Institute of Public Health

IPH response to a consultation on developing an Integrated Care System and Draft Framework for Northern Ireland

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Synopsis of IPH submission

Introduction

The Institute of Public Health informs public policy to support healthier populations in the Republic of Ireland and Northern Ireland.

Our key priorities are promoting health and wellbeing, improving health equity, and reducing health inequalities through evidence, policy, and partnership.

The Institute responded to a consultation on developing an Integrated Care System for Northern Ireland, launched by the Department of Health in July 2021.

The draft framework for a new Integrated Care System proposes a reform of health service structures. The model seeks to empower local providers and communities to collaboratively plan, manage and deliver care for their local population with regional organisation and delivery of regional and specialised services.

Key Observations

The Institute of Public Health is supportive of reforms which aim to improve health and reduce health inequalities, empower local communities, and invest in prevention throughout the life course. The Institute made a number of recommendations, including the need for more clarity on governance and reporting structures as well as more information on how change management of this scale will be delivered.

The Institute would welcome a greater emphasis on equity-focused measures driven by the principle of proportionate universalism and highlighted the need for an overarching strategy to address health inequalities through action on the determinants of health.

This could be supported with tools, such as Health Impact Assessment, and through a cross-departmental commitment to a Health in All Policies approach. The Institute highlighted the need to invest in strengthening resilience as we move to the new model to capture learning from the COVID-19 pandemic and prepare for future public health threats.

IPH Response

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

Integrated Care System NI

Draft Framework

Consultation Response Document

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Are you responding on behalf of an organisation?		**Yes**
Organisation *(If applicable)*	**Institute of Public Health in Ireland (the Institute)**	

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?

Mostly agree.

Additional comments:

In this section, we have provided some general comments followed by suggested changes.

Overall strategic direction

IPH broadly welcomes the direction of health system reform set out in the draft framework, which recognises the need for new approaches to enhancing population health and better integration between health improvement and health care planning, management and delivery.

This is a critical time to design and deliver reforms to deliver better health for the population in Northern Ireland (NI). Life expectancy is improving in NI, but the rate of improvement has slowed significantly in recent years. Reduced mortality from circulatory diseases and cancers are significant achievements but increases in mortality from non-traffic related accidents, other circulatory illness and mental and behavioural disorders threaten to stall life expectancy in the region. While life expectancy is incrementally improving, healthy life expectancy remains static, meaning many people live more of their years in ill-health. The healthy life expectancy inequality gap was 13.5 years for males and 15.4 years for females. The level of healthy and disability-free life expectancy, and the inequality gap within these measures, is showing no improvement over time.[1]

There are important insights from a (pre-pandemic) assessment of the comparative performance of health systems in 11 high income countries. The four features of the top-performing countries included:

- Provision of universal coverage and removal of cost barriers
- Investment in primary care systems to ensure that high value services were equitably available in all communities to all people
- Reduction of administrative burdens that divert time, efforts, and spending from health improvement efforts and
- Investment in social services, especially for children and working-age adults.[2]

The changes proposed in the ICS model are aligned with this evidence, most directly with the second and third bullet points above. Northern Ireland, unlike Ireland, has a distinct advantage in terms of an established system of universal health service coverage. The degree to which the system will allow for development of social services is less clear.

[1] (https://www.health-ni.gov.uk/news/life-expectancy-northern-ireland-2017-19)
[2] (https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly)

IPH perspective on outcomes from the ICS model

IPH welcomes the commitment to health improvement through action on the determinants of health and a strategic focus on the prevention of disease and reducing health inequalities, as stated in section 21 of the draft framework. A Strategic Outcomes Framework is mentioned, but no details were made available for this consultation. From an IPH perspective, we propose the following as potential priority outcomes of the new ICS model, if successfully implemented:

- Enhanced processes for community engagement on health improvement
- Development of place-based approaches to health improvement and tackling health inequalities
- Greater integration between health improvement, health protection and health service development
- Enhanced accessibility of health and social care, and better equity in access and outcomes in line with population needs
- Greater alignment between health systems across the UK and across the island of Ireland, facilitating knowledge sharing and collaborative development
- Enhanced potential for cross-border cooperation to meet the health needs of those living in border areas

Provide more clarity on the change pathway

The draft framework is presented as the blueprint for how health and wellbeing and health and social care will be planned, managed, and delivered. However, the full model of change for health improvement and health inequalities is not clearly depicted in the draft framework. The consultation document and draft framework refer to a broad list of 'problems or 'challenges' that exist within the current system. These are mentioned in different ways in different places across the consultation document and draft framework. References are made to issues of fragmentation, silo working, bureaucratic barriers and limited accountability for decision making. These issues are placed alongside wider concerns over sustainability of health and social care services, waiting lists and the extent of health inequalities in the region. Similarly, several different 'solutions' are presented in the draft framework including enhanced working across traditional boundaries, improved trust in working environments, greater partnership and collaboration alongside greater autonomy, flexibility and agility in local decision making and a greater focus on addressing health inequalities. Section 10.13 of the draft framework frames the change in terms of better system connectivity, alignment, and integration while section 4.4 of the consultation document refers to improved efficiency and optimised capacity.

To foster a clear understanding of the change proposed, it would be useful to have a diagram or table that summarises clearly the change model – the issues in how the system works now, how things will be done differently under the new model, what these changes will realistically deliver for health, and by what pathway these changes will occur. The draft framework does not present an overall logic model/ theory of change diagram specifying the high-level inputs, processes, outputs, and outcomes. Developing a logic model at this time may support shared understanding on the aims of the reforms, promote buy-in and help with planning an evaluation. The draft framework and the consultation questions are heavily focussed on process and operational issues at local level (like membership of committees), with less detail on strategic level inputs, outputs, and outcomes. In this way it is not always clear the degree to which the framework is intended as a high-level strategic document and/or a document focussed on operational parameters.

