

Appendix 2



# Proposals for Health and Social Care Reform

Response to the paper issued by Department of Health,  
Social Services and Public Safety on 18 February 2008

7 May 2008

# The Chartered Institute of Environmental Health

**Our mission is to maintain, enhance and promote improvements in environmental and public health through knowledge, understanding and campaigning.**

As a **professional and awarding body**, we set standards for the education and professional development of our members and the public, awarding qualifications and accrediting universities and training courses.

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We are a **registered charity** with nearly 11,000 members across England, Wales and Northern Ireland.

Please note that this paper builds on and adds further detail to the previous paper which formed the basis of our discussions with the Stakeholder Engagement Panel on 11 April 2008.

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# Contents

	Page
1. Introduction	4
2. New regional Public Health Agency	4
Health Protection	5
Health Improvement	6
3. Funding arrangement, accountability and Local Commissioning Groups	11
4. Dept of Health, Social Services & Public Safety (DHSSPS)	14
5. Professional issues	14

## 1. Introduction

- 1.1 The CIEH welcomes the opportunity to comment on and input to this aspect of the ongoing Review of Public Administration (RPA). We have taken a proactive interest in this entire review from its inception and commencement in 2002. We have also taken an active involvement and interest in the review of the Public Health Function (RPHF) which was concluded in 2004.
- 1.2 The final report from the RPHF is, we believe, very relevant in the context of these latest proposals for the reform of the health sector and many of its recommendations, although as yet unimplemented, have relevance to and synergy with this latest paper and some of the proposals we would wish to make in respect of the detail. We further believe that many of the recommendations that were made within the RPHF are complimentary to and would enhance many of the current recommendations contained within the consultation paper.
- 1.3 The CIEH has consistently argued for a much stronger role for local government in public health. This is because we believe that the sector has control over and therefore significant potential to influence key issues which ultimately determine an individual's well being for example housing; food; air quality; leisure services; community development; economic development etc. In addition, local government already has a strong health protection role.
- 1.4 Local government works on a fully democratic model and therefore takes on board the views of communities in a way that other public bodies can not. Participative democracy will, in our opinion, be a critical issue for the future success of the community planning process and this in turn is vital to more significant gains in health improvement and the reduction of health inequalities in the future.
- 1.5 We therefore warmly welcome the Minister's clear commitment contained within these latest proposals to the aim of local government "working closely with the new structures and playing a pivotal role in developing plans to improve the public's health".
- 1.6 The main areas of the paper which we would wish to comment on include the proposed new Regional Public Health Agency and local delivery models; funding and accountability mechanisms; local commissioning; the role and function of the Department; and professional environmental health issues that arise as both a result of the proposals as well as recommendations within the RPHF referred to at 1. 2.

## 2. New Regional Public Health Agency

- 2.1 We strongly welcome the clear focus on public health within the health system that a new Regional Public Health Agency could potentially provide. We believe that it has the potential, provided that it is correctly constituted; that the structures and relationships are right; and that there is appropriate accountability; to potentially consolidate and integrate future public health planning and delivery in a way which could significantly benefit health improvement and health protection.

- 2.2 We further welcome the suggestion that the RPHA would be multi-professional and have included our comments in relation to this specific issue in the final section of this paper at 5.8.
- 2.3 We also note that one of its roles would be to provide support to local government (and others) in improving the health and well being of local communities. This is much needed and warmly welcomed particularly in terms of access to expert advice, support, data and research. We believe that this should be further strengthened through statute.
- 2.4 We further note that it is proposed that a statutory requirement be introduced to require local government to consult with the agency in the development of community plans. This is entirely acceptable in terms of ensuring that the community planning process (and outcomes) incorporates a strong focus on improving health and reducing inequality. Indeed it is our view that these goals are in fact conceptually at the very heart of and rationale for community planning. However the requirement for statutory consultation with the new RPHA needs to be appropriately balanced. It would however be inappropriate for any regional agency to have the ability to control the community planning process as this would negate the whole concept of such plans being fundamentally informed by the communities whose lives they seek to improve.
- 2.5 We believe that the leadership of the new RPHA will be critical to its success. Public health is now widely recognised worldwide as a multidisciplinary area and there have been a number of appointments to similar roles in other parts of the UK of persons from non medical professional backgrounds.
- 2.6 Building on the previous point, a key role for whoever is appointed to lead the new agency will be to ensure that its work both commences and remains truly multi-disciplinary, cross sectoral, and inclusive. We therefore believe that potential candidates should be appointed on the basis of their ability, experience and competence to deliver such outcomes as the top priority rather than professional background or expertise in public health which, whilst obviously very relevant, is not necessarily in our view the principal attribute required for such a position.

