Northern Ireland Rural Women’s Network (NIRWN)

Response to Proposals for Health and Social Care Reform

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1.0 Introduction

Northern Ireland Rural Women's Network (NIRWN) is a regional network established to articulate the voices of women in rural areas. It is jointly funded by Department of Agricultural and Rural Development (DARD) and Department for Social Development (DSD) under the EU BSP Programme.

NIRWN has four key objectives:

- developing weak community infrastructure in areas where little or no community based rural women's groups exist,
- increasing rural women's capacity and opportunities to influence decision-making and policy formulation,
- running Northern Ireland wide communication campaigns with a local focus, highlighting the value of rural women's contribution,
- offering a training and capacity building programme to rural women across the region.

NIRWN through its policy work strives to highlight the inequalities that rural women face. The last census showed that almost 35% of Northern Ireland's population live in rural areas. We welcome the opportunity to comment on the Proposals for Health and Social Care Reform.

Policymakers face a number of challenges when addressing health inequalities. Ensuring that strategies tackle the macro environmental factors that feature in policy on inequalities in health, and to ensure that health becomes a prominent issue in a social justice policy. The root causes of inequalities in health are the complex interaction between personal, social, economic and environmental factors. This means that a broad-based policy is required to tackle inequalities in health. NIRWN welcomes that public health is at the centre of policy and strategy within the new proposals. We welcome the commitment to tackle the underlying causes of poor health.

NIRWN would like to see specific policies addressed through the new proposals to improve the health status of rural women in Northern Ireland through gender focused policies. Current inequalities and inadequacies in, and unequal access to health care and related services; such as caring responsibilities, stereotyping, flexibility, cultural, low pay, disability and inaccessible transport need to be addressed through gender proofing services and policies related to health and social care provisions.

Inequalities Monitoring System (IMS) 2007 report highlighted a number of inequalities that exist for the rural population:

- For all health and social care facilities with the exception of hospitals providing learning disability inpatient services, the average access

time from rural areas was more than 40% worse than for Northern Ireland generally

- Although the relative inequality gaps in access time in both deprived and rural areas have generally decreased in recent years, the gaps that exist are still reasonably large
- In 2006, a person aged under 75 years of age, living in the most deprived areas was 40% more likely to die than a similar person living in Northern Ireland overall. Males and females aged under 75 living in deprived areas were 42% and 36% respectively more likely to die than overall males and females in Northern Ireland
- Access times to all types of facilities are longer from rural areas than non-rural areas, with access to Opticians from rural areas almost three times as long as from non-rural areas
- The average response time to incidents in rural wards is 7 minutes greater than to incidents in non-rural wards.

The rural dimension to the problems associated with accessing services are greatly exacerbated for rural women in terms of having caring responsibilities, flexibility, cultural, low pay, disability and inaccessible transport. It is recognised that people living in rural areas experience difficulties with regard to the provision of services and accessing such services. For some services, patients are required to travel long distances to attend appointments or consultations. This problem does not exist to the same degree in urban areas.

2.0 General comments

2.1 Gender representation

A new Regional Health and Social Care Board that will focus on financial management, performance management and commissioning.

NIRWN would like to take this opportunity to stress the importance that the make up of the board is gender representative, considering that women constitute more than half of the population of Northern Ireland, gender representation across all health and social care boards is essential.

2.2 Performance Management

A critical issue identified in the independent review of health and social care services in Northern Ireland completed in 2005, was the absence of clear accountability arrangements. The existing HPSS performance management system was characterised as centrally-driven within a hierarchically-managed organisation Appleby (2005).

Performance management, mechanisms need to be put in place to ensure effective service delivery. Over and above the need to track spending for reasons of financial probity, the main performance policy monitoring focus should be on tracking outcomes, not spending per se. The new proposals state ‘ performance management and improvement to ensure the delivery of

targets, objectives and standards set by the Minster'. We would envisage that performance management design and planning would be achieved best through a consultation process involving users, carers and community and voluntary sectors.

