

# Review of Brighton and Hove Healthy City Programme

Phase IV

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International Health Development  
Research Centre (IHDR)



University of Brighton

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Review of Brighton and Hove Healthy City Programme (Phase IV) IHDRC, August, 2008

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## **FOREWORD**

This review was written by staff from the International Health Development Research Centre (IHDR) at the University of Brighton. The IHDR review team for this project consisted of Professor John Kenneth Davies, Dr Nigel Sherriff, and Caroline Hall.

IHDR is established within the Faculty of Health and Social Science to provide a focus for research, development, and consultancy related to knowledge development and dissemination in salutogenic and socio-ecological aspects of health and wellbeing. The work of IHDR is based on a concept and philosophy of holistic health, not just disease, and a belief in participation and empowerment, social justice and equity.

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- Research
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- Theoretical aspects of health development and health promotion
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- Knowledge creation and dissemination systems for health promotion monitoring and evaluation

- International health promotion policy and practice
- Capacity-building in relation to migrant-friendly cross-cultural health
- Integrated settings based approaches to health promotion

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# List of Abbreviations

BS	-	Business Sector
CVSF	-	Community and Voluntary Sector Forum
DPH	-	Director of Public Health
HA	-	Healthy Ageing
HC	-	Healthy City/Cities
HI	-	Health Inequalities
HIA	-	Health Impact Assessment
HCM	-	Healthy Cities Movement
HCN		Healthy City Network
HCP	-	Healthy City Partnership
HFA	-	Health for All
HUP	-	Healthy Urban Planning
IHDRC	-	International Health Development Research Centre
LA	-	Local Authority
LAA	-	Local Area Agreement
LSP	-	Local Strategic Partnership
PA/AL	-	Physical Activity/Active Living
PAG	-	Project Advisory Group
PCT	-	Primary Care Trust
PH	-	Public Health
PS	-	Public Sector
WHO	-	World Health Organization

# Executive Summary

## Background and Aims

In 2004, Brighton and Hove joined Phase IV of the WHO Healthy Cities Programme and was formally designated as a WHO Healthy City. As Phase IV ends in December 2008, Brighton and Hove will be invited to join Phase V from January 2009. To assist key stakeholders in this decision-making process and to optimise future operation of the Healthy City programme, the International Health Development Research Centre (IHDRRC) at the University of Brighton was commissioned to conduct a review to scope whether added value has accrued from the City's role as a Healthy City.

The key aims of the review were to assess:

1. Whether the Healthy City approach is making a positive contribution to the health and wellbeing of the people of Brighton and Hove.
2. Whether Brighton and Hove's relationship with the WHO Healthy Cities Network has facilitated the progress of public health policy and practice within the City.
3. How the Healthy City Partnership can evolve to optimise the potential for health improvement and reduction in inequalities within the City.

## Review Design

The review consisted of two distinct and interrelated elements: first, desk-based work to include a review of selected literature and second, in-depth qualitative research with stakeholders of the Brighton and Hove Healthy City Partnership to include individual interviews and a half-day facilitated workshop.

## Summary of Main Findings

### Contribution of the Healthy City approach to the health and wellbeing of the people of Brighton and Hove

#### *Principal achievements and added value*

The principal achievements and/or impacts of the Brighton and Hove Healthy City (HC) programme focussed on broad awareness of the World Health Organization (WHO) 'badge'. This helped to legitimise health and raise its profile across the City, facilitated political 'buy-in' for the HC Programme, and increased strategic partnership working. It also raised the profile of the City more broadly in international and European arenas, legitimatising and endorsing the work of the Healthy City Partnership (HCP). However, some stakeholders were unable to identify key achievements of the HC Programme for various reasons. These included having only recently joined the Partnership; a lack of clarity around objectives (HC Programme and HCP), targets and key benchmarks; failure of the HCP to reflect upon and celebrate its successes; and difficulties in attributing impact or influence specifically to the HC Programme.

#### *Phase IV core themes*

Important achievements for Healthy Urban Planning (HUP) and Health Impact Assessment (HIA) included raised awareness of the impact of urban development on health and wellbeing; embedding HUP principles and objectives into the City Council planning strategy; and enabling HIA to form a key part of council planning developments. This has been achieved by delivering a series of training programmes to council planners throughout the City.

However, a limitation has been the lack of capacity and resources required for expansion of HIA. The non-statutory nature of HIA has meant that the outcomes can only be advisory.

Under the Healthy Ageing (HA) theme, key achievements have included raising awareness of older people's health issues by shifting the focus towards the wider determinants of health, to include issues such as increasing independence and

social inclusion by strengthening the role of older people in decision making and incorporating consultation into strategic plans. Nevertheless there was some difficulty in reporting achievements specifically attributable to the HC Programme. Comments made regarding Physical Activity/Active Living (Physical Activity/Active Living) reflected issues raised earlier - for example on the positive side - raised awareness, increased partnership working, and added kudos from the HC badge; and negatively – identifying attribution and measuring progress.

### *Health inequalities and wider determinants of health*

The HC Programme has helped to raise awareness of health inequalities in the City by providing a strategic focus to encourage cross-sectoral partnership working. However a lack of understanding as to the role of the HCP in tackling inequalities was noted. In attempting to address the wider determinants of health, stakeholders found it difficult to make a direct causal link from specific ongoing projects and infrastructural developments to the HC Programme. However, it was felt that awareness had been raised on what constituted the wider determinants of health, as a direct result of the HC Programme, and the long-term financial benefits of related work was recognised.

### **Relationship with WHO, Phase IV, and participation in Phase V**

In terms of the relationship to WHO, there were mainly negative responses from stakeholders, particularly in terms of the lack of on-going technical and practical support and advice received from the WHO HC office (currently based in Copenhagen). WHO's communication mechanisms were perceived as being inefficient, and as a result, the sub-networks had been unable to work in a cohesive and sustained way. In contrast, the European, and UK/Ireland HC Networks supported one another, acted as a reference point for one another and formed a united voice to WHO as and when appropriate. Lack of resource and poor management in the Copenhagen office were perceived as key factors for the lack of support. On a positive note, the technical training offered by WHO advisors has been invaluable for some Brighton and Hove officers, and the benefits of this training had been translated into practice at a local level, and the skills disseminated to a wider pool of officers.

Key themes arising from Brighton and Hove's participation in the WHO network included the kudos mentioned earlier and the knowledge exchange between cities which it has facilitated. This participation has had a positive impact on the development of policy, in particular in the areas of HUP and HIA.

The sub-networks have provided a forum for the exchange of knowledge, the development of tangible ideas for implementation in Brighton and Hove, and the provision of technical training. Whilst recognising some benefits of participating in the WHO HC network, there was some uncertainty as to whether the progress made in policy and practice, could in fact be directly attributed to WHO and the HC Programme, or whether the work would have been achieved anyway.

The ongoing uncertainty around the detail of Phase V of the HC Programme meant that stakeholders found it difficult to make a reasoned decision as to whether Brighton and Hove should continue to participate. However, stakeholders commented on the following issues – the potential costs of their participation, WHO priorities compared with Brighton and Hove's priorities and that there should be synergy between the two in order to justify Brighton and Hove participating in Phase V. The benefits again reflected the perception that there is kudos attached to being a WHO designated City, the HC Network's 'pool of knowledge' which would continue to be a resource for the City, and the HC Programme acting as a 'vehicle' for the delivery of a broad public health agenda.

## **The Healthy City Partnership**

This section of the report focused specifically on the 'health' of the HCP itself, to explore how it could evolve to optimise the potential for health improvement and reduction in inequalities within the City. A number of key themes emerged including: value of involvement; appropriate priorities; community consultation and engagement; terms of reference; membership; working practices; vision for the future and; key challenges.

### *Value of involvement*

Stakeholders felt there were clear benefits to being involved in the HCP on behalf of their organisations and/or sector. Benefits included a sense of legitimacy by the

HCP for endorsing action at local level, higher visibility, facilitating intersectoral collaboration, and enabling joint working.

### *Appropriate priorities*

In general, stakeholders reported that the HC priorities were also the appropriate priorities for the City. Some also suggested a number of other priorities they felt should additionally be addressed including mental health, substance (mis)use, and sexual health. Stakeholders felt there was a need to consider local demographic variations across the City, and to ensure that potential conflict between WHO, local and national priorities would be addressed.

### *Community consultation and engagement*

Stakeholders were asked what mechanisms were in place for the HCP to consult with local citizens of Brighton and Hove. Interviewees reported that consultation was made using the existing mechanisms of various partners from the HCP via their own communication systems. However, most felt there were too many consultations with communities in the City, and that it was necessary to work in a more joined-up way with other organisations, sectors, and agencies in the City in order to make optimum use of resources. Stakeholders felt that the HCP needed to be clear about the purpose of consultation and engagement with local communities, and to ensure that the conceptual difference between the two terms was recognised.

In general, stakeholders felt that existing communication mechanisms had not been effective, and that the HCP should design and operate its own dedicated communication strategy and delivery mechanism.

### *Terms of Reference*

Although there was general support for the Terms of Reference in their current format, most participants felt they needed to be reviewed and updated in order to evolve with the development of the HCP. Suggestions were made on how this could be done including references to working practices, membership, elaboration

of the link to the Local Strategic Partnership, and the need for some specific and measurable objectives and targets/deliverables. Concern was expressed as to whether the HCP was sufficiently empowered to achieve the Terms of Reference together with the implications for the HCP of future plans for the formulation of a health and wellbeing partnership.

### *Membership*

Most stakeholders felt that membership of the HCP was reasonably mixed in terms of sector representation and seniority. However, many felt there was a need for membership to be revisited in order to ensure representation from additional sectors (e.g. business) and that appropriately senior level individuals were involved to ensure action outcomes. Stakeholders reported wanting clarity about the recruitment of members to the HCP, and their own role and functions within the Partnership, relating this particularly to uncertainties about accountability.

### *Working practices*

Stakeholders felt that the HCP was probably working as well as it could, based on the available resources and current policy context. However, there was broad agreement that the HCP had not been working in the most effective and efficient way. Common concerns (as examples) related to the lack of capacity and resources, and the lack of strategic direction. Stakeholders proposed a number of ways forward to improve the effectiveness and efficiency of the Partnership's working practices including the development of a strategy and operational plan, more focussed and interactive meetings, linking more explicitly to the LSP, and becoming involved in commissioning.

### *Vision for the future*

There was some overlap here with other sections of the report. Most notably, interviewees reported that their vision for the future was for the HCP to function in a more strategic and collaborative way including becoming more influential and visible and being clearer about its purpose. This strategic shift was seen as a crucial element in the decision to join Phase V of the HC Programme. Other visions for the HCP included a review of membership and working practices, being

able to demonstrate 'short-term wins', and the development of an on-going, comprehensive monitoring and evaluation system.

### *Key challenges*

Stakeholders reported that clarifying potentially competing priorities at local, national, and European level would be a key challenge for the HCP in the future. Other challenges reported included ensuring appropriate senior members participated in the HCP, and for the HCP to address its strategic credibility and power to influence action at a local level as well as the HCP becoming embedded into the mainstream.

## **Recommendations**

Given the cross-cutting nature of the findings of this review, it was decided to present our recommendations in the form of an analytical framework adapted from characteristics of successful HC projects as specified by Tsouros (1990; see also Hancock, 1993). In doing so, a number of suggestions are proposed for potential action by the HCP.

### **Strong political support**

- The HCP needs to engage with senior politicians from all political parties to ensure their commitment and active participation. The city of Helsingborg (Sweden) has achieved this high level of political commitment and we recommend that the HCP considers this approach in some detail as a potential model for adoption (see Halling and Östergren, 2008).
- It is likely that the lack of engagement by senior politicians and some senior stakeholders in the City, who may consider WHO designation simply as a badge of status, may be influenced by a lack of awareness of the underpinning principles and breadth of the HC approach as a settings-based approach to health promotion. It is therefore proposed that the HCP needs to explore ways of facilitating understanding regarding the core values and ideals of the HC Programme amongst key politicians and senior

stakeholders. It is suggested that this could be achieved by holding an 'open day' to which politicians and other senior stakeholders could be invited. In doing so, this is likely to raise significantly the profile of the HCP and ensure appropriate political accountability.

- To assist in this process of gaining further political understanding and support for the HC approach, the HCP should utilise more creatively the practical examples of short-term impacts. This could provide evidence to demonstrate the HC approach in action, and it is suggested that achievements of the HUP and HIA core themes, for instance, could serve this purpose.

### **Effective leadership**

- Although stakeholders were positive about the local leadership of the HCP, it was noted that the officers involved are regularly working at near full capacity. It is suggested that the Partnership should consider a more equitable division of leadership responsibilities. This could mean empowering its members to represent HCP interests in other networks and thereby delegate specific leadership tasks. The recent example of utilising the Vice-Chair in this way is a positive move in this direction. Other members of the Partnership should be similarly engaged as and when appropriate.
- When considering the decision to join Phase V of the WHO HC Programme, the HCP should ensure the dedicated commitment of adequate resources by WHO senior management to enable effective leadership and support to the Programme. This would include a well-resourced and experienced secretariat (which is likely to be outsourced from the WHO Copenhagen office) together with assurances concerning the necessary time and resources for the HC coordinator to provide effective and sustainable leadership. This would also help to ensure effective guidance and support from WHO technical advisors.

- It is recommended that the HCP looks to establish potential ways of ensuring regular and effective two-way communication with the WHO Secretariat.

### **Broad community ownership and strong community participation**

- The terms 'community participation', 'community empowerment' and 'community development' are frequently left undefined or used interchangeably (Peterson and Lupton, 1996). The HCP needs to seek conceptual clarity concerning the difference between consultation and engagement with local communities and include subsequent action in their future strategy and work plans.
- In addition, the HCP needs to address the issue of community ownership as a fundamental value of the HC approach and translate this into the core activities of the Partnership.
- It is of course acknowledged that a major challenge and tension exists in the HC approach between working at the highest strategic level (top-down approach) and at the same time, also engaging directly with communities (bottom-up approach). However, it is important that the HCP addresses this issue within its strategy if it is to enable local citizens to have a direct influence on health-related policy and decision-making within the City.

### **High visibility**

- The kudos derived from designation as a WHO HC should not be underestimated. To capitalise on this and achieve the required visibility and credibility, there is a need for a comprehensive communication strategy. This strategy should include clear and measurable objectives, identify appropriate target audiences and set out key mechanisms for effective delivery. Such target audiences should be diverse including citizens and communities within the City as well as senior politicians and senior stakeholders from a range of sectors including the private/business sector.

The strategy should also make more creative and extensive use of the Brighton and Hove HC logo which was highly valued amongst stakeholders.

- A key objective of the HCP communication strategy should raise awareness of the impact of the HC approach, to include specific examples of its achievements. This may help to counter the uncertainty expressed by stakeholders regarding the difficulty in attributing added-value to the HCP.
- The locality and working practices of the HCP are important with regard to visibility and raising awareness. The current practice of holding HCP meetings in different locations and venues across the City should continue. However, it is suggested that some HCP meetings could be open to the public as a means of enabling accessibility and thus raising visibility at the community level.

### **Strategic orientation**

- As a matter of urgency, and of critical importance, the HCP needs to develop a comprehensive long-term strategy and shared vision for its future work. This should not 're-invent the wheel' but build upon existing city plans and available strategic documents. However, it is recommended that such a strategy should demonstrate how WHO/European priorities can facilitate the achievement of local and/or national targets and priorities.
- As part of the delivery of the HCP strategy, short-term, medium-term, and long-term operational plans with clear objectives and process and/or proxy measures should be developed. Ongoing mechanisms to monitor and evaluate these operational plans should be incorporated from the outset.
- The terms of reference for the HCP will need urgent review and updating in light of the above recommendations. In doing so, it will be necessary to take on board some of the expressed concerns of stakeholders including, for example, whether the HCP is actually empowered to achieve these terms of reference. The HCP's accountability to the LSP should also be clarified and incorporated into its terms of reference.

## **Adequate and appropriate resources**

- It is proposed that additional and significant sources of funding or secondment opportunities for appropriate staff are secured to support coordination and delivery of the Brighton and Hove HC Programme.

## **Effective committees**

- Numerous concerns were raised regarding the format and culture of HCP meetings. It is recommended that the HCP reviews its working practices, for example, by considering whether the current business style meeting involving all members of the Partnership with a lengthy agenda, series of formal presentations, and extensive paperwork, is the most appropriate and effective method. It is therefore suggested that the HCP considers alternative models for adoption. For instance, this might include smaller and more interactive meetings/workshops on specific themes, and designating certain members to take on particular roles and responsibilities (perhaps on a rotating basis).
- There was a lack of clarity as to the role, function, responsibilities, and accountability of members of the HCP. There was also uncertainty as to why and how people are invited to become members and/or attend meetings, as well as confusion and a lack of understanding about the broader HC approach and what this means in practice. It is strongly recommended that an HCP 'members' pack' is developed to address and provide clarity on these important issues. Such a pack could include for example: the scope and purpose of the HCP; HCP strategy and work plan; background information on the WHO HC approach; terms of reference; local networks and infrastructures; members' code of conduct, and details of current membership. It is expected that this will facilitate more active engagement by members in the work of the Partnership. Furthermore, it may also assist in encouraging shared ownership and a sense of group cohesion.

- Membership of the HCP should be reviewed on a regular basis to ensure equitable sectoral balance and appropriate representation from sectors not adequately represented (for example, business sector, community interest and residents' groups). In this process, seniority of membership should be considered to ensure action outcomes within their own organisation/sector.
- The work of the HCP in facilitating intersectoral collaboration and carrying out project administration has been extremely successful and of high quality. It is proposed that this work continues and can only be strengthened by additional support resources as recommended above.

# 1.0 Introduction and background

## 1.1 Concepts and principles: The WHO Healthy Cities Programme

The WHO Healthy Cities project is a long-term international development initiative which aims to place health high on the agenda of local political decision-makers, key groups at city level, and the population at large (Kickbusch, 1989; Tsouros, 1995a). It aims to promote comprehensive local strategies for health and sustainable development, and ultimately, seeks to enhance the physical, mental, social, and environmental health and wellbeing of the people who live and work in cities and related municipalities in various regions of the world.

The Ottawa Charter, which established a solid foundation for the theory and practice of health promotion, has become internationally accepted as a framework for action to improve health and tackle inequalities in health (WHO, 1986a). The HC project was developed initially in the WHO European Region in 1987 as a means of actioning the Ottawa Charter at local city and municipality level. The HC project is built firmly on the principles and values underpinning both WHO's Health for All strategy (WHO, 1978; WHO, 1981; WHO, 1998), WHO Health 21 (WHO, 1999) and Local Agenda 21 (see Dooris, 1999; WHO, 1997a). Consequently, a particularly strong emphasis is given in this urban settings approach to equity, social justice, participatory governance and solidarity, inter-sectoral collaboration and action to address the broad determinants of health. The HC concept is dynamic. Its shape and content has been influenced over time by a wide range of factors including new global strategies and WHO regional and inter-regional priorities; changing socio-political, demographic and organisational contexts, lessons learnt from past experience, and advances in the evidence base relevant to interventions that address the determinants of health.

Since its inception, the European HC Programme has developed through four phases, with each phase giving particular attention to a number of priority themes. In addition to these specific themes, the HC approach focuses in particular on building strong organisational structures for health at the local level but within a

broader European and international context (de Leeuw, 2001). The core principles of the HC approach are to facilitate commitment to the HC approach at the highest political level of the City or municipality, to create organisational structures for implementing processes and policies, to formulate a common vision of the City with a focus on public health development and on specific themes, and finally to build both formal and informal networks, within the HC project. These principles are central in all phases of the HC project (WHO, 1986b).

Phase I of the project (1987-1992) was devoted to planning and preparation (Kickbusch, 1989). This phase consisted of 35 cities in the network; the main focus was on creating new structures to act as change agents and introducing new ways of working for health in cities (WHO, 1997b). Phase II (1993-1997) was more action-oriented with a strong focus on formulating and implementing Health for All oriented city policies, developing city health profiles and comprehensive city health plans that set explicit targets, addressing issues such as equity and sustainable development and also establishing mechanisms to promote accountability for health (Doyle *et al.*, 1997). This phase essentially involved speeding up of the adoption and implementation of policy at the City level, strengthening national and sub-national support systems and building strategic links with other sectors and organisations that have had a major influence on urban development (Doyle *et al.*, 1997). Phase III (1998-2002), focused on progressing action to promote urban and global health in ways that were both innovative and sustainable. The work reflected international policy developments and built on the experiences and successes of the first two phases. Phase IV (2003-2008) will shortly be coming to an end and has focused on core developmental themes including: healthy urban planning, health impact assessment, healthy ageing, and physical activity/active living (PA) (WHO, 2003).

#### **Phase IV Core Themes: Sub-Networks**

WHO has established European sub-networks to take forward the work of three of the core themes: HIA, HUP, HA. The sub-networks, guided by WHO, steer the technical and strategic agenda for the delivery of Phase IV. More specifically, the role of the sub-networks is to advance the understanding and experience of the

core themes as well as developing products that will have benefits to the WHO network as a whole. In this way, the sub-networks further develop the concept (of HIA, HUP, HA) by experimenting and implementing innovative projects, by developing practical guidance and case studies and by organising training and learning events for all the WHO Network Cities. The sub-networks each meet at least once annually, under the direction of a lead city. A maximum of 15 cities, chosen by WHO, can be members of each of the sub-networks. A report of each of the sub-networks is provided to WHO at each of the meetings, and these are also posted on the WHO's password protected website, which is accessible to WHO Network Cities. Brighton and Hove have been members of the HUP and HA sub-network since 2005, and the HIA sub network since 2006. There is no formally established WHO sub-network for PA.

### **National Healthy Cities Networks (HCNs)**

National HCNs have been set up across Europe to mobilise and inspire cities to develop responsive local strategies for urban health and sustainable development (WHO, 2003; Lafond et al 2003). The main objective of the National HCNs is to support cities in implementing the HC approach, and in addition, many networks have become a significant resource for national governments. The UK does not have a dedicated formal HCN. The role was assumed by the Health for All (UK) Network until 2005. The UK and Ireland Healthy Cities Network continue to actively work together, and have formal affiliation with the United Kingdom Public Health Association (UKPHA). In this way, a contribution can be made by the UK and Ireland HCN cities to the scientific and technical work programme of UKPHA and thus to the wider UK public health and health promotion agenda. Funding is currently being sought to work independently as a network.

## **1.2 What is a Healthy City?**

The HC approach conceptualises a major shift in our understanding of health. It is a city that is:

*“...continually creating and improving those physical and social environments and expanding those community resources that enable*

*people to mutually support each other in performing all the functions of life and in developing their maximum potential.” (Hancock and Duhl, 1986)*

It is important to clarify and understand the concepts and principles of the WHO Healthy Cities programme. Within the Programme, a ‘Healthy City’ is defined in terms of process and outcome. It is not a city that has achieved a particular level of health; rather, it is one that is conscious of health and striving to improve it. The achievement of the designation of a ‘Healthy City’ is not an outcome, it is part of a process by which the City is conscious of health and is constantly striving to improve it instead of achieving a particular level of health (Tsouros, 1995a; Baum, 2002). Thus any city can be part of the HC movement, regardless of its current health status; what is required is a commitment to health and a structure and process to achieve it (Tsouros, 1995a). The WHO encourages cities to target and solve local problems and engage people from various parts of the community in the HC process. The approach involves facilitating collaboration among citizens and people from business, government and other sectors of society who recognized that their synergy could be used to maintain and improve the wellbeing of the entire community (Kenzer, 1999).

The strategic scope of the WHO Healthy Cities project, its principles, methods and vision have been related to four overarching elements (WHO, 2003):

1. Action to address the determinants of health and the principles of Health for All/Health 21;
2. Action to integrate and promote European and global public health priorities;
3. Action to put health on the social and political agendas of cities;
4. Action to promote good governance and partnership-based planning for health.

These action elements have been expanded into strategic goals, themes, structures and ways of working (WHO, 2003). These strategic goals include:

1. Promoting policies and action for health and sustainable development with an emphasis on the determinants of health, people in poverty and the needs of vulnerable groups;
2. Increasing accessibility of the WHO European Network to all member states of the European Region;
3. Promoting solidarity, cooperation and working links with European cities and WHO Healthy Cities;
4. Strengthening the national standing of HCs in the context of policies for health development, public health and urban regeneration;
5. Playing an active role in advocating for health through partnerships; and
6. Generating policy and practise expertise, good evidence and case studies that can be used to promote health in all cities in the region.

