HEALTHY CITIES Belfast

Working together for a healthier Belfast

Response to Proposals for Health and Social Care Reform, DHSSPS

6 May 2008

Summary

Belfast Healthy Cities welcomes the opportunity to comment on the proposals for reform of the health and social care system in Northern Ireland.

This is a summary of our comments by section.

Overall comments (page 3)

We welcome the proposed emphasis on health and wellbeing and tackling inequalities. However, we believe that as health outcomes are determined by many social factors, engagement with all sectors is essential for this and believe the system should be based on a broad ethos of engagement and information sharing both externally and internally.

Regional Health and Social Care Board (page 6)

We stress it is essential to build in safeguards for long term work such as health improvement and community development. The RHSCB should commission this work to streamline the process, but to ensure public health influence commissioning and other plans should be jointly signed off with RPHA. LCGs should consist of broad expertise relevant to health and wellbeing, and particularly the role of communities, social care and mental health should be strengthened. While local autonomy is crucial to meet differing needs, it is essential that LCGs work within a regional framework to ensure fairness. A formal network linking LCGs to the third sector and other sectors that influence health and wellbeing should be established to add value, improve knowledge exchange and inform change.

Department of Health, Social Services and Public Safety (page 11)

Belfast Healthy Cities agrees with the proposal to streamline the Department. We emphasise that the Department must engage with external stakeholders and the health and social care system, notably LCGs and RPHA, when developing policy. Investing for Health should be recognised as an overarching framework for

improving health across the public administration, but leadership from the Department and the Ministerial Group on Public Health must be strengthened.

Regional Public Health Agency (page 12)

Belfast Healthy Cities believes the RPHA has the potential to significantly increase the focus on health and wellbeing, and enable a coherent regional framework. Further work is required to determine the local format of the Agency and we believe Joint Local Health Units with local government should be considered for this.

We strongly support the proposal to co-locate RPHA staff with LCGs and local government and propose a model currently employed by NISRA, where staff are outposted to agencies and part of their structures. However, we suggest health improvement staff currently employed by Trusts could remain with Trusts to ensure mainstreaming of health improvement. If this happens, formalised networks must be developed to ensure consistency with the regional framework.

We also strongly support the proposed statutory duty on LCGs and local government to consider RPHA advice, and stress that RPHA staff need to be involved in projects from an early stage. They should also have a lead role in community planning for health and wellbeing and in building capacity in preparation for this.

Health and Social Services Councils (page 17)

We note this section includes one of few mentions of communities, and stress it is important that the Council(s) must not become the only mechanism for external stakeholders to engage with the health and social care system. In the context of a broad ethos of engagement, we see a key role for the Council(s) to advise citizens on where and how to engage with the system. Belfast Healthy Cities supports Option 1, which combines regional coherence with local input and is also coterminous with LCGs.

Belfast Healthy Cities has been engaged in a process with Belfast Health Action Zone, Eastern Area Investing for Health, Belfast Health and Social Care Trust, Belfast City Council and the Belfast LCG (designate) aimed at exploring more coherent approaches to health improvement under the new political and administrative structures within the city.

1. Introduction

Belfast Healthy Cities welcomes the opportunity to comment on the proposals for health and social care reform in Northern Ireland.

Belfast Healthy Cities is:

§ An independent organisation which works to shape and influence healthy public policy, and has for 20 years been a strong voice for a model of health that emphasises tackling the social determinants of health, through joined up action. We are a leading member of the World Health Organization European Healthy Cities Network, which currently has over 80 member cities and focuses on developing local**,** intersectoral approaches to health improvement, as well as introducing new concepts and innovative ways of working that highlight the link between health and its broad determinants.

§ Our work is guided by the WHO Network, with common themes translated into the local and regional context. We have successfully introduced a number of new concepts to Belfast and Northern Ireland, including health impact assessment, intersectoral health development planning and healthy urban planning. Belfast Healthy Cities is considered expert in its field and has been described as an pioneer of innovative approaches to health improvement in the city as well as the region as a whole.

§ Healthy Cities is fundamentally a partnership approach; based on a belief that and that all sectors have a role to play in improving health and wellbeing. The Belfast Healthy Cities partners include Belfast City Council, Belfast Health and Social Care Trust, DHSSPS, Eastern Health and Social Services Board, Northern Ireland Housing Executive, DoE Planning Service and Queen's University of Belfast as well as Bryson Group, East Belfast Partnership, Belfast LCG (designate), Ulster Cancer Foundation and Opportunity Youth.

