Eight big themes

1. Understanding and overcoming the trust deficit
2. Greater recognition of community-led and peer-led activity
3. What and why; multi-purpose spaces
4. Location of the premises
5. Transport, parking, access and accessibility
6. Welcoming environments
7. Quality and inclusive culture in facilities management
8. Ownership of, or control over, the premises and processes

1: Understanding and overcoming the trust deficit

Through this project we sought to gain some insight into how previous encounters with statutory services, including but not limited to the NHS, have shaped people's relationship with and expectations of services. This is important background because:

- Some of the groups we spoke to have significant health and care issues and therefore have a significant need for NHS services
- Some of the groups have significant experience of the negative impacts of stigma because of their condition, or who they are
- This programme relates to NHS-owned buildings so community use of the buildings involves navigating a well-established power-dynamic

We found significant levels of wariness, scepticism and distrust of NHS and other statutory services across many groups. At the same time, we found a desire to have more positive relationships and a willingness to engage, as long as services are listening.

"A lot of communities have had such a lot taken away. The trust is gone... people think it's a fad."

"It takes time, allowing people to heal… it takes time and trust!"

There were significant differences in the experiences of the different communities we spoke to and many nuances to the background to the trust deficit. This is summarised in table five below These different experiences need to be understood, acknowledged and addressed if the NHS is to build trust.

Table five. Perspectives on trust and the trust deficit

Group	Perspectives on trust, and the trust deficit, from those we spoke to
Carers	Carers say they are frequently faced with judgement. Parents who care for children said they experience 'parent blaming', either for the condition or for elements of their child's behaviour. They have received draconian threats by letter for changes to appointments despite having made a significant effort to communicate well. Children who care for a parent are often treated dismissively.
People with, and recovering from, drug and alcohol dependency	There were trust issues raised, although there was frustration in the ability to access GP consultations.
Rural communities	There were no trust issues raised.
People with a learning disability	The only trust issue that came up was in relation to confidentiality: They asked for somewhere to go to shut the door and have a confidential conversation.
People of Somali origin or heritage	There were no trust issues raised. *"Somali people have a positive attitude towards medical services."*
People with experience of mental ill-health	The people we spoke to with experience of, and recovery from, mental ill-health pointed to significant trust issues with the NHS. They felt doctors' agendas for their mental health are predominantly medical. While younger doctors are now learning about Health Creation and how to help people in newer, fresher ways, many doctors remain 'stuck in their ways'. *"The medication never helped. It just kept me in the status quo. I saw nine different GPs before I got referred to somewhere where I started to get a solution."* Medical environments are not welcoming. And it feels to them as though the mental health agenda is the medic´s agenda, that they're being asked to join in with.
People from the LGBTQ+ community	There were no trust issues raised.

Table five. Perceptions on trust and the trust deficit cont…

Community	Perspectives on trust, and the trust deficit, from those we spoke to
Women from South Asian origin or heritage	There were no trust issues raised.
Disabled people	By highlighting problems with access and the environment disabled people often feel, they can be branded as troublemakers. We were told about a parent advocating for their child being labelled as 'mad' – it was written in the patient's notes.
People from the Roma community	Many Roma have negative experiences of using health services in their countries of origin, and this contributes to a distrust of health and care providers and a reticence to access services in a timely manner. This results in healthcare inequalities. These factors will impact on their belief in, or willingness to access, a community venue.

Although the focus groups and interviews we undertook did not go into great detail about how to build trust, a few insights were offered. These centred around making the effort to talk to people on their own turf:

"Go to the barber shops, parks, temples, mosques – the places where people reason with each other. Stop going to the hospital, job centres, GPs [to find out what people think]."

"To engage with the people who are most vulnerable… you have to go into the 'hard to engage' spaces."

The Health Creation Framework offers significant insight and approaches for trust building. In particular the six features of health creating practices – Listening and responding, Truth-telling, Strengths-focus, Self-organising, Power-shifting and reciprocity – are hugely important for creating constructive relationships at the frontline.

