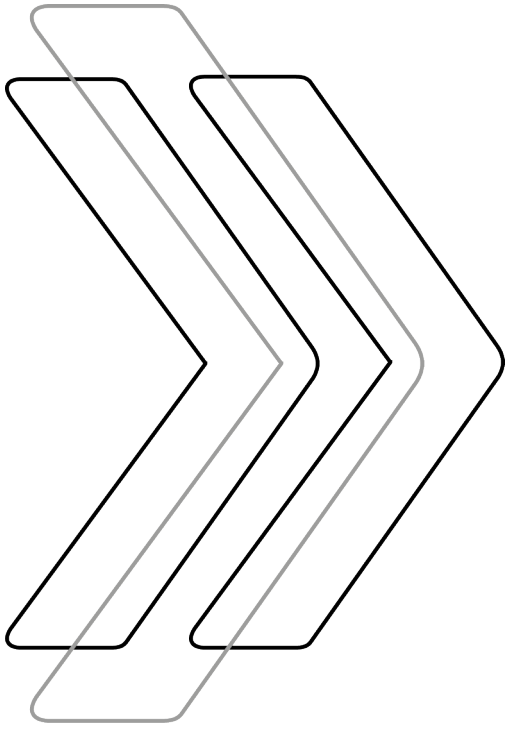
The King's Fund

Ideas that change health and care

Social prescribing and NHS facilities

How could the NHS better use its facilities to support social prescribing, holistic care and community resilience?



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This independent report was commissioned by NHS Property Services. The views in the report are the author's and all conclusions are the author's own.

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1 A tale of two health centres

Visitors to the Bromley by Bow Centre in East London enter through a rusticated stone arch, designed by William Kent, which in the 18th century served as the riverside entrance to Northumberland House on the Strand. By the turn of the 20th century it had completed the implausible journey from the Embankment to Bromley Recreation Ground. By the end of the century, it had been reclaimed by local people as the entrance to their new community centre.

As you pass through the arch, you find yourself in a small cobbled courtyard and garden, with one path to the left leading you into the centre, the other to the right sweeping round to the park at the back. You walk through a wood and glass corridor into the centre, before the space opens out into a reception and meeting area, with a beautiful curved reception desk and a café overlooking the park. From here, corridors guide people to social groups, arts workshops, employment, housing and financial advisors, a children's play area, a nursery, a GP surgery and a church. When I last visited five years ago, the park at the back was being used for cooking groups, picnics and sports.

The architect Gordon MacLaren, who designed these buildings, describes our experience of walking through the centre as a 'procession'. The walk through the courtyard and garden helps to create a sense of calm, that this is a place of safety and sanctuary. The artwork, decoration and furniture, made by local people, help to create a sense of shared ownership, that this is a placed owned by and for the local community. The hub and spoke design and meeting places encourage connectivity. This is a place where people are invited to linger, with garden seats and quiet corners, rather than one designed for 'throughput', getting people in and out as quickly as possible.

A few miles to the west, there is another health and community centre, one that interviewees explained had taken its early inspiration from Bromley by Bow. The local clinical commissioning group's website describes it as a 'flagship health hub [that] brings together health and social care services in a state-of-the-art building'. You pass through business-like sliding doors into an enormous, three-story glass atrium, a little like the foyer of a modern shopping centre, almost empty except for two banks of multi-coloured, washable PVC chairs.

You input your details on a touchscreen or approach one of the five receptionists, each working for a different GP practice, before waiting in silence for your appointment. A TV screen cycles messages on drinking and weight loss and reminds you of how much people have cost the NHS by not turning up for appointments this month. The glass panels offer a view onto a park at the back but block access to it. When your name flashes on the screen, you are directed up the grand staircase to the doctors' consulting rooms on the upper floors.

Like Bromley by Bow, the intention was to bring together NHS services, social services and community organisations to promote health, wellbeing and holistic care. But despite the very best intentions and millions of pounds spent on this project, the similarities with Bromley by Bow are superficial. There is nothing to create a welcoming space for the community, let alone a sense of common ownership. The tenancy agreements prohibit the use of blue tack, let alone installing local people's art on the walls. Gaining permission to move a noticeboard took a year.

This is not the sort of place anybody visits without an appointment, say to read a book or catch up with friends. If you did, the staff would probably move you on. A community group asked if they could run yoga classes in a corner of the empty atrium, but this was rejected on health and safety grounds. Local voluntary organisations could never afford the rent for the empty spaces on the higher floors. When Covid-19 hit in March 2020, the doctors, nurses and social workers at the centre needed to pool resources. Despite working in offices just a few metres away from each other, none of them had ever met before.

Figure 1 The Bromley by Bow Centre's entrance and courtyard

2 Introduction

This paper, commissioned by NHS Property Services explores how NHS services, in particular primary and community services could make better use of their facilities to support social prescribing, holistic care and community resilience. The paper explores the range of strategies NHS organisations might deploy to make better use of estate for these purposes, from making the environments more welcoming and making it easier to book and use rooms, to how to ensure that more substantial redesign of facilities is successful. It also considers how they might bring together traditional healthcare, social prescribing and community activities in a useful way; and how the NHS could make its facilities available to local people in ways that support regeneration.