Clarify the role of law reform as part of health reform

The draft framework is presented as the blueprint for how health and wellbeing and health and social care will be planned, managed, and delivered. However, the draft framework makes no direct mention of deploying the legal powers of the Northern Ireland Assembly to discharge its obligation to realise the right to health of members of its population and satisfy its constitutional duty to safeguard the public, beyond the Bill allowing for dissolution of the Health and Social Care Board. There is significant potential for legal frameworks to assist in effective responses to infectious disease and to address major risk factors for the rising burden of chronic disease.[3][4] There are many examples of the use of legislation to support health service reform – for example Switzerland introduced a federal law on prevention and health promotion alongside a wider health system reform.

A recent UK Government paper sets out the legislative proposals for a Health and Care Bill to help support the proposed reforms to the English health system. Two forms of integration will be underpinned by legislation, namely

- integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle.
- greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people.

Tools used within this legislative framework include a duty to collaborate, placing a 'Triple Aim'[5] duty on health bodies, collaborative commissioning, and the use of joint appointments. The paper states "*our aim is to use legislation to provide a supportive framework for health and care organisations to continue to pursue integrated care and other sources of value for service users and taxpayers in a pragmatic manner. As the system emerges from the pandemic, these legislative measures will assist with recovery by bringing organisations together, removing the bureaucratic and legislative barriers between them and enabling the changes and innovations they need to make."* [6]

There is no clarity within this UK Government paper, or within NI's draft framework, or within section 1.2 of the Equality Screening Assessment document on the framework, on whether the Health and Social Care Bill integration provisions could apply to devolved administrations. Further clarity is needed on the degree to which the legislative measures set out in the UK government paper might be deployed in Northern Ireland, or indeed whether other legislative changes will be considered to support the change to a new ICS.

Provide further detail on the change pathway to reducing health inequalities

The Institute welcomes reference to the reduction of health inequalities within the definition and objectives of the ICS, but we would also welcome a consistent mention of inequalities within the vision and section 4.4 (which we understand refers to priority outcomes). However, although the intent to address health inequalities is clearly stated,

[3] https://www.who.int/healthsystems/topics/health-law/chapter2.pdf?ua=1

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446780/

[5] The IHI Triple Aim | IHI - Institute for Healthcare Improvement

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960548/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-web-version.pdf

there is little detail on how this will be achieved in practice or the change pathway. Health inequalities are referred to in the draft framework as persisting, with partnership working and assessment of local need cited as key measures to mitigate the impact of health inequalities. The change to ICS would be supported by an allied inequalities strategy/ framework and an expert co-ordination unit to design and deliver the supports necessary to mobilise 'actors' in the wider system to understand and respond to local health inequality issues. The need for a more targeted approach to health inequalities was highlighted at a recent session of the NI Assembly Health Committee. The Health Committee chairperson called for a dedicated, joined-up approach to tackling health inequalities informed by the necessary expertise:

'*If we are serious about tackling the crippling inequalities that we see, we need to take a more serious approach. It would be worthwhile to include someone with a specialism and a dedicated focus on ensuring that the programmes are being put in place to tackle and target this, the finance is being put in place and the outcomes are being tracked and measured to ensure that we see year-on-year improvement.*'[7]

The Marmot Review[8] recommends two policy goals in a framework for action on tackling health inequalities:

- Create an enabling society that maximizes individual and community potential
- Ensure social justice, health and sustainability are at the heart of all policies

The focus on these could be much stronger in the draft framework, which implies an intent, but is very much focused on service delivery and operational matters. There are useful insights from the experience in England, as highlighted in a recent paper by Dr Bambra and colleagues. In 2019, the NHS England developed 'The NHS Long Term Plan' which required local healthcare systems to develop their own local response plans. Health inequalities were a prominent feature of the plan, which set out to establish a 'more concerted and systematic approach to reducing health inequalities' alongside a number of specific inequalities initiatives such as supporting minority ethnic groups. However, the plan failed to outline how local and national systems could systematically approach health inequalities with an expectation that local healthcare systems would each develop their own approaches.[9] Research has shown this can be challenging for local systems, resulting in local plans being vague and lacking a systematic approach. The lack of a national health inequalities strategy provided another barrier to effecting change across local health systems. For a systematic approach to reducing inequalities, a broad framing of inequalities is needed to highlight how multiple different aspects of disadvantage lead to substantial differences in healthcare and health outcomes. Without

[7] committee-26261.pdf (niassembly.gov.uk)

[8] Fair Society Healthy Lives full report (parliament.uk)

[9] https://www.rcpjournals.org/content/futurehosp/8/2/e204

this, there is a risk of disproportionate attention being given to some groups over others; on the so-called 'deserving poor' at the expense of the 'undeserving poor'.[10]

Provide clarity on the how the life-course approach will be applied

The draft framework does not propose a definition of what is meant by life-course approach; referring to 'whole life-course of conditions, from prevention through to intervention and recovery where possible.' The Institute recommends that the draft framework uses the World Health Organization (WHO) definition of the life-course approach, which is as follows:

'The life-course approach aims at increasing the effectiveness of interventions throughout a person's life. It focuses on a healthy start to life and targets the needs of people at critical periods throughout their lifetime. It promotes timely investments with a high rate of return for public health and the economy by addressing the causes, not the consequences, of ill health.'[11]

This definition is in line with the NI public health strategic framework 'Making Life Better', particularly with themes "Giving Every Child the Best Start" and "Equipped Throughout Life" which take account of needs across the life-course with emphasis given to children and young people.[12] Primary prevention in early years has been recognised as a best buy for investing in population health and reducing health inequalities and a central strand of the Making Life Better framework. We would welcome clarity on how the ICS model will ensure a continued focus on giving every child the best start in life.

