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People powered primary care: learning from Halton

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Abstract

Purpose – A community-centred approach to health called Community Wellbeing Practices (CWP) is being offered to patients at all 17 GP practices in Halton in order to respond more appropriately to patients' social needs, which are often an underlying reason for their presentation at primary care services. The paper aims to discuss these issues.

Design/methodology/approach – Delivered in partnership with a local social enterprise this approach is centred on the integration of community assets and non-medical community-based support provided by the voluntary, community and social enterprise sector. The core elements include community navigation, social prescribing and social action approaches.

Findings – The CWP initiative has supported more than 5,000 patients over the last four years and has evidenced demonstrable improvements in a range of health and social outcomes for patients.

Research limitations/implications – The initiative has been well received by clinicians and social care professionals and has contributed to a cultural transformation in the way health and care professionals are responding to the identified needs of the community.

Practical implications – Using community-centred approaches in this way may help to augment clinical outcomes as well as reduce demand on over stretched public services.

Social implications – Community-centred models such as the one in Halton have the potential to empower citizens to play an active role in creating healthier communities by catalysing a “people powered” social movement for health.

Originality/value – The CWP model in Halton is a good example of the way community-centred approaches to health can be integrated with health and care pathways to augment clinical outcomes and reduce demand on over stretched services.

Keywords Health and wellbeing, Social enterprise, Voluntary and community sector, Community navigation, Community-centred approaches, Social prescribing

Paper type Case study

Introduction

The publication of the Wanless Report in 2004 and the *Five Year Forward View (5YFV)* ten years later have emphasised a need to deliver a prevention agenda to stem the rising tide of wholly avoidable illnesses and a concomitant rise in demand for healthcare services. Until more recently, preventative health initiatives have focussed on “downstream” lifestyle interventions in spite of the strength of evidence challenging such approaches (Scott-Samuel and Smith, 2015). However, the publication of Sir Michael Marmot’s “Fair Society, Healthy Lives” Report in 2010 has strengthened the call to focus on the “causes of the causes” of poor health which he and others attribute to the “social inequalities in the conditions in which people are born, grow, live, work and age” (Marmot, 2010). Consequently, it has been argued that efforts to improve the nation’s health must also consider the social determinants of health and this has spawned a growing interest in community-centred health approaches (Rippon and Hopkins, 2015; Finnis *et al.*, 2016).

In this paper, I will reflect on my experiences co-designing and implementing community-centred approaches in health over the last decade across the Northwest of England which includes developing interventions such as social prescribing, community navigation and social action and volunteering schemes. I will describe what I believe have been the critical success factors in the development of these approaches. I will discuss the main outcomes from the Community Wellbeing Practices (CWP) model in Halton thus far and the proposed next steps in this iterative community-centred health approach. Using community-centred



approaches in this way may help to augment clinical outcomes for patients as well as reduce demand on over stretched public services. I will argue that community-centred models such as the one in Halton have the potential to empower citizens to play an active role in creating healthier communities by catalysing a “people powered” social movement for health.

The borough of Halton in Cheshire

Halton is situated in the Northwest of England and is made up of two neighbouring towns – Runcorn and Widnes. The health inequalities for people in Halton are substantial with people living on average a greater proportion of their lives with an illness or health issue that limits their daily activity when compared to the England average (Rippon and Stansfield, 2015). In relation to a number of health indicators the health of people in Halton is generally poorer than in other parts of England. For example, 35.2 per cent of adults are classified as obese, worse than the England average. The rate of alcohol-related harm is also worse than the average for England as is the rate of smoking-related deaths. Mental health problems account for the largest cause of ill health and disability in Halton (Rippon and Stansfield, 2015; Public Health England, 2004).

Levels of deprivation are higher than average with about 26.7 per cent (6,600) children living in poverty. Life expectancy for both men and women is lower than the England average; around 8.9 years lower for men and 8.0 years lower for women in the most deprived areas of Halton than in the least deprived areas. At ward level there are areas where these inequalities are greatest, the Windmill Hill and Kingsway ward in particular are cited in the Halton Joint Strategic Need’s Assessment (JSNA) as having significant challenges (Rippon and Stansfield, 2015).

