NEW LOCAL

A COMMUNITY-POWERED NHS

Making prevention a reality

Adam Lent, Grace Pollard and Jessica Studdert

We need the same imagination and ambition as when the NHS was created 74 years ago, to renew it for the health challenges of today. This means pushing outside all of our professional comfort zones to shake up the boundaries between mental and physical health, GPs, acute and wider local services, putting the community at the heart of a new system. This report achieves just that - setting out a much-needed new vision for a community-powered NHS that should be a rallying call for everyone invested in creating better health for all."

Prof Donna Hall, Chair, New Local & Bolton NHS Trust

As chair of an ICS I was inspired by this fantastic piece of work and will want to read it again and again. My belief is that it will be of significant value across the country, as it will serve to provoke, catalyse and challenge the mindsets of leaders across healthcare systems as we enter a new phase of integration – including my own."

Raj Jain, Chair, NHS Cheshire and Merseyside Integrated Care Board

At a time when the NHS faces immense challenges, more of the same will not be sufficient. Now is the time to work differently by devolving responsibility for decisions and engaging people and communities in work to improve health and care. The case for community power is compelling and this report showcases examples of where this is already happening. It also offers practical guidance on how to bring community power into the mainstream of the NHS."

Prof Chris Ham, Co-Chair NHS Assembly

New Local is an independent think tank and network with a mission to transform public services and unlock community power.

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Thank you also to the King's Fund and the attendees at our joint event on how ICSs can improve health outcomes and reduce inequalities. In addition, we are grateful to all who participated in a range of other New Local facilitated sessions over the course of this project. These events and workshops helped to shape our thinking on the practical opportunities for ICSs to work alongside communities and the support needed to help those working across the system make this a reality. We would particularly like to thank Professor Donna Hall, Claire Kennedy, Chris Ham, and Raj Jain for sharing insightful feedback on an early draft of the report.

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Any errors or omissions are those of the authors alone.

Adam Lent, Grace Pollard and Jessica Studdert

EXECUTIVE SUMMARY

The NHS at risk

The National Health Service was founded on a single principle: healthcare would be universal and free at the point of care. Today that principle is under threat as never before.

Demand for healthcare has grown for many years leading to unsustainable pressures on NHS services. The elective care backlog was 6.48 million in April 2022,[1] but had already reached 4.4 million people before the pandemic.[2] Many other areas of healthcare face significant demand challenges, including primary care, mental health and social care. Put simply, there is far too much ill-health for the NHS to treat in anything like a timely and safe fashion with its current level of resource.

This demand crisis is now threatening the founding principle of the NHS. As a proportion of GDP, Britons now pay almost as much as Americans on out-of-pocket healthcare spending while the poorest 20 per cent of households have increased their spend on hospital costs by over 100 per cent in the last decade.[3]

This move away from free healthcare is compounded by growing fiscal strain. Analysis based on projections from the Office of Budget Responsibility (OBR) suggests that health spending could increase from 7.3 per cent of GDP pre-pandemic to 9 per cent of GDP by the end of this decade.[4] This risks becoming politically unsustainable as other parts of state spending lose out or extra pressure is placed on taxpayers already struggling with a troubled economy.

1 'NHS backlog data analysis'. BMA. (based on NHS England Consultant led referral to treatment waiting time statistics). https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis (Accessed 24/06/22).

2 *Delivery Plan for Tackling the COVID-19 Backlog of Elective Care*. (2022). NHS England.

3 John Burn-Murdoch. 'UK healthcare is already being privatised, but not in the way you think'. The Financial Times. (28 April 2022).

4 Shah, K., Smith, J. and Tomlinson, D. (2022) *Under Pressure: Managing fiscal pressures in the 2020s*. Resolution Foundation.

Sooner or later, policymakers will have to seek a way out of this fiscal quagmire and without a radical shift in how we approach healthcare, there is a real risk that will mean rationing provision or the phasing in of charging for treatment.

The limits of traditional public service paradigms

It is very widely accepted that the only sustainable solution to the demand crisis is to move away from the NHS's very strong focus on treating illness when it arises to a focus on preventing illness from developing in the first place. But since its foundation, the NHS has been shaped by two paradigms that strongly reinforce the former acute response rather than a prevention approach. These are the state paradigm and the market paradigm (summarised in the table below). Neither reckoned with the growth in demand. Nevertheless, they maintain their firm grip on how healthcare is delivered, reinforcing an organisational culture and set of practices that treats acute response as the overwhelmingly central aspect of the NHS's role while marginalising efforts to prevent demand occurring in the first place.

Enabling a meaningful shift to prevention that can reduce demand over the long-term in a humane and sustainable fashion will require a shift to a new community paradigm (summarised in the table on the following page).

Three NHS paradigms: state, market and community

The NHS	State paradigm	Market paradigm	Community paradigm
Key organisational principle	Standardisation	Efficiency	Prevention
Key problems seeking to solve	Treating illness	Treating illness more efficiently	Preventing illness, alongside treatment when needed
Locus of power	Clinician and Whitehall bureaucrat	Clinician and manager	Clinician and community
View of service user	Deficit-led: primarily a passive patient	Transaction-led: a customer with choice determined by provider	Asset-led: a participant in their own health and wellbeing
View of communities	Not in the purview of services	A source of treatment alternatives through social prescribing	Equal partners with deep insight into effective service response
Implementation method	Top-down, uniform model of provision	Targets, performance management and productivity drives	Devolution, culture change and deep community engagement
Organisational relationships	Separate specialist organisations	Competition between organisations	Collaboration and shared community-led mission across organisations
Funding model	Centrally planned funding model	Activity-based funding model	Place-based funding allocations, joint investment in prevention
Accountability	Whitehall	Whitehall, across an increasing number of arms-length bodies	Local accountability in the context of a national outcomes framework
Approach to engagement	Not widely pursued	Patient feedback sought through closed surveys	Community participation viewed as essential to service design
Attitude to data	Quantitative data informs decision-making at the top	Quantitative data informs performance management within different services	Quantitative data, combined with qualitative community insights, informs prevention shift

A new community paradigm

The community paradigm is based on the principle that communities themselves have valuable insights into their own circumstances and what they need to thrive. Communities should therefore be able to exercise genuine influence and where possible direct control, over the decisions, resource and services that support their lives.

Proper prevention is impossible without active, participating individuals and communities. This is because prevention is not something that can be *done to* people in the traditional service delivery sense, rather it must be *achieved with* them. This means health institutions need to be capable of working alongside communities, responding to their insights, and investing in them so they can actively participate in shaping better places and services.

This much more outward-facing, community-led approach enables three profound shifts we identify as needed to move from today's acute response approach to prevention.

The first is the shift towards healthcare which is much more capable of understanding a person's context beyond the specific condition they present. As one evidence submission to this report reflected this is about the workforce being able to "look at individuals holistically and understand that they are not defined by ill health".[5] Only in this way can healthcare bodies work with individuals and their wider networks of support to keep them healthy rather than just treat their illness.

The second shift is towards recognising the individual as an active participant in their own health outcomes. A very great deal of the work of prevention must be conducted by individuals themselves in the absence of the healthcare professional. This means a far greater emphasis on empowering individuals within the context of wider communities of support.

Thirdly, there needs to be a shift in the role healthcare bodies play in addressing the social determinants of health. The evidence is strong

5 Evidence submission – Wigan Council.

that stressful personal circumstances, isolation, poor housing and poverty are major causes of ill-health.[6] Equally, the local environment within which someone lives also has a major bearing. Air pollution, lack of green space, high incidence of violent crime, unsafe roads and a host of other environmental factors will clearly increase the likelihood of ill health very considerably for those who live in those areas. Addressing these factors requires healthcare bodies to work directly with the communities affected by these social and environmental conditions.

All three of these shifts require a fundamentally different mindset and set of practices for health institutions and the professionals working within them – away from mostly treating ill individuals within the hospital or clinic and towards working outside the healthcare institution with communities and partners to address the underlying causes of ill health.

The community power paradigm in practice

The features of a community-powered approach cannot be reduced to a single rigid model. The organisations already adopting community power are making it their own - rooting it in the unique aspirations and priorities of their communities. Nevertheless, it is possible to discern three broad principles that underpin the adoption of community-powered approaches.

Principle One: Community participation in decision-making

Engaging communities more deeply in the strategic decisions that affect their lives is a trend of growing importance across the world as well as in the UK.[7] A key feature of this engagement is that it is deliberative and consensus-building, based on techniques such as citizens' assemblies but incorporating a range of other more or less formal approaches. This now needs to become a core part of how Integrated Care Systems (ICSs) make decisions as systems.

6 Marmot, M. et al. (2010). *Fair Society, Healthy Lives: The Marmot Review. Strategic Review of Health Inequalities in England post-2010*.

7 See *Innovation Citizen Participation and New Democratic Institutions: Catching the deliberative wave.* OECD. https://www.oecd.org/gov/innovative-citizen-participation-and-new-democratic-institutions-339306da-en.htm (Accessed 24/06/22).

There are two reasons for this. First, it cannot be said in any meaningful fashion that healthcare institutions are really handing more influence to communities if the big strategic decisions that shape our healthcare are still taken deep within institutions by groups of officials or clinicians. Secondly, such engagement can also play a more specific role in the move to a preventative approach. It has the power to generate exceptionally useful knowledge from within communities when designing and implementing prevention strategies.

Principle Two: Mobilising community assets

It is self-evident, given the role of active communities in prevention that a genuinely prevention-focused NHS would understand that it had a central role in mobilising community assets. Community assets vary widely in nature from place to place but broadly include the detailed local understanding of people within communities; voluntary activity and grassroots action; pre-existing and potential networks of peer support and information-sharing such as faith communities, sports clubs and hobby groups; and buildings, space and local institutions such as schools, parks, pubs or community centres that are used and trusted by communities. Involving communities in this way is highly context specific. It is thus difficult to generalise about what that involvement might look like, but extensive case studies are presented in the report.

Principle Three: Growing a community-focused organisational culture

Organisational culture change is particularly important for a shift to a community-powered approach because of the diversity and unpredictability of solutions and challenges that the approach tends to generate. This means that community-powered organisations need to act and think in ways that can respond positively to such creative opportunities.

In addition, the evidence from bodies moving to a community-powered approach is that the biggest obstacle by far to change is existing organisational culture which tends to favour hierarchy, risk-aversion, wariness of engagement with communities and a very strong focus on professionalised acute response.

Creating a community-powered NHS

There are many inspiring initiatives to move towards a community-powered approach in the NHS. However, these currently operate on the edges of the system outside the prevailing state and market logic. As Integrated Care Systems take shape, there is an opportunity to embed a community paradigm throughout the system, but this cannot be guaranteed given the power of previous paradigms. There will need to be a series of steps taken at both national and local level to enable the shift to a truly community-powered NHS.

1. The role of national bodies: from command and control to permission and adaptation

1.1. Government and NHS national leadership should commit to a ten-year moratorium on any further imposed structural reform within Integrated Care Systems to let community-focused relationships and culture embed.

1.2. Government and NHS national bodies should commit to stop initiating short-term pilots as a method of change, and instead focus on developing continuous improvement mindsets and supporting peer learning exchange around community-powered prevention.

1.3. National bodies should reduce their over-reliance on single-service performance targets as ICSs collectively define place-specific objectives with the help of their local communities.

1.4. The Government should set out a clear cross-Whitehall plan to shift the centre of gravity of our health system towards prevention and address the wider determinants of health across all policy areas.

2. The role of systems, places and neighbourhoods: From separate organisations to mission-driven collaboration for community power

2.1. Proactively build in the voice and representation of communities to decision-making.

2.2. Give parity to the value of community expertise alongside clinical and professional expertise in strategic planning and service design.

2.3. Ensure that equity, diversity and inclusion strategies are not an add-on, but are core to ensuring that both leadership and the wider workforce embodies the lived experience of communities.

2.4. ICSs should be a starting point for an equal relationship between health partners and local government, with the role and assets of councils recognised as essential for effective prevention.

2.5. Recognise culture as a key enabler that can shift institutional behaviour, and ensure it is a strategic priority for leaders to actively foster a culture conducive to collaboration with communities.

2.6. A strong system-wide vision and an active workforce development plan should focus on building the behaviours and skills required to work with communities as equals.

2.7. Recognise the potential of primary care networks to catalyse the shift from deficit-based to asset-led working with communities.

2.8. Improve data standards to recognise the value of qualitative data alongside quantitative metrics to inform service design.

2.9. Use data to mobilise communities around the challenge of health inequalities.

2.10. Use the fourth ICS ambition which sees a role for the NHS to support broader social and economic development as an opportunity to reduce health inequalities by addressing the wider determinants of health outcomes.

2.11. Integrated Care Boards should commit to shifting a proportion of budgets from acute care to community-led prevention at system and place level, and grow this over time as collaboration matures.

2.12. Create a level playing field for VCS and service user groups in the procurement of healthcare services while requiring those groups to commit to ensuring diversity and wide community representation.

1. THE NHS AT RISK

Our National Health Service is facing a demand crisis that is placing its foundational principles at risk. The day-to-day impact of growing demand pressures are experienced daily by patients and NHS employees. There is far too much ill-health for the NHS to treat in anything like a timely and safe fashion with its current level of resource. The result is growing waiting lists, deteriorating quality of care and a stressed workforce with many leaving healthcare professions, and not enough people joining.

This demand crisis is systemic in nature. It would be wrong, for example, to see it as a short-term consequence of the Covid pandemic. In fact, the pandemic simply exacerbated a long-term rise in pressure on our healthcare services. For example, the elective care backlog was 6.48 million in April 2022,[8] but had reached an already significant 4.4 million people before the pandemic.[9]

Access to care and treatment has become increasingly constrained over the years. During austerity, despite relative "protection" of health budgets compared to other services, funding has not kept pace with demand pressures and people are experiencing increasingly long waits as a consequence. Since 2012, the proportion of people waiting in A&E for more than four hours has increased from around 7 per cent to just under 40 per cent, and the proportion of cancer patients being treated after a GP referral has decreased from around 87 per cent (exceeding the 85 per cent target) to around 67 per cent.[10]

Yet there is evidence of growing unmet demand reaching back further beyond the last decade. Despite higher levels of funding during the 2000s producing shorter waiting times and improving overall quality of care, there were still identified gaps in equity of access, for example

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8 'NHS backlog data analysis'. BMA. (based on NHS England Consultant led referral to treatment waiting time statistics). https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis (Accessed 24/06/22).

9 *Delivery Plan for Tackling the COVID-19 Backlog of Elective Care*. (2022). NHS England.

10 Baker, C. (2022). *NHS Key Statistics: England, February 2022*. House of Commons Library.

there continued to be a higher concentration of GPs in more affluent areas.[11] Improvements in acute services from investment had arguably dominated policy, with less success in responding to an identified public appetite for more community-based care, and a growing prevalence of some conditions like obesity[12] and mental ill health[13] to which services proved less responsive.

There is now a high risk of abandonment of the founding principles that underpin the NHS, of healthcare provided to everyone free at the point of use.

From the standpoint of today, the cumulative impact of the demand crisis is potentially existential for the NHS. The data presented above shows that it is increasingly difficult for services to deliver universal healthcare to people when they need it. There is now a high risk of abandonment of the founding principles that underpin the NHS, of healthcare provided to everyone free at the point of use. This can happen by *default* or *design*.

The *default* route is an erosion of the notion of universal and freely available healthcare, as the public becomes gradually used to rationed services and the need to pay, in one form or another, to receive adequate care. As demand rises, rationing of public provision and informal but increasingly common recourse to private forms of healthcare amongst those who can afford it gradually expands without any single significant break. We would reach a point where a two-tier, rationed NHS simply becomes a concrete reality accepted and largely unquestioned by voters or policymakers. Indeed, one could make a strong argument that we are already some way down the track of this default route.

There are signs of a growing number of patients abandoning the NHS for private healthcare and paying to receive the full care they need. Analysis has shown that the UK is the G7 nation with the fastest rise in healthcare expenditure from private personal or voluntary insurance sources: this has quadrupled since 1980.[14] As a proportion of GDP, Britons now pay almost as much as Americans on out-of-pocket healthcare spending while the poorest 20 per cent of households have increased their spend

11 Thorlby, R. and Maybin, J. (eds.) (2010). *A high performing NHS? A review of progress 1997-2010*. Kings Fund.

12 Ibid.

13 'Mental Health'. The King's Fund: https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-mental-physical-health (Accessed 24/06/22).

14 Thomas, C. et al. (2022). *The State of Health and Care 2022*. IPPR.

on hospital costs by over 100 per cent in the last decade.[15] Despite confirming widespread support for the principles of the NHS, IPPR/YouGov polling from November 2021 emphasises the risk of future opt out.[16] This found that only 10 per cent of people wouldn't access private treatment if access to NHS care fell below a certain standard – another 17 per cent indicated they wouldn't because they couldn't afford it.[17] There is also a risk the rise in use of private sources could increasingly affect publicly funded healthcare capacity: polling for The Times found that while a record 1.6 million used a paid-for GP in the two years to 2022, half of GPs surveyed said they would consider private work for an online service.[18]

The *design* route is the result of deliberate decisions by policymakers in response to the demand crisis. This would include the significant expansion of charging for services to both help fund the NHS and suppress demand. It would also likely involve more explicit decisions to ration care taken either at a political level or within the hierarchy of NHS England. Such decisions may be justified by policymakers on apparently moral or even health grounds – such as limiting treatment for those with supposedly self-inflicted conditions such as drug, alcohol or smoking-related illness – but the intention and effect will be to reduce demand and hence the pressures on acute services.[19]

There are signs that conditions are emerging that would enable the design route to develop. There is evidence of declining public satisfaction with the NHS - a British Social Attitudes survey in March 2021 found that it had fallen to 36 per cent. This is an unprecedented 17 percentage point decrease on 2020, and the lowest level recorded since 1997 when satisfaction levels were at 34 per cent.[20] Although there is clear evidence that the declining satisfaction is a symptom of the demand crisis (people report waiting times and staffing shortages as main reasons), some media commentators have used the data to question the efficacy

15 John Burn-Murdoch. 'UK healthcare is already being privatised, but not in the way you think'. The Financial Times. (28 April 2022).

16 Thomas, C. et al. (2022). *The State of Health and Care 2022*. IPPR.

17 The standard being exceeding the 18 week wait for GP referral for non-urgent treatment.

18 Lay, K. et al. 'Huge rise in patients turning to private GPs'. The Times. (27 May 2022).

19 For a discussion of this, see Edwards, N. et al. (2015). *Rationing in the NHS*. Nuffield Trust.

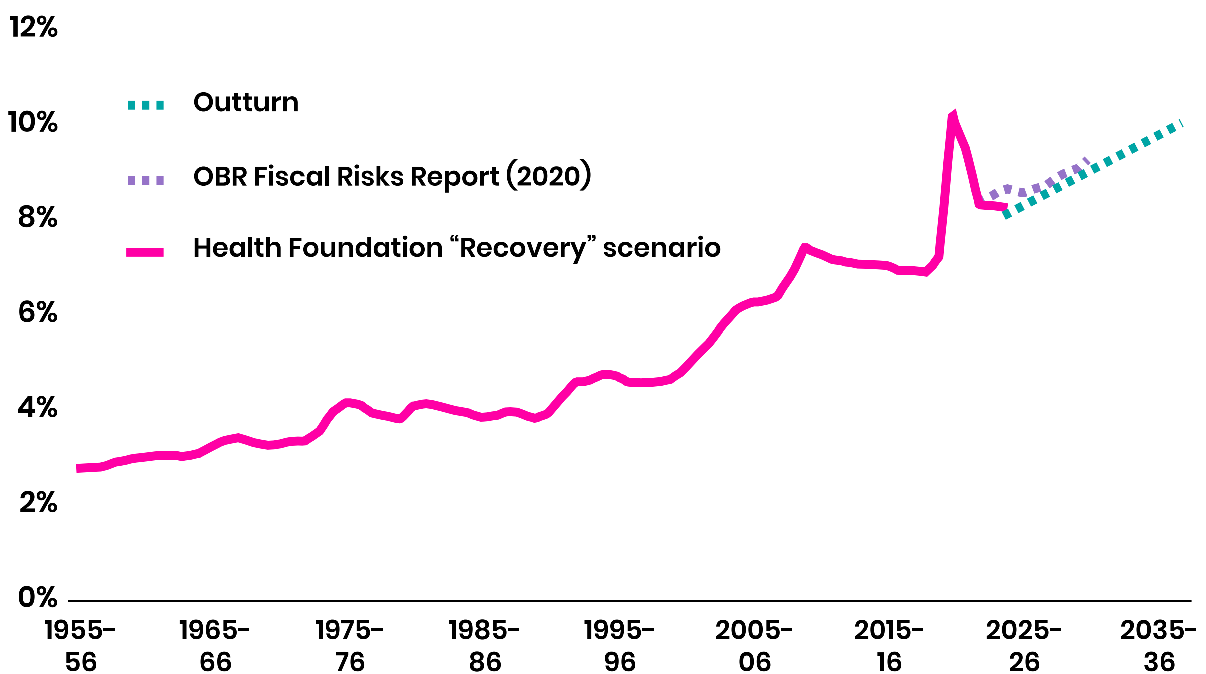
20 British Social Attitudes Survey 2021. NatCen Social Research. For analysis see: Wellings, D. et al. (2022). *Public Satisfaction with the NHS and Social Care in 2021: Results from the British Social Attitudes Survey*. Nuffield Trust and the King's Fund.

of the NHS and moot the idea of incentivising private provision growth.[21] There is a risk a growing number of voices within Westminster think tanks, the mainstream media and MPs begin advocating these policy shifts.

These political pressures are compounded by growing fiscal pressures. Current forecasts show that health spending is likely to face significant long term upward pressure due to demographic changes and rising costs of medical treatments. Analysis by the Resolution Foundation, based on projections from the Office of Budget Responsibility (OBR) suggest that health spending could increase from 7.3 per cent of GDP pre-pandemic to 8.4 per cent in 2022-23, and up to around 9 per cent of GDP in 2030-31,[22] potentially reaching 10 per cent by the end of the 2030s.

Figure 1: Health spending could reach 10 per cent of GDP by late-2030s

Outturn and projected spending on health and as a share of GDP: UK



*This graph is reproduced from Shah, K., Smith, J. and Tomlinson, D. (2022) *Under Pressure: Managing fiscal pressures in the 2020s*. Resolution Foundation.

