

Community Development and Health Network (CDHN)

Integrated Care System (ICS) NI

Response to consultation

17 September 2021

1. About CDHN

Community Development and Health Network (CDHN) is a regional network with over 2,100 members from the community, voluntary, social enterprise, local Government and public sector organisations across Northern Ireland. Our members range from large voluntary organisations to local volunteer-led community groups. We work in cross-sectoral partnerships to tackle health inequalities using community development approaches in four main ways:

- Policy development and advocacy
- Training development and facilitation
- Networking and connecting our members
- Building evidence-based practice through innovative programme implementation and evaluation.

CDHN is committed to excellent impact practice using outcomes frameworks to measure the impact of our programmes.

2. About this response

This response was developed by the CDHN staff team, it was informed by:

- Information gleaned from DOH and NICVA consultation workshops.
- Our expertise and knowledge garnered through ongoing engagement with communities and HSC professionals through our co-designed programmes.
- Feedback and discussions from CDHN Board, community partners and other stakeholders.
- **Feedback from our membership engagement event** held by CDHN on 09 September 2021.

The purpose of the **membership engagement event** was to provide the space to discuss some of the questions and issues our members and others interested in the topic may have about the new Framework and how it will be implemented. CDHN shared its draft response prior to the event. In total 48 people attended. The Voluntary, Community and Social Enterprise (VCSE) organisations included representatives from large regional voluntary organisations, local voluntary organisations, community organisations and Healthy Living Centres across Northern Ireland. The Health and Social Care representation included those

working with ICPs, a GP advisor, representatives from membership organisations and pharmacists. The full notes of the event can be found in Appendix A.

CDHN programmes that informed our response include:

- *Building Community-Pharmacy Partnership (BCPP)* - HSCB funded regional programme works in partnership on projects that address health inequalities at the community level.
- *Elevate Capacity Building programme*, co-created with the PHA, regional programme that provides opportunities for the development of skills, knowledge and expertise in community development to tackle health inequalities.
- *Self-Care Pharmacy project* - regional programme that aimed to improve the knowledge and understanding of self-care for minor ailments through a health literacy approach.
- *Inspiring Impact* - CDHN is the NI partner, the programme provides peer learning networks and online resources so that the community and voluntary sector can improve its impact measurement and learn from others.

3. Overall comments

CDHN welcomes the opportunity to respond to the Department of Health's future planning model consultation. We are broadly in support of the proposed reorganisation to an Integrated Care System for Northern Ireland. CDHN has long advocated for a system shift towards an adequately and more evenly resourced funding model that better serves populations before they get ill through prevention, early intervention, diagnostics and screening and supports recovery in the community and primary care settings.

CDHN is cognisant of the current pressures on the health system, dedicated staff workforce and patients, as everyone struggles with the competing priorities of the pandemic and the historic backlog of unacceptable waiting lists in diagnostics and care. It is important to recognise the value and expertise of frontline HSC workers and their ongoing involvement in, and contribution to, implementing the changes proposed.

We are hopeful that the draft framework proposed will incentivise all those responsible for health and social care at every level. Working collaboratively in a joined-up, well-resourced, comprehensive health and social care system will reduce health inequalities, bring positive change to staff and patients; and lead to better health outcomes for all.

With our hope, there is some apprehension that the model will not be realised as envisaged. Members expressed some concern that the model will be just another initiative/project that "*we have seen before*", where the involvement of people and communities is tokenistic and there are few notable changes to health and social care, nor improved outcomes for patients. For the model to be successful, we feel it is vital that community-centred approaches for health and wellbeing are integral in the delivery.

These approaches are about mobilising assets within communities, promoting equity, increasing people's control over their health and lives. They help ensure there is meaningful engagement and participation of people and communities.

Person-centred and community-centred approaches takes time, there needs to be a medium to long term approach with multi-annual funding for the health and social care system, and a strong focus on prevention, early intervention and continuity of care.

4. Consultation

The key issues which CDHN has identified are as follows:

- Community centred approaches, putting people and communities are at the heart of the model
- Learning from previous integration initiatives and sharing good models of inter-sectoral practice
- Resourcing the community engagement and participation in design and decision-making
- Partnership, collaboration and recognition of existing power imbalances to improve culture of democratic decision-making
- Development and contribution to the setting and delivery of outcomes at each level of the ICS system
- Health literacy as a core principle and a way of doing work

We have woven these throughout our answers to the specific consultation response.

5. Response questions

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?

We broadly agree that the shift away from a highly bureaucratic provider/commissioner model is the right approach. We warmly welcome the model's population health approach to reduce health inequalities, and the emphasis placed on the social and environmental determinants of health. It places people at the heart of the model through the identification of the needs of individuals and communities (*patient centred and community centred approaches*).

We are pleased to see that collective action forms part of the definition of the ICS system. Building collaboration and partnership into the design, delivery and management of health, social and community system is a key factor in the success of this proposed transformation process.

We recommend a further addition in paragraph 2.8 of the framework: The model will address inequities in the System. This would be keeping with the spirit of the ICS model proposed.

Inclusion of key engagement approaches

We note that community engagement and community development are not specifically mentioned in the framework. Community Development is referenced as key principle in

relevant HSC strategies¹. It is the foundation for the most appropriate and long-term approaches to connect with and empower more vulnerable or marginalised communities, to be heard, and fully participate in the decisions affecting their lives and their communities.

The PHA [Expansion of Community Development Approaches](#)² demonstrates that the process of community development has the potential to improve health outcomes and reduce health inequalities. A healthy community is one which is more self-reliant and is less likely to place increased demands on the health and social care system. The Kings fund '[A vision for population health](#)'³ view is that integrated care systems will not be successful if they do not engage seriously with the role of communities in improving and sustaining good health. They recommend community development and community commissioning approaches to support communities to improve their health themselves. (See our response to Q11 for more detail on engagement, involvement and participation).

Co-production is only mentioned once in the whole document. We feel a lot more emphasis needs to be placed on co-production and co-design and reference made to the [DoH co-production guide](#)⁴. Adopting a co-productive approach is at the heart of improving people's experience of care. Co-production done well can improve care outcomes, it can enable systems to become more effective, efficient, and is rewarding for the staff who provide care.

The Patient and Client Council is in the glossary of terms; however, it's formal role is not mentioned in the document.