2: Greater recognition of community-led and peer-led activity

NHS Property Services' main focus in the Social Prescribing Programme is to support social prescribing activity. Through the conversations, this project drew out some important insights relating to the breadth of community activity that happens outside of formal social prescribing activity that could be supported by this programme, by NHS Property Services and by the NHS more generally.

Beyond social prescribing

Not all the groups we spoke to had heard of social prescribing, although where they had, they were generally positive about it.

"Social prescribing; I've been begging for it! For autistic people, sensory experiences help a lot."

Some community groups described what they are doing as 'social prescribers' for their communities. Bristol Somali Resource Centre described everything they do as 'social prescribing' for people from their community and while formal social prescribers frequently make referrals to them, their activity is not supported financially by the NHS.

Self-sufficient communities

A number of the community cohorts we spoke to are quite self-sufficient. They will go to other members of their community before they seek help from the NHS.

The Roma community relies heavily on informal networks and often don´t see a need to access other support. The women of South Asian origin we spoke to explained they will often turn to their community for support. They consider primary care and hospitals as the supporters of their health and wellbeing and are not familiar with community services and support as part of this.

Some groups suggested that communities could organise and run facilities being offered in these spaces such as cafes and creches. Some suggested communities manage the whole facility, and some wanted an ownership stake.

All communities wanted the NHS to value their strengths and to help them support each other within their communities.

Support for peer-support

Several people also talked about the success of peer-support in creating health.

Peer-support is where someone who has had the same or similar experiences comes alongside a person and helps them to find their own way to a better life and better health, drawing on their own experiences to help guide them. It can be a very successful way to help someone reconnect with others and with themselves, build their confidence and take control of their lives in ways that work for them. A number of people suggested that NHS Property Services' Social Prescribing programme could actively and officially support peer-supporters, including DIY peer-supporters, by making spaces available for them to meet and learn together and with the people they're supporting.

Being aware of and support broader community Health Creation

Communities create health within their own communities often without recourse to medical help or to formal social prescribing. This happens in many informal ways. While communities are interested to explore the potential for new community premises, it's important that they complement the spaces that are already available and being used by communities.

Greater recognition of the many ways communities create health, and support for them to do so through the Social Prescribing programme, would be beneficial. It is important that NHS Property Services doesn't limit itself to only supporting paid, formal social prescribers but sees the programme offer as more broadly supporting communities to create health.

THCA recommends that NHS Property Services renames its Social Prescribing programme and makes it explicit that the programme is intended to support communities to create health and wellbeing whether or not this is through formal Social Prescribing.

Calling the programme ***Creating Spaces for Community Wellbeing*** or something similar is more accurate, and it will resonate well with communities, as it places a value on their efforts which are often informal and largely go unrecognised. It would signal that the spaces are for them and not just for formal social prescribing activity.

THCA also recommends that NHS Property Services undertakes research with communities into what community spaces are already available in a locality, how they are used and what the gaps are. This will help to ensure that development of a building complements what's already available.

3: What and why: multi-purpose spaces

Many groups favoured multi-purpose, rather than single purpose, spaces.

Multi-purpose can mean several things

'Multi-purpose' can mean the same spaces being used by multiple communities for many different purposes. It can also mean integrating a range of specific services within buildings so people can access several services through a single visit, often referred to as a 'one-stop-shop'. It can also mean a hybrid model where some services are located in buildings that are used for a variety of other purposes by several communities.

"Multi-purpose buildings are better, we don't want to be singled out."

The benefits of multi-purpose spaces; being part of something bigger

The people we spoke to offered a range of reasons including:

- the potential to mix with people who aren´t the same as them, offering them the possibility of connecting with different aspects of themselves

"It helps not to be known as just one thing."