The key principles that underpin the Healthy Cities approach are:

- a definition of health as a broad state of wellbeing, crucially influenced by social factors;
- a corresponding focus on equity and tackling inequalities in health,
- a belief that health improvement must take place through intersectoral collaboration; and
- an emphasis on engaging with citizens and communities in the process

These principles will form the basis for our comments on the proposed reforms to the health and social care structures, as we believe they must be prioritised to achieve better health outcomes for the people of Northern Ireland. Accordingly, we have also chosen to respond in a free format, as we think that this allows for

full consideration of the issues. Our response has also been guided by twenty years of intersectoral working for health within the city, but particularly within the last ten years.

Belfast Healthy Cities has been engaged in a process with Belfast Health Action Zone, Eastern Area Investing for Health, Belfast Health and Social Care Trust, Belfast City Council and the Belfast LCG (designate) aimed at exploring more coherent approaches to health improvement under the new political and administrative structures within the city.

2. Overall comments

Belfast Healthy Cities welcomes:

- the proposed emphasis on health and wellbeing and tackling health inequalities as core to the health and social care system. This resonates with the central principles of the Healthy Cities approach, and we believe that if implemented fully, it has the potential to significantly improve health and wellbeing and reduce the need for costly specialist treatment. However, we would like to see similar emphasis on social care, which is more community oriented, has an important support mechanism particularly for vulnerable groups and also has a central role in prevention of ill health and social exclusion.

- We also welcome the associated aim to create a system that proactively improves health and wellbeing. In our reading, this means a new focus on investing in prevention and early intervention, which has the potential to significantly reduce inequalities in health and reduce healthcare expenditure. In line with comments below, Belfast Healthy Cities would suggest it also means engaging with communities to equip and support them to take more responsibility for their own health, and giving them a role in identifying targets and performance indicators. We note that the Wanless Review of long term NHS resourcing (2002, accessed at http://www.hm-treasury.gov.uk/Consultations_and_legislation/wanless/consult_wanless_final.cfm 17.4.8) found the biggest potential savings and health improvements from the 'fully engaged' scenario, where citizens collaborate with service providers to develop need responsive services and at the same time gain capacity to take responsibility for their health.

Concerns & Challenges:

Our main concern relates to the ways in which the health and social care system will engage with:

- external stakeholders including sectors which have a key role in improving health, particularly public sector bodies, other government departments that both contribute and fund health and social care programmes
- the third (voluntary and community), and
- collaborate internally

In the diagram on page 12, both remain unclear at present. While a focus on 'patients, clients and carers' is to be welcomed, this implies direct service users, whereas there are few references to 'communities' as broad stakeholders, or indeed to key stakeholders outside the health and social care system. Similarly, we believe 'concerns being listened to' is not equivalent to stakeholders being part of strategy, planning and service development, which we see as essential for sustainable health improvement.

2.1 Engagement with external stakeholders

- Belfast Healthy Cities suggests that there should be an ethos of broad engagement with communities, the third sector and other stakeholders throughout the system, in line with our focus on enabling sectors to shape policy and delivery of health improvement.

- This could take place through mechanisms including existing partnerships, representation on LCGs, and membership of advisory groups, satisfaction surveys and new, direct partnerships with communities and other sectors such as DoE Planning Service. Procuring services from the third sector would also contribute to engagement. Crucially, these issues must be considered when designing structures, staff roles to ensure external stakeholders are able to have formalised links with HSC agencies.

- The Stakeholder Engagement approach being rolled out by DHSSPS is a beginning, but more concrete opportunities must be provided alongside this within all parts of the system, including DHSSPS itself as the policy driver. We also note that in a diagram of the engagement system, presented at a Stakeholder Engagement workshop in November 2007, service users are not directly connected to it. It appears the role of this Forum is limited and does not offer a strategic framework for external sectors to fully engage with the system.

2.2 Internal collaboration

- Belfast Healthy Cities would suggest and stress that to achieve a proactive and efficient health and social care system, it is equally essential to develop a model of collaborative working across the HSC system that will most effectively utilise expertise from all sub sectors. Put simply, agencies within HSC should be obliged to share expertise and work

together to identify priorities, targets and approaches that work based on identified current and future needs, achieved results and lessons learnt. Most importantly, this would mean a mechanism for RHSCB, LCGs as local level commissioning experts, and RPHA as public health and health improvement experts, to work with DHSSPS in policy development and target setting, which is currently not evident but could be formalised in the proposed strategic-control framework.

- In addition to this, a formal network with public sector bodies; relevant government departments (defined by programmes of care and health improvement priorities); the third sector and the independent sector would strengthen policy development but would also act as a mechanism on lessons learnt during implementation and delivery.