There is no reference to personal and public involvement (PPI). PPI is a legislative requirement for Health and Social Care organisations as laid down in the Health and Social Services (Reform) Northern Ireland Act 2009 and one of the key strands underpinning the DoH 10-year Quality Strategy. Will this be part of the mechanisms to involve service users, carers and the public in the ICS?

Social Prescribing is an innovative and growing movement on the island of Ireland, providing a valuable bridge for patients into wider community-based services and supports. It has the potential to reduce the financial burden on the NHS and particularly on primary care. There are ongoing initiatives in NI, many already linked to integrated health planning in their areas, to ensure that vulnerable and socially isolated have access to the right services in a timely way. How will social prescribing fit into the model?

Figure 3 – what does our vision look like?

The ICS focus in Figure 3 (vision) appears to be heavily weighted towards a medical model of health and less on a social model, wider determinants and people, places and communities. In Figure 3, the four circles on the right-hand side outline specialist care, primary care, support for self-care and improved outcomes. It doesn't include the wider determinants of health or the role of community and places in improving health and wellbeing.

¹ Making Life Better A whole system framework for public health 2013-2023, Making it better through Pharmacy in the Community, Health and Wellbeing 2026: Delivering Together and the Social Work Strategy 2012-2022.

² DoH and HSC (2018) Expansion of Community Development approaches: Report to Transformation Implementation Group

³ Buck, D, Baylis, A, Dougall, D & Roberston, R (2018) A vision for population health: Towards a healthier future, The Kings Fund

⁴ Department of Health (2016) Co-Production Guide: Connecting and Realising Value Through People

Figure 3 also suggests that the three top circles lead to improved outcomes with one adding to the other.

The King's Fund '[A vision for population health](#)' bases its model on four interconnecting pillars - wider determinants of health, our behaviours and lifestyles, the places and communities we live in and with, and an integrated health and care system. They state that a more balanced approach is required which distributes effort across all four pillars and crucially makes the connection between them.

All these factors lead to improved outcomes, all have a part to play in ending social and health inequalities. We propose that this wider vision is incorporated into the figure 3 diagram, to better align with the written description of the ICS framework. Also, the outcomes circle in the diagram, may be better placed sitting at the right-hand side of the other circles rather than at the bottom, again to represent that the new Strategic Outcomes Framework will incorporate the wider determinants of health.

Communicating the vision and model

As the ICS is developed, it is important that health literate messages and information about the vision, model and range of services in the ICS are communicated to both those directly involved in the ICS and the wider public.

One of the key findings of CDHN's Self-Care Pharmacy project was that people do not always know where to get help, how they can get help with their health and/or social issues that impact on their health and how to choose the right service at the right time.

If the ICS brings changes to where services are delivered and how they are accessed, people need to be informed about any changes to the current health and social care system and about what will remain the same. In order to improve efficiency and optimise capacity, people need to be aware that alternative services are available and how and when they can access them.

It would be useful to name the range of services to be included in the ICS – those at the area level and the specialist services at regional level. This will provide clarity and it will make the framework more relatable to the public.

It would also be useful to say how and why the new system will achieve better outcomes for patients, so they can understand how this change will benefit them.

We welcome digital solutions; however, it poses some real challenges. The ICS must be cognisant of digital exclusion and further exacerbating inequality. Information and messages need to go beyond online sources and social media to ensure that socially and economically excluded groups have the right resources to participate in society as equals and not an afterthought.

Any advice services about where to get help with health or social issues relating to health need to be free and independent. This is important to consider from a social determinants' perspective, particularly for those who are disadvantaged, vulnerable or marginalised. Engagement with the independent advice sector will be important to find out what information and training they may require in continuing to play their valuable advisory role for citizens.

Another key finding of CDHN's Self-Care Pharmacy project was that many health and social care staff do not fully understand each other's roles and are not fully aware of the services that are available in the community. Similarly, the VCSE sector does not always fully understand health and social care roles and services and what other support is available in the VCSE sector.

The ICS will bring many people to work together, they need to understand each other's day-to-day roles as well as their role in the ICS, this is crucial for effective partnership and meaningful engagement (see Q7 response for further detail on this).

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.

We are broadly in agreement with the values and principles underpinning the framework and are suggesting the inclusion of two more for your consideration - *community centred approaches* and *health literacy*.

Community centred approaches

We think 'community-centred approaches for health and wellbeing' need to be included as a value and principle as they are a key part of an effective integrated care model. Community-centred approaches are not just community-based, they are about mobilising assets within communities, promoting equity and increasing people's control over their health and lives. [Public Health England](#)⁵ have identified four different strands of community centred approaches.

- *strengthening communities* – where approaches involve building on community capacities to take action together on health and the social determinants of health
- *volunteer and peer roles* – where approaches focus on enhancing individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities
- *collaborations and partnerships* – where approaches involve communities and local services working together at any stage of planning cycle, from identifying needs through to implementation and evaluation
- *access to community resources* – where approaches connect people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation

⁵ Public Health England and NHS England (2015) A guide to community-centred approaches for health and well-being



Source: A guide to community-centred approaches for health and well-being NHS England 2015

Health literacy

We feel health literacy should be added as a value and principle. Health literacy is recognised as a key determinant of health and is a means of addressing health inequalities in line with prevention commitments. Evidence shows that improved health literacy is beneficial for individuals, community, health and social care and policy⁶:

Individual

- Health literacy is key to supporting people to manage their own health and wellbeing. It is the first of [seven pillars](#)⁷ of self-care, people with improved health literacy feel more confident to be active partners in their healthcare and make informed and shared decisions about their health.
- They have the skills to better navigate the healthcare system in a timely way– which we know can be very complex and may change with the new ICS
- They feel more empowered to take control of the social determinants of health and have a say in their own health.

Health and Social Care System:

- Research shows that when health literacy is prioritised, health outcomes improve and the relationships between the patient and their health professionals are better.
- People feel more confident to understand their medication, what they are taking and why they need to take it to improve their health.

⁶ WHO (2013) Health Literacy The Solid Facts

WHO (2019) Draft WHO European roadmap for implementation of health literacy initiatives through the life course

The health literacy place <http://www.healthliteracyplace.org.uk/evidence/health-literacy-impact>

⁷ The international self-care foundation: The seven pillars of self-care

- All of this helps to reduce re-admission and repeat appointments, and over reliance on A&E as a last resort.

