Creating health and wealth by stealth

Community anchor organisations, prevention services, and the wider determinants of health

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locality
the power of community

power to change

VCSE health & wellbeing alliance

Contents

Executive summary

Aim

This research forms part of Locality's and Power to Change's work on the government's Voluntary, Community, and Social Enterprise Health and Wellbeing Alliance (HW Alliance). It seeks to understand how community anchor organisations (CAOs) can be better involved in health systems which successfully address illness prevention priorities within communities and through a wider-determinants-of-health approach.

This report builds upon our previous research into the impact of CAOs on the wider determinants of health. CAOs – which tend to be the largest and most established neighbourhood organisations – have broad and deep impact in this area. This is true not only of the number of wider determinants they address, but also of the range of population groups they reach.

We have sought to apply and extend the findings of that research to the investment in CAOs by the health system. Such investment can support them to provide impactful and sustainable health promotion and illness prevention services. This includes both those prioritised in the NHS Long Term Plan – including weight management, alcohol management, and smoking cessation – and others of interest for local authority public health teams. The report is based on a review of existing literature in this area, surveys and interviews with CAOs across England, and interviews with colleagues from a diverse range of health system roles.

The wider determinants of health are social, economic and environmental factors that influence health, wellbeing and inequalities.[1]

Key learnings

Our survey of CAOs found that most deliver their prevention work through an approach that combines multiple types of healthy living and wellness support. This means that specific services for individual prevention priorities, such as those mentioned above, tend to be embedded into a broader programme of support targeted at a range of health determinants – particularly social and economic ones. This reflects the holistic, whole-person approach taken by CAOs as illustrated in our previous research.

Key to the success of CAO prevention work for communities experiencing health inequalities was the consideration of cultural competence. CAOs led by and serving minoritised communities understand how to adapt services to be relevant to the practices and sensibilities of such groups.

In general, and despite the opportunities for impact presented by CAOs, we found that they were under-engaged by local health systems. However, we have identified four key ways in which health systems can improve the involvement of CAOs for the delivery of wider-determinants-led prevention services. These will be vital as we move forwards from the pandemic and through a cost of living crisis that will present significant risks to health. The role of CAOs in supporting local people with their income, benefits, bills, and employment will be particularly important for their wellbeing.

1. Maximising good practice:

- **Learning from pandemic partnerships** – During the Covid-19 pandemic, it became clear to local statutory bodies that supporting communities, particularly those most at risk, would not be possible without the networks and agility of VCSE partners. Due to deep-rooted health inequalities, those most impacted by the pandemic will also be the most impacted by other conditions too. There is much to be learned from pandemic-era partnerships to tackle these through prevention services.

- **Peer-led health promotion** – Health messaging has the greatest chance of landing with its target audiences when it comes from those they trust. Whether in the form of "community health champions", peer support groups, or otherwise, we found that the messenger is as important as the message. Peer-led health promotion, facilitated by CAOs, is more likely to be tailored to its audience, making it more relevant and accessible.

- **Co-location of clinical services in CAO settings** – There are interesting examples across the country of local health bodies and CAOs sharing physical space. The effect of this is two-fold. Firstly, it improves understanding and collaboration between the two around wider-determinants-based prevention work. Secondly, by placing statutory health services within trusted community spaces, it also helps to increase their access by those least likely to attend purely clinical settings.

2. Finding the right delivery approach:

- **Integrated Health and Wellbeing Services** – CAOs are well-placed to deliver this formalised model of holistic prevention service. Compared to larger, national providers, they are more likely to provide a service which is trusted, accessible, and long-lasting in impact.

- **Social prescribing** – Despite their inherent role as promoters of the social determinants of health, the extent and quality of CAO involvement in formal social prescribing is mixed across the country. CAOs provide differing and valuable forms of social prescribing in different places. They also present an opportunity to decentralise delivery of the standard Link Worker model of social prescribing where capacity and appetite exists. By placing Link Workers directly within CAOs, their knowledge of, and connection to, local community and activities will only enrich the service they provide.

3. Achieving collaborative commissioning:

- **Inclusivity and cultural competence** – Across all health system priority prevention areas, CAOs led by and serving minoritised communities are able to interpret commissioned services for maximum impact. They do this by using appropriate language, recruiting influential community members, reflecting cultural practices, and using accessible communication channels.

- **Asset-based community development** – Traditional commissioning is likely to focus solely on the needs of communities and not the strengths they already possess to address them. By designing prevention services which begin from and develop the resources, skills, and experience of community members, commissioners can facilitate local people to support their own wellbeing. CAOs can support with this as the approach is foundational to the way they work.

- **Capacity and capability building** – Often, commissioning bodies will not see past a perceived lack of capacity and capability of CAOs to deliver prevention services. But in doing so, they misunderstand the rigour of these organisations and forego the quality of a potential service based on years of local knowledge, expertise, and trusted relationships. Investing in the core functions of CAOs can support them to find the necessary time to effectively bid for and deliver prevention services.

4. Measuring outcomes usefully

- **Understanding impact on the wider determinants of health** – The value of a wider-determinants-based approach to creating healthy communities is clear.[2] However, it is difficult to demonstrate a direct link between the improvement of any determinant for an individual and a reduced need for them to access future health services. As such, we have identified a need to shift the collective mindset away from individual output targets for prevention services. Instead, focus should be on developing a wider-determinants-based theory of change model for better health.

- **Data collection and impact monitoring** – In order to achieve such a shift, a compromise needs to be reached between commissioners and CAOs to better understand the opportunities and realities of monitoring prevention services. Co-producing impact monitoring processes as part of the commissioning cycle, with a focus on "test and learn" approaches, is likely to get the best out of providers and their services.

Recommendations for the health system

The overarching lesson from our findings is the need for a large-scale shift in prevention service commissioning and practice to realise the value of CAOs for the health system and in reducing health inequalities. Based on the learnings above, we have produced a set of 12 individual recommendations for the health system to help achieve this. They are targeted at Integrated Care Systems (ICS), Primary Care Networks (PCN), local authorities, and national policymakers. If adopted, they will improve the way prevention services are designed, commissioned, delivered, and measured.

Maximising good practice:

1. Use the Covid-19 pandemic experience as an opportunity to build from, including strengthening community engagement and reviewing the necessary rigour of contracts.

   ICS | Local authority

2. Support peer-led health promotion as an effective method of tackling health inequalities.

   National | Local authority | ICS

3. Make co-location as achievable as possible by supporting community asset ownership and identifying community spaces in which to co-locate.

   ICS | Local authority | PCN

Finding the right delivery approach:

4. Make CAOs lead providers of Integrated Health and Wellbeing Services to increase the impact of such programmes on health inequalities.

   ICS | Local authority

5. Explore and support diverse forms of social prescribing, including the embedding of Link Workers within CAOs where appropriate.

   ICS | PCN

Achieving collaborative commissioning:

6. Work with CAOs to co-produce culturally competent prevention services with the best chance of tackling health inequalities.

   ICS | Local authority

7 Understand the assets of local communities and design prevention services that make the most of them.

National ICS Local authority

8 Understand and invest in the capacity and capability of CAOs to produce sustainable and impactful prevention outcomes.

ICS Local authority

Measuring outcomes usefully:

9 Move away from short-term prevention targets towards a theory-of-change approach to reducing ill health, based on proxy indicators.

National ICS Local authority

10 Consider the value of compassionate services that destigmatise health issues for greater engagement.

ICS Local authority

11 Embrace "test and learn" approaches to prevention services.

ICS Local authority

12 Make systems for data collection, feedback, and reporting consistent.

National ICS Local authority

Recommendations for CAOs

Our research has also developed five practical learnings for CAOs to increase their involvement in health system prevention services right now:

1. **Understand and communicate to the health system the value of the CAO approach for the wider determinants of health** – CAOs should use wider determinants models such as the Inclusive and Sustainable Economies framework (see Figure 1, p.10) to understand their current impact and what works best for disadvantaged communities. They should also seek to capture the longer-term consequences of their work on the progress of their service users to demonstrate the change towards healthier living.

2. **Find the right contacts within Integrated Care Partnerships (ICPs)** – CAOs should actively seek out contacts within ICPs early in the development of prevention initiatives to influence place-based prevention strategy. Involvement and/or influencing of the new "VCSE alliances" within ICPs should be a priority for this.

3. **Connect with local Primary Care Networks (PCNs)** – Close working relationships with GP surgeries and other PCN partners are crucial for effectively tackling shared prevention priorities, including through social prescribing.

4. **Tackle local priorities with other VCSE partners** – Collaborating with other local VCSE partners to develop joint approaches is important for both tackling shared issues and showing strength and worth to the local health system.

5. **Demonstrate ability to meet the rigours of current health system contracts** – While we encourage more accessible, co-produced prevention service contracts, CAOs can prepare themselves for delivery in their current form. This may include demonstrating their existing ability to manage rigorous evidencing requirements and tighter governance restrictions.

To find out more about Primary Care Networks and Integrated Care Systems, Boards, and Partnerships, visit The Kings Fund.

1.

