Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

THE DONALDSON REPORT

RECOMMENDATIONS

Consultation Response Questionnaire

CONSULTATION RESPONSE QUESTIONNAIRE

You can respond to the consultation document by e-mail, letter or fax.

Before you submit your response, please read Appendix 1 about the effect of the Freedom of Information Act 2000 on the confidentiality of responses to public consultation exercises.

Responses should be sent to:

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Responses must be received no later than 22 May 2015

I am responding: as an individual ☐
on behalf of an organisation ☑
(please tick a box)

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Background

On 8 April 2014 former Health Minister Edwin Poots announced his intention to commission former Chief Medical Officer of England, Professor Sir Liam Donaldson, to advise on the improvement on governance arrangements across the HSC.

Sir Liam was subsequently tasked with investigating whether an improvement in the quality of governance arrangements is needed and whether the current arrangements support a culture of openness, learning and making amends.

The Donaldson Report was published by the Health Minister Jim Wells on 27 January 2015. It sets out 10 recommendations which refer to a wide range of areas across the health service in Northern Ireland. The full report can be accessed at:

http://www.dhsspsni.gov.uk/donaldsonreport270115.pdf

Purpose

This questionnaire seeks your views on the recommendations arising from the Donaldson Report, and should be read in conjunction with the report which includes the recommendations.

The consultation questionnaire

The questionnaire can be completed by an individual health professional, stakeholder or member of the public, or it can be completed on behalf of a group or organisation.

Part A: provides an opportunity to answer questions relating to specific recommendations and/or to provide general comments on the recommendations.

Part B: provides an opportunity for respondents to give additional feedback relating to any equality or human rights implications of the recommendations.

When responding to Part A please indicate which recommendation(s) you are providing feedback on:

Please tick which recommendations you are providing feedback on	
Recommendation 1	✓
Recommendation 2	✓
Recommendation 3	✓
Recommendation 4	✓
Recommendation 5	✓
Recommendation 6	✓
Recommendation 7	✓
Recommendation 8	✓
Recommendation 9	✓
Recommendation 10	✓
General Comments	✓

Part A
Feedback on Recommendations

Recommendation 1

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.

The Report states that '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.'

The process of creating these recommendations will entail Personal and Public Involvement (PPI) on behalf of the panel and consultation with all relevant stakeholders.

Q1. Do you agree that a panel of experts should be appointed to make recommendations on the configuration of Health and Care services in Northern Ireland? If so, should this panel be made up of international experts?

Strongly agree Agree **Neither** Disagree Strongly disagree

Comments:

In response to the Donaldson Report, the Patient and Client Council (PCC) developed an engagement exercise with members of the public with the aim of gathering views on the report and its recommendations. There were two key engagement approaches focusing on (1) feedback from the public via the PCC Membership scheme members and the PCC website and (2) views from PCC Local Advisory Committee members. To collect views from Membership Scheme members, the PCC included an article in the PCC Membership Scheme Updates Newsletter, informing all members of 'The Right Time, The Right Place' report, detailing its recommendations and asking for their views. In addition, views from members of the public were requested via the PCC website. Through these exercises, a total of 136 people responded with comments. Views from members of the PCC Local Advisory Committees were also collected via a series of group discussions. Given that total membership of the Local Advisory Committees at time of reporting is 41 individuals, with a total of 136 comments via additional engagement mechanisms, the PCC engaged with a total of 177 people. The findings from this engagement exercise have helped to inform the Patient and Client Council's response to this consultation.

Given the nature of open responses received as part of our engagement exercise, it has not always been possible to assign specific numbers to the qualitative data outlined in this response. However, as a general guide the following definitions will give the reader an indication of the frequency of occurrence of comments:

- 'few' = 10% of people or less
- 'some' = 11% to 25% of people;
- 'many' = 26% to 50% of people;

- ‘the majority’ = 51% to 75% of people; and,
- ‘most’ = 76%+ of people.

Overall, 68% of membership scheme members who responded to the PCC engagement exercise either ‘agreed or broadly agreed’ with the Donaldson recommendations. They believed HSC has to change and are still supportive of the Transforming Your Care (TYC) journey but impatient at the slowness of its implementation.

In response to recommendation 1, evidence gathered by the PCC highlighted that some people felt more effective leadership was necessary to make changes in Health and Social Care (HSC). It was believed that the Donaldson Report was necessary in order to get an external viewpoint on how HSC is run in Northern Ireland. Hence, it was felt that recommendations should be implemented as Donaldson is an “outsider” offering a different and valuable perspective on HSC. Frustration was also expressed with how decisions are made in the current system. For example, it was highlighted how the process for consulting on implementing recommendations can take too long and can be expensive and time-consuming. In this context, some people embraced the idea that key decisions in HSC should be made by external experts.

However, whilst some people welcomed the idea of an international panel of experts to be commissioned to recommend reconfiguration, others disagreed as they felt this would be costly to implement and they would not be experts in Northern Ireland. Indeed, it was believed that there are currently too many politicians, managers and admin staff involved in HSC and the establishment of an international panel of experts could add to what is perceived as a high level of bureaucracy already in HSC.

