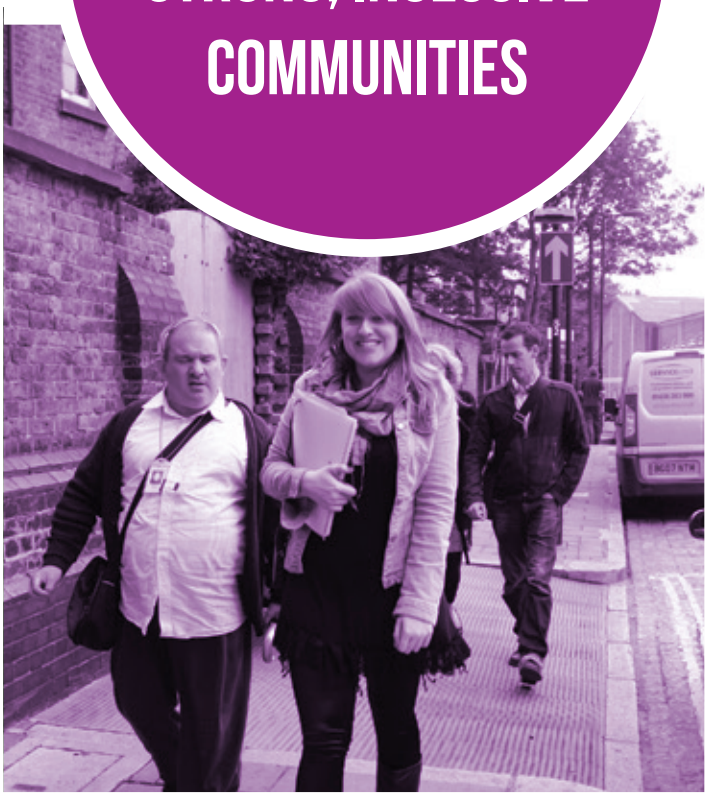
Public Health England

think local act personal

DEVELOPING THE POWER OF STRONG, INCLUSIVE COMMUNITIES



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WELCOME

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1. STRONG, INCLUSIVE COMMUNITIES - THE NEXT STAGE OF PERSONALISATION

Personalising health and social care has travelled far since its inception in 2007 delivering real and lasting change to many people's lives. The recent NHS Mandate to personalise the NHS and extend the use of personal health budgets continues the drive toward fundamentally reshaping services[1]. However, Think Local Act Personal's (TLAP) new partnership agreement demonstrates the sectors' recognition that there is still a long journey ahead:

Personalisation is fundamentally about better lives, not services. It is rooted in the power of co-production with people, carers and families to deliver better outcomes for all. It is not simply about changing systems and processes or individualising funding, but includes all the changes needed to ensure people have greater independence and enhanced wellbeing within stronger, more resilient communities.[2]

The original goal of personalisation always recognised the significant role that strong communities play in supporting health and wellbeing and envisaged the development of community capacity as a major contributory factor toward wholesale transformation. This Framework demonstrates there is growing evidence that makes this approach compelling both in terms of what it means to the health and wellbeing of communities as well as what it can offer to a sector facing unprecedented financial and demographic challenges. The next stage of personalisation should therefore focus on redesigning services through co-production and strengthening social capital through community development; activities that put strong and inclusive communities at the heart of the future health and care system.

Think of a carpenter who has lost one leg in an accident a year ago. Clearly he has a deficiency. However he also has a skill. If we know he has a missing leg, we cannot build our community with that information. If we know he has capacity as a wood worker, that information can literally build our community[3]

Think Local Act Personal (TLAP) has promoted innovative ways of developing strong and inclusive communities since 2010, working alongside partners to explore the potential for community capacity building and complementary changes in services. Together these changes have aimed to support people to make best use of their own and their communities' assets to improve both physical and mental health, wellbeing, independence and quality of life.

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John's mental health had deteriorated disconnecting him from his family and community. One of John's major concerns was the state of his property which was having an impact on his health. A Local Area Coordinator (LAC) introduced John to a group of neighbours who worked with him to sort out his house and garden. John talked about this 'act of random kindness' as a significant turning point for him. John spent Christmas with his family for the first time in ten years, has widened his social network and, through his passion for IT, is now supporting some of his neighbours with their computing problems.[4]

TLAP's work in this area has helped publicise many of the excellent examples of innovative work taking place to build and nurture active and supportive communities. However, it has also become clear that these are often highly localised and that current pressures can lead to a retraction in these initiatives rather than elevating them to centre stage. A strategic approach that can be adapted locally is now needed that brings together the wealth of learning and the growing evidence base about community capacity building and the co-production of outcomes. TLAP, in partnership with Public Health England (PHE), has therefore developed this Framework to enable Health and Wellbeing Boards to make the development of strong and inclusive communities integral to their work.

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Mrs. Booth is 82 years old and has a Homesharer called Nina. As Mrs. Booth has got older she has lost the confidence to be able to drive and this has resulted in her finding it difficult to visit her husband who has dementia and who lives in a nursing home as well as maintaining her friendships and relationships. In return for accommodation Nina drives Mrs. Booth to visit her husband and friends and helps her to cook and entertain at home. Having Nina sleeping in the house has given Mrs Booth real peace of mind[5].

The Framework goes further than recommending that Health and Wellbeing Boards simply 'add on' the development of strong and inclusive communities to their already long list of priorities. Instead it uses this approach to fundamentally rethink how people, communities and services can more effectively and efficiently work together to co-produce outcomes. This will enable Boards and their partner agencies to fulfil their obligations around integration and new Care Act wellbeing and prevention duties, as well as respond to the ongoing pressure on public finances.

The Framework has been trialled with a number of trailblazer Health and Wellbeing Boards each of whom refined and adapted it to reflect local circumstances. All of the Boards valued the Framework for bringing together a wide range of existing strands of thinking, research and practice into a single compelling and well evidenced narrative. TLAP and PHE will continue to support Health and Wellbeing Boards by promoting innovation, gathering evidence and examples of good practice and developing means to measure the impact of community development (see Section 5 'Next Steps).