A recent evaluation[13] of Sure Start Children's Centres in England looked at the impact of the programme on children's health outcomes. There was evidence that the impacts of the Sure Start programme last well beyond the end of the programme itself, with some of the most notable impacts seen in adolescence, nearly a decade after children have 'aged out' of eligibility. Although the evaluation found an increase in hospitalisations among very young children (aged 1), this was offset by reduced hospitalisations during childhood and adolescence. The evaluation found that Sure Start services had a large impact on infectious illness. In early adolescence, there were far fewer hospitalisations for mental health reasons and there was a greater decline in hospital admissions for injuries among boys than among girls. The report authors suggest that these effects point to potential longer-term benefits from Sure Start supporting children's socio-emotional and behavioural development. The Sure Start programme had a significantly larger impact for children in disadvantaged areas, at least from age 9 onwards. The Sure Start programme has demonstrated value for money, with reductions in hospitalisations offsetting approximately 31% of the costs of Sure Start provision. The report authors suggest a model that combines universal services with an area-based focus on disadvantaged neighbourhoods can be a promising approach to early years interventions. The planning phase for an ICS provides a unique an opportunity to take account of the learning from

[10] https://www.rcpjournals.org/content/futurehosp/8/2/e204

[11] WHO/Europe | Life-course approach

[12] Making Life Better - A Whole System Framework for Public Health 2013-2023 (health-ni.gov.uk)

[13] The health impacts of Sure Start https://ifs.org.uk/uploads/BN332-The-health-impacts-of-sure-start-1.pdf

programmes such as Sure Start and similar early years interventions. This evaluation indicates that investment in early years and promoting child health and wellbeing in disadvantaged communities has the potential to reduce health inequalities and should be considered in the development of the model.

We would welcome clarity on how the ICS model will ensure a continued focus on giving every child the best start in life. By investing in the life course approach, it is possible to limit ill health and the accumulation of risk throughout life. Therefore, it can provide high returns for the health service and contribute to social and economic development. For example, investment in early childhood, child and adolescence and preconception, pregnancy and childbirth care can yield a 10-to-1 benefit to cost ratio in health and socioeconomic benefits as well as reduce rates of non-communicable disease in the future.[14]

Incorporate a Health in All Policies approaches and use of supportive tools like Health Impact Assessment

Although the framework refers to the importance of working in partnership with sectors outside of health, it provides no formal endorsement of a deeper 'Health in All Policies' approach, the strategic importance of which is becoming increasingly recognised in other countries.[15]

To support the Health in All Policies approach in practice, the Department may wish to consider making a recommendation for the use of Health Impact Assessment (HIA) in certain circumstances. HIA could be applied to the overall model, or it could be applied at local level when new proposals are being considered. HIA provides a tool for considering the health impacts of proposals (which may originate from the health system or outside the health system, for example in environmental planning, social protection, policing or transport) and modifying them to ensure that the health benefits are maximised, and health equity is addressed. The Institute will shortly publish a suite of updated guidance documents which will provide the direction and tools needed to undertake a HIA. HIA is aligned with the ICS model in that it provides an opportunity to drive inter-sectoral collaboration and values systematic stakeholder engagement to influence decisions which can impact on health at regional, local or community level.

The Institute agrees with the fundamental importance of partnership working and the reduction of silos, both within and outside of HSCNI. Improving health and reducing health inequalities requires a combination of empowering individuals to take responsibility for their health whilst creating the social, economic, and environmental conditions for individuals to thrive and live healthy lives. The participatory approach has been used in other countries to inform health plans successfully. For example, Skane, Sweden, has been acknowledged by WHO as a champion in the use of participation to inform health plans, legislation and achieve the 'whole-of-government' and 'whole-of-society' approach suggested in Health 2020. Their regional development strategy has been shared by WHO as an example of best practice and exemplifies the success of the participatory approach[16]. Learning from the success of other countries who are adopting a similar approach may be useful in the development and implementation of the ICS model.

[14] Health matters: Prevention - a life course approach - GOV.UK (www.gov.uk)
[15] https://www.euro.who.int/__data/assets/pdf_file/0006/199536/Health2020-Short.pdf
[16] Taking a participatory approach to development and better health: Malmo-Skane Region - en (who.int)

Suggested clarification – the model of community engagement, planning and place-making

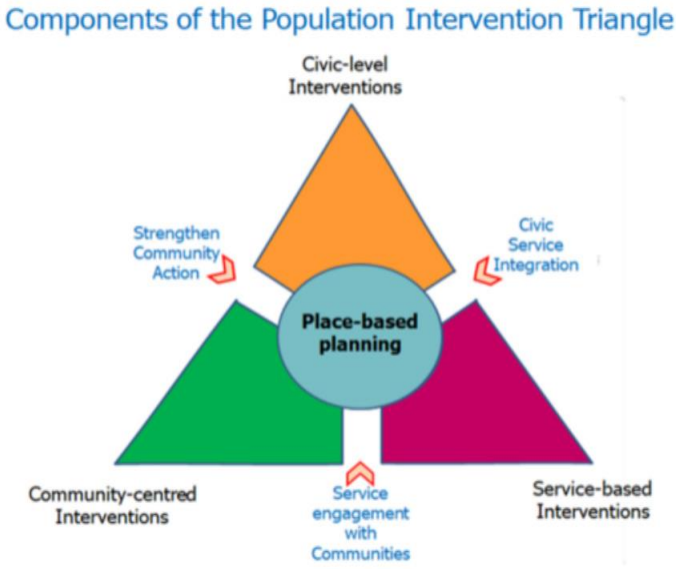
The Institute welcomes the intent to empower local communities and providers to be engaged in development and implementation of the new model, however the draft framework is not clear on how this will be implemented or monitored in practice. Community engagement in public health interventions has a positive impact on a range of health and psychosocial outcomes, across various conditions.[17] Empowering local communities and individuals so that they can be effectively involved in decision making is encouraged in the Marmot Review, a key text for effectively reducing health inequalities. PHE research on community-centred public health concludes that a whole system response is needed to most efficiently improve the health of those who are most deprived, which involves scaling a range of community-centred approaches, addressing community level determinants, and working at all levels of a system.[18]