Many people felt that there should be greater focus and investment in frontline staff to deliver high quality care, rather than investment in experts. This view has also been highlighted in the PCC’s recent work. Last year, the PCC conducted a study (The People’s Priorities, 2014) to understand people’s views on future priorities for Health and Social Care in Northern Ireland. A total of 1,080 members of the general public in Northern Ireland completed a questionnaire which asked respondents to identify their priorities for health and social care. These findings were used to identify an overall top ten priority order, as these findings were most reflective of people from across Northern Ireland. In particular, people’s top priority in HSC was frontline staff. Evidence from this work highlighted that people wanted to see more investment in frontline staff and improved health service management. In this context, the PCC’s engagement exercise on the Donaldson review highlighted that people believed there should be less investment in experts and greater investment in ground level staff.

Q2. If such a panel is appointed, should political representatives have the final say in accepting any recommendations?

Strongly agree	Agree	Neither	**Disagree**	Strongly disagree

Comments:

Whilst some respondents in the PCC feedback on the Donaldson Report engagement exercise believed politicians should have a chance to agree recommendations of a new structure, others highlighted that people felt there were too many politicians involved in HSC and this was preventing change. People who expressed this view believed that some politicians are hesitant about making unpopular decisions which may be needed within HSC. In particular, participants felt that political influence is preventing change in HSC. A specific example was noted from some people in relation to the total number of hospitals in Northern Ireland versus the clinical need for these hospitals and it was believed that political agendas were influencing and preventing tough decisions, which some people felt were necessary, from being made. Indeed, a general view expressed in the PCC's engagement exercise on the Donaldson Report from some was doubt that current leadership in HSC could effectively implement these recommendations.

"How are all your recommendations going to happen? This is a small island and if our politicians find it hard to agree what hope for any of said recommendations?" **(PCC Feedback from the recommendations of the Donaldson Report, membership scheme respondent)**

"Great, but our politicians will go their own way." **(PCC Feedback from the recommendations of the Donaldson Report, membership scheme respondent)**

Hence, evidence gathered by the PCC indicated that some people had a lack of confidence in current HSC leadership to make crucial changes. At times, people believed HSC was used as a political weapon, and called for all parties to work together to deliver a high quality HSC service in Northern Ireland.

"Current N.I. politicians do not have the collective mutual capacity to come together and guide and steer the N.I. health service. Strategic development should be taken out of their hands." **(PCC Feedback from the recommendations of the Donaldson Report, membership scheme respondent)**

It was in this context that people called for action and not just words. Evidence gathered by the PCC also indicated that most people believed key decisions in HSC should be made by health professionals and patients, rather than politicians.

"Panels for health care should be made up from ground force people, ordinary public, all aspects of the hospitals covered by representatives - nurses, doctors etc. I don't think MPs or government bodies, who are just elected for a few years, should have big impacts on how health should be implemented, they don't have the knowledge or the experience necessary to put the proper work into action." **(PCC Feedback from the recommendations of the Donaldson Report, membership scheme respondent)**

The PCC therefore notes that patients, clients and health professionals should have a greater say in key decisions in HSC.

Q3. Are there alternative ways for Northern Ireland to determine a configuration of health and social care services commensurate with ensuring world-class standards of care?

If you consider there is, please complete the box below

Comments:

Generally speaking, the PCC's engagement exercise highlighted that people believed that more focus should be placed on frontline staff in HSC. This is further supported in the PCC's recent work. As previously mentioned, The People's Priorities (2014) found that people's top priority in HSC was frontline staff. For many of those who prioritised health and social care staffing levels, the key issue was to see more resources and funding going into frontline staffing and less spending on managerial and administrative staff.

"Reduce top heavy management and invest more money in frontline and community care staff." **(PCC People's Priorities, female questionnaire respondent, 55 - 64 years old)**

It was also believed that panels of experts could prove costly. This is also highlighted in the recent work of the PCC (The People's Priorities, 2014) which has identified that people believe money and resources are wasted across HSC each year as services are not delivered in the most cost-effective or efficient way. In this context, the PCC's feedback on the Donaldson review exercise highlighted that some people felt that there should be less investment in experts, and a greater use of patient and frontline staff views at ground level to guide and influence changes to Health and Social Care.

"How much will the 'panel of experts' be paid? Why not ask the real experts – patients?" **(PCC Feedback from the recommendations of the Donaldson Report, membership scheme respondent)**

"By fully engaging with patients and their families, much can be learnt. Patients need to be involved and feel their voice can be heard." **(PCC Feedback from the recommendations of the Donaldson Report, membership scheme respondent)**

The PCC therefore suggests that the views of patients, along with frontline staff and health professionals who work with patients and clients are often best placed to make the decisions which are necessary to help deliver world-class standards of care in Northern Ireland.