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Legislation and policy

A number of recent legislative and policy developments introduce new duties and expectations on statutory organisations, which support the aims of this Framework:

- The Care Act which comes into force in April 2015 rebalances the focus of care and support and makes explicit the need to promote wellbeing and prevention rather than intervening only at points of crisis. Fundamental to these new duties will be the role of communities and social networks.
- The Social Value Act (2012) requires all public bodies to consider how the services they commission and procure might improve the economic, social and environmental wellbeing of the community. "Social Value" involves looking beyond the price of the individual contract and considering the social impact on the community when a contract is awarded.
- The Health and Social Care Act (2012) created Health and Wellbeing Boards, and replaced Local Information Networks with local Healthwatch organisations to involve local people in the commissioning, scrutiny and provision of health and social care services. The Act introduced GP commissioning and transferred public health responsibility to local authorities.
- The Children and Families Act (2014) establishes a pathway for children with special educational needs and disabilities which work towards clearly defined outcomes, from birth to 25. Central to the Act is preparation for adulthood and the enablers seen as key to supporting preparation are personalisation, co-production and integration

National initiatives

- The National Collaborative for Integrated Care states the need for major change that will deliver better coordinated services around preventing and meeting needs and make a clear shift toward prevention, early intervention and independent living.
- Integrated Personal Commissioning of health and social care envisage a "greatly expanded role' for non-traditional providers which should include asset based community developments
- The Better Care Fund is a £3.8 billion pooled budget that shifts resources into social care and community services and was announced by Government in June 2013. The clear intention is that this funding will support transformation and integration of health and social care services.

Newcastle's 'Get Connected' means that a community activity for a family is just a phone call away. Dance, sports, music, and art hubs will find low cost activities which will take into account children's disabilities and successfully introduce them to new pursuits[6]

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2. SHAPING THE COMMUNITIES PEOPLE WANT

When people in the London Borough of Camden were asked to describe the type of community in which they would like to live they pointed to two things (see Figure 1).

Firstly, a friendly place where people support, trust and look out for one another and respect diversity (often referred to as a community with a high level of social capital). Secondly, somewhere where there are indoor and outdoor places to meet and do things together and where there are good universal services - whether publically funded or commercially provided (for example shops, bank, cafes, travel, education and work opportunities).

Figure 1: A strong, inclusive community

Unfortunately many people find their health and wellbeing undermined by a lack of access to the universal support and opportunities available to others and through living in sometimes hostile and non-inclusive communities. This can lead to isolation, social poverty and, for people who use services[i], a higher probability than others of having to use expensive specialist services when this wouldn't otherwise be necessary.[i] For this reason, it is particularly important to think about the community and its resilience as part of an overall strategy to improve health and wellbeing.

i This document uses the term 'people who use services' to denote people who use health services or social care services, or both.

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The Carers café is established as a mutual and run by volunteers who include people with learning disabilities, long term unemployed and older people. Apart from functioning as a café it also hosts a range of activities such as carers' surgeries, coffee mornings, councillors' surgeries and drop in sessions.[7]

The learning to date shows that by prioritising strong and inclusive communities in their overall strategies, Health and Wellbeing Boards can positively impact on health outcomes whilst also knocking on the open door of local aspirations. Tackling the wider determinants of health and wellbeing by building better places to live, making services more joined-up and responsive to people when they need them and enabling people more control over their lives is a compelling narrative in any locality.

'Dementia capable communities' nurture the assets that make a place safe, welcoming and enabling to people with dementia. In practice this means providing a safe physical environment and actively empowering people with dementia to have a voice and stay in control of their lives for as long as possible. It also means support to develop social networks, with old friends and new, enables the person with dementia to offer their skills as well as receive help. Local champions go out and encourage a welcome response in shops, pubs and buses[8].

Our work to date suggests that this narrative should translate into Health and Wellbeing Strategies including a range of coordinated action in two important linked areas (See Figure 2):

1. **Community self-help** - building people's social support networks; enabling reciprocity; making best use of the resources and assets which are available in the local area; and making sure that people who use services, including people with long-term conditions, get a chance to pursue their own interests and contribute to community life.
2. **Effective coproduction** – making full use of the assets and skills that local communities and people who use services can bring to the table alongside those of practitioners. By moving away from a narrow focus on meeting needs through practitioner provided services to making much more effective use of the complementary skills and assets of people, communities and practitioners.

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Figure 2: The Framework: Combining people's own assets with those of the community and organisations to more effectively co-produce outcomes

The development of **community self-help** can take many forms and be implemented at different levels from large scale community wide approaches, for example the Health Empowerment Leverage Project[9] to smaller scale more targeted initiatives such as a Pub Lunch scheme[10].

Asset Based Community Development (ABCD) is one such approach. It starts from the evidence that community and social networks and enabling reciprocity have a fundamental impact upon health and wellbeing. One researcher exploring the link between an asset based approach and health and wellbeing concluded that, "*The connection is clear: individuals need communities and communities need engaged participants to thrive*"[11] and "*This means extending opportunities for participation, and actively addressing the inequalities gap which undermines the solidarity which binds citizen and wider society*"[12]. ABCD does this by inverting the existing model of needs and deficits, instead focusing on the skills, knowledge, resources, connections and potential within the community; and building on what is working and what it is that people care about.

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Developing more **effective co-production** between people who use services and practitioners requires the development of an equal relationship in both the codesign of services and the delivery of outcomes. This makes best use of both people's own and their communities' assets as well as those of organisations. There is much to change. The current service delivery culture is geared up to make best use of practitioner expertise and, at best, to only consult with people who use services to decide what treatments and support they should receive. Targeted services are often provided in a highly siloed and self-contained way with little opportunity for front-line staff to get to know people as whole people and link with their local communities. Many universal services are only tailored to the needs of the 'average citizen'.

Plymouth Court is a very sheltered housing scheme run by an owners' company in Redditch. The owners include people of various ages and with differing needs. Beyond a basic amount of domestic assistance each owner can agree a tailor-made package of support. This flexible approach to care and support is believed to save the NHS the equivalent of five nights of hospital care per resident per annum[13].

Universal and targeted services

Universal services are those which are open to all. These include statutory services such as primary care and social housing as well as those provided under contract by private sector providers, for example, many leisure centres and public transport. Universal services also include commercial services such as banks, shops, cafes and employment. Whilst nominally open to all, many focus on the 'average citizen or consumer'. This has the often unintended effect of excluding people who have additional support needs. In turn this reduces people's access to services and cuts them off from important day to day opportunities to interact with others in their local community. Instead they must rely on targeted services specifically tailored to their needs or, go without. Targeted services include more specialist health care, supported housing, tailored educational, employment and leisure provision as well as care and domiciliary support. Except for services purchased by people who self-fund their care, access to these services is gate kept by practitioners and is subject to eligibility thresholds.

