FROM PATIENTS TO POPULATIONS

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Project

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Optimising involvement in the NHS long-term plan

Summary

1. The 2019 NHS long term plan depends on the whole population becoming more involved in the health agenda. The Personalisation section offers a social model of health, with social prescribing (SP) as a main plank.
2. Supporting and strengthening community organisations is vital to optimise residents' involvement in health, and forms part of the SP Link Worker role.
3. Social prescribing is likely to be unsustainable without a strong community engagement and development approach. This would support residents and community groups in activities about health, the whole range of social determinants of health, improvements to neighbourhoods and shared decision-making with the statutory sector.
4. But it will be difficult for SP workers to carry out community support merely as a background to their substantial workload of individual cases. Wider strategy, input and training is needed.
5. Social prescribing could form a pivot for an interagency approach to creating local community engagement and development strategies (or strengthening them where they already exist).
6. Marginal resources devoted to community involvement in the different public services could be brought together to form and implement such strategies.
7. Arrangements would vary according to local circumstances, with hosting and management by the best placed body, which might in some cases be primary care networks.
8. Five practical factors are outlined which are needed to build such strategies within the framework of the NHS 10 year plan, spearheaded by the personalisation programme.

The plan. The NHS long term plan[1] aims for shared responsibility for healthcare and wellbeing between the NHS and the general population. It takes major steps towards rebalancing the health system between treatment and prevention, hospitals and community care, towards greater self-management of long-term conditions, and from purely medical solutions to fostering wellbeing through the social determinants of health. Thus, the plan depends not only on changes within the health system but on generating more active involvement in the health agenda throughout the population.

[1] www.longtermplan.nhs.uk, Jan 2019

The personalisation agenda. One of the main themes of the plan is Universal Personalised Care[2]. This is to be implemented through a comprehensive model addressing the whole pyramid of health need: at the top providing specialist treatment for the 5% of the population with complex needs; in the middle range, supporting the 30% of people with long term physical or mental conditions; and at the base helping the whole population to stay well and to make informed decisions when their health changes.

Social prescribing. Social prescribing (SP) is one of six elements which go to make up the comprehensive model for personalisation[3]: 'Social prescribing and community based support enable all local agencies to refer people to a link worker, to connect them into community-based support, building on what matters to the person... and (this will) connect people to community groups and voluntary organisations that are supported to receive referrals.'[4] There are 300-400 link workers in early 2019, and NHS England undertakes to fund and train 1000 more and rising over five years, to be located within local primary care networks. The link workers will guide and support people in choosing purposeful local activity, which will often be found in the local community and voluntary sector. They will have caseloads of around 250 people a year, between them supporting up to 3% of the local population. Early studies suggest that social prescribing reduces unnecessary recourse to surgeries and A&E.

Rich detail. The plans for this work are elaborated in a satellite document, *Social Prescribing and Community-Based Support Summary Guide* [5]. Despite being called a summary, this contains the most detailed available account of how the expanding occupation is expected to be organised, including draft job description, person specification and common outcomes framework. We take this to be the 'standard replicable model and outcomes framework' for social prescribing anticipated in Action 8 of the Personalisation plan[6].

The link worker role. The link worker role is described as having four key responsibilities. The first two are concerned with taking referrals and providing personalised support to the individuals and their families and carers. The other half of the job is concerned with support to communities and their groups and organisations:

> '*3. Draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups to receive social prescribing referrals. Ensure they are supported, have basic safeguarding processes for vulnerable individuals and can provide*

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[2] https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/

[3] https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/

[4] Ibid, p21-22

[5] https://www.england.nhs.uk/publication/social-prescribing-and-community-based-support-summary-guide/

[6] *Universal Personalised Care*, p42

> *opportunities for the person to develop friendships, a sense of belonging, and build knowledge, skills and confidence*
>
> *4. Work together with all local partners to collectively ensure that local VCSE organisations and community groups are sustainable and that community assets are nurtured, by making them aware of small grants or micro commissioning if available , including providing support to set up new community groups and services where gaps are identified in local provision'*[7].

This kind of support is exactly what depleted local community sectors need. The guide in effect recreates the main substance of community development. But there is a stark disproportion between this complex, skilled and demanding work and the provision of capacity to achieve it.

Objectifying community life. A particular strength in the Guide is that it triangulates the social prescribing process, looking at it in turn from the viewpoint of individuals, of communities and of the health system. This could become a breakthrough in rethinking a health system which has hitherto been managed overwhelmingly just in terms of individuals and institutional systems. Seeing community life in objective terms, as a whole stratum of social life between individuals and systems, provides much greater flexibility in modelling how to meet changing patterns of healthcare need.

