Learning from the community response to COVID-19; how the NHS can support communities to keep people well

Supported by The Health Foundation

A poem by Daphne Murphy that captures the spirit of community

Invisible, deadly, scary

What shall I do?

Stay at home

I am alone…

Loving kindness comes alive!

The weekly shopping is brought to my door

Unexpectedly, a generous hamper is placed before me.

A tasty bowl of stew,

A delicious afternoon tea

These caring touches showing thoughtfulness to me.

What did I do?

Reading, Writing, Walking, Gardening

Waiting, wondering, listening, praying.

A time of silence yet linking up by phone

With friends and family, near and far

In this invisible war.

A time for patience and a time for hope.

Moving forward positively to a new way of life confident

That all shall be well and all manner of thing shall be well.

Contents

The views expressed in this report do not reflect those of The Health Foundation.

1.0 About The Health Creation Alliance

The Health Creation Alliance is the only national cross-sector movement addressing health inequalities through Health Creation.

Our mission is to increase the number of years people live in good health in every community.

We achieve this by:

- connecting the voices of people with lived experience to those setting the policies and designing systems and services

- drawing on our members and extensive connections to bring together movements and collaborations that energise and empower professionals and local residents to take action

- helping places to establish 'Health Creation communities of learning' that bring together professionals from diverse backgrounds, community members and people with lived experience to learn from each other

- increasing the profile and status of Health Creation with policy makers, systems leaders and practitioners as an essential part of addressing health inequalities.

You can join The Health Creation Alliance for free and become part of the movement here.

The views expressed in this report do not reflect those of The Health Foundation

2.0 Foreword

Local communities galvanise around issues that matter to them – this is at the heart of all 'community responses' where communities connect, self-organise and take community-led action to address local needs.

A good example of this was when the South Yorkshire communities came together in response to the devastating floods of November 2019 when a month´s rainfall fell in less than 24 hours. The community response included setting up relief centres, providing emergency accommodation and food, coordinating community action and helping the victims of the flooding in their clear up.

Another example is the Lancashire communities coming together over eight years to oppose fracking in their local areas. Ultimately the action of these communities and others in the country contributed to the ending of fracking in England in November 2019.

Dealing with the impact of COVID-19, and the restrictions imposed, is another of these ´galvanising´ issues that mattered to communities, albeit one that affected every community in the country. This led to many more connected communities that have helped keep people well during the pandemic and the ensuing lockdowns.

Unlike many other galvanising events, COVID-19, a contagious disease caused by severe acute respiratory syndrome coronavirus 2, is fundamentally medical in nature and it is therefore of particular relevance to the NHS. In addition, dealing with the impact of the pandemic on people's mental health, the economic impact on people´s health and wellbeing, and the management of those that suffer long-COVID, means that the health issues associated with the pandemic will need addressing for many years to come.

The question now is: 'How can the NHS learn from the community response to COVID-19 to sustain and support community networks so that they keep on connecting, taking action, having control, improving health and keeping people well?'

This report captures the outcomes of a research project that considers this, and although it considers what the NHS can learn..., it's important that NHS staff recognise that there is no dichotomy between the NHS and communities, as all staff working for the NHS are in fact part of a local community.

Photo by Matheus Bertelli from Pexels

3.0 Executive Summary

COVID-19 has affected communities in different ways and, for some, the effects of the pandemic have been devastating. It has also shone a harsh light on the underlying inequalities in society and reinforced the urgent need for society to do more to address health inequalities.

COVID-19 also demanded that the NHS adopts different ways of working. Examples include primary care focussing on digital methods to continue service delivery and acute trusts and systems having to prioritise and reorganise care processes and pathways. The NHS has learnt from this. The NHS could also learn from how communities self-organised in response to COVID-19. If the different parts of the NHS respond, respect and connect well to networked and organised communities, this could support a better future in which inequalities are more effectively addressed.

At the heart of this learning is a recognition of the intrinsic value and power of people and communities, and especially the strength and power of networks. The realisation that health and care providers can´t meet all the needs of their patients, coupled with the extraordinary coming together of people, communities and local organisations in response to COVID-19, has demonstrated the value of individuals and their communities in complementing NHS services to support and enhance the broader health and wellbeing of local people.

However, such community-led action doesn´t just happen. In fact, there are many interrelated and complex factors that contribute to its success. As we build back better, the NHS is a key stakeholder that has an important role, in partnership with other local agencies, in supporting communities to participate in creating their own health and wellbeing. This is both in terms of the pandemic recovery, and in helping the health and care system to make significant and important shifts that will, over time, lead to a sustainable reduction in health inequalities.

To achieve this, the NHS needs to adopt different ways of working with communities. This project was undertaken to uncover what the NHS can learn from the community response to COVID-19 and about how it can best respond.

The research uncovered that a key contributor to the health and wellbeing among those people who received support and services during the pandemic was remaining connected. Where people had meaningful connections with others, they felt supported, sought support when needed and they were better able to feel in control of their lives; a critical consideration given that feelings associated with a loss of control are closely associated with the pandemic.

Similarly, connected communities that act and take control together are healthier communities. The research demonstrated that where communities were well connected before the onset of the pandemic, the initial community response to the pandemic was faster, better co-ordinated, more focussed and more effective. People and organisations were able to connect and come together at speed and because of established relationships and respect, there was trust and they were able to align behind a common purpose and allocate the most appropriate resource to the job in hand.

The NHS needs to be an integral partner to, and an enabler of, these 'connected communities'. To help all parts of the NHS achieve this, this project, through a series of 67 interviews with people with lived experience, community representatives and healthcare professionals that are leading the way in collaborating with their community, identified the attributes, enabling attitudes, solutions to barriers and some key recommendations for how the NHS can better work with communities.

Our insights and recommendations are useful for everyone who has a role in health, care and wellbeing. This includes: the entire health, social and care workforce, the Department of Health and Social Care, NHS England and NHS Improvement, Public Health England and those involved in establishing the new Unit for National Health Improvement and Promotion. It also includes: Integrated Care Systems, Acute Trusts, Primary Care Networks and Local Authorities.

3.1 Summary of enabling attributes demonstrated by connected and organised communities

When people and communities connected, self-organised and acted to meet the needs of their community, there were a range of key attributes that contributed to local success.

Through reflecting on these 'community attributes' during planning exercises, NHS employees will be in a better position to know how best to collaborate with people and communities.

- A clarity of focus on what needs to be delivered and why
- Understanding the needs of people and communities
- Having the community's trust and confidence
- An infrastructure to support co-ordination and skills deployment
- Respect for and trust in established providers
- Effective two-way communication

3.2 Summary of barriers and some enablers to supporting people and communities

Through the first wave of the coronavirus pandemic, many barriers were overcome by people and communities to enable different ways of working with the NHS to emerge rapidly. Appreciating these barriers provides a useful insight into ways in which the NHS can better collaborate with and support community. These barriers and enablers are summarised below.

Barrier and enabler	**Barrier** and enabler
A lack of capacity • Align NHS volunteer resources with those of the community; source additional volunteers from among patients (and not the usual suspects)	**Digital literacy and exclusion** • Support local organisations focussed on improving digital inclusion and literacy
Funding constraints • Get behind community-led projects and support their bids for funding; support them get their voice heard by commissioners on why they should be funded	**Protecting vulnerable people** • Provide guidance, support and training for the community
Needless bureaucracy • Review and streamline approaches to community engagement, setting aside bureaucracy that has little purpose and reviewing that which does, with input from the community	**Lack of awareness of support available among communities** • Work with community groups to develop suitable communications to inform patients of community support available
Poorly established social infrastructure • Act as a catalyst to connect and facilitate collaboration between local people, the community and other stakeholders	**Language and cultural relevance** • Engage with people with lived experience and collaborate with local communities to address people's needs
Lack of trust in traditional systems • Partner with community-facing organisations that understand their community to engage with that community	**Sustainability of community services** • Employ a strategic-level connecting role such as a Strategic Relationship Development Lead
Lack of a community voice • Support development of a community voice starting from where the appetite within the community lies	**People being too proud or ashamed to accept support** • Prioritise reciprocity in your relationships with patients, ask them for help rather than what do they need

3.3 Summary of enabling attitudes demonstrated by connected and organised communities

By considering these attitudes, the NHS will be in a better position to collaborate with people and communities as equal partners, while supporting them take action for themselves.