Developing a community-centred model of health

Halton Clinical Commissioning Group (CCG) in partnership with Halton Borough Council (LA) commissioned an established, local social enterprise called Wellbeing Enterprises Community Interest Company (CIC) (see Box 1) to design and deliver a project to test out the effectiveness of community-centred health approaches in primary care. This project came about following months of conversations with senior leaders in the NHS and the LA about how we might harness new insights about the ways that social determinants impact on health outcomes over the life course (Foresight Report Mental Capital and Wellbeing Project, 2008; Holt-Lunstad *et al.*, 2010).

A pivotal moment in the project’s evolution came when colleagues and I presented these insights to the Board of Directors at Halton CCG. On reflection I believe this opportunity helped to catalyse what I now refer to as a “courageous wellbeing conversation”. The presentation appeared to be well received by members of the Board with many

Box 1. About Wellbeing Enterprises CIC

Wellbeing Enterprises CIC is an award winning social enterprise recognised for its innovative community-centred approaches in health and wellbeing in the UK. Over the last 10 years they have supported more than 20,000 people to make demonstrable improvements in health and wellbeing levels. Their mission is to help people achieve healthier, happier and longer lives. They do this by educating the general public, mobilising the assets in the community, and working together with partners to tackle the underlying causes of poor health. The organisation was one of the first health and wellbeing Community Interest Companies or “CICs” to set up in the UK back in 2006. The company is asset locked ensuring that the profits of the company are used to benefit society. I set up the company while working as a Health Improvement Specialist for the NHS as I was frustrated at the lack of investment channelled towards the public mental health and wellbeing agenda so I decided I would take action with a group of likeminded individuals (www.wellbeingenterprises.org.uk and www.investinwellbeing.org.uk).

describing how these insights resonated with their experiences in clinical practice. I recall one GP saying of the presentation “I often feel as though I put a sticking plaster on a much bigger problem in my patient consultations”. Looking back over this meeting I think it helped that some of the senior leaders present had previously worked in the voluntary, community and social enterprise (VCSE) sector and/or in mental health services where one could argue that the influence of the social determinants can be more directly observed.

Plans to pilot a community-centred model of health in three GP practices were quickly superseded at the request of the Chair of the CCG, in favour of full coverage across all 17 GP practices to ensure equitable provision. For nine months, Wellbeing Enterprises staff collaborated with a wide array of partners which included public health consultants, GPs, health and social care commissioners, VCSE professionals and patients and the public to develop shared aspirations for this community-centred model.

This culminated in a “Shared Purpose” day in which representatives from more than 50 organisations came together to develop a shared purpose and a set of shared values that would underpin this community-centred model of health. The shared purpose that was agreed was “Today, improve the wellbeing of others” and the shared values were “collaborative leadership; trust and imagination”. I think this developmental stage was especially important as it focussed everyone’s attention and energy on a shared aspiration that transcended individual institutions. Our shared purpose and values became the foundations upon which future partnerships were forged and it helped Wellbeing Enterprises’ staff to navigate the complexities and tensions that played out from time to time when working with a diverse range of sectors.

A theory of change for CWP

We invested a considerable amount of time in the early stages developing and refining a theory of change that would describe the way that the CWP model would bring about improvements in health. Key concepts that informed our theory were: salutogenesis – developed by Aaron Antonovsky (1979), which focusses on the determinants of good health with a particular focus on people’s resources, capabilities and the mechanisms that create and sustain health. We also incorporated asset-based approaches to health (Foot and Hopkins, 2010; Rippon and Hopkins, 2015) and insights into how people are able to build a sense of control and autonomy in their lives (Sen, 1999; Whitehead *et al.*, 2016).

Central to our proposed theory of change was a recognition that health problems are caused or exacerbated by social problems (Marmot, 2010), and so we felt it was important to offer social solutions to respond to such challenges that would complement medical treatments. In respect of this, we reviewed the available literature looking at community wellbeing interventions and chose to focus on three core offers: community navigation, social prescribing and social action (South, 2015).