Whether or not an international panel of experts get engaged, the PCC welcomes evidence based change. However, such evidence must be shared with the public to ensure that they are involved in change and understand the need for it.

Recommendation 2

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.

The Report states that ‘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.’

In response to this finding the Minister announced, on 27th January 2015, that Departmental officials have been asked to undertake a review of the effectiveness of existing commissioning arrangements. This is due to report in the summer of 2015.

Q1. Do you agree with this recommendation?

Strongly agree   Agree   [✓ **Neither**]   Disagree   Strongly disagree

Comments:

Whilst not all the people who provided feedback to us gave detailed views in relation to this recommendation, a number of people noted to the PCC that they felt that there needs to be a more effective commissioning system in Northern Ireland. It was felt by some that the current commissioning system is ineffective and out dated. These views are supported in recent work undertaken by the PCC. Specifically, last year *The People’s Priorities* (PCC, 2014) sought to understand people’s views on future priorities for Health and Social Care in Northern Ireland. Findings in this study indicated that people were concerned about money and resources being wasted across their health and social care services every year because they are not being delivered in the most cost-effective or efficient way.

“Identify where spending will affect the greatest improvement in patient outcomes.” **(PCC People’s Priorities, male questionnaire respondent, 16-24 years old)**

However, whilst there was some agreement that there needs to be changes to HSC commissioning, there were questions from some people around this recommendation on what it would mean for patients and clients. Many people queried what a new system would look like and felt that implementing changes could be expensive. It is therefore suggested that greater clarity as to how this recommendation would be implemented and the benefits that changes would make to patients and clients need to be more clearly articulated by the Health and Social Care system.

Recommendation 3

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.

The Report states that ‘The demands on hospital services in Northern Ireland are excessive and not sustainable. This is a 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 together with too many 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.’

In his presentation to the Health Committee on 28 January 2015 Sir Liam stated that he had highlighted paramedics and pharmacists as examples of areas where innovations could take place to improve the quality of care whilst potentially releasing some of the pressure on hospitals.

Existing Transforming Your Care documents, including the Vision to Action Consultation and the Strategic Implementation Plan, can be found at http://www.dhsspsni.gov.uk/index/tyc.htm

Q1. Do you agree with the recommendation for a new Transforming Your Care implementation plan?

Strongly agree Agree Neither Disagree Strongly disagree

Comments:

Many people commented on this particular recommendation via the PCC engagement exercise, highlighting in particular that more focus is needed on Transforming Your Care (TYC). In principle, most people believed that TYC is good but it needs to be implemented effectively. Generally speaking, there were queries about why TYC has not been successfully implemented to date, and there were some concerns expressed that this was due to an ineffective implementation plan and a lack of funding.

“Transforming Your Care in principle is good but most people are aware that it cannot be fully implemented without a major input of resources.” **(PCC Feedback from the recommendations of the Donaldson Report, membership scheme respondent)**

Hence, it was believed by many that TYC is not working effectively. This view has also been highlighted in the PCC’s recent work. The People’s Priorities (2014) highlighted that people believed that there was inadequate funding for TYC. Whilst there was acknowledgement that funding was being cut in hospitals, participants indicated that there was insufficient evidence to show this money had been re-invested in community care.

“With TYC they are taking the money out of the hospitals but I don’t see the benefit of community care…so I think TYC is not going to work unless there is community care and more money put in.” **(PCC People’s Priorities, male focus group participant, 65 years old or over)**

As a result, many people believed that there should be greater investment in TYC. Suggestions in the PCC feedback on the Donaldson Report included more focus on frontline staff; increased GP opening hours; better training for professionals and equal investment in the community. It was also noted that big decisions still need to be made on, for instance, how many hospitals Northern Ireland needs in the future. Some people in this engagement exercise believed that there are too many acute hospitals in Northern Ireland but talk of closure results in public panic. On the other hand, other people felt that hospital closures should not take place unless better infrastructure was introduced. Nevertheless, despite different opinions people felt it was imperative that any potential savings made through hospital closures should be re-invested into the community. In general, it was believed that the effective implementation of TYC would help alleviate some of the pressures placed on frontline staff.

“If TYC is not placed successfully within the community, then a feed down approach from the hospitals and health care trusts and vice versa, will cause a link in the chain to break, creating more demand and grid lock within the trusts and imminent failure for all.” **(PCC Feedback from the recommendations of the Donaldson Report, membership scheme respondent)**

Overall, findings from this engagement exercise and the recent work of the PCC have indicated that people are unhappy with the current provision of TYC. In this context, some people felt that TYC should be abandoned until it has adequate resources to be successfully implemented.

“TYC should be abandoned unless true financial commitment to fund the scheme is forthcoming.” **(PCC Feedback from the recommendations of the Donaldson Report, membership scheme respondent)**

However, as many of the people that we have talked to in our work have broadly been supportive of TYC as an approach to how HSC services should be provided in the future, the PCC would be supportive of the introduction of a new costed, timetabled implementation plan for Transforming Your Care.