There has never been a stronger case for this approach to supporting health, wellbeing and community resilience. Covid-19 has exacerbated the socio-economic disparities that condemn poor people to ill health in England (Davenport *et al* 2020). The country is facing unprecedented levels of chronic disease and mental illness, little of which can be tackled primarily through a medical model of care (Charlesworth *et al* 2020; Marshall *et al* 2020).

Nor, arguably, has there been a greater opportunity to redeploy public resources to enable this approach. Reviews by Lord Carter of Coles and Sir Robert Naylor have highlighted the scale of the opportunity to make better use of NHS estate as well as other resources (Lord Carter of Coles 2018; Naylor 2017). The transition to online primary care, community and outpatient services, accelerated in response to Covid-19, will mean that more NHS facilities lie vacant or significantly underutilised, while the community organisations that we depend on for recovery are going bankrupt because they cannot pay their rent (Charities Aid Foundation 2020). Thankfully, NHS organisations are, right now, committing to a more proactive role as 'anchor institutions', where they deploy their budgets, estate and other resources to protect the economic resilience of their communities.

Focusing on primary care and community facilities, the paper considers the small practical changes that a primary care practice or other service might take, right now, to harness its facilities for the community, from access to the 'community room' to what to do with the small plots of land dotted around NHS facilities. It also considers what principles might guide more substantial redesign and repurposing of NHS facilities, so we create more Bromley by Bows, and fewer examples of centres that don't work for patients.

If we are to do justice to these questions, this paper must also confront an enduring conundrum: the 'riddle of Bromley by Bow'. Ever since the centre opened, there has been a steady stream of influential visitors. Princess Diana, Cherie Blair, Gordon Brown and Andrew Lansley among many others. Each one of these distinguished visitors, along with many other leaders from health, social care and the voluntary sector, leaves enthused and determined to spread the Bromley by Bow model.

At times over the past thirty-five years, hundreds of millions have been spent on new health and care centres inspired at least in part by the Bromley by Bow model (Elliot *et al* 2007). The Bromley by Bow charity has itself, with some success, helped more than 50 organisations to adapt its approach. And yet, while a few exist, it is extremely difficult to find health and community centres that feel comparable to the original. The second type of health and wellbeing centre in our prologue? You can find that in towns and cities across England.

When we attempt to copy innovation, there is a risk that we home in on superficial features of the design, while overlooking the hidden details, the things that really make the innovation work (Dixon-Woods 2015). After so many visits to Bromley by Bow, so many good intentions, and so many failed attempts to replicate the model, we must consider that possibility here. We visit, we leave uplifted, but perhaps we contrive to draw the wrong conclusions about what matters? If this is the case, then what are the real secrets to Bromley by Bow's and other similar centres' success, the things that we really need to copy with fidelity?

The paper is based on desk research on social prescribing and the use of NHS facilities and over twenty-five interviews with national leads for social prescribing, policy experts, leaders of NHS and other public services and facilities managers. After our desk research, we held interviews with policy-makers responsible for social prescribing, leaders of national programmes, and thought leaders on social prescribing, among others, to gain a sense of the main themes to explore, including the main barriers and enablers to better use of NHS facilities for community activities.

We also used these interviews to identify the examples of good and less successful practice described in the paper. Wherever possible, we interviewed a number of people from the services described in the paper to gain a broad range of perspectives on each service. For example, we talked to GPs, practice managers, practice nurses, social prescribers and volunteers. For some of the sites, we were also able to interview people who had participated in the initial development of the service, including NHS commissioners, the leaders of

consultation and engagement with the public, architects and designers. We do not name the small number of less successful centres described in the paper.

3 Opening the doors to the temple

Alyson McGregor, the national director of Altogether Better, an organisation that supports 'collaborative practice' and meaningful relationships between the NHS and communities, described her own experiences as a patient attempting to collaborate with health services. After a programme of group physiotherapy at a community hospital, she asked for access to the room when vacant so that she and other patients could continue the exercises on their own. There had been a long wait to receive just six sessions of group physiotherapy. Alyson and other participants realised that they would benefit from carrying on the exercises together, something which would improve their health and reduce the pressures on NHS services.

After brief consideration, the clinicians leading the service concluded that Alyson, a national NHS leader and another service user, a teacher from the local school, could not be trusted with the key to the room. She might forget to lock the door, they group might damage the equipment, that is the rubber mats, and they might do the exercises incorrectly – exercises that they were in any case supposed to continue unsupervised at home.

Interviewees told us about similar examples where NHS staff weren't able to allow community members and voluntary sector organisations to use NHS facilities for community activities, even though the spaces were at least partially vacant, there would be little inconvenience and few costs for the NHS, and the planned community activities would have improved health and wellbeing. In some cases, community members were denied access to 'community rooms' that had been established specifically for community use.

One exercise group was denied access to facilities because their yoga mats were considered a trip hazard. Another because they would have to lock up after staff had gone home. At one spectacular healthy living centre in London, very similar to the example in our prologue, there is a large community space that has almost never been used. When a local vicar and women from a nearby council estate started occupying it for their weekly meetings, they were immediately evicted.

These examples suggest that there are attitudinal and cultural barriers, as well as practical and regulatory barriers, to effective collaboration between the NHS,

local people and community organisations, on use of NHS facilities. Alyson McGregor and Dan Hopewell, the Director of Knowledge and Innovation at the Bromley by Bow Centre, argued for a reappraisal of who really owns NHS facilities, one that recognises that these facilities are not the property of NHS staff or even, in a moral sense, the property of the institutions that hold the title deeds. Instead, they were purchased and developed with taxpayers' money to serve the interests of the health and wellbeing of communities.