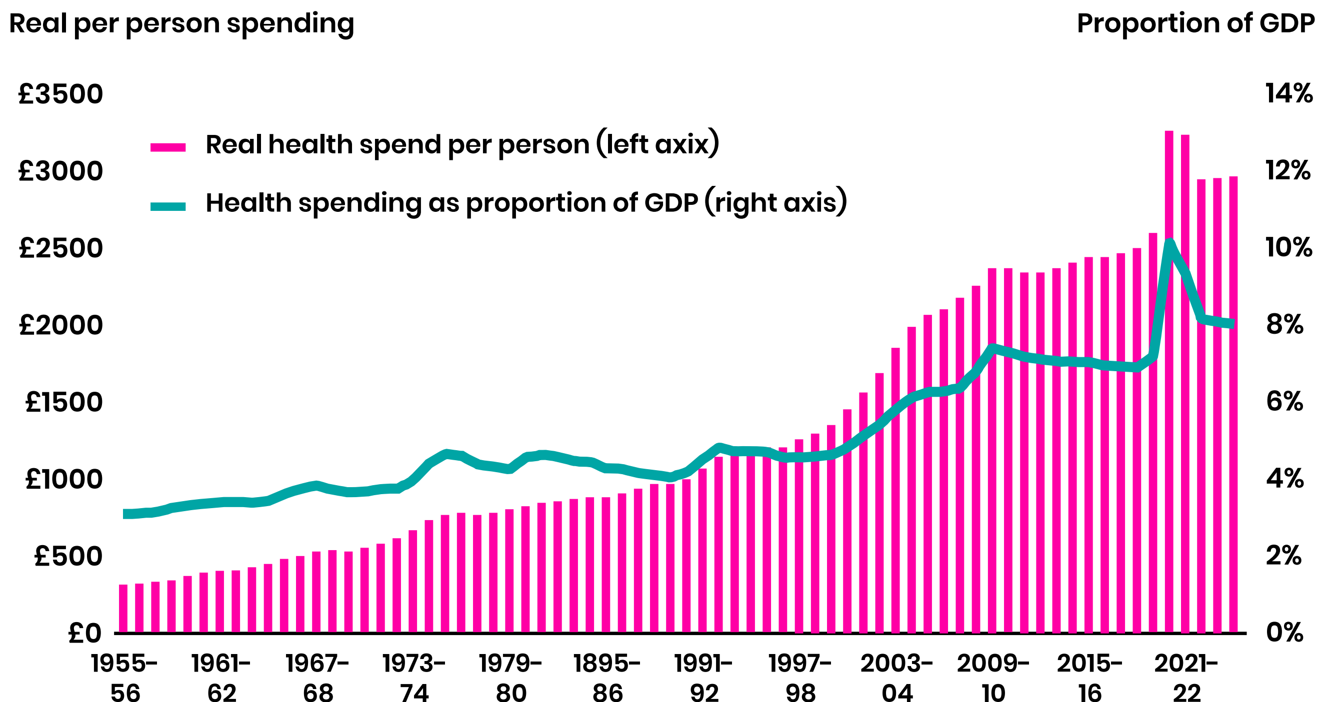
NOTES: Devolved health spending assumed to grow in line with health spending in England from 2021-22 to 2024-25.
SOURCE: Analysis of OBR, Economic and Fiscal Outlook, October 2021; OBR, Fiscal Risks Report, July 2020; HM Treasury, Autumn Budget and Spending Review 2021, October 2021; HM Treasury, Public Expenditure Statistical Analyses 2020, July 2020.

21 Kate Andrews. 'Normal people are paying the price for NHS failures'. The Spectator. (1 April 2022). https://www.spectator.co.uk/article/nhs-failures-are-forcing-people-to-go-private (Accessed 24/06/22).
22 Shah, K., Smith, J. and Tomlinson, D. (2022) *Under Pressure: Managing fiscal pressures in the 2020s*. Resolution Foundation.

To set this in a broader historical context, health spending as a proportion of GDP will have tripled between 1955-56 and 2024-25. As the Resolution Foundation set out compellingly, in previous decades this increase in the overall proportion of public spend dedicated to health has been managed using measures such as increasing the tax base as incomes have risen, and decreasing national defence spend over the post-war decades. These measures have diminishing returns in the 2020s, with low defence spending despite increased global threats and stagnating real terms wages combined with a rising cost of living.

Figure 2: Health spending has almost tripled relative to GDP, and risen ninefold in real per person terms since 1955-56

Real (2020-21) terms per person spending on health and as a proportion of GDP: UK, 1955-56 to 2024-25



*This graph is reproduced from 8Shah, K., Smith, J. and Tomlinson, D. (2022) *Under Pressure: Managing fiscal pressures in the 2020s*. Resolution Foundation.

NOTES: Total health spend is assumed to grow the same rate as TDEL for the Department of Health and Social Care in Spending Review 2021. Values are deflated using the OBR's GDP deflator.
SOURCE: Analysis of HMT, PESA Tables various, and Spending Review 2021; OBR, Economic and Fiscal Outlook Oct 2021; Bank of England, A millennium of macroeconomic data for the UK, 2020.

Recent attempts at reform demonstrate how the need to resource the NHS has knock-on effects on other areas of public service spend. The 1.25 per cent levy on national insurance which commenced in 2022, was originally earmarked for historically underfunded social care. Yet the major recipient of this extra £13 billion a year is actually the NHS to meet emergency pressures, with only £5.4 billion overall ultimately for social care (and of that, only a heavily back weighted £3.6 billion will go to local government who actually provide for social care).

There is thus a growing risk that the extra funding demanded by the NHS to meet rising demand becomes politically unsustainable as other parts of state spending either continue to lose out or extra pressure is placed on taxpayers already struggling with a troubled economy. Sooner or later, policymakers will have to seek a way out of this fiscal quagmire and, without radical reform of the NHS, that will mean rationing healthcare or the phasing in of charging, directly or indirectly.

If this sounds somewhat alarmist, it should not. Social care, which receives far less public policy attention than the NHS, has endured successive rounds of increasing rationing (euphemistically referred to as the raising of thresholds) and rising charges over recent years as demand has outstripped resource. Governments to date may have steered clear of adopting these measures in the NHS either out of principle or fear of a voter backlash. But there will come a point when the demand pressures become so severe that a government may well calculate that failure to take such 'tough' decisions is more damaging than not taking them.

Thus, the NHS is now in perilous position. If we are to avoid being the generation which relinquishes the core principles of the NHS for future generations, we must understand the nature of the challenge at hand and respond with a clear-sighted vison of change. The rest of this report explains what lies behind the unprecedented risks facing the health service and how they can be alleviated in a long-term, sustainable and humane fashion.

2. THE ORIGINS OF THE DEMAND CRISIS

To understand why demand for healthcare has been rising, it is necessary to explore the range of likely causes. On one level, the origins of this crisis are widely observed as having their roots in the demographic and socio-economic causes of prolonged ill health, and policy decisions to date, particularly with regard to funding. More recently, these stressors on the system have been compounded by the pandemic, but largely predated it. We explore each in turn in this section, but this paper contends that it is not these factors alone which cause the demand pressures.

The deeper origin of the demand crisis facing the NHS must also be attributed to the traditional service delivery paradigms which dominate our healthcare system.

The deeper origin of the demand crisis facing the NHS must also be attributed to the traditional service delivery paradigms which dominate our healthcare system and influence the practices and mindsets within it. These rely on paternalist and transactional methods to meet demand pressures, which are only capable of confronting them as they present, rather than being able to prevent them emerging in the first place. Therefore, at best they do nothing to reduce demand, but at worst they actually increase it. This section will move on to explore these and the consequences they have for the limitations on the current system to work in ways that reduce demand pressures over the longer term.

The nature of demand is shifting as we live longer, often with multiple conditions

One of the most widely recognised causes of pressure on the healthcare system is the fact that the UK – like all older industrialised economies – has an ageing population. In the UK by 2045, there are projected to be 3.1 million people aged over 85 compared to around 1.7 million in mid-2020.[23] As medical advances and technology have improved outcomes across a range of health conditions, more people are entering older age having survived these health challenges compared to previous generations.[24]

23 'National population projections: 2020-based interim'. (12 January 2022). Office for National Statistics. https://www.ons.gov.uk/releases/2020basedinterimnationalpopulationprojections (Accessed 24/06/22).

24 See for example, Charlesworth, A. and Johnson, P. (eds.) (2018). *Securing the future: Funding health and social care to the 2030s*. The Institute for Fiscal Studies and The Health Foundation.

This overall good news has implications for the use of healthcare services. As people age, they may require increasing health and care support for more complex, multiple conditions and may need more intensive end-of-life care. The impact of our ageing population manifests in different parts of the health and care system. In the acute sector, a significant proportion of the overall growth in emergency hospital admissions is associated with older people.[25] In primary care, GPs face increasing pressure to support older people to manage complex multiple long-term conditions.[26] Social care provision is widely recognised as not sufficient to meet this growing demand,[27] with estimates of what it would take to stabilise the current system and meet future demand ranging from an additional £6bn a year to £14.4bn by 2030-31.[28] Beyond simply responding to the increased pressure on care services, as our population ages there is a need to focus on increasing overall healthy life expectancy – ensuring people experience as many years as possible in good health.

As a result, the health challenges our society faces and what we need from our health service has changed significantly since 1948. This shift in the so-called burden of disease is both placing pressure on health and care services and challenging a medical model designed largely to treat episodic illness. People are increasingly living with long-term and multiple health conditions which require ongoing care and support, as opposed to a one-off treatment. It is estimated that one in four people in England, particularly older people, are living with two or more long-term conditions (what is known as multimorbidity).[29] This is placing additional pressures on services. The Health Foundation, for example, found that people with 2 or more conditions accounted for around 50 per cent of admissions to hospital and outpatient visits– translating to over 55 per cent of NHS costs.[30]

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25 Between 2013-14 and 2016-17 there was a 9.3 per cent growth in emergency admissions to hospitals of which older people being admitted made up half of the growth. *Reducing Emergency Admissions*. (2018). National Audit Office.

26 Baird, B. et al. (2016). *Understanding Pressures in General Practice*. The King's Fund.

27 'What should be done to fix the crisis in social care?' Alderwick, H. et al. The Health Foundation (30 August 2019).

28 Idriss, O. et al. (2021). *Social Care Funding Gap*. The Health Foundation.

29 *Multiple Long-Term Conditions (Multimorbidity): Making sense of the evidence*. (2021). National Institute for Health Research.

30 Stafford, M. et al. (2018). *Understanding the health care needs of people with multiple health conditions.* The Health Foundation. For further details on methodology see pg. 11.

There has also been a rise in non-communicable diseases in line with how our lifestyles have changed since the era of post-war rationing when the NHS was established. For example, in England, there has been a steep increase in the number of people living with obesity over the last forty years – this is particularly significant given obesity is a risk factor for a range of chronic health conditions.[31] Growing numbers of people live with these chronic health conditions – for example in 2021 it was estimated that 4.9 million people in the UK are living with diabetes (90 per cent of whom have type 2 diabetes), with a doubling of cases in the last fifteen years.[32]

Health inequalities have been getting worse

The 2020 ten-year update of the influential Marmot Review showed a decade in which health inequalities have widened, while improvements in life expectancy have stalled or even worsened for some people.[33] In England, there are significant differences in life expectancy for those people living in the most and least deprived areas – 9.7 years difference for males and 7.9 years difference for females. Marmot's work shows that there is a social gradient in health: in other words, the poorer people are, the worse their health. Health inequalities are driven by social inequalities and our health is significantly shaped by the social determinants such as where we live, our education and our work.[34]

This not only has moral consequences for our society, but deepening health inequalities and rising deprivation have direct links to rising demand on the NHS. Deprivation is a factor contributing to poor health, adding to the risk of having multiple health conditions.[35] Some health conditions are disproportionately linked to poverty – for example, obesity prevalence in England is higher in the most deprived areas compared to the least.[36]

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31 Hancock, C. 'Patterns and trends of excess weight among adults in England'. UK Health Security Agency. (4 March 2021).

32 "Diabetes diagnoses double in the last 15 years". Diabetes UK. (4 May 2021). https://www.diabetes.org.uk/about_us/news/diabetes-diagnoses-doubled-prevalence-2021 (Accessed 24/06/22).

33 M. Marmot et al. (2020). Health Equity in England: *The Marmot Review 10 years on.* Institute of Health Equity. Note: life expectancy for women in the most deprived 10 per cent of areas fell between 2010-12 and 2016-18.

34 Marmot, M. et al. (2010). *Fair Society, Healthy Lives*: *The Marmot Review. Strategic Review of Health Inequalities in England post-2010*.

35 Stafford, M. et al. (2018). *Understanding the health care needs of people with multiple health conditions.* The Health Foundation.

36 Hancock, C. 'Patterns and trends of excess weight among adults in England'. UK Health Security Agency. (4 March 2021).

Those living in the most deprived areas will spend fewer years in good health than those living in more affluent areas, which will indirectly increase pressure on services. For example, in 2018 to 2020, females living in the most deprived areas were expected to live less than two-thirds (66.3 per cent) of their lives in good general health, compared with more than four-fifths (82.0 per cent) in the least deprived areas. In addition, male disability-free life expectancy at birth in the most deprived areas was 17.6 years fewer than in the least deprived areas in 2018 to 2020.[37]

There is evidence that the NHS has not responded enough to evidence of inequity in access and experience of healthcare amongst groups with worse health outcomes.

Poor health is significantly shaped by factors outside of the health system and traditional models of service delivery within the NHS have not focused on recognising or addressing those wider social determinants. Yet even within its direct sphere of influence, there is evidence that the NHS has not responded enough to evidence of inequity in access and experience of healthcare amongst groups with worse health outcomes. For example, deprived areas of England tend to experience worse quality of NHS care as well as poorer health outcomes.[38] In addition, the NHS Race & Health Observatory has identified how "ethnic inequalities in access to, experiences of, and outcomes of healthcare are longstanding problems in the NHS, and are rooted in experiences of structural, institutional and interpersonal racism".[39]

There is increasing recognition that the NHS needs to do more to address inequalities in access, experience and outcomes of healthcare. Some of these objectives are captured in the most recent Integrated Care System reforms (see box on page 25), which for the first time bring together NHS organisations with local authorities and other partners to work as an integrated system across a geographical area, with clear priorities to tackle health inequalities and support broader social

37 These figures relate to life expectancy at birth and healthy life expectancy at birth in England from 2018 to 2020 by the Index of Multiple Deprivation. See: 'Health State life expectancies by national deprivation deciles, England: 2017 to 2019'. (25 April 2022). Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2018to2020 (Accessed 24/06/22)

38 'Poorest get worse quality NHS care in England, new research finds'. QualityWatch - Nuffield Foundation and The Health Foundation. (23 January 2020). https://www.nuffieldtrust.org.uk/news-item/poorest-get-worse-quality-of-nhs-care-in-england-new-research-finds (Accessed 24/06/22).

39 Kapadia, D. et al. (2022). *Ethnic Inequalities in Health: A rapid evidence review*. NHS Race and Health Observatory.

and economic development. However, it is clear from the above that health inequalities inevitably mean many people get sicker than they should and many do not get the treatment they require leading to more numerous and more complex conditions. As we explain below, addressing this will require ICSs to embrace radical change.

The impact of the pandemic has compounded demand pressures

The pandemic has compounded demand pressures on NHS. Before the pandemic waiting lists were already rising but by April 2022 the elective care backlog stood at 6.48 million.[40] While the elective care backlog has been the focus of a great deal of public and political attention, pressures are felt beyond hospitals, in other parts of the system including primary care, mental health and community care, as well as in social care.[41]

Workforce pressures have also been compounded in the pandemic – the 2021 NHS staff survey showed 46.8 per cent of staff feeling unwell in the last 12 months due to work related stress and 31.1 per cent saying they often think about leaving the organisation they work in.[42]

The pandemic exposed the extent of health inequalities, whereas previously they had largely been hidden from mainstream public view. But the disproportionate impact of Covid for people from ethnic minority communities, disabled people and those living in deprived areas[43] has starkly reinforced the need for action on health inequalities. As yet, we do not understand fully the wider knock-on impact of the pandemic on the social determinants of health – but The Health Foundation has noted the potential wider health implications which could come from issues such as schools closing and the economic shock.[44] While still reeling from the trauma of the pandemic, rising

40 *'NHS backlog data analysis'.* BMA. (based on NHS England Consultant led referral to treatment waiting time statistics.) https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis (Accessed 24/06/22).

41 *Clearing the Backlog caused by the Pandemic.* (December 2021). House of Commons Health and Social Care Committee.

42 *National Results Briefing 2021*. NHS Staff Survey.

43 See Suleman, M. et al. (2021). *Unequal Pandemic, Fairer Recovery: The Covid-19 impact inquiry report.* The Health Foundation.

44 Ibid.

inflation and a deepening cost of living crisis already appears to be having a negative impact on people's health.[45]

Funding has not kept pace with rising demand

Funding for the NHS has not kept pace with these growing demand pressures. Despite health funding receiving relative 'protection' in comparison to other departmental spend during austerity years, the NHS still received the tightest funding settlements in eight successive years before the pandemic hit.[46] And the NHS was not immune from the knock-on effects of reductions in other service spend, such as to local government which is responsible for social care. For example, delayed transfers of care – where patients are ready to leave hospital to transfer to another supported setting, but were unable to do so due to lack of availability - were identified in 2017 as one of the most significant pressures and risks in the NHS.[47]

A vicious cycle in which spiralling demand for acute care means resources are redirected away from efforts to reduce demand.

While not necessarily a direct cause of rising demand pressures, there can be little doubt that inadequate funding for the NHS can compound those pressures. Patients left waiting longer for treatment are inevitably more likely to develop more severe or complex conditions that require more intensive or longer-term treatment. Over-stretched staff and resources can mean less effective treatment which then is more likely to lead to patients returning for further treatment. And there is a risk of a vicious cycle in which spiralling demand for acute care means resources are redirected away from efforts to reduce demand, through public health and prevention, propping up acute provision in the short-term, but only exacerbating demand pressures in the medium to long-term.

As explained throughout this paper, the solution to the demand crisis is not to simply throw more money at acute care. This is politically and fiscally unsustainable and ultimately will do nothing to resolve rapidly rising demand which is caused by much longer-term structural issues

45 'Over half of Brits say their health has worsened due to rising cost of living'. Royal College of Physicians. (16 May 2022).

46 Charlesworth, A. and Johnson, P. (eds.) (2018). *Securing the future: Funding health and social care to the 2030s*. The Institute for Fiscal Studies and The Health Foundation.

47 'The rise of delayed transfers of care'. (2017). NHS Providers Briefing.

than simply a lack of resource. However, there is no doubt that NHS underfunding is making the problem worse. The response must be a combination of improved funding settlements *and* a radical shift in the way the NHS works to be better able to resolve demand pressures before they emerge or deteriorate.

What are Integrated Care Systems and how will they respond?

The latest reform to England's health system is designed to integrate health and care services across a defined geography. England is now covered by 42 Integrated care systems (ICSs), as fully operational statutory bodies from July 2022. They are intended to bring together all organisations that support health across a geographic area with a mandate to work collaboratively as a system. This comprises all NHS organisations, including hospital trusts, community and mental health teams, GPs and other primary care services. It also includes wider services including local government (responsible for social care and public health among a wide range of local services), care providers, other frontline professionals and the voluntary sector.

Two new statutory bodies collectively comprise the ICS. **Integrated Care Boards** (ICBs) are responsible for NHS services and funding. They have legal responsibility for NHS resources and commissioning services within their area, taking on this role from Clinical Commissioning Groups (CCGs). **Integrated Care Partnerships** (ICPs) bring together the NHS with partners across the ICS geography including local authorities and other organisations including those from social care. The ICP is tasked with developing a broad integrated care strategy focused on identifying and meeting the health needs of the local population. The ICB is tasked with producing a five year plan for how NHS services will be delivered to meet these needs, which must "take account" of the ICP strategy.

ICSs collectively have four clear aims: to improve population health and healthcare; to tackle unequal outcomes and access; to enhance productivity and value for money; and to help the NHS support broader social and economic development.[48]

The deeper origin of the demand crisis: failed state and market paradigms

The demographic, socio-economic and funding-related causes outlined in the previous section undoubtedly play significant roles in the current demand crisis confronting the NHS. But alone they do not provide a full picture of the problem. Notably, these widely accepted causes fail to acknowledge the central role of the public service paradigms that have historically shaped and still shape NHS policy, values and practices.[49]

These paradigms, we argue, never took account of rising demand pressures and while they still dominate, will prevent the NHS and policymakers tackling the challenge head on. ICS reforms provide an opportunity to respond more effectively by taking a more integrated approach across health, care and other organisations. But unless the full nature of the origins of demand crisis are recognised, there is a risk that the deep system change required is not pursued, and the organisational behaviours of these paradigms persist into the new structures.

In the New Local paper, *The Community Paradigm*, we showed how public services in the UK have been shaped by a succession of three paradigms which have profoundly informed mindsets and practices across the public sector. We described the paradigms as follows:

48 Integrated Care Systems: Design framework. (2021). NHS England.

49 The authors introduced the idea of public service paradigms in *The Community Paradigm*. Based on the work of Thomas Kuhn, a paradigm has two elements: an acceptable range of practices and beliefs; and an underlying set of principles that both justifies and governs those practices and beliefs. For Kuhn paradigms can shift very radically when they no longer match the reality of the world they seek to order and manage. See Kuhn, T. (1962) *The Structure of Scientific Revolutions*, University of Chicago Press.

- **Civic paradigm:** Lasting from the sixteenth to the early twentieth century, this was based on an evolving patchwork of independent bodies delivering limited public services funded by voluntary contributions and, increasingly, some tax.

- **State paradigm:** This transformed public services from the 1940s through to the early 1980s. They were unified under central government and entirely tax-funded with the goal of providing universal, comprehensive and free-at-the-point-of-use provision. The state paradigm extended the hierarchical systems already evident under the civic paradigm, based on the firm belief that officials and experts knew best how to care for the wider public. Service users and communities were widely regarded as passive recipients.

- **Market paradigm:** This developed in the 1980s and is now reaching the end of its era of influence. It sought to improve the cost and efficiency of public services by introducing market incentives such as competition and choice into provision. It did not, however, effectively dismantle the hierarchical practices of the state paradigm. Rather, it introduced a strongly transactional element into the relationship between service and user within the existing architecture of provision.