2.3 Engagement

NIRWN welcomes that 'patients, clients and carers must be given the opportunity to voice their concerns and be sure that they are listened to. Engagement should be a statutory function, and should also involve wider communities in the planning and delivering of services. The point of engagement needs to be clarified under the new proposals.

2.4 Rural proofing and gendering proofing of Health and Social Care Services

The service must be centered on the needs of patients, clients and carers' given that 35 %of NI population is rural based it's essential that services are rural and gender proofed to ensure that the needs of those accessing services are considered.

2.5 Social model of health care

NIRWN welcome that new structures will be based on prevention and primary care. A system geared towards improving health for all and reducing health inequalities would have to comprise measures to tackle the underlying causes of ill health, promote better health, prevent illness and intervene early in the development of life-limiting and life-threatening diseases. Coote, (2004). NIRWN advocates the need for a social model of health.

Democratic Unionist Party (DUP) health spokesperson, Iris Robinson, at her party's 2006 conference. Ms Robinson said: 'The social model of health isn't just about disease and illness. It also emphasises the environment, education, employment, poverty and housing among other factors. The health of any individual is a product of social, interpersonal, psychological and environmental factors, and is not simply a medical matter'.

It has also been the basis of Scottish health policy under devolution since the publication of Our National Health by the Scottish Executive (2000), as one former senior health official put it, public health has become 'the day job' for the health service and local authorities there, with the emphasis within the NHS tilting towards primary care and prevention.

Wilkinson and Pickett (2006) found that nearly three quarters of 168 studies found a relationship between the health of citizens and income inequality. This relationship was stronger still as one moved from local to regional to national studies, suggesting that class structures, coming more clearly into view as the scale enlarged, were the key determinant.

Stronger emphasises on how the new structures will address health inequalities needs to be incorporated.

2.6 Community Development

It is essential to integrate community development through all health and social care work. Under current proposals responsibility will sit with RPHA. Women living in rural areas experience multiple social problems for example, lack skills and qualifications, isolation, living on a low income and coping with difficult personal and other circumstances. A community development approach to health and wellbeing seeks to work upstream, concentrating on the root causes of ill health and giving individuals more control over their own health and wellbeing.

There is a need for effective community based services with a special focus on managing chronic conditions and the problems associated with disadvantage. In addition, many services currently delivered in the hospital should be available in the community setting with appropriate linkages to specialist support.

A two year study carried out by the charity the Sainsbury Centre for Mental Health and the National Institute for Mental Health in England considered the impact of community based mental health teams. Apart from improving engagement, the study revealed that the community based services approach reduced the number of hospital admissions and offered a wide range of help from assistance with medication and doing everyday tasks to guidance on education and employment.

2.7 Local Commissioning Groups (LCGs)

Genuine lay representation on Local Commissioning Groups is essential. Under the new proposal the lay representative is reduced from 2 to 1. NIRWN welcomes the representation of local council, however in order to ensure that an appropriate representation is achieved, the lay representation is increased to 2 as outlined in the original proposals. The Council representation should not substitute the lay representation.

The process of appointments to the LCG is not clear. Will this be achieved through a public appointments process? Again NIRWN advocates the need for gender representation on LCGs.

The new local authorities to be established following the Review of Public Administration should be given a power of general competence, to allow a role in public health locally. Allied to community planning, this should be seen as central to their exercise of civic leadership. This would allow for a more 'joined-up' approach between health and local government. Contained in the Executive Summary it states 'that account has been taken on other models in England, Scotland and Wales'. In Scotland, the powers of well-being and community planning conferred on local authorities have been used to good effect in co-operation with the health service, for example between the council

in West Lothian and the Lothian NHS, to the extent that a £160 million joint budget is administered by the West Lothian Community Health Partnership (CHP). With local targets driven by the community-planning process, in the context of national priorities, the CHP has focused on prevention in terms of children and older people, teenage pregnancy, local diagnostics and care of cancer, innovative models of self care, and healthy eating and food distribution.

