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Contents

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We can learn from supervision

Welcome to the new edition of our Annual Supervision Report. The aim of the report is to provide information to service providers and others who have responsibility for health and social services about important observations and assessments that have been made during our work with supervision of health and social services.

Although we have tried to present a varied selection of our experience, it is difficult to give a complete and representative picture of all the work carried out by the Offices of the County Governors, the Norwegian Board of Health Supervision in the Counties, and the Norwegian Board of Health Supervision (the central office). We have had to select a sample of cases. Those who wish to obtain a broader view of our work, and who wish to go into more depth, can find more detailed information on our web site (www.helsetilsynet.no) and the web sites of the Offices of the County Governors (www.fylkesmannen.no).

A common feature of the articles in this report is that they deal with matters that we mean are useful for perusal, discussion and reflection by those who have responsibility for health and social services in Norway. We see that problems and deficiencies identified by one service provider are often recognised as problems and deficiencies for other service providers. We see that deficiencies are corrected when they are pointed out during the course of supervision. The importance of supervision is also highlighted by the increasing number of municipalities and health trusts which present the results of supervision to their governing authority to be dealt with by the management committee. This is a positive development, which, in our view, is in line with the principle of internal control that forms the basis for management of health and social services.

However, we are constantly surprised when deficiencies in service provision that have been detected in one place also occur in other places, without attracting attention or without being corrected. In our view, this is a clear indication that providers of health and social services do not always learn from the mistakes of others.

Of course, organizations that learn from mistakes must actively learn from their own experience and from the results of the services they provide themselves. But they must also be able to learn from the positive and negative experiences of others. Our web site can be useful in this respect.

State supervision is an important guarantee for legal safeguards, by identifying and dealing with the shortcomings and deficiencies of individual service providers. But supervision also provides experience that is of general value, that can and should be used to improve the safety and raise the quality of health and social services. This will only occur if we manage to spread information about our experience to service providers, and if they then use the information and experience gained from supervision in their development work.

We have little managerial control of the development work of service providers. The main responsibility for this lies with those who have responsibility for service provision.

However, we do have responsibility for spreading information about our experience to service providers. Up until now we have concentrated on making the results of supervision generally known. We see that this is not enough to ensure that our experience is used to the extent that we mean is appropriate. Therefore, in our Strategic Plan for 2007–2009, spreading information about the experience gained from supervision is one of the areas we have decided to pay particular attention to.

During the next few years, we must concentrate more on following up the findings from supervision and the experience we have gained. In order to do this, we need effective teamwork and communication with service providers. The Annual Supervision Report is a small, but hopefully useful, contribution to this teamwork.

Lars E. Hanssen

Has the reform of health and social services for people with alcohol and drug problems led to improved services for these people?

The reform of health and social services for people with alcohol and drug problems (henceforth called the Reform), which has been given priority at the political level, aimed to improve treatment services for this group of people. The Reform was initiated in 2004, but much work is still to be done before all treatment services have reached a level consistent with specialized health services of high quality. In particular, supervision has shown that patients' rights are not met, and that many services suffer from a lack of professionals with the necessary skills.

This area was chosen as an area for countrywide supervision, for three reasons:

- the Reform involved both changes in allocation of responsibility for services and new requirements for the content of services
- this area has been given high priority at the political level
- we had knowledge about the need for improved quality of treatment services for people with addictions.

The Reform was initiated on 1 January 2004. The aim of the Reform was that people with complex problems associated with alcohol and drug use should receive improved services that are better coordinated, and that the results of treatment should be better. This involves a reform of both allocation of responsibility and of the content of services. Specialized health services were given responsibility for ensuring that alcohol and drug abusers receive specialized treatment provided by a multidisciplinary team in accordance with sound professional standards. Among other things, the Storting (the Norwegian parliament) stressed that multidisciplinary specialized services for alcohol and drug abusers should involve different professional disciplines, such as social disciplines, psychology and medicine. Expectations of the Reform are high. This area was seen as an interesting and important area for countrywide supervision for several reasons. First, it is an area that is largely new for specialized health services. Second, politicians had high ambitions for the reform. Third, treatment of alcohol and drug addiction often involves a group of people with many health problems. In addition these people are vulnerable, and many of them have difficult lives.

The report "Norwegian Alcohol and Drug Abusers – Health Problems and Health Services in Relation to General Supervision" (Report from the Norwegian Board of Health 2/2005) identified the need for improving the quality of treatment for alcohol and drug abusers. Our knowledge about this area is somewhat incomplete, but the main impression was that many alcohol and drug abusers do not receive the services they need. In many places, lack of capacity and long waiting times gave cause for concern. This was particularly of concern for patients with so-called double diagnosis (serious mental illness and addiction), and for clients who were suitable for medication-assisted rehabilitation. There was reason to believe that the regulations regarding patients' rights were interpreted differently within different services, particularly with regard to assessment of whether patients have the right to essential health care. Lack of coordination within and between different sections often acted as a barrier to achieving the aims of treatment. Updated, knowledge-based guidelines for multidisciplinary, specialized treatment for people with alcohol and drug addiction were needed.

As a result of the Reform, the regional health authorities (RHAs) took over 32 county municipal treatment services. The RHAs took over contracts with 42 private treatment services. These contracts had previously been with the county municipalities. A special feature of this area is the large number of private service providers. The RHAs were also given responsibility for organization of medication-assisted treatment (MAR).

Countrywide supervision can provide knowledge about whether statutory requirements have been met, and about whether the Reform has had the intended effects. Treatment services for alcohol and drug abusers should have been reorganized in 2006 in line with the reform.

Limitations

In order to obtain adequate background information, and in order to identify themes and areas in which the risk of deficiencies occurring is high, meetings were held with representatives of client organizations and professional groups. A meeting was also held with the Advisory Group on Gender Issues, the Norwegian Board of Health Supervision. The various contributors confirmed what the supervision authority already knew about vulnerable areas in which the risk of deficiencies occurring is high. When sections at different administrative levels are involved in providing services, ensuring continuity in service provision presents a challenge. This is a challenge when providing services to alcohol and drug abusers, since it is important that specialized health services and municipal health services have established good routines for working as a team. Therefore, it was regarded as desirable that countrywide supervision of this area of service provision should include both specialized services and municipal services. However, it was decided that supervision that included both administrative levels was too extensive, and, taking into account the available resources, supervision was limited to multidisciplinary specialized services.

Supervision was based on specific criteria and operationalization of sound professional standards within the different sections:

- teamwork with other service providers at other levels
- client participation
- employees with the necessary skills and the way the services are organized
- documentation of service provision to individuals (the requirement to keep patient records) and of work with continual quality improvement. What types of system or measures had the institution developed/drawn up

to ensure that different requirements are met (management requirements)?
- supervision focussed on the following aspects of referral:
  - how do the services ensure that the deadline of 30 working days for assessing the right to essential health care is met?
  - what criteria are used for assessing the need for essential health care?

Supervision activities focussed on four different phases of treatment for alcohol and drug abusers:
- referral and assessment
- clinical investigation
- treatment
- completion of treatment

The types of institution in which supervision was carried out

In every region, supervision was carried out in six different types of institution:
- two institutions that, commissioned by the Regional Health Authority, have assessed the need for essential health care, in accordance with the Patients' Rights Act
- an institution that provides detoxification treatment
- an out-patient clinic
- an institution that provides in-patient care of less than six months duration
- an institution that provides in-patient care of more than six months duration.

At least one of the chosen institutions should provide treatment for alcohol-related disorders, and one of them should be private. We did not aim to assess institutions that only provided medication-assisted rehabilitation (MAR). These services are continually evaluated by others.

Findings

The institutions where supervision was carried out were not chosen with the aim of being a representative sample. However, the Norwegian Board of Health Supervision believes that the findings provide valuable information about how the services function. Altogether, supervision was carried out in 22 institutions. Thirty-two nonconformities were identified and 22 observations (comments regarding areas identified as having potential for improvement) were made. In four of the 22 institutions, no nonconformities were found. Nonconformities were found in all the four different phases of multidisciplinary specialized treatment for alcohol and drug abusers that supervision focussed on.

Deficiencies were identified in meeting the deadline of 30 working days for deciding whether patients have the right to essential health care. Deficiencies were also found in relation to an adequate number of employees with the necessary skills in assessment, clinical investigation and treatment. It is particularly difficult to ensure that there are enough specialists, particularly doctors. The practice related to diagnosis was found to be inadequate in several institutions, in that patients were not given a diagnosis according to WHO's classification (ICD-10). Work with individual plans is not carried out adequately in many institutions. The Norwegian Board of Health Supervision was told that this is something that the municipalities should do. The content of patient records was incomplete. In several institutions, patient records were not stored in such a way as to ensure necessary limitation of access. Management of medication was not in accordance with statutory requirements. Medication was not prescribed in accordance with sound professional standards. In many cases, patients were not discharged in accordance with sound professional standards. For example, case summaries were not available within a reasonable time, and routines for cooperation between specialized health services and municipal health services had not been developed. The Norwegian Board of Health Supervision also found that several institutions do not have adequate management systems to ensure that statutory requirements are met.

Supervision has shown that there is a long way to go before alcohol and drug abusers receive all the rights they are entitled to in accordance with the Patients' Rights Act. Some sections of the service have insufficient professional expertise. This weakens all types of treatment and increases the risk that the services provided are not in accordance with sound professional standards. The Norwegian Board of Health Supervision challenges the professional groups to develop the system of qualifications, so that work with multidisciplinary specialized treatment for alcohol and drug abusers is relevant for obtaining a qualification as a specialist. This will help to improve recruitment to this priority area. Supervision has confirmed the view of the Norwegian Board of Health Supervision that well-qualified and committed management is a decisive factor in developing high-quality services for patients.
Many institutions still have a long way to go before all types of treatment have reached a level consistent with specialized health services of high quality. This supervision has shown that several institutions are working systematically to improve their services, so that the intentions of the Reform can be realized.

Reference:
Report from the Norwegian Board of Health Supervision, 3/2007. Oslo, Norwegian Board of Health Supervision 2007. Guidelines for Supervision. www.helsetilsynet.no

Variable services for children with special needs

Countrywide supervision in 2006 of services for children with special needs has shown that the services offered to these children vary. The services vary in the different municipalities, and according to the availability of professional expertise.

Breach of the right to information and participation, and widespread lack of routines and measures that are necessary to ensure individually adapted and coordinated services, were identified. This applies to all phases of care, from assessment and planning to implementation, follow-up and evaluation of measures. In many cases, it is the parents themselves who coordinate services. It is uncertain whether services are predictable and effective, and whether resources are utilized efficiently. The Norwegian Board of Health finds this unacceptable. More attention should be given to systematic management (internal control) and continual work with evaluation and improvement of services.

During the period 2002–2006, countrywide supervision has been carried out in several areas in which coordination of services, individual plans and the right to assessment and essential health care in specialized health services have been themes for supervision. Findings from supervision carried out in 2006 indicate that municipalities and health trusts have not learnt from deficiencies that have been identified earlier, and have not used this information to improve the quality of services.

Areas for supervision

Supervision in 2006 of services for children with special needs included municipal health and social services and specialized health service units for children with special needs. Supervision was carried out in 40 municipalities, and 21 specialized health service units.

The themes for supervision of municipal health and social services were whether the municipality ensured that:

- children in the target group are assessed, in accordance with sound professional standards
- needs are assessed and services are planned and coordinated for each individual
- planned services are implemented, evaluated regularly, and adapted according to needs.

The themes for supervision of specialized health service units for children with special needs were whether the health trust ensured that:

- the right to be assessed and to receive essential health care is met
- children in the target group that are referred for the first time are adequately assessed, and that measures are planned and implemented
- children in the target group that need to be followed up by specialized health services are followed up by specialized health service units for children with special needs.

The target group for supervision was children aged 0–18 with congenital, early manifested or early acquired neurological conditions or damage to the nervous system. These children often require several different types of service, both health services, social services, and other types of service, over a long period of time. Many people are involved in providing these services.

Client participation, professional expertise, teamwork and coordination of the different services, are essential for a targeted and continuous process that is in accordance with sound professional standards. Measures for managing activities and processes are necessary in order to avoid services that are dependent on individuals, and that are unpredictable.

Municipal health and social services

A decision must be made about who should coordinate the work of assessing the condition of the child and his or her need for services. Routines for information and co-operation must be familiar, and they must be followed. In several municipalities, allocation of responsibility between the health centre and the regular medical practitioner was not clarified. Different sections referred children to specialized health service units, when the doctor had not examined the child or assessed the need for referral. It varied whether the regular medical practitioner was involved in planning and evaluating services, and whether the regular medical practitioner received information from the specialized health service unit. Many families had more contact with the doctor in the specialized health service unit than with the regular medical practitioner. If the general medical practitioner is not involved, it is difficult for him or her to take responsibility for these patients.

In nearly three of four municipalities deficiencies were identified in routines and measures to ensure coordinated planning and regular follow-up of services for children with special needs in cooperation with children and parents. In such situations, whether services are coordinated, and to what extent they are coordinated, is dependent on individuals. In many municipalities, it was not clear who had responsibility for coordination. Routines for cooperation between and within different types of municipal services and specialized health services were either lacking or they were unclear. Almost half the municipalities did not have a coordinating unit, or the tasks of the unit were not clearly defined. The Norwegian Board of Health Supervision will discuss with the National Directorate for Health and Social Affairs whether there is a need to develop more detailed guidelines.

Individual plans provide a practical tool for ensuring that services for people with long-term complex needs are in accordance with sound professional standards. In more than half of the municipalities there was variation in whether individual plans were used, and how they were used. The responsibilities of the coordinator were unclear. In several places, routines for developing and following up individual plans were not familiar, or were not followed. In some places, day nurseries and schools did not wish to participate in developing individual plans, because this is not one of their statutory duties. The Norwegian Board of Health Supervision will ask the Ministry of Health and Welfare to take up the issue of whether the legislation

relating to day nurseries and schools should contain a legal authority about individual plans, so that a wider range of sections have a duty to cooperate.

Provision of services that are in accordance with sound professional standards is dependent on having personnel with the necessary knowledge and skills. Measures for ensuring that personnel had adequate knowledge, training and follow-up were deficient in almost half of the municipalities. This was particularly the case for personnel in municipal respite care units, private personnel who provide respite care, and support persons.

Respite care is essential for parents of children with disabilities and chronic disorders. Possibilities for parents to choose between municipal and private personnel who provide respite care varied. Parents often had to recruit private personnel themselves. In a few municipalities, the time between when the decision about respite care was made, and the time when the decision was implemented, was half a year. This is too long. Respite care was either minimal or else not adapted to individual needs in about one third of municipalities.

Services for children with special needs

Organization and supply of services for children with special needs, and the availability of professional expertise, was variable. There were differences in the number of professional posts, and in the availability of specialists, particularly specialist doctors. Two units did not have a doctor, and some units only had a part-time doctor. There was variation in the kind of disorders that the services included, and in the types of service that were offered. The Norwegian Board of Health Supervision will discuss these difference with the owners and with the regional health authorities.

Services for children with special needs are specialized health services. For services for people with special needs, the transition between municipal services and specialized health services is unclear. Comprehensive training is given to municipal personnel, but in some of the services for children with special needs there was not enough capacity to give necessary training. Supply of out-patient services varied in some places according to the distance to the municipality. In many cases, children in municipalities where there was a lack of professional expertise were followed up more closely and received a more comprehensive service from the specialized health service unit, than children with corresponding needs in other municipalities. The Norwegian Board of Health Supervision points out that the municipalities have responsibility for providing essential health care, and they must intensify their activities to obtain the professional expertise that is lacking.

Through supervision it was found that one third of services for children with special needs did not meet the deadline for assessing referrals, and that informing parents and the referral agents about the result of the assessment was inadequate. Some of the services did not give a deadline for providing treatment for patients who had the right to essential health care. In addition, it was found that one third of the services did not meet the deadline that was given for providing treatment. Patients with lower priority were admitted before patients who had the right to essential health care. In some places, personnel were not familiar with statutory requirements and their practical significance.

To a large extent, specialized heath service units for children with special needs ensured that children and parents were given information, and that they were able to participate in investigations and in planning the measures to be provided. Two units did not ensure that an interpreter was provided when children and parents could not communicate in Norwegian. This is a breach of the right to information, and makes client participation difficult.

Practice varied in relation to giving feedback to municipal services after the first investigation. This varied according to whether a written summary report was sent, and when it was sent, and whether a meeting to sum up the case was held with parents and municipal personnel, and when this meeting was held. In more than half of the specialized health service units, it was found that it was only in rare cases that the regular medical practitioner had received such reports when others had referred the child.

Most of the specialized health service units meant that preparation of individual plans is a municipal task, and they did not initiate work on such plans themselves. It also varied to what degree personnel in these services participated in preparing and following up plans when the municipalities led this work. In a few of the institutions where supervision was carried out, we found that it was not clear whether the specialized health service unit or the municipality had responsibility for implementing the measures that were planned. Some of the specialized health service units lacked routines for regularly assessing the measures that were provided.

Check-ups were carried out as planned in the specialized health service units. In a couple of places, coordination of examinations caused problems. Most of the units had well-established routines for providing information and for organizing the transition from child services to adult services or to services within another section of the specialized health services. However, in several places the municipality was expected to send a new referral. In a few of the places where supervision was carried out, we found that the specialized health services could not provide the comprehensive services that young adults needed, and that these clients previously had received as children.

Some municipalities and specialized health services provided better services for children with special needs than others. Supervision has identified serious deficiencies in routines and measures that shall ensure that services for children with special needs are well coordinated and adapted to individual needs. The Offices of the County Governor and the Norwegian Board of Health Supervision in the Counties will follow up the relevant units to ensure that deficiencies that have been detected have been corrected.

Reference:
Report from the Norwegian Board of Health Supervision 4/2007. Oslo, Norwegian Board of Health Supervision, 2007. Guidelines for Supervision. www.helsetilsynet.no

Use of coercion and restraint for people with mental disabilities – there are still deficiencies in the way services are organized

In 2006, the Offices of the County Governors carried out countrywide supervision to examine whether municipalities ensure that services are organized in such a way as to ensure that coercion and restraint are used as little as possible for people with mental disabilities who receive social services (Social Services Act, Chapter 4A). Supervision was carried out in 59 municipalities. Deficiencies were found in 53 of the 59 municipalities. In 32 municipalities the Offices of the County Governors found deficiencies in provision of social services for people with mental disabilities, and in 44 municipalities they found deficiencies related to use of coercion and restraint for people with mental disabilities.

The Norwegian Board of Health Supervision is concerned that management of services is inadequate in so many municipalities. It is unacceptable that many municipalities do not meet the requirements related to use of coercion and restraint. Legal safeguards for these clients are thus not adequately ensured.

For several years, the Norwegian Board of Health Supervision has been concerned about social services for people with mental disabilities. In 2005 the Offices of the County Governors carried out countrywide supervision of municipalities that had made decisions about use of coercion and restraint and/or reported measures taken to avoid injury in critical situations. In 2006, we focused on municipalities that have **not** made such decisions or reported such measures. The Offices of the County Governors considered the risk of deficiencies in services, when deciding which municipalities to include.

