SHEFFIELD CITY COUNCIL
CABINET
Report

Report of:	Richard Webb - Executive Director of Communities and Jeremy Wight - Director of Public Health
Report to:	Cabinet
Date:	16th October 2013
Subject:	**DEVELOPING THE SOCIAL MODEL OF PUBLIC HEALTH**
Author of Report:	Chris Shaw

Summary: This report sets out the work undertaken by the Members' Task and Finish Group on Public Health to develop the Social Model of public health within the city, and includes a proposal to adopt the Social Model as part of the Council's overall vision for Public Health as agreed at Cabinet during 2012.

In addition, the report sets out the outcome of the first area of public health investment which has been reviewed within the context of the Social Model: the Healthy Communities Programme

Reasons for Recommendations:
There are two separate elements to this report. The first proposal seeks approval for a Social Model of Public Health. This model was decided upon by the Member Task and Finish group after receiving presentations and information from a number of different perspectives on the things impacting on Health Inequalities and Public Health. The Members in the Task and Finish Group concluded that this was the most appropriate Model taking into consideration all these different perspectives

The second element is the recommendations regarding the review of the existing Healthy Communities Programmes. These recommendations were reached by the Task and Finish Group, again after considering data and presentations on outcomes, expenditure, and delivery mechanisms and considering how to best

deliver community approaches to public health taking account of the proposed Social Model and within the current SCC financial and organisational context

Recommendations:

Members are asked to:

- Approve the adoption of the Social Model of Public Health as an addition to the policy statement set out in the vision for public health agreed at Cabinet on 25 January 2012 – the Model is set out in section 4 of the report.
- Approve the direction of travel for changes to the current Healthy Communities Programme. and request the Director of Public Health and the Executive Director Communities, in consultation with the Cabinet Member for Health, Care and Independent Living and the Executive Director Resources to develop and implement a plan to achieve these changes on a phased and structured basis during 2014/15.
- Agree delegated approval to take forward proposed changes to the Healthy Communities Programme. The implementation plan should build on what wider evidence there is to develop a programme which delivers maximum impact to the current Healthy Communities areas, in the context of the Social Model. The Plan needs to reflect Members wishes to see delivery of the Task and Finish recommendations implemented as quickly as is reasonably practicable, reflecting the need to ensure the proposals fit seamlessly within the localities proposals and addressing any legal and HR requirements arising from the recent transfer of Public Health into the Local Authority It should also address the issue of rebranding the programme to fit within the localities context.
- Approve giving six months' notice to current Voluntary Community and Faith sector providers within the Healthy Communities Programme, consistent with the VCF Compact and current contractual obligations, and that an engagement exercise commences with potential VCF providers about future arrangements.

Background Papers:

Category of Report: **OPEN**

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* Delete as appropriate

Statutory and Council Policy Checklist

Financial Implications
YES Cleared by: Liz Orme
Legal Implications
NO Cleared by:
Equality of Opportunity Implications
YES Cleared by: Adele Robinson
Tackling Health Inequalities Implications
YES
Human rights Implications
NO:
Environmental and Sustainability implications
NO
Economic impact
NO
Community safety implications
NO
Human resources implications
NO Cleared by Christine Prime
Property implications
NO
Area(s) affected
Relevant Cabinet Portfolio Leader
Councillor. Mary Lea Cabinet Member for Health, Care and Independent Living
Relevant Scrutiny Committee if decision called in
Healthier Communities and Adult Social Care
Is the item a matter which is reserved for approval by the City Council?
NO
Press release
NO

Report to the Cabinet

DEVELOPING THE SOCIAL MODEL OF PUBLIC HEALTH

1.0 SUMMARY

This report sets out the work undertaken by the Members' Task and Finish Group on Public Health to develop the Social Model of public health within the city, and includes a proposal to adopt the Social Model as part of the Council's overall vision for Public Health as agreed at Cabinet during 2012.

