INTEGRATED CARE SYSTEM

DRAFT FRAMEWORK CONSULTATION

ANALYSIS DOCUMENT

JANUARY 2022

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1. INTRODUCTION AND BACKGROUND

1.1 The Minister of Health granted approval in October 2020 for the commencement of a programme of work to develop an Integrated Care System (ICS) model in NI in line with the vision set out in *Health and Wellbeing 2026: Delivering Together* which articulates the need to empower local providers and communities to plan integrated continuous care based on the needs of their population, with specialised services planned, managed and delivered on a regional basis.

1.2 To support the model, a Draft Framework has been developed which provides a blueprint for the future of planning and managing health and social care services in Northern Ireland. It provides an overview and guidance on the proposed ICS model to allow the system to design and adopt the relevant approaches, policies and structures required to make the new system a success.

1.3 The draft framework includes detail on the population health approach, definitions, vision, values and principles, and how regional and local levels will be developed and operate. It ensures that clarity and direction is provided where appropriate, but that there is flexibility built in to the system to allow each area to develop and evolve based on the identified needs in their area and resources and assets available to them.

1.4 The framework document details how the future model will work, enabling improved collaboration and partnership between sectors and organisations. The model will provide for greater autonomy and decision making at local levels, whilst ensuring the co-ordination and delivery of regional and specialised services at a regional level where appropriate.

1.5 The model will ensure that the planning, management and delivery of services are more agile, flexible and responsive to identified local needs, less bureaucratic and process driven, and more outcome focussed than the current approaches. Importantly, the model will operate with the involvement of all key partners.

2. THE TARGETED CONSULTATION PROCESS

Targeted Consultation

2.1 A targeted consultation on the Draft Framework[1] was launched on 19Th July 2021, closing on the 17th September 2021. Stakeholders were invited to submit a response via:

- Online portal hosted on Citizen Space;
- Downloading the Consultation Response Template; and
- Sending an email, or a written submission through post.

2.2 The following documentation was provided to assist with the consultation process:

- A consultation document setting out the background to the draft framework and details on how to respond to the consultation;
- A copy of the Draft Framework document; and
- A copy of the consultation response document (including detail on how responses can be completed online or returned via hardcopy/email).

Engagement & Events

2.3 Following launch of the targeted consultation, two workshops were organised with key stakeholders with over 200 attending across both events.

2.4 The events where held on 3rd August 2021 and 3rd September 2021. The purpose of the engagement events was to provide an oversight of the framework document and gauge initial feedback. There was opportunity to discuss various elements of the framework further within breakout rooms, and each session ended with a poll for attendees to complete.

2.5 A summary of the feedback provided at these events and details of the poll results can be found at **Appendix A**.

2.6 Department officials also aided other organisations where possible in the facilitation and support of independent events. Among these, NICVA hosted an event on the 31st August with over 150 attendees.

[1] https://www.health-ni.gov.uk/consultations/future-planning-model-targeted-stakeholder-consultation

2.7 The feedback from these events was very helpful, and was also considered in the response analysis set out in chapter 4.

3. ANALYSIS OF RESPONSES

Overview of responses

3.1. In total, 122 formal responses were received. Of the 122 responses received:

- 25 were received via Citizen Space; and
- 97 were received via a direct submission to DoH.

3.2. The majority of questions posed within the consultation document asked if respondents agreed or disagreed with the specific aspect of the framework and provided scope for additional comments. However, question 2 around the values and principles instead asked for comments on those detailed in Section 5 of the framework along with any proposed additions, meaning the respondent was not required to explicitly state if they agreed or disagreed.

Statistical breakdown

3.3. The quantitative analysis set out below is based on those who responded directly to the questions posed within the consultation document. 103 out of 122 responded directly to the questions within the consultation.

3.4. The percentages of agree/disagree in table below are reflective of the answered questions only.

3.5. Where responses did not provide specific answers to the questions they do not form part of the percentages in the table below, although all comments and suggestions received have been considered.

Question	Agree	Disagree	Number of responses
1 – Is this the right approach?	92%	8%	98
2 – Values and Principles	N/A	N/A	N/A
3 – Ministers role in strategic direction	88%	12%	98
4 – Local autonomy and accountability	89%	11%	94
5 – Regional Group oversight and coordination	95%	5%	91
6 – Establishing of AIPBs	91%	9%	92
7 – AIPB responsibility of planning & delivery	93%	7%	94
8 – AIPBs & controlling budgets	89%	11%	91
9 – AIPB minimum membership	62%	38%	91
10 – AIPB chairmanship	71%	29%	93
11 – Development of Locality & Community membership by AIPBs	84%	16%	90

3.6. The following sections provide a summary of the key themes, messages and suggestions which emerged from each of the questions and within the areas covered in the consultation document.

3.7. Any responses which did not use the response template were also considered in the information provided below.

4. INTEGRATED CARE SYSTEM DRAFT FRAMEWORK CONSULTATION

ICS Approach and Direction of travel

4.1. The draft framework provided a blueprint for how we will plan, manage and deliver services in Northern Ireland moving forward. Question 1 asked if the respondent agreed or disagreed if this is the right approach to adopt in Northern Ireland.