If we accept this principle that NHS facilities are community assets for health and wellbeing, rather than institutional assets, this should have a profound impact on decision-making about access to them. If NHS facilities are seen as shared with communities and are to be used in the service of those communities, the default position might logically be that community members and community organisations should be granted access to them, without cost or at a nominal cost, for activities that support health, wellbeing or community resilience.

The approach of NHS staff should also switch from granting access on an exceptional basis, to granting access as a matter of course, except when there are genuine problems that cannot be overcome.

Alyson McGregor and Dan Hopewell also argue for a change in the relationships between NHS managers and clinicians and the communities they serve. It is very hard to envisage a vibrant collaboration between the NHS and local communities in using NHS facilitates, the sort of thing we see at Bromley by Bow and its successors, without strong, trusting relationships. When NHS staff start to trust and respect community members, our interviews suggest that this is repaid. Alyson McGregor described a situation where volunteers were unable to lock up at the Robin Lane Health and Wellbeing Centre in Pudsey, West Yorkshire. There was a problem with the key. The volunteers ordered pizza and slept there for the night rather than leave the premises open and at risk.

As well as these changes in attitudes and culture, there also clearly need to be some practical changes to how access to NHS facilities is managed. For example, there needs to be somebody who people can contact to access facilities and a friendly and accessible system for booking them. The failure to appoint anyone or put in place a booking system has meant that the community spaces in some multi-million-pound health centres are never used as intended. Some NHS property companies' room booking platforms provide a potential solution to these problems, providing a simple way to search for and book rooms at NHS properties.

It helps if the NHS can do simple things to make the space useable, for example providing a kitchen area for tea and coffee, easy access to facilities rather than multiple locked doors, access in the evenings when more people are free to attend activities and parking if possible. While it needs to ensure people's safety, the NHS needs to avoid creating bureaucratic obstacles that make it hard to use facilities in practice, for example requirements that small groups complete laborious risk assessments, that users have their own insurance, or that only constituted organisations can use shared facilities, something which excludes hundreds of small informal groups that do a huge amount for community wellbeing.

Of course, there may well be competing demands for access to facilities and a need to decide whose needs come first. There will also sometimes be genuine practical difficulties that make it hard to allow community members to access some facilities. We are not arguing that NHS staff should simply ignore these issues and grant access anyway. One message from our interviews is that where there are real problems, the NHS needs to see if there are simple ways around them. Where the decision-making is more complicated, it needs to take a broad view of the costs and benefits, rather than simply considering institutional interests, focusing only on the costs to the NHS, or ignoring the benefits of many community activities for health, wellbeing and community resilience.

Finally, there is the matter of costs. If we agree that NHS facilities are community assets, it follows that community members and organisations should be able to access them for free, or at least at a marginal price that reflects the costs of heating, maintenance and utilities, for not-for-profit activities that support health, wellbeing and community resilience. At the Old Trafford Wellbeing Centre in Greater Manchester, local community groups can rent out rooms for £4.50 per hour.

For voluntary organisations delivering remunerated services, a common approach has been to charge rent at the market rate. At present, however, many voluntary sector organisations that communities depend on are in severe financial difficulty. There is also evidence of substantial vacant space at NHS facilities that were designed to bring different services together. At some of the health and wellbeing centres we looked at, whole floors have been mothballed because nobody could afford the rent. There is surely a case for bringing down the rates for voluntary organisations to use this vacant space if it creates an opportunity to bring different organisations together in effective partnerships. NHS organisations are increasingly committed to acting as 'anchor institutions', a concept that implies making efforts where appropriate to protect the resilience of local communities.

Figure 2 Creating a welcoming environment at the Blackmore Vale GP Practice

4 Creating welcoming environments

At the Limelight Centre in Greater Manchester, a health and wellbeing centre within a new housing development, you pass through a front courtyard into a huge, colourful indoor space. At the front of this open plan space, there is a fantastic, low-cost café. Further back, the space becomes a library, where school children rush in at around 4.00pm to use the computers and get their homework done. Around this central area, there are meeting rooms, a dance floor, a beauty salon, a nursery and a kitchen that people can use to cater for their own weddings or christenings. If you visit, there might be a bouncy castle in the courtyard, people learning the Charleston, tai chi classes or drumming sessions.

When you walk up to the health services on the first floor, there is an unmistakable change in atmosphere. The metre-high reception desks are back, the TV screens with public health notices, the banks of waiting room chairs designed, against the evidence on what promotes health and wellbeing, to minimise contact as people wait for appointments. The space on the ground floor welcomes you in. The space on the first floor says a different set of things.

As well as a change in mindset, many people we spoke to argued for a change in aesthetic if the NHS is to make better use of its facilities with local communities. Becky Seale, a researcher who co-led research on the Bromley by Bow model, argued that features of the design help create the conditions for effective partnership with communities(Stocks-Rankin *et al* 2018). When you walk into the centre, the evidence of local art and craftmanship reminds you that this is place owned by and for the local community, one where professionals and the public collaborate rather than one side doing things to the other.

