Mobilising Community Assets – 10-Year Health Plan Submission

Q1. What does your organisation want to see included in the 10-year plan and why?

1.1 Introduction to MCA

Mobilising Community Assets to Tackle Health Inequalities is a £30m UKRI-funded research programme, running over three phases from 2021-2027.

https://www.ukri.org/what-we-do/browse-our-areas-of-investment-and-support/mobilising-community-assets-to-tackle-health-inequalities/

The programme investigates how community assets such as museums, libraries, creative and community organisations, parks and waterways can help to address health inequalities and how they can be strategically integrated into healthcare systems.

Drawing on the evidence generated by 40 funded projects across the UK, we make recommendations for a 10-year health plan that:

- Prioritises reducing health inequalities and addressing the wider determinants of health and adopts a cross-departmental and whole-system approach to achieve this
- Recognises the value of community-based approaches for population health and supports the integration of community and VCSE partners into Integrated Care Systems (ICSs), including long-term funding models to ensure the work is sustainable
- Represents lived experience and community expertise
- Supports further multidisciplinary research into health inequalities and the value of community assets for health

Examples provided are from projects funded by the programme.

1.2 Prioritising Health Inequalities

Health inequalities are unfair and avoidable differences in health outcomes between different population groups. Not only unjust, they cost the NHS £4.8bn annually, place a burden on public services, and impact national productivity. With the gap in healthy life expectancy between the most and least affluent areas of England predicted to persist, we must address inequalities to reduce pressures on the NHS.

Addressing the wider determinants of health - Only 20% of health outcomes are determined by clinical factors. 80% is made up of the wider determinants of health such as education, skills, income, employment and working conditions, the built and natural environment, housing, access to services including legal services, and power and discrimination.

Tackling health inequalities requires a cross-sector approach, which improves the conditions in which people live, addresses the causes of ill-health, and supports people to live healthier lives. Creating healthy and sustainable places and communities is a key policy objective outlined by the Institute for Health Equity, alongside strengthening the role of prevention.
https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

Shifting to prevention – Up to 40% of the burden on health services is avoidable by preventing the onset of chronic conditions. (https://committees.parliament.uk/committee/356/longterm-sustainability-of-the-nhs-committee) One in six adults currently lives with a long-term condition, and record numbers of people are economically inactive due to ill-health (https://www.health.org.uk/publications/health-inequalities-in-2040). This is likely to increase as the population ages. Prevention and early intervention is necessary to reduce the impact on the NHS.

- The 10-year plan should focus on reducing health inequalities and addressing the wider determinants of health – this is vital for the sustainability of the NHS
- A whole-system approach is required. We recommend a cross-departmental approach to addressing health inequalities within national government along with a health in all-policies approach, with health impact embedded into all government missions. This should also be reflected across arm's-length bodies such as Arts Council England, Natural England, Historic England etc. which should consider health in their strategies and funding streams.
- The 10-year plan should recognise the value of community assets for prevention and reducing health inequalities and embed community-based approaches.

1.3 Community assets as health assets

Community assets are organisations, individuals, networks and places which are used to support community interests. This includes libraries, museums, galleries, heritage sites, charities, creative, faith and community organisations, green and blue spaces, community allotments, sports and exercise-related assets and housing, debt and legal advice services.

Community assets are known to improve health outcomes and play an important role in supporting people to maintain good health. NICE guidelines recommend community engagement to improve health, and to provide people with a sense of belonging and pride in the place that they live.

(See: Thompson et al (2021) https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-021-01590-4; National Centre for Creative Health (2023) https://ncch.org.uk/creative-health-review; Seers et al (2022) https://publications.naturalengland.org.uk/publication/5777215462834176)

During covid-19, community-based organisations responded quickly and flexibly, with an understanding of local need, to provide activities which reduced isolation and loneliness and supported mental health and wellbeing. (Mughal et al (2022) https://doi.org/10.3390/ijerph19074086)

Social prescribing recognises the impact of the wider determinants of health and the role of community assets in preventing ill-health and supporting people with long-term or complex health conditions to manage their health and wellbeing. Already a key element of personalised care in the NHS Long Term Plan, social prescribing offers patients increased choice and control over their care, and leads to savings in systems through reduced healthcare utilisation - https://socialprescribingacademy.org.uk/read-the-evidence/the-impact-of-social-prescribing-on-health-service-use-and-costs/

