



## Welcome to CHEX-Point Newsletter - *issue number 50!*

For 50 issues CHEX-Point Newsletter has brought you a detailed look at how community-led health contributes to strong, empowered and healthy communities. CHEX's role is to support community organisations and their public partners, highlighting the effectiveness of community development approaches to tackling inequalities – and CHEX-Point is one way for us to do that.

In this issue we look back at the progress community-led health has made, with articles from former CHEX Manager Janet Muir (who retired in 2015) and Hilda Campbell from COPE,

both sharing their perspectives and insights about their work.

Then, we examine where community-led health is now with our latest case studies: MORE Communities at the Centre. Five stories show the significant contribution community-led organisations make to health and wellbeing in their local communities. We also see how HIIC - Health Issues in the Community - training has made a difference to people's lives.

Finally, we look to the future with the Community Empowerment (Scotland) Act. Now passed, the Act offers opportunities

for community-led health organisations to have influence and involvement in local decision making - and shape the on-going development of the Act itself.

So thank you for reading for the last 50 issues! Here at CHEX we're always focused on highlighting the experience, skills and determination of local community-led health organisations and the approaches they take - and we hope CHEX-Point Newsletter carries on helping to do that.

# The Way We Were....

...building expertise towards healthier communities



## Janet Muir, recently retired Manager of CHEx takes a trip down memory lane and looks towards the future for community-led health

Nov. 1999 was when it all started for me at CHEx. I'd been working at the Poverty Alliance and although many of the community groups had health as a top priority, very few actually called themselves community health groups. Community-led health was still in its infancy and the excitement of new challenges was there for me and many others. The network of community health projects were keen not only to share ideas and practice between themselves, but also influence health policies and the delivery of mainstream health services.

The Network grew rapidly in those early years, mainly through the NOF programme of healthy living centres and more community organisations wanting to improve the health of individuals and the wider community. CHEx was buzzing in response to this high energy and drive. Demands for discussions around health inequalities, developing new methods to engage local people, new ways of working with health professionals and routes into influencing decision-makers were all top of the agenda.

The national health improvement policy at the time 'Improving Scotland's Health: The Challenge' (2003) had begun to take community-led health seriously and prioritised the approach in its '4 pillars' for action. Many were unsure what community-led health actually meant! And this opened the door for CHEx organisations to clearly articulate the benefits and case for community-led health for delivery at all levels. This activity led to CHEx joining other national health intermediaries in particular NHS Health Scotland and Community Food and Health Scotland to work towards shaping health and social policies and practice. Healthy Communities: Meeting the Shared Challenge Programme (2007-2010) enabled capacity building with all sectors with an interest and responsibility in delivering health improvement. Community-led health organisations were joined by a diverse range of workers from the NHS, local authorities, housing associations and the third sector to explore different aspects of community-led health - from understanding the health



benefits and building community connections to capturing the impact and measuring the change. Despite this priority given to the approach, community-led health organisations continued to face recurring and many new demands. Local needs reflected increasing issues around mental health, people who had thus far tended to be excluded were becoming more organised, in particular BME and LGBT groups, and there was greater expectation to be 'fit for purpose' and consistently demonstrate impact. Significantly, resources to meet these new demands tended to stay static. CHEX and community-led health organisations had to up their game to make a stronger case for additional and sustained resources.

Mixed reactions from those new to the approach forced organisations to be particularly clear about what they were attempting to achieve. In responding to expressed need, organisations were pulled in many different directions and the introduction of outcome-focussing planning presented a useful framework to articulate need, outcomes, outputs, inputs and processes. Key to planning and evaluation was the participation of local people and many organisations began to use Learning, Evaluation and Planning (LEAP) which enabled an interactive, participatory process with all interested people.

As community-led health gained greater currency more and more policy makers and practitioners wanted evidence of the strengths and uniqueness that the approach delivered. It wasn't just about evidencing change in individual behaviour or the provision of certain services, it was the need to show that the health outcomes of communities had improved through the involvement and empowerment of community members. SCDC and CHEX highlighted evidence and the nature and extent of impact to the Scottish Parliament's Local Government and Regeneration Committee in 2014.

