



Northern Ireland Council for Voluntary Action

# NICVA'S RESPONSE TO *A Healthier Future*

**March 2005**  
CONS: 444

## **1.0 Introduction**

- 1.1 NICVA (the Northern Ireland Council for Voluntary Action) is the umbrella body for the voluntary and community sector in Northern Ireland. It provides its 1,130 members with information, advice, training and support services on a wide range of issues, together with representation for the sector as a whole.
- 1.2 NICVA works to achieve progressive social change, based on equality and equity, working through a community development approach, to empower local communities to pursue their own needs and agendas.
- 1.3 NICVA welcomes the opportunity to respond to this consultation paper. We welcome this far-sighted strategy and its attempt to look ahead to the joined-up needs of tomorrow in ways which are creative and people-centred. We recognise the long and deliberative consultation process that went into the drafting of the strategy and which involved a wide range of people. This approach has clearly contributed to the holistic vision of the document. The sub-headings follow those set out in the consultation.
- 1.4 NICVA's Policy Manifesto, which is developed in consultation with our members, has a section dedicated to health, and states the following, which informs the rest of this response:

'The voluntary and community sector has a long history in a wide range of health issues as both an advocate and service provider. The services provided have covered the whole range from cancer services and respite care to mental health and hospice care. The sector believes that anti-poverty measures and education at a community level are the most effective ways of preventing illness and increasing the general health and wellbeing of society. Investment in the health development message through community and peer education and development programmes, and support for user-led self management programmes is a necessity if health is to be improved and spiralling health costs in acute services are to be reduced in the future.'

## **2.0 Investing for Health and Wellbeing**

- 2.1 This section provides a comprehensive overview of the current challenges. We welcome the key population health outcomes listed. We would welcome further detail on where and how this ties in to the existing Investing for Health programme.

## **3.0 Looking Ahead: a Changing World**

- 3.1 In addition to all the factors listed (box, p31), our future population will also have greater caring responsibilities, and this must be factored in to any strategy both in terms of carer support needs and the wider economic impact.
- 3.2 On page 34 the role of carers as part of the team is recognised, but not that of service users themselves. There continues to be a limited connection between health care providers and service users, while a greater level of participation would benefit both.

#### **4.0 Our Vision for the Future**

- 4.1 We welcome the vision and focus set out in this section, but would add that work done in a community setting must be done in partnership with the voluntary and community sector, in order to really reach into the community and to build on the good practice already in existence.
- 4.2 Engaging communities must also involve listening to communities – this needs to be a two-way exercise to be effective. Real change in many areas can best be achieved by addressing lifestyle, rather than purely medical solutions. Targeted frontline loading of finances into health promotion and relevant issues like obesity will lead to savings on acute services spending in the future. We would welcome clarification as to whether ‘any form of treatment or care’ includes mental health needs (para 3.3).
- 4.3 Can the health gap (para 3.5) ever be effectively reduced without tackling the wealth gap? The gap between what is earned by the lowest and highest earners in Northern Ireland is growing, and there continues to be no Anti-Poverty Strategy to tackle this.
- 4.4 We welcome the vision stated at para 3.7, however, there is no mention of services provided by and contracted out to the voluntary and community sector in the paragraphs on page 39. Providing services for communities at community level is something the sector has been doing successfully over a long period.
- 4.5 Flexible access to services is to be welcomed, and must be done efficiently in order to afford such services. The types of access described must also be sure not to isolate those who cannot benefit from them, as for many people face to face contact will be their only link to service providers. Integration with other key services should be more comprehensively considered, as multi-purpose, single point of access provision will make access easier for users and save money.
- 4.6 Regarding the issues of terminal illness and right to life, the time is ripe for a public, ethical debate on quality of life, before more and more cases make our headlines. Duplication of services due to sectarian issues should be recognised as wasteful (para 3.14) and this should be examined in light of *A Shared Future*.

- 4.7 Care must be taken that working conditions do not lead to a '2-tier' workforce with staff working for contracted out services being paid less. This is already an issue for some organisations that have been unable to retain staff as they cannot pay raises which have been given to public sector staff. Resourcing pressures will become more apparent as science and technology advance, and this should be planned for now.
- 4.8 Facilities (para 3.20) should be accessible both physically and in terms of hearing loops, translation provision etc. There is also a need for awareness training for all frontline staff in how to deal with disability and other equality issues. Commitment to accessibility should apply to both H&SS sites and multi-purpose or remote access arrangements.

