Community Development and Health Network (CDHN) is a regional network organisation, consisting of over 1800 organisations. We support and engage our network to advance their knowledge and skills in community development, to influence policy and to use community development to reduce health inequalities.

CDHN believe the governance, quality and safety of our health and social care system is of paramount importance. We welcome the Donaldson review and the opportunity to respond to the issues raised, most notably the recommendation for action on Transforming Your Care.

**Recommendation 1:** **Coming together for world-class care**

*We recommend that all political parties and the public accept in advance the*

*recommendations of an impartial international panel of experts who should be*

*commissioned to deliver to the Northern Ireland population the configuration of health and*

*social care services commensurate with ensuring world-class standards of care.*

CDHN fully understand the rationale and frustration which has prompted this recommendation; the failure of our politicians to show leadership and implement evidence based change as laid out in Transforming Your Care (TYC). However we would argue that the recommendation should not be acted upon for several reasons.

* The democratic process is of vital importance in Northern Ireland, given that we live in a post conflict situation. Any action which sets a precedent and can be interpreted as undermining the democratic system and process in Northern Ireland may fuel future instability. Such instability is unwanted and potentially dangerous in a post conflict situation.
* Northern Ireland has already carried out a review and delivered recommendations and plans for action in relation to our health and social care system, TYC. There is no need to repeat a similar exercise so soon following this, the money, resources and time could be better spent.

Instead of implementing recommendation 1 CDHN calls on our politicians, clinical and health and social care leaders to show strength and leadership. Our leaders should be ensuring the public are fully informed of the evidence as to why change is required and the potential health benefits. When decisions must be made that do not have public support but has clear evidence for improved outcomes, then it is a necessity that our leaders take unpopular decisions regardless of the pressure.

**Recommendation 2:** **Strengthened commissioning**

*We recommend that the commissioning system in Northern Ireland should be redesigned*

*to make it simpler and more capable of reshaping services for the future. A choice must be*

*made to adopt a more sophisticated tariff system, or to change the funding flow model*

*altogether.*

CDHN fully agree that the commissioning process should be strengthened. In principle we agree that there is much which could be taken from the experience in England, but we need to learn from the positives and negatives rather than simply trying transplant a similar system here.

Learning from the English system which should be considered:

* The increased cost of commissioning due to administration and bureaucracy. A House of Commons select committee report and research by the carried out University of York clearly attribute significant increases in costs to NHS England to the commissioning process. Both acknowledge that exact figures are difficult to pinpoint due to a lack of consistency in the way data is defined and collected.
  + We should take note of the areas where these reports detail increased expenditure and try and keep these to a minimum from the start.
* The disconnect/perceived disconnect between Care Quality Commission and local commissioning groups. “Even if the politicians, NHS England and the Care Quality Commission are all behind [something] you then get down to the local CCGs [clinical commissioning groups] who do their own thing. At the moment they make decisions, some of it based on gut feeling. What we need them to do is understand the needs of the local population and make sure the resources match that.”  Mark Winstanley, Chief Executive of Rethink Mental Illness.
  + While it is vital that local commissioning groups are able to respond to local need, this must take place within a regional framework, as set by HSCB and PHA, to prevent the emergence of a postcode lottery health and social care system.

If Northern Ireland is to introduce a tariff system there is also learning to take from England.

* Leading doctors have written in the BMJ that the tariff system, where hospitals are paid by treatment, has been a contributing factor to an increase of unnecessary and costly interventions. Careful consideration about how to mitigate against this impact would need to happen before introducing a tariff system.