4.2. Of the 98 respondents who provided an answer, 92% agreed this was the correct approach for Northern Ireland.

4.3. From the feedback, the emerging themes, messages and suggestions include:

- General support and agreement surrounding the need for change though any change needs to be against deliverable time frames, with a number of respondents seeking clarity around this.
- A number of respondents queried with the ongoing pandemic if this was the ideal time to begin a critical change process such as this.
- The level of increased autonomy and accountability at a local decision-making level was welcomed, putting the person at the centre being a guiding principal. A number of respondents did raise some concerns around access to and availability of services varying within each region, creating a 'postcode lottery'.
- The engagement of the Community and Voluntary sectors through development of a formal mechanism was greatly welcomed. Some responses asked how the Department will ensure communities are involved in the planning of services in a meaningful way.
- There was concern the new model increases the amount of bureaucracy rather than reducing it.
- Some respondents felt that a greater emphasis of co-production and co-design is needed within the framework.
- Creating strong links between Area Integrated Partnership Boards (AIPBs) and Community Planning Partnerships is vital to avoid any duplication or missed opportunity.
- Greater clarity is required around accountability.
- Greater clarity is required on how the needs of individuals and communities will be identified.

- The Department of Communities will be an important partner, with some suggestions that they may be better placed to manage social care.
- It was noted that an approach to remove a commissioner/provider split would be more beneficial for Northern Ireland and the framework does not reference this.
- Concerns were raised that the model was a hybrid which was ushering in the path of privatisation of the health service.

Departmental Response on Approach and Direction

4.4 The Department acknowledges and welcomes the general support that this is the right approach for Northern Ireland.

4.5 Our existing system and approach as a whole has not reached its full potential, and limitations have emerged with services being commissioned with individual providers rather than on the basis of a whole systems approach to meet identified need. Key to the new approach is that it seeks to harness not just the strengths of the HSC sector, but by looking beyond at what can be achieved when we work in partnership with community and voluntary sector, local government and other statutory partners, and with service users and carers. A fully developed ICS will have more delegated authority and responsibility for managing resources for local population areas than our current approach, and to act flexibly to deliver improved health and wellbeing outcomes rather than predetermined service models.

4.6 The Department acknowledges that whilst the Framework document provides the blueprint and vision for the new model, there remains much more work to do in order to deliver a fully functional Integrated Care System. There are a number of workstreams which have been established to progress work across a number of areas and this work will continue over the coming months. These include:

- <u>Framework & Local ICS Implementation</u> – to support and deliver the production of a framework to underpin the establishment of the ICS model across NI, and to lead on the development of local level structures and systems to support the ICS NI model, as set out in the framework document;
- <u>Strategic Outcomes Framework</u> – to develop a new process for setting strategic priorities and outcomes at a Ministerial / Departmental level to inform the work of the ICS model;

- Regional Group – to develop the definition of regional roles and responsibilities and to support successful partnership working both at a regional level and within the wider ICS;
- Review of Planning Processes – to identify improvements to the planning cycle to support the new integrated care model and the population health approach;
- Regional Planning of Services – to consider regional planning of services within the new ICS model;
- Funding – to define the most appropriate and fit-for-purpose funding model to support the integrated approach;
- Data & Health Intelligence – to assess the data and intelligence requirements of the iCS and define the data provision and analytical specifications; and
- Communication and Engagement - to lead on co-designing and delivering a regional Communications and Engagement plan, supporting the implementation of ICS NI.

4.7 Co-production, co-design and co-delivery are essential components of an integrated care system approach and a broad range of stakeholders have already been consulted with and are represented across the various workstreams and within the project structures.

4.8 Cognisant of the need to ensure those involved are supported to fully participate, discussions are underway through the ICP Third Sector forum to explore mechanisms to foster ongoing involvement of these key stakeholders going forward.

4.9 A working group has also been established to explore the most effective mechanism for service user and carer involvement and to develop guidance for how co-production with service users and carers should be embedded with the ICS model.

4.10 In addition to the workshops that were carried out as part of the draft framework development and targeted stakeholder consultation, a full engagement programme has also been designed in collaboration with both the Integrated Care Partnership (ICP) Programme Team and Patient and Client Council to capture people’s needs and priorities in relation to their own health and wellbeing. This will provide participants with the opportunity to inform and shape the main themes of the Strategic Outcomes Framework, and produce strategic outcomes which will reflect the priorities identified.

4.11 Moreover, the learning from these processes will provide invaluable insight into how best to design the continual engagement mechanisms to ensure the system embeds the values of co-production and co-design throughout its planning activities.

4.12 In relation the timing of the change, the Department is cognisant of the impact the pandemic has had on our health and social care services and wider society, and whilst it is understandable to raise concerns over implementing change in such a landscape, the pressures the system currently faces highlight the need to embrace change now more than ever before.

4.13 The response to the pandemic has highlighted the importance and ability of our various systems and sectors to come together in order to deliver collectively the services and support that individuals and communities need, in the way that they need them. There is a willingness and desire in the system to embrace this way of working. It is important that we capitalise on this and the current opportunity to move forward with the reform and rebuilding of our system that will provide better ways of working rather than revert to what has come before.

4.14 What must be acknowledged however is that implementation of an Integrated Care System is a complex undertaking and will take significant time to fully develop. Implementation, therefore, will be taken forward at a pace which does not add unnecessary pressure and that will account for the need to provide the scope for the model to mature over time in order to reach its full potential.

4.15 It should also be noted that following publication of the draft framework for consultation, developments with regards to the Health and Social Care Bill will have a direct impact on the timeline for implementation. The Bill which successfully completed Final Stage in the Assembly (7 December 2021), and includes a duty for the Department to bring forward legislative provisions to underpin the ICS model before it can be formally established. These provisions will not be possible to bring forward until autumn 2022 at the earliest (indicative timeline only). It is important to note that the work on the development of an Integrated Care System will continue, however the timeline for establishment of certain elements, such as AIPBs, will now be underpinned via the development of regulations. A more definitive timeline will be produced in due course.