It would be useful to have more information on the methodology that will be used to shift autonomy to the local level. Other than membership of Boards, roles and responsibilities and other operational arrangements, the framework provides no detail on the methodology that will be used to successfully engage with the local setting, or how the change will be evaluated to determine its effectiveness. Sections 1.12 and 1.14 refer to assets already within the system which support integration already in place, notably the Community Planning process. It is not clear the degree to which the AIPB work will occur alongside community planning or whether community planning will be partially or fully subsumed into the ICS model, or indeed vice versa.

Local level decision making can play a role in reducing health inequalities across the life-course by taking a joined-up 'place-based approach'; an approach that is needed due to the complex causal pathways of health inequalities and is an important foundation of producing population level change in outcomes[19]. A joined-up approach that treats the 'place', and not just the individual, is considered necessary if we are to measurably reduce inequalities in health.

The population intervention triangle (PIT) is used as a framework for action to reduce health inequalities in recent guidance published by PHE on place-based approaches for reducing health inequalities.[20] It was developed from practical experience working to achieve measurable population level change in health and wellbeing outcomes, including addressing health inequalities between and within local geographies. It forms the main elements of effective place-based working and describes how the main components of intervention capable of producing measurable population level change relate to each other:

[17] The effectiveness of community engagement in public health interventions for disadvantaged groups: a meta-analysis (biomedcentral.com)
[18] Community-centred public health: Taking a whole-system approach (publishing.service.gov.uk)
[19] Place-based approaches for reducing health inequalities: main report - GOV.UK (www.gov.uk)
[20] Place-based approaches for reducing health inequalities: main report - GOV.UK (www.gov.uk)



Suggested change: include a commitment to change management for the health and social care workforce in transitioning to new ways of working

The draft framework says it will 'support and empower staff'. The Institute would welcome information on specific measures that will be taken to ensure that staff are consulted with, trained appropriately, and supported; particularly those who will have new and higher levels of responsibility.

The workplace setting is considered one of the most important determinants of health, and so there is an opportunity to lead by example by investing in the health and wellbeing of its workforce. The Marmot Review lists several key components of a positive work environment, including 'having the ability to participate in organisation decision making'.

The Nuffield Trust research report provided evidence-based recommendations on how to best support health and social care staff in the NHS, particularly at times of change such as developing new models of care[21]. These recommendations include workforce planning and training, safe governance and regulatory arrangements, clear communication on workforce related issues from sector regulators, research on workforce redesign and the dissemination of good practice examples.

Suggested change: include a commitment to co-ordinate with the roll-out of Slaintecare in Ireland and to develop an agreed interface model for health planning in border counties.

The draft framework for Northern Ireland has significant similarities to reforms taking place in other UK jurisdictions, and in Ireland. The *Government of Ireland Slaintecare Implementation Strategy and Action Plan 2021-2023* incorporates system changes that are like those proposed in the new ICS model. The strategy commits to establishment of community healthcare networks as well as older persons and chronic disease

[21] Reshaping the workforce to deliver the care patients need (nuffieldtrust.org.uk)

management hubs and an enhanced role for primary care. The Sláintecare Integration Fund has supported 123 Health Service Executive funded and NGO sector projects, to test and evaluate innovative models of care providing a 'proof of concept'. Selected projects will transition to mainstream funding through the Enhanced Community Care Workstream. The roll-out of the SlainteCare Healthy Communities Programme, linked to the Healthy Ireland Action Plan 2021-2025, will determine the approach to health improvement in six new regional health areas. Population based approaches to service planning will also be deployed across these areas. To maximise knowledge sharing and experience on the introduction of integrated care systems across the island, and to maximise system efficiencies, we recommend that provision be made within this framework for ongoing North-South cooperation on the development of health system reforms. In addition, we recommend that a commitment to develop an agreed interface model for health planning in border counties. This could be achieved through mandating an advisory group to examine the issues and make recommendations to the leadership structures in both jurisdictions.

Suggested change: extend the existing commitment to sustainability to include climate change mitigation and adaptation

Sustainability is mentioned in this framework in the context of funding instability and the impact on long waiting lists. Sustainable development can also be considered as development which meets the needs of the present without compromising the ability of future generations to meet their own needs[22].

The health service is responsible for an estimated 4-5% of the country's carbon footprint, with the NHS having higher emissions than the global average for the healthcare sector. Reducing greenhouse gas (GHG) emissions, particularly long-lived pollutants such as carbon dioxide (CO_2), as far as possible to zero is crucial to protect public health, as research has shown that GHG emissions and climate change have a profoundly negative impact on the social and environmental determinants of health. The negative health impacts of climate change disproportionately impact those who are most disadvantaged, and so contribute to the widening the health inequality gap.

In NI there is no overarching strategy or coordination to address the negative health impacts of climate change, or sustainability of the health and social care system. There is substantial scope to be much more engaged with actions in the rest of the UK and beyond. NHS England have developed a 'Greener NHS programme' which aims to deliver the world's first net zero health service and respond to climate change to improve health now and for future generations, as well as the development of a strategy for sustainable development of the NHS[23].