- Finally, Belfast Healthy Cities suggests capacity building with the Assembly and the Executive is vital, to improve understanding of the long term benefits and thus willingness to invest in health improvement amid competing interests that will produce more tangible short term results. Capacity Building programmes have been a core part of Healthy Cities business in increasing understanding across sectors of the links between non health policies and health improvement and of understanding inequalities in health.

3. Proposals for the Regional Health and Social Care Board

3.1 Governance and constitution

- In line with our view that engagement with external stakeholders should be core to the new structures, Belfast Healthy Cities suggests that this is taken into account under efficiency and effectiveness, and that RHSCB as financial controller has a key role in ensuring the system provides value for money measured in terms of local needs met and stakeholders engaged to support this.
- The performance management measures should expressly include indicators of (community identified) needs met, community and user satisfaction and engagement with stakeholders. The Community Development and Health Network (CDHN) have developed a performance management framework for community development work, which Belfast Healthy Cities would urge to be used in setting these.

Regarding the constitution, Belfast Healthy Cities believes that the central role and power of RHSCB should be reflected in its Board.

- The Board should also include stakeholders affected by its decisions, including a community/lay, patient and staff representative.

- § The LCG Chairs should be accountable to the CE of the Board, and the RPHA representative should be its Regional Director Public Health.
- § We note that it is proposed the RPHA representative will be non executive, and would stress that to ensure mainstreaming of health and wellbeing across the system, there must be a mechanism to guarantee RPHA strategic influence on the RHSCB.
- § It is also important social care is represented, to ensure that health improvement needs of population groups are aligned with social care needs – a key challenge within the proposed structures which separate social care and health improvement

3.2 Financial and performance management

In principle, Belfast Healthy Cities agrees with strong financial and performance management.

- We believe, however, that the format of potential incentives and sanctions and performance related resourcing need detailed and inclusive debate. For instance, we emphasise that it is essential to build in safeguards for health improvement and community development work, which is long term in nature. Similarly, we believe there should be a degree of flexibility in targets, so that Trusts can divert funds between programmes of care to meet unexpected need – primarily between clinical programmes. Overall, high quality needs assessment and forecasting is vital to ensure targets and commissioned services correspond to need.

3.3 Commissioning and LCGs

Belfast Healthy Cities welcomes the clear rationale that commissioning is best done sub regionally to best serve differing populations and needs, and also the proposed emphasis on wellbeing, tackling inequalities, local knowledge and engagement with external stakeholders. This is again in line with the Healthy Cities approach and in our view key to an effective and sustainable system.

- § To most effectively mainstream health and wellbeing, we believe that RHSCB/LCGs also should have responsibility for commissioning health improvement. Commissioning and other plans could be jointly signed off by RHSCB/LCGs and RPHA.

- § A single commissioning body could avoid the current confusion and competitiveness that is created through funding by various aspects of the health system. This can be unhelpful and this unhelpfulness is more visible at the delivery end than it is at the top level within the health system. BHC appreciate that based on their experience this may be more relevant to health improvement than social care delivery. However

working within the third sector, we are aware this creates duplication of health resources, which is unacceptable in today's climate of efficiency.

Belfast Healthy Cities presented detailed views on this in the Stakeholder Engagement exercise in April, and the written submission is included as Appendix 1 (page 18).

LCG Boundaries

As there will only be five LCGs, we would query how local these really can be, and how different the structure will be from the existing four HSS Boards. We also note that the very local Community Commissioning Associations have been scrapped. We would urge the number of LCGs to be kept under review, particularly in the context of community planning that will be a function of the new Councils by 2011. We see LCGs as central participants in the process, and believe that as close coterminosity as possible is essential for effective community plans. At minimum, no new Council should be divided between two LCGs. We also believe that like RPHA, LCGs should be obliged by legislation to participate in the community planning process to ensure a joint and coherent approach to public health and health improvement locally.

Process for engagement

- In light of the sub regional, rather than strictly local, nature of the LCGs it is essential that there is a **clear process for engagement with local communities, the third sector and non health public and government stakeholders.**

- Belfast Healthy Cities believes community planning should be an essential part of this, but in addition LCGs should collaborate with existing local partnerships and fora. They should also be expected to develop links and partnerships with other sectors with a key impact on health, such as housing, transport, regeneration, education and planning, with the aim of mainstreaming health in policy development. Again, sectors should be identified based on health improvement priorities but if the overall goal of public health and health improvement is to develop healthy public policy then in addition to priorities, policy priority areas should be identified for influence, eg economic development policy.