4.16 In terms of concerns regarding additional bureaucracy, the Integrated Care System model will look to promote collaboration and partnership working, across sectors and traditional organisational boundaries, in order to work to identify and remove any barriers and unnecessary bureaucracy in our system. Indeed, the ICS model is not seeking to impose additional bureaucracy and administration, rather the aim is to develop a more agile and responsive system that can act in a more timely and efficient manner to local needs.

4.17 The model seeks to reflect and recognise the different levels which exist within the wider system at present and looks to bring the constituent parts of the system together in order to enable more effective partnership working and collaboration. The ambition for the ICS to focus on population health means that there must be effective mechanisms to reach into and work with existing local communities and community groups so that we better understand what is supporting good health and wellbeing and what more needs to be done. The framework document will be updated to better describe that requirement and how the locality level of the ICS will need to work with local communities to ensure those effective mechanisms are in place as opposed to establishing another level of or structure.

4.18 The Department noted the various concerns raised around the potential of creating a 'postcode lottery'. Ultimately as the ICS matures it will see greater autonomy and responsibility being placed at a local level. It is important to acknowledge that the ICS model will be driven by an agreed set of strategic outcomes, informed by needs assessment and local input and intelligence. Each local area will look to address these outcomes in a manner that is reflective of their identified local population needs and which is in line with the agreed strategic direction. Information and data on population needs will be available to ensure informed decisions are made.

4.19 Work is also ongoing to develop the role and responsibilities of the regional group, which, through a cross-membership of local and regional personnel, will protect local autonomy while ensuring regional consistency of outcomes. 'Similarly work will be undertaken to ensure that there are mechanisms and processes in place which fosters co-operation and collaboration between local areas, enabling shared learning and examples of best practice to inform the planning, managing and delivery of services across NI. The ICS model is about all levels of the system working together and not in isolation. Whilst the AIPBs are component parts of the new model, it is important to emphasise that ICS NI is one planning system.

Governance and accountability structures established at Regional and AIPB level will help reduce unwarranted variation.

4.20 Regarding concerns about privatisation, the Department is clear that this is not the purpose or intention of the new model. The model is designed to underpin and sustain our health and social care system, ensuring resources and assets are used in the best possible way in order to achieve improved outcomes for our population and reduce health inequalities. While working partnerships with cross-sectoral bodies and organisations will be essential, the management and leadership of health and social care will remain the responsibility of the public sector HSC organisations. The Department will also establish governance and accountability procedures in line with standard practice to register interests of AIPB members. The success of the ICS model will depend on drawing on a wide range of knowledge and expertise, with Departmental oversight. Whilst it is acknowledged that the ICS model will be driven by the HSC, and that ultimately the budget will be the responsibility of the respective health partners involved, collaboration and partnership working with those within our sector, and beyond, is fundamental in achieving a truly integrated system.

Values and Principles

4.21 Section 5 set out the Values and Principles for the new model. The question asked for feedback and comments, along with suggestions for additional inclusions.

4.22 The key themes, messages and suggestions emerging from the responses include:

- Widespread support for the values and principles, in particular the inclusion of "ensuring the person is at the centre of the model, with the aim of achieving improved outcomes for individuals and communities".
- A signed partnership agreement/code of conduct would aid the establishment of mutual respect and compromise.
- Addition of "health literacy" to point 4 of the values and principles.
- Co-production should be explicitly referred to as part of the values and principles.

Departmental Response on Values and Principles

4.23 The Department acknowledged the suggestion to specifically reference co-production within the values and principles. The framework will be amended to include "adhering to the principles of co-production". As stipulated in the values and principles, all partners will work together to foster a culture of openness, transparency and trust.

4.24 The Department considered the suggestion of the inclusion of health literacy within the values and principles. This has been taken under consideration, and the framework will be amended to reflect this.

4.25 The framework document notes the requirement of a partnership agreement, and that this will be the responsibility for local areas to develop. Additional guidance will be developed to help inform and support local areas in developing these agreements.

Strategic Direction and Ministerial Role

4.26 Question 3 of the response document referred to the role of the Minister and Department within the model, specifically, the setting of the overarching strategic direction and the expected outcomes to be achieved, whilst holding the system to account. Respondents were asked if they agreed or disagreed with the role detailed within section 7 of the framework.

4.27 Of the 98 respondents who provided an answer, 86% agreed with the role of the Minister and Department within the model. It was expressed in a number of responses that the Minister and Department be recognised in leadership positions within the model in order to drive the model forward.

4.28 Key themes, messages and suggestions which emerged from the responses include:

- A number of respondents noted the need for cross-departmental cooperation, particularly the involvement of the Department of Communities as a key partner.
- A number of respondents welcomed the development of the Strategic Outcomes Framework with key representative groups. Some respondents sought clarity on how the population profile and the Strategic Outcomes Framework will be developed.
- There were queries if the Department would use involvement principles in setting Strategic Direction to ensure people with lived experience had a view.
- A number of respondents welcomed further information on some of the detail around what quantitative and qualitative data will be included in the population health profile, and who would be involved in its development.
- Clarity was sought on the definition of "a population" within the framework, specifically to clear confusion if this could mean geographical area or local government boundaries.
- Clarity was sought around what would inform the Minister and Department's strategic direction.
- There were suggestions that a plan should be in place to prevent a postcode lottery from occurring, which was also raised under the direction of travel.