Policy makers and decision-makers were particularly keen to know how good practice could be replicated and scaled-up across the country. The pressure to demonstrate the impact was constant and CHEX worked with the organisations and with other national partners for better systems to streamline the collection, presentation and use of evidence which resulted in improved arrangements in some areas.

Fast forward to 2016 and it is heartening to see the survival of many community health organisations and the embedding of community-led health approaches in some public services. CHEX's recent case studies bring life to the health benefits for individuals and the wider community in Fife, Inverclyde, North Glasgow, East Edinburgh and the Western Isles.

Throughout the last 5 years national policies on health inequalities and integration of health and social care have established that communities have a significant part to play in working with health professionals. Not only on implementing policies but influencing policies with new evidence of unmet need. This strategic involvement has been greatly welcomed by community health organisations, but highlights the need for ongoing capacity building with public sector partners that are new to working with communities as active participants instead of passive recipients of health care and health improvement.

The successful implementation of these policies are based on health professionals being better equipped to reach priority groups - having a people centred approach that empowers and skills people, engaging people, having links with community networks, helping communities to identify their own issues, expressing their views and having a voice in collective action - community-led health has shown to effectively facilitate processes in developing good practice. Scotland is fortunate that it has a strong sector and commitment within some public services to ensure the approach is sustained and extended. The Community Empowerment Act (2015) provides duties and offers opportunities for the approach to be further embedded in the practice of all community planning partners. CHEX continues to offer opportunities to engage with finalising the Act's guidance and regulations and come this autumn it should be - all systems go!

We know the task of improving Scotland's health is daunting. Mobilising communities in the face of growing inequality and reduced public expenditure is a tall order. To some extent the political will has been demonstrated, but needs to go much further and systemise across the country the commitment to good practice that enables community-led health to flourish and thrive in all communities.

Now, as a community volunteer I'm gearing up to contribute and be part of this growing movement.

# Working together to make a difference: **COPE Scotland**



## COPE Scotland **Co Designing Solutions**

### **Hilda Campbell, Chief Executive Officer at COPE Scotland, outlines how community-led, co-produced approaches are core to their work.**

Community led initiative, co design, co-production, user led, participatory budgeting, and more - I personally think these are varied terms to discuss one thing: Working together to make a difference considering all parties' agendas, skills, experiences and points of view. This makes sense to me, how can we really find solutions to the current challenges we all face if we don't involve all stakeholders in the process?

At COPE Scotland involving people has always been at the core of what we do. When we started in 1991 we worked with the local Drumming Up Health Volunteers to survey, well..... everyone! The main question of the survey was

*“Hello, we have £42,000 to create a community led mental health service, how do you think we should spend the money?”*

The results were two fold: people who had experience of ill health wanted community led services and other people's responses highlighted some work needed to be done to challenge

stigma and people's perception of mental ill health and mental wellbeing in general.

Working with a group of local people in the Unemployed Workers Centre who had experience of mental distress, we invited them to become our steering group to see if the direction of travel was what people had really asked for. Our funding came from the Urban Aid Programme and we were fortunate to be overseen by Glasgow City Council Social Work Department who got what we were trying to achieve with the local community and supported that.

In our first year in 1991 we had a chair, which transformed to a room in a community flat, which became a whole flat, then two flats, then thanks to local business man John Oliver 4,000 square feet of purpose built premises. Back in that first year we offered support to 21 people! Our steering group went on to become a management committee and are now a Board. We began by listening to people and working with people to find solutions and this remains core to our purpose. Our running costs now are



around £250,000 a year and we are fortunate to receive around 75% of that as core funding from Glasgow City Council Integrated Grant Fund. The rest we secure from other grant sources e.g. the Self-Management Impact fund as well as income generation we do ourselves. Interestingly there are some funding sources we do not go for, not because we don't need the resources, but the tune you dance to would be that of the funder as opposed to the community and people with lived experience. So in looking for funding, it's important we have funders who respect our values and commitments to involving communities and we are fortunate that we have funders who support this. Now we offer support in excess of 2000 people a year.