Introduction

As part of our ongoing work on the government's HW Alliance, we have been exploring the role of CAOs in local health systems. These are organisations that:

- **are independent and community led**
- **tend to be multi-purpose, employing staff, providing services and activities, and managing community assets, to tackle local challenges**
- **are committed to positive economic, social, or environmental change in their community, with any surplus funds reinvested in local impact**
- **generate a diversity of income streams, including trading goods and/or services**
- **provide a voice to local people in the shaping and delivery of community services**

In March 2022, as part of the HW Alliance we published our report, The impact of community anchor organisations on the wider determinants of health. This research – with 20 CAOs across England – illustrated the depth and breadth of the impact they have on the wider determinants of health in their communities. There were four key aspects to their impact:

- **The range of population groups they support** – 13 different groups on average
- **The range of wider determinants they address** – on average, 91% of those listed in the Inclusive and Sustainable Economies Framework (see **Figure 1**)
- **The impact they have on the quality of life of their broader communities** – including through greater skills, income, and socialisation
- **The impact they have on the quality of life of those most impacted by health inequalities** – including through improved living conditions, financial stability, and empowerment in the community

The golden thread running through the work of all CAOs to achieve these outcomes was also clear – the holistic nature of their services. As our research found:

> **"By delivering... a wide range of services, activities, groups, and amenities in one place, these organisations can take an individualised, whole-person approach to support. This results in a wider offer that is complete, familiar, and trustworthy for the beneficiary. As such, they can build and maintain strong relationships with a wide range of community members, particularly those marginalised, disadvantaged, and furthest from traditional or statutory support services. This positively impacts not only the individual's quality of life, but also that of their social and family networks."** [3]

Having established the impact of CAOs in this area, we saw an opportunity to apply this to current thinking and practice in the delivery of services for health promotion and illness prevention. How could leaders and commissioners in the health system achieve national and local priorities in this area by tapping into the CAO model? What could the wider determinants approach mean for the sustainability and long-term impact of commissioned prevention services? And how could CAOs best position themselves to take advantage of such a shift?

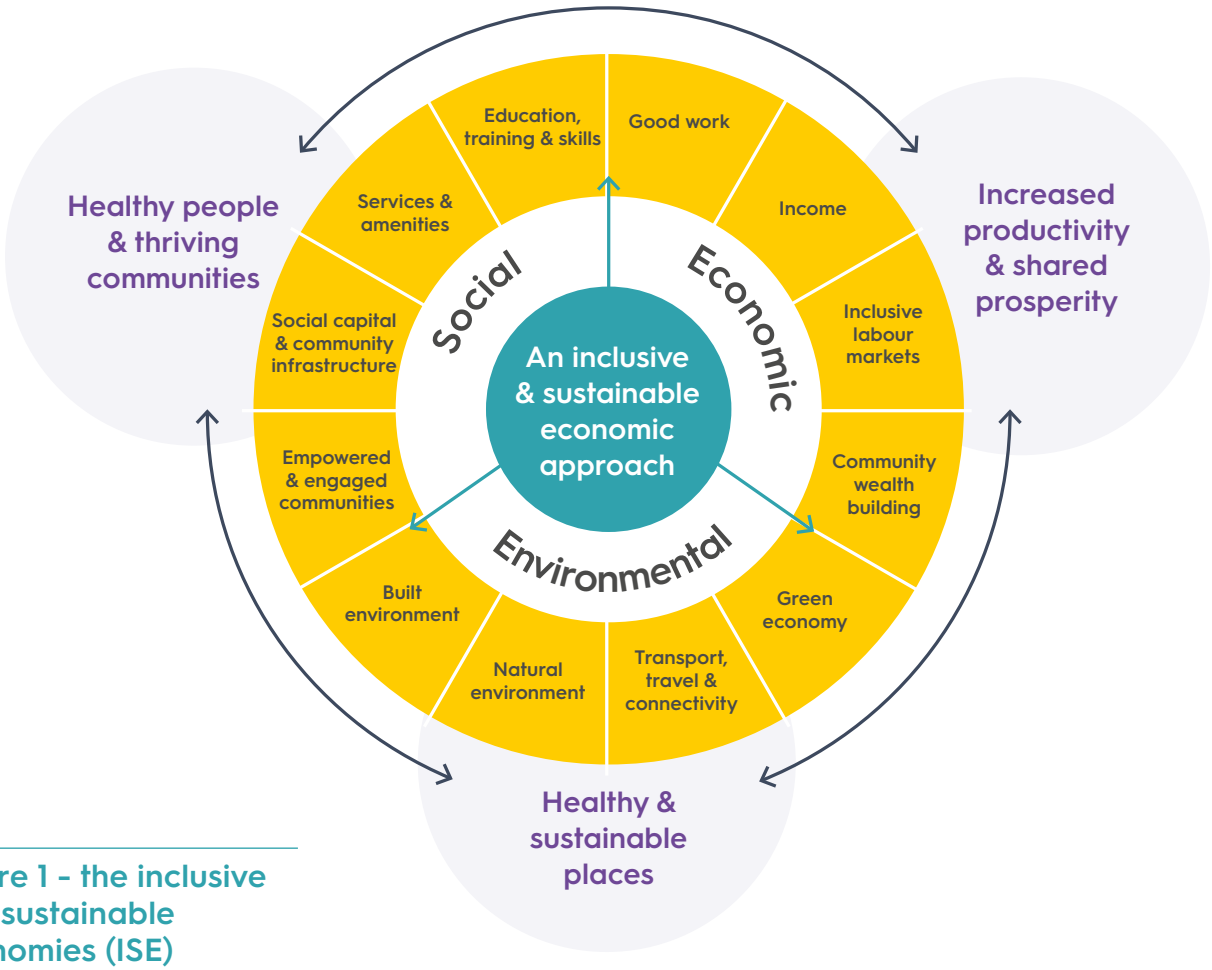


Figure 1 - the inclusive and sustainable economies (ISE) framework, OHID[4]

Our research

Between June and October 2022, with the guidance of the Office for Health Improvement and Disparities (OHID) and NHS England's Prevention team, we carried out four stages of mixed-method research in an attempt to answer those questions:

1. **Desk-based research and literature review** – into the existing evidence for the value of CAO-led prevention services.

2. **In-depth research with CAOs** – through a survey and interviews exploring their scope, focus, approach, business model, partnerships, and cultural competence of their prevention related work.

3. **Interviews with health system colleagues** – to understand the system's current methods for delivering key prevention services, including existing or potential relation to CAO activities.

4. **Cross-sector roundtable** – of research participants focussed on translating initial findings into relevant recommendations for the health system and CAOs in this area.

The research participants

CAOs

We gathered evidence from 20 CAOs across the country (see Figure 2, p.12). Most are found in suburban (60 per cent) and urban (35 per cent) settings. The majority are also in the top two deciles for deprivation – Index of Multiple Deprivation (IMD) deciles 1 (30 per cent) and 2 (30 per cent). The average IMD decile for all respondents is 2.7. As established organisations, the respondents have a larger turnover on average than most community organisations. Sixty per cent earn more than £500,000 per year.

Thirty per cent of the organisations are led by individuals from communities experiencing racial inequity. 75 per cent support people from communities experiencing racial inequity, while 70 per cent have leaders that reflect their local population.

The organisations serve a broad range of population groups (see Figure 3, p.12). This includes a significant focus on marginalised and disadvantaged communities. All of the respondents support people experiencing socioeconomic deprivation,[5] while 95 per cent support people of disadvantaged protected characteristics[6] and/or people from health inclusion groups.[7]

Health system colleagues

We also spoke to health system colleagues across the country. These interviews were designed to explore the views and experiences of national, regional, and local service designers and commissioners around the involvement of CAOs in the provision of prevention services. We spoke to four local authority public health commissioners and three Integrated Care Board (ICB) prevention commissioners across London, the West Midlands, and Yorkshire and the Humber. We also spoke to two NHS England health inequalities leads, and one NHS England workforce lead.

Figure 2 - map of respondents

1. Bromley by Bow Centre
2. BS3 Community Development
3. Cardigan Centre
4. Centre4
5. Charles Burrell Centre
6. CommUNITY Barnet
7. Community360
8. FWT - a centre for women
9. Highfields Centre
10. Labriut Healthy Living Centre (JCCG)
11. Mary Seacole House
12. Meadow Well Connected
13. Moat House Community Trust
14. Nishkam Civic Association
15. People Matters Leeds
16. Southern Brooks Community Partnerships
17. Southmead Development Trust
18. St George's Lupset Community Centre
19. Sussex Community Development Association
20. Yorkshire Children's Centre

