Scottish Urban Regeneration Forum

SURF : sharing experience : shaping practice

Health, Wellbeing and Regeneration – Developing the linkages
Royal College of Physicians & Surgeons, Glasgow.

SURF Open Forum Outcomes Paper - Summary

Plenary speakers: Grace Moore, Associate Director of Health Promotion & Inequalities, NHS Ayrshire & Arran.
Lizanne Conway, Health Improvement Programme Manager, NHS Health Scotland
Chair: Edward Harkins, SURF Networking Initiatives Officer

Participants: Fifty participants from community planning partnerships, community and voluntary sector organisations and intermediaries, the private sector, Local Authorities, Housing Associations, NHS, Higher and Further Education Institutions and other partnership bodies and funding agencies, such as Communities Scotland and Scottish Enterprise.

Part One: A brief summary of some Key Issues raised and discussed by participants:

- **That health and health improvement are everyone's responsibility, and this needs a cross-sector, holistic, approach.** Widely used definitions of health improvement and health illustrate this reality.

- **Effective community-led approaches** are shown in research examined by the Task Force as to tend to be open, responsive and flexible supporting individual participation and a group approach whilst recognising the central importance of mental wellbeing and wider issues of local importance.

- **Involvement in community-led health** is shown in research examined by the Task Force as having the potential to help increase confidence and sense of control as well as knowledge development, all within a sense of increased motivation and security.

- **Taking the recommendations of the Task Group forward** (the themes are evidence based, planning & partnership, sustainability and capacity building) needs a range of opportunities and issues to be grasped on a holistic basis. It will be important to build links to important cross-sector policies and stakeholders who may not be readily seen or 'badged' as health practitioners.

- **For community-led health improvement, more evidence was needed,** together with better definitions of what is to be measured and why.

- **There are significant challenges and issues around the building of a better evidence base** that were identified by participants.

- **Policy-making needs to be informed by actual circumstances and practice as well as long-term evidence.** Participants agreed on the aim of linking integrated delivery to policy making, mainly by ensuring evidence of effective delivery is gathered and fed back into the policy cycle.

- **Health-promoting environments for work, life and recuperation** were seen by many participants as important. Arguably, many great health improvements have come from civil engineers and public health specialists:

- **The importance of high quality design in support of health-promoting environments** was particularly remarked on by participants.

- **Good community engagement practice is essential to effective community-led health.** Participants wanted policy makers to be encouraged to go to the community level more often and the community should be involved in appropriate ways in policy-making. Community Engagement Standards need to be implemented, and consultation structures must follow purpose. There is a perceived need to build experience and competences in these areas among those working in community-led health and regeneration.

A more detailed description of the foregoing issues for further reference is given in Part 2 on the following pages. Copies of the speakers' Powerpoint presentations are available at:
http://www.scotregen.co.uk/knowledge/events.asp?sid=9

Part Two: A more detailed reflection of the foregoing issues raised and discussed by participants:

- **That health and health improvement are everyone's responsibility, and that this needs a cross-sector, holistic, approach** is shown by two widely-used definitions:

    - Health improvement as: "Key aspects of activity to reduce inequalities, working with partners not only in the NHS but in other sectors such as education and workplaces. It involves engagement with structural determinants such as housing and employment, as well as working with individuals and their families within communities to improve health and prevent disease through adopting healthier lifestyles" (1)
    - Health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (2)

- **Effective community-led approaches** are shown in research examined by the Task Force as to tend to:

    - Be open, responsive and flexible
    - Allow active individual participation and empowerment
    - Recognise the central importance of mental wellbeing
    - Promote a group approach
    - Help people re-connect with their communities
    - Directly tackle wider issues of local importance to health

- **Involvement in community-led health** is shown in research examined by the Task Force as having the potential to:

    - Help increase confidence and sense of control
    - Assist in skills and knowledge development
    - Help increase motivation, hopes, ambitions and a sense of purpose
    - Create a greater sense of security

- **Taking the recommendations of the Task Group forward** (the themes are evidence based, planning & partnership, sustainability and capacity building). This required, for participants, a range of opportunities and issues to be grasped:

    - Participants saw a key priority as being raising awareness with professionals as to how health is linked to all policy areas: there was a sense among participants that there is 'a big awareness-raising exercise' to take on. Overall, the link between policy and practice was

seen as weak. Participants argued that policy linkages need to be visibly made at Scottish Cabinet level as well as at community planning level.