So what are the benefits of this participatory budgeting, co design and production you may ask. Well for us this has included working with communities and people with lived experience to develop systems which have enabled COPE to become a highly community-led, open organisations which offers a range of services based on the local community's need.

Really though, if you want to get a flavour of why it's not only desirable but essential we work with people and communities to find solutions then please we invite you to watch a series of videos, made by people involved with COPE Scotland. For us, to work any other way, would simply not



make sense. Only by working together can we achieve the transformational change which is so badly needed to see people as assets and not problems, and to find ways to solve some of the real challenges of inequality and poor health which is of concern to us all.

Involving people doesn't just mean having them in a room and paying lip service to what the people say. It's listening and acting on what they say, not what you think they said which fits with what you want. Participatory budgeting, co design and production can be scary as the balance of power and control shifts, but when we stop thinking about control and start thinking about co-operation then something magical can happen.

You can find out more about COPE at [www.cope-scotland.org](http://www.cope-scotland.org).



# An Act of empowerment?

**Here, we provide an introduction to the Community Empowerment (Scotland) Act and its opportunities for community-led health.**



The Community Empowerment (Scotland) Act received Royal Assent on 24 July 2015 and the final version can be read [here](#).

The three major provisions of the Act that are of interest to community-led health are: the strengthening of community planning to give communities more of a say in how public services are to be planned and provided; new rights enabling communities to identify needs and issues and to request action to be taken on these, and the extension of the community right to buy or have greater control over assets. Underpinning all these provisions is a welcome intention to focus attention on disadvantage and inequality.

## **Community Planning**

Under the Act Community Planning Partnerships (CPPs) must now by law exist in every Scottish local authority area and local authorities and a range of other public service partners must now, by law, participate in CPPs. CPPs must participate with any community bodies which the partnership considers likely to be able to contribute to community planning with a focus on involving organisations which represent disadvantaged groups.

As well as developing, publishing and annually reporting on “local outcomes improvement plans” (replacing Single Outcome Agreements), the CPPs must identify disadvantaged localities within their planning area and prepare and publish a “locality plan” for each.



## Participation Requests

Participation requests are designed to help communities, of identity as well as geography, enter into a dialogue with public authorities about issues or services on their own terms. To initiate a participation request, a community body must identify an outcome they want to help improve and be able to show how they can contribute to improving this outcome. If the authority agrees to the request, an 'outcome improvement process' begins. This process will vary depending on the local context but can broadly be described as a process where community bodies and agencies work together to achieve better outcomes for people.

## Taking over assets

Various provisions and changes to previous legislation are contained within the Act that should make it easier for community organisations to own, lease or make use of assets such as land and buildings. The Act extends the Land Reform (Scotland) Act 2003 so that urban as well as rural communities can now take advantage of the 'right to buy' land and buildings. Another provision is that community groups can apply to buy, lease, manage or simply use land and buildings that are owned by public authorities. Furthermore, community bodies now have a right to buy "abandoned or neglected land" which the owner of the land (or building) is unwilling to sell.

## What does the Act mean for community health organisations?

With their focus on community health and wellbeing in the widest sense, community led-health organisations are ideally placed to make use of the Act's provisions. We would hope that any legislation that improves community involvement in CPPs will lead to an increased



amount of productive partnership working between community-led health organisations and statutory partners. Examples of how participation requests might be used include discussing with service providers how they could better meet the needs of users and even proposing to take over the delivery of services. Community control of assets also has potential for communities, such as ensuring their future use is for the benefit of the community, increasing the confidence and sense of control of local people. It can also assist groups to embark on new ventures, such as setting up community shops, hubs or cafés, which can generate income to put back into the community.