Community

- When people in communities have good health literacy skills, it strengthens community resilience to address the social issues that lead to health inequalities.
- It also means people are more informed and better equipped to engage with community initiatives that aim to improve health and wellbeing.

Policy

- It is evident how improving health literacy at other levels has a positive impact at a policy level, for example, more cost-effective use of medicines, supporting adherence and independence as well as patient self-care and self-management

The word 'adhere'

We are struck by the choice of the word 'adhere to' in the values statement. We often think in terms of embracing or living up to these principles and promoting them through their work. For such a cultural shift to happen successfully, it will need to be facilitated and encouraged. The production of guidelines to demonstrate the best practice elements and approaches for partnership working will be essential if there is to be adherence to this principle.

Partnerships and Cross Sectoral collaborations

Partnership working is both a key principle and a suggested approach underpinning this framework. This is something to be welcomed. Although the prospect of implementing this approach is daunting, it is the right goal to pursue.

As stated in 6.8 of the document:

"The focus on partnership and cross-sector collaboration throughout this framework is a recognition of the wide range of determinants of health and wellbeing."

The section also states that new services and interventions will not always be HSE owned, due to the nature of the population health approach. This will require an innovative approach to contracting services, sharing responsibilities and targets across the sectors. The detail here is crucial and it would be useful to highlight any good partnership models that exist in the system currently, to promote integrated service development and delivery.

We would like further consideration to be given on how to realise the principles in point 3 and point 4 as we feel that there needs to be more recognition of the **power** imbalances that exist and how this may play out around a representative structure of **equals**.

Point 3 states

"Adhere to the principles of parity and inclusion between partners; acknowledging the skills, experience and value that each partner can bring"

Unfortunately, a power imbalance currently exists in how we value knowledge and expertise in society. Valuing and including people's lived experience in policy and decision-making is

no longer a “nice to have”, it is a key piece in our understanding of the problems we are all trying to solve. VCSE organisations have a key role to play in ensuring that people’s voices are heard.

Power dynamics need to be addressed on representative structures to ensure that all feel, comfortable, confident and able to meaningfully engage (see Q7 & Q11 responses for more on power and participation).

Power and organisational autonomy

Point 4 States:

“Agree, clear and transparent ways of working together, having a mutual understanding of each other’s existing governance arrangements and structures”

We propose that **respect is added** to the statement above. Current commissioning arrangements for the VCSE sector will need to be addressed, in an atmosphere of mutual understanding and respect to avoid tensions around existing short term commissioning arrangements. Current commissioning arrangements reinforce the view that the C&V sector is less important than the private or public sector in partnership arrangements. In addition, current procurement policy does not encourage joint funding, joint ownership or shared intellectual property. This does not foster the right environment for learning and sharing and co-production. This will need to be addressed early as it will impact on potential outcomes (see also Q7 response).

We feel more discussion and clarity is needed around engagement, partnership working and the envisaged role and expectations for the VCSE sector and citizens.

For true collaboration, partnership, and co-design to happen, VCSE expertise and engagement in the model must be fully embedded in the model and publicly resourced. Community and Voluntary organisations do not have the financial or resource capacity to meaningfully participate at no cost.

For this collaborative work to succeed, a wider change in fiscal policy at the Executive level, towards multi-annual public financing and funding is required. This will lead us away from short-term decision-making to a medium to long-term approach at all levels.

Tools to monitor and measure values and principles

Our membership is keen to know what tools will you use to monitor and measure the expression of these values and principles within the system and to the benefit of patients and stakeholders?

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?

This sounds like a reasonable and accountable governance structure. The framework does not give much detail on how it would look in practice.

We would like more clarity on the role of the Minister and Departments in the model. Some questions have been generated from discussions as follows:

- What is the power of veto and how does that evidence generated from both the regional and area population profiles support evidence-based decision making?
- What processes are in place to monitor progress and what are the reporting mechanisms?
- How does this fit with the current power sharing arrangements? What is the role of the health committee?
- The population health approach, particularly when looking at the wider determinants of health, will be across all Government departments. Other departments have a responsibility for different social determinants of health. If other departments aren't involved, it can't address health inequalities. How are they going to be incentivised to collaborate?
- How does the ICS link its work programme to other strategies, E.g., Anti-Poverty strategy? What type of monitoring and reporting arrangements can be used to support this?
- There needs to be a balance between oversight and interference. The Minister should have no remit to interfere, stop or suspend the delivery of any health and social care service if it does not align with the views of their political party. This is particularly important if a service has been identified through local needs or has been established as a fundamental human right to health.

We recognise that implicitly this framework is advocating an evidence-based approach to support decision-making processes and prioritisation of resources to deliver a better standard of care for all. The importance of involving citizens in the production of population profiles is a key consideration. The outcome of these decision-making processes should be open and transparent. This will build trust and lead to better co-operation on this long-term strategy to improve our key public services.

Strategic Outcomes Framework

The expected contribution of the VCSE sector to measure progress against the strategic outcomes framework and local outcomes needs to be clear. If there is an expectation for them to collect outcome data, training and support will be required for this to be completed effectively and this needs to be resourced by HSC. Many VCSE organisations, particularly smaller organisations, will not be able to do this without extra support and resource. Earlier this year, CDHN undertook some primary research on impact practice in NI as part of the Inspiring Impact programme. The report found that while impact practice knowledge and understanding has increased over the last 10 years, more support is still needed in the planning and implementation of impact practice.

The VCSE sector also need to be involved in the co-design of the strategic outcomes framework as well as local outcomes and measures. They will understand the priorities to focus on to improve health and wellbeing in their community. They will also be aware of the challenges and barriers to collecting data in the community and provide guidance on how these could be overcome or alternative data collection options.

OBA has a focus on quantitative data, there will be evidence of impact that may not be reflected in quantitative indicators or performance measures. Qualitative data, including the lived experiences that go deeper than 'the story behind the baseline', also need to be included.

We would welcome further discussion on how the VCSE sector can be assisted to play a meaningful part in this area.

Evaluation of model

This is a new approach, there is a lot of learning for all involved and teething problems are expected. As well as the outcomes approach, it is really important that an overall process evaluation of the implementation of the ICS needs to be planned from the outset. The evaluation can find out how it works and how it produces outcomes, including knowing which aspects of the ICS are important and how different aspects of the ICS work together and what helped and hindered the approach. This will be particularly valuable where different methods are employed in each AIPB, locality or community. The learning can be shared, and improvements or redesigns can be made.