- This work should build on existing partnerships and expertise from the public sector, but particularly from within the third sector that has significant experience, skills and expertise in working intersectorally and beyond a single issue remit.

- Developing partnerships with the community and voluntary sector is particularly important in the context of procuring services from the sector. There is limited reference to third sector in the proposals. This must be strengthened and measures put in place to ensure increased

understanding of the contribution that the third sector makes to health and well being. We also believe LCGs as commissioners are key to this, there should be clarification of the role of Trusts and sub contracting in relation to sub contracting services.

- Third sector delivery will not only strengthen community influence and capacity, it will also support vital community based jobs and infrastructure, thus contributing to economic and social prosperity. It can further improve local access to services and enable local flexibility. In many cases, third sector delivery will provide best value for money as the infrastructure and local knowledge is already in place.

- Formal network/s should be established between the third sector and Commissioning that act as a support and advisory mechanism between the sectors. The formal network should be linked to executive responsibility within RHSCB/RPHA and LCGs (ie. those who have Commissioning responsibility) but the remit of the formalised network could be extended. Based on BHC's experience this could bring significant expertise and added value to strategic policy development; knowledge learning and exchange; skills development; performance management and recommendations for change, regionally and locally. It is currently a major gap. A joint approach by CO3 and NICVA to work with DHSSPS in the development of this would be welcomed by the third sector.

Division of roles between RHSCB and LCGs

In the proposals paper, there appears to be potential confusion in the accountability lines and roles of the LCGs and RHSCB as a whole. Crudely, LCGs appear to have operational power, working to frameworks set by DHSSPS while RHSCB undertakes more strategic monitoring functions. While Belfast Healthy Cities agrees that LCGs should have strong autonomy in order to meet locally differing needs, we believe that RHSCB should ensure regional consistency and fairness. To the same end of avoiding a 'postcode lottery' of divergent services, LCGs should be obliged to collaborate and share information. The proposed staffing arrangements appear to contribute to this and Belfast Healthy Cities welcomes this, provided adequate resources are given to LCG work.

Constitution of LCGs

Belfast Healthy Cities believes that the LCGs should consist of broad expertise relevant to health and wellbeing, in order to commission most effective and locally appropriate services. Consideration to engaging other sectors in commissioning for health improvement should be included, if non health sector targets are priority areas for health improvement.

Clinical representatives: As we believe that health care is only one factor influencing health outcomes, we believe the full range of needs would be better served by an additional social care professional. Mental health covering both children and adult services should be given priority within the team. We believe that one clinician potentially should be a secondary health care specialist, ie. consultant, to complement the knowledge of GPs. The public health professionals should be a RPHA representative to ensure its proposed influence throughout.

Lay representatives: We note that in the new proposal, the number of lay representatives on the LCGs has been cut from two to one. We believe this should be reconsidered, as lay representatives have highly valuable contextual expertise that may not be available to clinicians, while they also contribute to community empowerment. We would suggest the voluntary and community sector should be included here with a dedicated representative. Lay representatives should also be supported to develop a feedback system with communities.

We note that merit criteria will continue to apply. While this is wholly appropriate, we would question the original criteria that required clinical or change management experience, and would suggest community based experience of health improvement is equally valuable. We also believe it is essential to clarify as soon as possible how the new LCGs will be formed.
An Alternative to including the third sector on LCGs is to develop the formal network with the Third sector as identified under the Process for Engagement section of this response.

Elected representatives: We broadly welcome the proposal to include elected representatives on LCGs. We would suggest and emphasise, however, that representatives should have experience in the health field, and that Councils should appoint them, to ensure maximum benefit for the community planning process. It is also important that commissioning remains need led.

A capacity building programme for elected representatives, including engagement with communities as a complementary activity to political representation, is essential to ensure that they are able to fully engage in the process.

4. Proposals for the Department of Health, Social Services and Public Safety

Belfast Healthy Cities welcomes the proposal to streamline the Department in line with the wider reform and enable it to concentrate on policy development and strategic leadership.

- Our key concern is a lack of detail on proposed collaboration mechanisms, and we refer back to our overall comments. Specifically, if DHSSPS will retain responsibility for developing public health policy it, like RHSCB and local government, they must engage with RPHA from the early stages to ensure the right issues and identified local needs are considered. They must also engage with non health sectors in a formal way to ensure implementation of health improvement policy is conducted in the intersectoral way in which the proposal aspires. A key role is supporting resourcing and target setting. Transferring the Research and Development Office from CSA may be important to ensure adequate capacity within the Department, but should not replace or duplicate the capacity proposed to be concentrated within RPHA.