In addition, the report sets out the outcome of the first area of public health investment which has been reviewed within the context of the Social Model: the Healthy Communities Programme

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE

2.1 The adoption of the Social Model seeks to create a new framework for the delivery of Public Health programmes and projects which reflects the impact of the wider determinants of health on health inequalities in the City It will result in a re-focussing of public health effort to better reflect the impact of the social and psychosocial aspects of health (see model below) Essentially it will result in a firmer recognition that some of the personal behaviour change required to improve public health can only be addressed within a wider context of issues such as poverty, employment, social isolation and positive mental wellbeing, and that public health delivery should increasingly acknowledge that.

2.2 The review of the Healthy Communities Programmes will create programmes on the ground which better reflect the principles described above

3.0 OUTCOME AND SUSTAINABILITY

3.1 Adoption of the model is designed to create a framework to direct activity to reduce Health Inequalities and improve public health. Once the model is agreed, the impact of the Model should go beyond the public health resource within the Council, and be a framework which is used within other services and indeed across VCF organisations and communities in order to create a wider impact on these inequalities. Because the model is designed to impact on mainstream service it has a sustainable platform

3.2 The Healthy Communities review is the first examination of current public health activity through the lens created by the Social Model and delivery of the Review is designed to impact as described above. Once approved the Model will be used to examine other current public health expenditure

to ensure the principles behind the spend reflect the Social Model

4.0 MAIN BODY OF THE REPORT

Members established a Public Health Task and Finish Group in 2012, chaired by Cllr Mary Lea. Its initial work was to examine key public health issues during the transfer of Public Health responsibilities from the NHS to Sheffield City Council. Phase 1 of the Member Review concluded in September 2012. It set out priorities for future Public Health investment in 'five big changes' and 13 areas for action - a number of these recommendations informed investment decisions within the 2013/14 budget and set the basis for the next stage of Member Review following the transfer of responsibilities.

Phase 2 of the Task and Finish Group, had four objectives:

- Develop a social model of Public Health and Wellbeing to inform thinking and activity across Sheffield City Council, including the Council's contributions to outcomes in the Health and Wellbeing Strategy.
- Use the model to build community empowerment and individual resilience to help people make healthier life choices, be more involved in decisions about their own health, and improve community wellbeing through personal development.
- Use the model to review the current Healthy Communities Programme and investments, and to establish a new model of investment from 2014 onwards.
- Identify the leadership skills within communities and the Council workforce required to take this forward.

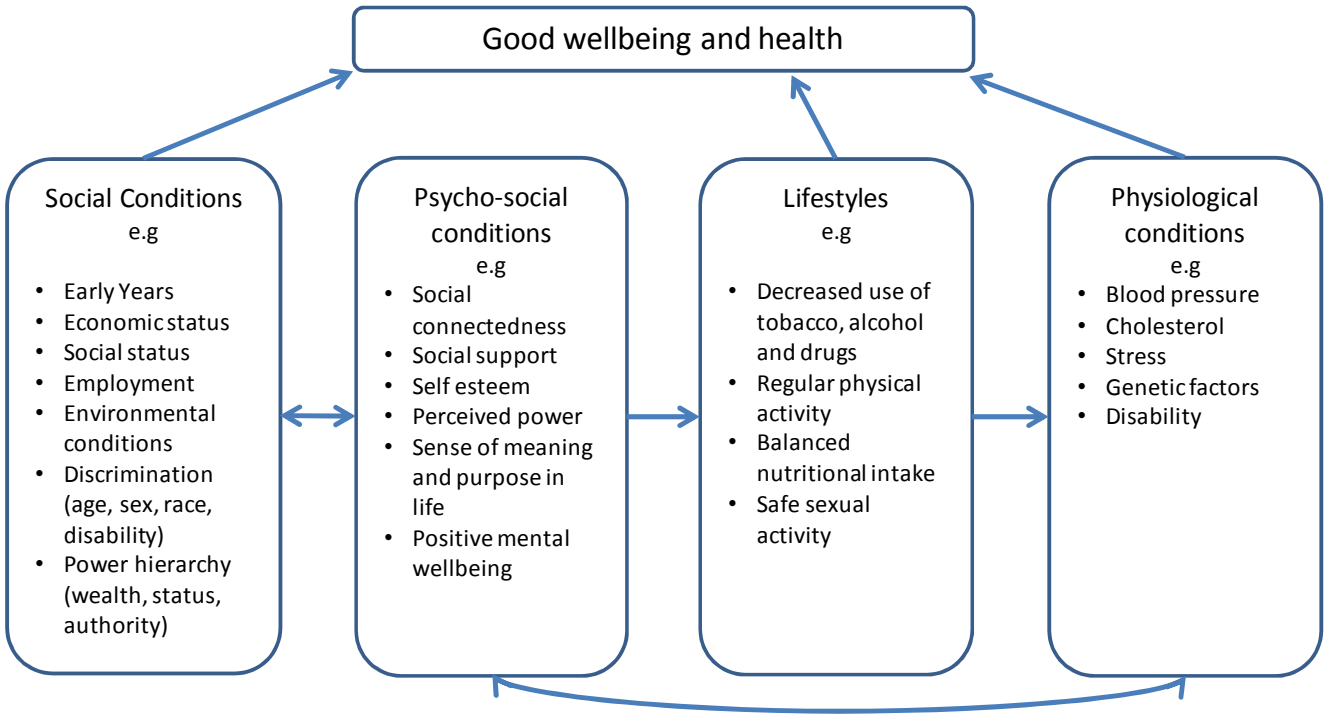
Whilst Public Health specialists in the city have promoted, where possible, a social model that is community based, the transfer of responsibilities to local government provides a fresh opportunity to examine and develop the potential of these approaches.