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Whilst practitioners' expertise is to be valued it can be deployed far more effectively if it is used to actively complement people's own lived experience. For this to happen there must be recognition that outcomes are most effectively achieved when they are co-produced by making active use of the expertise and assets of people who use services, communities and practitioners. This requires a change in working relationships[14] and a shift from practitioner-led service design to co-design of services with people who use them. In targeted services, this is the experience of self-directed support; Camden's work on mental health day services; shared decision-making and the Year of Care in health; and Tower Hamlet's personalised approach to supported housing. Change can take place at a local or system wide level, the NESTA funded People Powered Health Project exemplifies the latter. In universal services examples include: collaboration with cafes, pubs and others to provide community toilets[15]; buses that allow people time to reach their seats before moving off[16]; and innovative library provision[17].

The self-management for life programme works with both patients and practitioners to help them improve health outcomes. Patients learn from experienced peer facilitators what they can do to help themselves and how to make the best use of the time spent with their healthcare professionals. Training is also provided for clinicians, and health and social care professionals to better support patients to become optimal self-managers[18].

The Framework requires community self-help and the development of more effectively co-productive services to be developed in tandem. Local Area Co-ordination (LAC) offers an example of how this this can be achieved. Local Area Coordinators work in partnership with individuals to promote social inclusion by drawing on and developing the resources available in the community. They start from individuals' skills, aspirations and their social networks (e.g., family, friends and neighbours) and enable people to participate in community groups and make use of universal services. Where community groups, universal and targeted services are not well tailored to individual needs, they will work with those services to modify their practice. Well-established in Western Australia, the LAC model is now gaining traction in the UK. Evaluations show LAC is cost effective and delivers positive results for individuals and their families by playing a significant role in preventing crisis interventions[19].

An example of how Boards might begin mapping across these two areas of community development and co-production to make progress toward strong and inclusive communities within their own areas is set out in Appendix A.

3. WHY FOCUS ON COMMUNITIES AND CO-PRODUCTION?

Because it improves health and well being

The view that co-producing with communities leads to improved health and wellbeing is gaining traction across the sector. The National Institute of Health and Care Excellence (NICE) has recommended investing in community programmes which emphasise developing and maintaining social networks and promoting resilience[20] Elsewhere NICE has asserted that co-producing outcomes may lead to more positive health outcomes as well as improving other aspects of people's lives by improving their sense of belonging and wellbeing[21].

Professor Marmot (2012) is unequivocal in his belief that health and wellbeing are heavily influenced by communities and social networks. Moving beyond the everyday approach to consultation, will, in his view, enable 'radical reform' and nurture "individual and communal health, wellbeing and resilience, [build] local confidence, capacity and capability to take action as equal partners in addressing health inequalities"[22].

In Oxford, street parties enable residents to have their street closed to traffic for a day and to organise a simple 'meet the neighbours' tea party and/or to provide games, events (film-screenings are popular), live music and other entertainment. As one resident said, "It's as though people have a sense of community built into them deep down but we need something to happen to trigger it and bring it into the open." One street has instigated coffee mornings as a result of the party, while in another a group of parents agreed to set up a baby-sitting circle. In more challenging areas, Streets provided a development worker to run training sessions for community workers and active residents to boost their confidence and know how[23].

There is a growing evidence base to support these views.

Among the many findings in Dr Brian Fisher's review he shows that:[24]

- Low levels of social integration and loneliness significantly increase mortality whilst people with stronger networks are healthier and happier.
- Social networks are consistently and positively associated with reduced illness and death rates
- The most significant difference between this group and people without mental ill health is social participation. Social relationships can also reduce the risk of depression.
- Areas with poor social capital experience higher rates of cardiovascular disease in general and recurrence of acute coronary syndrome, in particular among lower income individuals.
- Several studies have suggested that social networks and participation may act as a preventative agent.

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In NESTA's People Powered Health project Nigel Mathers, Vice Chair and Care Planning Lead, Royal College of General Practitioners comments:[25]

'There is strong evidence to support the development of new relationship between patients and professionals in the consulting room. Patients tell us that they want us to do more to support their own self-care. And we know that patients who are active participants in managing their health and healthcare have better outcomes than patients who are passive recipients of care... This is especially true for the growing number of patients living with one or more long term conditions.[ii]

However, shared decision making is not yet the norm and many people want more information and involvement in decisions about treatment care or support than they currently experience. Embedding this shift into systems, processes, workforce attitudes, skills and behaviours is a considerable challenge.'

ii A long term condition is defined as a health condition that cannot be cured but can be controlled by medication. Examples of a long term condition include diabetes, heart disease and chronic obstructive pulmonary disease. Long term conditions affect more than 15 million in England, a figure set to increase over the next 10 years. www.gov.uk/government/policies/improvingquality of-life-for-people-with-long-term-conditions

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The New Economics Foundation's Five Ways to Wellbeing evidence review found that:[26]

- Social relationships are critical for promoting well-being and for acting as a buffer against mental ill health.
- Feelings of happiness and life satisfaction have been strongly associated with active participation in social and community life.
- For older people, volunteering is associated with 'more positive effect and more meaning in life'.
- Supporting others has been shown to be associated with reduced mortality rates.

And the benefits of this approach extend beyond health and social care and present good arguments for a joined-up local approach to community empowerment [27]**:**

- Areas with stronger social networks experience less crime and less delinquency.
- Neighbourhood Watch can reduce crime by 16-26%.
- The time credits organisation Spice documented a 17% reduction in crime following the introduction of a timebank scheme in local youth groups.

Because there are diminishing returns from efficiency savings

Whilst there is still scope to make the current health and social system more efficient, the level of these returns is diminishing. The Local Government Association reports that the majority of councils believe the prospect for delivering further efficiencies will be running out by 2015/2016 with a projected funding gap of £12.4bn by the end of the decade. The Commons Health Select Committee has advised that the pursuit of NHS efficiencies has reached its peak but the required 'transformation of services had barely begun and was now urgent'. The King's Fund recently reported that almost a tenth of Clinical Commissioning Groups were in deficit at the end of 2013/2014[28] whilst the NHS forecasts a £30bn funding gap by 2021.[29]

Add to this pessimistic financial forecast the challenge arising from a growing population, increased morbidity and a reduction in the number of family carers able to provide support, and it becomes clear that business as usual is no longer an option.[30] It is time to embrace different thinking.

