

# Delivering health and wellbeing through the voluntary and third sectors in rural areas

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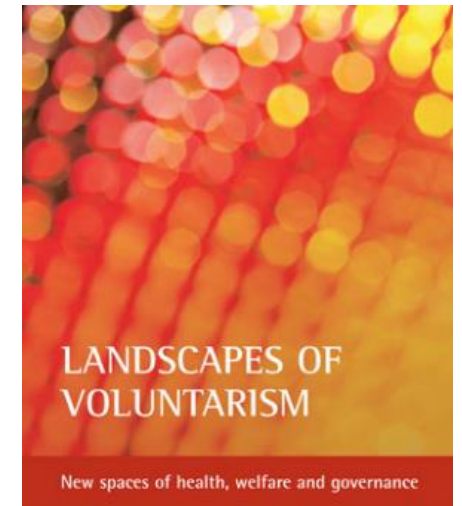
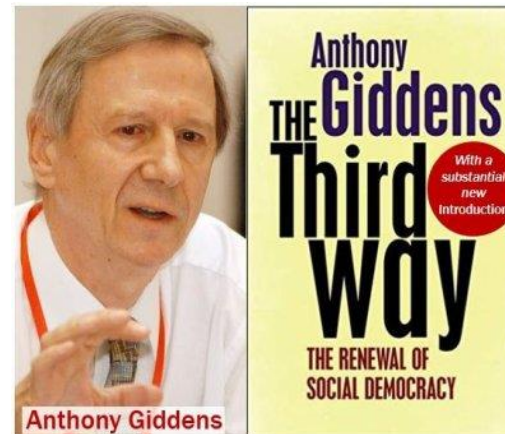
# Overview of the presentation

- ▶ What is the link between health, wellbeing and the voluntary and third sectors?
- ▶ Why does this link matter to communities, service providers, policy makers and academics?
- ▶ How is this link conceptualised differently by the actors and stakeholders involved in, and affected by, the relationship.
- ▶ What does all this mean for remote and rural communities?
- ▶ What are some of the challenges, opportunities and research gaps that we should be thinking about?
- ▶ Examples from the research evidence base.



# the link between health, wellbeing and the third sector

- ▶ My interest in this topic started in around 2007 (12 years ago)
- ▶ Brown had just become Prime Minister – after ten years of a labour government
- ▶ The influence of the Third Way and Anthony Giddens
- ▶ Increasing research interest from 1997 + in delivery of public services by non-state providers
- ▶ Academics start to consider geographies of voluntarism and social enterprise



# the big questions

- ▶ Do/can third sector organisations deliver health and care services that used to be provided by the state (from provider to commissioner)?
- ▶ Can this happen in rural areas (economies of scale, market failure)?
- ▶ What are the impacts of this for remote and rural residents and communities?
- ▶ Does this kind of delivery (particularly through social enterprise) have additional or add-on wellbeing benefits?
- ▶ Do social enterprises and other types of third sector organisation generate wellbeing in rural communities?
- ▶ If so, how do they generate wellbeing? What does this wellbeing look and feel like?



# the link

- ▶ Third sector organisations provide health, care and wellbeing services.
- ▶ Third sector organisations facilitate wellbeing indirectly through their activities (for individuals and communities).