It proved difficult in the early stages to resist the temptation to define our key performance indicators (KPIs) from the outset; however, there was a collective sense that this might lead us down a wrong path as we had not yet fully explored how the model might derive benefits for patients and the wider community. We did not want to fall into a trap of hitting targets and missing the point. Over several weeks of discussions, we decided on a way forward that we felt would satisfy the need to demonstrate impact while also maintaining a degree of flexibility in the model to respond to the needs and aspirations of patients and the community as our knowledge and insights grew. We agreed on a series of broad, thematic KPIs (see Box 2) while we trialled and tested out different approaches. On reflection, I think this was a critical success factor in enabling the model to grow and develop as it did. Within nine months of agreeing our thematic KPIs we had worked up sufficient detail in the model to replace these with a suite of robust outcome focussed KPIs.

Box 2. Thematic KPIs for the CWP model

- (a) Developing the practice environment.
- (b) Providing wellbeing initiatives.
- (c) Building skills and competencies of practice staff.
- (d) Engaging stakeholders in the wider system.
- (e) Marketing and communication.

A community-centred offer for patients

We met with staff at all 17 GP practices prior to launching the CWP model to seek their “buy in”. These preliminary meetings provided useful insights into how health professionals believed the model could support patient’s needs. Every practice was required to opt in to the model to help us to ascertain the levels of commitment from the outset. The first wave roll out of the model included seven participating GP practices, with the remaining ten practices signing up after six months. We were understandably delighted to have full participation in the programme despite there being some scepticism from a small number of clinicians in the early stages.

We offered brief interventions training to health professionals to help them to respond more effectively to patients’ social needs. The training provided insights into the Five Ways to Wellbeing (Aked *et al.*, 2008), motivational interviewing and the BATHE technique (Stuart and Lieberman, 2008). Feedback from staff about this training showed that they found it useful in their consultations with patients. A simple referral process was implemented in the GP practices so that health professionals could refer patients into the CWP service. We ran an extensive marketing campaign to raise the profile of the service to health professionals, patients and the public. We piloted a range of novel engagement projects to encourage stakeholders to become actively involved in the CWP model following the initial start-up phase. These included posting letters in GP mailboxes, handing out flyers in supermarkets and in the town centre, e-mailing out newsletters and undertaking community wellbeing projects (see Box 3).

A Wellbeing Review

The central premise of the CWP model is that once a health professional has identified that social issues are impacting on patient health and wellbeing they are offered a referral for a non-medical Wellbeing Review (see Box 4) carried out by a CWO at the Wellbeing Enterprises team. Wellbeing Reviews take place at a variety of venues in the community including the GP practices themselves as well as community centres and voluntary organisations in an effort to reach into the community. In addition, there is an option for people to self-refer into CWP services and this was promoted widely to aid the uptake amongst the general population.

Box 3. Doctorpreneurs

In the initial start-up phase CWO’s offered grants of £500 to staff from participating GP practices that were willing to collaborate with patients on community projects to improve patient wellbeing. We ran “Doctorpreneurs” projects in the majority of practices and this proved to be an effective way of engaging health professionals and strengthening relationships between GP practice staff, Wellbeing Enterprises staff and wider community stakeholders. Successful “Doctorpreneur” schemes included Tango Dancing on Prescription, Nordic Walking projects, a GP Practice garden make over and Tennis Clubs.

Box 4. Wellbeing Reviews

Wellbeing Reviews are typically 45 minutes in length and consist of a semi-structured conversation focussing on what is going on in a person's life. Patients can talk about anything they like in their Wellbeing Review and staff are skilled at helping patients to drill down to the pertinent issues impacting on their health and wellbeing at the time. The patient and CWO work together to identify key social issues; map individual strengths and capabilities and identify personal and community resources at their disposal. Working together they develop a personalised plan for wellbeing. Patients are also introduced to the Five Ways to Wellbeing (Aked *et al.*, 2008) and are encouraged to set goals aimed at gradually introducing these into their daily activities.

