Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
23rd July 2014

Report of: Dr Jeremy Wight (Director of Public Health)

Subject: Update Report on developing a Social Model of Health/ Health Communities Review

Author of Report: Chris Shaw (Head of Health Improvement)

Summary: Following the "call in" of the report "Developing the Social Model of Public Health" and the attendance of the Head of Health Improvement and Councillor Mary Lea at the extraordinary meeting on 5/11/2013, that meeting requested that a follow up report be provided to include an implementation plan, targets for the work and how outcomes will be measured. A report was submitted in March although not all the details requested were available

The March Committee requested that a further report be given at their meeting in July 2014 as follows:-

8.4 (c) that a written update report on progress with the Social Model of Public Health/be included on the agenda for each future meeting of the Committee

Developing and implementing the Social Model of Public Health –

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	

Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	**X**
Briefing paper for the Scrutiny Committee	**X**
Other	

The Scrutiny Committee is being asked to:
The Committee is asked to consider the proposals and provide' views, comments and recommendations)

Background Papers:
Cabinet report October 2013 Developing a Social Model of Public Health
Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee **Category of Report:** **both** OPEN

Report of the Director of Public Health

Progress Report on Developing the Social Model of Public Health

1. Introduction/Context

Following the "call in" of the report "Developing the Social Model of Public Health" and the attendance of the Head of Health Improvement and Councillor Mary Lea at the extraordinary meeting on 5/11/2013, that meeting requested that a follow up report be provided to include an implementation plan, targets for the work and how outcomes will be measured. A report was submitted in March although not all the details requested were available

The March Committee requested that a further report be given at their meeting in July 2014 the Minute read as follows:-

8.4 (c) that a written update report on progress with the Social Model of Public Health/be included on the agenda for each future meeting of the Committee

2. Purpose of the Report

To comply with the minute above and provide Members with a progress update It has not been possible to submit the full detailed Commissioning Strategy for the programme as it is contains commercially sensitive information on contract values, locations, outcomes etc.

3 Background

2.1 The Scrutiny Committee called in the Cabinet Report 'Developing a Social Model of Public Health in October 2013

2.2 The original Report provided details of a Member Task and Finish Group who developed a Social Model of Public Health based on a Model of Risk by Labonte *(1993 Health Promotion and Empowerment: Practice Frameworks. Centre for Health Promotion, University of Toronto. Issues in Health Promotion no. 3)*

2.3 Members of the Scrutiny received a presentation detailing the rationale for the model, and the consequences of adopting the model in terms of the Task and Finish Group conclusions following their review of the Healthy Communities Programmes (Community based programmes working in the most deprived third of communities in the City). Following the presentation some specific questions were asked, particularly around the implications of the Healthy Communities Review, and the introduction of commissioning specifically for Social Capital.

- 2.4 Answers were provided in the March report although it was stressed that a full outcomes and measures document for social Capital commissioning will be commercially sensitive until the commissioning specification is published A report was provided in the March which provided :-
- A written progress update on the Healthy Communities Review
- A definition and examples paper on Social Capital
- A summary delivery structure
- A Project Delivery chart with timelines

The March report also considered some external factors influencing scope and delivery which were :-
Sheffield Task and Finish Group on Building Community Resilience
Integrating Health and Social Care.
Review of Grants and commissioned funding to the VCF Sector

It was stressed that a full outcomes and measures document for social Capital commissioning will be commercially sensitive until the commissioning specification is published

This report provides an update from the March Report.

3. What does this mean for the people of Sheffield?

3.1 The aim of the Social model implementation is to ensure maximum health impact of Public Health investment. This model reflects the Members views that Public Health is affected by factors beyond individual behaviours and seeks to better integrate this community based public health work into existing City-wide support infrastructure.

4. Recommendation

4.1 The Committee is asked to consider the implementation update and and future proposals and provide views and comments.