The Guide expects SP to improve community life in these ways:

> *"Communities are stronger and more tolerant, because people from all backgrounds are supported through social prescribing to be involved in community groups. There are more people who volunteer and give their time back to others.*
>
> *Communities understand the power of social prescribing in reducing health inequalities, by supporting a power shift, enabling people to take more control of their lives, be less isolated and make connections.*
>
> *Communities are aware of how social prescribing encourages community development and increases local community assets. Resources and support are available locally to spot gaps in community provision, help people to create new groups and provide informal support in their neighbourhoods. ... Local community groups are able to take referrals from link workers because they have sustainable grant funding..."* [8]

However, community life is also vital to the health agenda in multiple other ways which should be considered at the same time in relation to prevention and other areas of the long-term plan.

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[7] *Summary Guide,* p19-20
[8] *Summary Guide*, p9

Down to earth. The Guide is unrealistic in supposing that link workers can help the development of communities as a side issue, and with no special training for it, whilst also handling caseloads of 250 individuals a year. This disproportion is even more concerning when one considers that some localities have not merely 'gaps' in community provision but gaping chasms. Loss of community spaces and venues during the austerity decade has meant that in many places community groups have nowhere they can meet easily and affordably. An estimated 12,000 assets such as community centres, youth centres, libraries and village halls have been lost even within the last four years[9]. Many pubs have also closed. The asset-based approach often lacks physical assets to operate in. Lack of affordable local places for social, physical or mental recreation is undoubtedly a factor in exacerbating isolation, depression, youth crime and other issues driving additional need to the door of the NHS. A review by a committee of MPs in May 2019 concluded that areas which had suffered the largest cuts to youth services had seen the largest increases in knife crime.[10]

Participation is lower in disadvantaged areas. 10% of people in the most deprived areas were involved in social action in 2017-18 compared with 20% in the least deprived[11]. Volunteering in general has declined during the austerity period[12] and 44% of people from the lowest socio-economic groups have never volunteered compared with 34% from the highest[13].

At a time when other community work input is sparse it is not credible that this design for social prescribing alone can do much to strengthen the community sector in the most disadvantaged places, which are often the places making most demand on the healthcare services. The vision, however, is right so far as it goes, and the social prescribing input could be a spearhead for a more coordinated framework.

Development options. Should the SP role be cut back to the individual caseloads and not attempt the complementary community-strengthening role? That would mean that it would be likely to work least well in the most disadvantaged neighbourhoods, where fewer viable community groups may be available, reinforcing the health inequalities that the plan seeks to overcome.

The alternative is to follow through the implications of the dual role but develop a wider strategy to place it in. A deeper understanding of how the community sector functions would reveal a basis both for wider effects and wider potential contributions both from NHS and external sources.

Wider health effect of the community sector. The condition of local community groups is fundamental not only to the 3% of the population who may be socially prescribed in a given year but to the 97% who are not. It is fundamental to prevention as well as personalisation; to the 'whole population'

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[9] https://www.thebureauinvestigates.com/stories/2019-03-04/sold-from-under-you, March 2019

[10] 'Youth club funding cuts put children at risk of violence', *Guardian*, 7.5.2019

[11] *Community Life Survey, 2017-18*, DCMS, 2018, Chapter 5

[12] Ibid, Chapter 4

[13] *Kickstarting a New Volunteer Revolution*, J Davies Smith et al, Royal Voluntary Service, 2019 (undated)

base of the demand pyramid as well as the middle segment of recognised need. A well-functioning local community sector is, in effect, an organic self-referral health system for the whole population, channelling people voluntarily into meaningful, motivating, rewarding social activity which helps to prevent them from moving higher up the pyramid of health need.

Contact, confidence, control. Additionally, community groups are not only vehicles for health-giving participation but instruments for residents to improve the conditions of the neighbourhood, both directly through their own activities and through negotiation with service providers. Securing a new amenity, improving the environment, restoring a bus route, contributing to service redesign or blowing the whistle on poor service performance are health-giving at a multiple and repeated level, ameliorating the conditions which have led to excessive demand in the first place.

About 17% of local voluntary and community groups are directly concerned with health, 30% have health as one of their aims and most of the rest are concerned with other local issues which also affect health ('the social determinants' of health): housing, education, employment, welfare, faith, safety, environment, sport, arts and transport.[14] All the public agencies dealing with these issues have community involvement objectives of their own which they are hard put to achieve under present conditions but would be able to do better in a more coordinated framework.