An evaluation of a cross-departmental £5.77m Green Social Prescribing Pilot programme in the NHS found that linking patients to nature-based activities in their communities improved mental health and wellbeing and provided a Social Return on Investment of £2.42/£1 invested. It concluded that a more joined-up approach to commissioning and procurement of community activities was necessary to embed the programme within health service delivery, including ending precarious, short-term funding for community providers - https://randd.defra.gov.uk/ProjectDetails?ProjectId=20772

To address health inequalities, social prescribing must be available for those who are most marginalised or vulnerable, and in the poorest neighbourhoods. The Thriving Communities

programme helped to build this community offer - https://www.artscouncil.org.uk/thriving-communities-fund-evaluation-report

Example: Prescribe Heritage Highland examined the key conditions necessary for scaling up non-pharmaceutical interventions in rural areas where social isolation, deprivation and poor mental health can be common. Working with local partners from the heritage and cultural sectors, culture and nature-based interventions were offered through museums and archive centres across the Highland region. Referral and delivery processes were established and explored from multiple perspectives including service commissioners, third-sector providers, participants and referrers - https://ncch.org.uk/case-studies/prescribe-heritage-highland

Community assets and health inequalities

A whole-system approach is required to address the underlying structural causes of ill health, such as poverty. At a local level, community-based approaches offer targeted solutions to reaching those most in need, living in the poorest areas.

Community organisations build strong relationships with their communities over time, and have a good understanding of the local context, particularly in areas affected by deprivation, or in communities that are marginalised or excluded. They can act in a flexible and agile manner, to best meet local needs. Community engagement, particularly where people are empowered to identify their own needs and co-design solutions, helps to overcome powerlessness and marginalisation caused by health inequalities. Asset-based approaches build social connection and capital and empower communities to make the improvements they want to see in their local area. https://assets.publishing.service.gov.uk/media/5a7561a7ed915d7314959860/A_guide_to_community-centred_approaches_for_health_and_wellbeing__briefi___.pdf

Co-production refers to partnership and power sharing between professionals, communities and people with lived experience to co-create solutions. It involves 'working with' communities not 'doing to', and done well can lead to services that best meet need, and therefore better health outcomes, improved quality and better value for money - https://www.england.nhs.uk/long-read/working-in-partnership-with-people-and-communities-statutory-guidance/#the-benefits-of-partnership

Example: REALITIES in Health Disparities supports communities to build new systems based on their local needs to support health and wellbeing. Working in three local asset hubs across Scotland, the project co-produced a systems-level model with community members, policymakers, practitioners and researchers, bringing together different types of knowledge and evidence to understand the complexities of health inequalities. REALITIES linked personal experiences with local and national statistics, led by communities experiencing trauma, displacement, homelessness, poor mental health, addiction, social injustice and poverty. https://health.ed.ac.uk/research/current-research/realities-in-health-disparities

1.4 Integrating community assets into health systems

The NHS has a significant role in supporting a preventative, community-based approach that addresses inequalities. This can be through its role as an anchor organisation adding social value in local communities, and by forming equitable and sustainable partnerships with community-based organisations.

Integrating community assets into health systems will relieve pressure on the NHS, supporting people to stay healthier for longer and manage their health in the community, reducing GP and acute care utilisation.

Working closely with communities will support ICSs to meet their duties to improve population health outcomes, tackle inequalities, enhance productivity and value for money, and support broader social and economic development.

Communities should be central to the NHS Core20PLUS5 approach to tackling health inequalities, co-designing solutions which address the wider determinants of health in the most deprived areas and developing services that are appropriate for 'inclusion health groups' most likely to face barriers to access.