**Recommendation 3:** **Transforming Your Care (TYC) – action not words**

*We recommend that a new costed, timetabled implementation plan for Transforming Your*

*Care should be produced quickly. We further recommend that two projects with the*

*potential to reduce the demand on hospital beds should be launched immediately: the first,*

*to create a greatly expanded role for pharmacists; the second, to expand the role of*

*paramedics in pre-hospital care. Good work has already taken place in these areas and*

*more is planned, but both offer substantial untapped potential, particularly if front-line*

*creativity can be harnessed. We hope that the initiatives would have high-level leadership*

*to ensure that all elements of the system play their part.*

CDHN fully support the implementation of recommendation 3. Renewed focus, energy and resources needs to be allocated to Transforming Your Care as a matter of priority. As Donaldson highlights support for TYC is starting to wane due to lack of action. The opportunity for change through the implementation of TYC should be seized before support dissipates completely.

CDHN completely endorses the enhanced role of pharmacists. Pharmacists offer support in the management medicines, treatment of minor aliments but they can also aid the development of public health, and there are a number of key policy documents and practical projects in Northern Ireland which support this notion:

* CDHN lead a programme entitled Building the Community Pharmacy Partnership (BCPP) investing in the development of partnerships between Pharmacists and the local community. It highlights the key role pharmacists can play a within their communities, in the prevention and management of illness and building healthy communities. Through the use of a rigorous impact evaluation toolkit the Programme is demonstrating the impact of meaningful partnerships between pharmacists and local communities.
* In 2014 the DHSPPS launch a five year plan for community pharmacy entitled: “making it better through Pharmacy in the Community”. The strategy provides a clear direction for the delivery of pharmacy services in the community over the next 5 years. A direction which lies not only in the dispensing and supply of medicines, but also in the provision of advice, information and services to help people gain better outcomes from their medicines and live healthier lives. “
* The Health Plus Pharmacy initiative in NI “recognises the important role pharmacy has to play in keeping communities healthy and well.  To receive the award a Health+Pharmacy will have shown that it meets a variety of standards on issues such as staff training, the premises and working with a range of organisations to support health and wellbeing.”

**Recommendation 4:** **Self-management of chronic disease**

*We recommend that a programme should be established to give people with long-term*

*illnesses the skills to manage their own conditions. The programme should be properly*

*organised with a small full-time coordinating staff. It should develop metrics to ensure that*

*quality, outcomes and experience are properly monitored. It should be piloted in one*

*disease area to begin with. It should be overseen by the Long Term Conditions Alliance.*

CDHN are unclear why the self management of chronic disease has been included as a recommendation. It is not that we do not support the principles of the recommendation but feel that it is out of place in this review. TYC made seven recommendations with regard long term conditions. It is therefore implicit that the implementation of recommendation 3 would achieve the aim of this recommendation, therefore making it redundant.

**Recommendation 5:** ***Better regulation***

*We recommend that the regulatory function is more fully developed on the healthcare side*

*of services in Northern Ireland. Routine inspections, some unannounced, should take place*

*focusing on the areas of patient safety, clinical effectiveness, patient experience, clinical*

*governance arrangements, and leadership. We suggest that extending the role of the*

*Regulation and Quality Improvement Authority is tested against the option of outsourcing*

*this function (for example, to Healthcare Improvement Scotland, the Scottish regulator).*

*The latter option would take account of the relatively small size of Northern Ireland and*

*bring in good opportunities for benchmarking. We further recommend that the Regulation*

*and Quality Improvement Authority should review the current policy on whistleblowing and*

*provide advice to the Minister.*

CDHN welcomes the expansion of the regulatory function. We do not oppose the outsourcing of the function **IF** it improves quality. However if there is little difference between RQIA developing and enhancing their work and outsourcing then CDHN would be strongly in favour in keeping the function with RQIA. We would also ask that the option of collaborative working between RQIA and Healthcare Improvement Scotland be considered as an alternative to complete outsourcing.

**Recommendation 6**: ***Making incident reports really count***

*We recommend that the system of Serious Adverse Incident and Adverse Incident*

*reporting should be retained with modifications.*

CDHN agree with the recommendation. Any actions which lead to resolution of incidents and produce learning must be taken.