The HC Movement currently has expanded globally and consists of several thousand participating cities on all continents (O'Neill and Simard, 2006). Perhaps unsurprisingly therefore, the issue of assessing whether or not the movement is having an impact and adding value has long been a key issue and matter of debate (de Leeuw, E. & Skovgaard, T., 2005). During the last two decades attempts have been made to develop a universally accepted series of indicators to evaluate HC projects (WHO 2001). However, this has not been achieved, in part, due to the individual nature and stage of development of each HC. O'Neill and Simard (2006) argue that the proper way to evaluate HC initiatives is more than anything else a political task to be negotiated between various stakeholders rather than the use of external quantitative measures.

The diversity of perspectives and the variations in implementation of HC world-wide provide researchers with a multiplicity of foci and approaches for potential review and/or evaluation. In evaluating two HC projects in Bangladesh, Burton (1999) has noted three categorisations of HC evaluations: 1) evaluations of projects across countries and/or regions (e.g. Draper *et al.*, 1993; Harpham *et al.*, 2001), 2) evaluation of particular aspects of a selection of HC projects (e.g. Costongs and Springett, 1997; Donchin *et al.*, 2006; Nunez *et al.*, 1994; Ouellet *et al.*, 1994; Webster, 1999), and; 3) evaluation of individual HC projects (e.g. Baum and Cooke, 1992; Burton, 1999; Halling and Östergren, 2008).

The current review falls into the third category as it represents an appraisal of the Brighton and Hove HC Programme from the internal viewpoint of its stakeholders. There are of course important reasons for reviewing and/or evaluating Health Cities, in this case, at an individual project level. For instance, assessing whether the Programme has changed anything in local and strategic political processes, to provide a comparison with other cities in the WHO Network of HCs, to generate knowledge of interest to the scientific community, or to maintain the political legitimacy of a HC Project (O'Neill and Simard, 2006).

It is important to note that this review focuses primarily on process and the structures that support process (see table 1). In doing so, we of course recognise the difficulties and challenges inherent in adopting such an approach. Individuals are often accustomed to, and indeed want to, see hard outcomes and tangible deliverables, especially in the short term. However, the process of making a city healthier does not lend itself to quick, easy measurable results meaning the HC initiative can be difficult to defend in some arenas (Hancock, 1993).

*Table 1 Characteristics of a successful Healthy Cities project*

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Strong political support
Effective leadership
Broad community ownership
High visibility
Strategic orientation
Adequate and appropriate resources
Sound project administration
Effective committee(s)
Strong community participation
Intersectoral collaboration
Political and managerial accountability

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Source: Tsouros, 1990 (cited in, and adapted by, Hancock, 1993)

This of course has implications for research, and in conducting this review, we embrace a qualitative research framework that allows us to examine what is working and what is not providing both short and long-term insights to enable the Brighton and Hove HCP to evolve. We also adopt aspects of the characteristics of a successful HC project as outlined by Tsouros (1990) and refer back to these in the discussion and recommendations section as a useful benchmark.

### **1.3 The Brighton and Hove Healthy City Programme**

In 2001, Brighton and Hove chose to adopt the WHO's Healthy Cities approach to achieve its health improvement objectives. The HC model was identified as the best fit to achieve improved health and wellbeing within the cultural, social, political and organisational context of Brighton and Hove. An HC Forum was established in 2001. This was the fore-runner of the City Health Partnership (2002), which eventually became the Healthy City Partnership (2005). The HCP aims to bring together champions from each sector with the authority or influence to commit their organisations to joint action to improve health and reduce health inequalities within the City.

In July 2004, Brighton and Hove's application to join the WHO Healthy Cities Programme Phase IV (2003-2008) was successful and was formally designated as a WHO Healthy City. This was based on the City's strong political support, commitment to partnership working and to improving health and reducing health inequalities through action on the wider determinants of health.

Since joining the HCN, Brighton and Hove has focused on the implementation of the four Phase IV core themes, which are healthy urban planning, healthy ageing, and health impact assessment, together with active living/physical activity. In addition, the HC Programme has embraced wider public health activities in line with national and local priorities.

As Phase IV ends in December 2008, and WHO will invite Brighton and Hove to join Phase V from January 2009, this therefore provides an opportune time frame to review whether the HC approach has facilitated added value to improving the conditions for health and wellbeing in the City. Moreover, it also presents a valuable opportunity to explore how structures, processes and relationships may be enhanced to optimise a positive contribution to achieving improved health outcomes for the local population. Consequently, the present review constitutes an initiative to assess qualitatively, the impact of Brighton and Hove's HC Programme from the perspective of its key stakeholders.

## 1.4 Aims and objectives of the Review

In order to assist key stakeholders in this decision-making process and to optimise future operation of the HC Programme, the International Health Development Research Centre (IHDRC) at the University of Brighton has been commissioned to conduct a review to scope whether added value has accrued from the City's role as a healthy city. This review assesses the benefits and costs specifically from the following inter-related perspectives:

- The HC approach
- Participation in Phase IV of the WHO Healthy Cities programme
- The HCP

The key aims of the review were to assess:

1. Whether the HC approach is making a positive contribution to the health and wellbeing of the people of Brighton and Hove.
2. Whether Brighton and Hove's relationship with the WHO Healthy Cities Network has facilitated the progress of public health policy and practice within the City.
3. How the HCP can evolve to optimise the potential for health improvement and reduction in inequalities within the City.

## **2.0 Review design**

This qualitative review was carried out by staff from the International Health Development Research Centre (IHDRC) at the University of Brighton. The review consisted of two distinct and interrelated elements: first, desk-based work to include a review of selected literature and second; in-depth qualitative research with stakeholders of the Brighton and Hove HCP to including individual interviews and a half-day facilitated workshop.

### **2.1 Qualitative review of selected literature**

To inform primarily the development of the interview schedules and facilitated workshop, a qualitative review of selected literature was conducted by the IHDRC review team during the early stages of the project (April, 2008). This documentary review included published and grey literature around the WHO Healthy Cities movement, as well as more local literature relating specifically to the Brighton and Hove HCP (e.g. strategies, action planning documents, policies, minutes, reports, briefing papers, etc). Relevant materials for inclusion were identified with the assistance of the Project Advisory Group (PAG)<sup>1</sup>.

### **2.2 Qualitative research**

Following the review of selected literature, qualitative research with stakeholders of the Brighton and Hove HCP was carried during May and June 2008. Qualitative methods were seen to be particularly appropriate because epistemologically, qualitative interviewing can allow a rich and meaningful way of generating data by gaining access to individuals' narratives and analysing their use and construction of discourse. Moreover, qualitative methods can be particularly appropriate because they allow explanations and findings, perhaps not yet anticipated or known, to arise inductively from the data.

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<sup>1</sup> A Project Advisory Group was set-up prior to the commencement of the review and met 3 times at strategic milestones. Members of the PAG included: Terry Blair-Stevens, Paul Jarvis, Professor John Kenneth Davies, Dr Nigel Sherriff, and Caroline Hall.

### 2.2.1 Sample

Up to 35 structured face-to-face interviews with stakeholders (e.g. public, statutory, elected, community and voluntary, neighbourhood and communities, business) were originally planned to be conducted in addition to a half-day facilitated workshop with all members of the Brighton and Hove HCP in addition to other key stakeholders. To identify potentially suitable participants for inclusion in the review, IHDRRC worked closely with the PAG to ensure stakeholders from each of the five sectors reflected in the Local Strategic Partnership (LSP) were identified. Final recruitment was based on an individual's professional role/sector and their contribution to Brighton and Hove HC Programme rather than any demographic criterion (e.g. gender, age, ethnicity etc). In total, 30 individuals were identified through this process as being stakeholders appropriate to interview for the review. Of these 30, 27 individual in-depth interviews were actually conducted including two telephone interviews with stakeholders from the WHO European Office in Copenhagen and the chair of the UK and Ireland designated WHO Health Cities Network in Belfast. Three individuals contacted did not wish to participate in the review. A list of stakeholders and their affiliation is provided in Appendix B. A summary of stakeholders interviewed by sector can be seen in Table 2 below.

*Table 2 Interviewees by sector*

<b>HCP members by sector</b>	<b>N</b>	<b>Type of Interview</b>
Public Sector	7	Face-to-face
Local Authority	6	Face-to-face
Public Sector/Local Authority	3	Face-to-face
Business	2	Face-to-face
Community and Voluntary Sector	6	Face-to-face
European/other	3	Telephone
<b>TOTAL N</b>	<b>27</b>	

### 2.2.2 Individual in-depth interviews

All interviews took place May and June 2008 and were conducted by all three members of the IHDRRC review team. A semi-structured interview schedule was developed in collaboration with the PAG (see Appendix F). Based on this core

schedule, two slight variations were also produced for interviews with different stakeholders. The interview schedule was designed to act as more of an *aide-mémoire* to remind the researcher of the areas to be covered rather than as a tool to prescribe the actual list and order of questions to be asked. Therefore, in developing lists of categories and questions the intention was to provide a framework to ensure coverage of the same kinds of questions and addressing all 3 aspects of this review, whilst maintaining the flexibility to change should circumstances dictate.

Most interviews lasted for approximately an hour. The purpose and process of the interview was explained and all participants signed a consent form before being interviewed (see Appendix G). Participants were also given an information sheet about the review (see Appendix H).

### **2.2.3 Facilitated workshop**

In addition to the individual interviews, a half-day facilitated workshop was held with key stakeholders of the HCP in June 2008 (see Appendix J for a list of participants). The overarching aim of this event was to examine the 'Health of the HCP'. Facilitated by the IHDRRC review team, the workshop aimed to supplement the data generated from the individual interviews and involved a number of reflective small group exercises as well as larger group (plenary) discussions on topics such as: the role of the HCP within Brighton and Hove, terms of reference, roles and functions of individual members, working practices, and recommendations for the future of the HCP (see Appendix I for the Programme and full details of the tasks).

## **2.3 Data analysis**

All stakeholders agreed to their individual interviews being recorded, transcribed, and content analysed. Notes taken by the researcher(s) were also subject to equivalent analysis where appropriate/relevant. Similarly, all generated materials produced during the facilitated workshop (e.g. focus group discussions, flipcharts, discussions, etc) were recorded and content analysed for inclusion in the review.

The following conventions were used for the transcription of the interview data: [ ], background information or contextual note; “ ”, direct quotation; [...], text extract from same interview or extract from a different interview to follow.

All interviewees' names were anonymised using a coding system devised according to the LSP structure as stated in the 2020 Sustainable Community Strategy (i.e. public sector, local authority, community and voluntary sector forum, and business sector). This approach was used rather than identifying individuals using their job title as it enabled stakeholders to remain as anonymous as possible, whilst preventing the potential loss of impact; for example where knowing the job title or association of a person may add significant weight to a statement or quote.

## **2.4 Ethical considerations**

Ethical approval for this review was sought from the Faculty of Health and Social Science's Research Ethics and Governance Committee (FREGC) at the University of Brighton, prior to any fieldwork taking place. This committee meets to ensure the integrity and quality of research proposals in all matters concerned with the management and ethics of research involving human participants, research that draws on secondary data carrying personal or organisational information, and other research which is deemed to present ethical or governance issues. As part of this process, the level of risk involved in research projects is considered (against the Faculty's agreed criteria) and, where appropriate, recommendations are made at reducing the level of risk.

During this review full measures have been taken to ensure informed consent, confidentiality, privacy, and data protection. All data (including copies of signed consent forms) has been kept securely against unauthorised access and complied with data protection legislation (i.e. participants were informed of, and agreed with, the transcription/storage procedure before participating in the interview). No payment was made to stakeholders.

## 3.0 Findings of the Review

The findings of this review are presented in three parts. First we present thematically, the findings relating to whether stakeholders feel the HC approach has made a positive contribution to the health and wellbeing of the people of Brighton and Hove. Second, we explore Brighton and Hove's relationship with WHO and examine whether the WHO Healthy Cities Network has facilitated the progress of public health policy and practice within the City. Finally, we present the findings relating to the health of the HCP and look at how it could potentially evolve to optimise health improvement and the reduction in inequalities within the City.

### 3.1 Contribution of the Healthy City approach to the health and wellbeing of the people of Brighton and Hove

At the start of the interviews, stakeholders were asked to outline what they thought were the principal achievements and/or impacts of the HC Programme in relation to the health and wellbeing of the people of Brighton and Hove. In doing so, participants were also asked to reflect on the added value of the HC Programme, and to comment on what they thought hadn't been achieved during participation in Phase IV.

#### 3.1.1 Principal achievements/impacts of the HC Programme

In terms of the principal achievements and/or impacts of the HC Programme, analysis revealed three clear themes emerging from stakeholders' narratives including raising awareness, gaining political support, and increased partnership working. In terms of the former, most interviewees we spoke to felt that the HC Programme and having the WHO HC 'badge' had helped to legitimise health and raise the profile of health across the City at political, strategic and local levels:

*"It has brought a lot of kudos and raised the profile of health issues in the City by having that stamp of WHO...that's an achievement in itself." (CVSF 4)*

*“It has brought to the fore health considerations in the City - certainly at a political level...it has created a high profile and has legitimatised health and wellbeing as an important issue - so health shouldn’t be seen in isolation but very much part of the wider work that the City Council does as well, in terms of education, planning, environment etc.” (PS10/LA)*

In talking about the raised profile of the City, some respondents also referred to the European and international stage:

*“It’s raised the profile for work in Brighton, the work that’s already going on in Brighton locally. It’s raised that very much on the national and international stage or the European stage and I think this has been an excellent benefit that we wouldn’t have gained otherwise if we’d not been part of this European network.” (PS9)*

*“...It has placed us as one of the leading cities in Europe - I don’t think there are too many places in Europe that have made the policy and strategic links between health and other strategies as well as Brighton has done.” (LA1)*

Second, in accordance with one of the main goals of the WHO European HC project, a number of interviewees felt that an important achievement of the Brighton and Hove Healthy City Programme had been putting health high on the political agenda and gaining a certain level of political buy-in from local politicians:

*“It’s placed health high on the agenda of the local authority in particular, and enabled us to obtain a significant level of political support.” (PS9)*

*“It’s buy-in from the politicians. You have to have buy-in from politicians to get any of this done and as a sub-set of that, a buy-in from officers in the Council because what politicians want, officers want of course. I think a lot of officers saw this as a real opportunity to do things differently.” (PS3)*

Third, many stakeholders felt the HC Programme had made significant progress in developing and increasing strategic partnership working across the City, and in

some cases, leading directly to more operational impacts on the population of Brighton and Hove. The opportunity to bring key partners together combined with strong leadership from the HC Programme Manager and Chair of the HCP were felt to be important driving factors in this success:

*“The HC Partnership acts as a focal point to bring together the sectors on strategically co-ordinated action on the wider determinants of health and action on health inequalities...” (PS10/LA)*

*“It has had the effect of consolidating and deepening partnership working, and as a consequence of that, it has put the broader aspects of health and public health onto the agendas of those organisations.” (PS4)*

*“It’s not so much the [HEALTHY CITY] programme for me, it’s the Partnerships behind it and the leadership by Tom [CHAIR OF HCP] and Terry [PUBLIC HEALTH PROGRAMME MANAGER] has been strong. At a strategic level there has been much closer working between PCT and City Council which has really been helped by Terry’s joint role within King’s House and the PCT.” (LA5)*

*“The main benefit is in terms of bringing all those different people from those different backgrounds into the same room together with the knowledge that in most cases what they are also doing is then taking information away and sharing it within their own networks. So it’s a ‘knowledge in and information out’ set up which is very beneficial.” (CVSF 4)*

*“The HCP is there as a strategic body to look after public health and it is there to influence the work of the other organisations and partnerships around it - I think it has been successful in that.” (LA6)*

Although most respondents were able to comment on what they felt the healthy city programme had achieved, a small number of interviews reported that they

found it difficult to do so. Reasons cited for this included being a recent addition to the HCP membership and therefore not feeling they had an overall grasp on what had been achieved in the past, the HCP failing to celebrate or remind itself of its previous successes, and a lack of clarity in terms of benchmarks and specific targets:

*“It is hard to say what has and hasn’t been achieved...It seems to be a conduit of lots of information - so probably a 2 or 3 hour meeting where lots of information is received and sometimes I am not sure – I haven’t quite worked out how that fits into some of the bigger picture work.” (LA3)*

*“I find that very difficult to answer because I haven’t seen what the objectives of the Programme are so I don’t quite know what it set out to achieve in the first place. As far as I can see the vast majority of any decision making and planning around health happens in other fora.” (PS2)*

### **Added Value of the HC Programme**

In their interviews, stakeholders were also asked to comment on the added value they believed the WHO Healthy City Programme brought to Brighton and Hove city. More specifically, they were asked what had been achieved that perhaps may not have been achieved without the HC Programme. In general, although many of the stakeholders we spoke to felt that it was difficult to tease out what may or may not have happened without the HC Programme, there were still a number of themes emerging in response to this question. These themes largely reinforced the principle achievements explored above, and in doing so, suggested that the achievements could be directly attributed to the HC Programme. For instance, the most common response was around increased partnership working. More specifically, a number of individuals felt that increased partnership working had facilitated the relationship between the PCT and the City Council, brought key stakeholders together, and assisted in increasing engagement/communication with the key sectors and groups across the City:

*“There’s a definite improvement in communication between the various groups in the City and the Council...the HCP has linked up enabled it to achieve a better impact and greater penetration, so the various programmes going on through the City have built better lines of communication between themselves, and themselves and the public.”*  
(BS2)

*“There have been some very good local partnerships arising out of it. Projects and activities that have brought people together where the spin-offs might not be exclusively on HC type programmes, but bringing people together to work together and think together has other benefits and has helped to build relationships and networks locally - that might not have happened in the same way without the HCP.”* (LA2)

*“Having a partnership that is consulting a broader spectrum is beneficial...the community and voluntary sector are obviously very aware of health inequalities...and, yes, it [THE HEALTHY CITY PROGRAMME] certainly delivers on that...It gives the sector a voice which is good for everyone in the City.”* (CVSF 5)

In addition (and a recurrent theme throughout the report) some individuals felt that the HC Programme and the profile of the WHO HC ‘badge’ were important in helping to provide impetus and a more strategic focus on health inequalities and the wider determinants of health, as well as assisting in delivering on local and regional government health targets, and may be attributed to securing funding for local projects:

*“The added value is that there’s been a more focused discussion about how health inequalities work. Would that have happened if the HC Partnership didn’t exist? Yes, but it would have been called something different and wouldn’t have had the WHO badge...But I think it [the HCP] is a really positive force for doing things differently and ticks all the boxes for the LSP and all the Government Office South East’ targets around health*

*inequalities and all those other things...It would help if the Government had the same targets throughout the system, but given that they don't, it does help us to deliver the local targets.” (PS3)*

*“We put in a bid to Sport England and got £350k so we've now got Active for Life workers in all the areas of deprivation...because Brighton and Hove has this reputation, and part of that is being an HC, we got it. It's adding weight to the bids you put in...kudos, and that badge - now we can build on that because we had that funding and so you can build on that again.” (PS5)*

A further recurrent theme raised in relation to added value, concerned the difficulties in attributing and measuring the influence and/or impact of the HC Programme given its strategic role, rather than a more delivery focus or model of working:

*“It has brought key stakeholders together, it has supported collaborative thinking and planning and also service deliver. But it is sometimes difficult to say what has happened as a result of HC and what might have happened anyway...it is a difficult thing to separate.” (PS1)*

*“...The HCP are the experts really for a wide range of things around health and health matters, but they are not the responsible bodies; the responsible bodies are still the PCT, still the NHS, the Sussex Foundation Trust whatever, voluntary sector organisations etc that actually do the delivering. The HCP isn't the deliverer – it influences and creates contexts and it develops strategy and moves things along in the right direction – which is sometimes less measurable but no less influential and no less important.” (LA6)*

### **What hasn't been achieved by the HC Programme?**

In terms of what the Brighton and Hove HC Programme hadn't achieved, most stakeholders did not have a response to this question or were fairly non-specific in

their comments. However, some issues did arise including concerns about specific programme areas such as HIA and healthy ageing, as well as the need for the HC approach and concepts to be more widely understood, and issues of marketing and branding. For example, in relation to health impact assessments and healthy ageing, three stakeholders commented:

*“Most of the areas covered have been extremely successful...The HIA is a difficult process and is perhaps the one where we have had least success, partly we need to do more together to try and work out an affordable way of doing it and then how to use it most effectively - because there isn’t any statutory requirement for HIA in a planning application and it would be really useful if we could find a way of giving that additional weight so it can be useful in taking decisions.” (LA1)*

*“Around healthy ageing I think we could have done more, I have seen more outcomes from the strategic part of the work.” (PS8/LA)*

With regards marketing and branding of the HC Programme, some individuals commented:

*“I think we could have some more tangibles [OUTCOMES] which would help in branding. We feel it focuses too much on a strategic overview type level and some things; we almost badge them as HC after they’ve happened whereas we really should be driving those a lot more.” (PS8/LA)*

*“The induction of HC and HC concepts hasn’t been sufficiently known and understood to enable it to be embedded across all policy areas. In terms of marketing, there has been an insufficient lack of overall marketing of Brighton and Hove as a HC. I know we have the HC logo but that has not impacted on citizens’ knowledge and understanding of it. Also in terms of marketing it has been sporadic in that it has been linked to specific programmes and you need that but also you need an overall marketing strategy to go with it.” (PS1)*

### 3.1.2 Core themes (including key achievements and difficulties/obstacles)

Phase IV of the WHO HC Programme focused on four core themes of (1) Healthy Urban Planning (2) Health Impact Assessment (3) Healthy Ageing and (4) Physical Activity/Active living. Working to a common agenda, the aim of Phase IV was to encourage cutting-edge innovation and share expertise with member cities, national governments and the international community. For each of the WHO HC core themes, interviewees were asked to comment on the main achievements of the theme as well as any key difficulties/obstacles that had arisen. It is worth noting at this point that the majority of responses reported in this section are from the technical officers located in the PCT and City Council given their greater and more direct involvement in these aspects of the HC Programme.

#### Healthy Urban Planning (HUP)

The HUP core theme of the WHO HC Programme addresses both the natural environment (parks, green areas, natural pathways, etc) and the built environment (housing, transportation, and workplaces). Urban planning can control or influence the physical and social environment of cities to promote healthy living. Brighton and Hove has been a key member of the HUP Sub-Network since 2005.

