CHEX response to Public Health Review engagement questions

March 2015

CHEX welcomes the opportunity to submit a response to the Public Health Review group's engagement paper. We have addressed the five questions from our perspective as a third sector intermediary supporting and promoting community development approaches to health improvement. Our responses to the questions will therefore highlight the role and contribution that community-led organisations and the wider approach can make to the challenges outlined in the paper.

1) How can public health in Scotland best contribute to the challenges discussed? Specifically, what is your view and evidence of the Strengths, Weaknesses, Opportunities and Threats (SWOT) to the contribution of the public health function in improving Scotland's health and reducing inequalities?

The Public Health Review group's engagement paper rightly focuses on the social and economic determinants that influence good health. The New Economics Foundation (nef) states: "without tackling the underlying causes of harm, 'midstream' and 'downstream' measures will have little or no lasting effect."[1] By focusing on social and environmental factors that influence health, rather than on the treatment of individuals, public health has the potential to help improve national, local and individual health outcomes in the longer term.

NHS Health Scotland's health review for the Ministerial Taskforce on Health Inequalities identifies structural, fiscal, legislative and welfare policies, targeted at early years and disadvantaged groups, as the most effective policies for reducing health inequalities.[2] An example of such a policy would be the extended welfare system proposed by the recent Expert Working Group on Welfare.[3] Another example, suggested in the Taskforce Review,[4] is a 'living wage'.[5] In addition, NHS Health Scotland argues that such measures are likely to be more *cost*-effective, since they reduce the need for expensive downstream health initiatives further down

[1] http://www.neweconomics.org/publications/entry/the-wisdom-of-prevention
[2] *Ibid, p42*
[3] Expert Working Group on Welfare (2014) *Re-thinking Welfare: Fair, Personal & Simple* http://www.scotland.gov.uk/Publications/2014/06/7760
[4] Scottish Government (2014) *Equally Well Review 2013* http://www.scotland.gov.uk/Resource/0044/00446171.pdf p15
[5] See http://www.livingwage.org.uk/

the line.[6] Another way of thinking about this is in terms of "social investment", whereby redistribution and welfare help to support people to participate fully in society.[7]

The March 2014 report from the Ministerial Taskforce into Health Inequalities emphasises the importance of building social capital, working with the third sector, communities co-creating and co-delivering services, harnessing community assets and place-based approaches.[8] Community-led health approaches have empowerment at their core, establishing the priorities of communities and, together with communities, developing ways of addressing these priorities. Moreover, community-led health organisations have the knowhow and experience when it comes to building the confidence and skills of people to enable them to take part in improving their health and the health of their communities. Community-led approaches help to tackle power inequalities that can only be challenged if people have control over their lives and what happens in their communities.

CHEX urges that the Public Health Review takes forward this message that tackling health inequalities needs to address wider social inequalities, and that community-led approaches should be part of upstream national measures to tackle inequalities. Indeed, we see community-led health organisations with adequate resourcing as having an essential role in ensuring that disadvantaged communities have control over how distant policy initiatives affect them. This will ensure people have the sense of control over their own lives that is essential to healthy lives and communities in Scotland.

The Public Health Review engagement paper states that the core question for the review is: "How can we be more effective in tackling health and social inequalities, and increasing healthy life expectancy in Scotland in a sustainable way?" CHEX strongly agrees that this is the right question to put at the heart of the review. If everyone who defines themselves as working in public health were to make this question the main focus of their work then we would have made a basic, yet important, step towards making public health's contribution to the challenges described the best it can be.

The flipside of this is that public health too often diverts its attention from prevention and social and environmental factors towards the lifestyles of individuals. NHS Health Scotland's health review for the Ministerial Taskforce on Health Inequalities argues that too much effort has been put into tackling the 'downstream' health effects of inequalities.[9] Strategies to tackle health inequalities, the review highlights, too often take the form of ameliorative health promotion campaigns, awareness raising and efforts to change behaviour. This 'lifestyle drift', the paper continues, is a

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[6] NHS Health Scotland (June 2013) *Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities* http://www.healthscotland.com/uploads/documents/23047-1.%20HealthInequalitiesPolicyReview.pdf, p44

[7] Expert Working Group on Welfare (2014) *Re-thinking Welfare: Fair, Personal & Simple* http://www.scotland.gov.uk/Publications/2014/06/7760 p37

[8] Scottish Government (2014) *Equally Well Review 2013* http://www.scotland.gov.uk/Resource/0044/00446171.pdf

[9] NHS Health Scotland (June 2013) *Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities* http://www.healthscotland.com/uploads/documents/23047-1.%20HealthInequalitiesPolicyReview.pdf, p10

common problem when public agencies try and implement health inequalities strategies.[10]