The Act's provisions are not yet in force. Separate parts of the legislation will come into force over 2016 and it is expected that most parts will be in place by summer 2016. The full details of the legislation will emerge as these guidelines are published, as well as how far reaching the legislation is in terms of shifting power from government to communities.



If you are interested in finding out more about the Act and what it means for community-led health organisations, please read CHEX's full policy briefing on the Act here: <http://www.chex.org.uk/news/article/implications-and-opportunities-community-empowerme>

# Health Issues in the Community

## Great Statistics, Wonderful Stories



### Here, Robert Cuthbert, Development Manager at CHEX, provides an overview of HIIIC in 2015

Here at CHEX we have just completed an analysis of post course evaluations of HIIIC, Parts 1 and 2, for 2015.

There were 787 returns from 104 people completing at least one part of the course, a return rate of 74%. The evaluation asks a range of questions about people's experience of the course and what they have taken from it.

Returns show an overwhelming 96% of people find it enjoyable with one respondent commenting

*"The course was a great time. I was looking forward to every Friday to being here. This has given me a thirst to learn more about my community and a lot of other things."*

90% of people said their understanding about the health issues affecting their community had improved and 93% said they had a greater understanding of the health issues affecting disadvantaged groups in the community.



At a personal level:

- **56%** felt their study skills had improved;
- **89%** said their communication skills had improved;
- **91%** reported increased self-confidence, and
- **82%** said their self-esteem had got better.

One student said

*“I have found myself in a new area, working with others in a classroom- something I haven't done since I left school. I find myself more confident now, and I thoroughly enjoyed the experience”*

When asked what they intended to use their learning to do once the course was finished:

- **57%** said they will go on to further training or education;
- **57%** said they will use their learning as a positive experience in their personal lives;
- **51%** will use what they have learned to improve their personal health and well-being;
- **48%** will get more involved in the health issues affecting their community and
- **47%** will get more involved in general issues affecting their community.

Whilst these are great statistics we also wanted to look a bit deeper into the impact HIIC had made within communities. To do this, we commissioned one of our Core Tutors to undertake a series of case studies within 4 different communities. The findings demonstrate a positive impact on individuals and communities.



# Health Issues *in the Community*

For example, one of the case studies focused on The Havoc Group from Westcliff, Dumbarton. Having completed HIIC Part 1 the group have stayed together, engaged with the wider community and elected members to gather support for a local, accessible community facility in their area.

We successfully launched the Case Studies in November 2015, with representatives from three of the four case study groups making fantastic, short presentations about the journey they had been on. Apart from the camaraderie formed within their group, what shone through were not only the achievements and ambitions of each group within and for their community but also the clearly stated views of each speaker who gave often very personal accounts of what positive impacts the course had had on them as individuals.

The launch targeted representatives of organisations which had little or no previous involvement with HIIC. Not surprisingly, given what they heard, the response was very positive with great interest being shown in getting courses run for them and for becoming HIIC tutors themselves.

As we said: Great statistics: Wonderful stories!

**There's more information on HIIC available at [www.chex.org.uk](http://www.chex.org.uk).**



# More Communities at the Centre

CHEX profiles five community-led health organisations



CHEX's latest case study publication presents in-depth information of five organisations from the CHEX network. This is the second edition of our Communities at the Centre publications and significant changes have taken place since the first edition two years ago. People have become energised through the Scottish referendum on independence and new opportunities are emerging through the integration of health and social care and the Community Empowerment (Scotland) Act. However, low income communities continue to struggle with austerity measures and the onslaught of 'welfare reform'. The encouragement to build community assets and co-produce local services still has a long way to go. The evidence however shows that community-led health organisations continue to grow and findings from research, evaluations and case studies highlight their significant contribution to informing health policy and practice development.

