

Department of Health
Organisational Change Directorate
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Future Planning Model - Targeted Stakeholder Consultation Response from BMA Northern Ireland

Introduction

BMA Northern Ireland welcomes the opportunity to respond to this targeted stakeholder consultation on a future planning model for Northern Ireland.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

We would like to thank the Department of Health team undertaking this consultation for presenting these proposals to BMA Northern Ireland committee members and staff at an engagement event held on 2 September 2021. This submission aims to reflect the feedback provided at that event alongside subsequent contributions from members.

General comments

BMA Northern Ireland has contributed to numerous reviews and initiatives over the course of many years which seek to deliver improvements to the way that health services are planned and delivered in Northern Ireland. Much of what is proposed isn't new. The challenge will be in implementing the final model in a way that ensures appropriate levels of flexibility and autonomy for clinicians, parity between all partners involved and an honest conversation with the public about what they can expect from the NHS and care services in the future. BMA Northern Ireland acknowledges and welcomes the concept of the future planning model and is pleased to play its role in helping to ensure that it is fit for purpose and delivers the improvements we all want to see.

Further to the specific questions posed by the consultation document, there are several broader issues that will undoubtedly impact the effective development and implementation of the new model. The timing of this programme of work, for example, is a particular challenge

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given the current pressures in the system as a result of the ongoing coronavirus pandemic. This is also against a well-recognised backdrop of pre-existing and significant waiting lists and workforce challenges.

At the same time, we do recognise that there are some instances where the pandemic has led to better, more efficient working practices, with clinicians given more freedom to work in new ways. This offers the opportunity to reflect on the need for overly bureaucratic or onerous requirements in future and illustrate, in our view, improved practices on which the proposed model can build.

The financial and legislative context is a further consideration that will impact on the successful implementation of the model. Where similar integrated systems have been developed elsewhere, additional financial resource has been made available and, in some instances, the frameworks have been placed on a statutory footing through specific primary legislation. Additional resource will almost certainly be required to help build in early wins and gains that demonstrate the concept can be successful. Whether or not the model would be more successfully implemented through legislation should also receive further consideration.

Workforce

Crucially, workforce considerations are wholly absent from the proposals which, in our view, represent a critical risk to the successful implementation of the model. The document is heavily focused on structures and processes and that, at this stage, may be appropriate. However, the absence of a recognition of the workforce that will be needed to deliver this model is concerning.

The Expert Panel¹ acknowledged the importance of the workforce and identified a fourth dimension in their triple aim, acknowledging the need to pay attention to the people who will deliver the services on the front line.

The key factor in any decision on the provision of services is a well-staffed service, that is high quality and safe. Local area plans based on political expediency in response to local pressures will unlikely result in improved patient access. Local views must be balanced with clinical considerations; sustainability; safety and value for money. Value for money is not about achieving the lowest price, but the best use of resources for intended outcomes. To this end, further consideration of how effective workforce planning, that involves those delivering services, can be undertaken at appropriate regional and area levels will be of great importance.

Response to questions

- 1. 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?**

BMA Northern Ireland agrees that the way in which services are planned and managed in Northern Ireland requires improvement. On this basis, we support the principle of developing a

¹ Bengoa. R., et al (2016) *Systems Not Structures: Changing health and social care. Expert Panel*. Available at: <https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report>

new planning model that can support the delivery of quality, sustainable health and care services into the future.

The ICS model could provide an important, dedicated focus on the wider determinants of health, helping to address health inequalities, and bringing services together in a way that puts a focus on working across agencies to deliver positive health outcomes tailored towards the needs of the community.

Responding to the *Programme for Government: draft outcomes framework* in March 2021, BMA Northern Ireland acknowledged that closure of the HSCB would result in the shift from a commissioning model to a planning model, through the creation of integrated care systems, which would include linking in with the community planning framework. Whilst welcoming this intention, we reinforced the need not to miss this opportunity to put population health planning at the centre of these proposed changes.

As we described in this response, the BMA's current president, Sir Harry Burns, has developed a different approach to tackling health inequalities². At a meeting with BMA members in which he detailed his methodology, members left feeling that the traditional approach to health inequalities were no longer fit for purpose. Sir Harry said that health inequalities are caused by not enough wellbeing, not too much illness, and outlined the key elements that are needed for wellness:

- An optimistic outlook
- A sense of control and internal locus of control
- A sense of purpose and meaning in life
- Confidence and an ability to deal with problems
- A supportive network of people
- A nurturing family.

For the creation of health, the social and physical environment must be comprehensible, manageable and meaningful. The absence of these would mean that the individual would experience chronic stress in their lives. He concluded that if we continue to focus the manifestations of health inequalities such as alcohol, obesity and smoking and not look to the causes, we will fail current and future generations - *"The circumstances in which children are born and raised determine the choices they make and the outcomes they experience"*³.