Dr Jeremy Wight
Director of Public Health

Appendix I

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
23rd July 2014

Progress update on implementation of Social Model of Health through the Healthier Communities Programmes and developing the Social Capital Commissioning Strategy

Background

The Members Task and Finish group on Public Health, after developing the Social Model of Health recommended that the HCP should more explicitly address the social model of including the development of social capital. This original report was called in by Members in October and further report was submitted to Scrutiny in March. At that meeting Members asked for an update in July

Essentially what follows is a question / answer based summary of the progress made in developing the Commissioning Strategy for the Community Well Being programme, which was previously known as the Healthy Communities Programme (HCP).It includes further details on locations and outcomes not featured in the March Report

What is the Community Wellbeing Programme Commissioning Strategy trying to achieve

Aim To sustain and develop social capital in areas of the city where there is the most potential to improve individual and community health and wellbeing, by:

- Identifying community providers who are capable of developing social capital locally - building on and helping people and communities make use of existing local infrastructure and activities
- Providing funding through community providers for specific activities that develop social capital and help people improve their wellbeing
- Building on the good practice developed as part of the previous Healthy Communities Programme
- Aligning approaches with the model emerging from the 'Keeping People Well at Home' work stream (part of health and social care integration work)

What are the origins of this change?

The Members Task and Finish group on Public Health report set out the work to develop the Social Model of public health within the city. In addition, the report includes the outcome of a review of the Healthy Communities Programme within the context of the Social Model. The work of the review is described in the Cabinet report on 18th October 2013.

This report will focus on proposals about the how the future work should be commissioned based on the members review which states that:

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 approved Social Model. (see March Scrutiny Report) particularly focusing on the underlying root causes of ill-health and poverty, enhancing 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;*
- *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*

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

Why Commission for Social capital ?

Health inequalities arise when some people have less access than others to resources that support health and wellbeing. There are many risk factors which contribute to health inequalities including poverty, low educational achievement, poor environment, lack of self-esteem and hope. These can result in lower levels of physical and mental health, reduced wellbeing 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?

The recognised definition taken from the Office for National Statistics (ONS) – part of the Office for Economic Co-operation and Development (OECD) is as follows :-

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

Within the definition the key areas 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

Within this definition Social Capital is normally divided up into discreet, but overlapping types:

(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

What are the proposed key areas of work to be provided to achieve social capital outcomes ?

1) Asset Based Community Development
2) Health and Wellbeing Community interventions relating to community needs
3) Health Trainers and Health Champions – separate commissioning proposals

Achieving Social Capital outcomes by using an asset based community development approach

- Work with the local community to build on strengths in individuals and communities. Actively build capacity and confidence identify their priorities and ideas for development. Utilise the methodology employed through Asset Based Community Development of Community Builders and Community Connectors
- Increase connectedness between individual people and community organisations, and between community organisations themselves.
  - Identify community assets
  - Determine what is already working and generate more of it
- Provide and increase access to volunteering opportunities for example utilising Community Health Champions Programme

- Increase access to Health Trainers to increase skills and confidence
- Increase access to training to increase skills and confidence including the Community Development and Health Training courses.

Achieve Social Capital outcomes, as way of working, in sustaining and providing interventions which improve health and well-being.

All health improvement interventions should utilise key elements of social capital as a way of working by increasing connections and personal networks. Providers should work with local community to sustain and identify interventions which improve wellbeing for example :

- Increasing self-esteem and confidence and promote mental health and wellbeing
- Increasing physical activity, increase healthy eating and reduced smoking, alcohol and substance misuse

How will the programmes effectiveness be measured?

Work is currently underway to develop an evaluation frame work with a University partner to:

- Agreed evidence-based strategies for evaluating how community-based improvements in social conditions lead to better psychosocial wellbeing, changes in lifestyle and better health outcomes
- Building capacity of staff in community organisations to routinely monitor activity and outcome via a co-designed data collection system
- A commissioning model that is informed by community-based evidence of effectiveness

The initial specification will include a requirement to use an individual assessment tool such as the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) or an Outcome Star approach

Timescale: when will the CWP be Commissioned?
. Commercial services have recommended the new contract should commence in April 2015 , in order to give sufficient notice to current providers if they are not successful.   It is recommended that the contracts agreed will be for 2 years (there will be an opportunity to vary this contract within the 2 years.
Model of Procurement How will we procure these programmes?