We identified an emerging fourth paradigm, which we called the ***community paradigm***, which has deep roots in the changing nature of service delivery on the ground and is growing in application. Just as previous paradigms had developed to confront the public service challenge of the age, the key problem the community paradigm seeks to resolve is that of rising demand for services. Crucially, this is met with deep recognition of a key opportunity of our age: the increased appetite and expectation amongst people that they should have influence over their own lives. The community paradigm thus locates power outside formal institutions and with communities themselves, and seeks new ways of giving them meaningful influence, power and control. The table on pages 28-29 sets out the four public service paradigms, identifying key differences and progressions between them.

Four public service paradigms

	Paradigm			
	Civic	State	Market	Community
Period	Sixteenth to mid-twentieth centuries	Mid-1940s to early 1980s	Mid-1980s to mid-2010s	Emerging late 2010s
Key organisational principle	Basic services designed and delivered by voluntary and mutual associations and limited local state	Public services designed and delivered by experts employed by the state	Public services designed and delivered to work like a business transaction and act like a market	Public services designed and delivered by and with communities
Key problems seeking to solve	Alleviating destitution and delivering basic local infrastructure	Meeting cradle to grave needs and slaying the five 'giant evils'	Operating efficiently and meeting user demand for choice	Reducing rising demand by meeting citizen appetite for participation
Ideal locus of power	The civic association and its leaders	The state and its bureaucrats and experts	The service customer	The community and the people in its network
View of service user	Passive subject	Entitled and passive citizen	Customer	Creative collaborator with public servants
View of public servant	Volunteer/ enlightened bureaucrat	Cog in a machine	Cost centre	Creative collaborator with citizens
Implementation method	Charitable and mutual activity, municipal activism	Institution building	Market creation	Culture change
Iconic policies	The Poor Laws, the workhouse, slum clearance, public provision of gas and waterworks	Establishment of the NHS and welfare state; National Insurance expansion	Compulsory competitive tendering; user choice; provider/ commissioner split	Unconditional devolution; participatory and deliberative democracy; collaborative delivery; community commissioning

	Paradigm (continued)			
	Civic	State	Market	Community
Organisational culture	Hierarchical	Hierarchical	Transactional	Creative, collaborative
Funding model	Charitable and mutual contributions, plus limited taxes from local state	Public funds distributed and controlled by experts and bureaucrats	Public funds follow user demand and placed in hands of individual users	Funds distributed and controlled by user groups, communities and citizens
Location of governance	Decentralised: charitable and mutual boards, local state	Centralised: Whitehall and directed local councils	Centralised: Whitehall and corporate providers with shrinking local council role	Decentralised: community groups, local councils, decentralised public services
Attitude to technology	Designed to assess, monitor and control dependents	Designed to improve bureaucratic efficiency	Designed to enable faster, more diverse offer to service users	Designed to provide platforms for collaboration and community mobilisation
Political context	Laissez-faire era	Social Democratic era	New Right era	Anti-establishment era
Buzzwords	Deserving/ undeserving, charity	Expert, plan, regulations	Efficiency, competition, choice	Collaboration, prevention, shifting power
Intellectual hero	Thomas Gilbert, Eighteenth century Poor Law campaigner	William Beveridge, Author of the Beveridge Report	Milton Friedman, Free market economist	Elinor Ostrom, Economist focused on community self-organisation

The Community Paradigm considered public services as a whole. It found particular resonance with the local government sector, perhaps due to councils' role as the most directly democratic part of the public sector, and responsibility for services that are naturally more relational – social care, public health and wider preventative provision.

it is clear that the NHS model in particular has been profoundly shaped by the first three paradigms: civic, state and market. Its long historical origins can be found in a wide variety of charitable, civic and mutual organisations which provided healthcare to select groups or to those in need over many centuries. The looser civic paradigm was gradually replaced by growing state provision throughout the early Twentieth Century and then finally almost entirely consolidated and extended under the control of the state with the foundation of the NHS in 1948. Its more recent history has seen waves of market-based reforms designed to inject efficiency and increase productivity into the system. The influences of these paradigms on healthcare, in particular the state and market paradigms and their relationships with communities, are under-appreciated by mainstream public policy although their existence has long been identified.[50] This section will now explore the influences of the state and market paradigms within the NHS in more detail, before the next chapter will consider the emerging role and value of a stronger community role in more detail.

The state paradigm

The NHS has always been, in many ways, the epitome of the state paradigm organisation. Funded entirely through taxation (until the introduction of limited charges for prescriptions in 1952), the NHS was centralised on the Department for Health, extremely hierarchical and run by a group of powerful officials and medical professionals, with little space given to patients' own insights into their health.

The state model was particularly strong in the NHS because it aligned well with the hegemony in the healthcare sector of the so-called

50 In 1975, US political theorist Robert Alford identified three groups of competing interests in healthcare policy: professional monopolists (clinicians - who were dominant); corporate rationalisers (bureaucrats – who were challengers) and the community (patients and the public – who were repressed). See Alford, R. (1975). *Health Care Politics*, University of Chicago Press, cited in Ham, C. (2009). *Health Policy in Britain*. Red Globe Press. Sixth Edition.

'medical model' with its roots deep in the scientific philosophy and practices developed during the Enlightenment. The medical model regarded patients as a collection of symptoms that required objective diagnosis by a highly trained specialist who would then prescribe some form of medical intervention proven (in theory at least) by scientific research followed by monitoring and the calibration of treatment if necessary. This process-driven approach, organised around the role of the clinician and with the patient as a passive categorisable 'case', found a very comfortable home within the state paradigm.

The market paradigm

From the 1980s onwards, the market paradigm began to shape the wider public sector and gradually came to influence the NHS. The 1990s saw the introduction of an 'internal market', which split the NHS into providers and purchasers requiring hospitals and other providers to compete against each other for contracts from commissioning bodies. During the 2000s there was an increased emphasis on 'patient choice', in which the individual was given some limited 'consumer' type ability to exercise preferences, albeit predetermined by providers. The 2012 Health and Social Care Act was a major effort at marketisation requiring most NHS contracts to be put out to competitive tender for which NHS bodies were to be given no special preference as had been the case in the past. More recent policy shifts focused on integration and collaboration have been based on a recognition of the limits of a marketised approach. Measures including the formalisation of ICSs and the establishment of new provider collaboratives,[51] are a further break with the logic of market-based competition.

The state and market paradigms are not capable of addressing rising demand.

Like the rest of the public sector, the confluence of the state and market paradigms has created a hybrid model that combines transactional market-driven mindsets and practices with hierarchical state-focused mindsets and practices. The problem with this situation is that neither the state paradigm nor the market paradigm were designed to address

51 Wickens, C. 'Provider collaboratives: explaining their role in system working'. The King's Fund. (21 April 2022).

the contemporary challenge of rising demand. The former aimed to provide comprehensive and free access to a standardised level of medical care. The latter hoped to streamline activity and create a more efficient NHS. As a result, both models share a fundamental design flaw which sits comfortably with a medical model, but at best fails to address rising demand and at worst exacerbates it.

That flaw is the construction of NHS provision around acute response. Deeply influenced by the medical model, both paradigms simply assume that the primary role of a health service is for unwell patients to present themselves for treatment and have their condition managed or cured by highly trained specialists. A hospital-led model of care is based on the primary role of the NHS to simply respond to demand as it presents in the short term, not attempt to reduce it in the longer term. As such, the practices, expertise, behaviours, structures that might pro-actively respond to and reduce rising demand – usually described as 'prevention' – operate largely outside or on the margins of the NHS.

What do we mean by prevention?

We identify two dimensions to prevention. Firstly, there is a narrower understanding of clinical prevention, early intervention and support focused on helping people to manage long-term conditions and live well. The second dimension is understanding the need to get up-stream of the first kind of prevention activities and address the wider social determinants of health outcomes including social networks, employment, housing and the environment. Understanding prevention in its broadest sense is crucial for tackling health inequalities. Whereas the first, narrower definition addresses the clinical presentation of poor health, the second recognises the root causes.

Taking the term prevention in its broadest sense therefore, we refer to the range of activity, assets and capacities that can support good health and wellbeing. These exist within individuals, their wider family and social networks, and communities. These can all

be enhanced or bypassed by services, and some public provision can be focused on prevention by being organised in ways that engage with complex life circumstances. These will tend to be multidisciplinary teams and those which employ asset-based approaches that address the circumstances of the "whole person" rather than the professional specialism.

It can be argued that the term prevention itself is deficit-led as it implies stopping something negative, rather than promoting something positive. But we feel the term is a useful one to counter its opposite in this context – an acute, medicalised stance that can respond to crisis once it occurs, but does not recognise measures to stop conditions emerging or deteriorating in the first place.

The state and market paradigms presume patients are passive recipients, not active participants.

Both paradigms promote a model of the patient as a recipient of care who has little meaningful agency in the maintenance of their own health and well-being (see box on pages 32-33). The state paradigm is shaped by the medical model, which tends to see health professionals as 'experts' and patients as passive recipients of this expertise.

Professional knowledge and skills are clearly essential. But a passive role for patients is at odds with the fact that much of the work of maintaining good health and wellbeing happens out in communities not driven by professionals in health settings.

The market paradigm does envisage a slightly more active patient, but only in the sense that they should behave like a consumer choosing between alternative treatment centres. This marketised notion of patient choice doesn't actually transfer power to individuals, it still rests with the providers who determine what is on offer. The power imbalance is that of individual versus institution. The concept of individual as part of a wider community which potentially has more collective power vis a vis the institution, is underdeveloped. Moreover, this more business-

like relationship between individual-as-consumer and provider could arguably be even more damaging to the need to reduce demand. Encouraging a transactional mindset on the part of the patient who can 'shop around', risks embedding the assumption they need not take any responsibility for their own health and well-being.

In the context of an ageing population, greater prevalence of multiple long-term conditions and increased recognition of the impact of wider social determinants of health outcomes, such an approach to individuals in the abstract, rather than in the context of their networks and communities, is not sustainable.

The state and market paradigms have problematic responses to system pressures which reinforce acute response and marginalise prevention.

A strong focus on upward accountability detaches health institutions from the places they are based in and the partners they need to work alongside.

The state paradigm has always relied on edicts from government or the NHS's national leadership as a way of driving improved performance. While performance targets have in some cases been important for improving standards,[52] they have also been problematic, with electoral cycles and national politics driving a focus on easy-to-articulate output targets often focused on acute response performance. This top-down approach creates an inward-looking organisation which incentives certain practices and behaviours in order to comply with narrow and short-term output targets. As Professor Sir Chris Ham notes, this can foster "a culture of compliance and risk aversion that inhibits innovation and engagement with local people. At its worst, reliance on standards and targets has the effect of disempowering those working in the NHS, creating an over dependence on the centre and a substantial workload in responding to regulators."[53]

A strong focus on upward accountability detaches health institutions from the places they are based in and the partners they need to work alongside. These drivers, in turn, marginalise efforts to do the complex

52 For an interesting discussion on this see Davies, N., Atkins, G. and Sodhi, S. (2021). *Using Targets to Improve Public Services*. Institute for Government.

53 Ham, C. (2022). *Governing the Health and Care System in England: Creating the conditions for success.* NHS Confederation.

work of prevention which requires a focus on the specifics of place in close collaboration with the assets and energy of the local community within which the healthcare system is situated.

The market paradigm emphasises behaviours which undermine a shift away from the dominant acute-led model towards greater prevention. The logic of competition is at odds with the cross-system efforts that are fundamental to a more preventative approach. Efforts to break the system up along the lines of competing institutions and the commissioner/provider split have reinforced the primacy of separate organisations and the boundaries between them rather than pooling funding, capacity and expertise. Most damagingly, the market paradigm response to demand pressures is to seek efficiency and drive productivity within these organisational or service siloes. This narrow focus on driving down short-term costs has a blind spot for the longer-term value of investing in the very prevention that would reduce demand in the first place. But this logic dominates, as Secretaries of State are very fond of efficiency drives, and providers face pressures to ration or salami slice provision in the short term, rather than invest capacity and focus on the work of preventing serious illness in the first place.

The roots of a new community paradigm for the NHS can be found in existing practice that challenges the dominant state and market logic.

Alongside the external drivers of rising demand, it is vital to understand that the NHS that has been created over the last 75 years is completely unfit to address the existential crisis of rising demand it now faces. Fortunately, the picture is not universally bad. There are many great initiatives inside and outside the NHS which aim to shift away from acute response and towards meaningful prevention. There are also signs that the Government and the NHS leadership recognise this, having brought about the shift to ICSs designed to be more collaborative between NHS and non-NHS organisations for better service coordination across a place.

But we should not fool ourselves. Integration alone will not lead to prevention. Prevention is still extremely marginalised within the NHS:

state and market paradigms disincentivise prioritising and investing in it. It is not at all clear that the Government or NHS leadership fully understands the origins of the demand crisis within existing paradigms that shape how the NHS responds, and will shape how NHS organisations work with partners within new systems. There is a risk that unless the dominance of these mindsets is recognised and challenged, the same hierarchical and transactional behaviours will simply be transplanted into the new structures. There is still a great deal of change that needs to happen in the culture and practices of the NHS if the demand crisis is to be addressed. The rest of this paper will now explore what that change must look like.

3. WHY COMMUNITY POWER?

Community power is based on the principle that communities themselves have valuable insights into their own circumstances and what they need to thrive. They should therefore be able to exercise genuine influence and where possible direct control, over the decisions, resource and services that support their lives. This is not just a moral concern for improving the lives of individuals, but a way of ensuring the best use of public resource for sustainable outcomes.

An essential insight from community power is that health institutions, and the wider public sector, need to work with people and communities in order to shift towards a prevention approach. Indeed, proper prevention is impossible without active, participating individuals and communities. This is because prevention is not something that can be *done to* people in the traditional service delivery sense, rather it must be *achieved with* them. This means health institutions need to be capable of working alongside communities, responding to their insights, and investing in them so they can actively participate in shaping better places and services.

Proper prevention is impossible without active, participating individuals and communities. This is because prevention is not something that can be done to people in the traditional service delivery sense, rather it must be achieved with them.

What is a 'community'?

The term community refers to the groups or networks of individuals where mutual interest and collaboration more or less formally can achieve a beneficial goal. This can be defined by geography – where specific units such as a neighbourhood can be defined by their shared use of and attachment to place. It can also relate to groups not defined simply by geography, but who collectively define themselves by a shared need, condition or characteristic. This can include people experiencing the same health condition, people who use the same service, or more broadly people of the

same demographic characteristic such as age or ethnicity. These groups may primarily identify with each other and develop mutual interests based on such a shared characteristic – or combination of characteristics - but their geographic proximity often also plays a role in their shared experience and ability to convene.

Community power already exists in communities – the challenge for public services is how to work with it for better outcomes, rather than bypass it or pretend it has no consequence. The idea of working in community-powered ways has been gaining support and is being put into practice particularly across local government although there are some excellent examples of community power in the NHS and the wider public sector. This growing movement of community-led activity was reflected in the submissions to a Call for Evidence New Local held in 2021 to inform our understanding of the role of community power and the NHS. This received a wide range of submissions from people involved in different ways and in different parts of the health, care and wider system of support. The rich diversity of practice, projects and experience of the current system conveyed in the submissions has directly informed our analysis here.

The evidence base is growing. In New Local's 2021 report, *Community Power: The Evidence*, it was shown that community-powered approaches demonstrate six major benefits.[54] Of these, three explain why that approach can be so much more effective at prevention compared to other paradigms which favour acute response. These are that community power:

- Enables public services, their workforces and users to operate in a more preventative and less acute response-driven way
- Improves personal health and well-being making ill-health less likely to emerge
- Improves the resilience and collective well-being of local communities directly improving the social determinants of health.

54 Pollard, G., Studdert, J. and Tiratelli, L. (2021). *Community Power: The Evidence*. New Local.

The subsequent chapter will explore in detail the nature of the challenging shift for a public service from state and market paradigms to a community paradigm, with a focus on the implications for the NHS. But first, this chapter will explain why community power has much greater capacity to address the demand crisis confronting the NHS than older paradigms, exploring each of the three key benefits in turn.

The opportunity to involve communities in the NHS

The idea of involving communities and people's participation in their own health has long been identified as essential to the long-term viability of the NHS, but implementing it systemically has proved elusive. Back in 2002, The Wanless Review which took a 20-year long term view on NHS pressures and the resources it would need. Wanless outlined three potential scenarios, the third of which was the most ambitious and optimistic – the 'fully engaged' scenario. This outlined a vision of the public being highly engaged in their own health. Of the three, this model had both the best health outcomes and was the least expensive, at the time projecting it would save the NHS £30bn if it were to succeed.[55]

The Wanless vision has not been realised and the power of people and communities has not been harnessed in the pursuit of better health and wellbeing. But over the years, similar principles have been in the background of NHS reform plans. In 2014, The NHS Five Year Forward View identified the "renewable energy represented by patients and communities" that the NHS needed to draw upon. A wider role for NHS organisations within communities was also articulated - a "social movement" realised through the NHS's role as an employer, partnerships with the VCS, and community volunteering.[56]

55 Wanless, D. (2002). *Securing Our Future Health: Taking a long-term view.*

56 *NHS Five Year Forward View*. (2014). This vision was supported in practice through Realising the Value, a programme led by Nesta and The Health Foundation, developing the evidence based and practice around person and community-centred approaches in health. See Realising the Value. https://www.nesta.org.uk/project/realising-value/ (Accessed 24/06/22).

The NHS Long-Term Plan, published in 2019, built particularly on personalised care and how services could better work around the needs of people.[57] A key part of this personalised care agenda was the commitment to expand social prescribing in which individuals are offered non-medical, community-based activity to improve their health.

The idea of Patient and Public Involvement (PPI), in which patients, family members, carers and the wider public are engaged to help improve services is evolving within the NHS. Yet to date it has largely operated independently of wider asset-based community development activity, operating within existing public service models and delivery.

1. Shifting from acute to preventative mindsets and practices

A system-wide focus is required to enable a prevention approach, but in this paper, we focus specifically on what that means for the NHS. From this perspective there are two broad dimensions to prevention. First, there is a narrower understanding of clinical prevention and early intervention, and support focused on helping people to manage long-term conditions and live well. The second dimension is understanding the need to get up-stream of the first kind of prevention activities and address the wider social determinants.

Community power offers essential insights to inform this prevention approach, focused on how public institutions work with people, including how they enable, facilitate and resource individuals and their communities. Marmot's work on empowerment of individuals and communities as the route to improving health and wellbeing proves particularly important here. His emphasis on addressing disempowerment across three areas – material conditions, psychosocial (particularly referring to levels of control), and political or people's voice[58] - provides a powerful framework for change.

57 *NHS Long-Term Plan.* (2019).
58 Marmot, M. 2015. *The Health Gap: The challenge of an unequal world.* Bloomsbury. Page 93.

NHS bodies in both acute and primary care cannot simply outsource preventative activity to external partners and continue business as usual with their treatment-led approach.

Our contention is that NHS bodies in both acute and primary care cannot simply outsource preventative activity to external partners and continue business as usual with their treatment-led approach. This sucks the energy, resource and system focus away from prevention. Under ICSs, a focus on prevention needs to reach all parts of the system if it is to be valued and mainstreamed. As one evidence submission emphasised: "This is also not the role of public health, it's the role of the entire NHS workforce at all times".[59]

There are three very profound shifts needed to move from today's acute response approach to the prevention approach we describe above. These shifts underlie the need for a fundamentally different way of working on the part of the healthcare professional and on the part of the healthcare recipient. These recognise a new relationship between health institutions, professionals and people and communities.

The first shift needed is towards health services which are more capable of understanding a person's context beyond the specific symptom or condition they present with. This means a greater focus on designing and delivering services in order to help people to access them, but also to enable healthcare professionals to work with people in ways that recognise their wider context and experience. As one evidence submission reflected this is about the workforce being able to "look at individuals holistically and understand that they are not defined by ill health".[60] This is important for both prevention and early intervention as well as for working with people to manage health conditions.

This second shift is towards recognising the individual as an active participant in their own health outcomes. A very great deal of the work of prevention must be conducted by individuals themselves in the absence of the healthcare professional. This role is important both for preventing illness and managing existing health conditions. For example, those with diabetes maintaining leg and foot hygiene and health or, more generally, whole populations taking exercise and eating a healthy diet. While these ideas are not new and exist within today's system, what is proposed within this prevention approach is a far greater emphasis on empowering individuals within the context of wider communities of support.

59 Evidence submission – George House Trust.
60 Evidence submission – Wigan Council.

Thirdly, there needs to be a shift in the role the healthcare bodies play – as a set of organisations and as place-based partners – in addressing the social determinants of health. A great deal of the success of a preventative approach relies on the context within which individuals find themselves. One GP has described this as an ecological approach, which focusses on "creating conditions for health to flourish". This is an explicit shift in practice away from a "healthcare as a factory" mindset reliant on industrial metaphors seeking to fix people and which views patients "in isolation from their environment".[61] The evidence is strong that stressful personal circumstances, isolation, poor housing and poverty are major causes of ill-health.[62] Equally, the local environment within which someone lives also has a major bearing. Air pollution, lack of green space, high incidence of violent crime, unsafe roads and a host of other environmental factors will clearly increase the likelihood of ill health very considerably for those who live in those areas.

These shifts require a fundamentally different mindset and set of practices for health institutions and the professionals working within them.

All three of these shifts require a fundamentally different mindset and set of practices for health institutions and the professionals working within them – from working with individuals and communities on the design and delivery of services; to looking outside healthcare institutions to proactively work with communities and partners to address the underlying causes of ill health.

One submission to our call for evidence captured this imperative well:

"The system should work closely with the community and voluntary sector to support people to build connections, networks and have a sense of ownership over where they live. Cohesive, resilient communities with peer support networks are more likely to be able to rely on each other during difficult times, and influence the environment they live in to support healthy behaviours. They also help combat loneliness, isolation, anxiety and depression – relieving pressure on the system."[63]

There are pockets of professionals across the health and care system for whom the understanding of prevention in the broader sense set

61 Orrow, G. (2021). 'Designing an ecological approach to health'. BMJ.

62 Marmot, M. et al. (2010). *Fair Society, Healthy Lives: The Marmot Review. Strategic Review of Health Inequalities in England post-2010.*

63 Evidence submission – TAWS.

out here will resonate. These emerging areas of practice are discussed further in the next chapter. But it is worth noting here the development of strengths-based working across a range of areas.