Climate change and sustainability are central to the NI public health strategic framework 'Making Life Better', particularly in relation to the following themes: Empowering Healthy Living, Creating the Conditions, Empowering Communities and Developing Collaboration. There is also a legislative requirement, as sustainable development was written into NI

[22] https://www.fph.org.uk/media/2591/k1-fph-sig-principles-of-sustainable-development-final.pdf
[23] https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2021/02/Sustainable-Development-Strategy-2014-2019.pdf

legislation under Section 25 of the Northern Ireland (Miscellaneous Provisions) Act 2006. In the UK, the Climate Change Act was introduced in 2008 with the aim of reducing GHG emissions to be 100% lower than the 1990 baseline by 2050. Scotland and Wales have their own climate legislation, and Wales has gone even further by legislating for wellbeing with the 'Well-being of the Future Generations (Wales) Act 2015'. Draft climate change legislation is process in Northern Ireland with two Bills being considered at present.

As this is clearly the direction of travel, it would be remiss not to use the opportunity to embed sustainability into the new ICS. By investing in sustainable healthcare now, the NI health service could make significant financial savings; WHO estimate a benefit to cost ratio of 2:1, meaning that "the health gain value from climate action is double the cost of mitigation policies at global level"[24].

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.

Suggested change- include proportionate universalism as a principle of the new model

The Institute recommends a higher-level commitment to tackle inequities in both the vision and principles of the ICS model. We recommend greater emphasis on equity focussed measures at both strategic and operational level driven by an over-riding principle of proportionate universalism. This was described by Marmot as taking universal action but with a scale and intensity that is proportionate to the level of disadvantage.[25]

In terms of the proposed principle on proportionate universalism, this could be made tangible through actions such as a commitment in the model ICS to convene an expert advisory group to make recommendations on equity focussed measures, strategic commitment to conduct a health equity audit as part of a mid-term or final review alongside periodic health equity audits of services and strategy actions. Section 7.1 of the draft framework refers to a commitment to "lead a major programme of action to improve population health and reduce health inequalities". It is not clear whether this will be operationalised principally through the ICS model or whether a new inequalities strategy is under consideration, or whether this will be progressed through Making Life Better or its successor strategy.

Proportionate universalism can also be applied in the allocation of resources, including funding, facilities, staff time and specialist skills, and in decisions on priorities for research and monitoring. The draft framework does not provide detail on how allocation formulae might be applied to different areas in Northern Ireland based on deprivation, demography or identified health needs. An analysis of the increase of NHS resources provided to so-called 'NHS Spearhead' areas between 2001 and 2011 recorded a reduction in

[24] https://www.who.int/health-topics/climate-change#
[25] https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

inequalities from causes amenable to healthcare, adding to objective evidence of a favourable return on investment from this approach[26][27].

Suggested change- incorporate principles aligned with community-centred public health

PHE have undertaken substantial research into community-centred public health[28] and recommend a series of principles which the Department may wish to consider as the ICS is developed:

- ✓ Strong leadership to adapt radical approaches to reduce health inequalities
- ✓ Collective bravery for risk-taking action and a strong partnership approach that works across sectors and gives attention to power and building trusting relationships with communities
- ✓ Co-production of solutions with communities
- ✓ Recognising the protective and risk factors at a community level that affect people's health, and how these interact with wider determinants of health
- ✓ Shifting mindsets and redesigning the system, aligned to building healthy, resilient, active, and inclusive communities.

Suggested change- incorporate the Sustainable Development Goals (SDGs)

The Institute recommends that the SDGs are applied to the values and principles of the ICS. WHO consider the SDGs to be 'powerful mechanisms to improve health and to reduce health inequities'. Specific SDGs can be considered social determinants of health, including 'No Poverty', 'Good Health and Wellbeing', 'Quality Education', 'Gender Equality', 'Decent Work' and 'Economic Growth', 'Reduced Inequalities', 'Sustainable Cities and Communities' and 'Partnerships for the Goals'. WHO strive to support health organisations with ensuring that health is integrated across the SDGs, for health to be seen as a contributing sector to the attainment of the 2030 Agenda for Sustainable Development and to ensure that SDG policies and actions do not have a negative impact on health or worsen inequalities.[29]

Suggested change – Apply gender mainstreaming to the framework

The role of gender and the impact it has on health and health inequalities is not addressed in the draft framework. The Equality Impact Assessment refers to 'men and women' in terms of the development of population health data by gender, but deeper approaches to gender are now being applied to policy development. The WHO recognises that "In order to ensure that women and men of all ages have equal access to opportunities for achieving their full health potential and health equity, the health sector needs to recognise

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26 Barr B

, Bambra C, Whitehead M, Duncan WH. The impact of NHS resource allocation policy on health inequalities in England 2001-11: Longitudinal ecological study. BMJ 2014;348: g3231.

27 https://www.rcpjournals.org/content/futurehosp/8/2/e204

28 Community-centred public health: Taking a whole-system approach (publishing.service.gov.uk)

29 20190218-h1740-sdg-resource-pack-2.pdf (who.int)

that they differ in terms of both sex and gender. Because of social (gender) and biological (sex) differences, women and men face different health risks, experience different responses from health systems, and their health-seeking behaviour, and health outcomes differ".[30]

The Institute recommends gender mainstreaming be applied to all aspects of the model. This is defined by WHO as 'the process of assessing the implications for women, men, and gender diverse people of any planned action within a health system, including legislation, policies, programmes, or service delivery, in all technical areas and at all levels'. This engagement must go beyond the presentation of data by gender and instead recognise the deeper role of gender in determining health and the interaction with healthcare services.

Suggested change- enhance public understanding of the framework and its diversity and inclusion dimension

The draft framework mentions inclusion and person-centred service delivery; however, it does not detail how the model intends to increase inclusivity or accessibility for hard-to-reach groups or minority ethnic groups. The Institute has several suggestions to improve accessibility of the ICS model and truly enact inclusion:

- Consider health literacy in the design and delivery of the ICS at the regional and local level, particularly when communicating change to local communities and service providers
- Develop a Plain Language Summary of the proposed model to foster greater engagement as the ICS is developed
- Ensure that all communications are accessible in language to reduce barriers for those who experience accessibility issues; for example, those do not speak English as a first language, are visually impaired or have learning difficulties.