- Willingness to connect with others; to collaborate and not compete

- Recognising where others are better at taking action and providing services; transferring responsibility to them

- Avoiding politics, rapidly dealing with conflict and accepting that at times there will be disagreement

- Commitment to listening to people and super localisation to meet their needs

- A "Can Do, Let´s Just Get This Done" attitude

- Recognising the value of established organisations as enablers, catalysts, potential funders and shifters of power

3.4 Summary of key recommendations and solutions to meeting these

1. NHS staff at all levels need to recognise and appreciate **the value of community**

   ➢ Acknowledge that collaboration between NHS and community can improve population health and reduce demand on services

2. If the NHS takes time to **connect and build relationships**, it will build trust and better understand the communities, their agenda, needs, connections and reach

   ➢ Identify the local infrastructure network organisation and undertake a joint mapping exercise, use this to guide outreach

3. Local patients would benefit if the NHS **contributed to funding** community

   ➢ Consider match funding community initiatives – alongside others such as local authorities – where community-led activities reduce demand on health services

4. The NHS has a role to play in working with others to help **create the conditions** for communities to thrive

   ➢ In collaboration with others, act as a catalyst to help build community connections

5. The NHS would benefit from **meaningful engagement** with people with lived experience and their communities in the development of strategies and programmes throughout the system, including at the Integrated Care System (ICS), Provider Collaborative, secondary care, Primary Care Network (PCN) and GP Practice levels

   ➢ Undertake a survey of patients asking them to what matters to them, speak and listen to patients

6. The NHS can learn from the more diverse communication approaches adopted due to COVID-19 to support **better two-way communication** with communities and patients in place

   ➢ Work with the local community to audit what communications platforms and approaches worked best during COVID-19; use this to inform future two-way communications

7. The NHS should recognise the value of **reciprocity** and factor this into interactions with patients to preserve people's self-esteem and to support them to build confidence to do more for themselves and their community

   ➢ Make sure patients have the opportunity to give as well as to receive

8. The NHS should consider how it can use its property assets to **provide places** for communities to meet

   ➢ Support for the roll-out of NHS Property Services ´community spaces for patient wellbeing´ initiative

9. Work with local communities to support people to **connect and self-organise** to address other significant health issues that affect a local population

   ➢ Share, interpret and act on Population Health Management data in collaboration with local communities

4.0　Background to the project

The coronavirus pandemic has shone a harsh light on health and socioeconomic inequalities and the its impact has fallen disproportionately on some of society's most vulnerable individuals and communities.

Build Back Fairer: The COVID-19 Marmot Review,[1] published in December 2020, argues that a decade of growing inequality in England partially explains why it has had one of the worst COVID-19 infection and mortality rates in Europe, and why England risks emerging from the pandemic as an even more socially and economically divided nation. In England, for the period March to July 2020, COVID-19 mortality rates in the most deprived local areas were double those in the least deprived areas and the highest excess mortality rates outside of London during the pandemic have been in poorer regions, like the West Midlands, and North-West and North-East England.

As we build back better, there is an urgent need for societal changes to protect population health and wellbeing in the future, with a particular focus on tackling health inequalities.[2]

The need to take urgent action to address health inequalities is acknowledged by NHS England and NHS Improvement who within their 'Implementing phase 3 of the NHS response to the COVID-19' pandemic advised:[3]

Please take urgent action, in collaboration with local communities and partners, to increase the scale and pace of progress in reducing health inequalities, and regularly assess progress.

Collaborate locally in planning and delivering action to address health inequalities, including incorporating in plans for restoring critical services by 21 September; better listening to communities and strengthening local accountability; deepening partnerships with local authorities and the voluntary and community sector; and maintaining a continual focus on implementation of these actions, resources and impact, including a full report by 31 March.

To be successful, efforts to address health inequalities must enable local people to be active partners in the process of building their lives. When individuals and communities gain a sense of purpose, hope, mastery and control over their lives and immediate environment, their health and wellbeing is enhanced.

This means treating them as equal partners and focusing on what matters to them. This is reflected in shared decision-making that is increasingly being recognised as contributing to improved patient outcomes, increased patient and physician satisfaction, improved patient and physician communication and sometimes a reduction in costs.

This is also reflected in the co-production and co-design of systems and services with defined groups of patients or services users where the principles adopted are:[3]

- recognising community and people as assets
- building on community and people's capabilities
- developing two-way, reciprocal relationships
- encouraging peer support
- blurring boundaries between delivering and receiving services
- facilitating rather than delivering

The principles behind shared decision-making, co-production and co-design must extend to NHS employee's relationships with local communities to increase their collective agency.

COVID-19 has also illuminated the power of people and community to support the health and wellbeing of their communities. In response to the pandemic, people and communities connected en-masse, self-organised with speed and took decisive action to meet some of the needs of their communities. Some of this action was taken by individuals, or by groups of individuals that came together to take control. Some of it was undertaken by small grass-roots community groups often in collaboration with established Voluntary Community and Social Enterprise (VSCE) organisations, local agencies, local authorities or the NHS. However these actions were delivered, people and communities made, and continue to make, a significant contribution to their community's health, wellbeing and ability to stay well.

It is a recognition by The Health Creation Alliance and The Health Foundation of the power of community and the benefits of shared decision-making, co-production and co-design, that led to this project; a project that considers what the NHS can learn from the experiences of local people and communities that connected and self-organised to take action to address some of the COVID-19 needs of their communities.

1. Marmot M *et al.* Build Back Fairer: The COVID-19 Marmot Review. http://www.instituteofhealthequity.org/resources-reports/build-back-fairer-the-covid-19-marmot-review, Last accessed 7 April 2021.
2. COVID-19—break the cycle of inequality. The Lancet Public Health. January 20, 2021. https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(21)00011-6/fulltext. Last accessed 7 April 2021.
3. https://www.england.nhs.uk/publication/implementing-phase-3-of-the-nhs-response-to-the-covid-19-pandemic/. Last accessed 7 April 2021. https://www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/co-production/In-more-detail/. Last accessed 7 April 2021.

More specifically the project set out to consider what the NHS could learn from the following perspectives:

- the types of roles people and communities took on and the activities they continue to deliver

- the attributes and attitudes that enable people and communities to connect and self-organise

- how the removal of some barriers and/or introduction of new approaches helped create the conditions that enabled people and communities to rapidly take on activities in support of their communities

- how The Health Creation Alliance´s Health Creation Framework might be used to make sense of the community response to COVID-19 and how it can be deployed to drive a change in frontline practice, systems and commissioning

In this report, we have focused on the relevance of the perspectives to the range of organisations that make up 'the NHS'. We have not been specific about which NHS organisations should take the lead on which recommendations. This is because as the latest reforms take effect, the roles and responsibilities or different parts of the systems are changing, and they are changing in different ways in different places and neighbourhoods.

What we do know is that those leading ICSs will have a critical role to play in facilitating adoption of the recommendations by different NHS stakeholders.

This is because their responsibilities are to meet health and care needs across an area, coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

Beyond that, it is for local systems to work out how they respond to the recommendations, which parts of the system take the lead, and in what ways they do this.

Sometimes it will be possible through existing roles such as GPs, link workers, practice managers, community practitioners, hospital managers and mental health teams, while some recommendations will require new non-clinical roles to be recruited.

The learnings from this project complement two other publications delivered by The Health Creation Alliance and supported by The Health Foundation. The first of these is a report entitled Health Creation: How can Primary Care Networks succeed in reducing health inequalities? that was launched in January 2021. The second, builds off the first and is entitled: Primary Care Networks and place-based working: addressing health inequalities in a COVID-19 world. A partners' perspective. Reference to relevant points made within these publications has be made throughout this report.

This third report in the series, provides a different perspective through the eyes of the community. It reports on their lived experiences during COVID-19 and highlights how key lessons can be learnt on how communities and providers can work together to address health inequalities and help keep their communities well.

A note about 'language'

One of the difficulties of writing any report that is intended to share the insights, experience and recommendations from those outside the NHS, with the NHS, is the different use of words that mean essentially the same thing. Because of this is it can be hard for people operating in each sphere to grasp the relevance of what someone operating in the other sphere is saying to them and sometimes a single word can mean entirely different things to people who work within and outside the NHS. This in turn can lead to misunderstandings and confusion.

Every effort has been made in this report to make the language clear to people working within and outside the NHS.

5.0 Defining Community

There is often confusion around what is meant when the NHS is urged to 'engage or work in partnership with communities'. Precisely what the 'voluntary and community sector' is, how it works and how it differs from community-based organisations and businesses remains a mystery to many.

In this report we aim to offer some insight into the different sorts of organisations operating within the community and the sort of roles they might play.

The Voluntary, Community and Social Enterprise (VCSE) sector is the term frequently used outside the NHS to describe this sector that includes many different types of organisation. The VCSE sector is changing as networks are coming together and organising to achieve more together, including through local consortia to bid for contracts, for example.

In table one below, we consider the type of organisation and ways in which the NHS can connect. We have purposely not focused on the legal form – such as whether the organisation is a charity, community interest company or has another underpinning legal form. This is because the legal form is far less important, from the perspective of how the NHS might respond, than other factors such as the size, focus, geography, nature of the group and how well networked it is.