With this in mind, we would urge that this approach to understanding the causes and wider determinants of health inequalities, rather than simply how these inequalities are manifested in society, is adopted and integrated into the proposed model.

Despite BMA Northern Ireland's acknowledgment of the need for change, and broad support of the principles behind the ICS proposals, issues still remain which will require further consideration.

Our response to the PfG draft outcomes framework also called for a more robust evidence base to be established and critiqued to ensure that it is fit for purpose and helps to deliver the intended improvements. Given the link between the proposed ICS model and the PfG outcomes, we maintain our concerns about the PfG outcome framework and believe more clarity could be offered ensure all parts of the system are working toward the same shared objectives, and that this is grounded on a solid evidence base. This is crucial for the ICS model

² BMA (2020) *Politics vs evidence: a president's passion*, available: <https://www.bma.org.uk/news-and-opinion/politics-vs-evidence-a-president-s-passion>

³ Sir Harry Burns (24th Feb 2021) Presentation on BMA Northern Ireland Members

to be a success and will require close and ongoing engagement with those at the frontline of health services, alongside other key stakeholders.

It's also the case that simply changing the planning model for change's sake, won't deliver the improvements needed. Further reassurances are required that the changes will deliver a real improvement on the status quo, leading to a less complex system that demonstrably improves health outcomes for the people of Northern Ireland. For example, whilst the functions of the HSCB will be, for the most part, transferred to the DoH, this in and of itself doesn't necessarily equate to a reduction of bureaucracy or ensure effectiveness and efficiency in planning and commissioning. There are significant levels of complexity within the proposed ICS model, which require proper examination to ensure that the transformation arrangements are truly transformative and not simply creating additional and unnecessary barriers, within a system of already insufficient resource.

2. 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.

Principles underpinning the model are to be welcomed, and those suggested offer a good foundation for further development. It's important that these aspirations match what is deliverable through the implementation of the model. Clearly, for example, all partners working within the current system recognise the importance of person-centred planning and delivery. However, systemic barriers often prevent this happening in practice, much to the frustration of clinicians and the public. The proposed ICS system must not only set out the principles that partners should adhere to but foster an environment in which they can be successfully delivered on in practice.

Building on these principles, BMA Northern Ireland would like to see a specific reference to clinical involvement within the planning and delivery of health services. In practice, this would help ensure the expertise and experience of GPs and secondary care doctors is fully utilised.

We would also seek to ensure that leadership throughout the ICS model is provided by public bodies, and not private providers. It is our view is that it is not essential to have commissioning if the right planning and delivery model is in place, as is the case in other parts of the UK, and so the model should be implemented on this basis, with leadership reflective of this principle.

3. 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?

It's appropriate that overarching strategic direction is set by the Minister and DoH, which helps to ensure accountability. That the Minister and Department will set outcomes to be achieved is, again, appropriate. However, it will be important to fully engage relevant stakeholders, including doctors and others at the forefront of the health service, to ensure that outcomes are realistic within the existing context. This engagement will be equally important when developing a benchmark health and well-being profile, and the associated strategic outcome framework and indicators.

The role of the Minister and DoH could be enhanced, however, and we would reinforce some of the calls made in the BMAs *Caring, Supportive, Collaborative*⁴ report. Governments must

⁴ BMA (2019) *Caring, Supportive, Collaborative*, available: <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/the-future/caring-supportive-collaborative-a-future-vision-for-the-nhs>

incentivise NHS bodies, including hospitals, GP practices, public health, and community services to work together as one system. This will involve bringing together doctors, other healthcare professionals and patients to design systems built on trusting relationships between previously isolated parts of the NHS.

Greater funding and support should be made available for schemes designed to build professional and social connections between clinicians across traditional working divides.

Furthermore, the 2015 *Review of HSC commissioning arrangements*⁵ raised notable issues that aren't clearly addressed in the ICS proposal. For example, the review noted a strong sense from stakeholders that there is a need to identify a clear point of leadership within the system, and clarify roles and responsibilities of – and lines of accountability between – the various HSC bodies. The extent to which this is realised by these proposals is unclear and it's vital that lessons from previous reviews are learnt, to ensure the success and sustainability of the future model.

4. 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?

The overall ICS model and how it will look when applied to Northern Ireland, broadly reflects existing structures. The regional group will undertake many of the existing HSCB functions and the role of the PHA will be unchanged. The area groups are co-terminus with existing HSC trusts, with the local and community structures aligning with GP Federations and Integrated Care Partnerships.