Both in 2005 and in 2006, supervision was carried out to investigate whether municipalities ensure that services are organized in such a way as to ensure that social services are provided with the least possible use of coercion and restraint, and whether the services provided to clients are adapted to their changing needs, in accordance with the Social Services Act, Section 4–2 a–d.

Social services adapted to individual needs?

An important aim of legislative control of use of coercion and restraint for people with mental disabilities is to ensure that clients receive services in accordance with sound professional standards, and that coercion and restraint are not used to compensate for inadequate services and lack of economic resources. This is important in relation to ensuring legal safeguards.

The municipalities shall manage the services so as to ensure that clients' rights to social services are met. Among other things, the municipality must assess which factors need to be investigated in order to assess service needs, and whether these factors are taken into account when service provision for individuals is planned. For example, when decisions are made, the reasons for the decisions must be documented, and the types of services that will be provided must be described in detail. If the needs of the client change, the municipality must have procedures to ensure that this is detected, and that the client receives services that are adapted to these changing needs.

The municipalities shall ensure that all stages of administrative procedures are carried out correctly. For example, decisions to provide or not provide services shall be given in writing. This gives clients and their representatives the possibility to appeal. Client participation is important in the whole process. The right to participate means that clients shall have the possibility to give their views and influence the choice of services provided. Well-specified, written decisions based on individual assessment of individual needs shall form the basis for service provision. It must be possible to justify decisions, and for clients to appeal about decisions.

The supervision that was carried out in 2006 identified that there were still many deficiencies in allocation ofservices (see previous reports: Reports from the Norwegian Board of Health 9/2003, 6/2005 and 2/2006). For example, documentation of individual assessments was lacking, decisions had not been made about which services clients should receive, decisions were not justified and were not evaluated, and staff were not aware of decisions that had been made. The Offices of the County Governors also found inadequacies in relation to documentation of client participation in allocation of services, and individual assessment of the basis for allocation of services.

Coercion and restraint

Coercion and restraint refer to measures that clients resist, or measures that are so invasive that they must be regarded as use of coercion and restraint, irrespective of whether they are resisted or not. Municipalities shall organize services in such a way that coercion and restraint are only used when their use is in line with sound professional and ethical standards. Before such measures are used, other solutions must have been tried. The conditions for use of coercion and restraint are that their use is absolutely necessary to avoid or limit injury. If there are no clear criteria for what is professionally and ethically acceptable in relation to use of coercion and restraint, then much is left up to the subjective assessment of the individual service provider. Therefore in the legislation, emphasis is placed on rules to be followed in order to ensure that the legal safeguards of clients are upheld.

Use of coercion and restraint is in breach of the provisions in the Social Services Act, Chapter 4A, when:

- regulations for administrative procedures for use of coercion and restraint as measures to avoid injury in critical situations are not followed
- coercion and restraint as part of care or as measures to change behaviour are used, when decision processes in accordance with legislative requirements have not been followed
- coercion, restraint or radical surveillance, such as warning systems, are used, when the conditions for use of coercion and restraint have not been met..

A precondition for providing services that are in accordance with sound professional standards is that municipalities, through procedures and other measures, ensure that coercion and restraint are not used if the aims of treatment can be achieved using less invasive measures. Examples of such measures are training and organization of services. Coercion and restraint must only be used in

such a way and to such an extent that is necessary and professionally sound, taking into account the care of the client and the safety of others. Several factors can lead to increased acting-out and self-injury, and thus to the use of coercion and restraint. Examples of such factors are: inappropriate organization of services, lack of individual services, inappropriate ways of organizing groups, lack of staff with relevant qualifications, and too many different service providers.

The findings and experience gained from this countrywide supervision are in line with earlier findings and experience (see previous reports: Reports from the Norwegian Board of Health 6/2005 and 2/2006). Use of coercion and restraint that is in breach of the provisions in the Social Services Act, Chapter 4A has also been detected in 2006. In 2006, deficiencies were found in 44 of 59 municipalities.

The Offices of the County Governors have ascertained that coercion and restraint are used when decisions about their use have not been made, and that control is lacking, since measures taken to avoid injury in critical situations are not followed up. Many of the examples of use of coercion are similar to those detected by the Offices of the County Governors in 2005: installation of comprehensive alarm systems, pyjamas with buttons on the back, locked doors, locked rooms such as kitchens and bathrooms, limited access to food and personal possessions, and regular and planned use of coercion when no decision has been made about this. The experience gained from supervision also shows that routines for reporting use of measures to avoid injury in critical situations have often been developed, but that these routines are often not followed in practice. Many municipalities do not use these reports to evaluate and improve the services.

Both in 2005 and 2006, supervision has shown that members of staff have variable and inadequate knowledge about and understanding of the concept of coercion. For example, they do not know, or they do not understand, when they use coercion, and therefore they do not report its use. Many of the municipalities that were investigated have not ensured that teaching has been given about the legislation that regulates the services. Also, the municipalities do not adequately assess the staff's needs for teaching and training, neither do they assess whether these needs have been met.

Challenges for the municipalities

Supervision has shown that the municipalities face challenges in relation to administrative procedures that are in accordance with sound practice. Examples are assessing and documenting individual needs, and evaluating different stages of the procedures. Written documentation provides an important basis for evaluating service provision. Supervision has shown that many municipalities do not adequately manage planning, organization, implementation, maintenance and evaluation of services for people with mental disabilities. In addition, they do not have routines to ensure systematic quality improvement of the services. Thus, the management in these municipalities cannot know whether people with mental disabilities receive services that are in accordance with sound professional standards, and whether coercion and restraint are used as measures to compensate for inadequate services.

In relation to use of coercion and restraint that is in breach of the legislation, the situation is fairly similar in municipalities that have taken decisions and those that have not taken decisions about use of coercion and restraint. The findings from supervision show that in several of the municipalities that have been investigated, there are breaches in reporting use of coercion and restraint, as was found in 2005. The municipalities face great challenges in relation to avoiding whenever possible the use of coercion and restraint, and ensuring that these measures are used in accordance with sound professional standards in cases when they must be used.

Reference:
Report from the Norwegian Board of Health Supervision 5/2007. Oslo, Norwegian Board of Health Supervision, 2007

For a detailed description of the methodology used, see the guidelines for supervision: www.helsetilsynet.no

Training programme for following up supervision

Countrywide supervision in 2005 of legal safeguards for people with mental disabilities in the case of use of coercion and restraint, identified deficiencies in many municipalities related to administrative procedures and skills in identifying use of coercion and restraint.

Therefore, in the spring of 2006, the Office of the County Governor in the county of Sør-Trøndelag and the Services for Adults with Special Needs developed a training programme to raise the level of skills in the municipalities. The programme aims to reach as many service providers as possible, including part-time staff and extra staff. The training programme does not demand a high level of resources, and skills that are available in the municipalities are utilized. The programme has been carried out in three municipalities: Klæbu, Melhus and Midtre Gauldal. In addition, the programme is underway in the municipality of Orkdal. Teaching takes place in groups comprising staff from different services in the municipality and goes over three months.

One of the aims of the training is to make service providers more familiar with the legislation. Examination of cases and legislation is therefore a central theme. One of the factors that makes the programme successful is that participants work in small groups with descriptions of cases. The programme ends with a meeting, at which the Office of the County Governor and the Services for Adults with Special Needs present professional and legislative topics.

Experience of using the municipalities' own professionals as leaders of the training groups has been positive. Participants are encouraged to make themselves familiar with the legislation related to use of coercion and restraint. There has been much enthusiasm and useful debate, so that participants have been able to discuss their experiences, for example their experiences of finding alternatives to coercion and restraint. It is positive that participants come from different services. Some of them have more experience than others of working with clients who offer resistance. The Office of the County Governor in the county of Sør-Trøndelag will continue with the programme in 2007.

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Supervision cases are becoming more serious

In 2006, the Norwegian Board of Health Supervision dealt with 251 supervision cases – nine more than in 2005. The increase in the number of administrative reactions is greater than the increase in the number of cases. In 2006, the number of administrative reactions given by the Norwegian Board of Health Supervision was 183, compared with 168 in 2005. For 76 cases, no administrative reaction was given. Seventy health care personnel lost their authorization in 2006, compared with 46 in 2005. One case can result in several administrative reactions.

The basis for initiating a supervision case is often a complaint from a patient or relative. In cases that lead to loss of authorization, information often comes from an employer or prosecuting authority. Other sources of information that can form the basis for supervision cases are the media, the patient ombudsman, compensation cases and various reporting systems. When the Norwegian Board of Health Supervision in the County believes that there may be reason to react against a health care personnel, the case is forwarded to the Norwegian Board of Health Supervision (the central office), which has the authority to give a formal administrative reaction. This reaction can be a warning or withdrawal of the health care personnel's authorization.

During the last few years, there has been a steady increase in the number of administrative reactions given by the Norwegian Board of Health Supervision. The number of administrative reactions increased from 168 in 2005 to 183 in 2006. This increase may indicate that the cases that are sent on to the Norwegian Board of Health Supervision are more serious.

Seventy health care personnel lost their authorization in 2006, compared with 46 in 2005. In 2006, as in 2005, in the majority of cases, the reason for withdrawal of authorization was alcohol or drug abuse or other personal circumstances. Another reason for withdrawal of authorization in several cases is that the health care personnel has had a sexual relationship with a patient.

About half of the supervision cases that ended up with an administrative reaction against an individual health care personnel in 2006, were cases involving physicians (79 cases). Fifty-one physicians received a warning, 21 lost their authorization, 5 had their authorization restricted, two lost their right to prescribe medication in group A (narcotic drugs) and group B (prescription drugs that are addictive), and one lost his/her authorization as a specialist.

Thirty-four health care personnel lost their authorization because of alcohol or drug abuse. Nurses were most represented in this group – 19 of the 34 were nurses. Fourteen health care personnel lost their authorization because of their behaviour – mainly criminal acts that are regarded as incompatible with practice as a health care personnel. Five health care personnel lost their authorization because of sexual exploitation of a patient, five because of their own illness and four because they had previously lost their authorization in another Nordic country.

With regard to appeals against the decisions of the Norwegian Board of Health Supervision, 44 cases were forwarded to the Norwegian Appeals Board for Health Personnel. Decisions were made about 35 cases. In 31 cases the decision of the Norwegian Board of Health Supervision was affirmed, and in four cases the decision was reversed. One person withdrew his appeal after the case had been sent to the Appeals Board.

The Norwegian Board of Health Supervision dealt with 32 supervision cases against institutions. Thirty institutions were given criticism for inadequate organization, including inadequate internal control systems. No cause for criticism was found in two cases. In most cases, it is the Norwegian Board of Health Supervision in the Counties that give criticism to the management for deficiencies in organization or management of health services.

In 17 cases, the authorization of health care personnel was suspended while their cases were being dealt with, and in one case authorization as a specialist was suspended.

The Norwegian Board of Health Supervision received notification from 14 health care personnel that they renounced their authorization, and 6 physicians renounced their right to prescribe medication in groups A and B. In the majority of these cases, a supervision case had already been initiated against the health care personnel.

The time taken for dealing with supervision cases has increased slightly from 2005. The mean time taken for dealing with a case was 7 months in 2006 (5.8 months in 2005) and the median time was 6 months (4.8 months in 2005). On 31 December 2006, 150 supervision cases were being dealt with by the Norwegian Board of Health Supervision.

Table 1 No. of administrative reactions and no. of cases completed without an administrative reaction, 2002–2006

	Administrative reaction	No administrative reaction
2002	103	71
2003	125	55
2004	148	101
2005	168	87
2006	184	76

Table 2 Administrative reactions against health care personnel given by the Norwegian Board of Health Supervision in 2006 – figures for 2005 in brackets

	Warning	Loss of authorization	Loss of the right to prescribe medication in groups A and B	Limited authorization	Loss of authorization as a specialist
Doctor	51 (56)	21 (15)	2 (12)	5 (0)	1 (0)
Dentist	4 (6)	3 (3)	0	0 (0)	
Psychologist	2 (5)	4 (2)		0 (0)	
Nurse	8 (10)	24 (18)		1 (3)	
Auxiliary nurse	2 (4))	11 (5)		1(0)	
Social educator	0(0)	2 (1)		1(0)	
Midwife	0 (2)	0 (0)		0(0)	
Physiotherapist	1 (1)	0 (1)		0(0)	
Other groups	3 (1)	6 (1)		0(0)	
Unauthorized	1 (2)				
Total	72 (87)	71 (46)	2 (12)	8 (3)	1 (0)

Table 3 Reason for withdrawal of authorization, according to health care personnel group, 2006 – figures for 2005 in brackets

	Nurse	Auxiliary nurse	Doctor	Other	Total
Alcohol and drugs	19 (12)	3 (3)	7 (7)	5 (1)	34 (23)
Illness	1 (0)	0 (0)	3 (0)	1 (1)	5 (1)
Sexual exploitation of patient	0 (0)	3 (0)	0 (4)	2 (3)	5 (7)
Behaviour	2 (3)	5 (2)	3 (2)	4 (2)	14 (9)
Unsound professional standards	1 (0)	0 (0)	3 (1)	1 (0)	5 (1)
No improvement after a warning	0 (1)	0 (0)	2 (0)	1 (1)	3 (2)
Authorization lost in another country	1 (2)	0 (0)	3 (1)	0 (0)	4 (3)
Other	0 (0)	0 (0)	0 (0)	1 (0)	1 (0)
Total	24 (18)	11 (5)	21 (15)	15 (8)	71 (46)


H
bA1c
C6 H12 O6
mmol/liter
diabeteemellitus

Serious deficiencies in management of high blood sugar by general practitioners

The seriousness of mistakes in the diagnosis, treatment and follow-up of patients with high blood sugar (hyperglycaemia) is illustrated by seven cases that the Norwegian Board of Health Supervision received in 2004. The outcome for the patient in five of the cases was death.

The vital issue in cases involving general practitioners is whether the doctor has adequately assessed whether the patient's condition was serious, and whether enough was done to avoid an adverse outcome. The Norwegian Board of Health Supervision also assesses whether the doctor had sufficient information to decide which action should be taken. The signs and symptoms found at the time form the basis for this decision. The outcome shall not influence the assessment of whether the doctor acted in accordance with sound professional standards. It is the risk of damage that is decisive.

Basically, it is the doctor's diagnostic and therapeutic assessment and the advice given that form the basis for the assessment of whether he or she acted defensibly, that is to say, in accordance with sound professional standards. When signs and symptoms are unclear and atypical, a "wait-and-see" approach can be defensible. If the outcome is serious, an important consideration in relation to sound professional practice, is whether the doctor has had recent contact with the patient. This will often be the case for patients with hyperglycaemia.

Medical mistakes

The inadequate or incorrect assessments made by general practitioners in these seven cases relate both to diagnosis and follow-up of patients.

In the first case, in which it was known that the patient had diabetes, the doctor had not obtained information about the patient's blood sugar level.

In the second case, the doctor did not consider the possibility that a 19-year-old man had diabetes. Seen in isolation, in this case the doctor did not act in accordance with sound professional standards, since he had not to an adequate degree reduced the possibility that a condition was present that made it necessary to confirm the diagnosis. However, in assessing whether the doctor had acted in a way that was not in accordance with sound professional standards, it was taken into account that he had given adequate advice about follow-up of the patient under supervision. The result was that the doctor was not given a warning.

In the third case, the patient was also under supervision. However, the doctor did not respond when he was informed that the condition of the patient had deteriorated. He was therefore given a warning.

In the fourth case, the patient had been to an optician. The optician suspected diabetes, because of the need for new glasses, and referred the patient to his regular general practitioner. However, the patient did not give the referral slip to the doctor, and the correct diagnosis was therefore not made. This example illustrates how important it is for personnel in all sections of the health services to ensure that important information reaches the right health care worker.

The fifth and sixth cases involved incorrect treatment with medication.

The seventh case is a good illustration of the challenges and dangers associated with patients who suffer from chronic diseases. Neither the specialist nor the regular general practitioner followed up a patient who was treated with medication that put him in danger of developing hyperglycaemia. The regular general practitioner has responsibility for coordination of treatment, but the course of events shows how difficult it can be to ensure that this responsibility is adequately met.

In the last case, a long time had passed between taking blood tests at routine check-ups and the patient becoming critically ill. Normally, this means that it is not probable that the outcome is related to possibly undetected serious illness. However, when a blood test indicates significant hyperglycaemia, it is necessary to ascertain what measures were taken when the result of the blood test was known. In this case, the measures were not in accordance with sound professional standards.

In three of these seven cases, comments were made about the way in which the specialist or the specialized health services dealt with the patients. This applies to information about both inadequate alertness and follow-up of the patients. However, the conditions were not found to be so serious that there was reason to investigate these cases further.

Detection of serious disease

All the patients in these cases had signs and/or symptoms that indicated the possibility of serious hyperglycaemia, though not always at the first consultation. The reason for this is that these signs and symptoms can be transient. If the doctor has not considered diabetes at the first consultation, this is not necessarily regarded as not in accordance with sound professional standards. However, if the disease develops to a serious stage, and this is not detected, then this will be assessed as not in accordance with sound professional standards. In this case, the patient is exposed to serious danger.

Diagnosis and treatment of serious hyperglycaemia is life-saving, because it can prevent life-threatening complications. The Norwegian College of General Practice (NSAM), through its Action Programme for Diabetes, has made an important contribution to raising the level of knowledge of general practitioners about diabetes. Therefore, the large number of such cases in 2004 gives cause for concern.

What is the Norwegian Board of Health Supervision Doing?

An administrative reaction in the form of a warning can be given when the Norwegian Board of Health Supervision identifies practice that is not in accordance with sound professional standards, and when it can be shown that the practice may involve a significant burden to the patient or involve danger for the safety of the patient when providing health services. Administrative reactions in accordance with the Health Personnel Act shall contribute to ensuring that health care personnel act in accordance with sound professional standards, and in this way increase the level of patient safety and quality in health services. Spreading information by the supervision authorities about the assessments of such cases contributes to quality improvement in health services.

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Supervisor or service provider in one's own home

Flexibility and client management are positive characteristics of client-managed personal assistance (CPA). How can we carry out supervision of this arrangement without undermining or checking these positive characteristics?

"Strictly speaking, you can say that management is management, but it is a different kind of management when the task is yourself. It is different to manage people when you are lying naked in bed. You have to have decided what the terms are in advance. In this situation you are not so clearly a manager. You have to be extremely good to cope with that. Therefore, you need to set the conditions in advance, and you have to have built up your role as supervisor. This is important, but not easy. It is demanding. Therefore, I think it is scary that the municipality has not developed any kind of training programme whatsoever. I am concerned that this will gradually undermine the arrangement. I worry that we will end up with many cases where the arrangement maybe won't function so well, because of lack of training".

Hanne is 35 years old. She became paralysed from the neck down in 1988 and has had CPA since 1992. She has 52 hours a week, provided by four assistants.

"Of course, we can now bank on the table and say that the arrangement is established by law. But it doesn't help much as long as there are no clear criteria for getting the service. It is up to the municipality to make an assessment. Of course, we have the right to appeal and complain, but it takes guts to keep going. And very often it is about things that could be clearly formulated, and about documenting needs in such a way that the municipality can't get away with doing nothing. It is a bit like shadow boxing. There is no-one there to receive the blows".