- LCGs should have a particular role in providing evidence of existing and future need in relation to the social as well as clinical aspects of health, which should guide overall resourcing. They should also support DHSSPS to engage with the community, voluntary and private sector, through the formal networks and relationships they will develop. All of the above should form crucial parts of DHSSPS input into Programme for Government and budget planning processes.

- Direct engagement with the community, voluntary, private sectors, public sector bodies and relevant government departments is essential if DHSSPS is to lead development of capacity and service delivery in these sectors, and also to ensure their input into the public health and other service frameworks. As noted above, the Stakeholder Engagement initiative could be further developed or a formal network established to ensure this happens at an executive level.

- In principle, we welcome the proposal that DHSSPS will be responsible for cross governmental policy, such as Investing for Health, as the Department is likely to have most significant influence on other Departments. However, it is essential that leadership and skills are significantly strengthened within DHSSPS for such policy development and implementation and that leadership for a commitment to mainstreaming health as the responsibility of all Departments is provided. Specifically in relation to public health and health improvement, this has not been evident in the past and the Ministerial Group on Public Health must also be strengthened.

Investing for Health should be recognised as an overarching framework for improving the health of the population and must feed down from all government departments and inform the development and work of local partnerships. It must not act as a separate competitive entity within the system.

5. Common Services Organisation

Belfast Healthy Cities broadly welcome the proposed Common Services Organisation (CSO), as an appropriate rationalisation of services that allows for coherent and regionally consistent development of the specialist services provided. It is important that the function suggestions form the CSO in relation to contractual compliance are closely linked to commissioning of family health services and managing of the contracts which will be the responsibility of RHSCB.

The Board of the CSO should be built from client organisations to ensure influence on the direction of services provided and appropriate performance indicators. To ensure equitable services across organisations the CSO should have Service Level Agreements with each, which should be scrutinised by the Department. There should also be a complaints procedure.

6. Public health and proposals for the Regional Public Health Agency

Belfast Healthy Cities strongly welcomes the proposed emphasis on public health and refer to overall comments on this. We also welcome the proposed emphasis on the underlying determinants of health and the broad partnership approach mentioned in relation to RPHA functions. We wish to see both aspects prioritised across the health and social care system as this will enable significant progress on tackling inequalities and improving health for all.

- Our suggestion of the RPHA is that it could have an organisational structure similar to that currently employed by the NI Survey and Research Agency (NISRA), where staff are out posted to Departments/Units as part of their structure, but for the purposes of concentrated expertise and professional development are formally employed by a specialist agency. We also understand the RPHA will primarily be a delivery agency.

- In principle, we welcome these proposals as significantly increasing the potential focus on health and wellbeing, particularly at the crucial delivery end. A single organisational structure would also enable more coherent working and priority setting based on a regional framework.

- § However, the practical arrangements and structures, particularly at local level, require considerable development in collaboration with all stakeholders. In Belfast, there is an ongoing process referred to earlier involving Belfast City Council, North and West Belfast Health Action Zone, Belfast HSC Trust, Eastern Area Investing for Health, Belfast LCG (designate) and Belfast Healthy Cities, to explore a future local, joint model for health improvement that would engage both the health sector and local government

- § There should also be links to the academic world, importantly the new Northern Ireland Centre of Excellence for Public Health Research based within Queen's University of Belfast, particularly in relation to knowledge learning and evidence bases.

- § There should also be strong links with WHO Globally and European wide to bring new learning, evidence and approaches to public health and health improvement regionally.

It must also be clarified what the regional framework will be. If this is to be the current public health strategy *Investing for Health*, a guarantee for strengthened leadership would be required.

In addition, while we believe commissioning health improvement should remain with RHSCB (see page 7 and Appendix 1, page 18), but as already suggested be formalised with RPHA who also should have a key role in all public health and health improvement policy.

6.1 Transferring functions and agencies

Belfast Healthy Cities believes the key functions proposed for the RPHA are appropriate and enable a broad focus on health and wellbeing. We are, however, concerned that there is no explicit mention of tackling inequalities and would stress this must be included as key to health improvement.

We would also welcome explicit definitions of what is meant by health improvement and public health, as this will have a crucial impact on programmes delivered and models of working. In our view the focus must be on tackling issues at community and society level – in partnership with communities – and not only at the individual level, as in traditional health promotion. As an example, reflected in the Foresight report on obesity to the UK government (2007, accessed at http://www.foresight.gov.uk/Obesity/Obesity.html 8.4.08) obesity should be tackled in collaboration with planners and transport providers, and not simply as a lifestyle issue (*Belfast Healthy Cities' programme on healthy urban planning is one model for this, developed by the World Health Organization).*

We believe the agencies and functions proposed to constitute the RPHA are also appropriate. At a more strategic level, commissioning plans developed jointly by RPHA, LCGs and other sectors with a role in health improvement are essential to align priorities and provide this flexibility. Reporting procedures must also be put in place to ensure both RPHA and Trusts get appropriate information on progress, for example in the form of regular update meetings or monitoring submissions. Staff could remain employed by Trusts to ensure health improvement remains mainstreamed within Trusts but if this is to happen networks should be formalised for delivery within the regional strategy/RHPA.