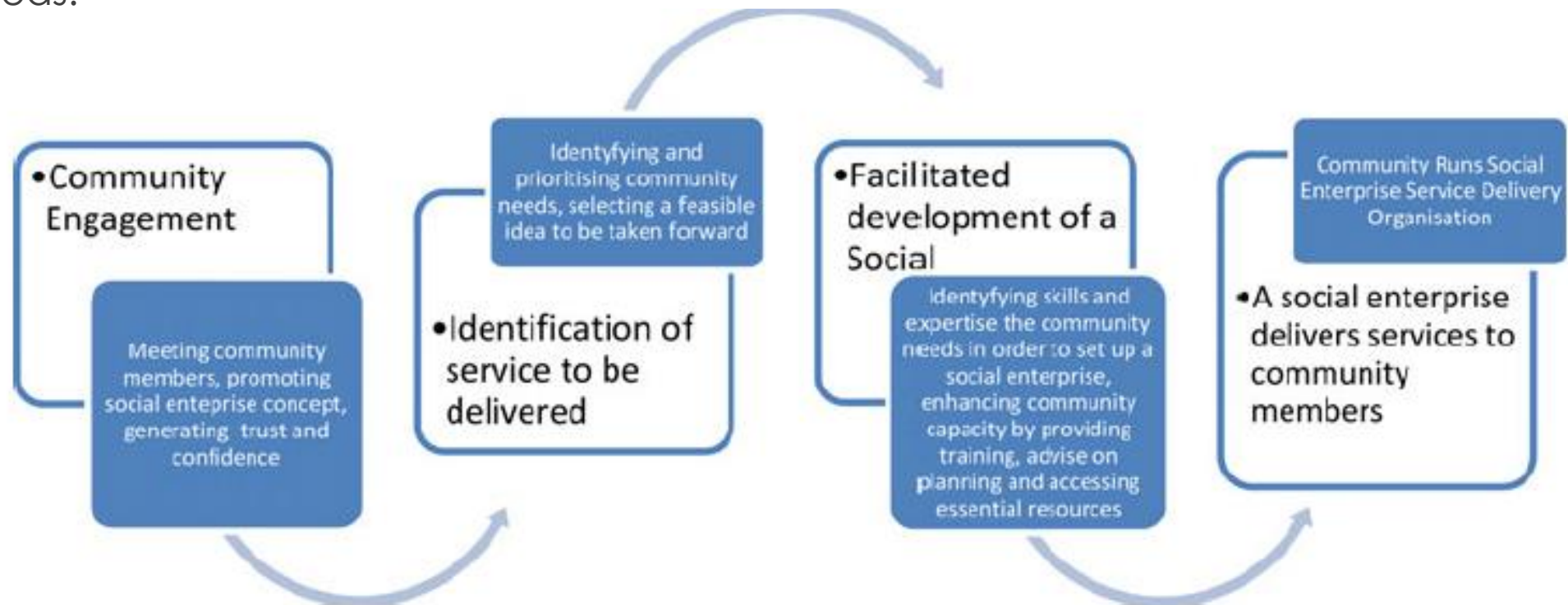


# why does it matter?

- ▶ Services provision, efficiency and suitability.
- ▶ Public sector budgets and austerity.
- ▶ Policy that encourages community involvement and co-production.
- ▶ Policy that encourages preventative spend, e.g. let's keep people healthy and out of hospital.
- ▶ Increasing evidence that non-pharmaceutical interventions work.
- ▶ People enjoy engaging with third sector organisations and their activities.
- ▶ People increasingly recognise that community activities can contribute to 'staying well'.
- ▶ Wellbeing can help communities thrive and survive.

# Provision of services

- ▶ Third sector organisations can, and do, provide health, care and wellbeing services in rural areas.



### Capability

Resources that facilitate physical and social mobility; enabling the abilities and skills to lead a flourishing and satisfying life; helping to overcome or tackle issues of discrimination and stigmatisation

### Security

Resources that increase understanding of, and offer protection from, contemporary social and environmental risks

## Spaces of Wellbeing

### Integration

Resources that facilitate embeddedness in networks of social relations that, especially at the local scale, can build self-esteem and mutual valuing

### Therapy

Resources that help with physical, mental and emotional healing



# Social Prescribing

- ▶ Social prescribing – a way of linking patients in primary care with sources of support within the community to help improve their health and wellbeing (Bickerdike et. al., 2017).
- ▶ Despite clear methodological shortcomings, most evaluations presented positive conclusions (Bickerdike et. al., 2017).
- ▶ Community-based arts groups that are professionally facilitated may provide a therapeutic environment for participants: feeling accepted; gaining a sense of social belonging (Stickley and Hui, 2017).
- ▶ Emerging evidence suggests that SP holistic interventions can contribute to improvement in patient wellbeing, reduction in anxiety and depression and attendance at GP surgeries (Kimberlee, 2015).
- ▶ Stakeholders...perceived that social prescribing increased patients' mental wellbeing and decreased health service use (Kilgarriff-Foster, 2015).

# Challenges for rural

*The qualitative analysis showed that community members identified some positive aspects of being involved in service co-production, relating to sense of community, empowerment and personal satisfaction. However, negative impacts included increased feelings of **pressure, strain and frustration** among those who took part in the co-production process. Overall the community was reluctant to engage with 'transformative' co-production and **traditional provider-user dynamics were maintained.***

*(Munoz, 2013)*

# Challenges for rural

Dr Carolyn Wallace, Judith Stone and Dr Sally Rees (2018)

- ▶ These third sector community and neighbourhood groups are what Welsh Government are calling community assets and the key to maximising the value of care and sustaining our NHS services.
- ▶ But, they face inequality in the workplace (where occasionally they are not recognised as part of the multi-agency team)
- ▶ Short term funding focused on referrals as opposed to the whole of the social prescribing journey.
- ▶ Local community and neighbourhood organisations struggle to survive. They provide these services often free of charge through volunteers or reduced charges subsidised through charitable moneys they have to actively raise. They battle daily with finances, wondering if contracts are going to be renewed due to cuts in public funding, facing clients when services are suddenly discontinued, juggling funds or closing the charity or group when larger organisations don't pay invoices on time.
- ▶ ***If social prescribing is indeed part of the answer to sustaining our health and social care services for the future, the question we must ask is how can we shift funds to build and sustain the community and neighbourhood assets which receive and resolve the referrals which are at first presented in primary and secondary care or in social services?***

Thank you for listening

