IMPLEMENTATION UPDATE FOR SCRUTINY COMMITTEE REGARDING HEALTHY COMMUNITIES REVIEW AND SOCIAL CAPITAL COMMISSIONING

MARCH 2014

BACKGROUND

As part of the Members T +F Group on Public Health a Report was submitted to Cabinet in October which agreed the "Social Model 'of Public Health and also made recommendations regarding the future of the current Healthy Communities Programme.

The implementation of this element of the report was delegated, within the report to the Director of Public Health and the Director of Health, Care and Independent Living. A small officer group was charged with delivering on their behalf. This report provides an update on progress

HEALTHY COMMUNITIES REVIEW

Delivery has been broke into 3 components:-

- Internal delivery structure and external commissioning (Public Health lead)
- Contract Management (Communities Contracts and Partnership team lead)
- Engagement (Public Health lead)

Internal delivery structure and external commissioning

- Structure and funding boundary agreed
- Structure proposals agreed
- MER launched with staff and TU late March/Early April
- Already agreed to voluntary severance for some 2 staff through the SCC corporate scheme in the Communities Portfolio. Although there may be further applications for VER/VS compulsory redundancies will be minimal.
- Interviews commence w/c May 5th
- Completion by May 12th

Contract Management

- Waiver secured from procurement for 6 months
- Notice of 6 month contract extension provided to Current HC providers
- Champions and trainers extended with current providers for 6 months
- Contract deliverables agreed within the extensions
- PH Contract, all contract management will be undertaken by Communities Contracts and Partnership Team)
- Existing contract closedowns will be undertaken June – Sept 2014

Engagement

- **Current Provider Event held in December**
- **Wider provider event held in February, results disseminated**

SOCIAL CAPITAL COMMISSIONING

Internal delivery structure and external commissioning

- Commissioning Strategy to be drafted by May
- Work underway on how to measure outputs and outcomes + community impact
- Suggesting the commissioning is broken into 'lots' across the 7 localities,
- Suggesting smaller providers work within larger providers to deliver their role within these 'lots'

Contract Management

Awaiting drafting of commissioning strategy as above

Once Commissioning Strategy confirmed Contracts will work with Commercial Services and PH Management to procure new service

Engagement

Awaiting strategy draft to arrange procurement support / information session for potential providers

APPENDIX II

HEALTHY COMMUNITIES REVIEW

UPDATE TO SCRUTINY COMMITTEE 10TH MARCH 2014

DEFINING, AND COMMISSIONING FOR SOCIAL CAPITAL

SOCIAL CAPITAL

Health inequalities arise when some people have less access than others to resources that support health and well-being. There are many risk factors which contribute to health inequalities including poverty, low educational achievement, poor environment, and lack of self-esteem and hope. These can result in lower levels of physical and mental health, reduced well-being and shorter life expectancy. Developing social capital is one way to tackle the health inequalities that result from social isolation, low levels of support and low self-confidence.

What is Social capital?

(Taken from Office for National Statistics (ONS), the Office for Economic Co-operation and Development (OECD))

'networks together with shared norms, values and understandings that facilitate co-operation within or among groups' -

The degree of social cohesion which exists in communities. It refers to the processes between people which establish networks, norms, and social trust, and facilitate co-ordination and co-operation for mutual benefit (WHO 1997)

Key aspects of social capital are:

The pattern and intensity of networks among people and the shared values which arise from those networks.

Greater interaction between people which generates a greater sense of community spirit.

The main aspects of social capital include citizenship, 'neighbourliness', social networks and civic participation

Why develop social capital?

Social capital supports the development of protective health factors which result from strong networks, good levels of support and positive relationships which help to integrate individuals and communities. These benefits include:

Increased confidence and self-esteem.

A sense of connectedness and belonging.

The ability to bring about change in your own life or in your community.