Typically over a four-week period, the CWO supports the patient to navigate a range of local community-based support that can help to resolve underlying social problems. They meet for a follow-up appointment four weeks later to review progress and if issues have been resolved the CWO will then maintain telephone contact at regular intervals up to 12 months post intervention to ensure the patient is making progress; otherwise the face-to-face contact remains in place. In addition to one to one support, patients have access to a range of community-based activities including educational courses, hobby and interest groups and volunteering opportunities.

It is important that the CWOs are seen to be an integral part of the GP practice team and so they attend practice team meetings and spend a proportion of their working week in the practice setting delivering health promotion initiatives and meeting with patients in the waiting rooms. As the model became more established opportunities presented to integrate the CWP model with core activity in the primary care setting. For example, CWOs were invited to join the Primary Care MDT meetings that took place at GP practices were patients at risk of readmission to secondary care had their care reviewed by a multidisciplinary team. This was an important development in the model as it enabled us to focus our resources on "pressure points" in the health and care system by supporting patients whose social needs were most likely to have a detrimental effect on health. All CWOs have access to the EMIS practice system and are able to leave notes on patient records to keep the health professional informed of the progress of the patient receiving their support.

The CWOs established links with a variety of local agencies that could support patients with social issues including housing, the voluntary sector, the police, community centres, schools and colleges to name a few. They developed asset maps to identify the resources at their disposal, where they were located and how they could be accessed. Patients accessing the CWP services have a wide range of social problems including housing issues, unemployment, lack of basic provisions, loneliness and isolation, relationship difficulties and stigma and discrimination. The CWOs were able to support patients in a number of ways including providing a listening ear, connecting patients to specialist support, providing health promotion advice and/or access to learning opportunities (see Box 5).

Halton Public Health Team has developed practice level JSNAs which provide detailed health demographic data for each of the 17 GP practice populations. Triangulating this intelligence with insights from clinicians and consultation data from patients and the public provides a powerful way of targeting CWP resources to address the most pressing patient needs. Consequently each CWO has devised a Practice Action Plan in collaboration with stakeholders to focus community-centred approaches on priority needs. This has led to targeted health promotion campaigns, collaborations with voluntary sector agencies and efforts to improve the uptake of the winter flu jab – a key target for the GP practice itself.

Insights from the borough wide JSNA have been the motivation for a plethora of partnerships with clinical teams to address key health challenges using complementary

Box 5. Patient stories

Mike; cycling his way to wellbeing...

Mike is in his mid 60s and has been living with a diagnosis of dementia for some time. Mike presented at his GP practice with his wife who was also his main carer after his condition had progressed quite suddenly. It transpired that Mike could no longer go cycling; his lifelong passion – because he kept getting lost and on one occasion he went missing for 8 hours, leaving his wife frantic with worry.

Having ruled out other medical issues, the GP concluded that Mike needed help to reconnect him with his passion for cycling and referred him and his wife to their local CWO who was able to connect him with a local cycling group who agreed to pick him up and take him home after each session. As soon as Mike reconnected with his passion for cycling, his mental wellbeing improved and consequently his symptoms subsided. Mike is now enjoying his love for cycling again and making friends with people who share his passion and importantly his wife is getting respite from her caring responsibilities.

Bob and his Ukulele talent...

Bob is in his late 50s and lives with a respiratory condition called Chronic Obstructive Pulmonary Disorder (COPD) which had resulted in several emergency admissions over a short period of time. Bob's case was reviewed at a Primary Care MDT, and as well as addressing his medical needs, his GP suggested that a CWO could pay him a visit to determine his wider wellbeing needs. While visiting him at his home, the CWO noted that his house was affected by damp and it transpired that Bob's boiler had broken several months ago which coincided with his emergency admissions.