- Culture change in agencies and organisations was seen by participants as essential for better linkages. This includes the middle managers; not just the senior policy makers and the frontline staff. Community planning offices where staff are jointly housed was seen as helpful, as is joint training. 'It all helps to understand each other's language and cultures better, which in turn helps linkages'.
- For many participants, one of the biggest challenges is what people actually think 'health' is. People often revert to the 'medical' model and their understanding of their own health needs to be widened to the concept of 'wellbeing'. This would be done by extending understanding to housing, employment etc. There are challenges around doing this because of a lack of experience of engaging with the community on the part of many local authority and Scottish Executive agency staff.
- Some participants argued that there was a need to focus further on making personal health more of a responsibility for an individual person. As an example, it was asserted that healthy eating in schools failed where it is imposed – there is a need to involve parents and children in shared ownership of such initiatives. However, this must be supported by making available meaningful choices - people need to be empowered to actually do something about improving their health.
- Participants discussed uncertainty over what evidence there is across Scotland that people in local communities know what a Community Health Partnership or a Community Planning Partnership is. Moreover, are local people really represented in the new Community Health Partnership or Community Planning Partnership structures? Is one person really representative of a 'whole community'?
- For many participants a Public Partnership Forum must be established in each Community Health Partnership, and should be linked to the community. It was hoped that these Public Partnership Fora would be the structure to link-up the community-led health improvement agenda.
- Some participants were enthusiastic on how there are many para-health and ancillary workers, service users and organisations that can be brought into play through a holistic community regeneration approach. For example, there is the role of Community Learning and Development workers who contribute to health although it's not in their job description. Among the many specialist practitioners in public health and the 'wider workforce there is much work that is not 'badged' as health, but that is directly relevant to health – and often linked to communities. Another rich potential contribution is the role

of Registered Social Landlord staff (Housing Associations and Co-operatives etc.)

- **For community-led health improvement, more evidence was needed, together with better definitions of what is to be measured and why**. This was generally agreed by participants. There were concerns that insufficient evidence exists on with which to fully understand and replicate the health impact of community-led activity. The Task forces also recommended further building of the evidence base by:

    - Using designs and methods that recognise the timescales and complexities
    - Identifying and setting out clearly the links between objectives, inputs, outputs, and outcomes
    - defining success in ways that reflect a broad view of health and its determinants
    - Working with the community and voluntary health sector to build a greater knowledge of what factors enable or block community health

- **Challenges and issues around the building of a better evidence base** were identified by participants:

    - An assumption that existing monitoring and evaluation practice is not fit for purpose. This is especially true on evidence for successful practice in supporting progress in community.
    - Community-led health improvement is complex and some participants argued that good evidence should lead to funding 'doors opening' for sustainability and funding.
    - Participants noted that a difficulty is that almost all evidence goes upwards and not down. Some participants perceive that threats arise from the generation of evidence - will gathering it, or the findings of it, be 'another hurdle' for fund-seeking community-based organisations?
    - Tensions are generated between funders requiring delivery, and others' needs for information collection for longer term organisational learning.

- **Policy-making needs to be informed by actual circumstances and practice as well as long-term evidence.** Participants agreed on the aim of linking integrated delivery to policy making, mainly by ensuring evidence of effective delivery is gathered and fed back into the policy cycle.

    - Many participants emphasised the importance of tangible evidence of policy linkages at Scottish Cabinet level as well as at community planning level (for example, between health improvement and community regeneration).

- Some participants argued that Scottish Executive departments don't seem to be working across the policy agenda and between policy areas. However, the usefulness of events such as this SURF Forum in this respect was highlighted. It was argued that a joint Government agenda is more of a vision than a reality, but is still a worthwhile pursuit.
- Some participants needed assurance that local and national politicians have sight of Community-led Task Group reports, as well as needing a better connection between local communities, Community Health and Community Planning Partnerships and Executive departments.
- A particular aspect raised by participants was 'how does housing strategy link into community regeneration and health, and how does housing impact on the Health Improvement strategy?'. Views were expressed that, as asset and income rich organisations, Housing Associations could or should be playing a more significant role. It was pointed out that the housing conditions survey remit had been moved from Communities Scotland into the Executive and there are other evidence sources such as the Scottish Housing, Health and Regeneration Research Project (SHARP).