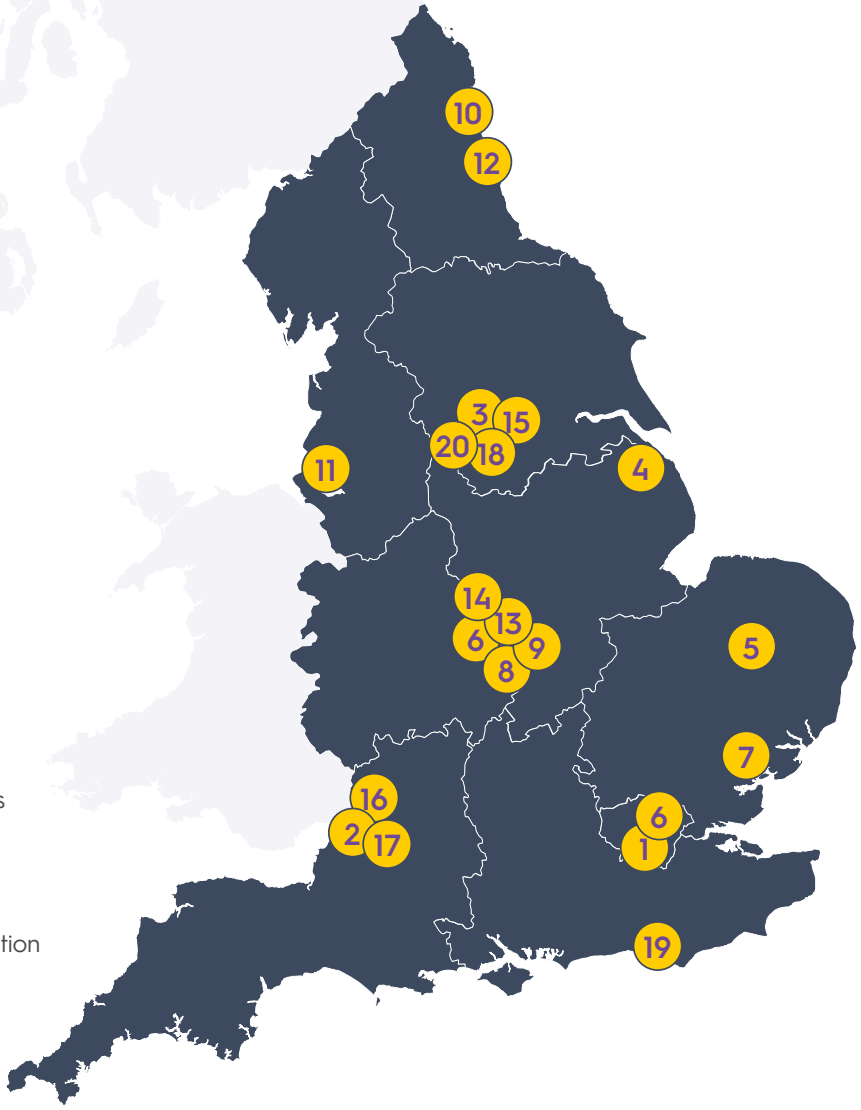
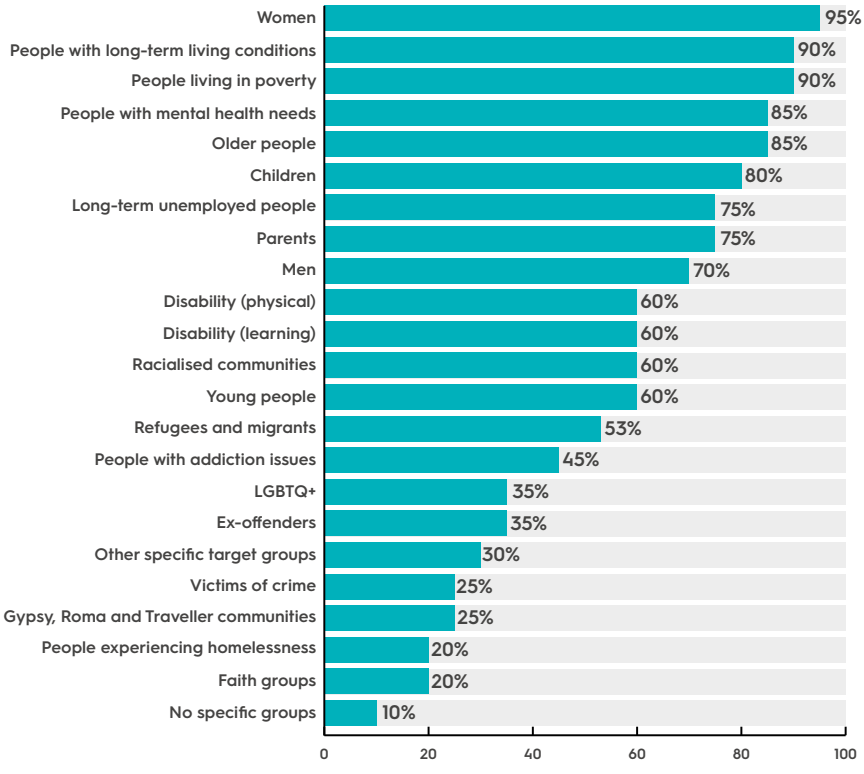


Figure 3 - Population group types served by respondents



The value of CAOs in prevention – key survey statistics

Our survey of CAOs explored the types of prevention services they provide, the wider determinants their approach tackles, their cultural competence, and their relationship to local health system commissioning.

Relevance to local and national prevention priorities

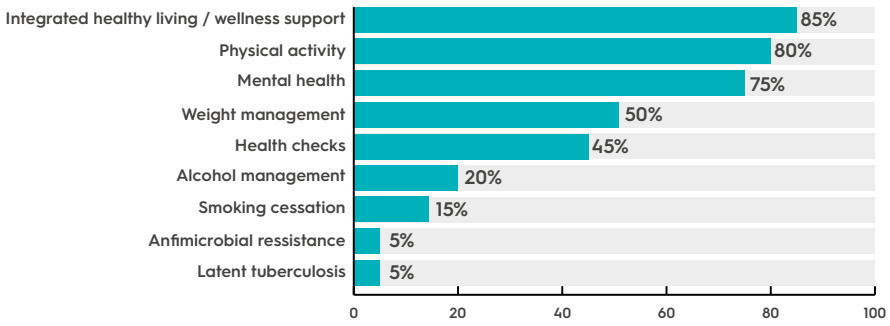
We plotted their activity against the five key prevention areas in the NHS Long Term Plan – weight management, alcohol management, smoking cessation, antimicrobial resistance, and latent tuberculosis. We also included other prevention areas of particular importance for OHID (see Figure 4).

The key finding here is that CAOs mostly deliver their prevention work by combining multiple types of healthy living and wellness support into one, integrated programme. While CAOs are less likely to provide standalone services for individual prevention areas such as alcohol management and smoking cessation, they will instead embed these issues into the broader programme of support. This is a demonstration of the holistic, whole-person approach illustrated in our previous research.[8]

By taking this holistic view, this approach considers the wider determinants which impact an individual's likelihood of, for example, returning to smoking, abusing alcohol, or struggling to maintain a healthy weight.

It is also worth noting that only one of our respondents reported any specific activity to prevent antimicrobial resistance or latent tuberculosis in their community. While included as priority areas for NHS England, there was little knowledge or understanding of these more clinical issues among the CAOs. This presents an opportunity for greater information sharing and collaboration between local health systems and CAOs.

Figure 4 - % of CAOs providing services in certain prevention areas



Impact on the wider determinants

As with our previous research, our survey used the Inclusive and Sustainable Economies Framework (see Figure 1, p.10) as the basis for investigating which wider determinants of health our CAOs' prevention services addressed. We also included two additional determinants – mental wellbeing and community resilience – for a broader picture of impact.

The results found that CAOs were most likely to address the social and economic determinants of health. At least half of respondents reported using their prevention services to address social capital and community infrastructure, community empowerment and engagement, and community resilience. These perhaps more abstract social determinants were then supported by action in more tangible

areas, such as good work, income and wealth, services and amenities, and education, training, and skills.

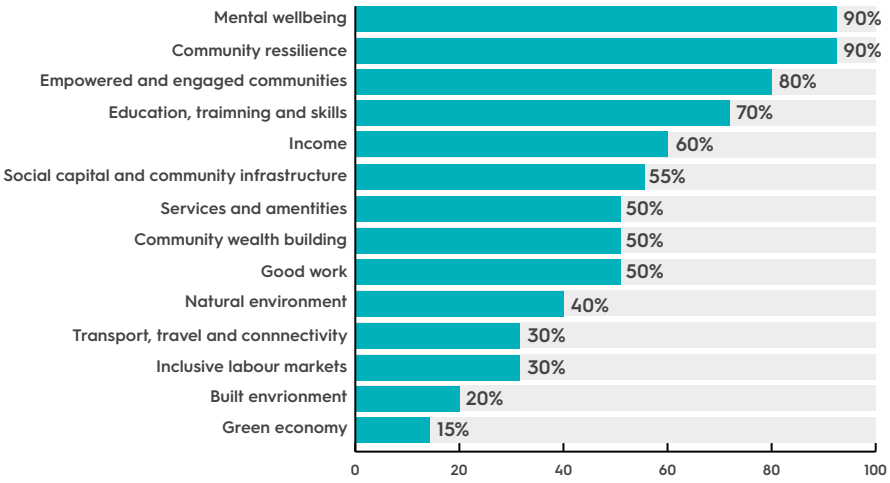
Cultural competence

One issue raised in our previous research was how the efficacy of prevention services is dependent on their cultural competence. If a service is not designed with the values, norms, and practices of particular cultures in mind, it will struggle to engage its target audience. CAOs – particularly those led by and supporting communities experiencing racial inequity – are well aware of this. Our new research found that 55 per cent of respondents provide culturally specific prevention services to particular population groups.

Health system funding

Despite the breadth and depth of impact that CAOs have on prevention, they are still under-engaged by local health systems in this area. There is a 50-50 split of respondents being funded by the NHS to deliver prevention services, while fewer than half (45 per cent) are funded to do so by their local authority.

Figure 5 - % of CAOs addressing different wider determinants of health through prevention services



Case studies

Throughout this report, we have included examples of the work and experience of CAOs across the country. These aim to provide real-world detail to the findings of our research. This includes illustrating the good practice already taking place and highlighting the obstacles CAOs face in engaging with the health system on prevention priorities. For further case studies of the work done by CAOs to tackle the wider determinants of health, see our previous research.

2.

Commissioning community anchors for wider-determinants-led prevention services

As we progressed through this research, four distinct areas of learning emerged. They cover in more detail exactly how and why CAOs should be better commissioned to provide wider-determinants-led prevention services.

They are:

- Maximising good practice
- Finding the right delivery approach
- Achieving collaborative commissioning
- Measuring outcomes usefully

Each of these important insights, if considered strategically by local health systems, could provide the basis for a new approach to healthy living with a more sustainable and long-term impact. This should be considered of particular importance as we move through a cost of living crisis that will deeply impact poverty as a health determinant.

Maximising good practice

There is a vast amount of good practice between CAOs and health systems to be learnt from and built upon in the promotion of good health locally. Here, we explore three common trends.