The CWO supported Bob to access a grant scheme to get a new boiler installed, which coincided with a reduction in his hospital admissions. The CWO talked with Bob about what was going on in his life. Bob had been bereaved several years ago. He explained how his "wife was his life" and how he had been feeling "shut off from the world" ever since. The CWO discovered that Bob could play the Ukulele and helped him to set up a Ukulele hobby group which became so popular that a local shop now sells them. Bob said of his time with his CWO "She was magic, she got me out and about again, and now I help others to discover their talents".

community-centred approaches alongside standard clinical interventions. Notable examples are the collaborations between the CWOs and the Increasing Access to Psychological Therapies (IAPT) and CAMHS practitioners. The CWOs have provided low-level psychosocial support to patients with mild to moderate mental health problems as an adjunct to standard therapeutic or pharmacological interventions as a way of responding to patient's social needs, and also as a means of reducing demand and improving flow in these services.

"Ways to wellbeing" social prescribing service

A comprehensive social prescribing service runs alongside the one to one Wellbeing Review service in the CWP model to provide patients with access to a range of psychoeducation and social inclusion programmes varying in length from four to eight weeks. Social prescribing links patients to non-medical sources of support in the community (Local Government Association, 2016). The "Ways to Wellbeing" social prescribing service provides opportunities for patients to learn life skills-based cognitive behavioural approaches, mindfulness, self-care strategies, sleep hygiene and relaxation techniques alongside hobby and interest groups such as singing, dancing and knitting clubs.

All the social prescriptions have a core educational component focussing on problem solving skills, goals setting and developing an awareness of the Five Ways to Wellbeing (Aked *et al.*, 2008). The courses are delivered at community venues across the borough as a means of reconnecting patients with community assets that can bolster a sense of wellbeing. All patients complete a "moving forward" plan towards the end of their intervention in which they map out assets of people and place that can help them to stay engaged and active in the community so they are able to maintain their progress (see Box 6).

Box 6. Living well – with a long-term condition

Living Well is a self-help programme that enables individuals with a diagnosed long-term health condition to share coping techniques, build support networks, mobilise their strengths and capabilities and take positive steps to improve their health and wellbeing.

The four-week programme utilises the personal insights and experiences of patients and empowers them to better manage their long-term condition. The course introduces evidence-based practical tools and techniques for improving self-care, and participants are supported to develop a structured wellbeing plan to sustain long-term health and wellbeing.

Participant learning outcomes:

- to enable participants to share their personal insights and experiences of living with a long-term condition;
- to raise awareness of self-help techniques to better manage their long-term condition;
- support participants to take positive steps to improve their health and wellbeing; and
- help participants to develop a structured plan to sustain long-term health and wellbeing.

The “Five Ways to Wellbeing” are embedded throughout the programme and participants are supported to complete wellbeing pledges linked to these as a way of activating participants to engage in health promoting behaviours.

Social action and its potential to transform healthcare

Patients and the public play a pivotal role in the design and implementation of the CWP model. Patients are seen as assets with strengths and experiences that can be harnessed to ensure the longer-term sustainability of the model. Indeed, a significant number of patients who make use of the social prescribing service return to co-facilitate sessions with tutors. By sharing their personal stories they are able to help others to overcome their difficulties “it’s good to talk to people who have been through similar problems and come out the other side. It gives me hope that I can do the same”.

Volunteers are the lifeblood of the CWP model and we have established successful volunteer schemes in several GP practices in which patients have joined Patient Participation Groups or delivered health promotion projects. We also provide volunteering opportunities for people interested in administration, project support or acting as a Wellbeing Ambassador in the community (see Box 7).

Over recent years, we have partnered with UnLtd – the Foundation for Social Entrepreneurs to offer grants and specialist support to local people who have ideas for social change. In keeping with our view that citizens are assets, we have developed an initiative that invites the community to develop projects that they believe will tackle the most pressing local health and care needs. We offer Try It, Do It or Build It awards ranging from £500 to £5,000 for local people get their ideas for social change off the ground.

