HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM THE Scottish Community Development Centre (SCDC)

Introduction

Formed in 1994, SCDC is the lead body for community development in Scotland. We work to our vision of an active, inclusive and just Scotland where our communities are strong, equitable and sustainable. SCDC works with community groups, community development practitioners, government and other policy makers, and local partnerships and agencies across Scotland who want to involve communities in their work. SCDC is strongly concerned with tackling poverty and inequality, concerns that are at the heart of community development.

The Community Health Exchange (CHEX) has been part of SCDC since 1999 and works to support and promote community development approaches to improve health and wellbeing. We provide support to a network of community-led health initiatives and their public sector partners who are tackling health inequalities in communities across Scotland. We work strategically to support community-led health initiatives to engage with policy makers, and operationally to help link community-led health initiatives, voluntary organisations and public sector agencies together to tackle health inequalities and achieve health and wellbeing outcomes with and within their communities.

Our response is based on our knowledge and experience of working with community-led health initiatives and their partners, and our involvement in the structures and processes of public health reform in Scotland. Our role within the reform process is to advocate for community development approaches as an important part of the health system and to promote greater recognition of the community and voluntary sectors’ role in prevention, participation and partnership working within public health and health and social care services.

Question 1. Considering the Health and Sport Committee’s report on Public Panels, what changes are needed to ensure that primary care is delivered in a way that focusses on the health and public health priorities of local communities?

Community-led health

We believe that in order to be more preventative, primary care needs to invest in and harness the potential of community-led health. Community-led health is a way of improving health and wellbeing that starts with what people say is important to them. It follows the social model of health which recognises that our health and wellbeing results from factors including work, education, housing, leisure and the way we organise ourselves as a society.

Community-led health organisations are focused on tackling inequality in all its forms. They involve people experiencing poverty as well as disabled, BME, LGBTQ people and other
marginalised groups at all levels of their work. In order to improve health and wellbeing and the factors which impact on this, it is important to involve the people who are most affected. That way services will be more relevant to the people who use them, and decisions will be more appropriate to those they impact on. Community-led health builds people’s capacity to influence service delivery and people get direct benefits from being involved in decisions that make services better. They feel they have more of a stake in their communities and services and develop increased skills and confidence. This is essentially what is meant by ‘empowerment’ and it has knock on effects for health and wellbeing. So, the very process of community-led health in increasing participation and control has direct health benefits – prevention in action.

An example of this approach is the Health Issues in the Community (HIIC) Course, which aims to develop community members’ understanding of the range of factors that affect their health and the health of their communities. The course introduces concepts around the social model of health. It draws on people’s experiential learning and explores how issues around poverty, inequality and social justice can be addressed collectively using community development approaches. A group of women in Douglas, Dundee who have completed part 1 of the course has turned their lived experience into action. They developed a play based on how their families had experienced and dealt with issues around mental-ill health, self-harm and addiction. The play helps ‘shine a light’ on their experience of mental health services and has been delivered numerous times, including to the former Health Minister Shona Robison and at a meeting of the Mental Health Strategic Planning Group meeting in Dundee.

The women themselves have gone on to speak publicly about the course and its benefits – demonstrating the increased skills and confidence they have gained. They are engaged in processes to improve delivery of mental health services and some have gone on to volunteer with Healthy Minds, a drop-in service being developed locally, offering mentoring to people who are going through mental trauma. They have also formed a self-reliant craft group to generate some income and help their own mental wellbeing. This demonstrates how community development can enable and empower independent, collective action by community members on health issues, and how they can contribute to the improvement of health services, including primary care.

CHEX has put together a range of reports, case studies and other resources showing the value and impact of community-led health approaches, available on our website, and including: our last CHEX policy briefing on social prescribing which summarises a mass of evidence on the benefits that community-led organisations bring to working with people experiencing mental health issues, loneliness and isolation and other health issues; our Communities at the Centre case studies from 2013 and 2015 which show a range of ways community organisations around Scotland work with local people to improve health and wellbeing; our case studies highlight how community organisations with a health focus have made use of the Community Empowerment (Scotland) Act, and how one CHEX network organisation has engaged with local health and social care structures; and our role in highlighting some of the work Public Health England has been doing promoting and
evidencing “community-centred approaches for health and wellbeing”. In addition to a guide to community-centred approaches which CHEX has highlighted previously, Public Health England have pointed to evidence building the case for investing in community-centred approaches that increase social capital and, in turn, health and wellbeing.