* **Health-promoting environments for work, life and recuperation** were seen by many participants as important. Arguably, many great health improvements have come from civil engineers and public health specialists:

  - At a local level the operating environment – buildings, open spaces, community meeting spaces – is crucial, and must be designed to be inclusive of all groups.
  - Local Authorities/Health Boards could be crucial in better enabling people be involved in their own health, wellbeing through regeneration.
  - The built environment needs to encourage healthy choices; people are often brought in at a stage in design where only tinkering is possible. It is vital to empower people to get involved in local activity.
  - Property and land Developers should be assessed on the health benefits of their proposed developments – whether these are private or public sector developments, or hybrids like PPP projects.
  - In regeneration we need to think more about the effect of the built environment on health. Could hospitals in the city form part of the regeneration agenda?
  - The social aspect of communities and networks is very important – social connections and going out socially together. This 'social capital' should be built on, and professional 'outside' agencies need to avoid inadvertently disrupting or degrading any existing social networks or ties.

- **The importance of high quality design in support of health-promoting environments** was particularly remarked on by participants.

  - USA research has shown that good design can reduce internal room sound levels that lead to measurable significant improvements in in-patients' quality of sleep and satisfaction scores. In similar fashion, patient falls and injuries can be reduced by better layouts allowing enhanced observation.
  - We should profile our communities and highlight the key health risks and require design to relate to these. Evidence of progress in this direction is given by Health impact assessments of local development strategies that entail looking at the effect on people's lives (Glasgow East End).
  - Transport design should factor-in exercise needs and aspirations – and it must include provision for healthy and safe pedestrian traffic and cycling; European countries with the highest rates of cycling, e.g. Denmark, have the lowest rates of obesity.
  - There is much potential to be investigated on the potential benefits of links between 'the Arts' and health design.

- **Good community engagement practice is essential to effective community-led health.**

  - Participants wanted policy makers to be encouraged to go to the community level more often and the community should be involved in appropriate ways in policy-making.
  - The Task Group's National Standards paper has tried to pull the two standards for NHS and Communities Scotland together but participants asked 'how do we put Community Engagement standards into action?'
  - Participants were asked 'how can end users be consulted and engaged best? There were assertions that 'currently it's not happening'. It was argued that Community structures need to be really clear and user-friendly so that lay members know who to talk to. Participants felt that case studies on the outcomes and savings benefits of being 'joined-up' would be useful to conduct.
  - Good examples were cited of where Community Health Partnership structures had increased the opportunity for people to be creative and take risks. In Falkirk, six community health groups have formed to engage with local citizens, therefore seeing people as 'people' and not 'patients.' Community Health Groups are formed from local people and representatives from local health projects, which is in addition to the Public Partnership Forum.
  - A few bad examples were described of support being withdrawn from successful projects, and of community involvement in health issues

where NHS staff wanted people to look only at NHS priorities, or fit into existing structures for engagement.

References:

(1) Griffiths S, Jewell T, Donnelly P (2005) *Public Health in Practice: the three domains of public health. Public Health* 119:907-913
(2) WHO, *Preamble to the Constitution of the World Health Organization*. 1948,

Other Workshop facilitators: Pippa Coutts, Supporting Change Programme Lead, Scottish Community Development Centre for Mental Health
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Purpose of this Paper: This paper is intended to encapsulate the general flow of this inter-active forum comprising of the above plenary programme and subsequent workshops. It is not possible to reiterate every nuance and detail. The views stated reflect, wherever possible, the broadest consensus views of participants. The paper is, for purposes of context, necessarily repetitive in parts. **A fuller version is available from the 'Knowledge Centre' on the SURF website.**

Background to the Forum: SURF delivers a national programme of Open Forums with the aim of offering its networking service to all regeneration practitioners and interested parties across Scotland. This networking activity is funded by Communities Scotland. SURF will continue to act as the independent facilitator for the network, bringing together key players, and produce constructive Outcome Papers to help inform policy decision-making and practice.

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