Rune is 39 years old. He has a progressive muscle disease, and has had CPA since 1994. He has 22 hours a week, provided by two assistants.

The quotes are from Ole Petter Askheim's book:

Å leve er mer enn å overleve. Funksjonshemmede med brukerstyrt personlig assistanse forteller (There is more to living than just surviving. Physically handicapped people who receive client-managed personal assistance tell their stories) published by Gyldendal in 2006.

The Norwegian Board of Health Supervision plans to write a report. We will collect and evaluate available information, and discuss which aspects of CPA and economic assistance for carers should be given special attention by the supervision authorities. CPA has been presented in detail in recent reports, but we do not have enough information about the situation regarding economic assistance for carers.

Client-managed personal assistance means that people with reduced function have their own personal assistants who they are supervisor for. The municipality, the client or a cooperative of clients can have formal responsibility as employer (in Norway we have one cooperative ULOBA). Presently there are about 1500 people working in this service, which has been tried out since 1990, and has had its legislative basis in the Social Services Act since 2000.

Economic assistance for carers involves payment made by the municipality to relatives or volunteers who provide care in their own home for people who have comprehensive needs for care because of age, physical disability or illness. Of 7500 contracts per year, about half of them are for care of the carer's own child, and about one third are for care of a spouse. Half of the carers receive economic assistance for eight hours or less per week.

The quotes presented above illustrate some of the provisional results related to characteristics of CPA that are relevant for supervision:

- The services are provided in a way that is closely intertwined with the clients' private lives
- The client, or people who are close to the client, have responsibility for service provision at times or in situations when the client is vulnerable
- This responsibility can be quite separate from the overall responsibility of the municipality for ensuring that services are provided in accordance with sound professional standards
- The legislation allows for much judicial assessment and is interpreted differently in different municipalities
- There are large differences between different municipalities in the way these arrangements are put into practice.

The final results of supervision will be available in the course of 2007.

"If you go in alive you come out alive" – but what happens next?

The Norwegian Board of Health Supervision has collected information about follow-up services for people who have suffered from alcohol poisoning (1) – a theme that has received much less attention in the media and less debate in society than overdose with opiates. The results show that services for these people are haphazard and that follow-up services are variable.

Alcohol is the intoxicating substance that is most used, and that contributes to much mortality and morbidity, both chronic diseases, injuries and other disorders. On a worldwide basis, alcohol causes about as much loss of health in the form of lost life-years as tobacco. Research has shown that alcohol abuse can be an important contributory factor in many common illnesses encountered in general practice and specialized health services. Alcohol-related admissions to hospital can be because of long-term high consumption or acute intoxication. A report from SINTEF shows that there has been an increase in the number of hospital admissions due to alcohol poisoning, particularly among young women, but also among men over 35 years of age (2).

Sources of information

In collecting information, the Norwegian Board of Health Supervision carried out a search of the literature and contacted researchers and representatives from administrative and clinical sectors of the health services. The aim was to describe possible vulnerable areas where there is a risk that follow-up services may be inadequate.

Lack of information

Despite much research in the field of alcohol and drugs, there is a lack of information about alcohol poisoning. In our search, we found little systematic information and documentation about who people with alcohol poisoning are, how many of them receive health care, where they are treated, and what kind of follow-up services they are offered. Taking into account the scope and the consequences of alcohol-related diseases and acute intoxication, the Norwegian Board of Health Supervision is very concerned that relatively little knowledge and data are available about alcohol poisoning.

People with alcohol poisoning at emergency units/hospitals

A broad spectre of people come to emergency units or hospital with alcohol poisoning. However, our results indicate that three groups are over-represented 1) young people, often with mental health problems and little experience with, and control over, their alcohol consumption, 2) heavy alcohol users who have marginalized and chaotic lives, and 3) adults with chronic alcohol problems or chronic alcohol use in combination with other drugs, who have reduced tolerance due to health problems.

A lack of comprehensive follow-up services

The literature review carried out by the Norwegian Board of Health Supervision gives a picture of inadequately coordinated services that are haphazard and variable, and variable follow-up services for people who have suffered from alcohol poisoning. There appears to be regional variation in follow-up services, in internal routines for follow-up, in attitudes to alcohol and drug problems, and in knowledge and skills related to follow-up services and follow-up needs. These results indicate that improvements are needed in this area.

Several different authorities have responsibility for providing adequate services to people with alcohol and drug problems that can lead to significant health and social problems. Health authorities and service providers are responsible for ensuring that health professionals have knowledge about what is adequate quality of the services. If professional standards and guidelines are unclear or not documented, there is a risk that services may be inadequate. In relation to follow-up of people who have suffered from alcohol poisoning, there are several issues that need to be clarified, such as what is expected of the services, and what kind of services are in line with sound practice and sound professional standards.

Regional health authorities, health trusts and municipalities are responsible for ensuring that the services that are provided are in accordance with sound professional standards. The aim of the reform of health and social services for people with alcohol and drug problems is to give these people improved services that are coordinated better, and that the results of treatment are better. Regional health authorities are responsible for providing adequate, comprehensive treatment services, in particular acute detoxification services for alcohol and drug abusers. Specialized health services and municipal health and social services have a duty to cooperate with each other.

The Norwegian Board of Health Supervision will send this report to the relevant authorities, and expects the responsible authorities on different levels to use the available information when developing services for people who have been treated for alcohol poisoning.

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Complaints about the right to receive medication-assisted rehabilitation

The Norwegian Board of Health Supervision is the main body with responsibility for dealing with cases of complaint concerning clients' rights in accordance with health and social legislation. This involves responsibility for ensuring that the legislation is interpreted and practised in a way that is as much as possible uniform and sound over the whole country. As a rule, decisions taken by the Norwegian Board of Health Supervision in the Counties are final and cannot be appealed against. However, in special cases, the Norwegian Board of Health Supervision can assess whether decisions should be reversed, in accordance with the Public Administration Act, Section 35. However, the involved parties do not have the right to have their case reassessed, in accordance with Section 35.

As the main responsible body, the Norwegian Board of Health Supervision has now received 15 enquiries about clients' rights in accordance with the Social Services Act and the Patients' Rights Act. Five of these enquiries were requests to reverse decisions in accordance with the Public Administration Act, Section 35. The Norwegian Board of Health Supervision found grounds for reversing the decision in one of these cases.

In this article we will take a closer look at issues regarding medication-assisted rehabilitation (MAR).

After the reform of health and social services for people with alcohol and drug problems (hereafter called "the Reform"), drug addicts receiving multidisciplinary specialized treatment now have rights in line with other clients who receive treatment from specialized health services. But providing health and social services that are in accordance with sound professional standards to drug addicts presents special challenges for service providers. For example, client participation is essential in order to achieve a satisfactory result.

Our experience has shown that clients in this group believe that the criteria for admission to and discharge from MAR are too strict. In some cases we have also seen that the multidisciplinary support team for these clients does not function in the way intended according to the MAR regulations. The following case that was dealt with by the Norwegian Board of Health Supervision in 2006 provides an illustration of this.

A client's parents contacted the Norwegian Board of Health Supervision (the central office) to get an assessment of the way the Norwegian Board of Health Supervision in the County had dealt with a complaint about the decision to discharge the client from MAR. They also requested an assessment of the treatment and follow-up their drug-dependent daughter had received from MAR.

However, at the time the parents contacted the Norwegian Board of Health Supervision, the daughter had been readmitted to the MAR project, and had received essential health care. But the case is still important in principle.

The client had been discharged from MAR because she had taken other drugs. Before being discharged, she had been given a warning. She was then advised to contact social services to get help to apply for detoxification and thus avoid being discharged from MAR, or else, within about three weeks, to document that she was drug-free. She contacted social services straight away and contacted them again several times. Because of an oversight on the part of social services, they did not apply for a place for her for detoxification until after she was discharged from MAR. Her parents contacted MAR and expressed concern for their daughter's situation. They were then informed about the conditions for readmission to MAR, such as the requirement to document 6 weeks abstinence from drugs before readmission.

The patient complained about the decision to discharge her, and deficiencies were detected in several areas:

- a meeting of the group of people responsible for the client had not been held, in accordance with the client's individual plan
- social services had not followed up the client's request to apply for a place for detoxification, so that discharge from MAR could be avoided
- alternative types of treatment had not been considered for the client before she was discharged from MAR
- according to the client and her parents, she was discharged without follow-up, either from social services or health services.

The Norwegian Board of Health Supervision in the County concluded that discharge from MAR was legitimate, but that the patient had the right to essential health care after discharge. With regard to readmission to MAR, the Norwegian Board of Health Supervision in the County stated that the requirements for admission to MAR for clients who had previously been discharged because of use of other drugs should be stricter than for other clients. They also stated that it was up to the specialized health services to decide when it was justifiable (in accordance with sound professional standards) to readmit the client to MAR.

In the reply to the parents, the Norwegian Board of Health Supervision in the County stated that breach of the conditions for MAR after an individual assessment can result in discharge. Alternative types of treatment and the consequences of discharge are part of the individual assessment.

In addition, the Norwegian Board of Health Supervision in the County commented that at the time the client was discharged from MAR, she had been using other drugs for three months. They thus questioned why the MAR project had found it necessary to discharge the client at that particular time. They must have known how difficult it was for her to get a place for detoxification, and that she was motivated for detoxification. In contrast to the Norwegian Board of Health Supervision in the County, the Norwegian Board of Health Supervision (the central office) was of the opinion that the decision to discharge the client should have been based on a more comprehensive evaluation of the client's situation.

With regard to the question of readmission, in the opinion of the Norwegian Board of Health Supervision (the central office), the case should have been dealt with differently both by the MAR project and by the Norwegian Board of Health Supervision in the County. Instead of giving an orientation about the conditions for readmission, they should have dealt with the case as a complaint of breach of the right to receive essential health care in accordance with the Patients' Rights Act. A central issue would then have been whether the conditions for readmission were too strict. This did not appear to have been assessed, either by the MAR project or by the Norwegian Board of Health Supervision in the County. MAR's requirement for documentation of six weeks' abstinence from drugs, and the deadline of three weeks that the client was given to document abstinence from drugs, appeared to be arbitrary, and thus unfounded and subjective.

Changes under way

The Ministry of Health and Care Services recently sent a memo out for comments regarding changes to the Patients' Rights Act and the Specialized Health Services Act after the Reform. The recommendations are mainly related to interpretation and practice of the Patients' Rights Act after the Reform, which came into force on 1 January 2004. In addition, the Ministry recommends some juridical changes and two regulations that allow more detailed regulations relating to MAR and to the implementation of the arrangement regarding free choice of hospital.

In the hearing statement from the Norwegian Board of Health Supervision, we have stressed the need for defining the rights of drug addicts more clearly in the legislation. Among other things, we support the recommendation that clients who are suitable for MAR in general should have the same rights as clients in other groups, and that the assessment about whether a client has the right to MAR should be made on the basis of the general rules in the Patients' Rights Act and other professional guidelines.

This means that we also agree that the present guidelines with special admission criteria and rules for discharge should be withdrawn. We have also pointed out that necessary follow-up by the municipal social services of drug addicts who have the right to receive treatment from specialized health services, cannot be implemented without changes to the Social Services Act. Drug addicts' rights to receive social services and offers of adequate housing and activities must be strengthened in this way, and harmonized with their rights to receive health care in accordance with the Patients' Rights Act. The need for these legal safeguards cannot be met by making a new regulation regarding the requirement for a plan of measures, pursuant to the Patients' Rights Act.

Health and social services for people suffering from mental illness

Health and social services for people suffering from mental illness have been considerably improved during the last few years. But services for many of the people who need the most comprehensive services are still inadequate, and we need to assess whether the measures provided are good enough.

In 2006, the Norwegian Board of Health Supervision collected information to build up a comprehensive picture of health and social services for people suffering from mental illness. The information was collected from verbal accounts and assessments from the Norwegian Board of Health Supervision in the counties and the Offices of the County Governors, from findings of supervision documented in supervision reports and registers, and from recent research and evaluation. The documentation covers both municipal health and social services and specialized health services. Areas have been identified in which the risk of deficiencies in the services occurring is high, and where, according to the assessment of the Norwegian Board of Health Supervision, institutions and municipalities need to put in more economic and professional resources to improve the services.

The Development Plan for Mental Health is entering its last phase. For several years various new measures have been implemented and the services have been reorganized so that they are more decentralized.

In many municipalities, particularly in small municipalities, it has been difficult to obtain and keep enough qualified personnel, and to organize the services in such a way that very different groups of clients in different age groups are offered services that are in accordance with sound professional standards. In addition, there are many unsolved problems in grey areas and with division of responsibility between different administrative levels. In mental health institutions there are many clients who are ready to be discharged, who have comprehensive needs for care that the municipalities are unable meet. On the other hand, there are many municipalities in which clients with comprehensive needs for services have been received, but where professional and practical support from specialized health services is inadequate. The result is that many of these clients are at risk of receiving inadequate services.

One of the things that concerns the supervision authorities is that, in many places, service providers have too little knowledge about the legislation and little understanding of the importance of meeting the requirements of the legislation, in order to ensure that treatment is in line with sound professional standards, and that clients receive their basic statutory rights.

Shared responsibility for maternity care – when cooperation fails

Midwives and doctors have some areas of responsibility and some tasks that are the same, and some that are different, but they shall cooperate and have a common goal: optimal care and treatment for mothers and babies. Expectations associated with birth are high, and when something goes wrong many people will question whether the help they received was in accordance with sound professional standards. Some people complain to the supervision authorities.

During the period 2003 until 2006, the Norwegian Board of Health Supervision dealt with 33 supervision cases related to pregnancy and birth. These were 21 cases of infant deaths, five cases of babies with serious birth injuries, and two cases of maternal mortality. During the same period, the Norwegian Board of Health Supervision in the counties assessed 274 cases related to obstetrics and gynaecology, the Norwegian System of Compensation for Injuries to Patients made 237 decisions in cases relating to birth injuries to babies, and the health trusts reported approximately 350 adverse events to MedEvent – the Reporting System for Adverse Events in Specialized Health Services.

The following factors are often to be found in supervision cases:

- inadequate observation/follow-up during birth
- incorrect interpretation of electronic foetal monitoring
- failure to request assistance and delayed intervention when developments in the course of a birth are abnormal
- inexperienced health care personnel or temporary health care personnel.

Red and green zones

The Storting (the Norwegian Parliament) has decided that maternity care shall be differentiated. This means that health care personnel shall monitor and follow up pregnant women according to a specific assessment of risk. Maternity services must be organized to deal adequately with both normal births and births which involve increased risk. Midwives and doctors have different areas of responsibility, and they shall complement each other in such a way that pregnant women receive health care according to sound professional standards. Midwives have responsibility for normal births, and the necessary skills for dealing with them. Doctors have responsibility for births that are not assessed as being normal, and have the necessary skills for dealing with such births. Midwives and doctors are expected to cooperate closely. Many maternity units have so-called red and green groups. The green group has responsibility for normal births, and is managed by a midwife. The red group has responsibility for births that are assessed as having increased risk.

Necessary preconditions for differentiated maternity care that meets sound professional standards are a high level of professional skills, correct assessment of risk, clear allocation of responsibility, good communication and close cooperation between health care personnel and between different levels of maternity care. If there are indications during the course of a birth that developments are abnormal, health care personnel must detect this, the level of preparedness must be raised, and extra assistance must be obtained. In some cases we have seen that the threshold for increasing the level of preparedness has been too high.

The midwife in charge – a midwife without responsibility?

Many maternity units have an arrangement with a midwife in charge for each team on duty, who acts as a link between midwives and doctors. The Norwegian Board of Health Supervision is positive to this type of arrangement, but it is important to clarify who has responsibility and authority when such arrangements are chosen. In some cases, the arrangement has functioned as an extra level that has caused delay. The reason for this is that the mandate for the midwife in charge may be unclear. She needs to have an overview and allocate tasks, but she does not have overall professional responsibility for the other midwives. We have seen cases in which a midwife has contacted the midwife in charge instead of contacting a doctor, and this has led to provision of health care that was not in accordance with sound professional standards.

Unclear responsibility and inadequate communication

The Norwegian Board of Health Supervision has detected cases in which unclear responsibility and inadequate communication between the involved health care personnel has led to provision of health care that was not in accordance with sound professional standards. This has happened between midwives and the midwife in charge, between midwives and doctors, and between doctors and senior consultants. This has happened on all levels, but has particularly occurred on busy duties when the number of staff has been at a minimal level. Inadequate clarification and allocation of responsibility was also one of the major findings in the countrywide supervision carried out in 2004 in all the maternity units in the country.

Midwives and doctors sometimes have different opinions about the level of risk associated with a birth. This can lead to different opinions about when a doctor should be called. Assessment of whether progress is normal can be subjective. Combined with lack of skills, inadequate routines and unfavourable practice, this has led to the threshold for calling for assistance being too high.

Maternity care in accordance with sound professional standards – a management responsibility

Obstetrics and gynaecology are areas in which professional decisions have serious consequences. Such decisions often have to be taken under pressure of time. Incorrect assessments are unavoidable. It is therefore especially important that the system has sound, accepted procedures and routines that ensure optimal communication, cooperation and allocation of responsibility. It is only in this way that the number of incorrect assessments can be kept to a minimum. The requirement of sound professional practice also applies to organization of services. The management has responsibility for ensuring that services are organized in such a way that it is possible for health care personnel to fulfil their duty to practise their profession in accordance with sound professional standards. Health care personnel must have the necessary skills, allocation of responsibility must be clear and understood, and duty rotas that are compatible with provision of services that meet sound professional standards must be established. The risk of maternity services that do not meet sound professional standards is only reduced to a minimum when risk areas are detected, errors and events that could have led to errors are reported, adverse events are analysed, and measures to prevent repetition of adverse events are initiated.

Examples of supervision cases related to maternity care dealt with by the Norwegian Board of Health Supervision

Midwife in charge

An inexperienced midwife called the midwife in charge because she was uncertain about the progress of a birth and the foetal heart monitoring. The midwife in charge was under stress because of pressure of work. She gave advice about the progress of the birth, but did not advise calling for the assistance of a doctor. The midwife did not realize that the midwife in charge had not understood that the foetal heart monitoring should also be assessed. The midwife in charge was called again, and it was only then that she realized that the foetal heart sounds were abnormal. The doctor was called, the baby was delivered using vacuum extraction, but the baby had already got a severe birth injury. The midwife said that she had relied on the assessment of the midwife in charge that it was not necessary to call a doctor. The midwife in charge said that she had not had professional responsibility for the birth, and that it was up to the other midwife to call a doctor herself if necessary.

The Norwegian Board of Health Supervision found that the Health Trust had provided health care that was not in accordance with sound professional standards, since the work instructions for the midwife in charge were imprecise and ambiguous. We also found that both midwives had acted in a way that was not in accordance with sound professional standards, since they had not detected alarming signs that should have led to them seeking assistance from a doctor at an earlier stage.

Maternity clinic

A locum midwife was given responsibility for a delivery at a maternity clinic. An experienced midwife offered to be locum children's nurse at the birth. The locum midwife perceived that the birth was not progressing normally. However, she allowed the locum children's nurse to take a very active role in the delivery and followed her professional advice. When asked directly, the locum children's nurse did not recommend that a doctor should be called. The locum midwife did not therefore call a doctor, and the baby died during the birth. The midwife stated that she had attached importance to the advice she had received, while the locum children's nurse stated that it was up to the midwife to assess whether or not she should follow the advice she had been given.