## The five case studies are:

### **Collydean Community Connections in Fife**

– initiated by four local agencies and organisations, while underpinned by a commitment to community-led approaches, Collydean Community Connections organised a programme of activities that brought together the two halves of Collydean as well as older and younger people;

### **Craigend Resource Centre in Inverclyde**

- having been developed more than 20 years ago, by and for local people, Craigend Resource Centre has gone from strength to strength. While continuing to respond to locally identified needs, Craigend also works with the government and national agencies on health and employment issues.



## Just Like Us in Glasgow

– as an organisation that grew out of the trauma felt by those who lost someone close to them as a consequence of drug or alcohol use, Just Like Us turns this overwhelming experience into positive support for others. The group supports those who come to their weekly drop-in sessions in a local church hall.

## Old Knock School in the Isle of Lewis

– despite having its own strong sense of geographic identity, the community of Point on the Isle of Lewis lacked an ‘everyday’ hub where people could catch up and bump into others they hadn’t seen in a while. A group of active local people took it upon themselves to take over a disused school and convert it into a community building containing a shop and café.

## The Ripple Project in Edinburgh

– having been set up in 1996, the Ripple Project provides a wide range of activities involving young and old alike. The difference it makes to people’s lives is significant and with local people still in control of its future in its Management Committee it looks set to continue its work of providing local opportunities for years to come.

While they have different starting points, a mixture of expertise and experience and varying levels of support, they all have a common goal of involving community members in the health priorities that matter to them. The case studies show the significant contribution each organisation makes to health and wellbeing in their local communities.

As well as the narrative of what these organisations do and the impact they have, CHEX has included a logic model for each case study, based on the [Community-led Health Logic Model](#), showing the inputs, processes, activities, intermediate and long term outcomes for each organisation. The models show both commonalities in approaches such as engaging communities in dialogue about health issues, but also highlight the different activities used in working towards intended outcomes.

[Download More Communities at the Centre](#)



# CHEX News: What we've been up to!

## Public health review published

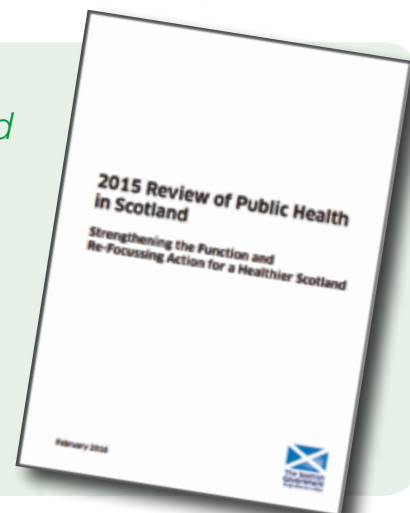
The report from last year's public health review consultation has been published by the Scottish Government recommending that a new public health strategy should be drawn up to help to focus efforts to make Scotland a healthier place.

The review was commissioned by the Scottish Government to look at how Scotland's public health community could work better together, bring about further improvements in the nation's health and well-being and tackle health inequalities.

Chaired by Dr Hamish Wilson, the review group gathered views from public health professionals across sectors. Its recommendations include:

- The development of a national public health strategy
- An enhanced role for public health professionals in new integrated joint boards, that will link NHS and local authorities as part of health and social care integration, and in community planning partnerships
- Further work to review organisational arrangements in Scotland
- Planned development of the public health workforce and wider staffing
- Clarifying and strengthening the role of directors of Public Health
- Achieving greater coordination of the valuable input from public health academics

*"Community empowerment and co-production present a major opportunity for public health, not least in terms of building resilient communities."*



CHEX contributed to the review consultation, calling for the contribution of community-led approaches to public health to be better recognised. In a section entitled "Third Sector and Communities", the report acknowledges that public health "should be 'doing things with, not to' local communities". The role of the third sector and community development in working with and empowering marginalised groups is emphasised.

The report also emphasises:

- Prevention and a focus on the social determinants of health inequalities;
- "solutions go beyond the direct control of public health";
- asset based approaches and co-production;

Read the Scottish Government press release and download the report.

Views expressed in CHEX-POINT are not necessarily those of CHEX, unless specifically stated.

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