



12th May 2008

To Whom It Concerns

NWCN Response To “Proposals For Health & Social Care Reform”

North-West Community Network is a community development, membership-led organisation that provides support to the Community & Voluntary sector in the North-West by way of advocacy and representation at various levels, support in terms of dissemination of public policy information and interpretation and a focal point for the sector in the area.

North-West Community Network welcomes the opportunity to contribute to the consultation process in relation to the proposed changes to Health & Social Care structures in Northern Ireland as laid out by DHSSPSNI in February 2008.

The Network also appreciates the comprehensive circulation of the supporting materials around this consultation process, including the 20 item questionnaire. On this occasion, the Network has elected to loosely follow the format of this questionnaire though many of the points to be made are cross-cutting and pertinent to more than one area.

The basis for the Network’s response is ongoing dialogue with its membership and the wider contingent of Community & Voluntary sector groups in the North-West, as well as recorded comments from workshops organised in the North-West, in conjunction with NICVA and CDHN.

It is also appropriate at this point to assert that this response is constructed from a Community Development perspective, having perceived within the proposals the scope to build in greater attention to and practice around equality, participation and inclusion.

Once the consultation period has closed, it is important that contributors have a sense that their views have been taken on board. On this note, it would be very useful, as has happened in some past consultations, if DHSSPSNI were to outline the impact that consultation responses have made and/or outline where particular responses have not been factored in to any changes to the proposals.

With Regards

Colin Devine

Co-ordinator, NWCN

Preamble:

Following consultation in the North-West the following points/questions require to be included as part of this response, additional and complementary to the questionnaire responses below:

- The key issue within all these proposals is the delivery and quality of efficient, effective public services, not the needs of future components in the structures
- The “diagram” does not (sufficiently) indicate how, when and where the C&V sector will be engaged, raising the question of whether community groups are being perceived within the new structures as uniquely service providers
- The coordination of delivery needs to involve other departments, leading not only to shared accountability and commissioning but acceptance of responsibility in a landscape of increased funding competition
- Coordination between RPHA, commissioning, and delivery – need clear boundaries and responsibilities (different bodies doing local commissioning)
- Local delivery on public health would be difficult from regional agency – should stay local and work with communities on the ground where they currently are
- Providers should be able to respond locally – health improvement needs to be there as well as health promotion
- Community planning should be where these links should be made
- There are strong, some say evidential concerns that the 3% departmental efficiency savings are and will be passed onto the C&V sector
- There is insufficient reference to (if not fear around) retaining what good practice and productive working relationships are already out there (cf. IfH & HAZ)
- “One lay person can’t speak for everyone” / “Councillors don’t understand health”
- RPHA commissioning needs local presence – there are relationships and partnerships already there (should have commissioning responsibility with local aspect)
- Need clear accountability for public health outcomes
- Councillors must be interviewed and selected like everyone else
- RPHA should be spread across different parts of structure (should keep focus at structural level but operate locally)

- Both urban/rural lay representatives needed at LCG level
- Trust health promotion practitioners very worried they would lose C&V sector work if they merged with RPHA.
- Genuine engagement must be resourced
- Need to fully embrace community development approach
- Relationships lost during change – loss of institutional memory.
- Why is there limited reference to social care?
- Why is there limited reference to 'communities' – the proposals mostly talk about patients, clients and carers?
- What are the implications of local government involvement in health and social care?
- Role of carers and wider communities as well as patients and clients?
- In terms of commissioning responsibility between the RHSCB and the LCGs – who is in charge, which way does accountability go?
- If there is a public appointments process, will the criteria used in the first process be revised (i.e. the need of previous clinical management experience)?
- Where has the Statutory Duty of Engagement gone?
- Will councillors be able to represent something other than party line?
- Savings should be made in statutory sector rather than C&V sector
- Move to contracts for projects that work – away from pilots
- Number of lay representatives on LCGs been reduced from 2 to 1 - why?
- Reference to the role of the community and voluntary sectors, especially when it comes to local planning, delivery and engagement?
- Why has public health, health improvement and health inequalities work been separated out into a Regional Public Health Agency?
- Need to acknowledge the community and voluntary sectors' role in the design, planning and delivery of health and social care.
- Are they imagining public health prevention that is based more around a medical model than a social model?
- Why has the number of lay representatives been reduced from 2 to 1?
- Will the LCG or the RHSCB have the final say on commissioning decisions?