Suggested change- specify a 'check- in' system to maintain fidelity to values and principles

The draft framework does not make clear how fidelity to values and principles will be monitored during implementation, or in other words, how these principles will be 'kept in mind' during operational decision making. The Institute would invite the Department to consider the following questions:

- What processes are to be put in place to ensure that values and principles are considered in planning and delivery of the model ICS?
- What are the opportunities for review and challenge when decisions diverge from these values and principles?
- What is the scope for involvement of stakeholders in assessing the alignment of principles with delivery?

[30] https://www.who.int/gender-equity-rights/knowledge/9789241597708/en/

Suggested change – commit to the principle of international cooperation and knowledge exchange

There are key priority areas for cross-country learning and innovation across the UK and the island of Ireland, and within similar health system reforms across Europe. System developers have identified advantages to sharing learning on the following domains[31]:

- Person- and population-centredness
- Integration of services across all health sectors and traditional health system boundaries
- Reforms in the long-term care, hospital care, primary care, and mental health care components of the system
- Preconditions for improved functionality of the health system

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?

Mostly agree.

Additional comments:

It is appropriate that the Minister for Health and Department of Health should have strategic oversight over the new model. In line with the values listed above, strong leadership and partnership will be required to drive the new direction. Clinical and public health expertise will be required to support and inform the strategic direction, and so a democratic leadership approach may make best use of the skills and expertise within and outside of HSCNI; particularly as the focus is shifting to a community-based, participatory model of care.

Suggested change – provide more detail on the governance and reporting model

The Institute welcomes the information provided on governance and accountability in Section 13. Further clarity on how this structure will interface with existing governmental bodies would be helpful. For example, it would be useful to understand how existing Ministerial and Departmental groups will link in with the model and its implementation. The governance and reporting model will also need to complement the model for delivery shown in the draft framework. At present, the draft framework does not comment on reporting mechanisms. A high-level reporting structure and more information will facilitate

[31] https://to-reach.eu/wp-content/uploads/2021/05/PolicyBrief-41-TO-REACH-What.pdf

understanding of how reporting will fit in with governance and organisational arrangements.

The need for change is clearly articulated in the draft framework, however there is no reference to change management models or theories on which to base this or where the responsibility for overseeing change management will lie. A useful example may be the Health Service Executive guidelines on change management in health services which are based on an organisation-development approach and founded on principles of co-production, acknowledging that people who receive and deliver services are best positioned to guide change.[32]

Suggested change – managing risk

IPH recommends that the framework formally recognise factors which assist reforms in any health system and the risks to, and risks from, the changes proposed. While some factors may be specific to the social, economic, and political context of NI, others can be identified from studies of health system reform in other countries.[33] A recent review of factors influencing reforms in health systems in OECD countries concluded that success is contingent on factors largely exogenous to the health reform process. The following issues have been identified as critical to success:

- the availability of information and research on health system performance
- institutional factors which support good governance
- political leadership, especially at the top of government
- technical competence of staff implementing reforms
- the use of incentives to align the motivations of the main actors in the system with the objectives of policy
- the availability of resources to purchase improvements
- the utility of public administration and management, including hospital management.

The Department may be interested in the section on 'enabling programmes' set out in the Slaintecare Implementation Strategy and Action Plan 2021 – 2025 in the Republic of Ireland. There are many overlaps in the reforms being proposed in the draft ICS framework and in Slaintecare. This section of Slaintecare presents programmes that are foundational and essential for implementation of the reform programme, including regular engagement with the political system at national and local level, development of high-level partnerships; communications programmes and processes to support staff engagement and citizen input as well as a capital investment plan and workforce development programme.

Suggested change – commitment to independent evaluation

The Institute suggests early consideration of independent process and outcomes evaluation. It is optimal to set up such evaluations in advance to establish a baseline before change occurs. Evaluation is a key component of any system change and can be used to inform the model as it develops.

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[32] People's Needs Defining Change - Health Services Change Guide

[33] Docteur, E. and H. Oxley (2003), "Health-Care Systems: Lessons from the Reform Experience", *OECD Health Working Papers*, No. 9, OECD Publishing, Paris, https://doi.org/10.1787/865047648066.

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?
Mostly agree.
Additional comments: As referred to previously, the Institute endorses a move to local, participatory decision making. Empowering local communities and individuals so that they can be effectively involved in decision making is identified as a component of best practice in the Marmot Review, a key text for effectively reducing health inequalities. PHE research on community-centred public health concludes that a whole system response is needed to most efficiently improve the health of those who are most deprived, which involves scaling a range of community-centred approaches, addressing community level determinants, and working at all levels of a system[34]. Local level decision making will play a role in reducing health inequalities across the life-course by taking a joined-up 'place-based approach'; an approach that is needed due to the complex causal pathway of health inequalities and is an important foundation of producing population level change in outcomes[35].

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?
Mostly agree.
Additional comments: Clarification required- The interface with governance and reporting mechanisms at regional level There are some unknowns in terms of the membership of the Regional Group and more detail of the roles and responsibilities it will have. For example, if the group will include membership from CMO/Minister for Health or, if not, how it will interface with policy leads in Making Life Better and related priority public health strategies in the Department of Health. The Institute suggests public health and clinical representation be considered to provide specialist knowledge of population health, health inequalities, equitable access to

[34] Community-centred public health: Taking a whole-system approach (publishing.service.gov.uk)
[35] Place-based approaches for reducing health inequalities: main report - GOV.UK (www.gov.uk)

services, quality of care and sharing of best practice. Furthermore, the interface between governance, reporting mechanisms and delivery is a little vague within the draft framework. This detail would facilitate better understanding of how all parts of the model will work together.