Analysis of the narratives provided by stakeholders in relation to this theme revealed that most interviewed felt that Brighton and Hove has made significant achievements in terms of HUP particularly with regard to raising awareness of the potential impact of urban development on health:

*“Overwhelmingly for us is its awareness. If we talk about healthy planning, people don’t blink and say what on earth are you on about? – It’s recognised - Terry and Lydie [PUBLIC HEALTH DEVELOPMENT AND IMPROVEMENT MANAGER] have done a huge amount of work in terms of educating planning officers of where we are at.” (LA1)*

*“It’s raised awareness of the connectivity between urban planning and its impact on health and wellbeing. Its also highlighted the impact of urban development on short and longer term health issues and outcomes and has*

*introduced HIA application to the planning process which has been positive.” (PS1)*

*“It [HUP] has been very successful in raising awareness amongst the planning groups, that there’s more to their role than just, you know the physical layout of the City, and the physical infrastructure of the City, that they need to see how that impacts on the residents and the communities - I get the sense that Brighton is seen as having done very well in this.” (BS1)*

A number of stakeholders referred to the strategic and political impact of the Brighton and Hove HUP work as being important achievements. For instance, in terms of embedding HUP principles into strategies and policies, and thus engaging planners and planning systems in the City Council leading to the establishment of health impact assessment as a key component of Council planning developments:

*“Embedding HUP principles and objectives into strategy in a pragmatic, feasible and achievable way. We can demonstrate that through the local development framework and its core strategy and its various development plans and supplementary documents.” (PS10/LA)*

*“...The way in which they [THE HCP] have helped to develop the local development framework for us in terms of it turning its head towards public health. It’s always difficult to know what would have happened if the HCP didn’t exist but if you look at the difference between the local plan, as was, and the local development framework as it is emerging, then they are poles apart...” (LA6)*

*“...bringing together PH practitioners of specialist and urban planners, working together which we hadn’t done in the past, which has meant that we were able to include health considerations very explicitly and policy documents in the local development framework (LDF)...We have also agreed at a political level that every new major project development in the City will be subject to a health impact assessment screening.” (PS6/LA)*

A second major theme in response to this question related to the training of city planners around health and wellbeing which was perceived by many to be key achievement of the HUP theme:

*“We have trained a large body of key officers - including city planners, transport planners, sustainability officers, economic development and regeneration officers - in HUP principles and practice and we can demonstrate how that awareness, knowledge and capacity building is actually demonstrated in tangible outputs... We have held master classes, building up those skills in detail; developing a capacity of officers from the planning departments in the City Council who can work in collaboration with their counterparts in the Public Health Department on specific projects. This is ongoing but tangible work.” (PS10/LA).*

*“The joint training we have done with health urban planners has helped to create a tangible outcome. The training programme has been implemented through the auspices of the HC, and has been excellent in terms of building those links with planners and has brought them together.” (PS8/LA)*

In addition, training was also perceived as being helpful in addressing the challenges of intersectoral working, and more specifically tackling the wider determinants of health:

*“...It’s enabled us to get health training, health promotion, public health training onto the agenda of staff development for planners throughout the City. I know that quite a number of planners have been through these staff development courses and I think this has been a major benefit. In some ways it’s been a challenge breaking down the barriers that people have in their understanding about health and trying to move from health in a very medicalised or health sector narrow concept to one considering holistic health, and particularly the way the environment influences people’s health.” (PS9)*

*“Other difficulties, maybe initially a challenge together teams that had not historically worked together, and also very different, not just working cultures, but a lot of people in UP didn’t know what we were doing in health. They view health as just the provision of services or its management, but it’s about the wider determinants of health; and likewise, in PH, including myself, we had little knowledge of the complexity of the planning processes, so it was about recognising that and trying to overcome that through training. But this is ongoing and we just have to be mindful of that.”*

*(PS6/LA)*

Perhaps unsurprisingly given their lesser day-to-day involvement in the HC work, two representatives of the Community and Voluntary Sector Forum (CVSF) drew attention to the difficulty in commenting on the achievements of the HUP theme. This was due to not knowing whether work being done was directly attributable to the HCP or whether it was happening anyway as part of the Council’s work:

*“We have been part of agreements of how they are looking at the bike lanes and things like that. I am not sure whether that is a direct result of HCP or whether that is something the Council was doing anyway. It’s a little unclear what influence the HCP actually has on urban planning.” (CVSF 5)*

*“...it’s not always quite clear what’s cause and what’s effect and quite often it can be many different things together which give the positive effect...I find it quite hard to answer these to know categorically well this came out of being a HC.” (CVSF 6)*

### **Key difficulties/obstacles linked to HUP**

Narratives revealed that stakeholders held reasonably similar views in terms of perceptions regarding key difficulties and/or obstacles linked to the HUP core theme. Inextricably linked with health impact assessment, by far the most common theme related to a lack of capacity and resources particularly in terms of the amount of time and support needed to complete HIAs as part of planning developments:

*“The biggest challenge is about the capacity to do some of the work, and I don’t think it’s so much that the work can’t be done, it’s the capacity to do it.” (PS3)*

*“I think we’ve been very fortunate in the sense that we’ve had a lot of goodwill had political support...the fact that it doesn’t come with any resources is one of the obstacles we face and satisfying yourself that you are making good use of public money and that you are not actually wasting it on a talking shop. That’s been one of the big barriers.” (PS8/LA)*

Other perceived difficulties and/or obstacles included issues concerning local politics:

*“Local politics can get in the way so you look at some of the things that may or may not be proposed, Park N Ride for buses, traffic restriction or car free housing, all those kind of things that may have positive health impacts, may not be politically palatable...how far they get implemented is ultimately a political decision – but I think that is where Terry has done some excellent work in integrating with the political, bringing health into the political context, working a lot with local politicians to make sure that health is on the agenda.” (LA6)*

### **Health Impact Assessment (HIA)**

Health Impact Assessment is a methodology (and core theme closely linked with Health Urban Planning) which assesses the impact of various plans, programmes and projects for their impact on health and wellbeing. The objective of HIA is to advise politicians and decision-makers on how to enhance beneficial effects and reduce the harmful effects of proposals. Brighton and Hove has been a member of the WHO HIA Sub-Network since 2006.

Analysis of the narratives provided by stakeholders revealed that most interviewed felt that Brighton and Hove had made significant achievements in terms of HIA,

particularly with regards raising awareness of the impact of urban development on health and wellbeing:

*“It has certainly raised awareness of the impact of urban development on a population’s health and wellbeing. Also the application of HIA on the built development within the City - we have had full council support for new policy requiring all major built developments to be screened for potential HIA, that is a good thing.” (PS1)*

*“Three years ago I probably wouldn’t have known what a HIA mean...and now I have and I think that’s a direct result of the HC Programme.” (LA2)*

This theme was seen as coming to the fore at an opportune time to influence the City Council’s core planning strategy as this was to be reviewed anyway.

*“The timing was brilliant as [the HCP] were able to have significant influence over the strategic documents and that will obviously influence the later documents that come on from that...” (LA1)*

In addition, stakeholders referred to specific examples of where HIA had been completed as indicators of achievement in the HIA core theme:

*“The one that I know about is the one done around the Marina development...the HCP was involved with developing the plans, in commenting on them before they were then put out to public consultation so that the health impact had already been taken into account in the initial plans...from as far as I was involved with it, it seemed like a good process.” (CVSF 4)*

*“A key achievement would be advancing the use of health impact assessment locally...examples include the transport plan, the housing strategy and the two urban developments. There have been others as well such as smoke free Brighton...” (PS10/LA)*

*“...We’ve had some good successes in working with developers – we thought they might be resistant to undertake HIA, it’s yet one more assessment for them to do, but I think with the work in the Marina, we have demonstrated that we can do that successfully...So we have had some very good and practical pieces of work in terms of the HIA.” (PS6/LA)*

### **Key difficulties/obstacles linked to HIA**

Difficulties in this core theme were again inextricably linked to those expressed for HUP. Most notably, stakeholders felt the HC Programme lacked the capacity and/or resources to complete HIAs. This primarily included the large amount of time needed to complete HIAs and the need for appropriate training to conduct them:

*“It is resource intensive - a lot more than we thought. Not only are there quite in-depth analyses (studies), they are time consuming, expensive...It’s finding the time to do it...we have had a little bit more capacity to take on board the HC agenda but it is quite time consuming.” (LA1)*

*“...It is to do with capacity...it is very, very time consuming to do it appropriately so we do try to prioritise the HIA that people ask us to do and there are occasions when we have to say no.” (PS10/LA)*

Moreover, some stakeholders also commented about the non-statutory nature of HIAs meaning that the outcomes can only be advisory and therefore, may have little realistic ‘clout’. For instance, as two participants reported:

*“I’m not always sure that HIAs are the most effective tool because sometimes people see them as a bit over bureaucratic and ‘well we’ve thought about that and it would be great but we are not because of cost, because of this, because of that or because of the other’...It’s not a criticism of them, it’s rather how effective HIA can be? Maybe in other parts of Europe people do say ‘well the HIA says this, so we won’t do it’ - the political reality in Britain is that’s probably not the case and the HIA does not have the final say...” (LA6)*

*“It’s also about politics with a small ‘p’ - because you’re not necessarily going to come up with the answer that people want to hear - you’re going to maybe come up with something that actually, ‘well we don’t think it’s a good idea that you build this, or if you do build it then it should look like this, or it should have this in it’ - and it’s actually not necessarily what people want to hear and so I think the political interface is quite difficult sometimes.” (PS3)*

Training again emerged as a theme with divided opinions as to whether sufficient training had been provided/occurred to warrant the growing demand for HIA to be carried out at a local level. For instance, some stakeholders believed adequate and useful training had been provided and that this had facilitated joint working between the PCT and Council planners:

*“We’ve had very good training in HIA which we’ve provided for people in the City Council, planners and wider than that and also the PCT. We’ve brought in expertise from outside to help inform the health impact assessments that we have done...” (PS8/LA)*

*“The greatest one [ACHIEVEMENT] has been the training up of a number of staff both in the PCT and the planning division and the joint working that that has facilitated.” (LA1)*

In contrast, other stakeholders felt there was a need for the development of core training to build up and develop expertise within the Local Authority and Public Sector:

*“There’s a level of expertise involved - you have to be able to do it consistently and do it frequently to build up that expertise - so we are still at that stage where we are still bringing in experts from outside. I would like to have seen it where we had the capacity and the capability to do it in-house.” (PS8/LA)*

*“One of the issues that needs to be covered is about making that sure that everybody who is involved in the planning process is aware of potential*

*impact on health and that goes back to developing some core training...”*  
(CVSF 4)

### **Healthy Ageing (HA)**

HA is an approach that switches the emphasis away from a traditional focus on health and social care services. The underpinning principle behind this theme is that actions on the wider determinants of urban living can enhance the health and independence of older people. Brighton and Hove have been involved in the WHO Healthy Ageing Sub-Network since 2005 and currently actively support Stockholm, the lead city for the Sub-Network, to carry out its coordinating duties.

A key theme arising from the interviews in relation to achievements in the healthy ageing core theme was that of raising awareness of older people's health issues and establishing health ageing as a key priority for the City:

*“Healthy ageing has been given much greater priority and this has helped to address the previous inequality in access to services and facilities for Older People.”* (CVSF 2)

*“The healthy ageing work that has been going on as well has been very important....it's been good just to see that there is a real push in the City to help older people be as healthy as possible and to promote health, healthy living, social inclusion and all those sort of things whether it's mental health but also physical health.”* (CVSF 5)

*“I really feel that the HC Programme has put healthy ageing on the map for the first time in Brighton and Hove as a kind of major strategic issue and one which requires inclusion and very prominent inclusion in city-wide planning at the highest and longest term level...Consequently, the importance and the centrality of healthy ageing is now very well established so a lot of people know what's meant by that and what's involved and what the local issues are in a way that they simply wouldn't have done 3 years ago in my view, so that's a principal achievement.”* (LA2)

In addition, achievements in this theme were reported to have achieved some tangible and important outcomes including strengthening the role of older people in the decision making process, ensuring healthy ageing principles were embedded in key strategies such as the Older People's Services Strategy and the Strategic Commissioning Plan:

*"We have in the City an existing tradition and commitment to supporting older people in the decision making process through the Older People's Council. The HA theme has raised further awareness of that and strengthened it and has contributed to embedding it into certain policies and strategies and actions - so the joint commissioning strategy for older people, the local area agreement, there's a lifelines' project and so on...In terms of empowerment and participation of older people in decision making, it has put that higher on the agenda. Access to services of all kinds has been questioned and has begun to be addressed so, for instance, we have single access point, information services are becoming more cohesive, strategy is being followed by action." (PS1)*

*"...the sub network has done quite a lot to help develop the commissioning plans for older people, the local commissioning planners, so we've got a commissioner for older people services and she and another couple of people have worked together with people in other places to say, this is what we're doing here, what are you doing in your neck of the woods - I think that's been very helpful." (PS3)*

Moreover, other stakeholders commented on additional achievements concerning developing innovation in terms of thinking and practice:

*"There are some discreet areas where we've have been able to advance practice such as developing a commissioning outcomes focussed framework for the voluntary sector contracts that the Council uses to commission prevention related work with the voluntary sector. We now*

*have a much more health outcomes focussed approach to how we commission.” (PS10/LA)*

*“The Healthy City programme has stimulated some worthwhile pieces of activity and demonstration activity has stimulated thinking and innovation in the way we set about promoting HA locally...one is the 50+ community programme...another example is the lifelines initiative...I don't think it would have been so possible or even have happened without the kind of platform of partnership thinking, which the HC Programme had established.” (LA2)*

*“...We've had two major conferences, cross sector, where older people have been actively involved. There has been production of an older people's services directory and also as a result of the HA theme, the older people's reps now have a seat and a voice on the HCP and that wasn't in place before. So they are feeding into and informing the decision-making process, they are actively involved in the HCP in a variety of ways and it has raised awareness of the importance of empowerment and participation of older people in shaping strategy and policy. It doesn't always happen overnight again, or easily, but it has raised its status.” (PS1)*

*“What [HA] it did for us was to bring an extremely useful level of consultation into our strategic plans which opened up... the connection with health and HA brought people into the consultation on our plans in a very different way so it allowed us a way in to find out how people use the City, use spaces in the City, which was a completely different perspective that we hadn't had.” (LA1)*

### **Key difficulties/obstacles linked to HA**

Although some stakeholders we spoke to felt there had been some important developments and impacts concerning the healthy ageing theme, some respondents commented that they found it hard to talk about what the key achievements of the theme had been:

*"I really just don't know, sorry." (PS7)*

*"Couldn't say what the key achievements are, no." (CVSF 4)*

*"Well I don't know..." (BS1)*

*"Don't know." (LA4)*

*"I haven't worked directly on HA – I know some good work has been done...I'm not sure how practical this has been translated in Brighton and Hove, compared to urban planning or health impact assessment where we have taken the concept and applied them - I know there was an older people's profile developed which was very good..." (PS6/LA)*

*"I don't know anything about it..." (BS 2)*

*"In this area I do have concerns because...HA has been almost invisible." (PS2)*

The latter quote (above) particularly highlights some of the reported difficulties experienced in this theme in terms of the challenges in separating out the added value of the healthy city work from what was already happening in the City on healthy ageing prior to joining Phase IV of the WHO healthy city programme:

*"I think the healthy ageing in terms of local tangible outputs is less easy to sell because we are doing a lot of the healthy ageing anyway, it is a key part of our agenda, we are already well established. It's been less easy to tell what that input has been into it..." (PS9)*

*"This is a difficult one because as a city we were already performing well on the HA related objectives before we got involved in Phase IV - it is therefore difficult to demonstrate how we have tangibly added value to current practice in Brighton and Hove..." (PS10/LA)*

In addition, one stakeholder whose key responsibilities relate to the HA agenda highlighted the conceptual challenge HA presents compared to the other more practical impacts from the core themes of HIA and HUP:

*“There is perhaps a fundamental lack of understanding between what is a more practical thing – elements such as HUP and HIA versus the concepts of empowerment/participation and access which are obviously are potentially very challenging concepts and take much longer to embed than practical actions - because it involves a fundamental shift in values, cultures etc and that isn’t going to happen easily or quickly.” (PS1)*

However, although an important point, other stakeholders pointed out the importance of moving from concepts to practice in order to justify allocating resources to this area of work when competing with other day-to-day priorities including core business:

*“From a manager’s point of view it’s probably about the time commitment we need to do in building up those links and then the benefits back into the system...For me we have to juggle our day to day activities delivering core business - I think it is about trying to understand what the benefits of all of this are for the time that is involved, and really what are the tangible differences.” (LA3)*

*“Resources are always clearly a difficulty so making the case for additional spending or additional commitment to innovation to preventative work in a climate where resources are ever restricted and pressurised and mainstream services gobble them up. So clearly it’s difficult to map out space and resources for innovation in these areas, so that’s one major difficulty.” (LA2)*

## Physical Activity/Active Living (PA/AL)

Physical activity is a fundamental means of improving people's physical and mental health. It reduces the risks of many non-communicable diseases and benefits society by increasing social interaction and community engagement. HC emphasises the importance of physical activity as part of everyday life, not as an optional extra to be added at the end of a busy day.

Similar to the other core themes, analysis of stakeholders' narratives revealed that majority of responses reported in this section were mostly from the technical officers located in the PCT and City Council given their greater and more direct involvement in this aspect of the HC Programme. Nonetheless, responses concerning this core theme's achievements were still fairly sparse and quite mixed although they still tended to follow the achievements of the other core themes such as raising awareness, increased partnership working, and the WHO HC 'badge' adding weight to funding bids:

*"...We're now getting the active for life team to work very closely with the Food Partnership which is brilliant...so it's about bringing all those different agencies together - the HCP is helping it. So we've got the Children and Young People's Trust and South Downs and the PCT and the Food Partnership and the Council all working together which is good...and I think the HCP gives it higher profile." (PS5)*

*"...the Cycle Demonstration Town... the presence of the [HEALTHY CITY] Partnership added weight to that bid. I think what the Partnership is does is it adds weight to bids around improving PH which individual organisations or other partnerships within the City might want to put forward." (CVSF 4)*

Interestingly, some interviewees also made explicit synergies with the other core themes including health urban planning and healthy ageing. For instance, one stakeholder involved in planning in the Local Authority, made an insightful link between sustainable transport in the City and health/physical activity, whilst also

drawing attention to a fundamental change in thinking concerning the perception of open spaces:

*“It is the link that has been made clearly between sustainable transport and health. So encouraging people to walk, encouraging people to cycle, the benefits that come from using the bus in that people tend to walk part of the journey...I am aware now that you see a bit of open space, you go round a housing estate, and there’s large blocks of flats surrounded by grass and ‘don’t kick a ball here’ in the grass. You realise that just because it is open space doesn’t necessarily mean that it is accessible open space for people to use actively - our concern about that might change the way that we see a lack of facilities...” (LA1)*

Similarly, two other respondents noted links between physical activity/active living and other core themes:

*“...Encouraging people to enjoy open and green spaces is a very good initiative - they have health walks organised and quite a few older people I know are involved in that, so that’s been a very good initiative... also the green gyms, that’s been good.” (CVSF 2)*

*“The way we have taken this forward here –AL is part of the built environment and when we have new developments, you look at how you can promote AL, cycling, walking etc. It’s the same for HIA and HA.” (PS6/LA)*

### **Key difficulties/obstacles linked to Physical Activity**

Again, similar to the issue raised in previous core themes, particularly healthy ageing, many interviewees had difficulty in attributing added-value to the HC Programme in relation to the physical activity/active living core theme:

*“I think we have done a lot through active living coordinators who have done some good work - but I’m not sure how much has been based under*

*the HC banner. That maybe a weakness in a sense that maybe we should have done more through the Healthy City Partnership of trying to bring that in..." (PS8)*

*"The stuff we have done around cycling has been very good. I'm not sure whether this is directly linked to the HCP but I know it was involved in that and that we've attracted some new funding." (PS2)*

However, although attribution was a difficulty for many of those interviewed in terms, most individuals we spoke to nonetheless felt that the work under this core theme had been strengthened by the Health City approach. Moreover, it was felt that perhaps the HCP need to address this issue of attribution head-on and look at ways of demonstrating achievements more clearly. Although lengthy, the following quote illustrates this point well:

*"My difficulty with this is attribution - it's knowing which of the things are genuinely attributable to, even in part, to the HC and maybe that's a weakness in a sense. Something we could have done better, or might still need to do, is demonstrating more clearly how the HC Partnership has actually brought about and can claim some credit for some of the service improvements, innovation, and gains that we're all claiming for it...the 50+ community programme - we've got a piece of work in there which is exclusively about developing new physical activity and exercise opportunities for older people over the age of 50. Now I can't attribute that directly to the HC Programme but what I'm saying is that without the HC involvement, that may not have been something that would have occurred or even been possible." (LA2)*

Responses about the difficulties and challenges in this core theme were, in general, fairly disparate. Some examples of responses included the following: a lack of profile in relation to other core themes; dominance of sport over active living; difficulties in measuring progress and; changing attitudes. For instance, some interviewees commented:

*“It’s a profiling thing...I haven’t felt that the active living stuff has been profiled in quite the same way...” (PS8/LA)*

*“There has been a tension in the past around the primacy of sports versus active living, and that’s always challenging...” (PS10/LA)*

*“One of the difficulties is around measurement. With a lot of local planning and policy making these days, everything is target driven - you need to have a relatively simple means of measuring achievement and we haven’t.” (CVSF 4)*

*“Residents’ views - So often people are very happy to see a children’s playground in the middle of a park, but are not so keen to see a playground at the end of their garden because it’s noisy. People seem to be terrified of teenagers sitting in groups and particularly terrified if you actually give them a reason to be there so it’s a big hurdle to get over.” (LA1)*

### **3.1.3 Health inequalities**

One of the most challenging goals of the HC Programme is to reduce health inequalities by addressing the social determinants of health, including poverty, social exclusion and the needs of vulnerable groups (WHO, 1997b; Carlisle, 2000). Health-related inequalities exist across various groups defined by gender, age, race, geographical location, lifestyle, income and social class. Some of these are biological and essentially unavoidable while others reflect the inequities that exist across society.

In this section, we asked participants to outline how they felt the HC Programme had addressed health inequalities in the City and to support this with examples of evidence. With some exceptions, most stakeholders we spoke to experienced some difficulty in answering this question. We suspect this may be because of some of the complexities involved in the theoretical concept of health inequalities and more specifically, then relating this to tangible processes and outcomes in the

context of Brighton and Hove as an HC. Consequently, rather than answering *how* the Brighton and Hove HC Programme had addressed health inequalities, respondents tended to discuss outcomes which related more directly to the health inequality agenda (e.g. obesity and nutrition, smoking cessation, and teenage pregnancy etc).

*“We’ve addressed inequalities through health promotion, smoking cessation, teaching cooking skills...also with active living. We’ve had an active living worker first in EB4U [EAST BRIGHTON] and then we’ve spread it to the rest of the priority areas...” (PS5)*

*“...In terms of interventions – they can look at inequalities in child health which could be through the uptake of breast feeding and early nutrition , it could be through access to immunisation as well as work on stopping smoking as well...there has been some good work on that.” (PS6/LA)*

*“...we have had smoking cessation, programmes linking into nutrition, obesity - Also the spotlight – a programme raising awareness around ageing and the inequalities perceived or otherwise around services for older people and so on, that has been helped by the HC Programme.” (PS1)*

However, some stakeholders were able to cite some examples of evidence of how the HC Programme has addressed health inequalities across the City. These responses, referred mainly to the *Strategy to Reduce Health Inequalities* in Brighton and Hove (Brighton & Hove TPCT 2005) (which was endorsed by the HCP in 2005 and updated with a technical supplement and endorsed by the HCP 2007), and the HCP’s contribution to the recent city-wide *Review of Inequalities* published in January 2008.

*“We have a health inequalities strategy produced by the PCT that identifies a number of targets for intervention...” (PS6/LA)*

*“The principal way has been by developing and designing a realistic and effective strategy on tackling health inequalities.” (PS9)*

*“... the major advance locally has been the work that has been put in on behalf of the local strategic partnership on health inequalities, which has been a big slice of the reducing inequalities review that we’ve had commissioned for the City. So I think that Terry and Tom have had a very large part in designing that reducing inequalities work from a health perspective.” (LA2)*

In line with comments concerning achievements of each of the WHO core themes, one of the key themes from participants’ narratives was that the Brighton and Hove HC Programme had helped to raise the awareness of health inequalities in the City:

*“...it’s [HEALTH INEQUALITIES WORK IN THE CITY] been largely about putting the issues on the local agenda and raising an awareness and a preparedness for people to engage with thinking about health inequalities.” (LA2)*

*“There is a much greater awareness [OF HEALTH INEQUALITIES] from the [DPH] annual report...It’s very thorough and helpful and clearly shows where the areas of deprivation are...you can then use that as evidence to get funding to develop projects to hopefully resolve some of those issues...I think the availability of that information is very positive.” (CVSF 6)*

More specifically, some stakeholders also felt that the HCP had also helped to raise awareness in terms of the political agenda as well as providing a strategic focus to draw other sectors together in tackling health inequalities:

*“Health inequalities have been a primary focus and they [THE HCP] have been successful in raising the political agenda...the HCP have done a lot of really good work...” (LA 6)*

*“The HCP has given a strategic focus to addressing HI...and has been a focal point to draw the energies of the various sectors together to progress and check on performance...The reality is that HI is within the Terms of*

*Reference of the HCP, it is an active focus to what we do, but the work would have to be done anyway because it's a priority for the NHS and the City Council. So the HCP became a focal point for marking progress and monitoring our activity on HI." (PS10/LA)*

Some respondents commented that it was difficult to demarcate tangible outcomes in terms of health inequalities and the role of the HCP in the process; partly because the work is ongoing but also because inequalities are very interwoven and difficult to separate:

*"It's a tough one this because it's an ongoing process. There has been a lot of work going on in the areas of the City which have identified socio-economic problems and there have been specific actions that have been aimed at those areas – but a lot of those inequalities are linked to socio-economic deprivation and therefore linked to lifestyles. They are all interconnected, you can't really separate them." (PS1)*

*"...I think maybe we should have been more forthright about separating out health inequality work specific to the Healthy City programme - We've just tied it all together so it becomes hard to say if there are any tangible increases or improvements in health inequality as a result of the HC... there is evidence that we are making progress but there's too many confounding variables so that could mean there are a whole host of things that are actually doing that..." (PS8/LA)*

Moreover, some respondents who occupied senior positions in the City felt unclear as to how or whether the HCP had addressed health inequalities. The latter quote particularly seems to point to a lack of understanding about the role of the HCP and its relation to the City Council and PCT. This suggests that more work is perhaps required to ensure stakeholders of the HCP understand fully the role and function of the HC Programme in Brighton and Hove:

*"I could not be sure that the HCP has made a substantial contribution to our work on improving public health and tackling health inequalities. I think it*

*has helped and been a catalyst but I do not think in itself it has been mission critical.” (PS2)*

*“I’m not sure that it has [ADDRESSED HEALTH INEQUALITIES]. I am very impressed with the City Council’s work on inequalities – that’s more likely to lead to dividends because it’s being considered at the tables where people with authority are sitting and making decisions.” (PS7)*

#### **3.1.4 The wider determinants of health**

In this section we asked stakeholders of the HCP to comment on how they felt the HC Programme had addressed the wider determinants of health across the City. Similar to the previous section on health inequalities, in general, participants found this very difficult to answer and responses were often quite muddled.