Departmental Response on Strategic Direction and Ministerial Role

4.29 The Department noted clarity was sought around the definition of "a population" within the framework document. The term 'population' can mean different things depending on the

specific context. For example, each outcome in the Strategic Outcomes Framework will relate to the condition of health and wellbeing we want to improve for the NI population as a whole (known as 'population accountability'). Separately, for the purposes of this framework, when referring to a local population, there are 5 local 'Areas' which are determined in line with existing Trust geographical boundaries. However, within these Areas, there may be smaller local populations, specific to certain demographics or smaller geographical areas, with an identified need to be addressed.

4.30 The Department acknowledged a number of references to the prevention of a 'postcode lottery' within responses to this question and a response to this has been detailed at paragraph 4.16.

4.31 A number of respondents sought clarity on what would inform the strategic direction and the use of involvement principles. The strategic direction will originate from the health and wellbeing needs of the population. This will be assessed initially via a population profile based on official data and statistics as well as any qualitative information available.

4.32 A dedicated Strategic Outcomes Framework workstream with a sub group focusing on Data, Outcomes and Engagement has been established and continues work on the draft strategic outcomes and forming the population profile.

4.33 A full programme of engagement has been designed with the advice and support of the Patient and Client Council and Integrated Care Partnership Programme Team in order to reach out to key citizen hubs and gather insight that will contribute to the design of strategic outcomes that reflect the health and wellbeing needs of that population. It is the intention to have an initial draft of the Strategic Outcomes Framework developed in early 2022.

4.34 Work is underway to identify the data and health intelligence requirements of the ICS once it has been established. In addition, work is ongoing to identify the best planning and reporting processes to be implemented throughout the system to best enable both the development of the strategic direction and inform the monitoring and reporting of systems' performance at all levels.

Autonomy and Accountability at a Local Level

4.35 Section 8 of the framework sets out what the ICS model will look like when applied to Northern Ireland. Respondents were asked if they agreed or disagreed with the shift of autonomy and accountability to local ICS arrangements.

4.36 Of the 94 people who answered the question, 89% agreed it was the right approach.

4.37 Key themes, messages and suggestions emerging from the responses include:

- Many respondents welcomed the consideration given to Community Planning, noting structures at a local level should align with Local Government Districts and Electoral Areas.
- A number of respondents noted the increased flexibility and efficiency within the proposed model in addressing health issues.
- Some responses highlighted concerns that additional tiers would increase the level of avoidable bureaucracy.
- Clarification was sought on how the work of the ICS will be influenced by locality and community levels.
- A number of respondents queried where the budgets are held, and who is responsible for the administration of the system.
- Many respondents aired caution around the potential for, and mitigation against a 'postcode lottery' which was mentioned in previous chapters.
- It was suggested that a feedback system for monitoring and evaluation would be essential.
- Clarity was sought by a number of respondents as to how the local and regional group representatives will be appointed. It was noted this should be in a uniform way with open opportunity for people across multiple sectors.
- Some respondents proposed the need for a robust governance and accountability structure, aided by a two way flow of communication between the Regional, Area, Locality and Community levels.

Departmental Response on Local Autonomy and Accountability

4.38 Clarity was sought on how the work of the ICS would be influenced by locality and community levels. As the framework outlines, the exact number and role of locality and community structures is still to be determined. The framework highlights that these should be feeding

into the work of the Area level by informing and influencing strategic planning, and actively promoting inclusion of third sector organisations, communities and the wider public sector.

4.39 Some initial exploration with stakeholders around the role of the locality and community level suggests those levels of the ICS should be developing an in depth understanding of local communities, mobilising the local community, gathering local intelligence to feed back to the AIPB and sharing their learning to ensure a connection across the whole ICS.

4.40 With regards to the holding of the budget and the accountability for system administration, as outlined within the framework document, there would be no substantial changes proposed to current financial models in the first instance. Work is being progressed to develop a new funding model for ICS NI. An initial research study has commenced into potential funding models to support an integrated approach and their suitability in a Northern Ireland context.

4.41 The Department acknowledges that additional clarity is sought as to the appointment of representatives to the local and regional levels of the model. Work is currently underway to provide further detail and guidance on both local and regional levels of the ICS which includes exploration of how members will be appointed. This includes assessment of existing approaches and practices, such as how members are appointed to current structures such as LCGs and ICPs. Further detail will be provided in due course.

4.42 It is also acknowledged that responses included references regarding concerns over additional bureaucracy. The Integrated Care System model will look to promote collaboration and partnership working, across sectors and traditional organisational boundaries, in order to work to identify and remove any barriers and unnecessary bureaucracy in our system. The Department also addressed concerns around bureaucracy in paragraphs 4.14 and 4.15.

Regional Group

4.43 The Regional Group was outlined in sections 8 and 9 of the Draft Framework. Question 5 in the response template asked respondents if they agreed with the establishment of a Regional Group to undertake an oversight, coordination and support function within the ICS model.

4.44 Of the 91 people who answered the question, 95% agreed this was the correct approach and a Regional Group should be established.