There is evidence to show that increasing social capital results in better health, higher educational achievement, better employment outcomes, and lower crime rates.' ie housed, healthy, hired and happy

Different types of social capital

Can be described in terms of different types of networks:

(i) bonding social capital – describes closer connections between people and is characterised by strong bonds, for example, among family members or among members of the same ethnic group; it is good for 'getting by' in life

(ii) bridging social capital – describes more distant connections between people and is characterised by weaker, but more cross-cutting ties, for example, with business associates, acquaintances, friends from different ethnic groups, friends of friends, etc; it is good for 'getting ahead' in life

(iii) linking social capital – describes connections with people in positions of power and is characterised by relations between those within a hierarchy where there are differing levels of power; it is good for accessing support from formal institutions. It is different from bonding and bridging in that it is concerned with relations between people who are not on an equal footing. An example would be a social services agency dealing with an individual, for example, job searching at the Benefits Agency

Examples of Outcomes to increase social capital:

Bonding	Outcomes Increased confidence. An increased feeling of personal wellbeing
Bonding measures	More connections with family + ethnic group, carers, child support + close friends Feeling of safety/ Happiness / useful
Bridging	Outcomes An increase in participation/engagement in local community outside immediate network An increase in connecting and sharing -thoughts, ideas, conversation, food capabilities
Bridging measures	Number new acquaintances – newer ones, useful ones 'contacts' organisations Doing things for other people (befriending, mentoring), meeting joining local groups
Linking	Outcomes Positive outcomes from contact with agencies - Job Centre Plus, GP, Police, Active engagement in groups addressing local issues - health, environment, poverty, safety
Linking Measures	Reduction in reactive contact with statutory agencies including demand on health and social care Gaining - jobs, volunteering , accessing training, affordable finance, credit, reduced debt, level of active involvement

FUNCTIONS AND STRUCTURE OF FUTURE PUBLIC HEALTH, HEALTHY COMMUNITIES TEAM

With these changes, from May 2014 the service will be responsible for:

- Leading and developing the work in the Healthy Communities Programme areas covering working in the most deprived areas of Sheffield. Ensure the programme is linked with other interventions and priorities in the locality including other VCF funded interventions
- Locality based working leading the Health and Wellbeing agenda across 6 locality areas.
- Working with local members, Locality and Housing teams, GPs, local communities and community leaders to deliver public health outcomes.

- Whole time equivalent locality posts to have a role for a key area of work across the city
- Engaging communities in decisions about improving health and wellbeing in their communities.
- Ensure Health Trainers service is commissioned with continued investment in Public Health staff as a management and delivery hub to govern, manage and coordinate this service. Jointly funded with CCG.
- Lead the development and implementation commissioning strategy for Healthy Communities Programme, Health Trainers, Health Champions and Practice Champions.

SUMMARY

All of these elements outlined above mean that significant change in the structure is required to:

- Create a Public Health team that is able to provide the kind of strategic and operational support that the Council will need in the future in relation to Public Health locality working.
- Enable the management, development and delivery of the work of the Community Development and Health Programme, Health Trainers and the training and development of SCC staff
- To commission the Healthy Communities Programme, Health Trainers, Health Champions & Practice Champions to increase social capital.
- Reduce costs in the staffing budget to reinvest in root causes of poor health.

The structure attached in this document attempt to satisfy these aims.