We welcome that the commissioning functions of the Regional Health and Social Care Board will have 'strong links with local communities, with voluntary and community sector organisations and the engagement of communities in securing the health and well being of their people'.

Northern Ireland's voluntary sector has much to be proud in the delivery of health services. Oliver (2007). Ballybeen Women's Centre, for example, has achieved much on health issues, having found through a local survey on the suburban Belfast working-class estate high levels of mental ill health among women, related to dependency on anti-depressants and smoking-related illnesses.

The voluntary sector generates capillary networks in society which the public sector cannot match, and such networks of social support are key to our resilience and well-being, especially for the elderly, the disabled and predominantly women who care domestically for both. Coote (2004). The role of the community and voluntary sector is given insufficient attention in the new proposals.

2.8 Co-terminosity

NIRWN advocates the need for LCGs to have co-terminosity with other service provisions. The decision to have 11 councils will have an impact on the number of LCGs. The benefits of co-terminosity will be lost particularly those relating to commissioning if they are co-terminous with other statutory services. This is not made clear in the new proposals.

2.9 Commissioning and Service Delivery

Commissioning recognition of the differing needs of local populations is important, it's essential that the commission arrangements are based on local knowledge and expertise, that services are based on local community needs. We are however of the view that whilst commissioning bodies need to be small enough to assess local need, they also need to be representative in order to commission effectively.

One of the key functions of the Department of Health, Social Services & Public Safety (DHSSPS) 'are cross-governmental in nature (e.g. cross-governmental initiatives such as in *Investing for Health* and the cross-governmental children's strategy *Our Children Our Young People our Pledge* and wider regulatory responsibilities allied to the Medicines Act and Misuse of Drugs Act which go beyond health and social care). Clearer direction is

required that specifies how it will work with the Regional Public Health Agency.

We welcome that the Regional Health and Social Care Board will have its own legal entity, separate from government as much as possible and at the same time will have the ability to empower citizens to make decisions that affect their own health.

Regarding the Patient-Client Council, it is important that this structure is shaped and driven by service users and local community need. It should be an autonomous body with the right to commission reports without the direction of the DHSSPS.

3.0 Health and Social Services Council

Option 1 would be NIRWN's choice, with a single independent regional body, as we believe this would provide more consistency.

4.0 Summary of points

Gender and rural proofing services and policies related to health and social care provisions.

Gender representation across all health and social care boards is essential.

Performance management design and planning would be achieved best through a consultation process involving users, carers, community and voluntary sectors.

Engagement should be a statutory function, and should also involve wider communities in the planning and delivering of services. The point of engagement needs to be clarified under the new proposals. Will this be a statutory function?

NIRWN advocates the need for a social model of health.

Stronger emphasises on how the new structures will address health inequalities needs to be incorporated.

A community development approach to health and wellbeing which seeks to work upstream, concentrating on the root causes of ill health and giving individuals more control over their own health and wellbeing.

There is a need for effective community based services with a special focus on managing chronic conditions and the problems associated with disadvantage.

Genuine lay representation on Local Commissioning Groups is essential .The lay representation on LCGs is increased to 2 as outlined in the original proposals.

The process of appointments to the LCG is not clear. Will this be achieved through a public appointments process?

NIRWN advocates the need for LCGs to have co-terminosity with other service provisions. The decision to have 11 councils will have an impact on the number of LCGs. The benefits of co-terminosity will be lost particularly those relating to commissioning if they are co-terminous with other statutory services. This is not made clear in the new proposals.

The role of the community and voluntary sector is given insufficient attention in the new proposals.

The new local authorities to be established following the Review of Public Administration should be given a power of general competence, to allow a role in public health locally. Allied to community planning, this should be seen as central to their exercise of civic leadership.

The role of the community and voluntary sector is given insufficient attention in the new proposals.

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Clearer direction is required that specifies how DHSSPS will work with the RPHA.

Regarding the Patient-Client Council, it is important that this structure is shaped and driven by service users and local community need. It should be an autonomous body with the right to commission reports without the direction of the DHSSPS.