

# At the heart of health

Realising the value  
of people and  
communities

Report

*February 2016*



## About this report

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This report explores the value of people and communities at the heart of health, in support of the NHS Five Year Forward View vision to develop a new relationship with people and communities.

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## Acknowledgements

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# At the heart of health

Realising the value of people and communities



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# Executive summary

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This report explores the value of people and communities at the heart of health, in support of the NHS Five Year Forward View vision to develop a new relationship with people and communities.

Our starting point is that health and care services need to work alongside individuals, carers, families, social networks and thriving communities. This report seeks to bring together in one place a wide range of person- and community-centred approaches for health and wellbeing. It provides an overview of the existing evidence base with a particular focus on the potential benefits of adopting person- and community-centred approaches.

We hope this report will help commissioners, policymakers and practitioners to understand the range of approaches available, some of the key components and their potential to improve health and wellbeing outcomes, NHS sustainability and social value.

Person- and community-centred approaches to health and wellbeing have come a long way over the past fifteen years: from pioneering practice situated outside of the mainstream, to a central place in NHS England's vision for the NHS. There is growing consensus about the need for health and care services to embrace the benefits of taking a more person- and community-centred approach.

Yet, despite this policy focus and many good examples of person- and community-centred approaches being implemented in frontline practice, it is still far from being 'the way we do things' within health and care services.

It is important that we now do much more to better understand which person- and community-centred approaches work in what circumstances and how to achieve much greater take up and spread of the most effective approaches.

## Why?

First and foremost because we believe there is a strong moral and ethical case for a health and care system which starts from what matters to individuals and recognises the central contribution that strong, resilient communities can make to support health and wellbeing. Put simply, it is the right thing to do. It enables people to have a voice, to be heard, to be connected and to have the opportunity to choose how best to live their lives and the support to do so.

Secondly – although no less importantly – it is because these approaches 'work'. There is a growing – and increasingly convincing – body of evidence from research and practice that these approaches lead to better outcomes and significant benefits for individuals, services and communities. Of course there is still much we don't know and the evidence in some areas is mixed or inconclusive. But we strongly believe that we need to combine a continued focus on building the research evidence along with implementing, testing and evaluating these approaches in practice.

## What are person- and community-centred approaches for health and wellbeing

Person- and community-centred approaches for health and wellbeing include a wide and diverse range of activities, interventions and approaches. These range from collaborative consultations with health and care professionals that focus on what is most important to people, to community dance classes in the local hall. They happen in formal health and care settings, people's own homes and in the wider community.

Despite this diversity, these approaches are united by a common purpose: to genuinely put people and communities at the heart of what they do – focusing on what's important to people, what skills and attributes they have, the role of their family, friends and communities and, given all this, what they need to enable them to live as well as possible.

## What we know about 'what works'

There is a compelling case that the time has now come for person- and community-centred approaches to health and wellbeing. The drive for services to do more to empower individuals and communities is growing. This is coupled with the increasing body of evidence from research and practice that these approaches can improve outcomes.

We see the significant potential for person- and community-centred approaches to improve outcomes for individuals and communities, as well as to ensure more effective allocation of limited public finances. There is evidence from research and practice to demonstrate the benefits of person- and community-centred approaches, across three dimensions of value:

- **Mental and physical health and wellbeing:** Person- and community-centred approaches have been shown to increase people's self-efficacy and confidence to manage their health and care, improve health outcomes and experience, to reduce social isolation and loneliness, and build community capacity and resilience, among other outcomes.
- **NHS sustainability:** These approaches can impact how people use health and care services and can lead to reduced demand on services, particularly emergency admissions and A&E visits.
- **Wider social outcomes:** Person- and community-centred approaches can lead to a wide range of social outcomes, from improving employment prospects and school attendance to increasing volunteering. They also can potentially contribute to reducing health inequalities for individuals and communities.

The two separate annexes to this report (**Annexes 1 and 2**) report on the review of the evidence across the field of person- and community-centred approaches for health and wellbeing, undertaken by the Institute of Health & Society at Newcastle University. The team of health economists carried out a search of global academic health literature, resulting in over 500 evidence sources being identified. For this report, we also draw on a wide range of other evidence from research and practice to help consolidate what we know about the field.

Our overall assessment is that the evidence is still emerging with good evidence in some areas of practice such as peer support and self-management. In other areas, particularly those focusing more on community asset-based approaches, the evidence is still at a much earlier stage of maturity.

Across the three dimensions of value, we have the most evidence about the potential of person- and community-centred approaches to improve physical and mental health and wellbeing. We still need to know a lot more about the impact on NHS sustainability, although there is good evidence that self-management support reduces use of acute services, and emerging evidence which shows the potential of other approaches. There is also a growing focus on how working with communities can contribute to wider social outcomes.

While we should continue to strive to improve the evidence of the impact of these approaches, we believe a compelling case has been made to adopt and implement them now. To realise the vision of truly person- and community-centred approaches for health and wellbeing, the challenge now is twofold: to be more precise about what works in what circumstances and to better understand how to embed and scale the most effective and appropriate approaches.

## The Realising the Value programme

The Realising the Value programme is designed to develop the field of person- and community-centred approaches for health and wellbeing by building the evidence base and developing tools, resources and networks to support the spread and increase the impact of key approaches.

Realising the Value has identified five focus areas for the next phases of work. Together, these five areas demonstrate a commitment to the principles of person- and community-centred approaches for health and wellbeing and show significant potential to enhance the quality of life of people living with long-term conditions and deliver benefits across the three dimensions of value:

- Peer support.
- Self-management education.
- Health coaching.
- Group activities to support health and wellbeing.
- Asset-based approaches in a health and wellbeing context.

Over the coming months the programme will:

- Work closely with local partner sites to understand their experience of implementing person- and community-centred approaches on the ground, and to develop practical tools to support implementation and greater adoption.
- Seek to improve our understanding of what influences the behaviour of individuals as well as what factors can positively impact on organisational culture.
- Make recommendations for policymakers and others about what is needed to support change on the ground and creating the conditions for these approaches to flourish.

The outputs of the programme, later in 2016, will be grounded in both evidence and practice. They will be relevant to commissioners, providers and practitioners putting person- and community-centred approaches into practice, as well as to policymakers and other decision-makers. The programme also seeks to build a network of local places and organisations committed to putting this agenda into practice, to sustain momentum beyond the lifetime of the programme.

CHAPTER 1

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# Introduction

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*“I was a quivering, shivering wreck on 21 tablets a day - and 20 months later I’ve been off medication for nine months and my children are amazed that one person can change so much in such a short space of time. They never thought it would be possible and neither did I - but it is.”*

Participant in Creative Minds group arts sessions run by the Artworks in Halifax.

*“Person-centred care has made things easier for me to manage and it’s reduced the number of missed appointments – you can’t argue with that!”*

Diabetes specialist nurse ([personcentredcare.health.org.uk/diabetes](http://personcentredcare.health.org.uk/diabetes)).

*“Without Positively UK I wouldn’t have been the person I am today. Through the support groups I was able to make friends and I now have a social life. Through the motivation I received I went back to school, have gained a BA and look forward to getting back to work.”*

Positively UK Service User.

We are at a critical juncture. For years, there has been sustained work by many to put people and communities at the heart of their health. This is felt through vibrant networks of people supporting each other, people living the life they want through personal budgets, and people working as partners with professionals to realise personal goals. There is now strong enthusiasm for this to become the way we do things – the norm – rather than the experience of the few.

There is much that health and care services do to support our quality of life, particularly if we live with long-term conditions or a disability. Living an independent and fruitful life can also often be significantly enhanced through our informal and everyday relationships with carers, families, friends, networks and communities. And people themselves can play a critical role in their own health and care. To unlock this potential, formal services and the wider community sector need to interact in ways that tap into the ‘renewable energy’ of individuals, social networks and communities. This has demonstrable potential to improve individuals’ health and wellbeing, reduce demand on health and care services and lead to a range of wider social outcomes.

How can we re-engineer our system so that health and care services work alongside thriving communities to realise the value of people and communities at the heart of health?

This is the focus for Realising the Value – a programme designed to develop the field of person-centred, community-based approaches for health and wellbeing by building the evidence base at the same time as developing tools, resources and networks to support the spread and increase the impact of key approaches.

Our starting point is the strong moral and ethical case for person- and community-centred approaches for health and wellbeing: put simply, it is the right thing to do.<sup>1</sup> It enables people to have a voice, to be heard, to be connected and to have the opportunity to choose how best to live their lives, and gives them the support to do so.<sup>2</sup>

The other key rationale for these approaches is that they ‘work’. While the evidence base is still emerging, there is a growing – and increasingly convincing – body of evidence from research and practice that these approaches lead to better outcomes.

Person- and community-centred approaches can and do lead to significant benefits for individuals, services and communities. They can improve individuals’ health and wellbeing; reduce demand on formal services such as reducing unplanned hospital admissions, and address health inequalities by contributing to wider social outcomes such as employment and school attendance.

Person- and community-centred approaches for health and wellbeing have come a long way over the past 15 years: from pioneering practice situated outside of the mainstream, to a place at the heart of NHS England’s vision for the NHS. Practice that felt radical and challenging just a few years ago – such as personal budgets – is now enshrined as ‘right to have’ legal duties for statutory services. There are also new collaborations across the statutory, voluntary and community sector.\*

The NHS *Five Year Forward View*<sup>3</sup> reflects this increasing recognition of the role of people and communities in their own health. It sets out a clear vision for the NHS to develop a new relationship with patients and communities in which patients’ own life goals are what count. It promotes wellbeing and independence as key outcomes of care and argues that people with a long-term condition should be supported to manage their own health and care. It also recognises the important role strong communities play in supporting health and wellbeing.

This vision is being taken forward in a number of different ways including the Integrated Personal Commissioning programme and the New Care Models programme, which includes a focus on empowering patients and communities.\*\* The voice of the voluntary and community sector has grown from an ‘outsider’ perspective to being increasingly embedded in core business, such as through the Five Year Forward View’s ‘People and Communities Board’.

The increasing recognition of putting people and communities at the heart of health is happening within the broader context of services facing intense financial pressure. There is, therefore, particular interest in the extent to which these approaches can be better for people themselves and, through improving their lives, can reduce their need for formal health and care services, particularly acute and emergency services.

Realising the Value is strongly aligned with the Five Year Forward View. In particular, Chapter 2 focuses on a more engaged relationship with patients, carers, citizens and communities to promote wellbeing and prevent ill-health. Realising the Value builds on the Five Year Forward View commitment to “*invest significantly in evidence-based approaches such as group-based education for people with specific conditions and self-management educational courses, as well as encouraging independent peer-to-peer communities to emerge*”.<sup>4</sup>

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\*For example the Coalition for Collaborative Care (C4CC), which has grown from 14 founding partners in 2014 to 47 today.

\*\*The New Care Models programme includes work “to deliver care that is personalised, coordinated, tackles inequalities and effectively provides for the whole population.” [www.england.nhs.uk/ourwork/futurenhs/new-care-models](http://www.england.nhs.uk/ourwork/futurenhs/new-care-models)

## This report

This report looks across the field of person- and community-centred approaches and sets out the potential benefits of these approaches. Throughout, we are focused on the value<sup>5</sup> that person- and community-centred approaches can contribute in three key areas:

1. Mental and physical health and wellbeing
2. NHS sustainability
3. Wider social value

There are existing systematic and other evidence reviews that cover parts of the evidence base across this broad and diverse field, but they remain disparate. This report, therefore, seeks to bring together in one place a wide range of approaches that aim to support individuals and communities to be at the heart of their health and wellbeing.

In particular, this report sets out what we mean by person- and community-centred approaches and how these have developed across health and social care and within community development fields. Chapter 4 sets out what we know about ‘what works’ from the existing evidence base to support the case for their wider adoption. Chapter 5 identifies five approaches with significant potential to enhance the quality of life of people living with long-term conditions:

1. Peer support
2. Self-management education
3. Health coaching
4. Group activities to support health and wellbeing
5. Asset-based approaches in a health and wellbeing context

Chapter 6 sets out what steps we will take in the remainder of the Realising the Value programme to support the implementation of these approaches, including cultural and systems change.