Table one. Type, features and ways of connecting with ´community´

Type of community organisation / VCSE	Typical features	Ways in which the NHS can connect
Individual person who prefers autonomy, such as Daphne whose poem can be found on page two	• Unique energy • Passion • Self-sufficient	• Offer to make use of what a person has to offer e.g. for Daphne, display her poem in a hospital or GP surgery
Individual person who wants to work with others on something	• Unique energy • Passion • Sociable • Specific skills or experience to draw on	• Help them connect to relevant people e.g. someone who shares their passion or who complements their skills and ambitions • Support for specific projects such as health promotion activities o while these are often organised by VCSE infrastructure organisations with local authorities, you could do this through a Local Area Coordinator, Community Navigator or Community Development Worker

Grass-roots community group	• Special interest group; may be geographical or thematic focus
	• Passionate people at the core
	• Self-organised
	• Small infrastructure
	• Can be well organised
	• Often informally organised
	• Flexible
	• Open to others joining – some may be small groups, while others may have a membership
		• Talk to group members
		  o understand their special interest
		  o find out about their ideas/vision
		• Ask them how you can help them thrive
		• Strategic-level connectors can develop services with them

Type of community organisation / VCSE	Typical features	Ways in which the NHS can connect
Associations and membership organisations	• Constituted groups more formal than grass-roots groups • Often organised around a particular theme, such as residents associations or parent teacher associations • Passionate and willing to provide feedback • Often limited to small set of priorities and may be less engaged on wider areas	• Connect with them to explore their needs and priorities • Share information and seek feedback • Can be an excellent way to disseminate information
Community-led Centres and Hubs including volunteer centres, Children Centres	• Led by members of the community, or with strong involvement of community members in structures • Have use of local premises to meet • Friendly, open to others 'dropping in' • Place to connect residents to services in an informal setting to break down barriers and problem-solving • Access to a range of agencies/activities • View them as service providers in own right • Always well networked	• Talk & listen to group members • Get to know them as people, be visible and visit often • Ask about their ideas/vision • Ask them how you can help them thrive • Invest time in them, they are a hugely valuable resource • Partner with them if they request this • Run services from their premises – uptake will be high
Local community infrastructure organisation (sometimes called 'community anchors')	• Some Community-led Centres/Hubs have become community infrastructure organisations through COVID-19 • Varying size from local authority level to constituency level • Well networked to others • Organising infrastructure	• Support them to organise community-led programmes across the whole community • Are often available to, or already supporting, smaller community organisations e.g. through targeted training programmes • Ask them to connect you to grass-roots community groups • Invest in them • Partner with them
Faith groups	• May be large and well-established e.g. church or mosque • Can be small and informal groups e.g. prayer groups • Strong links and trust in certain communities • May have access to niche communities • Have language skills to reach diverse community • Passionate and dedicated • Often have limited resources	• Reach out to faith leaders and find out local needs • Attend partnership meetings • Tap into services such as Ward Forums with Local Authorities, residents associations or food banks • Can be an excellent way to disseminate information or to access complimentary support services

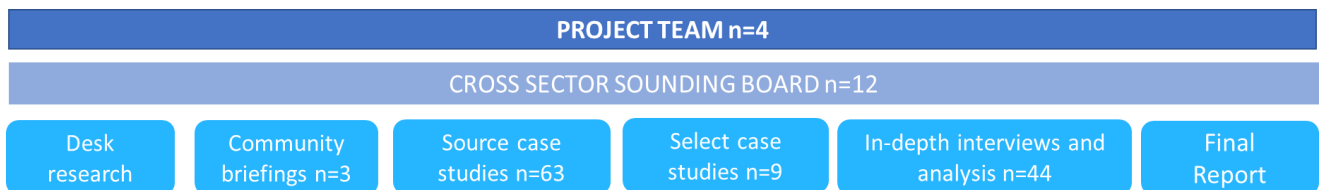| Type of community organisation / VCSE	Typical features	Ways in which the NHS can connect
Housing providers – Including registered social landlords and community-led housing	• Formally organised with clear structure • Vary in size • Often provide a support package or programme to tenants and sometimes other residents in locality • May have a focused customer base, including older adults, those with mental health challenges or substance misuse	• Discuss needs of tenants • Find out what gaps exist in the services • Understand niche market • Discuss options linked to specific health outcomes based on market, e.g. drug and alcohol programmes, as fit with tenant profile
Community Interest Company / Social Enterprise	• Trades to make a return • Usually offers services that are useful to the community • Reinvests the surplus into community benefit • Predominantly employs people who are from the local community • They can help to create wealth within your community	• Talk to them about the difference they make (1) to the people who use their services (2) to the people who work for the business • Contract them e.g. to do catering, grounds maintenance etc • May be run partly by service users as part of wider support programmes, e.g. mental health support, and can be a useful pathway to support patient recovery and progress
Timebanking UK (TBUK) and its national network of time banks TBUK is the national infrastructure organisation providing guidance for safeguarding as well as being the national voice to influence policy	• Timebanking is a way to encourage people to help one another and differs from volunteering, it ethos is that for every hour of support you get, you give an hour to others • Time banks are locally based and for a base where people can trade their time (no money changes hands) • Time bank coordinators help people realise their strengths and value to the community • People feel time rich even when they may be cash poor • The Department of Work and Pensions support Timebanking. It recognised that it can improve confidence and skills for local people who get involved and they it has approved timebanking hours as contributing towards job seeking hours	• Connect on a national level to Timebanking UK to help share the learning and benefits of timebanking • Timebanking is a vehicle to support social prescribing and can be used within GP surgeries • Support timebanking by helping to embed it into CCGs and other support services via TBUK • Discover the evidence of health and wellbeing benefits when people realise their own value and self-worth • Consider using timebanking to support your own staff and colleagues (you can use it as a time bank of purpose) • See the value in linking community pharmacies, community groups, mutual aid groups and timebanking
Large national charity e.g. Mind, Age UK	• Regional or national infrastructure • They lead many programmes themselves • Not necessarily well connected local organisations	• Sometimes funder or supporter of local services, e.g. through grant awards • Often have smaller branches that meet more local needs through tailored services, often at local authority level
Private businesses – CSR programmes	• Often highly skilled • May bring professional skills such as legal or financial knowledge • Short-term availability, often to limited to a few days	• Many large private businesses offer employees volunteer days as part of CSR programmes and can give their time on a short-term basis to very specific projects, such as running focus groups or providing advice and/or consultancy matching their professional skills

6.0 Project methodology

The project was led by a Project Team comprising four individuals with extensive experience of working with communities and health, housing and social care stakeholders. It was supported by a Sounding Board comprised of 12 individuals representing people with lived experience, and a range of disciplines including volunteers, VCSE, community development, primary and secondary care, public health, commissioning and the life sciences industry.

Following desk-based research that reviewed a wide range of reports and recommendations on ´building back better´ to uncover what others were saying about the value of the NHS collaborating with community, a call for case studies was put out through The Health Creation Alliance membership, social media channels and the Sounding Board members. This was supported by three briefings at which attendees could learn more about the project, while informing its delivery.

A total of 63 case studies were submitted for review. Of these nine were selected for in-depth analysis resulting in a total of 44 in-depth interviews of duration 1-2 hours. These included 27 individual interviews and three group interviews. Interviewees included community providers and representatives, VCSE organisations, volunteers and people who received services, all of which bought front-line experience to life.

Figure one provides a diagrammatic overview of the project methodology.

<u>Figure one. Project methodology</u>

PROJECT TEAM n=4					
CROSS SECTOR SOUNDING BOARD n=12					
Desk research	Community briefings n=3	Source case studies n=63	Select case studies n=9	In-depth interviews and analysis n=44	Final Report

THE PROJECT FINDINGS AND RECOMMENDATIONS

7.0 Roles taken on by people and communities in response to COVID-19

In responding to the needs of local people, a wide-range of activities were undertaken, many of which were delivered far quicker that established services could have done.

While shopping, phone support and medicines delivery were widely reported, community responses and support activities went well beyond this.

By appreciating the breadth of support offered by people and communities, the NHS can better understand some of the contributors that kept people well during the pandemic. Key to this was ensuring people remained connected. Where people had meaningful connections with others, they felt supported, sought support when needed and they were better able to feel in control of their lives; a critical consideration given that feelings associated with a loss of control are closely associated with the pandemic.

"Beyond practical support, such as delivering food parcels, keeping people connected was a key focus of our activities. Knowing that there is someone out there who cares, and someone that can be contacted if need be, gave people real peace of mind". Volunteer for a Mutual Aid Group

Table two below considers some of the activities delivered by people and communities as they relate to practical, educational, emotional and social support.

Table two. Activities delivered by people and communities in response to COVID-19

Practical	Educational	Emotional	Social
Helplines and interpreting support			
Food banks and home delivery of food packages	Generating materials, translation materials and disseminating	Doorstep Peer-to-Peer support	On-line and doorstep choirs
Shopping and medicines collection and delivery	Educational meetings	On-line counselling	On-line exercise, yoga, dance classes and similar activities
Identification of issue at doorstop and reporting to provider	One-on-one discussion	Phone check-in	Circulating craft kits and sharing outputs
Provision of IT equipment and digital training	Through social media channels	Suggestions and guidance on things to keep busy – an alphabet of ideas	Providing seed kits and sharing vegetables
Dog walking, gardening	Tracking and addressing misinformation	Friendship/befriending phone service	On-line social events
Hospital runs and hospital comfort packs	Supporting learning and signposting to on-line learning	Neighbour connecting	On-line art and craft events
Small grants	Through local print and broadcast media	Wellbeing support through local print and broadcast media	On-line book clubs

8.0 Attributes of connected and organised communities during COVID-19

When people and communities connected, self-organised and acted to meet the needs of their community, there were a range of key attributes that contributed to local success.

Through reflecting on these 'community attributes' during planning exercises, NHS employees will be in a better position to know how best to collaborate with people and communities.

Figure two below summarises these key attributes. They are considered in more detail below through sharing the voices of the participants in the projects.