Becky also emphasised the importance of beautiful environments particularly for the most deprived people in society. Many people across the country have become used to spending their time in run-down waiting rooms to receive assessments, instructions and allowances. Becky made the case that these environments subtly tell us something about our worth. Beautiful environments, for example the astonishing stained glass and furniture made by local people at Bromley by Bow, remind people that they are valued, something that can change people’s perception of themselves, their relationship with others and their sense of aspiration.

Most health care staff and patients will have to make do with rather different premises to the Limelight Centre or Bromley by Bow. Jane Dawes, the managing partner at the Blackmore Vale GP Practice, described adopting Altogether Better's approach to collaborative practice, and making small but impactful changes to make services more welcoming to communities. These included, for example, taking down paternalistic signs, putting up artwork and letters from local children, hanging bags on the reception desk with books for children to take home, having a tea and cake corner in the waiting room where you can chat to the surgery's health champions and reorganising the layout to encourage conversation.

For Jane, these small but symbolic things help remind staff and local people that we are all human beings, that we are here to care for each other, and that health care is a humanitarian endeavour. Since they made the changes, Jane explained that the relationships between receptionists, other staff and service users have improved with fewer arguments and complaints. It is possible that these environments encourage health care staff to engage more humanely with their service users.

The NHS appears to find it particularly difficult to create these welcoming environments that might encourage warmer relationships, a greater sense of co-ownership and closer collaboration. A paper by The King's Fund on improving patient experience of almost a decade ago makes similar points about the need to create more welcoming environments to support wellbeing and collaboration (Waller *et al* 2011). At the Limelight Centre, the ground floor provides a masterclass in how to welcome people into a building. The leaders of the health services walk through it every day on their way to their surgeries. Yet the clinics on the first floor remain sterile and forbidding.

For Dan Hopewell, the perception of health care as a service industry leads people to think that high quality health care environments should look like shopping centres or banks, with touch screens rather than human contact, rather than places that feel safe, welcoming and humane. Changing the aesthetic can signal a change in philosophy about how care should be delivered, and a change in thinking about the appropriate relationships between professionals and service users, something that some staff may disagree with.

Restrictive rules and regulations also evidently get in the way: contractual requirements preventing people putting things on the walls, contractual requirements on changes to facilities that mean in practice that it can taketake a year to move a notice board, and rules requiring even small changes to be made by an approved contractor, which means that minor changes like installing a new electricity socket can end up costing thousands of pounds. There is surely a case

for those with the power to do so to reassess the costs and benefits of these requirements if they prevent staff creating appropriate environments for care.

Figure 3 Furniture and artwork at the Bromley by Bow Centre

5 Collaboration with communities

Sarah MacLaren, now a registrar working in the NHS, remembers spending her weekends at the Bromley by Bow Centre when she was a child in mid 1990s. She remembers watching local people lay the cobblestones in the front courtyard and a group of local artists, including the Chilean sculptor Santiago Bell, developing the centre's distinctive stone carving, stained glass and ceramics. Meanwhile her father, Gordon MacLaren, oversaw the construction of the new buildings that would over the next few decades become the café, community spaces, workshops and primary care clinic.

The leaders of the Bromley by Bow Centre in the 1980s and 1990s were influential people who had clear views on the early direction of the centre. Nevertheless, a wide range of people from local communities in Tower Hamlets were actively involved from the start. There may have been an idea in the mid-1980s but there wasn't a blueprint. Nobody had mapped out a centre combining the arts, education, community activities and health services to address the social determinants of health and wellbeing. Instead, Bromley by Bow was a grassroots initiative where local people tried different things, drawing on the resources around them, to address specific needs in their communities, a process of trial and error over three decades that has led to the centre people visit today.

Joe McIndoe, the partnerships manager for the charity Groundwork, shared his experiences as a partner or observer in the construction of several new health and wellbeing centres attempting to replicate the Bromley by Bow model. The officials overseeing these developments generally start with a very clear blueprint of the type of centre they want to create, typically based on models they have seen working elsewhere, rather than starting by developing close relationships with the local community and a deep understanding of what local people really want and need from these facilities.

The engagement with local communities often happens at a relatively late stage, when the officials responsible, sometimes in the leading clinical commissioning group, have already decided what the centre should look like and what services it should provide. This engagement is typically restricted to setting up advisory groups or formal consultations, rather than the more fluid partnership between

institutions and local people that developed at Bromley by Bow. There are no local people laying the cobblestones in the courtyard.

The officials leading these projects may not have the expertise, time or resources to engage communities effectively. In some cases, the pressures for public bodies to spend surpluses in year make it particularly difficult to do so. In one example, the public consultation on a new centre was run in parallel with the design and build so that the funding could be spent within the financial year. When the centre opened, people started pointing out the design flaws.

These differences in approach go a long way in explaining why public authorities have found it so difficult to replicate centres that bring health and communities together effectively. If local communities are engaged cursorily, rather than actively driving the project, they are unlikely to feel any great sense of commitment or ownership to the enterprise once the facility is built.

If officials start with a preconceived blueprint, rather than exploring sincerely with local people their needs and priorities, there is a risk that they replicate the sort of approaches that seem to work well in other areas, while failing to understand the sort of person likely to visit this new centre and what they really need. One centre was set up in a place that few local people could get to unless they had a car.