It is essential that a formalised regional intersectoral Group is also established within/alongside the RPHA to ensure that intersectoral health priorities are agreed with these sectors and (in the absence of joint budgets) to ensure they are resourced for implementation. This group could also have a performance and accountability role. The relationship between this regional group and the Ministerial Group on Public Health should be clarified but it is essential to keep in mind that some of the key issues affecting inequalities in health are the responsibility of regional agencies; eg. Housing, education and policing (Should this be moved?)

6.2 Nature of public health support

- Belfast Healthy Cities believes that **the proposed role for RPHA in supporting commissioning, policy and service development is crucial for successful mainstreaming of health and wellbeing.** In particular, **we welcome the proposed role working with local government,** which is crucial for mainstreaming health improvement and tackling inequalities in the community planning process. The proposed role with RHSCB and LCGs is equally crucial in order to influence commissioning priorities and targets.

- Belfast Healthy Cities strongly **supports the proposal to co-locate RPHA staff with RHSCB/LCGs and local government. Indeed, we suggest that RPHA staff should form an integral part of the LCG teams and health improvement teams within local government.** In practice, this means dedicating RPHA staff long term to individual LCGs or District Councils, and integrating them in these organisational structures, as in the NISRA model. This is essential to maximise the potential to mainstream the wellbeing agenda within broader health agendas and develop wider understanding of the issues. Formally, RPHA staff may need a Service Level Agreement with the host organisation, based on RPHA priorities.

- We suggest, however, that the public health support function and health improvement function should be seen and implemented more holistically than currently proposed. In practice, RPHA teams out posted to LCGs or

local government should include both public health and health improvement specialists, and the support should involve both strategic advice and (contributing to) delivery. Belfast Healthy Cities also suggests the strategic support should focus on providing advice and evidence, supporting needs assessment, facilitating intersectoral collaboration and ensuring services cover all aspects of health relevant to citizens, rather than on quality assurance and staff credibility as outlined in the proposals paper.

- Understanding health determinants; knowledge of tools for intersectoral health improvement and partnerships skills will be an essential component of the public health function support and will require significant capacity building for internal staff and for those to be outposted and for those within local government. It should be noted that currently many of the skills and expertise in relation to these aspects are within the third sector.

- We welcome the proposed statutory duty on RHSCB/LCGs and local government to engage with RPHA. However, we emphasise that this must be involvement from the early stages, as RHSCB and the LCGs will not have health improvement expertise. Therefore, there should be a duty on RHSCB/LCGs and local government to take on board suggestions and advice. To make this as strong as possible, Belfast Healthy Cities suggest commissioning plans and future community plans should have joint sign off with RPHA. As already noted, RPHA must also have an influential position on the RHSCB Board and on future community planning bodies.

It is important that resources are made available to support partnership work, which should include developing both community approaches and intersectoral collaboration with agencies outside the health sector. Importantly, Belfast Healthy Cities would suggest that given the experience to date, this requires budgets across sectors to be sliced for partnership working.

6.3 Community planning and local format of RPHA

- Belfast Healthy Cities believes that community planning structures should be core to RPHA delivery at a local level. A key advantage of RPHA is that it enables a regionally coherent health improvement framework, under which local community plans for health and wellbeing can be developed. It also provides a platform and catalyst from which health and wellbeing can be put at the core of community planning for health.

- Within this, health should be placed at the strategic level within Community Planning processes that encompasses all sub structures within Community planning. Evidence from Community Planning Health Partnerships from England and Scotland point to limited progress in health

improvement and in addressing health inequalities through a sub structure partnership approach.

- Referred to earlier in this paper, there have been **ongoing discussions within Belfast about a joint model for delivery on health improvement** between health organisations (LCG (designate), Belfast Trust, Belfast HAZ and Eastern lfH), Belfast Healthy Cities and Belfast City Council. These discussions suggest that this joint model would fit under the umbrella of the RPHA and Community Planning. BHC support this as a way of strengthening a joint approach to tackling health inequalities and delivery on health improvement within the city. Fitting under the joint umbrella of health and Council is in BHC's view the best initial location for such a model but as Community Planning matures and additional functions are part of Councils remit under RPA, consideration could be given to location within Community Planning. Within this, we see a lead role for RPHA in this, and a key support role for RPHA staff and third sector staff that have the expertise in facilitating the health partnership.