- reducing stigma as people don't have to know the specific reason people are going there

- creating spaces for a range of non-service specific activities/events will help to engage people who would benefit from the services, but are unaware or reluctant to do so
- the potential for multi-purpose spaces used by many groups to help build strong communities (increasing the social ties between people is proven to improve people's and communities' health)
- it can bring different cultures and generations together. One example given was of immigration advice being the draw for one individual, while a sport activity might be the draw for their son
- the intersectionality between the groups and the tendency of system processes to categorise and split people up too much
- multi-purpose places for activities, with screens for watching videos and to use online communication
- adequate space, facilities and equipment to cater for diverse, multi-generational needs with a focus upon low income families/citizens and supporting cross-sector working between various agencies workers

Multi-purpose buildings benefit from 'connecting activities' that serve many different groups. Examples of this include an affordable cafe a gig night, Wi-Fi and private spaces for using the Wi-Fi.

These things will encourage people to visit the centre and connect with others; they provide a platform to raise awareness and engage people in the services on offer.

"Structure events where a variety of local communities come in… 'structured events' could be going to others' events… a structured set of conversations, a little BBQ, a dance."

"It's about linking people to where they might find the wellbeing… rather than the prescription note."

Flexibility to accommodate diverse needs

Some communities have more specific culturally sensitive needs, so where multi-purpose spaces are being created this needs to be done in a culturally sensitive way. For example, women of South Asian origin request women-only spaces, and cooking facilities because preparing and eating food together is a bonding experience. Also, cafes don't typically provide culturally reflective food. Both of these could be negotiated within a multi-purpose building, for example, through making Thursdays the day when women of South Asian origin take over the cafe, potentially cooking for other members of the community too, and when suitable spaces are dedicated as women-only spaces.

Several groups said that private rooms to talk in confidence with others where important so a mix of small rooms and larger spaces would work well in multi-purpose buildings.

4: Location of the premises

Where the buildings are located is very important to many groups. Again, there were a range of perspectives on what constitutes a 'good location' and also what to avoid. Individuals from at least two groups expressed some suspicion as to why some NHS buildings were empty in the first place with a concern that a poor location would make it less useful to both the NHS and to communities. Geographically remote locations don't work well.

Diverse perspectives on 'a good location'

Different groups offered many other insights into what makes a good location (and what to avoid):

- The carers we spoke to wanted community buildings to be located close to other facilities…

"…so that many people will be tempted to use these spaces too."

This was tied up with their desire not to be pigeon-holed or isolated, but to be in spaces where they can connect with others and feel more integrated into their community.

- A criminal justice perspective was offered from one group with a plea not to develop community spaces on the borderline between warring factions or gangs. Where this has happened in the past, the venues are not used

"They make these huge beautiful buildings and rip up the small little places… and they put it on the borderlines."

- A large number of Bristol's Somali Community live in one part of the city, Barton Hill. If they could get access to an accessible NHS venue where they could hold events to their own schedule, close to where their community lives, it would make a big difference
- Location of venues is a perennial problem for rural communities due to the dispersed nature of residents and infrequent public transport. Towns and villages are usually the most sensible places for venues; however, survey respondents also pointed out that flexibility of access to unused NHS buildings would help.

"One rural project had a village hall venue for activity and wanted to use a vacant room in GP surgery across the road – the red tape required to hire the room was very tricky as VCSE aren't allowed to do so."

- Developing community venues close to addiction services, such as substance misuse services, was not seen to be a good idea by the focus group for people with experience of mental ill-health; they didn't want the two to be associated with each other in the public's mind. However, some of the people from the focus groups of people with, and recovering from, drug and alcohol dependency wanted services they use to be located within a venue that is used for other purposes

Listen to invest wisely

A plea to listen to different groups about where, and where not, to invest resources was made by a number of groups. Also they suggested that NHS Property Services considers how the investment can help to improve the building's surroundings too, with input from the local community.

This was borne of experience of their advice having not been heeded in the past, and buildings having to be reworked or not being used at all.

"One of the buildings has gone back for refurb."