Recommendation- clarifying the strategic approach to chronic disease within the proposed Regional Population Health and Wellbeing plan

The Institute agrees that the Regional Population Health and Wellbeing plan should be informed by local intelligence and population health needs. This methodology is supported by evidence; a recent Cochrane review that compared the impact of integrated disease management programmes versus usual care for people with chronic obstructive pulmonary disease (COPD) found that the integrated approach probably resulted in positive health outcomes and recommended that policy makers should use local needs to inform the development of integrated disease management to ensure that it is context sensitive[36]. In the context of chronic diseases like diabetes, COPD and musculoskeletal conditions and the context of an ageing population, there may be value in providing more detail on the strategic approach to chronic disease prevention and management, building on existing assets in the system, to support the new model. [37]

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?

Mostly agree.

Additional comments:

We agree with this approach. We would welcome a high-level commitment that AIPBS established in border areas will be supported to work in cooperation with similar structures in the Slaintecare Regional Health Areas to best meet the needs of people living in border counties, including those structures overseeing the Slaintecare Healthy Communities Programme, population needs assessment and the Citizen Care Masterplan.

[36] Integrated disease management interventions for patients with chronic obstructive pulmonary disease - Poot, CC - 2021 | Cochrane Library

[37] https://www.health-ni.gov.uk/sites/default/files/publications/health/pesmp-ltc-ni-19-20.pdf

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?**
Mostly agree.
Additional comments: An effective place-based approach to the planning and delivery of services requires leadership, co-ordination and genuine partnership working with locality and community levels as well as with partner organisations. Lack of devolved autonomy was cited as a key barrier to population-based approaches in the Bengoa report. Considering this, delegating authority to a devolved group such as AIPB seems appropriate provided the AIPB includes members who are best placed to form strong relationships with the local community.

Q8. Do you agree that AIPBs should ultimately have control over a budget for the delivery of care and services within their area?
Mostly agree
Additional comments: The expert panel report 'Systems Not Structures: Changing Health and Social Care'[38], commonly known as the 'Bengoa Report' gave several recommendations for a new approach to commissioning and delivery of care in NI. One of the identified failings of the commissioning model was 'to effectively shift accountability to the provider level' which led to an 'overly transactional approach'. It also noted that the lack of a devolved budget and insufficient autonomy had been identified in other jurisdictions as key factors contributing to the failure of population-based models. The Bengoa report is a good basis for the model, as its recommendations are based on lessons learnt from Accountable Care Systems elsewhere, service provider views and the Triple Aim framework developed by the Institute for Healthcare Improvement (IHI). In line with the responsibility for planning and delivery, it seems appropriate that the AIPBs are also given the responsibility to manage their own budget. The Bengoa report found that new commissioning models which hold local integrated care organisations

[38] Systems, not structures - Changing health and social care - Full Report (health-ni.gov.uk)

accountable for people's health and the cost of treatment can be used to maximise the benefits of integration.[39]

Suggested change- need for a clear approach to assess investment needs and cost-effectiveness of the model

The draft framework presents very little information on fiscal considerations of the ICS model. Section 4.4 of the consultation document makes light reference to the potential for improved efficiency and optimised capacity and latter sections focus on greater autonomy and accountability for local level budgeting. At macro level, the draft framework states that 'no substantial changes are being proposed to current financial models, processes or procedures in the first instance'.

Changing to a model that prioritises prevention across the life-course will require initial investment but generate substantial returns. A systematic review of return from investment in public health interventions found that for every £1 invested in public health, £14 will subsequently be returned to the wider health and social care economy.[40] There may be additional opportunities to benefit from revenue generated from existing regulatory measures, such as the Soft Drinks Industry Levy which returned £336m to the UK Treasury in the financial year 2019/20.[41] Ring-fenced funding for public health interventions could be enhanced through hypothecation of taxation on tobacco products, sugar sweetened drinks and other unhealthy commodities.

Additional information on how AIPBs will be encouraged to invest in health promotion interventions and to ensure efficiency and equity in their investments is key. Public health interventions that invest in health improvement can be challenging, as they are subject to the phenomenon of positive time preference and require discounting to adjust for this.

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

Mostly agree.

Additional comments:

Supporting evidence for involvement of service users

The Institute welcomes the commitment to service user involvement and agrees it is a fundamental component in the development and implementation of the model. In the final review of the New Strategy Direction for Alcohol and Drugs (Phase 2) service user

[39] https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf

[40] Return on investment of public health interventions: a systematic review | Journal of Epidemiology & Community Health (bmj.com)

[41] https://www.gov.uk/government/statistics/soft-drinks-industry-levy-statistics/soft-drinks-industry-levy-statistics-commentary-2020

involvement was identified as an area of achievement within the strategy. Strong leadership provided greater opportunity for representation and meaningful involvement of service users and the community and voluntary sector[42].

Involving service users in the design of the new model is an approach that is supported by NICE, which recommends involving people in peer and lay roles to represent local needs and priorities[43]. Service user involvement is particularly important in present times to maintain public trust. Government decision making during the COVID-19 pandemic has been criticised for lack of communication and consultation; for example, recent findings from the Young Lives and Times survey in NI showed that 72% of young people felt that government didn't listen to young people when making decisions about COVID-19[44].

Interface with children and family representation

To improve equity of access to healthcare services, it is important that hard-to-reach, minority, and marginalised groups are represented. To promote prevention in early years as recommended in Making Life Better, the needs of children, young people and families are a priority. This could be provided through establishing linkages with local child and family services representatives such as the Children and Young People's Strategic Partnership (CYPSP), which would provide both regional and local perspectives on the delivery of children's services.