CHAPTER 2

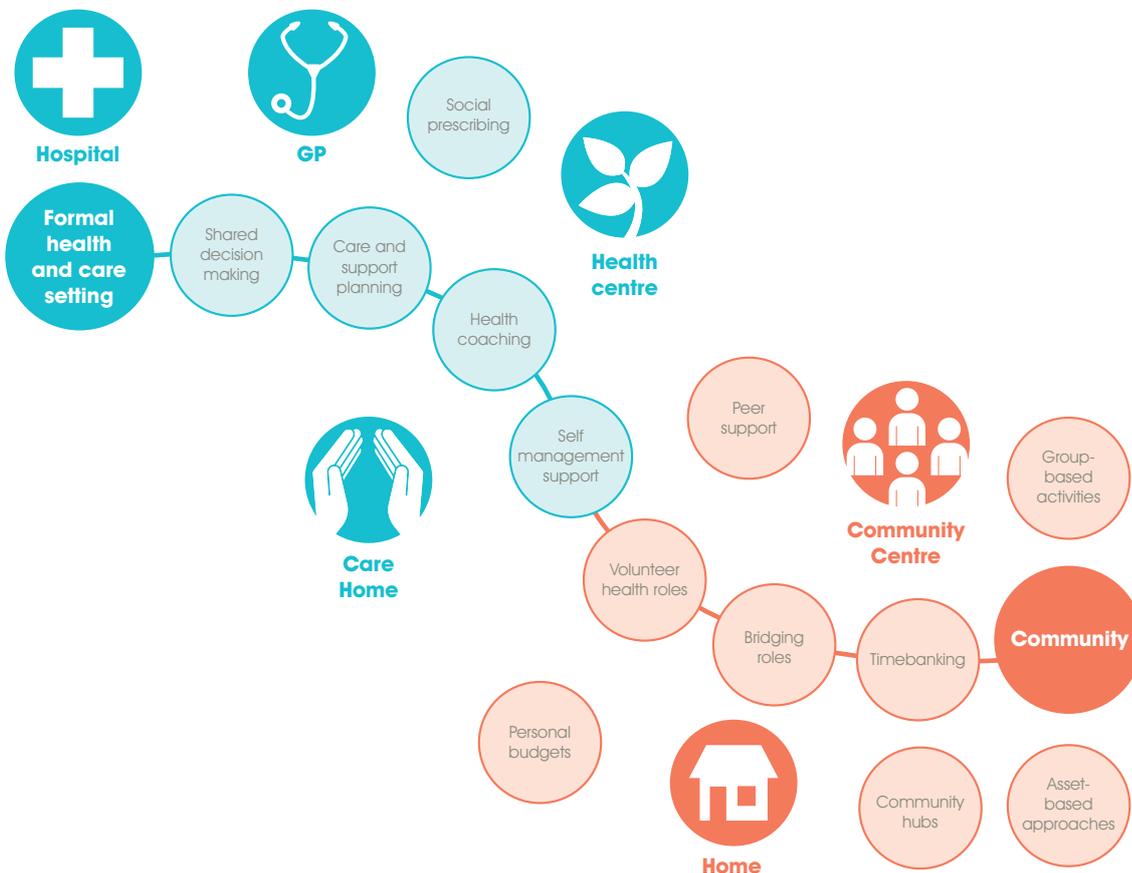
# What are person- and community-centred approaches for health and wellbeing?

Person- and community-centred approaches for health and wellbeing range from collaborative consultations that focus on what is most important to people, to community dance classes in the local hall. They happen in formal health and care settings, people’s own homes and in the wider community.

This variation means that these approaches are like a mosaic, a myriad of options that have developed in response to what different people need and want in different places.

The diagram below sets out some common examples of person- and community-centred approaches for health and wellbeing and some places they often take place. There is also an increasing blurring of the boundaries; for example, peer support can happen in a hospital and self-management education can take place in a community group.

Figure 1: Common examples of person- and community-centred approaches



The Appendix sets out a number of these approaches in more detail, including what they are and what we know about the evidence for them.

This diversity also means there is no single definition of person- and community-centred approaches for health and wellbeing. Yet, despite this, these approaches are united by a common purpose: to genuinely put people and communities at the heart of what they do – focusing on what’s important to people, what skills and attributes they have, the role of their family, friends and communities and, given all this, what they need to enable them to live as well as possible.

Rather than proposing a definition for this emerging field, we suggest person- and community-centred approaches broadly fit within three main categories:\*

1. Approaches that enable people to **look after themselves better**, including understanding their condition, managing their symptoms and improving their diet, and education tailored to particular conditions.
2. Approaches that enable people to **have meaningful relationships** that help them improve their health and wellbeing through, for example, peer support networks and community groups.
3. Approaches that enable people to **work collaboratively with professionals**, such as collaborative consultations and health coaching.

Figure 2: Three main categories of person- and community-centred approaches



## What makes these approaches work?

There are increasingly strong theories about how these approaches create change. These focus on knowledge, skills and confidence leading to behavioural change. This is sometimes called ‘activation’ (see **Box 1**) and is related to concepts of hope, resilience, grit and self-efficacy.

The hypothesis is that approaches such as peer support help to build the knowledge, skills and confidence of individuals and communities. This enables people to take action to improve and manage their health and care in ways such as improving their diet or managing their symptoms better.

It is increasingly thought that the combination of these factors is important: knowledge alone, for example, is not sufficient to enable people to change their behaviour and manage their health and care effectively.<sup>6</sup> Behavioural insight perspectives can also help in understanding these factors. One model to support behavioural insights focuses on three factors: Capability, Opportunity and Motivation.<sup>7</sup> Understanding the behavioural drivers of these approaches is an integral part of the Realising the Value programme.<sup>8</sup>

\*These categories were directly informed and shaped by an open consultation in the early stages of the programme which attracted almost 100 responses, as well as the input of the Realising the Value consortium members and advisory group.

Wider social context is another important factor in enabling people to become more in control of their health and wellbeing. There is increasing evidence that community cohesion, resilience and social capital can contribute to improving health and wellbeing, reducing rates of depression and preventing falls, as well as enhancing life-skills, increasing rates of employment and higher education and improving social relationships.<sup>9, 10</sup> These factors largely lie outside the control of health and social care services, so the challenge is how can the world of formal care align to build stronger communities:

“Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill.”

Marmot (2010) Fair Society Healthy Lives Final Report.

## BOX 1 • Focus on: Patient Activation

The Patient Activation Measure (PAM)<sup>11</sup> is a measure that can help us to understand where people are in terms of their levels of knowledge, skills and confidence, as well as to measure whether particular interventions improve activation.

PAM scores have been found to be a robust predictor of a number of health behaviours and to be closely linked to, among other things, clinical outcomes and costs of care. Evidence suggests that: people who have low levels of knowledge, skills and confidence are less likely to take an active role in staying healthy. They are less likely to seek help when they need it, to follow health professionals' advice, or to manage their health outside of formal treatment. Conversely, people who are highly 'activated' are more likely to adopt healthy behaviour, to have better clinical outcomes, fewer hospital admissions and to be more satisfied with health care services.<sup>12</sup>

A recent US study found that “patients with the lowest activation levels had predicted average costs that were 8 per cent higher in the base year and 21 per cent higher in the first half of the next year than patients with the highest activation levels”.<sup>13</sup>

People's level of activation can be improved. Approaches that have been shown to have a positive impact on activation also impact on other key outcomes. Additionally, people who start at the lowest activation levels tend to improve the most, indicating that there is opportunity to support the least engaged and challenge health inequalities.

Using the patient activation measure, a recent US study found that an individual's baseline level of activation (or knowledge, skills and confidence) is a reliable predictor of a range of outcomes over time and can help to predict future health care costs. This suggests that investing in approaches that target activation could have great potential. However, we still need to know more about which approaches are most effective at improving activation.<sup>14</sup>

## Making it happen: enabling mechanisms that are gateways to change

In order to be most effective, person- and community-centred approaches must be supported by a range of enabling mechanisms.

A key mechanism is personalised care and support planning. This is a systematic process in which people with long-term conditions and their carers work in partnership, very often with health and social care professionals, to identify their treatment, care and support needs. This can range from medical care through to support to connect with local services, peer-support networks and other community groups.<sup>15</sup>

Other things which can act as important enablers of these approaches are:

- **Social prescribing:** people can receive a ‘social prescription’ as a way to connect to services and groups outside of formal health or social care (for example, to join a local peer-support group) to help them manage their health and care and achieve their goals.
- **Personal budgets:** giving people control over how the money allocated for their health and care is spent.
- **Bridging roles (health trainers, community navigators, health champions):** roles undertaken by people, often drawn from the local community, who work with individuals to connect them with local services and help them to navigate them.

The House of Care (see **Figure 3**) can provide a useful framework for thinking about how these enablers fit together. It has primarily been developed to describe the interdependent factors that need to be in place to ensure coordinated person-centred care and support planning for people living with long-term conditions. Crucially, the model integrates and connects formal health services with community services and social networks - ‘more than medicine’<sup>16</sup> approaches that encompass many of the community and asset-based approaches included in the Appendix.

Figure 3: The House of Care

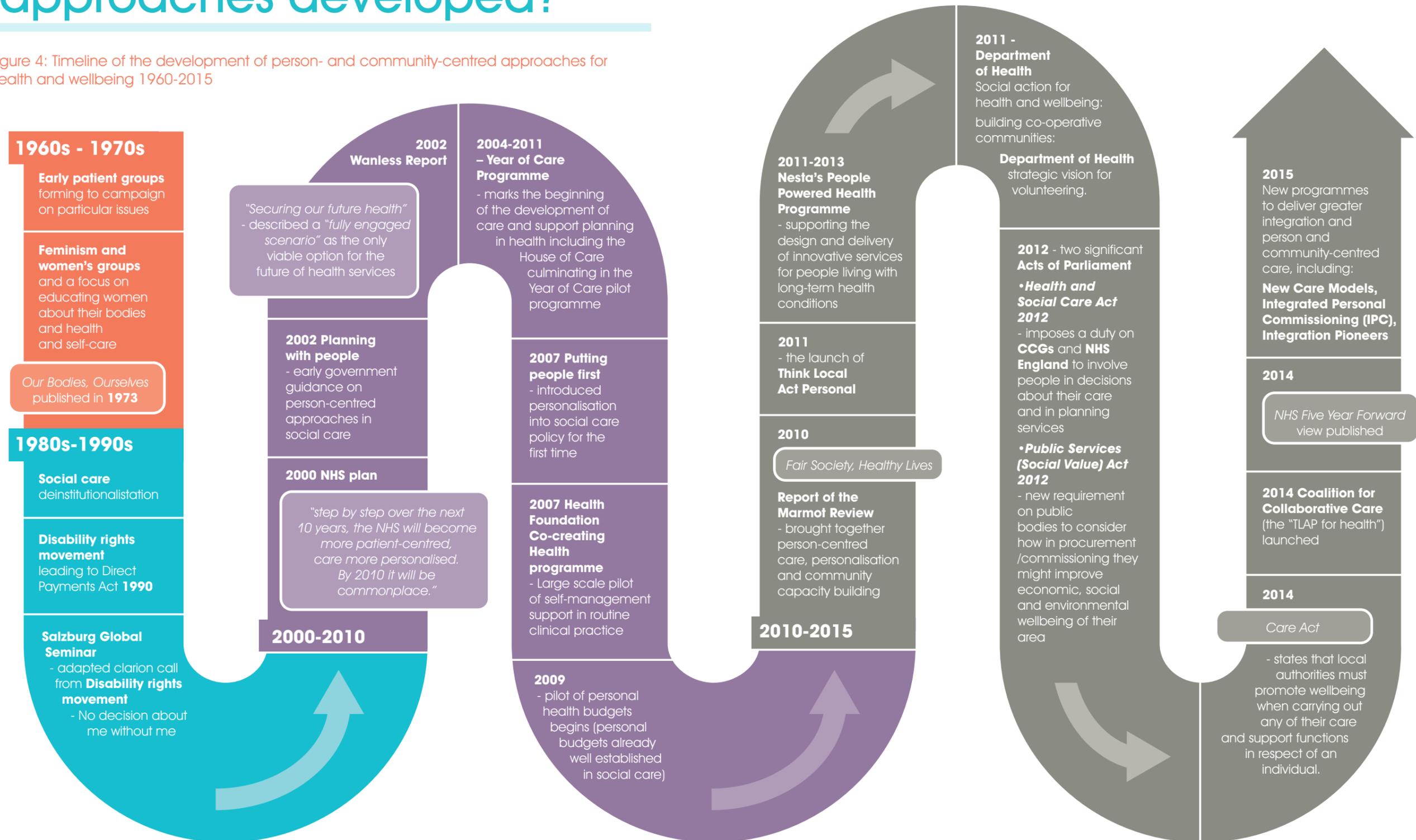


The diagram of the House of Care shows the different elements that are needed to ensure coordinated person-centred care as described in the previous paragraphs.