- How will the DHSSPS work with the new Regional Public Health Agency?
- Community development approaches do not only apply to public health work, but to all health and social care work.
- Engagement with users, carers and communities should be mainstreamed throughout the health and social care system.
- implications of taking health improvement and health inequalities work out of the commissioning and provision organisations i.e. LCGs and Trusts
- How will RPHA & RHSCB support the role of the community and voluntary sectors in tackling health inequalities?

QUESTIONNAIRE RESPONSES:

Q1 The Department is seeking your views on the functions, constitution and governance proposals for the new Regional Health and Social Care Board

- There is a strong view that there should not be a “one-size-fits-all” emanating from the role and functions of the new RHSCB, that there must be a blend between what are clearly identified and actionable regional priorities and more locally identified issues/needs
- This is especially the case in terms of performance management which must be structured and delivered in such a way as to provide for evaluation and monitoring of local as well as regional targets; this is the only way in which LCGs and the RHSCB can provide a longer-term contribution to future PFAs
- There is an incumbent duty, within performance management, to reflect the health promotion agenda so that indicators relate as much to the erosion of health inequalities as they do to understandable yet not fully reflective measurements on treatment and waiting times.
- This said, it is deemed imperative that the local focus and perspective provided by LCGs becomes the bedrock for not just the style of commissioning that is needed but that this should become evidenced/recognised through a measured yet majority devolution of commissioning budgets to LCGs.
- For this to work well and provide an appropriate and joint assessment of local/regional need, this requires for LCGs to be central components within the RHSCB composition, whether this be through self-selected nominations or the chairs of each of the five new LCGs, with appropriate support structures alongside and underneath. Without this it is difficult to see, through the “diagram”, how, firstly, community contribution could be made at regional level and secondly how a longer-term health promotion agenda could be developed without that pre-eminence given to the expression of local need
- In terms of reporting and governance, it is vital that the new Trusts have connection to the LCGs to create an essential dynamic between delivery and commissioning – if Trusts are to report to the RHSCB, this makes the case for LCG representation at RHSCB level all the more important
- As a regional entity, it is clear that the RHSCB will need to have a central base but there is a clear case for co-location on a cross-regional basis which not only supports equity of opportunity but also further garners local knowledge and expertise and militates against any losses from over-centralisation

Q2 The Department is seeking your views on the functions, constitution and governance proposals for the Local Commissioning Groups, including membership.

- With the proposed reduction from seven to five LCGs, the issue of co-terminosity is one which obviously occurs – it is to be welcomed that the LCGs will map to the Trust areas but within the wider context of RPA and Community Planning, the loss of cross-

sectoral co-terminosity needs to be accounted for and this can only be done through putting a premium on local arrangements, accentuating structures that allow for cross-connection and communication with arrangements within e.g. local government, education, housing

- From a relationship, intelligence and familiarity perspective, it is absolutely essential that commissioning is genuinely placed at LCG level as this is where the most meaningful interactions will take place, not just between the local and regional, but also across sectors

- LCG composition is an area where the community has strong views:
 - Objection to the reduction in lay representation from two to one LCG members – no rationale given, and questions remain over openness and fairness of process used for previous lay representation (cf. Desirable criteria for previous clinical management experience)
 - If community representation is what is meant, it should be called this – lay suggests mutual exclusivity between sectors
 - Geographically and thematically, the diversity of community voice needs to be captured and it could be argued that even two lay representatives is insufficient to achieve this
 - The introduction of elected representation is welcome in that it invites a wholly different set of skills, experience and perspective but it needs to be clearly outlined that this is not linked directly to any reduction in lay representation.
 - Lay and elected representation need to be treated as different yet complementary conduits into community expression, both working together to maximise the informing of commissioning bodies on current local need and, over time, a cyclical input into future Priorities for Action
 - Elected representation should be decided on merit basis, in similar fashion to lay representation
 - Need to avoid over-representation by health professionals, but also need to ensure equitable involvement of social care professionals

- As part of the transition process, there should be recognition of the insight and experience amassed through the ongoing seven LCG model and, equally based on merit, due attention should be given to the retention of this in the passage towards the five LCG model