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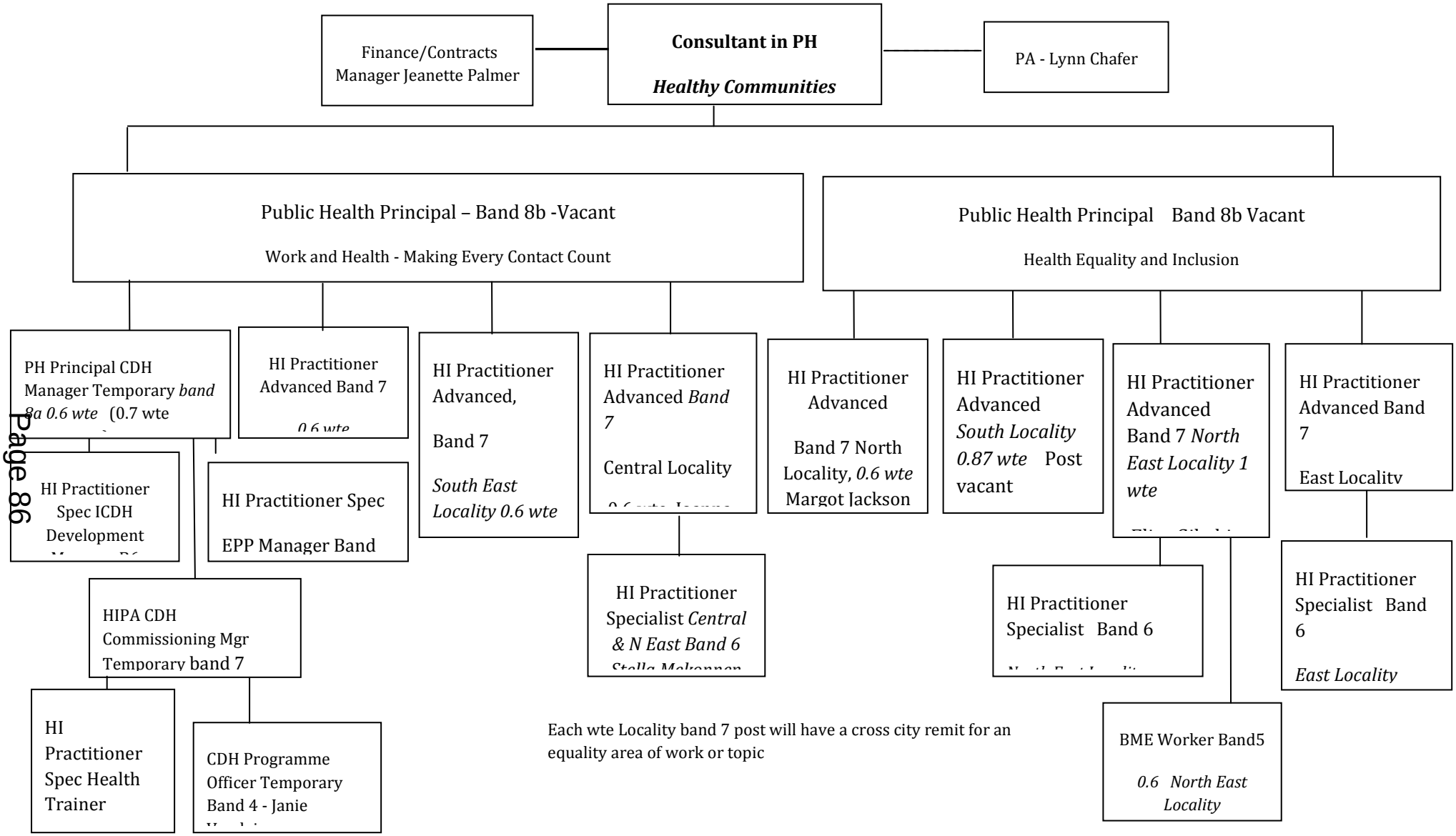
IMPACT OF REDUCTION IN THE HEALTHY COMMUNITIES TEAM ESTABLISHMENT

The reduction in HCP staff will mean that some work cannot continue and other areas of work will be reduced. The total number of staff in the establishment is 21. This will be reduced to 13 staff (including the new PH training post), the impact of this will be spread across the localities and partnership operation, but this proposal seeks to minimise this impact by using the existing commissioning capacity in Communities instead of internal capacity within the Healthy Communities team, creating some capacity in the key areas seen by the Task and Finish Group, and also retaining existing capacity in some key partnership areas such as the Health trainers and Health Champions.

Appendix 1- Healthy Communities Structure Current Establishment


Finance/Contracts Manager Jeanette Palmer
Consultant in PH
Healthy Communities
PA - Lynn Chafer
Public Health Principal – Band 8b -Vacant
Work and Health - Making Every Contact Count
Public Health Principal Band 8b Vacant
Health Equality and Inclusion
PH Principal CDH Manager Temporary band 8a 0.6 wte (0.7 wte
HI Practitioner Advanced Band 7
0.6 wte
HI Practitioner Advanced, Band 7
South East Locality 0.6 wte
HI Practitioner Advanced Band 7
Central Locality
HI Practitioner Advanced
Band 7 North Locality, 0.6 wte
Margot Jackson
HI Practitioner Advanced
South Locality 0.87 wte Post vacant
HI Practitioner Advanced Band 7 North East Locality 1 wte
HI Practitioner Advanced Band 7
East Locality
HI Practitioner Spec ICDH Development
HI Practitioner Spec
EPP Manager Band
HIPA CDH Commissioning Mgr Temporary band 7
HI Practitioner Specialist Central & N East Band 6
HI Practitioner Specialist Band 6
HI Practitioner Specialist Band 6
East Locality
HI Practitioner Spec Health Trainer
CDH Programme Officer Temporary Band 4 - Janie
Each wte Locality band 7 post will have a cross city remit for an equality area of work or topic
BME Worker Band5
0.6 North East Locality

Appendix 2

Proposed New Structure