5: Transport, parking, access and accessibility

While accessibility of buildings themselves was the main theme for the group of disabled people, it was also raised as important by other groups who have older or disabled members and who want to create an accessible environment. The broader issues of being able to get to the venues and timely access to them were also shared by several groups.

Transport and parking

People want to be able to get to venues without too much cost and stress. Having a venue close to where they live is very convenient but not always possible. For many groups, including women of South Asian origin, people from rural areas, people from the Roma community and disabled people, affordable public transport was highlighted as being very important. In rural areas in particular, concerns over infrequency of buses were an additional concern making community transport schemes more important to engage.

Parking arrangements are important to get right, even if this is about developing agreements with other venues close by to use their parking spaces at certain times of the day or providing a 'drop-off' area. Some disabled people and carers need dedicated parking close to the venue at the times they want to use the facilities.

THCA recommends that NHS Property Services always undertakes a transport audit – including bus timetables and costs, consultation with people who run community transport schemes and parking arrangements – to be sure they know what form of transport is already in place to support people to get to the building. Where the transport is inadequate, NHS Property Services could bring transport groups and other local stakeholders together to work up a plan to enable access to venues.

Access to the buildings

Being able to book venues easily is important in rural areas in particular where the location can be a big factor in what makes a venue useful to a community.

However, it would also be appreciated by other groups. The current system for room-booking is seen as bureaucratic and awkward and sometimes prohibitive for community groups.

Several groups asked for keys to access the buildings. This is tied up with wanting more control over use – see Big Theme 8. An additional driver for rural groups is so they don't have to wait for the official key-holder to turn up. If they don't, it could involve a significant wasted journey.

THCA recommends NHS Property services reviews and simplifies its room-booking processes making it easier for community groups to book rooms. In some instances it might also be appropriate to install key code access and arrangements for granting autonomous access to certain groups.

Accessibility and communications

The disabled group asked for an Access Statement, informed by disabled people and updated regularly, to be made available on websites for every building. However, they also wanted a shared commitment to, and responsibility for, 'inclusive design' and for fixing problems proactively on the grounds that accessible spaces offer broad benefits to many people, not just disabled people. Cultivating this shared approach helps to build support for and broad appreciation of truly inclusive environments; it can help to bring diverse communities together and support community cohesion.

THCA recommends that NHS Property Services requires an Access Statement to be drawn up and regularly updated by an 'accessibility group' that advises on improvements to access and published on its website for all of the premises it makes available for communities to use.

6: Welcoming environments

Almost all the groups said that a good, welcoming environment that is safe and comfortable is very important. When this type of environment is created, people are more likely to feel relaxed and more able to talk and connect with others. While some pointed to the need for buildings to be 'not too NHS-like' in design and function, many positive reasons for the community to engage with the space were offered.

Having a welcoming, inclusive and culturally sensitive reception from people managing the facilities is a big part of this and is picked up in Big Theme 7. There were some common elements to what a welcoming and attractive physical environment looks and feels like.

An effective community space should look to balance all these requirements while supporting, understanding and creating something of an experience.

Inclusive design and balancing different needs

Building inclusive design into spaces early on – making communal venues accessible for disabled people – benefits everyone and all groups. It would enhance the draw for many groups and support long-term sustainability and use of facilities. Involving many different groups in this process would help to meet the specific needs of particular groups and find solutions to any tensions that arise over use of communal spaces.

The welcoming feel needs to be reflected throughout all parts of a building including reception, meeting rooms, shared areas where people can connect and rooms that might be used for consultations and face-to-face meetings.

"Getting into a building is one thing, feeling you belong there is another."

An affirming environment

Community buildings need validating, affirming spaces that recognise people as human beings and offer them the 'space' to express themselves.

For some, such as people from the LGBTQ+ community, this means actively communicating they are welcome there. For others this means feeling safe in the space, for example, by having women-only spaces or times.

And for many people, this means not placing unnecessary restrictions on use of the space, for example, through strict policies and procedures that would limit use, such as not being able to put posters on notice boards.