The good news is that these problems do not inevitably condemn an initiative to failure. Interviewees recognised that some of these problems occurred in the development of the beautiful Michael Burke Wellbeing Centre in Suffolk. While it has been a struggle, it has been possible to develop stronger connections with local people and adapt the facility to local needs after the construction was finished. However, not all of these initiatives seem salvageable. Some of these buildings won awards for architecture when opened, but have remained empty ever since.

The Limelight Centre in Greater Manchester was an example of a new centre developed in full partnership with the local community. Leaders from Trafford Housing Trust visited Bromley by Bow in the early 2010s and committed to copying not just aspects of its facilities, but its approach to coproduction with the local community.

Before starting the planning process, the trust appointed a community development worker to build relationships with the local community and understand its needs. Staff spent time talking to local people in the street about the development, ran street parties to get everyone involved and set up design action groups with local people to oversee different aspects of design and

construction. The community made all the key decisions: the decision to knock down the existing centre, the decision to relocate the local church to the other side of the main road, and the design and layout of the centre.

The result is a centre that people like to visit and addresses genuine needs in the community, like how to manage an affordable marriage or christening for example. When Limelight opened in 2017, the trust and local community had already developed the relationships and ways of working needed to make the centre a success.

6 Catalysts and connectors

Kay Keane, the manager of Alvanley Family GP practice in Stockport, another Altogether Better collaborative practice, describes spending her first few months at the practice getting to know local people and the community around her. She started chatting with people in the waiting room about their needs and their experiences of visiting the practice. She got to know the patients personally, for example an older lady, Florence, who visited the practice two or three times each week, partly because of health problems but mainly because her social support networks had broken down.

Kay also went outside into the local shopping precinct and talked to local shopkeepers about their relationship with the neighbouring GP practices. She talked to the local allotment society who gave the practice a piece of spare land to run gardening and cooking clubs. The woman who runs the chip shop knew a civil engineer who brought round a team of apprentices to renovate the site.

Around the corner from the practice, Kay found a community café that was fighting for business. She established a partnership with the café to host peer support groups and community activities. Every month, two of the practice's health champions, who are also musicians, run an incredible sing along at the café with local people. The café generates additional revenues. The singalong arguably does more for some people's wellbeing than any prescription the GPs could have offered.

Whenever there is effective collaboration between public services and communities, on use of facilities and other things, it appears that there is somebody like Kay, or a group of people like Altogether Better, who play the role of catalysts and connectors, encouraging the community to get involved in using NHS facilities and spotting opportunities to bring different community, voluntary sector and public resources together.

In our two primary care examples, brilliant practice managers found a way of playing this role alongside their day jobs. At Bromley by Bow, there is a team of staff responsible for developing partnerships with local communities, other voluntary sector organisations and public services. At the Limelight Centre, there are managers and community connectors whose role is to create partnerships with local people, local businesses and local voluntary organisations.

When attempts to recreate Bromley by Bow go wrong, the absence of people playing these connector roles also seems to be a significant part of the problem. Consider the health and wellbeing centre in our prologue. The intention was to create a centre bringing together a range of health services, social services, voluntary sector services and community activities to support health, wellbeing and holistic care.

Once the construction was complete, nobody was responsible for overseeing the centre and ensuring that these ambitions were achieved, for example bringing together the right mix of services, making connections between them, and building relationships with the local community. Instead, the property management company leased the floor space to whoever could afford it, leading to an incongruous mix of services. One local GP has tried to offer leadership but lacks the time, resources and authority to bring the centre to life. Staff who were supposed to benefit from working on a single site never meet each other. Local people are unaware that this was supposed to be a community space.

These examples seem to reveal a blind spot in NHS authorities' thinking about how to bring together pubic services, the voluntary sector and local communities in shared facilities. They seem willing on occasion to spend considerable resources constructing impressive centres. A new health and wellbeing centre in some parts of England can cost many millions. However, they are unwilling to provide the ongoing support to deliver a partnership model effectively, assuming incorrectly that somebody else will pick up this responsibility once the build is complete.

Community organisations like the Bromley by Bow Centre and Community Action have the expertise and local connections to bring together partners and communities in ways that deliver more holistic care and better use of shared resources. It is possible that some primary care networks might evolve so that they can play this role. But a small amount of funding needs to be dedicated to the activity. Without tens of thousands per year to support their operation, the many millions invested in these centres risk being wasted.

Figure 4 Connecting people and resources at the Alvanley Family Practice, Stockport, Greater Manchester

WELLBEING PRESCRIPTION

NOTE Did you know that Alvanley Family Practice Health Champions can offer so much more than you think. Check the list below to see if any of the services or activities may be of interest to YOU. Just put a tick in the box of those you like the look of, complete your name and contact details and pop it in to reception. Alternatively you can email us with your inquiry and details to: **stoccg.healthchampions@nhs.net** or telephone **0161 426 5757**