Suggested change – need for specialist public health expertise on AIPB

Representation from public health medicine consultants and trainees will benefit the work of the AIPB. While operational capacity may be a barrier during the COVID-19 pandemic, it would be useful to consider how the model might support public health specialists to meaningfully contribute to the AIPB in the longer term. For example, this could be an opportunity to expand the remit of public health consultants to include development of the new model.

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

Additional comments:

The Institute welcomes the move towards primary care focused planning and the positioning of GPs more centrally in local health improvement and service delivery. If the

[42] Review of the New Strategic Direction for Alcohol and Drugs – Phase 2 (2018) https://publichealth.ie/sites/default/files/20180814_NSD%20Report_FINAL%20LF.pdf

[43] Community engagement: improving health and wellbeing and reducing health inequalities (nice.org.uk)

[44] NI Young Life and Times Survey - 2020_21: COVLIST (ark.ac.uk)

aim of the ICS, like the NHS Long-term plan, is to boost out-of-hospital care and reduce the divide between primary and secondary care, then GPs should have a central role in the AIPB.

Building capacity in communities and in prevention was identified as a key change needed in 'Health and Wellbeing 2026: Delivering Together'. There are substantial challenges faced by primary care including insufficient workforce to meet demand, which will not be addressed by a reactive model of care. To put this in context, approximately 95% of the care people receive during their life is provided by primary care[45].

A significant proportion of healthcare resources are currently allocated to treating patients with multi-morbidity[46], much of which is preventable. Based on current evidence, prevention should be a priority consideration in the ICS. The proposed role for primary care within the ICS allows for greater focus on prevention, through multi-disciplinary teams and allied healthcare professionals.

Primary care has a unique opportunity to influence some of the determinants of health and prevent disease. Strengthening the capacity of primary care through the integration of multidisciplinary teams (MDT) is already being enacted in HSCNI to bolster care in the community and prevent unnecessary hospital attendances and admissions. By co-chairing the AIPB, the views of not only GPs but the whole MDT can therefore be represented.

Going forward, it will be important to ensure GPs are appropriately supported to take on these new roles, with the necessary cover, training, and skills development in place. Consideration of the resource implications for AIPB membership should be included in the overall planning and budgeting for the roll out of the model.

There is also value in giving a more prominent role to public health specialists within the AIPB. Public health representation and leadership will elevate preventative approaches within integrated care and help to ensure the health inequalities agenda is preserved as a strategic and operational priority of the AIPB.

The Institute also suggests that the AIPB design a suitable interface with community/district nurses, public health nurses, community midwives and health visitors, as well as community development and community relations leaders. This group will have insights into the delivery of care in the community which could usefully inform the design and planning in integrated care services.

It will be important for the Regional Group and AIPB to consider the role of private health and social care providers within the new model and how this interface will be managed. This is likely to be particularly relevant to the care of older people and those with long term conditions or disability, especially when moving from community-based care to care within private residential care settings. The future plan for integrated care would benefit from more detail on how the statutory and private health care providers will operate and collaborate within the new model.

[45] health-and-wellbeing-2026-delivering-together (health-ni.gov.uk)
[46] https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003514

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
Additional comments: The Institute supports the proposal above, assuming the AIPB is sufficiently connected to the local community and can secure members who are best placed to foster positive relationships and connections with the local population. Within the draft framework, there is a strong focus on the membership of the AIPB and groups at local and community level. The Institute recommends that in developing this model, the Department of Health places greater emphasis on using evidence of effective inmodels of care in other jurisdictions; considers accessibility and availability of local data and adopts appropriate community engagement processes to ensure the new model is the suitable to meet the needs of local communities.

General Comments
Please add any further comments you may have: A comment on system resilience The Institute recognises the challenges faced by HSCNI in recent years as well ongoing and future challenges posed by other public health threats such as the burden of chronic disease, worsening mental health- particularly on the island of Ireland- and climate change to name a few. Forward planning and a strong focus on resilience in the design and implementation of the new model is vital, and we would welcome a recognition of system resilience in the framework for ICS. WHO refer to system resilience as 'the capacity of a system to absorb, adapt, anticipate and transform when exposed to external threats – and/or to forecast shocks that bring about new challenges and opportunities – and still retain control over its remit and pursuit of its primary objectives and functions'.[47] The COVID-19 pandemic exposed the fragility of health systems in Northern Ireland and across the world. Evidence is emerging and we are yet to understand the true impact of the pandemic on service delivery and health outcomes. It will be important to examine the evidence in terms of service uptake and

[47] Strengthening resilience: a priority shared by Health 2020 and the Sustainable Development Goals (who.int)

service user experience to inform future service planning which must prioritise narrowing the health inequality gap. Section 2.9 of the draft framework refers to ‘an opportunity to bring forward a model for planning and managing services that build on the learning of the responses to COVID-19’. However, it was not clear what processes are being put in place to capture learning and translate it into proposals for strengthening of the health system and the ICS model.

The new model is an opportunity for NI to strengthen the resilience of our system to 'better tackle current and future patterns of ill health; create conditions for the protection and promotion of health and the reduction of health inequities; and increase preparedness in dealing with unexpected risks for population health’.[48] There are different areas in which resilience could be enhanced, and some examples include strengthening primary care capacity, investing in workforce development, planning and support, and integrating strong leadership and governance structures.

Thank you for taking the time to respond to the consultation.

Please submit your completed response by **17 September 2021** using the details below:

E-mail:

OrgChgDir@health-ni.gov.uk

Hard copy to:

Department of Health
Future Planning Model
Annex 3
Castle Buildings
Stormont
Belfast
BT4 3SQ

[48] Strengthening resilience: a priority shared by Health 2020 and the Sustainable Development Goals (who.int)