## **Health protection**

- 2.7 We note and welcome the proposal to incorporate the existing health protection functions of the four existing health and social services boards within a new Health Protection Unit (HPU) within the new agency.
- 2.8 There are significant dimensions of health protection that will remain outside the remit of the new RPHA. We note and agree that the new HPU would need to retain and develop existing linkages with both the Health Protection Agency (United Kingdom) and local environmental health departments. However there are other agencies with very significant roles in the health protection agenda, in particular the Food Standards Agency (FSA), the Health and Safety Executive (HSE) and the current Environment Heritage Service (EHS)<sup>1</sup>. Strong linkages will need to be developed with

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<sup>1</sup> Should there be the establishment of an independent environmental protection agency in Northern Ireland as the review of environmental governance concluded in 2007 has recommended then the existing EHS will cease to exist. However, the new RPHA should develop strong links with such a new agency if it is created given the fundamental role that environmental protection plays in health protection.

each of these agencies in order to capitalise on efficiency and develop optimal integration and avoidance of duplication for health protection in Northern Ireland.

- 2.9 Whilst there are significant regional aspects to health protection there are also equally vital local considerations such as capacity to respond to incidents and local intelligence. To that end it is imperative that the new Agency retains a strong local health protection perspective and that the benefits that were inherent in the previous four board setup are not lost but rather developed further. This will require the establishment of some form of 'local' public health teams. The make up of such teams should reflect the multidisciplinary and multi agency nature of health protection (refer to following model).
- 2.10 We believe that there is great merit in a model which will work alongside the new health trusts and has the flexibility to incorporate what we understand are imminent proposals on future local government structures, and in particular the 'shared services' concept. To that end we would suggest that it is vital that DHSSPS continue to liaise closely with colleagues in DOE and in particular those on the Local Government Review team and Modernisation Unit.
- 2.11 Leadership as well as a sense of 'shared' ownership is critical for such local teams. To that end there could be merit in joint appointments as such arrangements clearly give a strong sense of co ownership. However the long term sustainability and viability of such teams/units cannot be compromised by the ability of partners to opt out and so such an option would be dependent on continued and sustained funding arrangements. Should the concept of joint appointments at local level be seriously considered, as we believe it should be then there may well be scope to pilot such a model ahead of the proposed reforms to local government due in 2011. (See 2. 21)

## **Health improvement**

- 2.12 The ten year strategy, Investing for Health Strategy (IfH), published in 2002 by the former executive has been described as "a ground breaking policy document"<sup>2</sup>. IfH was and is, quite rightly in our view, very clearly designed on a social rather than a medical model of health. As such the Investing for Health partnerships (IfHPs), established as a key delivery vehicle for the delivery of the strategy and its targets, have worked in different ways in different parts of NI. To some extent this reflects not only the need to develop partnerships in away that is best suited to fit local arrangements, but also the fact that the health improvement agenda is a very crowded marketplace in terms of the number of existing organisations and initiatives that are active within it. This also varies across the sub regions in Northern Ireland. For example, in Belfast City Council area there are, in addition to the council and the IfH partnership, several other key organisations and networks whose primary focus is health improvement and reducing health inequalities such as Belfast Healthy Cities, the North and West Health Action Zone, and a wide range of community and voluntary organisations. Through this reform and other associated processes a way must be found to better integration and collaborative working in order to reduce duplication, overlap, and above all improve collaboration, all of which will lead to better outcomes for the public.