An options appraisal has been conducted with regard to the best way to procure this service

The preferred option for procurement is a competitive tender, for 2 years with built in flexibility to vary the contract.
The advantages are this would provide timely implementation of members' review of developing social capital. It would provide flexibility in order to align this investment with the model emerging from the 'Keeping People Well at Home' work stream (part of health and social care integration work).

(Integrated health and soclal care (IHSC) is using a commissioning model which will invite providers to apply on an area basis in coproduction with other providers including GPs. Development of IHSC will be incremental and introduced in different phases in specific areas. The model may also include direct council provision in areas with little appropriate VCF infrastructure.

What will we measure ?- Community Wellbeing Programme Proposed Indicator measures (Draft)

OUTCOMES	ACTIVITY
• Increased confidence. • An increased feeling of personal wellbeing • An increase in participation/engagement in local community outside immediate network • An increase in connecting and sharing - thoughts, ideas, conversation, food capabilities. , • Active engagement in groups addressing local issues - health, environment, poverty, safety • Positive outcomes from contact with agencies - Job Centre Plus, GP, Police,	• Work with the local community to build on strengths in individuals and communities. • Deliver all health & wellbeing improvement interventions by developing social capital as a way of working, increasing connections and personal networks. • Work with local community to sustain and identify interventions which improve health. • Increase access and enable access to city wide health improvement support services eg - and access to affordable credit , Move More, smoking cessation service and weight management. • Increase and enable access to services which help to address e wider determinants of health including- fuel and food overty Debt management, Advocacy, training
OUTCOME INDICATORS	**OUTPUTS**
• More connections with family + ethnic group, carers, child support + close friends • Feeling of safety/ Happiness / useful Number new acquaintances – newer ones, useful ones 'contacts' organisations • Doing things for other people (befriending, mentoring), meeting joining local groups • 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	Outputs to be identified with provider : Indicative outputs : • Number of beneficiaries • Number of points of contact • Number of community activities sustained and newly developed • Number of service users taking part in/supported to access other health improvement interventions • Number of service user engaging with volunteering, education, training and work related activities • Number of referrals and signposting onto other services to address wider determinants of health • Reductions in use of doorstep lenders, Reductions in reliance on food banks, reductions in debt and increase use of cheaper fuel tariffs

Increasing Social capital

How will the programmes work with local partners

Delivery of the CWP aims to ensure links with and joint work with the Health and other partners Local Area Partners Panels, Council Housing and Housing Associations.

How will the programmes work with Health Services ?

It will be important to ensure links between NHS and the CWP interventions. And the programmes will maintain close links with the NHS particularly the Clinical Commissioning group and the constituent CCG localities groups, GP associations and GP practices. It will aim to secure wider ‘ buy in ‘ aiming to :-

- Increase number of GPs referring into community interventions using social prescribing
- Identify those with long term conditions and/or at risk of health problems and increase access to interventions in the CWP.
- Identifying vulnerable groups and those most at risk using social care – older people, people with learning disabilities and mental health problems
- Provide Sheffield Health Trainers service in GP practices and increase the number of people supported by health trainers
- Provide and increase access to community screening programmes for those most at risk.
- Improve appropriate access to NHS services including community interventions which increase knowledge about NHS and Social care services.

How will the programmes integrate with Health and Social Care ?

Providers of the CWP will:

- contribute to Asset Based Community Development in Keeping people safe in own communities work stream of the Better Care programme
- will be able to deliver the specific services commissioned to achieve Asset Based Community Development, build on and increasing the capacity of their contract to deliver this work. A contract variation will be established to achieve this approach.

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