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?

CDHN broadly agrees with this approach of local evidence-based decision-making and accountability for resources spent. This will better meet the needs of the whole population and improve their health outcomes.

Figure 4 (The ICS NI Model)

The ICS NI Model depicted in Figure 4 is not reflective of the narrative. The model does not make clear there are 5 AIPBs.

The model places community groups to the outer right-hand side of the model, providing no indication of how this is connected to the area level system. Similarly, the model does not indicate the role of local intelligence and how it will inform the model and the decision-making processes of the AIPB.

VCSE sector role in model

It would be helpful to clarify the future ICS expectation of the VCSE sector role. Our members have highlighted areas where there is a potential role, based on our reading of this framework. This list is not exhaustive.

- As representatives in the newly established decision-making structures, supported by the system to participate effectively
- Identifying and supporting the engagement of citizens in the local decision-making process so that those experiencing social and health inequalities are not excluded.

- Local VCSE sector knowledge and expertise about the place they live in. The availability of or gaps in infrastructure and other assets and resources. They will know about what stops or hinders community based public services from working well in a joined-up-way, for the whole population.
- VCSE involvement in thinking about the outcomes we want the system to achieve for the whole population, in a joined-up system.
- Their role in gathering and sharing data, interpreting the data (adding in stories of lived experience to enrich or explain the data) to make good decisions on prioritising services and supports for people in communities.
- Their role in co-designing and delivering targeted interventions that uncover and address population needs and support adaptations in the wider system.
- Their role as a specialist service provider in community and patient led services, supporting and advocating for those who have complex needs and are falling between the cracks of mainstream service delivery (ineligibility).

It would also be helpful to know the process for agreeing how many local and community level partnerships will be included in the final model and whether the Department has any preferred model in mind.

Roles in model

We have some questions about roles in the model.

- Where do regional, UK wide and Ireland-island wide VCSE organisations sit in this model? They may not always have a community or locality level presence; however, they can bring a lot of knowledge and expertise to the ICS.
- Where do local councils fit into the model? What is their role? How will it be aligned to community plans?
- Where do Allied Health Professionals fit into the model?
- Where does Northern Ireland Ambulance Service (NIAS) fit into the model?
- Will there be a role for academic institutions?

Standards and training

What are the standards that are going to be put in place and training given for members at every level? For example:

- Key concepts: All of those involved should have a common understanding of the key concepts in the ICS e.g., Population health, health inequalities, outcomes frameworks and OBA, lived experience. We are aware from delivering training in CDHN that people have limited and different understanding of concepts. This is a key part of health literacy noted in response to Q1 & Q2.
- Quality information and advice giving, signposting and patient centred referral pathways
- Best practice partnership working (see Q2 response).
- Involving communities in needs analysis, monitoring and decision making (for representatives).
- Community engagement (see Q11 response).
- Outcomes (see Q3 response).

IT system and data sharing agreements

Key consideration to make the model work at all levels of the system and across all areas of care.

Learning from existing and past practice

Other integrated types of groups exist in NI e.g., community partnerships, community planning, housing organisations, health and wellbeing networks as well as the 17 Integrated Care Partnerships. The learning from these processes/experiences needs to be taken into consideration. The things that may not have worked and finding out how these can be resolved are as important as finding out what worked.

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?

CDHN broadly agrees with the establishment of a regional group.

Detailed plans for testing the approach will be essential for the sustainability of the model. This should be considered and built into the set up and reporting arrangements from the outset.

Membership of the regional group needs to be clarified. The VCSE should be represented at this level, and they need to be representative of the whole community. The VCSE sector is very diverse, one or two organisations cannot represent the views of all unless a system is put in place for them to gather the perspectives of others. This could be similar to a partnership board or forum for the AIPB proposed in paragraph 12.10.

There should be a two-way system for sharing local data. The VCSE sector has local intelligence about lived experiences, needs and priorities from many sources in a variety of formats. How will they be able to share this with the regional group to influence decision making processes? The VCSE sector would also benefit from having any data collected shared with them. This will help with their future planning and in funding and tendering processes.

Paragraph 3.3 says *"The involvement and knowledge of local communities in the foundation of the model to ensure that decision making is informed by all available evidence and identified need"*. They should also be involved in the interpretation of the local intelligence and population health data; this will help fill in the gaps in understanding.

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?

CDHN broadly agrees with the establishment of AIPBs. We would caution against overlaying the new model on top of old Trust structures and boundaries and established inter-departmental working arrangements, particularly as the time frame for establishment of the

structures is so tight. A new system of governance and responsibility will be required to encourage population health thinking, and evidence-based decision-making.

A system for recording any unforeseen blockages or obstacles to working in this way as well as sharing of good practice needs to be established. This should be facilitated by the regional oversight group (perhaps part to paragraph 9.1).

The culture of sharing and collaboration between the key stakeholders involved should be incentivised and fostered throughout. It would be useful to look at models of existing good practice – the work of the ICPs is an important place to start.

This could also form part of a process evaluation (see response to Q3 for more comments on evaluation).

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?

We agree with the levels and the AIPB being coterminous with the HSC Trust areas. Consideration will need to be given on how the councils will be involved as they are not coterminous with the Trusts. This was discussed at our engagement event and some people did not agree with it being coterminous with the Trusts. This may need explored further.

We agree that AIPBs should have responsibility for planning and delivery of services within their area. However, there needs to be some parameters around this so that people can access care and services in a different AIPB if it is not available in their area and avoid a 'postcode lottery' for health and social care services.

Guidance and support should be provided to the AIPBs to help ensure that power dynamics are acknowledged and a balance of power across the structure in setting priorities is sought. This balance of power should be across health and social care specialisms as well as with the VCSE sector, service users and carers. Spaces should be created for representatives to talk to each other, increase their understanding of each other's roles and share learning. (This is connected to the values and principles in Q2 and Health literacy response in Q1).

Key to this understanding is that real power imbalances of wealth, opportunity and access to services exist in our society. People who are most in need are also at risk of facing barriers that exclude them from our social and health care services, as they are currently designed. They are the least likely to participate in the current structures for patient and community involvement. Action is required to address these issues at a structural level, provide the means for excluded groups to participate in the types of local decision-making processes envisaged. Communities have a role to support and empower people to play their part in an inclusive society.