Learning from pandemic partnerships

The Covid-19 pandemic presented the world with one of history's biggest and most urgent exercises in illness prevention. In England, it fell to local health systems, and particularly local authorities, to turn national policy into practice to slow the spread of the disease and support local communities. But in doing so, these statutory bodies quickly realised that this would not be possible without close partnership with their local VCSE sector. In many places, it became clear that the sector could respond quickest to the crisis. The community infrastructure built up over time meant the sector knew where help was needed, what it should look like, and how to deliver it quickly.

There are various examples of how the pandemic improved the ways CAOs and local health systems worked together. The NHS England Board has already identified the need to build on these to strengthen wider prevention services to benefit the same at-risk communities.[9]

- In **Colchester**, Community360 chair a local strategic partnership called "One Colchester". This multi-agency group includes senior representatives from across the local and regional public and VCSE sectors, including Colchester City Borough Council, Essex County Council, and Suffolk & North East Essex Integrated Care Board. During the pandemic, the group became a key emergency response vehicle. Meetings were moved from quarterly to weekly to ensure all partners were working closely on a shared response within communities.

- In **Batley and Spen**, NHS funding was distributed to Yorkshire Children's Centre (YCC) by the local authority to run a "Community Champions" programme. This involved recruiting and training local people to become health ambassadors among their peers, initially to increase awareness and understanding of Covid-19, including testing and vaccination.

As the pandemic eased, this then moved to general wellbeing and the after-effects of Covid. As YCC say, **"The project was the best use of local authority money in a long time – the Champions spoke to 15,000 members of the public and were involved in the vaccination of 45,000 people."** See **Peer-led health promotion** on the next page for more on this service model.

- Similarly, in **Wolverhampton**, the ICB is building on the success of funding local CAOs to increase vaccine uptake. It has continued this and will be considering shifting this funding to organisations for other prevention activities, including physical activity, health checks, and social prescribing.

It's important to note, however, that this type of collaboration was not present in all areas of the country. Other respondents spoke of how some NHS funded local services, such as social prescribing, "withered" during the pandemic and are yet to be properly re-established.

Peer-led health promotion

The Batley and Spen example (see previous page), is just one of a number of peer-led health promotion initiatives active across the country. The "community health champion" model is one of the most common, but other forms exist too. All such models share a common characteristic – using the knowledge and connections of local people to reach communities the health system has otherwise struggled to engage. And they are having promising results in many places:

- In **Hackney**, the council has recognised the need for culturally appropriate healthy eating and weight management support that is tailored to the needs of individuals. Differing cuisines and wider-determinants-based barriers to physical exercise mean that different ethnic groups – particularly black and South Asian communities – require messaging to be delivered in different ways. As in Batley and Spen, a Covid-focussed community health champions programme has now been extended, with local CAOs funded to use the model for other prevention areas. Through this, for example, these organisations are working on diabetes and hypertension public health awareness projects.

- In **Bristol and South Gloucestershire**, CAOs like BS3 Community and Southern Brooks are facilitating peer support groups to support community members with a wide range of needs, and particularly in relation to mental health. The focus on developing the social networks of individuals here is key.

There is also much to be learned from NHS England's own foray into the community health champion model. The Core20PLUS5 Community Connectors pilot has funded several ICBs to recruit, mobilise and support peer influencers to help engage local people with health services. This is coordinated by local VCSE organisations seen as "pivotal" delivery vehicles. Connectors are local people with unique insight into the barriers faced by those in their communities. As well as offering health advice to community members, they also advise local NHS providers on how to reduce barriers and design accessible services. The pilot is part of the overarching Core20PLUS5 approach – designed to reduce health inequalities in the most deprived and disadvantaged communities (both of place and identity) across five key clinical areas.

As the Community Connectors programme develops, our research suggests that CAOs are ideally placed to adopt the coordinator role in communities across the country. Indeed, the programme's designers see a wider determinants approach as key to its success. For example, Connectors can support peers around income, transport, mental wellbeing, and access to the natural environment.

Co-location of clinical services in CAO settings

One of the most tangible ways in which local health bodies and CAOs can collaborate to increase the uptake of prevention services is by sharing physical space. This can take various forms and has particular impact on improving the access of statutory health services by those least likely to engage with purely clinical settings. Examples from our research include:

- In **Leeds**, the Cardigan Centre building is also home to the local PCN. This allows the PCN to deliver services closer to the community, saving time and targeting need. Clinical support is provided from one of the rooms in the centre, allowing people to feel more comfortable in a setting they often trust more than their GP surgery.

- In **Tower Hamlets**, the Bromley by Bow Centre operates a "health partnership" model, including an on-site GP surgery. As such, both the Centre and GP surgery staff can work together to provide all the prevention services surveyed for in our research, based on a close and shared understand of their patients' wider needs. For more information on the impact of this model for social prescribing, see p.22.

- In **Liverpool**, two local GPs regularly visit groups at Mary Seacole House (MSH) – a mental health charity and resource service primarily serving racialised communities and refugees. This includes visits to a women's health support group to discuss, for example, the menopause, breast cancer, and gynaecological problems – issues that the women may not feel comfortable discussing elsewhere or in clinical settings. MSH also hosts a volunteer GP and dietician who run other groups to discuss issues such as smoking and diabetes. Such discussions around smoking, for example, often uncover links between an individual's relapse after quitting and trauma or stress in their daily lives. MSH is then able to offer one-to-one emotional support to help individuals overcome this and thus be more likely to give up smoking for good.

Respondents in our research report that these types of co-location increase trust for, and relevance of, statutory health services and prevention messaging in different communities. The reduction of stigma is also an important factor – an individual could be attending a community space for many reasons and can therefore be more anonymous in accessing healthcare where that is stigmatised.

Finding the right delivery approach

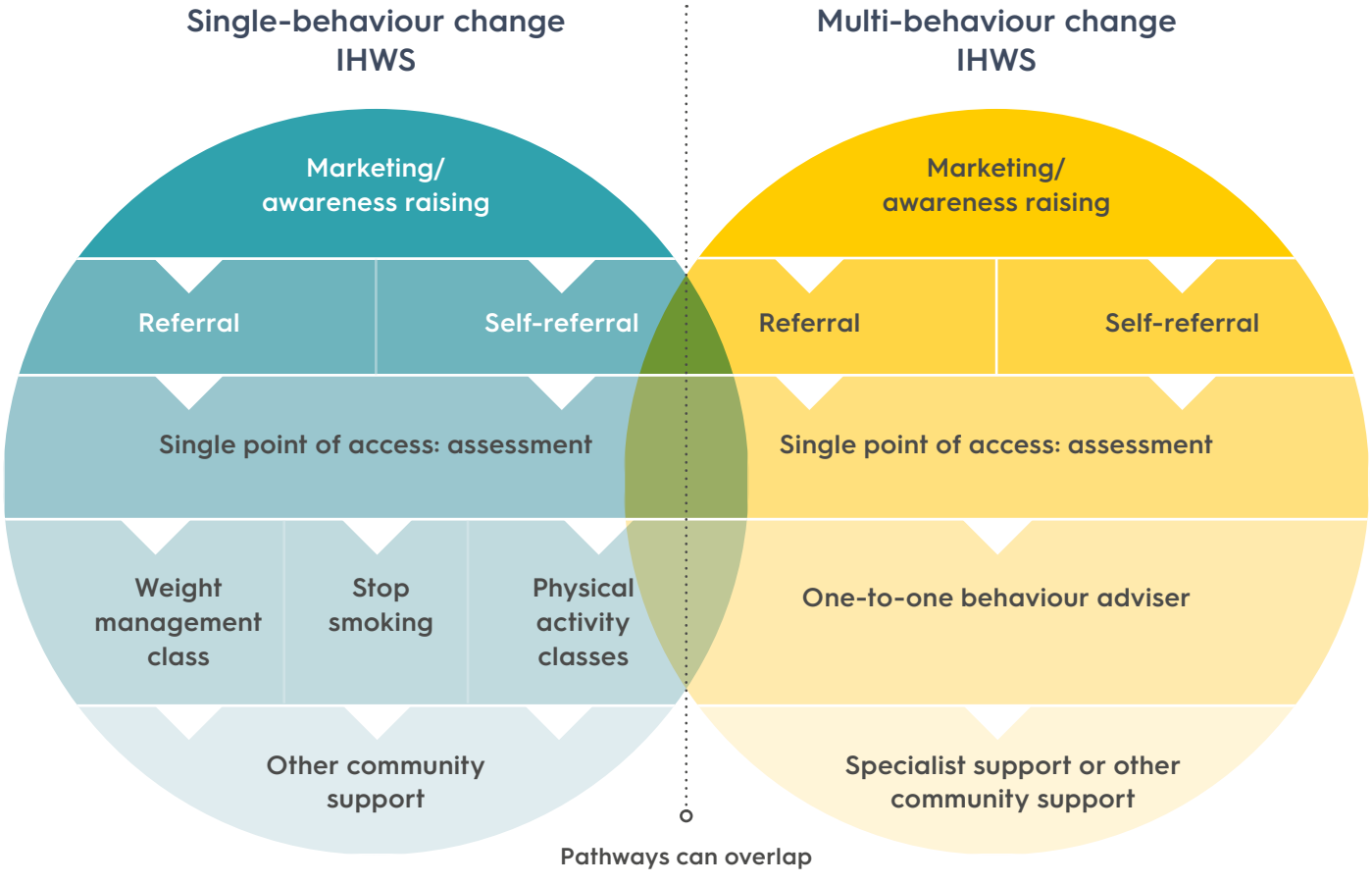
There is much to learn, from the many good practice examples above. But how do we develop common approaches to involving CAOs in the delivery of wider-determinants-led prevention services that make the most of them? It is important to note that one size rarely fits all from place to place, but our research highlights methods worthy of further exploration and adaptation.

