

Integrated Care System NI
Draft Framework
Consultation Response Document

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

Personal details	
Name	Vivienne Fitzroy
Email address	Vivienne.fitzroy@rcslt.org
Are you responding on behalf of an organisation?	Yes
Organisation <i>(if applicable)</i>	The Royal College of Speech and Language Therapists

The questions set out on the following pages are to help gather views and guide responses in certain areas. General comments can also be left at the end of this document on any aspect of the framework.

Please note: the boxes provided for additional comments in each question can be expanded.

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

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

Agree

Additional comments:

The Royal College of Speech and Language Therapists supports the move towards an integrated care system model in Northern Ireland. The rationale for change is well evidenced, as outlined in the document, and we fully support the Department's commitment to bringing that change into effect.

We acknowledge that much detail is yet to be formulated by the Department on how the model will operate in practice, and that a fully developed ICS will evolve and take some time to develop. Notwithstanding this, we have concerns over adequate representation for Allied health professionals (AHPs) and the process for future commissioning decisions. We have raised concerns at recent Department of Health stakeholder events about the lack of representation and access for Allied Health Professions in the new model and these are detailed below more fully – in simple terms, it is only the right model if the right people are around the table.

We are concerned that a lack of strategic and area representation will lead to a lack of understanding about the needs of people with communication and swallowing difficulties, as well as the role of Speech and Language Therapists and what they can contribute to population health outcomes across the whole lifespan.

Specific comments about the broad blueprint as outlined in section 3 are:

1. We welcome the ambition within the model to “reduce health inequalities and deliver improved health and social wellbeing outcomes for our population”. The collaborative working envisaged needs to be based on a robust analysis of the needs of the local population. For example, it will be vital to ensure that incidence of speech, language and communication needs (SLCN) in the local population are understood and considered. However, we would welcome some more information on how the robustness of the data will be assured and how gaps will be identified?

This is particularly relevant to health inequalities. For example, 10% of all children will have speech, language and communication needs. However, in areas of high deprivation in Northern Ireland, around 50% of children here begin school with speech, language and communication needs (SLCN)¹. If left unidentified and unsupported children can experience serious and sometimes lifelong adverse effects on their educational attainment, employment opportunities and mental health. However, at present, there is no universal regional measure of pre-school language readiness that provides robust population health data.

In terms of adult commissioning across integrated services there is a similar need to ensure that SLCN and dysphagia incidence are understood, and commissioning is

¹ RCSLT NI (2020) Briefing to Expert Panel on Educational Disadvantage in NI available here [Response-to-expert-panel-in-persistent-educational-underachievement-Oct-2020.pdf \(rcslt.org\)](#)

appropriate considering both patient risks and the public health and prevention aspects. In addition, all health and social care staff need to understand how to make reasonable adjustments for communication to maximise health outcomes – from primary care to urgent care and specialist care.

2. We note the mention in section three of working “beyond” the HSC sector and we welcome the reference to both local councils and the importance of the community and voluntary sector in later sections of the document. However, how will the structures support and engage with other government departments such as education, justice and economy to inform outcomes and develop plans? Around 60% of Speech and Language Therapists (SLTs) in Northern Ireland work with children and young people, for example children with Special Education Needs (SEN) and have a statutory duty to provide services. Is there an opportunity for regional, area and local planning to join up with partners such as the DE and EA at a strategic level, and with the education sector leaders at a local level to inform planning and highlight need?

We believe that this model could offer an opportunity to explore joint commissioning beyond the HSC if supported to do so, which in turn could offer the possibility of a more holistic approach to treating and supporting children, adults and their families.

Case Study: Joint commissioning to tackle high incidence of SLCN in area of multiple deprivation

- ‘One Service, One Solution’ in Worcestershire sees the NHS and Local Authority jointly commission core speech and language therapy services for children and young people with speech, language, and communication needs (SLCN). Each school has a named SLT, and the option of commissioning additional top-up activities. Evidence-based programmes are embedded into pathways, resulting in clear routes for early identification, information, and resources.
- Impact: Children at risk of SLCN in targeted early years settings have decreased on average by 20%.

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

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

Comments:

The RCSLT would welcome an explicit reference in the values to **communication** – that all partners within the ICS commit to effective and inclusive communication in all contexts to promote the health and wellbeing of individuals and the wider population.

The ability of patients to be able to effectively communicate is key to improving care and health outcomes through more successful understanding, discussion and engagement. Not only do SLCN commonly affect people at vulnerable times in their lives, but they also affect some of the most

vulnerable members of our society, including people with learning disabilities, autistic spectrum disorders, dementia and stroke survivors.

The risks of communication exclusion are caused by people misunderstanding or being misunderstood. The impact of these risks includes health inequality, poor health literacy, social isolation and poor mental wellbeing, and could ultimately lead to barriers in accessing NHS and social care.

The RCSLT and its partners have launched a nationally recognised symbol – the [Communication Access Symbol](#) - to represent communication access in the UK, akin to the more widely known disability access symbols such as the wheelchair access symbol and the visual and hearing impaired symbols, as well as underpinning standards. If an organisation displays this symbol it will show they are meeting defined standards both at operational and organisational levels, creating a more inclusive environment for people with communication difficulties.

Creating an inclusive communication environment is essential to reduce communication barriers and subsequent prejudice and exclusion from society. It also supports work to address health inequalities and is foundational to creating a person-centred model that is open to all, as envisaged in the values and principals outlined here.