Box 7. Social action case studies

Yvonne – a Volunteer Wellbeing Ambassador

Yvonne is in her 20s and was referred to us by her GP who believed that she had skills that were of use to the community. Yvonne has learning difficulties and is a frequenter attendee at her GP practice – visiting on average once a week. Yvonne explains that she gets lonely from time to time and she wishes she had someone to talk to. Yvonne initially met with a CWO at her local community centre. During her Wellbeing Review, Yvonne explained that she is a sociable person and enjoys helping others. She was more than happy to volunteer her time as a Community Wellbeing Ambassador. “I love it” she explains. “I have a cup of tea and talk to people who live locally [...] I tell them about the Five Ways to Wellbeing and I encourage them to have a go like I do [...] It’s nice to be able to help in this way”. Yvonne’s GP has fed back to her CWO that her visits to the Practice have reduced to one a month, and importantly that Yvonne is enjoying her new volunteer responsibilities”.

This has kick-started a wide range of social entrepreneurship activity culminating in community projects such as volunteer environmental schemes, healthy eating pop-up cafes and veteran air fix model clubs.

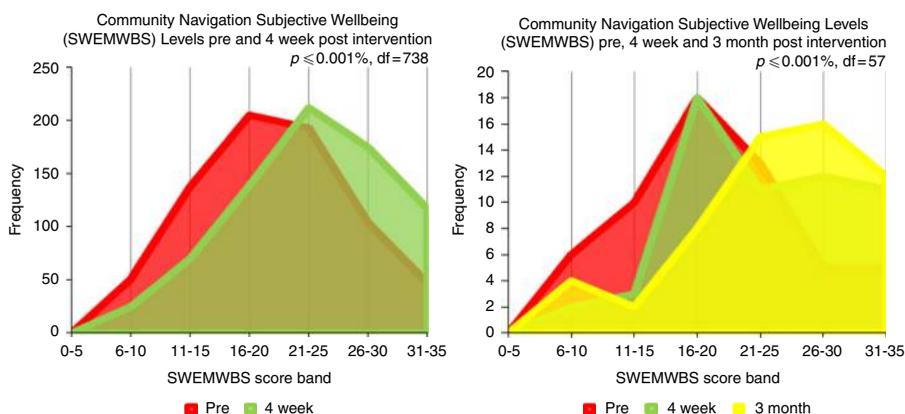
This scheme has been so successful that continuation funding has been secured from Halton CCG and matched by UnLtd to expand the scheme to work specifically with young and older “would be” social entrepreneurs. Interestingly, more than half of successful applicants stated that they live with a disability or long-term health condition and we speculate that this approach offers a novel way to helping citizens to reframe their experiences and support their recovery.

Outcomes of the CWP model

The CWP model has supported over 5,000 patients to date and outcome data have shown statistically significant improvements in a range of health outcomes including depression symptoms (PHQ9), anxiety levels (GAD7), subjective wellbeing (SWEMWBS) and health status (EQ5D). Our patient outcomes data for our one to one interventions show a 73 per cent improvement in patient subjective wellbeing scores with 67 per cent of patients sustaining these improvements three months post intervention ($p = 0.001$) (Swift *et al.*, 2015) (see Figure 1). In the case of our social prescribing interventions, we observed a 69 per cent improvement in subjective wellbeing scores (SWEMWBS) and a 65 per cent reduction in depression symptoms four weeks post intervention ($p = 0.001$) (see Figure 2).

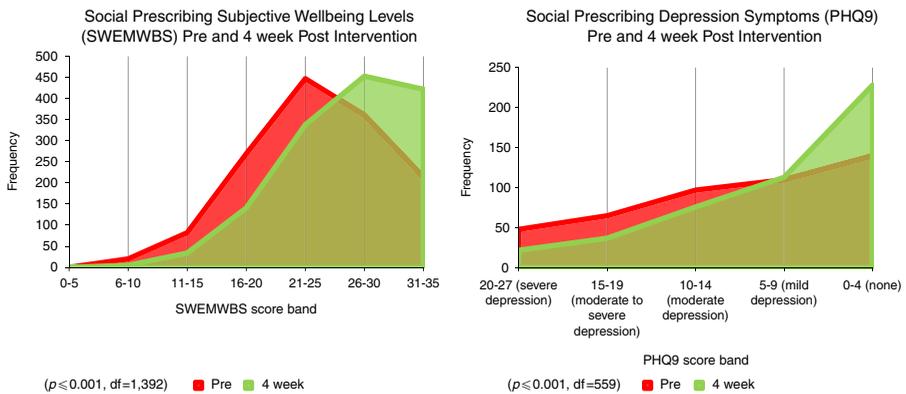
In addition to patient health outcome data, we collate a raft of qualitative data to try to determine the wider impact of the CWP model on patient’s lives. We report a sample of these patient stories in our quarterly contract meetings with commissioners. We are also able to report on the numbers of health-related goals patients achieve with support from their CWO; our most recent analysis showing that 60 per cent of patients were successful in achieving these personal goals four weeks post intervention.