# How have person- and community-centred approaches developed?

Figure 4: Timeline of the development of person- and community-centred approaches for health and wellbeing 1960-2015

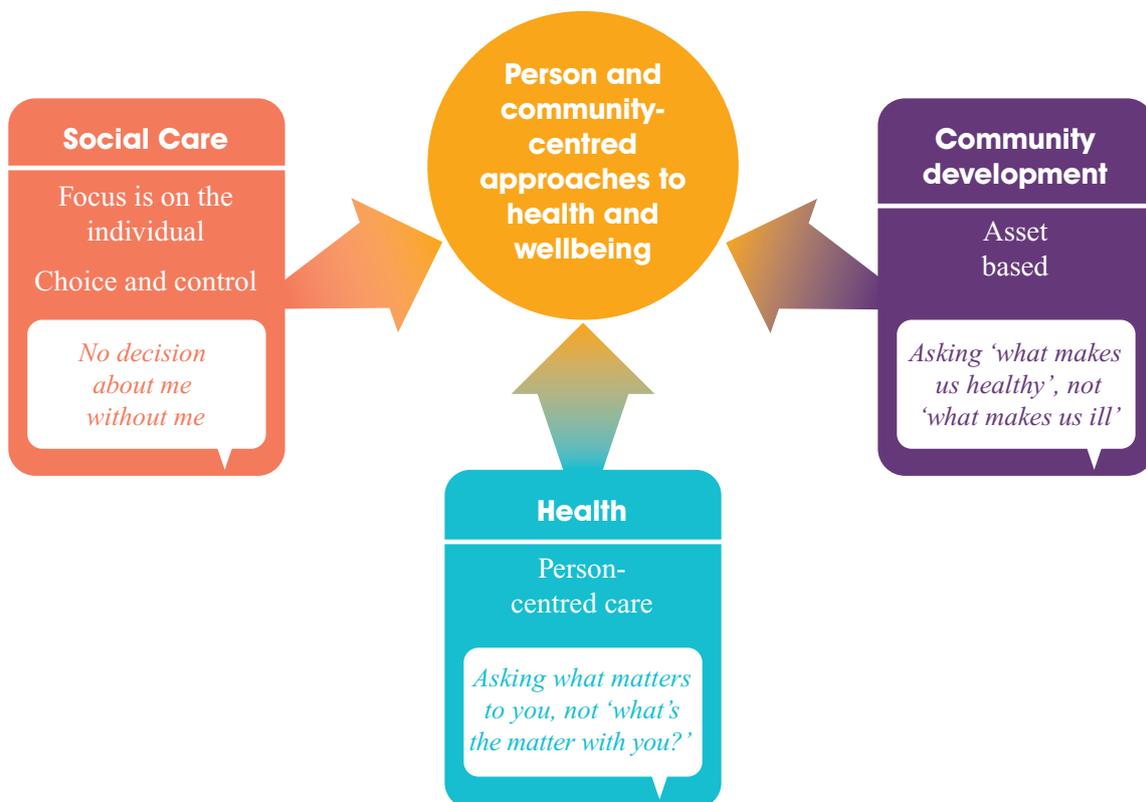
The timeline shows some key points in the development of person- and community-centred approaches for health and wellbeing, with a particular focus on the ‘crossing points’ between health, social care and wider community-centred approaches.



Person- and community-centred approaches for health and wellbeing have developed somewhat independently in the NHS, in social care and in the field of community development, but with clear influences on each other. While they often use different language, and the specific interventions and approaches can vary, there are equally many similarities, particularly in relation to the goals they are seeking to achieve. They could therefore be understood as ‘tributaries’, starting from different places but now converging into a common pool of approaches, all of which put people and communities at the centre:

- Within **health care**, the implementation of person (or patient) centred care<sup>17</sup> has focused on supporting and empowering individual patients to make decisions about and to manage their own health and care. Person-centred care has traditionally been service-led but more recently has focused on approaches that can happen outside of formal health settings.
- Within **social care**, these approaches are considered part of the ‘personalisation’ agenda and generally focus on enabling individuals to have greater choice and control over their life and the services they receive. A key element of this has been expanding the use of personal budgets.<sup>18</sup>
- Community-centred approaches\* have their roots in the field of **community development**, community engagement or other participatory methods of community building. These approaches often focus on informal group-based activities. There is a growing interest in this field to demonstrate its potential to contribute to improving health and wellbeing and reducing health inequalities.<sup>19</sup>

Figure 5: ‘Tributaries’ to person- and community-centred approaches



A diagram showing the development of person- and community-centred approaches in health, social care and community development fields.

\*We use the NICE definition of ‘community’: an umbrella term to cover groups of people sharing a common characteristic or affinity such as living in a neighbourhood, or being in a specific population groups, or sharing a common faith or set of experiences. NICE (2014) Community engagement to improve health.

Finding a way to work across these three tributaries, without losing their individual value, is a key challenge. The traditional boundaries between these approaches can get in the way of attempts to achieve greater integration; or the desire of frontline staff to provide joined up and holistic services for individuals. Two key factors underpin all three approaches and provide a basis for bringing them more closely together:

- Recognition of the individual strengths, capabilities and skills that people bring to their interactions with health and care professionals or as part of their community.
- Commitment to collaborative relationships between professionals and service users, patients and carers and between services and communities, often underpinned by the principles of co-production **(see the Appendix for a definition of co-production)**.

## CHAPTER 4

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# An overview of the evidence and the benefits of person- and community-centred approaches

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There is a compelling case that the time has now come for person- and community-centred approaches for health and wellbeing. The drive for services to do more to empower individuals and communities is growing. This is coupled with the increasing body of evidence from research and practice that these approaches can improve outcomes. We see the significant potential for person- and community-centred approaches to improve outcomes for individuals and communities - as well as to ensure better value for the significant investment of public money in health and social care services.

Yet, despite many good examples of person- and community-centred approaches being implemented in frontline practice, it is still far from being ‘the way we do things’ within health and care services.<sup>20, 21</sup> Too often these approaches are limited to committed teams or individuals, the so-called ‘innovators’ and ‘early adopters’. For example, despite policy commitments on care planning, only about 5 per cent of eligible people with long-term conditions report that they have a care plan, and more than one in four of these people said they were not involved in the development of the care plan.<sup>22</sup>

To realise the vision of truly person- and community-centred approaches for health and wellbeing, the challenge now is twofold: to be more precise about what works in what circumstances and to better understand how to embed and scale the most effective and appropriate approaches.

## Overview of the evidence

As this report outlines, there is a large and diverse range of approaches to supporting individuals to be active partners in their own health and care, and to supporting and developing resilient communities that can help maintain and improve health and wellbeing. Unsurprisingly, this means that there is an equally broad and diverse range of evidence, from a range of sources including research trials and evaluations of programmes, as well as qualitative evidence and stories from patients, professionals and service managers.

As part of Realising the Value, the Institute of Health & Society at Newcastle University conducted a scoping review of a wide range of person- and community-centred approaches for health and wellbeing (**Annex 1**). This review drew on systematic reviews of the evidence across a wide range of interventions and approaches with a view to identifying promising approaches for the economic modelling, and to help choose the Realising the Value five focus areas. It has also provided helpful further insights into the evidence base overall and for the Realising the Value focus areas in particular. For this report, we have also drawn on a wide range of other sources from the formal research evidence, as well as evidence from evaluations of programmes seeking to embed these approaches in practice and policy reports and publications which provide further analysis and insight into the impact and potential of different approaches.

Our overall assessment is that:

**The evidence base is still emerging.** While some aspects of person- and community-centred approaches for health and wellbeing are rich in evidence, in other areas the evidence is mixed or inconclusive. There are also many gaps in the research: questions that have not been asked or addressed fully. Although there have been a number of programmes, research and policy documents seeking to demonstrate the potential of person- and community-centred approaches, there is still much we do not know.

**The evidence base is complex and disparate.** As more organisations and areas adopt these approaches there is an increasing range of evidence – from formal research but also learning from implementation – which makes it difficult to bring together in a way that makes sense and can be used by policymakers, commissioners and others. It can be difficult to know where to start or what approaches are likely to best meet the needs of people and communities.

Despite the limitations of the current evidence base, a wide range of person- and community-centred approaches have been shown to lead to positive outcomes, and there is increasing work to develop the evidence base in these areas. While we should continue to strive to improve the evidence of the impact of these approaches, we believe a compelling case has been made to adopt and implement them now.

## BOX 2 • Improving the evidence base for person- and community-centred approaches

There are three key areas where we think more can be done to improve the research, implementation and evaluation of person- and community-centred approaches:

- 1. Developing the right measures:** Measurement is a key challenge in both research and practice for person- and community-centred approaches.<sup>23</sup> Research studies often create bespoke measurement tools for specific interventions or studies which are not necessarily relevant for real-life implementation and make it difficult to compare outcomes across a range of studies. Building a combination of bespoke and standardised measures into future research design would be hugely valuable.
- 2. Understanding context:** Context<sup>24, 25</sup> affects whether and how person- and community-centred approaches are implemented, and whether they are successful. Even with seemingly simple interventions that have been proven to work elsewhere, the power dynamics and culture in organisations or settings can make achieving the desired outcomes much more complex.<sup>26</sup>
- 3. Navigating system levers (such as legislation and regulation, incentive and workforce education):** A better understanding of the impact of system levers on the adoption and spread of person- and community-centred approaches for health and wellbeing will help policymakers to explore how they can best support the adoption and spread of these approaches.

## The benefits of person- and community-centred approaches

There is a growing body of evidence from research and practice to demonstrate the benefits of person- and community-centred approaches, across the three dimensions of value.<sup>27</sup>

- **Mental and physical health and wellbeing:** Person- and community-centred approaches have been shown to increase people's self-efficacy and confidence to manage their health and care, improve health outcomes and experience, to reduce social isolation and loneliness, and build community capacity and resilience, among other outcomes.

- **NHS sustainability:** These approaches can impact how people use health and care services – and in particular can lead to reduced demand on services, particularly emergency admissions and A&E visits.
- **Wider social outcomes:** Person- and community-centred approaches can lead to a wide range of social outcomes, from improving employment prospects and school attendance to increasing volunteering. They also can potentially contribute to reducing health inequalities for individuals and communities.

Across the three dimensions of value above, the most consistently reported positive outcomes relate to improvements in mental and physical health and wellbeing, although the ways in which these approaches can improve health and wellbeing for individuals are varied and can be condition or intervention specific.

Cost-effectiveness of interventions is much less reported in the formal research evidence although there is good evidence about the positive impact of self-management support on reducing use of health care resources, particularly acute services and and some emerging evidence from research and practice for peer support and health coaching.

In terms of NHS sustainability, a number of organisations have sought to quantify the potential global impact of patient and community empowerment. For example, Reform<sup>28</sup> estimates stronger patient engagement, including more self-care, improved public health and greater patient contribution to their care, could save £2 billion, nearly 10 per cent of the NHS England target saving. Monitor<sup>29</sup> has estimated that teaching people with long-term conditions to manage their own care could save between £0.2 billion and £0.4 billion. Nesta<sup>30</sup> has estimated over £4.4 billion a year could be saved if the NHS adopted innovations that involve patients, their families and communities more directly in the management of long term health conditions.

Looking more widely, methodologies, such as social return on investment, suggest that for every £1 a local authority invests in community development activity, £15 of value is created.<sup>31</sup> And the value of voluntary activity in the UK has been estimated at £23.9 billion,<sup>32</sup> with a financial value of potentially £700k in an acute Trust.<sup>33</sup>

The savings suggested in these reports are illustrative only, and there are important caveats to their use,\* but such attempts can help to focus attention on person- and community-centred approaches.

There is also emerging evidence and theories of change which suggest that many person- and community-centred approaches for health and wellbeing can contribute to improvements in wider social outcomes, both for individuals themselves (increased employment or education prospects, greater social connections) but also wider community and societal benefits (more volunteering, stronger, more resilient and more connected communities).<sup>34, 35</sup>

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\*They may be based upon a small number of studies and may under-account for broader economic costs (and benefits) or of cumulating benefits from different approaches which may lead to double/multiple counting of the same saving. These global figures also do not factor in that these are complex social interventions being introduced into a complex environment of existing systems and practices; the local context for the intervention, with differential cost-benefit starting points, is therefore likely to lead to differential cost-benefit outcomes.

## CHAPTER 5

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# Realising the Value five focus areas

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The Realising the Value programme has identified five focus areas for the next phases of work.

Together, these five areas demonstrate a commitment to the principles of person- and community-centred approaches for health and wellbeing and show significant potential to enhance the quality of life of people living with long-term conditions and deliver benefits across the three dimensions of value:

- **Peer support**
- **Self-management education**
- **Health coaching**
- **Group activities to support health and wellbeing**
- **Asset-based approaches in a health and wellbeing context**

In choosing the five focus areas, we were interested in interventions which were promising based on evidence from a range of sources. We also wanted to ensure we had a spread of approaches from those which are typically service-led to those which are family-rooted within communities. To achieve this balance we used a process called Multi-Criteria Decision Analysis (see **Box 3**).

Self-management education and peer support have (relatively) strong evidence, in the context of an immature evidence base. The evidence review undertaken by Newcastle University, one of the Realising the Value partners, found that the evidence beyond these two interventions was mixed and included significant gaps. Therefore, the remaining three focus areas were chosen by a combination of: relative strength of academic evidence (where available); strength of practice-based evidence; and balance across the types of interventions included (to ensure, for example, that community-based interventions were included).

We recognise that there are overlaps between these five focus areas, and across the broader spectrum of person- and community-centred approaches. Even when speaking about a seemingly discrete intervention, the boundaries are not always clear-cut. We will seek throughout the programme to better understand the connections between different approaches and how they can work together to achieve maximum impact. For example, a programme of self-management education may involve elements of peer support and health coaching as well as education or information provision.

For the remainder of Realising the Value, we will be working with one site in each of the five exemplar areas, as well as with wider communities of interest in the five areas. See Chapter 6 for more information on how we will work with the sites and what tools and resources the programme will produce.

### BOX 3 • How we chose the five focus areas

Realising the Value aims to identify approaches which show promise to increase value across three domains: mental and physical health and wellbeing, NHS sustainability and wider social value. We are also interested in approaches from across the broad field of person- and community-centred approaches for health and wellbeing, not just those led by health or care services. This informed our approach to selection and the criteria we developed.

We used a Multi-Criteria Decision Analysis (MCDA) process. This method involves key stakeholders in agreeing objectives and criteria, as well as assessing trade-offs between different choices. This type of active consensus-building was used to help to define scope.

The Realising the Value MCDA process was designed to prioritise approaches based on the research evidence combined with wider practice-based evidence and the broader definition of value used by the programme.