Integrated Health and Wellbeing Services

The Integrated Health and Wellbeing Service (IHWS) model has been adopted in several places across the country. It is often commissioned by local authorities as a single point of access for health and wellbeing services, supported by local organisations. They may involve a single adviser supporting an individual to change multiple behaviours. Or they may refer clients to one or more single behaviour change activities.[10]

Figure 5, below, provides a visual comparison of the single and multi-behaviour versions of the model.

Figure 5 - the two types of IHWS (courtesy of The King's Fund - see endnote 10)



Less formally, this is what CAOs do every day – taking a holistic, whole-person approach to provide or connect individuals with services to improve the wider determinants of their health.

Existing evidence highlights areas where a greater involvement of CAOs could help overcome issues with, or add further value to, the delivery of IHWSs. For example:

- **Trust for provider, service, and staff** – Where the service is provided by the local authority or a national provider, there is evidence of potential service users being uncomfortable with unfamiliar staff they don't know or trust. They suggested this could be overcome by promoting the service through, for example, trusted voluntary sector organisations and existing community networks.[11] Better still would be for the service to be provided by those organisations and their staff with whom service users already have a connection. This could help overcome the challenges of another practice – using Public Health England[12] branding in an attempt to gain service user confidence. Our primary research suggests the opposite could in fact be true, particularly for communities more likely to distrust government health institutions due to historic discrimination. Instead, endorsement and provision by local, trusted CAOs may provide a better chance of increasing engagement with an IHWS.

- **Remit of support** – Evidence suggests that a focus on the wider determinants of health (as done by CAOs) is a sensible approach for IHWS commissioners to take.[13]

- **Long-term support** – It is debatable whether a time-limited service of, for example, 12 weeks, provides sufficient support for all service users to reach their goals.[14] The inherent nature of CAOs as deep-rooted, community-led organisations committed to their place means they are better suited to providing long-term support to individuals.

- **Local accessibility** – In rural areas with low population densities, IHWSs may require consultation and triage to take place over the phone, rather than face-to-face, due to poor transport links.[15] If such services were designed to be less centralised and more neighbourhood-based, they could benefit from delivery by CAOs in smaller, local, more accessible community spaces.

There are further interesting lessons to be learned from the design and commissioning of IHWSs in specific places. For example, in **Luton**, the council shaped their service by speaking to communities to raise awareness and gather insights from existing lifestyle services. This has led to the inclusion of "community navigators" – in the peer-led health promotion vein – to coordinate and signpost services for clients in need of support.[16] CAOs are well positioned both to represent the views of local people and recruit such navigators.

Meanwhile, in **Suffolk**, before releasing the tender for their IHWS, the council undertook a period of intense market engagement. By involving hundreds of organisations, potential bidders, communities, residents and the VCSE sector, the process itself was used to iteratively design the service. The net effect was that both the commissioner and the successful provider could resolve any teething problems early on and embed partnership working from the start.[17] This approach corresponds closely to Locality's Keep it Local principles for local commissioning, with relevance not just for local authorities but for wider health system commissioners.

In speaking to CAOs and local health partners, we also uncovered fresh examples of the development and implementation of IHWSs and their relation to local CAOs. For example:

- In **Thetford**, Norfolk County Council have seen the value in the Charles Burrell Centre's integrated model of support and want to scale it up to see if it translates county-wide. There is an understanding that integration with CAO services is key and support needs to go beyond just NHS care, but in a way that promotes partnership to avoid duplication.

- In **Haringey**, the IHWS, "One You Haringey" (OYH), is delivered by national, private sector provider Reed Wellbeing. The provider works in partnership with local CAOs and other VCSE organisations. It has established a strong referral pathway for such organisations to refer service users into OYH as well as to facilitate community engagement activities. OYH is not directly provided by local CAOs and other VCSE organisations. Although they provide a number of useful related activities locally, the council highlights issues with the capacity, resource, and technical skills of organisations like these to provide such a service. This type of feedback is not uncommon from councils, but more can be done to understand the suitability of such organisations to deliver contracts. Equally, there are ways of addressing these concerns to deliver an impactful and locally-rooted service while also developing the capacity and capability of the local VCSE sector. The Suffolk approach, above, is one example – along with the broader Keep it Local principles. This topic is explored further from p.24 below – **Achieving collaborative commissioning.**

Social prescribing

When discussing social prescribing, it is important not to lose sight of its essential concept and the various ways it can be achieved. It is necessarily rooted in the wider determinants concept of health promotion and illness prevention. It takes a holistic approach to an individual's wellbeing and seeks to connect them with social, economic, and environmental activities in their local communities to support this.

The standard model of social prescribing within the NHS is through Link Workers. These staff are employed by either the PCN or a local VCSE organisation and aim to support individuals following referral from one of numerous possible sources, including self-referral. It is this model that we have examined below as a delivery approach for prevention services by CAOs. However, it is important to recognise that such organisations have, by their very nature, been delivering forms of social prescribing for many years before the introduction of Link Workers. Equally, such forms may correlate with the IHWS and peer-led health promotion models described above. As such, there is much to be learned by local health systems from the experiences of their local CAOs in this area.

Most of the 20 CAOs we spoke to (75 per cent) have some sort of formal involvement in social prescribing locally – as employers of Link Workers, referrers to them, and/or as providers of activities. However, it is clear that the extent and quality of their involvement is mixed across the country:

- As mentioned above, Bromley by Bow Centre in **Tower Hamlets** has developed an effective approach to social prescribing in which Link Workers are part of "integrated teams" in co-located "health partnerships". Working across both the CAO and the GP surgery, they are seen as part of both staff teams, increasing trust and engagement from service users.

- In **north London**, CommUNITY Barnet maintains regular dialogue with local GPs to discuss its community-led services, including for mental health conditions. This benefits clients and GP staff, allowing the latter to swiftly refer patients. This improves the journey from GP to Link Worker to community service for clients.

- Elsewhere, however, a common complaint is a lack of funding available for CAOs to provide activities to which people are prescribed. We heard this from respondents across the country, in **Bristol**, **Leicester**, **Birmingham**, and **North Shiels**. There may be lessons to learn from **Kirklees** in this area, however. There, Yorkshire Children's Centre have taken a key role as an anchor organisation to work with the local authority and ICB to help ensure that services for social prescribing actually exist. While there still may be need for more money, close partnership working between all parties is proving vital.

- In other places, a lack of communication between the health system and CAOs means that the former is not aware of the full range of services the latter provides. This leads to the incomplete or mis-prescription of individuals. This is also true where there is no formal relationship for social prescribing, but GPs still refer patients directly to CAO services they happen to know of.

Different models of social prescribing will have value based on the existing structures and assets within different communities. This will determine whether the Link Worker model is the most suitable. Where it is, and where there is capacity and appetite, we have found particular value in the embedding of Link Workers within CAOs – for example, the Bromley by Bow Centre approach. However, even it laments cuts in funding reducing the time a Link Worker can spend with a patient. This means there is now no time for follow-up to help them understand the eco-system of support in the neighbourhood.

Achieving collaborative commissioning

Producing prevention services that achieve real impact requires intentional collaboration between commissioners, service users, and prospective providers. Through co-production, commissioners can better understand:

- what local need looks like
- how to meaningfully engage target users
- what assets already exist within communities to address it
- how to build sustainable, wider-determinants-led delivery models within them

Inclusivity and cultural competence

If the health system is as serious about tackling health inequalities as the Core20PLUS5 approach suggests, it cannot rely on one-size-fits-all service design. We heard many times in our research, for example, that common guidance on diabetes and weight management is simply not appropriate for South Asian and Black African and Caribbean communities. We heard, for example, how the NHS's Eatwell Guide lacks relevance for the cuisines of these communities. Particularly when themselves led by people from such communities, CAOs often work to adapt guidance and services to make them culturally competent. Our respondents provided many examples of this:

- In **north London**, CommUNITY Barnet delivers a peer-to-peer diabetes prevention and wellbeing service using 'Health Educators', commissioned by the local authority. As an anchor organisation, it leads the service and works in a successful partnership with other local charities. The Health Educators are able to speak local community languages and therefore discuss and translate guidance with target audiences in their peer groups. Successful strategies have included speaking to parents about adjusting eating habits, tailored for each community's cuisine. This way, information "spread like wildfire" and was far more effective than telling people to change their diet with no relevant guidance. Engagement has also taken place at local places of worship. For South Asian Muslim communities, for example, Health Educators attend mosques and prepare curry to share, beginning a discussion about sugar content, risks for diabetes, and healthier alternatives.
- In **Coventry**, FWT – A Centre for Women runs MAMTA – an award winning service aimed at improving child and maternal health outcomes for women from ethnically diverse communities. This includes cascading key national health messaging around pregnancy – eg, on smoking, eating, weening, and breastfeeding – in an inclusive and accessible way. As a women-only centre, it is a safe and trusted place for service users. There is a bank of language skills across the staff team, or accessible via translators. A crèche is made available to those with childcare responsibilities to make accessing services easier. The centre is also easy to access from across the city, being situated on a main bus route. As well as alleviating these types of wider determinants related barriers through greater connectivity and access to amenities and community infrastructure, the services themselves take a holistic, whole-person approach. For example, if accessing the employability programme, women will also be encouraged to disclose any domestic issues. In providing health

and wellbeing services for sex workers in the city, FWT will also provide holistic support from drug and alcohol abuse.

- In **Gateshead**, Labriut Healthy Living Centre has supported the NHS and public health to bring health and wellbeing messaging and education to the local Jewish community in a culturally appropriate way. It played an important role in sharing Covid-19 information during the pandemic, particularly as the community doesn't generally have access to mainstream media. While the national TV, radio, and social media campaigns were not reaching the community, Labriut helped the local authority to devise communications that would. They created specially designed flyers and newsletter with all the relevant health information and restrictions and delivered them to every home in the community.