In parts of social care, there is a growing focus on shifting from a deficit-approach to understanding people's priorities and how these can be enabled, championed by movements like #socialcarefuture[64] and deployed through models of support which draw on informal associations, like Shared Lives[65] and the Cares Family.[66] In mental health practice, there has long been a strong focus on individuals in the context of their wider networks and peer support. Public health as a discipline focused on population level health outcomes naturally recognises the role of community centred approaches, and the pandemic response was a live example of how vital it was the wider public played an active role through behaviour change, following the rules and coming forward to be vaccinated. In primary care, increasing numbers of GPs are pioneering new approaches that work directly with communities outside the walls of the practice to build the network, connections and social infrastructure to support good health and wellbeing.

Taking an asset-based approach to communities for successful prevention: The Wigan Deal

Wigan council was one of the first local authorities to pursue community-powered approach and has been one of the most successful in doing so – not least in terms of health outcomes. Since 2014 the 'The Wigan Deal' has recast the delivery of public services to emphasise the reciprocal relationship between services and people, in order to boost prevention, support the health and wellbeing of residents, as well as navigate the impact of austerity.

64 See https://socialcarefuture.blog/ (Accessed 24/06/22).
65 A charity focussed on models of supported shared living, see https://sharedlivesplus.org.uk/ (Accessed 24/06/22).
66 A charity focussed on building connections within neighbourhoods, see https://www.thecaresfamily.org.uk/ (Accessed 24/06/22).

To do this, Wigan sought to reframe the relationship between local authority and local people. This is in part attitudinal: all staff receive 'Deal' training, equipping them to rethink how they work alongside service users and the wider community, using an 'asset-based approach' to identifying the strengths of individuals and communities and taking a holistic view of residents' wellbeing, including causes of ill-health [see case study on page 87].

The council also changed its strategic approach. Commissioning processes were redesigned to support the involvement of the voluntary and community sector, and it transferred 35 of its assets to communities. Notably, despite the need to make overall budget reductions, the council prioritised significant financial investment into community groups. From 2013 to 2018, a dedicated Community Investment Fund put £10 million into community organisations and projects. Recipients included a group that works to tackle prevention of young suicide; an arts organisation that delivers creative workshops to people including mental health service users and dementia sufferers, and an athletics trust offering sports opportunities to vulnerable young people.

As the King's Fund's comprehensive analysis of the Deal set out, the principle of the fund was that the money given was "an investment rather than a grant". Recipients received close support from the council, with the expectation that projects should ultimately become self-sustaining. Monitoring was kept deliberately light, with the recipient organisation setting its own goals.[67]

All this has had tangible results. A council evaluation estimated that over its first four years, the fund amounted in a social return on investment of £1.63 for each £1 invested – reached in part by reduced demand for health, social care, and other public services.

Two years after the original Deal, the council developed The Deal for Health and Wellness, with a wider range of partners including the CCG, local NHS foundation trusts, care providers and

67 Naylor, C. and Wellings, D (2019) A citizen-led approach to health and care: Lessons from the Wigan Deal, The King's Fund.

Healthwatch. Like the first Deal, this involved reciprocal pledges between these partners and local residents: the former would provide seven-day access to GP services and leisure facilities – for example – while the latter would go for regular check-ups and support older people to be active.

The Deal principles are embedded across health and care partnerships, as well as into health contracts and through the borough's Community Wealth Building networks. Meanwhile its 'Health Movement for Change' now totals 23,000 citizens including health champions, heart champions, cancer champions, dementia friends, and young health champions.[68]

The list of 'post-Deal' health improvements is significant. Between 2011 and 2019, life expectancy rose by 31 months across the borough, at a time where the UK average lifespan fell. In Wigan's most deprived wards, women's lifespans increased by an average of seven years.[69] Early deaths from cardiovascular disease and cancer have fallen. The proportion of adults who were physically active increased from 48 per cent in 2012 to 63 per cent in 2017. Smoking rates among pregnant women and manual workers fell, as did hospital stays for alcohol-related harm.[70] Care Quality Commission assessments indicate that the quality of social care services in Wigan also improved.[71]

Foundations laid by the Deal aided the Covid-19 response. Mature, egalitarian partnerships between the council, the NHS, and the voluntary and community sectors were able to spring into action to respond to the pandemic's unprecedented challenges – redeploying staff and creating hyper-local community hubs to coordinate local responses.

68 Asset-based approaches in local authorities: the Wigan experience. Local Government Association case study: https://www.local.gov.uk/asset-based-approaches-local-authorities-wigan-experience (Accessed 24/06/2022).

69 Oglethorpe, K. 'The community cure? Why hospitals can't heal health inequalities'. New Local. (8 July 2021). https://www.newlocal.org.uk/articles/the-community-cure/ (Accessed 24/06/22).

70 Asset-based approaches in local authorities: the Wigan experience. Local Government Association case study: https://www.local.gov.uk/asset-based-approaches-local-authorities-wigan-experience (Accessed 24/06/2022).

71 Naylor, C. and Wellings, D (2019) A citizen-led approach to health and care: Lessons from the Wigan Deal, The King's Fund.

Today, the original Community Investment Fund has been replaced by a Community Recovery Fund which has so-far invested over £250,000 in grassroots organisations. Meanwhile, the Wigan Deal is being rewritten for 2030, with a continued commitment to work as an equal partner with local communities, recognising their strengths and assets and the power they hold to help transform people's lives.

2. Improving personal health and wellbeing

Much of the public and political debate about prevention occurs in very individualistic terms. It is widely assumed that individuals need to be exhorted, incentivised or pressured into taking better care of themselves. This is what leads to the focus on public information campaigns, information technology such as apps and the pressure to raise taxes on unhealthy products.

However, there is exceptionally strong evidence that the collective rather than the individual plays the most significant role in successful prevention. The collective can operate at both the specific and general level. Social networks can be highly effective at helping people facing particular health challenges. But, more generally, strong communities and networks keep people healthier, just as deprivation and isolation can cause poor health. This section will look briefly at these two aspects in turn and then explain how a community-powered approach to healthcare relates to these benefits.

The value of peer-support networks to help people maintain or improve health has been recognised for a long time. Alcoholics Anonymous has been in existence since 1935, the National Childbirth Trust since 1956 and Weight Watchers since 1963. These organisations and countless similar bodies operating at local, national and international level, work because they use the power of the peer support network. That power resides in part in the role such networks can play in sharing advice and good practice. They also offer the huge benefit of mutual encouragement and support for what can be challenging processes of personal change

and commitment. Clearly, these groups also tap into something much deeper – the way a collective effort to achieve a goal encourages all those who are part of that collective effort to stay the course. The sense that you are not alone and that you have a group of friends travelling the same path seems to be an enormously powerful driver of positive human behaviour.

At a more general level, there is also considerable evidence that being part of strong social networks – whether health oriented or with no health focus at all – is an extremely important determinant of good health.[72] There are multiple reasons why this might be the case but given that the evidence linking mental health to physical health is now so strong, a major factor is clearly that being part of strong networks reduces loneliness and depression, provides a greater sense of agency and control and hence improves overall health.

Healthcare professionals should focus heavily on helping to establish strong networks and communities.

The implications of the power of networks and community for a healthcare system hoping to shift to a preventative approach are profound. It suggests that healthcare professionals should focus heavily on helping to establish strong networks and communities. The experience of those parts of the public sector already working in this way, particularly in local government, is that public services and their employees can play a very powerful catalytic role in doing just this. Building capabilities in communities, convening networks, identifying and supporting potential leaders become crucial aspects of a public servant's activities.

But the lessons are clear that for professionals this is primarily a catalytic and ongoing supportive role. Ultimately power and some resource need to be provided to community members themselves to launch, maintain and expand the networks that underpin both the peer-support and more general interconnections that drive good health. The state, however benevolent, cannot create or lead the social capital that is an inherent part of community activity itself – a truly community-powered mindset and approach is required from a healthcare system that wants to take this profound route to prevention.

72 Marmot, M. et al. (2010). *Fair Society, Healthy Lives: The Marmot Review. Strategic Review of Health Inequalities in England post-2010.*

PFG Doncaster: Community-based peer support for people with mental health conditions

PFG Doncaster is a powerful example of community-based peer support.[73] The group developed with the support of former social worker Kelly Hicks, who applied her practice to people with mental health problems who felt unsupported by the formal mental health system. But instead of working with each on a one-to-one basis, she encouraged a community of mutual support to grow. The name of the group evolved from Personalisation Forum Group to People First Group, reflecting their evolution from a more medicalised advocacy group to a stronger sense of community empowerment.

As the peer support network matured, their impact has deepened. Through a buddy system, group members support each other to attend to general life admin, fun activities and mutual talking therapies, so that in an estimated 90 per cent of cases they no longer contacted the crisis team. The group took control of their own building to run the Wellness Centre, created as an antidote to stigmatising clinical mental health day centres they had experienced. This peer support model has been replicated within particular communities, including amongst Muslim women, and members have presented at sessions for mental health professionals so they can learn more about user experience.

According to an evaluation framework developed by the Centre for Welfare Reform in partnership with PFG Doncaster, Doncaster MBC and NHS commissioners, the social value of PFG Doncaster was £3.2 million in 2019. The statutory financial support they received was only 1.5 per cent of this sum, so in other words by spending £1, statutory services have seen £69 of value created. Just before Covid hit, PFG Doncaster were commissioned to provide their own peer-based crisis support service Safe Space, with a

73 Duffy, S. (2021). *Growing Peer Support: Peer-led crisis support in mental health services*. Centre for Welfare Reform.

pathway designed from members' experience and connected to both statutory and wider VCS support. In its first year of operating throughout 2020, coinciding with the pandemic hitting, it supported over 1,000 referrals. PFG Doncaster has recently established a partnership with the Yorkshire Ambulance Service, piloting a dedicated crew to divert from A&E seven days a week.

3. Improving the resilience and collective wellbeing of local communities

The role of the collective in good health and wellbeing goes beyond the power of networks to provide peer support or a sense of connection and agency. Marmot found that poverty is a major driver of ill-health not solely because of the personal toll of deprivation but because of the lower prevalence of collective goods in poorer areas of the country: decent housing stock, job opportunities, green spaces, safe streets, clean air, sources of cheap and healthy food, reliable childcare and schools.[74]

The fact that many areas of the UK do not have these collective goods is not the fault of communities themselves. Addressing the causes of this deep structural poverty and inequality is well beyond the scope of healthcare organisations or any public service. But this does not mean that it is sustainable for NHS organisations to operate in isolation or abstraction from communities where these social and economic causes of ill health exist.

It is evident that communities with strong networks and a sense of agency are more likely to be able to demand action from authorities to address the shortfall in collective goods and even to create improved collective goods themselves.

Of course, under the current paradigms, the notion that the NHS would support local communities to campaign for better collective goods or

74 Marmot, M. et al. (2010). *Fair Society, Healthy Lives: The Marmot Review. Strategic Review of Health Inequalities in England post-2010.*

deliver them as best they can themselves would appear to step beyond its role and remit. But we may be beginning to see a nascent shift here underpinned both by the strong evidence of the role of those goods in promoting health coupled increasing recognition of the limits of relying solely on a medical model. There is now, for example, growing interest in how NHS organisations can be anchor institutions, and an imperative for change set out in the fourth aim for ICSs to support the NHS to contribute to wider social and economic development. But a significant shift in practice, mindsets and resources would be needed to make this a reality. The Canadian Community Health Centre model provides a good example of how formal healthcare provision with primary care at its heart can combine with community development to actively address wider determinants and structural factors that affect health outcomes. There is no such similar formalised approach in the UK, albeit some GP practices are blurring the boundaries between formal primary care and community mobilisation (See mobilising community assets on page 68).

Combining primary care and community development to support health in the context of wider determinants - Canada's Community Health Centres

Community Health Centres are a model of fully integrated healthcare widely used across Canada, in which formal primary care is combined with health promotion, illness prevention and community development to be responsive to the needs of individuals in the context of different communities.[75] Moving beyond the family doctor model, primary care physicians are part of a wider inter-professional team including social work, psychology and psychiatry, in addition to health promotion and illness prevention services. This enables a responsive offer based on the needs each individual rather than the clinician. For example, Taibu CHC in Ontario offers childcare to people who wish to access the activities they offer such as mental health workshops of physical fitness sessions, reducing barriers to access.

75 For more information, see The Canadian Association of Community Health Centres: https://www.cachc.ca/ (27/06/22).

In parallel to this, CHCs have an explicit mission to address the more systemic social, economic and environmental factors that negatively determine health outcomes. Each CHC is governed by community members who set its priorities and has wider ongoing community participation built into its practice. Deeply informed in this way by community insight and intelligence, CHCs then initiate programmes and partnerships that are responsive to identified community issues and needs. These are often focused on wider determinants of health outcomes such as housing, transport, education, employment, income and food security. CHCs include activities such as youth clubs, gardening clubs and partnerships including with legal aid and local food banks. One CHC recognising the negative health consequences of poor education attainment, set up the separate Pathways programme to tackle high school drop out rates and decreased them from 56 to 10 per cent.

There is a strong focus on equity and working directly with communities who face marginalisation and experience the greatest barriers to good health outcomes, for example through structural racism, discrimination or cultural incompetence. For example, Taibu CHC directly serves the local community but has a wider geographic remit to serve the black community on a wide range of issues “cradle to grave”. This involves developing best practices and advocating to reduce unequal outcomes. For example, sickle cell disease has a higher prevalence amongst black populations but there are significant barriers to accessing appropriate care due to poor understanding of presenting symptoms at hospitals, so there is a focus on raising awareness. Ontario has established a network of Aboriginal Health Access Centres which are focused on bringing the community-led primary care CHC model to these communities, including offering traditional healing and a range of social and family support.

This chapter has set out how core community-powered approaches are to a major shift to a preventative approach within our healthcare system. Its argument stands as a firm counterpoint to the current shallow debate about prevention which tends to focus heavily on the role of individual choice rather than community and collective action.

The chapter also reveals how alien much of this sounds – despite its basis in strong evidence – to a healthcare system that has a centre of gravity in acute response, favoured by the medical model and supported by the wider dominance of state and market paradigms in our public services. There is a long way to go to generate the necessary change if we are to genuinely address the demand crisis and defend the foundational principles of the NHS.

The next chapter now turns to outline what the practical features of a more community-powered NHS would be, operating in the context of an integrated health and care system. The case set out builds on the energy and ambition already present in the system - innovative existing practice which is shifting how communities and health institutions are working together. Collectively, these examples start to provide us with a hopeful vision of what a community-powered healthcare system could look like if these practices became mainstream and business as usual across partner organisations.

4. WHAT DOES COMMUNITY-POWERED HEALTHCARE LOOK LIKE?

Unlike the state and market paradigms – or indeed the medical model – in a community paradigm more power and resources would be directed out into communities to give them greater control over addressing the underlying causes of ill health. Professional (in this case clinical) expertise would sit alongside community expertise.

As participants within communities, people would exert collective power over institutions rather than be treated as a collection of individuals. There would be opportunities for people as communities of place and of need or interest to get involved in the design and deployment of NHS services focused on both upstream prevention and providing care that is responsive to people's needs.

The grid on page 54 sets out some key features of the NHS operating under the state and market paradigms, and how these would shift under a community paradigm.

This section will explore the range of practice that already exists across the UK and globally, which demonstrate community-powered approaches in action and point in the direction of the shift to a community paradigm we set out in the table above.

The features of a community-powered approach cannot be reduced to a single rigid model or toolkit. We conceive of community power as an approach, a principle grown out of communities themselves and the grassroots community and voluntary organisations within them, that is now shaping thinking within the public sector, particularly in innovative parts of local government and increasingly the NHS. The organisations and teams seriously adopting community power are growing and expanding it to make it their own - rooting it in the aspirations and priorities of their communities, places and services.

Three NHS paradigms: state, market and community

The NHS	State paradigm	Market paradigm	Community paradigm
Key organisational principle	Standardisation	Efficiency	Prevention
Key problems seeking to solve	Treating illness	Treating illness more efficiently	Preventing illness, alongside treatment when needed
Locus of power	Clinician and Whitehall bureaucrat	Clinician and manager	Clinician and community
View of service user	Deficit-led: primarily a passive patient	Transaction-led: a customer with choice determined by provider	Asset-led: a participant in their own health and wellbeing
View of communities	Not in the purview of services	A source of treatment alternatives through social prescribing	Equal partners with deep insight into effective service response
Implementation method	Top-down, uniform model of provision	Targets, performance management and productivity drives	Devolution, culture change and deep community engagement
Organisational relationships	Separate specialist organisations	Competition between organisations	Collaboration and shared community-led mission across organisations
Funding model	Centrally planned funding model	Activity-based funding model	Place-based funding allocations, joint investment in prevention
Accountability	Whitehall	Whitehall, across an increasing number of arms-length bodies	Local accountability in the context of a national outcomes framework
Approach to engagement	Not widely pursued	Patient feedback sought through closed surveys	Community participation viewed as essential to service design
Attitude to data	Quantitative data informs decision-making at the top	Quantitative data informs performance management within different services	Quantitative data, combined with qualitative community insights, informs prevention shift

Based on this recognition that there is no single model, and based on the evidence of existing practice, we identify three broad principles that underpin the adoption of community-powered approaches:[76]

- **Principle One:** **Community participation in decision-making**
- **Principle Two:** **Mobilising community assets**
- **Principle Three:** **Growing a community-focused organisational culture**

We shall now explore how each of these can be employed in a health context, with a strong focus on where these principles are already being applied and where evidence of their impact already exists.

Principle One: Community participation in decision-making

Engaging communities more deeply in the strategic decisions that affect their lives is an increasingly common feature of governmental and public sector decision-making. This is a trend of growing importance across the world as well as in the UK.[77] A key feature of this engagement is that it is deliberative, consensus-building and meaningful. This marks a break with the more limited and closed form of *consultation* traditionally undertaken by services, which are usually designed to secure popular 'buy-in' for decisions that have already been taken or surface any concerns.

Increasing participation in decision-making is being driven mostly within some innovative parts of local government, whereby a growing number of councils are using a variety of methods to engage communities more deeply. These range from formal and intensive approaches such as citizens' assemblies to much more simple techniques such as 'open conversation' which involves council workers

76 For a wider discussion on this see Lent, A. and Studdert, J. '5 Routes to Community Power'. New Local. (3 June 2021). https://www.newlocal.org.uk/articles/routes-community-power/ (Accessed 27/06/22).

77 See *Innovation Citizen Participation and New Democratic Institutions: Catching the deliberative wave.* OECD. https://www.oecd.org/gov/innovative-citizen-participation-and-new-democratic-institutions-339306da-en.htm (Accessed 24/06/22).

or a third-party engaging residents in informal discussion about their priorities. A good example of using formal deliberation on health and care specifically is the London borough of Camden, whose Health and Wellbeing Board initiated a citizens' assembly to identify priorities and expectations for the health system, which set the framework for its five-year health strategy.[78]

As the case studies in this report show[79] there is also growing experimentation with such engagement emerging from within some parts of the NHS, although this remains relatively underdeveloped. One pioneering example is in Morecambe Bay, where the population health team used health inequalities data about the 15 year gap in life expectancy within a six mile radius as the basis for conversations with the community about what could be done to overcome this.[80] Early work with schools developed into wider conversations with the public in general, using tools from the Art of Hosting network,[81] to convene conversations about how people could live life more fully together. Lots of initiatives and developing practice has resulted, from mental health cafes, to churches setting up listening services in GP centres and clinical teams adopting a coaching approach in consultations.

Experimentation such as this, with communities themselves providing insight into how formal provision should be shaped, now needs to become mainstream rapidly and a core part of how ICSs make decisions as systems. There are two reasons for this: one general and one more specific.

First, such engagement is part and parcel of a general move towards a more community-powered approach. It cannot be said in any meaningful fashion that healthcare institutions are really handing more influence to people if the big strategic decisions that shape our healthcare – locally or nationally - are still taken deep within the institutions by groups of senior clinicians, officials, civil servants or ministers – even if local government and some voluntary sector representatives are now also around the table. Such direct community

78 See page 61 for more details.
79 See pages 60 to 68 for examples.
80 Knox, A. "How can community involvement reduce health inequalities?" The King's Fund Blog. (5 September 2018).
81 See http://artofhosting.org/

engagement and involvement is a vital part of building the connection, trust and dialogue which underpins a truly community-powered approach. Thus, if a general shift towards community power is a key part of a similarly general shift towards prevention, then drawing communities much more deeply into strategic decision-making is vital.

Such engagement can also play a more specific role in the move to a preventative approach. It has the power to generate exceptionally useful knowledge from within communities when designing and implementing prevention strategies. Inevitably, community members understand a lot more about the communities they are part of than the professionals delivering a service. The experience of councils that have engaged communities in this way, is that this insight ends up being critical to the success of a decision.

This is particularly the case for communities that are rarely engaged by the public sector and hence often very poorly understood by public institutions, and sometimes termed ‘hard to reach’ (when in fact, as one evidence submission highlighted, “acknowledging that services, not communities are ‘hard to reach’ is essential in initiating meaningful change” [82]). It is also very relevant to communities with a shared and complex health condition which can create unique life circumstances that need to be understood in detail when any prevention approach is being designed. One evidence submission captured the potential here:

“Meaningfully involving communities in the design and delivery of activities and services mean that services would better reflect the people they are for, and better identify and address the barriers people face to accessing them.”[83]

Community engagement of this type also opens up the possibility of mobilising communities around the goal of improved health and well-being. Public sector bodies are finding that deliberative forums and processes are not solely good places to help with decision-making but also provide opportunities to catalyse community action to

82 Evidence submission – MAC UK.
83 Evidence submission – TAWS.

achieve improved outcomes. This is particularly important in relation to prevention, given that it relies on communities and their members taking a more autonomous and contextual approach to their own health than is expected under the acute response model.

Some avenues already exist for people and communities to engage at a strategic level with parts of the NHS. Individuals can participate in shaping local healthcare through forums like GP patient participation groups and Healthwatch.[84] Participation in commissioning processes is another recognised route, with statutory guidance setting out how communities should be involved and providing best practice on approaches like co-production, social value and community development approaches.[85]

The shift to ICSs offers an important opportunity for the NHS to mainstream taking decisions at local level in a way that empowers rather than side-lines communities. These approaches could particularly help support the work of integrated care partnerships and place-based partnerships - there is an opportunity to begin to strengthen joint-working towards prevention by anchoring it around a shared understanding of the experiences and priorities of the communities these partnerships serve.