Example: Building a Well Communities Research Consortium to address health disparities through integrated care systems in London and Northamptonshire built an interdisciplinary and cross-sectoral Well Communities Research consortium working collaboratively and inclusively to develop ways to scale up, embed and spread community and asset-based approaches within ICSs. Working in ethnically diverse pockets of deprivation, the project developed a blueprint for change, which has influenced the way partner systems respond to health inequalities.https://www.arc-nt.nihr.ac.uk/research/projects/building-a-well-communities-research-consortium-to-address-health-disparities/

ICSs provide the infrastructure to establish a whole-system approach to health, incorporating the wider determinants of health and addressing health inequalities. Although community assets are a vital resource in this space, they face challenges in sustainability due to limited and short-term funding, and a current lack of integration into systems precludes the spread and scale of effective approaches.

Example: **Creative Health Boards** will develop a new model for embedding creative health and community assets in health systems across the UK, establishing collaborative forums for community representatives and health systems to work together to integrate community assets into services in a sustainable way - https://creativehealthboards.org.uk/

- The 10-year plan should recognise the value of community assets in a 'community health ecosystem' and facilitate their integration into ICSs, through equitable and sustainable partnerships that allow community assets to thrive.

1.5 Lived experience and community expertise

Lived experience engagement is vital to understanding the causes and impact of health inequalities and to co-design effective solutions. There are barriers to meaningful engagement (for example, practical challenges of providing transportation and payment, as well as the establishment of good relationships and creating safe spaces for the exchange of ideas).

- Lived experience and community expertise should be embedded into the development of the 10-year plan.
- The plan should recognise the value of lived experience and community expertise and ensure that meaningful engagement and co-production are incorporated into the design and delivery of services.

Example: Building and evidencing community asset partnerships in housing and health to address health disparities in north-east Cumbria This project brought together services, academics and people who have been homeless to collaboratively improve the health and wellbeing of all community members. An innovation budget through which Experts by Experience (EbE) could design a project to improve service delivery and access to an accredited research skills training module ensured EbE were equal partners in the project. Through a series of cross-sectoral

stakeholder workshops, a shared understanding was formed across service providers, researchers and EbE, and a digital map of homelessness services was produced.

https://www.northumbria.ac.uk/about-us/news-events/news/connecting-services-and-communities-to-support-people-experiencing-homelessness/

1.6 Evidencing the value of community-based approaches

Whilst there is good evidence that community assets are good for health and wellbeing, further research is necessary to assess their impact in addressing health inequalities and the benefits to systems of integrating community assets.

Collaborations between community groups, service providers, local authorities, health commissioners, GPs, and researchers using longitudinal methods are needed within a multi-disciplinary approach to address societal and structural health inequalities and to demonstrate and articulate the social and economic value of this approach over the long-term
https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-021-01590-4

Qualitative evidence that demonstrates the impact on people and communities should also be acknowledged in decision-making.

Lived experience and community expertise should be integral to research. Mobilising community assets is a multi-disciplinary programme, with lived experience embedded across the programme, and community-co-researchers in every project. Continued support for this type of research from UKRI, NIHR and other research funders will facilitate the development of innovative solutions and models of implementation.

- The 10-year plan should include research into what works well when assessing the impact of community-based approaches. Methodologies which can adequately measure and articulate the full value of community-based and preventative approaches over time will demonstrate the impact of these approaches on systems and justify further investment.
- The 10-year plan should acknowledge the need for research which incorporates lived experience and community expertise, and support research funding that facilitates this.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

2.1 Shift to Communities

We believe the shift to communities should incorporate the wide range of existing community assets (for example, libraries, museums, heritage sites, green and blue spaces, creative and cultural organisations, charities and community groups) that have such a significant impact on maintaining health and wellbeing.

To maximise the power of community assets to improve population health and reduce inequalities, we must create the conditions for these organisations to flourish. This will include developing a supportive infrastructure for community-based organisations, and equitable and sustainable partnerships with systems.

- The 10-year plan should recognise community assets as health assets and ensure their integration into a neighbourhood NHS and at strategic level.