The Norwegian Board of Health Supervision found that the Health Trust had provided health care that was not in accordance with sound professional standards, since the routines when using locum health care personnel were unclear, and the routines for transferring patients to another unit, and for calling for professional help from a doctor in the case of abnormal progression of a delivery, were imprecise. Both midwives had acted in a way that was not in accordance with sound professional standards during the delivery, by not calling for a doctor or transferring the patient to another unit.

Great pressure of work

A woman giving birth was connected to advanced electronic foetal monitoring equipment. The foetal heart sounds were assessed by a doctor as being abnormal, but no action was taken, because according to the guidelines it was in accordance with sound professional practice to wait. The doctor then gave priority to four other difficult deliveries. The midwife reported that she contacted the doctor again several times. Both the doctor and the senior consultant were very busy, and denied that they had been called by the midwife. The baby was delivered using vacuum extraction after 90 minutes and had then serious birth injury.

The Norwegian Board of Health Supervision found that the Health Trust had provided health care that was not in accordance with sound professional standards, since there were no adequate routines for calling for assistance in the case of great pressure of work. Neither the midwife nor the doctor had acted in a way that was not in accordance with sound professional standards.

Follow-up and equipment

A post-natal woman with mild preeclampsia became acutely ill with headache and extremely high blood pressure. The midwife in the maternity unit contacted the doctor, who prescribed intravenous treatment to lower the woman's blood pressure. The equipment for this was not available in the maternity unit. In addition, there were no established routines for dealing with serious preeclampsia. Therefore, it took an unnecessarily long time to obtain the correct equipment and to begin the necessary treatment. The woman died four days later of a brain haemorrhage, caused by high blood pressure.

The Norwegian Board of Health Supervision found that the Health Trust had provided health care that was not in accordance with sound professional standards, since clear routines for following up patients in the unit with preeclampsia had not been established. None of the midwives or the doctors who had been involved had acted in a way that was not in accordance with sound professional standards.

Necessary training and cooperation

A woman giving birth was connected to advanced electronic foetal monitoring equipment. The midwife called a relatively inexperienced doctor several times, because of abnormal heart sounds. The doctor interpreted these as not dangerous and left the maternity unit to carry out other duties. With hindsight, it is clear that the doctor had misinterpreted the changes in the foetal heart sounds. Two senior consultants who were on duty and sat in the staff room in the maternity unit watching television, were not informed. The midwife trusted the doctor's assessment. The doctor was called again when the foetal heart sounds suddenly became very poor late in the course of the delivery. The baby was then delivered by forceps by one of the senior consultants, but died a few days later from the birth injury.

The Norwegian Board of Health Supervision found that the Health Trust had provided health care that was not in accordance with sound professional standards, since interaction between the health care personnel on duty was inadequate. Also, junior doctors had not received adequate training. It was also found that the doctor had acted in a way that was not in accordance with sound professional standards, since she had not called for assistance when she had too many tasks.

Electronic patient records and the duty of confidentiality

Through supervision of two large health trusts in 2006, it was found that confidential information in the electronic patient record systems was not adequately protected to ensure that employees without a legitimate reason did not have access to the information. The reason for this was partly that the computer systems were developed in such a way that access could not be controlled in the way specified in the legislation, and partly that the existing possibilities for limiting access were not fully utilized. Because of lack of control systems, there was little risk that employees in clinical departments would be discovered if they sneaked a look in electronic patient records.

The legislation lays down requirements that health care personnel shall prevent other people from gaining access to information about people's health or disease status or to other personal information. This relates to information that health care personnel have through their role as health care personnel. Thus the duty of confidentiality is not just a passive duty to remain silent, but also an active duty to prevent unauthorized persons from gaining access to confidential information.

The Regulations Relating to Patient Records contain provisions that specify that, in institutions that provide health care, a patient record system shall be established. The patient record system shall be organized both to ensure necessary access to and distribution of patient records, and to protect information against inspection by unauthorized persons.

Exchange of confidential information between health care personnel can only take place when it is essential for the treatment and follow-up of the patient, or when there is another judicial reason for giving such information.

In May 2006, the Norwegian Board of Health Supervision and the Norwegian Data Inspectorate jointly carried out supervision of Helse Bergen Health Trust, Haukeland University Hospital. The aim of supervision was to examine how the health trust ensured that the duty of confidentiality was upheld, and how access to the patient record system Doculive and the patient administration system PMS was controlled. The areas for supervision included registering data in patient records and giving out information from electronic patient records, and management of access to electronic patient records and the patient administration system PIMS.

In June 2006, the Norwegian Board of Health Supervision and the Norwegian Data Inspectorate jointly carried out similar supervision of Aker University Hospital Health Trust. The themes for this supervision were safeguarding the duty of confidentiality and access to the electronic patient record system DIPS.

Supervision was carried out as system audits, and lasted for two days. A system audit is carried out by examining documents, interviewing members of staff, and carrying out other investigations. Measures and practice used by the health trusts were assessed in relation to the relevant requirements in health legislation, the Health Register Act and the Personal Information Act.

We identified nonconformities in both places. The definition of a nonconformity is failure to meet requirements laid down in or pursuant to laws or regulations. The nonconformities were that the health trusts did not ensure that confidential personal information in the electronic patient record systems was adequately protected against access from employees who did not have a legitimate reason to have the information. The nonconformities were generally related to large groups of health care personnel having access to all or parts of the electronic patient records, irrespective of whether they were involved in treatment of patients or not. The reason for this was partly that the computer systems were developed in such a way that it was not possible to meet the requirements laid down in the legislation regarding the duty of confidentiality and management of access to patient records, and partly that the health trusts did not fully utilize the possibilities that were available in the systems for limiting access.

Each year health care personnel record millions of entries in patient records. All these entries are logged automatically. Because of the large number of entries, the limited resources used for control, and inadequate control routines, employees in clinical departments who take a look in patient records when they have no legitimate reason to do so run little risk of being discovered. Log control is therefore not assessed as an appropriate means of identifying misuse.

We are not finished with following up supervision, and it is therefore not yet clear how the health trusts will solve the challenges that were identified by this supervision.

The theoretical basis for social work

Social work is a practical subject, which has the aim of helping people to solve their social problems. In the legislation that governs much of the practice of this profession, clients are broadly identified as all inhabitants in the country, but in practice, social workers mainly work with underprivileged groups and with implementing social policy. The targets for social work are both people and the context in which they live, so social work makes an important contribution to comprehensive services. Such a broad focus requires a broad theoretical foundation. Therefore, a broad theoretical foundation should not be regarded as incompatible with a sound theoretical foundation in understanding and developing the profession of social work within health and social services in Norway.

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Theory and professionals

Social worker is not an official title, but is used in everyday language as a collective title for the professional groups child welfare worker, social worker and social educator*. These professions have a common theoretical basis, but also many differences. Social educators have a theoretical basis in health and environmental work, particularly with people with mental disabilities, child welfare workers have special competence in social education with children and young people, while social workers are generalists who work at the individual level, the group level and the community level. The professions use somewhat different methodology. The term social work is mainly used by social workers.

Social workers work within a wide range of areas. The largest area is municipal services – child welfare services, health services, social services and nursing and care services. Many social workers work in specialized health services. Social workers also make an important contribution in the fields of employment and welfare services, criminal care, school services, state administration of services for children, young people and families, education, research etc.

The practice of social work can be divided into four main areas:

- social work with individuals
- social work with groups
- community work
- social administration and planning.

In addition, social workers have tasks related to teaching, research and professional development.

Generalization as a specialty

Social work has clear roots in sociology, with elements from social psychiatry, psychology and ethics. In Norway, it also has roots in the welfare state and legislation, in common with political science, jurisprudence and economy. The different perspectives are connected to ethics and human rights, and the core of social work is found in this broad construction. Because social workers have knowledge about individuals and society, their efforts can be directed at the interface between clients and their surroundings, such as personal networks, places of work, help agencies and public administration. Many social workers are specialists in the following areas: clinical work with people with mental health problems, family therapy, alcohol and drug problems, and environmental therapy. Some social workers have taken further education: a masters degree or a doctorate degree.

The broad orientation of the subject can be seen as a response to some of the challenges that more and more specialized health and social services face. An aim is that municipal services and specialized services shall cooperate to supply the services that clients need. More and more people use both primary and specialized health services, or receive services from parallel organizational structures. Many clients say that this type of organization hinders a holistic approach. They would like to see more coordination between different levels of organization. They would also like to see that health services offered a greater diversity of services that effect the quality of people's lives. In other words, clients express the wish that the interaction between people and their situation should be taken into account.

The theoretical contribution of social workers involves merging different perspectives, with the view of having a holistic approach. However, it is important that the theoretical breadth of social workers is not seen as incompatible with theoretical depth. This can easily be the case if individual elements in the subject are seen in isolation from the whole. Much can be gained in this respect by comparing general skills in social work with, for example, general skills in general practice, where the generalist perspective has become a specialty.

In particular, a generalist perspective can be justified in relation to the establishment of NAV (the Norwegian Labour and Welfare Organization. The establishment of this organization has involved the amalgamation of employment offices, national insurance offices and social security offices). If new groups of people are to participate in the labour market, we must think afresh, both about how the labour market can be adapted, and how other services can provide rehabilitation and follow-up. The political aim to get more people into work and fewer people dependent on social security requires a holistic approach for services to meet clients' needs using the resources available in society. It is precisely here that the special skills of social workers are to be found. It is essential that NAV, both at the level of the state and in the municipalities, utilizes these skills, in order to achieve the aim of providing coordinated follow-up of clients within the NAV system.

A theoretical basis for social work

Taking the generalist perspective of social work seriously involves systematic work with the broad theoretical basis that forms the foundation of this field, rather than simplifying it and making it more specialized. Human rights, ethical guidelines for the profession and various political steering documents, along with theory and research, make up a central part of the theoretical basis. However, there is a need to clarify on what foundation, and with which aim, social work incorporates these elements into the construction of this subject. It is also important that the breadth of the theoretical basis is taken seriously, by addressing the inherent inconsistencies in the theoretical basis.

A clarification of a common theoretical basis would allow social workers to document their contribution to the services, more than just relatively simple and limited descriptions of methodology. This would provide clients with better information about the kind of social assistance they can expect to receive, and give sounder justification for decisions that are taken. In this way, the services become clearer, more available and less controlling.

Just as important as clarifying the theoretical basis for social work, is discussing the characteristics of this basis. Unfortunately, there is a tendency for services to overflow with abstract theoretical models and instrumental methods that are not adapted to concrete challenges in the everyday work of social workers.

We must aim to identify and develop basic norms, standards and values, so that the services can take a critical look at what they provide, and identify the practical consequences of this insight[1]. If we do not do this, external criticism can be demoralizing, and internal aims can be difficult to meet, since social workers end up in situations they cannot deal with. In this context, the discussion about the quality of social services is relevant. This theme has been on the agenda when assessing the issue of authorization of child welfare workers and social workers, who, because they are social personnel, are not encom-

passed by the current authorization arrangement for health care personnel. The quality of social services and authorization of social workers are closely connected issues. A discussion about quality of services involves a discussion about the theoretical basis for the services. We also need to decide how quality can be ensured and how theory can be developed at the institutional level and for each individual service provider.

Merging theory and practice

The theoretical basis for social work and social services can best be developed by establishing structures that combine practice and theory. The university hospitals have a sound tradition for integrating practice, education and research. It is positive that a project along these lines has been initiated with the University College and University Social Security Office (HUSK). The project involves cooperation between four municipalities (Stavanger, Sandnes, Sola and Randaberg), a university college (Agder) and three universities (Trondheim, Oslo and Stavanger). Here, social workers will have access to relevant research and theory, the educational institutions will be able to identify the theoretical basis that is needed for practice, and researchers will obtain an understanding of which issues are relevant for the services.

It is also positive that more social workers are taking further education, and that they work both with research and teaching, and in health and social services. Having social workers with such qualifications will help in the process of improving the services by using new knowledge and the results of research.

New ways of working and new structures for combining training, research and practice, will address the complexity of the subject, by integrating theory and practice, and by being orientated towards both individuals and society. In this way social workers can contribute to achieving the objective of all health and social services: to provide services of high quality, within a system that has a holistic approach, in a humanitarian way[2].

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*) Social educators are encompassed by the Health Personnel Act

Supervision and research

In accordance with the Specialized Health Services Act, Section 3–8, hospitals have a duty to carry out research. However, it is up to the management at each hospital to decide the level of resources allocated to this area. Supervision of medical research is one of the tasks of the Norwegian Board of Health Supervision.

During 2006, research has been exposed to scrutiny through attention in the media about scientific fraud in several areas, including the area of health services research. Medical research is an area that has previously received very little attention from the supervision authorities.

In 2006, the Norwegian Board of Health Supervision finished dealing with a supervision case regarding a research project at Aker University Hospital Health Trust. We found that the project was in breach of the requirement in the health legislation to meet sound professional standards. In the research project, experiments were carried out on patients, without adequately assessing whether their inclusion in the project was in accordance with sound profession standards, and without obtaining informed consent from them. In addition, the way in which tests were taken was assessed by the Norwegian Board of Health Supervision as not being in accordance with sound professional standards, because the procedures involved increased risk for the patients.

The two doctors who were responsible for the project received a warning for breach of the Health Personnel Act, Section 4, relating to the requirement to meet sound professional standards. Hospital management is also responsible for ensuring that health services offered and provided to patients are in accordance with sound professional standards. Hospital management has a general responsibility to ensure that services are provided within the framework of the legislation, and has a duty to ensure that research projects that the hospital is responsible for are carried out in accordance with statutory requirements. According to the assessment of the Norwegian Board of Health Supervision, the hospital lacked routines or other systematic measures to ensure that the research project in question was run in accordance with health legislation.

The Norwegian Board of Health Supervision found that Aker University Hospital Health Trust had not ensured that the research project in question was run in accordance with the Specialized Health Services Act, Section 2–2, the Regulations Relating to Internal Control, Section 4, and the Biobank Act, Section 12.

The Norwegian Board of Health Supervision is also dealing with a case regarding research at Rikshospitalet-Radiumhospitalet University Hospital Health Trust. A doctor who has committed scientific fraud has lost his authorization as a doctor and as a dentist. The case against the health trust is still being dealt with. Both this case and the research project at Aker University Hospital Health Trust have been reported to the police to assess whether the circumstances represent a breach of the law. Both cases are under investigation.

Experience from supervision and alternative ways of supervising alternative treatment

During the last few years, the Norwegian Board of Health Supervision has received several enquiries and cases regarding alternative treatment. Most patients believe that the Norwegian Board of Health Supervision supervises alternative treatment in the same way as health services and health care personnel within traditional treatment services. But there is no statute in the Alternative Treatment Act* for public supervision of alternative treatment. The Norwegian Board of Health Supervision only supervises health services and authorized health care personnel.

New types of alternative treatment methods are continually being offered. These vary from those that involve minimal risk, to those that can involve a serious risk for the patient's health and safety.

Current legislation limits the possibilities for the Norwegian Board of Health Supervision to supervise alternative health care workers who are not authorized according to the Health Personnel Act. The strategy of the Norwegian Board of Health Supervision to meet the challenges related to supervision of alternative treatment, has been to cooperate with other supervision authorities.

Development of legislation

Alternative treatment is defined as treatment that is provided outside the health service. Previously, this type of treatment was regulated according to the Quackery Act. Over time, attitudes in society to alternative treatment methods have changed, and more acceptance of these methods is now required from the public services. This has led to a new act relating to alternative treatment, which came into force on 1 January 2004. A challenge in developing this legislation has been to find a balance between patients' freedom of choice and their need for protection.

According to this act, neither the Norwegian Board of Health Supervision, nor other public supervision authorities, have direct responsibility for supervision of alternative treatment. One exception is that the Consumer Ombudsman supervises marketing of these services. However, the Alternative Treatment Act does allow the Norwegian Board of Health Supervision to apply for prosecution against an alternative health care worker when a serious breach of the law has taken place that has been deliberate or involved serious negligence, or when the supervision authority is made aware of alternative treatment that represents a serious risk for the patient's health.

A certain level of control of alternative practice is carried out through so-called "self justice", in that alternative practitioners can establish organizations that can be registered in a public register administered by the Directorate for Health and Social Affairs. One of the conditions for such registration is that the practitioner organization must establish an impartial complaints board, which can intervene in the case of non-serious members. However, it is not compulsory for alternative health care workers to be registered in a practitioners' register in order for them to be able to practise alternative treatment. In practice, this means that a practitioner who is excluded from an organization can still continue to practise.

Supervision according to the health personnel act

When alternative treatment is carried out by authorized health care personnel, the provisions in the Health Personnel Act apply in addition to the provisions in the Alternative Treatment Act. The Health Personnel Act lays down explicit requirements that authorized health care personnel shall practice in accordance with sound professional standards, irrespective of whether they practice within the ordinary health services or within alternative services. The Norwegian Board of Health Supervision carries out supervision to ensure that authorized health care personnel meet the requirements laid down in the Health Personnel Act.

Grey area

From the enquiries the Norwegian Board of Health Supervision has received from patients who complain about alternative treatment they have received, we see that many people are not aware that there is a distinction between practitioners who are authorized and those who are not. More ambiguity is created, since the border between alternative treatment and treatment in the general health services can appear to be diffuse. For example, more and more new types of treatment are offered in which the practitioner uses equipment that is normally used in the health services, for example laser equipment.

It is a challenge to make patients understand that the supervision authorities can intervene in relation to an authorized nurse who runs a clinic for alternative treatment, but has limited authority if the alternative health care worker is not authorized. Also, it may seem unfair that an authorized health care worker runs the risk of receiving an administrative reaction from the supervision authorities, while an alternative health care worker without authorization does not receive the same supervisory follow-up.

Cooperation with other supervision authorities

Even in cases in which the Norwegian Board of Health Supervision has no legislative supervision authority, it may be apparent from the information about a case that the health of the patient is at risk. In such cases, to an increasing degree, the Norwegian Board of Health Supervision has cooperated with other supervision authorities, who, on the basis of the legislation governing their supervision, have the possibility to intervene. In this way, the Norwegian Radiation Protection Authority, in consultation with the Norwegian Board of Health Supervision, has followed up cases regarding treatment with laser equipment, and the Consumer Ombudsman has followed up cases of unprofessional marketing of alternative treatment.

In 2006, the Norwegian Board of Health Supervision and the Consumer Ombudsman also carried out joint supervision of marketing of cosmetic surgery. This proved to be most effective and appropriate. Joint supervision of other areas of alternative treatment is therefore being planned with other relevant supervision authorities in 2007.

*Act of 27 June 2003 No. 64 relating to alternative treatment of disease etc.

Anne Karen Jenum
Photo: Samfoto

A lighthouse for community medicine

Dr Anne Karen Jenum was awarded the Karl Evang Award for 2006. She received the award for her work over many years with health promotion and health education in the field of community health, primarily in the urban district of Romsås in Oslo. Dr Jenum is a kind of lighthouse for community medicine, said Steinar Westin, in his speech at the award presentation.

For many years Dr Jenum has been interested in social inequalities in health, and has worked with practical prevention, health promotion and health education.