The process was informed by:

**A scoping review (Annex 1) of the evidence** across the field of person- and community-centred approaches for health and wellbeing, undertaken by the Institute for Health & Society at Newcastle University. The team of health economists carried out a search of global academic health literature, focusing on evidence of the highest quality (randomised control trials and systematic reviews) and resulting in over 500 evidence sources being identified.

An **open consultation** to identify a long list of approaches and grey literature to support these approaches.

A number of meetings with a group of **expert stakeholders** including the Realising the Value consortium and advisory group members and a number of other individuals with expertise in the area.

The rest of this chapter provides more detail on these five focus areas, including what the evidence tells us about their potential impact.

## 1. Peer support

### What is peer support?

Peer support in health and care encompasses a range of approaches through which people with similar long-term conditions or health experiences support each other in order to better understand the condition and aid recovery or self-management. It can be delivered on a one-to-one basis, which may be in person or through telephone support, or through a peer support group. Peer support is largely provided on a voluntary basis, although in some instances people are paid for being peer supporters.

One-to-one support approaches include peer listening, to enable someone to talk through current concerns and offer support and encouragement, and peer mentoring, where the mentor is a positive role model, actively helping the mentee to progress along a self-management or recovery path. Groups have traditionally been in the format of regular face-to-face meetings, although there are now also growing numbers of online peer-to-peer forums, such as Big White Wall.<sup>36</sup>

Peer support can be offered across a wide range of, usually long-term conditions. The largest body of research relates to peer support for people with mental health conditions and diabetes.<sup>37, 38, 39</sup>

### Key components of peer support

Whether one-to-one or in a group, the essential components of peer support include:

- Co-production of support between people who share a similar condition.
- Support provided by those who have experience of living with the condition, not by health professionals.
- The content of peer support sessions being largely determined by the participants.
- Being asset-based – recognising people's resources and potential.
- The sharing of experience and reciprocity between people as equals.
- Working towards wellbeing and recovery.

Peer support may be a component within other forms of self-management support. For example, it may have an educational component to be delivered alongside more general peer support, or, within a health coaching frame, it may focus on helping people to identify what they want to achieve and to reach goals through manageable steps.

### The benefits of peer support

Peer support has been shown to lead to significant improvements<sup>40</sup> for people with long-term physical and mental health conditions across a range of health and wellbeing outcomes including:

- Individuals' knowledge, skills and confidence to manage their health and care ('patient activation').
- Physical functioning and ability to self-care.
- Quality of life.
- Social functioning and perceived support.

#### KEY BENEFITS

Peer support has the potential to improve a range of wellbeing outcomes, including patient activation, physical functioning, quality of life and social functioning.

Some of the benefits of peer support appear to be dependent on health condition. In mental health, outcomes such as empowerment, recovery and hopefulness were improved significantly as a result of peer support. In diabetes, peer support led to significant improvements in depression, knowledge of their disease and biomedical outcomes, particularly blood glucose levels, weight loss and improved cholesterol.<sup>41</sup> A number of studies have shown that peer support for people with serious mental illness led to increased activation (knowledge, skills and confidence, alongside improvements in physical health-related quality of life, physical activity and medication adherence among the participants).<sup>42</sup>

The reciprocity of peer support is a key benefit. The act of helping someone else as a way of paying back for help previously received can be a deeply rewarding and therapeutic experience in its own right. For example, peer support workers in mental health often experience an increased ability to cope with their own mental health issues. Studies of peer support in diabetes have found that the volunteer supporters are less likely to experience depression, have heightened self-esteem and self-efficacy and improved quality of life, even after adjusting for baseline health status and socio-economic status. As in mental health, by providing support to others, peer supporters with diabetes seem to have improved health behaviours themselves.<sup>43</sup>

Equally, receiving care and treatment from someone who is on their own journey of recovery can be comforting.<sup>44</sup> A key benefit for people receiving peer support is the greater perceived empathy and respect gained through support from a peer. Peer supporters report benefits for themselves of increased self-esteem, confidence and positive feelings that they are doing good to others. It can help people feel more knowledgeable, confident and happy, and less isolated and alone.

The evidence base is still developing and, in particular, is mixed on outcomes such as impact on hospital admissions and readmissions, and whether peer support reduces length of stay. There is also little research that adequately assesses cost effectiveness. However, there are some examples from practice, such as a project in Nottingham which employed eight peer support workers who supported 247 inpatient and community clients in mental health services to contributing to a 14 per cent reduction in inpatient stays among the people they supported, saving around £260,000.<sup>45</sup>

### Making it work

Peer support is likely to be most effective for improving health outcomes when delivered one-to-one or in groups of more than ten people, and most effective for improving health outcomes when it is based around specific activities (such as exercise or choirs) and focuses on education, social support and physical support.<sup>46</sup>

From the evidence base, there are many practical challenges that need to be considered when developing a peer support service, for example:

- Careful training, supervision and management of all involved, with sufficient organisational support for the programme – peer support is not ‘free’.
- Discussion with peer supporters on the amount of time they are able to commit, their own interests, and feasible numbers of people they are able to provide support for.
- Regular opportunities for peer supporters to share experiences, solve problems, provide mutual support and receive additional training as well as ongoing and visible recognition for their efforts.

- Due to the nature of having a long-term condition, peer group members may have difficulties attending regular face-to-face meetings, therefore groups work well when they are not time-limited or tied to the delivery of particular training content, but can offer a mechanism for responsive, sustained support.
- When peer-support groups include a self-management education component, it is important that the content is delivered flexibly as issues arise for people in the group, so they apply newly acquired knowledge to their own lifestyles and exchange information and experiences, enabling participants to learn from each other.
- The employment of peer-support workers needs careful handling when there are paid and volunteer peer supporters, so that volunteers do not feel ‘hard done by’.

#### **BOX 4 • Peer support in practice: Lambeth Living Well Collaborative**

The Lambeth Living Well Collaborative, established in 2010, is a platform of partners who have come together to radically improve the outcomes experienced by people with severe and enduring mental health problems. The Collaborative is made up of people who use services, carers, commissioners across NHS Lambeth Clinical Commissioning Group and Lambeth Council, voluntary and community sector, secondary care and primary care. Lambeth was also one of six teams supported as part of Nesta’s People Powered Health programme.

Overall, the joint aim of the collaborative is to enable people in Lambeth to achieve the following ‘Big Three’ outcomes.

- **Recover & Stay Well:** experience improved physical and mental health
- **Choose:** experience increased self-determination and autonomy
- **Participate:** be part of daily life on an equal footing with others - to ‘connect’, ‘give’ and ‘be included’.

Peer support plays a key role across the collaborative which supports a whole range of organisations that have peer-support initiatives. These include Mosaic Clubhouse, Thames Reach, Certitude, Look Ahead, Mind, South London and Maudlsey NHS Foundation Trust (SLaM).

This joined-up approach has resulted in a significant reduction in referrals to secondary care since November 2013 – a reduction of about 50 per cent per month. Over 60 per cent of people who have been supported were previously not known to secondary care services. Over 500 people have been supported within the Community Options Team and Primary Care Support Service. Over 600 contacts have been made with Solidarity in a Crisis, an out of hours Peer Support Service; over 550 people have accessed Connect and Do, an initiative that focuses on building people’s confidence and reduces social isolation, and 110 people have taken up Personal Budgets.

## 2. Self-management education

### What is self-management education?

Self-management education includes any form of formal education or training for people with long-term conditions which focuses on helping people to develop the knowledge, skills and confidence to effectively manage their own health and care. The content of self-management education varies depending on the nature of the people taking part and, often, on their condition and their information and support needs.

Self-management education is a core component of many wider self-management programmes. Of the studies reviewed by Newcastle University (**Annex 2**), almost half of all studies on diabetes self-management included an educational component. Education was the main focus of 93 per cent of asthma self-management studies, 86 per cent of cardiovascular disease (CVD) studies and 96 per cent of chronic obstructive pulmonary disease (COPD) studies, although it was less common in other areas such as arthritis.

Self-management education can be delivered in different ways; it may be face-to-face or online; one-to-one or in groups. Structured group education can be generic (i.e. for people regardless of their long-term condition) or specific to a particular condition or group (e.g. group education for school children with asthma or structured education for people with Type 2 diabetes). Resources such as leaflets, booklets, guidebooks, CDs and videos are sometimes provided as part of self-management education but this tends to vary by specialty, being common in cardio vascular disease and less common in mental health, for example.

### Key components of self-management education

The diversity of approaches, methods, tools and techniques used to implement self-management support, including education, can make it difficult to distil a standard set of core components. Support for people to self-manage is most effective when it is focused on helping people to change their behaviour by developing their knowledge, skills, and confidence in their ability to manage conditions, as opposed to simply providing information.<sup>47</sup>

Figure 6: Continuum strategies to support self-management

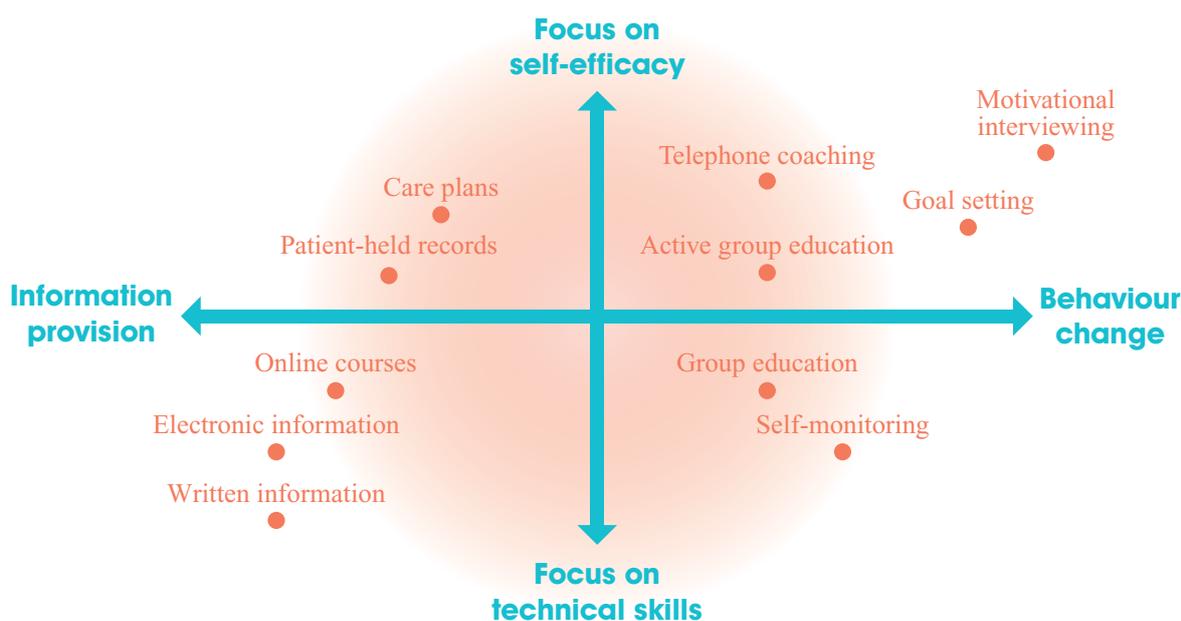


Diagram showing the range and spread of strategies that can be used to support self-management and their different areas of focus

Source: The Health Foundation (2011) *Evidence: Helping people help themselves. A review of the evidence considering whether it is worth while to support self-management.*

## The benefits of self-management education

The benefits of self-management interventions are wide ranging. There is good evidence that supporting people with long-term conditions to self-manage their health and care can lead to significant improvements in:

- Health outcomes (including self-efficacy, activation, knowledge of their condition; self-rated health).
- Clinical or biomedical outcomes including blood pressure and cholesterol across a range of conditions and HbA1c in diabetes.
- Social outcomes including improved communication and relationships.

### KEY BENEFITS

Supporting people with long-term conditions to self-manage their health and care can lead to significant improvements in their health, as well as wider outcomes like improved communication and relationships.

A systematic review of self-management education trials, for example, found that people with diabetes who participated in self-management education had improved glycaemic control and lower blood pressure and people with asthma had fewer attacks after attending a self-management course.<sup>48</sup>

There is good evidence from the UK and internationally that self-management support interventions can significantly reduce demand on acute services, including A&E visits, unplanned hospital admissions and readmissions.<sup>49</sup> The evidence on the impact of self-management on the use of other health care services and on costs overall is much more mixed.

On the one hand, there is good evidence that self-management support can reduce health care utilisation, including the use of emergency services, and can lead to people being more likely to stick to treatment plans and to take their medications as prescribed.<sup>50</sup> For example, a review of asthma self-management found interventions led to successful reductions in health care use.<sup>51</sup> Within the UK, studies have shown this approach had significantly reduced the rate of hospital admissions and readmissions, in specialties including diabetes, COPD, asthma and cardiology.<sup>52</sup> On the other hand, some research and programmes have shown that self-management programmes may lead to people engaging more frequently with primary care (for example, seeing their GP or practice nurse).<sup>53</sup> One reason for this mixed evidence may be poor reporting of outcomes on health care utilisation and costs.<sup>54</sup> In addition, it can be difficult to track the impact of an intervention across the health care system as a whole.