“TYC should be progressed urgently with funding reallocated to the community sector.” **(PCC Feedback from the recommendations of the Donaldson Report, membership scheme respondent)**

Q2. Do you agree that alternative models of working for healthcare professionals, including pharmacists and paramedics, should be examined to help address the pressure on hospital services? If so, which staff groups do you feel could have an expanded role?

Strongly agree **Agree** Neither Disagree Strongly disagree

Comments:

Findings from the PCC's engagement exercise on the Donaldson Report indicated broad agreement with expanding the role of pharmacists and paramedics. In addition, other work of the PCC (The People's Priorities 2014) found that A&E services were a top priority for people, who wanted to see the improved delivery of A&E services and a reduction in waiting times. It was in this context that some people in the PCC's engagement exercise felt that expanding the role of pharmacists and paramedics would help reduce the demand on these services.

However, whilst many people agreed with expanding the role of pharmacists and paramedics, others believed that paramedics and pharmacists can only do so much. Generally, people felt that there was a lack of clarity and detail in the report, particularly in relation to Transforming Your Care. Whilst the report suggested the creation of an expanded role for pharmacists and paramedics, some people in this engagement exercise noted that Donaldson does not state how this would materialise. However, if implemented successfully, people believed this suggestion may help alleviate some of the pressures placed on hospitals and frontline staff.

The PCC therefore suggests that there needs to be greater clarity on what is precisely meant in terms of expanding the role of pharmacists and paramedics and how exactly this would be implemented, as this may help alleviate some of the pressures on frontline staff and hospitals which, as previously highlighted, is something which the PCC has consistently found in our recent work as a concern for people.

Recommendation 4

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.

The Report states that ‘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.’

The Department launched a policy framework for long term conditions – *Living With Long Term Conditions* – in April 2012. The Public Health Agency chairs a Regional Implementation Group, which includes representatives from the Long Term Conditions Alliance and other key stakeholders, which is overseeing the development of an action plan on long term conditions. This will include consideration of key metrics.

The Living with Long Term Conditions document can be accessed at:
http://www.dhsspsni.gov.uk/long-term-condition.htm

This supports the delivery of the Programme for Government which makes a commitment to enrol people who have a long-term (chronic) condition, and who want to be enrolled, in a dedicated chronic condition management programme. Between 2011/12 – 2012/13 there was a 13% increase in the number of people enrolled in such programmes and a 25% increase in the frequency of such programmes.

Q1. Do you agree with the proposed focus on enabling people with long term conditions with the skills to manage their conditions?

[✓ **Strongly agree**] Agree Neither Disagree Strongly disagree

Comments:

Generally speaking, evidence gathered by the PCC through the Donaldson engagement exercise indicated that people believed patients should manage their own conditions where it is possible for them to do so. It was also highlighted that this is something some people already do successfully. This is further supported by the PCC report ‘The Painful Truth’ (2014). This study aimed to capture people’s experience of services provided for the treatment and support of those living with long-term chronic pain, capturing the personal impact that pain has had on people’s lives. The data collected and presented in this report represented the views of over 2,500 people (2,459 people completed a questionnaire and 61 people participated in focus group discussions) in Northern Ireland who live with long-term pain. Some people felt that conventional medication did not work for them and talked about the many ways in which they had learned to self-manage their pain including; relaxation techniques, pacing exercises, changing diet, self-hypnosis, using hobbies or word puzzles as a distraction, learning about their own condition, mindfulness, meditation, determination, and adopting a positive attitude.

***"I have taught myself to focus on things beyond my pain such as mental arithmetic, word games, word patterns."* (PCC respondent, The Painful Truth)**

Findings from this study highlight the positive role self-management can have for people with long-term illnesses. This view is further supported in other work of the PCC. For instance, the PCC conducted a study (Views on Telemonitoring Services. A summary of experiences of nine people, April 2014) to understand the experiences of people who use telemonitoring services to monitor a range of long term conditions including diabetes, COPD and CHD. A series of in depth interviews were undertaken with patients who have used or are currently using telemonitoring services. The people that we talked to in the PCC Telemonitoring Services study reported that the health technologies that they used had a positive impact on their ability to understand and self-manage their long term conditions with confidence.

***"It gives me knowledge of my own condition and lets me know what to keep my eye on…It also makes me feel more involved."* (PCC Telemonitoring Study participant, male, 45-55 years, COPD)**

***"Although I am the patient this also makes me part of the medical team, it makes you feel involved in your own wellbeing rather than putting responsibility on the hospital."* (PCC Telemonitoring Study participant, male, 65-75 years, Type 2 diabetes)**

These examples indicate the positive impact self-management has had for individuals. However, it was also noted that self-management of chronic conditions would not be suitable for all patients and some may need more support than others. Evidence gathered through the PCC Feedback on the recommendations of the Donaldson Report suggested that many people would still need professional contact when self-managing their own conditions. This view has also been reported in our recent work. Indeed, findings from The Painful Truth (2014) indicated that some participants were disappointed at the lack of advice and information they received from their GP and other health care professionals on how to manage their symptoms on a day to day basis. A few people noted the complete lack of any treatment plan or interest on behalf of their GP in helping the patient control their pain. This lack of action and 'nothing can be done' attitude of some GPs and health professionals was frustrating for people.