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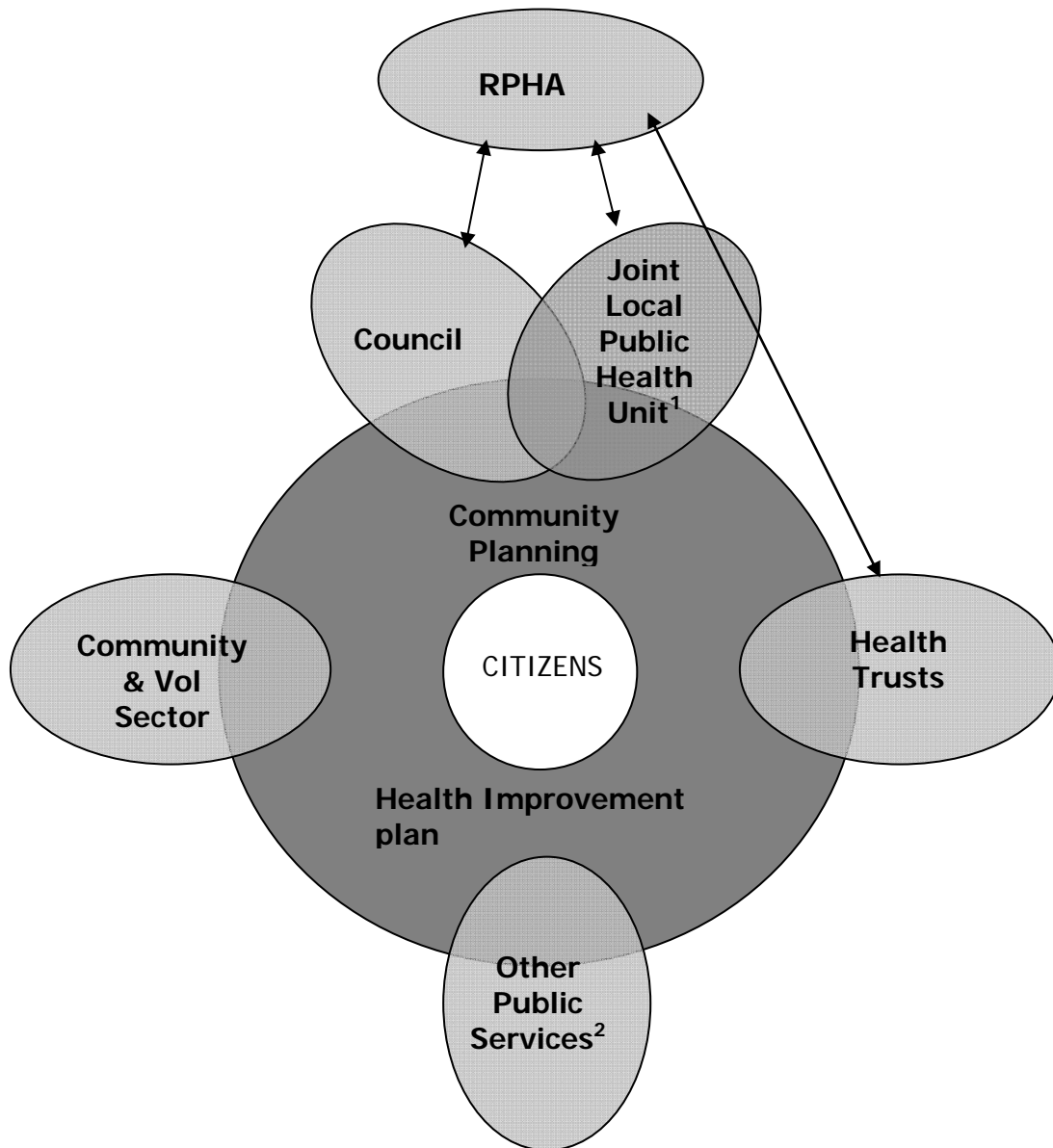
<sup>2</sup> Bates, Evan (2005), "Health and healthcare in Northern Ireland", in Politics of Health Group (2005), UK Health Watch 2005: The experience of Health in an unequal Society ([www.pohg.org.uk](http://www.pohg.org.uk))

- 2.13 Future health improvement planning (i.e. the design of local programmes; interventions and services) should be inextricably linked to the new community planning function of local government. This will be further supported by the statutory power of wellbeing that is likely to be conferred on the sector.