– When I was an assistant public health physician in the county of Finnmark, I met young men who died of heart and circulatory diseases, and living conditions were difficult for the population in general. It was a shock to meet reality in this way, and I felt that the education I had received had not given me the tools that I needed to prevent these problems, said Dr Jenum, when describing the background for her interest in community medicine.

When she returned to Oslo at the end of the 1970s, Dr Jenum worked as a physician in the eastern districts of Oslo.

– Here I also met ill-health, and again experienced that I did not have the tools to work with prevention. For a long time I felt like a lonely soul in this area. I searched for methods, and I put the essence of what I believe in into practice in my clinical work. I have learnt a lot from patients. It has been enriching and informative to enter the worlds of my patients, she said.

Among other positions, Dr Jenum has been district medical officer in Romsås from 1997 to 2004, and has been strongly committed to community health in this district.

– The population is clearly defined and limited, so it was possible for me to get to know the people, and to be able to do something. But it was important to make a survey of the situation first, said Dr Jenum.

– The aim was to identify the factors related to mortality, and to do something about them. Data from the health surveys of 40 year-olds helped me to begin with. All the time it has been important to be able to document and evaluate the effect of measures that have been implemented, she continued.

The "Romsås Project" (MoRo – Motion in Romsås) was established through cooperation between the district administration and several other organizations. The project was a combined research programme and community health programme. In addition to Dr Jenum, a physiotherapist, a health consultant and a nurse worked in the project. The Norwegian College of Physical Education and Sport and Aker University Hospital Health Trust were also important contributors to the project.

The aim of the research programme was to investigate the effect of increased physical activity on the risk factors for type 2 diabetes and heart and circulatory diseases in the population.

– It has been hard work, but rewarding and informative. The greatest challenge was to get funding for the project. We did not foresee this, and used 1-2 years longer than we had planned. In order to get things done, it is important to remain enthusiastic along the way, she said.

– One of the things that has given me most pleasure with the project, is that the positive results we obtained were equally positive for people with low education and high education, and for immigrants and ethnic Norwegians. The project also created pride in the population. A local politician said: We can now stand up tall.

– This made all the hard work worthwhile, said Dr Jenum.

Dr Anne Karen Jenum defended her PhD in 2006, with a thesis that presented the results of the project. The main results were published in the journal *Diabetes Care*.

– Health promotion has had far too little status among physicians working in primary heath services. But with the large differences in health and mortality in Oslo, we must examine the risk factors and try to do something about them, believes Dr Jenum.

– It is very important to give priority to preventive measures in Groruddalen. It can be worse and more expensive for society to do something later, she says.

– Groruddalen provides a clear example that responsibility for health should be shifted from the individual level to the community level.

At the moment, Dr Jenum has a post-graduate scholarship with the Diabetes Research Centre at Aker University Hospital. At the same time she works part-time as a general practitioner in Romsås.

Monitoring vulnerability and quality

There are many sources of information, with different aims, and of varying quality. As a supervision authority, how can we organize, summarize, interpret and use all the information on health and social issues that is constantly produced, for the purpose of supervision?

In 2006, as part of the project "area surveillance by the supervision authorities" (TOP), the Norwegian Board of Health Supervision carried out a survey of skills in methodology among employees in the supervision authorities. The survey provided a useful insight into the daily work that the Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties carry out in order to monitor important areas of health and social services in their county.

Many sources of information

The Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties have close contact with health and social services, both municipal services and specialized health services. A lot of information is obtained from supervision, for example from system audits, supervision cases and cases of complaint. Information is also obtained through continuous contact with institutions, both planned and ad hoc, from administrative tasks, from internal and external meetings, and from enquires from health and social personnel, relatives, client organizations and the media.

The staff report that they have little time to keep up to date with relevant register data, scientific journals, government reports and research reports in a systematic way. These sources are more often used for specific tasks, or more by chance depending on the special interests of the individual member of staff.

Collectively, these sources provide a wealth of information that is unique for the supervision authorities, but that also demands much resources to relate to. Information possessed by individual members of staff that has not been not organized, recorded or discussed, can be utilized for new tasks or events. In one county, they expressed this in the following way:

The sum of everything we see and hear forms the basis for choosing our targets for supervision. Something happens as a result of what we are talking about at the moment: "Here we see that there can be a good reason to…". We often get an impression from complaints and enquiries that the services are under a lot of pressure, even though these enquires may not result in supervision cases or cases of complaint…. We deal with the things that crop up. The areas are so large that we cannot constantly investigate them all. We have to look at the areas where things are building up. This means that we have to have members of staff who understand the system, who have intuition, who sense what needs to be followed up, and who ask "what is going on here?".

Developing sound methods for collecting information involves, for example, investigating what intuition and an understanding the system consists of. Individual experience can provide essential information, but has doubtful status as a source of information. We need methods that can increase the value and relevance of knowledge gained from the experience of the Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties. We also need to raise the level of consciousness and reflection of members of staff, so that they use their intuition, recognise relevant information, and ask: "What does this tell us about? How can we use this information? How does this information supplement other information we have about health and social services? What shall we do about it?

Recognising useful information and making sound assessments requires that departments have methods and systems for collecting and organizing information that individual members of staff acquire through various channels and from different areas. This is necessary in order to take care of the collective knowledge the department has about health and social services in the county.

Complex aims

The supervision authorities are required to follow trends and to have an overview of the populations' needs and of the health and social services that are provided. The aim is to help to ensure that health and social services meet the requirements of sound professional standards, and to intervene if services are in breach of statutory requirements. In other words, the supervision authorities shall exercise control, but they shall also ensure that the findings of supervision are used by the services in their work with improving the quality of the services they provide. This requires comprehensive knowledge.

First, we need to focus on both problems and success. Exercising control involves identifying or exposing vulnerable areas, where there is a danger that deficiencies related to statutory requirements may occur.

Second, we need both descriptive and normative knowledge: both good descriptions of the situation and sound assessments of what is adequate in relation to statutory requirements.

Improvement and development

Members of staff in the Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties have qualifications in the fields of medicine, health, social services, social sciences and law. They represent a broad spectre of traditions in knowledge and understanding of methodology. This diversity is primarily a resource, but it also demands knowledge and discussions about methodology in the departments.

In order to improve and develop systematic work with the knowledge base of the supervision authorities, in 2007, the Norwegian Board of Health Supervision shall carry out training in methodology, in cooperation with members of staff in the Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties.

Temporary staff recruitment agencies for health services – a resource and a challenge

Up until 2000, there was a general prohibition against hiring out staff in Norway. One reason for this was the experience that hiring temporary staff led to the resignation of permanent staff, and that companies had to hire the same staff at a higher cost (NOU 1998: 15).

Increasing needs for manpower, low unemployment rates and adaptations to a common European labour market, resulted in the prohibition against hiring out staff being withdrawn from 1. June 2000. As a result, private agencies for recruiting and hiring out health care personnel have been established.

Updated statistics about private recruitment agencies are not available. However, statistics from the Employment and Recruitment Register show that about 1 100 health care personnel were hired out from 16 recruitment agencies in 2001 (Fafo: the Institute for Applied Social Science, 2002:17). In 2002, there were between 30 to 40 recruitment agencies (Dagens Næringsliv 08.07.2002). A survey carried out in 2006 by the Norwegian Board of Health Supervision showed that the number of recruitment agencies was about the same in 2006 as in 2002.

Temporary staff recruitment agencies are used for supplying temporary staff to cover vacant posts, sick leave, holidays and hectic periods for health services. Some institutions also hire temporary staff for whole departments or units.

Temporary staff recruitment agencies recruit a large proportion of their staff from abroad, particularly from countries within the EEA. Many of the staff have been educated in countries outside Europe or the EEA.

Recruitment of health care personnel from other countries contributes to a net increase in supply of manpower to Norwegian health services. This is desirable in order to improve the supply of health services in Norway, but involves the risk of draining other countries of qualified health care personnel.

Temporary staff recruitment agencies pay higher wages than public employers. Helse Bergen Health Trust has calculated that expenditure on salaries is 30–50 per cent higher when temporary staff are used instead of permanent staff (Norwegian Radio Hordaland 17.04.2002). There is therefore reason to believe that use of temporary staff recruitment agencies has the effect of increasing wages. The wage level is also a factor that makes foreign health care personnel choose to obtain work through recruitment agencies rather than to be employed directly by a municipality or health trust.

The Norwegian Board of Health Supervision has found from supervision that use of temporary staff involves an increased risk of deficiencies in the services. Some of the reasons for this are:

- Unclear distribution of responsibility between the employer (the recruitment agency) and the delegating authority (the municipality or health trust) leads to a lack of control of professional qualifications (education and authorization) and suitability for the post.
- Uncertainty about the responsibility of the employer and the right of the delegating authority to give instructions to health care personnel.
- Inadequate training of temporary staff in local routines.
- Inadequate follow-up and continuity in treatment of patients.

The Norwegian Board of Health Supervision expects health service managers to take the necessary steps to ensure that use of temporary staff does not have negative consequences for health services. We will direct our attention to the use of temporary staff in health services in 2007.

Isolation of infection in hospitals

Supervision of ten hospitals in the autumn of 2006 showed that in general infectious patients were isolated in accordance with sound professional standards. However, the Norwegian Board of Health Supervision pointed out nonconformities at seven of the hospitals. These nonconformities related to deficiencies in organization, lack of procedures, lack of updating of procedures, lack of following procedures, lack of personnel, and inadequate initial examination of the patient by the staff. The number of isolation units varied a lot in the different health trusts, but this was not a critical factor.

In the autumn of 2006, the Norwegian Board of Health Supervision and the Norwegian Labour Inspection Authority carried out supervision of the plans and measures that are implemented to prevent and limit infection of and from patients and staff in ten health trusts[1]. Supervision was part of the health authorities' "Action Plan for Prevention of Hospital Infections 2004–2006", and was also included in the Norwegian Labour Inspection Authority's campaign "Keeping Watch" with health, safety and environmental conditions in hospitals.

In accordance with the Regulations Relating to Control of Communicable Diseases in Health Services, health institutions are required have an infection control programme. An infection control programme is a programme that includes all necessary measures for preventing infections in health institutions and for dealing with outbreaks of infection. All necessary measures to prevent infection in an institution shall be documented in the infection control programme. The programme shall be part of the institution's internal control system.

As part of the preparations for carrying out supervision, the Norwegian Knowledge Centre for the Health Services was asked to assess the available knowledge about a selection of issues relating to isolation of patients with infectious diseases. They carried out a systematic search of the literature, and made a critical evaluation and summary of the available documentation of the effect of isolation as a measure to control airborne infection from infectious patients. One of the conclusions of the report was that most of the studies showed that good effect was achieved when several measures were used at the same time, but few studies had tested the effect of individual measures used alone. On the basis of this documentation it was difficult to draw conclusions about which measures are most important, and to assess the value of isolation of airborne infection compared with other measures.

Supervision was carried out at two hospitals in each regional health authority. The areas we specifically investigated were: organization, routines, training, availability of staff resources, practice, and resources for isolation of contact infection and airborne infection. This included measures in the infection control programme, dealing with nonconformities and management's focus on control of infection.

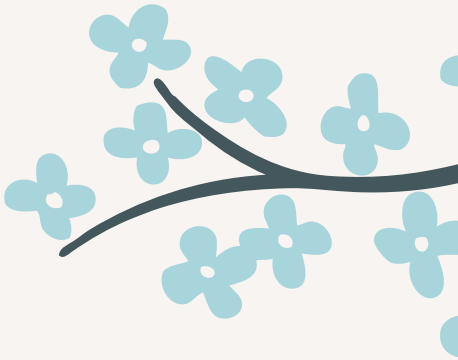
Supervision was carried out for two days at each the hospitals. Steering documents and practice were assessed in relation to health legislation and legislation relating to the working environment.

The Norwegian Board of Health Supervision identified from one to three nonconformities at seven of the hospitals:

- At four of the health trusts, the doctor who had responsibility for coordinating control of infection was not placed administratively directly under the management.
- At two of the health trusts, the health care personnel with experience of control of infection were neither represented in the quality control committee, nor connected with the committee in another appropriate way.
- At two of the health trusts, not all the staff for whom it was relevant were tuberculin tested and tested for antibiotic-resistant bacteria before they were appointed or reappointed to their post in the health institution.
- At one hospital, there was no doctor with responsibility for coordination of control of infection and no hygiene nurse.
- At one hospital, the doctor with responsibility for coordination of control of infection had not been allocated time to carry out this work.
- One health trust did not ensure that the infection control programme was updated as necessary and followed.
- One health trust did not have a comprehensive, updated infection control programme with content in accordance with the regulations.
- At one health trust, isolation of patients to prevent contact infection was not always carried out in accordance with sound practice in all of the units.

In addition, comments were given to six of the health trusts that it would be an improvement if they raised the standard of, or increased the number of, normal isolation units, and/or airborne infection isolation units.

We are not finished with following up supervision, and it is therefore not yet clear how the health trusts will solve the challenges that were identified by this supervision.



[1] Sørlandet Hospital Kristiansand, Telemark Hospital Skien, Aker University Hospital, Lovisenberg Diakonale Hospital, Helse Fonna Haugesund Hospital, Helse Førde Førde Central Hospital, Helse Nordmøre og Romsdal Molde Hospital, Helse Nord-Trøndelag Hospital Levanger, Nordlands Hospital Bodø Sentrum and Helse Finnmark Clinic Kirkenes.

Summary of registration of cases of suicide in mental health care

In 2005 and 2006, the Norwegian Board of Health Supervision carried out an investigation of cases of suicide among patients who were under the care of mental health services. These are cases that were reported to the Norwegian Board of Health Supervision in the Counties. The aim of the investigation was to obtain a reliable overview of the number of reported cases and to carry out a quality control of the way in which the cases were dealt with in relation to supervision of the services.

Collection of data was completed on 31 December 2006, and after this time the Norwegian Board of Health Supervision has worked with summarizing the results of the project. The material included all completed cases dealt with by the supervision authorities during these two years. This means that the number of completed cases is not the same as the actual number of cases during the year.

We registered 59 cases in 2005 and 116 cases in 2006. Of these 175 cases, 60 cases were investigated as supervision cases.

Criticism of the system was given for 20 cases. The institutions received advice/counselling or criticism for many of the same areas that we pointed out before the registration began: health care personnel have inadequate skills in assessing suicide risk, and many of the institutions lack routines for training about assessment of suicide risk and measures for suicide prevention. An in-patient stay in the department is often too short in order to make a diagnosis, adequate protective measures are not taken during the vulnerable transition phases in treatment, and documentation is still inadequate.

The Norwegian Board of Health Supervision has chosen to focus on the system in these cases. We know that an increasing number of institutions are focusing on training and measures to prevent suicide. However, our figures indicate that these measures are not adequately implemented in the day-to-day running of the clinics, and that the health trusts still have great potential for improvement in these areas. This topic will be dealt with in more detail in a separate report, from the Norwegian Board of Health Supervision.

Supervision of specialized health services

During the period 2002-2005, the Norwegian Board of Health Supervision in the Counties carried out supervision of 275 specialized health services. In 51 of these cases, supervision was initiated locally within different areas of somatic specialized health services. The decision to carry out supervision is based on an assessment of areas and services where there is a risk that deficiencies in the services may occur, and where the aim is to inspect the institutions regularly. Supervision was carried out as system audits, that is supervision in which it is investigated whether the institution ensures, through its internal control system, that services are provided in accordance with health legislation. This article presents a brief description of what we have learnt from this supervision.

Supervision, initiated locally, was carried out in five health regions during the period 2003-2005. Most supervision was carried out in the Central Norway Health Region. In this region, supervision was carried out in 15 institutions, which is almost twice as many as in Eastern Norway and Southern Norway Health Regions. With the exception of eight private institutions, supervision was carried out in public health trusts. Supervision was mainly carried out as part of the local plans for supervision in the counties. In five institutions supervision was carried out because of reports that gave cause for concern from the institutions, or because of complaints.

The following areas were themes for supervision:

- patients' rights (12)
- quality improvement committee, internal control, dealing with nonconformities, and the duty to report adverse events (12)
- maternity units (11)
- admittance and discharge of patients, documentation and internal control in private hospitals (6)
- communication, documentation, routines and procedures associated with continuity of patient care, internal coordination and coordination between municipalities and specialized health services (6)
- organization and running of ambulance and emergency services (4).

Supervision that was carried out as part of the local plans for supervision, was mostly carried out in the same areas as those for previous countrywide supervision. The guidelines that were developed for countrywide supervision could therefore be used. In general, the findings were similar to the findings from countrywide supervision.

Services provided in maternity units were generally found to be satisfactory, but there is room for improvement, both in small and large maternity units. Supervision of organization of ambulance and emergency services showed that these services also generally functioned satisfactorily and that the population received the services they needed.

Several breaches of the legislation were identified regarding patients' rights and quality improvement work in hospitals. These breaches were in the same areas in 2004 and 2005 as in countrywide supervision carried out in 2002 and 2003. Quality improvement committees had been established and were part of the hospitals' internal control systems, but, with a few exceptions, there were serious deficiencies in getting the systems to function satisfactorily. Most of the hospitals had introduced a system for reporting nonconformities, but in many cases it was not clear what should be reported and how reports should be used to improve the quality of the services. There were several examples of lack of a common understanding of what a nonconformity is, and failure to report adverse events, even though they were regarded as nonconformities. Many hospitals did not act in accordance with the provision in the Patients' Rights Act about dealing with referral or treatment of patients who have been granted the right to essential health care. The small private hospitals assessed referrals and initiated treatment more speedily than the large public hospitals, but the short deadlines for providing treatment did not apply for all diagnoses.
A real improvement seems to have taken place in the way specialized health services ensure that patients receive their right to free choice of hospital.

In the view of the Norwegian Board of Health Supervision, it as unacceptable that breaches of the legislation are still to be found in the same areas, several years after countrywide supervision was carried out. The management in the health trusts must initiate measures to ensure that everyone is familiar with statutory requirements and that these requirements are fulfilled, in order to reach the aims of health legislation. Management must also take responsibility for ensuring that health trusts systematically learn from their own experience and from the experience of others.


AMBULANSE
AMBULANSE

The municipalities must take 24-hour on-call services for general practitioners seriously

The municipalities do not use their management rights. A survey of 24-hour on-call general practitioner services, carried out by the Norwegian Board of Health Supervision, has shown that these services are inadequate, and that they are not run according to standard guidelines.

The municipalities have responsibility for ensuring that 24-hour on-call services are available for the population. General practitioners have a duty to organize their services so that they can see their patients who need immediate help. This functions best in small municipalities, where general practitioners take responsibility for this themselves. General practitioners take less responsibility for this duty in municipalities where there are many general practitioners. In a Gallup survey carried out in 2002, using the telephone number found in the telephone catalogue, it was relatively easy to obtain contact with a doctor during the day in only 40 per cent of municipalities. Supervision of these services was carried out in 2005, and it was found that access to general practitioners during the day was inadequate in 25 per cent of municipalities in which supervision was carried out.

In large municipalities, where special units have been established to provide this service, access is better, but the result is that patients also use these units for ordinary consultations. This limits access for patients with acute needs, and undermines the intention of the regular general practitioner scheme.

