S H E F F I E L D C I T Y C O U N C I L

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 5 November 2013

PRESENT: Councillors Mick Rooney (Chair), Sue Alston, Janet Bragg, John Campbell, Katie Condliffe, Roger Davison (Deputy Chair), Tony Downing, Adam Hurst, Martin Lawton, Jackie Satur, Diana Stimely, Garry Weatherall and Joyce Wright

Non-Council Members (Healthwatch Sheffield):-

Helen Rowe (Healthwatch Sheffield)

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Anne Ashby and Alice Riddell (Healthwatch Sheffield).

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified were resolutions may be moved to exclude the public and press.

3. DECLARATIONS OF INTEREST

3.1 Councillor Martin Lawton declared a personal interest in agenda item 6 – Call-in of Cabinet Decision on Developing the Social Model of Public Health, as a Member of the Task and Finish Group on Public Health, which had developed the Social Model of Public Health within the City, which had been considered by the Cabinet at its meeting on 16th October 2013.

4. PUBLIC QUESTIONS AND PETITIONS

4.1 There were no public questions or petitions.

5. CALL-IN OF CABINET DECISION ON DEVELOPING THE SOCIAL MODEL OF PUBLIC HEALTH

5.1 The lead signatory to the call-in was Councillor Ian Auckland and the co-signatories were Councillors Roger Davison, Shaffaq Mohammed, Andrew Sangar and Diana Stimely.

5.2 The Committee scrutinized the decision of the Cabinet at its meeting held on 16th October 2013, approving 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 the Cabinet meeting held on 25th

January 2012, and considered a joint report of the Executive Director, Communities and Director of Public Health submitted to the meeting on 16th October 2013. Attending the meeting for this item were Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living, Chris Shaw, Director of Health Improvement and Jeremy Wight, Director of Public Health.

5.3 Councillor Ian Auckland outlined the reasons for the call-in, indicating that there was a distinct lack of detail and clarity in the report, specifically regarding the proposed re-allocation of funding. He referred to the improvement in health outcomes under the present Healthy Communities Programme, questioning the need for change, and expressing concern at the potential risks of removing funding from other areas of health work.

5.4 Chris Shaw reported on the reasons behind the report, indicating that, following the transfer of the Public Health function from the Primary Care Trust to the City Council, Members had expressed a wish to see how the function should be implemented from a Local Authority point of view. He stated that the report now submitted set out details of the work undertaken by the Members' Task and Finish Group on Public Health, to develop the Social Model of Public Health within the City, together with details of the outcome of the first area of Public Health investment which had been reviewed within the context of the Social Model – the Healthy Communities Programme.

5.4 The Task and Finish Group had been established in 2012, chaired by Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living, and Phase 1 of the review, included outlining Members' thinking, but did not detail any specific conclusions as they had not been reached at that point. The second phase of the work had four objectives, one of which was to develop a Social Model of Public Health and Wellbeing to inform thinking and activity across the City Council, including the Council's contributions to outcomes in the Health and Wellbeing Strategy. As part of this work, interviews had been held with a number of groups and individuals, which resulted in a draft model being produced, as well as providing Members with some information on a number of existing Public Health programmes already in operation.

5.5 Mr Shaw indicated that the main reason for the review of the Healthy Communities Programme was that Members considered that some of the work being undertaken to tackle health inequalities was not as effective as it could be and that in order to address this issue, a shift in investment in some areas was needed. It had been considered that the proposed shift in investment would better reflect the emerging social model and result in an increase in the number of people who would be able to make changes to their behaviour and lifestyles. The aim was to change the existing Healthy Communities Programme to

one that operated within the context of the proposed Social Model, particularly focusing on the underlying root causes of ill health, such as poverty, unemployment and poor housing. A potential to enhance social, capital and community development was also identified. In response to comments made by Councillor Auckland regarding potential risks, Mr Shaw stated that whilst it was not possible to give any assurances in terms of potential risks involved, Members were confident that any changes made to the existing Healthy Communities Programme would be made to the benefit of Sheffield residents. He reported that work would commence shortly on producing a number of measurable indicators for the new proposals.