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

CDHN broadly agree that AIPBs should have control over the budget. Similar to our Q7 question response, if a service is not available in a AIPB area due to budget constraints but is available in another AIPB area, people should still be able to access if needed.

Some VCSE organisations may be represented in the AIPB and are also commissioned by health and social care to deliver services. Mechanisms need to be put in place to ensure that being a representative on the ICS does not hinder or benefit an organisation when tendering for the delivery of work or services. Consideration will also need to be given as to how to manage tensions in a group where organisations are in competition with each other for a tender/award to deliver work.

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

At present, membership appears to be heavily weighted towards health and social care. More clarity is needed on the role of the VCSE sector membership and how they will be represented on the AIPBs. Engagement plans need to be developed for this to work effectively; we note this is mentioned in para 12.13.

See Q11 response for more detailed information.

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?

Yes, we agree initially that this should be co-chaired by the HSC Trust and GPs, we also strongly agree that the chairpersonship should be for each AIPB to determine moving forward and that it should be open to all members. The change of chair is essential in addressing the power dynamic which often sits with the statutory sector.

Clarification will need to be made if there is a conflict of interest where chairs also have responsibility for other high-profile roles.

Q11. The framework allows local areas the flexibility to develop according to their particular 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?

We agree that the framework should allow local areas the flexibility to develop according to their particular needs and circumstances. Not every area will be coming from the same starting point and there may be big differences in areas. What works in an urban area may not work in a rural area, models will be rural proofed.

However, there needs to be overall support and guidance on membership, engagement, involvement and participation.

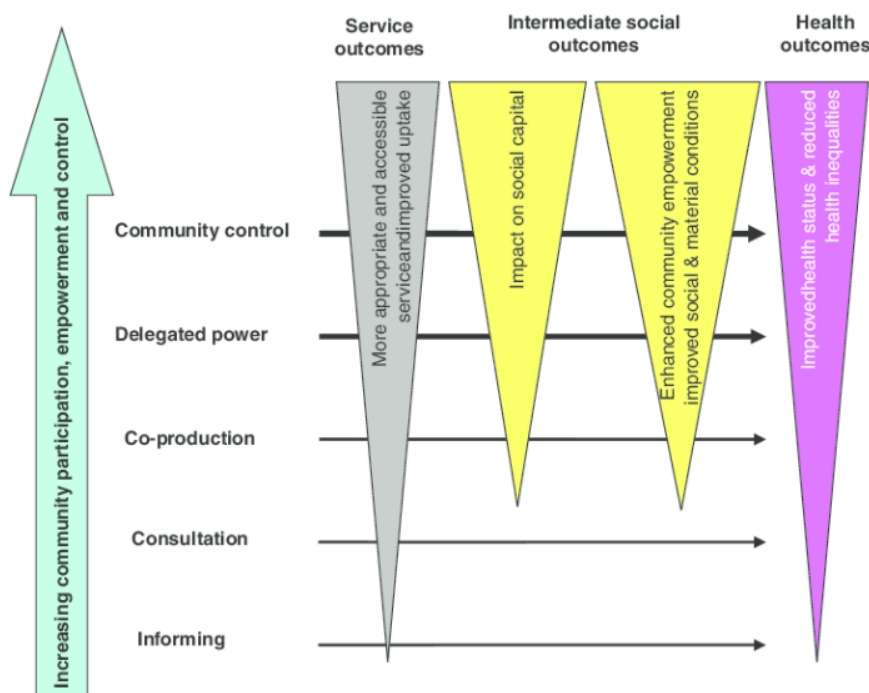
Engagement, involvement and participation

Guidance and support must be provided to the AIPB on community-based approaches and specifically community engagement and participation.

Different levels and types of community engagement have different impacts on a range of outcomes, including health. The diagram by Popay (2006) outlines how approaches which

involve informing or consulting communities are likely to have a marginal impact on people's health (or no or marginal impact on any other outcome at the individual or population level). In contrast, the more a community is supported to take control by being involved in the design, development and implementation of activities to improve their lives (i.e., coproduction, delegated power or community control), the more likely their health (and a range of other outcomes) will improve.

Without the guidance, the AIPB and model could become tokenistic and follow the informing or consulting route or there could be different levels of engagement across the model which could lead to different outcomes.



Source: Popay 2006 Community Engagement, community development and health improvement. A Background Paper prepared for NICE⁸

Community engagement will also be a key mechanism for gathering 'lived experience'. The lived realities of people within communities will only be heard when sought out by people that have built trust and relationships with individuals and solidarity with the local community. It is also important that those who are not currently using health and social care services are heard, exploring their lived experiences could help identify areas where prevention and early intervention initiatives could be implemented to keep people healthy and well.

⁸ Popay, J (2006) *Community engagement and community development and health improvement: a background paper for NICE in Community engagement to improve health* (2008) NICE Public guidance paper 9

Definitions of membership

Definitions are crucial and consideration needs to be given as to what the difference is between the roles of the members and the knowledge and experience is relevant for the role. For example:

Community sector: They may not be regular HSC users but know what it is like to live in their community and will have knowledge and experience of the wider determinants of health that impact upon people's health and wellbeing. They bring the 'lived experience' of living in a community. Do they represent themselves or the local community?

Voluntary sector: Their role could include patient advocacy; expertise and experience in delivering services; condition expertise and health intelligence; and health commissioning. Are all these necessary or should others be added?

Service user: Are these the people that bring the patient voice? They bring the 'lived experience' of being a user of health and social care service or living with a health condition.

Training and support are essential for all those represented on the group to ensure they know what their role is, how everyone should be meaningfully involved and who they can go to for help and support if needed. Programmes such as '[Involving People](#)' could be really beneficial.

Resourcing the VCSE contribution to the model

Meaningful engagement, involvement and participation takes time and money. While some of the people involved may be volunteering, volunteering is 'not free'. VCSE organisations spend time building relationships with people to help increase their confidence and skills so they can get involved in different initiatives and programmes. VCSE organisations have to find capacity in their teams to take part in groups and to engage and reach out to other organisations to bring their voice to the table and represent the wide range of organisations in the sector. The capacity will often not be there without financial resource to support the on-going development of this work.