Feedback from health professionals about the CWP model has been exemplary with 100 per cent of GP practice staff canvassed anonymously reporting satisfaction levels of 6/10 or more (1 being very poor and 10 being excellent). In the same survey, all GP practice staff reported that the model had improved access to community-based services for their patients (see Box 8).



Notes: Community navigation service 73 per cent of surveyed patients had improved subjective wellbeing scores (SWEMWBS). This change was highly significant ($p = 0.001$). In total, 67 per cent of surveyed patients had improved SWEMWBS scores three months post intervention

Figure 1.
Health outcomes from
the community
navigation service



Notes: Social prescribing programme 69 per cent of surveyed patients had improved subjective wellbeing scores (SWEMWBS) ($p=0.001$). In total, 65 per cent of surveyed patients had a reduction in depression (PHQ9) symptoms scores. This change was highly significant ($p < 0.001$)

Box 8. Testimonies from health professionals

“Sometimes medicine isn’t the answer and having conversations with patients about accessing activity groups or trying new things has given me a greater depth to understanding my patients – it feels like you’re reaching out to the social circumstances in their lives” (GP).
 “The service can be as important to our patients as the medical healthcare that we provide, and it often provides a much needed lifeline” (Practice Nurse).
 “It’s been nothing but positive, both for the patients and clinicians in opening up options to ease patients through difficult times and social circumstances” (GP).

A preliminary study carried out by academics at the Heseltine Institute for Policy and Practice at the University of Liverpool aimed to understand the ways in which the CWP model was supporting the reconfiguration of community networks and support structures. The findings from this preliminary study appear to support the view that this model is spawning novel community connections which enable resources and innovations to flow more freely. However, it should be noted that more work is needed to corroborate this preliminary finding (Swift *et al.*, 2015).

Creating social value using community-centred approaches

It has been possible to realise several additional untended outcomes by commissioning a local social enterprise to design and deliver the CWP model. I believe this has enabled us to extend the reach and impact of this community-centred health approach far beyond primary care provision. For example, Wellbeing Enterprises CIC was able to leverage grant investment to expand the CWP model to patients receiving CAMHs and IAPT provision in order to counter potential bottlenecks in these services and improve patient outcomes. More recently investment has been secured to expand the “Ways to Wellbeing” social prescribing service locally and investment from UnLtd has unleashed an ecosystem of social entrepreneurs who it is hoped will leave a lasting legacy. Wellbeing Enterprises is currently diversifying its offer through the development of asset mapping digital technology, which again has come about as a direct result of the novel partnerships which have been developed through using community-centred approaches.

The *5YFV* calls for greater collaboration between health and the VCSE sector and I believe the CWP model in Halton provides a shining example of what is possible through such a collaboration. Indeed, a recent paper by the Richmond Group of Charities describes a range of ways in which the VCSE sector can support the transformation of healthcare (Weston *et al.*, 2016). In light of this, Wellbeing Enterprises working with a local VCSE partner have been successful securing a contract with a local Acute Trust to support them in their aspirations to expand their volunteering provision and mobilise “patient power” as a way of improving patient outcomes and their experiences of care. Opportunities like this one have come about from “courageous wellbeing conversations” with healthcare leaders who have seen first-hand the impact that the CWP model has had in primary care. It is hoped that other opportunities will now come about to explore how community-centred approaches can be delivered in acute and community care providers and this is a key strategic priority for Wellbeing Enterprises CIC.