However, there are also some promising emerging findings from evaluations of self-management support programmes which show the potential of these approaches to reduce demand on services and to reduce costs. A six month longitudinal survey study of almost 1000 people taking part in the Expert Patient Programme found that participation in the programme led to significant decreases in the use of a range of health services including GP consultations, outpatient appointments, visits to A&E departments and use of physiotherapy. A randomised controlled trial of the same programme found that people who got immediate access to a course reported ‘considerably greater health related quality of life’ and concluded that the Expert Patient Programme was likely to be cost effective.<sup>55</sup>

There is some evidence that disease specific self-management education programmes may be more effective than generic courses, in terms of changing resource use, such as reducing the number of hospital admissions or unscheduled appointments with doctors, as well as reducing the number of days people have away from work or school, particularly for people with asthma.<sup>56</sup>

## Making it work

Self-management education programmes are most successful when they are part of a wider programme to embed self-management or person-centred care. This includes ensuring staff have the knowledge, skills and confidence to support people to self-manage, and that an organisation's wider systems and processes facilitate self-management such as enabling people to see their medical records or get test results in advance of consultations.

There are a number of additional factors which are likely to make this approach more effective:

- A focus on enhancing people's confidence and motivation as well as giving them relevant knowledge and skills.
- Programmes being organisationally integrated so that staff are able to easily access educational materials or refer someone to other support services or self-management courses.
- Flexible enough to meet people's diverse needs.
- Providing opportunities for social interaction and peer support.
- Tailoring self-management support approaches to people's circumstances (e.g. their condition, life circumstances including ethnicity and their readiness and ability to be involved in their care).
- Staff training should involve whole teams and a clear message to create common understanding.<sup>57</sup>

As with many person- and community-centred approaches for health and wellbeing, there remains a gap in the evidence about which types of self-management support, including education, work for which groups and in what circumstances. This can make it difficult for commissioners and others to know which particular approaches they should be implementing. For example, 87 per cent of the studies of self-management education reviewed by Newcastle University did not report whether the self-management intervention studied was lay or professionally led. Where studies reported that they covered face-to-face self-management education programmes, many did not report whether these were 1:1 or group based.<sup>58</sup>

### BOX 5 • Self-management education in practice: Education to live well with type 1 diabetes

DAFNE (Dose Adjustment for Normal Eating) is a structured education patient programme in intensive insulin therapy and self-management. People with type 1 diabetes are taught to match their insulin dose to their chosen food intake on a meal-by meal-basis.

DAFNE provides 38 hours of structured group education and is delivered by specially-trained diabetes nurses and dietitians, to groups of between six and eight over a consecutive five-day period, or one day per week over a five-week period on an outpatient basis.

A full economic evaluation of the DAFNE programme was published in 2004 and considered by NICE as part of the development of guidance on the use of patient education models for diabetes. The potential efficiency savings from DAFNE are estimated at £48 million per year nationally, or £93,133 per 100,000 population, as a result of reduced complications.

“*My bottom line in life is to function and DAFNE gives me that ability. For me, it is not a diabetic treatment initiative, it is my life. It informs my hourly, daily, weekly, monthly, yearly decisions; continually improving my health and my contribution to life. I have lost weight and vastly improved my blood glucose control. Together, DAFNE and I are delivering the best results in diabetic care I've experienced in 25 years.*”

### 3. Health-coaching

#### What is health coaching?

Health coaching is a form of coaching that aims to help people to set goals and take actions to improve their health or lifestyle and can be described as: ‘Unlocking a person’s potential to maximise their own performance (..) helping them to learn rather than teaching them’.<sup>59</sup>

A systematic review of coaching in health care defined health coaching as: “... a patient-centred approach wherein patients at least partially determine their goals, use self-discovery or active learning processes together with content education to work towards their goals, and self-monitor behaviours to increase accountability, all within the context of an interpersonal relationship with a coach. The approach depends on a one-to-one relationship with a coach. The coach is generally a health care professional\* trained in behaviour change theory, motivational strategies, and communication techniques, which are used to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and wellbeing.”<sup>60</sup>

Health coaching was largely developed in the US to support people with alcohol and substance addictions. In recent years it has spread to other countries, including the UK, and has been used to support people with a range of long-term conditions and other health or lifestyle needs.

#### Key components of health coaching

While health coaching can take many forms, there are a number of common characteristics<sup>61</sup> across the different methods and approaches. These include:

- Empowering people to take ownership and responsibility for their health.
- A focus on an individual’s goals rather than what professionals think they should do.
- An equal and collaborative relationship between the individual and the coach.
- Asset-based – recognising people’s resources and potential and ability to change.
- Focus on helping people to assess where they are now and where they want to get to rather than exploring the past or historical reasons for present-day issues.
- Helping people plan and break down their goals into manageable steps.
- Helping the individual find the solutions and way forward regarding their issues; the individual is the expert on their life.
- Challenging habits, behaviours and limiting beliefs.

There are some overlaps with other person-centred care approaches, for example a focus on setting goals in personalised care and support planning. However, a key distinction between health coaching and some other approaches, such as self-management education, is that the health coach is not there to teach, advise or counsel but, rather, to support people to find the answers themselves and plan and achieve their goals.<sup>62</sup>

Health coaching can be done on a one-to-one basis, in pairs or in small groups.\*\* It is usually a separate intervention but there are a number of programmes where health care professionals are being trained in health coaching to support routine consultations with patients. Health coaching can be in person or – for individual coaching at least – by telephone.

\*Although health coaches do not need to be health professionals and can be drawn from a wide range of backgrounds and professions.

\*\*ICF recognises group coaching for groups of 15 or less. Any more than that, it can become more like a training programme.

## The benefits of health coaching

“Coaching encouraged me to consider where I wanted to be and how I could get there. It enabled me to take back control.”

Former client of a health coach.

Health coaching can help to improve people’s motivation to self-manage or to change certain behaviours<sup>63</sup> and the internal thinking/feeling processes which underpin them. It can also increase confidence in their ability to do this.

Health coaching interventions have been shown to increase participants’ activation (knowledge, skills and confidence to manage their health and care). A study of over 2,000 patients with a range of long-term conditions - asthma, diabetes, coronary heart disease and chronic obstructive pulmonary disease (COPD) - who received health coaching showed increases in activation using the patient activation measure,<sup>64</sup> as did a telephone health coaching intervention with ‘a high risk population’, comprising individuals with existing conditions such as depression, congestive heart failure, diabetes, hypertension, asthma and low back pain.<sup>65</sup>

### KEY BENEFITS

Health coaching can help to improve people’s motivation to self-manage or to change certain behaviours, as well as supporting people to adopt healthy behaviours and make different lifestyle choices.

Health coaching can also support people to adopt healthy behaviours<sup>66</sup> and make different lifestyle choices. There is also some evidence that health coaching can lead to improvements in health or clinical outcomes such as cholesterol levels, blood pressure, increased effectiveness in pain management or increased weight loss, although the research evidence is mixed. This may be because the studies that looked at this were too small or over too short a time frame to allow the impact on clinical outcomes to be assessed.<sup>67</sup>

A report looking at the evidence around health coaching found that the quality of studies exploring the costs or cost-effectiveness of health coaching is widely variable, but some randomised trials are available, and non-randomised studies have also suggested a trend towards reduced costs, and reduced service use (for example reduction in hospital admissions) from health coaching.<sup>68</sup>

## Making it work

Some form of education or training is essential for health coaches although there is no set training or agreed core competencies. Ideally training should be adapted to the needs of the group. The appropriate length of training will depend on the purpose and goals of using coaching and whether coaches will be incorporating skills into existing consultations or undertaking 1:1 coaching on an ongoing basis, although two days is seen as the minimum for basic health coaching training. Other factors in successful health coaching training include opportunities to practice skills such as role play and some form of ongoing support and refresher training for coaches.<sup>69</sup>

A wide range of people can be health coaches. While health coaches are often health care professionals, they don't need to be. In recent years there have been more initiatives training lay people as coaches to work with people with the same or similar medical conditions. Other initiatives train GPs or practice nurses in health coaching with a view to them using the techniques and tools, such as motivational interviewing, either as part of separate coaching sessions, or within routine consultations with individual patients.

The evidence suggests that health coaching may be more successful where:<sup>70</sup>

- Coaches are recruited for their commitment and motivation.
- Attention is paid to the practical and emotional support needs of coaches.
- The organisational context or culture is receptive.

### BOX 6 • Health coaching in practice: Being Well, Salford

Health coaching is a core component of Being Well Salford, a service commissioned by Salford City Council and managed by Big Life Centres. The focus is on enabling participants to improve their lives.

The service is delivered in partnership with seven other VCSE organisations in Salford; Social Adventures, Unlimited Potential, Langworthy Cornerstone, Salford Community Leisure, YMCA and People's Voice Media. Being Well is the Realising the Value partner site for health coaching.

Supported by coaches, participants take control and rethink how they can make their own positive changes to their lives. The service is offered to people who want to make changes to two or more of the following areas in their life: weight, smoking, alcohol, physical activity, low mood or depression.

Participants can be with the service for up to 12 months and are then contacted to see how they are doing with the changes that they have made. On leaving the service;

- 48 per cent of smokers had quit smoking.
- 70 per cent had increased their self-efficacy significantly.
- 21 per cent reduced their weight more than 5 per cent.
- 88 per cent of participants had adopted at least three behaviour change goals within six months.
- 93 per cent said they have increased awareness of opportunities and services.

*“I felt listened to, and no other service has ever fulfilled this for me. You helped me identify the reasons behind my actions and why I felt fed up and low. I now feel more positive about my ability to do things and I am thankful that I have done this.”*

## 4. Group activities to support health and wellbeing

### What do we mean by group activities to support health and wellbeing?

There is a wide range of group activities that can be beneficial to support health and wellbeing; from exercise classes, to cookery clubs, community choirs, walking groups and gardening projects.

These can help for many different people in the community; including parents with young children, older people, people with mild to moderate depression and those who are socially isolated. Many group activities promoted through health and social care organisations may be focused on an aspect of healthy living in order to also increase physical health. These activities can include a cookery class which encourages healthy diet, a wide range of exercise classes targeted to meet the needs of those who are less likely to join local leisure centre classes, or activities which involve physical activity, such as gardening groups in parks or public spaces.

### The benefits of group activities

There is a lack of systematic or review-level academic evidence about group activities, which is a common issue for many community-centred approaches for health and wellbeing.

The broader evidence base, which includes programme evaluations and observational studies, has shown that overall group activities can contribute to wellbeing, feelings of social inclusion and that healthy activities can be influential in changing behaviour to benefit individual health.

People report increased feelings of wellbeing from taking part in group activities, particularly when they have little other access to social events or groups with a focus of shared interest.<sup>71</sup>

It also seems that being involved in group interaction with others with a shared interest can aid feelings of wellbeing. As well as having a positive benefit for individuals, group activities can also contribute to strengthening the community itself.

Some examples of positive impacts of group activities include:

- Depression and social isolation affect one in seven people over 65 and there is increasing recognition that social isolation adversely affects long-term health. Research indicates that interventions which promote active social contact, encourage creativity, and use mentoring, are more likely to positively affect health and wellbeing.<sup>72</sup>
- There are health and wellbeing benefits of ‘civic environmentalism’, such as belonging to a ‘friends of parks’ group. Belonging to such a group exposes people to the benefits of the natural environment, to other people and to opportunities to make a contribution which is socially valued. There appears to be potential for the use of civic environmentalism to promote health, wellbeing and social connectedness, including for groups with identified health vulnerabilities.<sup>73</sup>

#### KEY BENEFITS

Group activities can contribute to wellbeing, feelings of social inclusion, and healthy activities can be influential in changing behaviour to benefit individual health.

- A study with socially isolated older people reported improvements in alertness, self-worth, optimism about life and positive changes in health behaviour from a range of group social activities.<sup>74</sup>
- The evidence for the benefit of diet and cookery-related activities is, to date, fairly limited, but there are exploratory studies which indicate that this can be an effective means of engaging people.

### Making it work

From the existing evidence base, issues relating to access seem especially important to make group-based activity work in practice. In particular, access for people who are not currently availing themselves of opportunities in the community, particularly those who are at risk of social isolation, depression or obesity and are not accessing free or low-cost opportunities for physical activity provided through public leisure, sports and fitness facilities.

Other access issues include overcoming barriers related to transport and venues, and not relying on websites and social media for services for older people.

As health services increasingly recognise the benefits of group activities for health and wellbeing, different mechanisms for referring and connecting individuals with group activities are developing. These range from offering group activities alongside health services (**see Box 7**), through mechanisms such as social prescribing, or through roles such as community navigators or health champions. We do not yet know whether any particular mechanisms are more likely to lead to people engaging in group activities.

Asset-based and other community approaches, which focus on working collaboratively with communities to map assets and develop solutions to community-identified needs, often lead to the establishment of a range of community and group activities. For example, a project based on community organising in Littlehampton led to the development of a range of group activities including a youth club, arts group and community ‘edible garden’.<sup>75</sup>

### **BOX 7 • Group activities in practice: RIPPLE – Respiratory innovation: promoting a positive life experience**

People with Chronic Obstructive Pulmonary Disease (COPD) experience chronic ill health and are at risk of early death. The symptoms of COPD, including breathlessness and coughing, can lead to and amplify anxiety, low self-esteem and social isolation. These in turn lower mental wellbeing and can result in both poor self-management and a lack of engagement with key treatments, such as smoking cessation and pulmonary rehabilitation. People can become trapped in a negative cycle where poor self-management leads to worsening symptoms.