Figure two. Summary of key attributes of connected and organised communities

Clarity of focus	Insight and understanding of people/community needs	Community trust and confidence	Infrastructure to support co-ordination and skills deployment	Respect for and trust in established providers	Effective two-way communication
➢ Urgency to act ➢ What is being delivered ➢ Why this is needed	➢ People involvement ➢ Reflect diversity ➢ Language specific ➢ Culturally specific and sensitive ➢ Disease specific ➢ Multiple disparities ➢ Contextualise within broader issues	➢ Relevence of support ➢ Accepting of support ➢ Accepting constructive critisism	➢ Fascilitating and catalysing ➢ Organised capacity ➢ Accountable leadership from within and at all levels ➢ Anchor institutions ➢ Established organisations refocusing	➢ Guidance and support ➢ Established/tap into infrastructure ➢ Funding	➢ Between people ➢ Within communities ➢ Peer-to-peer ➢ Social media ➢ Traditional ➢ Between agencies

8.1 Clarity of focus

Clarity. The quality of being clear and easy to understand

"It was while shopping with a friend just before lockdown that I realised that vulnerable people wouldn't be able to shop for themselves. It also dawned on me that lots of people can't order online, don´t have family or friends that can shop for them, and that the usual volunteers would also be unavailable. That was when we realised what we had to do and why. A shopping service". Co-founder of a Mutual Aid Group

8.2 Insight and understanding of people and community's needs

Understanding. The power of comprehension

"…a good example in terms of lack of patient involvement from BAME communities – and lack of support for the cultural needs of patients, was that the nurse tried to feed my father, a Muslim, with Ham pie – this cannot be acceptable and it can be really distressing". Director, community empowerment Community Interest Company

"Importantly, for some of the most successful activities, people with lived experience were represented within the team delivering these". Practice Manager

"Prior to COVID-19, we already had a pretty good appreciation of health and social inequalities and the complex interaction between these. While this might sound pretty academic, right from the start of the pandemic, we recognised that people faced multiple interacting issues and we could only meet a few of these". Co-founder and Director, Wellbeing Partnership C.I.C

As an established organisation, we pride ourselves in understanding the needs of those we support. However, given that we have never had to deal with a global pandemic, we reached back out to our community when developing our COVID support". Project lead for a community network

8.3 Community trust and confidence

Trust: firm belief in the reliability, truth, or ability of someone or something

"The existence of a network of local organisations, and the work it has undertaken with Portuguese-speaking populations meant the community knew of and trusted us. This made a huge difference in us being able to engage with people in support of our activities, and for people to engage with us when needing support". Co-founder and Director, Wellbeing Partnership C.I.C

8.4 Infrastructure to support co-ordination and skills deployment

<u>Infrastructure</u>: the basic physical and organisational structures and facilities needed for the operation of a society or enterprise.

"Within two days the initiative took off. We soon realised that the area we needed to support was too large, so we appointed four Regional Leaders with Deputies as a back-up. This 'infrastructure' built resilience into the service. This in turn built confidence in what we were doing and this led to people referring to us. And so we grew". Co-founder, Mutual Aid Group

"While our ability to mobilise was unhindered by formal systems, bureaucracy and the need to fit into an infrastructure, we soon recognised that certain skills were required and co-ordination was needed to effectively deploy these". Other Co-founder, Mutual Aid Group

"What really made our work fly was good leadership that facilitated and catalysed organised capacity. Where activities involved established organisations, this meant a refocus of their normal activities. Not that they could deliver many of these given the restrictions." Community Network lead

"By matching the right organisation to the task, grass roots organisations are capable of doing very sophisticated things. For example, being authorised for 'controlled substances' medicines delivery". Volunteer, Mutual Aid Group

8.5 Respect for and trust in established providers

<u>Respect</u>: a feeling of deep admiration for someone or something elicited by their abilities, qualities, or achievements.

"It is all about trust. With the onset of the pandemic and introduction of restrictions on work, travel, and social activities the Local Authorities and VCS organisations set up support, and provided a range of services to vulnerable people. However, these were all predominantly English speaking based and the Portuguese speaking community in Lambeth neither trusted, nor were able to engage with, these organisations due to language and cultural barriers. This is where we stepped in". Co-founder and Director, Wellbeing Partnership C.I.C

"Established organisations that we knew did a great job at aligning us and other groups. Whether leading an activity, supporting people deliver an activity or enabling an activity through training or funding, respect among all parties made things much easier". Community emergency co-ordinator

8.6 Effective two-way communication

<u>Communication</u>: the imparting or exchanging of information by speaking, writing, or using some other medium

"From the outset, working very closely with health and care providers was critical in developing and getting consistent and clear messages out to the community. With the GP surgeries closed there was little support for the BAME community. This in turn led to a lot of confusion and misinformation. So, working through the mosques and getting the message out through Friday prayers, appropriate literature in the right languages, and being there to answer queries, really helped to bring the community together and support their understanding of what COVID safe really meant". Chair of Council of Mosques

9.0 Enabling attitudes demonstrated by connected and organised communities during COVID-19

Communities demonstrated a range of attitudes that supported collaborative working with minimum conflict.

By considering and learning from these attitudes, the NHS will be in a better position to collaborate with people and communities as equal partners while supporting them take action for themselves.

The key attitudes uncovered through the research included:

- Willingness to connect with others, to collaborate and not compete
- Recognising where others are better at taking action and providing services and transferring responsibility to them
- Avoiding politics, rapidly dealing with conflict and accepting that at times there will be disagreement
- Commitment to listening to people and super localisation to meet their needs
- A "Can Do, Let's Just Get This Done" attitude

- Recognising the value of established organisations as enablers, catalysts, potential funders and shifters of power into the community to do things they are best placed to do; relieving established organisations of some tasks

"It was never an us or them, although we were able to act quicker. Once we got going, working with established organisations was great. They provided us with expertise, training and loads of support. We provided a deep understanding into our neighbourhoods and feet on the ground". Member of Mutual Aid Group

10.0 Barriers and enablers to supporting people and communities

Through the first wave of the pandemic, many barriers were overcome to enable different ways of working to emerge rapidly. Appreciating these barriers provides a useful insight into ways in which the NHS can better collaborate with and support communities.

The following table considers some barriers and details those enablers that did, or could, help overcome them. Some of these could be considered and explored when meeting with local communities to discuss their needs and agendas, while others could be considered as part of the planning process.

<u>Table 3. Barriers and enablers</u>

Barrier faced in responding to COVID-19	NHS enabled solutions that did/could help to overcome the barrier
A lack of capacity to support local communities given that many established volunteers were shielding	Collaborate and align the volunteer resources of general practices with those that are available within the community Source additional volunteers from among patients (and not the usual suspects)
Funding constraints impacting on ability to provide support	Get behind community-led projects and support their bids for funding Become a conduit for your community to reach and be heard by commissioners; help commissioners to understand why they should fund community-led work
Bureaucracy impacting on ability to take action	Review and streamline approaches to community engagement, setting aside bureaucracy that has little purpose and reviewing that which does, with input from the community
Poorly established infrastructure; no social infrastructure identified	Assess the existing provision of community development with local authorities and other local partners, and support further capacity where necessary Act as a catalyst to connect and facilitate collaboration between local people, the community and other stakeholders

Barrier faced in responding to COVID-19	NHS enabled solutions that did/could help to overcome the barrier
Lack of trust in traditional system support among the community	Partner with community-facing organisations that understand their community and work with them/fund them to provide education, information and support
Lack of a community voice	Support development of a community voice by connecting and facilitating collaboration between patients and their community; start from where the appetite within the community lies
Digital literacy and exclusion	Consider digital as just one of a range of communications platforms and solutions to supporting patients; continue to offer face-to-face consultations where appropriate Support for local organisations focussed on improving digital inclusion and literacy
Ability to rapidly support vulnerable people given the need to understand and adhere to safeguarding practice as laid down by local policy	Provide guidance, support and training on safeguarding and dealing with vulnerable people; work with a local provider to do so, such as the local authority or a housing provider
Lack of awareness of support available among communities	Work with community groups to develop suitable communications to inform patients of community support available
Language and cultural relevance	Engage with people with lived experience and from the communities that represent them to understand their needs and collaborate to provide multilingual support and solutions
Sustainability	Play your part in maintaining connection and collaboration between local people, the community, VCSE organisations and other established organisations at a strategic level Employ a strategic-level connecting role such as a Strategic Relationship Development Lead Consider how you might make a financial contribution to enable communities to take action and run services that plug important gaps
People being too proud or ashamed to and for and/or accept support	Prioritise reciprocity in your relationship with patients; ask them for 'their help' rather than a sole focus on what they need

11.0 The Health Creation Framework; making sense of COVID-19 related community activity in support of a better future

Creating health

To be well, people need a sense of purpose and control over their lives. The NHS can help create the conditions to achieve this. This requires:

- a recognition that creating health must sit alongside treating ill health and prevention of illness

- a shift away from an exclusively bio-medical model for addressing health issues to one that creates the conditions for people to be well through social processes

- shared decision-making, co-production and co-creation to be seen as the normal way to work with communities as well as patients, asking them "what matters to you" as oppose to "what is the matter with you?"