4.45 The key themes, messages and suggestions which emerged from the responses included:

- A number of responses queried the representation of the group, indicating it should include cross sectoral representation beyond the health service, including across government departments and the community and voluntary sector.
- Concerns had been raised around other areas of representation, such as Allied Health Professionals, social care, education and pharmacy.
- There was widespread encouragement that a clear governance and accountability structure would be required, with clarity around reporting mechanisms and delivery. The feeling across respondents was that another Regional Group would add duplication and excess bureaucracy.
- A number of respondents queried if the Regional Group will be able to explicitly or covertly overrule an AIPB.
- A number of respondents raised queries around workforce, and if this is to be incorporated within the remit of the Regional Group, meaning it would be cross sector.
- Some respondents queried the need of a two-way system for sharing local data of lived experience, needs and priorities back to the Regional Group, to help influence a decision making process.
- The Regional group should take its lead on priorities from the regional networks such as diabetes and stroke.
- The role of the Regional Group should also include setting the strategic direction, priority areas for improvement or change, enablers such as workforce, and infrastructure.
- The role of the Regional Group should include regional and specialised services as these would be too heavy for an AIPB.
- There was a suggestion that the four levels could be reduced to two or possibly three whereby the Regional and Area levels combine leaving no need for five AIPBs. In alternative, a three level structure of Regional, Area and a combined local/community.

- It was noted that the statutory requirement to have a Health representative from commissioning within community planning, and if this representative would be assigned to Regional or AIPB level.
- Clarity was sought around the process for sharing data with the Regional Group to influence and join up a decision making process.

Departmental Response on Regional Group

4.46 Regarding the membership of the regional group, it is important to note that each AIPB will be a key member, acting on behalf of the full AIPB membership which will include various partners, professions, and third sector peers. Cross-department involvement is agreed as important and further work will be undertaken to consider how best this can be achieved. There is a need to identify an effective membership while avoiding creating a large unwieldy group.

4.47 In relation to the concerns raised around the regional group overruling AIPBs, the Department would consider such a relationship as counter-intuitive of the integration approach. Experience shows us that such a relationship did not work in the past and therefore the new arrangements need to be different, built on new ways of working which is why AIPBs, the area/local component of the ICS, will have a key role at the regional level.

4.48 Following queries on the inclusion of workforce, the Department recognises the importance of the workforce agenda in addressing the challenges of the health and social care system, and it will require a regional focus to align workforce training and qualifications to the needs of the population.

4.49 Regarding the setting of priorities, the regional group, like other parts of the ICS, will be informed by the Strategic Outcomes Framework., The key principle is that there is one planning system working collaboratively together on agreed outcomes, with clarity on roles and responsibilities.

4.50 The Department acknowledges that a number of responses referenced concerns that the new model would increase bureaucracy and administration. The ICS model will look to promote collaboration and partnership working, across sectors and traditional organisational boundaries, in order to work to identify and remove any barriers and unnecessary

bureaucracy in our system. The Department previously addressed concerns surrounding bureaucracy in paragraphs 4.14 and 4.15.

4.51 With regards to the statutory requirement to have a health representative within community planning, key to the model will be building partnerships with stakeholders from other sectors. One of these will be Local Councils and our partners in Community Planning and engagement has begun on the best approach to adopt.

4.52 Our model will look to align and integrate with the work of Local Councils where it is appropriate to do so. It is also worth noting that the statutory requirement for health representation in community planning does still remain with both HSC Trusts and the PHA named in current regulations.

AIPB Establishment and Role

4.53 Within the Draft Framework, the establishment of five Area Integrated Partnership Boards is outlined, the purpose of which is to deliver improved outcomes at a local level. Sections 8 and 10 within the framework provided detail on the local levels of the model and the role of AIPBs.

4.54 Within the response template, question 6 asked respondents if they felt the establishment of AIPBs was the right approach to deliver improved outcomes. Of the 92 respondents who chose to answer the question, 91% agreed this was the right approach.

4.55 The key themes, messages and suggestions which emerged from the responses include:

- There was widespread agreement that AIPBs should be established, and the learnings from current LCGs would be important.
- The establishment of AIPBs will foster a culture of sharing and collaboration between the key stakeholders involved.
- Concerns were raised about the potential for the five AIPBs to cause a "postcode lottery".
- Clarity was sought on how these new bodies would interact with existing structures, in particular 3rd sector partners.
- Concerns arose around the infrastructure and resources required to support AIPBs
- Queries arose around the systems to ensure that data is valid, up to date and credible.
- The board level of the AIPB appears dominated with service providers, with a lack of equality given to community and voluntary, local council, and service users and carers.
- Clarity was sought around the Terms of Reference for the AIPBs and how they operate.
- Clarity was sought around the role of the AIPB in setting or redirecting budgets set to them from a Regional level to meet priorities. The new funding model will ultimately be underpinned by a funding approach that will put local areas in control of a budget for their population.

4.56 Question 7 then queried if respondents agreed that the AIPBs should have responsibility for the planning and delivery of services within their area. Of the 94 respondents who chose to answer this question, 93% agreed that responsibility should sit with AIPBs.

4.57 The key themes, messages and suggestions which emerged from the responses were:

- A large number of responses aired caution around the creation of a "postcode lottery" where different versions of the same service get commissioned in different areas.
- A number of responses sought clarity about the exact responsibilities and resources AIPBs will having regarding their local workforce.
- A number of respondents sought clarity around locality level structures and community level structures, and how representation at each level is decided.
- Clarity was sought around the position it leaves Trusts in terms of management, accountability, service delivery, and contracts of employment.
- Queries were raised around how the current proposal delivers on the principle of parity and inclusion between partners.

4.58 Question 8 asked respondents if they agreed that AIPBs should control the budget for delivery of care and services within their area. Of the 91 respondents who chose to answer this question, 89% agreed that budget control should sit with an AIPB.