Consequently, the data presented in this section is necessarily brief and should be interpreted with some caution given it was apparent that many stakeholders of the HCP were not really clear about the concept of the wider determinants of health.

Nevertheless, in general, a number of participants in one way or another felt that the HC Programme had addressed the wider determinants of health:

*“I think Terry’s work in particular with colleagues has brought about in the City an engagement on the wider determinants that were previously not present and not very focused. So I think there has been progress on that.” (LA2)*

*“There is plenty of infrastructural development and ongoing projects and services within the City that actively address the wider determinants of health, not necessarily lead by HC work, but that contribute to the HC agenda.” (PS10/LA)*

One stakeholder clarified that the Partnership was addressing the wider determinants of health through the various documentation:

*“...As evidence, I would point to the HC development plan, the monitoring reports that are included in the DPH reports. I would also point to the local area agreement and the 2020 committee strategy in the various performance frameworks there that distil related areas of work - not necessarily lead by the HC Partnership but are contributing to that priority within the 2020 sustainable community strategy that is focussed on developing a healthier city.” (PS10/LA)*

A number of participants felt that raising awareness of the wider determinants of health and its long-term financial impact was a particularly important achievement of the HC Programme:

*“It’s awareness raising and enables partners, in all the sectors, to see that if we don’t address the wider determinants of health it’s costing us more further down the line...we’ve been able to raise awareness and give support in terms of what action we can undertake in partnership through the City Health Development Plan...” (PS10/LA)*

*“It has brought to the attention of many people that health is influenced by a wide range of determinants...that is a considerable achievement.” (PS7)*

*“It [THE HC Programme] has encouraged and enabled a variety of people in different disciplines and across the sectors to start thinking about the wider determinants and their contribution to the health improvement agenda in the City. So it’s actually put it on the agenda and on the table for a lot of people who hadn’t previously thought about it.” (LA2)*

However, comparable to some of the comments concerning health inequalities in the previous section, some stakeholders drew attention to the difficulty in providing ‘hard’ evidence that the HCP had addressed the wider determinants of health, partly because of work already going on in the City that falls outside of the HCP specifically. Moreover, some stakeholders didn’t feel the HC Programme was having an impact on the wider determinants of health and that this was due to

small project funded schemes and not having the appropriate ‘players’ engaged with the HCP. As the following quote articulates:

*“Only in a marginal way...there are a large number of little schemes which individually have very modest impact, collectively they don’t really add value to one another and are seen little tiny bits of money - It’s not committing mainstream resources...The difficulty for me is that in trying to be very inclusive and engaging with a broad number of groups – which is good – it has missed out the major players. Whether we like it or not, the money and the authority sits with 3 or 4 major organisations across the City who are not engaged in the HCP.” (PS7)*

Furthermore, one participant felt that although the need to address the wider determinants had been recognised within the Local Area Agreement and other strategies, there was little evidence of a common way for people to work:

*“The partnership approach and the people that sit round the table, I don’t think it is quite there yet. There is the recognition that you have to deal with housing, you have deal with employment, domestic violence and long term unemployment etc - so all of those links to the wider determinants of health but there is still a challenge on the ground. The evidence is the Local Area Agreement, the strategies, the sustainable community strategy, all of the joint targets that are shared around these determinants but the evidence that there is a common change to the way that people work is yet to be proven.” (LA5)*

## **3.2 Relationship with WHO, Phase IV, and participation in Phase V**

This section examines the broader context of Brighton and Hove’s participation in the WHO Healthy City Programme by exploring the relationship of the City to WHO, as the directing body for the overall Healthy City Project. In doing so, the issue of whether the WHO Healthy City Network has brought added value to

Brighton and Hove is considered, particularly in relation to the facilitation of policy and practice in the City. Lessons learnt from other European and UK HCs are additionally examined in this process. Finally, stakeholders' views on whether Brighton and Hove's should participate in Phase V of the HC Programme are outlined which include a more detailed analysis of the potential challenges, costs and benefits this could bring to Brighton and Hove<sup>2</sup>.

### **3.2.1 The WHO Healthy City Network: added value for Brighton and Hove?**

In order to ascertain the degree of added value being a WHO designated HC has brought to Brighton and Hove, stakeholders were asked their views on whether they perceived the WHO HC Network to be functioning well. Views were clearly divided over this issue. For instance, in terms of more favourable views, some stakeholders focused on the benefits gained through being part of wider national and international networks, and particularly around how the network facilitated an exchange of knowledge and ideas across the participating cities, as well as leading to tangible outcomes. Furthermore, some participants felt that belonging to such networks helped to increase ambition and raise morale at a local level:

*“The idea that you can meet with lots of people from around the world to talk about what you’re doing and what they’re doing is a fantastic opportunity.” (PS3)*

*“There were some quite clever ideas from Italy around pairing student accommodation with older people’s accommodation – those sorts of things that just get you thinking in different ways that opens up the different perspectives on how you might solve a particular issue.” (LA1)*

*“There’s an element of if we’ve got something like that – membership of wider network, both national and international, helps to drive up our own*

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<sup>2</sup> It should be noted that given the technical nature of the questions in this section (e.g. relating to aspects of the WHO HC Programme, business and sub-network meetings etc), only stakeholders directly involved in these activities (mainly officers of the HCP) were asked them. Consequently, the findings in this section of the report are based on a reduced sample size of n = 14).

*ambitions and it gives us other people to go to, other people to compare with – there can be tensions that work in a very positive way and if we can see another city that is similar to us in profile but is doing better at something, it might pull us to try and do that better. Or if we are doing particularly well at something, we can feel justly proud of our achievements.” (CVSF 4)*

Other favourable responses included an acknowledgement that being associated to a WHO network could offer a certain amount of kudos (as was also picked up in section 3.1) and was perceived as adding value to Brighton and Hove, and to be something that could be benefited from:

*“The WHO has a great deal of prestige that is not to be discounted. It has proved useful to us...to have the prestige of being inside a WHO programme and to be able to say that, and to be able to say the PCT was a leader in that.” (PS4)*

*“...there is a certain bit of kudos attached to it and that is not to be undervalued.” (CVSF 4)*

*“There’s some good speakers at the WHO conferences so their brand is able to pull in people on climate change or art in the urban environment and lots of things that you wouldn’t actually know unless you were actually immersed in that particular agenda.” (PS8/LA)*

However, whilst there were some positive connotations related to being part of the WHO network, some stakeholders held more negative views around the functioning of the network. Some specific responses referred to a lack of strategic support and operation, and poor management as the following quotes illustrate:

*“I don’t think it is functioning well – it’s gone through highs and lows; highs where it has given better strategic support and guidance but those highs have been much more sporadic and over the last 2 years. The strategic support has been very disappointing, it has been minimal.” (PS10/LA)*

*“No, I don’t think it is working very well.” (LA1)*

*“...the way that the WHO is set up and managed is exceptionally poor in terms of the Healthy Cities Network. It’s not very efficient, I think it gets lots of money from lots of people, and I’m not certain what value it adds...I think the idea is fantastic, I think the way it operates is poor.” (PS3)*

Some uncertainty was also expressed as to whether the network itself was adding value, particularly at a local level and primarily due to the lack of visibility of outcomes delivered:

*“I don’t know - it is not particularly visible to me.” (PS7)*

*“I really do struggle about what we bring back to the City - we have got some really good links, we bring back some bits but how that is making a difference to what we deliver in the City, I have to say I am not sure.” (LA3)*

### **3.2.2 Brighton and Hove’s working relationship with WHO**

In addition to the more general comments above, stakeholders were also asked to remark in more detail about aspects of the working relationship with WHO that had or perhaps had not, worked so well. In response to this question a number of key themes emerged from the analysis concerning Brighton and Hove’s relationship with WHO which reflected a number of areas as functioning poorly: the management of the HC network by WHO, and the related strategic direction and communication coming from the WHO office in Copenhagen:

*“...there is a general feeling, which is mine as well, that there is a need for better coordination really...” (PS6/LA)*

*“What hasn’t worked well is the regularity of communication from the WHO office and the lack of participation in ongoing sub-network meetings. Sub-network meetings are there to provide advanced development and progress by the cities in the delivery of the Phase 4 objectives. There has been a*

*lack of clarity about budget allocation and just a general sense of malaise and strategic drift. They are very, very slow in getting strategic papers out to us and in the UK context, if we are to keep our politicians on board we need to be kept regularly briefed about the future direction of the Programme.” (PS10/LA)*

*“The setting of the strategic direction and the quality and regularity of communication, leadership and guidance from WHO head office, resources or the lack of them particularly administrative resources...” (PS1)*

Possible reasons for the lack of support to Brighton and Hove were proposed as being a result of limited resources within WHO, competing with the fact that the HC Programme is at full capacity:

*“There were very few resources at WHO European office level. The individuals who run the Programme, is constantly fighting for resources and has very little admin or other support to do the work.” (PS4)*

*“it is run on a shoe string...there is a little bit of leadership but because it has grown so much I don't think WHO have enough resources to devote to it...We have lots of cities who want to join the HC initiative, and too many people who want to be on the sub-networks. It's almost like a victim of its own success in a sense.” (PS8/LA)*

However, some positive comments were made about past experiences with WHO, particularly in relation to the more occasional, but valuable input from WHO staff, as well as technical support given by WHO advisors:

*“...That's been good. For HIA, Erica Isson has been excellent in the training and strategic guidance that she has provided. Hugh Barton and Marcus Grant have been excellent again in terms of strategic guidance and the tools and training that they have provided...Having said that I am thankful for the support that the Head of the Programme has given to the City when we were setting up the Programme locally and particularly in supporting our*

*Celebrating Age work locally in July 2006...So there have been occasions when WHO and the Head of Programme have been very, very supportive.”*  
(PS10/LA)

### **3.2.3 Brighton and Hove: policy and practice**

In their interviews stakeholders were asked whether they felt Brighton and Hove’s relationship with the WHO Healthy Cities Network had facilitated the progress of public health policy and practice within the City. They were also asked to consider any facilitating factors and any barriers that may have prevented this.

The majority of stakeholders felt that as a result of being a WHO designated HC, progress had been made in the areas of policy and practice in the City. This was reported to be particularly so in relation to two of the core areas of foci for Phase IV of the Programme: Healthy Urban Planning and Health Impact Assessment.

*“I think it did yes...made a huge amount of progress.”* (LA1)

*“Yes, particularly in HIA and HUP and around the knowledge base – there is a strong case that that it has facilitated that.”* (PS8/LA)

*“...through the focus on the key objectives, it has enabled us to advance two areas in particular, HUP and HIA to a degree and pace that we would not have done so previously.”* (PS10/LA)

Reasons for this progress included the WHO ‘badge’ and international status, which in turn facilitated political support for the Programme:

*“It’s got political, politicians have to decide what they are going to do for the year and they are very worried. They want to make sure we can actually do it because the last thing they want is to sign for something they can’t do. It does give you that.”* (PS8/LA)

*“I think that having the WHO badge was a really good badge to have because it actually meant that some of the politicians were, ‘oh we’re a WHO HC, how fantastic is that?’ ” (PS3)*

In addition, exchanging practical experiences with other healthy cities enabled progress in the area of practice in particular:

*“In the early days we learnt a huge amount, we had a very clear idea from other people in the network as to the sort of areas we ought to be looking at...” (LA1)*

*“Through the sub-networks we were able to invite a planner from Odense in Denmark who had done some excellent work on cycling - we invited them here to give a presentation when Brighton and Hove was awarded the cycling demonstration project - a lot of that work has been looked at and some of it transferred in practice here, so that was a very positive outcome.” (PS6/LA)*

Furthermore, although some respondents felt that the progress in policy and practice was due to the relationship with WHO, some also felt that progress had also been increased by the involvement of committed key officers in delivering the HC agenda:

*“...There is a very clear agenda for Tom, Terry and Lydie and they are pursuing it and it pulling together a whole load of other people in the City in a way that doesn’t seem to be happening in the other cities.” (LA1)*

*“I know that the local officers here who relate to the network and who benefit from inclusion in it are adding value locally...our involvement in the network adds value yes, but I think we are almost wholly dependent on a few individuals who have to do the work to make that real.” (LA2)*

Less positive responses to the issue of whether the relationship with WHO had facilitated policy and practice were primarily linked to uncertainty as to whether the

work being done in Brighton and Hove could be attributed to the relationship with WHO, and questioned whether this would have been done anyway, and without WHO support. This theme reflects the earlier discussion about attribution, and demonstrates a particularly common theme within this review:

*“Probably - I don’t know - as I said earlier, I think that Brighton and Hove would have done some of these things anyway.” (PS3)*

*“I’m not sure the actual working relationship has meant that we have done anything that we wouldn’t have done otherwise. I felt it was a motivational factor, feeling that you belonged to a programme that you have certain thing you have to achieve, that you go to a business meeting – that has been the motivation – to have a framework.” (PS6/LA)*

### **3.2.4 WHO business and technical meetings: An enabler or hindrance?**

As a member of the WHO HC Network, Brighton and Hove are invited to and attend an annual WHO business meeting, as well as technical meetings, linked to the sub-networks. In their interviews, participants were asked how enabling these meetings had been in terms of helping them to draw insights from lessons learnt and giving practical direction to developments in Brighton and Hove. In addition, they were asked to consider what they thought had been the benefits and challenges of participating in these meetings.

A number of stakeholders felt that some lessons could be learnt from attending these meetings:

*“We did learn a few odd lessons and some times when it came down to small developments we learnt quite a lot.” (LA1)*

*“Practically you can get some good insights into other projects.” (PS6/LA)*

*“I think we could have made more use of it but it has been a help.”  
(PS8/LA)*

However, some barriers to the implementation of insights gained, or challenges were recognised, for example due to the differences in the operation and structure of local governments across Europe, and also due to the inaccessibility of the materials, presented and discussed at meetings:

*“They are quite helpful in a general way but the way that local government works in different parts of Europe is so enormously different and the level of intervention that is available to you is so different - so it’s quite difficult to learn from another city’s experiences.” (LA1)*

*“Some of the meetings I’ve been to, I’ve been to a couple of conferences where I wanted to kill myself. I have been to a couple and I really genuinely am not certain of that they know what they’re trying to do.” (PS3)*

Benefits to participating in the WHO business and technical meetings were related to the potential for learning from the broad spectrum of (international) participants:

*“It has got to be a good thing to be part of a broader international network. The difference between you and your own parochial city and you as being part a bigger, European wide, international discourse and learning is a good thing...It has given us ideas, you meet other people.” (PS4)*

*“Some excellent presentations and opportunities to meet with other people from other sub-networks.” (PS6/LA)*

An additional benefit was reflected as being the involvement of politicians at these meetings:

*“Business meetings have been very helpful to enable our local politicians to understand the agenda of what health improvement can mean in an urban context and what their role as a lead politician can mean to actively champion that agenda at a local level...they have had insights into strategic and practice examples elsewhere - that has genuinely resulted in*

*empowering and enabling our lead politicians over the years to then be active champions locally.” (PS10/LA)*

*“The benefits are for us to bring with us our politicians and chairs of the HCPs, so they can see for themselves what it is about and meet other cities and hear their experiences - its very good in that sense.” (PS6/LA)*

### **3.2.5 Phase IV core themes and related sub-networks**

Stakeholders were asked what tangible value participation in the sub-networks for the WHO Phase IV core themes (including HUP, HIA, and HA) had brought to Brighton and Hove.

There were a number of positive responses from stakeholders regarding value added through participating in the sub-networks, including the sharing of experiences resulting in some of the learnt concepts being embedded into policy at local level, and the dissemination of knowledge facilitating learning with other HC colleagues.

*“It is that sharing of knowledge and of ideas that has been positive.” (PS1)*

*“It has been good for our lead planner because it was new to that way of working, at European level, it’s been good sharing with other cities – their expertise and experience. I think there are limitations but there are some benefits – the usual benefits – the shared learning etc...” (PS6/LA)*

*“I would say the involvement has led to it being embedded into policy which is a positive thing.” (PS1)*

Some stakeholders also commented that participation in the sub-networks had been useful in translating new and shared knowledge into the development of practical, tangible projects in Brighton and Hove. For instance, as two individuals commented:

*“Insight into practice in other cities – tangible examples would be housing projects focussing on support for the elderly and integrating older people into inter-generational communities – that’s one example that’s been really helpful to help us inform how we approach those issues locally.” (PS10/LA)*

*“It has been quite helpful - it has kind of gone beyond planning. One of the presentations was about cycling and experiences learnt from one of the Scandinavian countries...and we are now one of the cycling demonstration cities.” (LA1)*

It was reiterated that training programmes linked to the sub-networks were of great value to stakeholders. In particular, the value has come from being able to translate the training into practice in Brighton and Hove, thus developing an increased workforce for delivering ‘best practice’ at local level.

*“I’ve certainly picked up from the staff involved in the HIA work that a lot of the training has actually come from being part of the WHO so through that network, they have picked up a lot in terms of the training...” (LA3)*

*“There’s been a lot of joint training. We now have a collection of urban planners in the City who are very clued into health so we meet regularly as a healthy urban planning steering group with transport, economic development there, major planning...I think it’s been very good.” (PS8/LA)*

An additional benefit of participating in the sub-networks was reported to be a more integrated way of working within Brighton and Hove, and particularly as a result of links developed between learning from the HIA and HUP sub-networks:

*“I think that Terry’s level of knowledge and expertise has made sure that health impact assessment and urban planning are as one so to speak.” (PS8/LA)*

*“It links to one of the other networks – the HIA sub-network because obviously in undertaking HIA there is a methodology in process there that’s*

*clearly defined, but we have linked that with the HUP tools as well, including the spectrum tool and the health screening checklist.” (PS10/LA)*

*“I know that Brighton and Hove were getting a good reputation across Europe in terms of the HUP planning stuff and how integrated it was.” (LA6)*

However, it was also recognised that it was not always feasible to translate the examples from other cities in Europe into tangible outcomes within Brighton and Hove due to local differences in policy and practice, and in structures and process' within cities across Europe, and also due to the nature of the physical local environment. Moreover, it was pointed out that there were diminishing returns in being involved in the sub-networks, in particular in relation to what was learnt at and through the meetings:

*“...the limitations are what apply to certain areas or countries in terms of planning regulations are not the same in other places.” (PS6/LA)*

*“...looking at examples of good practice elsewhere that can be adapted locally, and I use the word adapted strongly because one size doesn't fit all ...so what might be applicable in one urban setting might not necessarily be applicable in the little narrow streets and lanes of Brighton.” (PS1)*

*“Some of the work that is being done is on such a huge scale you couldn't replicate it and some of it is on such a small scale...by 2 or 3 meetings of the network and I was pretty much up to speed with what the whole idea behind what healthy planning was about...but it has been diminishing, the longer we have been a member of the network.” (LA1)*

Another criticism was lack of visibility of Brighton and Hove's involvement in the sub-networks, i.e. what was brought back to the City through involvement in the networks. This resulted in an inability to make a judgement on the actual added value of participating in the sub-networks:

*“They go to quite a lot things in different parts of the world, which I don’t really know a lot about. I don’t know if it adds any value or not. Do I think it adds value?...probably.” (PS3)*

*“...the sub network has been insular and I have only attended a couple of meetings - they spend a lot of time developing the networks - instead of this is what it means at a local level.” (PS6/LA)*

Furthermore, WHO was criticised for the lack of support/resource which was required for the sub-networks to work consistently and effectively:

*“Attending the meetings has been fine, but it would have been better to have kind of support in between so cities could continue to work together and been supported through that process.” (PS6/LA)*

*“It is probably linked to WHO office resources or lack of them because information is always last minute, you get used to that but it is not effective.” (PS1)*

### **3.2.6 Lessons learnt: Europe and UK/Ireland**

Stakeholders were asked what lessons had been learnt from other European cities that may be useful in helping Brighton and Hove HC Programme to move forward. In their responses, stakeholders outlined a number of practical ideas including, for example, issues around cycling, health impact assessment and urban planning, and the use of children’s centres for older people. Moreover, some stakeholders reported that ideas from other European cities had enabled them to think more broadly and to consider alternative approaches for implementation in Brighton and Hove:

*“There was quite a lot of work from Scandinavia about cycling, and there is a lot to be learnt...a lot of ideas to explore – around HA, around whether or not you bring older people together or whether you disseminate them throughout the community...all of those keep broadening your perspective.” (LA1)*

*“I’m not au fait with the details but I know that in Denmark a bit of their work on cycling...In Belfast some of the work on local engagement and HIA has been very useful.” (PS8/LA)*

*“Looking at specific experiences of other cities, there was some really good work done in Milan in urban developments, in housing for the people as well, so I think we brought back some specific ideas and projects to give us something to think about...” (PS6/LA)*

*“There were some specific things around HA and the proposed use of children’s centres for use also by older people...that was as a direct result of what she had seen from when she had been abroad.” (LA6)*

Consideration was also given to the possibility that lessons had either not been learnt from other cities, or that they were not visible to the HC stakeholders. As one senior officer stated:

*“I haven’t seen it. I guess a theme here might be that because I haven’t seen it doesn’t mean it’s not there. On the other hand I am relatively high profile and well engaged with the City’s health agenda both with local authority and the NHS more broadly - so if I’m not seeing it then I would have to ask the question, ‘is it there?’” (PS2)*

Building on the previous question, participants were additionally asked what lessons they felt had been learnt from the UK/Ireland WHO designated HCN that may be useful in helping the Brighton and Hove HC Programme to move forward. Most stakeholders said that benefits could be gained from actively participating in this network, particularly in terms of cities providing support to one another, sharing learning experiences, acting as reference points for one another and, for broadening perspectives and relating these experiences to local level. Linked to the concept of providing support to one another, an additional point raised was that the network was a useful mechanism for communicating with WHO:

*“It has been very helpful actually. Belfast has done some really good work on HIA...they’ve done some excellent work so they are always a very good reference point for us...It’s an opportunity to reflect on our own practices as well.” (PS6/LA)*

*“...so we help each other out and occasionally we do joint responses to national policy documents, not necessarily about the HC work but are related to our HC objectives...” (PS10/LA)*

*“A value of the national network has been that as a UK/Ireland city we’re able to then convey things with a united voice back to the WHO, for example on the proposal for Phase V core themes etc - so I think there is a lot of value in this national network.” (PS6/LA)*

### **3.2.7 WHO Healthy City: core objectives/strategic goals**

Participants were asked to consider whether Brighton and Hove had advanced WHO HC core objectives as far as possible. Where required, participants were provided with a full list of these objectives, presented as strategic goals by WHO, to facilitate their responses (see Appendix C).