Social prescribing

We support a continued focus on prevention, participation and partnership, all of which we see being part of a move towards the social model of health. An increased roll out of social prescribing should be part of this. In order to focus on the health priorities of local communities, social prescribing should be designed to tap into and, importantly, invest in, the community sector. Social prescribing therefore needs to:

1. Recognise community-led health organisations can have a key role in social prescribing, acting as the link, or bridge between statutory services and community provision.
2. Support individuals throughout the process and work with them to identify suitable community provision.
3. Be ‘scaled up’ further, with investment in the community sector and a focus on inequality, engagement and partnership vitally important to ensure it meets the needs of those who need it.
4. Focus, where possible, on projects that empower people and communities.

Community organisations can link people to suitable non-medical treatment and activities. They are likely to have a strong knowledge and understanding of their communities as well as of local community sector provision, enabling them to match up individuals to suitable services.

A new project is being funded in Scotland and Northern Ireland which will support community-led health organisations to better link primary medical care to community-based resources. Social prescribers will work with referred individuals to link them with local resources ranging from stress management services to community groups offering peer-support. A cross-border partnership, the SPRING Project is being led by Scottish Communities for Health and Wellbeing (SCHW) and the Northern Ireland Healthy Living Centre Alliance (HLCA). The National Lottery Community Fund is providing £3m to fund ten community-led health organisations in Scotland £40,000 per year for at least three years to develop the project and to host social prescribers. The SPRING Project describes a community-based approach to social prescribing as being effective:

- Because community-based organisations are best placed to know the range of community activities that are available in their areas. Primary care practitioners can trust them to find something appropriate without having to find it all out for themselves.
- Because community-based organisations often provide, or can offer access to, a wide range of activities, allowing people to develop flexible personal pathways, rather than being referred to just one type of activity at a time by primary care practitioners.
• Because ‘patients’ or users often trust a community-based organisation to be ‘on their side’ or be suitable for ‘people like them’, and so they may be more willing to engage.
• Because community-based organisations often take a community development approach, building capacity for the activities that are needed to respond to health needs.
• Because community-based organisations can offer people chances to feel in control of what happens to them, through responding to their own and community needs, involving volunteers etc.
• Because community-based organisations often offer people the chance to meet and get involved with a wider range of people in their community, combatting social isolation.
• Because the activities that community-based organisations can offer as social prescriptions are often also available to a wider range of people for whom they help to prevent potential ill health and poor well-being.

Question 2: Barriers to sustainable primary care system in both urban and rural areas

Due to ageing populations particularly in rural areas but also urban, and declining budgets, primary care is unsustainable as it currently is. We support a shift in focus towards prevention and community participation as a means of making services more sustainable.

Through our Supporting Communities Programme we have been working with local community organisations, both in urban and remote, rural areas to develop community led action plans that identify and respond to local issues affecting their community. Issues around health and social care services are routinely being identified as important, particularly where services become or remain inaccessible. Learning from the programme suggests that communities have an interest in working with primary care service providers to develop joint solutions to address the availability and accessibility of health and care services. We understand that this requires active engagement and dialogue between communities and service providers to develop different models of delivery and that building community and agency capacity to engage with each other is critical to this. For example, whilst the use of technology to assist self-management of conditions is welcome, a shared dialogue at community level would be important to address barriers in using technology, particularly in rural communities and identify what other measures could be used to maximise self-help, self-management and peer support.

Question 3. How can the effectiveness of multidisciplinary teams and GP Cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

We are aware of emerging programmes to develop more holistic, person-centred models of care, notably the work being led by Healthcare Improvement Scotland Ihub’s Neighbourhood Care Programme which will test models such as multi-disciplinary team working, reflective of local need and context, delivering person-centred care that enables individuals to live well in the community for longer. Another programme, Community Led
Support (CLS) seeks to change the culture and practice of health and social work towards a community focus in achieving outcomes, the empowerment of staff and a true partnership with local people. More recently, its support for People Led Care to develop community-led care provision in rural areas and explore alternative ways of commissioning care will provide valuable insights on how services can be better delivered at a neighbourhood level. The evaluation of impact and outcomes from these programmes and models will provide valuable learning on how outcomes and preventative approaches can be monitored and evaluated.

We would also suggest that communities and the organisations that support them should participate in evaluation processes so that they can also judge what works and what doesn’t, ensuring lived experience is ‘taken inside’ of the health system. Further, ‘softer’ outcomes such as increased confidence, participation and wellbeing, particularly for those who experience the poorest health and social outcomes, should be considered alongside health statistics and medical data as a measure of improved health and effective service delivery to tackle health inequalities.

For more information on SCDC and CHEX please contact Susan Paxton, Head of Programmes susan@scdc.org.uk