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Because there will be a return on investment

Both community development and the complementary redesign of universal and targeted services to enable the much more effective and efficient co-production of outcomes require investment. However this investment is likely to be offset by the savings resulting from improvements in health and well-being, reducing demand for services and enabling people who use services to be more independent. These savings are of different types:

- Cashable savings – where it is possible to reduce the volume of service provided and make pro rata savings in costs.
- Non – cashable savings – may arise where more effective approaches are successful in reducing demand, but, because of waiting lists or a high proportion of fixed costs no cash savings are released. They may also take the form of making more efficient use of existing resources that enable increasing demand for a service to be met within the current budget.
- Levering in investment – where changes in organisational models e.g. creation of a mutual, or the adoption of new practice models allow access to streams of funding of other resources such as volunteer time, that are not available to a statutory body.

Typically any one investment in community development or the development of more effective co-productive services will yield a mix of these three types of savings.

Savings for different types of community development may be found for:

- Whole community – where community development is used to improve the health and well-being of all local people in an area. For example, the Health Empowerment Leverage Project estimate that investing in the 20% most disadvantaged neighbourhoods in a typical local authority area would produce a health saving of £4,242,726 over three years - just over £1.41m a year[31].
- Particular population groups – for example disabled or older people. Partnerships for Older People's projects showed that overnight hospital stays were reduced by 47% and use of A & E Departments by 29%; phone calls to GPs fell by 28% and appointments by 10%. Every £1 spent on POPP services generated £1.20 in savings on emergency beds[32]. Befriending schemes for older people reduced social isolation, loneliness and depression among older people and hence the need for treatment. Schemes cost £80 per person per year to run and produce savings of £300 per person per annum[33]. In mental health, peer support saved bed days and reduced hospital re-admissions by 50% compared with traditional care, a saving of £28,000 each year in Leeds[34].

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Examples of savings from investing in more effective co-productive services are:

- Enabling people to take more control of their lives and health – for example, the Expert Patient Programme enables individuals to better manage their long term conditions producing a £6.09 saving for every £1 spent[35]. This includes: reducing GP consultations by 7%, outpatient visits by 10% and A&E attendances by 16%.[36]
- People providing part of the service themselves – for example, Shared Lives, where a person with learning disabilities becomes part of another family costs £645 compared with £995 per person in supported living[37]. The social return on investment of volunteering is £2 and £8 per £1 spent on supporting volunteers[38]
- Redesigning existing service models – moving away from providing direct services to enabling communities to run their own services. Through a transfer of assets to community providers Lambeth has so far delivered £2.4m in efficiency savings and also levered in £5.5m in investment into the borough[39].

4. HOW TO GET STARTED – WHAT HEALTH AND WELLBEING BOARDS CAN DO

Each of the trailblazer Health and Wellbeing Boards developed its own unique way of beginning to make use of the Framework. This led to the development of a number of different yet overlapping approaches each attuned to particular local circumstances and priorities. Emerging from this experience are a number of pointers that other Boards' might wish to build on in developing their own unique approaches to implementing the framework.

Keep people at the centre and focus on their outcomes

Capturing individual outcomes is vital to co-production and asset building and therefore to developing communities. A helpful approach to securing individual outcomes is the TLAP Making it Real framework. This outcomes based approach has co-production in both the design of the service and the achievement of outcomes at at its core and has the added advantage of an already considerable and still growing sign up from Health and Wellbeing Boards.[40]

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CSV Grandmentors in Islington, Hackney and Camden harness the energy and experience of older volunteers to support young people to find work, stay on in education or take up training. Many of the young people they support don't have positive adult role models, others lack direction, some have been in trouble with the police and others have been homeless. Grandmentors visit a young person regularly and help them work towards goals such as finding an apprenticeship or getting on to a college course[41].

Focus on both assets and needs

Joint Strategic Needs Assessments (JSNAs) in health and social care have tended to be heavily weighted towards understanding need in the community paying little or no attention to assets. Assessing need is vital work but to address those needs in the most successful and cost-effective way requires an understanding of the personal and community assets already out there. Southampton Health and Wellbeing Board is keen to explore this in more detail and has identified the development of a Joint Strategic Needs *and* Assets Assessments as a key objective.

Communities are complex and multi-faceted and it would not be possible or desirable to attain a perfect understanding of every aspect. There will always be numerous social groupings and associations which will fall under the radar, but 'bottom up' asset mapping can provide a wealth of vital information and an effective means of actively engaging with local people. For example, the asset-based community development, "stepping stones" approach provides a process that fully engages the community in assessing its assets and needs and deciding how to make best use of resources.[42]

In Derby, the Local Area Coordinator (LAC) Programme enables 'bottom up' asset mapping. LACs work co-productively with individuals who in many cases would not neatly fit into any of the adult social care client categories. They support individuals to develop social capital, build resilience and to understand their skills, gifts and talents. The programme is proving so successful both in terms of the impact on the individual's wellbeing and system change that Derby is now looking to roll this programme out across the Borough. It is also providing a rich picture of the assets that are available.

Doncaster and West Sussex are both using a TLAP developed model (See Figure 3) that enables them to work with local communities to identify the different types of community self-help that are contributing to increased health and wellbeing[43]

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Figure 3: Vulnerable older people: how community self-help and redesigning services can make a difference

Focus on all levels of prevention

The Care Act 2014 makes it a duty to ensure the provision of preventative services across three levels of care and support: primary (i.e., to prevent), secondary (to reduce) and tertiary (to delay). Initially the trailblazer sites envisaged that the Framework would be most applicable to developing primary level prevention. However when they focused on individual patient journeys they found that at different points in their lives people may draw on community support at all three levels of prevention. For example, at the secondary level, people requiring support will typically continue to live in their own homes and local communities where strong, inclusive communities are important potential sources of support. The evidence on savings also indicated that the quickest return from investment is found at the secondary level of prevention. In Sheffield, this resulted in a widening of their Better Care Fund (BCF) bid to include secondary as well as primary level prevention. This now includes other local commissioning budgets alongside those required in the BCF. Doncaster, using the TLAP framework, has based its bid on three themes: universal services, and short term and long term services.