It was of note that some participants were clearer than others as to what the core objectives consisted of, and it was apparent that there was some confusion over the differences between the WHO HC core objectives/strategic goals and the core themes for Phase IV of the Programme (i.e. HUP, HIA, HA, PA):

*“It’s not something that is very high on my radar and or this organisation’s.” (PS2)*

*“I’ve been told we have [ADVANCED THE CORE OBJECTIVES], but I don’t know enough detail about them to know whether we have or we haven’t.” (LA3)*

Once further clarification had been given where needed, responses to this question tended to be mostly positive and more detailed analysis of the responses underlined that the strategic objectives relating to policy and practice generation and know-how, and the promotion of policies and action for health (strategic goals 1 and 6) were seen as being particularly pertinent and apparent within Brighton and Hove:

*“We’ve got HC at the core of our policies; we’ve got HC as part of our community strategy...health as a major aim, the centre of the community strategy.” (LA1)*

*“Promoting policies and actions for health and sustainable development at local level I would say.” (PS1)*

*“Brighton and Hove has worked very closely to promote policies definitely with an emphasis on health inequality most definitely. We have links with France; people are good at making those connections. I’m not sure how much we have strengthened...or how we could evidence that...Generating policy. Yes I think they have and the urban planning and HIA we’ve done quite well.” (PS8/LA)*

An alternative view was that this was a difficult question to respond to because with the measurement tools available at local level, the data collected, the time scale of the HC Programme, it was hard to ascertain whether policy and practice related to/developed as a result of participation in the HC Programme, had advanced, or could be directly attributed to WHO core objectives/strategic goals:

*“There is a whole issue about the relevance or pertinence of much of the data...I think we need to be careful in terms of the performance information and data, whether things go up or down, so if things are getting better, I’m not sure we can always claim the credit for that.” (LA6)*

### 3.2.8 Phase V of the Healthy Cities programme

Stakeholders were asked for their views on whether Brighton and Hove should participate in Phase V of the WHO HC Programme. This was of course difficult to respond to for many given that WHO has not as yet given direction to what the key aims, objectives and priorities will be for Phase V. This uncertainty, perhaps unsurprisingly, resonated as a key theme in participants' narratives. Most stakeholders we spoke to felt they were unable to make an informed decision on the most appropriate course of action for Brighton and Hove in terms of whether the core themes for Phase V would align with Brighton and Hove's local agenda:

*"I say maybe...I say that because the key themes of Phase V, as far as I know, are still in discussion therefore the aims, objectives and priorities still remain unclear - because of that we are still unclear about how they might fit in to local level priorities and whether there might be potential conflict."*  
(PS1)

*"...I find this very hard to answer because I don't know how much of the HCP would continue if we weren't part of the WHO."* (CVSF 5)

Furthermore, some stakeholders were unclear as to what the resource implications of participation in Phase V of the HC Programme might be for Brighton and Hove. The potential financial and time costs were the most common themes:

*"I don't have a strong awareness of what that takes away from us in terms of resources financially, how much does it give and how much does it drain...so it's very difficult to make a kind of practical judgement..."* (BS1)

*"I don't know enough about what we might gain and also give, so I think we need to work out in relation to the time that we would need to be involved and to what level we would need to be involved give..."* (LA3)

Overall however, the response to joining Phase V was generally positive:

*“Yes, I think we should participate...” (PS9)*

*“Yes, absolutely.” (CVSF 1)*

*“More in favour than not.” (PS8/LA)*

*“I think they have to.” (CVSF 3)*

Respondents felt that tangible impacts for Brighton and Hove had been achieved during Phase IV of the WHO HC Programme and that this momentum should be maintained by continuing into Phase V:

*“It seems to me a pointless exercise to have gone through everything else, get everything functioning and then say we don’t carry on.” (CVSF 2)*

*“These things are incremental....so I guess the potential of involvement in the next stage is about building on that platform and it would be a disappointment and a waste not to participate, having done all that work. But it’s long term I think.” (LA2)*

In light of the some of the uncertainty surrounding Phase V of the HC Programme, some stakeholders suggest that the key technical officers involved in the HC Programme should be given the overall responsibility of making the ultimate decision as to whether Brighton and Hove should participate:

*“I would very much be guided by Terry and those people that are right at the heart of it as to what they think the value of it is - when you’re on any sort of a board your steer needs to be taken from the people who are doing it every day and the value that they get from it.” (BS1)*

*“My feeling would be I’d be guided by Terry and Tom as to their take on all of that...” (LA2)*

*“...You could argue that it’s the Healthy City coordinators that should just say...” (PS8/LA)*

### **3.2.8.1 Phase V: potential benefits, costs, and challenges**

Participants were requested to elaborate on their responses as to whether they thought Brighton and Hove should participate in Phase V of the HC Programme by considering what potential costs, challenges, and benefits this may have for the City.

#### *Benefits*

In terms of the potential benefits, there was wide agreement amongst stakeholders that the kudos of being a WHO designated city was an important benefit. This reinforced the earlier point around the added value which this brought to the City:

*“Ultimately it’s a badge that’s recognised - we are a WHO Healthy City - that looks good, no doubt about it...” (CVSF 6)*

*“The advantages are that we would have the brand of being associated with the WHO - we should not shirk that lightly as it’s not very often that a city is able to say that it has a WHO designation, so that does help...” (PS10/LA)*

*“So far there have been many benefits from those people for whom it’s important and that the badge and the engagement with Europe is an attractive thing to have.” (PS2)*

The benefits of participating in an international network and the increased learning and experience this had already, and would continue to, bring to the City were reported, as well as contributing to this developing pool of knowledge, and again reiterating the issue of added value for Brighton and Hove:

*“... being members of a wider HC network in Europe does give us insight into new practice and commonly shared challenges through Europe...”*  
(PS10/LA)

*“I think it would be beneficial to participate, because it gives a wider international aspect, because you can be very insular I think, and I think that all countries face the same challenges really.”* (CVSF 2)

*“Brighton’s got an awful lot to share on the international stage and we should be championing our city in that way, and connecting with the other British cities as well as those cities that are within the European WHO system.”* (BS1)

Moreover, the WHO HC was also recognised as being a useful ‘vehicle’ to enable the delivery of a wider public health perspective:

*“There are big opportunity costs and it enables me to give a resource to that work... This agenda allows me to deal with a wider canvas which would probably be difficult to do if we didn’t have the HC banner... I see this is as a means of fulfilling the whole remit of public health.”* (PS8/LA)

*“I think it does provide a strategic focal point to ensure that there is a focus on the wider determinants of health and public health activity.”* (PS10/LA)

### *Costs and challenges*

In terms of the potential costs<sup>3</sup> and challenges of being involved in Phase V of the HC Programme, the resource implications of both person time and the financial cost to the WHO as a participating city, and thus the required level of commitment to the Programme were the most commonly expressed themes:

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<sup>3</sup> Given the relatively negligible financial costs involved in joining the WHO programme and the complexity involved in identifying opportunity costs, it was considered beyond the scope of this review to carry out an economic analysis of participation costs involved in Phase IV of WHO HC Programme.

*“I know there’s a cost for us to be part of the WHO movement...but that’s not the only cost, there’s the cost of being out there, there’s the cost of going to the events, there’s the time cost of making sure we’re reporting back...” (BS1)*

*“...There are responsibilities, to take part in the international network of things and to complete the feedback and evaluation reports etc. I know they are quite demanding on Terry’s time...” (CVSF 4)*

*“The challenges are that it is a big commitment for the PCT - it is a huge commitment.” (LA1)*

An additional dimension to the cost-benefit analysis was the relationship of Brighton and Hove to WHO. As explored earlier, a common theme was the dissatisfaction from within Brighton and Hove with the level of support offered by WHO. This was translated into a potential cost of participating in Phase V of the HC Programme:

*“The reasons not to be involved are related to the minimal level of strategic support that comes from the WHO. I feel very nervous in some respects giving the WHO our support through our participation in the network...” (PS10/LA)*

*“The way I’ve seen this last phase - Terry has put in a huge amount of time and effort to actually do stuff within the WHO HC network...It’s the time and energy that people need to put in, in order to actually keep the WHO HC network supported.” (PS3)*

### 3.2.8.2 Stipulations

Some provisos were suggested as a way of addressing the challenges stated above, and helping to inform a decision on whether or not to participate in Phase V. For example, some stakeholders felt that there should be commitment at local level outside of the HCP to support the HC Programme:

*“...how effective it can be would be dependent on local factors and particularly about the positioning of the HC Partnership, its profile with the LSP and its command of resources and its impact, or its clout in terms of mainstream service delivery planning.” (LA2)*

*“We have a new constitution at the City Council, a new cabinet and a change of leadership - that has to be taken into consideration. Whether or not they would see that if we did decide not to participate, that it is not an important priority any more and how that would impact on the HC work generally.” (PS6/LA)*

Furthermore, it was felt that in order to be able to justify participation in Phase V of the HC Programme, it would be important to ensure that the benefits gained would ‘fit’ into the local agenda for improving health and wellbeing and that these would need to be visible to the wider population:

*“Given the investment we are making in officer and organisational time if nothing else I would want to be very clear that that was delivering on the objectives that we have as an organisation... is it worth the investment in the broadest sense here, not just money... if we do participate in Phase V we will need to be clearer about the benefits that we expect to get from it for the people of Brighton and Hove.” (PS2)*

*“It’s that balance between finding out what it is we need to do and the time that it requires from our officers to do those things that might otherwise be spent more directly on identified local needs.” (CVSF 4)*

In addition, some stakeholders felt that the leadership and ‘health’ of the WHO Head Office needed to be addressed if Brighton and Hove were to receive adequate support:

*“My proviso would be what the ‘health’ of the WHO office was. In other words, is Phase V going to be totally supported by WHO...” (PS4)*

*“What are the WHO actually going to do to make this work better?” (PS3)*

*“The additional responsibilities of the [WHO] HC Programme head - the impact of his potential level of commitment and engagement with Phase V. Whatever happens a programme like this needs a figurehead and an active participating figurehead – which is probably a contradiction in terms but it needs a very clear leader.” (PS1)*

### **3.3 The Healthy City Partnership**

This section of the report focuses specifically on the ‘health’ of the HCP itself and how it can evolve to optimise the potential for health improvement and reduction in inequalities within the City. Stakeholders were questioned on the following key themes related to the HCP:

- Value of involvement
- Priorities
- Community consultation and engagement
- Terms of reference (see Appendix A)
- Membership
- Working practices
- Vision for the future and key challenges

#### **3.3.1 Value of involvement**

In this section, stakeholders were asked to outline on behalf of their sector or organisation what benefits (if any) they had accrued from their involvement in the

HCP. Thematic analysis revealed a number of clear benefits emerging from stakeholders' narratives including: legitimacy by the HCP for endorsing action at local level, higher visibility, facilitating inter-sectoral collaboration, and enabling joint working. For instance, a number of respondents felt their sector/organisation's had benefited from being involved in the HCP because it provided a level of legitimacy for local public health activities in the City. As the following quotes demonstrate:

*"...it has given us a focus to move more upstream whether you see it as health promotion or public health or health improvement – it has given us a strategic focus where we are more accountable from a local partnership perspective in terms of how we spend NHS capacity and resources focussing on the wider determinants of health." (PS10/LA)*

*"It has also confirmed that the work that was already going on in terms of the development of European and international work, particularly linked to the health and social agenda, has been valid." (PS1)*

Secondly, respondents felt that the benefit of involvement in the HCP was its ability to raise the profile of their own sector and/or organisations, particularly in relation to the PCT and the community and voluntary sector. Moreover, as noted earlier in this report, the HCP profile was felt to be important in terms of funding applications:

*"It enables it...to keep a more public profile, a higher profile with partnership working."(PS4)*

*"...it has raised the profile of the community and voluntary sector to be at the same table as the PCT, the Council, and others..." (CVSF 5)*

*"It has raised the profile....it has really helped to give us real support from key people in the City....it also helps when funding applications go in because its like – oh yes that's the healthy living centre, so we know what they do." (LA4)*

Thirdly, many participants we spoke to felt that inter-sectoral collaboration had been facilitated by the HCP both within and outside of formal HCP meetings. Specific comments related to the HCP providing a framework for broad based programmes, helping to keep older people on the agenda, influencing social services, and benefiting the voluntary sector:

*“...the involvement in the HCP has broadened out and contributed to our understanding of what modernising social services provision for adults in the City needs to look like...it has raised some elements and aspects that hadn’t previously featured in social services managers’ discussions.” (LA2)*

*“It is a good way for us to engage with a much wider audience in terms of the voluntary sector and others and take forward a lot of the work that we do.” (PS6/LA)*

Finally, many stakeholders reported that joint practical work had been stimulated by the HCP in terms of specific topic based community interventions, and between major statutory agencies enabling them to meet specified targets and to explain practical inter-sectoral working:

*“It’s £900,000 worth of funding from the PCT for the Healthy Living Centre ...its one of the biggest recognitions of our impact that the PCT have funded...It wasn’t just one project bid...the Healthy Living Centre is...managing about 6 or 7 staff who do different types...mental health...drug abuse...teenage pregnancy...it will benefit the area and the City as well.” (LA5)*

*“In terms of the local authority and PCT working together...there has been some joint working...and...some of the tangible evidence we’ve seen in terms of working together, and bids and supporting projects together.” (LA3)*

*“It’s meant that some of our targets around partnership working and some of the health improvement targets have been met.” (PS3)*

However, despite these positive themes concerning the value of stakeholders' own sectors/organisations being involved in the HCP, there were also some more critical views. For instance, opinion from particular senior officers was that the HCP had only had marginal influences on policy development within the City, and on a conceptual level, that the HCP had not moved enough towards the broad health agenda:

*“There have been marginal benefits but if it were to disappear tomorrow the work would carry on. I’m not aware of any influencing of policy from the work of the HCP.” (PS2)*

*“We need to be looking at the whole picture together so that we are changing the emphasis away from – crudely speaking – ill health towards health. We’re not doing that at the moment.” (PS7).*

### **3.3.2 WHO Core Themes: appropriate priorities for the City?**

Bearing in mind the four core themes for Phase IV of the WHO HC Programme, stakeholders were asked whether they felt the HC Programme was focussing on the appropriate priorities for the City. There were a number of positive responses to this question:

*“In broad terms yes the priorities are correct. I can’t think of any other areas that the HC Programme as a broad programme could really concentrate on.” (LA1)*

*“...it’s good what we’ve done around urban planning...so that’s embedded in theory in the Council in terms of their planning processes.” (PS3)*

*“The four priorities in Phase IV are relevant priorities locally...HA is one where I think our systems and processes of engagement within the City were already well advanced.” (PS10/LA)*

Stakeholders were also asked to consider what other priorities should perhaps be addressed within Brighton and Hove. Specific areas and topics, in particular mental health and substance (mis)use, and sexual health including teenage pregnancy:

*“...from a PCT perspective our top priorities for health are firmly rooted in the characteristics of the local population so they are about sexual health services, mental health, health inequalities, and a range of other things...”*  
(PS2)

*“Sexual health issues are a big thing for us together with mental health in terms of suicide prevention...”* (PS8/LA)

*“We would like to focus on young people’s issues, substance abuse issues, alcohol and sexual health...”* (CVSF 6)

More broadly speaking, a key narrative emerged which reflected the importance of focussing on a more holistic concept of health i.e. not only focussing on mental ill health and social exclusion for example, but relating this towards positive mental health promotion and its links to social health and broader determinants such as employment and a more active participation in civil society:

*“One of the things emerging for us more strongly than ever in the City is the prevalence of mental health concerns and how much wellbeing is really about people’s sense of wellbeing and their ability to participate in local communities - the extent to which people have validation in terms of their relationships, their inclusion in local society and community, also things like skills development and work and the extent to which we should be working with the employment sector for example in looking at better solutions and pathways for people who have had mental health difficulties.”* (LA2)

Reference was also made by some stakeholders for the need to consider local demographic variations across the City, and to ensure that potential conflict between WHO, local and national priorities would be addressed:

*“For me the priorities for East Brighton might not necessarily be the priorities for the City...” (LA4)*

*“We have to work out how we are going to manage and measure and reach performance on the 35 targets we are about to set ourselves as a local health economy and wider with our partnership group...we’ve got a national indicator set which is cross-cutting, cross organisations, we’ve got a whole health and wellbeing agenda...how are we going to marry those up without us all spending lots of time at lots of different meetings, trying more or less to measure the same thing.” (LA3)*

*“...if the HC or Phase V means the City has to do something other than what is in our new local agreement, then whoever does this should be seriously arguing either don’t do it or make the targets match our local area agreement targets...the City and its partners shouldn’t be making up any more targets.” (LA5)*

### **3.3.3 Community consultation and engagement**

In their interviews, stakeholders were asked what mechanisms were in place for the HCP to consult with local citizens of Brighton and Hove. The most common response to this question was that consultation was made using the existing mechanisms of various partners from HCP via their own communication systems:

*“...in terms of involvement and participation the HCP...reaches out using the mechanisms of other organisations...” (PS4)*

*“The mechanisms in place for the HCP to consult with local citizens, well it’s who is around the table and what consultation mechanisms are in place for each of the organisations around the table...” (LA4)*

In general, stakeholders reported feeling that there were too many consultation exercises with communities within the City and this potentially led to duplication of

effort. Some stakeholders therefore proposed that it was necessary to share and collaborate more with other organisations, sectors, and agencies in the City in order to make optimum use of scarce resources:

*“...there is a culture of too much consultation and there is a need to do an audit of consultation with the local authority and the PCT.” (PS6/LA)*

*“All of us working in the public sector should be aligning our consultation work together - otherwise we will confuse the hell out of people. Secondly we’ve got limited resources, and thirdly the communities we are trying to engage with have got limited resources to either want or wish or need to engage with us.” (PS7)*

A key theme emerging from this discussion was why the HCP wanted to consult and engage with local communities, and to ensure that the conceptual difference between the two terms was recognised:

*“...there is a question for us to ask ourselves...what we mean by HC work and of what we should be doing in terms of engagement with communities and for what reason...We should only be doing it if we can offer something.” (PS10/LA)*

*“I think we need to make a difference between engagement and consultation...we need to be a bit more mindful about what it is we are doing.” (PS6/LA)*

In addition, stakeholders were asked how effective they felt existing communication mechanisms had been and whether they needed to be reviewed. Some stakeholders felt that the HCP should design and operate its own dedicated communication strategy and delivery mechanism:

*“It doesn’t have its own resource and I think it might need to do that otherwise it’s competing with everything else. So it’s all well to talk about*

*what we could potentially do in a meeting, but then you need someone to go away and do it.” (CVSF 4)*

*“...this is a major gap for the future and we need to look at ways in which we can keep citizens informed and consulted in a more empowering way.” (PS9)*

Although the HCP had commissioned externally a communication strategy this strategy had not been operationalised. Stakeholders offered suggestions to rectify this situation and also reported that options to fill this gap are currently being discussed in the PCT:

*“...[A HC COMMUNICATION STRATEGY] is my biggest disappointment over the last 5 years as far as HC work is concerned...I have regularly asked for more capacity and support, particularly from the PCT but their communications support keeps being pulled away into other crisis management issues...” (PA10/LA)*

*“I know from the work that we are doing with the PCT now is actually thinking we have to get our consultation strategies better, I think it’s probably an area we need to improve on.” (LA3)*

*“Overall what we need is a strategy and then a series of delivery mechanisms to enable that to happen, not least....engagement with the local media, mass media, which would be very useful in terms of keeping HC issues on the public agenda.” (PS9)*

It was suggested that the development of any communication strategy and delivery mechanisms should take full account of existing community support infrastructures within the City:

*“...that’s the problem, it’s not so much about the HC, who are a small resource trying to talk to lots of people, the problem is the way the City is structured in terms of its support to communities.” (CVSF 3)*

and also relate to citizens’ understanding of health and its determinants:

*“...most people in this city probably equate health with health services in terms of their primary care, hospital services, protection rates in hospitals, how quickly you can see your GP and those sorts of things. Whereas if you ask people what it means to be healthy most people would answer it’s about getting out and about and being active and enjoying life that sort of thing. They would give you a broader view of the definition of health but I don’t think we particularly engage them in that sort of thing.” (PS8/LA)*

When devising those aspects of the communication strategy that seek to engage with the community, it was felt that the HCP should relate this to relevant LSP networks:

*“...the LSP has grasped the importance of a more thorough going understanding of what community engagement in the City needs to comprise and how it needs to be resourced.” (LA2)*

*“Having got on the agenda of the Community Partnership, the LSP, and having got health into the community strategy, and with the LSP monitoring how that is doing, there is at least a mechanism for keeping health on the agenda.” (LA1)*

Practical suggestions were made to communicate more effectively with citizens and their communities:

*“There’s a case for going out and doing a few more road shows really, literally going out into some of the communities...through the organisations and local groups and organisations out in the community that people recognise.” (CVSF 4)*

The HCP strategy should engage with all citizens and sectors of the community and not just those deemed to be in most need or those who shout the loudest:

*“...we have a responsibility to equip everyone with sufficient information to be able to make informed judgements and decisions for themselves about what they can do about their own health... we’re falling short on that really...what the HC work has helped us to do is realise that this is about everybody in the City, it isn’t just people who have the most marked kind of health needs...” (LA2)*

*“...there is a real danger of only talking to those people that want to talk and might get engaged with us.” (PS2)*

### **3.3.4 Terms of Reference**

Both in their individual interviews and in the workshop held at the University of Brighton, stakeholders were asked if the HCP terms of reference were still ‘fit for purpose’. All participants were provided with a copy of the Terms of Reference, and given time to assess them (see Appendix A). It was of note that some stakeholders said they had not ever seen them or been shown them before. Despite this, there was general support for them in their current format:

*“I think they are fit for purpose.” (PS6/LA)*

*“They’re excellent and still relevant...Immediately I look at the various parts of it, I can think of an action that they have done to meet those requirements.” (LA1)*

However, most participants still felt that the Terms of Reference needed to be reviewed and updated in order to evolve with the development of the HCP:

*“They are still very relevant, but I think there is an issue about they might need to evolve because the HCP has evolved over time.” (PS10/LA)*

*“...I’m sure that these need to be reviewed and explored in much more detail on a formal level.” (PS9)*

Some additional and specific suggestions were made by various stakeholders in an attempt to improve them. For instance, it was suggested that references to membership and working practices should be included. As the following quotes illustrate:

*“...something more specific about membership would be good...include something about working and decision-making powers...” (CVSF 4)*

*“...they probably need reviewing - the Terms of Reference should include membership and accountability, and how often people meet, and what people are expected to do as part of the group...” (LA4)*

Although there was support for the Terms of Reference as a general visionary statement, there was concern as to how they were operationalised in practice and how effectively they were actually being met. It was suggested that they should be perceived as part of a strategy for the HCP, with specific objectives, measurable targets and deliverables in order to build in a degree of accountability:

*“In terms of leadership and vision it feels nice and woolly - like it’s saying the right things but...we’ve got to agree the most important health needs within the City, agree a strategy – I suppose this is about accountability... I don’t get a feel here about setting some clear goals or targets, whether that be through contracted out services or working with partners and people actually being held to account for delivering certain things.” (LA3)*

*“They are fine but they are not really what we do as we are driven by the tenants of the WHO - what they say are the HC priorities are what we work to...you have to put some reference to the reality to forward the objectives of the WHO which you don’t even mention here in these terms of reference, so I think this is perhaps more idealistic than what actually happens...it doesn’t say anything about achievements...it doesn’t say to deliver on any*

*targets or oversee...if that becomes a healthy wellbeing partnership then it probably will include more in the way of deliverables.” (PS8/LA)*

*“Overall they are fit for purpose - but how do we ensure that those objectives are met or at least we are moving forward on them on some tangible plan?” (CVSF 5)*

Moreover, concern was expressed as to whether the HCP was sufficiently empowered to achieve the Terms of Reference, and in addition how they link to the LSP infrastructure and how this operated in practice, together with future plans for the formulation of a health and wellbeing partnership:

*“I’m not sure whether the HCP is sufficiently empowered to deliver them [TERMS OF REFERENCE], so it is about power and influence and clout and muscle... in addition...it is tasked with coming up with a comprehensive plan for health improvement...to what extent is the HCP actually empowered and resourced to drive forward an action programme to equip that plan?” (LA2)*

*“Local Strategic Partnership – we all need to know more about how that works...” (PS1)*

*“This partnership is around health inequalities and maybe it needs to say that, or this...becomes the health and wellbeing partnership, doesn’t it? So how does that work? ...it needs a discussion about the health and wellbeing partnership because actually, if it’s going to be become that...it would be a different group and have a different focus.” (PS3)*

### **3.3.5 Membership of the Healthy City Partnership**

Stakeholders were asked if the most appropriate members were involved in the HCP in order to deliver the Terms of Reference. Narratives reflected that stakeholders felt that although the membership was reasonably mixed in terms of

sector representation and seniority, there was a need for the membership to be revisited in order to ensure representation from additional sectors:

*“...some quite senior managers and some quite junior managers...it did feel quite a mix of representation from across the organisations.” (LA3)*

*“If we could get more meaningful business input that would be the one thing I would like to see.” (PS8/LA)*

*“...the police must have been invited, did they turn up?...We had lots of people who represented members of the public but I’m not sure we ever had if you like members of the public from whatever groups...” (PS4)*

Although there was general support for the breadth of sectors currently involved in the HCP, some stakeholders reported that involvement should be at an appropriately senior level and/or that it needs committed individuals to ensure action outcomes:

*“...although there is really good representation of the stakeholders...who need to be involved and engaged with developing a HC - they are not necessarily the people who can provide the leadership and vision...The structure, the way it all works would have to change because if we invited senior strategic leaders to the meetings as they currently stand, they wouldn’t attend.” (PS7)*

*“...it’s only if you have got senior people on the HCP that you can change and do things differently.” (LA3)*

A number of questions were raised by stakeholders as to what their role and function within the HCP should be, reflecting a need for more clarity around this issue. In particular, their uncertainties related back to their accountability, both to the HCP and to their organisation. Moreover, there was clear uncertainty how

members were identified and invited to join the HCP and what specific commitment they were expected to make:

*“it’s not clear how, in the Terms of Reference, how people are opted in or become members...I was never asked, the group were never asked to co-opt me as part of the group, so who am I accountable to and who am I representing...also, how the chair and the vice chair are nominated would be a good thing to put in, and you know how long they’re the chair for should be put in the Terms of Reference.” (LA4)*

*“What needs to be strengthened is....what you can do as a member of the HCP, what membership means in terms of what responsibilities you are going to take on behalf of it.” (LA2)*

*“There needs to be clarity about does that membership answer back to somebody. So if you’ve got a sector, do other people within that sector hear anything from that membership that feeds them back about the HC?...I don’t know but it does seem to me that if you are sectoral on there [HCP] then actually there is a responsibility to brief others. I am not sure if that is actually happening.” (CVSF 3)*

Finally, one stakeholder felt that members could perhaps be invited from outside the usual statutory agencies, and proposed that change could potentially be facilitated through contractual arrangements with the wider employment field:

*“You want somebody who’s not into health, because you need people to go back to the core of the organisations and say, this is how it’s going to be. I suppose with everybody there, you’re preaching to the converted. Everybody sitting at that table is going to say that this is a good idea and it’s actually, if you really want to change things...trying to get the people who wouldn’t normally be there to come...I think it’s actually about thinking about, how else can you get to people...It’s actually saying to people, you will not get our business unless this is what you do...you would agree in the*

*contract that there would be five things they would do about keeping their staff healthy through the life of the contract.” (PS3)*

### **3.3.6 Working practices of the HCP**

Stakeholders were asked for their comments concerning the current working practices of the HCP. More specifically, stakeholders were asked whether they felt the HCP had been working in the most effective and efficient way and to offer suggestions were offered regarding the key driving factors and/or barriers to this.