The legislation and guidance for ICSs is promising in this regard - creating the flexibility for collaborative local systems. A commitment to the principle of subsidiarity, ambitions to direct resources to place-based arrangements, and emphasis on the importance of working with citizens, could certainly enable a deepening understanding of how NHS organisations can work with partners and communities.[86]

If community participation is viewed as an add-on or separate to the biggest strategic challenges facing the NHS, it will always occupy the margins. But as we argue and as the case studies below demonstrate in different ways, community participation is increasingly being

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84 'Local Health Services'. NHS England. https://www.england.nhs.uk/get-involved/get-involved/local/ (Accessed 24/06/22); and 'NHS England' https://www.england.nhs.uk/get-involved/get-involved/how/ (Accessed 24/06/22).

85 *Patient and public participation in commissioning health and care: statutory guidance for CCGs and NHS England*. (2017). NHS England.

86 *Joining up care for people, places and populations: The government's proposals for health and care integration*. (2022). Department for Health and Social Care.

recognised as important for securing positive outcomes on core strategic concerns of tackling inequality and improving population health outcomes, in addition to big immediate challenges like elective recovery waiting times.

For example, community participation has strong potential to help ICSs make progress on the strategic priority of reducing health inequalities. Marmot and colleagues have articulated the importance of engaging the public on this issue, reflecting:

"Effective and honest communication about social determinants is an essential component of garnering public support for the policies and investments in the social determinants of health that are required to once again improve health in England and reduce health inequalities."[87]

There are a growing number of good examples at both service and strategic levels within NHS and partner organisations including Health and Wellbeing Boards, demonstrating how communities can be more meaningfully involved in decisions and contribute their insights for better judgements or practice. The examples which follow give a flavour of these. The goal now must be for ICSs and all NHS bodies to learn from these experiences and make them a core part of how decisions are taken.

87 M. Marmot et al. (2020). Health Equity in England: *The Marmot Review 10 years on.* Institute of Health Equity.

Community participation in decision-making in practice

Involving citizens in the challenge of the elective care backlog: West Yorkshire Health and Care Partnership and Healthwatch

West Yorkshire Health and Care Partnership and Healthwatch partnered to convene a citizens panel in June 2021 with a remit to support communications around delays to planned care services in the area.[88] A panel of nine volunteers who were all on the waiting list for planned care met for two hours every fortnight for 12 weeks, joined by hospital managers, clinicians and staff from across the Partnership. Panel members shared their own experiences of waiting for treatment, including the impact on their physical and mental health, and how the waits were affecting their daily life and in some cases livelihoods.

The panel provided a great deal of valuable feedback which has helped to prioritise and focus services on what matters most to those affected by delays in planned care, for example through more attention to supported waiting. The panel's insights highlighted the importance of regular contact and updates, which would help peace of mind on behalf of individuals waiting. They highlighted some areas where hospital procedures could be improved to free up capacity, for example improved conversations with GPs to avoid incorrect referrals and identifying what could be done in a community setting rather than a hospital. The panel's views also provided insight for a range of services beyond just planned care – including mental health, personalised care and social prescribing services.

88 See *Seeking patients views on delays to planned care caused by the pandemic*, West Yorkshire Health and Care Partnership, June 2022: https://www.wypartnership.co.uk/application/files/3316/5596/5634/Seeking_patients_views_on_delays_to_planned_care_June_22.pdf (Accessed 29/06/2022)

An area of focus for the panel's discussions was health inequalities. Panel members raised non-clinical factors which were important to them, such as whether a person's ability to work was a factor in treatment prioritisation, or whether there was any recognition that some individuals might be more confident navigating the system than others. The panel recommended specifically that people with lived experience should be involved in the work of healthcare services so they meet the needs of people that access them. There is now a wider piece of work being conducted across all trusts in West Yorkshire looking at other factors that affect health inequalities as part of the overall prioritisation process.

Using community deliberation to set a strategic direction: Camden Health and Wellbeing Board

Camden Council and its partners are developing a vision for what a more community-powered health and care system looks like in practice. Their approach has demonstrated how communities can be involved in setting this strategic direction.

As an early step, in 2020 the Health and Wellbeing Board sponsored a citizens' assembly which brought together a representative group of residents to develop a set of expectations to inform the Joint Health and Wellbeing strategy and the focus of the integrated borough partnership.[89] Five facilitated events were held (four online due to Covid-19), and participants were also invited to be citizen scientists documenting their experiences of the pandemic alongside that of their families and communities. Participants identified three key priorities – on health inequalities, helping people to stay well, and how services work together and communicate with residents – and a set of expectations to

89 Evidence submission – Camden Council.

underpin them. These expectations covered a range of ambitions for a community-focused health and care system, in which communities are involved in resource decisions and the design of services; joined-up services mean people only have to tell their story once; grassroots organisations are supported; and people are empowered to help themselves and others stay well.[90]

Informed by these priorities and expectations, Camden's Joint Health and Wellbeing Strategy sets out how partners across the borough will take a population health approach with a strong focus on the social determinants of health. This will be guided by a set of shared principles and long-term strategic ambitions, also directly informed by the assembly. At the core of the strategy is a strong focus on community power shaping how the council, NHS, other partners, and communities will work together to improve health and wellbeing in the borough:

"Over the course of this strategy, our partnership will seek to test, learn and embed community power into Camden's health and care system, drawing directly on the knowledge and experience of people who live here." [91]

The strategy builds on a range of wider practice in Camden, including growing use of participatory and deliberative methods; approaches like social prescribing and community champions which draw on community assets and networks; and frameworks for strengths-based practice in adult social care and for teams working with children and families across the borough. Going forward, the HWB will champion people's participation, ensuring that citizens' voices inform its work. A neighbourhood approach will focus on how good health is promoted out in and led by communities alongside the VCSE. Equally, there is a strong emphasis on shifting the culture from "more paternal and transactional" approaches to more "collaboration" and "creativity". This is coupled with efforts to empower the wider workforce in Camden to develop strengths-based practice and recognise the value of existing community assets.[92]

90 Camden Health and Care Citizens' Assembly: Final report. (2020).
91 Camden Health and Wellbeing Strategy 2022-30.
92 Camden Health and Wellbeing Strategy 2022-30.

Gaining insights into the health and wellbeing of communities, Frimley Health and Care ICS's community panel

Since 2019, Frimley Health and Care ICS has run an online community panel as a way to gain greater insight into the communities it serves. The panel has over 1,500 members from across the ICS area. Surveys, focus groups and workshops have provided a way for people to share their views. The information gathered through the panel has helped develop understanding of the health and wellbeing of different communities and people's experiences of services.[93] The panel has looked at specific topics like people's views on volunteering.[94] During the pandemic, the panel was able to provide an important insight into people's health and wellbeing – from what was concerning them right now, their access to information about Covid-19, and their experiences of accessing services.[95]

This panel sits within the ICSs wider approach to working with the people it serves – known as Frimley's Community Deal. The Deal is about recognising that the ICS and partners need to work with people and communities to improve health and wellbeing. The Deal is being developed with communities in each place across the ICS, guided by a shared set of principles which focus on the role everyone can play and the importance of "building strong neighbourhoods".[96] This way of working with communities is practically developing through initiatives like the Innovation Fund aimed at supporting small community projects to improve health and wellbeing. In 2020/21, the Fund gave £140,000 of

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93 'Community Panel'. Frimley Health and Care. https://www.frimleyhealthandcare.org.uk/get-involved/community-panel/ (Accessed 29/06/22).

94 'Panel's views & experiences of volunteering'. Frimley Health and Care. https://www.frimleyhealthandcare.org.uk/get-involved/community-panel/panels-views-experiences-of-volunteering/ (Accessed 29/06/22).

95 Community Panel – Health and wellbeing during the Covid-19 pandemic. Results from the third survey (28th May to 14th June 2020). Frimley Health and Care. https://www.frimleyhealthandcare.org.uk/get-involved/community-panel/panels-views-and-experiences-during-the-covid-19-pandemic/ (Accessed 29/06/22).

96 'Community Deal'. Frimley Health and Care. https://www.frimleyhealthandcare.org.uk/about/our-plans-to-create-healthier-communities/community-deal/ (Accessed 29/06/22).

support across 34 projects across the Frimley geography. Frimley Health and Care also has an Insight and Involvement Portal which provides a platform for members of the public to look at and get involved in projects across the ICS which are seeking people's views and engagement.[97]

Supplementing data with insights from communities to address unequal health outcomes

Bolton NHS Foundation Trust Board care board has worked with the Council and the Clinical Commissioning Group to combine data and insights from local communities.[98] This has informed a shift towards prevention and early help across all public sector organisations in the town. In one example, data showed that the worst maternal health outcomes were concentrated in women living in super output areas in postcodes in the BL3 and BL4 areas of Bolton, which informed a dive into the more detailed circumstances of those neighbourhoods. In one community there was a particular issue with women presenting later than average during their pregnancy as it was considered bad luck to visit a GP before three months. The local community outreach midwife worked intensively with local women, GPs and community groups to understand the factors behind these choices. This informed the creation of a new local hub for pregnant women that has sought to remove cultural barriers to access and is focused on improving maternal health in a culturally appropriate setting.

Risk-stratification of the local population as part of the **Wigan Deal** has informed approaches to those most at risk which take a different starting point to the typical single-service response.[99] For example, it was established that £250,000 a year was being spent on 25 families across health, local government and other

97 *Draft Frimley People and Communities Strategy*. (May 2022). Frimley Health and Care.
98 Case study developed from interviews.
99 Case study developed from interviews.

services. Separate agencies were processing their needs and eligibility rather than taking a more connected, relational starting point that sought to understand their wider context. By adopting an approach that more proactively reached out to work with the families in the context of their networks and assets, better outcomes were achieved for both the individuals and the services, including unplanned hospital admissions amongst them reducing by 30 per cent within one year.

In **Gloucestershire**, joint work between the CCG, six local authorities in the area and Severn Wye, a local sustainability charity, interrogated health surgery admissions data. This identified the local park home community as an at-risk group: a largely elderly population with poorer health outcomes across the board, living in poorly or completely uninsulated accommodation. Using disabilities facilities grant sought via the council, the charity carried out the work to insulate the properties of the park home community. Comparing the admissions data from before and after the EPCs amongst this group, partners calculated significant savings from the energy efficiency improvements to both the NHS (over £400,000 over five years) and to society (over £7 million over five years). Given that the estimated annual cost to the NHS of cold homes is £1.4 billion a year, this approach demonstrates considerable efficacy, but also the necessity of a highly localised community-informed response.[100]

Putting people's experiences at the centre of HIV clinical care: George House Trust, Manchester

Based in Manchester, George House Trust has been providing HIV support, advice and advocacy services to improve health outcomes since 1985.[101] They run an HIV Intensive Support Programme which

100 Evidence submission - Severn Wye.
101 See https://ght.org.uk/ for more information and resources.

aims to improve how people engage with clinical services and adhere to their medication.[102] The programme is for people who have multiple and complex needs including experiences such as access to appropriate housing, drugs and alcohol, co-morbidities, poor mental health or domestic violence. People work one-to-one with a key worker who acts as a single point of access to help them navigate the system. The key worker supports the person with their wider needs while in turn helping them to better manage their HIV. The approach aims to ensure that the person is in the lead when it comes to designing their own support:

"The ultimate goal is to place the individual in the position to improve their own circumstances with the right level of intensive support for them, which they can then sustain on their own following the intervention."

This emphasis on understanding people's experiences is also built into the structure of the organisation itself. George House Trust is a user-led charity which works with volunteers and employs people who have themselves accessed services. Another important feature of the programme – particularly from the perspective of delivering person-centred support - is how it integrates with other services. The role of the intensive support worker is "to focus on the social needs of the individual and working in partnership with clinical and mental health services to address the health and psychological needs". Practically, this is achieved through NHS honorary contracts which mean intensive support workers can work closely as part of a clinical multidisciplinary team. This also helps clinical teams understand the programme and its value. Partnership work with Manchester Foundation Trust has been crucial to the success of the project.

George House Trust measures success using a range of different metrics which take in both improvements around clinical outcomes, wellbeing and "person-centred metrics" identified through working with individuals. By the end of March 2022, 96 per cent of the service users referred to the service had improved

102 This case study is based on evidence submission – George House Trust.

their engagement with clinic and 79 per cent had achieved an undetectable viral load. 79 per cent reported an improvement in their emotional wellbeing and 85 per cent in general wellness. 85 per cent had been stepped down to another service. An initial cost benefit analysis of the programme showed that every £1 invested returned £53 of benefit.

Designing services with young people to tackle the root causes of mental ill health: MAC-UK, London

MAC-UK is a charity which runs projects in London working with excluded young people - alongside voluntary, statutory and NHS services - who have high risk factors for poor mental health but also may find it harder to access traditional mental health services.[103] MAC-UK's approach is strongly focused on prevention through working with communities and young people:

"We believe in meeting people in their place and at their pace and designing and delivering services with, not to or for, people. We work on the principles of devolved power, improved equity and increased accessibility and believe systems change is key to achieving truly community led, preventative approaches."[104]

MAC-UK's unique INTEGRATE approach is not a 'traditional' service. Instead of spending time in clinical settings, teams get out into communities to the spaces where young people feel safe and spend time. There is a strong emphasis on working with individuals as part of their wider community. For example, this is reflected the practice of peer-to-peer referral – an important route to building trust. A core element of the approach is co-

103 For more on this see 'Our Work'. MAC-UK. https://mac-uk.org/our-work/ (Accessed 27/06/22); and Durcan, G., Zlotowitz, S., and Stubbs, J. (2017). *Meeting Us Where We're At: Learning from INTEGRATE's work with excluded young people*. Centre for Mental Health and MAC-UK.

104 Evidence submission – MAC-UK.

production – young people lead activities that interest them, giving them a chance to shape the project and gain valuable skills and experience. Alongside this, staff provide mental health support and work with young people to identify other help they need on issues like housing and benefits.[105] A second core element is the role of 'youth-led systems change', focused on opportunities to ensure young people's voices are heard and their experiences used to better inform how wider services are designed and delivered.[106] Practical examples of this include supporting them to get involved in campaigning and to provide training to public sector organisations on working better with young people.

The INTEGRATE approach has demonstrated impact for individuals and at a system level. The Centre for Mental Health evaluated three of MAC-UK's projects and found that the young people involved reported improved mental health awareness and improvements in mental wellbeing. These improvements were supported by clinician-rated measures as well. At a system level, in Camden, the CCG and the council went on to develop a strategy specifically focused on the transition between young person and adult mental health services.[107]

Principle Two: Mobilising community assets

Involving communities directly in the decisions, design and delivery of healthcare and wider wellbeing support is a fundamental part of a move to a community-powered approach to prevention. This can be seen as an effort to mobilise the many assets that communities have and which are routinely ignored and bypassed under the state and market paradigms. These assets vary widely in nature from community to community but broadly include the detailed local understanding of

105 For more details on the INTEGRATE approach see Durcan, G., Zlotowitz, S., and Stubbs, J. (2017). *Meeting Us Where We're At: Learning from INTEGRATE's work with excluded young people*. Centre for Mental Health and MAC-UK.

106 Evidence submission – MAC-UK.

107 Durcan, G., Zlotowitz, S., and Stubbs, J. (2017). *Meeting Us Where We're At: Learning from INTEGRATE's work with excluded young people*. Centre for Mental Health and MAC-UK.

people within the communities; voluntary activity and grassroots action; pre-existing and potential networks of peer support and information-sharing (such as faith communities, sports clubs and hobby groups); and buildings, space and local institutions (such as schools, parks, pubs or community centres) that are used and trusted by communities.

It is self-evident, given the role of active communities in prevention detailed throughout this paper, that a prevention-focused NHS would understand that it had a central role in mobilising community assets. Where the first principle set out above focuses largely on how to bring people's voices into the NHS, this second principle is much more about how the NHS supports what is happening out in communities. One evidence submission captured this well:

"The critical consideration here is how does the NHS participate in community (and react to that), not how the community participates with the NHS."[108]

Another emphasised the importance of *"recognising the role that 'non clinical' responses can play in delivering clinical outcomes."*[109]

The experience of the pandemic, both in the early days of the crisis through the rapid mobilisation of mutual aid and later on during the successful Covid-19 vaccine rollout, is a great demonstration of the role community mobilisation can play in delivering effective prevention. The evidence submitted for this report showed that services got out into communities and delivered "health where people are" for both testing and vaccines.[110] The importance of social infrastructure was demonstrated, both for vaccinations but also a whole range of vital support activities like food distribution.[111] Many within public services, the VCSE and communities report an unprecedented spirit of collaboration beyond professional remits and based on common humanity.[112] Particularly the wider recognition of the vital role of communities and local organisations - as one evidence submission captured:

108 Evidence submission – George House Trust.
109 Evidence submission – Board at Nova Wakefield District
110 Evidence submission – Power to Change.
111 Evidence submission – Locality.
112 This was a theme across a number of evidence submissions.

"The pandemic has highlighted the power of communities and the positive and tangible impact of involving them in delivering 'solutions' and their ability to offer an accessible, inclusive and flexible response."[113]

Involving communities in this way is highly context specific. It is thus difficult to generalise about what that involvement might look like and how it is pursued. The experience of organisations that have gone down this route is that this shift is dependent on the change in organisational culture described in the third principle detailed below. It requires an outward-facing approach from the public sector institution and a willingness to be led by the community itself rather than imposing preconditions on what exactly collaboration might look like or the areas it might address. That means, in practice, that healthcare bodies would need to have a far more permissive approach to the autonomous decision-making of frontline workers[114] directly engaged with communities, in addition to a willingness to allow diversity of approaches to flourish and some risk to be taken with community-led initiatives.

The case studies presented throughout this section offer an initial guide for the types of initiatives and approach that can emerge within this culture. There are three features which seem to be common across most or all experiences of successfully mobilising community assets.

The first is the amount of time it takes to mobilise communities. This approach is not a quick fix. Building the requisite relationships, trust and confidence within communities – particularly those most ignored by public sector bodies – can be the work of years. This requires patience and a long-term commitment on the part of NHS managers and leaders that is often absent particularly in the unhelpful context of numerous acute response targets imposed by NHS England and the Department of Health.

The second is the importance of capability building. Many communities

113 Evidence submission – West Yorkshire Health and Care Partnership.

114 For an interesting discussion on these issues see Coyle, D., Dreesbeimdieck, K. and Manley, A. (2021). 'Productivity in UK healthcare during and after the Covid-19 pandemic'. The productivity Institute.

lack the confidence or skills to work collaboratively with each other and public sector bodies in a focused and effective way. There is thus an obligation on public servants to commit time and effort to nurturing those capabilities. Previous New Local research has explored the features of mobilised communities as opposed to atomised communities.[115] These include a significant degree of coordinated dialogue within the community, the development of shared priorities and a clear understanding of how to use local assets and networks. Power shared with mobilised communities has a great opportunity to enhance and build further these capabilities, relationships and trust. By contrast, features of atomised communities include no established practice of shared dialogue and under-developed insight into existing assets. In these instances, or where previous experience of mishandled public sector consultation has bred cynicism, there is a need to focus more deeply on establishing the conditions for building capability and the expectation for greater shared power.

This leads directly to the third feature – the need to develop the skills and capabilities of public sector professionals including the NHS workforce. The state and market paradigms recognise formal skills and professional qualifications, and do not favour the skills required of a community-powered approach such as convening, facilitating, coaching and deep listening. Making the shift away from a skillset rooted in the notion that the professional knows best to one rooted in the insight that the community knows best is a major change for many public servants. Training, peer support and self-reflection is needed to make that change.

Fortunately, there is evidence, at a service delivery level in the NHS, of a growing awareness around the need to work with individuals and (although still to a lesser extent) with communities as active participants in their own health and wellbeing. One of the areas where this idea has been influential is the Comprehensive Model of Personalised Care - a set of programmes aimed at working collaboratively and flexibly with people around their health and care needs and drawing on their own insights and experiences.[116]

115 See Tiratelli, L. (2020). *Community Mobilisation: Unlocking the potential of community power*. New Local.

116 'Delivering Universal Personalised Care'. NHS England. https://www.england.nhs.uk/personalisedcare/upc/ (Accessed 24/06/22).

Social prescribing is part of the personalised care offer – the NHS's commitment to expanding this reflects growing recognition that encouraging people to participate in activities in their communities could help to improve their health and wellbeing. A strong theme within submissions to our Call for Evidence was the potential for social prescribing to strengthen the link between how the NHS supports individual patients and how it contributes to improving population health and supporting thriving communities. Locality shared a set of principles - built on learning through its Health and Wellbeing Network - to ensure social prescribing is part of the systems change needed to address health inequalities. One of the central principles is ensuring parity between a clinical model and social models of health, moving beyond a one-off transactional approach to one that more clearly recognises the potential to build longer term community capacity:

"Social prescribing should involve equal partnership between community sector and clinicians to co-design prevention-focused local health services. Social prescribing models which simply seek to 'refer out' to the community sector for non-medical issues create a disconnect between clinical and social provision and miss a vital opportunity to create a truly integrated approach."[117]

Power to Change also emphasise the importance of social prescribing building on and strengthening existing community networks and infrastructure. A great example of this in practice is Edbert's House, a community business based in Gateshead, which employs link workers who are seconded to GP practices. This gives link workers the connection into the NHS, while also through Edbert's House being connected to the organisation's wider community development work. The organisation also reinvests the fee from social prescribing into community action.[118]

In primary care some pioneering GPs have already begun to build this link by thinking differently about how to achieve the best outcomes for the patients who come through their doors. They are working with communities to nurture and grow activities, initiatives and

117 Evidence submission – Locality.
118 Evidence submission - Power to Change.

assets that are important to them. The Growing Health Together programme, developed by GPs across five PCNs in East Surrey, works with communities to identify, support and connect people to local clubs, networks and initiatives.[119] While GPs in each PCN are guided by the priorities and interests of their own communities, a set of common principles shape the approach. These emphasise taking time to understand what is happening outside formal health services; recognising a role focused on listening, enabling and connecting; and supporting communities to lead activities. In practice, this approach is resulting in a diverse and growing range of projects to help people get active, get out into green space, connect with others, and find support. Activities include a community garden, an intergenerational music project, and a peer support group for people who have a child with additional needs.