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Across the trailblazer sites the multi-level approach to prevention also led to consideration of the relevance of the community and co-production elements of the Framework at the tertiary level. Here, whilst some people may remain in their own or relatives' homes, many people are supported in sheltered housing, care or nursing homes. Utilising community and individual assets and resources at this tertiary level can be a helpful augmentation to formal health and social care services and play a key role in promoting wellbeing and maximising independence. This might include:

- changing care regimes to enable people to self-care and support one another;
- opening up care homes to local community participation and use; and
- Enabling care home residents to contribute to their local communities.

TLAP's building community capacity resources show that "giving" benefits the health and wellbeing of the giver as well as the receiver. Everyone has something to give, even at the end of life, the trick is finding out what and how and enabling them to do so.[44]

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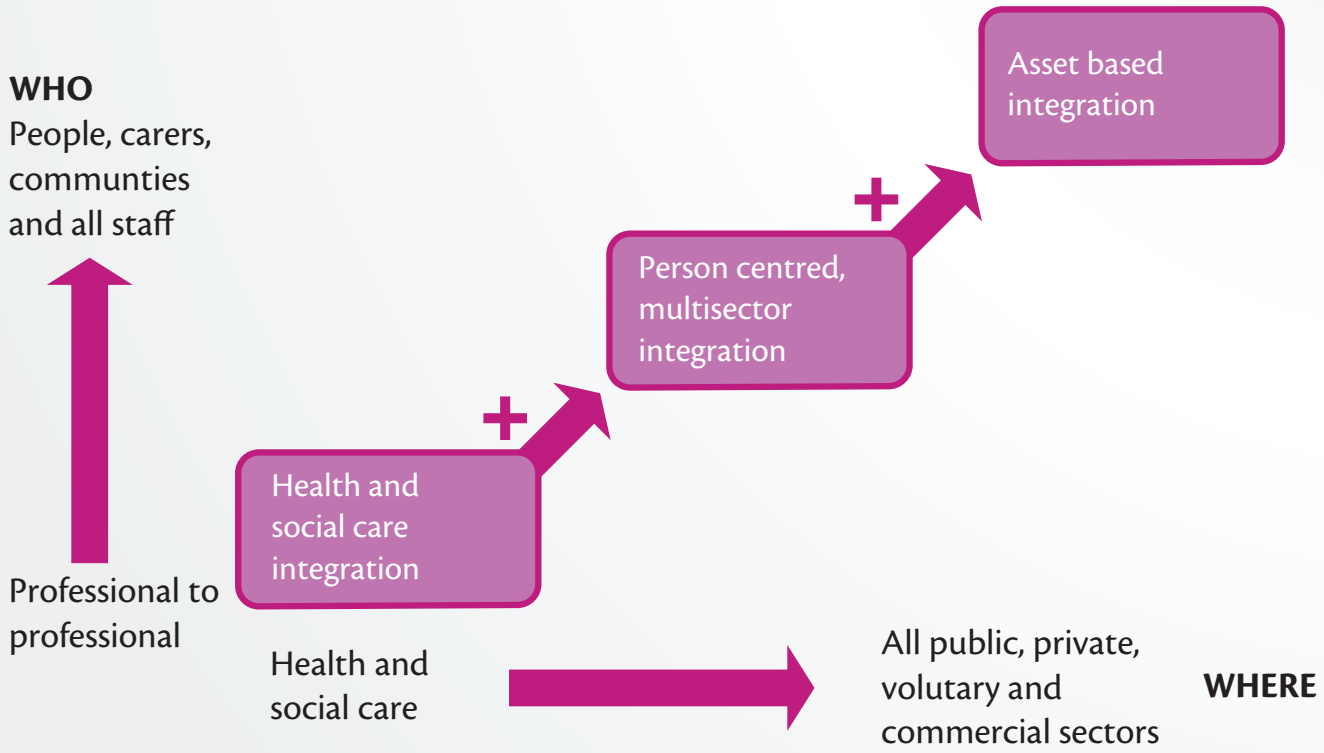
As part of the Skills for Care community skills programme, a series of learning sets were established for the various projects. In one of the end of life groups, one of the projects described how they had used a community skills approach with a person coming to the end of their life. This person was becoming more and more distressed and no one knew why. By having a conversation about the person's skills and knowledge it was discovered that this person was an expert gardener, distressed at not being able to get their garden right anymore. A group of volunteers were identified to come and learn gardening skills from this person and do their garden the way they wanted it done. Even at the end of this person's life they had skills and knowledge to share.[45]

Rethink integration

Current thinking and action on integration is still very organisation and service centred, often neglecting the role that people and communities play in promoting their own health and wellbeing. Recognising the need for a fundamental shift in thinking West Sussex developed a new way forward based on its strong inclusive communities Framework. The new approach builds on existing developments as part of a three stage transformation process (see Figure 4).

Figure 4: An asset based approach to integration



Stage 1: Health and integration – aims to smooth out the connections required between health and social care commissioners and providers and the processes that they use. The focus is on achieving better service to service integration and staff utilisation. Whilst it is recognised that this will also bring benefits to people who use services this is not the major aim of the change. Typical changes include: joint commissioning intentions and teams, single care plans and integrated provider teams.

Stage 2: Person-centred, multi-sector integration – at this stage the focus on health and wellbeing and its determinants is broadened. At the same time the organisational focus widens from health and social care to include the roles played by the full range of public, voluntary and commercial organisations across all relevant sectors. Dementia friendly communities and the use of community budgets are examples of this. At this stage, people and communities are the centre of the change envisaged, but the focus is still on how to make best use of organisational resources.

Stage 3: Asset based integration – incorporates the developments from the previous two stages and then goes further by putting the role that people and communities can play in enabling health and wellbeing, at the centre of integration. Organisational processes and services are redesigned to complement the existing and changed actions of individuals and communities. This includes rebalancing the power between practitioners and people and communities so that lived experience is given equal value alongside practitioner and clinical expertise. Investment is also made in community development and co-design of services as a key components of an integrated system. NESTA's People Powered Health system level changes, OPM's vision of an integrated approach to coproduction across health and social care and the TLAP Framework on this stage of integration.