- Leadership as outlined earlier from RPHA at a regional level is required particularly with other sectors that determine health, such as policing/Police Service of Northern Ireland, housing and education to support local models

- In proposing this, BHC also want to emphasise the expertise, skills and knowledge of a number of independent/third sector organisations who have been working in the health improvement field for many years and understand health determinants and approaches and delivery to health improvement. It is essential that these skills and expertise are integrated into the local models.

- BHC emphasise that significant capacity building with both elected representatives, local government officials is essential to enable the new Councils to effectively lead community planning.

Please refer to Appendix 1 for advantages/ disadvantages of RPHA and suggested remit or RPHA

6.4 Health Protection Unit

We support the proposals for establishing a Health Protection Unit within the RPHA. We suggest the Unit should have Service Level Agreements with Trusts to ensure equitable and appropriate collaboration.

7. Health and Social Services Councils

Belfast Healthy Cities note that the section on Health and Social Services Councils includes one of few mentions of communities as stakeholders in the system. We also note that the new organisation/s has the clearest remit for engaging with the public as a whole, as opposed to patients, clients and carers specifically, and will have significant voluntary and community sector representation on its Board.

While welcoming the above, **we would stress it is vital that the Councils do not become the only way for citizens and the voluntary and community sector to influence the system and we refer back to the suggestion for a formal network with the third sector.** This would considerably complicate the process and significantly weaken the opportunities to put improving health and wellbeing at the core of health and social care, particularly as it appears that the Council/s will continue to work primarily through a complaint type process.

Belfast Healthy Cities suggest that the Councils should complement and strengthen an inclusive and collaborative approach running through the health and social care system, with a key role in advising the public on where and how to engage with it.

To this end, we would also suggest that other health and social care bodies should have a statutory duty to collaborate with the Council/s in developing their service, rather than simply 'have due regard to representations and requests made by it'. This would be more proactive, could potentially reduce complaints and would strengthen democratic accountability to citizens.

Belfast Healthy Cities believes that Option 1, a regional body with five committees coterminous with Trusts would be the most effective, as it combines regional coherence with local input and also coterminosity with RHSCB/LCGs.

8. Agencies of the Department

Belfast Healthy Cities note that it is proposed to incorporate the Mental Health Commission into the Regulation and Quality Improvement Authority, although the Bamford Review recommended an independent body.

As mental health is a growing public health issue and a priority for the Department it is important that if amalgamated, the mental health functions are given appropriate specific resources.

Appendix 1

Belfast Healthy Cities Response to RPHA Stakeholder Engagement Panel Discussion

Q. Which organisation should have lead accountability for commissioning health improvement – the RHSCB or the RPHA? What are the advantages and disadvantages of each?

Response: It is the opinion of Belfast Healthy Cities that commissioning for health improvement should be lead by the RHSCB. Belfast Healthy Cities is an independent voluntary organisation and a leading member of the WHO European Healthy Cities network. Our response has been guided by our extensive experience of intersectoral working across a variety of Government departments and agencies, the health sector as well as the voluntary and community sector.

Advantages of RHSCB:

- Within the reform proposals the RHSCB and LCG's are tasked with developing health improvement commissioning plans with RPHA giving support to the development of these as well as supporting local government in community planning. There is potential if true partnership working takes place that joint commissioning plans can emerge, and duplication of commissioning of services can be avoided. *One example of this in practice was the development of the Healthy Ageing InterAction Plan by Belfast Healthy Cities which focused on the wider determinants of health. This was developed in partnership with and alongside the EHSSB Health and Wellbeing Strategy for older people who focused on health and social care.*

- Commissioning of all health related services is confined to one body (with LCG's acting as an arm to the RHSCB) thereby streamlining commissioning and ensuring consistency of the commissioning approach. It also prevents confusion over who has the authority to commission.

- With LCG's also taking on a commissioning role at a local level on behalf of the Board this gives rise to local flexibility in commissioning services in response to the needs of the area.