VCSE representation

As a richly diverse sector, all VCSE organisations should have an opportunity to get involved, priority should not be given to larger organisations - the voice of smaller community and grassroots organisations is just as important. There needs to be a mechanism in place to ensure that VCSE organisations are not able to push their organisational agenda and skew the community or locality need.

Duplication

When the groups are being developed, some mapping needs to be completed to find out what other partnerships and working groups are already in existence and who are members of all the groups. It shouldn't be the same people/representatives at every meeting and people going to each other's meetings. Where possible, look to building, adapting or merging rather than having duplicate groups.

Additional comments

Finance and budgets

There is no question on Finance and Budgets or maturity and future. These are fundamental to the successful working of the model as desired.

Multi-annual funding is needed – the investment will allow the population health model to get up and running while address the hospital crisis.

Mapping decision making

To gain a comprehensive understanding of the community who are currently involved and represented, it would be worthwhile considering a mapping exercise and what support structures are currently in place to support representatives to contribute effectively to the decision-making processes.

Thank you for considering our response. We are happy to engage with this process further at any stage.

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APPENDIX A: Notes from CDHN membership event

Health Inequalities and Health System Reform: A new Integrated Care System to address health inequalities in NI

1. About the event

The event was organised by Community Development and Health Network (CDHN) and held on Thursday 09 September, 10am to 12pm via Zoom.

The purpose of the event was to provide the space to discuss some of the questions and issues our members and others interested in the topic may have about the new Framework and how it will be implemented. CDHN shared our draft response prior to the event.

The event was not recorded, CDHN staff attended in a note taking facility. These notes were written up by the CDHN staff team. They present the key themes from the workshop discussions and do not include an analysis or interpretation. The comments are anonymous and have not been attributed to participants or their organisation. CDHN will use the findings to formulate our final response to the consultation.

Attendees

In total 48 people attended the event (this included 9 CDHN staff members). The breakdown of those who attended is as follows

Voluntary, Community and Social Enterprise (VCSE)	26
Health and social care	9
Local Government	3
Department of Health	1
CDHN Staff	9
Total	48

The VCSE organisations included representatives from large regional voluntary organisations, local voluntary organisations, community organisations and Healthy Living Centres. They were from across Northern Ireland. The Health and Social Care representation included those working with ICPs, a GP advisor, representatives from membership organisations, a GP advisor and pharmacists.

Agenda

- Welcome and introductions: Joanne Vance, Director, CDHN
- Setting the scene
 - Brenda Toal, Project Manager Future Planning Model, DoH and Sinead Malone, Business manager – Integrated Care Health and Social Care, HSCB
 - Gillian Lewis, Community Representative Experience and Chairperson, Lisburn ICP
 - Sara Graham, Chairperson, Long Term Condition Alliance Perspectives
 - Helen McNamee, CDHN Draft Response
- Mentimeter: Participants asked to add one word to a word cloud to “Describe how you feel about the future planning model”
- Break out session 1: Your views on the proposal -What do you think?
- Break out session 2: Community engagement and partnership working
- Break out session 3: Outcomes: What difference would you like to see in peoples’ lives?
- Final feedback and closing comments

2. Setting the scene

Joanne Vance, CDHN Director

Joanne welcomed everyone and noted the great range of membership represented at the meeting.

Brenda Toal, Project Manager Future Planning Model, Department of Health a

Brenda explained her new role as a project manager for the Department’s Future Planning model. Having worked previously at the Southern Trust, Brenda is part of a team of health practitioners who are working with the Department of Health to finalise and plan for the implementation of the Integrated Care System.

This is the initial consultation on the proposed model for the Integrated Care System. She outlined the reasons for the change and the timeframe for establishing the new structures, as the HSC Board will be closed at the end of March 2021. This first phase consultation is about setting out the vision for the system and the values and the principles that underpin it.

Everyone is conscious of the ongoing pressures, and some have questioned if now the right time to make to implementing a structural reorganisation change of the health system. The change is necessary and the shift towards an integrated health care model will bring services closer to communities, based on local needs.

The Department is going out to a range of stakeholders, to make sure that they get the structures right from the start, to bring about the changes in health care that we all want to see. That is, to bring better health and wellbeing outcomes for all and address growing health inequalities. It will require a change in the culture of how the whole system works. She outlined the need for training to support teams in this change. The Department has set up working groups to consider get the right population data to increase understanding, support evidence-based decision making, and establish an outcome measures framework.

Sinead Malone, Business manager – Integrated Care Health and Social Care, HSCB

Sinead added that the model will build on current good practice models that are working at the ICP level and community level. There are good examples of inter-sectoral partnership working. She acknowledged the expertise in the C&V sector and the value this brings to the new system. It is important that this relationship is respected.

Gillian Lewis, healthy Living Manager Community Representative Experience and Chairperson, Lisburn ICS

Gillian explained her role as community representative and Chairperson of the Lisburn Integrated Care Partnership. She has drawn on her experience of working on an integrated care team in Grampian, Scotland as she considers the proposed model for Northern Ireland.

- The importance of having clarity on the role and function of the community and voluntary sector representatives, with specific guidance on what is expected of them in this new structural partnership
- The right resources to support community and voluntary sector participation in service improvement and testing the delivery of innovative programmes in the community. Most organisations rely on annual funding to run their activities. Even when innovative programmes have demonstrated that they work, they are not progressed to core-funding. The availability of community resources is often taken as a given and not included in planning budgets.
- Representation: The partnership and collective action values and the principles expressed and new terms such as “parity”. Why then does the framework name the CEO of the relevant trust and a lead GP representative as the Chairpersons of each of the Area Integrated Project Board.
- Current arrangements allow for the Chairperson to be elected from any discipline around the table. The learning from previous is that power dynamics and power differences around the table need to be addressed to create the right culture. There is strength in numbers.
- The opportunities at ICP level for cross sectoral, cross disciplinary relationship building, which builds trust and collaboration on joint projects.
- The need for support and resources to communities to support the work on establishing and reporting on the Outcomes framework. There can be a lot of duplication in reporting requirements for community groups, under current reporting arrangements.

Sara Graham, Director of Versus Arthritis NI and Chairperson, Long Term Condition Alliance NI (LTCANI)

Sara shared the perspectives of the LTCANI members arising from an initial consultation. Key points raised:

- Members of the Alliance have been involved in previous reform processes and there was a feeling of having heard it all before.

