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COMMENT

The NHS needs to share power with the communities it serves

By Dr Brian Fisher, Director, The Health Creation Alliance, 27 October 2023

Brian Fisher elaborates how embracing community strengthening is the key to a sustainable and inclusive NHS, shifting from merely listening to empowering communities, improving health outcomes, reducing inequalities, and creating a brighter future for all

The recent national framework for NHS – action on inclusion health talks about listening to communities – as it should. Working with communities is essential to creating health and may be the key to the sustainability of the whole NHS.

But the framework has a missing piece, a piece that the NHS has long shied away from: community strengthening. We need to move from listening to power-sharing with communities.

As a GP, I could see the social forces acting on my patients – but there was little I could do about it. Once we set up a community development programme, however, we began to hear about local issues that could influence road safety, housing, and maternity care. We offered wholly new services requested by local people.

Supporting communities to identify the issues that matter to them and then working with them to address those issues is the next step. Prioritising communities' agendas – not merely identifying public health issues and cooperating to address those.

Community strengthening improves health

Building on community capacities to take action together on health and the social determinants of health, community strengthening includes community development, asset-based approaches, social action, and social network approaches. Connected and empowered communities are healthy communities. When people feel a sense of mutual trust as part of a group or community, both individual and collective health outcomes can be improved.

It can increase life expectancy. A meta-analysis showed a 50 per cent increased likelihood of survival for people with stronger social relationships, consistent across age, initial health status, follow-up period, sex, and cause of death. The magnitude of this effect is comparable to quitting smoking and it exceeds many well-known risk factors for mortality such as obesity and physical inactivity.

It can improve health behaviours. A community development intervention in Lewisham generated a high level of community capital and resulted in a 62 per cent increase in smoking cessation, compared with a 7 per cent increase in the rest of the area. There was a 22 per cent increase in consumption of fruit and vegetables and a 33 per cent increase in levels of physical activity.

It can reduce health inequalities and change local and national policies. Shifting power towards marginalised communities can reduce inequities in the social and environmental determinants of health, achieving long-term health equity outcomes. Joint decision-making can help deflect threats to local areas, for example attracting resources to create better places to live. Community strengthening had positive impacts on housing, crime, social capital and community empowerment.

It can reduce demand. A controlled set of studies in Newcastle, designed by academics, clinicians and local people, found an annual 9 per cent saving on secondary care services. These savings came from reductions in outpatients, electives and accident and emergency attendance.

It can improve other aspects of civic life. There was a fall in violent crime and unemployment during The Beacon Project in Cornwall and in Balsall Heath. Community involvement in Toronto was associated with a 49.9 per cent drop in violent crime rates overall over four years.

It's a good investment with a Social Return on Investment of about 1:4, particularly those interventions that share and shift power to communities.

This is how we can make community-strengthening business as usual across the NHS

By working cross-sections and creating the right examples and incentives, we can make it happen. Here is my list of how integrated care boards can embrace community strengthening:

- Requiring all ICSs to invest a proportion of the ICS budget to support community strengthening activity in communities with the highest levels of poverty and worst health outcomes.
- Requiring the NHS to adopt simple measures in performance monitoring, such as measuring social capital.
- Adopt a Community Power Act, like the Community Empowerment (Scotland) Act 2015, creating a statutory basis for Community Planning Partnerships.
- Introduce community strengthening models in every primary care network, for instance, community development, starting with the most deprived areas, perhaps by expanding ARSS. Here is a local model.
- Every local authority to expand local community-strengthening options.
- Enable an NHS workforce with the time, capacity and skills to be a real and valued partner in community strengthening.
- Provide dedicated funding to strengthen the evidence base for community strengthening.
- Encouraging ICSs to substitute some national indicators for local indicators that have been co-produced with communities.

An increasing number of practices want to do this kind of work, as the lessons of the pandemic are learnt. Using the local model, primary care and PCNs can make a growing impact on social determinants by sharing decisions with our communities.

This is what the Inclusion Health document should include. Let's talk about it together!