As part of the Health Foundation 2014 Shine Programme, University Hospital Coventry and Warwickshire NHS Trust took a whole systems approach to this challenge. A broad partnership was set up involving local patients and carers, primary and secondary care clinicians, academics, public health professionals, and third sector organisations to discuss and develop innovative solutions to the social isolation and anxiety observed in individuals with COPD.

After consultation with people living with COPD, the partners decided that an informal community-based clinic would act as a catalyst for increased involvement. This evolved into a group model which blended informal clinic and education sessions with social activities such as bingo, quizzes, singing and seated yoga every Monday afternoon in a community centre.

Results included:

- Reduced social isolation and anxiety.
- Increased mental wellbeing.
- Improved confidence in ability to self-manage.

Preliminary evidence - involving a small number of patients - suggests that attending the RIPPLE programme regularly may reduce the number of unplanned hospital admissions. The patients involved in RIPPLE are chronically ill and as such, you would normally expect their condition to deteriorate, leading to an increase rather than a decrease in hospital admissions. The RIPPLE team has secured additional funding through the Health Foundation's Spreading Improvement programme which will allow these findings to be further explored.

*“ Coming here, well, it's given me a social life I didn't have before...I feel like a fraud coming here now because I feel so good. ”*

## 5. Asset-based approaches in a health and wellbeing context

### What are asset-based approaches in a health and wellbeing context?

Asset-based approaches have a different starting point from other traditional approaches in health and care services. The aim of asset-based practice is to promote and strengthen the factors that support good health and wellbeing, protect against poor health and foster communities and networks that sustain health. The vision is to improve people's life chances by focusing on what improves their health and wellbeing and reduces preventable health inequalities.

Fundamentally, they ask the question "*What makes us healthy?*" rather than the deficit-based question "*What makes us ill?*" These approaches are based on creating and sustaining 'health assets'\* and in taking action that is health promoting – that seeks to build on the features that promote and sustain wellbeing. Broadly, asset based approaches are located in the community and neighbourhood, outside the traditional boundaries of health and social care services, to promote good health and wellbeing and strong social connections. An asset-based approach takes account of how people live and how they can be enabled to realise their potential, as individuals and as communities. There is also a strong focus as well on the things that matter to them, in all spheres of life, not just physical and mental health.

In essence, asset-based approaches for health and wellbeing seek to create approaches that are participatory, enabling people to lead action for health, and are underpinned by a focus on what makes us healthy.

Until recently, in England, there has been no high-level commitment to put community involvement at the heart of health policy and practice (these issues have been more prominent in Scottish and Welsh health policy). This has started to change with a number of recent high profile publications<sup>76</sup> building the argument that engaging individuals and their communities in health and wellbeing can contribute to reducing the burden of preventable disease and ease the pressures of increased demand on the health service by developing people's knowledge, skills and confidence to manage their own care.

There is a range of development approaches that are relevant to working with communities for health and wellbeing. For example, asset-based community development (ABCD) is a specific framework used to steer processes for community building. It starts by making visible and explicitly valuing the skills, knowledge, connections and potential in communities and neighbourhoods. Once identified, the process seeks to connect the assets for purposeful community action between residents, local organisations and informal community groups to build strong relationships between people and their reciprocal social networks. The aim is to mobilise local people to act on the things they care about and want to change. In this, the professional community development role is often to support people to recognise and mobilise the assets and resources they have. The asset-based approach places high value on promoting a sense of belonging, a capacity to control and finding meaning and self-worth, not specifically to promote individual wellbeing and health, but rather to connect individuals and enable flourishing communities.

### The benefits of asset-based approaches

As with many community-centred approaches, this is an area where practice on the ground is ahead of the academic research. There is a lack of systematic or review-level academic evidence about asset-based approaches for health and wellbeing.<sup>77</sup> To date, evidence of effectiveness on asset-based approaches in the UK is limited to a few local, emergent solutions within particular contexts, with little practical guidance on how to put them into practice at scale.

The published research demonstrates well-grounded theories around the value of health assets, and growing evidence of how to promote and sustain those assets to benefit individuals, families and communities.<sup>78</sup> The links that connect people within communities provide a source of resilience, access

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\*Assets refers to people, knowledge, skills, motivation and resources.

to support, opportunities for participation and added control over their lives; with these links people are more likely to have a high level of wellbeing and as a result, more positive health outcomes than they would otherwise.<sup>79</sup>

The social networks within communities create ‘social capital’, resources such as support, reciprocity through volunteering networks and links which bridge divides of power, status, knowledge and access. The quality and quantity of complex social relationships with family, friends and social networks have been shown to affect morbidity and mortality. People with stronger social relationships have lower mortality rates than those with poor or inadequate social relationships. These effects are comparable to those of well-established risk factors such as smoking, excessive alcohol consumption, obesity and lack of physical activity.<sup>80</sup>

#### KEY BENEFITS

The published research demonstrates well-grounded theories around the value of health assets, and growing evidence of how to promote and sustain those assets to benefit individuals, families and communities.

#### Making it work

Some asset-based activities have a direct link to health and wellbeing, such as time banking and micro-enterprise schemes which, for example, support older people to continue to live in their own homes through community-based support, such as help with shopping and gardening, befriending, or social activities. Other activities may be about building a strong sense of local identity and pride through projects such as reclaiming disused buildings for community use. Others may mobilise local assets to provide opportunities for small-scale enterprise and job creation. The focus for asset-based approaches can only be decided through deliberative and participatory processes, for example through co-production, which involves local people deciding their priorities for their community.

A theme to emerge from research to date is the potential tension between asset-based approaches and professional identity and ways of working among health care professionals. Published case studies also show that some people struggle with the new model,<sup>81</sup> as it is not the model of care they expect from the health service. This implies that training and support for both professionals and people will be required. In terms of community development approaches such as asset-based community development; we still need to know more about the best models for adoption and scale.

## BOX 8 • Asset-based approaches in practice: Supporting older people to live and thrive at home

The Shine project in Fife, part of a Health Foundation funding programme, took an assets approach to supporting older people to ‘not simply survive but thrive at home’. This involved having open conversations with older people and their carers about personal outcomes, harnessing community resources and developing local ‘microenterprises’ to help achieve those outcomes.

One of the findings of the project team was that co-creating solutions with older people, their families and the wider community can uncover hidden resources to help people remain well at home. The project team found a wealth of enthusiasm and creative solutions from micro and social enterprises, the voluntary sector and the wider community. Conversations with patients proved very fruitful and powerful, and reinforced the need to take this work forward despite its complexity.

The older people taking part were supported to achieve outcomes that mattered to them, many focusing on maintaining or building their independence. Specific outcomes including being able to get out and about independently, to meet new people or socialise with friends and volunteering in the local community. In one case, an occupational therapist worked with a house-bound client to support her to visit the local supermarket and improve her independence which led to an early discharge from a day hospital she was attending.

An external review identified changes in practice for health and care professionals who:

- Demonstrated increased confidence in and an appetite for this way of working.
- Were consistently using their increased knowledge of the range and value of resources within local communities.
- Consistently demonstrated a broader concern for and engagement with outcomes that were important to their client’s quality of life as well as those that they were more familiar with as rehabilitative health care practitioners, such as mobility.

“ I was working with one lady who had been in hospital. I was there to help her with kitchen tasks to ensure she was able to make herself something to eat and drink safely. And through conversation, boiling the kettle, making a cup of tea, she talked about her friends and their support while she’d been in hospital. Sitting safely in the kitchen drinking a cup of tea from a spill-safe beaker on her own really wasn’t what she wanted. She wanted to be able to make a pot of tea and serve it to her friends in her living room. She wanted to reciprocate. It was important for me to support that. We looked at how she would normally do things and together we worked our way through the various obstacles. ”

Summary of the evidence for the five focus areas

Approach	Disease areas	Health and wellbeing	NHS Sustainability	Wider social outcomes
<b>Peer Support</b>	Strongest evidence in mental health and diabetes	Positive outcomes across a range of health and clinical outcomes Often condition specific (eg hopefulness in mental health, blood glucose and weight loss in diabetes) Improves wellbeing of peer supporters Sometimes found to increase knowledge, skills and confidence (activation)	Mixed results on outcomes such as hospital admissions/readmissions/length of stay Little evidence of cost effectiveness	Wider benefits for peer supporters as well as those supported
<b>Self-management education</b>	Shown to be effective for a wide range of long-term conditions  Benefits have been found from both condition-specific and more generic education	Good evidence across a range of health outcomes: <ul style="list-style-type: none"> <li>• Self-efficacy</li> <li>• Knowledge of condition</li> <li>• Activation</li> <li>• Clinical/biomedical outcomes including blood pressure and cholesterol across a number of conditions</li> </ul>	Good evidence that it can significantly reduce the use of A&E and unplanned admissions/readmissions  Evidence of impact on wider health care services is mixed	Little robust evidence about wider impacts but can have broader benefits when implemented as part of a multi-component programme
<b>Health coaching</b>	Shown to lead to positive outcomes across a range of long-term conditions including mental health Can also be used for people seeking to improve healthy behaviours or with short-term need (eg pregnancy)	Can support people to adopt healthy behaviours and make different lifestyle choices Mixed evidence but can lead to improvements in cholesterol, blood pressure, better pain management and weight loss	Insufficient evidence but some studies have suggested a trend to reduced costs and service use	There are a small number of studies focused on volunteer health coaches which suggests wider benefits for the coaches themselves but, on the whole, little evidence
<b>Group activities for health and wellbeing</b>	Usually not focused on single diseases Often target people who are at risk of social isolation, including older people Many studies include group activities as part of another intervention so can be difficult to differentiate the 'group' component from other activities. Apart from a limited number of formal schemes, group activities are rarely formally evaluated unlike other interventions which contributes to the lack of evidence in this area	Evidence limited but shown to lead to improvements in self-worth, optimism and positive changes in healthy behaviour for socially isolated older people  Some studies indicate that participating in healthy group activities (eg exercise, gardening) can influence healthy behaviour change  Group activities are generally well attended/well liked and have high retention rates	Very little research evidence on cost effectiveness	Some studies have shown positive effects of involvement in local community activities in promoting social connectedness  Encouraging participation in community group activities can contribute to strengthening communities as well as benefiting individuals
<b>Asset-based approaches in a health and wellbeing context</b>	Covers extremely wide range of different approaches and activities some targeting individuals (eg befriending schemes), others being more community focused (reclaiming disused buildings or land for community use) or focusing on increasing volunteering (time banking) Difficult to summarise the evidence base	There are strong links between social relationships and reduced mortality and morbidity Asset-based approaches commonly work to increase community and social connectedness  There is good evidence on the theory underpinning assets but not yet the detailed evidence base on the precise outcomes from different asset-based interventions	Very little research evidence on cost effectiveness although some SROI studies of interventions such as timebanking suggest they could be cost effective	Can connect people with communities, build social networks and 'social capital' Reduce social isolation in older people (befriending)



**Good evidence**  
(either empirical or practice)



**Mixed or insufficient evidence**



**Little or no evidence or no evidence found in this review.**

Little evidence for a particular type of outcome may mean there is little research available, rather than that the approach does not work.

**Note:** This is a summary of the evidence for these approaches outlined above. This draws on the formal research evidence (often called empirical evidence) where this is available. As noted in the report, little systematic review level evidence exists for several of these approaches, in particular asset-based approaches and group activities for health and wellbeing. We have also drawn on a wider range of evidence and information including findings from

individual projects and evaluations and social return on investment analyses to try and present a rounded overview of the evidence for these approaches. Little evidence for a particular type of outcome may have more to do with the lack of research that has been undertaken or the variable quality in the design of the studies. It is not necessarily a reflection of the approach itself.

### More resources

On the basis of the responses to two open calls for tools, resources and evidence carried out in the Summer/Autumn 2015 and our ongoing stakeholder engagement, we have brought together a resource centre with practical tools and resources within the five focus areas of Realising the Value on the programme website: **[www.realisingthevalue.org.uk](http://www.realisingthevalue.org.uk)**.

We will continue to add to the resource centre over the course of the programme.

CHAPTER 6

# Conclusions and next steps for the Realising the Value programme

This report will help commissioners and policymakers to understand the range of approaches available, some of the key components and their potential to improve health and wellbeing outcomes, NHS sustainability and social value.

We have demonstrated the growing consensus about the need for health and care services to embrace the benefits of taking more person- and community-centred approaches, and recognised that there are a lot of people who are already working in this way on the ground. We have also set out a broad range of approaches which have demonstrated potential and promise, in relation to the various dimensions of value associated with genuinely putting people and communities at the heart of health and wellbeing.

We have also noted the gaps in the current evidence base. We have found limitations in terms of understanding both the potential impacts of a range of person- and community-centred approaches, and in ‘what works’ in implementing and scaling these approaches. There is a lot we do not know, but we have identified key things that need to be taken into account by those undertaking research or evaluating programmes, as well as by those wanting to interpret the findings of this work.