The evidence base for the Review

The group held nine sessions between February and June 2013. The sessions included evidence from external experts, from Sheffield's Fairness Commission, and from the lead officer of the current Healthy Communities Programme. The group considered a number of different academic social models of Public Health.

Developing a social model of health and wellbeing for Sheffield

In response to this evidence, Members developed the following model based on understanding what good wellbeing and health means in Sheffield. It has been chosen as it is clear, demonstrates the key drivers of wellbeing and health, and enables us to test the focus of our existing and future investment.



- The aim of Public Health investment in Sheffield is to tackle health inequalities. This will raise wellbeing and health for the whole population. The model sets out four 'categories of influence which will help determine future investment: Move away from a focus on lifestyles towards the root causes of ill health and poverty
- Increase the focus on strengthening community wellbeing and resilience.
- Focus on those people and communities with the least power and control over their lives.
- Focus on those things people and communities *themselves* say are barriers to their wellbeing and health. We will look to work with people and communities by using a co-production approach wherever possible.
- Build on existing strengths in individual people and communities.
- Increase connectedness
    - between individual people,
    - between individual people and community organisations, and
    - between community organisations themselves.
- Increase community engagement.
- Empower individuals and communities through increasing their knowledge.
- Make sure investment in programmes has the opportunity to influence local and national policy.

The model doesn't suggest every programme should address all these four areas, but it seeks to ensure that any programmes seeking, ultimately to change behaviours recognise when these other factors are barriers to the change ,and steps are taken to remove the barrier at an individual or collective level

Using the Social Model to review the existing Healthy Communities Programme (HCP) investment and develop recommendations

Overview

The current Healthy Communities programmes exist within the most deprived third of City, which is where the worst health outcomes (life expectancy, etc.) occur. They are community based programmes which work within local communities and seek to establish health priorities and act to improve them within a local context. There are 14 such programmes across these areas and they spend approximately £1.8 m on a mixture of internal staff and externally commissioned delivery (via local VCF organisations.) They are also the delivery vehicle for the Health Champions (included in the £1.8m costs which are currently commissioned separately) Some of the Programme Resource is for 'communities of interest' rather than specific geographic areas The HCP is currently located within the Council's Communities portfolio

Findings of the review of the Healthy Communities Programme

As a result of the review of HCP, Members concluded:

1) The Social Model should be taken forward through Healthy Communities Programme investment

The existing HCP programme should change to one that more explicitly addresses the objectives in the proposed Social Model: particularly focusing on the underlying root causes of ill-health and poverty and the potential to enhance social capital and community development.

This will involve an overall investment switch which sees more investment in tackling root causes and promoting social capital as means for improving public health; the honouring of existing joint investment commitments with the CCG; a reduction in the number of directly employed staff working in the HCP; and a re-design of services which are commissioned currently from the voluntary and community sector, albeit with the intention of retaining similar levels of investment in voluntary and community sector led activity

2) Community based public health work should form part of a new community based model, integrated with Locality Working

The Council's in-house community based resource should be truly community based: public health specialists should be part of the SCC locality arrangements working on the ground with local Members, GPs and community leaders to deliver improved public health outcomes. The

focus should be on:

hands-on work with individuals and communities, either through SCC public health staff based in localities or through local VCF organisations.