#### **A future model for local public health**

- 2.14 We would have serious concerns over any proposals to attempt to deliver local public health services and interventions, particularly within the health improvement domain of public health, from within a regional body in isolation. In fact we do not believe that this is neither appropriate nor likely to be as successful as a truly collaborative approach would be. It is unlikely, in our opinion, to lead the most effective implementation and subsequently outcomes in terms of improved population health and reductions in inequalities. For health improvement to be effective it must be shaped by the priorities and needs of local communities. To do this will require, in our opinion, proper and equitable local partnership arrangements for the local delivery of health improvement. The right model has arguably the potential to translate government policy (i.e. Investing for Health), and indeed the newly proposed agencies key aims and objectives, into reality. That being said the need for local input from the Public Health Agency is seen as very important for successful delivery of the health improvement function. Without active partnerships with district councils, with the local offices of other statutory organisations and with the community and voluntary sector within a locality, the necessary synergies will not be created. Regional policy must also be balanced by local responsiveness and accountability.
- 2.15 The excellent work that IfHPs have done over the last five to six years needs to be built upon and co locating them within a future local government framework which includes community planning and a power of wellbeing would, in our opinion, strengthen and enhance public health capacity at local level. It would also give public health a clear and distinct role and priority within the local government framework. A two stage diagrammatic model representing this proposal is shown overleaf:

**Figure 1:**  
**11 Jointly appointed Local Public Health Units (RPHA and Local Authorities)**



**NOTES**

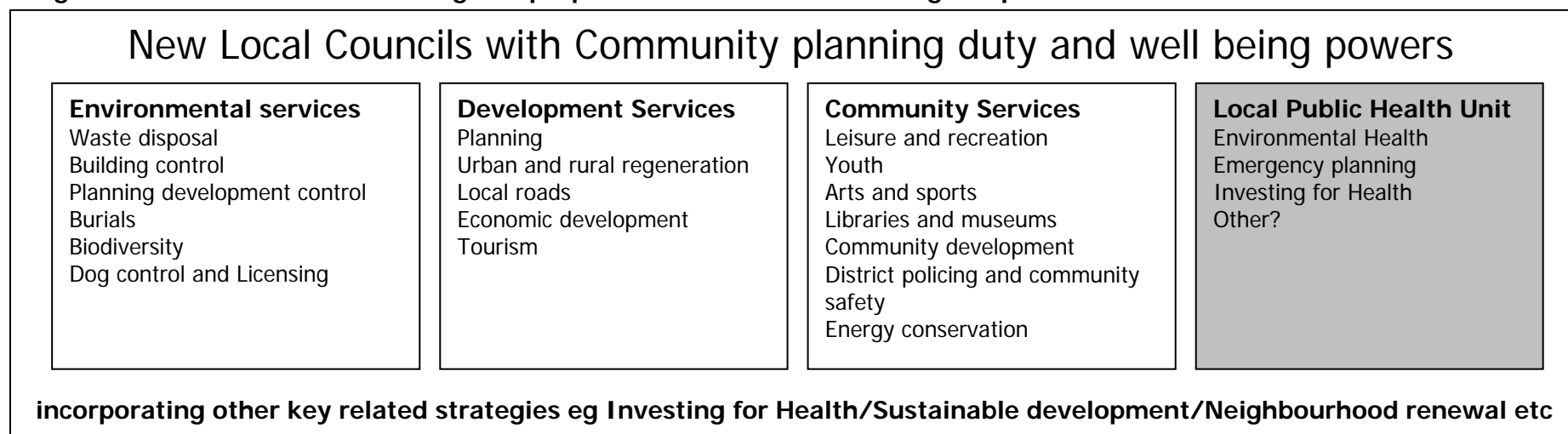
1. Jointly appointed Local public Health Unit (LPHU) (RPHA & Council).

Ideally these should be physically located within Local authority in order to facilitate the necessary collaboration with other key council services and roles fundamental to upstream health improvement. (See figure 2)

2. Other key public services of significance in health protection and improvement would include Environment and Heritage Service; Health and Safety Executive (HSE) NI Housing Executive; Education etc

The Community Planning Powers and concept provide an ideal mechanism to potentially significantly enhance coordination and integration of these wider public health roles. Again, the joint LPHUs proposed in this model would be ideally placed to both influence and collaborate with these other key services.