4.59 The key themes, messages and suggestions which emerged from the responses were:

- A large number of respondents noted the importance of transparency within funding streams.
- There was widespread agreement that budgets must allow for longer term planning, in particular a 3/5 year plan.
- A number of respondents noted the importance of AIPBs holding budgets, as this otherwise risks delaying the transfer of responsibility and control.
- A query was raised asking what opportunities there would be for income generation.
- A number of respondents suggested using a mechanism to ensure consistent provisioning of services within AIPBs, avoiding a "postcode lottery" of access to services.
- Caution was aired around budgetary decisions being driven by cost effectiveness and efficiency, or deprioritised to ease financial strains. Work is being progressed to develop a new funding model for ICS NI with associated governance and accountability to aid decision making and provide the best outcomes for the population.

Departmental Response on AIPB Establishment and Role

4.60 The Department acknowledges the comments which raised concerns around a 'postcode lottery'. These comments have been considered within previous questions and a response on this issue is noted under paragraph 4.16.

4.61 It was acknowledged that clarity was sought around the way in which new structures would interact with existing ones, specifically the third sector partners. The third sector will be pivotal partners within the ICS. Initial discussions are underway through the ICP Third Sector forum to explore mechanisms for the sectors' involvement in the further development and implementation of the model. The sectors views will be central to the development of additional guidance which DoH will issue on how AIPBs should be established and how they should operate.

4.62 The Department acknowledges the concern around the infrastructure and resource to support the AIPBs and that there will be a requirement for ongoing support for the development, implementation and operation of the new model. Work is underway to understand the resource required to implement the model, including identification and assessment of existing resources. It is anticipated that a specific support lead will be established for each AIPB and work has commenced on this aspect.

4.63 It is recognised that additional guidance will be required to support the implementation of the ICS model at all levels. Work is underway to work with partners to identify the key areas which guidance should cover and to develop that guidance in a collaborative way. It is likely that guidance will relate to – operating procedures, partnership agreements, governance and accountability arrangements, decision making frameworks and good practice in co-production.

4.64 A number of respondents sought clarity around local level and community level structures, and how representation at each level is decided. As outlined within the framework the exact number, role and membership of these groups is still to be determined. Initial exploration with stakeholders around the membership of these structures noted that those appointed should have strong leadership skills with strong connections in their sector or organisation. The Chair role was also noted as crucial, and this has been acknowledged and will be considered further.

4.65 It is acknowledged that representation on an AIPB raised some concerns. As many of these concerns were echoed within later questions, these have been reflected and responded to accordingly under the next section of this document. The Departmental response around issues of membership can be found at 4.79.

4.66 Some respondents sought clarity on the role of Trusts, specifically their position of management, accountability, service delivery and contracts of employment. Trusts are named partners within the ICS model, however for clarity they will continue to operate as existing statutory bodies. As detailed in the framework each organisation and body involved in the model will have existing governance and accountability structures, mechanisms and obligations, including those set out in statue. Statutory and contractual obligations must continue to be met and adhered to.

4.67 The Department noted the query regarding the delivery of the principles of parity and inclusion. It will be the responsibility of all partners involved in the ICS model to adhere to the values and principles set out within the draft framework, including those of parity and inclusion. Further work will be undertaken to provide additional guidance on the development of certain aspects of the model which will look to support and enable partners to adhere to the values and principles, such as guidance on the development of partnership agreements and decision making frameworks.

4.68 It is important to note that leadership and the behaviours demonstrated by partners will be critical to developing a model that works in practice. Supporting the development of collaborative leadership skills and developing an enabling culture for the ICS will be crucial to its success. Work is underway with the HSC Leadership Centre to design a programme of leadership and development support to underpin the ICS.

4.69 The Department acknowledged a number of queries arising around budgets and finance. Work is being progressed to develop a new funding model supports an integrated approach. We must ensure money reaches the right place to deliver the maximum health outcomes for service users and local populations. This must be done in a way that is fair, sustainable and deliverable. The development of a funding model is extremely complex, work has commenced on a research exercise into appropriate funding models and their suitability in a Northern Ireland context.

AIPB Membership and Chairmanship

4.70 The Draft Framework also outlined the proposed minimum membership for the AIPBs along with appointing of initial chairmanship. These were outlined in Section 10, with some additional context provided in Annex A of the document.

4.71 Within the response template provided, Question 9 asked respondents if they agreed with the proposed minimum membership outlined for an AIPB. Of the 91 respondents who chose to answer the question, 62% agreed with the minimum proposed membership.

4.72 The key themes, messages and suggestions which emerged from the responses include:

- Some responses asked for clarity around the AIPB membership process, specifically if it will be a fresh process or would priority be given to ICP & LCG current members.
- A large number of respondents commented on the membership list, noting the need for increased representation from various sectors. Some of the suggested inclusions for the membership were:
    - Increased number of community and voluntary sector
    - People with lived experience
    - Allied Health Professionals
    - Political representation as minimum
    - Local Council representative as minimum
    - Director for specialist services such as children's services, mental health services and learning disability
    - Trade Union representatives
- Suggested consideration given to user advocacy groups such as established user forums.
- A number of respondents highlighted the need for overarching guidance to ensure consistency.

4.73 Question 10 within the response template asked respondents if they agreed with the concept that initially each AIPB should be co-chaired by the HSC Trust and GPs. Of the 93 respondents who chose to answer the question, 71% agreed this is the correct initial approach.