- There is the opportunity for health improvement to link more closely with social services and be mainstreamed throughout health and social care. Some of the work we are doing in Healthy Cities, for example, the development of a detailed resource pack for professionals working with older people, will provide people from a range of sectors with the tools they need to signpost older people on to other services beyond their remit

Disadvantages of RHSCB:

- Within the proposals RHSCB will have lost its expertise to the RPHA for health improvement. It will therefore be important that the RHSCB be required through legislation to seek advice from RPHA on health improvement

- If the RHSCB were to be given the role of commissioning health improvement as well as commissioning health and social care there is a risk of lesser priority and focus being given to preventative work and public health improvement

Advantages of RPHA:

- If RPHA is to include staff from the Health Promotion Agency, health and wellbeing staff working in the existing health Boards including community development, Investing for Health and Health Action Zone (within Trusts) then the RPHA will have a strong body of staff with the expertise, knowledge and experience to commission health improvement.

- RPHA will be in a position to commission and advise on public health related research which would be valuable to the commissioning of services.

- There is potential for the RPHA to become a strong information and research base for a range of agencies on health improvement

Disadvantages of RPHA:

- If the RPHA as proposed in section 7.6 of the reform are to "provide public health programmes and initiatives at a regional and/or local level" which we read as delivery of these programmes, then by also giving them a commissioning role would this dilute the capacity for delivery given the relatively small staff team of 250-350 compared to the RHSCB proposed 400 staff. If RPHA is to commission services who is accountable for delivery?

- There is a risk that by giving RPHA commissioning as well as the RHSCB and LCG's that commissioning becomes top heavy compared to the number of staff delivering services, and detracts from the aim of the reform of making structures more streamline. It may also create confusion within health and social care but particularly with agencies outside that contribute to health improvement.

- There is potential duplication for the need for financial expertise in both RPHA and RHSCB for commissioning purposes

- It separates health improvement commissioning from commissioning of the rest of health and social care and so hampers the ability for health improvement to be mainstreamed as part of health and social care services

Gaps in the current proposed reform

- There is a clear gap in the proposed reform as to the mechanisms for involving the wider community, including the voluntary and community sector, in commissioning and delivery of services beyond membership of the boards of the new proposed structures.

- There is also a gap in the identification of the bodies that will be responsible for commissioning community and voluntary organisations to deliver health improvement services

- Whilst "tackling health promotion and inequalities" (p13) and the "underlying causes of poor health (p31) is mentioned briefly in the reform, greater emphasis should be placed in the document on tackling health inequalities especially within the function of the RPHA.

Suggested Role of the RPHA

- Where appropriate the RHSCB and RPHA should jointly develop strategies and plans. The RPHA should also coordinate the delivery of health improvement services across sectors to tackle the wider determinants of health, with input from local government and the community planning process as well as other organisations whose function contributes to health improvement. Top slicing of budgets for intersectoral working would allow this to happen. *Belfast Healthy Cities has recently been involved in the establishment of a Strategic Intersectoral Healthy Ageing group made of senior managers across sectors with the aim of improving coordination and planning of services for older people.*

- Provide the evidence base and learning for 'what works' in addressing health inequalities and improving health. The RPHA should have strong relationships with other relevant organisations such as the Centre of Excellence established in Queens and INIsPHO

- Engage with experts/academics and commission research to inform practice

- Ensure systems are in place to build and share knowledge, learning, training and monitoring to enhance health improvement within and across sectors

- Provide leadership on public health issues and ways to tackle health inequalities

- Provide a coordinated approach to the engagement of the wider community, including the voluntary, community and private sector, in the commissioning and delivery of services and provide resources to allow this to happen

- Incorporate and share learning from other places e.g. Ireland, UK, Europe, and Global. *Belfast Healthy Cities has been very active at a European level, for example, we are lead city within the Health Impact Assessment European sub-network. We would also be involved at a strategic level in decisions being made by the WHO Healthy Cities office in Copenhagen. The learning that can be gained from other cities, whether local or international should be further tapped into.*

- Identify joint health improvement corporate goals between local government, RPHA and RHSCB and other sectors and support the mainstreaming of health improvement

- Ensure health improvement is a key driver for setting priorities at all levels and be at the core of service delivery by frontline staff

- Provide officers, politicians and other sectors with the necessary support and training to ensure they have the knowledge and skills to mainstream health improvement and wellbeing across departments and sectors. *Belfast Healthy Cities has facilitated training on inequalities in health throughout the EHSSB area for several years now and more recently has expanded this training regionally*

- Provide a regional coordination/ collaboration centre for health partnerships including accountability, monitoring, learning and tool development to support organisations in their work to improve health. *Belfast Healthy Cities has experience of tool development, as well as providing training, on Healthy Urban Planning and Health Impact Assessment*.

- Strengthen commitment across Government departments to delivering on Investing for Health objectives

- Provide clear guidance as to role each body will have in relation to commissioning community and voluntary organisations to deliver health improvement services (including the role of HSC Trusts)