The Realising the Value programme is designed to make a contribution to addressing these issues – to develop the field of person-centred, community-based approaches to health and wellbeing. Understanding and building the evidence base for these approaches is critical but we also know that it is not, on its own, enough to achieve the change that is needed to make person- and community-centred approaches commonplace within health and care. We will therefore also develop useful tools to enable implementation, specific policy recommendations and a network of local places engaged in this practice.

## BOX 9 • Realising the Value local partner sites

In December 2015, the Realising the Value programme appointed five local partner sites. Each site has a wealth of experience working in one of the five focus areas. We will work closely with these sites to understand their experience of implementing person- and community-centred approaches on the ground, and develop practical tools to support implementation.

The five local partner sites are:

- Peer support: **Positively UK** provides peer-led support, advocacy and information to people living with HIV to manage any aspect of their diagnosis, care and managing life with HIV.
- Self-management education: **Penny Brohn UK** helps people to live well with the impact of cancer. The approach is delivered via day and residential courses and is widely known as the ‘Penny Brohn Whole Person Approach’.
- Health coaching: **Big Life Centres** delivers health coaching to anyone who wishes to make changes to two or more of their lifestyle behaviours; this includes low mood, isolation and anxiety.

- Group activities to promote health and wellbeing: **Creative Minds** is an initiative developed by South West Yorkshire NHS Foundation Trust, offering a range of creative approaches and group activities to help people who use the Trust's services to live well in their communities and reach their potential.
- Asset-based approaches in a health and wellbeing context: **Unlimited Potential** work to deliver, with local people, a range of asset-based approaches in a health and well-being context in Salford, such as 'Salford Dadz' – finding new ways to improve the well-being of fathers experiencing severe and multiple disadvantages.

We aim to do this in a number of ways:

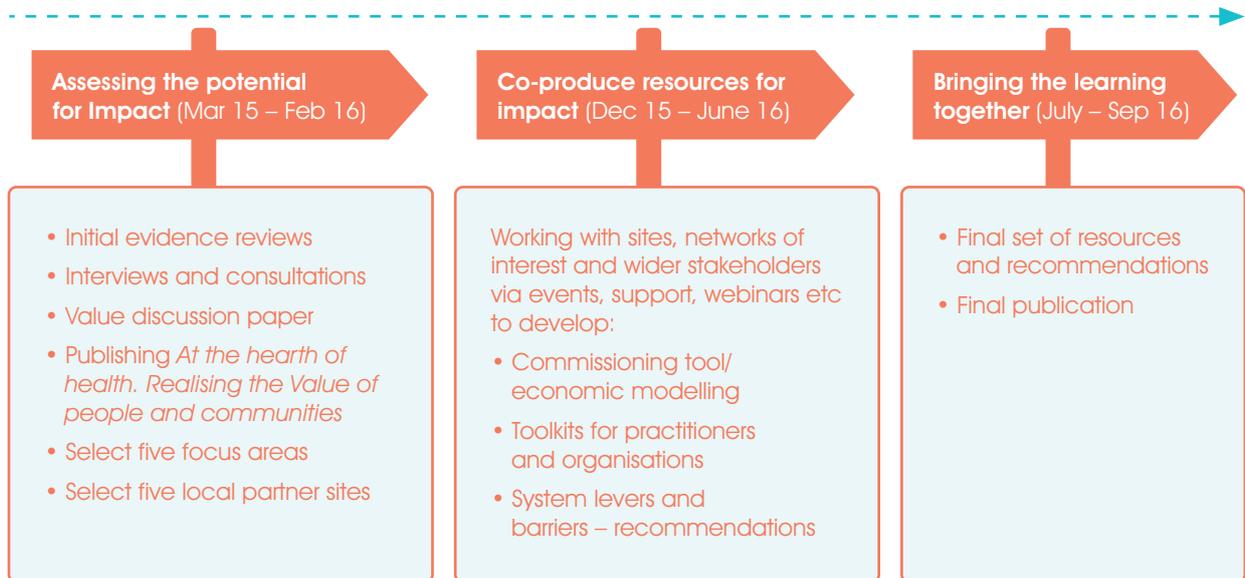
- Working closely with our five local partner sites to understand their experience of implementing person- and community-centred approaches on the ground, and develop practical tools to support implementation of person- and community-centred approaches.
- Connecting and spreading this learning to create greater adoption and spread of these approaches through communities of interest made up of other organisations and sites committed to person- and community-centred care.
- Working closely with other programmes, such as the New Care Models Vanguard sites and the PAM pilot sites, to ensure that our learning and practical tools can support the work of these teams.
- Improving our understanding of what influences behaviour of individuals (patients, service users, frontline staff) as well as what factors can positively impact organisational culture.
- Making recommendations for policymakers and others about what is needed to support change on the ground and creating the conditions for these approaches to flourish.

We will bring this work together in Autumn 2016 including:

- A pack of resources and tools to support implementation and spread; including co-produced toolkits to support local behaviour change, case studies from the local sites and beyond and 'how to guides' drawing on the experiences of local partner sites.
- An economic model, based on extracted local data combined with academic evidence, that shows the potential impact of the five selected person- and community-centred approaches. This modelling will be used to develop a tool for commissioners and others to support their understanding and decision-making.
- Wider communities of interest created and embedded to provide additional insight into the work on behaviours, system conditions and impact, and to build capacity and capability amongst the network to champion and spread person-centred and asset-based approaches.
- An overarching report which will bring together the key conclusions, findings and recommendations of the programme.

The outputs of the programme will be grounded in both evidence and practice and will be directly relevant to commissioners, providers and practitioners, putting person-centred, community-based approaches into practice, as well as to policymakers and other decision-makers. The programme also seeks to build a network of local places and organisations committed to putting this agenda into practice, to sustain momentum beyond the lifetime of the programme itself.

Figure 7: Overview of the Realising the Value programme



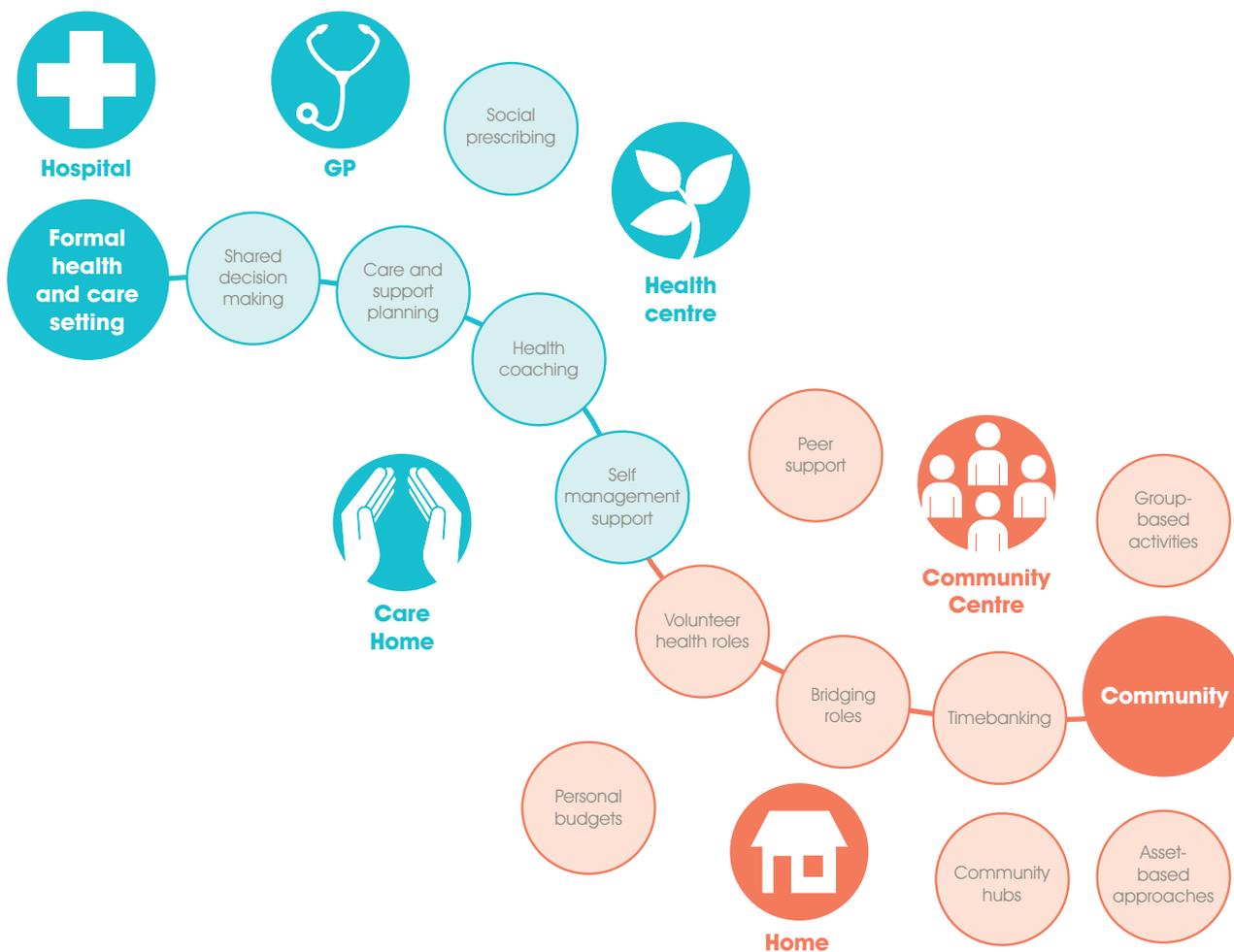
APPENDIX

# Key person- and community-centred approaches for health and wellbeing

This section summarises a number of key person- and community-centred approaches and enablers for health and wellbeing, in addition to the five focus areas for Realising the Value. Further information on the range of community-centred approaches can be found in the Public Health England and NHS England *A guide to community-centred approaches for health and wellbeing*. More information about person-centred care approaches can be found on the National Voices Evidence web pages.

Some of these approaches and enablers, such as shared decision-making and care and support planning, are traditionally based in and led by formal health and care services. Others, such as community asset-based approaches and group activities are, as their name suggests, more commonly developed within communities. There is a wide range of approaches and enablers that fall along the spectrum between formal care services and communities and there is an increasing blurring of the boundaries between them.

Figure 8: Common examples of person- and community-centred approaches



## Approaches

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This section describes a number of different person- and community-centred approaches for health and wellbeing. It summarises what they are and what we know from the evidence about their potential to improve outcomes for individuals and communities and to contribute to reducing demand on formal health and care services.

### Community hubs

Community hubs are community centres or other ‘anchor’ organisations focused on health and wellbeing. Often locality based they can also be network based. They usually provide multiple activities and services aimed at addressing health or the wider determinants of health. Some are part of existing community resources – libraries or faith settings. Others – like the Bromley-by-Bow Healthy Living Centre<sup>82</sup> - build social activities and support services into a primary health setting like a GP practice. They can include a range of activities and the mechanisms for delivery can include social prescribing.

Community hubs can open up access to existing voluntary and community sector services and resources, and reduce barriers to accessing services.<sup>83</sup>

#### More resources:

Public Health England and NHS England, *A guide to community-centred approaches for health and wellbeing* [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/417515/A\\_guide\\_to\\_community-centred\\_approaches\\_for\\_health\\_and\\_wellbeing\\_full\\_report.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417515/A_guide_to_community-centred_approaches_for_health_and_wellbeing_full_report.pdf)

### Shared decision-making

Shared decision-making recognises that clinicians and patients are equally important to the decision-making process. Clinicians provide information and evidence about treatment options; patients share what is important to them about their care, their social circumstances, their attitude toward risk and their values and preferences. Clinicians and patients work together to choose tests, treatments, management or support packages based on clinical evidence and the patient’s informed preferences.

Patients who have the opportunity and support to make decisions about their care and treatment in partnership with health professionals are more satisfied with their care, more confident in managing their health conditions and are more likely to choose treatments based on their values and preferences rather than those of their clinician.<sup>84,85</sup> Studies that have looked at economic outcomes have found that shared decision-making is usually cost-effective (because people choose less costly interventions such as major surgery) or cost neutral.<sup>86</sup>

#### More resources:

The Health Foundation person-centred care resource centre <http://personcentredcare.health.org.uk/person-centred-care/shared-decision-making>

Right Care Shared Decision Making resources <http://sdm.rightcare.nhs.uk/>

### Time banking

Time banks are platforms that organise and facilitate the exchange of time and skills between both people and organisations. Participants contribute their time and skills to the ‘virtual’ bank and in return they can receive time and skills from another participant. The skills that people contribute can be many and varied including IT, gardening, DIY, providing transport, baking or reading to an elderly person in their home.

Timebanking is different from volunteering as it is based on reciprocity – individuals are not giving their time or skills for free – they are both contributing and receiving.