4.74 The emerging themes, messages and suggestions from the responses submitted include:

- Some respondents felt that this is a good initial preparatory approach, though through time as the AIPB matures the chair would be open to all members of the board.
- Some responses welcomed the Health Sector taking the lead in the issue with resources, information and expertise, and that this initial appointment is a stepping stone to broader partnership.
- Some respondents raised concerns over reserving a co-chair role for a GP as opposed to an Allied Health Professional.
- A large number of respondents suggested an independent chair be appointed.
- A number of responses queried if this opportunity could be extended to service users, or a representative from the community and voluntary sector.
- Some responses sought clarity should there be a conflict of interest where chairs also have responsibility for other high profile roles.
- It had been suggested the appointment of a chair should be based on merit, with recognition of the skills required to manage the AIPB through its initial set up period.

Departmental Response on AIPB Membership and Chairmanship

4.75 It has been recognised by the Department that one of the main areas of feedback received among responses is the outlined minimum membership for an AIPB. The Department is grateful for the feedback in this area and will take this into consideration and use it to inform further thinking on what the minimum membership should be.

4.76 The Department acknowledges concerns that one representative from Community and Voluntary does not provide accurate representation from such a diverse sector, and as such work is being progressed with the ICP Third Sector Forum and a Service User Group to inform how representatives on AIPBs from these sectors are supported and provided with the appropriate mechanisms to enable effective representation. It is important to also note that the framework provides for the minimum membership and it will be for each Area to determine any additional membership required based on their local needs.

4.77 It is useful to note the framework lists requirement for a lead from each Community Planning Partnership from within the AIPB area. The Department notes that each CPP includes representation from local elected representatives, and rather than duplicate membership of existing groups, the proposed approach ensures that strong links and mechanisms for input

and involvement remain by allowing for a more streamlined and aligned mechanism for securing local community planning input to the planning process via their existing structures.

4.78 Further engagement is planned with partners in local councils and CPPs which will further inform how the ICS model will ensure the necessary and appropriate partnership working and collaborative approaches with these partners are developed moving forward.

4.79 The Department also recognises the significant role that AHPs have within the wider HSC system. It is proposed that a lead AHP representative also be included as a named member of AIPBs and the framework will be amended to reflect this.

4.80 As outlined at 4.76, the Department notes the membership list is not exhaustive and intended as a minimum requirement only. Each AIPB may consider additional memberships, either permanent or on an ad-hoc basis as they deem appropriate, for example from specific specialisms, professional bodies or local bodies.

4.81 The Department also recognises concerns noted around the initial Chairmanship position suggested for an AIPB, and will give further consideration to the proposed Chairmanship of AIPBs in light of this feedback. Any agreed changes will be reflected in the framework in due course

Locality and Community Level Membership

4.82 Section 10 of the framework outlined that memberships and arrangements for groups at locality and community levels should be the responsibility of the AIPBs to develop, determine and support.

4.83 Question 11 of the response template asked respondents if they agreed that the responsibility should indeed fall to the AIPBs. Of the 90 respondents who answered the question, 84% agreed AIPBs should hold this responsibility.

4.84 The key themes, messages and suggestions which emerged from responses include:

- A number of respondents noted a shared best practice between AIPBs would establish consistency.
- A number of responses praised the increased agility and responsiveness this would enable at a local level.
- A large number of respondents felt that locality and community levels should be amalgamated into one level.
- There was a number of responses who felt the membership of these levels should be set by the AIPB, but should include adequate Allied Health Professional, service user and carer representation.
- Concerns were raised that the additional levels increased bureaucracy.
- It was queried how the new model would ensure local people are involved in the decision making process.
- Some responses suggested the need to include safeguards to ensure membership is reflective of a balance between primary and secondary care.

Departmental Response on Locality and Community Level Membership

4.85 The Department acknowledged a number of responses which aired caution around an increase of bureaucracy and administration. This was directly addressed under paragraphs 4.14 and 4.15 earlier in the document.

4.86 The Department acknowledge suggestions of merging locality and community levels. This suggestion was raised in an earlier section, and the Department's response on this can be found at paragraph 4.15.

4.87 Queries around the involvement of local people in decision making arose. References throughout both the framework and this response document regarding co-production is the heart of this approach. A broad range of stakeholders are already represented across the various workstreams and within project structures, with ongoing and future engagement around the various aspects of the models development.

4.88 Work is also underway with the voluntary and community sectors, service users and carers specifically on co-production and PPI to identify and explore mechanisms to foster ongoing involvement of these key stakeholders going forward.

4.89 As outlined in the framework document, the exact number, role and membership of the groups at these levels is yet to be determined. It is acknowledged in the responses that this needs to be in an open and transparent way. As such work is underway to develop guidance to better support a consistent approach and appropriate representation.

Next Steps

- The Department will work to take account of feedback outlined within the response document to develop a further draft of the framework for publication in early 2022. This will be considered a live document and ongoing work will continue to help shape the final product.

- Work continues to be progressed under the various workstreams of the project as outlined earlier in the document. This work will produce further guidance and policy direction with regards to the development and implementation of the ICS model as we move forward. Stakeholders will continue to play a pivotal role in this work.

- Work will also be commenced in early 2022 to develop regulations to underpin the local area of the new model, and as acknowledged earlier in this document, the adjusted timelines will be reflected within the framework in due course.

Appendix A - Engagement Events Feedback and Poll Results

- The two workshops were held on 3rd August and 3rd September via Zoom to promote the framework which would hopefully translate into formal responses, and receive initial feedback from stakeholders while providing an opportunity to raise initial queries.