The Mobilising Community Assets to Tackle Health Inequalities Research Programme brings together researchers with partners from across health and social care, local authorities, community organisations, lived experience and to explore ways of working through which community assets can be integrated into health systems and scaled up to address inequalities, as well as investigating the barriers and enablers of this kind of approach.

https://www.ukri.org/what-we-do/browse-our-areas-of-investment-and-support/mobilising-community-assets-to-tackle-health-inequalities/

Interim findings show how effective partnerships can be established between community-based organisations, academia and health systems to reduce health inequalities.
https://ncch.org.uk/uploads/MCA-Interim-Report.pdf

2.2 Challenges

- **Inconsistent, short-term or project-based funding.** Short-term funding impacts the sustainability and scalability of community-based initiatives, with capacity diverted from delivery to identifying further sources of income. When further funding is unavailable, ending an effective programme can result in more harm than good for participants and inhibits the collection of evidence of impact over the long-term. Limited project-based funding pots can lead to competition rather than collaboration between smaller community-based organisations.

- **Lack of supporting infrastructure for community assets.** Interactions with systems can be complex for smaller community-based organisations. Funding and commissioning processes are demanding.

- **Lack of join-up between community services, primary care, hospital discharge and social care**

- **Evidencing impact of community-based approaches.** Community-based approaches are holistic and person-centred. The impact may occur over the long-term and may not be directly measurable. Short-term funding and limitations in capacity and resource for evaluation in small organisations compound this.

- **Availability of community assets.** The most deprived areas often also have lower levels of social infrastructure and less funding to support community assets. To address health inequalities, these communities must be supported to develop and maintain local assets.
https://www.jrf.org.uk/neighbourhoods-and-communities/focusing-on-doubly-disadvantaged-neighbourhoods

2.3 Enablers

Projects in the MCA programme developed strategies to mitigate and overcome these challenges.

- **Cross-sectoral Collaboration** is vital for successful delivery. There are key ingredients that enable successful collaboration:

    - **Time** is necessary to build a **shared language and understanding** between partners, and community-based organisations may need additional **resource** and **capacity-**

building support to engage in this. The importance of this relationship-building phase must be factored into funding and commissioning processes.
- **Readdressing power balance.** Projects in the MCA programme found that shifting power and decision-making to communities led to more effective solutions and empowered communities to make further changes in their areas.

- **Integrated Care.** ICSs offer the opportunity for community assets to be further embedded into systems. This should be done in a way that supports community-based organisations to maximise their strengths:

  - **Agility and flexibility** to respond to local need whilst allowing for innovation is a strength of community-based organisations. Layers of bureaucracy within larger organisations such as ICSs can stifle this. When flexibility is built in (through reliable contracts, equal partnerships and sufficient funding and staffing), community organisations can do what they know best, with positive outcomes.

  - **Sustainable funding models and long-term investment.** Sustainable funding models facilitate the development of long-term partnerships and trusting relationships key to effective cross-sectoral partnerships, and free up capacity in community organisations to focus on delivery.

  - **Data collection and measuring impact.** Longer-term investment or routine commissioning of community-based programmes facilitates the capture of data that can feed back the long-term impacts on individual health and wellbeing, but also the impact of the programme on the system and the economic and social value of investing in communities.

  - **Asset mapping.** Understanding the existing assets in a local area can help understand gaps in provision, facilitate collaboration and help social prescribing link workers to make full use of local opportunities. Systems can provide the resource and capacity to hold and maintain such a system.

Example: Community Solutions for Health Equity (Fylde Coast Research Collaboration) aimed to understand drivers of ill-health and health disparities in Fylde Coast and other coastal communities by mapping local services, building capacity in communities, and establishing co-production groups to actively engage key stakeholders in planning their integrated place-based care model for future research in the area. Social Network Analysis generated information on community providers, made available to Social Prescribing link workers and the ICS, and workshops provided insights for co-production models in health and social care research and service design. Links were made to the local Health Determinants Research Collaborative and Applied Research Collaboration. A knowledge exchange event identified where the findings and ideas generated could be transferred to other coastal areas. https://gtr.ukri.org/projects?ref=AH%2FX005895%2F1

- **Authentic co-production and embedding lived experience**

Community-based organisations are best placed to work with their communities to understand the barriers to good health and to co-produce appropriate, effective and acceptable services for individuals. Integrating community-based organisations helps systems to link with marginalised or

vulnerable groups who may not access services, and to reduce inequalities in communities of greatest need.