Growing Health Together was highlighted in the Fuller Stocktake of primary care as an example of how PCNs can work effectively with people and communities.[120] The review recognised the value of partnering and coproducing solutions with communities as part of efforts to improve population health and narrow health inequalities. It also reflected the need for time and resources for the workforce to properly engage in these efforts.

Some areas of practice are further strengthening this link between improving the health of individuals and mobilising assets in communities. Health creation is a method focused on how communities increase control over their lives and environment and in turn enhance their health and wellbeing. The Health Creation Alliance has championed this and articulated how health institutions could shift their practices to enable and support health creation.[121] Lord Nigel Crisp, former chief executive of the English NHS, has also championed health creation and the need for communities and local organisations to lead on this:

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119 See Growing Health Together 'About the Programme' and 'Places and Projects'. Here: https://growinghealthtogether.org/about/about-the-programme (Accessed 24/06/22).

120 Fuller, C. (2022). *Next Steps for Integrating Primary Care*: *Fuller Stocktake report*. Commissioned by NHS England and NHS Improvement.

121 They have developed five areas of focus to guide NHS staff and organisations to build their capacity to support health creation – listening and responding; truth-telling; strengths-focus; self-organising; and power-shifting. See: The Health Creation Alliance. https://thehealthcreationalliance.org/health-creation/ (Accessed 24/06/2022).

"My definition of health creation is that it's about the causes of health and about providing the conditions in which someone can be healthy and helping them to be so. It's what a parent does or what a good teacher or school or a good employer or community does. It's about helping people be resilient, capable, competent and healthy. It's a very wide definition in which health is linked with other things."[122]

In public health practice, community-centred approaches are focused on creating the conditions for good health through community capacity building; volunteering and peer-support activities; working with communities around local services; and connecting people into community resources.[123] The community or health champion model is another widespread approach building on community networks and peer-support - with varying focuses like widening participation, health education, linking people to services,[124] and more recently the Covid-19 vaccine rollout.[125]

There is now a clear opportunity to build on learning from the pandemic. response which illustrated the value of community

The value of community assets for both individual and population health presents both a challenge and opportunity for ICSs to consider how best to strategically support and invest in communities, and enable this to be led at place and neighbourhood level where most impact can be achieved. In particular, there is now a clear opportunity to build on learning from the pandemic response which illustrated the value of community or "social infrastructure as core health assets".[126] The approach taken within ICSs to strengthen relationships with the voluntary and community sectors will be important to this – both through forums to work in partnership and through commissioning approaches. The following case studies demonstrate how it is possible to mobilise community assets in practice, which needs to be recognised and embedded across healthcare systems.

122 Evidence submission – Nigel Crisp.

123 *A guide to community-centred approaches to health and wellbeing.* (2015). Public Health England.

124 *Community Champions: A rapid scoping review of community champion approaches for the pandemic response and recovery.* (2021). Public Health England.

125 'Community Champions to give Covid-19 vaccine advice and boost take up'. Ministry of Housing, Communities and Local Government and Department of Health and Social Care. (25 January 2021).

126 Evidence submission – Locality.

Mobilising community assets in practice

Supporting communities to become active participants in their own health: Healthier Fleetwood

The coastal town of Fleetwood, Lancashire is one of the most deprived places in the UK. About half of individuals registered at local primary care practices are in the most severe category of socioeconomic disadvantage, compared with about one-fifth for the national UK average. This has clear ramifications on the health of its 28,000 residents, whose life expectancy is significantly lower than the national average, with a higher prevalence of illnesses including diabetes, hypertension, and depression.

Rather than respond to this need in the traditional way, local GP Mark Spencer took a radically non-medicalised approach to improving health, involving community members in their own health creation. In 2016 Spencer started 'Healthier Fleetwood', an initiative that brought together three GP surgeries in an effort to bridge the gap between healthcare providers and local residents, and help people become active in improving their own health and wellbeing.

The crux of Healthier Fleetwood is its role in helping form local clubs, ranging from choirs, to fishing, to walking groups, to Men In Sheds therapy groups - the latter all-the-more pressing in a town that had suffered a high rate of male suicides. Today there are 28 such groups in the town, which are now largely self-managed by residents. All activities are designed pragmatically and firmly embedded within the customs and culture of the local community.[127]

127 Spencer, M. "Healthier Fleetwood': Creating healthier communities via improved social networking in a disadvantaged area of the UK'. British Journal of Diabetes 2017:17. https://bjd-abcd.com/index.php/bjd/article/view/240/421 (Accessed 27/06/22).

The decision to focus on social groups rather than medical intervention was informed by strong research associating participation within social networks – contact with friends, relations, acquaintances and colleagues – with positive health outcomes.[128] This is even more apt in the case of preventing noncommunicable diseases such as diabetes.

The idea of individual agency – selecting and running one's own groups – is vital to the Healthier Fleetwood vision, and is what sets the initiative apart from social prescribing. Indeed, before 2016, GPs had the option to prescribe gym-based exercises but they found low take-up as many people don't enjoy that particular form of activity. Simply by virtue of being part of these groups, the GPs observed significant shifts in behaviours from those participating from self-destructive to 'health-promoting'. People found connections, eased loneliness and became more physically active, making healthier choices. As Spencer has observed "we've seen folks lose a third of their body weight by singing,".

This is backed by data. In 2017/18, the three surgeries participating in Healthier Fleetwood had the worst rates for A&E attendance in their CCG. Within a year, these had dropped by an average of 17.2 per cent; bucking national trends. In the same year, they also reduced non-elective emergency activity by an average of 6.7 per cent.[129] The effect on professionals is also apparent. Spencer's own workload has eased, and he has more control over his working patterns and workload. And his surgery, which once struggled to recruit, now has GPs ringing up to enquire about jobs.

128 Uchino, B, N. et al. (2012). 'Social Relationships and Health: Is feeling positive, negative, or both (ambivalent) about your social ties related to telomeres?'. Health Psychol. 31 (6): 789-796. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3378918/ (Accessed 27/06/22).

129 Vincent, Forrester. 'My PCN: How Healthier Fleetwood neighbourhood blazed a trail'. Healthcare Leader. (28 April 2020). https://healthcareleadernews.com/case-studies/my-pcn-how-healthier-fleetwood-neighbourhood-blazed-a-trail/ (Accessed 27/06/22).

Community Health Workers: From Brazil to the City of Westminster

To improve population health, Brazil has developed a model that directly employs the core assets of a community – its members. Across the country, around 250,000 Community Health Workers (CHWs) look after the wellbeing of their neighbours. Assigned a 'patch' each, they work with the same approximately 200 families, visiting them once a month to keep track of their wellbeing, offer advice, and connect them with statutory or community services.

What distinguishes CHWs is that they are both community members and healthcare employees. This means they can bridge the gap between people and statutory services, becoming a single trusted person who can connect into both professional help and local opportunities. They focus on prevention - visiting regardless of expressed need or if an individual is already accessing services.

A CHW might enquire about general health concerns, immunisation records and prescriptions, as well as about concerns with employment, education or housing. Next, they might make connections with local services; organise community health education groups or signpost to community initiatives. They might identify at-risk children, spread public health messages and generally support individuals with low-level health problems.

Since their first adoption in the late 1980s, the CHW model has spread to cover 70 per cent of Brazil's population, with significant impact on health outcomes. Areas with high coverage of this model report a 31 per cent lower mortality for stroke, and 36 per cent lower mortality for heart disease.[130] Country-wide, there have been significant reductions in infant mortality and hospitalisations due to preventable conditions. There have also been improvements in screening uptake, breast-feeding uptake, antenatal care and

130 Rasella, D. et al. (2014). 'Impact of Primary Health Care on Mortality from Heart and Cerebrovascular Diseases in Brazil: a nationwide analysis of longitudinal data'. BMJ 2014; 349. https://www.bmj.com/content/349/bmj.g4014 (Accessed 27/06/22).

immunisation coverage, while the health gap between rich and poor has narrowed.[131] In addition, the scheme is not resource-intensive: costing approximately USD$50 per person per year. Brazil's government has responded to this success by developing funding mechanisms that reward municipalities for adopting the scheme, with incentives particularly targeted at poorer areas.[132]

Outside Brazil, the approach has begun to attract attention. In June 2021, a partnership between Westminster City Council and a GP practice in the London borough launched a pilot scheme. So far, four community members have been trained to act as CHWs in one of London's largest housing estates.

An evaluation is being led by Dr Matthew Harris of Imperial College, who first encountered the model when working as a doctor in Brazil. Initial findings demonstrate that local residents are receptive the presence of CHWs, who are themselves integrating well into the practice and are able to navigate between different services – pointing residents to housing, employment, and health services where appropriate. The surgery's GP also anecdotally identifies a drop in non-medical requests which need not or cannot be handled by a medical professional.[133]

Early findings identify a return of £3 for every £1 invested in this approach – a cost saving which will be important in demonstrating the value of this preventative model across the NHS, social care and local government.

One mark of success is that the National Association of Primary Care are promoting the model nationwide, with similar schemes now launched in Bridgwater, Liverpool, and Calderdale.

131 Johnson, C.D., et al. (2013). 'Learning from the Brazilian Community Health Worker Model in North Wales.' Globalization and Health. 9:25. https://globalizationandhealth.biomedcentral.com/articles/10.1186/1744-8603-9-25 (Accessed 27/06/22).

132 Bornstein, V. J. et al. 'Community Health workers in Brazil' Exemplars in Global Health. https://www.exemplars.health/topics/community-health-workers/brazil (Accessed 27/06/2022).

133 Oglethorpe, K. '" I'd like them for all my patients" The community members transforming a GP practice'. New Local. (25 April 2022). https://www.newlocal.org.uk/articles/community-health-workers/ (Accessed 27/06/22).

Helping people live a good life in their community and reducing unnecessary need for services: Local Area Coordination, Derby

Originating in Western Australia, Local Area Coordination (LAC) is a practical, asset-based approach that is increasingly being adopted by local authority and health partners across England and Wales.[134] A Local Area Coordinator will work in a defined neighbourhood of 8,000 – 12,000, and build relationships within the community, identifying people who may be isolated or at risk of needing formal services. Derby is one of the councils at the forefront of adopting the approach, having had coordinators for ten years – initially in two wards, but now in every ward in the city – and a strong track-record on evaluation and learning as the approach has matured.[135]

A number of features of LAC set it apart from how other parts of the system operate. There are no eligibility criteria or assessments; anyone who might need some extra support can introduce themselves to a coordinator. In practice, in Derby a large proportion of introductions are from health and social care teams often relating to factors like reablement, delaying the need for residential care or preventing hospital admission – all issues at that are central to demand pressures across health and care system.

A core commitment to strengths-based working is another defining feature. Coordinators work with individuals either intensively or by helping them connect to wider support; connect into and build community capacity; and help people navigate services to identify the right support. The approach looks first to individuals and their wider community, drawing only on formal services when best placed to offer support. Coordinators work with individuals to understand what is important to them to have a 'good life'. They 'walk with' that person to identify practical

134 See lacnetwork.org for more information and resources.

135 This case study is based on *Local Area Coordination in Derby: Evaluation Report 2018-2020.* (2021). Derby City Council.

responses like getting help with household tasks, connect them to activities or hobbies, and identify how best to address other life challenges like health, housing or finances.

There is a growing evidence base for the impact of Local Area Coordination, particularly for the individuals that coordinators work with. Derby's most recent evaluation (2018-2021) identifies the contribution of LAC within the system. There is evidence of LAC delaying people's entry into residential care and reducing delayed transfers of care between health and social care (DTOC). For example, estimates (due to data recording limitations) showed that per year, a person receiving on average 24 months of LAC support avoided on average 1 DTOC.

The contribution toward reducing crisis health interventions and appointments – A&E visits, inpatient admissions and outpatient appointments – is a more complex picture demonstrating the need to understand the nuances of demand in the system. Overall hospital attendance went up – but much of this is explained by people who developed new medical conditions or whose health deteriorated, and those who might not have ordinarily been able to connect to the right kind of health support. A large proportion of the group remained in a 'steady state' (with little change in attendance) – given the medical or other problems many of this group were facing, attendance may have increased without support from coordinators. But some people did reduce their use of services. For example, looking at an equal period of time before and after first introduction to a coordinator, 13 people collectively reduced their attendance from 99 visits before to 19 visits after.

Based on the projected increased caseload of LAC operating across all wards in Derby, supporting 765 people each year, the evaluation estimated some potential future cost savings in the system. For example, modelling showed that around 59 people could be delayed or prevented from needing residential care, 22 of whom would be likely to qualify for council funding. Based on a one- to three- year delay, savings could be between £376,376 to £1,129,128 per year.

Investing in community capacity: Heeley Plus Primary Care Network, Sheffield

Located in an ex-steel worker community, the Heeley Plus Primary Care Network in February 2022 committed to transferring 25 per cent of its additional roles budget to a local community anchor organisation, Heeley Trust.[136] This is a grassroots organisation with 25 years' experience transforming the local landscape and economy – including running a local park and a social enterprise business hub. The PCN aspires to eventually increase this to 25 per cent of their overall budget.

Heeley Trust had been developing links and partnership working with Local GP Practices for several years as part of their Community Development Approach. However, the Covid-19 pandemic was the catalyst for deeper and more formal collaboration. During this period, the Trust was at the forefront of supporting local people – delivering shopping, medication and feeding back health issues to practices. Heeley Trust then partnered with the PCN to deliver the vaccine programme, providing management, staff and volunteers and supporting 'vaccine hesitant' residents to understand more about immunisation. This experience helped convince previously reluctant practices to enter into a formal partnership.

An MOU now recognises Heeley Trust as the PCN's 'prime community provider' for three years. There are few strings attached, outside the expectation that the Trust helps the PCN's social prescribing aims and co-ordinates with other local voluntary sector organisations and community groups. The PCN and Heeley Trust have a joint leadership team, with regular meetings to co-design their approach. A core feature of this partnership is the offer of consistent funding. This has at least temporarily overcome an internal debate over how much resource should be directed towards traditional medical approaches, and

136 Case study developed from interviews.

how much to social approaches. It also provides Heeley with more consistent and reliable revenue than community groups can be accustomed to. It allows Heeley Trust to match fund and to cross subsidise services – adding value and developing their role as an equal partner in the PCN.

The partnership complements advances towards personalised and community-centred care already put into place when the PCN was formed. This allowed the creation of new roles including social prescribing link workers, health coaches and care coordinators – all of whom can now work in partnership with Heeley Trust. The PCN is cognisant of the fact that traditional outcome measures will not adequately capture this community-led approach. However, health coaches are already reporting significant improvements in people's weight, blood pressure and measures of confidence. Meanwhile, there have been increased referrals to link workers from a wider range of practitioners. The joint work looks set to continue. Heeley Trust and the PCN recently won a shared funding bid for a transformation fund worth over £150,000, and are jointly contributing to a Levelling Up fund bid.

Principle Three: Growing a community-focused culture

Although most people would be familiar with the phrase "culture eats strategy for breakfast", the role of culture in public service reform remains under-recognised.[137] It is much easier for policymakers to stipulate organisational structure and governance procedure, than it is to mandate behaviour and operating norms. So, the former is the focus of legislation and guidance, and the latter largely overlooked. And yet, if the power of communities is to be understood, valued and nurtured, institutions need to reflect how their own culture is critical to the success or failure of this.

Organisational culture change is particularly important for a shift to a community-powered approach because of the diversity of solutions,

137 Lent, A. and Studdert, J. (2018). Culture Shock: Creating a changemaking culture in local government. New Local.

opportunities and challenges that the approach tends to generate. Community power is not a model that can be simply transferred from place to place. Its evolution is determined by the particular communities who ultimately should influence and lead decisions and the nature of support. Since those communities are exceptionally varied in their priorities, assets and mindset, so their solutions will evolve in different ways. This means that community-powered organisations need to act and think in ways that can respond positively to such unpredictable diversity, as opposed to under previous paradigms which emphasise standardisation and expect to be able to codify linear processes within distinct organisational remits.

In addition, the evidence from bodies moving to a community-powered approach is that the biggest obstacle by far to change is existing organisational culture which tends to favour hierarchy, risk-aversion, wariness of rather than deep engagement with communities and, as detailed extensively here, a very strong focus on professionalised acute response. All these characteristics militate intensively against a community-powered approach and thus require radical change if that approach is to be meaningfully adopted.

Developing a community-focused culture across NHS organisations will require buy-in from system leaders and the workforce.

In practice, developing a community-focused culture across NHS organisations will require buy-in from system leaders and the workforce, as well as a shift in how NHS organisations relate not just to their direct partners in integration, but to the communities, places and economies they are part of. As one evidence submission captured:

"The NHS needs to accept the subset of health and well-being in the community and not be a driver of it. The barriers that exist are predicated on the NHS being the gatekeepers, the controllers, the policy leads on this. To release capacity within communities, new relationships between them and health care providers need to be made."[138]

ICS leaders have an essential role to play in modelling commitment to a community-focused health system and articulating this as a shared mission. Culture as an overall concept can be broken down into two domains: mindset and behaviour. For ICSs to succeed in working with

138 Evidence submission – C2 Connecting Communities.

the advantages of community-powered approaches their leaders and key influencers within the system need to have a mindset that values the understanding of lived experience and community insight. This needs to be identified as a core competency and developed as a recognised value. In turn, behaviours of those within the ICS need to reinforce and give practical expression to this mindset, including in how governance works. The role and influence of ICPs will be significant indicators of this mindset, and play a strong role reinforcing expected behaviours throughout the system. The approach of the West Yorkshire ICS in developing and disseminating a community-focused vision of healthcare is a great example of this in practice (see page 89).

A key challenge for ICS leaders will be creating the bandwidth to develop and deepen this community-focused priority against more immediate pressures. The NHS Confederation has highlighted the risk that "ICS structures will revert to old, more hierarchical ways of working".[139] On this theme, Professor Sir Chris Ham identifies how ICS leaders need to play the role of convenors and facilitators "[exercising] leadership in a non-hierarchical system"[140] – within this kind of leadership model there could be more space to champion the value of listening to, learning from and working with communities. The nascent experience of using citizens panels to deliberate some of the most complex challenges confronting health services, including elective recovery and sustaining wellbeing during a pandemic, demonstrates that focussing on critical demand pressures and deep citizen engagement isn't 'either or': rather, fusing the two can help effective prioritisation.

A shared mission championed from ICS leaderships needs to be supported by clear messaging and accompanying practice which demonstrates that working with communities at all levels is expected. Knowledge and understanding of the value of communities needs to be built across the workforce. This should be accompanied by support for staff teams to see how this community focus relates to their own role and to wider ambitions to strengthen prevention, address health inequalities and improve health outcomes. In turn, the collective ownership of these priorities would help to create strong networks

139 Pett, W. and Bliss, A. (2022). *The State of Integrated Care Systems 2021/22.* NHS Confederation. (page 34).

140 Ham, C. (2022). *Governing the Health and Care System in England: Creating the conditions for success.* NHS Confederation.

of distributed leadership across health and care systems. As one submission to our call for evidence put it, recognising:

"The value and importance of the individual's role in their own prevention (primary, secondary and tertiary prevention), and that not being a sentence in a strategy, but something that is understood by NHS leadership, NHS policy people at every level and every person on the ground. This is because people need to understand their role in prevention, not the 'system's' role."[141]

This shared purpose needs to extend from workforce and leadership to how health institutions are perceived – both by those that work within them, and by communities and by partners. Some organisations are using creative methods to give commissioners and practitioners the opportunity to more deeply understand people's experience of engaging with services, to better inform their approaches. The Manchester-based organisation Made by Mortals uses participatory arts practice techniques to bring this to life and blur the boundaries of service provider and user by giving the former strong insights into the experience of the latter.[142] They run a programme called 'Hidden', which is co-led by people with lived experience, and run an interactive audio project which "challenges listeners to walk in someone else's shoes using their own homes and lives as a theatrical backdrop".

Beyond the issue of workforce practice and skillsets, community-focused organisations need to play an active ongoing role in the places they are located within. Evidence to our research identified the opportunity of connecting anchor institution approaches to a wider role for NHS organisations in communities:

"A community-powered NHS would better acknowledge and play a more significant role in local economic development. Large NHS institutions would play a key role as local anchor institutions, but beyond this all services would be rooted in contributing to inclusive local economies."[143]

141 Evidence submission - George House Trust.

142 Evidence submission – Made by Mortals. For more on the potential of culture, heritage and the arts to support health and wellbeing, see the Social Glue project in Manchester. https://www.miahsc.com/a-social-glue (Accessed 24/06/2022).

143 Evidence submission - Power to Change.

Anchor institution strategies are a practical step to support a wider shift in the role of the NHS.

Anchor institution strategies are a practical step to support a wider shift in the role of the NHS – making clearer connections between health services and the means to influence the broader social and economic conditions which significantly affect people's health and wellbeing.[144]

There is growing practice to learn from here regarding the wide range of roles and impact NHS organisations can have: as employers promoting good work and opportunities; through procurement and commissioning recognising social value; as managers of significant capital and estate which can support community development; using these levers and assets to promote environmental sustainability throughout; and by establishing strong partnerships with other anchor institutions in a place such as in higher education, to wider social and economic benefit. The Health Foundation has compellingly set out emerging examples of this, and identified where attention is needed to embed anchor practices into the NHS, for example the importance of leaders treating "an anchor mission as a core part of the NHS's role and responsibility to local communities". On a practical level, this would need to involve ensuring staff have the time and skills to translate an anchor mission into practice – for example connecting local health and wellbeing goals to practical day-to-day approaches in areas like HR and recruitment.[145] These areas for development have much resonance with. and could practically contribute towards, wider proactive strategies to build a community-focused culture.

The following case studies outline some of the ways in which different health and wider public sector organisations are taking steps to shift their internal cultures towards being more permissive of the externally-focused activity that meaningful community power approaches are built upon.

144 An anchor institution generally describes a public sector organisation (though not exclusively) with features including being large in size, linked to a geographic area, and having physical assets and spending power. See: Reed, S. et al. (2019). *Building Healthier Communities: The role of the NHS as an anchor institution.* The Health Foundation.

145 Reed, S. et al. (2019). *Building Healthier Communities: The role of the NHS as an anchor institution.* The Health Foundation. See also for practical case studies of anchor institution practices.