There is extensive international and UK evidence that timebanking schemes increase the sense of community and can help build social capital – both important determinants of health, wellbeing and resilience. They also seem to be more successful than traditional volunteering in attracting more socially excluded groups.<sup>87</sup>

Evaluating the outcomes of timebanks can be difficult as these can vary depending on how they are set up, the range of services exchanged and how people access them. However, a recent economic analysis estimated that timebanking had an estimated net value of £667 per person per year and could be even higher if improvements in quality of life were also included.<sup>88</sup>

### More resources:

Timebanking UK <http://www.timebanking.org/>

## Volunteer health roles

Volunteers receive training and support to undertake roles within their community which are often focused on addressing health inequalities by reaching those who are often socially excluded. The range of health volunteering roles can vary greatly, depending on the identified needs of the local community or population.<sup>89</sup>

Befriending is a particular type of volunteering role which focuses on providing companionship to people who are at risk of social exclusion, often older people. It is estimated that around one million older people in the UK regularly go more than a month without speaking to anyone else and one in ten people over 65 reports being lonely all or most of the time.<sup>90</sup> Volunteers usually visit people in their own homes and provide companionship as well as help with small practical tasks, such as shopping. There are also examples of telephone befriending services, such as Age UK's 'Call-in Time'.<sup>91</sup> Befriending schemes are often community led but may also be service led. Befriending has been shown to reduce social isolation in older people, can lead to small but sustained reductions in depression and are cost effective when compared to usual services.<sup>92</sup>

Other examples of volunteer health roles include walking for health<sup>93</sup> and various environment and health volunteering projects, such as community gardens.

### More resources:

Public Health England and NHS England, *A guide to community-centred approaches for health and wellbeing* [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/417515/A\\_guide\\_to\\_community-centred\\_approaches\\_for\\_health\\_and\\_wellbeing\\_full\\_report\\_.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417515/A_guide_to_community-centred_approaches_for_health_and_wellbeing_full_report_.pdf)

## Working with communities

Much of what impacts health and wellbeing sits outside of formal health and care services. Communities, and the voluntary and community sector, have a vital contribution to make to health and wellbeing, and there is extensive evidence that communities that are well-networked and supportive, and where neighbours look out for each other, have a positive impact on people's health.<sup>94, 95</sup>

There are a range of approaches which focus on partnership working and collaboration with communities to improve planning and decision-making and to deliver services and activities which meet needs

identified by communities, rather than being imposed by external agencies. A common starting point for many of these approaches is a desire to tackle social or economic disadvantage or inequalities. These are often not primarily focused on health but the outcomes of these projects can be activities and services that positively impact health and wellbeing, including by increasing social connections within communities.<sup>96</sup>

In recent years the term ‘co-production’ has been used to describe some of these approaches, particularly within health and care services, but there are a range of other approaches which have commonly been used in public health and health promotion, a few of which we describe here:

**Co-production** – Seeks to develop equal and reciprocal partnerships between professionals and those using health and care services.<sup>97</sup> It is often used to describe a changed relationship between individual professionals and people with long-term conditions. But it can also describe an approach of working with groups of service users or communities to co-design and often co-deliver services and activities. The principles of co-production include a focus on assets and capabilities rather than deficits in individuals and communities, mutuality, engaging with peer and personal networks, removing boundaries between professional and service user roles and public services acting as catalysts rather than central providers of services.<sup>98</sup>

**Area-based initiatives** – Targeted at an area or neighbourhood level, these initiatives focus on partnership working and multi-faceted programmes which often include health alongside things such as education, economic development and urban regeneration. The World Health Organization’s Healthy Cities programme is a global movement of area-based initiatives within Europe. There are more than 100 Healthy Cities and 30 Healthy City Networks.<sup>99</sup>

**Community engagement in planning** – This covers a broad range of approaches which exist in health and social care to involve communities in planning and decision-making. Community planning approaches can use a range of methods such as area forums, open space meetings, user panels, residents committees and citizen’s juries. They are meaningful when efforts are made to ensure that processes are inclusive and involve groups who are often excluded or ‘seldom-heard’.<sup>100</sup>

A systematic review of community engagement approaches to reduce inequalities noted that community involvement ‘can be seen as a goal in itself’ because it encourages greater public accountability and transparency in decision making. It also noted that it can empower communities and is more likely to lead to services, activities and interventions that communities want and need and which, consequently, are likely to be ultimately more effective in improving health.<sup>101</sup>

Approaches which focus on deliberative and participatory engagement with communities can lead to significant positive outcomes for individuals, communities and services.<sup>102</sup> As with many approaches focused on empowering and strengthening communities and community engagement, a one-size-fits-all approach is unlikely to be successful. As a recent RSA report notes, ‘context is key and bespoke local engagement is required’.<sup>103</sup>

### More resources:

Public Health England and NHS England, *A guide to community-centred approaches for health and wellbeing* [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/417515/A\\_guide\\_to\\_community-centred\\_approaches\\_for\\_health\\_and\\_wellbeing\\_full\\_report.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417515/A_guide_to_community-centred_approaches_for_health_and_wellbeing_full_report.pdf)

RSA resources on public services and communities: <https://www.thersa.org/action-and-research/public-services-and-communities/>

Nesta People Powered Health <http://www.nesta.org.uk/what-we-have-learnt-people-powered-health>

## Enablers

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This section describes a number of enabling mechanisms which are necessary for the effective implementation and spread of person- and community-centred approaches for health and wellbeing.

### Bridging roles (health trainers, community navigators, health champions)

There are a number of approaches which involve people from the local community supporting people to connect with local services, navigate health, social care or other public services and, often, to support people to improve their health and wellbeing. These are important roles which can act to bridge the gap between formal services and the community. These bridging roles are often undertaken by volunteers who are already embedded in local communities but they are not necessarily ‘peers’ (see **peer support section in Chapter 5**). Common features of these roles are: outreach; communicating health messages; social support; signposting and sometimes practical assistance.<sup>104</sup>

Some roles like health trainers or health champions may be more focused on supporting individuals or communities to make positive changes to improve their lives or health, or establishing groups to meet local needs. Others may have more focus on signposting and connecting people to other local services. Many of course involve a combination of approaches.

One example is the Newquay Pathfinder. Initially supported by Nesta, and now renamed Living Well, the Newquay Pathfinder includes a Changing Lives Coordinator from Age UK Cornwall to act as a conduit between the health service, local authority, and other community services and the voluntary sector. During its first year, non-emergency hospital admissions reduced by 30 per cent and ongoing care package costs reduced by 5.7 per cent. There was also a 23 per cent improvement in people’s self-reported wellbeing.<sup>105</sup>

An economic analysis of the use of community navigators to provide debt and benefits advice estimated that the costs per year were around £300 per person but the benefits in terms of decreased absences from work, increased employment prospects and decreased benefits at £900 per person in the first year, rising if increases in quality of life due to improved mental health were also taken into account.<sup>106</sup>

#### More resources:

Public Health England and NHS England, *A guide to community-centred approaches for health and wellbeing* [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/417515/A\\_guide\\_to\\_community-centred\\_approaches\\_for\\_health\\_and\\_wellbeing\\_full\\_report.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417515/A_guide_to_community-centred_approaches_for_health_and_wellbeing_full_report.pdf)

Social Care Institute for Excellence on the impact of community navigators on preventing loneliness and isolation: <http://www.scie.org.uk/publications/briefings/files/briefing39.pdf>

People Powered Health Programme, Nesta. *More than Medicine: New services for people powered health*. London: 2013. [http://www.nesta.org.uk/sites/default/files/more\\_than\\_medicine.pdf](http://www.nesta.org.uk/sites/default/files/more_than_medicine.pdf)

## Personal budgets

A personal budget or personal health budget is a sum of money allocated to an individual by their local council or health service to pay for care or support to meet their needs. They can then work with their health or care professional to develop a plan for how the budget will be spent. This can include personal care or assistance as well as a range of non-health or care services. Personal budgets can be paid directly to the person (direct payment) or can be managed by the local authority or health services to arrange the services the person wants (managed budget). Most people receive a budget either for social care (personal budget) or health care (personal health budget) although the Integrated Personalised Commissioning Programme is exploring how social and health care services can be better integrated to provide holistic care and support, including through a joint personal budget.

Personal health budgets have been shown to significantly improve budget holders' care-related quality of life and psychological wellbeing<sup>107</sup> and are cost effective, particularly for people with mental health problems and those with the greatest needs.<sup>108</sup> They work best when they provide flexibility in the services that can be purchased, greater choice in how they are managed and when they are of higher value.<sup>109</sup>

Personal budgets in social care also improve quality of life for budget holders and carers.<sup>110</sup> Evidence is also beginning to show that people who hold personal budgets are using them to increase participation and activity in their communities which may contribute to building community capacity.<sup>111</sup>

### More resources:

Getting serious about personalisation in the NHS: <https://www.england.nhs.uk/wp-content/uploads/2014/09/tlap-getting-serious.pdf>

In Control publishes a range of resources on personalisation and personal budgets in health and social care: <http://www.in-control.org.uk/>

## Personalised care and support planning

Personalised care and support planning is a systematic process in which people with long-term conditions and their carers work in partnership, very often with health and social care professionals, to identify their treatment, care and support needs, based on their own assets, goals and priorities. It usually involves a conversation or a series of conversations where individuals and the professionals they are working with jointly agree on goals and actions for managing the person's health and care.

Involvement in care planning has been shown to improve people's confidence and skills to manage their health.<sup>112</sup> It is likely to lead to small improvements in some aspects of physical health such as better blood glucose levels, lower blood pressure for people with diabetes and better control of asthma.<sup>113</sup> The House of Care approach,<sup>114</sup> with care planning at its heart, has led to benefits for people with long-term conditions (involvement in decisions, better understanding of their condition, tailored support to improve their knowledge and confidence to self-manage), clinicians (more satisfying consultations, better outcomes for people with LTCs, a lever with commissioners) and commissioners (provides information needed to commission services that people want and clinicians value, greater value for money, as services provided meet individual needs and deliver improved health outcomes).

### More resources:

Personalised care and support planning tool: <http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/>

Royal College of General Practitioners. 'Care Planning. Improving the lives of people with Long Term Conditions': <http://www.rcgp.org.uk/~media/Files/CIRC/Cancer/Improving%20the%20Lives%20of%20people%20with%20LTC%20-%202012%2005%2009.ashx>.

Royal College of General Practitioners animation: <http://www.rcgp.org.uk/care-planning>

National Voices Care and Support Planning Guide: [http://www.nationalvoices.org.uk/sites/default/files/public/publications/guide\\_to\\_care\\_and\\_support\\_planning\\_0.pdf](http://www.nationalvoices.org.uk/sites/default/files/public/publications/guide_to_care_and_support_planning_0.pdf)

## Social prescribing

Social prescribing is a process/mechanism that professionals can use to connect people to services. Social prescribing can be used by professionals to connect individuals to services and groups outside of health care that may improve their health and wellbeing. A professional works with a patient to identify the types of activities that are likely to benefit the individual, and writes ‘a prescription’ directly to a service or refers the person to an intermediary, such as a link worker or navigator, with whom a package of services can be constructed. Common activities that are ‘socially prescribed’ include arts for health groups, walking groups, healthy eating and cooking classes and volunteering opportunities.

A recent RSA report found that pilot social prescribing projects have shown early promise. Social Mirror in Knowle West is a digital social prescribing app supported by health volunteers to identify people at risk of social isolation and to digitally ‘prescribe’ social activities for them to take part in. In the trial of Social Mirror, 77 per cent of users reported that they benefited from using the app. The project found that the Social Mirror app ‘*worked best for people who had no social connections, or who felt isolated, and who were not currently taking part in their local area.*’<sup>115</sup>

Social prescribing can lead to a range of outcomes<sup>116</sup> including:

- Better social and clinical outcomes for people with long-term conditions (LTCs) and their carers.
- More cost-efficient and effective use of NHS and social care resources.
- A wider, more diverse and responsive local provider base.
- Wider community benefits including increased community wellbeing and decreased social exclusion.<sup>117</sup>

A key factor in successful social prescribing projects seems to be making them as easy as possible for both professionals and patients to use. This might be through the use of technology, such as the Social Mirror app outlined above, or through providing ‘social prescription pads’ either on paper or electronically which makes it as easy for a doctor to ‘write’ a social prescription as a prescription for medication.

### More resources:

Public Health England and NHS England, *A guide to community-centred approaches for health and wellbeing* [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/417515/A\\_guide\\_to\\_community-centred\\_approaches\\_for\\_health\\_and\\_wellbeing\\_full\\_report.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417515/A_guide_to_community-centred_approaches_for_health_and_wellbeing_full_report.pdf)

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Year of Care Programme. ‘Thanks for the Petunias. A guide to developing and commissioning non-traditional providers to support the self management of people with long term conditions’: <https://www.diabetes.org.uk/upload/Professionals/Year%20of%20Care/thanks-for-the-petunias.pdf>

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## About Realising the Value

Realising the Value is a programme funded by NHS England to support the NHS Five Year Forward View. The programme seeks to enable the health and care system to support people to have the knowledge, skills and confidence to play an active role in managing their own health and to work with communities and their assets.

There are many good examples of how the health and care system is already doing this. For example, recognising the importance of people supporting their peers to stay as well as possible or coaching to help people set the health-related goals that are important to them.

Realising the Value is not about inventing new approaches, it's about strengthening the case for change, identifying evidence-based approaches that engage people in their own health and care, and developing tools to support implementation across the NHS and local communities. But putting people and communities genuinely in control of their health and care also requires a wider shift. The programme is therefore considering the behavioural, cultural and systemic change needed to achieve meaningful transformation.

[www.realisingthevalue.org.uk](http://www.realisingthevalue.org.uk).



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