- LCG/RHSCB staff locations must not be fixed or over-centralised. Relationships at local levels are essential if LCGs are to deliver on their role and localisation at this level will feed up to RHSCB level again promoting the longer-term cyclical nature of PFA/Agenda setting, informed by and sensitive to local issues

Q3. The Department is seeking your views on the process of obtaining local government representation on the Boards of Local Commissioning Groups

- Introduction of elected representation is to be welcomed as it creates an additional cross-communication opportunity and potential for a widening of the health/social care agenda
- Elected representation must not and cannot be seen as accounting for or replacing lay/community representation

- Notwithstanding groups size, there is no case for reducing lay representation as taken alongside the insertion of four elected representatives
- Regardless of the proportion of elected representation, this needs to be applied on a meritocratic basis; failure to do this would encumber the sizeable potential within the LCG level to deliver on the health promotion aims at the top of this process

Q4 The Department is seeking your views on the functions, staffing and governance proposals for DHSSPS.

- A more streamlined and delegation-friendly department is to be welcomed as is the potential for savings made at this level to be passed down to frontline service delivery. This increases the need for effective and rigorous performance management structures – from Departmental level down and, importantly, from community level upwards
- When considering the potential for a more social model of health, it would seem appropriate for more strategy responsibility to lie at LCG/RHSCB level, presuming the strong avenues for local/community involvement have been built in
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Q5 The Department is seeking your views on the additional functions, staffing and governance proposals for the common services organisation.

- The need for a Common Services Organisation is clear and it is key, further economies permitting, that some of the savings it can deliver may reduce the impact on community & voluntary sector groups
- From an equality as well as operational point of view, it is essential that attention to the Bain process/report is paid not only to avoid unequal distribution of public sector jobs but to retain good practice and existing working knowledge/relationships, all combining to ensure high-quality commissioning and delivery of services

Q6. The DHSSPS is seeking your views on the proposal to create a Regional Public Health Agency and the functions it would undertake.

It is to be welcomed, even at this late-in-the-day stage, that Public Health is given such attention but quite simply there is a risk that this important function becomes sidelined, and with it successful initiatives such as HAZ and IfH. It also seems as if the Community Development function would be placed within RPHA and this makes the relational lines within the “diagram” extremely important and indeed contentious.

It is not acceptable to publicly subscribe to the language of health promotion, early intervention and responsive care models then to re-site all importance on an acute, reactive health & social care model.

If the RPHA is to exist and with the above-mentioned contents, it needs to be, in real terms as well as diagrammatically, brought into the centre, with a direct connection to RHSCB – in governance, accountability and influence on local/regional commissioning decisions.

Q7. The DHSSPS is seeking your views on the proposal to incorporate Health and Social Care Trust specialist health improvement functions into the Regional Public Health Agency.

- This could actually work, centralising experience and expertise at an organisational level but it would then need to be backed up with a model that allowed this to interact with and be informed by local knowledge (of communities and personnel). It is deemed that this is not likely to be easily achieved with the separation between RPHA and RHSCB – co-location and regional dispersal of posts is essential for any “concentration” of specialisms to succeed equally across the new structures.

Q8. The DHSSPS is seeking your views on the proposal that, in the future, local government could be required, through legislation, to consult with the Regional Public Health Agency when developing its plans.

- I think the tone of this question is misplaced. What we are talking about here is Community Planning, which not only is a process at a more mature level of development in other parts of these islands, but one that in concept can deliver a much more efficient, targeted and proactive model of service delivery across sectors.

For this kind of approach to work requires a cultural shift in how things are done from top-level down as well as bottom-up and if this requires a legislative duty then so be it, as a voluntary cross-sectoral approach to genuine, shared commissioning is not going to happen without it.

This question accentuates the duty aspect rather than the good sense potential; further it identifies RPHA as the point of contact with local government – if RPHA remains with only a marginal incidence on commissioning, why has this agency been identified as the point of contact with local government? Should this be the scenario that pans out, it only underlines the need to have regional dispersal of posts across all the component parts of the new structures.

Q9. The DHSSPS is seeking your views on the proposal that the Regional Health and Social Care Board and its Local Commissioning Groups would be required, through legislation, to seek advice from the Regional Public Health Agency when developing their commissioning plans.