- the adoption of The Health Creation Alliance's Health Creation Framework by all frontline staff

11.1 Health Creation and the features of health creating practices

Health Creation is the process through which individuals and communities gain a sense of purpose, hope, mastery and control over their own lives and immediate environment; when this happens their health and wellbeing is enhanced.

Contact, **Confidence** and **Control** are the **3Cs of Health Creation**: attributes that characterise communities that have been most resilient during COVID-19.

This is because, building meaningful and constructive **Contact** between people and within communities increases our **Confidence** which leads to greater **Control** over our lives and the determinants of our health. People also need an adequate income, a suitable home, engaging occupation and a meaningful future.

Having **Control** over our lives and environments is proven to enhance health and wellbeing and to help people to better cope with health conditions, disability and ageing.

Alluding to this, Professor Marmot, author of 'Health Equity in England: The Marmot Review 10 years on says': "To tackle inequality, society needs to enable all children, young people and adults to maximise their capabilities and have control over their lives".

11.2 The five features of health creating practices

Professionals can help to create the conditions for people and populations to be well by adopting and embedding the 5 features of health creating practices within everyday practices and through health systems. These five – Listening and Responding, Truth-telling, Strengths-focus, Self-organising and Power-shifting – are the things that communities consistently say makes the biggest difference to them: these are the 'active ingredients' of Health Creation.

Health Creation happens…

…when local people and professionals work together as equal partners and focus on what matters to people and their communities

People need

Control
Contact
Confidence

…to be well

The 5 features of health creating practices
- Listening and responding
- Truth telling
- Strengths-focus
- Self-organising
- Power-shifting

The Health Creation Alliance is calling for:
1. The adoption of health creatng practices
2. Systems reform to support Health Creation
3. Enhanced education in Health Creation

Professionals can:
1. Adapt their current practice
2. Adopt whole new practices
3. Disrupt by working with communities to produce whole new solutions

12.0   Recommendations for the NHS for a better community focussed future

As part of the research, interviewees were asked, *"Based on your experience of interacting with the NHS during the pandemic, if you were presenting to an audience of 200 NHS stakeholders, what would you recommend they do in the future?"*. The responses to this and other interview questions have been distilled into nine recommendations and corresponding activities as summarised in the table below. These are considered in more detail following this.

In detailing these, The Health Creation Alliance recognises that the recommendations represent a journey for the NHS, starting with valuing community, and ending with applying the learnings for COVID-19 to other health issues. As with any journey, different parts of the NHS, and stakeholders within, it are at different stages on their journey and the very nature of the project uncovered established best practice already being adopted and delivered by some within the NHS.

In summary, community interviewees overwhelmingly said that the NHS must find the right response to the extraordinary community response to the pandemic – it must support and be a good partner in an equal relationship; critically, it must not expect to lead community wellbeing programmes.

It should be noted that some of the interviewees had had no direct interaction with the NHS when delivering community led activities, which could be a useful finding in itself.

Recommendation	Activity
NHS staff at all levels need to recognise and appreciate the value of community	➢ Acknowledge that collaboration between NHS and community can improve population health and reduce demand on services
If the NHS takes time to connect and build relationships, it will better gain the trust of and understand the communities, their agenda, needs, connections and reach	➢ Identify the local infrastructure network organisation and undertake a mapping exercise with them ; use this to guide connections with the community
Local patients would benefit if the NHS contributed to funding community	➢ Consider match-funding where your community has secured resources from other sources
The NHS has a role to play in working with others and listening to the needs of communities to help create the conditions for communities to thrive	➢ In collaboration with others, act as a catalyst to help build community connections that enable communities to take control
The NHS would benefit from meaningful engagement with people with lived experience and their communities in the development of joint strategies and programmes that clearly detail the role of the community throughout the system, including at the ICS, Provider Collaborative, secondary care, Primary Care Network and GP Practice levels	➢ Create spaces to listen. Ask them what matters to them and use this to inform a planning meeting with people with lived experience and community representatives
The NHS can learn from the more diverse communication approaches adopted during COVID-19 to support better two-way communication with communities and patients in place	➢ Work with the local community to audit what communications platforms and approaches worked best during COVID-19; use this to inform future communications
The NHS should recognise the value of reciprocity and factor this into interactions with patients to preserve people's self-esteem and support them to build confidence to do more for themselves and their community	➢ Make sure patients have the opportunity to give as well as to receive; help patients to identify their strengths and support them identify how to deploy these for themselves and within their community
The NHS should consider how it can use its property assets to provide places for communities to meet	➢ Widespread support for the roll-out of NHS Property Services ´community spaces for patient wellbeing´ initiative. More information about the initiative can be found here
Going forward, the NHS could work with their local communities to support people to connect and self-organise to address other significant health issues that affect a local population	➢ Share, interpret and act on Population Health Management data in collaboration with local communities

12.1 NHS staff at all levels need to recognise and appreciate the value of community

"The NHS needs to be better at valuing community. NHS staff need to recognise that community is an asset that can reduce demand, and it should proactively support community realise its value through funding. Community must no longer be considered as a free resource that´s good to have". Chair, Community Group

Increasingly the benefits of collaboration between the NHS and community are being recognised, these include a reduction in demand in the medium- to long-term, freeing up valuable resource. The community response to COVID-19 reinforced this.

In responding to the pandemic, it was the ability of people and communities to come together to deliver support and services with speed – based on deep understanding of local needs – that made their support so relevant and valuable.

"COVID-19 has really helped demonstrate where community can add value. Previously, we have tried working with GP practices, but it was too messy, too difficult. Also, too often if we do establish relationships, it would be ´hey that's great, we love what you do´ and people would be referred to us. However, once we started to talk about cost saving benefits to them and whether the Practice would invest in the organisation, we didn't see them for dust. I hope that this will change now". Programme Manager, Community Learning Partnership

The value to the NHS of communities, demonstrated by their response to COVID-19, is that they:

- understand and can respond to the micro needs of local communities

- can respond rapidly when required

- have a willingness to refocus established activities and programmes

- have a 'can do' attitude where no challenge is insurmountable

- can reach underserved (hard-to-engage) people and communities

- reduce demand on the NHS and other services

- have attributes that mean they can respond in very sophisticated ways (see Section 8.0 for a full list)

"Charity staff and volunteers are not qualified healthcare professionals - but their different skill sets and experience, plus local knowledge and networks, can be a powerful complement to NHS skills and knowledge". CEO, young person's charity

The benefits of working with local communities goes beyond the benefits to patients and reducing demand for NHS services, it extends to NHS staff themselves. Throughout COVID-19, working closely with local people and communities was at times extremely motivating for frontline primary care staff and for many, it has set in motion a renewed focus on relationship building.

"In addition to improving services, meaningful engagement with patients, local people and communities can add significantly to staff morale, with all the benefits this offers. Even a simple step such as renaming receptionists to The Patient Support Services Team can have a positive impact". GP

In this example, this change of name changed perceptions of the receptionist team being guardians of the diary alone, to them being enablers of patients´ health and wellbeing.

Spotlight on Northern Ireland

In County Antrim, Northern Ireland, the COVID-19 response in three towns – Ballymena, Larne and Carrickfergus – was led by Mid and East Antrim Agewell Partnership (MEAAP).

MEAPP has a good relationship with the Northern Health and Social Care Trust (NHSCT), one of the five health and social care trusts in Northern Ireland, as they run the Community Navigator project, a one-off signposting service for health and wellbeing (equivalent to Social Prescribing) and the IMPACTAgewell project, a community development led approach to integrated care. MEAPP also operate the Ageing Well Tender for the local Mid and East Antrim Borough Council. MEAPP are in touch with over 3000 older people and with a membership of nearly 150 local community groups they are very well connected. MEAPP also has a credibility with local community groups that meant that they were a natural facilitator and organiser of the emergency response to COVID-19.

MEAPP had recently undertaken an asset-mapping exercise. In response to COVID-19, this enabled them to quickly reach out to the groups they had identified, as well as existing partners to ask, "what can you do to help?" Many new groups they weren't previously connected to also joined the effort. Through a combination of leaflets, logging the information coming through phone calls (often from relatives) and through social media they very quickly got to know what the needs were meaning that they could respond accordingly. Within a matter of days, they had organised around 160 individuals and 32 community groups to provide a range of services for community members including hot meals for shielding people, support to get online to keep connected, ideas for things to do to fill the time, and medicines delivery. Over the period of the first lockdown they applied for, and were successful in, receiving over £60,000 of additional coronavirus funding for communities.

Ballymena Runners, who had been funded by NHSCT nine years earlier to run a 'Couch to 5k' programme for employees, was one of the groups that joined the effort. They are well known in the town and had been planning joint activities with MEAPP for older people when their usual running-related activities were curtailed by the lockdown restrictions. A handful of club members helped to deliver meals and comfort packs. They also became a registered volunteer group for the mass delivery of prescriptions through a policy proposal developed by MEAAP and delivered by the community. Much more than this, they have provided a listening ear for people and made new connections.

"We rang people asking how they are and if there's anything we can do … they're not short phone calls, people want to talk. It's good for us too! It makes you humble listening to the courage of the people. I value being connected to people I wouldn't normally be connected to".

Ballymena Runners reported that the efficient organising by MEAPP meant it worked "like clockwork". Good information flows and coordination have filled gaps without duplication. This has made it easier for people who wanted to help to do so.