***"No one doctor took responsibility for managing / contacting / assisting me with how I was coping with my condition - It has been left up to me to manage pain and contact my GP when required."* (PCC, The Painful Truth respondent)**

This suggests that self-management may not always work for people. On occasions, this may be because there is inadequate support within the process. Recent work by the PCC (The Painful Truth 2014 / Views on Telemonitoring Services 2014) has highlighted how adequate support in self-managing conditions can provide reassurance and peace of mind, for both patients and their family, from knowing that their condition was being closely monitored by a team of health professionals who informed them if anything was wrong.

"It has helped improve my quality of care and managing my own condition. I'm very glad it is there for me. It keeps you right and lets you get in touch with medical people very quick, quicker than normal. There's a team out in Newry and if there was an actual problem they would be here the same day. I would

***have to wait two weeks to go see my GP…It gets me in touch with someone who knows what they are talking about.”* (PCC Telemonitoring Study participant, male, 55-65 years, COPD)**

***“GP's physical support (medicine) emotional support (longer appointments and listening) and mental support (anti-depressants, listening and helping me learn meditation).”* (PCC, The Painful Truth respondent)**

These examples highlight that, whilst self-management of conditions can have a positive impact on individuals, sufficient support needs to be in place to ensure the continued provision of high quality care.

The PCC is therefore supportive of this recommendation to give people with long-term illnesses the skills to manage their own conditions. However, the PCC notes that adequate resources from HSC are needed to enable people to be fully supported in this process.

Recommendation 5

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.

The Report states that ‘The regulation of care is a very important part of assuring standards, quality and safety in many other jurisdictions. 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.’

In response to this recommendation the Minister announced, on 27th January, that he was seeking to speed up the roll out of unannounced inspections in acute hospitals, and that the 2003 Quality, Improvement and Regulation Order would be reviewed with a view to introducing a stronger system of regulation of acute health care providers. That announcement also advised that proposals would be submitted to the Executive for changes to the existing system of regulation of non-acute services.

More information on the role of RQIA and regulation can be found at www.rqia.org.uk

He also announced that a review of the operation of whistleblowing in health and social care bodies would be undertaken with recommendations on how to improve its effectiveness.

Q1. Do you agree that the regulatory role of RQIA should be expanded to focus more upon the services delivered by acute hospitals in Northern Ireland?

Strongly agree Agree **Neither** Disagree Strongly disagree

Comments:

In general, feedback from the PCC engagement exercise on the Donaldson Report highlighted the need for some improvements to regulation. Specifically, people felt that the role of RQIA could be strengthened and there should be more unannounced, regular inspections and that this may help improve the overall quality of care in HSC.

Q2. Do you agree that the functions of RQIA should be tested against the option of outsourcing this function?

Strongly agree Agree Neither Disagree Strongly disagree

Comments:

Feedback via the PCC engagement exercise on the Donaldson Report did not provide specific, detailed opinions in relation to this proposal, therefore the Patient and Client Council does not provide a view on this area.

Q3. Do you agree that the current policy on whistleblowing needs to be examined? If yes, are there any comments you wish to make on how the review is conducted or its scope?

Strongly agree **Agree** Neither Disagree Strongly disagree

Comments:

In general, findings from the PCC engagement exercise on the Donaldson Report highlighted that there was a need for greater protection for whistle-blowers. The PCC is therefore supportive of a review of the current policy on whistleblowing, to ensure adequate protection in this context.

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Recommendation 6

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.**

The Report states that ‘The system of incident reporting within health and social care in Northern Ireland is an important element of the framework for assuring and improving the safety of care of patients and clients. The 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.’

The Minister has announced that he will be instructing the HSCB and PHA to prioritise changes to the Serious Adverse Incident (SAI) system. He has also announced that a Never Events list will be developed for Northern Ireland and that he is beginning the process for creating a statutory duty of candour Northern Ireland.

An Adverse Incident is defined as ‘Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation.’ Particular criteria will then be used to determine whether an adverse incident constitutes a Serious Adverse Incident (SAI). More information on the background and procedure for the management of SAIs can be found at: http://www.dhsspsni.gov.uk/saibackground

Never Events are a sub-set of Serious Incidents and are defined as ‘serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. For more information about the system of Never Events in England, please see: http://www.england.nhs.uk/ourwork/patientsafety/never-events/

Q1. Do you agree with the proposed changes to the Serious Adverse System (SAI) in Northern Ireland?

Strongly agree Agree **Neither** Disagree Strongly disagree

Comments:

With regards to this recommendation, people in the PCC's engagement exercise highlighted that they had difficulty understanding some of the terminology used in the report in particular around this recommendation.