In terms of whether the HCP was working in the most effective and efficient way, there were some negative views expressed. Some felt that the HCP was too big, and tried to achieve more than its capacity enabled it to, and had too little direction:

*“I don’t think so. It has been too big, it has the wrong mix and perhaps it doesn’t feel like it’s actually then dealing – certainly within that meeting – with any subsequent issues.”(LA3)*

*“Brighton has so many partnerships, partnership on partnership, and my question is how can we make this partnership something from which specific actions emerge and something that is...really tangible as well...It could be improved.” (PS6/LA)*

*“The simple answer is no...it could work more effectively and more efficiently if we were all more aware of where we are going as a partnership and that we were really buying into that as partners...but I think it is so big it ends up not being able to make things.” (CVSF6)*

*“No, the Partnership is not working in the most effective way. The paper, the amount of stuff needs to be cut down...not trying to get so much into one meeting, and really enabling some proper discussion.” (BS1)*

However, some did stakeholders did report that although improvements could of course be made to the effectiveness and efficiency of the HCP, it was probably

working as well as it could based on the available resources, and considering the current policy context:

*“I think it is working as effectively and efficiently as it can within the current resources and policy contexts that we are working to locally...but I think we need to be more radical about what we can achieve...” (PS10/LA)*

Indeed, other participants did recognise the impact of resources on the HCP’s ability to work effectively and efficiently, and a suggestion was made to try and secure additional funding to add to the HCP’s resource base:

*“...[PUBLIC HEALTH PROGRAMME MANAGER] needs a Healthy City sort of coordinator...he needs that post because it is a huge amount of work.” (PS5)*

*“There’s not much money behind this on the whole...maybe we need to think about bringing more in, if we could look at some joint bidding work to Europe or looking at different streams other than the ones we have...” (BS1)*

Considering the available resources, and in terms of working practices, a common theme was the need for the HCP to be more strategic in its approach, perhaps through the development of a clear strategy and operational plan:

*“There should be a strategy and action plan...I don’t know where we are or what the big plan is and where we are on it...we haven’t got...an action plan that says, ‘this is what we’re doing and this is why we’re doing it, this is who’s leading and this is when it’s going to be done by’ - and that’s what I’d like to see and then I’d know my part in it and how I can link in with other people, because at the moment I don’t see that.” (PS5)*

*“A clearer strategic direction linked to clear actions because that then clarifies membership and it also clarifies commitment of members and their stake in the Partnership...to produce a strategy and an action plan that is*

*informed and consulted on by all key stakeholders - will give a structure and a direction for the Partnership both in terms of its future objectives, in terms of monitoring and review, and in terms of evaluation and informing..." (PS1)*

A number of stakeholders also proposed various other ways in which the HCP could become more strategic in its approach such as the meetings becoming more focused and interactive (e.g. by including small group discussions and considering fewer, practical issues on the agenda) and considering the use of away days:

*"Maybe it's getting people on more smaller, more flexible action groups, time limited because otherwise you create silos that engage in different areas and have a task and achieve it then take it back to the group...rather than just going to meetings being bombarded with reams of paper...there's no opportunity for me to actually sit down and network with those people."*  
(BS2)

*"...to have more strategic meetings, away-days if you like, which would enable members to be consulted on a more strategic basis, a more operational basis, rather than the basis of what I would call business meetings with very tight agendas and a number of key issues which need to be reported...share their experiences on a much more productive basis...allowing members to engage more actively in decision making, particularly about resource allocation."* (PS9)

*"[HCP MEETINGS] are too long, the agenda is too loose, we go off at tangents - we have long presentations and discussions about relatively marginal special interests."* (PS7)

*"It feels a little bit random as to what comes up...what would help is to have a smaller group of people working with the HC manager on the picture for the year ahead...so that we have got a bit of a schedule for looking ahead."*  
(CVSF4)

Moreover, stakeholders reported that it was important for all HCP participants to be able to engage fully with the agenda and to feel confident about making a contribution to the HCP:

*“Some people feel more involved than others, there is usually a core of people who are contributing at the meetings and others who don’t and there might be a number of reasons for that. We should explore that as a group.”*  
(BS2)

*“it seemed very technical, there was a lot of talk about bids, and really for lay people there, you hadn’t got a clue, because it was so technical, and a lot of the people were making the point that they wished they’d been consulted earlier...we might have been able to understand it much better, and take a view on it.”* (CVSF3)

Suggestions for improving the strategic approach of the HCP included using performance target and measures, linking the work of the HCP more closely to the policy context, for example, to the work of the LSP and 2020 Community Strategy, and by becoming involved in local commissioning:

*“I’d give it some performance targets to actually make sure it worked to measures...making it much more business-like. It needs to manage the business of reducing health inequalities in the City and if it is going to do that it needs to be much more accountable, responsible for the services it set out to deliver in the City.”* (LA3)

*“The LSP doesn’t listen often enough or actively enough to the HCP. There is a reporting relationship but I’m not clear at all how robust it is, I’m not clear what notice or what the LSP actually does about the reports that the HC Partnership brings to it. So I think that’s another aspect that should be strengthened.”* (LA2)

*“The opportunities to be more radical are linked to the 2020 sustainable community strategy and what’s called the Partnership Management Group.” (PS10/LA)*

*“We should be [OPERATING] the way the ‘Choosing Health’ (DOH 2004) funding is secured now through the HCP...all the bids went to the HCP last year which I think is a really good idea...funds are secured by the HCP and then go to the PEC [PROFESSIONAL EXECUTIVE COMMITTEE OF THE PCT] which seems a really good way of doing it...Although we do say what the priorities are.” (PS5)*

An additional theme was the need for increased teambuilding as an enabler for celebrating the successes of the HCP, but also to facilitate skills exchange with the idea of drawing upon one another’s experiences in a way that benefited the group as a whole:

*“The biggest thing for me is probably to actually feel that there is a real team - a real partnership rather than individuals coming together with their own representations, which is totally fine. But to...actually feel it is an actual team...And with the relative infrequency of the meetings you never feel you’ve got to know the people and to feel that you are working towards common goals...I think that goes back to this knowing what we are actually achieving and celebrating the successes that we do have or that we are involved in.” (CVSF6)*

*“...and put some mechanisms in place to gather a bit more of the skills and resources around that table and translate them into action.” (BS1)*

*“...another thing about partnerships is, where they work really well together is where people really have a chance to get to know each other...and if it is such a kind of influential group for the City, would we be better spending some of our time, spending a day together and doing a bit of work about getting to know each other and what our roles are.” (LA4)*

### 3.3.7 Vision for the future

Participants were asked to comment on what their vision of the HC for the future would be. In doing so, they were asked to consider how they felt the HCP could evolve to optimise the potential for health improvement and the reduction in inequalities in the City.

Unsurprisingly, there were a number of reiterations in terms of some of the common themes mentioned in the previous two sections (3.1 and 3.2). Most notably, interviewees reported that their vision was for the HCP to function in a more strategic and collaborative way including becoming more influential and visible and being clearer about its purpose (aims, objectives, and practical and/or measurable deliverables). For some, this strategic shift was seen as a crucial element in the decision to join Phase V of the HC Programme:

*“If we are to enter into the next phase, can we be very clear about why we are doing that and the added value...so we can be clear in more of an audit kind of way that the benefits we intend to deliver have actually been delivered.” (PS2)*

*“It [THE HCP] shouldn’t be there for the sake of being there - if it has no authority and no credibility there’s no point. It should keep going...but keep going with a purpose and the usual stuff about being able to measure the success and outcomes of what it does.” (PS4)*

*“There should be very clear, genuinely collaborative and integrated processes and action and that is where a strategy and an action plan would support that.” (PS1)*

*“It is much more about it...delivering a concerted programme for addressing health inequality and for quality of life improvement and that that activity the HCP is seen as leading and co-ordinating and delivering that on behalf of the main commissioning agencies...It’s a sense of it being not a really interesting and worthwhile sideshow but something that is centre stage in*

*terms of the way services are going to be developed strategically in the City.” (LA2)*

Furthermore, stakeholders articulated the need for this strategic rethink further by suggesting that the HCP members needed to be able represent Partnership interests in other networks. This is an important point and one which (implicitly) other stakeholders have raised i.e. the need to be more involved and to have a fully developed understanding of how they could potentially be involved:

*“There needs to be a strategic rethink about what the LA and PCT understand in terms of the potential for the HCP - and that they are much more committed to us working in a more flexible way on upstream measures with communities and neighbourhoods. The most recent example of pulling the public health ‘choosing health’ funds into the HC is part of the way forward. We insisted that all the bids that came in had to have a non-NHS partner, either leading or actively contributing as a main partner through that work...with support from the PCT, we need to be braver at letting go and agreeing with partners that they can represent Partnership interests in other partnerships and other activities.” (PS10/LA)*

Other issues stakeholders raised in their vision of the HCP, again referred to themes already addressed in previous sections. For instance, interviewees felt that the HCP needed to engage more fully with its stakeholders and the wider public in the decision-making processes, in a transparent and effective way. Other interviewees felt the HCP should draw more upon the skills of the community and voluntary sector, whilst others stressed the need for the HCP to have a much higher public profile which could include demonstrating practical outcomes and ‘short-term wins’. The restructuring of working practices relating to HCP meetings and members’ roles was also felt to be an important step in optimising the Partnership’s functioning:

*“We should have the flexibility and the commitment and the resources to engage much more effectively with all the sectors involved, particularly the*

*community and voluntary sector and the neighbourhood and communities, so we get closer to people in a grounded way.” (PS10/LA)*

*“My vision would be one in which...its profile within the public domain is much greater, much more dynamic.” (CVSF4)*

In addition, some stakeholders felt that an on-going, comprehensive monitoring and evaluation system should be installed to enable the HCP to work in the most effective and efficient way and achieve its objectives. Moreover, some said that such a system could not only help the Partnership to recollect its achievements, but enable it to reflect on comparative work in other European cities:

*“...there should be ongoing evaluation and review processes in place.”  
(PS1)*

*“We need to be mindful about proper evaluation and then how we take things forward, or not.” (PS6/LA)*

*“We should look for examples of what other cities are doing that we are not doing very well and seek to emulate those. We shouldn’t be just driven by looking at what problems we have...but we should be positive in our approach and look for some good examples of things that other people are doing...We should also recognise when achievements are made - It’s quite interesting that it was a struggle to say what the achievements have been of the Partnership, and maybe we are not very good at that as a partnership.” (CVSF 4)*

Finally, some stakeholders referred to Brighton and Hove’s links to WHO as an element of this ‘vision for the future’, with mixed opinion as to the need for WHO’s future involvement in taking forward the HC agenda in Brighton and Hove, as was discussed in more detail in section 3.2:

*“I’m more convinced from talking just now of the need for a HCP and a health and wellbeing partnership than I am for a WHO led city partnership.*

*It adds some value but my vision would be very grounded in what we want to do locally and not necessarily just what might be driven by WHO. I think we need to reflect on what direction WHO is going to drive the Healthy City movement in? And is it the direction Brighton and Hove want to go in.”*

*(PS8/LA)*

*“We will always have a requirement for a health focussed, cross sector partnership, whether it is through the WHO stuff it doesn’t really matter.”*

*(LA6)*

*“As a concept it’s a good idea. It’s a good place to bring people together to look at health inequalities. I’m not certain about the stuff with the WHO and I think it is about the WHO rather than our bit of it and in a way we can only influence that. I think we should think about what are the main priorities going to be for the City going to be over the next few years...” (PS3)*

### **3.3.8 Key challenges for the HCP in the future?**

Stakeholders were asked to comment on what they thought would be some of the main potential challenges for the HCP in the future. Responses in relation to this question concerned the clarification of priorities for the HCP bearing in mind the potential for conflict at local, national, and European level:

*“Prioritising the priorities - whose priorities are we going to address, local priorities, city priorities, WHO priorities? Some of those will be the same, but others might be conflicting...” (PS1)*

*“...it’s important to achieve local objectives and to give them primary accountability - in some way the challenge is to use national and European objectives in a very constructive and innovative way to achieve these local objectives.” (PS9)*

In identifying key challenges for the future, stakeholders again reiterated a number of themes that had emerged in previous sections including the difficulties in

ensuring appropriate senior members actively participate in HCP to drive change in their own organisations or sectors, and the need to change existing working practices and structures whilst also gaining adequate resources:

*“The key challenge is making sure that we have the right people working on the right agenda - making sure those people are senior enough to go and drive change in their organisations or who they represent.” (PS8/LA)*

*“If things aren’t going in the way we want to it [THE HCP] needs a structure to manage it because the agenda is so big...making it much more focussed on achieving the outcomes and taking action if it doesn’t.” (LA3)*

*“...the success of this has been down to a very small group of people in the PCT who have been fantastically enthusiastic and put in ludicrous amounts of time to do it.” (LA1)*

Furthermore, it was felt that a key challenge for the HCP was to address its strategic credibility and power to influence action at a local level, and that in order for the HCP to be embedded into the mainstream, stronger links would need to be made with the LSP as well as current and future local authority liaison structures:

*“We are tasked by the LSP to develop a city health development plan...but although the Partnership is responsible for the health of the City...we are not empowered...the PCT and the Council are the ones who are really responsible...so...where does the real power and accountability lie?...It [THE HCP] is not genuinely making a massive significant, strategic change...we don’t provide the leadership. Coordinated, intersectional action to improve health, well yes, we have a role in that, but it’s not the only one. Influence, policy yes, but we don’t make policy, we don’t make decisions...” (CVSF 6)*

*“One of the immediate challenges is that there is a requirement for each LA to have a health and wellbeing partnership and that partnership is meant to bring together partners from the various sectors in the City. Now, there’s*

*poor definition as to what that actually means in practice but currently within the City we have different boards and the HCP, and what the legislation is requiring us to do is to have something that is somewhere between the two, and the threat is that we would lose the focus on the wider determinants of health and action in HI, and I'm absolutely determined that doesn't happen, so that's for me the biggest challenge.”(PS10/LA)*

## 4.0 Summary of main findings

This section of the report summarises the main findings of this review and is presented according to: whether the healthy city approach is making a positive contribution to the health and wellbeing of the people of Brighton and Hove; whether Brighton and Hove's relationship with the WHO Healthy Cities Network has facilitated the progress of public health policy and practice within the City, and; the 'health' of the HCP.

### 4.1 Contribution of the Healthy City approach to the health and wellbeing of the people of Brighton and Hove

The findings in this part of the review relate to the principle achievements and added value of the Brighton and Hove HC Programme. The achievements, and difficulties faced under each of the four themes of Phase IV of the WHO HC Programme are explored. In addition, two core issues embedded in the Brighton and Hove HC approach were explored; tackling health inequalities and addressing the wider determinants of health.

#### *Principal achievements and added value*

The principal achievements and/or impacts of the Brighton and Hove HC Programme focussed on broad awareness of the WHO 'badge'. This helped to legitimise health and raise its profile across the City; facilitated political 'buy-in' for the HC Programme, and increased strategic partnership working. It also raised the profile of the City more broadly in international and European arenas, legitimatising and endorsing the work of the HCP. However, some stakeholders were unable to identify key achievements of the HC Programme for various reasons. These included having only recently joining the Partnership; a lack of clarity around objectives, targets and key benchmarks; failure of the HCP to reflect upon and celebrate its successes; and difficulties in attributing impact or influence specifically to the HC Programme.

### *Phase IV Core Themes*

Important achievements for HUP and HIA included raised awareness of the impact of urban development on health and wellbeing; embedding HUP principles and objectives into the City Council planning strategy; and enabling HIA to form a key part of council planning developments. This has been achieved by delivering a series of training programmes to council planners throughout the City. However, a limitation has been the lack of capacity and resources required to carry out HIA. The non-statutory nature of HIA has meant that the outcomes can only be advisory.

Under the healthy ageing theme, key achievements have included raising awareness of older people's health issues by shifting the focus towards the wider determinants of health, to include issues such as increasing independence and social inclusion by strengthening the role of older people in decision making and incorporating consultation into strategic plans. Nevertheless, there was some difficulty in reporting achievements specifically attributable to the HC Programme.

Comments made regarding physical activity reflected issues raised earlier - for example on the positive side - raised awareness, increased partnership working, and added kudos from the HC badge; and negatively – identifying attribution and measuring progress.

### *Health inequalities and wider determinants of health*

The HC Programme has helped to raise awareness of health inequalities in the City by providing a strategic focus to encourage cross-sectoral partnership working. However a lack of understanding as to the role of the HCP in tackling inequalities was noted. In attempting to address the wider determinants of health, stakeholders found it difficult to make a direct causal link from specific ongoing projects and infrastructural developments to the HC Programme. However, it was felt that awareness had been raised on what constituted the wider determinants of health, as a direct result of the HC Programme, and the long-term financial benefits of related work was recognised.

## **4.2 Relationship with WHO, Phase IV, and participation in Phase V**

This section explored the broader context of the City's participation in the HC Programme. Lessons learnt from UK/Ireland and European HC were discussed and the costs, benefits and challenges of participating in Phase V of the HC Programme examined.

In terms of the relationship to WHO, there were mainly negative responses from stakeholders, particularly in terms of the lack of technical and practical support and advice received from the WHO HC office (based in Copenhagen). WHO's communication mechanisms were perceived as being inefficient, and as a result, the sub-networks had been unable to work in a cohesive and sustained way. In contrast, the European, and UK/Ireland HC Networks supported one another, acted as a reference point for one another and formed a united voice to WHO as and when appropriate. Lack of resource and poor management in the Copenhagen office were perceived as key factors for the lack of support. On a positive note, the technical training offered by WHO advisors has been invaluable for some Brighton and Hove officers, and the benefits of this training had been translated into practice at a local level, and the skills disseminated to a wider pool of officers.

Key themes arising from Brighton and Hove's participation in the WHO Network included the kudos mentioned earlier and the knowledge exchange between cities which it has facilitated. This participation has had a positive impact on the development of policy, in particular in the areas of HUP and HIA.

The sub-networks have provided a forum for the exchange of knowledge, the development of tangible ideas for implementation in Brighton and Hove, and the provision of technical training. Whilst recognising some benefits of participating in the WHO HC Network, there was some uncertainty as to whether the progress made in policy and practice, could in fact be directly attributed to WHO and the HC Programme, or whether the work would have been achieved anyway.

The ongoing uncertainty around the detail of Phase V of the HC Programme meant that stakeholders found it difficult to make a reasoned decision as to whether Brighton and Hove should continue to participate. However, stakeholders commented on the following issues – the potential costs of their participation, WHO priorities compared with Brighton and Hove’s priorities and that there should be synergy between the two in order to justify Brighton and Hove participating in Phase V. The benefits again reflected the perception that there is kudos attached to being a WHO designated city, the HC Network’s ‘pool of knowledge’ which would continue to be a resource for the City, and the HC Programme acting as a ‘vehicle’ for the delivery of a broad public health agenda.

### **4.3 The Healthy City Partnership**

This section of the report focused specifically on the ‘health’ of the HCP itself to explore how it could evolve to optimise the potential for health improvement and reduction in inequalities within the City. A number of key themes emerged including: value of involvement, appropriate priorities, community consultation and engagement, terms of reference, membership; working practices, vision for the future and, key challenges.

#### *Value of involvement*

Stakeholders felt there were clear benefits to being involved in the HCP on behalf of their organisations and/or sector. Benefits included a sense of legitimacy by the HCP for endorsing action at local level, higher visibility, facilitating inter-sectoral collaboration, and enabling joint working.

#### *Appropriate priorities*

In general, stakeholders reported that the HC priorities were also the appropriate priorities for the City. Some also suggested a number of other priorities they felt should additionally be addressed including mental health, substance (mis)use, and sexual health. Stakeholders felt there was a need to consider local demographic variations across the City, and to ensure that potential conflict between WHO, local and national priorities would be addressed.

### *Community consultation and engagement*

Stakeholders were asked what mechanisms were in place for the HCP to consult with local citizens of Brighton and Hove. Interviewees reported that consultation was made using the existing mechanisms of various partners from HCP via their own communication systems. However, most felt there were too many consultations with communities in the City, and that it was necessary to work in a more joined-up way with other organisations, sectors, and agencies in the City in order to make optimum use of resources. Stakeholders felt that the HCP needed to be clear about the purpose of consultation and engagement with local communities, and to ensure that the conceptual difference between the two terms was recognised.

In general, stakeholders felt that existing communication mechanisms had not been effective, and that the HCP should design and operate its own dedicated communication strategy and delivery mechanism.

### *Terms of Reference*

Although there was general support for the Terms of Reference in their current format, most participants felt they needed to be reviewed and updated in order to evolve with the development of the HCP. Suggestions were made on how this could be done including references to working practices, membership, elaboration of the link to the LSP, and the need for some specific and measurable objectives and targets/deliverables. Concern was expressed as to whether the HCP was sufficiently empowered to achieve the Terms of Reference together with future plans for the formulation of a health and wellbeing partnership.

### *Membership*

Most stakeholders felt that membership of the HCP was reasonably mixed in terms of sector representation and seniority. However, many felt there was a need for membership to be revisited in order to ensure representation from additional sectors (e.g. business) and that appropriately senior level individuals were involved to ensure action outcomes. Stakeholders reported wanting clarity about

the recruitment of members to the HCP, and their own role and functions within the Partnership relating this particularly to uncertainties about accountability.