Daphne Murphy is an 83-year-old lady who was supported through this community network. Her poem that can be found at the beginning of this report sums up the benefit she gained. Much more than receiving hot meals, Daphne was helped to set up her new tablet to do video calls with her daughters and she particularly liked the booklet of 'Staying at home tips' with ideas for things to do and puzzles to 'help keep your mind active'. She felt looked after, connected and had peace of mind.

In the NHSCT:

"There's an understanding that what happens in the community is going to impact on their local hospital / health service".

The Trust has made an effort to understand what MEAPP and other community and voluntary organisations bring and the impact on outcomes by preventing deterioration, for example. The relationships have built up over time so that the VCSE groups inform NHSCT of new services they are developing, for example when they are successful in winning a bid to deliver a new service or enhance an existing one. NHSCT considers how they can help to bring sustainability to their work and has provided funding on occasion to support the VCSE to provide useful services in the community.

12.2 If the NHS takes time to connect and build relationships, it will better gain the trust of, and understand, their communities, their agendas, needs, connections and reach

"The NHS must understand community and not assume. Start with a mapping exercise, then listen and understand. It's not good enough just to refer patients into the community through social prescribing. Health care professionals must suspend their own agenda and listen to the concerns, challenges and the agenda of others. Come with a mindset of exploring possibilities. This will support organisations as well as patients and their practice". Programme Manager, Community Learning Partnership

The community response to the pandemic showed that communities have great local knowledge about what lies behind a lot of the problems they face that are often causing ill health. In some instances, communities are already responding and in others, they would be willing to do so it they could find the right sort of support. The first step to supporting communities to respond well is to understand who the community is and then reach out to them to listen to their perspective on the issues they face, and discuss with them how they would like to remedy those issues. This will help build the grounds for a good relationship.

"Local responses to COVID-19 demonstrated the power of established relationships. Where there were good relationships between key community representatives and a good worker within the NHS it made all the difference. Relationships matter. Trust matters. If you don't have that relationship and that trust, things fall apart very quickly." Community Development Worker

Local responses to COVID-19 were enhanced where there were established relationships between the NHS and community. In terms of those interviewed for this project, most of these relationships were at the practice level and were with any of the following: GP, Nurse, Social Prescribing Link Worker, Care Coordinator, Community or Link Worker or Practice Manager. However, relationships between community and the NHS don't just sit, and indeed shouldn't just sit with just primary care; they need to be established throughout the system including with ICS, Provider Collaborative, secondary care, mental health trust and Primary Care Network stakeholders.

"We have a very good relationship with our local community and our practice volunteers joined forces with the local mutual aid group volunteers to support access to medication. A local charity provided refurbished laptops and we set out to educate people to use them and how to order their medicines on-line." GP

However, COVID-19 also demonstrated that building a relationship and trust can take time.

Although some new relationships were forged during the pandemic, for many community representatives engaging with the NHS proved to be a challenge.

"Although we were calling people´s surgeries to alert them to issues we may have observed while delivering food parcels, some practices were very wary of our intentions. It was clear that not knowing us meant there was little trust. This changed over time as the surgeries got to know us". Co-founder, Mutual Aid Group

In some areas of the country there are bespoke staff responsible for liaising between the NHS/other statutory bodies, and their local communities. This occupation is found in different organisations, commissioned by a range of agencies including local government, the NHS, and other funders such as voluntary, community and social enterprise (VCSE) organisations.

Where in place, and in response to COVID-19, these people were able to refocus their activities and draw on established connections and networks to support their local communities. This project interviewed one such person from Kendal.

Spotlight on Kendal

Following storm Desmond in 2015 Kendal Community Emergency Planning Group (KCEPG) was set up to help people living in the town to recover from the devastating floods. Supported by Cumbria Community Foundation, Hazel was appointed as co-ordinator to lead the KCEPG with a focus on bridging the gap between the local council's emergency plans and the local community.

At the onset of the pandemic, Kendal Integrated Care Community (ICC) approached the group with a request that they join forces to help people in the community. Kendal ICC were aware of the work of the CEPG as Hazel sat on the Kendal ICC flooding sub-group.

This connection was critical to the collaboration; a collaboration in which Kendal ICC identified where those who might be vulnerable were living, while CEPG co-ordinated the volunteer feet on the ground.

Hazel put out a call for volunteers and by the end of April she had recruited 250 volunteers. Given CEPG's established relationships with the Cumbria County Council, Kendal Town Council and South Lakeland District Council, Hazel was able to effectively co-ordinate the activity of the volunteers in support of those that were referred to her for support, while raising any concerns picked up by the volunteers with the appropriate departments.

"My position enabled me to draw on my connections and build and co-ordinate a volunteer team that supported our vulnerable communities. The relationships we have built up over five years worked really well".

"The NHS should consider supporting paid development workers who spend their time out and about in the community talking, networking, building relationships and acting as a bridge between the NHS and community. Ideally this role should sit within an established community network, although I suppose that they could sit within a Primary Care Network". Community Development Worker

This quote from a project interviewee reflects the findings from the two other projects from The Health Creation Alliance that considered the role of PCNs in addressing health inequalities.[1,2] The recommendation in those reports is for PCNs to employ a Strategic Relationship Development Lead to build the relationship and develop new services with community-based organisations. S

Important attributes for this type of role, drawn from the interviewees for this project include:

- trusted and respected by the community, local agencies and statutory services
- ability to deliver communication that is right in its content, tone, timeliness and reach
- skilled at facilitating and enabling
- committed to ´helping people help themselves´
- willingness to share power with the community

The findings from this project also suggest that individual relationships with community are likely to sit best at the general practice or PCN level, although they can sit with any part of the NHS that interacts with the community. This includes ICSs who should be including representatives from the community within their governance structure, while allocating funds for community activity.

It should be noted that Public Health England currently has a Community Health and Wellbeing Worker apprenticeship standard in development,[3] a role that needs to understand local provision, develop relationships with individuals, communities and supporting organisations, and build on individual and community strengths to enable people to achieve what matters to them regarding their health and wellbeing. The Health Creation Alliance warmly welcomes this.

The findings also provide guidance on a number of steps those NHS staff leading on building relationships with their communities could consider:

➢ Undertake a mapping exercise
  o first check in with the local infrastructure network organisation and find out what they know and whether they have mapped local community services and networks. If no mapping has been undertaken, consider partnering with the infrastructure organisation to undertake a mapping exercise. Doing this will tap into their local knowledge and support relationship building
  o it should be noted that a mapping exercise will only provide a basis for reaching out to established organisations at any point in time, it is unlikely to uncover activities like lunch clubs which are often at a micro- or hyper-local level. Mapping helps signpost and should be considered as a planning step to listening and relationship building

➢ Reach out to and engage with local organisations identified through the mapping exercise

➢ Talk, listen, learn from what the organisations are sharing about their purpose connections, needs and the needs of those they represent; uncover other local activities

"Going forward, the NHS must listen to what has been going on – listen first and then build from this, as opposed to building services and listening to peoples thinking on these". Community Network Organiser

12.3 Local patients would benefit if the NHS contributed to funding community

"Be brave, if you see an organisation as a real asset to your patients, work together and support them". Project lead, Community Organisation

If the NHS recognises that people and communities have significant skills and resources and can effectively connect, self-organise and take actions to meet some of the needs of their community – they will be trusted to do so. This does require investment from a range of sources to sustain it. The community view is that the NHS should consider ways to devolve some funds to communities (but not try to control how they are spent).

:
1. Health Creation: How can Primary Care Networks succeed in reducing health inequalities
2. Primary Care Networks and place-based working: addressing health inequalities in a COVID-19 world. A partners' perspective
3. https://www.gov.uk/government/consultations/community-health-and-wellbeing-worker-apprenticeship-standard. Last accessed 7 April 2021

The reason the community holds this view is because when communities connect and act together it can have a role in keeping people well, which in turn reduces demand on some NHS services. For example, keeping people out of general practice can free up valuable practice staff time. However, even though the NHS benefits, historically funding for the community has come from local authorities.

The Northern Health Trust of Northern Ireland has provided funding to community groups on occasion, to fill gaps in funding and help to underpin the sector's sustainability. This is considered within the Spotlight on page 23.

"COVID-19 has really reinforced the fact that communities helping each other is hugely valuable. My fear is that we will be doing more stuff that the NHS should be doing, or paying for. I am all for encouraging community development, but this cannot just rely on good will and it must be properly funded to sustain it". Volunteer, disability support services

This feeling was particularly strong among those interviewees who stepped in to deliver statutory services as a result of NHS staff being deployed onto COVID-19 activities and other statutory staff being furloughed, where it took time to secure additional funding for their work from COVID-funds. Funds that it was recognised would not last for ever.

"At the start it was hugely frustrating. Statutory staff were furloughed and there was no one to support many of our most vulnerable. We picked up where established services failed and received no additional funding for this. It took a lot of time and effort to secure adequate funding. Time and effort that could have been better deployed elsewhere". Faith Leader

"In response to COVID-19 a huge volunteer force came together with established organisations, often oiled by COVID-19 funds. This of course was in response to a crisis and when this is all over, community organisations and volunteers cannot be expected to continue to meet the non-COVID needs of people without adequate funding". Project lead, Community Organisation

The topic of investment in community was one that was also considered in the recent report from The Health Creation Alliance on Primary Care Networks

The principles behind this investment extend to the wider NHS, including ICSs, acute trusts, mental health trusts and general practice.