"As a non-medical participant of the Patient and Client Council, I found some of the wording of the recommendations difficult to understand. Some of the terms meant nothing to me: cadre of leaders; valid metrics; adverse incidents, never events, for example." **(PCC Feedback from the recommendations of the Donaldson Report, membership scheme respondent)**

From our feedback exercise, people gave a number of general comments in relation to reporting of incidents, as detailed below:

- It is important that there is learning from incidents to avoid further incidents in the future;
- Staff should be supported to report incidents; and
- There needs to be quicker resolution for people who have a complaint or suffered harm in the system.

Q2. Do you agree with the creation of a list of Never Events for Northern Ireland? If so, what do you consider as Never Events?

Strongly agree Agree Neither Disagree Strongly disagree

Comments:

See above comments, Rec 6 Q1.

Q3. Do you agree with the introduction of a Duty of Candour in Northern Ireland?

Strongly agree Agree Neither Disagree Strongly disagree

Comments:

In October 2014, the PCC held a Patient Safety Conference. The aim of the conference was to initiate a dialogue on priorities for patient safety among HSC service users. The conference also aimed more generally to highlight awareness of patient safety (and other related) issues for members of the public.

The conference included a number of exercises to gather views from people who were present. These exercises were:

- A quantitative instant feedback polling exercise asking people a series of multiple response questions to get their views on issues in relation to patient safety.
- Two small group, facilitated sessions with moderators asking a series of open questions to delegates.

A total of 83 delegates took part in the polling exercise. Specifically, the PCC asked attendees their views on the Duty of Candour. Most respondents felt that Duty of Candour being a legal obligation would help to promote both openness and transparency in Health and Social Care (80.6%) and a culture of learning for healthcare professionals (78.8%).

During facilitated sessions, it was evident that most delegates believed that honesty is essential to quality healthcare, especially if there has been a serious adverse incident. Duty of candour was seen as something that facilitates openness by making it a statutory requirement. Candour is vital and the legal backing is needed to ensure that staff and organisations are honest when things go wrong. Indeed, some delegates were surprised that a legal ‘duty of candour’ or similar was not already in place. In this context, several groups agreed that the duty of candour was the most important thing that had to happen to improve safety, openness and transparency. It was believed that, if a statutory duty of candour was in place, it could improve the entire system.

The PCC therefore suggests that the introduction of a statutory Duty of Candour for HSC organisations has the potential to be welcomed by the public and be seen as a mechanism for helping to promote transparency and openness across Health and Social Care.

Recommendation 7

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 them 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.**

The Report states that ‘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 judgments 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 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. 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 those listed above) are orientated to performance management not development. There is a big space for a creative, positive and enhancing role.’

Q1. Do you agree that a National Institute for Patient Safety should be introduced in Northern Ireland?

Strongly agree Agree **Neither** Disagree Strongly disagree

Comments:

Findings from the PCC Feedback on the Donaldson review highlighted that patient safety is a top priority. It was suggested by some that the creation of a National Institute for Patient Safety may make reporting incidents less stressful and easier and that change is needed to the current system. A small number of people in the PCC feedback exercise felt however that there was no need to set up a new committee as this may add to what people felt to be too many bureaucratic structures within HSC.

This recommendation also suggested that it would be necessary to engage with patients and families to involve them in the Northern Ireland patient safety system. One of the main findings from the PCC's engagement exercise on the Donaldson Report called for a greater patient voice in HSC. The PCC's Patient Safety Conference in October 2014 also highlighted that the majority of delegates agreed that patients should have a role in ensuring that their care is safe. It was believed this would encourage a more open and transparent HSC. It is therefore suggested that proposed changes in relation to this area are made with patients and clients at the heart of the decision making process.

Q2. Do you agree with the suggested functions which should be included?
Do you feel there are additional functions relevant to the proposed institute?

Strongly agree Agree Neither Disagree Strongly disagree

Comments:

Feedback via the PCC engagement exercise on the Donaldson Report did not provide specific, detailed opinion in relation to this proposal, therefore the Patient and Client Council does not provide a view on this area.

Recommendation 8

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.

The Report states that '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.'

Q1. Do you agree that systems metrics should be introduced so that regular benchmarking can take place from regional level down to individual service level?

Strongly agree [✓ Agree] Neither Disagree Strongly disagree

Comments:

In general, whilst it was believed by some that the introduction of systems metrics would be costly, it was highlighted in the PCC Feedback from the Donaldson Report engagement exercise that this could help improve the standards across HSC in the future. It was felt by a small number of people that regular benchmarking with other countries, or areas which are similar to Northern Ireland, could also prove useful.

Q2. Do you agree with the establishment of a Clinical Leadership Academy in Northern Ireland?

Strongly agree [✓ Agree] Neither Disagree Strongly disagree

Comments:

Feedback via the PCC engagement exercise on the Donaldson Report did not provide specific, detailed opinion in relation to this proposal, therefore the Patient and Client Council does not provide a view on this area.