A potential strength of public health in Scotland is the growing recognition that promoting health and tackling inequalities is 'everybody's business' and not only the job of health services and providers. We would reinforce this given that health inequalities are rooted in wider socio-economic inequalities. For example: agencies and organisations working in regeneration, housing, employment and crime should be considered as public health partners. Crucially, third sector organisations are in a strong position to shape and implement services that improve health and tackle health inequalities. If we start from the acknowledgement by NHS Health Scotland that health inequalities have broad determinants and therefore need to be tackled in partnership across different sectors,[11] then the third sector's reach into so many diverse areas of life must be a crucial part of any way forward. As Voluntary Health Scotland (VHS) has argued, the third sector should be an equal partner in the new integrated health and social care landscape.[12] CHEX would add that community-led health, as part of the third sector, brings its own unique skills and reach into communities that can make a vital contribution to cross-sector work to tackle health inequalities.

Again, there is a flipside. A related threat to public health's ability to tackle inequality is that, despite the recognition that partnership is needed, too often in practice tackling health inequalities is seen as the preserve of the NHS. For instance, NHS Health Scotland has pointed out that *Equally Well* has failed to make the policy linkages between different government departments. For instance, policy on housing, the environment, community safety and employment all has a role to play in tackling health inequalities. Most resources for health and wellbeing have been channelled through the NHS.[13]

The review engagement paper states that: "for this function to be successful it needs to be delivered in partnership with individuals, communities, Scottish Government, local government, public, private and third sector organisations." For this to happen, CHEX recommends that public sector organisations outside health, the third sector and community organisations are all considered key partners in public health, as opposed to organisations that public health engages with. Similarly, they should be viewed as co-planners and not solely as delivers of services. Otherwise, there is a risk that public health does not take not take the holistic approach necessary to tackle social, economic and health inequality in Scotland

[10] *Ibid*, p18
[11] *Ibid* p41
[12] See VHS (2014) Submission to Scottish Labour's Health Inequalities Policy Review http://www.vhscotland.org.uk/wp-content/uploads/2014/05/VHS-Submission-Health-Inequalities-Review-May-2014.pdf p3
[13] *Ibid*

2) How can public health leadership in Scotland be developed to deliver maximum impact?

CHEX acknowledges that national bodies such as the Scottish Government and special NHS health boards must take a lead in public health partnership work. However, we would also emphasise that effective leadership needs to be taken at all different levels and across every different policy area. For instance, local authorities, geographic health boards, community planning partners and voluntary and community sectors all require leadership to bring their respective organisations/sectors into the fold as proper public health partners. In addition, leadership is required at middle management level, and at practitioner level, in order that forward thinking public health policies are implemented. In this regard, leadership is clearly more about being 'champions' that inspire and motivate others rather than being at the top of hierarchical structures.

Leadership attributes required – and valued by community-led health organisations we consulted while preparing this response – are as follows: a clear, strong vision; a commitment to social justice and tackling inequality; an understanding of, and willingness to embrace, partnership and participatory approaches such as asset-based methods and co-production; ability to facilitate rather than instruct; to be accountable to local communities; and a willingness to confront resistance to partnership, preventative and participatory approaches.

In our *Community-led Health for All*[14] resource, CHEX has developed a set of competencies necessary to promote and support community-led health approaches and enable them to affect significant change in health inequalities. They are relevant to wider efforts to tackle health inequalities, particularly those leading in public health. The competencies are:

- Knowing and understanding the community in which we work.
- Building and supporting groups and relationships.
- Building capacity to take action on priority health issues.
- Building equality and tackling inequalities.
- developing and supporting collaborative working
- developing and supporting sustainable influence.

These skills are particularly called for given the current policy environment emphasising the importance of prevention, partnership, participation and performance in efforts to improving our public services and the health and wellbeing of people in Scotland. The Christie Commission,[15] the Scottish Government's response to Christie,[16] the integration of health and social care[17] and the Community

[14] http://www.chex.org.uk/what-we-do/information-and-resources/chex-publications/community-led-health-all-learning-resource/

[15] Commission on the Future Delivery of Public Services in Scotland (2011) *Report on the Future Delivery of Public Services* http://www.scotland.gov.uk/Resource/Doc/352649/0118638.pdf

[16] Scottish Government (2011) *Renewing Scotland's Public Services: Priorities for Reform in Response to the Christie Commission* http://www.scotland.gov.uk/Publications/2011/09/21104740/0

[17] Scottish Parliament Bill (2013) *Public Bodies (Joint Working) (Scotland) Bill* http://www.scottish.parliament.uk/S4_Bills/Public%20Bodies%20%28Joint%20Working%29%20%28Scotland%29%20Bill/b32s4-introd.pdf

Empowerment (Scotland) Bill[18] can all be seen as contributing to, and being reflective of, a consensus that people and communities should be at the heart of reshaping public services.