Connected Care combines community-led needs assessment conducted by trained community representatives; recommendations based on a strict cost benefit analysis; cross sector service redesign or reconfiguration; and the set-up of new services co-produced by the community[46]

Take a risk stratified approach

People who experience two or more long term health conditions (LTCs) are at a much higher risk of suffering a significant loss of independence and requiring a subsequent increase in their level of health care. However, raised social care eligibility thresholds and ongoing pressure on budgets mean that more people than in the past, will no longer receive any form of state funded social care, placing greater pressure on NHS services raising the expectation that community support can keep people healthy and at home.

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Sheffield Health and Wellbeing Board is developing a comprehensive city wide approach to targeting people with two or more long term conditions. However, Sheffield recognises that whilst it has a rich mixture of community support the coverage across the city is patchy. Some of this support is well atuned to the needs of the most vulnerable and isolated individuals, while other support is not. Where support does exist, those in most need may not be signposted toward it or actively enabled to use it, suggesting that a more coordinated approach is needed. As a means of understanding the reach of existing community support to inform the development of its city wide approach, Sheffield produced a draft commissioning framework which it is now using to consult with voluntary, community and faith sector organisations (see Table 1).

Table 1: Sheffield - key functions to keep people well at home

Function	Intended outcome
Risk Stratification – so that people at real risk of declining independence and wellbeing are identified before they increase their call on the formal health and care system.	The people at most risk of declining health and wellbeing are well known.
Community Asset development – so that activities and support services are available locally that are attuned to the needs of people at risk.	People get advice and support locally that helps them to remain independent, safe and well.
Inform and Advise – so that people can self-help and find the support they need to stay independent and well.	Good advice and support are available locally 'tuned' to the needs of people at risk.
See and Sort – so that people identified as being at risk are actively (and assertively) supported to access community support activities and services.	People at risk are connected to activities and support that help them to be independent and well.
Self Care, Wellness Plan – so that people with longer-term needs are supported to maintain or regain their independence and wellbeing.	People needing extra care and support have a plan for what they, friends and services will do.
Life Navigator – so that people who struggle to navigate the system and stay in control of their care and support are helped to do so.	People have someone to help them e.g. navigate the system and stay in control.

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People with two or more long term conditions benefit greatly from being able to participate in community activities open to all. Unless these are available and 'tuned' to enabling them to participate no amount of linking and coordinating will make any difference. Central to all of these developments is therefore the need to invest in both primary as well as secondary level prevention.

Involve universal service providers

Universal services can also be at the forefront of enabling community development. For example, SPICE enables tenants in social housing to carry out housing maintenance and management tasks in exchange for community credits e.g. free tickets using up spare capacity in cinemas.[47] GP practices and housing associations have regular contact with, and the trust of, many people who are likely to experience poor health. They are therefore also in a good position to identify those people who would most benefit from community support and enable them to make use of it. This has led a number of the trailblazers to work with universal providers to both reshape their own services and enable more effective use to be made of existing community support. West Sussex is particularly interested in working with GP practices to further develop the ways in which they enable people to self-manage their long term conditions and enable people to access community support. To stimulate discussion, following on from a community consultation, TLAP developed for West Sussex an illustrative example of what this might look like in practice.[48]

Social prescribing links patients in primary care with non-medical sources of support within the community. Many social prescribing schemes use asset mapping tools in order to identify the potential sources of support so that GP practices and others can refer their patients. It connects people to the assets on their doorsteps. Research has found that prescriptions were being written for exercise and sport, book clubs, places to take part in the arts, green gyms, volunteering, mutual aid, befriending and self-help, advice on debt, legal problems and parenting support[49].

Enable community and cross-sector Systems Leadership

The changes to enable stronger, more inclusive inclusive communities and more effectively co-produced services are ones that will require investment from many different parts of the public sector from those concerned with community safety to those involved in economic development and sustainability. It will require Systems Leadership to enable best use to be made of the combined assets of people who use services, communities and organisations:

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'Systems Leadership is a way of working that shares the burden of leadership to achieve large-scale change across communities. It goes beyond organisational boundaries and extends across staff at all levels, professions and sectors. It involves people using services, and carers, in the design and delivery of those services. Systems Leadership recognises that leadership is not vested in people solely through their authority or position; so it involves sharing leadership with others, coming together on the basis of a shared ambition and working together towards solutions.[50]

The experience across the trailblazer sites is that people, communities and practitioners involved in making the changes will need to be able to challenge and change current practice within their own sectors and work across sectors. This will not be successful unless they have strong, consistent and pro-active cross-sector senior level backing.

This will require:

- **Core ownership of the change programme** by the Health and Wellbeing Board – the changes must be central to the Boards' core agenda and given prominence in all of its work.
- **Community leadership at board level** – the change in relationship within services and at community level that recognises people and communities alongside practitioners as co-designers and co-producers of health and wellbeing must also be reflected in the way Boards are led. Having community representatives on Boards and a focus on assets as well as needs makes this possible.
- **Pro-active championing** – much of the change will be achieved bottom up, however senior Health and Wellbeing champions for each project can play a critical role in giving staff permission to change existing ways of working and in tackling cross sector issues as they arise.
- **Strong political leadership at Board level** – Health and Wellbeing Boards are constituted bodies of councils and, in some cases, councillors may even have majority voting rights. It is vital that local political leadership buys in to the vision of community development and co-production and that back-bench councillors are also involved in how this might work on the ground in the wards they represent.
- **Strong clinical leadership at Board level** – Health and Wellbeing Boards can shape the overall strategy but to ensure local health commissioning is aligned with the principles set out here, strong buy-in from GP leaders and Clinical Commissioning Groups is essential.
- **The culture within organisations** to be based on an equal relationship between people who use services, their carers and practitioners. This gives equal weight to the training and expertise of practitioners and the lived experience of people.
- **Organisations to work with communities** – commissioners and providers getting to know the communities they service and avoid a 'top-down' approach to involving people.

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Develop a new approach to Health and Wellbeing Strategies

Growing and developing strong communities and reshaping services will also require a new approach to Health and Wellbeing Strategies. High level disease prevention targets may feature in local delivery plans but the overall vision needs to promote a more holistic view of wellbeing, incorporating the aspirations and hopes of local communities and residents. Ensuring this happens should be an on-going, iterative process that both engages the community and sells the approach to partners and stakeholders. It should demonstrate how community development and co-designing services to put co-production at their heart can meet a wide range of targets and that joint investment and action to do so makes sense[iii].