Key recommendations in that report included:

- ring-fenced money to be made available to PCNs specifically for the purpose of supporting community-led activity.

- getting behind community-led projects and supporting their bids for funding

- being a conduit for your community to reach and be heard by commissioners, helping them to understand why they should fund community-led work

- offer matched-funding to amplify their activity, where your community has secured resources from other sources

- recruit and pay community members as link workers and to undertake other connecting roles

- invest directly in community-building, either through supporting existing community development specialists that may be employed by other organisations or through funding community development specialists directly

Spotlight on Airedale, Wharfdale and Craven Health and Care Board

One NHS stakeholder that has recognised the value of creating health within their local community is the Airedale, Wharfdale and Craven Health and Care Board.

They have agreed, in principle, to direct 1% of the £220m health and care budget into community strengthening within three years.

This conscious decision to invest in communities' health creating activity needs to be adopted more widely and encouraged by NHS England and NHS Improvement.

Investment in community and the importance of a long-term view on this was made by Danny Kruger MP in his recommendations to the government as part of his ´Levelling up our communities: proposals for a new social covenant´[1] report. Within this he proposed that there should be consultation on the use of the £2bn+ which will shortly be available from new dormant assets: options include a new endowment, the Levelling Up Communities (LUC) fund, for perpetual investment in long-term, transformational, community-led local projects in left-behind areas.

12.4 The NHS has a role to play in working with others and listening to the needs of communities to help create the conditions for communities to thrive

For communities to thrive they need to be connected and have control. The community response to COVID-19 demonstrated that connected communities who were in control of the actions they delivered were able to rapidly respond to support their local community.

In areas where connections were less well established, tackling the impact of COVID-19 served as a rallying cry for people and local organisations to come together and collaborate.

The NHS, in collaboration with others operating outside the NHS, can act as a catalyst to help build the connections that enable communities to take control. By embedding the five features of health creating practices within their practices – **listening and responding, truth-telling, strengths focus, self-organising and power-shifting** – NHS staff can create the conditions for people and communities to thrive. This is considered in more detail in section 11.0.

Spotlight on the Lambeth Portuguese Project

The Lambeth Portuguese Community Project was initiated in 2015 through the intervention of Dr Vikesh Sharma, a GP Partner, Dr Cristiano Figueirdo, a GP training in Lisbon and the Portuguese Speaking Community Centre in Lambeth. It was established to address the health and wellbeing of the Portuguese speaking Community in Lambeth where an estimated one in seven people (c.40,000) speak Portuguese as their native tongue.

Lambeth Portuguese Wellbeing Partnership (LPWP) was set up from this. It is a grassroots network made up of over 40 local groups and community members. The Lambeth Portuguese Wellbeing Partnership combines their knowledge, passion, resources, and skills to improve the health and wellbeing of the Portuguese speaking community in Lambeth. A key initiative that the LPWP had initiated, prior to COVID-19 was the 'household model', developed to reduce health inequalities in the Portuguese-speaking populations of Lambeth. The household model reflects the fact that lifestyle (including alcohol consumption, food and nutrition, unemployment) has a major impact on patients' health. It also reflects that there is often a major dependency between the issues that a patient is experiencing and the person's household (family and close friends/neighbours). Rarely is an issue experienced in isolation and often the household has a major role to play in supporting a patient.

The interventions in this programme sought to improve not only the well-being of individual patients, but also family interactions. These relationships are based on self-esteem, empowerment, and connection – that is, the more these feelings are reinforced, the better the outcome for the family as a whole.

The connectivity and trust that the household model had developed was a key success element in how support services were established to address the challenges faced by the Portuguese-speaking community as the pandemic unfolded.

With the onset of the pandemic the Local Authorities and VCSE organisations set up support and provided a range of services to vulnerable people. However, these were all predominantly English-speaking based and the Portuguese-speaking community neither trusted nor were able to engage with these organisations due to language and cultural barriers.

The Lambeth Portuguese Wellbeing Partnership management team met and set out a strategy to address the fact that the language and cultural barriers that people were facing in trying to get support was not being addressed. The partnership established the COVID-19 Grupo Lusófono da Entreaiuda de Lambeth (Mutual Aid Group) and set up a telephone helpline, with Portuguese-speaking volunteers to support the Portuguese-speaking community. A call was put out for volunteers and the network of organisations engaged with the LPWP sprang into action.

1. Kruger D. Levelling up our communities: proposals for a new social covenant. https://www.dannykruger.org.uk/sites/www.dannykruger.org.uk/files/2020-09/Kruger%202.0%20Levelling%20Up%20Our%20Communities.pdf. Last accessed April 7 2021.

This spotlight clearly demonstrates how NHS employees played a critical role in connecting with others to help build an infrastructure within a community. In addition to helping to address health inequalities, this enabled the community to rapidly respond and adapt to COVID-19.

However, the onus isn't only on the NHS. Interviewees were clear that people and communities need also to take some accountability to build their own connections. COVID-19 acted as a catalyst for new connections being made, while competition for funds and organisational politics were largely set aside for a time. The NHS can play a key role in maintaining this new found spirit of collaboration.

"We must not forget that community collaboration is a two-way process. It isn't only the responsibility of the NHS to work better with and for their communities. People and communities have to voice themselves. They must ask for what they need, take responsive action and co-operate better with NHS". Volunteer for community organisation supporting refugees

People need the confidence to ask for what they need. Helping people to connect with others in their community can help build this confidence. The NHS has an important role to play in supporting their patients connect with others.

12.5 The NHS would benefit from meaningful engagement with people with lived experience and their communities in the development of joint strategies and programmes that clearly detail the role of the community throughout the system

NHS stakeholders include those within ICS, Provider Collaboratives, secondary care, Primary Care Network and GP Practice.

"Developing a strategy is a great place to start to build trusted relationships. Get patients and all those involved in supporting their health and wellbeing within a locality into a room – from VCSE, social care, public health, pharmacy – and work with them to identify a common purpose. Then consider what the perfect service would look like." Practice Manager

Practices with a clearly defined strategy for community engagement and support as part of their practice strategy were in a better position to collaborate with local organisation and volunteers to meet the needs of their patients.

This was particularly important for maintaining contact and supporting vulnerable, isolated and shielding patients where practices were able to rapidly combine resources of the practice with those of their community.

In developing such strategies, the NHS must engage with patients and their communities in a meaningful way. Some interviewees felt this is often seen as a 'tick box exercise'.

"*There is an opportunity to co-design new ways of engaging with communities and people with lived experiences, closing the loop so that people are not only engaged at sharing their experience, but they are engaged in the co-creation of services and evaluating their benefit".* Volunteer co-ordinator

Spotlight on Alvanley Family Practice, Stockport

In developing their 2021 Practice Strategy, the Alvanley Family Practice surveyed their 5,000 adult patients asking "what matters to them?"

The outputs from the survey were then used to inform a one-day planning meeting with practice staff and their Community Champions from which the strategy emerged. Importantly this approach is more than co-production as the plan is being led by patients with expert experience.

12.5.1 Beyond patient participation groups

"Patient participation groups are only part of the solution to understanding the community. In fact, there is a big difference between patient participation groups and community. In my experience [PPG] members tend to be middle class and privileged. This doesn't reflect the patients out there, many of which don't get heard". Lead, community organisation

To understand the community the NHS must go beyond patient participation groups, or similar bodies, alone. Traditionally patient participation groups have a deficit mindset – patients come along and talk about what is wrong with services. While it's important to understand what isn't working well, this negative attitude can result in low uptake and unrepresentative participation.

The NHS would benefit from also adopting a strengths-based or asset-based mindset, where people come together and are seen for what they can do to support a practice.

The importance of engagement in planning was also a topic considered in The Health Creation Alliance´s report entitled: Primary Care Networks and place-based working: addressing health inequalities in a COVID-19 world: A partners perspective.

Recommendations within this report apply to the wider NHS, including ICSs, acute trusts, mental health trusts and general practice. The recommendations included:

➢ Invite one or more community members to join your PCN board or leadership team so that you can hear about this work on a regular basis

➢ Invite local communities and organisations to contribute to your plans and efforts to tackle health inequalities, for example through a 'partnership board'

➢ Invite local partners/community groups to your training sessions and development days to explore ways of improving local health outcomes with the PCN team

12.6 The NHS can learn from the more diverse communication approaches adopted due to COVID-19 to support better two-way communication with communities and patients in place

"In our area local GPs rapidly established a face book page and WhatsApp group for the Portuguese-speaking community. This was critical in helping to connect people to the support and services that were available to them". Volunteer

The onset of the pandemic resulted in an explosion in the number of communication platforms and channels used to keep people connected and informed. The restrictions to face-to-face contact led to rapid adoption by the NHS of digital consultations, while platform such as Facebook and WhatsApp were adopted by some GP practices for the first time to keep their patients informed.