**Figure 2: Further detail on existing and proposed council functions alongside potential new Joint Local Public Health Unit**



**NOTES:**

1: Current council functions critical to **health protections**, almost all of which sit within Environmental Health, could potentially move into the new joint LPHU if it were to be located within the new Council Structures. **This would significantly enhance the opportunities for a more strategic and integrated approach to health protection between the new RPHA and local authorities.**

2: Current health protection functions that exist within environmental health include:

- Food safety
- Occupational health and safety
- Environmental protection
- Consumer protection (including increasing involvement in tobacco)
- Housing

- 2.16 Council functions and roles critical to upstream health determinants are extensive as depicted in the preceding diagram. Virtually all of both existing and future proposed functions (future functions as understood at present have been included in this diagram) have a significant impact on health and wellbeing in its full sense. In addition, as outlined earlier, the councils, and in particular the environmental health service are already involved in a considerable volume of specific health improvement related work.
- 2.17 Given this we believe that the above model represents significant potential for a way forward in terms of how the new Regional Public Health Agency could both operate at and exist at local level. The existing Investing for Health Partnerships could be relocated within the new joint Local Public Health Units where they would be arguably ideally placed to work alongside not only other services within the new LPHUs but also, and significantly, other council services e.g. community development; urban and rural regeneration; planning etc.
- 2.18 Such a model would also give solid mechanisms through which the new RPHA could provide support; advice; data and research and expertise to inform and assist the local health improvement planning process. Critically also it would lay a firm foundation for influence of the community planning process and associated targets etc.
- 2.19 The local public health units would need to be developed jointly to reflect the principal on which they are based. In practice the employment of existing staff within each sector (for example environmental health staff in local government and health improvement staff currently within health boards/trusts but in future possibly within the new RPHA) would stay with each respective organisation. However, there would be a number of new positions that should be jointly appointed (i.e. funded equally). The most notable of these would be the directors for the new LPHUs.
- 2.20 Whilst the staff within each LPHU would be accountable to the PPHU director, he or she would be accountable to both the local authority and the RPHA. The accountabilities will be different and should not be replicated or duplicated. There will also be a need for clarity in this. However we believe that such details can be resolved and that a sense of joint accountability is essential. It further reinforces and ensures the primacy of public health at a local level and equally a local input to the RPHA and would assist in building the shared sense of both ownership and common purpose between the new local authorities and the RPHA.
- 2.21 The CIEH recognises that the final arrangements for new local government roles and structures in Northern Ireland have not yet been decided and that, as referred to in the preceding comments on health protection, has some impact on devising the most appropriate public health model. However there is potential to pilot the proposed model within Belfast City Council (assuming their agreement) in the interim period between 2009 and 2011 when the new local government arrangements will be implemented.

### 3. Funding arrangements, accountability and Local Commissioning Groups

- 3.1 It is vital that public health funding streams are clear, transparent. The system in terms of commissioning appears complex and could result in confusion unless very clear mechanisms and processes are put in place. Clear lines of accountability for funding and spend are also vital.
- 3.2 It is also vital that the commissioning structures and mechanisms ensure that funding for health improvement and health protection receives the appropriate level of support and that such budgets are safeguarded to ensure they are not skewed towards acute services.
- 3.3 There is a concern that should the RHSC Board and the LCGs be solely responsible for commissioning public health services that two issues may arise:
- 3.3.1 That the that demands of commissioning care packages to meet acute, short term provision for the treatment of the public could be to the detriment of longer term health improvement and reducing inequalities and
- 3.3.2 That the potential for commissioning health improvement services outside of the health sector may not be maximised.
- 3.4 We believe that there is opportunity within this reform to rethink the way in which public health, and in particular health improvement work is commissioned. Again we would highlight the existing Investing for Health Partnerships which have arguably allowed new delivery models to be developed because of their ability to fund initiatives outside the traditional health sector. It is essential that this capacity is not lost within the new arrangements.
- 3.5 We believe that there is an argument for a division of public health commissioning between the new RPHA and the Local Commissioning Groups. The LCGs should be responsible for commissioning such work within the Trusts whilst a portion of the public health budget should be allocated to the new agency that could commission services through their local public health units. This would include and incorporate the community and voluntary sector that is vital to the delivery of health improvement and it is expected will be fully engaged through the community planning process.
- 3.6 Given the above scenario there are potentially two options for accountability frameworks in relation to public health funding. Either the new RPHA should be accountable directly to the department rather than the RHSCB for public health spending and outcomes or, alternatively that the RPHA is, like the LCGs, accountable through the proposed new Regional Health and Social Care Board (RSHCB).
- 3.7 Whilst we can see the merit in accountability resting completely within the RSHCB we also see difficulties, not least that it is envisaged that the new chief executive of the RPHA will sit on the RSHCB. Clearly there is a need for the RSHCB to have appropriate representation and input on public health matters but it would be inappropriate for this to be via the head of an organisation that was in turn accountable to the board he or she was a member of.