- In **Birmingham**, Niskham Civic Association speaks of the need to use channels of communication for services and guidance that are relevant and accessible to target audiences. They know, for example, that older people within the Sikh community they serve are unlikely to use the internet via computers but do use WhatsApp on their phones.

It was promising to see a growing understanding of inclusion and cultural competence by health commissioners in some places. In **Hackney**, for example, the council's public health team are continuing to work with residents, trusted local organisation staff, and wider health partners to build on the success of the pandemic-era community health champions programme. They and their community members are interested in doing more prevention work in this vein and are currently taking forward projects around diabetes and hypertension.

Asset-based community development

The starting point in the traditional commissioning cycle is to 'assess needs'. There is no doubt that this is crucial in identifying the purpose of a prevention service and what it should seek to achieve. And key to assessing needs accurately is to collaborate with local partners, such as CAOs and the communities they represent, as early as possible. Equally as crucial, but much less often stated in the cycle, is the assessment of local assets to address those needs. An excessive focus on what a community lacks can easily lead to its pathologisation – treating it as inherently defective – and the subsequent devaluing and disempowerment of its members.[18]

On the other hand, an asset-based approach to the design phase of the cycle starts with the community's inherent strengths. Through this lens, services can be produced which identify, maximise, and benefit from the existing resources, skills, and experience within a community. From here, individuals are facilitated to support their own wellbeing.

This is the asset-based community development (ABCD) approach, and it is foundational to the way CAOs work.

Indeed, many examples emerged from our research of how CAOs implement ABCD in the delivery of prevention services which strengthen the wider determinants of an individual's health. CAOs are both community assets themselves and act as repositories for other local assets such as knowledge and skills.

- In **Leicester**, Highfields Community Association focuses on collaborating with many other local organisations whose work compliments its own. As a larger organisation, it uses its space to bring these groups together to deliver services based on local assets. These grow skills and wealth locally by building capacity, resilience, and opportunities for residents.

- In **Bristol**, Southmead Development Trust identifies gaps in support locally as well as building on strengths to help develop existing but smaller community-led services. This approach is supported by maintaining a resource of people living in the community who have particular skills. They can then be matched with other people with a corresponding need.

- Along the **Sussex coast**, Sussex Community Development Association (SCDA) delivers the Making it Happen programme. This is focussed on discovering, celebrating, and building on the positive things in local neighbourhoods. Community Development Workers support people to connect with others, find the right expertise, resources, or information, and access funding to create positive change locally. This is ABCD to address health inequalities. SCDA then measures the impact of this change according to the wider determinants of health, including: making healthy lifestyle choices, access to green and open spaces, impact on loneliness and social isolation, and emotional wellbeing.

As illustrated in these examples, a prevention service commissioned with ABCD at its heart necessarily supports the wider determinants of health within a community. It has particular potential to strengthen local skills, build community wealth, increase connectivity, improve amenities, empower and engage communities, and strengthen social capital and community infrastructure.

Capacity and capability building

As highlighted in our previous research in this area,[19] and recapped in the introduction above, CAOs are often uniquely well-placed to provide "person-centred" services. They're able to reach a broad range of population groups (including those most affected by health inequalities), address a wide range of wider determinants, and achieve broad and deep impact on the quality of life of their residents.

However, they are often working on many fronts, tirelessly responding to local need in an era of perma-crisis, including most recently around the cost of living. While rich in local knowledge, expertise, and trusted relationships, they are often poor in capacity. They do not have teams of professional bid-writers like many larger, national organisations do. If they did, the quality of their experience would make for very strong bids. This does not mean, however, that they do not already have clear governance processes in place to ensure quality delivery. But targeted investment in core CAO functions can support them to win and deliver the most impactful and sustainable services for local people.

Our research has highlighted the strengths and weaknesses of health systems in adopting this approach currently:

- CAOs in parts of **London** and **Bristol** report that local commissioners do understand and value their impact on the wider determinants. However, the CAOs struggle to secure funding on that basis, and thus lack the capacity to expand their impact. They point to pressures on local authority budgets as a factor in this.

- Elsewhere, however, a lack of capacity and capability (perceived or actual) is used by commissioners as a reason to award contracts to national providers. But these organisations often lack the intrinsic understanding of people and place necessary to provide high quality services, as well as taking wealth out of the local area. This approach also fails to appreciate the due diligence undertaken by CAOs under law and while closely managing limited funds.

- Across **Yorkshire and the Humber**, regional public health leads are playing an important role in bringing partners together to build capacity and capability across the system. They can act as the link between the local and national to share expertise and facilitate networks and peer support between local authorities, the VCSE sector, ICBs and national partners.

One of the key principles of Locality's Keep it Local approach to commissioning it to commit to your community and proactively support local organisations. This is as true for ICSs as it is for local authorities alone, and there are green shoots of activity appearing among local health systems in this area.

In **South Gloucestershire**, for example, the council has used its own Keep it Local commitment to influence the local ICB and health care providers.[20] This has included a joint dedication of funds to the partnership to strategically tackle local health inequalities together. Key areas of collaboration for the partnership include working with the VCSE sector to improve financial security locally, support mutual aid groups, and deliver funding schemes such as the Household Support Fund and local Community Resilience Fund. The group is also now issuing contracts for several key place-based services, including:

- Hospital discharge pathways – supporting those leaving hospital to access appropriate care for recovery in the community

- Village agents – voluntary groups providing a health awareness presence in local villages

Through the partnership, the council have funded VCSE leaders to take part in strategic conversations. This recognises the fact that the sector can only input into work that it is remunerated for. The council is also funding fundraising and development capacity within the sector.

Measuring outcomes usefully

One of the most common areas of tension between local health commissioners and CAOs is impact measurement. Often, commissioners bemoan a lack of rigour in the collection and analysis of impact data by CAOs. Meanwhile, CAOs lament a lack of understanding by commissioners of the wider-determinants-led nature of their prevention work and the inherent difficulties in measuring this by conventional evidence metrics. So, where does the resolution lie? Our research has found progressive practice in this area in several parts of the country. Testimony from both CAOs and commissioners in these places suggests that flexibility, open-mindedness, and compromise are key.

Understanding impact on the wider determinants of health

There is now broad agreement that the wider determinants of health are more important than healthcare in creating healthy communities.[21] But there is an inevitable difficulty in evidencing a direct link between the improvement of any one determinant for a person, and the effect that has on their need to access healthcare services further down the line. As one interviewee in regional public health put it:

> **"Evaluations are really difficult. Take community health champion programmes, for example. These are very easy contracts to manage, but it's almost impossible to measure the health outcomes of those interactions. It's often not a controlled environment and follow-up with individuals is hard, so how can you attribute any one intervention to a particular outcome?"**

So, what is the answer? Our research points to the need for a national shift in mindset. Pivoting to a wider-determinants-led approach to prevention services requires understanding, agreement, and commitment around its theory of change towards better health:

- In **Wakefield**, St George's Lupset coined the phrase after which this report is named; as a CAO, they achieve "health and wealth by stealth". By providing space, time, and trusted long-term connections, they see individuals make the changes they need and want without realising it. When they make measurable improvements to the wider determinants of an individual's health (eg, helping them access the benefits they're entitled to, boosting their skills to help them find a job, or providing them with space for social connections), they see that person's health and wellbeing improve.

- Elsewhere, CAOs state that their local commissioning frameworks simply aren't sophisticated enough to understand a wider-determinants-led approach to outcomes. They suggest that the use of '**proxy indicators**' may well help to overcome this. Measuring, for example, the amount of extra income the CAO has helped an individual to access, or the number of new social connections it has helped them form. These can then be valued

as inevitably positive for that person's longer-term health.

- In some places, PCNs have shown a desire to move in this direction. In **Grimsby**, for example, they have approached Centre4 to help address the wider determinants of conditions like diabetes and chronic obstructive pulmonary disease (COPD) through social prescribing. In the case of COPD, which causes breathing difficulties, walking groups need even terrain with plenty of benches for rest to ensure such exercise and socialisation is accessible. In **Coventry**, after visiting and seeing the work of Moat House Community Trust in its community, relationships with the PCN switched from ongoing disagreements about "showing the evidence" to the awarding of a social prescribing contract with full-time equivalent staff. The PCN had seen the value of both referring into the Trusts' Grub Hub model of community services, and of being part of the broader network of local anchors that revolved around the Trust, including police and social care.

- We also saw the value of CAOs taking **'compassionate' approaches** to issues such as weight management. These are less associated with the pressure and stigma of weight loss and focus more on simply trying to improve someone's wellbeing and diet determinants. This then puts them in a stronger and more sustainable position for longer-term weight management.

Data collection and impact monitoring

To many commissioners, a theory-of-change-based model for prevention services may seem impractical and at odds with deep-rooted conventions of data collection for measuring impact.

But we have found scope for compromise. Indeed, both commissioners and CAOs need to better understand the opportunities and realities of monitoring prevention services:

- In **Hackney**, the council is aware that traditional local authority funding models dissuaded smaller, local organisations from applying. It sees the need for a more collaborative approach to impact monitoring. But it is also aware of the need for accountability and transparency over how money is spent and what it's achieving. It sees the need to find an approach that works for both parties, bearing in mind the capacity challenges smaller organisations face. Their time for filling in long monitoring forms and engaging in performance management is limited. For physical activity services, the council is increasingly using less resource-intensive grants rather than contracts, allowing more organisations to apply. It also sees that investing in the development and growth of CAOs would not only help the sector to compete with national providers in delivering larger services, but would provide an effective route for channelling funding down to the smaller organisations they support.

