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| Cover2 | logocolUNISON RESPONSETHE RIGHT TIME,THE RIGHT PLACE (DONALDSON REVIEW)May 2015 |

1.0 UNISON is the leading public service trade union in Northern Ireland and the largest trade union in the UK with over 1.3 million members. Our membership includes public service workers in health and social care, the education and higher education services; workers in local government, youth justice; workers in private sector service suppliers; and workers in the community and voluntary sectors. 84% of our members in NI are women. All of our members are NHS users. Consequently we respond in our usual capacity of representatives of service users and representatives of the health workforce. This submission is made on their behalf.

2.0 UNISON represents a clear majority of clinical and non-clinical workers in the HSC framework. We continue to act as advocate for their health, the health of their families, and the public health in all dimensions of the population.

**Context**

3.0 This consultation takes place at a challenging time:

* Health inequalities are increasing from a base of existing crisis, and remain unaddressed.
* The health of the people faces increasing damage from planned austerity, as evidenced by Stuckler and Basu in their key text ‘The Body Economic’.
* The system of healthcare has been reduced by ongoing cuts to a level where, despite commitment and professional standards from all health workers, the provision of services is on the cusp of risk and at the point of compromise to patient safety.
* The financial envelope is unsustainable and under-resourced, while performance on key metrics is in a tail spin of decline.
* The current commissioner-provider split structures are demonstrably not fit for purpose, and cannot deliver performance, standards of care, financial stability and address inequalities.

4.0 UNISON is therefore calling for radical reform in which the voice of health workers is heard loud and clear. This requires the immediate restoration of the recently abolished Partnership Forum, which means trade union input and contribution into all key policy issues, including those addressed by Donaldson.

5.0 UNISON’S key principles for reform are:

* Progressive elimination of heath inequalities through a public health model.
* The end of the application of austerity cuts to health, care and wider public spending.
* Workforce inclusion on the basis of respect for trade unions and their members.

6.0 Our current red lines are:

* End the commissioner provider split.
* Single point accountability through sub-regional ‘circles’ publicly owned and funded.
* Transparent funding on the basis of need.
* No outsourcing of health and care services, and the return in-house of services privatised.
* No charging for services, which should be free at the point of use.
* Honesty of information to workers, patients and clients, reversing the current weakening of performance standards in an attempt to gloss over the current crises.

DONALDSON Comment and Recommendation;

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

*“A proportion of poor quality, unsafe care occurs because local hospital facilities in some parts of Northern Ireland cannot provide the level and standard of care required to meet patients’ needs 24 hours a day, 7 days a week. Proposals to close local hospitals tend to be met with public outrage, but this would be turned on its head if it were properly explained that people were trading a degree of geographical inconvenience against life and death. Finding a solution should be above political self-interest.*

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 delivery to the Northern Ireland population the configuration of health and social care services commensurate with ensuring world-class standards of care”.

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| **UNISON Comment:**HSCB have been proposing for 3 years at least the removal of the current configuration of 10 major hospitals and its replacement by 5-7 ‘networks’. They have failed to achieve this or produce any coherent proposal. This is not simply because of the intensity of localised opposition, but the fundamental flaw that centralisation does not achieve the benefits proposed, particularly when new technology allows clinical dialogue without being on the same site, and standardisation of process – which Donaldson proposal UNISON endorses – can achieve consistent and improved clinical outcomes within the current configuration. As far as an international panel is concerned, it should not be funded by viremont from the current pressured budgets. In a democratic society, the solution has to be locally constructed and agreed. All advice and opinions are welcome, but to date our voice as the leading union in health and social care has been ignored and marginalised, and must be heard. |

DONALDSON Comment and Recommendation;

*Recommendation 2: Strengthened commissioning.*

*“The provision of health and social care in Northern Ireland is planned and funded through a process of commissioning that is currently tightly centrally-controlled and based on a crude method of resource allocation. This seems to have evolved without proper thought as to what would be most effective and efficient for a population as small as Northern Ireland’s. Although commissioning may seem like a behind-the-scenes management black box that the public do not need to know about quality of the commissioning process is a major determinant of the quality of care that people ultimately receive.*

We recommend that the commissioning system in Northern Ireland should be re-designed 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”.