Recommendation 9

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.

The report states that ‘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. 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.’

Q1. Do you agree that Northern Ireland should seek to put itself in a position where it has the best technology and innovation from all corners of the world and is recognised as the best in Europe? Should this include the development of a technology hub to identify the best technological innovations?

Strongly agree **Agree** Neither Disagree Strongly disagree

Comments:

Generally speaking, evidence gathered through the PCC’s feedback on the Donaldson review highlighted that many people believed the use of new technology, whilst sometimes costly to initially roll-out, is very important and could help improve treatment and care across the health and social care system in Northern Ireland. It was also felt that the development of a new technological hub could help identify the next technical innovations which would help enhance the quality and safety of patient care. Views expressed in the recent work of the PCC (Views on Telemonitoring Services. A summary of experiences of nine people, April 2014) have also highlighted the positive role the introduction of technology has had for people, where it is supported by committed and caring health and social care staff. Consequently, the people that we talked to in the PCC Telemonitoring Services study reported that the health technologies that they used had a positive impact on their ability to understand and self-manage their long term conditions with confidence.

The PCC therefore welcomes intelligent use of new technology to improve patient experience whether better/faster diagnostics, decreased need for travel and hospital admission, or simply easier access to appointments at local or regional service centres.

Recommendation 10

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 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).**

The Report states that ‘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 linked 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.’

The Minister has announced that a framework to strengthen the voice of patients at every level will be designed applying the best available worldwide evidence on measuring patient/client experience.

Q1. If you are unhappy with the response of a care provider regarding your care, do you agree that the substance of it should be looked at by people who are genuinely independent?

Strongly agree **Agree** Neither Disagree Strongly disagree

Comments:

It is important that patients and the public have confidence in the complaints process and increased transparency through an approach which is viewed as independent could help promote this.

Delegates at the PCC's Patient Safety Conference (2014) talked about the importance of a complaints advocacy service within Health and Social Care which is viewed as providing advice which is independent, impartial and supportive of client needs. It was noted by some delegates at the conference that they felt the PCC Complaints Support Service is a good example of this type of service.

Q2. Do you agree with the proposed changes to the Patient and Client Council?

Strongly agree Agree **Neither** Disagree Strongly disagree

Comments:

Fewer respondents in the PCC engagement exercise provided comments in relation to this recommendation in comparison with others, such as the need to implement Transforming Your Care. However, for those that did, a few people were supportive of the suggestion that the PCC Board could be reconstituted to include a higher proportion of current / former patients as it could give patients the chance to express their thoughts and opinions. However, it was also queried what exactly this would mean and look like. It was suggested that more information surrounding this idea would be useful.

Some respondents did embrace the aspects of a changing role for the Patient and Client Council. In relation to recommendation 7, which called for the establishment of a new Institute for Patient Safety, one respondent suggested this was not necessary, but could be incorporated into the role of the Patient and Client Council.

"No need to set up a new body. This could come under the Patient and Client Council with appropriate training and some input from an independent source." **(PCC Feedback on the Donaldson Report, membership scheme respondent)**

Q3. Do you agree that the organisations representing patients and clients with chronic diseases should be given a more powerful and formal role within the commissioning process? If so, do you have any comments on how this could be best achieved?

Strongly agree Agree Neither Disagree Strongly disagree

Comments:

Generally speaking, many people were supportive of a continued strengthening of the patient voice.

“A stronger patient voice should be encouraged in all settings.” **(PCC Feedback on the Donaldson Report, membership scheme respondent)**

Some participants expressed dissatisfaction that patients views are not always listened to by professionals.

“Recommendation 10 is vital, patients are put into working groups in name only. This needs to change. Their views need to be valued and services need to be shaped to meet their needs.” **(PCC Feedback on the Donaldson Report, membership scheme respondent)**

As noted in our response to recommendation 2, evidence gathered by the PCC broadly indicated that some people believed there should be a more effective commissioning system. The incorporation of organisations representing patients and clients may enable the patient voice to help influence and shape decisions. Given people’s views in relation to this proposal, the PCC is therefore supportive of giving organisations representing patients and clients with chronic diseases a more powerful and formal role within the commissioning process, as a mechanism for incorporating the patient voice into HSC.

Q4. Do you agree that patient experience surveys should be used to rate hospitals and allocate resources accordingly?

Strongly agree **Agree** Neither Disagree Strongly disagree

Comments:

Whilst few people spoke specifically about incorporating patient experience surveys to rate hospitals and the allocation of resources, evidence gathered highlighted that some people felt a greater patient voice is needed in HSC.

“*This is vital - the patients' voices must be listened to and acted upon.*” (PCC Feedback on the Donaldson Report, membership scheme respondent)

Some respondents expressed dissatisfaction that patients views are not always listened to by professionals. Additionally, other respondents argued that there should be less investment in experts, and a greater use of patient views at ground level in order to make changes to Health and Social Care, as highlighted in our response to recommendation 1.