- Sara agrees with Brenda and Gillian, cultural change is key and the engagement process with the C&V needs to at the early stages. How will this process be co-ordinated to ensure that regional organisations are included early and who will this be made transparent?
- It is a high-level document, more detail on how the model will work at each level is needed. C&V sector member, particularly those who deliver health and social care, have expertise. It is a missed opportunity not being brought in early to support a co-design process
- The timeframe for establishing the structures is tight. How will all the guidance material be prepared and rolled out in time for the end of March 2022? How will include the sector be included in this process. C/V orgs need to be at the table when these decisions are being made
- The Alliance members are particularly concerned about how Commissioning decisions will be made. Criteria needs to be robust and consistent across the 5 new areas.
- What about Allied health professionals and their role? They are not mentioned in the document.
- Good to see that the model differentiates between community and voluntary sector representatives. The sector is very diverse, and all have a role to contribute at reach level. Support is needed for all C&V representatives.

Helen McNamee, CDHN Draft Response

Helen provided an overview of 5 key areas that CDHN feel need to be considered in the ICS model. These are interwoven throughout CDHN draft response.

- Community centred approaches
- Engagement and participation
- Partnership, collaboration and power
- Development and contribution to outcomes
- Health literacy

- Previous integrated types of groups exist e.g., community partnerships. Where is the learning from these processes/ experiences? This should be taken into consideration. The things that may not have worked and finding out how it can be resolved is as important as finding out what worked.
- There is a wealth of evaluation and learning to carry forward from such groups as the Integrated Care Partnerships. Where does this information lie?
- Will the existing 17 ICP's remain?

Engagement and participation

- In the ICPs It is 1 rep from vol community – how does this 1 person engage with everyone? This can be very difficult.
- Two workshop participants explained how they sit on a panel for Community Planning, and it is daunting for these two very experienced persons. Power dynamics need to be addressed to ensure that all feel comfortable, confident and are able to meaningfully engage.
- When you are appointed to represent the community – you must have your finger on the pulse to know what the opinion is, and communication is key to this. There must be a feeding mechanism to the community representative(s) that they be well informed.
- Concerns about partnership with c/v sector – is it tokenistic involvement?

Role of other Government departments

- The proposal does not indicate how the other Government departments will be involved. It is led by DoH, other Government departments have a key role in the addressing the wider determinants of health. How are they going to collaborate? What is their part in it?
- If other Departments aren't involved, it can't address health inequalities.
- What tools will we use to make sure that everyone is living up to the values in the framework?

Working across health area boundaries

- Working across boundaries has not been a strength within the 5 Trusts- this is readily recognised especially by smaller regional organisations. How can this be addressed?
- How will the Trusts work better across boundaries with this new model?
- Would this be better if coterminous with Council areas?

The community and voluntary sector

- There are big differences within in the C/V Sector. Some groups are better resourced and are therefore retaining work.
- Finances are tight in the C/V sector, the model must be resourced.
- There has been extensive growth in the c/v sector which gives rises to confusion and duplication and overlap of services.
- C/V sector not just an add on and should be valued for its key role.

Grass roots and volunteers

How do you capture the views of the grassroots and the larger voluntary in this model?

- Important that the voice of the smaller groups who are at grass roots level is heard.
- Real voluntary sector are the volunteers working at ground level who are not resourced. There is a real need for these volunteers to be recognised for the work they do. Where will volunteers come from? There should be stronger reference to how volunteers can be funded.
- If using community sector, the mindset needs changed, volunteering is not free!
- Volunteer centres are integral to the model
- The three levels community, locality and AIPB are welcomed, as it will help ensure it goes to community level
- Important to recognise the fatigue caused by the pandemic in both the C&V and H&SC sector.

Culture, values and engagement

- Culture is a big barrier. Preconceptions of each other and misunderstanding of each other's role. It is important no baggage is taken into the model.
- What tools will we use to monitor that the values are implemented?
- Under values and principles, Introduction of Duty of candour - Judge O'Hara has been calling for it since the Hypontraemia case (more info <https://www.bmj.com/content/360/bmj.k551>)

Accessing support

- There is much confusion where to direct people to services which can be delivered best. We appear to be overrun with information but no actual support.
- A participant spoke from her perspective of working with young mums. Many of whom have mental health and housing issues. She spoke about the difficulty in accessing services for support from both the statutory and voluntary/comm sector – services are already overstretched, with long waiting times, leaves young mums vulnerable with nowhere to go. Commented that they have never seen it this bad.
- The people on the ground are aware of the needs in their local area. If the structures were working well these issues would be picked up at grass roots level. System needs be clearer as to who is most appropriate to offer support.

Evidence

- Important to capture what matters to people – health inequalities, poor mental health, disadvantage

2. Key parts of the Integrated Care System (ICS) model are engagement, partnership and collaboration.

- **How can we ensure there is community engagement throughout the system?**
- **How can we ensure that there is parity and inclusion between partners in the system?**

Support for representatives

- When in the role as a rep it is important to know you have the backing and resources behind you.

Existing practice

- We need to encourage and support grass roots and upwards engagement and refer to health and wellbeing networks and experienced bodies to tease out the approach they use
- The existing Council Officers and Community Planning structures can have a role to integrate this engagement.
- Strategem lead on community planning engagement in Belfast – could we look at this model?
- We need to look at the community planning structures. How do we integrate better & make the effort to do so? Community planning structures all have health targets.
- Housing organisations have community engagement officers – Is this an option?/ could it work?
- Derry and Strabane council have growth partnerships, 8 in total, made up of people from different areas which has been very successful in engaging with people. This was a great help during COVID it helped to cement action more quickly. This needs resources, time and effort leads to action, but these incur costs.
- The Housing Executive have Community Engagement Officers – is this an example of the way to go?
- Consider Liaison Officers to work with communities. This upfront cost would pay for itself in terms of delivering true engagement
- ICP experiences different across 17 areas – need to look and learn from it.

Supporting the voice of the c/v sector and individuals being heard.

- Expertise from the comm and vol sector is needed at the table but how do we empower and resource this?
- What way can we, as individuals have our needs heard?
- Concerned that C/V sector members are not supported to have a voice.
- If everyone puts the patient at the centre, we could work from there.
- Concerned that the Health Trusts and GP's will overwhelm the community voice. There needs to be a service user voice.
- Back to bureaucrats. They need to recognise the role of the Com/Vol sector. The people of the ground can feed up what is needed. The health service does not know the needs and priorities of the people, it needs the com/vol sector to advise them.

