



Developing the power of strong, inclusive communities

A draft framework for Health and Wellbeing Boards
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Health and Social Care in England is facing a daunting array of challenges. The budgets of local authorities who fund social care are falling, whilst demand, through demographic changes and rising expectations is growing in both sectors. There is a growing consensus that new and innovative ways of working are essential in order to negotiate these difficult times and avoid simply managing decline.

Key to achieving the change is revisiting the relationships that health and social care systems have with those they serve. This means recognising that people and communities want to be involved in decisions that affect them and have much to contribute themselves, yet are not always involved in an on-going, systematic and joined-up way about what happens in their local community. It includes thinking about the skills and knowledge that people have which can contribute to their own health and wellbeing and the support that people can give each other. It involves seeing people with health and social care needs as active co-producers of outcomes rather than passive recipients of services.

It also requires fundamental shifts in perception and the way things work. For example, the health sector needs to move away from planning services purely based on the aggregated needs of patients in GP practices and take a wider view of health and wellbeing in the wider community. In social care this means a return to principles of community development – making sure that people have the support they need to live independently but ensuring they remain active members of their local communities. The challenge is to make sure that people’s immediate health and care needs are met whilst simultaneously reducing the need for acute services.

The Think Local Act Personal Partnership (TLAP) has been working with public agencies, communities, the third sector, and academic partners to highlight how things can and are being done differently. This paper pulls together our work, and that of others, to provide a helpful framework for Health and Wellbeing Boards. It links to compelling evidence that better health and wellbeing can be achieved through building so-called “social capital” in our communities and is also a way of getting the most out of scarce financial resources. It will focus on:

- Enabling the development of strong and inclusive communities and the importance of this as an integral part of Health and Wellbeing Strategies
- The benefits of re-designing and tailoring public services so that professional expertise complements people’s own lived experience
- The critical role that Health and Wellbeing Boards can play in enabling more effective coproduction of outcomes
- Signposting evidence and examples of the community based approach.

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. This is 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 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



In recent years, Public Health has tended to focus on behaviour change and the targeting of individuals or groups. This work is important and shouldn't be diminished. However, trying to persuade people to stop doing things they like, such as smoking, drinking too much and eating junk food - and to start doing things they don't like such as more exercise and adopting a healthier diet - is hard to achieve and only part of the picture. By prioritising strong and inclusive communities Health and Wellbeing Boards can positively impact on health outcomes whilst also knocking on the open door of local aspirations. The idea of tackling some of the determinants of health and wellbeing by developing a local narrative about building better places to live, making services more joined-up and responsive to people when they need them and giving people more control over their lives is one that will chime well with people of all ages and backgrounds. As councillors know, it is also an easier political message to sell.

It is particularly important to think about community as part of an overall strategy to improve health and wellbeing in relation to older and disabled people and people with long-term health conditions. Unfortunately many disabled and older people find their health and wellbeing is being undermined by a lack of access to the universal supports and opportunities available to others and through living in sometimes hostile and non-inclusive communities. This can lead to isolation, poverty and,

for disabled people, a higher probability than others of being harassed and having to use expensive specialist services when this wouldn't otherwise be necessary.

Enabling people to make best use of their own and their communities' assets also requires changes in the way that targeted services are designed and delivered. Targeted services are often provided in a highly siloed and self-contained way. Hence there is little opportunity for front-line staff to get to know people as whole people, link with their local communities and enable them to make best use of their assets. The service delivery culture is mostly based on making best use of professional expertise to decide what treatments and support should be provided to individuals.

Whilst professional expertise is to be valued it can be deployed far more effectively if it is actively complemented by 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 both people and professionals. This requires a change in the working relationships and in the way services are designed to support people in achieving improved outcomes. This is the experience of self-directed support in social care and developments such as shared decision-making and the Year of Care in health.

Health and Wellbeing Strategies therefore need to include:

1. **Nurturing and growing people's social capital through community development** - building people's social support networks in the community, making sure that older and disabled people and people with long-term conditions get a chance to pursue their own interests and contribute to community life and making best use of the resources and assets which are available in the local.
2. **Redesigning services on a co-productive basis** – this takes into account the assets and skills that local communities and people who use services can bring to the table alongside those of professionals. By moving away from a narrow focus on meeting needs through professionally provided services, new ways can be found to make much more effective use of the skills and assets of people, communities and professionals.

As well as focussing on the important end result for people – better lives and improved health and wellbeing - these two approaches can reduce demands on services and bring cost savings (Figure 2).

Community development can take many forms and be implemented at different levels from large scale community wide approaches, for example the Health Empowerment Leverage Projectⁱ to smaller scale more targeted initiatives such as Pub Lunch schemeⁱⁱ.

In parallel with community development approaches coproduction can also be implemented at a service system and community wide level or via the redesign of targeted or localised service provision. The NESTA funded People Powered Health Projectⁱⁱⁱ focuses on system level change whilst Camden 's work on mental health day services^{iv} and Tower Hamlet's on personalised approach to supported housing describe more localised or targeted changes^v.