3) How do we strengthen and support partnerships to tackle the challenges and add greater value. How do we support the wider public health workforce within those partnerships to continue to develop and sustain their public health roles?

Many of the partners in wider public health are statutory agencies/bodies, such as local authorities, community planning partnerships, education institutions and frontline health workers. It is crucial that the Scottish Government and core public health bodies do all that is possible to ensure that these agencies and professionals understand, value and contribute to public health and, in particular, tackling inequalities. Information, resources and training are needed to help public services shift away from a centrally-driven service supply model to an enabling model, supporting and working alongside community organisations, local interest groups and wider communities to create a more participative, empowered and healthier Scotlan. This could build on a growing interest amongst public health partners in co-production, asset-based approaches and participative democracy.

The community-led health competencies would be a helpful resource in this regard. The competencies are applicable to both strategic managers and practitioners in sustaining good practice in community development approaches to improving health and tackling health inequalities. They link to workforce development frameworks/skills development programmes in public health, regeneration, community learning and development and community engagement and illustrate their value in practice examples at strategic and operational levels.

Through our consultation work for this response, community-led health organisations have told us that people in local communities are sceptical about health interventions, which appear to come and go without making a difference. CHEX feels strongly that the third sector, including community organisations, has a key role to play in tackling health and social inequalities, given their experience and expertise at working in and with disadvantaged communities. The community and voluntary sector is not only invaluable as a bridge between services and professionals on the one hand and communities on the other. It is well-equipped to be a central partner in engaging and empowering disadvantaged communities to participate in addressing the inequalities that affect them.

However, in order to fulfil this role, voluntary and community organisations must be adequately resourced. Many such organisations are already competing for reduced funding sources at the same time as they increasingly have to deal with the social/human costs of cut backs to public services. This sector has demonstrated through an established evidence base[19] that it has a significant contribution to offer

[18] Scottish Parliament Bill (2014) *Community Empowerment (Scotland) Bill* http://www.scottish.parliament.uk/S4_Bills/Community%20Empowerment%20%28Scotland%29%20Bill/b52s4-introd.pdf

[19] http://www.scdc.org.uk/what/community-ledhealth/

in terms of preventative and collaborative approaches, bringing people together to build community confidence, skills, influence and, ultimately, health. But it does require to be adequately resourced.

4) What would help to maintain a core/specialist public health resource that works effectively, is well co-ordinated and resilient?

And

5) How can we provide opportunities for professional development and workforce succession planning for the core public health workforce?

CHEX believes that the effectiveness, and professional development of a core public health resource cannot be treated separately from the issues of wider partnership and community participation. To be effective and co-ordinated in tackling health and social inequalities, all partners in public health must understand and be willing to embrace preventative, collaborative and participatory approaches to tackling inequalities. Policy developments along these lines such as Christie, the Community Empowerment (Scotland) Bill and the integration of health and social care have already been mentioned here, as have asset based-approaches and co-production. Other relevant developments are the Ministerial Taskforce into Health Inequalities and Scotland's National Action Plan on Human Rights (SNAP) which emphasises participation, accountability, non-discrimination and empowerment.

Many in both the core-public health and wider public health workforce are in a position to deliver or at least support the implementation of these policies. These include: those in health improvement, academic public health specialists, those in community planning, patient focus:public involvement workers, link workers within the third sector and primary care staff. Despite many having an interest in in working with communities in a preventative, participatory way, many also have limited experience of community work. CHEX's consultation work around the public health review has also identified a concern that those in fields related to public health too often continue to work in the same way, not wanting to be seen to 'rock the boat' and lose funding. We need to support the core and wider public health workforce to share experiences with one another around: helping communities to identify and take action on health issues that affect them; building equity, inclusiveness, participation and cohesion amongst people, their groups and organisations; and empowering people to work with service providers to influence and co-produce services.

Through our consultation, CHEX members have recommended how best to facilitate the sharing of such knowledge and expertise. The value of having open, 'safe' conversations allowing people to be honest about what works and what doesn't has been highlighted. Another practical suggestion put forward is the integration of offices for different partners involved in public health, including public and voluntary sector staff. Lastly, those with specialist roles need to be willing to listen to, and learn from, the skills and knowledge of those in different roles/sectors.