Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Integrated Care System NI

Draft Framework

Consultation Response Document

Please note that responses can also be submitted directly online via Citizen Space which can be accessed via the following link should this be a preferable option: https://www.health-ni.gov.uk/consultations/future-planning-model-targeted-stakeholder-consultation

Personal details		
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Are you responding on behalf of an organisation?		Yes *(delete as applicable)*
Organisation *(if applicable)*	**Rural Community Network**	

The questions set out on the following pages are to help gather views and guide responses in certain areas. General comments can also be left at the end of this document on any aspect of the framework.
Please note: the boxes provided for additional comments in each question can be expanded.

Q1. Section 3 describes and defines what an Integrated Care System (ICS) model is which provides the blueprint for how we will plan, manage and deliver services in NI moving forward.

Do you agree that this is the right approach to adopt in NI?

Agree / Disagree

(delete as applicable)

Additional comments:

The concept of "a collaborative partnership between organisations and individuals with a Responsibility for planning, managing and delivering sustainable care, services and interventions to meet the health and wellbeing needs of the local population" is one that RCN would be in favour of. We would make the following comments:

The development of new commissioning structures and processes will be a challenge whilst health and social care services are still working under the strain of the pandemic with large numbers of cases and hospitalisations and all the knock-on effects that continues to cause for service delivery. In addition, the unprecedented waiting lists for elective care are a further strain across the whole of the Health and Social Care system. Medical and care staff across all settings are reporting intolerable levels of stress and burnout.

RCN welcomes the proposal that involvement will go beyond the HSC sector bringing in all partners who can improve health and well-being outcomes, reduce health inequalities and tackle wider issues.

Which indicators will be used to measure progress in health and well-being outcomes and reducing health inequalities?

How will DoH ensure that communities are involved in the planning of services in a meaningful way? RCN is concerned that the Future Planning Model assumes a standardised strong community and voluntary sector across the region. Some areas are well resourced with paid staff and strong organisations others, less well so. There is considerable differential between voluntary groups and community groups and between rural and urban contexts. The community and voluntary sector cannot take its place at these tables unless it is assured of some longevity in the process. A sector that lurches in survival mode from year to year, as it currently does, cannot function in a process like this which aims to build skills, expertise and strong working relationships over time- the sector needs adequate multiyear funding to be enabled to take its place at these tables.

The document does not differentiate between those voluntary groups who are health service integrated (e.g. Action Cancer, Chest Heart and Stroke) and reliant and those outside of that picture who have a lot to contribute but who are less 'health' focused – (e.g. Advice NI). Those who work with the Health and Social Care system currently understand commissioning processes etc. so there is work to do to enable equity of participation.

Community organisations in many urban contexts employ paid staff so are better resourced to engage in these structures at AIPB, locality and community levels. In rural areas groups are run by volunteers, many of whom, are elderly and for whom succession planning has not been adequately addressed and will have additional challenges participating in these structures.

Local level decision making can only happen if community representatives are treated equally at decision making tables. It can only happen effectively if community representatives are resourced and supported in their role; that they understand the local contexts, the data and trends in their locality, and know how and when to report back to the wider community and not just their interest groups. They need to be supported to see broader strategic contexts (understanding the local and regional fit of services) rather than just localised issues.

Language barriers between health sector staff, clinicians and voluntary and community sector representatives need to be addressed – these are evident within ICPs and learning from that model should be used to support better working relationships in the ICS.

The private sector is missing from this entirely – as a private healthcare providers and social care providers are part of the health and social care system how can an integrated model ignore the private sector? They should be part of the process.

Q2. Section 5 sets out the Values and Principles that all partners will be expected to adhere to.

If applicable, please comment on anything else you think should be included.

Comments:

Some reference in the Values and principles should be made to the equality duty and the need to ensure health and social care planning and delivery takes account of equality considerations.

A reference should also be included to the duty imposed by the Rural Needs Act and recognition of additional challenges posed by delivery of health and social care services to rural communities.

A reference should be made to using the new structures to address the social determinants of health and to ensuring that all partners are committed to addressing issues that contribute to ill-health e.g. poor housing, poverty etc.

RCN was surprised not to see more reference to the values of co-design and co-production which are prominent in the Programme for Government.

How will the implementation of these values and principles be measured in practice across the different levels? Whose role is that and how will they respond if a group is found wanting in any of the areas?

This is a place-based model, region, health trust area, GP Federation/Integrated Care Partnership area, and community area. There is a need to think about how thematic health and social care issues can be planned for and implemented.

Q3. In line with the detail set out in Section 7 do you agree that the Minister and the Department's role in the model should focus on setting the overarching strategic direction and the expected outcomes to be achieved, whilst holding the system to account?

Agree / Disagree

(delete as applicable)

Additional comments:

Not sure that the Minister and Department should set strategic objectives and outcomes and hold the rest of the system to account, in this scenario how are the Minister and Department held accountable? There is a role for the Assembly Health Committee in scrutinising the work of the Minister and the Department but how will this scrutiny extend to the Regional and Area level?