“*By fully engaging with patients and their families, much can be learnt. Patients need to be involved and feel their voice can be heard.*” (PCC Feedback on the Donaldson Report, membership scheme respondent)

Delegates at the PCC’s Patient Safety Conference (October 2014) also believed that one of the best ways for patients to be involved in HSC is to raise any issues or concerns they have or give feedback on the care they have received. However, people felt they needed more advice, information and education to be able to do this. In this context, delegates felt that there should be a proactive approach within services to collecting feedback and patients should be given regular opportunities to suggest improvements. It was also suggested that this process should be anonymous as some people may fear that their feedback would affect their future care.

The development of a patient feedback system is something the PCC has championed for the past three years. The PCC has been working with the 6 HSC Trusts, the HSC Board and the Public Health Agency to procure and implement a Northern Ireland wide system for all HSC services so that patients, clients, carers and families can give online feedback to all HSC providers. The PCC has engaged with a wide variety of service user groups across Northern Ireland, running 13 focus groups in the summer of 2013, where service users were unanimous that a system such as this would add great value to HSC as this would give service users a 'voice' to speak to HSC organisations. It was believed that a system like this will make it easier to gather people's personal views of their care and will instil confidence in service users and the wider public that HSC organisations are genuinely listening to and acting on their feedback. It was not noted in these discussions however if people felt that such a system could or should be used to allocate resources, or that this would be an approach welcomed by the public in general. Therefore, further consideration on the appropriateness of such a system as a means for resource allocation would need to take place.

The PCC is naturally supportive of this recommendation which gives patients the opportunity to contribute and have their voices heard in HSC and that a range of mechanisms, including a dedicated feedback system, in addition to more traditional approaches, such as patient surveys should be considered to embed the importance of measuring patient experience throughout the Health and Social Care system.

General Comments

Please use the box below to insert any general comments you would like to make in relation to the recommendation from the Donaldson Report.

Comments:

In general, the people who contributed to the PCC's engagement exercise on feedback on the Donaldson Report welcomed the report recommendations. However, a general theme raised in this engagement exercise was scepticism around the implementation of the recommendations made in 'The Right Time, The Right Place'. In particular, respondents questioned whether there would be sufficient funding to support change. In addition, some respondents felt that a clear implementation strategy and effective Health and Social Care leadership was necessary so that these recommendations would become reality. As a result, respondents called for swift action, noting that these recommendations were overdue and emphasis should now be placed on action.

"It's action not words that all patients want to see. For too long we have listened to promise after promise – but little or no actions." **(PCC Feedback from the recommendations of the Donaldson Report, membership scheme respondent)**

Part B
Equality Implications

Section 75 of the Northern Ireland Act 1998 requires the Department to "have due regard" to the need to promote equality of opportunity between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without. The Department is also required to "have regard" to the desirability of promoting good relations between persons of a different religious belief, political opinion or racial group.

The Department has also embarked on an equality screening exercise to determine if any of these recommendations are likely to have a differential impact on equality of opportunity for any of the Section 75 groups. We invite you to consider the recommendations from a section 75 perspective by considering and answering the questions below. Answering these questions will contribute to the completion of the Department's Screening template and the screening outcome.

Q1. Are the actions/proposals set out in this consultation document likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the Northern Ireland Act 1998? If yes, please state the group or groups and provide comment on how these adverse impacts could be reduced or alleviated in the proposals.

Yes ☐ No ☐

Comments:

The Patient and Client Council does not provide a view on this area.

Q2. Are you aware of any indication or evidence – qualitative or quantitative – that the actions/proposals set out in this consultation document may have an adverse impact on equality of opportunity or on good relations? If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.

Yes ☐ No ☐

Comments:

The Patient and Client Council does not provide a view on this area.

Q3. Is there an opportunity to better promote equality of opportunity or good relations? If yes, please give details as to how.

Yes ☐ No ☐

Comments:

The Patient and Client Council does not provide a view on this area.

Q4. Are there any aspects of these recommendations where potential human rights violations may occur?

Yes ☐ No ☐

Comments:

The Patient and Client Council does not provide a view on this area.

Please return your response questionnaire.
Responses must be received no later than 22 May 2015
Thank you for your comments.

Appendix 1

FREEDOM OF INFORMATION ACT 2000 – CONFIDENTIALITY OF CONSULTATIONS

The Department will publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be disclosed on request. The Department can only refuse to disclose information in exceptional circumstances. **Before** you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely, the Department in this case. This right of access to information includes information provided in response to a consultation. The Department cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances. The Lord Chancellor’s Code of Practice on the Freedom of Information Act provides that:

- the Department should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the Department’s functions and it would not otherwise be provided

- the Department should not agree to hold information received from third parties “in confidence” which is not confidential in nature

- acceptance by the Department of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner

For further information about confidentiality of responses please contact the Information Commissioner’s Office (or see web site at: **http://www.informationcommissioner.gov.uk/**).

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