- Public Health specialists informing commissioning intentions with VCF organisations, so that the latter deliver the Social Model and the expectations set out in the Public Health Outcomes Framework

The new programme needs also to operate as part of changes which are taking place in children's services, adult social care, housing services and Place-based services.

This approach will require changes to the current in-house HCP staffing, with a reduction in the number of directly employed staff working on the programmes over a phased period to be completed by April 2015.

3) Investment in the VCF sector should build on the best of the current HCP and to achieve new priorities around root causes and social capital

This may mean re-designing current levels and patterns of investment. Notice needs to be given to current Voluntary Community and Faith sector providers within the Healthy Communities Programme, consistent with the VCF Compact and current contractual obligations. This needs to be followed by an engagement exercise with potential VCF providers about future service delivery consistent with the new Social Model priorities.

4) Honour joint investment with the CCG

Continue to invest in and support the Health Trainers programme, as part of a joint investment commitment with the CCG

5) Increase direct investment in root causes of ill-health and poverty

Begin a programme of investing in specific root causes initiatives, linked to Fairness Commission recommendations. This work could be started through a switch in current HCP investment priorities and should ensure that these proposals will address public health issues relating to poverty, isolation and loneliness (thereby increasing the emphasis on the social and psychosocial aspects of the model) and consider priorities in areas such as employment and housing.

Next steps

Given the scale of the proposed changes, and the financial position which the Council faces during 2013/14 and is likely to face throughout the period of the next Medium Term Financial Strategy (2014/15 – 2016/17), the proposed changes to the Healthy Communities Programme need to be implemented on a phased, but urgent basis during 2014/15, with completion by April 2015. This will need to include consideration of how Public Health can 'buy' improved public health outcomes from existing General Fund services which may otherwise be discontinued as a result of central Government reductions in the Council's overall budget settlement for 2014/15 onwards, and have greater influence over the totality of Council spend.

The ambition is to achieve delivery of the review in its totality over a period of between 6 and 18 months. Some elements will be achieved within 6 months and some actions will require a longer implementation period up to18 months (e.g. to ensure the right public health expertise is in the right place at the right time to assist implementation and to ensure compliance with Public Health Transfer requirements around staffing).

Outline details of the proposals in terms of 'end point' changes to investment profiling are shown in the table at appendix 1.

Equalities and Consultation implications

As a Council under the Equality Act 2010, s. 149, we have a Statutory Public Sector Equality Duty (PSED) to pay due regard to:

- Eliminating discrimination, harassment and victimisation
- Advancing equality of opportunity
- Fostering good relations

This means we need to understand the effect of our policies and practices on equality. This will involve looking at evidence, engaging with people and considering the effect of what we do on the whole community.

As part of our approach to demonstrate how we act fairly and meet our Duty we use Equality Impact Assessments (EIAs) as our vehicle to assess impacts on staff and customers of policies, proposals and functions. The proposals detailed in this report have been informed by work to understand the impact on fairness and including those who share protected characteristics under the Act.

Also a commitment to fairness and social justice is at the heart of the Council's values and is reflected in the options in the report. We believe that everyone should get a fair and equal chance to succeed in Sheffield. However we recognise that some people and communities need extra support and help to improve their health and so to reduce persistent health inequalities, and to reach their full potential, particularly when they face multiple layers of disadvantage and discrimination.

The evidence on public health has also been supported by the findings from the overall work over the last twelve months by both budget and non-budget related activity.. The task group held sessions between February and June 2013. The sessions included evidence from external experts, from Sheffield's Fairness Commission, and from the lead officer of the current Healthy Communities Programme. The group considered a number of different academic social models of Public Health.

However although the overall programme and the proposed changes are designed to reduce inequalities and increase fairness it is recognised that structural changes may still have potential adverse equalities implications. Therefore both the internal structure proposals and the emerging proposals regarding VCF commissioning will both be subject to appropriate level of Equalities Impact Assessment and consultation at the implementation plan/ structure change stage.