Figure 2: Combining people's own assets with community and organisational assets to more effectively co-produce outcomes



Why focus on communities and co-production?

There is plenty of evidence that strong, inclusive communities supported by services redesigned on a co-productive basis both promote improved health and well-being and save money.

Improved health and well being

The evidence shows that strong, inclusive communities impact both on overall physical and mental health and well-being as well as specific health conditions, such as heart attacks and social outcomes, such as community safety.

- **Improving overall health and well-being** – for example: people with adequate social relationships have a 50% greater likelihood of survival^{vi}; social support and activity may protect against dementia and cognitive decline^{vii}; and committing one act of kindness, once a week, over a six week period, boosts overall well-being.^{viii}
- **Impact on specific conditions and social outcomes** – compared with conventional approaches increased social cohesion and social networks can reduce fatal heart attacks by 25% in men^{ix}; social participation is the most significant predictor of difference between people with and without mental health problems^x; and time credit schemes for young people can reduce crime by 17%^{xi}.

Given the availability of this strong evidence of impact it is reasonable to ask ‘Why haven’t partners in the sector already invested heavily in community development and the redesign of more effective co-productive services?’. There are several reasons why, including:

- **Unaware of the evidence** – many commissioners and providers have little knowledge of the new approaches and that strong evidence exists for their effectiveness. Hence although the approaches may sound attractive they would not be considered as robust enough to merit inclusion in efficiency or other investment programmes.
- **Tuning up the current model** – much of the focus for change has been making the current service and professional focused model of service delivery more efficient and effective. This has produced real gains and in some areas there is further to go. It has therefore been rewarding to stay focused on existing approaches to improving outcomes with the consequence that the value of looking at alternatives was greatly diminished.

What then is changing to make it more likely that HWBs will now invest in alternative approaches to improving outcomes?

- **The limit of efficiency savings** – whilst there is still much to be done to make the current service delivery model more efficient the availability and the level of the returns are diminishing. Hence there is a willingness to look for alternatives.
- **Financial infeasibility of the current model** – an ageing population and rising rates of long term conditions will require massive extra investment in the current service model. This is not seen as either desirable or feasible.
- **A willingness to consider alternatives** – the future infeasibility of the current service model, reducing returns from efficiency savings, and a greater understanding of the costs and benefits of alternatives make it much more likely that they will now be considered.

Return on investment

Both community development and the redesign of universal and targeted services to be much more effectively co-productive require investment. However this investment is likely to be more than offset by the savings resulting from improvements in health and well-being reducing demand for services and enabling disabled and older people and people with long-term conditions 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 reduce 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 the 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 estimates 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^{xii}.
- **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%; and 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^{xiii}.
- **Specific community initiatives** – for example peer support in mental health can save bed days and reduce hospital re-admissions by 50% compared with traditional care, a saving of £28,000 each year in Leeds^{xiv}. Befriending schemes reduce 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^{xv}.

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 health conditions, producing a £6.09 saving for every £1 spent^{xvi}. This includes: reducing GP consultations by 7%, outpatient visits by 10% and A&E attendances by 16%.^{xvii}
- **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^{xviii}. The social return on investment of volunteering is £2 and £8 per £1 spent on supporting volunteers^{xix}

- **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 community facilities and also levered in £5.5m in investment into the borough^{xx}

Putting it into practice – What can Health and Wellbeing Boards Do?

As we have said, improvements in health and wellbeing will come from people, communities, service providers and commissioners changing the ways in which they enable the growing and nurturing of social capital and the way they redesign services so that people, communities and organisations can make best use of their assets. However, as many of the developments that are required need both whole population and cross-sector investment in local communities and service redesign these are best supported through collaborative action. Health and Wellbeing Boards are uniquely well placed to enable this collaboration.

A framework for Health and Wellbeing Boards in building social capital and maximising co-production involves:

- A focus on assets as well as needs
- Providing community and cross-sector leadership
- Promoting a vision and shaping the strategy
- Shaping priorities around building stronger communities and maximising co-production
- Co-ordinating cross-sector investment
- Evaluating and sharing the learning.

A focus on both assets and needs

Strategic Needs Assessment in health and social care has tended to be heavily weighted towards understanding need in the community rather than the assets that exist, the Joint Strategic Needs Assessment (JSNA) being the key local statutory document in this respect. Assessing need is vital work but to address those needs in the most successful and cost-effective way requires an understanding of the community assets already out there. This gives us the best chance of nurturing a community response to sustain and grow social capital and to redesign services to make best use of those assets.

Communities are such hugely complex and multi-faceted organisms that it is not possible or desirable to try to attain a perfect understanding of the communities in which we work. There will always be numerous social groupings and associations which will fall under the radar including, most obviously, friendships amongst neighbours who look out for each other.

The use of 'bottom up' asset mapping processes both to inform JSNAs and provide a means of actively engaging in a dialogue with local people can be particularly effective. The asset-based community development, stepping stones approach provides a step by step process that fully

engages the community in assessing its assets and needs and deciding how to make best use of its assets.