**Recommendation 7:** ***A beacon of excellence in patient safety***

*We recommend the establishment of a Northern Ireland Institute for Patient Safety.*

CDHN welcome the idea that Patient Safety is paramount and should be championed, but would urge caution against establishing another body to sit within the already many existing layers of the health and social care system. Northern Ireland needs to reduce the bureaucracy of health and social care in order to improve safety and quality, reduce costs and make the system easier to navigate for users. We would ask that consideration be given to whether an existing body could incorporate this role and become champion for patient safety.

**Recommendation 8: *System-wide data and goals***

*We recommend the establishment of a small number of systems metrics that can be*

*aggregated and disaggregated from the regional level down to individual service level for*

*the Northern Ireland health and social care system. The measures should be those used in*

*validated programmes in North America (where there is a much longer tradition of doing*

*this) so that regular benchmarking can take place. We further recommend that a clinical*

*leadership academy is established in Northern Ireland and that all clinical staff pass*

*through it.*

CDHN agree with this recommendation, and are aware that there are steps with the research and academic communities to develop the use of data for service improvement and for the treatment and management of disease and medicine. Links should be forged between relevant parties to prevent duplication and strengthen action.

**Recommendation 9:** ***Moving to the forefront of new technology***

*We recommend that a small Technology Hub is established to identify the best*

*technological innovations that are enhancing the quality and safety of care around the*

*world and to make proposals for adoption in Northern Ireland. It is important that this idea is*

*developed carefully. The Technology Hub should not deal primarily with hardware and*

*software companies that are selling products. The emphasis should be on identifying*

*technologies that are in established use, delivering proven benefits, and are highly valued*

*by management and clinical staff in the organisations concerned. They should be replicable*

*at Northern Ireland-scale. The overall aim of this recommendation is to put the Northern*

*Ireland health and social care system in a position where it has the best technology and*

*innovation from all corners of the world and is recognised as the most advanced in Europe.*

CDHN agree with this principle.

**Recommendation 10:*****A much stronger patient voice***

*We recommend a number of measures to strengthen the patient voice:*

*► more independence should be introduced into the complaints process; whilst all efforts*

*should be made to resolve a complaint locally, patients or their families should be able to*

*refer their complaint to an independent service. This would look again at the substance of*

*the complaint, and use its good offices to bring the parties together to seek resolution. The*

*Ombudsman would be the third stage and it is hoped that changes to legislation would*

*allow his reports to be made public;*

*► the board of the PCC should be reconstituted to include a higher proportion of current or*

*former patients or clients of the Northern Ireland health and social care system;*

*► the PCC should have a revised constitution making it more independent;*

*► one of the validated patient experience surveys used by the Centers for Medicare and*

*Medicaid Services in the USA (with minor modification to the Northern Ireland context) to*

*rate hospitals and allocate resources should be carried out annually in Northern Ireland; the*

*resulting data should be used to improve services, and assess progress. Finally and*

*importantly, the survey results should be used in the funding formula for resource allocation*

*to organisations and as part of the remuneration of staff (the mechanisms to be devised*

*and piloted by the Department of Health, Social Services, and Public Safety).*

CDHN completely supports any action which strengthen the patient’s voice. A strong patient voice helps ensure quality and responsiveness. CDHN agrees that the PCC should be more independent and patient experience surveys should be carried out annually.

CDHN is also in agreement that the board of PCC should include a higher number of patients, however we would agree that the greater inclusion of patients should extend beyond PCC. Though vital the patient client council is only one way in which the patient voice can be made stronger. Personal and Public Involvement was made a statutory requirement as part of the HSC Reform Act and if it is understood and implemented properly by health and social care staff there should be a greater involvement of patient throughout the system and processes. Therefore CDHN would like to see a greater emphasis on developing the understanding, knowledge and skills of all health and social care staff to implement and measure the extent to which quality engagement is embedded in their everyday practice.

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