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

Agree

Additional comments:

The outcomes to be achieved and key indicators for core services should be agreed regionally to ensure that there is regional consistency. This would enable effective transparency, scrutiny by the Minister and accountability of the system based on truly comparable data. However as outlined above, many population health outcomes can not be tackled by the ICS in isolation of other government departments. In other regions of the UK a more ambitious cross-departmental approach to reducing health inequalities has been taken². Whilst we are cognisant of the need to move as quickly as possible to transform the HSC system, we would welcome more information about the Executive-wide commitment to the ICS and what, if any, are the intersections between departmental lines of accountability and funding arrangements?

² The Kings Fund (2018), [A vision for population health | The King's Fund \(kingsfund.org.uk\)](#)

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?

Somewhat

Additional comments:

The RCSLT supports the principle of enabling local practitioners to have greater autonomy in designing services to meet the needs of their population. In practice, the RCSLT supports members to maximise their engagement and involvement in local-level decision-making as part of a shift to integrated systems in other jurisdictions. The RCSLT provides supporting resources and guidance for members on commissioning and planning, working with partners across sectors such as health and education where relevant. However, we are concerned that the model at present risks shifting accountability to professionals without adequate representation at strategic and area levels for SLTs and other AHPs. This is a cause for concern, both in terms of the impact on SLTs and the potential impact for people with communication and swallowing needs.

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?

Unsure

Additional comments:

It is vital that the regional group is representative including professional representation. It is unclear in the consultation document who will provide professional advice within and to this group.

Importantly, as mentioned above in question 1, the RCSLT share concerns with fellow AHP professional bodies that there is no minimum requirement to have professional representation for AHPs as a specific group, at either the regional group or area integrated partnership boards. This risks both underutilising the potential for AHP-led solutions and a lack of profession-specific advice at a strategic level.

AHP professional representation is not only an issue of maximising the benefit for patients and the system, but also integral to understanding patient safety and risk. For SLT, professional representation ensures adequate advice on accessible patient participation, through communication support and crucially, adequate guidance on patient safety around eating, drinking and swallowing difficulties, which can present a risk to life if not adequately and safely

managed. Furthermore, it highlights risks for our population in areas where SLT is not traditionally thought of or routinely commissioned, for example within acute mental health in-patient services.

Presently, Trust Delivery Plans and saving plans must have approval from professional leads. We are seeking assurance this professional oversight is mandated in the new ICS model in NI to ensure safety and quality assurance.

We welcome that the regional group will work in partnership with the PHA, however we are seeking more clarity around professional advice, when it will be sought, at what juncture and to what extent?

The RCSLT believes there is an opportunity to rebalance the representation of AHPs as the second largest HSC workforce, by enshrining representation of AHPs at the regional group. This would ensure that AHP capability was maximised and support patient safety through AHP professional advice at the most strategic level.

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?

Unsure

Additional comments:

As per our response to question 4, this again largely depends on ensuring that consistent representation at AIPBs across the region is achieved, guaranteeing that all sectors of service need are considered in all areas. We would also welcome more detail on how information will be shared across the system – between and across all five AIPBs – so that the whole region can benefit from work ongoing on different areas where it is useful to do so.

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?

Somewhat agree

Our SLT members have expressed some concern that the creation of five separate area plans may lead to a postcode lottery for some services. Will there be any minimum baseline of services that should be provided in each area and then development of specific additional services to respond to population need?

We also note that each AIPB will determine the links and governance structures between the area, local and community tier structures – will there be minimum guidance, and will there be opportunity for dialogue and learning across the areas? How would this be resourced?

We also are interested in understanding further the thoughts of the Department on how local-level decision-making will dovetail with the regional specialised services that will be commissioned by the regional group. For example, stroke community services have traditionally seen significant variation in the provision of SLTs as part of community stroke early discharge teams – how do we ensure that there is parity for patients across the region where there is an overlap in services between tiers?

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

Agree

Additional comments:

Providing there is appropriate financial accountability and control measures.

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

No

Additional comments:

As outlined above we feel that a dedicated AHP representative should be included. We would also support the inclusion of an education representative for children population. **Co-production and patient involvement** need to be part of local decision making and should be a fundamental part of the culture shift towards a collaborative model and collective action on health inequalities. To this end, a commitment to inclusive communication across the ICS as outlined above would also demonstrate a clear willingness to take tangible steps to *“Listen most carefully to those whose voices are weakest and find it hardest to speak for themselves” — Department of Health, Patients First and Foremost 2013.*

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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?

Unsure

Additional comments:

Has the Department considered the option of an independent chair for each AIPB? This would have the advantage of providing a more open and equitable starting point from which to make the significant culture shift required, as well as structural changes needed towards greater parity among partners. At a minimum we would expect that the chair of each AIPB would be open to all members of the AIPB.

Q11. The framework allows local areas the flexibility to develop according to their particular needs and circumstances.

As set out in Section 10, do you agree that the membership and arrangements for groups at the Locality and Community levels should be the responsibility of the AIPBs to develop, determine and support?

Unsure

Additional comments:

Would it be more optimal for locality and community level membership to also be subject to minimum membership requirements and additional membership to be optional and flexible depending on population need?

General Comments

Please add any further comments you may have:

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