Halton is rolling out community-centred approaches more widely following the recent launch of its Cultural Manifesto which aims to build on the strategic partnerships formed between health and art, enterprise, technology, sport and culture. This has opened the door to a limitless number of avenues through which community-centred approaches might develop locally. Indeed, it has been posited that the CWP model has helped to catalyse a social movement for wellbeing locally (Castillo *et al.*, 2016). A local senior leader describes the change the CWP model has brought about “This is public health work at its best [...] promoting wellbeing [...] resilience and impacting on wider issues in the borough [...] there’s big reciprocal conversations with local people using the service [...] not telling people what they need”.

Conclusion

The CWP model implemented in Halton has provided insight into the way community-centred approaches can be integrated with primary care provision as a way of augmenting clinical outcomes and improving patient care. The CWP model has the potential to function as a demand management strategy alleviating pressures on stretched clinical services. Interestingly, community-centred approaches appear to complement medical interventions. By connecting patients to community assets and resources – such as those provided by the VCSE sector clinicians are able to “reach out” to the social circumstances of a patient’s life. There is evidence of a range of positive health and social outcomes for patients through the CWP model which have been sustained longitudinally, however, further data analysis is required to corroborate these findings. Work is currently underway on an independent Cost Benefit Analysis to determine the economic return of this model – by comparing patient pre- and post-healthcare utilisation using a range of proxy health measures.

Implementing a community-centred approach to health “opens a door” and brings together diverse stakeholders to realise the ambitions of the *5YFV*. Reflecting on my own experiences I believe it is in the diversity of these collaborations that new innovations and ideas can emerge that make the aspirations of the *5YFV* possible.

I believe the key enablers of the CWP model in Halton were:

- (1) Having a well-established community focussed social enterprise to lead the co-design and implementation of community-centred approaches to health. This was an important first step in the development of the CWP model as it rooted the development of the initiative in the community right from the outset. The willingness to do so is testament to the unwavering commitment of leaders in the health and care sector in Halton to ensure that the community led the change that they felt was necessary to improve health outcomes.
- (2) Bringing together a range of diverse partners with patients and the public to dream for an alternative future. For this to happen there needed to be a shared

understanding of the value of imagination and creative thinking in order to explore the “art of the possible”. This meant refraining from critical analysis until later on in the project’s development. Developing a shared purpose and values laid the foundations for effective collaborations early on.

- (3) Accessible and authentic collaborative leadership. A willingness of senior leaders to actively engage in “courageous wellbeing conversations” and to step outside of perceived, conventional wisdom was a critical success factor enabling the CWP model to get off the ground. We were fortunate to have leaders who were accessible and willing to investigate alternative paradigms. In a way, I think they understood on a deep level that improving the health of the population is in some respects both an art and a science and consequently they were willing to see the world through both these lenses.
- (4) A willingness to collaborate with the VCSE sector as equal partners. There was a commitment to involve the VCSE sector at every stage of the CWP model development and implementation. Inviting VCSE representatives to key health and care meetings brought fresh perspectives to familiar problems and helped to challenge prevailing wisdom about what might and might not work.
- (5) Being guided by the evidence of what works but remaining flexible throughout the process. Using the available evidence in this way helped to shape the core features of the CWP model, however, it was important that we remained sufficiently flexible in our approach so that we could adapt and respond to new insights that emerged during implementation. Resisting the temptation to lock ourselves into rigid KPIs at the beginning enabled the model to develop iteratively.

There are clearly opportunities to integrate community-centred approaches more widely into secondary and community care providers and we have been exploring opportunities to refine our approaches with these organisations through grant funded initiatives such as the NHS England Demonstrator Site Project in which we trialled the role of volunteers in expediting the hospital discharge process and reducing readmissions rates. There are a plethora of possible ways in which VCSE providers could collaborate with healthcare organisations on the development and implementation of community-centred approaches to enhance patient care. However, it is yet to be seen whether such approaches will be taken up across the UK or whether this potential will remain untapped. In order for this to happen, there needs to be willingness amongst health and care leaders to start “courageous conversations” with diverse partners such as the VCSE sector and to invite them to play their part in the reconfiguration of health and care services so they are fit for the twenty-first century.

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Further reading

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