- What does a collaborative approach to impact monitoring look like, then? Referring back to the traditional commissioning cycle, the 'deciding priorities' and 'designing services' stages present a clear opportunity. Here, commissioners can engage early with both communities and prospective providers to co-produce not only what the service looks like but also what it should aim to achieve and how that should be measured. **Merton** is one local authority that sees the need for greater pre-contract stakeholder and market engagement to achieve this. For example, this has helped it support a smaller provider to move from its own

programme of weight management to the more prescriptive Tier 2 NHS service.[22] The council also recognises how the approach can help it to rethink how it looks at data collection. It sees scope for greater flexibility, here, based on how such organisations are working effectively already.

- Elsewhere, local authorities highlighted how collaboration and compromise can also be achieved through a dialogue on the approaches of both parties to public health, the wider determinants, and impact. There was a feeling that councils must accept that they don't know what will work in all situations. Instead, a **test and learn** approach is needed through which services are properly co-designed with communities and are given the space and time for implementation to assess impact.

- Some of the most striking evidence from our research addressed the **pitfalls of short-term, quantitative engagement and participation targets** for prevention services. Such pitfalls are particularly clear where they accompany services not focussed on addressing the wider determinants of health to support an individual to engage. Where this leads to difficulty for the provider in hitting the targets, the pressure they feel to justify this and maintain funding often leads them to explain away a lack of engagement by individuals as a lifestyle choice. They are more likely to claim that such individuals are simply choosing not to improve their health, rather than treat such disengagement as a symptom of the wider determinants of their health to be tackled in a different way.[23]

If local health systems and CAOs (and the VCSE sector in general) are to extricate themselves from the vicious cycle of evidencing impact, both sides need to meet in the middle. There must be honest dialogue about the shared local issues they both wish to address, the value of the wider determinants approach to tackling these, and the requirements and realities of demonstrating impact in a relevant and meaningful way.

3.

Recommendations for the health system

The four learning areas explored above also provide a useful framework to make recommendations to the health system.

They present opportunities at both local and national level to change the way prevention services are designed, commissioned, delivered, and measured. They underpin what needs to be a large-scale shift in these areas. Through them, the health system can begin to realise the value of CAOs in achieving its priorities and tackling health inequalities.

Maximising good practice

1. Use the Covid-19 pandemic experience as an opportunity to build from, including strengthening community engagement and reviewing the necessary rigour of contracts.

ICS Local authority

We know that supporting communities through the pandemic – particularly those experiencing the worst health inequalities – was easiest in places with strong existing relationships between the VCSE sector and statutory bodies. Whether or not this was the case where you are, now is the time to either embed those ways of working for the long term or take inspiration from achievements elsewhere. Urgency may have forced people to think differently and form slick, more effective partnerships, but this should provoke questions for the future too. For example, what has the experience taught you about who is best placed to deliver services which reach deep into communities? And, with delivery of services by the VCSE made much easier and faster by removing red tape during the pandemic, can there be a review of any unnecessarily restrictive contract requirements?

2. Support peer-led health promotion as an effective method of tackling health inequalities.

National Local authority ICS

However health messaging is disseminated, it is unlikely to influence groups most impacted by health inequalities if it comes directly from statutory bodies. The knowledge and connections of local people from those communities are essential to creating a dialogue and building trust. Nationally, evidence of the impact of peer-led health promotion could be strengthened through OHID, NHS England, and the National Institute for Health and Care Research. At ICS level, whether as part of NHS England's Community Connectors programme or otherwise, CAOs should be resourced to lead in the engagement of these peers. In doing so, ICSs should consider several key factors that may affect delivery locally:

- While effective, this type of community engagement comes with a cost for CAOs. The more localised or targeted it is, the better the results will be. But CAOs need funding to engage, grow, develop, and train such peer networks.
- A one-size-fits-all approach to this peer-led health promotion will not work in all places. Each minoritised community will have its own unique needs and will need to be approached in a way that works best for them.
- Labelling any such interventions as "health" related may have a negative impact on engagement. The wider determinants should be addressed as issues that come before health, are shared among the community, and do not carry stigma or judgement.

3. Make co-location as achievable as possible by supporting community asset ownership and identifying community spaces in which to co-locate.

ICS Local authority PCN

We have seen the value that the sharing of physical space by CAOs and local health bodies can have for the quality of services and levels of local engagement. Community spaces are often the most comfortable, trusted, and accessible places for people, particularly those most at risk of health inequalities. Considering the NHS Long Term Plan prevention priorities, this poses particular opportunities for improving the level of community engagement in important clinical issues like anti-microbial resistance and latent tuberculosis.

But CAOs across the country face a challenge in finding and maintaining appropriate space. Buildings aren't free and resource is required to keep them in community control, particularly during financial crises. By supporting CAOs to gain community ownership of assets, local health systems – including local authorities – can invest in the bricks and mortar of truly integrated healthcare. This can include providing the match funding required for CAOs to bid into the Community Ownership Fund. Beyond this, ICSs and NHS Property Services should proactively identify existing community-run spaces in which clinical services can be co-located.

Finding the right delivery approach

4. Make CAOs lead providers of Integrated Health and Wellbeing Services to increase the impact of such programmes on health inequalities.

ICS Local authority

As the IWHS grows in popularity as a holistic model of prevention, commissioning bodies must be aware of the very similar work CAOs are already doing every day in local communities. As such, they should be prioritised as providers for IHWSs that are trusted, impactful in their support for the wider determinants, long-lasting, sustainable, and accessible to all.

5. Explore and support diverse forms of social prescribing, including the embedding of Link Workers within CAOs where appropriate.

ICS PCN

Health systems should embrace the different potential models of social prescribing in different places. As with IWHSs, CAOs have many years' experience of what we now call social prescribing and will have found various ways to tackle local health inequalities. Where the Link Worker model is suitable, commissioners should work with CAOs to understand the scope for embedding these roles within them. CAO staff will often already have the knowledge and connections to play the Link Worker role better than anyone and can be resourced as such.

However, without the grass-roots funding to provide activities, there will be nothing for CAOs to prescribe to and/or deliver. As anchors, they are able to use funding to both deliver services themselves and to channel it to other local groups to support wider community infrastructure. Such steps would help to overcome two key recurring issues with the current system:

- Duplication of work, excessive meetings, and confused points of contact between the VCSE and the health system.
- The need for greater parity of esteem between VCSE prevention services and NHS clinical services.

Achieving collaborative commissioning

6. Work with CAOs to co-produce culturally competent prevention services with the best chance of tackling health inequalities.

ICS Local authority

We have seen how the success of a prevention service can hinge on its relevance and accessibility for its target groups. CAOs led by and supporting minoritised communities are key to this. Commissioners should work with these organisations to co-produce funded services that consider:

- appropriate language and channels of communication
- the influence of peer advocates
- the most pressing wider determinants of health for such communities
- relevant and practical examples of behaviour change
- how to best overcome cultural barriers to engagement

Importantly, such engagement and co-production should also move at the pace of the communities in question and support their own priorities.

7. Understand the assets of local communities and design prevention services that make the most of them.

National Local authority ICS

Commissioners should take the time to get out into communities and see first-hand the resources, skills, and experience they possess. This asset-based community development (ABCD) approach should then form the basis of any newly commissioned prevention services. This will necessarily support the wider determinants of health within a community. It may be that assets are spread across multiple VCSE organisations. In this case, an alliance contracting approach to commissioning may be best suited to maximise them.

Understanding of the ABCD approach could be supported nationally by the production of guidance and tools for local implementation. These may include understanding and mapping local assets, and incorporating them in the design of prevention services under Joint Strategic Needs Assessments.

8. Understand and invest in the capacity and capability of CAOs to produce sustainable and impactful prevention outcomes.

National | Local authority | ICS

Commissioners should not fall foul of the preconception that CAOs do not have the requisite governance or business acumen to effectively deliver contracts. As charities and social enterprises, they have to follow strict rules and regulations and budget often limited funds prudently. ICBs should, however, commit to investing in the capacity and capability of their CAOs to:

- help them bid for services they are best placed to provide to tackle health inequalities, including by becoming quality assured on local procurement frameworks.
- run long-term pilots to produce investment-ready services that are designed to succeed.
- help them secure the space they need to deliver prevention services effectively, including through community asset transfer.

Such investment should be accessible, moving away from the big hoops that CAOs needed to jump through to access it under previous Clinical Commissioning Groups. Where ICBs identify that they are lacking in CAOs, they should proactively support smaller local organisations to become CAOs through capacity building.

Measuring outcomes usefully

9. Move away from short-term prevention targets towards a theory-of-change approach to reducing ill health based on proxy indicators.

National | Local authority | ICS

To overcome the constant tension over evidencing impact, commissioners should work with CAOs to develop impact monitoring based on the accepted value of a wider-determinants-based approach. Here, impact on the determinants themselves can be used to demonstrate longer-term impact on health promotion and illness prevention. Similarly to the Office for National Statistics' Health Index, indicators such as access to services, economic and working conditions, and access to green space could be used.[24] This approach could be supported by national guidance from OHID.

10. Consider the value of compassionate services that destigmatise health issues for greater engagement.

Local authority | ICS

Particularly for issues such as weight management, smoking cessation, and alcohol management, services should be designed that focus on tackling their wider determinants for individuals. This diverts focus away from the unhealthy, stigmatised habit and towards wider, beneficial changes in living conditions. Understanding the lived experience of service users will be crucial for commissioners here.