An affordable cafe, with a range of things for people of all ages to do, was seen as very welcoming and sociable.

Large and smaller spaces

Alongside spacious communal areas where people can meet and activities take place, there was an appetite for smaller, 'private' spaces where people can find refuge and talk in confidence.

Calming, sensory environments

Low stress, calming and 'sensory' environments were mentioned often as an antidote to feelings of anxiety, boredom and disruptiveness which can prevent 'difficult situations' arising. Good lighting was also mentioned as part of this.

Hybrid meeting technology

The potential to host hybrid online/face-to-face meetings through screens in some meeting rooms was seen as welcoming to those who couldn't access the buildings physically.

Welcoming outside areas

Having a welcome approach to a building and the surrounding area is important. This means keeping the area clean and making sure it is attractive, somewhere people feel good being seen going into.

Outside areas more generally, with gardens, perhaps where people can grow vegetables, was seen as attractive. And for others, being able to get out easily to overcome feelings of restlessness or claustrophobia are part of the positive sensory environment mentioned previously.

7: Quality and inclusive culture in facilities management

The quality of facilities management came up frequently in the conversations.

Supporting emotional as well as physical accessibility

This went some way beyond managers' competency managing the premises, although that is important, into how they interact with people, how they respond to feedback and how they create the conditions for diverse communities to use the premises in a way that fosters relationships, trust and is inclusive. When seen in this way, 'accessibility' might be seen in terms of both physical accessibility and emotional accessibility – whether or not people feel they 'fit' and have a place in the community.

Disabled people came at this mainly through a physical accessibility lens. They spoke about the need for proactive maintenance – such as lifts, evacuation chairs – responsive repairs and good communications to provide timely and regular updates. Staff need to be properly trained in how to use equipment and also in how to provide information about access on their website. They need to be able to bring an 'access group' together and listen and respond to their feedback in a constructive manner.

Inclusivity training

Most groups felt that facilities managers needed to be well trained in how to manage premises in an inclusive fashion. Being skilled in fostering good relationships between the different groups and individuals who use the venues is an important aspect of facilities management as it creates the conditions for wellbeing.

The people we spoke to who have a learning disability felt that facilities managers need to be trained in learning disabilities, preferably by someone, or several people, who have a learning disability.

Equipping managers with better knowledge from a position of experience would help to reduce the potential for unconscious discrimination and it could also help them to take steps towards creating an inclusive culture so that people feel acknowledged, that they belong in the place and can be themselves.

Much of this was echoed by the Roma group we spoke to, who have experienced the negative impacts of stereotypical attitudes both from NHS staff and providers of community spaces in the past. They expect staff to be empathetic and felt there needs to be an emphasis on establishing a relationship of mutual respect and understanding between a community space, its staff and the Roma community. Education and outreach in a culturally appropriate manner would further help their community to be able to make use of the spaces.

Understanding different perspectives is important for facilities managers. While the LGBTQ+ community welcome a well-positioned poster welcoming people from their community, flying rainbow flags from the building might deter some people who might need discreet places of access so they are not outed by a hostile party.

Managers with lived experience

Several groups, but particularly those we spoke to who have experience of mental ill-health, felt that some management roles might be best undertaken by someone who has had some form of 'lived experience' themselves; people will respond well to ´real spaces with real people'.

"Population spaces with people with lived experience; they will have a heart for things".

Some felt that this role could be an opportunity for someone, or several people, with experience of living in an underserved community to gain access to paid employment.

THCA recommends that NHS Property Services enables a range of 'inclusivity training' for facilities manages, offered by a range of groups including people with lived experience. This should include how to manage premises and create welcoming environments used by diverse communities and how to create the conditions for people to come together and take action themselves.

THCA also recommends that NHS Property Services commits to developing people using their spaces, in particular people with lived experience of poverty, trauma and discrimination, to become facilities managers.