Cross government action to improve health and well-being and reduce health inequalities needs to include, for example, initiatives to address poverty and unemployment, tackle low pay, provide more social/affordable housing that's affordable to heat and tackle air pollution. These types of issues require a level of cross departmental working which has, to date, proved unachievable under the NI Executive structures. Some of these structural issues go beyond the NI Executive e.g. social security policies set by Westminster government and the introduction of Personal Independence Payment has had severe adverse health impacts on thousands of vulnerable people across Northern Ireland.

A serious level of engagement will be required with rural communities and other stakeholders if the Department is to ensure the provision of appropriate health and social care services as recommended by Bengoa. This engagement will also need to address cross departmental issues re. provision of better ambulance services, improved broadband connectivity and improved road infrastructure to ensure that rural dwellers are afforded equitable access to health and social care services even if they are further centralised.

How will this ICS Draft Framework complement other NI Executive initiatives such as the Anti-poverty strategy, Housing Supply strategy etc. if we are to address the social determinants of health?

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Workforce planning – attracting GPs to work in rural areas is difficult and the GP cohort in many rural areas is ageing with fewer GPs available to work in small rural practices. How will the department address workforce planning inequalities that leave populations without services by virtue of their geography and not their need

Q4. Section 8 sets out what the ICS model will look like when applied to NI. It is based on the principles of local level decision making which will see a shift of autonomy and accountability to local ICS arrangements. Do you agree with this approach?

Agree /

(delete as applicable)

Additional comments:

ICS model needs to include some recognition of provision of cross border health care services. Planning and delivery of regional and specialised services sits at regional level and assume that this means more specialised health care planning and delivery (on an all island or all UK & Ireland basis) will be undertaken there. However, there are issues at area and locality level around planning and delivery of healthcare services in border communities that need to be considered.

The framework states that the Area Integrated Partnership board partners participating in the model will have equality of influence. Will community and other statutory partners have the same influence as those partners with specialised clinical or health and social care management experience? In our experience this is highly unlikely and the power dynamics need to be recognised to be addressed. Creating a culture which combines the specialised clinical and management experience/knowledge of health and social care professionals with the non-professional but lived experience/knowledge of other partners will be extremely challenging. However, if it can be achieved, it has great potential to address long standing health inequalities. There is a need for training, resourcing and supporting people to sit at these tables – how will they be supported to understand the complexities of the system and how will they win an equal place at that table?

All 4 levels in the model should be cognisant of the duty imposed on the Department by the Rural Needs Act NI which states:

***"1**—(1) A public authority must have due regard to rural needs when—*

(a)developing, adopting, implementing or revising policies, strategies and plans, and

(b)designing and delivering public services."

Q5. As detailed in Sections 8 and 9, a Regional Group will be established to undertake an oversight, co-ordination and support function for the ICS. Do you agree with this approach?

Agree / Disagree

(delete as applicable)

Additional comments:

The undertaking of Rural Needs impact assessment is probably most critical at the regional level (see above) however it will be important across all 4 levels and must be given due regard as the Department seeks to rebuild health and social care services.

There is little mention of the role of the Regional Group about finance, budgets etc. and how decisions will be made as each of the 4 levels plan and implement health and social care services at their own level. Para. 9.3 states that the during 2021 and up to 31.03.22 the HSCB will continue to operate and undertake their statutory roles and duties in aspects of commissioning, governance, accountability and finance. Section 14 states that as the model and partnerships mature AIPBs will take control over planning and funding for services delivered in their localities.

In the interim will the HSCB statutory roles and duties transfer to the Regional Group after 31.03.22? If so, how long will the AIPBs take to mature before they can control planning and funding for services,

Q6. As detailed in Sections 8 and 10, do you agree that the establishment of Area Integrated Partnership Boards (AIPBs) is the right approach to deliver improved outcomes at a local level?

Agree / Disagree

(delete as applicable)

Additional comments:
RCN notes the role and responsibilities of the AIPBs what role/control will AIPBs have in setting budgets or redirecting budgets directed to them from regional level to meet local health and social care priorities?

At Para 10.4 the relationship between Trusts and GPs is highlighted as pivotal to enable successful partnership working across all sectors which is considered in further detail at Appendix A. GP involvement and insight are obviously critical as they, along with pharmacies, are the first points of contact between citizens with health needs and the wider health and social care system. They know and can navigate the wider health and social care environment on behalf of their patient depending on the health issues they present. Can they commit further time to AIPB work when they are under unrelenting pressures in delivering primary care in their practices?

Representation process onto AIPBs from Community and Voluntary sector, community planning partnerships, carers and service users needs to be considered carefully. Will this be by open nomination process, what are the selection criteria, skills, knowledge and aptitudes required. How will these representatives' feedback to local community networks etc. and engage with locality and community level structures proposed in the Framework?

The AIPBs may need to take decisions on planning and delivery of services that are publicly unpopular (e.g. relocation of services) – how will this impact on community and voluntary representatives?

