflict related trauma. In addition, we recommend that the Family Trauma Centre extend the provision of such services to include the adult population. We believe that extending the primary role of the centre beyond non-conflict related trauma increases the potential to integrate the centre more effectively with mainstream services, whilst still facilitating the provision of specialist services. In addition, the extension of services in this manner may also increase access to other funding streams via other programmes of care.

We recommend that the ethos of the centre should reflect the need to support the transition of clients from ‘victims to survivors’. The services provided by the regional centre should be clearly identified and monitored against agreed Service Level Agreements (SLAs) with service commissioners.

In view of the proposed change of emphasis of the Family Trauma Centre’s work we recommend the renaming and relaunching of the centre. Central to the relaunching of the centre is the need for DHSSPS to lead the development a communications strategy which will include outlining the role of the new regional centre. The purpose of the strategy should be to raise awareness of the centre and identity and communicate

the role of the centre to HPSS staff and the general public. It is our view that prior to developing the regional centre and as means of providing an accurate resourcing baseline for the proposed changes, that detailed reviews of staffing, skill mix and the future funding strategy of the centre are conducted.

Stakeholders consulted during this evaluation expressed concern regarding the location of the centre and in particular its accessibility to the whole population of Northern Ireland. Stakeholders also expressed concern regarding the restricted car parking facilities near the centre. **We therefore recommend that DHSSPS consider if the existing Family Centre facility is the most appropriate location for the proposed regional centre of excellence.**

In section 9 of this report we provided an analysis of the efficacy of the services provided by the Family Centre. Many of the recommendations made above in respect of the new regional centre relate to our findings presented in section 9. In particular:

- Increasing the remit of the regional centre to include adults as well as children and families;
- Formally extending service provision to include non-conflict related trauma; and
- Increasing accesses to services based on need, equity and NTSN.

In addition, we also recommend **that the new regional centre review its policy of charging in respect of training and consultation services.** We believe this is particularly important given the significant increase in this area of activity with non-HPSS organisations. We also **recommend that as a means of complementing mainstream service funding the new regional centre maximise new opportunities for income generation i.e. provision of services to the private sector, facilitation of research with private sector organisations etc.**

The independent review of staffing of the Family Centre conducted in July 2002 highlighted concerns regarding the need to prevent secondary traumatisation amongst centre staff. It is our view that the **new regional centre should develop a policy to ensure adequate support and protection for centre staff against secondary traumatisation.**

10.7 The Role of Outreach Centres

In order to provide equity of access to specialist trauma services **we recommend that outreach centres linked to the centre of excellence are established. The location of the outreach centres should be based on need and as far as possible meet the objectives of NTSN, and ensure equity of access on a rural and urban basis. We recommend the outreach centres provide a range of needs based specialist trauma services including services to children, families and adults. In addition, outreach centres should provide trauma services for treatment of conflict and non-conflict**

related trauma. Central to this model is the recommendation that the outreach centres and the centre of excellence work in a complementary manner with each other, with maximum utilisation of specialist skills and sharing of expertise. Service provision within the outreach centres should be subject to continuous evaluation and ensure that they respond to changing need and demand.

Wherever possible existing resources and expertise should be utilised, where appropriate. On this basis we recommend that the **Family Trauma Centre continue to build on its recent dialogue other services. In addition to providing local access to specialist services we recommend that local outreach centres provide a location for the provision of other appropriate trauma related services provided by statutory and non-statutory sector i.e. complementary therapies.**

10.8 Raising Awareness and Improving Communication

The findings of this evaluation have revealed that the Southern Area Trauma Advisory Panel have made a recent bid to the Victim Strategy Implementation Fund to fund awareness training for HPSS staff in respect of victim issues. We recommend **that this training initiative act as a pilot for potential rollout to the wider HPSS (subject to successful evaluation of the pilot). Training to HPSS staff should be prioritised based on need i.e. the extent to which staff have contact with those suffering from trauma.** In order to facilitate a process of continuous awareness of HPSS staff in respect of victim issues we recommend **integration of awareness training as part of standard HSS Board and Trust induction programmes.**

General awareness training for wider HPSS staff also requires to be complemented by specialist training and continuous specialist professional development. We recommend that **the regional centre of excellence take a lead role in facilitating specialist training and professional development i.e. via facilitation of training placements, advice to mainstream HSS service providers on the required skills for dedicated trauma services.**