The key distinctions between the current structures and the proposed model will be how these different levels operate in practice, what their functions and outputs are and, crucially, how the proposals enable effective and equitable partnership working. The roles and responsibilities of existing HSC trusts within the AIPBs will be particularly influential in this regard, as they will maintain significant levels of financial resource and authority over how that budget is utilised. Operating within these existing structures risks a continuation of existing working arrangements which aren't always conducive to partnership working. There is a risk that partners without comparable resource, such as GPs or community groups, will have less influence or face too much bureaucracy to make meaningful contributions. This power imbalance will need to be addressed to allow the new systems to thrive, creating an environment which fosters the development of dynamic and robust relationships and parity between partners. The Department of Health should further consider how budget delegation can form part of the implementation of the model to help establish legitimacy and authority.

Furthermore, whilst a shift to truly local decision making is welcome, we must note the current partnership infrastructure that is already in place, and ensure existing experience and expertise is fully utilised. For example, where the HSCB or local commissioning groups (LCGs) have made positive contributions to developing meaningful partnerships, we must make sure that these aren't lost. Primary care multi-disciplinary teams also represent a successful partnership model based on community knowledge and local need, with patients being seen by the right professional, at the right place, at the right time. These should be rapidly expanded as an early priority and could represent an early gain attributable to a new partnership model.

Similarly, the role of local councils and the interface between area population plans, local delivery plans and community partnerships planning, could be expressed more clearly to avoid

⁵ Department of Health NI (2015) *Review of HSC commissioning arrangements – Final report*, available: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/review-hsc-commissioning2015.pdf>

duplication and ensure full involvement of all relevant partners. This will be essential in understanding the manifestations of health inequalities as outlined above.

5. 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?

A body, such as the regional group, working in coordination with all other partners to provide an oversight, coordination and support function echoes, to a significant extent, the existing structure, with many of the proposed functions currently sitting within the HSCB. The rationale behind closing the HSCB, transferring functions to the DoH, only to then delegate functions to the regional board is not immediately clear. If a key aim of the new system is to reduce complexity and bureaucracy, then more clarity will be needed on the distinct roles of the regional board, DoH, PHA and other partners within the new model.

However, a renewed focus of regional population health and well-being planning is welcome and necessary.

The exact responsibilities of the new regional board, further to the support and oversight functions and the development of a regional health and well-being plan need to be clarified further. Specifically, we are concerned that while the planning and/or commissioning of some services should be done on a regional basis, others should be done on an area basis. This needs to be carefully considered, particularly with the input of those delivering specialist, high-impact, low-incidence health services, to ensure that there is fair and equitable coverage across Northern Ireland and that there is no 'postcode lottery' in the availability of more niche services.

Another important consideration which will particularly impact on the regional board, but also each level of the proposed model is the availability and reliability of accurate and meaningful data. When developing regional plans, consideration will need to be given to how priorities will be identified, alongside indicators and milestones outlining what progress and success looks like. Existing data sets tend to focus on health activity, rather than outcomes, and even these aren't always sufficient. New metrics and ways of collecting data on population health and well-being will be required if the proposed model is to be able to demonstrate its success. For example, the 2015 *Review of HSC commissioning arrangements*⁶ reflected that the role of LCGs in assessing local needs has not been realised, in part because of a perceived lack of data to support meaningful needs assessment.

Currently, much of our data sits within silos much in the way our services do. Transformation of the planning and delivery of services in Northern Ireland offers an opportunity to look at how data can be more joined up, including between primary and secondary care. The role of Digital Health and Care Northern Ireland (DHCNI) is not set out in the framework, but given its responsibilities for setting regional policy and developing best practice for HSC technology, digital and data – including data-sharing and transparency, DHCNI will have a key part to play in ensuring that implementation of the model is a success. There could also be an opportunity to engage the public regarding the appropriate use of their data not only for direct care purposes but also to help plan the services that will need to be provided locally to them as well as to help research.

⁶ Department of Health NI (2015) *Review of HSC commissioning arrangements – Final report*, available: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/review-hsc-commissioning2015.pdf>

Appropriate and effective use of data throughout the implementation of the model will be crucial to its success but significant work is needed, alongside the development of the ICS, to ensure that existing data is brought together and gaps are identified and addressed.

6. **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?**
7. **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?**
8. **Do you agree that AIPBs should ultimately have control over a budget for the delivery of care and services within their area?**

These questions seek views on proposals relating to the roles and responsibilities of the AIPBs. These boards appear to act as the key drivers to local autonomy and decision making, while still under the purview of the regional group.

BMA Northern Ireland welcomes the concept of more local decision making where this can deliver improved outcomes for people and offers meaningful autonomy and flexibility for those providing services, rather than further bureaucracy. Provided that doctors and others involved in the delivery of care are enabled to play a full part in service planning through their AIPB, then it follows that these boards should have the responsibilities proposed. We would suggest that, despite the complexities, control over areas budgets is delegated at the outset. Funding will be the key driver to implementing the model successfully.