Example: The Living Roots Project: Building a community asset and research consortium to address health equity in Ealing. This project used participatory and creative processes to build shared understandings and a framework to understand the key problems related to health inequity. The multi-sectoral consortium took steps towards a community asset and research partnership that centres the lived experience of individuals. The project piloted initiatives designed to improve community engagement in health equity work, for example training and supporting peer and youth social action researchers to explore and understand local resident views on health equity. Stronger relationships have been established across sectors, with an increased awareness of the need for community participation in decision-making.

https://www.ids.ac.uk/projects/the-living-roots-project-building-a-community-asset-and-research-consortium-in-ealing-west-london-to-address-health-equity/

- **Evidencing the impact of community assets**

Methodologies which can adequately measure and articulate the full value of community-based and preventative approaches over time will demonstrate the impact of these approaches on systems and justify further investment. (see section 1.6)

- **Community Assets in a neighbourhood NHS**

The Fuller Stocktake noted that Primary Care Networks that were '*most effective in improving population health and tackling health inequalities were those that worked in partnership with their people, communities and local authority colleagues'*. https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

Community assets are a vital part of the neighbourhood NHS. In primary care, co-located services, and link workers connecting people to community assets have improved health outcomes and helped to address inequalities. Multidisciplinary teams working at neighbourhood-level provide an excellent opportunity to further integrate community assets into health and social care systems. This will establish a thriving community health ecosystem, best able to meet the needs of its population.

Example: Art at the Start: creative community intervention for perinatal and infant mental health. Arts therapists were placed across galleries in Scotland, offering targeted interventions for vulnerable families. The project explored how the approach could be embedded as a referral route for perinatal mental health provision, feeding into NHS drives to offer diverse and sustainable perinatal and infant mental health provision. The programmes took referrals from health visitors, family nurse teams, educators, third-sector organisations and NHS perinatal and infant mental health teams. https://sites.dundee.ac.uk/artatthestart/mobilising-community-assets-to-address-health-inequalities-creative-community-intervention/

2.4 Key messages

- Community-based approaches offer targeted solutions to reaching those most affected by inequalities. Such approaches are based on trust and understanding of the local context and are co-produced with community members to best meet need, often at a hyper-local level.

- As such, there is no one-size-fits-all approach to scaling effective interventions. However, the Mobilising Community Assets Programme identifies the key ingredients necessary to maintain effective cross-sectoral partnerships, integrate community assets into systems and create the conditions for community-based approaches to flourish.

- Investment in infrastructure which supports community-based organisations to work collaboratively to develop innovative solutions to health needs will bring long-term benefits to individuals, communities and systems, supporting people to live well for longer, and reducing the acute pressures on the NHS.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

3.1 Capture and analysis of data

Technology can be used to better capture, share and analyse data across a whole system, to identify underserved populations and target provision accordingly. Such data can be used to consistently monitor the impact of community assets and to demonstrate the benefits over time in relation to key system priorities, including economic impact.

- Health systems should develop data collection and monitoring systems and support community-based organisations to input data. This will streamline reporting for community-based organisations and generate a coherent dataset, relating to key system targets, which can demonstrate impact over the long term. Amalgamated analysis at system level will demonstrate the full value of investing in communities and preventative approaches.

Partnerships with private technology companies could build community-based activities into health apps and digital platforms, for example recording how and where people engage in community-based health activities.

Example: Arts4Us works in collaboration with ICSs and community organisations, focusing on the mental health of young people aged 9 to 13, a group at significant risk of developing mental health problems while transitioning from childhood to adolescence. The project will create an easy-to-use digital platform where evidence-based local arts activities can be made accessible for children and young people, their families and relevant organisations and services. https://www.edgehill.ac.uk/research/healthresearchinstitute/research-centre-for-arts-and-wellbeing/arts4us/

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

4.1 Defining prevention

The Mobilising Community Assets Programme explores how community assets can be mobilised in primary prevention by addressing the wider determinants of health, improving the conditions in which people live, supporting people to live well for longer and reducing health inequalities.

Using the expertise of community-based organisations, projects have also established networks, referral routes and co-produced services linking people at risk of ill-health or living with long-term conditions to sources of support and early intervention, contributing to secondary prevention. https://ncch.org.uk/uploads/MCA-Interim-Report.pdf

4.2 Challenges

The challenges in a shift to prevention have been well noted.