Provide community and cross-sector leadership

The changes that need to be made require a radical rethink of what personal, community and organisational assets are available and the role of services and front-line professionals.

The investments needed to enable stronger and more inclusive communities and more effectively co-productive services are ones that are required from many different parts of the public sector from those concerned with community safety to those involved in economic development and sustainability. Key policy levers that can be used to enable this cross sector working are:

- **Care and Support Bill^{xxi}** - introduces a general duty of well-being for local authorities, Well-being is construed very widely including health and social care but also: education and employment; social and economic well-being; and the contributions individuals can be enabled to make to society. This is backed by a mutual duty to cooperate between the local authority and partner organisations.
- **Making It Real^{xxii}** – is a TLAP initiative that puts coproduction at the heart of personalisation. At its core are a set of ‘I’ statements created by people requiring support through which they spell out the experience they would expect from a gold standard service. The statements cover both contributing to, and drawing on, community resources and ensuring the effective coproduction of outcomes. Strong and growing sign up is been achieved from both commissioners and providers.
- **National Collaboration for Integrated Care and Support^{xxiii}** - a national commitment by government and local partners to system wide implementation of integrated care that has coproduction and building and using community assets at its core. In particular it focuses integration on producing improvements in people’s experience as measured by the Making It Real ‘I’ statements and those from National Voices. HWBs are central enabling the overall change programme.

The people, communities and professionals 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 backing.

This will require:

- **Core ownership of the change programme by the Health and Wellbeing Board** – the changes must be central to the HWBs 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 professionals as 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 both 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.

Key to the cross-sector approach is the agreement of a set of principles that promote a new relationship with people and communities. *The culture within organisations* should be based on an equal relationship between people who use services, their carers and professionals. This gives equal weight to the training and expertise of professionals and the lived experience of people. *Organisations should work with communities* – commissioners and providers getting to know the communities they service and avoid a ‘top-down’ approach to involving people.

Promoting a vision and shaping the strategy

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 re-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.

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

TLAP’s *‘Are We There Yet?’*^{xxvi} provides a useful framework to underpin Health and Wellbeing Strategies by describing four key elements of building strong, inclusive communities and helping to map and plan:

- Building social support networks
- Encouraging membership of groups
- Nurturing an inclusive community
- Enabling everyone to make a contribution

‘Are We There Yet?’ uses a series of ‘I’ statements to describe what good would look like for both people and organisations in terms of building stronger and more inclusive communities and sets out a vision of a ‘gold standard.’ The ‘I’ Statements are centred around the four themes above. Using the tool would allow HWB boards to undertake a co-produced self-assessment, identify areas for priority action and steer planning.

The overall HWB strategy should incorporate a set of principles which should underpin its investment in community development and the redesign of more effective coproductive services.

Shaping priorities around building stronger communities and maximising co-production

In deciding on investment priorities Health and Wellbeing Boards will take into account a range of different criteria. These may include:

- when to invest in community development;
- which communities need most help;
- what planned service redesigns provide the best opportunities to build in more effective coproduction.

Co-ordinate cross-sector investment

The collective resources of Health and Wellbeing Boards are very significant, in terms of staff time and skills and services that are commissioned and provided. With current financial restraints it makes sense to try to maximise the use of these resources and the impact they can have on Health and Wellbeing.

A cross sector approach can enable sectors to gain through joint investments. Hence stronger more inclusive communities can lead to reductions in crime, improvements in health and social wellbeing and employment prospects. Sharing the cost across sectors also reduces the cost of such investment to any one of the partner sectors.

However there will also be other investments where one sector will have to invest to produce the improved outcomes but the savings will mostly accrue to another sector. This is where a cross sector approach to investment is even more essential. Instead of considering investments in community development or co-productive redesign on a project by project basis HWBs 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.

Evaluate and share the learning

The effectiveness of a Health and Wellbeing Board's investment in developing stronger, inclusive communities can be measured in a number of ways:

- **Improved outcomes** – tracking trends in health and social outcomes for communities and specific groups of people who have been targeted via community development and service redesign activities.
- **Savings** – monitoring the impact of interventions on the demand for services and the amount and cost of the services provided.
- **Experience of living in communities** – logging the degree to which all people in a community experience stronger and more supportive links and have the opportunities they want to make a contribution.
- **The new relationship** – where culture change has been implemented checking on whether the change as experienced by people using services has also improved.

TLAP's *Does it Work?*^{xxvii} is a guide to evaluating initiatives for their impact on social capital and community capacity. It suggests different methodologies for different types of services or projects and emphasises the importance of involving local people in evaluation.

Conclusion

There is compelling evidence that better health and wellbeing can be achieved through developing stronger and more inclusive communities and re-designing and tailoring public services so that professional expertise complements people's own lived experience. Health and Wellbeing Boards are and can play a crucial role in enabling this to happen in a systematic way at a local level. TLAP is providing active assistance to HWBs to do so through the production of this framework and the provision of follow up support.

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