Coordination. What is needed, in short, is an interagency approach to creating comprehensive local community engagement and development strategies (or strengthening them where they already exist). Arrangements would vary according to local circumstances, with hosting and management by the best placed body, which might in some cases be primary care networks. But any existing neighbourhood umbrella bodies or community development initiatives should never be overridden but consulted and built upon. So the first step would be an audit of what already exists. Around a third of local community and voluntary groups include community development as one of their aims, 16% having it as a priority.[15]

We would stress here that it is the practical substance of community development we are concerned with, not the label or the ideological debates which sometimes attach to it. Similar work may be done in different styles and methods under headings such as community organising, community activation, the asset-based approach or health creation. What affects all methods, however, is that work of this kind has declined in England during the past decade. The health agenda requires a new community engagement and development framework and provision, with clear outcomes and measures. This could build on the social prescribing guidance but add other objectives and

[14] https://www.ipsos.com/sites/default/files/migrations/en-uk/files/Assets/Docs/Polls/nscse-national-survey-2010-topline.pdf Questions 3 and 4

[15] ibid

measures, in particular about levels of community participation and the condition of the local community sector.

Five practical factors. In conclusion we would highlight five factors which need to be explored in more detail in order to build local community development strategies within the framework of the NHS plan:

1. The neighbourhood setting as a factor in combating health inequalities.	It is not sufficient to target extra help for overcoming health inequalities[16] solely by local authority areas. As is well known, health inequalities are often even greater between wards in a single LA than between LAs. So action must be further differentiated by wards. The level of community activity in wards (which correspond roughly or exactly to neighbourhoods) should be a factor in plans of action. Neighbourhoods with major health disadvantages may also have sparser community and voluntary organisations. With catchment areas of up to 50,000 people, covering around six or seven wards or neighbourhoods, PCNs may be appropriate vehicles for managing this action, in association with larger teams drawn from a variety of partners, or there may already be suitable bases in the neighbourhoods to which the NHS input could be added. The use of ward boundaries and populations as a framework to measure progress should guide but not constrain CD fieldwork methods, which respond flexibly to how residents themselves perceive their neighbourhoods.
2. Physical and material assets in communities.	The asset-based approach began by stressing that local assets include people as well as physical assets such as community buildings. Latterly the phrase is much used to mean people only, without reference to physical assets at all. But a certain level of physical and material assets is essential to the functioning of community groups and networks. Affordable meeting space, seedcorn grants and support from community workers are fundamentals without which it is very difficult for the community sector to grow in disadvantaged areas[17]. There are a number of ways that physical community assets could be recovered but these must be investigated on a local basis. Where the NHS is releasing redundant buildings[18] their conversion for use as community assets should be considered likely to yield a higher real value than a cash sale. In some areas negotiations could be undertaken with property developers, in ways explored by the Healthy New Towns initiative (which benefited existing as well as new residents)[19]. Working with local authorities, community amenities should be a priority claim on Community Infrastructure Levy and S106 agreements. But developers and planners should also be urged to go beyond statutory obligations to maximise community life and interaction by designs, spaces and buildings which facilitate social meeting of all kinds. The Church Commission on Housing announced in April 2009 should also be urged to consider how church assets can

[16] LTPlan, 2.25
[17] *Firm Foundations*, Home Office, 2004
[18] LT Plan, 6.21
[19] *Putting Health into Place*, NHS England and others, 2018

	contribute even more than they already do to community amenities as well as to housing. This is not to downplay social assets. Both physical and social assets are important, and their connections should be explored through engagement with local residents. David Morris et al frame the aims of this work in terms of 'community capital' (rather than social capital), as yielding four types of 'dividend' - wellbeing, citizenship, community capacity and economic benefit.[20]
3. Resourcing community involvement on a wide partnership basis.	Strengthening local community sectors would not only widen the pool of organisations able to receive SP referrals but have a preventive effect across the population. To maximise this, ways of channelling extra resources for community activation should be built into ICS and PCN planning. Resources could come from a number of different points within the long term plan plus external sources. A thriving community sector addresses the full range of social determinants, so the benefits are felt by all local public agencies. Whilst few will have any spare resources, many will already have a small – too small – investment in community participation, whether in the form of cash or officer time. The fact that SP link workers will accept referrals from all local agencies, not just health, should help to persuade partner agencies to contribute, perhaps through secondment of community workers who in any case are too isolated and would benefit by being in an interagency team. Bringing these marginal resources together into local community development teams with the NHS input could produce a more powerful impact for all partners.[21] The successive cohorts of SP officers appointed between 2019 and 2024 could gradually be allocated increasing proportions of time and training for the community development side of the work as the next wave of their colleagues comes on stream. Regarding cash costs, such as grants to community organisations, staff and premises costs, the participation agenda should be seen as a priority bidder for a proportion of cash released by NHS productivity growth[22] . Links could be explored with areas benefiting from National Lottery investments such as the 'Big Locals' and areas where community organising schemes are being run by the Office for Civil Society. On improving employment opportunities, negotiations could be undertaken with Local Enterprise Partnerships, which

[20] Matthew Parsfield, Ed (2015), *Community Capital: the Value of Connected Communities.* London: RSA