## **5.0 Involving People: Caring Communities**

- 5.1 We welcome the commitment made in Policy Direction 4, and the recognition of the importance of effective public engagement to help design services that will truly meet need. However this needs to be real mutual engagement with mutual commitment, not a tokenistic move to encourage participation. It is good that appropriate support needs are recognised (para 4.7) as many service users will have such needs. One way of encouraging involvement and getting across important messages that has not been explored in this strategy is peer education. This has often proved effective in engaging those who would feel alienated by service providers and in communicating hard messages in ways in which they can be heard and understood. It has been particularly successful with young people, but would work just as effectively with other groups.
- 5.2 The list of potentially excluded people does not acknowledge migrant workers, and the recent case in Coleraine shows an obvious lack of strategy in this area.
- 5.3 Although we welcome the commitments to engaging with people and working with the sector, the idea of 'actively examining the scope for increasing the number and type of services that are delivered through the voluntary and community sector' rings hollow at a time when many organisations are closing due to lack of funding, and frontline services and programmes such as the Children's Fund are being cut. It is important to learn from previous arrangements such as Investing for Health Partnerships; however we would be interested to know how public involvement will develop in light of the Review of Public Administration. We would be interested in finding out more detail about the Public Involvement Steering Group proposed at 4.13.
- 5.4 Again the reference to the sector taking on areas of work (para 4.16) does not seem possible in the current funding climate. Community Development should be about allowing people to have a say and to interact; about enhancing not cutting services.

5.5 We welcome the sections about the relationship between Departments, agencies, education and the sector, however nowhere is the private sector mentioned – regulation in care homes continues to be a key issue. More focus should be placed on holistic health care services in a range of settings and active ageing.

## **6.0 Responsive Integrated Services**

6.1 We welcome the recognition of the need to cross all types of boundaries. As highlighted above, sectarian boundaries cost providers money which could be better directed into care provision.

6.2 Reference to access standards applying across both urban and rural areas needs to be linked to accessible transport, with routes and timetables that allow service users to actually get to facilities when they need them. Service provision in an integrated way in key venues would make this easier, as stated in 5.42, but again such a location would need to be accessible to all users. Co-location of services, while efficient and providing benefits to users must be thoroughly thought out and consulted on with the local community to ensure that no vulnerable group will suffer as a consequence. There is an ongoing need for the Department to liaise with the Department for Regional Development and transport providers to ensure access to centres, particularly in rural areas.

6.3 While we welcome the commitment to using all the potential of ICT to aid both professionals and service users, it must be remembered that many people do not have ICT access, and they would tend to be from the more vulnerable groups such as those on low income, older people and those in isolated rural areas. Any advances in ICT provision must not be to the detriment of such groups.

6.4 Reference to the growing health needs of an ageing population (5.50) needs to also look at tackling ‘bed-blocking’, as well as improving community care services and making them more accessible and affordable. We have concern about the idea of buying extra capacity from the private sector – surely the onus should be on increasing public sector capacity?

6.5 Whilst ensuring equality between women and men in health and social services is hugely important, not enough attention has been paid here (page 65) to other areas of equality eg race, disability, age, nor to multiple identity issues.

6.6 We support the involvement of carers, as their role is only set to grow in the coming years; however policy would also be better informed by involving service users in some of this work. Our Policy Manifesto calls for adequate respite systems for carers, and quality training, information and support services: “Carers’ unpaid work must not substitute or replace proper statutory and professional provision when it is appropriate. Carers should be assisted to understand their rights as well as their responsibilities, to know what to expect of a quality service and be able to engage with health professionals to achieve that.”

- 6.7 Supported housing should be based around the concept of lifetime homes and older people should be encouraged to remain in their own homes for as long as possible, with comprehensive care packages available easily and affordably. Older people's health care should be viewed holistically and they should be treated with dignity by professionals at all times.
- 6.8 Regarding emerging health problems such as obesity, prevention and promotion are vital. Again this can be achieved in many ways, via peer education and curriculum change for example, and it is only by targeting frontline spending that future crises can be tackled.
- 6.9 Recognising the valuable contribution to society that people with disabilities make is important and should be promoted by the Department, however it is vital to do this without being patronising, and being sensitive to language etc. The strategy recognises that 'this contribution is often limited by the exclusion of people with disabilities from aspects of daily life leading to significant disadvantages compared to the rest of society'. However it is not enough to simply be aware of this – the Department should promote disability rights both across Government and in public, and actively try to limit disadvantage.

## **7.0 Teams Which Deliver**

- 7.1 We welcome the recognition of the dedication and skills in the sector (para 6.2) but would like to see this reflected in funding priorities and areas such as pay inequalities – as noted above, when the Department raises the pay levels of its employees but does not build this in to funding for contracted-out services, it makes it difficult for the sector to retain staff.

## **8.0 Making it Happen**

- 8.1 We welcome the commitment to improving joined-up working and look forward to seeing this in practice. Community Planning can only be effective when the community itself is fully involved and respected in that planning process. It is worth noting that 'community' can mean both those who live in a specific area and also a community of interest such as older people, carers or those with a specific disability.