- Support needed for Com/Vol organisations who are part of the forum. Resources are needed to help them engage with and reach out to other organisations to bring their voice and concerns to the Board, and to be able to represent the wide range of organisations in the sector.
- Need for greater partnerships with bigger and smaller c/v organisations. All organisations need to be involved not just the larger organisations. Larger charities and organisations seem to have the bigger say, could have their own agenda.
- Deeper relationships. Visit communities and speak with com/vol representatives to learn of the problems and needs in the community.
- Community sector can be seen as the poor relation and their involvement is tokenistic. This needs to be addressed
- Partnerships are normally top heavy with stat orgs where community voice isn't heard. This needs to be addressed.

Engagement and participation

- Needs to be carefully thought and structured to integrate people at all levels.
- Important to start by acknowledging the power dynamic, often sits with the statutory sector. So, selecting Chairs and how and where meetings are held can help shift that at least cosmetically to start with and before a culture shift sets in
- DoH should use NICE Pathways from community participation, empowerment and control to health improvement as a reference point and guide, to ensure that community engagement is taking place beyond just informing and consultation.
- All opportunities advertised publicly – no detail yet
- Important that community partners have close relationship with communities and that it is about the work taking place on the ground
- Community pharmacy should be represented
- Stop silo working – need joined up approach

Resource

- C/V involvement will need to be resourced for the c/v sector to integrate fully. C/V sector do not have the resources internally

One size doesn't fit all

- What works in urban areas may not work in rural areas. Any models need to be 'rural proofed'
- Not every area or people involved will be coming from the same starting point. Some will have lots of experience and others have none.
- Urban areas are very well resourced.
- Needs are different in different areas. All communities need their say. Belfast is not the centre of the universe and regional areas need Comm/Vol representation as well.

Long term view

- Don't take a short-term view as is traditional in Government. Set up powerfully and thoughtfully to stay strong on engagement collaboration and partnership and think about

the medium to long term. Co-production is difficult, and the co-ordination function is very complex.

Chairpersonship

- Question over the Trust Chief Exec and Lead GP chairing the AIPBs. It was clarified that this will be adopted initially to get the groups started but it will be determined moving forward and open to all members
- Will there be conflict where chairs have responsibilities to chair other high-profile roles?

Duplication

- There are many partnerships and working groups out there, should not be the same people going to each other's meetings.
- If something is already out there that works, look to building, adapting or merging rather than having duplicate groups.

3. The ICS model is about improving health and wellbeing outcomes and reducing health inequalities. Think about an ideal world where this model is being delivered, what difference would you like to see to people's lives as a result of the ICS?

People would like to see (outcomes)

- Medications continue to be available
- Everything will be done to avoid you going to hospital
- Quick instant access for services for all
- Equality of access to services.
- Everyone able to access all services no matter where they live - ability to work across trusts where the need can be addressed better in another area.
- My children and grandchildren supported and engaged through their community, not dependants of a system
- A built in means to challenge the success of H&SC
- Recognition of the increasing complexity in dealing with a growing elderly population going forward.
- Ideal outcome for people on the ground is that it would make the system easier to navigate and less confusing.
- The ideal would be if the system enabled people to be more aware of what services are available and know what the right service for me is, at the right time. (People don't need to know about all the changes that are taking place that won't impact them, but they do need to be informed and made aware of how the system is changing and how that will affect them)
- Knowing that someone is accountable for population health in my area.
- The thing I would like to see change in people's lives is having access to preventative and maintenance health services. For example: access to wellbeing and mental health support well before a crisis. Access to maintenance physio, exercise and AHP services (which has all but disappeared from state provision). If we integrate and value services

across sectors better and manage to shift pressure and investment away from 'emergency interventions' then some of those things could be available more routinely to people....and they would be happier and healthier (whatever their 'healthy' looks like).

- Lived experience and knowledge held within community being used to being shape and inform services (and evidence that it is being used)
- Ideal outcome would be if services are person-centred, co-designed and co-produced.
- C/V orgs that involved in the model are a voice for the most vulnerable people, who don't have the skills, confidence, capacity to advocate for themselves. (Those people that might not be engaging with services/part of groups, but who are missing out because they are not in a position to have their voice heard)

Communicating the ICS

- How can we help people to know what to expect?
- Where do they go for what they need to address their individual issue?
- People who are financially secure can get help outside the system if they need to – How can the poor and most disadvantaged people be supported to access the right services?
- Important to consider health literacy – lacking in the community – people don't know where they can source support

Health Messages

- There are lots of issues around following public health messages, e.g., Eat healthily – link to Marmot research and cost for this prohibitive for many families. New messages from the ICS need to be cognisant of this.

Learning from what works and continuing what works

- When things work well there should be a mechanism to keep them going, there is a tendency to move onto new topics and drop something that is working well along the way.
- Don't' reinvent the wheel - Local population Health plans could be developed and promoted to support great ideas and activities, so they are not lost- only to be re-introduced down the line.

Links to other strategies

- The social determinants of health are really relevant to the Anti-Poverty strategy and other strategies. How are they going to be connected?

Efficiency

- At present potential full use of expensive equipment is not being utilized. Encourage an 8.00am to 6.00pm appointments structure to be more efficient. This of course brings its own problems with staffing it must be recognised.
- More creative thinking around bringing the Services to the people. Re-introduce the mobile service units to engage more effectively locally.

Role of NI Ambulance Service

- The role of the Northern Ireland Ambulance Services (NIAS) and their place within the model was queried (they are not included as member of Area Integrated Partnership Board?) would be useful to know where they fit. Another participant was there had been conversations with the Department and NIAS.

Tendering, commissioning and contracts

- Commissioning and tendering of contracts for work in the C/V sector needs to be considered. C/V orgs represented on groups could be in competition with each other. The tensions this could create will need to be considered and managed.
- Some C/V organisations could deliver services much better than another organisation but as they aren't as articulate in demonstrating this they don't get or loose a contract.
- Concern re tenders – organisations must continue to exist and be relevant
- Less waste – spend money on what is needed rather than what funders require you to do.

- ENDS -

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