PART 1 *I am interested in receiving more information about the following:*

- ☐ **Weekly Walks -** *Every Wednesday 12 o'clock from practice*
- ☐ **Coffee and Conversation** - *Feeling alone, fancy a chat?*
- ☐ **Social Events for New Mums** - *Don't feel isolated and alone*
- ☐ **Pram Pushers Walk** - *Bring along junior for a friendly walk*
- ☐ **Singing for Health** - *Monthly Singalongs with the Champions*
- ☐ **Knit and Natter** - *Friendly banter with like minds*
- ☐ **IT Skills -** *Let's get you started with the basics*
- ☐ **Telephone Support** - *A friendly voice on the end of the line*
- ☐ **Practice Allotment** - *Growing and much, much more!*
- ☐ **"Veg on prescription"** - *Grow it, cook it. eat it !!!!*
- ☐ **SMILE Sessions** - *Armchair Excercise; Walking Football etc.*
- ☐ **Feed the Birds** - *Our scheme for wildlife and wellbeing*
- ☐ **Arc Centre** - *A variety of arts for relaxation & wellbeing*
- ☐ **Introduction to Volunteering** - *Why not get involved?*
- ☐ **Community Organising and Listening** - *Short course*

PART 2 *I understand that the details I give will be passed to the Alvanley Family Practice Health Champions who will then contact me with the information I have requested*

Name:

Contact Number/Email address:

7 Small but practical changes

Kathryn McDonald is a support services manager for NHS Property Services based at its support centre at Houghton-le-Spring in Tyne and Wear. She is also an enthusiastic gardener and somebody with an interest in how to support healthy communities. Every day on her way to work, she would pass a plot of overgrown land owned by NHS Property Services next to Houghton Primary Care Centre. She put forward a proposal to NHS Property Services to turn the site into a community garden, gained funding for a shed and tools, found twenty volunteers from within NHS Property Services willing to spend a few days gardening, and worked with Groundwork UK to renovate the site.

With a few thousand pounds of seed funding, they cleared the debris, established a system for collecting groundwater, made polytunnels using thrown away plastic bottles, created disabled access and built a network of raised planting beds. Within a few months, an unloved strip of land had been transformed into a beautiful community garden.

Kathryn established a partnership with Sunderland Recovery College who now oversee the garden and run courses there for people recovering from mental health problems. Participants love working together outdoors, growing their own food and cooking and eating together. People from the local community have started coming back to the space. The plan now is to engage more volunteers and local people in maintaining the garden and growing food for the community.

We heard about many similar examples of small but impactful changes to take underused outdoor and indoor space and make them useful for local communities: turning a small amount of outdoor space into an allotment, allowing a group of 'men in sheds' to turn a hospital outbuilding into a repair shop, giving a charity access to a spare room to run a food bank, or turning a corner of a GP surgery into a 'living room' where volunteers can chat with people struggling with poor health or isolation. The King's Fund's report on gardens and health provides other examples, such as the Lambeth GP Food Co-op, where people with long term conditions grow food for sale to King's College Hospital (Buck 2016).

What's striking is just how little resource is needed to make better use of these spaces and the scale of the benefits for local communities. The organisations

responsible for managing NHS services also benefit. You no longer need to pay for so many security firms to visit vacant buildings or repairs to vandalised facilities if community members are helping to take care of them. However, we need people to be able to take time away from their other responsibilities and organisations to create an enabling environment for these types of project, for example proportionate processes for considering small scale changes in how facilities are used. Some people we talked to abandoned similar plans after time consuming discussions with estates managers about the costs, benefits and hypothetical risks of redeploying corners of estate.

Some of our examples provide a glimpse of what could be achieved if organisations were more systematic in spotting and exploiting opportunities to redeploy estate for community use. At Alvanley Family Practice and Blackmore Vale, among other examples, the practice managers and practice health champions pursue many different opportunities to make better use of their facilities and other resources in the local area: creating a community space in the waiting room, turning a corner into a place for children and families, turning a spare corner of outside space into an allotment or garden, finding a small area where people can cook and eat, making small changes to open up a spare room or 'health promotion' room for the community, or making better use of nearby spaces, such as the church hall or the local café.

While they may lack the grandeur of a purpose-built site, these pragmatic strategies, if applied consistently, can bring together the range of resources we see at centres like Bromley by Bow. Given the costs of new builds, and the risk of these projects going wrong, it is possible that more can be achieved through accumulating pragmatic changes than pinning our hopes on new buildings. For this to happen, though, people like Kathryn McDonald, Jane Dawes and Kay Keane – and their many colleagues – need the time to pursue a concerted strategy rather than one-off projects.

Figure 5 Construction of the Houghton-le-Spring Community Garden

8 The case for co-location

At the Blackmore Vale GP practice in Dorset, the first thing you see as you walk into the surgery is the small community wellbeing hub in an alcove by the reception. While you are waiting for an appointment, the volunteers who staff the hub, known as practice health champions, might offer you a cup of tea and some home-made cake. During your medical appointment, the nurse or doctor might also suggest you spend some time with the health champions, wonderfully empathetic people who, like a social prescribing link worker, are skilled in connecting people with local resources that could improve their wellbeing. The health champions might connect you with a peer support group for pain management or chronic fatigue, encourage you to try a mindfulness class or invite you to join the cooking club for a meal. They even have pedal buggies to help people with limited mobility get to these activities.

Dan Hopewell and other interviewees made a strong case for adapting existing NHS facilities to bring together primary care services and a range of other support services and community activities together on a single site. On average, primary care practices in England see close to one million people every day. People are familiar with their practices and generally find it easy to get to them. Some people, like Florence at Alvanley Practice, are willing and able to come to the practice but might struggle to get to other locations. When primary care and social support are located at the same site, it becomes easier to connect people with the support they need, for example a GP can walk patients round to the health champions rather than handing a leaflet for appointments at a different location. The King's Fund's research on volunteering in general practice also highlights benefits of co-location, including an increased likelihood that health care staff will refer patients to social prescribing services located at the same site (Gilbert *et al* 2018).