The overall Health and Wellbeing strategy should incorporate a set of principles which underpin its investment in community development and the redesign of more effective co-productive services. Both Doncaster and Southampton have formally endorsed the Framework and Dudley's Health and Wellbeing Board have made building community capacity and resilience a key priority.

KeyRing provides supported living networks for people with care and support needs living in the community. Members of the network share their skills and talents with each other and with their communities. Each KeyRing network has a volunteer who sees members regularly and helps the group work together. KeyRing networks improve individuals' social life and confidence, enabling members to be more resilient in terms of living independently in the community[51].

Adopt a collaborative approach to priority setting and savings

Some of the changes that accompany the implementation of the Framework will result in savings in the short term, others will take longer to be fully realised. Sometimes the savings will be realised by the Health and Wellbeing Board partner who does the investing. However there will also be other investments where the savings will mostly accrue to other sectors. This is where a cross sector approach to investment is essential. Instead of considering investments in community development or co-productive service redesign on a project by project basis Boards' should commit to invest in a portfolio of projects. These should be chosen to have maximum impact on priority need, where possible creating synergy with other changes as well as balancing out the investment required and the savings accrued across the partner sectors. This is one of the building blocks of effective Systems Leadership:

iii For examples of the benefits in health, social care, educational standards and crime and antisocial behaviour see Evidence, Efficiency and Cost-Effectiveness and the Strategic Briefing

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'Leaders need to see themselves as part of the collective leadership of the system, as well as a leader of their own organisation. Organisational success must not come at the expense of the system as a whole.[52]

5. NEXT STEPS

Think Local Act Personal and Public Health England are committed to providing ongoing support to Health and Wellbeing Boards to make the necessary changes to develop strong and inclusive communities. We will:

- Continue to offer support to the existing trailblazer sites to take their implementation of the Framework further
- Use Action Learning Sets to support further trailblazers to build on the learning from the original sites and develop their own local solutions
- Deliver regional dissemination events focused on the identified priorities of Health and Wellbeing Boards within those regions.
- Establish a Building Community Capacity Network to coordinate the work taking place nationally, exchange and disseminate good practice and develop means to measure the impact of this work.
- Ensure the Building Community Capacity section on the TLAP website continues to provides tools, methodologies, initiatives, case studies to support organisations in taking this forward.
- Continue to research the impact of the use of the Framework on: developing a culture of co-production; improving the experience of living in communities; boosting health and wellbeing outcomes; and delivering savings.

RESOURCES

Think Local Act Personal has a comprehensive range of resources available on its website to support building community capacity. Tools, methodologies, evaluations, research, cost effective evaluations, case studies and an interactive 'how to' guide can all be found at www.thinklocalactpersonal.org.uk/BCC/

APPENDIX A

Marking progress toward strong and inclusive communities.

The table below reflects the two fundamental areas of the Building Community Capacity framework: community self-help and effective co- production. The table provides a template for how localities might begin to map existing resources and identify the interventions needed to develop strong communities. The table can be easily modified to suit local conditions.

	Key Outcomes	Current interventions	Making it Real marker	Interventions needed
Community self-help	Building mutual support			
	Facilitating connections			
	Enabling inclusion			
Co- produced service redesign • Universal services • Targeted services	Strengthening community ownership			
	Reshaping services			

END NOTES

[1] NHS England. (2014). **Integrated Personal Commissioning Prospectus**. [Online]. Available from: *www.england.nhs.uk/ourwork/commissioning/ipc*

[2] Think Local Act Personal. (2014) **Working together for personalised community based care and support: A partnership agreement** 2014 – 17 [Online]. Available from: *http://www.thinklocalactpersonal.org.uk/_library/Homepage/PartnershipAgreement_final_2_June.pdf*

[3] Foot J and Hopkins T. (2010). **A glass half-full: how an asset based apporach can improve community health and well-being**. IDeA. quote from page 14 John P. Kretzmann and John L. McKnight, pp. 1-11, from Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets, Evanston, IL: Institute for Policy Research (1993).

[4] Derby City Council. *Local Area Coordination in Derby* (

[5] Woodhead N (...) Local Area Coordination in Derby. Derby City Council *http://www.communitycatalysts.co.uk/case-studies/contributing-and-keeping-active/*

[6] Lazarus C, Miller C and Smyth J. (2014). **How to commission for personalisation: guidance for commissioners and others in children and young people services**, KIDS network.

[7] http://www.communitycatalysts.co.uk

[8] Foot J. (2012.) What makes us healthy: the asset approach in practice – evidence, action, evaluation [Online]. Available from: *www.assetbasedconsulting.co.uk/uploads/publications/WMUH.pdf*

[9] Stuteley, H et al. (2011). **Empowering Communities for Health** [Online.] Available from: *www.healthempowerment.co.uk/wp-content/uploads/2012/DH_report_Nov_2011.pdf*

[10] Summarised from **Pub Lunch Club** at Community Impact Bucks. [Online]. Available at: *http://www.communityimpactbucks.org.uk/pages/pub-lunch-club.html*

[11] Grady, M. cited in Friedli L. (2009). *Mental Health, Resilience and Inequalities*. World Health Organisation Regional Office for Europe. [Online]. Available from: *www.mentalhealth.org.uk/publications/mh-resilience-inequalities/*

[5] Grady, M. cited in Foot J. (2012). **What makes us healthy? The asset approach in practice: evidence, action, evaluation** Grady, [Online]. Available from: *www.assetbasedconsulting.co.uk/uploads/publications/WMUH.pdf*

[13] Stevens J. (2013). Growing Older Together: The case for housing that is shaped by older people. [online]. Availalbe from: *www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Reports/HLIN_CaseStudyReport_GrowingOlderTogether.pdf*

[14] Miller C, Alekason V and Bunnin A. (2012). **Coproduction of health and wellbeing outcomes: the new paradigm for effective health and social care**, OPM

[15] **See Public Toilets in London**. London Assembly. (2011). [Online]. Available from: *http://www.london.gov.uk/moderngov/documents/s4497/Public%20Toilets%20-%20Appendix%201%20-%20draft%20repo.pdf*

[16] Clive Miller (2010). **Personalisation of universal services: 1. Bus travel OPM** [Online]. Available from: *http://www.opm.co.uk/wp-content/uploads/2014/01/Personalisation-of-public-transport_buses.pdf*