Health care personnel with on-call duty are available via the closed health radio network. Only half the municipalities in the country ensure that doctors are regularly available via the health radio. The equipment is complicated to use, and those who are responsible do not ensure that health care personnel receive adequate training in its use.

In small municipalities with few general practitioners, the duty rota can present a problem. The establishment of inter-municipal on-call services can encourage recruitment and stability of general practitioners, can lead to higher quality services, and can ensure a reasonable on-call duty rota. However, local populations and politicians are sceptical to organizing these services in large districts. The municipal authorities have to assess the risk, by weighing up efficiency against availability and the time aspect.

Routines, training and skills

On-call services require doctors who have the necessary skills, and who can communicate well with patients and with other health services. Doctors are alone in situations, and have limited access to support services. Supervision has shown that the risk of making mistakes, and the risk of complaints being made, is greater than for ordinary day-time general practitioner services. Typical incidents are associated with serious acute conditions such as dehydration, acute pain and recently identified diabetes. There is a higher proportion of supervision cases involving male doctors who have Norwegian as their second language. In some cases, inadequate systems have been detected, for example, related to documentation, cooperation with emergency units, ambulance services and hospitals, sending information to general practitioners and following up test results.

As a result of supervision of municipal on-call general practitioner services in 2005, deficiencies were detected in checking the qualifications of health care personnel working in on-call services, and in providing essential training. Even though general practitioners are self-employed, and are not under the management of the municipalities with regard to professional issues, the municipalities still have a duty to ensure that services are organized in accordance with sound professional standards.

To a greater degree, municipalities must establish clear guidelines for on-call general practitioner services, about qualifications, training, patient record systems, information to regular general practitioners and dealing with test results. Municipalities cannot deny their responsibility by referring to the responsibility general practitioners have themselves for providing services in accordance with sound professional standards.

FROM THE OFFICES OF THE COUNTY GOVERNORS AND THE NORWEGIAN BOARD OF HEALTH IN THE COUNTIES

Previously, the annual supervision report has contained a summary of what the supervision authorities in the counties have reported to the Norwegian Board of Health Supervision (the central office) about conditions in their own county, based on the so-called "worth-knowing-about" reports. This year, because these reports are no longer produced, we have chosen another approach. We have asked some of the people who work at the county level to write short articles on specific topics that are relevant for the services, for supervision and for dealing with complaints.

Contact with the municipalities

In planning and carrying out their work, the Offices of the County Governors, as administrative body and supervision authority for social services, need to receive opinions from clients.

The tasks of the Offices of the County Governors that relate to social services are directed at the municipalities. This applies to their roles as complaints body and supervision authority, and to a large extent in relation to giving advice and counselling, though counselling may also be given directly to clients on request. Thus the municipalities are our clients. In some situations we are also partners in cooperation for development tasks.

At the Norwegian Board of Health Supervision in Nordland, we have positive and constructive contact with the municipalities, and a reasonably good overview of the services. This is based on information obtained from, for example, projects carried out during the last 6–7 years, supervision, dealing with complaints, and various surveys. During the last few years, we have carried out three surveys in the following areas: social care in the municipalities, the need for qualified staff in social services, and challenges associated with establishing NAV (the Norwegian Labour and Welfare Organisation). These surveys have been used both as the basis for planning out-reach services such as courses and conferences, and for giving feedback to municipalities.

It is important for us to communicate well with the municipalities. Our experience has shown that enquiries from clients and their representatives are mainly dealt with satisfactorily, through advice and counselling. However, some enquiries need to be followed up. In 2006 we carried out incident-related supervision of municipalities, based on enquiries from clients. We plan to carry out similar supervision in February 2007.

The Office of the County Governor in Nordland

The situation regarding establishment of NAV offices and challenges for the Office of the County Governor

Conditions in the county of Sør-Trøndelag are favourable for the success of the NAV Reform (the Norwegian Labour and Welfare Reform). The municipalities have been working for a long time with establishing service offices and with locating the different offices that provide services at the same place. Many people were involved in the project to coordinate employment offices, national insurance offices and social security offices, and there is a positive tradition of good communication between the state and municipalities, and between government institutions.

In the autumn of 2005, the Government Employment Offices (Aetat), the National Insurance Service, the Norwegian Association of Local and Regional Authorities (KS) and the Office of the County Governor in Sør-Trøndelag entered a partnership to work with the NAV Reform. A county group was established, under the leadership of the Office of the County Governor, to promote good communication between the state and the municipalities, to coordinate NAV (the Norwegian Labour and Welfare Organization) and other services, to assess joint measures, and to share experience.

Preparations and the establishment of NAV offices in 2006

In the spring of 2006, meetings were held with all the municipalities to discuss the aims of the reform, the need for a strategic approach and the choice of offices to carry out a pilot project. Information was sent out regularly, and NAV was a frequent theme at joint meetings of KS and the Office of the County Governor.

When NAV had been established, NAV's project group was given responsibility for the local processes taking place in each municipality. The county group kept its coordinating role, and has been important for communication between the state and the municipalities. In the autumn of 2006, NAV had several discussions with the municipalities, and the eleven NAV offices that will be established in 2007 were chosen. In November 2006, the county group held a conference for all the municipalities to discuss the status of the work being carried out in the municipalities and the challenges for 2007.

The Office of the County Governor in Sør-Trøndelag has wished to contribute actively to facilitate work with NAV. In addition to participating in the county group, the Office of the County Governor allocated NOK 150 000 to each municipality for cultural activities and for training. We have also worked with activities related to the assignment from the National Directorate for Health and Social Affairs to raise competence in the area of municipal social services.

Challenges for 2007

It will be a great challenge to establish eleven NAV offices before the deadline, while maintaining good communication between the state and the municipalities, taking care of the staff and achieving our goals. At the same time we must ensure that the municipalities that are going to establish offices in 2008-2009 choose a strategic approach at an early stage, and work well with NAV.

In 2007, the Office of the County Governor will continue its work to make sure that the partnership between the state and the municipalities functions well, so that the inhabitants receive better and more coordinated services. It is particularly important that activities associated with social services in the municipalities support the NAV Reform, and are coordinated with NAV's activities. Raising the level of competence of people who work in social services, and cooperation with the county office of NAV to provide training in the local NAV offices, will be given priority.

Many municipalities have chosen to include several municipal health and social services in the NAV offices, in addition to the services that have to be included. These are services that the Office of the County Governor and the Norwegian Board of Health Supervision in the County shall carry out supervision of. This presents a challenge for the supervision authorities, since it is not yet decided how supervision with NAV shall be carried out.

The Office of the County Governor in Sør-Trøndelag

The system or the individual?

In accordance with the Health Services Supervision Act, the Norwegian Board of Health Supervision in the County is required to carry out supervision of all health services and health care personnel. When information is received about a possible deficiency in health services, more information about the matter is obtained, in order to assess whether the supervision authority should react. But who or what should the reaction be aimed at?
Has an individual (a health care worker) made a mistake? Or should attention be directed towards the system (the health service)? Or is the deficiency the result of interaction between an individual mistake and a deficiency in the system?

Some health care personnel work so independently that to a large degree they manage and control their own work, for example general practitioners, dentists and physiotherapists in solo practice. If they act in a way that is not in accordance with sound professional standards, then they must be prepared to accept the consequences themselves.

However, to an increasing degree, health services have become complex organizations, in which the individual health care worker has limited influence over the conditions for practising his or her profession. He or she does not perform as a soloist, but is a member of a team in which each member is dependent on the others. Further, each team works in cooperation with other teams. If the organization does not have systems and routines to ensure that quality is rooted in the system, the result can be deficiencies in the health service, even though each individual health care worker conscientiously fills the functions he or she is allocated. And if there is no internal control system with a sound learning cycle, deficiencies can be repeated time and time again with different people in the role of the person who makes a mistake.

Health care personnel have a duty to work in accordance with sound professional standards, pursuant to the Health Personnel Act. Health care personnel who act in breach of this provision risk an administrative reaction from the supervision authorities. But the legislation also stipulates that health services must be organized so that individual health care personnel are able to meet their statutory duties. It is an increasing challenge for both the Norwegian Board of Health Supervision in the Counties and the central office to analyse deficiencies in the system within the complex organization of health services, and to place responsibility where it rightly belongs.

The Office of the County Governor in Vest-Agder

An increasing number of complaints

During the last few years, the Norwegian Board of Health Supervision in the County of Hordaland has dealt with an increasing number of complaints about failure to meet patients' rights. There were 91 complaints in 2006. Most of the complaints are about three areas: the right to essential health care from municipal health services, the right to essential health care from specialized health services, and economic assistance to cover travelling expenses.

Different priorities

Giving equal priority to patients is still a problem in the specialized health services. Practice has shown that there are different opinions about the conditions for providing essential health care. Therefore patients do not always get the same offer of services. Deadlines for providing health care that meet the requirement of providing health care that is in accordance with sound professional standards, also vary. This applies to both somatic and psychiatric health services. There are probably several reasons for these problems. One reason may be that assessments are not carried out independently of the health service supply that is available at the institution where the assessment is made. These assessments are difficult, and require sound guidelines and experienced staff.

A high threshold for getting a place in a nursing home

With regard to municipal health services, complaints are often about limited access to places in nursing homes. This has several consequences. For example, some municipalities allow elderly people to share a room in a nursing home, to compensate for a lack of places. Some municipalities set too high criteria for allocating a permanent place in a nursing home. Other municipalities allocate other types of help outside the home, which do not necessarily meet all the client's needs. An example of this is allocation of a place in a residential home where supervision and care is not provided 24 hours a day. This gives cause for concern. The number of complaints that the Norwegian Board of Health Supervision in the County of Hordaland has given approval to has increased during the last year.

The Office of the County Governor in Hordaland

The Norwegian Board of Health Supervision in the media

The Norwegian Board of Health Supervision was mentioned over 8 900 times in the Norwegian media in 2006, compared with 7 800 times in 2005. The search engine "Google" gave 164 000 hits for the search queries "Helsetilsynet" (Norwegian Board of Health Supervision) and "2006".

A perusal of cases about us in the archives of the media surveillance bureau "Retriever" shows that the media cover a wide range of the issues we deal with, both planned supervision and incident-related supervision.

At the beginning of January last year, both the Norwegian Board of Health Supervision and the Norwegian Medicines Agency reported a dealer of Chinese herbal medicine to the police after a woman was admitted to St. Olav's Hospital with serious kidney damage. This was reported in the local newspaper Adresseavisen.

In the same month the news bureau ANB reported that the Norwegian Board of Health Supervision would initiate a supervision case against Jon Sudbø, even though no patients had been injured as a result of his scientific fraud. As everyone in Norway knows, a supervision case was initiated.

Also in January, the media began to report the "Kristina case" at Haukeland University Hospital. The Norwegian Board of Health Supervision took over the supervision case in March, when the Chief County Medical Officer in Hordaland declared himself disqualified.

In February the local newspaper Bergens Tidende reported a supervision case regarding a birth at Lærdal Hospital. Both the hospital and Helse Førde Health Trust were given criticism for having unclear routines, and for not having ensured that the midwives who were involved had received adequate training.

At the end of the month, the national newspaper VG reported that two researchers at Aker University Hospital had received a warning from the Norwegian Board of Health Supervision for having carried out research on patients that did not meet the requirements of sound professional standards. The hospital was given criticism for breaches of laws and regulations related to patient treatment and research. The case was also reported to the police.

In March, several media referred to the reports summarizing the results of countrywide supervision, and to other matters reported in the Annual Supervision Report 2005. There were over 100 reports in the media related to the Annual Supervision Report.

In the same month, there were reports on local television in the counties of Tromsø and Finnmark that an increasing number of adverse events that could have led to injury to patients, are reported to the Norwegian Board of Health Supervision. However, many patients are not informed about the incidents. The report was based on the Report from the Norwegian Board of Health Supervision: Annual Report 2005 for MedEvent (Meldesentralen – the Reporting System for Adverse Events in Specialized Health Services).

In April, the Norwegian Board of Health withdrew Norwegian authorization from a Danish doctor, who, among other things, had prescribed Subutex to Norwegian drug addicts in Denmark. This was reported in the local newspaper Bergens Tidende. For NOK 9 000 Norwegian drug addicts could buy a trip to Denmark, which included a consultation with a doctor, a prescription and one month's supply of Subutex tablets. The doctor had already lost his right to prescribe drugs in class A (narcotic drugs) and class B (prescription drugs that are addictive) in Norway, in 2004.

In May, the Norwegian Board of Health Supervision issued instructions to Helse Vest Regional Health Authority to improve the situation at Sandviken Hospital. That psychotic patients have to sleep in the corridors, because there are no rooms available, is a very serious situation. That this situation is permanent, is unacceptable, said the Director General of the Norwegian Board of Health Supervision to the local newspaper, Bergensavisen.

In June, the national newspaper, Aftenposten wrote about the report of the Norwegian Board of Health concerning the chain of events from when emergency service headquarters (AMK) are informed that an unconscious person has been found until the ambulance service has completed dealing with the event. In the newspaper it was reported that in several cases patients were asked to give their personal details before their vital functions were checked.

In July, it was reported in the local newspaper Adresseavisen that the Norwegian Board of Health Supervision had applied for prosecution against Trondheim Municipality after a woman died in a fire in her sheltered accommodation. The woman had been granted 24-hour care, and at the same time her remote control safety alarm had been taken from her.

In August it was reported in the media that the Norwegian Board of Health Supervision had requested that the scientific fraud at Rikshospitalet-Radiumhospitalet Medical Center should be investigated, after the supervision case had been transferred from the Norwegian Board of Health Supervision in Oslo and Akershus.

In the same month, NTB wrote that patient records at Haukeland University Hospital are too easily available. This was detected after supervision carried out jointly by the Norwegian Board of Health Supervision in Hordaland and the Norwegian Data Inspectorate.

In September, the newspaper Dagens Medisin wrote about the survey carried out by the Norwegian Board of Health Supervision of temporary staff recruitment agencies for health services. An examination of 44 supervision cases against health care personnel in 2004 showed that almost half of the cases involved health care personnel who were either employed by a recruitment agency or hired out by a recruitment agency.

In October, the local newspaper Moss Avis reported that the Norwegian Board of Health Supervision was concerned about the use of temporary staff at Østfold Hospital, in connection with a supervision case against a Danish locum doctor. A supervision case was initiated after a baby suffered brain damage during birth. Other supervision cases also demonstrate how important it is that temporary staff are familiar with routines at the hospital.

In November, most of the media reported that Haukeland University Hospital received criticism about certain aspects of the supervision case, the so-called "Kristina case". The theme was communication between the hospital and the relatives.

At the end of November, the media reported that Jon Sudbø lost his authorization as a doctor and a dentist because of scientific fraud. In December, NTB reported that Sudbø had withdrawn his complaint about the decision.

And in the opinion of the Norwegian Board of Health Supervision…

In this article we present a selection of the opinions of the Norwegian Board of Health Supervision, taken from hearing statements in 2006. All the hearing statements referred to here, and those that are in the list at the end of the article, can be found on our website www.helsetilsynet.no.

Proposal for the National Health Plan (2007–2010)

- When administrative and professional management of health services appear to be separate, this presents a great challenge. In order to meet the challenges related to quality and prioritization, administrative and economic management must be closely merged in the Health Plan, and this must be supported by the actions of the state.
- Specialized health services are in a period of consolidation after the reform of health authorities and health trusts. The services must be given time "to settle", and quality and economy must be monitored.
- A broad range of measures and many actors can influence quality and prioritization. New bureaucratic structures will not necessarily lead to an improvement in the way the challenges related to quality and prioritization are dealt with.
- Internal control is the system that the authorities have chosen to use for legally established quality management in health and social services. In the draft National Health Plan, internal control is presented as something other than quality management. It is presented as a measure to ensure that less stringent norms than those that are needed to ensure sound practice/sound services can be met. According to the legislation, institutions shall be managed in such a way that they do the right things in the right way and achieve the right results.
- Sound practice and sound professional standards are two sides of the same coin. Sound practice is the core of the requirement to provide services that meet sound professional standards. Service providers shall provide services that meet the requirements of sound professional standards, and sound practice shall be their aim. When the impression is given in the Health Plan that the level of sound professional standards lies well below the level of sound practice, it becomes unclear what quality requirements actually are. One can be left with the impression that poor quality services meet statutory requirements.

Changes to the Patients' Rights Act and the Specialized Health Services Act after the reform of health and social services for people with alcohol and drug problems

- The right to choose the place where one receives treatment should apply for all multidisciplinary treatment for alcohol and drug abusers, and for medication-assisted rehabilitation (MAR).
- An individual plan should be offered to clients receiving MAR, as for other clients. An individual plan does not give clients the right to receive services in addition to those that are laid down in the Social Services Act.
- The right to care services, practical assistance and training, and comprehensive social rehabilitation must be strengthened for everyone who is receiving, or who has previously received, multidisciplinary treatment for alcohol and drug abuse. The legislation must strengthen clients' legal safeguards regarding both these services and health services.
- The Ministry of Health and Care Services should assess whether the Control Commission should have the same role for patients who are admitted for alcohol and drug addiction as for other patients, and whether these clients should be given the same right to be represented by a lawyer.

Proposal for regulations regarding municipal vaccination services according to the national vaccination programme

- In our opinion, the draft regulations have so many weaknesses that we do not recommend that they are adopted. The arrangements that the authorities propose in order to improve vaccination coverage for seasonal influenza should not involve the risk that preventive work carried out in health centres and school health services can be weakened in the long run. The authorities must give clear and unambiguous guidelines about what is expected of the municipalities in order for them to fulfil their duties pursuant to the Communicable Diseases Control Act. It must also be clear what is expected of risk groups and the population. The effect of a vaccination programme for influenza is questionable, if the people at risk shall pay for vaccination themselves.
- The legislative basis for the programme for vaccination of children should not be moved from the Regulations Relating to Municipal Health Education and Health Promotion in Health Centres and School Health Services, to new Regulations Relating to a National Vaccination Programme. The vaccination programme is an important part of health centre services and school health services.

Proposal for changes to the Biotechnology Act

- Pre-implantation diagnostics in combination with tissue-typing, with the aim of producing a healthy child with similar tissue type, who can be a stem cell donor for a sibling who has a serious congenital disease, raises special issues of principle. These issues are different from those for other types of pre-implantation diagnostics.
- Traditionally, diagnostics and new treatment methods in Norwegian medicine have been introduced as a result of research, experience, experimental diagnostics, experimental treatment and observation carried out over time. A corresponding process has not taken place in this area.
- The method is technically difficult, and there are few examples of a successful result. There are few places where this type of diagnostics is carried out. Experience with the method is therefore very limited, and it can still be regarded as experimental treatment.
- Since the method involves so many ethical dilemmas, it is important to proceed cautiously. We agree with the views presented in the Proposition to the Odelsting No. 64 (2002–2003): There is reason to be very critical of every method that can involve using one human being

as a measure for another. Even though this is prevented by current Norwegian legislation, there is a danger that pre-implantation diagnostics may be used in the future for purposes other than those allowed today.