### *Working practices*

Stakeholders felt that the HCP was probably working as well as it could be, based on the available resources and current policy context. However, there was broad agreement that the HCP had not been working in the most effective and efficient way. Common concerns (as examples) related to the lack of capacity and resources, and the lack of strategic direction. Stakeholders proposed a number of ways forward to improve the effectiveness and efficiency of the Partnership's working practices including the development of a strategy and operational plan, more focussed and interactive meetings, linking more explicitly to the LSP, and becoming involved in commissioning.

### *Vision for the future*

There was some overlap here with other sections of the report. Most notably, interviewees reported that their vision for the future was for the HCP to function in a more strategic and collaborative way including becoming more influential and visible and being clearer about its purpose. This strategic shift was seen as a crucial element in the decision to join Phase V of the HC Programme. Other visions for the HCP included a review of membership and working practices, being able to demonstrate 'short-term wins', and the development of an on-going, comprehensive monitoring and evaluation system.

### *Key challenges*

Stakeholders reported that clarifying potentially competing priorities at local, national, and European level would be a key challenge for the HCP in the future. Others challenges reported included ensuring appropriate senior members participated in the HCP, and for the HCP to address its strategic credibility and power to influence action at a local level as well as the HCP becoming embedded into the mainstream.

## **5.0 Discussion and recommendations**

The diversity of perspectives and the variations in implementation of HCs worldwide have provided researchers with a multiplicity of foci and approaches for their potential review and/or evaluation (Burton, 1999). The current review presents a qualitative, individual project level appraisal of the Brighton and Hove HC Programme from the internal viewpoint of its stakeholders.

Combined analysis of the dataset (including thematic analysis from the individual interviews, a review of selected documentation, and a half-day facilitated workshop) elicited a number of core themes which are presented here. To assist in the analysis and synthesis of these findings, we have drawn upon the characteristics of successful HC projects as specified by Tsouros (1990; see also Hancock, 1993) and outlined in the introduction to this report. In addition, we also present a number of recommendations for potential action by the HCP.

### **5.1 Strong political support**

The HC project is a long-term initiative which aims, amongst other things, to place health and a commitment to health high on the agenda of local political decision-makers (see Kickbusch, 1989; Tsouros, 1995b). A clear outcome of this review is that the HCP has gained strong political support locally as evident from a number of sources. Perhaps most pertinently, the Brighton and Hove HCP is a formal member of the family of partnerships under the City's Local Strategic Partnership (LSP). The LSP is the City's lead strategic partnership, and in this regard, is committed to improving the health of the local population and reducing the inequalities in health that exist within the City. The LSP has endorsed the HC approach as the key strategic mechanism to achieve this within the City. Consequently, HC principles and objectives have begun to be embedded in a number of key strategies in the City during Phase IV including, for example: the Strategic Commissioning Plan, Transport, Housing, Local Development Framework, Older People's Services, and Sports and Active Living. In addition, stakeholders revealed a strong perception of political 'buy-in' from the City which they felt added legitimacy and endorsement to the HCP.

However, despite the level of political support for the HCP, a number of individuals still felt that the HC approach has remained on the margins rather than becoming central to the City's strategic planning process; as recommended as a key objective of the HC approach (Dooris, 1999). Although clearly influential, the HCP has no basis in legislation and therefore little decision-making power and may be viewed by many as remaining a discrete 'project' or 'initiative' rather than being embedded in to the mainstream (for example, see Baum *et al.*, 2006). The challenge therefore is for the HCP to move health and wellbeing so it can become a core strategic driving force and "*...a sustainable mainstream process for influencing decision making and planning within Brighton and Hove*" (Blair-Stevens, 2002). However, our evidence suggests that this still remains an important task for the Partnership which may only be met with the commitment and active participation of senior politicians representing all political parties. Securing political commitment at the highest level will not only strengthen the necessary legitimisation, but also help with strategic direction and influence, and in this way raise available resources for the project (Tsouros, 1996).

### *Recommendations*

- The HCP needs to engage with senior politicians from all political parties to ensure their commitment and active participation. The city of Helsingborg (Sweden) has achieved this high level of political commitment and we recommend that the HCP considers this approach in some detail as a potential model for adoption (see Halling and Östergren, 2008).
- It is likely that the lack of engagement by senior politicians and some senior stakeholders in the City, who may consider WHO designation simply as a badge of status, may be influenced by a lack of awareness of the underpinning principles and breadth of the HC approach as a settings-based approach to health promotion. It is therefore proposed that the HCP needs to explore ways of facilitating understanding regarding the core values and ideals of the HC programme amongst key politicians and senior stakeholders. It is suggested that this could be achieved by holding an 'open day' to which politicians and other senior stakeholders could be

invited. In doing so, this is likely to raise significantly the profile of the HCP and ensure appropriate political accountability.

- To assist in this process of gaining further political understanding and support for the HC approach, the HCP should utilise more creatively the practical examples of short-term impacts. This could provide evidence to demonstrate the HC approach in action, and it is suggested that achievements of the HUP and HIA core themes, for instance, could serve this purpose.

## **5.2 Effective leadership**

Local government in its broadest sense has a key role in establishing the conditions for health and healthy public policies in all sectors. A key part of this process is the development of intersectoral mechanisms and structures linking different departments and sectors to enable them to work collaboratively and in partnership with one another. The challenge therefore is to ensure effective leadership to avoid potential problems related to vested interests and internal conflicts (Hancock, 1993). In general, stakeholders were positive about the current leadership of the HCP by the HC Programme Manager, Chair, and Vice-Chair of the HCP. However, some felt that the expertise and responsibility for the HCP depended on too few individuals; this has meant that the potential political exposure of the HC approach has perhaps been (unintentionally) limited.

In terms of leadership from the WHO Healthy Cities Secretariat, currently based in the European Regional Office in Copenhagen, stakeholders were generally negative and their comments highlighted a lack of consistent and sustained leadership and effective technical direction for the Programme. Moreover, concerns were expressed over the benefits gained from attending various business and technical meetings. Regular and effective communication with WHO was also raised as being problematic.

## Recommendations

- Although stakeholders were positive about the local leadership of the HCP, it was noted that the officers involved are regularly working at near full capacity. It is suggested that the Partnership should consider a more equitable division of leadership responsibilities. This could mean empowering its members to represent HCP interests in other networks and thereby delegate specific leadership tasks. The recent example of utilising the Vice-Chair in this way is a positive move in this direction. Other members of the Partnership should be similarly engaged as and when appropriate.
- When considering the decision to join Phase V of the WHO HC Programme, the HCP should ensure the dedicated commitment of adequate resources by WHO senior management to enable effective leadership and support to the Programme. This would include a well-resourced and experienced secretariat (which is likely to be outsourced from the WHO Copenhagen office) together with assurances concerning the necessary time and resources for the HC coordinator to provide effective and sustainable leadership. This would also help to ensure effective guidance and support from WHO technical advisors.
- It is recommended that the HCP look to establish potential ways of ensuring regular and effective two-way communication with the WHO Secretariat.

### **5.3 Broad community ownership and strong community participation**

The underlying values and principles of the HC approach mean that “*people themselves must be empowered individually and through their local communities to take control of their health*” (Davies and Kelly, 1993, p.4). Broad community ownership (engagement) and community participation remain key components of the HC approach (Baum *et al.*, 2006). Reflecting these values and principles in a briefing paper for the initial HC Forum the Brighton and Hove HC approach was

stated as providing the means by which local people can have a direct influence on health-related policy and decision-making within the City (Blair-Stevens, 2002).

However, Boonekamp *et al.* (1999) suggest that a major weakness in the development of many HC projects is that of effective community participation in municipal health policies. Although channels are often established for local community groups to communicate their ideas, in practice there is no participation in decision-making, leaving decisions to the professionals in control of the project. This can be particularly problematic as health policies will have no roots in the community. This weakness appears to be reflected in the Brighton and Hove context because, although local communities are consulted on a regular basis in the City, there does not appear to be true engagement and joint ownership. Moreover, our evidence suggests there is a lack of understanding in the Partnership (and amongst wider stakeholders) concerning the conceptual difference between consultation and engagement.

### *Recommendations*

- The terms 'community participation', 'community empowerment' and 'community development' are frequently left undefined or used interchangeably (Peterson and Lupton, 1996). The HCP needs to seek conceptual clarity concerning the differences between consultation and engagement with local communities, and should include subsequent action, related to these concepts in their future strategy and work plans.
- In addition, the HCP needs to address the issue of community ownership as a fundamental value of the HC approach and translate this into the core activities of the Partnership.
- It is of course acknowledged that a major challenge and tension exists in the HC approach between working at the highest strategic level (top-down approach) and at the same time, also engaging directly with communities (bottom-up approach). However, it is important that the HCP addresses this

issue within its strategy if it is to enable local citizens to have a direct influence on health-related policy and decision-making within the City.

## **5.4 High visibility**

A major challenge for the HC approach is to generate visibility for health issues and move the holistic concept of health higher on the local social and political agenda (Kickbusch, 1989; WHO, 1997a). Evidence from this review suggests that the Brighton and Hove WHO HC 'badge' facilitates a number of benefits for the City, most notably, raising the profile of health at political, strategic, and operational levels.

### *Recommendations*

- The kudos derived from designation as a WHO HC should not be underestimated. To capitalise on this and achieve the required visibility and credibility, there is a need for a comprehensive communication strategy. This strategy should include clear and measurable objectives, identify appropriate target audiences and set out key mechanisms for effective delivery. Such target audiences should be diverse including citizens and communities within the City as well as senior politicians and senior stakeholders from a range of sectors including the private/business sector. The strategy should also make more creative and extensive use of the Brighton and Hove HC logo which was highly valued amongst stakeholders.
- A key objective of the HCP communication strategy should raise awareness of the impact of the HC approach, to include specific examples of its achievements. This may help to counter the uncertainty expressed by stakeholders regarding the difficulty in attributing added-value to the HCP.
- The locality and working practices of the HCP are important with regard to visibility and raising awareness. The current practice of holding HCP meetings in different locations and venues across the City should continue. However, it is suggested that some HCP meetings could be open to the

public as a means of enabling accessibility and thus raising visibility at the community level.

## **5.5 Strategic orientation**

To gain full value from the HC approach, it is essential for HC projects to adopt a long-term perspective and gain a comprehensive view of opportunities for policy development (WHO, 1997b). As many policy changes require several years to come to fruition, an ambitious and pro-active approach is needed to provide direction for long-term action whilst allowing flexibility for changing circumstances. Moreover, according to O'Neill and Simard (2006), HC projects must decide for themselves their short, mid and long-term needs for evaluation and equip themselves with an appropriate monitoring and evaluation process to meet their own needs.

### *Recommendations*

- As a matter of urgency, and of critical importance, the HCP needs to develop a comprehensive long-term strategy and shared vision for its future work. This should not 're-invent the wheel' but build upon existing city plans and available strategic documents. However, it is recommended that such a strategy should demonstrate how WHO/European priorities can facilitate the achievement of local and/or national targets and priorities.
- As part of the delivery of the HCP strategy, short-term, medium-term, and long-term operational plans with clear objectives and process and/or proxy measures should be developed. Ongoing mechanisms to monitor and evaluate these operational plans should be incorporated from the outset.
- The terms of reference for the HCP will need urgent review and updating in light of the above recommendations. In doing so, it will be necessary to take on board some of the expressed concerns of stakeholders including, for example, whether the HCP is actually empowered to achieve these terms of reference. The HCP's accountability to the LSP should also be clarified and incorporated into its terms of reference.

## 5.6 Adequate and appropriate resources

According to WHO (1997b, p.39), *“people, money, and information are needed to make projects work...Healthy City projects fail because in one way or another they do not build the capacity needed to become effective advocates for innovation and new policies.”* It is clear from the literature that in order for HC projects to perform effectively they need skilled personnel and adequate funds. Moreover, it is evident from this review that key personnel involved in the HCP are highly valued for their dedication and contribution. However, it was also evident that with appropriate and dedicated resources (including additional personnel), there is the potential for increasing the efficiency and effectiveness in which the HCP works.

### *Recommendation*

- It is proposed that additional and significant sources of funding or secondment opportunities for appropriate staff are secured to support coordination and delivery of the Brighton and Hove HC Programme.

## 5.7 Effective committees

HC projects need to create organisational structures and administrative systems in order for them to facilitate intersectoral collaboration and action. According to Tsouros and Draper (1993, p.30) *“Multisectoral committees that provide political direction for projects, oversee their planning and promote communications amongst organisations that become project partners, are essential ingredients in project success”*. In general, the HCP has been working well at its current resource level and within its local policy context. However, although it has not been working in the most effective and efficient way, it has great potential to evolve to optimise the potential for health improvement and the reduction in health inequalities within the City.

### *Recommendations*

- Numerous concerns were raised regarding the format and culture of HCP meetings. It is recommended that the HCP reviews its working practices, for

example, by considering whether the current business style meeting involving all members of the Partnership with a lengthy agenda, series of formal presentations, and extensive paperwork, is the most appropriate and effective method. It is therefore suggested that the HCP considers alternative models for adoption. For instance, this might include smaller and more interactive meetings/workshops on specific themes, and designating certain members to take on particular roles and responsibilities (perhaps on a rotating basis).

- There was a lack of clarity as to the role, function, responsibilities, and accountability of members of the HCP. There was also uncertainty as to why and how people are invited to become members and/or attend meetings, as well as confusion and a lack of understanding about the broader HC approach and what this means in practice. It is strongly recommended that an HCP 'members' pack' is developed to address and provide clarity on these important issues. Such a pack could include for example: the scope and purpose of the HCP; HCP strategy and work plan; background information on the WHO HC approach; terms of reference; local networks and infrastructures; members' code of conduct, and; details of current membership. It is expected that this will facilitate more active engagement by members in the work of the Partnership. Furthermore, it may also assist in encouraging shared ownership and a sense of group cohesion.
- Membership of the HCP should be reviewed on a regular basis to ensure equitable sectoral balance and appropriate representation from sectors not adequately represented (for example, business sector, community interest and residents' groups). In this process, seniority of membership should be considered to ensure action outcomes within their own organisation/sector.
- The work of the HCP in facilitating intersectoral collaboration and carrying out project administration has been extremely successful and of high

quality. It is proposed that this work continues and can only be strengthened by additional support resources as recommended above.

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World Health Organization (2003). *Phase IV (2003-2008) of the WHO healthy cities network in Europe: goals and requirements*. Copenhagen WHO

## Appendix A – Healthy City Partnership Terms of Reference

# HEALTHY CITY PARTNERSHIP TERMS OF REFERENCE

*Our goal is to improve health for all and reduce health inequalities within the City.*

*Our aim is to improve the conditions for health within the City.*

*Our objectives are to:*

- *Provide leadership and vision to improve health for all within the city;*
- *Co-ordinate intersectoral action to improve health and reduce inequalities in health;*
- *Influence policy and decision-making which maximizes health for all within the City and develop new policies where appropriate;*
- *Communicate with and secure participation of local communities;*
- *Support action to address the health needs of vulnerable and socially excluded groups.*

*We are tasked by the Local Strategic Partnership to:*

- *Agree the most important health needs within the City*
- *Agree a strategy to work together to reduce health inequalities*
- *Develop a City Health Development Plan*

*We are accountable to the Local Strategic Partnership in demonstrating how we achieve our objectives.*

*We are jointly accountable to each-other for delivering our agreed actions.*

## Appendix B – Healthy City Partnership Membership List<sup>4</sup>

Name	E-mail	Organisation	Formal member/ other	Comment
Trevor Freeman	<a href="mailto:tf.fsb@trekar.com">tf.fsb@trekar.com</a>	Federation of Small Businesses and 2020 Community Partnership	Formal	
Angela Flood	<a href="mailto:angela.flood@bhcpct.nhs.uk">angela.flood@bhcpct.nhs.uk</a>	PCT	Technical officer	Healthy Ageing/ international
Ann Norman	<a href="mailto:ann.norman@brighton-hove.gov.uk">ann.norman@brighton-hove.gov.uk</a>	Councillor	Formal	
Anne Meadows	<a href="mailto:anne.meadows@brighton-hove.gov.uk">anne.meadows@brighton-hove.gov.uk</a>	Councillor	Formal	
Barbara Myers	<a href="mailto:Barbara@barbaramyers.com">Barbara@barbaramyers.com</a>	Food Partnership	Formal	
Caroline Hall	<a href="mailto:Caroline.Hall@brighton.ac.uk">Caroline.Hall@brighton.ac.uk</a>	IHDRC, University of Brighton	Sub for John Davies	
Nigel Sherriff	<a href="mailto:n.s.sherriff@brighton.ac.uk">n.s.sherriff@brighton.ac.uk</a>	IHDRC, University of Brighton	Sub for John Davies	
Cat Tardif	<a href="mailto:cat.tardif@bhcpct.nhs.uk">cat.tardif@bhcpct.nhs.uk</a>	PCT	Technical officer	Communications
Clare Pirie	<a href="mailto:clare.pirie@bhcpct.nhs.uk">clare.pirie@bhcpct.nhs.uk</a>	PCT	On list for info	
Denise D'Souza	<a href="mailto:denise.d'souza@brighton-hove.gov.uk">denise.d'souza@brighton-hove.gov.uk</a>	Brighton Council – Head of Community Care	Formal	
Jane Simmons	<a href="mailto:Jane.Simmons@bhcpct.nhs.uk">Jane.Simmons@bhcpct.nhs.uk</a>	PCT	Formal	
Jim Baker	<a href="mailto:jim.baker@ageconcern-bhp.org.uk">jim.baker@ageconcern-bhp.org.uk</a>	Age Concern	Formal	
John K Davies	<a href="mailto:j.k.davies@brighton.ac.uk">j.k.davies@brighton.ac.uk</a>	IHDRC, University of Brighton	Formal	
Julian Lee	<a href="mailto:Julian.Lee@bhcpct.nhs.uk">Julian.Lee@bhcpct.nhs.uk</a>	PCT	Formal	
Kate Lawson	<a href="mailto:kate.lawson@bhcpct.nhs.uk">kate.lawson@bhcpct.nhs.uk</a>	PCT	Technical Officer	Health Promotion
Lydie Lawrence	<a href="mailto:lydie.lawrence@brighton-hove.gov.uk">lydie.lawrence@brighton-hove.gov.uk</a>	PCT & Council – Public Health	Technical Officer	HUP / HIA / Children's health
Paul Martin	<a href="mailto:Paul.Martin@brighton-hove.gov.uk">Paul.Martin@brighton-hove.gov.uk</a>	Council – Adult Social Care Policy	Technical officer	Older people/ Arts
Peter Wilkinson	<a href="mailto:Peter.Wilkinson@bhcpct.nhs.uk">Peter.Wilkinson@bhcpct.nhs.uk</a>	PCT	Technical officer	Health inequalities
Ford Richard	<a href="mailto:Richard.Ford@sussexpartnership.nhs.uk">Richard.Ford@sussexpartnership.nhs.uk</a>	Sussex Partnership	Formal	
Rob Fraser	<a href="mailto:Rob.Fraser@brighton-hove.gov.uk">Rob.Fraser@brighton-hove.gov.uk</a>	Council - Planner	Technical officer	City planning
Simon Lewis	<a href="mailto:simon@citycoastchurch.co.uk">simon@citycoastchurch.co.uk</a>	City Coast Church	Formal	CVSF
Simon Newell	<a href="mailto:simon.newell@brighton-hove.gov.uk">simon.newell@brighton-hove.gov.uk</a>	Council – 2020 Community Partnership	Formal	
Stuart Johnson	<a href="mailto:stuart.johnson@hoveymca.org.uk">stuart.johnson@hoveymca.org.uk</a>	YMCA	Formal	CVSF

<sup>4</sup> Document obtained from Terry Blair-Stevens as of 29th May, 2008.

Terry Blair-Stevens	<a href="mailto:Terry.Blair-Stevens@bhcpct.nhs.uk">Terry.Blair-Stevens@bhcpct.nhs.uk</a>	Council & PCT – Public Health	Formal	
Thurstan Crockett	<a href="mailto:Thurstan.Crockett@brighton-hove.gov.uk">Thurstan.Crockett@brighton-hove.gov.uk</a>	Council - Head of Sustainability & Environmental Policy	Technical Officer	Sustainability & Environmental Policy
Tom Scanlon	<a href="mailto:tom.scanlon@bhcpct.nhs.uk">tom.scanlon@bhcpct.nhs.uk</a>	Council & PCT – Public Health	Formal	
Denise Stokoe	<a href="mailto:dstokoe@btinternet.com">dstokoe@btinternet.com</a>	PCT – Non Executive Director	Formal	
Louise Hulton	<a href="mailto:l.hulton@options.co.uk">l.hulton@options.co.uk</a>	PCT – Non Executive Director	Formal	
Thea Allison	<a href="mailto:Thea.Allison@bhbcop.org.uk">Thea.Allison@bhbcop.org.uk</a>	Business Community Partnership	Formal	
Helen Graham	<a href="mailto:Helen.Graham@eb4u.org.uk">Helen.Graham@eb4u.org.uk</a>	Healthy Living Centre	Observer	Manager of East Brighton HLC
Paul Allen	<a href="mailto:paul.a.allen@brighton-hove.gov.uk">paul.a.allen@brighton-hove.gov.uk</a>	Council - Director ebndc Partnership and Head of Neighbourhood Renewal Development and Strategy	Technical Officer	Neighbourhood Renewal Development
James Hodgson	<a href="mailto:james.hodgson@brighton-hove.gov.uk">james.hodgson@brighton-hove.gov.uk</a>	Council & PCT – Public Health	Administrative support to HCP	
Paul Jarvis	<a href="mailto:paul@versatilityplus.com">paul@versatilityplus.com</a>	Vice-Chair Healthy City Partnership	Formal	
Harry Steer*	<a href="mailto:Hrry371@aol.com">Hrry371@aol.com</a>	Older People's Council	Formal	
Ian Shurrock	<a href="mailto:Ian.Shurrock@brighton-hove.gov.uk">Ian.Shurrock@brighton-hove.gov.uk</a>	Acting Head of Sport & Leisure	Technical Officer	Sport & Leisure
Jan Sutherland	<a href="mailto:Jan.Sutherland@brighton-hove.gov.uk">Jan.Sutherland@brighton-hove.gov.uk</a>	Council - Community Sports Development Manager	Sub for Ian Shurrock	
Patricia Mullins	<a href="mailto:patricia.mullins@sussexpartnership.nhs.uk">patricia.mullins@sussexpartnership.nhs.uk</a>	Sussex Partnership Trust	Administrative support to Richard Ford and Annette Kid	
Annette Kid	<a href="mailto:Annette.Kidd@sussexpartnership.nhs.uk">Annette.Kidd@sussexpartnership.nhs.uk</a>	Sussex Partnership Trust	Sub for Richard Ford	

## **Appendix C – WHO HC Phase IV Strategic Goals**

*Cities designated to Phase IV have six strategic goals:*

1. To promote policies and action for health and sustainable development at the local level and across the European Region, with an emphasis on the determinants of health, poverty and the needs of vulnerable groups.
2. To increase accessibility of the WHO Healthy Cities Network to all Member States of the European Region.
3. To promote solidarity, cooperation and working links between European cities and networks and with cities and networks participating in the healthy cities movement in other WHO Regions.
4. To strengthen the national standing of Healthy Cities in the context of policies for health development, public health and urban regeneration.
5. To play an active health advocacy role at European and global levels through partnerships with other agencies concerned with urban issues and networks of local authorities.
6. To generate the policy and practice know-how, the good evidence and the case studies for promoting health to all cities in the Region.

## Appendix D – Letter(s) of Invitation (face-to-face and telephone)



**University of Brighton**



**International Health  
Development Research Centre**

Faculty of Health and Social Science  
Mayfield House  
Falmer campus  
Brighton BN1 9PH, UK  
ihdrc@brighton.ac.uk

Date:

[Stakeholder Address]

Dear [name]

The Brighton and Hove Healthy City Partnership have requested a formal review of the Healthy City Programme which is to be carried out by the International Health Development Research Centre (IHDRC) at the University of Brighton. Terry Blair-Stevens has suggested that I contact you, as a key stakeholder, to inform this review.

The review is intended as a positive critique of progress against WHO and associated local Health City objectives and should inform how local objectives and structures are refined, how capacity is developed and how resources are aligned to ensure effective delivery of these priorities.