"*Digital cannot just be the default solution for engaging with people and communities – it is an enabler. While COVID-19 has focussed minds on digital exclusion and a great deal of effort was put into addressing this, lot's of people still don't have access to the equipment, don't have broadband and/or can't afford broadband or data packages, don't know how, or have the confidence to use IT".* Vice Chair of a community organisation supporting people living with disabilities

The onset of lockdown also shone a light on the challenge of overcoming digital exclusion among many older, underserved and disadvantaged communities.

While progress was made in addressing exclusion for people who can´t afford, don´t have access to, or don´t have the skills or confidence to use digital communication, there was also a recognition that multiple communication channels need to be deployed if those in need of support were to be reached. These included:

• Leaflets and posters
• Local broadcast and newspapers
• Telephone calls, texting
• Local free magazines
• Information sheets delivered with prescriptions and food parcels
• Promotion of telephone help lines
• Socially distanced door-step visits

The onset of the pandemic also led to a lot of fear, confusion and misinformation. In response to this, different community groups played a critical role in communicating clear, factual and supportive messages to their communities in a way that the NHS couldn't match.

The role of the community was particularly relevant for:

• some BAME communities where faith groups took a leading role in keeping people informed
• communities for whom English isn´t their first language
• hard to reach and isolated communities
• digitally excluded communities
• those with poor health literacy

"The NHS can learn a huge amount from how we engaged with some of the most vulnerable and hard to reach in our community, after all they are their patients." Faith Leader

To capitalise on the learnings from COVID-19, local NHS stakeholders could work with their community and undertake an audit of the different communication channels used. From this the most effective approaches to two-way communication with different patient groups, families and their communities can be identified and embedded into daily practice. This audit should include what worked, why it worked and who is best to deliver the messages, while the new approaches adopted should be audited at 12 months to ensure they are adding value to two-way NHS communications.

11.7 The NHS should recognise the value of reciprocity and factor this into all interactions with patients to support people take action to support others

Beyond providing a platform to engage with those who may be too proud to accept support, reciprocity – people receiving support and making a contribution to support others – was another key feature of the pandemic response. The benefits of this to individuals were multi-faceted and included providing them with a purpose, making people feel valued and connecting them to others.

This is backed up by research on the five steps to mental wellbeing[1] that suggests that acts of giving and kindness can help improve mental wellbeing by:
- creating positive feelings and a sense of reward
- giving people a sense of purpose and self-worth
- helping people connect with other people

"One of the volunteers, who herself started as a person in need of support, said "It has been the most incredible journey of my adult life". The community spirit was amazing. She felt as scared as anyone else, lost her income and had personal fears for the future. Being able to focus on volunteering with others was good for her. By helping others, she helped herself as well". Local co-ordinator, Mutual Aid Group

Spotlight on Timebanking

Timebanking is a hyper-local mechanism firmly based on the consent of reciprocity. A time bank member can give an hour to help another person – and they can also request an hour of someone's time in return whenever they want or need it. Timebanking enables people to provide as well as receive support when they feel able, thus contributing to their local communities but also setting a strong foundation for a healthy life, connected with fellow community members. Of particular interest is the unique way timebanking values each and every person, helping them to recognise their own self-worth, and improving their wellbeing. For this reason the NHS could consider referring patients to their local time banks where established.

1. https://www.nhs.uk/mental-health/self-help/guides-tools-and-activities/five-steps-to-mental-wellbeing/. Last accessed 7 April 2021

Spotlight on Timebanking cont…

With the advent of the pandemic, the need for volunteers increased across the health and social care sector and the third sector. However, timebanking is different to volunteering, enabling members to define themselves not only by the way in which they need help, but also the way in which they can give help. Giving and receiving hours increases the interest and participation of local people who often do not see themselves as traditional volunteers, but are more than happy to help another person in their community. When people engage in timebanking, natural mutual support networks are created, which in turn enhances community cohesion and creates a responsive vehicle to deliver operationally quickly on the ground.

Reciprocity and mutuality are the core values underpinning timebanking; this again distinguishes it from traditional volunteering as at its heart is the belief that everyone has something to offer. It is about acknowledging that people can make different important contributions to their community. This is core to timebanking's appeal and would be lost if more transactional approaches were pushed.

"For example, with the food hub - people have heard about what we are doing… they lost their job and they need help and have never asked for help before in their lives and they see the time bank as a friendly and open environment… they feel much more relaxed and able to ask for help and they can't wait to give something back". Time bank broker interviewed December 2020

These principles situate timebanking as community and not charity. Timebanking engages people in relationships with each other to join and become an active part of a community rather than 'in need'. Its success is based upon breaking down the duality of those in need and those who give.

"I am a firm believer that timebanking isn't volunteering. For me it's just all about being part of a community… we are trying to get away from this idea of charity - that one person does for another... it's about the whole community and how do they contribute". Time bank co-ordinator interviewed December 2020

For more information on time banking visit Timebanking UK , the only national organisation providing all the resources, learning and training on how to use timebanking or set up community time banks.

12.8 NHS buildings are a resource that could be used for the benefit of communities

"It was so much more than a place to prepare and dispatch food parcels, it became our source of support. We worked long hours for free, but we were doing it together for our community". Local volunteer at community centre

"Although I didn't visit the centre, just knowing it was there was reassuring. When I passed it, knowing it was a place where people came together to help others, was a real comfort." Recipient of support

While place-based support for communities has always been highly valued, the pandemic really brought home the importance and value of a physical asset. Even during lockdown when doors were closed to the public, many provided a hub for volunteers to come together and support each other while preparing to support their community.

The NHS Property Services is embarking on a new campaign called 'Creating community spaces for patient wellbeing'. As the owner and manager of 10% of the total NHS estate and 30% of its primary care estate, it is committed to creating strong local voluntary sector partnerships to transform vacant space into indoor and outdoor social prescribing spaces. More information about the initiative can be found here.

12.9 Going forward, the NHS could work with their local communities to support people to connect and self-organise to address other significant health issues that affect a local population

While this recommendation was not explicitly uncovered through interviewing the project participants, it is a key recommendation that is implicit within much of the report and it should be a key consideration for the NHS as it further embraces Population Health Management.

Population Health Management focuses on data as a means of understanding the causes of ill-health and to guide action. This will work best when data generated by NHS organisations is shared with local organisations and the community and combined with other data and insight to:

➢ demonstrate the need to take collective action on a particular health issue that is relevant to the local population

➢ develop a rounded profile of the issues faced by local populations that are having an impact on their health and wellbeing

➢ draw up solutions to addressing the local health need, and actions that all local stakeholders can deliver alone or in collaboration with others

Local organisations could also source additional insight. Sourcing this doesn't have to be cumbersome and it could be as simple as reviewing telephone calls to a helpline, or tracking on-line discussions.

Through adopting a more collaborative approach, inroads could be made to addressing the health needs of local communities – such as improving weight management, addressing respiratory diseases or improving outcomes in cancer – in a manner that focuses on the 'causes of the causes' rather than focusing directly on a biomedical model to addressing the needs.

13.0 Further spotlight on The Health Creation Alliance

As the only national cross-sector movement addressing health inequalities through Health Creation, in delivering on our mission to increase the number of years people live in good health in every community our primary focus is on underserved and disadvantaged communities. This is particularly relevant given the disproportionate impact of COVID-19 on these communities.

The Health Creation Alliance is an inclusive membership organisation, with members drawn widely from across many voluntary and professional sectors. We also have members who come from a predominantly 'lived experience' perspective, ranging from 'expert patients' to community leaders to people who have a range of vulnerabilities – such as use of criminal justice system, substances misuse, mental ill-health, homelessness, childhood trauma, domestic abuse – and who have not always found it easy to have a voice and access health, social care and other services.

Become a member of The Health Creation Alliance

Join our national cross-sector movement for Health Creation, access our resources and get information about all our activities here.

Benefit from our Discovery Learnings Programmes

Health Creation requires action across systems and at all levels. It happens principally through constructive and meaningful relationships where people can learn from each others' experiences and through blending their ideas. This can best be enabled through bringing together professionals from diverse backgrounds, community members and people with lived experience to learn from each other.

Every place is different so diverse place-based communities are important for the learning process. But communities can also learn from each other so a national network of health creators across many sectors is a hugely valuable resource to aid learning.

To deliver long-term sustainable improvements in health and reduce health inequalities, the practice of Health Creation has to become embedded across whole systems. It is not a distinct service or practice that can be learned through traditional teaching. Rather, it is a different way of approaching everything we do. Health Creation needs to become 'the way we do things round here'.

Spotlight on The Health Creation Alliance continued…

The Health Creation Alliance Discovery Learning Programmes offer learning opportunities through structured, bespoke programmes for 20 to 40 participants. Participants learn with, and from, others, including those from the same, and other, professional backgrounds.

Our Discovery Learning Programmes:

- ➢ maximise sharing, discovering with others and experiencing new ways of working within a safe and trusting environment
- ➢ employ our bespoke reflective Health Creation toolkits to develop the know-how and confidence to do things differently
- ➢ aim to establish a discovery learning habit that can be continued long after we have stepped back
- ➢ are only designed when we have a good understanding of a place and services being delivered

If you would like to learn more about our Discovery Learning Programmes and how they might be right for you and your organisation, please email neil@thehealthcreationalliance.org

For more information on The Health Creation Alliance and our activities, please visit our website.