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| **UNISON Comment:**The English model of commissioner provider split with tariff is not appropriate here. As indicated in our preliminary statement, there should be directly funded and accountable circles of provision embodying the commissioning and provider functions, and empowered to promote the wider public health agenda to reduce inequalities. Such radical change requires in particular the Department and HSCB to consider the removal of specific roles and responsibilities, and in the case of HSCB the consequences of its own abolition. All work of merit and those who deliver it should be sustained within a new configuration that will be fit for the purposes outlined in our proposals.  |

DONALDSON Comment and Recommendation;

*Recommendation 3: Transforming Your Care – action not words.*

*“The demands on hospital services in Northern Ireland are excessive and not sustainable. This is phenomenon that is occurring in other parts of the United Kingdom. Although triggered by multiple factors, much of it has to do with the increasing levels of frailty and multiple chronic diseases amongst older people using the hospital emergency department as their first port of call for minor illness. High-pressure hospital environments are dangerous to patients and highly stressful for staff. The policy document Transforming Your Care contains many of the right ideas for developing high quality alternatives to hospital care but few believe it will ever be implemented or that the necessary funding will flow to it. Damaging cynicism is becoming widespread.*

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”.

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| **UNISON Comment:**As a Non-Executive Director of the HSCB stated at the last meeting Transforming Your Care is virtually a busted flush now it is being incorporated into mainstream Commissioning. More than half of the ‘shift left’ funding quoted arises from resettlement, which was an agreed policy and commitment years before TYC was launched. There should be an external audit of TYC in the light of the analysis emerging from HSCB of where we are with the 99 original proposals. UNISON as the leading health and care union will then indicate its own priorities for action and transformation within a framework that supports workers rather than imposes the shadow and threat of privatisation. |

DONALDSON Comment and Recommendation;

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

*“Many people in Northern Ireland are spending years of their lives with one or more chronic diseases. How these are managed determines how long they will live, whether they will continue to work, what disabling complications they will develop, and the quality of their life. Too many such people are passive recipients of care. They are defined by their illness and not as people. Priority tends to go to some diseases like cancer and diabetes and not to others where provision remains inadequate and fragmented. Quality of care, outcome and patient experience vary greatly. Initiatives elsewhere show that if people are given the skills to manage their own condition they are empowered feel in control and make much more effective use of services.*

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 co-ordinating staff. It should develop metrics to ensure that quality, outcomes and experience are properly monitored. It should be piloted in one disease area to being with. It should be overseen by the Long Term Conditions Alliance”.

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| **UNISON Comment:**This proposal is years overdue. Funding cannot be removed from existing budgets to deliver it. UNISON is prepared to support the creation of such self management networks and find ways to resource them from the existing skill base of our members. The support of such networks must be a public NHS function, not a privatised one. |

DONALDSON Comment and Recommendation;

*Recommendation 5: Better regulation.*

*“The regulation of care is a very important part of assuring standards, quality and safety in many other jurisdictions. For example, the Care Quality Commission has a very prominent role in the inspection and registration of healthcare providers in England. In the USA, the Joint Commission’s role in accreditation means that no hospital wants to fall below the standards set or it will lose reputation and patients. The Review Team was puzzled that the regulator in Northern Ireland, the Regulation and Quality Improvement Authority, was not mentioned spontaneously in most of the discussions with other groups and organisations. The Authority has a greater role in social care than in health care. It does not register, or really regulate, the Trusts that provide the majority of healthcare and a lot of social care. This light-touch role seems very out of keeping with the positioning of health regulators elsewhere that play a much wider role and help support public accountability. The Minister for Health, Social Services and Patient Safety has already asked that the regulator start unannounced inspections of acute hospitals from 2015, but these plans are relatively limited in extent.*

We recommend that the regulatory function is more fully developed on the healthcare side of services in Northern Ireland. Routine inspections, some announced, 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 whistle blowing and provide advice to the Minister”.

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| **UNISON Comment:**It is our perception based on recent evidence that the decisive powers and impact the RQIA should have been weakened through Departmental and political pressure. For example, the robustness of the January 2014 report on the major incident in Accident and Emergency was then followed by the soft and indecisive recommendations in the follow up report on the general problem in A&E. This totally failed to recognise the criticality of the ongoing situation and was equivalent to moving deck chairs on the Titanic and failed to recognise the impact of bed reductions and excess levels of bed occupancy. Therefore the RQIA needs a stronger mandate and internal capacity building to stand up for the principles of best health care, resist private sector pressure where their performance is inadequate, and become an organisation that the community and all stakeholders trust to say what is wrong and what needs to be put right. This must be irrespective of any excuse of funding difficulties. The RQIA should engage with UNISON on a regular basis under protocols on specific issues where care is seen to be problematic.  |

DONALDSON Comment and Recommendation;

*Recommendation 6: Making Incident reports really count.*

*“The system of incident reporting within health and social are in Northern Ireland is an important element of the framework for assuring and improving the safety of care of patients and clients. They way in which it works is falling well below its potential for the many reasons explained in this report. Most importantly, the scale of successful reduction of risk flowing from analysis and investigation of incidents is too small.*

We recommend that the system of Serious Adverse Incident and Adverse Incident reporting should be retained with the following modifications:

* Deaths of children from natural causes should not be classified as Serious Adverse Incidents;
* There should be consultation with those working in the mental health field to make sensible changes to the rules and timescales for investigating incidents involving the care of mental health patients;
* A clear policy and some re-shaping of the system of Adverse Incident reporting should be introduced so that the lessons emanating from cases of less serious harm can be used for systemic strengthening (the Review Team strongly warns against uncritical adoption of the National Reporting and Learning System for England and Wales that has serious weaknesses);
* A duty of candour should be introduced in Northern Ireland consistent with similar action in other parts of the United Kingdom;
* A limited list of Never Events should be created;
* A portal for patients to make incident reports should be created and publicised;
* Other proposed modifications and developments should be considered in the context of Recommendation 7”.