- A presentation was led by Martina Moore at the event on 3rd August, and a similar presentation delivered by Paul Cavanagh at the September event. Attendees were then divided into breakout rooms to allow some additional discussion, guided by questions to gauge initial feedback on the framework. In the case of each question to guide discussion, a top 5 was sought from each room to be reported back when the breakout rooms ended. The questions were;
  - What do you see as the benefits / opportunities this proposed model could bring?
  - What do you see are the main enablers to make this ICS model effective?
  - Are there any other key messages about the framework?

  The top 5 themes reported back regarding each question are detailed below.

  Top 5 Benefits / Opportunities brought by the model:
  - Cultural change
  - Local autonomy, authority and flexibility to deliver
  - Focus on outcomes
  - Build on the work of ICPs and making sure knowledge and learning is carried over
  - Welcome focus to address health inequalities

  Top 5 main enablers to make the ICS effective:
  - Robust, accessible and meaningful data
  - Involvement and influence from the community and voluntary sector
  - Effective leadership
  - Co-production of priorities
  - Digital solutions to enable sharing of data across boundaries and organisations

  Top 5 other key messages:
  - This will take time to establish, timescales are challenging
  - Clarity of governance and accountability
  - Role of PHA
  - Concerns about a ‘postcode lottery’
  - Role of the independent sector

- At the end of the sessions, attendees were asked to respond to a poll consisting of 3 questions around the event. The questions asked if attendees agreed, disagreed or needed more time to consider. The polling questions and results were;
  - Following today's event I now have a better understanding of the ICS model proposed within the framework.
  - Following today's event I / my organisation will intend to submit a response to the consultation
  - The ICS model laid out in the framework is the right approach to adopt in NI.

- The results of the polls held are included in the below table.

End of event poll results for 3rd August 2021 – Total attendees which responded to the poll: 58			
	Agree	**Disagree**	**Need to consider further**
Better understanding of ICS model	93%	7%	N/A
Intend to submit a response	81%	0%	19%
This is the right approach for NI	59%	0%	41%

End of event poll results for 3rd August 2021 – Total attendees which responded to the poll: 37			
	Agree	**Disagree**	**Need to consider further**
Better understanding of ICS model	95%	5%	N/A
Intend to submit a response	70%	5%	24%
This is the right approach for NI	78%	3%	19%

Appendix B - List of Respondents to Consultation by Organisation

HSCNI	Community Pharmacy NI	Northern Ireland Housing Executive
Parenting NI	Cancer Focus NI	South Eastern Integrated Care Partnerships, HSCB
HSCNI	Institute of Public Health in Ireland	Long Term Conditions Alliance NI
Derry City and Strabane District Council	British and Irish Orthoptic Society	Independent Health Care Providers (IHCP)
NICRCF	Stroke Association	Belfast ICP's - HSCB
Beat	Sinn Fein	Information Commissioners Office
Ards and North Down Borough Council	RCGP NI	Marie Curie
HSCNI	The Confederation of Community Groups	British Association of Dramatherapists NI
BHSCT	Community Development & Health Network (CDHN)	Teva UK Ltd
Lymphoedema Network NI	Guide Dogs NI	West Belfast Partnership Strategic Health Group
Nexus NI	Northern Integrated Care Partnerships	Northern Ireland Chest Heart & Stroke
Lisburn and Castlereagh City Council	Royal College of Podiatry	Red Cross
Western Federation Support Unit	Cedar Foundation	Western Integrated Care Partnerships
MindWise	Fermanagh & Omagh District Council	Versus Arthritis
British Dietetic Association NI Board	Ulster Farmers Union (UFU)	NIPEC
WHSCT	International Foundation for Integrated Care - Ireland	Royal College of Nursing
Impact Network NI	Age NI	Mid Ulster District Council
Developing Healthy Communities	Royal College of Speech & Language Therapists	Barnardo's
NHSCT	NILGA	South Eastern LCG
Business Services Organisation (BSO)	National Pharmacy Association	The Resurgan Trust

Badoney Development Partnership	Advice NI	All Ireland Institute of Hospital and Palliative Care (AIIHPC)
Belfast Healthy Cities	Royal College of Midwives	Co Down Rural County Network
ME Support NI	Belfast Trust	South Eastern Healthy Living Alliance - Members of the Healthy Living Alliance
Rural Support	Armagh, Banbridge & Craigavon Council	NI Neurological Charities Alliance c/o MS Society
The College of Optometrists	SEHSCT	Royal College of Psychiatrists NI
Omagh Forum for Rural Association	Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC)	Women's Regional Consortium
North Coast Community Transport	Stronger Together Network	Equality Commission for NI
Belfast City Council	NHSCT	NSPCC
East Belfast Community Development Agency	SHSCT	Pharmacy Forum NI
Brown O'Connor Communications	WHSCT	Diabetes UK
Mid & East Antrim Borough Council	Society of Radiographers	Epilepsy Action
BMA, Cymru Wales	NIPSA	Rural Community Network
Women's Resource & Development Agency	NIADA	Optometry NI including NI Optometric Society (NIOS)
BDA	RCPCH	Healthy Living Centre Alliance
Action for Children	UNISON	Upper Andersonstown Community Forum
Association of British Pharmaceutical Industry	Royal College of Occupational Therapists	ARC
Extern	BASW NI	Derry City and Strabane District Council
Centre for Independent Living	CSP	
NHSCT	PCC NI	

There were a total of 7 responses received from independent parties. These included carers, independent GPs and those who preferred not to say. These have been omitted from the above table for GDPR reasons.