5.6 Members of the Committee raised questions and the following responses were provided:-

- Whilst there was no detail available at the present time, officers were in the process of working through the outcome profile, with a view to providing a new profile sometime in 2014.

- There were no details available at the present time regarding which services/programmes would be reduced/stopped following the proposed shift in investment.

- There would be an emphasis, as part of the new Healthy Communities Programme, on targeting the psycho-social pillar of the model, including loneliness and social isolation. There was evidence to suggest that breaking down these barriers, rather than targeting specific health improvement programmes, resulted in an improvement of people's wellbeing and health.

- In terms of screening appointments for both men and women over the age of 60, reminder letters were sent to those people who did not attend their initial appointment. It was accepted that there would always be a number of people who would not attend such appointments, but every effort was made to highlight the importance of attending.

- The level of funding as part of the review equated to £1.8 million, which was not considered a significant amount in terms of overall Government spending on health. The proposals were to re-invest the funding specifically to address the objectives in the proposed Social Model, particularly focussing on the underlying root causes of ill health and poverty and the potential to enhance social, capital and community development. Following the review, the Healthy Communities Programme would continue to target those residents within the most deprived third of the City.

- As part of the review, Members did not see any evidence to show that any of the existing work under the Healthy

Communities Programmes would stop, although there was a possibility that funding in some areas of work could be reduced as a result of the shift in investment. Members were clear that they did not wish to lose the excellent work undertaken under the current Healthy Communities Programme, but considered that the shift in investment in certain areas of work could improve the work even more. One of the recommendations of the Cabinet at the meeting on 16th October 2013, was to 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 take forward proposed changes to the Healthy Communities Programme and as part of this work, every effort would be made to ensure that the good work undertaken under the Programme would continue.

- The proposed shift of emphasis in terms of investment, from lifestyles and physiological conditions, to social and psycho-social conditions, had been proposed on the basis that some people faced significant barriers in terms of changing their behaviour, and therefore needed targeting before they could go on to make the relevant lifestyle changes. It was considered that the proposed shift in investment would go a long way to helping people overcome some of these barriers.

- The work undertaken as part of the current Healthy Communities Programme had contributed to an increase in life expectancy rates across the City, although levels of health inequality had remained broadly the same.

- Whilst there was evidence to show that health inequalities broadly followed deprivation in the City, examples of inequality could be found, in pockets, in all areas of the City.

- As part of the review, officers had discussed the issues relating to barriers faced by some individuals in terms of access to employment opportunities. Although communication between the Department of Health and Department for Work and Pensions could be improved, efforts were being made to provide improved links between the two areas of work within the City as people in work or those who had better employment opportunities often experienced better health.

- In terms of timescales, due to the level of work required, it was planned that the majority of the work in connection with the proposed changes to the Healthy Communities Programme would be undertaken during spring/summer 2014, with a latest possible implementation date of 1st April 2015.

- It was likely that the £290,000 funding in respect of Social Capital would potentially be commissioned through the existing local Voluntary, Community and Faith (VCF) organisations, but it would be through an open process. The Council would shortly be commencing discussions with the existing VCF providers, then would commence discussions with all potential providers with the aim of implementing such programmes over the next six months.

- Arrangements would be made for all the background papers and information produced as part of the review undertaken by the Members' Task and Finish Group on Public Health to be circulated to Members of the Committee.

5.7 RESOLVED: That the Committee:

(a) notes the contents of the joint report now submitted, together with the comments now made and the responses provided to the questions raised; and

(b) agrees (i) to take no action in relation to the called-in decision and (ii) that, as part of its Work Programme, it monitors the progress of this work, over its 18 month delivery period, including the receipt of a monitoring report from the Director of Health Improvement at its meeting to be held in March 2014, outlining the implementation plan, targets, how outcomes would be measured and progress on commissioning.