- 3.8 For this reason we favour the first option, i.e. that the RPHA should account directly to the department for both its planned public health outcomes and financial spending. This will then allow the RPHA to play a full part in the work of the RSHCB and in particular its role in holding the LCGs accountable for health improvement outcomes proportionate to their budgetary allocation.
- 3.9 In terms of accountability at more local level cross agency work should be driven by mandatory consultation on community plans, public health plans and commissioning plans among others. This consultation should operate horizontally across all organisations and agencies at a local level and should also occur vertically obtaining the commitment of the RPHA at a regional level, of the RHSCB where this body control funding, of the DHSSPS and across departments where necessary via the Ministerial Group for Public Health.
- 3.10 In terms of accountability, it is considered that the role of the Ministerial Group on Public Health is vital, but it should be stressed that this Group has had limited success in the past and so its remit, constitution and drive need to be substantially strengthened. A mechanism also needs to be found which ensures unwavering commitment from all relevant departments. Since the formation of the IfH ministerial group several others have emerged, which in itself is testament to the solidity of the model as a means for ensuring and driving integration across government. However, whether the capacity exists to sustain several ministerial groups, each of which have strong synergies and overlaps between them (for example IfH; sustainable development; anti poverty and neighbourhood renewal are all inextricably linked and indeed complementary to each other) is perhaps debatable. We believe the concept of such high level accountability and drive is vital. However there needs to be better mechanisms found than currently exists to sustain this.
- 3.11 Ultimately a more complete accountability framework needs to be established which clearly demonstrates who will hold who to account, for what and how this will happen. This obviously is inter-related with the commissioning processes. The accountability framework must recognise the multisectoral, social, economic and environmental aspects of public health improvement. Therefore the framework needs to consider how others can be held accountable for delivery and this needs to be linked to community planning in a formal way in the longer term.
- 3.12 An operating framework and scheme of delegation will also be important to ensure sufficient flexibility at local level, whilst maintaining appropriate governance arrangements.
- 3.13 There needs to be a new performance management system which delivers improved population health outcomes and not simply enhanced services. There should be a continual strategic needs assessment process to enable the development of long term population targets and outcomes. Improvements need to be made to the process for collecting, analysing and using information on health determinants and on the performance of public health services and this will require investment, knowledge and capacity. It is anticipated that this will be part of the support role of the RPHA to all sectors.
- 3.14 It is also important that performance also relates to other public agencies such as housing, police, education, etc and there needs to be a mechanism to ensure they can contribute to setting the agenda via community planning partnerships.

- 3.15 We note, welcome and support the Minister's latest proposals to enhance the representation of local government on the local commissioning groups (LCGs) as well as the RPHA Board. It is important to note however that this on its own will not deliver a significantly enhanced role for local government in public health.
- 3.16 We also note and warmly welcome the Minister's intention to review the currently proposed five LCGs once the final outcomes of local government reform are clear. We believe that coterminosity is vital for comprehensive and more effective integration.