What process is in place for managing decision making and conflicting views within AIPBs? Furthermore, if AIPBs and Regional Group disagree on local approaches adopted to deliver desired outcomes how will that conflict be managed?

Para 10.16 sets out the key tasks for each AIPB to undertake, with target dates for completion of some steps. There is no indication of how these key tasks relate to budgets or finance for health and social care service delivery.

There may be practical difficulties for Community and voluntary sector participation as most CVS organisations are not sustainably funded.

Social prescribing could be an opportunity to implement more widely community-based approaches to health and well-being that begin to address some of the social determinants of health and have the potential to reduce the burden on health and social care services by promoting health literacy.

Q7. Section 10 of the framework provides further detail on the local levels of the model, including the role of AIPBs.

Do you agree that AIPBs should have responsibility for the planning and delivery of services within their area?

Agree /

(delete as applicable)

Additional comments:

In principle we agree but how much autonomy will AIPBs have and how much decision making will be retained at the regional level? There needs to be close collaboration across AIPBs to ensure people can access care and services in another AIPB if those care and services are not available in their own AIPB area to avoid a postcode lottery for health and social care services.

Also issues over power and equality in whose voices and perspectives are given priority on decision making processes of AIPBs.

There will also be a gap between what the AIPBs may wish to deliver and what has already been commissioned if "no substantial changes are being proposed to current financial models, processes and procedures in the first instance." (Para. 14.4)

Q8. Do you agree that AIPBs should ultimately have control over a budget for the delivery of care and services within their area?

Agree /

(delete as applicable)

Additional comments:

We need to explore different methods of procurement that are less price based but place a value of social return on investment – that place a value on things like holistic and wrap around services that offer added benefit and such as community connectivity and enhanced support for the individual. Procurement for health and social care services should not be equivalent to purchase orders for goods/building supplies.

Community wealth building needs to be a part of this agenda for change – we need to think about how to build assets and resources within communities to ensure these models

are accountable and working for the local community – how will that be measured and tweaked in the future.

As stated above there will be a gap between what the AIPBs may wish to deliver and what has already been commissioned if "no substantial changes are being proposed to current financial models, processes and procedures in the first instance." (Para. 14.4) The time taken to develop a new funding model to facilitate this approach runs the risk of undermining the whole process if local communities fail to see any positive changes to the delivery of health and social care services in their area.

Some Community and Voluntary sector organisations may be represented on an AIPB as well as being commissioned to deliver health and social care services. Consideration needs to be given to how conflicts of interest are managed to ensure that participation in any of the ICS structures is not a benefit or block to an organisation seeking to tender for health and social care service provision.

Q9. As set out in Section 10, do you agree with the proposed minimum membership of the AIPBs?

/ Disagree

(delete as applicable)

Additional comments:

As set out at Para 10.6 membership of AIPBs is heavily weighted towards health and social care. More information is needed on the role of the Community & Voluntary sector reps. on the AIPBs and more consideration given to their support and resourcing to have an effective voice in these Boards. The range and diversity of the Community and Voluntary sector across Health Trust areas will be difficult to represent by two leads, one each from the Community and Voluntary sectors.

Q10. As set out in Section 10 of the framework (and noting the additional context provided in Annex A of the document), do you agree that initially each AIPB should be co-chaired by the HSC Trust and GPs?

Agree

(delete as applicable)

Additional comments:

Agree that initially the AIPBs should be co-chaired by HSC Trust Chief Executive and a lead GP representative in the first instance. However, it is important that the chairperson should be open to all members/sectors in future as AIPBs mature.

Q11. The framework allows local areas the flexibility to develop according to their needs and circumstances.
As set out in Section 10, do you agree that the membership and arrangements for groups at the Locality and Community levels should be the responsibility of the AIPBs to develop, determine and support?

Agree /

(delete as applicable)

Additional comments:

Agree that the arrangements for representation at the locality and community levels should be the responsibility for AIPBs to develop and support according to their own area circumstances, what works in Belfast will not necessarily work in the Western Trust Area. Having said that the Department needs to offer overall guidance on principles for community involvement and engagement to the AIPBs to ensure that representation at locality and community levels is appropriate and is broad enough to inform the new structures and shape services accordingly. The Department needs to ensure best practice and sharing of good practice across AIPBs and at locality and community levels to ensure that community engagement is continuously improved across NI.

Issues of equality of representation and equity of participation need to be explored and barriers to engagement and involvement need to be identified and addressed.

All Community & Voluntary sector organisations should have an opportunity to get involved and the voices of smaller grass roots organisations need included as well as the larger voluntary organisations who may focus on specific health conditions.

General Comments
Please add any further comments you may have: Workforce planning and workforce burnout are fast becoming existential threats to the delivery of health and social care services. RCN is concerned that there is no reference to the role of health unions within this structure – this would seem to be a serious omission. How these new structures will shape health and social care spending in the coming years will be critical to their success. We would have liked to have seen some further detail on the Department's early thinking on this crucial issue.

Thank you for taking the time to respond to the consultation.
Please submit your completed response by **17 September 2021** using the details below:

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Hard copy to:

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