Q8: Ownership of, or control over, the premises and processes

Having more control over access to premises and how they are run – including who owns and controls the buildings – emerged spontaneously in some of the focus groups. While the perspectives and reasons varied, the standard model of leasing to a main tenant who then sub-lets the premises to a range of community groups, was felt to be too narrow.

"One day, I'd like to have community shares so I can be an owner and call the shots on maintenance. It's easier – if something is owned by the community, then it's easier for someone to say I'm part of this community too."

Ownership of premises

The groups that unprompted told us they would like to have an ownership stake in the building include: Carers, People with experience of mental ill-health, disabled people and people from rural communities. The group of people with experience of mental ill-health wanted to work with the community to develop it.

"Give it to us, we'll sort it out!"

One group likened community ownership to the example of a community shop.

Reasons offered for wanting to have an ownership stake included:

- Frustration about not being included in discussions as the buildings are established or redeveloped. Too often this is done without talking to the people that are expected to use the buildings
- The potential for individuals and communities to become more empowered through having a stake, and therefore more control, in their community building
- The commitment effect whereby people invest their own time and resources into the design and management of the building
- The increased potential for 'making it right for them'.
- The savings that could be made through either selling or gifting buildings to the community

"It's easier to sell the asset – get a quick buck but then have to pay double/treble… Give the asset to the community – save that… "

"Letting the community build it – when they have helped to build it, they are involved, they are more inclined to get involved in running it. People need to be employed (paid) in this process."

Control over access to and use of premises

Some groups wanted to have access to the building, for example by having keys or key codes, so that they could enter and use the premises out of hours.

When asked, the Bristol Somali group said that they already have their own office space for one-to-one meetings but they wanted control over use of larger events spaces for bigger meetings. Having the keys and/or access to the venue out of regular 9-5 hours, so that they can have meetings according to their community's needs and schedules, was very important to them, especially since many people in their community have small jobs working unsociable hours and juggling childcare. However, owning the premises was not important *per se.*

Reasons given by groups for wanting more control over access and use of premises included:

- Being able to host events at times that suit their community
- Being able to offer an evening 'youth centre' to enable young people to meet together, offering a place for them to talk about issues affecting their communities and keeping them away from 'unhelpful activities'
- In rural areas, delays to get access to buildings, where travel is involved for the keyholders, are a cause for frustration

"We need access in terms of permission to be keyholders."

- Being able to offer women only space and time
- Not being hindered by over onerous NHS guidelines and policies for use of buildings

"If we had a room we would be able to run everything from that one space – it would make a big difference. It's not about owning it, but about maximising the opportunities for the community."

Not all groups were specifically asked about this issue so this does not exclude other groups also being interested in ownership and control over assess and use. However, the matter of ownership and control goes beyond the buildings and is clearly part of a bigger issue about people being unable to get access to the things that would make their lives better.

"Need a whole cultural shift over the people who own/control your access to the resources you need."

Inclusive models of ownership and control favoured

All the groups that raise the issue of ownership and control were mindful of the need to be inclusive and share the space and ownership of it with other groups. This is in line with the strong desire for multi-purpose spaces.

The disabled people we spoke to felt that collective ownership and control could be a route to greater levels of understanding and cohesion between different groups.

"Shared ownership / responsibility would … draw people in and connect them to the behaviour, maintenance and workability of a community building. Working together with disabled people to… [foster] a culture of raising and taking responsibility for fixing problems proactively would help to consolidate this shared approach."

The focus groups did not go into depth about specific models, beyond the headlines of 'community shares', 'co-ownership' or a 'cooperative model of ownership'.

THCA recommends that NHS Property Services commits to the principle of handing control over access to the property to the community, finding appropriate ways that work for local communities. Where appropriate and a suitable model can be found, ownership by the community should also be considered.

THCA also recommends that NHS Property Services undertakes further work to explore different existing models of ownership and control, to deliver on the commitment. Many collective leasing and community ownership models and already exist and it is important to learn from them about what works best and what outcomes can be achieved in which circumstances.

20.0 Contacts

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