11. Embrace "test and learn" approaches to prevention services.

Local authority | ICS

Open-mindedness and compromise are needed on both sides to accept gaps in knowledge and co-produce pilot services with the time and resource to iterate for greater final impact. This should be seen as part of normal quality improvement practices. This could be achieved by taking an Innovation Partnership approach to commissioning a service, beginning with a research and development phase to produce the most effective service.

12. Make systems for data collection, feedback, and reporting consistent.

National Local authority ICS

CAOs face complex and differing requirements for collecting impact data. This is even more acute when working with seldom heard communities experiencing the greatest health inequalities. The type of data to be collected and the system through which to feed it back needs to be clearer, more relevant, and more accessible. This may involve using simpler data collection processes, more compatible IT systems, and common communication channels. They key is to make approaches between different local commissioners consistent for providers. This could also be supported by national guidance.

4.

Recommendations for community anchor organisations

As well as developing recommendations for statutory bodies, our research also produced learnings for CAOs on increasing their involvement in health system prevention services.

All of the CAOs interviewed saw a clear role for supporting in the uptake of priority health system prevention services and campaigns. They saw a particular role in working with commissioners to co-produce such work to ensure it meets the needs of the communities they serve. However, finding the opportunities for such collaboration has proved a challenge for CAOs. While the long-term solution lies in a balancing of power between both parties, there are ways that CAOs can help to improve the current relationship.

1. Understand and communicate to the health system the value of the CAO approach for the wider determinants of health

We have already advocated for a sea-change in the way the health system measures the impact of prevention services. There should be a move away from short-term output targets and towards a theory of change approach. To support this, CAOs need to understand clearly how their work positively impacts the wider determinants of health of local people. The Inclusive and Sustainable Economies framework (see Figure 1, p.10) provides a useful tool for doing this. Our previous research found that, on average, CAOs address 91% of the determinants in the yellow boxes.[25] As such, they are uniquely placed within communities, helping to produce healthy and thriving communities, with increased productivity and prosperity, in sustainable places.

To communicate this effectively, CAOs should have processes in place to measure the longer-term consequences of their work on the various determinants. For example, while we know that access to 'good work' is critical to reducing health inequalities,[26] a CAO programme to increase employability skills cannot automatically be assumed to lead to good work for a participant. Where possible, the longer-term progress of an individual from such a programme into good work should be captured, including evidence on the impact it had on improving their ability to secure the work. Doing so can help commissioners to understand how benefit from CAOs. It can support them to move away from narrow services focussed on specific clinical issues (eg, smoking cessation) towards a broader and more impactful wider-determinants-based service.

2. Find the right contacts within Integrated Care Partnerships health contracts

While the shift to Integrated Care Systems aims to improve partnership working and channels of communication, it is important to remember that the NHS is not homogeneous from place to place. CAOs should actively seek out contacts and do so early in the development of any initiatives or ideas to influence place-based prevention strategy. There are now 'VCSE alliances' in each of the 42 Integrated Care Partnerships across the country, designed as formal mechanisms to involve the sector in local health planning. However, there is not yet a standardised way for organisations to feed into their local alliance. The lead may be taken by the main Council for Voluntary Service (CVS) within the area – often a good place to start in understand how to access the alliance. But CAOs have a crucial part to play as the leading VCSE organisations working on the ground and should be forthright in staking their claim for inclusion.

3. Connect with local Primary Care Networks

The most important day-to-day health system relationship for a CAO will likely be with their local PCN. For example, these networks of GP surgeries and other local health and care providers are positioned to refer patients to social prescribing activities provided by CAOs. Or they may be able to visit community spaces to directly engage local people in key health messaging. The closer this working relationship – to the point of co-location as an ultimate aim – the better able both parties will be to tackle shared local priorities. CAOs can help PCNs to understand trends in the local wider determinants of health, their impact on the wellbeing of individuals, and the nature of the health inequalities they face. This can be supported by inviting PCN leads – as well as ICS leads – to visit community spaces and witness first-hand the impact of activities. This is crucial to ensuring hyper-local funding and resources are distributed as effectively as possible, including to and through CAOs.

4. Tackle local priorities with other VCSE partners

As we push for a more integrated, whole-system approach to the commissioning of prevention services, CAOs can find strength in numbers among local VCSE partners. They should collaborate and "do their homework" on the shared issues affecting neighbourhoods and wider places. Developing joint solutions based on what they know works, particularly from a wider determinants perspective, can provide a persuasive argument for commissioners. It can help in encouraging them to take an alliance contracting approach, where multiple organisations work together to provide a service based on collective ownership of opportunities and responsibilities.

5. Demonstrate ability to meet the rigours of current health system contracts

We are aiming for impact monitoring and contract management based less on unilaterally determined outputs and more on co-produced measurements and requirements that are helpful and realistic. In the meantime, however, there are practical steps CAOs can take to demonstrate their ability to deliver health system contracts in their current form. While CAOs will often have strong governance and financial protocols, they may be less used to communicating them as part of grant-funded projects. Health system contracts may require providers to demonstrate a high threshold for evidencing impact, adhere to strict rules on information sharing and consent, follow particular legal processes, or manage other less common restrictions. If market engagement by the commissioner is insufficient to let CAOs ask the necessary questions, they should seek this information out proactively. This should, however, be done in tandem with understanding and communicating their wider determinants impact, as above. This can help maintain pressure on the local health system to reconsider its orthodox approach.

Endnotes

1 https://www.londoncouncils.gov.uk/our-key-themes/health-and-adult-services/public-health/wider-determinants-health

2 The King's Fund, 2012/13, "Broader determinants of health: Future trends". Available at: https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

3 Locality, 2022, "The impact of community anchor organisations on the wider determinants of health". Available at: https://locality.org.uk/assets/images/LOC-CAWD-Report-2022-WG08.pdf

4 Public Health England, 2021, "Inclusive and sustainable economies: leaving no one behind (executive summary)". Available at: https://www.gov.uk/government/publications/inclusive-and-sustainable-economies-leaving-no-one-behind/inclusive-and-sustainable-economies-leaving-no-one-behind-executive-summary

5 Socioeconomic deprivation is measured using England's Index of Multiple Deprivation (IMD), which provides an overall relative measure of deprivation for each Lower layer Super Output Area (LSOA). It follows an established methodological framework in broadly defining deprivation to encompass a wide range of an individual's living conditions. People may be considered to be living in poverty if they lack the financial resources to meet their needs, whereas people can be regarded as deprived if they lack any kind of resources, not just income. See: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/socioeconomicinequalitiesinavoidablemortalityinengland/2019

6 It is against the law to discriminate against someone because of; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. These are called protected characteristics. See: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

7 Inclusion health is a 'catch-all' term used to describe people who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence, and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes. See: https://www.gov.uk/government/publications/inclusion-health-applying-all-our-health

8 Ibid, 3

9 NHS England, 2022, "NHS England Board meeting". Available at https://www.england.nhs.uk/wp-content/uploads/2022/11/221201-item-7-board-paper-prevention.pdf

10 The King's Fund, 2018, "Tackling multiple unhealthy risk factors: emerging lessons from practice". Available at: https://www.kingsfund.org.uk/publications/tackling-multiple-unhealthy-risk-factors

11 Cheetham et al, BMC Health Services Research, 2018, ""It was the whole picture" a mixed methods study of successful components in an integrated wellness service in North East England". Available at: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3007-z

12 Public Health England has now been disbanded. From 1st October 2021, its functions were transferred variously to the UK Health Security Agency, the Office for Health Improvement and Disparities, NHS England, and NHS Digital.

13 Ibid, 9.

14 Ibid.

15 Ibid.

16 Ibid.

17 Ibid.

18 Powell et al, Critical Public Health, 2017, "Theorising lifestyle drift in health promotion: explaining community and voluntary sector engagement practices in disadvantaged areas". Available at: https://www.tandfonline.com/doi/abs/10.1080/09581596.2017.1356909

19 Ibid, 3.

20 Locality, 2022, "Principles in practice: Lessons and examples from the Keep it Local Network". Available at https://locality.org.uk/assets/images/LOC-KIL-Report-2022-JUL-WG06.pdf

21 Ibid. 2.

22 See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/737905/Tier2_adult_weight_management_services_guide.pdf

23 Ibid. 17.

24 Office for National Statistics, 2022, "How health has changed in your local area: 2015 to 2020". Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/howhealthhaschangedinyourlocalarea2015to2020/2022-11-09

25 Ibid, 3.

26 The Marmot Review, 2010, "Fair Society, Healthy Lives". Available at: https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

Locality

Locality supports local community organisations to be strong and successful. Our national network of over 1,600 members helps hundreds of thousands of people every week. We offer specialist advice, peer learning and campaign with members for a fairer society. Together we unlock the power of community.

Power to Change

Power to Change is the independent trust that supports community businesses in England.

Community businesses are locally rooted, community-led, trade for community benefit and make life better for local people. The sector owns assets worth £870m and comprises 11,300 community businesses across England who employ more than 37,000 people. (Source: Community Business Market 2020).

From pubs to libraries; shops to bakeries; swimming pools to solar farms; community businesses are creating great products and services, providing employment and training and transforming lives. Power to Change received an original endowment from the National Lottery Community Fund in 2015 and a further £20 million grant in 2021.

VCSE Health and Wellbeing Alliance

The VCSE Health and Wellbeing Alliance (HW Alliance) is a part of the VCSE Health and Wellbeing Programme (HW Programme) which is delivered by Department of Health and Social Care and NHS England and NHS Improvement (the system partners).

The HW Alliance is new network of 18 member organisations (and one coordinator) established to collaborate and coproduce to bring different solutions and perspectives to policy and programme issues. All HW Alliance members represent communities that we need to hear from as we develop health and social care policy and programmes.

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locality.org.uk

Locality | 33 Corsham Street, London N1 6DR | 0345 458 8336

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