Changes to the regulations relating to assessment of suitability for teacher training to also apply to education in the health and social fields

- Over the last few years we have been contacted by several university colleges, because they believe that the Act Relating to Universities and University Colleges does not provide an adequate legislative basis for excluding students who are not regarded as suitable to be health care personnel.
- Out of consideration for the safety of patients and the quality of health services, everyone who undergoes education that gives them the right to be authorized as a health care personnel in accordance with the Health Personnel Act Section 48, should be encompassed by corresponding provisions.

Earlier help for children and young people with mental disorders and/or alcohol and drug problems

- We agree with the working group that one of the side-effects of the use of deadlines for receiving treatment is that meeting a deadline can become an aim in itself, so that the purpose of giving timely and sound health services to vulnerable groups fades into the background.
- There is also a danger that a deadline for treatment can be regarded as a normative deadline that represents sound practice for all patients, so that all treatment that is provided within 90 days of referral is regarded as having met the requirement of sound practice. If the deadline is too short, there is no room for giving priority to patients on the basis of professional assessments.
- Treatment guarantees can direct increased focus on specialized health services and less focus on local networks and measures to provide assistance (for example, schools, psychiatric services for young people, municipal health services and school health services).

Hearing statement from the EU: "Consultation Regarding Community Action on Health Services"

- Because patients more and more often travel abroad to receive health care, there is a need for patients to be able to check health care personnel's authorization. Authorization and supervision authorities in Europe need to work towards more similar legislation, and need to cooperate with supervision of health care personnel.
- Dealing with complaints is more difficult after the complainant has returned to their own country. In some countries, the patient plays an important role in investigating the complaint, and in such cases foreign patients experience serious difficulties in following complaints procedures.
- Compensation arrangements are very different in different countries. The authorities should ensure that adequate information is available about the arrangements in each country, and speed up the process of harmonizing the regulations.

Other hearing statements from the Norwegian Board of Health Supervision

New Regulations Relating to Quality and Safety Requirements when Handling Human Cells and Tissue

Changes to the regulations in connection with changes to the Mental Health Care Act and the Patients' Rights Act

Different types of expert declarations given by health care personnel to legislative bodies (the Graver Report)

Changes to the Regulations Relating to Tapping, Processing, Storing, Distributing and Issuing Human Blood and Blood Components and Administration of Health Information in the Blood Donor Register (the Blood Regulations)

The legal authority for the central database for electronic prescriptions

Proposal for Regulations Relating to Donation, Issuing, Testing, Processing, Conserving, Storing and Distributing Cells and Tissue

Establishment of a pseudonym register for termination of pregnancy, proposals for changes to the Regulations Relating to Termination of Pregnancy, and proposals for changes to the Regulations Relating to Prescriptions

NOU (Official Norwegian Report) 2005:8 Equality and Availability

NOU (Official Norwegian Report) 2006:6 When Safety is the Most Important Factor

Draft Overall Plan for Health and Social Emergency Preparedness

Emergency Preparedness – the need for changes to acts and regulations

Report regarding a Nordic Sami Convention

Operational plan for coordination of national activities abroad by the Norwegian Police Directorate

Facts and figures

This chapter in the Annual Supervision Report presents an overview of the most important tasks that the Offices of the County Governors, the Norwegian Board of Health Supervision in the Counties and the Norwegian Board of Health Supervision (the central office) carry out as supervision authorities and appeals bodies.

Contents

COMPLAINTS RELATING TO FAILURE TO MEET PEOPLE'S RIGHTS TO RECEIVE SOCIAL SERVICES

Table 1 Complaints regarding the Social Services Act dealt with by the Offices of the County Governors Trend 2004–2006 and the result of cases in 2006 according to type of cases

Office of the County Governor	2004	2005	2006						
				Social Services			Economical assistance		
	Cases dealt with	Cases dealt with	Cases dealt with	Cases dealt with	Proportion of decisions affirmed (%)	Proportion of decisions revoked or reversed (%)	Cases dealt with	Proportion of decisions affirmed (%)	Proportion of decisions revoked or reversed (%)
Østfold	548	514	426	72	44%	55%	348	67%	32%
Oslo og Akershus	2 287	1 278	1 223	227	48%	49%	863	73%	25%
Hedmark	229	257	208	34	56%	44%	162	90%	10%
Oppland	205	183	193	46	76%	24%	147	78%	18%
Buskerud	378	393	384	75	40%	51%	302	80%	17%
Vestfold	365	318	336	53	51%	49%	266	85%	16%
Telemark	286	245	188	25	68%	32%	149	90%	9%
Aust-Agder	110	119	99	42	55%	46%	54	85%	14%
Vest-Agder	262	168	166	20	75%	25%	144	81%	19%
Rogaland	634	525	377	43	74%	23%	330	78%	22%
Hordaland	569	588	506	102	61%	37%	379	76%	22%
Sogn og Fjordane	111	117	104	33	39%	57%	64	67%	30%
Møre og Romsdal	256	280	224	51	55%	45%	166	69%	30%
Sør-Trøndelag	284	223	235	34	47%	50%	194	75%	24%
Nord-Trøndelag	126	137	95	24	42%	42%	67	73%	25%
Nordland	314	307	260	51	57%	41%	194	74%	24%
Troms	245	220	226	55	62%	38%	160	86%	13%
Finnmark	124	149	101	19	47%	53%	79	70%	30%
Total	7 333	6 021	5 351	1 006	54%	44%	4 068	78%	22%

The total percentage is not always 100% because rejected cases are included in the cases dealt with, but not in the result of the cases.

Dealing with complaints relating to the Social Services Act is a substantial task for the Offices of the County Governors, though there has been a large reduction in the number of case over the last few years, as shown in Table 1. Altogether, the Offices of the County Governors dealt with 5 351 cases in 2006. Part of the reason for reduction in the number of cases is that some of the cases dealt with by the Offices of the County Governors that relate to other legislation are not included in the figures in the table. The main reason is probably because there are fewer complaints about decisions made by the municipalities. Another reason may also be that more complaints are supported by the municipalities, so that the cases are not sent further to the Offices of the County Governors.

Tables 1 and 2 present figures for cases in which individuals have complained about a decision that the municipality has taken pursuant to the Social Services Act, and that the Offices of the County Governors have dealt with in their capacity as appeals body. About four out of five complaints are about economic assistance. Other complaints are mainly about social services. Examples of cases relating to economic assistance are complaints about the amount of economic assistance, and more specific complaints about expenses for accommodation, clothes, dental treatment, medication, furniture and travelling. Complaints are also made about the conditions for receiving economic assistance and the type of help offered. Examples of this are complaints about economic assistance given as a loan, and complaints that the municipality has taken a refund in economic assistance paid later. Complaints about social services are often about economic assistance for carers and practical assistance, for example, reduction in home help services. Some complaints are about support contacts and respite care.

In 2006, the Offices of the County Governors affirmed the decision of the municipality in 78% of cases (2005: 71%, 2004: 74 %). The proportion of decisions that were affirmed was lowest for cases relating to social services. When the decision of the munici-

pality is not affirmed, this means that the complainant is either wholly or partially supported. In such cases the Office of the County Governor may reverse the decision of the municipality, or the decision may be revoked and returned to the municipality to be dealt with again, sometimes with clear instructions to allocate more.

In 2006, the Offices of the County Governors were required to deal with cases of complaint within three months. In 2005, 90% of cases were dealt with within the deadline, in 2006 85%. At the beginning of 2006, there were 841 cases that had not been dealt with, by the end of 2006, 878 cases. 5 388 cases were received in 2006 (in 2005: 6154, in 2004: 6 394).

The main impression is that the Offices of the County Governors have control over cases of complaint pursuant to the Social Services Act.

*The services are: a) practical assistance and training including CPA (client-managed personal assistance)
b) respite care
c) support contact
d) places in institutions or accomodation with 24-hour caring services
e) economic assistance for carers.

Table 2 Complaints regarding the Social Services Act dealt with by the Offices of the County Governors – complaints about social services according to the different types of services. 2006

Office of the County Governor	Services in the Social Services Act Section 4–2 * a)	CPA	b)	c)	d)	e)	Other provisions in Chapter 4	Total
Østfold	15	7	9	12	3	31	2	72
Oslo og Akershus	57	8	38	32	5	93	2	227
Hedmark	12	6	5	7	4	6	0	34
Oppland	16	3	6	6	0	14	4	46
Buskerud	19	9	10	1	0	43	2	75
Vestfold	18	6	10	6	0	18	1	53
Telemark	8	3	4	3	0	10	0	25
Aust-Agder	9	6	2	13	2	14	2	42
Vest-Agder	3	0	1	2	2	10	2	20
Rogaland	13	3	5	12	0	10	3	43
Hordaland	25	6	17	22	1	33	4	102
Sogn og Fjordane	10	4	3	5	2	13	0	33
Møre og Romsdal	16	6	10	8	2	14	1	51
Sør-Trøndelag	7	0	5	6	0	16	0	34
Nord-Trøndelag	8	1	3	2	3	8	0	24
Nordland	11	5	4	16	3	16	1	51
Troms	10	2	11	9	0	25	0	55
Finnmark	4	0	3	2	0	8	2	19
Total	261	75	146	164	27	382	26	1 006

COMPLAINTS REGARDING FAILURE TO MEET PEOPLE'S RIGHTS TO RECEIVE HEALTH SERVICES

The Norwegian Board of Health Supervision in the County is the appeals body when a person has not received their rights pursuant to the Patients' Rights Act and certain other regulations. Those who have responsibility for the services shall have reassessed the case before a complaint is sent to the Norwegian Board of Health Supervision in the County. The Norwegian Board of Health Supervision in the County can assess all aspects of the case. The decision of the Norwegian Board of Health Supervision in the County is final.

The increase in the number of complaints from 2004 to 2005 is partly due to the introduction of the provision in the Patients' Rights Act about the right to transport to health services. The increase in the number of complaints indicates that there is an increasing awareness about patients' rights among the population.

In 346 of the 867 cases (40%), the complaint was partially or wholly supported, or the decision was revoked because of errors in the way the case was dealt with, or for other reasons. This is the same proportion as in 2005.

[1] Several of the cases dealt with by the Norwegian Board of Health Supervision in the Counties are assessed on the basis of several provisions. Therefore the number of provisions can be higher than the number of cases.

[2] The figures are slightly different from previously published figures, because the figures are corrected when inaccuracies are detected.

Table 3 Complaints regarding failure to meet people's rights to receive health services Number of cases completed by the Norwegian Board of Health Supervision in the Counties according to specific provisions in the legislation 2004, 2005 and 2006

Provision	Provision regarding:	2004[2] Number of cases	2005[2] Number of cases	2006 Number of cases	2006 Of which decision in favour of the complainant
Patients' Rights Act					
Section 2–1 first paragraph	The right to required health care from the municipal health services	32	66	61	26
Section 2–1 second paragraph	The right to required health care from specialized health services	74	138	163	87
Section 2–2	The right to an assessment within 30 workdays	6	25	25	22
Section 2–3	The right to a reassessment	4	3	8	5
Section 2–4	The right to choose hospital	9	15	30	14
Section 2–5	The right to an individual plan	10	13	19	13
Section 2–6	The right to transport to health services	67	323	391	57
Chapter 3	The right to participation and information	12	22	19	8
Chapter 4	Consent to health care/ the right to refuse health care	3	1	5	3
Chapter 5 and Health Personnel Act sections 42, 43 and 44	The right of access to/ correction and deletion of patient records	45	58	60	38
Municipal Health Services Act					
Section 2–1	The right to required health care	147	188	158	73
Dental Health Services Act					
Section 2–1	The right to required dental care	1	2	2	0
Other sections that give the right to health services		24	4	1	0
Total number of assessments of specific provisions[1]		434	858	942	
Number of cases[1]		396	775	867	346

Table 4 Supervision of social services Number of system audits carried out by the Offices of the County Governors 2004, 2005 and 2006

Office of the County Governor	2004	2005	2006
Østfold	7	9	9
Oslo og Akershus	6	16	14
Hedmark	4	10	9
Oppland	4	7	7
Buskerud	8	11	13
Vestfold	3	8	8
Telemark	3	8	6
Aust-Agder	8	7	8
Vest-Agder	5	8	8
Rogaland	3	8	9
Hordaland	5	10	15
Sogn og Fjordane	9	9	9
Møre og Romsdal	6	6	12
Sør-Trøndelag	8	14	11
Nord-Trøndelag	10	7	6
Nordland	10	9	9
Troms	6	8	8
Finnmark	4	5	7
Total	109	160	168

System audits

In 2006, the Offices of the County Governors carried out 168 system audits (see Table 4). This supervision was carried out in 155 municipalities and urban districts. In 28 of the system audits, no breaches of laws or regulations were detected.

Seventy-seven of the 168 system audits were carried out jointly by the Norwegian Board of Health Supervision in the County and the Office of the County Governor, according to both health and social legislation.

The Offices of the County Governors carried out countrywide supervision of two areas, according to guidelines developed by the Norwegian Board of Health Supervision:

- legal safeguards in the case of use of coercion and restraint for people with mental disabilities – 59 system audits
- health and social services for children with special needs – 40 system audits.

The summary reports of countrywide supervision have been published in the Report Series of the Norwegian Board of Health Supervision.

Altogether, 69 system audits were carried out that were not part of countrywide supervision. The institutions and themes for these system audits were chosen on the basis of information that the Offices of the County Governors have about risk and vulnerability in their own county (see the article on page 27).

These 69 system audits included:

- services for alcohol and drug abusers pursuant to the Social Services Act Chapter 4 – 14 system audits
- administrative procedures for domiciliary services – 12 system audits.

Per 31 December 2006, there were still eight open nonconformities (breaches of laws or regulations that had not been corrected) relating to social services. These had been detected in system audits carried out in 2005 or earlier. Four of them related to unlawful use of coercion and restraint for people with mental disabilities, three were related to services for alcohol and drug abusers and one was related to the requirement for an individual plan.

Use of coercion and restraint for people with mental disabilities. Social Services Act Chapter 4A

Table 5 Use of coercion and restraint for people with mental disabilities. Social Services Act Chapter 4A. Number of decisions etc. 2006

Office of the County Governor	Decisions taken by the municipalities – Section 4–A5 third paragraph, a		Decisions reassessed by the Office of the County Governors – Section 4A–5 third paragraph, b and c			Dispensation from the requirment to undergo training – Section 4A–9 number	Local supervision – Section 2–6 number
	Number of decisions*	Number of people the decisions related to	Number of decisions approved	Number of decisions not approved	Number of people the decisions related to		
Østfold	1 000	86	22	3	15	12	6
Oslo og Akershus	3 956	234	73	4	53	46	18
Hedmark	245	48	28	0	28	24	12
Oppland	466	42	54	1	45	45	15
Buskerud	958	47	47	3	23	17	16
Vestfold	435	39	24	0	17	10	5
Telemark	184	47	15	3	8	13	7
Aust-Agder	195	22	9	1	8	0	9
Vest-Agder	747	62	51	0	32	7	18
Rogaland	2 372	102	91	2	57	59	5
Hordaland	10 598	158	160	1	81	76	42
Sogn og Fjordane	607	37	18	4	12	8	14
Møre og Romsdal	1 417	42	71	2	33	30	4
Sør-Trøndelag	1 582	53	37	1	29	12	8
Nord-Trøndelag	99	8	64	0	42	68	17
Nordland	174	24	101	0	41	38	33
Troms	1 478	35	24	1	23	13	5
Finnmark	926	9	9	6	7	8	10
Total	27 439	1 095	898	32	554	486	244

*The explanation for the variation is related to how good the routines are in the municipality for reporting decisions about use of measures to prevent injury in individual situations. The explanation may also be that the municipalities report a large number of decisions in the period before decisions about use of restraint are approved.

Legal safeguards for the use of coercion and restraint for individuals with mental disabilities are regulated in the Social Services Act Chapter 4A. The Offices of the County Governors have several tasks in relation to these provisions (see Table 5).

The municipalities report decisions about measures to avoid injury in emergency situations (individual situations) to the Offices of the County Governors, pursuant to Section 4–A5, third paragraph, a. In 2006, 27 439 decisions were taken, relating to 1 095 persons.

Planned measures to avoid injury in repeated emergency situations must be authorized by the Offices of the County Governors. Authorization must also be obtained for measures to meet clients' basic needs for food and drink, dressing, rest, sleep, hygiene and personal safety, including education and training, pursuant to Section 4A–5 third paragraph b and c. The Offices of the County Governors authorized 898 decisions in 2006. These decisions related to 554 persons:

- measures to avoid injury in repeated emergency situations – 295 decisions
- measures to meet clients' basic needs for care – 349 decisions
- use of mechanical restraint – 19 decisions pursuant to letter b, 50 pursuant to letter c
- use of invasive warning systems – 47 decisions pursuant to letter b, 129 letter c
- education and training – 9 decisions.

The Offices of the County Governors gave dispensation from the requirement to undergo training in 486 cases, which in the Social Services Act, Section 4A–9, applies to personnel who shall implement measures according to Section 4A–5, third paragraph b and c.

The Offices of the County Governors settled one complaint about measures pursuant to Section 4A–5, third paragraph a, and prepared the cases for three complaints regarding measures pursuant to Section 4A–5, third paragraph b and c, to be dealt with by the County Committee for Social Affairs.

On 215 occasions, the Offices of the County Governors carried out local supervision of measures pursuant to Section 4A–5, third paragraph b and c, according to the duty to carry out supervision in Section 2–6, first paragraph, second point. Local supervision was also carried out 29 times pursuant to other provisions.

Issuing instructions

In 2006, the Offices of the County Governors did not issue instructions according to the Social Services Act.

SUPERVISION OF HEALTH SERVICES

Table 6 Supervision of health services. Number of system audits carried out by the Norwegian Board of Health Supervision in the Counties. 2004, 2005 and 2006

Office of the County Governor	2004	2005	2006
Østfold	12	10	13
Oslo og Akershus	8	23	23
Hedmark	10	11	10
Oppland	12	7	6
Buskerud	15	12	10
Vestfold	10	11	15
Telemark	11	10	13
Aust-Agder	11	15	14
Vest-Agder	11	8	13
Rogaland	7	11	18
Hordaland	15	23	20
Sogn og Fjordane	11	13	10
Møre og Romsdal	11	12	15
Sør-Trøndelag	11	15	14
Nord-Trøndelag	10	8	12
Nordland	17	14	22
Troms	10	14	14
Finnmark	10	5	7
Total	202	222	249

The Norwegian Board of Health Supervision in the Counties carried out 249 system audits in 2006 (see Table 6):

- municipal health services – 157 system audits in 138 municipalities and urban districts
- specialized health services – 87 system audits
- other services – 5 system audits.

In addition, the Norwegian Board of Health Supervision in Rogaland carried out two system audits and 21 other types of supervision of health-related conditions in the petroleum industry.

Altogether, 77 system audits of municipal health and social services were carried out jointly by the Offices of the County Governors and the Norwegian Board of Health Supervision.

In 35 of the 157 system audits of municipal health services, no breaches of laws or regulations were detected.

In 2006, the Norwegian Board of Health Supervision in the Counties carried out countrywide supervision of two areas, according to guidelines developed by the Norwegian Board of Health Supervision:

- health and social services for children with special needs – 61 system audits.
- multi-disciplinary specialized services for alcohol and drug abusers – 25 system audits.

The summary reports of countrywide supervision have been published in the Report Series of the Norwegian Board of Health Supervision.