For Dan and others, however, the strongest argument for co-locating activities was the impact on relationships, culture and ways of working in health services. They suggested that health professionals were more likely to develop more collaborative relationships with other professional groups and service users if they spent more time in the same spaces getting to know each other. At Blackmore Vale, the practice health champions spend their time in the surgery office and the staff room as well as the reception area. The doctors, nurses and volunteers get to know each other. I found my own preconceptions challenged when I talked to one of the health champions. I had expected an older person

with time on their hands. I met a person with astonishing breadth of personal and professional experience, empathy and insight into the people she supports.

There is also some evidence that bringing different people and activities together on a single site can help to change healthcare professionals' perceptions of their work and their approach to care. While things are changing, Dan Hopewell argued that a significant proportion of primary care doctors still have a limited understanding of the social determinants of ill health. When they start to spend more time with social prescribers and health champions, they begin to understand what is really driving ill-health, even in people they have been looking after for decades. As they develop a better understanding of what social prescribers and others do, and its value, they start to bring a stronger focus on social and psychological factors into their own practice.

For some of our interviewees, there was a longer-term ambition in co-locating health and other support services: laying the foundations for a 'social model of health' which addresses the social causes of ill-health as a key primary objective, rather than as an afterthought once the medical consultation is completed. Under this approach, some people might see the social prescriber or health champion first, on the basis that social activities are a better solution than medical care for many health and wellbeing problems, with the medical staff in an important supporting role. It is a model that has already been operationalised in mental health crisis services, where peer support workers engage with people in the first instance, bringing the medical staff in on rare occasions where this is needed.

Of course, it is clear from the examples above that simply juxtaposing medical services, social prescribers and community activities in the same building does not necessarily lead to any of these hypothetical benefits. The primary care doctors and social workers in the London centre described in section 1 above never talked to each other. The wonderful community hub on the ground floor of the Limelight Centre seems disconnected from the health services on the first floor.

The architect Gordon MacLaren was sceptical of claims that architecture can overcome significant human problems. As he put it, the design of a facility is not going to pacify an angry service user, transform a high-handed doctor into a people person, or turn warring tribes into happy families. At most, the design of facilities might nudge people a little towards different behaviours or make particular interactions more or less likely. At best, colocation is one of a number of possible enablers for better relationships, culture change and closer team working between healthcare staff, social prescribers, social workers, voluntary

sector organisations and local people. The following section discusses some of the other ingredients that need to be present.

It is also clear that primary care facilities are a good place to connect with, and locate additional services for some people, but might be less suitable for others. There are people who pop into the primary care practice as part of their weekly routine. Some people with mental health problems, however, have strong reasons for wishing to avoid support in places that feel like traditional medical services. As discussed above, these problems are most significant in environments that feel sterile and unwelcoming. The conclusion is not that we should try to cram as many social services as possible into primary care facilities, only that these can offer a useful site for some services, for some people, in some localities.

Figure 6 The Michael Burke Wellbeing Centre and Garden, Hartismere, Suffolk

9 A virtual Bromley by Bow

In Stockwell, South London, a primary care doctor, Vikesh Sharma and a health and wellbeing consultant, Will Nicholson have been working with the Guy's and St Thomas' Charity to develop a virtual Bromley by Bow. In the mid-2010s, Vikesh became concerned about the wellbeing of the local Portuguese population in Stockwell, people who arrived in Stockwell in the 1970s and 1980s, but remained isolated from the rest of the population, with poor levels of literacy, limited fluency in English, poor health and high levels of deprivation. They established the Lambeth Portuguese Wellbeing Partnership to improve the health of the local Portuguese community, and started doing practical things such as providing health information in Portuguese and meeting the local community at street events.

Following the success of the partnership, Vikesh and his colleagues set up the 'Thriving Stockwell' initiative, a neighbourhood health and wellbeing partnership to support the entire population in Stockwell. There is now a network of forty partner organisations who meet regularly to improve health and wellbeing in the community. They spot opportunities to pool insight and make better use of their combined resources, for example working with the local housing association to help people who run into financial difficulties, sending health staff into local schools, partnerships between health services and arts organisations to use the arts to promote wellbeing, and developing open spaces for outdoor activities.

Vikesh and his colleagues would have liked to bring together health and other services at a single centre for the Portuguese community, just as the Bromley by Bow Centre had done for its working class and Bangladeshi communities in the 1980s. But they didn't have the resources or the space. Instead, they focused on creating a virtual partnership between the different public services, community organisations and local people who could improve things for the community.

Will Nicholson described a little about how they had developed partnership working in the network. Anybody who is committed to improving wellbeing in Stockwell is welcome to participate. The network values the contributions of all participants equally, whether they are from public services, the voluntary sector, local businesses or are members of the public. They meet at a different location each month, for example the youth centre, school, GP surgery or arts centre. Wherever the group meets, the co-ordinators give the host organisation an opportunity to tell the network more about themselves, their work and priorities. They also look for opportunities for partners to contribute to the event, for

example bringing arts into the GP practice or catering for the session. Even though they aren't co-located, they can still engineer the sorts of connections that Bromley by Bow's environment encourages. You probably need to do this even if you are on a shared site.