Growing a community-focused culture in practice

Supporting the workforce to take an asset-based approach to working with people and communities: Wigan

Support and development for the workforce has always been a core component of the Wigan Deal.[146] What is now known as 'Deal training' is central to how the workforce in Wigan is supported to work in an asset-based way with individuals and communities. As the King's Fund has documented,[147] this training developed in a surprising way. Some of the council's social care staff were trained by an anthropologist in ethnographic methods to support an evaluation they were participating in. A lasting legacy of this training came when the team started applying what they had learnt to their own practice in social care and began having 'different conversations' with the service users they supported. Initially, this approach was developed further across the adult social care and health directorate. But as the Deal began to develop, the ethnographic training was taken out to everyone across the organisation. This meant all staff, whether frontline or not, taking part in the training and applying the principles of it to their own role.

The training builds on ethnographic techniques which encourage staff to see the people they engage with and support in their wider context – who they are, their ambitions and experiences, what are their strengths and assets, and the people – their family, networks and communities - around them. An important principle that draws on anthropology is the value of recognising and putting to one side any preconceptions before going into a conversation with

146 See case study on page 43 for more detail on the Wigan model and impact.

147 Naylor, C. and Wellings, D. (2019). *A citizen-led Approach to Health and Care: Lessons from the Wigan Deal*. The King's Fund.

a person. In this way, they start to build up their understanding of a person, what is important to them and how they can be best supported both from their own strengths and skills, their wider community and public services.[148] The key is human to human contact, rather than a practitioner to client relationship.

This asset-based way of working has been promoted beyond the council to the rest of the public sector and other partners in Wigan. A practical example of how this has been done is 'Our Deal for Healthier Wigan experience' which is designed for health and care staff across the council, VCSE and other partners. This initiative supports the workforce to understand what it practically means to take an asset-based approach, particularly making use of the opportunities to have different kinds of conversations with people. Staff are encouraged to think more about people as individuals rather than 'patients', and to take time to understand the strengths of those individuals as well as the wider community resources and networks that could support them.[149] Through this emphasis on staff training, Wigan is building a shared understanding of how public servants and partners work in a community-focused way. The training was, and continues to be part of a wider culture change programme which empowers staff to work differently focussed around Wigan Deal principles. The BeWigan Behaviours are also very much at the heart of this - be Positive, Accountable, Courageous and Kind.

148 Ibid.
149 Evidence submission – Wigan Council.

Supporting and building capacity in the workforce and communities: West Yorkshire Health and Care Partnership

West Yorkshire Health and Care Partnership is focused on building a system where public sector partners, VCSE and communities work together to improve population health outcomes, take preventive action on ill health, and tackle health inequalities.[150] The Partnership's strategic activities underpin this with a multi-layered approach which pays attention to growing organisational culture and leadership, developing knowledge and skills in the workforce, and building capacity in communities.

The Partnership's recent work on health inequalities demonstrates what this multi-layer approach looks like in practice. In 2020, the impact of Covid-19 was a catalyst for the Partnership to commission an independent review on addressing health inequalities for ethnic minority communities in West Yorkshire. In response to the review, the Partnership has sought to take action across the workforce and in communities, and emphasised the links between these areas - "successfully tackling health inequalities becomes more likely if your workforce and leadership is reflective of the communities we serve".[151] Related to the workforce specifically, actions have included a fellowship programme to support staff from ethnic minority backgrounds in their development as senior leaders at different stages in their careers. The programme is open to people across the system, whether they work in the NHS, local authorities or the VCSE. [152] Other actions have included the development, with the Race Equality

150 *Better Health and Wellbeing for Everyone*: *Our five year plan*. (2019). West Yorkshire Health and Care Partnership.

151 *Tackling health inequalities for ethnic minority colleagues and communities*: *One year on report.* (2021). West Yorkshire Health and Care Partnership.

152 West Yorkshire Health and Care Partnership. People Plan: Workforce Strategy (2021-2025). See also: 'The Fellowship Programme'. West Yorkshire Health and Care Partnership. https://www.wypartnership.co.uk/our-priorities/system-and-leadership-development-programme/system-leadership-and-development/bame-fellowship-programme (Accessed 27/06/22).

Network, of a Racial Inequalities Training package to support and train colleagues across the system.[153]

Wider action has focused both on supporting capacity in communities and supporting the workforce with confidence and skills to address health inequalities in their role. A large amount of grant funding has been directed out into community organisations to support activities to address health inequalities – for example supporting eleven organisations with a £100,000 'Targeted Prevention Grant Fund'. A Health Inequalities Academy supports the workforce through resources, training, communities of practice, and a Health Equity Fellowship, supporting fellows from across the system (including the VCSE) around how they and their organisations can address health inequalities.[154]

A strong VCSE sector is recognised as important for building the infrastructure of a responsive health and care system that people and communities can be involved in. This is another area the Partnership prioritises through its dedicated 'Harnessing the Power of Communities Programme' – the aim of which is to support a VCSE sector which can act as "an equal partner" in the health and care system. The programme has focused on strategic issues including sustainable funding for the sector, ensuring VCSE voices are involved in decision-making, awareness raising about the role of the VCSE, and a focus on VCSE led pathways targeting prevention.[155] This commitment is further reinforced in the Partnership's People Plan, through for example a focus on ensuring the workforce recognises the importance of the roles played by the VCSE as well as by volunteers and carers. Other practical actions have included raising awareness about career opportunities in health and care within the VCSE and also supporting an impactful volunteering offer.[156]

153 *Tackling health inequalities for ethnic minority colleagues and communities*: *One year on report.* (2021). West Yorkshire Health and Care Partnership.

154 Ibid.

155 'Working with our Voluntary, Community and Social Enterprise sector partners'. West Yorkshire Health and Care Partnership; and *Harnessing the Power of Communities Strategic Plan*. Both accessed here: https://www.wypartnership.co.uk/our-priorities/harnessing-power-communities/working-with-vcse-partners(Accessed 27/06/22).

156 West Yorkshire Health and Care Partnership. People Plan: Workforce Strategy (2021-2025).

Creating a culture of community ownership of healthcare: The Nuka System of Care, Alaska

The Nuka System of Care is an approach to health and wellness provided in Southcentral Alaska, USA, to a population of around 60,000 Alaska Native and American Indian people.[157] It is founded on a mutual partnership between the healthcare organisation Southcentral Foundation and the Alaska Native community. It was developed in the late 1990s following legislation that allowed Alaska Native people to take greater control of their health services, recognising very poor outcomes amongst their community.

Emanating from a phase of active community introspection, conversations and community analysis to determine how best to meet people's 'mind, body and spiritual needs', the approach is one of the most radical examples of community ownership and parity with professionals that exists today. Based on acknowledgement that both the health system and communities bring knowledge and expertise, it is specifically designed to overcome the limitations of a purely medical model with paternalistic and hierarchical relationships between provider and patient. The community is not understood as patients or consumers, but as "customer-owners". This has significant consequences both for how employees see their role in the context of an explicit acknowledgement of where control lies, and how the community itself plays an active role in decisions over how best to support their own health and wellbeing.

The approach to provision focusses on developing deep, long-standing relations with the community and same-day access to services. Settings provide the full range of primary care, dieticians, case workers, behaviourists, pharmacists and other support

157 This case study draws on a range of sources, including Sara Heath. 'Reimaging patient engament in a value-based care delivery system'. Patient Engagement Hit. https://patientengagementhit.com/news/reimagining-patient-engagement-in-a-value-based-care-delivery-system (Accessed 27/06/22).; 'Nuka system of care, Alaska'. The King's Fund https://www.kingsfund.org.uk/publications/population-health-systems/nuka-system-care-alaska (Accessed 27/06/2022).

staff – focused on mind and body together. Health councils comprising community members provide local governance of healthcare settings and draw in wider family members from the native community. Employees understand their role performing an active feedback loop to understand how community needs are continually evolving and to constantly respond.

The Nuka System of Care has had incredible results. The Alaska Native population had previously been in the bottom fifth percentile in almost all measurable health outcomes, and it is now in the 75th and 90th percentile in almost all health outcomes, as compared to the US national HEDIS benchmarks (Healthcare Effectiveness Data and Information Set). The community served has measurable low high-acuity utilisation, low emergency department and hospital use, low specialty care referrals and total costs to care well below the national average.

The foundation of strong, trusted community relations proved invaluable when the Covid pandemic unfolded.[158] Health councils immediately entered dialogue about the particular impact the virus would have to their communities, for example living in remote but densely concentrated villages and relying on small aircraft for links across the state. Key decisions relating to the vaccine rollout where also carried out directly by the community including information about risks and prioritisation, leading to particularly high uptake rates.

Towards a new community paradigm for healthcare

There is one final but important aspect to note about the three principles of a community-powered approach. It is very hard to find examples of public sector bodies that have implemented all three principles. There are fascinating and even inspiring cases (many

158 Elias Miranda. 'How to build the foundations for a community-based crisis response'. Institute for Healthcare Improvement. (21 April 2021). http://www.ihi.org/communities/blogs/how-to-build-the-foundations-for-community-based-crisis-response (Accessed 27/06/22).

presented here) of healthcare or wider public services that have embarked on radical shifts to engaging communities in decision-making, mobilising community assets or shifting cultures. Some have even adopted two of the principles but closer investigation of any case often reveals that the adoption of a third principle has either not been considered or has been rejected or resisted. One evidence submission captured this:

"Despite a wealth of evidence and recognition within health policy-making, community-led approaches are not yet mainstreamed into the way our health system is designed and commissioned."[159]

This will need to change if community power is to be fully adopted across the healthcare system in order to bring about a wholescale shift to prevention. New Local's research and experience of working directly with public sector bodies looking to move to a community-powered approach is clear that the three principles reinforce each other in profound ways. Deliberative engagement creates the space to discuss community mobilisation. Community mobilisation encourages organisational culture shift as public bodies find themselves responding constructively and creatively to community rather than institutional imperatives. And organisational culture change sustains, strengthens and widens the beneficial outcomes, practices and opportunities emerging from deliberative engagement and community mobilisation. In short, community power works best when it challenges and transforms the whole system in every aspect of its work from strategic decision-making through to the minutiae of daily service delivery.

To that end, the next and final chapter explores a series of recommendations for both national and local decisionmakers and organisations, which if pursued would realise a shift to a new community paradigm for healthcare in practice.

159 Evidence submission – Locality.

5. CREATING A COMMUNITY-POWERED NHS

A wealth of practice exists to demonstrate how community-powered approaches can make a difference for health outcomes. As the previous chapter demonstrated, there are many pioneering examples from within healthcare of communities participating in decision-making, practice focused on mobilising community assets and institutions growing more of a community-focused culture.

The challenge now is for community-powered practices to become mainstreamed.

Yet currently, these initiatives can be found ad hoc, largely operating on the edges of the system and outside the prevailing state and market logic. This reinforces a focus on the primacy of activity-based acute response, driving efficiencies with targets and micro-managing performance. This logic will always be a beast that needs to be fed, crowding out the bandwidth to reflect on how different ways of working could be developed. The challenge now is for community-powered practices to become mainstreamed in order to realise their potential to resolve demand before it emerges or reaches crisis point. This would lead a paradigm shift within the system away from limited state and market approaches, developing a new system logic more focused on supporting prevention and as capable of promoting health and wellbeing as it is of administering treatment when required.

As ICSs develop, there is an opportunity to embed a community-focused approach, but no guarantee. Whether community power can play a core role alongside clinical expertise within new integrated system, place and neighbourhood structures remains to be seen. The potential is for an approach to healthcare focused outside the walls of institutions, supporting people as active participants in their own health outcomes, in ways which recognise and enhance the wider determinants of outcomes.

To that end, this section explores how the shift towards a community-powered NHS could be achieved in practice. It covers two main

sections: recommendations for national bodies and recommendations for systems, places and neighbourhoods – those within the new ICS footprints. These recommendations focus on how policy and practice can be attuned to enable working outside the boundaries of existing institutions and putting communities themselves in control. They explore how, after the focus on new governance structures necessitated by the ICS reforms, there now needs to be a primary focus on the culture, behaviour and new operating norms within systems. These need to be recognised, protected and nurtured at both national and local levels, with a clear mission to shift the centre of gravity of the system towards prevention, focused on improving health outcomes and reducing health inequalities.

1. The role of national bodies: from command and control to permission and adaptation

High levels of nationally-directed activity and resource limit the ability of local actors within NHS bodies to focus on developing 'lateral' collaborative partnerships with other organisations in a place and work more directly with communities. The creation of ICSs implies greater room for manoeuvre for partners within each geography to identify the population health needs and inequalities as they exist in different places, and to innovate to make best use of capacity and assets to respond.

National and regional NHS bodies will need to recognise that if reforms are to embed and succeed in meeting their aims, including improving population health and reducing health inequalities, the next phase must focus on developing these lateral relationships across ICSs, rather than reinforcing upwards accountability at every turn. In practice this will mean creating the scope for NHS organisations to operate outside their territorial boundaries, shaping shared priorities and missions with partners in local government and the voluntary sector, and opening out to the influence and participation of communities themselves. The following recommendations are designed to bring this about in practice by creating a coherent national framework for new systems to mature within.

1.1. Government and NHS national leadership should commit to a ten-year moratorium on any further imposed structural reform within Integrated Care Systems, in order to let community-focused relationships and culture embed.

Wave after wave of structural reforms have been enormously disruptive to those working within the health system.[160] Restructures encourage organisations to focus inwards as new roles, teams and governance structures are established, at the expense of facing out to communities.

Organisations within ICSs now need the time and space to mature as systems, enabled by consistent strategy and policy from the centre. With the permanence of statutory footing for ICSs, government and NHS national leadership should commit to end new initiatives that would disrupt this priority for relationships and trust to grow and embed. A bold ten-year moratorium on further imposed structural reform creates long-term assurance outside the political and fiscal cycles that can dominate public institutional behaviours. This will signal that national leaders are serious about their commitment to prevention and shifting population health outcomes, since strategies to achieve deep change will take time to achieve impact.

The focus within systems has to be developing a shared mission, supported by a culture conducive to working beyond organisational boundaries across partnerships and with communities. Effective collaborative, community-focused working cannot be driven top down or occur within a predetermined timeframe but must be given a chance to evolve and deepen over time. Where change is identified as necessary, this should be from within ICSs themselves.

160 The last decade alone has seen the establishment and disbanding of CCGs, Integrated Care Pioneers, Vanguards, Sustainability and Transformation Partnerships, Accountable Care Organisations, and more.

The role of national bodies needs to focus on providing consistency to support this evolution and removing barriers which prohibit it or second-guess it by mandating change. Future updates of the NHS Long Term Plan should emphasise this next phase of embedding integrated relationships and practice.

1.2. Government and NHS national bodies should commit to stop initiating short-term pilots as a method of change, and instead focus on developing continuous improvement mindsets and supporting peer learning exchange.

To add further assurance and stability to ICSs, national bodies should also commit to stopping new pilots and instead recognise that system reform requires a different approach to fostering innovation and adaptation. Pilots are by definition selective, ad hoc and operate only in isolated areas, so the applicability of learning from one place is by definition limited in another area with a different context and no sense of ownership.

Realising more community power is best understood as a set of approaches rather than a rigid model that can be replicated, so it needs to be pursued, shaped and bought into by practitioners everywhere. In the words of one interviewee, "you are either doing system change or you're not. We don't need marginal experimentation in the short term, we need long term organisational transformation". To support learning and adaptation more effectively across systems, the focus for national bodies should instead be on supporting the development of continuous improvement mindsets and reinforcing that expectation across ICSs. In particular, some parts of the existing healthcare system such as acute hospital trusts, may need extra challenge to develop practices of transparency, openness to feedback and learning from mistakes.

There is also a clear role for national bodies to play in facilitating learning between ICSs and supporting communities of practice to thrive. The mutual reciprocity of sharing insights and lessons learned with peers is a more effective way of understanding how change happens within in complex systems. It enables more three-dimensional understanding of the interplay of factors like culture, leadership and finance as opposed to the more two-dimensional method of being informed of the outcome of best practice somewhere else.

1.3. National bodies should reduce their over-reliance on single-service performance targets as ICSs collectively define place-specific whole population health outcome objectives, with regulation evolving to support this.

The continued over-reliance on national targets led from within the NHS itself has the potential to undermine the ability of ICSs to develop whole system missions beyond NHS bodies. ICS leaders themselves cite overly burdensome bureaucratic regulation and performance management as a barrier to systems working, especially under significant demand pressures.[161] If organisational accountability persists, organisational activity and behaviours will take priority over system-wide activity and behaviours which need to develop and embed. To enable a meaningful shift towards community priorities, partners will need to have scope to identify shared place-based aims beyond the boundaries of any single organisation, for which they are collectively responsible. These will need to relate to data on population level health outcomes and identified inequalities, which will manifest in distinct ways in different places. They will need to focus on system challenges and wider determinants which are not solely healthcare focused

161 Pett, W. and Bliss, A. (2022). *The State of Integrated Care Systems 2021/22.* NHS Confederation.

given where they are unmet the consequences for demand on clinical care are profound.

In the short term, it will be hard to wean national bodies, especially national health leaders, off state-market paradigm target-setting as a route to securing change. Even though their history has largely been that they have been missed, ineffective or incentivise the wrong behaviours, single-issue output targets are tangible and easy to convey to a public audience to herald intent. But to be effective and responsive to local conditions, ICSs should be able to set and prioritise locally agreed shared goals with partners across a place outside the purview of the Department of Health and NHSE – including with local government who have a direct democratic mandate and are locally accountable. As ICSs mature, separate national targets should evolve into a national framework that establishes a few outcomes with which to hold local systems to account. These should be strategic and related to the core ambitions of ICSs including population health and reducing health inequalities. Within that overarching framework – permissive rather than prescriptive – local partnerships should be able to decide which more focused outcomes they should work towards and what metrics track progress.

National regulation will need to adapt to new systems working to provide more intelligent oversight within a framework co-produced with ICSs, attuned to developing collaborative systems working.[162] Alongside this national oversight, the practice of peer-led improvement should develop, supported by national bodies but focused on peer challenge across ICSs.[163] This is a good route to intelligent systems oversight which emphasises sharing expertise for more nuanced and focused support based on how change actually happens within complex systems.

162 Ibid.

163 Danny Mortimer. 'A more agile approach to regulation is needed as we embed system working'. HSJ. (18 March 2022).

1.4. The Government should set out a clear cross-Whitehall plan to shift the centre of gravity of our health system towards prevention and address the wider determinants of health outcomes across all policy areas.

A feature of the dominant state and market paradigm is a siloed approach to policy that separates out areas for departmental focus which are in practice umbilically linked. The systemic failure to address the wider determinants of health outcomes is proof of the limits of this way of devising policy. Health is treated separately from policy focused on economic development, income security, housing and education – despite the fact that from the perspective of the individual and at a community level, they are mutually inter-linked and reinforcing.

There is a risk that the Department of Health pursues a narrow, medicalised approach to prevention and reducing health inequalities which focusses on particular clinical manifestations of poverty such as obesity and smoking, rather than their root causes. There is an equivalent risk that other Government departments pursue strategies which undermine the mission to reduce health inequalities, for example presiding over real-terms benefit cuts and widespread income insecurity, failing to ensure viable high quality social and affordable housing, and pursing narrow public service efficiency drives that fail to recognise the value of investing in prevention. National policy persists in being misaligned: for example, even where the Levelling Up agenda has outlined a clear mission to reduce health inequalities by 2030, it is pursuing a parallel devolution agenda that is not connected the new ICS landscape.

As place-based integration between health, local government and wider partners takes shape, Whitehall's operating norms also need to become more integrated so that they support rather than undermine system working. The Treasury and the Department of Health should lead a long-term, cross-government plan to shift an increasing

proportion of health funding from acute response to community-powered prevention. This would involve more sophisticated accounting practices from the Exchequer which recognise the costs of disinvesting from communities and the consequences for rises in acute spending in overall public expenditure.

As the Levelling Up mission to reduce health inequalities is committed to legislation, every domestic department should produce a clear plan to contribute to the reduction of health inequalities that they assess all future policy against, and which are collectively aligned across Whitehall. In the medium term, Government should seek to align devolution with integrated care systems working, with a place-focus at the core so that partners across local areas can make collective investment led by locally identified priorities.

These nationally-focused recommendations are designed to create a permissive framework that is conducive to community power, by supporting the effective development of systems working in places. The recommendations are designed to reduce the negative consequences of the top-down state paradigm and efficiency-focused market paradigm which currently motivate and underpin national policymaking. This is a massive culture shift for central government which will not happen overnight, but it is no less important to state and restate the urgent need for Whitehall to shift its approach.

In the meantime, and regardless of central governing practices and behaviours, there are a number of ways in which actors within systems can focus on creating the conditions for community power to enhance the impact of our healthcare in practice. It is to this local level that the recommendations now turn.

2. The role of systems, places and neighbourhoods: From separate organisations to mission-driven collaboration for community power

ICS reforms create new architecture and principles for subsidiarity within systems to places and neighbourhoods, which are conducive to building a strong focus on community power, assets and capabilities into our

healthcare system. But this will not happen by accident. To achieve it will involve recognising and unlearning traditional ways of working, supplanting these with new operating norms and behaviours which value of community voice, insights and influence alongside clinical expertise.

Embedding community power within NHS bodies is best conceived of as a parallel mission to ensure communities participate within existing NHS processes, while also ensuring the NHS participates meaningfully in communities. This means the whole system, at every level and throughout the workforce needs to recognise the role and value of communities in their approach. This section sets out a series of recommendations aimed at achieving this shift in practice.

2.1. Proactively build in the voice and representation of communities to decision-making.

As new system architecture embeds, community participation needs to be actively built into ICS decision-making and activity at all levels. In the context of integration, NHS partners should be wary of viewing local government and the VCS as a proxy for community voice. Councils and community organisations can certainly provide representation and share learning on community empowerment, but the relationship with communities cannot simply be outsourced to them while NHS bodies carry on business as usual. Direct, ongoing community involvement needs to be sought to inform decisions over how healthcare is allocated and accessed. In this way, integration will need to move beyond simply a market-paradigm influenced set of transactions between health, local government and VCS partners. Rather, it is an opportunity for all institutions to develop a new shared agenda and investment plans, with communities at heart.

Much of this will be led at place and neighbourhood level, but community voice and representation should purposefully be built into leadership committees. Within the new formal

decision-making structures of ICSs – the strategic ICPs and the financially accountable ICBs – there is a risk that traditional state and market-influenced interpretations of governance will persist: those which focus on finance, performance management, risk and audit, for example. To let communities into these spaces in meaningful ways will entail these bodies challenging themselves to move beyond these comfort zones of professional management.