Altogether 115 system audits were carried out in the municipalities that were not part of countrywide supervision. These system audits included:

- 21 nursing homes
- 8 services specially for elderly people with dementia
- 16 health services for elderly people living at home
- 12 system audits of health-related emergency planning
- 11 system audits of emergency services.

Nonconformities from more than one year ago

Per 31 December 2006, there were still open nonconformities (breaches of laws or regulations that had not been corrected) in 28 places where system audits had been carried out in 2005 or earlier (30 at the end of 2005 and 40 at the end of 2004). Of these 28 nonconformities, one was from 1999, one from 2001, one from 2003, 11 from 2004 and 14 from 2005. Four were from supervision of health trusts and 24 from supervision of various municipal services.

The Norwegian Board of Health Supervision in the Counties will follow up nonconformities with the owners and the people responsible for running the services, until the services are in line with statutory requirements.

Issuing instructions

In 2006, the Norwegian Board of Health Supervision issued instructions to seven municipalities, and gave a warning about issuing instructions to five municipalities, about lack of plans for health and social emergency preparedness. The cases have been dealt with pursuant to the Municipal Services Act and the Health and Social Emergency Preparedness Act.

SUPERVISION CASES (INDIVIDUAL CASES) IN THE HEALTH SERVICES

Supervision cases dealt with by the Norwegian Board of Health Supervision in the Counties

Supervision cases are cases dealt with by the Norwegian Board of Health Supervision in the Counties on the basis of complaints from patients, relatives and other sources, concerning possible deficiencies in provision of services.

In 2006, the number of new cases per 100 000 inhabitants varied from 26 in Rogaland and Møre og Romsdal to 86 in Troms. For the whole country, there were 2 333 new supervision cases (50 per 100 000 inhabitants, compared with 45 in 2005). 177 of these cases were rejected because they were obviously unfounded or because they were statute-barred (too old).

The number of supervision cases being dealt with by the Norwegian Board of Health Supervision (the backlog) increased from 1 016 at the end of 2005 to 1 048 at the end of 2006.

The requirement concerning the length of time taken to deal with cases, laid down in the government budget, is that more than half of the cases shall be dealt with within five months. This requirement was met in nine counties in 2006 and 15 counties in 2005 (Oslo and Akershus are counted separately). For all the counties seen as a whole, this requirement was not met. However, the requirement applies for a maximum of 1 700 new cases, and there were 2 333 new cases in 2006.

Table 7 Supervision cases dealt with by the Norwegian Board of Health Supervision in th Counties. Number of completed cases and number of cases that took more than 5 months to deal with. 2004, 2005 and 2006

Office of the County Governor	Number of completed cases			Percentage of cases that took more than 5 months
	2004	2005	2006	
Østfold	116	127	157	79%
Oslo og Akershus	395	295	392	53%
Hedmark	83	91	119	81%
Oppland	79	59	61	38%
Buskerud	115	150	96	52%
Vestfold	84	90	127	34%
Telemark	85	78	96	69%
Aust-Agder	48	59	65	45%
Vest-Agder	67	68	100	40%
Rogaland	111	137	101	48%
Hordaland	136	161	192	42%
Sogn og Fjordane	47	36	47	11%
Møre og Romsdal	71	70	66	74%
Sør-Trøndelag	110	147	124	33%
Nord-Trøndelag	73	52	78	70%
Nordland	94	113	144	55%
Troms	89	74	118	28%
Finnmark	43	70	41	65%
Arrears Project[1]	107	117		
Total	1 953	1 994	2 124	52%
Of which, cases completed without being assessed[2]	269	267	340	

[1] Because the Norwegian Board of Health Supervision in Oslo and Akershus, Østfold and Hedmark took a long time to deal with cases, the Norwegian Board of Health Supervision (the central office) took over 224 cases (the Arrears Project). The project was completed in September 2005.

[2] These are cases that were completed without being assessed, by requesting the person who was complained against to contact the complainant in order to find an amicable solution.

Table 8 Supervision cases dealt with by the Norwegian Board of Health Supervision in the Counties. Number of cases according to legislative basis for assessment of cases. 2004, 2005 and 2006

Legislative basis	Number of cases		
	2004	2005	2006
Provisions in the Health Personnel Act			
Section 4. Sound professional standards: behaviour	202	218	231
Section 4. Sound professional standards: examination, diagnosis and treatment	1 325	1 361	1 499
Section 4. Sound professional standards: medication	171	204	219
Section 4. Sound professional standards: other	246	254	295
Section 7. Emergency treatment	44	56	39
Section 10. Information	98	77	97
Section 16. Organization of the services	141	150	148
Chapters 5 and 6. Duty of cinfidentiality, right of disclosure, duty of disclosure	97	87	103
Sections 39–41. Patient records	264	207	267
Section 57. Fitness to practice: alcohol and drug abuse	46	40	32
Section 57. Fitness to practice: other reasons	74	51	52
Provisions in the Specialized Health Services Act			
Section 2–2. Duty of sound professional standards	294	378	382
Other legislative basis for assessment	476	480	533
Total number of provisions as legislative basis[1]	3 478	3 563	3 897
Number of cases assessed[1]	1 684	1 727	1 784

[1] Several of the cases dealt with by the Norwegian Board of Health Supervision in the Counties are assessed on the basis of several provisions. Therefore the number of provisions can be higher than the number of cases.

Supervision cases are often complex. Table 8 shows that on average each case has more than two legislative bases for assessment. The theme that is most often assessed is sound professional standards. The next most common theme is the duty to keep patient records. There are few cases about alcohol and drug abuse and other issues relating to fitness to practice, but these cases often end up with an administrative reaction from the Norwegian Board of Health Supervision.

Supervision cases dealt with by the Norwegian Board of Health Supervision (the central office)

The Norwegian Board of Health Supervision (the central office) deals with the most serious supervision cases, that are sent over from the Norwegian Board of Health Supervision in the Counties. In 2006, the Norwegian Board of Health Supervision completed 252 cases and received 257 new cases. In 184 cases, administrative reactions were given to health care personnel: 71 cases of withdrawal of authorization and 72 warnings. In 17 cases, authorization was suspended while the case was being dealt with. Supervision cases dealt with by the Norwegian Board of Health Supervision are presented in the article on page 11.

MEDEVENT

Medevent (Meldesentralen – the Reporting System for Adverse Events in Specialized Health Services) is a database for reports of events that are registered according to the Specialized Health Services Act, Section 3–3. Health institutions have a duty to send a written report to the Norwegian Board of Health Supervision in the County in the event of serious injury to patients, or events that could have led to serious injury to patients, that occur as a result of provision of health care, or as a result of one patient injuring another.

The Annual Report 2005 for MedEvent provides a summary of the experience gained from these events. The number of reports of adverse events that occurred in 2005 that were registered in the database per 1 September 2006, was 1 902. About one-third of the reports (34%) were reports of serious injury, and over one-half (52%) were reports of incidents that could have led to serious injury.

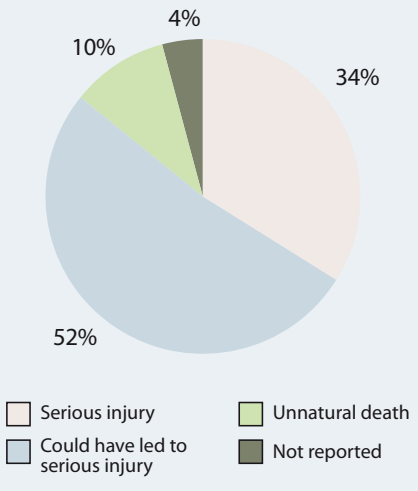
There were 191 reports of unnatural death (10% of all reports of events that occurred in 2005). Twenty-eight per cent of these events happened in mental health care and five per cent were associated with use of medication.

Seven per cent of reports were of events associated with birth. In 79% of these, the event was associated with the woman, and in 21% the child. There were five reports of unnatural death of the child during birth.

Only one per cent of reports were associated with blood, blood products and blood transfusion. None of these were reports of unnatural death.

Fourteen per cent of reports were of events that occurred in mental health care, and 63 per cent of these were related to cases of self-inflicted injuries, suicide and attempted suicide.

Figure 1.
Reports of adverse events that occured in 2005, pursuant to the Specialized Health Services Act, Section 3–3 (n=1902)



USE OF OUR WEBSITE: www.helsetilsynet.no

In 2006, there were approximately 1 065 000 visits to our website (2005: 650 000) and about 4.2 million visits to specific pages (2005: 3.0 million). The most popular sites were (number of visits in brackets):

- publications (1 240 000)
- supervision reports (898 000)
- the websites of the Norwegian Board of Health Supervision in the Counties (432 000)
- legislation (318 000).

ACCESS TO DOCUMENTS

In 2006, the Norwegian Board of Health Supervision received 3 009 requests from the media for access to documents in the Electronic Mail Records. There were 2 265 in 2005, 2 136 in 2004, and about 1 700 in 2003.

Press coverage in 2006 is presented in the article on page 37.

PRESS RELEASES

9/2006. Karl Evang Award presented to Anne Karen Jenum

8/2006. This year's Karl Evang seminar: Violence against children – a challenge for health services

7/2006. You can now nominate candidates for the Karl Evang Award

6/2006. Cosmetic surgery clinics break the law

5/2006. Who are the recipients of coercion and restraint in mental health care?

4/2006. Serious deficiencies in confidentiality and patient record keeping in surgical departments

3/2006. People with long-term complex needs receive fragmentary and divided services

2/2006. Press conference for the Annual Supervision Report 2005

1/2006. An increase in the number of administrative reactions given by the Norwegian Board of Health Supervision.

DIRECTIVES FROM THE NORWEGIAN BOARD OF HEALTH SUPERVISION

The Norwegian Board of Health Supervision did not publish any directives in 2006.

FINANCIAL STATEMENT 2006

Table 9 Financial statement 2006. Budget chapters 721 and 3721, the Norwegian Board of Health Supervision (NOK 1000)

Income/expenditure	Budget	Accounts	Difference
Expenditure: fixed wages	39 927	39 135	792
Expenditure: variable wages	5 454	6 228	–774
Operating costs (rent, cleaning, electricity, security etc.)	8 791	8 910	–119
Other expenditure	16 715	15 696	1 019
Total expenditure	70 887	69 969	918
Income	÷2 369	÷3 155	786
Net expenditure/saving	68 518	66 814	1 704

Expenditure for dealing with complaints, and supervision carried out by the Norwegian Board of Health Supervision in the Counties, was covered under the budget chapter 1510, the Offices of the County Governors.

Countrywide supervision in 2007

As early as the spring of 2006, the Norwegian Board of Health Supervision decided which areas should be investigated as countrywide supervision in 2007. Countrywide supervision means that the Offices of the County Governors and/or the Norwegian Board of Health Supervision in the Counties carry out supervision with the same theme in all the counties, usually as system audits.

The areas that have been chosen for supervision in 2007 are:

- municipal health and social services for adults suffering from mental illness
- quality and sound professional practice in accident and emergency units in somatic hospitals
- respite care services and support person services in accordance with the Social Services Act.

Supervision is carried out as system audits. This means that emphasis is placed on whether the services are managed in such as way as to ensure that the requirements in health and social legislation are met.

Why do we inform about the areas in advance?

The aim of supervision is to ensure that health and social services are provided in accordance with sound professional standards. In the process of choosing the areas for supervision, the Norwegian Board of Health Supervision assesses whether there is a risk that the services are not good enough. By directing attention towards vulnerable areas, and areas where there is a danger that services are deficient, the supervision authorities wish to encourage service providers to initiate measures to improve the services. Directing attention towards supervision and areas for supervision is a way of stimulating improvements.

When choosing areas for countrywide supervision, the Norwegian Board of Health Supervision wishes to focus attention on areas in which internal control is required to ensure that services are provided in accordance with sound professional standards. For example, these can be areas in which services are provided to clients who have difficulty in taking care of their own interests and ensuring that their rights are met. Through internal control, the services shall implement measures that ensure that clients' rights are met, and improve service areas for which deficiencies in services have serious consequences for clients.

By providing information about the areas that have been chosen for supervision in the following year, the services have the possibility to initiate work on quality improvement in important areas and to focus on management of the services. Experience has shown that there is still enough for the supervision authorities to deal with, when the areas for supervision have been defined in more detail and the specific services or institutions have been chosen.

Countrywide supervision in 2007

For 2007, preparations are being made to carry out one countrywide supervision in each of three areas: municipal health and social services, specialized heath services and social services.

Municipal health and social services for adults suffering from mental illness

As part of supervision, municipal health and social services for adults suffering from serious mental illness shall be investigated. Among other things, the following themes shall be investigated: how municipalities identify people who need help, how they assess clients' needs, and how they ensure that clients receive adequate services according to their rights. Other themes for investigation are: how municipalities follow up patients under treatment, how they coordinate essential services, how different sectors cooperate, and how they ensure that services are adapted to individual needs after clients are discharged from in-patient care.

An important theme for this supervision is how health and social services are coordinated, to ensure that people suffering from serious mental illness receive adequate help.

Respite care services and support person services in accordance with the Social Services Act

As part of this supervision, the Offices of the County Governors shall investigate whether municipalities ensure that respite care services and support person services are allocated according to sound professional standards, and whether the personnel who provide these services have adequate knowledge and skills.

Supervision shall be directed towards all the relevant client groups. Respite care in residential units for children, and support person services in these units, shall not be investigated, since countrywide supervision of residential units for children is planned at a later date.

Quality and sound professional practice in accident and emergency units in somatic hospitals

This is an area for supervision within specialized health services. This theme has been chosen because hospital accident and emergency units illustrate several relevant issues related to organization and running of specialized health services. Particular challenges are faced in providing accident and emergency services because the activities are unpredictable, and because the doctors who work there are under the management of different departments/clinics/divisions. This demands coordination of responsibility and authority, and organizational and managerial measures to ensure that the services that are provided meet sound professional standards.

Supervision shall include the services provided to patients from when they arrive at the accident and emergency unit until when they leave the unit. Particular attention shall be paid to the services provided to patients who do not have a diagnosis when they arrive, and to situations that can be described as everyday crises, that is to say when the workload is particularly great even though no previous dramatic events have taken place. As part of supervision, the relationship between professional and managerial challenges in the accident and emergency unit shall be investigated.

Publications from the Norwegian Board of Health Supervision

Reports from the Norwegian Board of Health Supervision

In this series of reports, the Norwegian Board of Health Supervision presents the results of supervision of health and social services. Full text versions of the reports in Norwegian, and summaries in English and Sámi, can be found on our website: **www.helsetilsynet.no.**

1/2006
Documentation and Confidentiality in Hospital Departments of Gastrointestinal Surgery
Summary of countrywide supervision in 2005 of communication between health care personnel and between health care personnel and patients in health trusts that provide surgical treatment for patients with acute diseases and cancer in the gastrointestinal tract

2/2006
Legal use of Coercion and Restraint?
Summary of countrywide supervision in 2005 of use of coercion and restraint for people with mental disabilities

3/2006
Fragmentary and Divided Services?
Summary of countrywide supervision in 2005 of municipal health and social services for adults over 18 years of age with complex and long-term needs for services

4/2006
Use of Compulsory Admission and Treatment in Mental Health Services

5/2006
Annual Report 2004 for MedEvent
(Meldesentralen – the Reporting System for Adverse Events in Specialized Health Services)

6/2006
Survey of Sedation and Pain Relief for Terminally Ill Patients

7/2006
In cases of Emergency…
Emergency events involving unconscious patients. Are they dealt with differently when they may be associated with use of alcohol, or illicit or prescribed drugs?

Supervision info

In Supervision info (Tilsynsinfo) the Norwegian Board of Health Supervision provides information about important topics from supervision cases (individual cases) and other health legislation material related to supervision. You can subscribe to the full text electronic version of this publication on our website: **www.helsetilsynet.no.**

1/2006
Theme: Patient records, the duty to keep patient records

2/2006
Theme: Use of alternative treatment methods

Correspondence

The themes for some of the correspondence from the Norwegian Board of Health Supervision in 2006 are listed below:

Proposal for changes to the Health Personnel Act: new Section 59 relating to limitation of authorization when the requirements for withdrawal of authorization are not met (16 October)

Background information: security in mental health care (10 October)

Contribution to the national strategy to combat inequalities in health (30 September)

Municipal emergency services: the findings and assessment of the Norwegian Board of Health Supervision (4 September)

Completion of Supervision Case – Breach of the Specialized Health Services Act and the Regulations Relating to Internal Control. The research project "Hip Fracture Project" at Aker University Hospital Health Trust (22 February)

Correspondence is published on our website: **www.helsetilsynet.no:** publications/decisions in individual cases. Hearing statements (see the article on page 38) and correspondence regarding instructions given to institutions and administrative reactions given to health care personnel are also published on our website.

Annual reports about health and social issues

The Norwegian Board of Health Supervision in the Counties publish annual reports about services, supervision and complaints in the county. These reports are aimed at health and social services and public administration in the county, and the central authorities. They can be found in full text in Norwegian on our website.

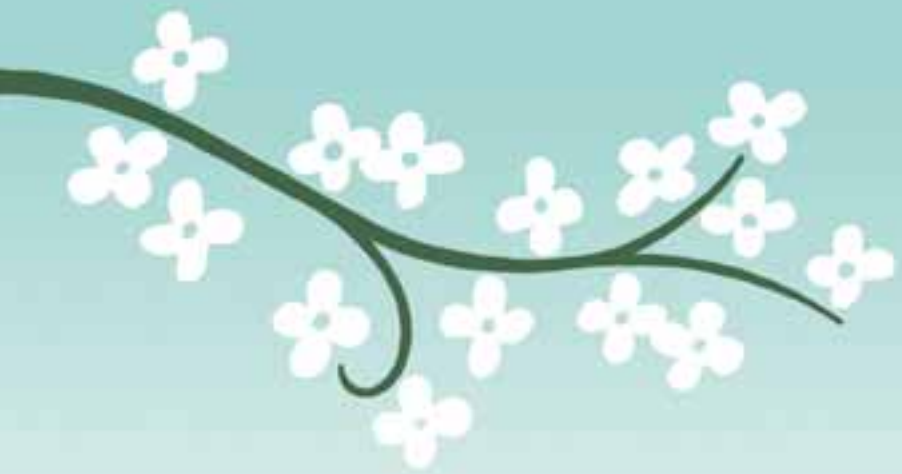
Articles

Each year about 15–20 articles are published by employees of the Norwegian Board of Health Supervision. These are published (or there is a link to the article) on our website.

www.helsetilsynet.no
The website of the Norwegian Board of Health Supervision is primarily for people who have responsibility for health and social services, and for journalists. The website was visited about 1 065 000 times in 2006.

On the website you will find:

- **Requirements laid down by the authorities for health and social services:**
  acts, regulations, directives and other documents that give the authorities' interpretation of acts and regulations
- **The results of the work of the supervision authorities:**
  supervision reports, the report series: Report from the Norwegian Board of Health Supervision, the newsletter, Supervision info with completed supervision cases, other publications, hearing statements, letters, articles
- **Information to the public about how to make a complaint about health and social services**
- **Information about how the supervision authorities work:**
  methods, sources of information, plans for supervision, tasks, authority and organization



KF65 VIRTUAL GARDEN Illustrations: Svein Storksen

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