Financial Implications

Fundamentally this proposal seeks to use the Healthy Communities budget to address the health priorities reflecting the adopted Social Model of Health.
It should be stressed that the figures in the appendix are indicative at this stage, reflecting Members' comments in the Task and Finish Group discussions. It is proposed that a detailed, costed implementation plan is developed by the Director of Public Health and the Executive Director Communities, in consultation with the Cabinet Member for Health, Care and Independent Living and the Executive Director Resources and has the necessary sign-off before implementation takes place.

The overall financial plan is that current HCP investment:

- Be switched as set out in this report, to deliver the new Social Model and to give a greater focus on root causes and social capital
- May give some scope for Public Health grant to 'buy out' existing General Fund activity so as to more directly improve public health outcomes and make efficiencies in

wider Council spend as part of the Medium Term Financial Strategy

Human Resources Implications

Detailed implementation plans will be developed to address the HR implications of the proposed changes to the HCP programme. There are a number of vacancies within the current HCP team and a new structure will need to be developed and made subject to formal consultation. It is proposed that changes are implemented on a phased basis during 2014/15 to maximise the capacity required and to ensure that staff are either appointed to the new community based public health service, re-deployed to other suitable vacancies within the Council or that vacancies are managed through natural turnover. Notwithstanding this Members have stressed the importance of not losing momentum on this project and implementation should be as quick as is reasonably practicable. This will also minimise uncertainty during the changes.

Recommendations

Members are asked to:

- Approve the adoption of the Social Model of Public Health as an addition to the policy statement set out in the vision for Public Health agreed at Cabinet on 25 January 2012 – the Model is set out in section 4 of the report.
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fit within the localities context.

- Approve giving six months' notice to current Voluntary Community and Faith sector providers within the Healthy Communities Programme, consistent with the VCF Compact and current contractual obligations, and that an engagement exercise commences with potential VCF providers about future arrangements.

5.0 ALTERNATIVE OPTIONS CONSIDERED

5.1 During the course of the Task and Finish Group several academic and practical interpretations of Public Health approaches were considered but the consensus in the group was that the proposed most succinctly represented the evidence and experience they had received

5.2 The recommendations regarding the Healthy Communities Programmes were reached through a process of analysis of inputs, outputs and outcomes along with expertise from the programme area. The recommendations reflect the conclusions of the Group

6.0 REASONS FOR RECOMMENDATIONS

6.1 The new responsibilities of the Local Authority regarding Public Health present opportunities for the Council to bring its influence and resources to bear on the long standing health inequalities across the City .These recommendations seek to create a framework and commence delivery on approaches to addressing these inequalities. The proposals better reflect the organisations experience and understanding of local communities whist acknowledging the good practice locally and nationally

7.0 REASONS FOR EXEMPTION (if a Closed report)

7.1 Not Applicable

8.0 RECOMMENDATIONS

Members are asked to:

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- Approve giving six months' notice to current Voluntary Community and Faith sector providers within the Healthy Communities Programme, consistent with the VCF Compact and current contractual obligations, and that an engagement exercise commences with potential VCF providers about future arrangements.

Chris Shaw
Director of Health Improvement
4th October 2013

Appendix 1

Indicative Spending Profile for Healthy Communities Review

Area of Spend	**Current (£000)**	**T+F Group Proposed (£000)**	**Difference (£000)**
Healthy Communities Internal (staffing costs)	760 (currently spending 623 due to vacancies + p/t roles)(excl Health trainers staffing – see below)	**350 (excl Health trainers staffing - see below)**	-410
Healthy Communities commissioned (VCF Spend)	526	**273**	-253(note this reduction can be offset by the investment in Social Capital Below
Social capital/building community capacity	0	**290 (see below)**	+290
Funding for Root Causes (including some new Fairness Commission based spend plus some support for mainstream SCC services with an increased PH orientation	0	**400**	+400
Expert Patient Programme	27	**0**	-27
Health Trainers	300 (incl 90 staffing)	**300 (210 partner funding and 90 staffing)**	0
Health Champions	185	**185**	0
Total	1798	**1798**	0