BMA Northern Ireland have concerns over existing commissioning arrangements and has consistently questioned whether these offer value for money and result in the best care for patients. In many instances they actively discourage collaboration, due to reliance on market competition. Similarly, we have pointed to how the block contract model is crude and can result in perverse incentives which leads to stagnation and fragmentation in the delivery of health and social care. As a result, we do support proposals which begin to address these concerns and that favour collaboration and effective local service planning.

The areas covered by the AIPBs reflect the current boundaries of the HSC trusts. Whilst this will clearly have institutional and structural benefits, there are risks that may arise as a result. Basing the new system around pre-existing structures, as mentioned previously, will serve to continue the existing power imbalance that exists between partners. HSC trusts will maintain their statutory responsibilities and authority over their funding and resources. At the same time, other partners who contribute to implementing the proposed model will need to feel as though they have a genuine role in decision making. Previous reviews have led to the development of partnership structures which have felt, to many, like a 'talking-shop', with no real control or authority and, consequentially, key stakeholders disengaging. The 2015 *Review of HSC commissioning arrangements* references the need to ensure that key stakeholders have a sense of 'ownership'. Whilst we acknowledge the longer-term intention of AIPB controlled budgets and shared accountability, further work is needed in the interim to ensure that the delivery of the model within these existing structures can be done successfully. We would advocate that delegation of budgets takes place at the outset of implementation as this will be a key driver of success.

BMA Northern Ireland also strongly believe that further clarity is needed about the exact responsibilities and resources AIPBs will have regarding their local workforce, including long-term planning, recruitment, and retention.

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

- 10. 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?**
- 11. 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?**

The AIPB membership arrangements proposed broadly reflect the key partners who should be involved in the planning in delivery of health and social care. Whilst we recognise and welcome the key role identified for GPs, we would prefer to see more specific detail on the role secondary care doctors will be expected play, to ensure they can contribute meaningfully and effectively to planning arrangements. The framework could fall short in respect of clinical leadership and representation, if there is no mention of LMCs or LNCs, or the need to involve consultants, SAS doctors, or junior doctors in the work of the AIPBs.

Similarly, further consideration may be required on the role of local councils, not solely in how they can effectively contribute to health and well-being plans, but how these will align with community partnership planning and other existing partnership mechanisms. The input of voluntary and community sector organisations will also be important, but their funding is often annual or otherwise time-limited, which may not be compatible with the longer-term planning preferred in the proposed model. Simply enabling NGOs secure funding to be providers of a service misses the broader sustainability and long-term funding of this sector. This can also impact on issues of clinical governance – if community and voluntary organisations are to be equal partners in planning and delivery, then the services they provide need secure, long-term backing and robust quality management. GPs and other doctors and health professionals retain clinical accountability for patients referred to services provided by other partners, so there will need to be significant investment in ensuring appropriate infrastructure exists to enable these services to be reliable and of high quality.

We broadly welcome that GPs will initially co-chair AIPBs, but would refer to previous comments in relation to the level of influence of HSC trusts. A point not referenced in the draft framework is how the AIPBs will be supported administratively. There will be additional cost to this, but the secretariat to the board will also have influence over the timing of meetings, the drafting of minutes and papers, as well as other important practicalities. This is a significant role, and in our view, one that should be fully resourced and ideally undertaken independently of HSC trusts.

The framework also set out limited functions attributed to local and community groups, with the majority of these to be set out by the AIPBs. We would welcome further guidance on the relationship between different levels within the model and how each group can interact and feed-in to ensure that they operate in coordination with each other.

Summary

BMA Northern Ireland is pleased to contribute to this targeted consultation on a future integrated model of care planning in Northern Ireland.

As well as responding to the specific questions raised in the consultation document, we have also set out a number of general comments and, in particular, concerns around workforce planning to ensure that any new model is properly resourced and staffed to deliver the care that people in Northern Ireland need.

To be clear, the model through which services are planned and delivered is part of the wider health and care system which, even prior to the coronavirus pandemic, was subject to extreme pressures. The pandemic has significantly exacerbated these pressures.

Alone, a new planning model will do little to solve the crises in funding, staffing shortages, mental health and social care services, crumbling estate and other major problems facing the NHS. These challenges require an ongoing focus on developing a collaborative NHS, properly funded and staffed, publicly delivered and publicly accountable.

Once again, we would like to thank the department for the opportunity to respond to this important consultation. Should you have any questions in relation to it, please contact Judith Cross, head of policy and committee services, in the first instance via jcross@bma.org.uk

Yours sincerely



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