For Will, these initiatives highlight some of the ingredients for effective partnership working to take off: some sense of the shared objective, active facilitation, regular interaction and equality in relationships amongst others. He also highlights the need to develop a culture of reciprocity. Health services often approach voluntary and community organisations with an expectation that they should help deliver the health agenda. Health services need to come ready to help partners achieve their own objectives as well.

Will Nicholson has a possible answer to the riddle of Bromley by Bow: the mystery of why so many influential people have visited, why so many people left uplifted and determined to recreate the model, but why it is still so hard to find centres in England that are comparable to the original, and why so many of the multi-million-pound attempts to recreate Bromley by Bow feel, frankly, hollow.

Staff focus on the superficial physical features of the design rather than the hidden details that make an innovation work. In Will's own words, we visit Bromley by Bow and assume that success lies in the beautiful cobbled courtyard, the café, the garden and the colocation of different services. We fail to notice the people and intangible infrastructure that holds this form of partnership working together.

10 Summary of findings

This paper has highlighted some of the challenges that NHS organisations face in sharing resources with communities, as well as the features of successful partnerships between institutions and communities. It paper has argued that one priority is to attend to intangible factors as a basis for more effective partnership workng. NHS managers and clinicians need to reappraise the question of ownership, recognising that NHS facilities are community resources, paid for by taxpayers to serve the interests of communities.

NHS staff need to build stronger and more equal relationships with communities, as a basis for better partnerships. They also need to build strong collaborative working with communities to develop a shared vision and shared plans for using facilities. In our examples, the health and care staff who attended to these intangibles now have vibrant partnerships with their communities, allowing them to make better use of estate and other shared resources. Those who started with the designs and the buildings have often constructed empty shells.

We have also argued that, in tandem with a change in relationships and ways of working, there needs to be a change in aesthetic. There is a strong case for reviewing the commercial aesthetic, copied from banks, accountancy firms and shopping centres, and starting to create more welcoming environments which make people feel at ease, valued and included. People are unlikely to want to make better use of NHS facilities without a sense of belonging. Services could start with small things such as taking down paternalistic notices, making waiting rooms more hospitable to children and families and replacing the regimented banks of chairs with arrangements that allow people to talk to each other.

Our examples suggest that small, practical changes seem to trump grand plans. Once NHS staff have developed more collaborative arrangements with voluntary organisations and local communities, they can start exploring dozens of small but significant opportunities to make better use of their estate. These approaches have already turned outbuildings into workshops and many small plots of land into gardens and allotments. Services need to pursue concerted strategies rather than one-off projects to get the most from this approach.

Whether NHS services are pursuing small practical changes or grand schemes, there needs to be resourcing for ‘catalysts and connectors,’ individuals or organisations with the skills and resources to build relationships with voluntary organisations and the community, bring the right mix of organisations and

activities onto a site, spot opportunities for collaboration and bring the constituent parts together. Without these catalysts and connectors, even the most ambitious plans tend to go wrong. Grand new buildings become parking lots for services. Nobody can remember why they re-located there. The people who were supposed to work more closely together never meet each other.

As well as philosophy, relationships and ways of working, these examples highlight the need for some changes to decision-making processes, rules and regulations to make better use of NHS estate with communities. For example, we have argued that the NHS should switch from granting access to facilities on an exceptional basis to granting access wherever this is practically possible, avoid using spurious arguments to refuse access, and work with communities to overcome practical difficulties when they arise. We have also suggested the need for some simple changes to the rules governing use of NHS estate to make it easier to create welcoming and hospitable environments for communities.

Summary of key findings

- Whether directly or indirectly, taxpayers have funded the development of the facilities used to deliver NHS services.
- NHS staff and organisations should allow community members to use NHS facilities for activities that support health, wellbeing and community resilience, wherever this is reasonably possible.
- If they are to do this, a precondition is to create more welcoming environments, where people feel a sense of common ownership, and where people would enjoy carrying out a broader range of activities.
- A second precondition is for NHS services to build stronger collaborative partnerships with their communities, so that they develop together facilities that respond to local people's priorities and needs.
- NHS staff need to make it practically easier for community members and community organisations to use NHS facilities, for example by removing or modifying bureaucratic rules and procedures.
- Public services need to provide funds for individuals or voluntary organisations to act as catalysts and connectors, if they are to turn NHS facilities into vibrant hubs to support health and wellbeing.
- While there is a tendency to focus attention on major new projects, NHS staff and communities can create vibrant wellbeing hubs by accumulating small changes in how estate is used.
- There are strong apparent benefits to bringing together a broader range of services and community activities on NHS sites, in particular to change culture and ways of working within health services.
- However, co-location is unlikely to deliver these or other intended benefits without proactive strategies to develop more collaborative working between different services and community groups.
- The long-term objective should be to create healthy spaces, welcoming spaces where people feel a sense of belonging, connecting spaces which help to build relationships, and flexible spaces that can be adapted to different uses to support health and wellbeing.

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13 About the author

Ben Collins joined The King's Fund in 2015 as a project director, working for the Chief Executive and across the Fund, including on policy and supporting the NHS in developing new care models.

Before joining the Fund, Ben worked as a management consultant. He has advised central government and the national bodies on a wide range of issues including economic regulation, provider finance, the provider failure regime and new organisational models. He has also worked with large numbers of NHS purchasers and providers on strategic and operational challenges.

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