- If this is how the structures come into being, the legislative duty would be welcomed, especially as it has the potential to marry the carriage of democratic voice from community level via LCG (lay and elected representation) with established public health initiatives (IfH &HAZ) and Community Development responsibility.

It would be the community view though that this contains risk and that the aims of the reforms would be maximised through siting RPHA closer to if not with RHSCB.

Q10. The DHSSPS is seeking your views on the proposal to appoint the Chief Executive or a senior Executive of the Regional Public Health Agency. As a non-Executive of the Board of the Regional Health and Social Care Board.

- Why as non-Executive Director? This seems to put restraints on the influence of the Public health agenda.

Q11. The DHSSPS is seeking your views on the proposal of how to make the work of the Regional Public Health Agency fully multi-professional.

- This would occur more naturally if the RPHA was more closely aligned to and worked on a collaborative basis with the RHSCB/LCGs.

Q12 The Department is seeking your views on the proposals for the Agencies referred to in Section 8.

- Future capital/estate decisions should be placed at LCG/RHSCB level, with reference to department and CSO.
- RQIA should remain “independent”/separate to other component organisations

Q13 The Department is seeking your views on the proposals for the two options, set out in Section 9, to replace the HSS Councils.

- Option 2

Q14 The Department is seeking your views on the constitution of the new organisation(s) under each of the proposed options, set out in Section 9, to replace the HSS Councils.

- Regard needs to be given to: the merit principle, input from elected representatives, scope for local/community contribution – due attention to these will support the success of any new option

Q15 The Department is seeking your views on the human rights implications of the proposals for Health and Social Care reform and any issues you think relevant.

- There is a need to ensure the rights of the marginalised and “hard-to-reach” are enshrined in all design and delivery aspects of the new structure

Q16 Can you identify any additional relevance evidence or information which the Department should have considered in assessing the equality impacts of these proposals?

- Not at this time

Q17 Can you identify any other potential adverse impacts, with supporting evidence, which might occur as a result of these proposals being implemented?

- The fact that the greater majority of jobs in the Western area are in the public sector
- There is high deprivation in the Western area. The five District Councils in the Western area are in the top 11 of the most deprived Councils in Northern Ireland, and Derry and Strabane have particularly high levels of deprivation as measured against social and economic indices.
- The balance between rural and urban living within the Western area is recognised as being significantly different from other parts of Northern Ireland. The challenge of identifying and meeting the needs of the dispersed population adds a complexity to local commissioning. It is therefore essential that rurality remains to the fore in the commissioning of services.
- There is a high percentage of female employees (including those married with children) in the Western area in jobs which will be directly affected by the restructuring of the HSC, and the issues of work life balance needs to be considered in terms of any changes to travel times and career opportunities
- There are concerns and evidence from elsewhere in the UK that reorganisation leads to further centralisation. We would emphasise the need to avoid what we term ‘gravitational pull’ towards the centre. We would also contend that it is very important not to consider the location of bases in the health and social services sector in isolation from the location of other RPA affected organisations

Q18 Can you suggest any other mitigating measures to eliminate or minimise any potential adverse impact on the staff concerned?

- Not at this time

Q19 Have the needs of the Section 75 categories of people been fully considered in this EQIA? If not, please provide details and supporting evidence.

- From a Community Development perspective, it is clear that awareness to all equality-linked legislation has been shown but it is not the awareness that is needed, it is the equality and inclusion-proofed delivery, design and commissioning of services that will be looked at. Unless LCGs become the central location of decision-making and budgetary control then this duty will be at severe risk of not being met.

Q20 Do the proposals afford an opportunity to promote equality of opportunity and/or good relations?

- Further to the above answer, the window of opportunity for these proposals, in terms of delivering equality and addressing health inequalities lies in strong local commissioning, retention and development of links with communities and organisations working within and from these communities and top-to-bottom parity of esteem for all stakeholders.
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CONSULTATION RESPONSE QUESTIONNAIRE

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

Before you submit your response, please read **Appendix 1**, at the end of his questionnaire, regarding the Freedom of Information Act 2000 and the confidentiality of responses to public consultation exercised.

Responses should be sent to:

E-mail: **hscreforms@dhsspsni.gov.uk**

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RESPONSES CANNOT BE CONSIDERED AFTER MONDAY 12 MAY 2008

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