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| **UNISON Comment:**The system of Adverse Incident reporting requires fundamental reform within Trusts and provider organisations. Again and again, this union has had to deal with reports of AI forms being submitted but ignored. We have even had to deal with the consequences of health workers being informed that any submission should not be made and will be a ‘black mark’ on their record with the Trust. This is intolerable. Fundamental and accountable culture change is required from the top level of Trusts to change this damaged culture, which clearly arises from the pressures of ongoing austerity. UNISON supported the duty of candour in the aftermath of the Francis Review in England, and sees no objections to this becoming part of professional regulation and Agenda for Change contracts. Any portal for incident reports should also have full access on a protected basis for staff to express concerns.  |

DONALDSON Comment and Recommendation;

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

*“There is currently a complex interweaving of responsibilities for patient safety amongst the central bodies responsible for the health and social care system in Northern Ireland. The Department of Health, Social Services and Public Safety, the Health and Social Care Board, and the Regulation and Quality Improvement Authority all play a part in: receiving Serious Adverse Incident Reports, analysing them, over-riding local judgements on designation of incidents, requiring and overseeing investigation, auditing action, summarising learning, monitoring progress, issuing alerts, summoning-in outside experts, establishing inquiries, checking-up on implementation of inquiry reports, declaring priorities for action, and various other functions. The respective roles of the Health and Social Care Board and the Public Health Agency are clearly specified in legal regulations but seem very odd to the outsider. The Health and Social Care Board has no full-time officers of its own who lead on quality and safety and no in-house medical or nursing director. These functions are grafted on from the Public Health Agency. The individuals concerned have done some excellent work on quality and patient safety and carry out their roles very conscientiously. However, symbolically, and on grounds of organisational coherence, it appears strange that the main body responsible for planning and securing care does not hold these functions in the heart of its business. The Department of Health, Social Services and Public Safety’s role on paper is limited to policy-making but, in practice, steps in regularly on various aspects of quality and safety. The Review Team thought long and hard before making a recommendation in this area. In the end, we believe action is imperative for two reasons; firstly, the present central arrangements are byzantine and confusing; secondly, the overwhelming need is for development of the present system to make it much more successful in bringing about improvement. Currently, almost all the activities (including these listed above) are orientated to performance management not development. There is a big space for a creative, positive and enhancing role.*

We recommend the establishment of a Northern Ireland Institute for Patient Safety, whose functions would include:

* Carrying out analyses of reported incidents, in aggregate, to identify systemic weaknesses and scope for improvement;
* Improving the reporting process to address under-reporting and introducing modern technology to make it easier for staff to report, and to facilitate analysis;
* Instigating periodic audits of Serious Adverse Incidents to ensure that all appropriate cases are being referred to the Coroner;
* Facilitating the investigation of Serious Adverse Incidents to enhance understanding of their causation;
* Bringing wider scientific disciplines such as human factors, design and technology into the formulation of solutions to problems identified through analysis of incidents;
* Developing valid metrics to monitor progress and compare performance in patient safety;
* Analysing adverse incidents on a sampling basis to enhance learning from less severe events;
* Giving front-line staff skills in recognising sources of unsafe care and the improvement tools to reduce risks;
* Fully engaging with patients and families to involve as champions in the Northern Ireland patient safety program, including curating a library of patient stories for use in educational and staff induction programmes;
* Creating a cadre of leaders in patient safety across the whole health and social care system;
* Initiating a major programme to build safety resilience into the health and social care system”.

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| **UNISON Comment:**There can be no in principle objection to the creation of an Institute for Patient Safety. There must be transparent revenue and capital funding for this using conventional public procurement, and location must be in one of the 10% most disadvantaged wards. There must be no diversion of funding from current budgets under pressure, and the additional cost must be an Executive collective contribution to our health. Training in patient safety must be expanded and repeated to ensure consistent application and standards, and therefore there needs to be review and expansion of the diminished training budgets in the current system. This training must apply to all HSC/NHS staff who interact in any way with the patient and client environment, and also be an expanded requirement for external providers in eg. domiciliary care. |

DONALDSON Comment and Recommendation;

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

*“The Northern Ireland Health and Social Care system has no consistent method for the regular assessment of its performance on quality and safety at regional-level, Trust-level, clinical service-level, and individual doctor level. This is in contrast to the best systems in the world. The Review Team is familiar with the Cleveland Clinic. That service operates by managing and rewarding performance based on clinically-relevant metrics covering areas of safety, quality and patient experience. This is strongly linked to standard pathways of care where outcome is variable or where there are high risks in a process.*

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”.