Instead, these core decision-making bodies need to understand their role as drivers within the system for community voice, active participation and a relentless focus on health inequalities as part of a shift towards prevention. Communities need to have opportunities to get involved in decision-making bodies across a full spectrum including through both direct membership and more generally through agendas which create opportunities for community voice and challenge alongside professionals. Governance processes should build in requirements to demonstrate how communities have been involved in plans on an ongoing basis. Full openness and transparency should guide activity, with formal meetings always held openly and online to maximise engagement and build in a culture of accessibility.

2.2. Give parity to the value of community expertise alongside clinical and professional expertise in strategic planning and service design.

Community insights should be understood as integral to impactful decision-making over resource investment and prioritisation across the board. The insights of communities can play an active role in tackling the biggest strategic challenges facing the health system, including immediate pressures like elective recovery and long-term challenges like health inequalities. Case studies in this report demonstrate that identifying and involving the

communities on the receiving end of these system challenges can shine valuable light on potential solutions and prioritisation. Communities of place, identity or condition also need to be involved in the design of services they use, to ensure accessibility, cultural competence and impact.

It is easy to view community engagement as a tick-box exercise or community consultation as a useful add-on as plans are being finalised. But communities need to be involved right from the start of any decision-making process to help define the very scope of the challenge at hand, and to ensure their role in prevention is at the forefront of formal service deployment. As the experience of the Covid-19 vaccine rollout showed, community insight is an essential partner to clinical expertise in ensuring health support is accessible and appropriate in practice. This deep value of community insight, realised at a point of national crisis, now needs to be embedded in mainstream planning and delivery.

This will involve understanding the limits of clinical and professional expertise, and shifting from a 'telling' to a 'listening' mindset. There is a particular opportunity to involve communities directly in the core mission of ICSs to tackle health inequalities. The lived experience of those cohorts identified in each ICS as part of the core 20 per cent experiencing deprivation, needs to directly inform how the health system responds. ICSs and place partnerships should identify clear active engagement strategies to meet with and listen to the health experiences of communities within their identified core 20 per cent cohorts, and use this insight as the basis for planning.

2.3. Ensure that equity, diversity and inclusion strategies are not an add-on, but are core to ensuring that both leadership and the wider workforce embodies the lived experience of communities.

In the context of developing a culture and norms that embody a deep understanding of communities, ensuring equity, diversity and inclusion (EDI) is at the core of a community-powered approach. The default assumption that communities need to be actively involved in decision-making from the strategic level to day-to-day service provision can be embedded by ensuring both the leadership and workforce reflects the diversity and richness of lived experience that exists.

Leadership teams should strive to reflect the communities they serve, and draw in, through both professional and governance roles, people representative of the geographical area they operate within.[164] Leaders need to ensure that decision-making processes are actively open to the voice and representation of the range of communities they work with. This needs to include communities identified as experiencing health inequalities, in particular local ethnic minority groups. It should also include communities of condition whose voice needs to be heard when considering services appropriate to their circumstances. Workforce development should actively involve developing anti-racist strategies in order to gain a deep understanding of how structural racism manifests day-to-day, and support a relentless focus across staff teams on overcoming this in practice.[165]

164 Evidence Submission - George House Trust.

165 There are many good practice examples to draw on for effective anti-racist strategies which build ownership across the workforce, including the North West Care Alliance https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2021/10/Antiracist-Framework.pdf (Accessed 27/06/2022).

2.4. ICSs should be a starting point for an equal relationship between health partners and local government, with the role and assets of councils recognised as essential for effective prevention.

For ICSs to meet their ambitions, particularly around improving population health outcomes and reducing inequality, the role of local government as part of the system is pivotal. As ICSs have taken shape, the role and value of council partners in the new structures has been patchy, and focussed on status issues such as the role of elected members on boards. There is a risk that unless NHS partners recognise non-clinical value beyond their own institutions, the NHS-led ICBs will dominate decisions within ICSs, and the ICPs in which local government and other partners participate are increasingly side-lined with no power to compel funding to follow the strategy.

Local government is responsible for a range of services that are essential for a community-powered system of healthcare. Upper tier councils run social care and public health, so have a direct stake as providers of support that can keep people out of acute and primary care settings, and living independently. But local government at all levels provide a range of services that engage in the wider determinants of health outcomes: including housing, planning, environment, economic development, parks and leisure. In addition, many of the case studies in this report demonstrate that councils are at the frontier of developing new ways of working with communities in asset-based ways and building in their participation to decision-making. So, on a number of different levels, the role and expertise of local authorities within ICSs has enormous potential to shape truly responsive systems, drawing in all assets of places and existing provision to the cause of better health outcomes. This needs to be recognised by health partners, who will need to work with humility and openness to learning from councils' democratic experience and significant place-shaping role. This starting point

of equal relationships between health and local government partners should then signal an equal approach to wider local services and ultimately, communities themselves.

2.5. Recognise culture as a key enabler that can shift institutional behaviour, and ensure it is a strategic priority for leaders to actively foster a culture conducive to collaboration with communities.

Those within institutions tend to recognise structure over culture as an enabler of change, and the former is often overplayed at the expense of the latter.[166] It is easier to stipulate organisational hierarchy and follow governance procedures, than it is to shift behaviour and operating norms. Culture cannot be mandated or regulated, but the wrong culture can be a powerful barrier to change, just as the right culture is a key enabler to new ways of working. Across ICSs, fostering a culture conducive to working with communities as equals needs to be recognised as integral to shifting towards prevention in practice.

At the system level, there is a real opportunity to mark a break from previous state- and market-influenced NHS cultures of hierarchy, organisational territorialism and performance management. New missions and values across organisational boundaries need to be collectively developed and shared between everyone working within the system. At the level of places, where integrated partnership working is happening in practice, notably between health bodies and local government partners, new collaborative relationships should be fostered through the prism of communities rather than separate organisations. In the context of a shared understanding of the specific economic, social and demographic circumstances across places, new multiagency teams can work

166 Lent, A. and Studdert, J. (2018). Culture Shock: Creating a changemaking culture in local government. New Local.

collectively to better engage with the needs of communities holistically, responding not just to clinical presentation but addressing wider determinants of health outcomes alongside.

To create an environment conducive to fostering these relationships across organisations, those in formal positions of leadership at all levels of the health and care system have an integral role in fostering a community-focused culture across the workforce, both directly in terms of the permission they give to the workforce and indirectly through the behaviours they personally model. In order to lead the evolution of health and partner organisations from traditional organisational working to system working, leadership behaviours will need to transition from hierarchical to lateral system leadership. This needs to be recognised as critical to the success of integrated care systems, explicitly articulated and hardwired into organisational practice, recruitment and personnel development.

To that end, the grind on page 109 outlines the traditional leadership styles must be left behind and system leadership behaviours that need to be promoted and embedded to sustain a culture capable of facing out to communities and drawing their insight into the system.[167]

System leaders work within an extremely complex environment and have significant statutory responsibilities combined with huge pressures to deliver in highly challenging operational, financial and political circumstances. But because individuals cannot do everything within a system, a core responsibility of leadership is promoting and supporting the right behaviours to develop and embed across the workforce.

Those working within the system need to know they will be backed by their leaders while building new relationships beyond the boundaries of their organisation. Trusted relationships between partner organisations and communities is a powerful vehicle for

167 For more discussion on leadership in an age of networks rather than institutions, see Heimans, J. and Timms, H. (2018). *New Power.* Doubleday Books.

change, so there is an onus on system leaders to share the risk and let these develop. This means being explicit and persistent in communicating the clear expectation of deep listening and relationship building with communities.

Old vs new leadership styles for community power

Traditional leadership styles	System leadership styles
Seeks change using procedure	Seeks change through influence
Manages complexity with answers	Navigates complexity with openness
Focusses on the "what": tells the workforce	Focusses on the "how": asks the workforce
Emphasises upwards accountability	Drives frontline autonomy
Reinforces accountability to organisation	Builds shared accountability across a place
Pushes organisational priorities down the hierarchy	Creates space within the system for shared priorities to develop
Focusses on the risks of innovation	Focusses on the risks of status quo
Prime focus is governance	Prime focus is culture
Colleagues would say they are risk averse	Colleagues would say they are courageous
Values only formal experience within the system	Values also lived experience from outside the system

Following the Messenger and Pollard Review's recommendation for a single set of core leadership and management standards for NHS managers,[168] we suggest it is a priority for such system-focused competencies for managers as well as senior leaders to inform these and begin to embed the necessary culture shift across the workforce. The NHS Leadership Academy should collaborate with partners in local government representative bodies to extend system management and leadership standards across health and care settings.

2.6. A strong system-wide vision and active workforce development should focus on building the behaviours and skills required to work with communities as equals.

Creating a culture that is conducive to working with communities won't happen by accident. It requires time and dedication. At system level, the focus needs to be on developing and embedding a shared vision and purpose which signal a clear system-wide set of priorities. This should include clear principles for working with communities to tackle health inequalities and shifting to prevention as core rather than an add-on to clinical care. This collective approach at a system level needs to retain the flexibility at place and neighbourhood levels to develop new ways of working and design provision based on what matters to communities.

Workforce development plans should include training for those in organisations within the system to support them to understand how their role links to the wider vision and purpose. Specific skillsets in asset-based approaches including how to have strengths-based conversations and in ethnographic techniques to develop listening skills, should be supported in a range of roles including senior leaders, managers, commissioners, clinicians and other frontline workers and public-facing administrative staff. The system also has a role in supporting peer learning and communities of practice to develop, both within specialisms such

168 Review by Sir Gordon Messenger and Dame Linda Pollard. (2022). *Leadership for a Collaborative and Inclusive Future.*

as primary care networks and between them. These can focus on the methods and tools for effective community participation, including deliberation, facilitation, hosting skills, co-production and appreciative inquiry.

2.7. Recognise the potential of primary care networks to catalyse the shift from deficit-based to asset-led working with communities.

In the context of a richer understanding of localised health experiences and patterns of poor health outcomes, primary care networks (PCNs) can be a real catalyst for opening up a different relationship with communities led by their assets rather than focused on deficits. The Fuller Stocktake recognised the huge potential for primary care networks to operate as fully integrated neighbourhood teams.[169] But the potential is deeper than just that of multi-disciplinary teams organising themselves at a hyper-local scale. There is now a real opportunity to shift power and control more meaningfully towards communities themselves, to influence their own health and wellbeing.

Everyone working across ICSs should now recognise and actively support the potential of primary care networks to pursue a different relationship with communities, using asset-based practice such as ABCD[170] and Health Creation.[171] These practices demonstrate the value that can flow from reframing the conversation with communities from a deficit-led "what's the matter with you?" to a strengths-based "what matters to you?". This different starting point can unlock a very different dialogue, one which recognises the wider determinants of health outcomes and the assets within places that impact on them.

169 Fuller, C. (2022). *Next Steps for Integrating Primary Care: Fuller Stocktake report*. Commissioned by NHS England and NHS Improvement.

170 See Nurture Development. https://www.nurturedevelopment.org/ (Accessed 24/06/2022).

171 Health Creation Alliance. https://thehealthcreationalliance.org/health-creation/ (Accessed 24/06/2022).

PCNs have an opportunity to shift the primary care approach to community engagement beyond simply consulting them in a narrow sense, to growing deep roots in neighbourhoods and recasting the clinician-patient relationship to one of equals, each with valuable insight to bear. This would involve more opportunities for co-design and co-production which are fundamental to communities gaining real power to shape services. As evidence submitted to the research observed, "Co-production and community engagement help to address the powerlessness associated with structural inequalities… [providing] opportunities to break down historical, systemic and socio-cultural barriers, through creating more responsive support structures that better meet the needs of communities who may be apprehensive".[172]

There is a particular opportunity for PCNs to develop social prescribing from a method that is largely transactional between clinical setting and community assets, to one that is more relational and capable of building community capacity in the long term. Social prescribing should not be a one-way transaction, but a reciprocal exchange which offers reflections back into the primary care setting about how best to understand and nurture community networks.

2.8. Improve data standards to recognise the value of qualitative data alongside quantitative metrics to inform service design.

ICSs provide a footprint at an appropriate scale to understand and be led by population health data. Organisations across ICSs including trusts, primary care and councils, need to share and layer data between then to develop a clear understanding of system- and place-level experience. Clinical data can be supplemented with free school meals and housing data, for example, to gain a more

172 Evidence submission - MAC-UK.

three-dimensional understanding of inequalities.[173] Using shared intelligence in this way is at the core of informing an integrated response. Data "has no ego"[174] and can provide a good starting point for conversations between partners and with communities to define problems and identify appropriate responses.

Quantitative datasets alone do not provide a complete picture of demand or experience, so data requirements need to evolve to incorporate qualitative data, including community voice as an essential component. Insights from communities will fill valuable gaps in context, for example ethnographic data can supplement understanding of the issues and provide meaning to statistics. This can help inform how funding formulas should be calibrated to mitigate the impact of deprivation or structural inequality, for example.[175]

Data standards should evolve to recognise the weaknesses of decontextualised statistics, divorced from individual and community outcomes, as a basis for service planning.[176] These higher data standards can then inform a test and learn approach at place level, to work with communities to improve their health and wellbeing and understand the impact of these measures on prevention. This can generate a shared evidence base for deeper system-wide recognition that investment in community-led provision can reduce demand on acute services in the medium to long term.

2.9. Use data to mobilise communities around the challenge of health inequalities.

The role of data should not be limited to internal understanding within the system, crucial though that is. Data can also provide

173 *Health Creation: Addressing national health inequalities priorities by taking a health creation approach.* (2022). Health Creation Alliance.

174 From interviews.

175 *Health Creation: Addressing national health inequalities priorities by taking a health creation approach.* (2022). Health Creation Alliance.

176 Evidence submission - National Survivor User Network.

the basis for raising awareness and mobilising communities around the challenge of health inequalities. Some health leaders are already seeing their role as sharing data with communities, and using it as a starting point to listen to them understand and interpret it.[177] The purpose is not just to feed back into the system but also to raise wider awareness outside the system of the impact on individual life chances, and challenge any sense of fatalism that it doesn't need to be like this. This would be a first step on a route to mobilising communities into action and co-creating different approaches that tackle inequality more effectively.

The Community Health Centre model in Canada[178] demonstrates how it is possible to combine clinical and multi-disciplinary health and wellbeing services with a wider community mobilisation role focused on addressing the wider determinants of health outcomes. As PCNs develop and using system level data-insights, place partnerships should be driving much greater public understanding of health and wellbeing, with a focus on addressing wider determinants such as housing, work and the environment.

2.10. Use the fourth ICS ambition which sees a role for the NHS to support broader social and economic development as an opportunity to reduce health inequalities by addressing the wider determinants of health outcomes.

Alongside improving population health, tackling unequal outcomes and improving productivity, ICSs have a fourth mission to help the NHS to support broader social and economic development. However, as survey evidence from the NHS Confederation has revealed, ICS leaders feel least confident

177 *Health Creation: Addressing national health inequalities priorities by taking a health creation approach.* (2022). Health Creation Alliance.
178 See Case Study on page 50.

about this ambition and over two thirds felt neutral or negative about the progress they had made towards delivering it.[179] Where action has been initiated, it has been in rather narrow social value terms regarding apprenticeships or the local contribution of procurement spend. In many areas NHS bodies are beginning a shift to understand their role as an anchor institution, but the full range of possibilities are underdeveloped.

In the context of understanding Marmot's evidence of the wider determinants of health outcomes, there is enormous potential for this fourth ambition to lead a shift within the NHS to focus on addressing the social and economic root causes of ill health, alongside its clinical role. At present a narrow institutional view of the NHS's wider social and economic role is combining with a narrow medical view of health inequalities which focusses on the clinical presentations of poverty and deprivation. Taking a broader approach to both, would envisage NHS organisations as part of a system focused on prevention and tackling the causes of poor health outcomes alongside offering treatment. In practice, this would mean developing a sophisticated system-wide understanding of the drivers of ill health, informed by complete datasets and the insights of communities themselves, to establish wider place-based investment strategies designed to mitigate them before medical episodes occur.

2.11. Integrated care boards should commit to shifting a proportion of budgets from acute health budgets to community-led prevention at system and place level, and grow this over time as collaboration matures.

The reality for NHS bodies is one of enormous financial strain, the culmination of years of funding not keeping pace with demand,

179 Pett, W. and Bliss, A. (2022). *The State of Integrated Care Systems 2021/22.* NHS Confederation.

insufficient social care provision and the continuing pandemic response. This creates enormous pressures on hospitals and within primary care as waiting lists dominate priorities. Short-term pressures create strong incentives to seek immediate efficiencies within the existing approach, to the detriment of collective upfront investment which may see savings returns only in the medium term. This needs to be resisted, and ICSs provide a vehicle for mitigating the risks of shifting resources within the system to gradually shift investment over time from a heavy dominance on reactive acute provision to a greater focus on effective prevention.

As demonstrated by some ICSs who have already embarked on this approach, notably West Yorkshire Health and Care Partnership, it is important to take a determined approach to resource reallocation and reprioritisation as a system. This would seek to gradually expand investment in community-led prevention as a proportion of overall budgets, designed to improve health and wellbeing outcomes and thereby reduce the need for acute care and higher intensity support.[180] Within ICSs and via accountable ICBs, evidence from the impact of investment will need to be tracked and inform future business case planning. Ultimately, ICSs provide an opportunity to ensure the funding flows from the vision, rather than the vision flowing from the funding, and being rather reactive and narrow as a consequence.

180 Evidence submission - West Yorkshire Health and Care Partnership.

2.12. Create a level playing field for, and invest, in the capacity of the VCS and service user groups, who in turn should commit to ensuring diversity and wide community representation.

The voluntary and community sector is an umbrella term for a wealth of local and community organisations including local service user groups and patient representation groups such as Health Watch, who have a rich insight into communities and often enjoy high levels of trust with them. Within a more community-powered NHS they have an integral role to play: it is important that they are supported to develop capacity and that in turn they challenge themselves to be as open and reflective of the diversity of communities they represent.

Commissioners and healthcare professionals need to develop a clearer understanding of the role and value of the VCS to running services and meeting wider objectives. Large-scale contracting and crude market-led mechanisms such as payment by results fail to account for the value of smaller scale and localised projects that can make an enormous difference to health outcomes amongst different communities.[181]

Where local VCS organisations including HealthWatch claim to or have a clear purpose to represent communities, they should be proactive in ensuring widescale participation. There can be a risk of a few individual semi-professionalised patient representatives working within the system in the way the system requires. These organisations should work to increase diversity and participation from communities in a way that reflects the local population and can effectively feed in a range of views to the system.

181 Evidence submission – Locality.

CONCLUSION: A MOMENT TO SEIZE

The NHS is facing the most severe test since its foundation. A combination of factors has coalesced to place more long-term demand pressure on healthcare provision than it has ever experienced. As we have explained in detail in this report, this situation is compounded by dominant working practices and mindsets that were never designed to address rising demand and may well be exacerbating the problem.

This report has also shown that there is a solution: a radical shift towards a healthcare system focused as much on preventing illness as treating it by working collaboratively with communities as equal partners in the design and delivery of healthcare. Importantly, we have also shown that this is not an abstract notion but one that is already being put into practice by visionary healthcare professionals and community organisations. The task now must be to turn what are marginal practices into mainstream ones.

The question, however, remains open as to whether the will exists for such a profound change in the ways NHS bodies work. Some of the new Integrated Care Systems are using their establishment as an opportunity to start thinking and working differently. The ambition, however, is decidedly patchy with others seemingly treating the shift as little more than a change in governance structures.

But the real responsibility for any meaningful effort to affect a sustained move to a community-powered prevention approach resides with policymakers in Westminster – at least, initially. In an institution as hierarchical as the NHS and a country as centralised as ours, the starting pistol must be fired by those at the very top if a system-wide change is to happen. Sadly, the message from above remains deeply confused. Ministers regularly talk about the need for greater prevention while simultaneously cutting funding to public health and trumpeting any extra money for acute response. They establish a new NHS structure

that is designed to focus on place-based population health while refusing to relinquish top-down, one-size-fits-all targets and micro-meddling. Most notably, there is a failure to fully acknowledge that until Whitehall works far more collaboratively with local public services and communities to develop a meaningful and integrated programme to address poor housing, joblessness, poverty and deepening socio-economic inequality, then there will be no effective turning back of the tide of rising demand for healthcare.

The truth is it is not just healthcare professionals who need to shift their mindset to move towards a truly community-powered and preventative approach; Westminster must do the same. The best policymakers lead unavoidable change and commit to explaining to the public precisely why that change is unavoidable and what it must look like. To date, there has been too much policy inertia and rhetorical grandstanding and not enough self-reflection and visionary leadership. Without that shift it will be the NHS, its founding principles and, ultimately, the population that suffers. We hope this report can play its part in preventing such an outcome and instead open up minds to what could be a more impactful and secure future for the NHS.

APPENDIX: SUBMISSIONS TO OUR CALL FOR EVIDENCE

To kick off our research, over the summer of 2021, New Local held a call for evidence to seek views on the potential for community power to play a stronger role within the NHS. We received submissions from a wide range of individuals and organisations, which were invaluable to our research, highlighting analysis, personal experience and case studies from different parts of the existing system. We are grateful to everyone who took the time to respond, and the list of submitters who have given permission to be named in our report follows here:

Assura

Birmingham City Council

Board at Nova Wakefield District

Bridges Outcomes Partnerships

Camden Council

C2 Connecting Communities

Bradford Districts and Craven Health and Care Partnership

Derby Community Parent Programme

Dr Paul Fox

Ewanrigg Local Trust

George House Trust

Great Manchester Combined Authority

Guy Peryer

HealthWatch West Berkshire

HealthWatch West Sussex

Inspiring Communities

Jody Clark

Locality

MAC-UK

Made by Mortals

National Survivor User Network

Lord Nigel Crisp

Nottinghamshire County Council

Outside the Box

Owen Garling

Power to Change

Severn Wye

The Active Wellbeing Society (TAWS)

West Yorkshire Health and Care Partnership

Wigan Council

As the NHS faces ever-rising demand, its founding principles of being free and universal are under threat.

This report shows that there is a solution: a radical shift towards a healthcare system focused as much on preventing illness as treating it. Working collaboratively with communities as equal partners in the design and delivery of healthcare.

By moving towards a community-powered health system, we can make prevention a reality, protect the NHS's future and improve health for all.