#### 4. DHSSPS

- 4.1 We note the proposals to reduce the size of the department in the context of these new proposals. We would broadly agree with the proposed responsibilities that it would retain. We have always taken the view that government should quite rightly be ultimately responsible for policy development and the setting of key strategic targets. However we would caution against these being over prescriptive, particularly for future health improvement policies. One size will not fit all and different solutions will be required for different areas within Northern Ireland
- 4.2 There is a need for the department to develop a much stronger strategic relationship with the local government and community and voluntary sectors as key partners in the delivery of the wide public health agenda. It is vital that models and processes for this are developed through close liaison with the local government RPA and modernisation teams in DOE as well as other key bodies such as NILGA, SOLACE, CO3 and NICVA.
- 4.3 Within government itself we strongly support the Ministerial Group on public health as a concept. However there is a need to find better mechanisms to ensure that it is more effective in achieving better integration across government departments for public health ends. Part of this needs to include securing real and sustainable commitment from senior officials within the respective government departments.
- 4.4 We are aware of the existence of other 'ministerial' cross departmental groups on other key cross cutting strategies such as neighbourhood renewal, poverty and (potentially in the future) sustainable development. However, we would question whether their continued existence in this current format and configuration is actually sustainable or indeed appropriate. Each of these issues is cross cutting and is of key public health significance. There is much scope for improving both the interconnectedness between them as well as a need to 'desiloise' the issues.
- 4.5 There is also a need to find mechanisms to enhance the capacity of the considerable professional public health expertise currently within DHSSPS to contribute to key areas of public policy that are of great public health significance. Some clear examples (by no means exhaustive) would include sustainable development (OFMDFM); environmental and planning policy (DOE); poverty (OFMDFM); and Housing policy (DSD).

## 5. Professional issues

- 5.1 The CIEH fully subscribes to the concept of multidisciplinary public health. As such we recognise that there are a wide range of professionals who need to provide input and expertise at a variety of different levels: in policy development; research; operational planning and service delivery. However within this section as the professional body for environmental health it is appropriate that we comment only on professional issues relating to environmental health.
- 5.2 By way of some background, apart from our work to develop professional competencies and frameworks within the profession itself through our accredited undergraduate programmes; Continuing Professional Development scheme; Assessment of Professional Development scheme and recently Chartered status (via Privy Council), the CIEH has also been heavily involved in the development of the UK Voluntary Register for Public Health (at both executive committee and advisory board level) and currently is involved with the Health Sector Skills Council in developing a framework for health protection and health improvement.
- 5.3 There is a tendency perhaps to think of environmental health practitioners (EHPs) in their more 'traditional' employment settings i.e. as environmental health officers (EHOs) within the local government sector. However, increasingly EHPs are employed within for example the Department of Health (DOH); the Department of Food and Rural Affairs (DEFRA); the Food Standards Agency (FSA); Health and Safety Executive (HSE); The Environment Agency (EA); and the Health Protection Agency (HPA). There is a clear and increasing recognition of the benefits that they bring in terms of skills and thinking to multidisciplinary public health.
- 5.4 The review of the public health function (RPHF) which reported in December 2004 made a number of specific recommendations that related directly to environmental health. In particular recommendation four related specifically to the need to broaden the contribution of environmental health in the public health function.
- 5.5 The review of environmental governance which reported last year (2007) also stressed the need for better engagement between health and environmental policy (referred to at 4. 5 in this paper) and in particular specifically identified environmental health as a key professional discipline in providing this (the suggestion made within that report that suggests the transference of the environmental health capacity currently in DHSSPS to DOE is not a view that we would support).
- 5.6 We believe that there is a need to build professional environmental health input at a number of levels within both the context of the preceding points and in light of the proposals within the consultation paper.
- 5.7 The public health role of environmental health within DHSSPS (currently a single individual) should be strengthened and enhanced through additional appointments in order to assist in developing the department's strategic relationship with local government; enhance the department's capacity to provide advice and input to other areas of government policy and further increase capacity to contribute to public health policy development.
- 5.8 We further believe that there is a clear argument for EHP posts within the new RPHA given that the intent is clear within the paper that the Agency should be

multidisciplinary in nature. We would argue that such posts could clearly assist the new agency not only in bringing critical environmental health expertise to its health protection work, but also in assisting it develop the critical links with the environmental health service in the local government sector. EHPs could also potentially assist in connecting the agencies work with other cross cutting government policies that significantly impact wellbeing and have a strong health dimension. Examples of these, as previously mentioned, might include sustainable development; neighbourhood renewal; planning policies and broad environmental policy.