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| **UNISON Comment:**There is at this point major distrust here over performance statistics which are can-openers rather than genuine measures, and are now being modified to disguise damaging and downward trends in delivery. They normally pass without significant comment at Trust Board or HSCB level, and are not understood by the wider community who aspire to the best health and social care they deserve. So new metrics would be encouraging, but they must be publicly accountable and understandable rather than the preserve of a clinical and technocratic elite. The proposed clinical leadership academy should have the comments we applied in the previous section on funding and location applied, and the definition of clinical must encompass nursing, allied health professionals, and all workers who are required to make autonomous decisions to ensure quality and safety of patient and client services. |

DONALDSON Comment and Recommendation;

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

*“The potential for information and digital technology to revolutionise healthcare is enormous. Its impact on some of the longstanding quality and safety problems of health systems around the world is already becoming evident in leading edge organisations. These developments include: the electronic medical record, electronic prescribing systems for medication, automated monitoring of acutely-ill patients , robotic surgery, smartphone applications to manage workload in hospitals at night, near-patient diagnostics in primary care, simulation training, incident reporting and analysis on mobile devices, extraction of real-time information to assess and monitor service performance, advanced telemedicine, and even smart kitchens and talking walls in dwellings adapted for people with dementia. There is no organised approach to seeking out and making maximum use of technology in the Northern Ireland care system. It could make a big difference in resolving some of the problems described in this report. There is evidence of individual Trusts making their own way forward on some technological fronts, but this uncoordinated development is inappropriate – the size of Northern Ireland is such that there should be one clear, unified approach.*

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 organisation 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”.

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| **UNISON Comment:**The Technology Hub proposed will benefit from the principles of separate funding and location and procurement model identified in earlier UNISON comment. The ideas that support New Technology Solutions on patient safety must encompass the entire workforce, many of whom on our training programmes have clear and excellent proposals for change and improvement, and the clear capacity to develop them in wider context. |

DONALDSON Comment and Recommendation;

*Recommendation 10: A much stronger patient voice.*

*“In the last decade, policy-makers in health and social care systems around the world have given increasing emphasis to the role of patients and family members in the wider aspects of planning and delivering services. External reviews – such as the Berwick Report in England – have expressed concern that patients and families are not empowered in the system. Various approaches have been taken worldwide to address concerns like these. Sometimes this has been through system features such as choice and personally-held budgets, sometimes through greater engagement in fields like incident investigation, sometimes through user experience surveys and focus groups, and sometimes through direct involvement in the governance structures of institutions. In the USA, patient experience data now forms part of the way that hospitals are paid and in some it determines part of the remuneration of individuals. This change catalysed the centrality of patients to the healthcare system in swathes of North America. Observers say that the big difference was when dollars were lined to the voice of patients. Northern Ireland has done some good work in the field of patient engagement, in particular the requirement to involve patients and families in Serious Adverse Incident investigation, the 10,000 voices initiative, in the field of mental health and in many aspects of social care. Looked at in the round, though patients and families have a much weaker voice in shaping the delivery and improvement of care than is the case in the best healthcare systems of the world.*

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 Patients and Client Council 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 Patients and Client Council should have a revised constitution making it more independent;
* The organisations representing patients and clients with chronic diseases in Northern Ireland should be given a more powerful and formal role within the commissioning process, the precise mechanism to be determined by the Department of Health , Social Services and Public Safety;
* One of the validated patient experience surveys used by the Centres 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)”.

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| **UNISON Comment:**UNISON members are also patients and clients, as are their families, partners and carers. They therefore should have access and weight within any consideration of patient and client voices. Incorporation of chronic disease representative organisations in any process of commissioning or decision making must require the establishment of the highest standards of governance and practice.In particular, there must be very clear rules on conflict of interest when some of these organisations are now also operating in provider roles. Funding should be according to need, and not compromised by either raising funding or fining particular public institutions. The approach previously taken by HSCB of ‘fines’ being applied to Trusts on A&E performance issues over which they had no control because of bed reduction decisions taken by HSCB demonstrates how this funding model fails. It is utterly unacceptable to vary local remuneration in health care when the current model, even though under pressure through Departmental decisions and the increasing weakness of the UK Pay Review Body, is based on proper principles of equal value in job evaluation.  |