The review has 3 aims:

1. Whether the healthy city approach has made a positive contribution to the health and wellbeing of the people of Brighton and Hove?
2. Whether Brighton and Hove's relationship with the WHO Healthy Cities Network has facilitated the progress of public health policy and practice within the city?
3. How the Healthy City Partnership can evolve to optimise the potential for health improvement and reduction in inequalities within the City?

We will be contacting you by phone next week to find out whether you wish to participate in the review. If you agree, we can then arrange a convenient time and location and will send you the interview schedule to help you to start thinking about these issues. In practical terms, we would need somewhere quiet for the interview as we will need to record it for research purposes. However, if this is not possible, we can arrange for the interview to be held in a suitable location at the University of Brighton.

Yours sincerely

Prof John Kenneth Davies

Director  
International Health Development Research Centre



**University of Brighton**



**International Health  
Development Research Centre**

Faculty of Health and Social Science  
Mayfield House  
Falmer campus  
Brighton BN1 9PH, UK  
ihdrc@brighton.ac.uk

Date:

[Stakeholder Address]

Dear [name]

The Brighton and Hove Healthy City Partnership have requested a formal review of the Healthy City Programme which is to be carried out by the International Health Development Research Centre (IHDRC) at the University of Brighton. Terry Blair-Stevens has suggested I contact you, as a key stakeholder, to inform this review.

The review is intended as a positive critique of progress against WHO and associated local Health City objectives and should inform how local objectives and structures are refined, how capacity is developed and how resources are aligned to ensure effective delivery of these priorities.

The review has 3 aims:

1. Whether the healthy city approach is making a positive contribution to the health and wellbeing of the people of Brighton and Hove?
2. Whether Brighton and Hove's relationship with the WHO Healthy Cities Network has facilitated the progress of public health policy and practice within the city?
3. How the Healthy City Partnership can evolve to optimise the potential for health improvement and reduction in inequalities within the City?

We will be contacting you by phone next week to find out whether you wish to participate in the review. If so, we can then arrange a convenient time and will send you the interview schedule to help you to start thinking about these issues. In practical terms, as this will be a phone interview, we will need your permission to record it for research purposes. I look forward to working with you.

Yours sincerely

Prof John Kenneth Davies

Director  
International Health Development Research Centre

## Appendix E – List of Interviewees (N = 27)

Name	Affiliation/Position	Interview Type
Jane Simmons	PCT - Head of Partnerships and Public Engagement	Face-to-face
Richard Ford	Sussex Partnership Trust - Executive Director	Face-to-face
John Kenneth Davies	IHDRC, University of Brighton - Director	Face-to-face
Angela Flood	PCT - European Development Manager	Face-to-face
Kate Lawson	PCT - Head of Health Promotion	Face-to-face
Darren Grayson	Chief Executive PCT	Face-to-face
Tom Scanlon (Chair HCP)	PCT/City Council - Director of Public Health	Face-to-face
Lydie Lawrence	PCT/City Council Public Health Development and Improvement Manager	Face-to-face
Terry Blair-Stevens	PCT/City Council - Public Health Programme Manager	Face-to-face
Jean Spray	Former Chair of Brighton & Hove City Teaching PCT and former Chair of the Healthy City Partnership	Face-to-face
Thea Allison	Brighton & Hove Business Community Partnership - Director	Face-to-face
Trevor Freeman	Federation of Small Businesses/2020 Community Partnership	Face-to-face
David Nicholls	City Council - Programme Manager Adult Social Care	Face-to-face
Rob Fraser	City Council - Head of Planning Strategy	Face-to-face
Helen Graham	Healthy Living Centre Manager	Face-to-face
Paul Allen	Director ebndc Partnership	Face-to-face
Denise D'Souza	City Council - Director of Community Care	Face-to-face
Simon Newell	2020 Community Partnership	Face-to-face
Harry Steer	Older People Council Chair	Face-to-face
Stuart Johnson	Hove YMCA - Youth and Community Services Manager	Face-to-face
Jim Baker	Age Concern, Director	Face-to-face
Paul Jarvis	Vice-Chair HCP	Face-to-face
Simon Lewis	City Coast Church, Administrator	Face-to-face
Joan Moorhouse	Member of the Older People's Coalition/ former member of Older People's Council	Face-to-face
Agis Tsouros	WHO European Office - Head of Centre for Urban Health	Telephone
Elisabeth Bengtsson	Helsingborg Healthy City Project Coordinator	Telephone
Joan Devlin	Belfast Healthy City Project Coordinator	Telephone

# Review of Brighton and Hove Healthy City Programme (Phase IV)

## CORE INTERVIEW SCHEDULE

### Introduction

*[Things to be mentioned at the start of the interview/checklist]*

- Thanks for participation
- Purpose of the interview (see below)

A decision as to whether the City should seek re-designation as a Healthy City and join Phase V of the Programme needs to be made by September 2008. To assist key stakeholders in this decision making process and future operation of the healthy city programme, a review is being conducted to scope the value accrued from the City's role as a healthy city. The aims of the review will be to assess:

1. Whether the healthy city approach is making a positive contribution to the health and wellbeing of the people of Brighton & Hove.
  2. Whether Brighton & Hove's relationship with the WHO Healthy Cities Network has facilitated the progress of public health policy and practice within the City.
  3. Health of the Healthy City Partnership and how it can evolve to optimise the potential for health improvement and reduction in inequalities within the City.
- We would like to tape this discussion for research purposes
  - There are no right or wrong answers and you can terminate the interview at any time without reason or not answer any questions that you feel uncomfortable with
  - Informed consent form to be signed and copy of participant information sheet
  - Anonymity is difficult given the nature of the review; however, all data will be kept confidential and stored securely.

There'll be five main sections to the interview, and it will last for about an hour. Any questions before we start?

## **TAPE ON**

**For the purposes of the tape, this is an interview with (name) on (date)**

### **Section One – background**

1. Can you give me a brief outline of your professional day-to-day role or other role that links you to the HCP (e.g. do you represent community, business, private, public? etc)
2. Can you give me a brief overview of your role within the HCP? E.g. why are you a member?
3. How long have you been a member?

### **Section Two - Is the healthy city approach making a positive contribution to the health and wellbeing of the people of Brighton & Hove?**

4. In your view, what have been the three principal achievements of the Healthy City Programme? What hasn't been achieved that you would have liked to have seen happen?  
e.g. at a *strategic* level (policy, plans etc)  
*technical* level (guidance, tools, knowledge, skills development etc)  
*operational/practice level* (contribution to achievement of health-related Indicators, evidence of implementation of principles and objectives, explicit use of tools and guidance)
5. What added value do you think the HC programme has brought to B&H?  
e.g. delivery of local priorities and targets, improved working practices regarding healthy public policy, increased partnership working etc.

### **Core Themes (3+1)**

*Phase IV focused on four core themes of (1) Healthy Urban Planning (2) Health Impact Assessment (3) Healthy Ageing and (4) Physical Activity/Active living. Working to a common agenda, the aim was to encourage cutting-edge innovation and share expertise with member cities, national governments and the international community.*

#### *Healthy Urban Planning*

6. In terms of HUP, what have been the three key achievements involved in this theme?
  - What have been the key difficulties/obstacles linked to this core THEME?
  - What tangible value has participation in the HUP sub-network brought to Brighton and Hove?

#### *Health Impact Assessment*

7. In terms of HIA, what have been the three key achievements involved in this theme?
  - What have been the key difficulties/obstacles linked to this core THEME?
  - What tangible value has participation in the HIA sub-network brought to Brighton and Hove?

#### *Healthy Ageing*

8. In terms of Healthy Ageing, what have been the three key achievements involved in this theme?
  - What have been the key difficulties/obstacles linked to this core THEME?
  - What tangible value has participation in the Healthy Ageing sub-network brought to Brighton and Hove?

### *Active Living/Physical Activity*

- 9 In terms of Active Living/Physical Activity, what have been the three key achievements involved in this theme?
- What have been the key difficulties/obstacles linked to this core THEME?
  - What tangible value has participation in the Active Living/Physical Activity sub-network brought to Brighton and Hove?

### **Health Inequalities**

- 10 How do you think the HC programme has addressed health inequalities? What evidence supports this?

### **Social (and wider) determinants of health**

- 11 How do you think the HC programme has addressed the wider determinants of health? What evidence supports this?

### **Intersectoral work and partnerships**

- 12 How engaged has the HC programme been with partners and stakeholders from key sectors in the city? (e.g. Public Service provision, Private sector, local authority departments, voluntary Sector, Residents' groups and Community Networks, etc).
- Which partners/stakeholders should be involved but aren't?
  - Which groups are over/under represented?

### **Section Three – Relationship with WHO, Phase IV, and potential participation in phase V**

- 13 Do you think the WHO HC Network is functioning well and providing the city with added value?
- What aspects of the working relationship with WHO have/have not worked well?  
e.g. strategic clarity, quality and regularity of communication, leadership and guidance from WHO Head Office, active facilitation, Technical support from WHO officers and external WHO experts.
  - So bearing in mind the above, do you think Brighton & Hove's relationship with the WHO Healthy Cities Network facilitated the progress of public health policy and practice within the City? If so, in what way? If not, why not, what barriers have prevented this?
- 14 WHO business and technical meetings – how enabling have these been in terms of helping B&H to draw insights from lessons learnt and giving practical direction to developments in B&H? What have been the benefits/challenges in participating in these meetings?
15. What lessons have been learnt from other European cities that may be useful in helping B&H HC programme to move forward?
- 16 What lessons have been learnt from the UK/Ireland WHO designated healthy cities network that may be useful in helping B&H HC programme to move forward?

### **Phase IV**

- 17 How has B&H advanced WHO HC core objectives as far as possible?

## **Phase V**

- 18 What is your view on whether B&H should participate in Phase V of the WHO Healthy Cities Programme? What might the challenges or costs/benefits be in this participation? (e.g. financial, conflicting/competing priorities etc).

### **Section Four – The Health of the Healthy City Partnership**

- 19 How do you think your own sector/ organisation has benefited/not benefited from being involved in the HCP? (e.g. raising profile organisation, influencing policy etc).
- 20 Is the healthy city programme focusing on the appropriate priorities for the city? If not what other priorities do you believe it should address, why and how?

### **Community participation and empowerment**

- 21 What mechanisms are in place for the HCP to consult with local citizens?  
- How effective has this been? (e.g. Qs on communication strategy – has this been dropped? Where are we in this? What hasn't happened and what should happen if city participated in phase V?  
- What have been the strengths/weaknesses/challenges of using such mechanisms?
- 22 How do you keep citizens in the city informed about health? How effective has this been?  
- What have been the strengths/weaknesses/challenges of using such mechanisms?

### **Terms of Reference**

- 23 Are the HCP Terms of Reference still 'fit for purpose'? If not what changes do you think are required?

### **Membership**

- 24 Are the most appropriate members involved in the HC partnership to achieve the delivery of the Terms of Reference?  
- Who should be involved but isn't?  
- Which groups are over/under represented?  
- Does membership need revisiting?

### **Working practices**

- 25 In terms of working practices, if there was one thing you could do to improve the HCP what would that be? e.g. number and style of meetings from technical, formality, didactic etc.
- 26 Has the Partnership being working in the most effective and efficient way? If so what are the key driving factors? If not, then what are the barriers and challenges, and how can these be tackled?  
e.g. value of the away-day workshop in Hove 05 – purpose was to make HCP less didactic and more dynamic – has this been achieved?

## **SECTION FIVE – Next Steps**

- 27 What is your vision for the Healthy City Partnership for the future?
- 28 How can the HCP evolve to optimise the potential for health improvement and reduction in inequalities within the City? How should the HCP proceed? How should it develop? What needs to change to enhance delivery of HC objectives?
- 29 What might be the key challenges for the HCP in the future?
- 30 Are there any points you would like to make that we have not discussed?

**TAPE OFF and thanks.**

**Reminder of the workshop on 17<sup>th</sup> June, starting at 1.30pm Mayfield House.**

**INTERVIEW END**

**For further details (after the completion of the review) please contact:**

**Professor John Kenneth Davies**  
Director

**International Health Development  
Research Centre (IHDRC),**  
Faculty of Health and Social Science  
University of Brighton, Mayfield House,  
Falmer  
Brighton, BN1 9PH, UK

**Tel:** +44 (0)1273 643 476

**Fax:** +44 (0) 1273 644 508

**Email:** [j.k.davies@brighton.ac.uk](mailto:j.k.davies@brighton.ac.uk)

**Web:** [www.brighton.ac.uk/hss/ihdr](http://www.brighton.ac.uk/hss/ihdr)

**Terry Blair-Stevens**  
Public Health Programme Manager

Brighton & Hove City Council  
Brighton & Hove City PCT

**Tel:** 01273 291 083

**Email:** [terry.blair-stevens@brighton-hove.gov.uk](mailto:terry.blair-stevens@brighton-hove.gov.uk)

## Appendix G – Consent Form

- ◆ I agree to take part in this consultation which is being conducted as part of a review of Brighton & Hove Healthy City Programme, organised by the International Health Development Research Centre at the University of Brighton
- ◆ The researcher has explained to my satisfaction the purpose of the study and the possible risks involved.
- ◆ I have had the procedure explained to me and I have also read the information sheet. I understand the procedures fully.
- ◆ I am aware that I will be required to participate in an individual interview and/or facilitated workshop.
- ◆ I understand that any confidential information will be seen only by the researchers and will not be revealed to anyone else.
- ◆ I understand that I am free to withdraw from the investigation at any time.

Name (please print).....

Signed.....  
.....

Date.....  
.....

## **Appendix H – Participant Information Sheet**

### **Review of Brighton and Hove Healthy City Programme**

International Health Development Research Centre  
Faculty of Health & Social Science  
University of Brighton

#### **Invitation**

You are invited to participate in this review of Brighton and Hove Healthy City Programme. Before you decide it is important for you to understand why the review is being done and what it will involve. Please take time to read the following information carefully, discuss it with others if you wish, and ask questions to clarify any queries you may have.

#### **What is the purpose of this study?**

The University of Brighton (International Health Development Research Centre) is working with Brighton and Hove Teaching PCT, City Council, and Healthy City Partnership (HCP) in order to assist key stakeholders in deciding whether the City should seek re-designation as a WHO Healthy City and join Phase V of the World Health Organization (WHO) Programme. The review is funded by the PCT and City Council and is being overseen by an advisory group consisting of representatives from these organisations as well as staff from the International Health Development Research Centre at the University of Brighton.

The review will assess the benefits and costs accrued so far from participating in the WHO Healthy Cities Programme by exploring the following three inter-related perspectives:

1. The healthy city approach
2. Participation in Phase IV of the WHO Healthy Cities Programme
3. The Healthy City Partnership (HCP)

The aims of the review will be to assess:

1. Whether the healthy city approach is making a positive contribution to the health and wellbeing of the people of Brighton & Hove.
2. Whether Brighton & Hove's relationship with the WHO Healthy Cities Network has facilitated the progress of public health policy and practice within the City.
3. How the Healthy City Partnership can evolve to optimise the potential for health improvement and reduction in inequalities within the City.

The review will be carried out by IHDRRC staff with a range of representatives of key stakeholder organisations within the City, and will consist of three main aspects:

1. Review of selected literature (to include both qualitative and quantitative analysis where appropriate)
2. Interviews with key stakeholders
3. Facilitated workshop with members of the HCP

The review of literature has been conducted in order to inform what the content of the interview and facilitated workshop should be. In addition, it gives an overview of the healthy city programme and its progress to date.

At the end of the review, recommendations will be made by the review team based on the information collected during the individual interviews and facilitated workshop. These findings will be presented to the advisory group as well as the HCP who will consider the recommendations on whether Brighton and Hove should seek re-designation as a healthy city.

#### **Do I have to take part?**

It is up to you whether or not to take part. If you do decide to take part, you will be given the information sheet to keep and asked to sign a consent form. If you decide to take part, you are free to withdraw at any time without giving a reason. A decision to withdraw, or a decision not to take part will not affect you in any way.

**What will happen to me if I do decide to take part?**

If you agree to take part, you will be invited to attend an individual interview and/or to participate in a facilitated workshop. You will be asked about the healthy city approach, your views on potential participation in Phase V of the WHO Healthy Cities Programme, and finally the work of the Healthy City Partnership. Individual interviews will last approximately one hour, and will be recorded for the benefit of the interviewer only. Locations will be agreed with you well in advance. Participants will not be identified by name in the final report unless they indicate otherwise. The facilitated workshop will last approximately 3 hours (half-day) and the outcomes recorded by rapporteurs for use in the final report. Again, participants will not be identified by name in the final report unless they indicate otherwise. The workshop will take place in a community venue within Brighton and Hove.

**What are the possible disadvantages of taking part?**

We do not envisage there being any disadvantages to taking part in this review.

**What are the possible benefits of taking part?**

The information gained from this review will be used to inform the decision as to whether Brighton and Hove should seek re-designation as a WHO Healthy City and join Phase V of the Programme. This decision will have a significant impact on future public health and health promotion policy and practice in the City and it is therefore important that you participate.

**What if something goes wrong?**

If you do not feel happy with the interview/discussion you can leave at any time. If you have any kind of complaint or concern, you can also contact me afterwards, or my colleague, Professor John Kenneth Davies ([j.k.davies@brighton.ac.uk](mailto:j.k.davies@brighton.ac.uk)).

**Will my taking part in the study be kept confidential?**

All individual interview data will be strictly confidential. The interviews will be recorded to assist in later data analysis. All tapes will be stored securely during the life of the project, and destroyed after completion of the review.

In terms of the facilitated workshop, at the start of the workshop, an agreement will be made concerning the Chatham House Rule which reads as follows:

*"When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed".*

This rule aims to provide anonymity to speakers and to encourage openness and the sharing of information. People usually feel more relaxed if they don't have to worry about their reputation or the implications if they are publicly quoted. Quotes from the interviews and workshops may be used in the final report but will be anonymous unless otherwise requested by you.

**Reimbursement of transport costs.**

No reimbursement for transport will be provided as participation in the interview is considered a part of your everyday work role.

**What will happen to the results of the research study?**

The results will be incorporated into a final report which will then be reviewed by the project advisory committee and Healthy City Partnership. It will be used to inform the views of key decision-makers in deciding whether the City should seek re-designation as a WHO Healthy City and join Phase V of the Programme.

**Who has reviewed the study?**

The project advisory group (consisting of representatives from IHDR, the PCT and City Council) as well as the University of Brighton's Faculty of Health and Social Science Research Ethics and Governance Committee (FREGC) have reviewed the project and given it their support.

**Contact for further information**

[J.K.Davies@brighton.ac.uk](mailto:J.K.Davies@brighton.ac.uk) – Professor John Kenneth Davies, Director, IHDR

[n.s.sherriff@brighton.ac.uk](mailto:n.s.sherriff@brighton.ac.uk) – Dr Nigel Sherriff, Research Fellow, IHDR

[caroline.hall@brighton.ac.uk](mailto:caroline.hall@brighton.ac.uk) – Caroline Hall, Research Fellow, IHDR

**For further details (after the completion of the review) please contact:**

**Professor John Kenneth Davies**

Director

**International Health Development  
Research Centre (IHDR)**

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University of Brighton, Mayfield House,  
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**You are invited to keep a copy of this sheet for your information.**

## Appendix I – Facilitated Workshop



University of Brighton



# Review of Brighton and Hove Healthy City Programme (Phase IV): Partnership Workshop

17<sup>th</sup> June 2008 (13.00-16.30)

The Boardroom  
Mayfield House, Room 301  
Falmer Campus, University of Brighton,

## Final Programme

13.00-13.30	Registration and Refreshments
13.30	Objectives & Working Processes Prof John Kenneth Davies
<b>13.40</b>	<b>Group Work Task 1</b>
14.40	Feedback and Discussion
15.00	Refreshment break
<b>15.15</b>	<b>Group Work Task 2</b>
16.05	Feedback and Discussion
16.25	Closing remarks Prof John Kenneth Davies
16.30	End



University of Brighton



## Review of Brighton and Hove Healthy City Programme (Phase IV): Partnership Workshop

### Scope and Purpose

The overarching theme for the Workshop is: **'The Health of the Healthy City Partnership'**. During the Workshop, specifically in relation to Phase IV of the WHO Healthy City Programme, we will assess how far we have come as a partnership group - where we have set out from, where we are currently, and where we want to go in the future. We will together explore and assess this process from the perspective of individual members and the sectors they represent on the Healthy City Partnership (HCP).

During the afternoon, participants will be divided into two work groups each having their own group work task. Participants will be given clear guidance regarding these tasks which will have achievable and expected outcomes. Each of the groups will be expected to present their ideas back to the wider plenary group, following which there will be an opportunity for discussion to arrive at some agreed recommendations which will be incorporated into the current review.

### Group work 1 (60 mins)

**Please consider the following points for discussion, and in doing so, develop a list of recommendations for the future. Please ensure all three components of the tasks are completed. Suggested timings are indicated below:**

1) The role of the HCP within Brighton and Hove (past, present and future)  
What was it established to achieve? Is it still fulfilling those original functions (refer to the Terms of Reference). What should the role of the partnership be in the future? **(15mins)**

2) For this task, please conduct a SWOT analysis to address the following:

What are the roles and functions of individual members in the partnership (past, present and future)?

In doing, so you may wish to consider the points below:

Individual contribution to the partnership, How can this be more effective in the future?  
Are the most appropriate members involved in the HCP to achieve effective and efficient delivery of its terms of reference? E.g. Who should be involved but isn't? Which groups are over/under represented? Does membership need revisiting?

**(30 mins)**

3) Based on the discussions above, please devise a list of agreed recommendations for the future of the HCP **(15mins)**

### Group work 2 (50mins)

**Please consider the following points for discussion, and in doing so, develop a list of recommendations for the future. Please ensure all three components of the tasks are completed. Suggested timings are indicated below:**

1) Format, timing and working practices of the HCP

- Lack of specific strategy and operational work plan for the HCP
- Lack of dedicated budgetary/resources provision
- Chair and governance responsibilities – should this be reviewed? What about a rolling chair? Need to establish formal governance procedure with formal decision making processes i.e. voting rights and responsibilities, proxy voting, etc. **(25mins)**

2) How can the work of the HCP become more visible and effective e.g. to senior colleagues in different sectors; to citizens of Brighton & Hove? **(10mins)**

- 2)** Based on the discussions above, please devise a list of agreed recommendations for the future of the HCP **(15mins)**

## Appendix J – List of Workshop Participants



**University of Brighton**



Brighton and Hove

### List of Workshop Participants

#### Attended

Name
Thea Allison Director, Brighton & Hove Business Community Partnership
Jim Baker Director, Age Concern
Terry Blair-Stevens Public Health Programme Manager
Angela Flood European Development Manager, PCT
Trevor Freeman Federation of Small Businesses and 2020 Community Partnership
Lydie Lawrence Public Health Development and Improvement Manager PCT/Council
Kate Lawson Health Promotion Lead Manager, PCT
Simon Lewis Community and Voluntary Sector Forum representative
Joan Moorehouse Member of the Older People's Coalition/ former member of Older People's Council.
Simon Newell 2020 Community Partnership
Tom Scanlon Director of Public Health, Council/PCT
John Kenneth Davies IHDRC, University of Brighton
Caroline Hall IHDRC, University of Brighton
Nigel Sherriff IHDRC, University of Brighton

#### Apologies

Name
Paul Allen Neighbourhood Renewal, Council
Thurston Crockett Sustainability & Environmental Policy, Council
Julian Lee
Helen Graham
Harry Steer Chair, Older People Council
Jane Simmons Head of Partnerships and Public Engagement, Brighton & Hove City PCT
Denise D'Souza Community Care, Council
Jan Sutherland
Ryan Edwards

Active for Life Coordinator, Council
Richard Ford Sussex Partnership
Rob Fraser Planner, Council
Paul Jarvis Health City Partnership
Anne Meadows Councillor
Barbara Myers Food Partnership
Jean Spray former Chair of Brighton & Hove City teaching PCT and former Chair of the Healthy City Partnership
Denise Stokoe PCT
David Nicolls Council

### Invited but no response

Name
Peter Wilkinson PCT
Ian Shurrock Sport and Leisure, Council
Ann Norman Councillor
Clare Pirie PCT
Paul Martin Adult Social Care, Council
Stuart Johnson Community and Voluntary Sector Forum Representative, YMCA Hove
Louise Hulton PCT
James Hodgson PCT/Council



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