The findings of the evaluation indicated that opportunities exist to improve communication across all stakeholders involved in HSS services to victims of the conflict. It is our belief that the other recommendations contained within this report i.e. clear definitions of roles and responsibilities, redefining the terms of reference of the IDG etc. will facilitate improved communication. However, we also recommend **the development of a communications strategy, targeted at both HPSS staff, the voluntary and community sector and the general public. The objective of such a strategy is to clarify and raise awareness of communication channels. In order to improve communication with the general public we recommend that the communications strategy address issues such as development of a comprehensive on-line service directory for services to victims, development of a service map indicating service delivery points and means of access etc.**

In addition we believe that an opportunity exists to raise awareness of the public health affects of the conflict and the need to facilitate transition from a culture of victims to survivors. On this basis **we propose the DHSSPS work with the Health Promotion Agency to explore the potential for the development of a targeted public health campaign.**

10.9 Resourcing Services

Under 10.5 we outlined our recommendations in respect of the proposed new service delivery model. It is our view that these proposals present new opportunities for access to mainstream funding i.e. beyond the funding resources of family and childcare programmes. We recommend that **future funding for HSS specialist trauma services (provided under Service Level Agreements) is sourced primarily from health and personal social services. In addition, we recommend that future funding arrangements are formalised within the development of a funding strategy.**

In addition to a robust funding strategy the proposed new service model also requires to be underpinned by appropriate human resources. Our earlier recommendations contain proposals in respect of raising awareness and facilitation of specialist training. Under section 10.6 we also recommend a staffing and skill mix review in respect of the services to be provided by the centre of excellence and outreach services. In addition, **we recommend that where possible specialist skills transfer is maximised.**

The proposed new service delivery recommendations will impact on service provision accommodation. Where possible we **recommend maximum utilisation of existing accommodation for outreach services.** However, we **also stress that future decisions on the location of outreach services should not be bound only to the use of statutory facilities, but also take cognisance of wider community and voluntary facilities where appropriate.**

10.10 Standards, Monitoring and Evaluation

The findings of this evaluation have indicated that there are stakeholder concerns regarding the definition of services provided (i.e. counselling or befriending) and the standards of such services. In order to reflect best practice and to ensure that services provided are of the highest possible standard we recommend **the development of Service Level Agreements. Such agreements should be applied to the provision of services by the centre of excellence, outreach services and where appropriate voluntary services. In the case of the latter we recognise that this proposal is only practical with some the better established forms of voluntary service provision. Service Level Agreements (with standards) should clearly define service provision boundaries and should be developed with reference to best practice and guidance from the centre of excellence and the Regulation and Improvement Authority. Evaluation and monitoring processes should be developed in order to monitor SLA's.**

This review makes some far reaching recommendations for change. The actions to accompany such changes are articulated in the action plan in section 11. We recommend **the development of a monitoring and evaluation framework in order to ‘track’ progress of the recommendations of this evaluation.**

In section 4.7 we identified that each of the TAPs have developed strategies/business plans to varying degrees of detail. We recommend **that an agreed and standard approach to business planning and monitoring is developed with the TAPs. Such business plans should reflect the actions and funding required to take forward local TAP initiatives and also any individual TAP actions and funding required to take forward joint initiatives with other TAP’s on a regional basis. Quarterly monitoring reports should be provided by each TAP to OFMDFM.**

In section 9 we provided our findings in respect of the planning and monitoring arrangements which support the Family Centre. It is our view **that the proposed new service delivery model should be supported by a long-term plan with robust budgetary and expenditure evaluation. This plan should include all aspects associated with the operations of the regional centre of excellence and the outreach centres.**

10.11 Research and Dissemination

The findings of the evaluation have indicated that opportunities exist to facilitate more effective feedback on service development evaluations and research. We recommend **that the regional centre of excellence act as a central point of reference of research and evaluation sources. In order to facilitate this process individual stakeholders involved in the provision of HSS services to victims have a responsibility to feedback research and evaluation findings to the centre of excellence.**

The Research Branch of OFMDFM are currently developing a Code of Ethical Principles for Researching Vulnerable Groups. **We endorse the application of these principles in any future research studies with victims of the conflict.**

11 ACTION PLANNING

11.1 Introduction

This section of our report seeks to translate the evaluation recommendations into a series of actions to be taken forward. The action plan is illustrated in Appendix 4. Each recommendation has been broken down into a series of scheduled tasks with an indication of timescales, lead responsibilities and stakeholders involved.