[17] Ibid. *www.Thinklocalactpersonal.org.uk/_library/Resources/BCC/CaseStudies/OPM_Personalisation_of_libary_services.pdf*

[18] *http://www.selfmanagementuk.org/services/self-management-life*

[19] Broad R et al. (2012). **Local Area Coordination** [Online]. Available from: *www.derby.gov.uk/media/intranet/documents/transformation/adultshealthandhousing/localareacoordination/local-area-coordination.pdf*

[20] National Institute of Health and Care Excellence. (2013.) **Behaviour Change, LGB 7**, [Online]. Available from: *www.nice.org.uk/advice/lgb7*

[21] National Institute of Health and Care Excellence. (2008). **Community Engagement, PH9** [Online]. Available from: *www.nice.org.uk/guidance/ph9*

[22] Foreword to Foot, J. **What makes us healthy** [Online]. Available from: *www.assetbasedconsulting.co.uk/uploads/publications/WMUH/pdf.*

[23] More information available from: *www.oxstreets.org.uk* and *www.streetsalive.org.uk*

[24] Fisher, B. et al (2011). **Empowering Communities for Health: Business Case and Practice Framework**. **Health Empowerment Leverage Project** [Online]. Available from: *http://www.thinklocalactpersonal.org.uk/_library/BCC/HELP_cost_savings_report_report_Nov_2011.pdf* (accessed 28 November 2013)

[25] Hampson, M, Langford K, Baeck P. (2013). **Redefining consultations: changing relationships at the heart of health** NESTA

[26] [Online] Available from: *www.neweconomics.org/publications/entry/five-ways-to-well-being-the-evidence*

[27] Think Local Act Personal. (2012). **Building Community Capacity: Evidence, Efficiency and Cost-effectiveness**. [Online]. Available from: *www.thinklocalactpersonal.org.uk/_library/BCC/Building_Community_Capacity_-_Evidence_efficiency_and_cost-effectiveness.pdf*

[28] Cited in Bennett, Dr. (2014). **Getting Serious About Personalisation in the NHS**. [Online]. Available from: *www.thinklocalactpersonal.org.uk/Latest/Resource/?cid=10259*

[29] Nuffield Trust. (2013). **Autumn Statement confirms that a decade of austerity lies ahead for the NHS** [Online]. Available from: *www.nuffieldtrust.org.uk/media-centre/press-releases/nuffield-trust-autumn-statement-confirms-decade-austerity-lies-ahead-nhs*

[30] McNeil,C, Hunter,J. (2014). T**he generation strain: Collective solutions to care in an ageing society**. Institute of Public Policy Research. [Online]. Available from: *www.ippr.org./publications/the-generation-strain-collective-solutions-to-care-in-an-ageing-society*

[31] Hampson, M., Langford K., Baeck P. (2013). **Redefining consultations: changing relationships at the heart of health** NESTA

[32] Windle K et al. (2008). **The National Evaluation of Partnerships for Older People Projects: Executive Summary** PSSRU [Online. Available at: *www.pssru.ac.uk/pdf/rs053.pdf*

[33] Knapp M et al. (2011). **Building Community Capacity: Making an Economic Case**. Personal Social Services Research Unit, London School of Economics and Political Science [Online]. Available from: *www.thinklocalactpersonal.org.uk/_library/BCC/Making_an_ecconomic_case_doc.pdf (accessed 28 November 2013)*

[34] Stamou, E. et al (2010). **Lived Experience Leading the Way: Peer Support in Mental Health, Together UK**. [Online]. Available from: *http://www.together-uk.org/wp-content/uploads/downloads/2011/11/livedexperiencereport.pdf (accessed 28 November 2013)*

[35] Kennedy R. (2011. **Social Return on Investment (SROI)**. SelfCare 2011;2(1):10-20 [Online]. Available from: *http://www.selfcarejournal.com/view.abstract.php?id=10035 (accessed 28 November 2013)*

[36] Phillips, J., **Self Care Reduces Costs and Improves Health - The Evidence**. Expert Patients Programme [Online]. Available from: *http://www.expertpatients.co.uk/sites/default/files/files/Evidence%20for%20the%20Health.pdf (accessed 28 November 2013)*

[37] Slay, J. (2011) More Than Money: Literature review of the evidence base on Reciprocal Exchange Systems. NESTA

[38] Joseph Rowntree Foundation. (1997). **The economic equation of volunteering** [Online]. Available from: *http://www.jrf.org.uk/sites/files/jrf/sp110.pdf*

[39] Lambeth Council, **Act Together Communities Team** [Online]. Available from: *http://www.thinklocalactpersonal.org.uk/_library/ACT_Together_at_Lambeth.pdf*

[40] Making it Real - Marking progress towards personalised, community based support. Think Local Act Personal. [Online]. Available from: *www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/TLAP/MakingItReal.pdf*

[41] **Older people mentoring young people - Grandmentors**. CSV[Online}. Available from: *www.csv.org.uk/volunteering/mentoring-befriending/grandmentors*

[42] Recovery & Asset Based Community Development (2014) [Online] Available from: *www.nurturedevelopment.org*

[43] Think Local Act Personal. (2014 forthcoming.) Developing a community capacity building portfolio

[44] Henwood M., (2014). **Skills around the person. Skills for Care**. [Online]. Available from: *www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/Community-skills-development/Skills-around-the-person.aspx*

[45] For more information about the Skills for Care Community Development Programme go to: *http://www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/Community-skills-development/Community-skills-development.aspx*

[46] Turning Point (2014) Connected care: doing things differently *http://www.turning-point.co.uk/media/209014/cc0013_connectedcarebrochure_proof.pdf*

[48] Clive Miller (2014 forthcoming) People and Practice: a new way to boost health and wellbeing: an outline for discussion Think Local Act Personal. *http://www.justaddspice.org/our-work/housing.html?phpMyAdmin=11mNo6jEpJm5YSM6PATCqQb02P1*

[49] Richard Vize (2014) The revolution will be improvised: stories and insights about transforming systems Leadership Centre for Local Government *http://www.localleadership.gov.uk/docs/Revolution%20will%20be%20improvised%20publication%20v3.pdf*

[50] Ibid

[51] For more information, please visit *http://www.keyring.org/site/KEYR/Templates/Generic3col.aspx?pageid=222&cc=GB*

[52] Ibid