[21] *Commissioning Community Development for Health*, Health Empowerment Leverage Project (HELP) and Coalition for Collaborative Care, 2018

[22] NHS Long Term Plan, 6.3/ 6.7

	were awarded £1.8bn in 2019 for this purpose in some disadvantaged areas. Community Asset Transfers and the growth of community businesses should form part of the plans.[23]
4. Establishing measures of community strengths in the ICS[24] accountability and performance framework and primary care networks.	Levels of community involvement amongst a given population, and the condition of the local community sector can be assessed objectively[25]. A small core of standardised local measures could be established, building on the national citizenship survey and other research, which we propose to review during 2019. The absence of the community activity dimension in most JSNAs has meant that local strategies in health and other public services have often lacked a participation element. Measures of participation and the condition of local community sectors should become a standard component in regional and local planning, and it should be possible to relate them to reduction in demand on NHS services in a similar way to that being developed for social prescribing.
5. Understanding the economy of the community sector.	The voluntary and community sector is largely treated as a single element in the LT plan. But professional charities are primarily service providers whilst resident-led community groups are vehicles for participation and neighbourhood improvement. There is often little connection between these two types of organisation in a given locality, other than through the thin stratum of umbrella groups and community centres which specifically support a range of smaller groups. Social enterprises may also occupy a hybrid position, delivering commissioned services whilst creating local jobs. A CD strategy needs branching methods for the different types of organisation. All types of organisation may use volunteers and thereby contribute to health, but community groups have far more volunteers for their size and cost. 'Small charities have 5.62 volunteers for every £10,000 of income received whereas the largest charities only have 0.02 volunteers for every £10,000'[26]. Support for community groups is therefore by far the most economic vehicle for multiplying participation. (See figure).

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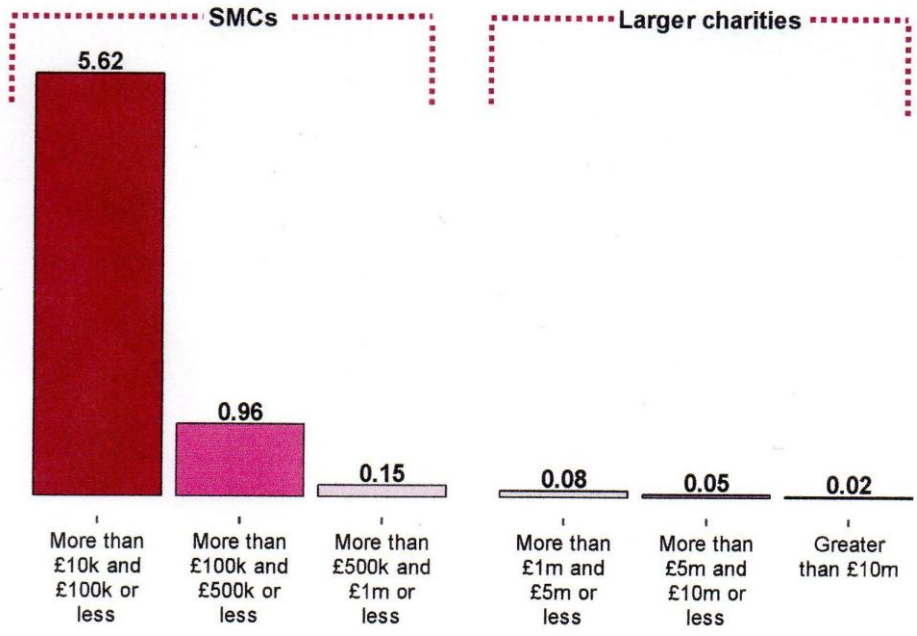
[23] See Bruni, F. Et al, *The Economics of Community Asset Transfers*, Power to Change ?2018 [undated].https://www.powertochange.org.uk/research/economics-community-asset-transfers/

[24] Integrated Care Systems

[25] *Commissioning Community Development for Health*, Health Empowerment Leverage Project (HELP) and Coalition for Collaborative Care, 2018, Appendix 6

[26] Dayson et al, *The Value of Small*, Open University and IVAR, 2018 . https://www.ivar.org.uk/research-report/value-of-small/

Figure 3.2: Median ratio of volunteers to income of general charities according to size (no of volunteers per £10,000 of income)



Source: Register of Charities (Charity Commission for England and Wales)

Cited in Dayson et al, op cit

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Action. During 2019-23 we propose to research action in these areas to develop insight into how they emerge and operate best within the new framework. We welcome interest from Integrated Care Systems, Clinical Commissioning Groups, Primary Care Networks, Public Health departments and others. We may be able to offer some help on planning, training and evaluation in connection with these issues. But we look to the major players to take them up in larger ways.

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