- https://www.nhsconfed.org/publications/report-unlocking-prevention-integrated-care-systems
- https://www.gov.uk/government/publications/the-hewitt-review-an-independent-review-of-integrated-care-systems

Despite widespread recognition that prevention is necessary for the sustainability of the NHS, the focus for health systems is the immediate challenges including backlogs, waiting times and pressures on A&E. This results in short-termism. The benefits of prevention initiatives take longer to realise and are difficult to measure in terms of health and economic impact. Resource available for prevention in health budgets remains low and is applied variably across the county.

A preventative approach that addresses the wider determinants of health requires a whole-system approach, incorporating the NHS, local authorities, public health and communities. Without full integration and effective partnerships (section 2.3), silo working can hamper efforts and can result in no single body taking responsibility. Cuts in real terms to local authorities and public health, and limited funding for VCSE and community-based organisations, hamper prevention.

4.3 Enablers

- **Screening and Surveillance**

Screening and surveillance services will help to identify risk factors for ill-health and facilitate early intervention. These services must be available and accessible to all, particularly those least likely to engage with the health service. Provision of services or self-testing kits through existing community assets can help to improve uptake.

Example: ReCITE works in Primary Care Networks in areas of high deprivation in Merseyside to address low uptake and engagement with breast cancer screening services by co-developing poems, videos, photos and artwork for use in a roadshow that engaged women, family and friends in community settings. A community innovation team model brought together community organisations, creatives, volunteers, social prescribers, GP practices, nurses, care coordinators and data specialists. This community-led approach used data from community-collected behavioural insights and collaboration with local creatives to conduct targeted outreach activities that successfully reduced the number of women who did not attend their breast screening appointments by up to 24% at participating GP practices.

https://www.lstmed.ac.uk/sites/default/files/Anfield%20%26%20Everton%20handout%20updated.pdf

- **Working with communities to address the wider determinants of health and reduce health inequalities**

Health inequalities are avoidable and unfair. They are estimated to cost the economy £32bn/year. The burden of chronic disease is distributed unevenly, disproportionately affecting those living in the poorest areas (as exemplified by the 18-year disparity in healthy life expectancy between the most and least affluent neighbourhoods in England).

Barriers to access to services such as structural racism or mistrust of the system can put people off attending primary care or screening opportunities, denying them early diagnosis and intervention. A prevention-focused system must overcome these barriers.

Example: Co-producing integrated place-based supports to enable healthy ageing-in-place for Roma communities will inform the co-design of integrated place-based hubs to target health inequalities in mid to later life for older Roma groups. These hubs will connect statutory and non-statutory organisations to deliver targeted interventions and influence a shift in health, wellbeing and place policy and practice for Roma groups. https://www.hw.ac.uk/news-archive/2024/major-new-research-to-tackle-health.htm

Working with communities is vital to address the wider determinants of health and health inequalities. Whilst strong advocacy and whole-system approaches are required at national and system-level to prioritise addressing the structural causes of ill-health, such as poverty, community-based approaches offer targeted solutions to reaching those most in need. Community-based organisations can:

1. Improve access to health services
    - Draw on trusting relationships and understanding of local context to raise health literacy and tackle health-related stigma
    - Understand barriers to accessing healthcare
    - Co-design effective programmes and care pathways
    - Build bridges between systems and communities to establish acceptable and accessible routes to care

2. Address the wider determinants of health to keep people healthy

We know that 80% of health outcomes are a result of non-medical factors. Therefore, to tackle the causes of ill-health it is necessary to look beyond the NHS and adopt a whole-system approach that supports people to live well for longer.

Community assets are central to improving the conditions in which people live. **Asset-based approaches** encourage community connection and cohesion, addressing loneliness and isolation and building social capital and a sense of belonging, empowering communities to address the issues affecting them.

Example: **Arts and Culture in Health Ecosystems** (ARCHES) used community-based participatory research to work with four community anchor organisations, in areas of high levels of multiple deprivation, focussing on their role and activities in tackling health inequalities by developing relationships with people through access to the environment and creative activity. It found that community organisations understand their people and places and ensure services are inclusive, provide whole-person support, and engage people in the first steps to improving their health and wellbeing. However, they are stretched by insufficient funding and burdensome reporting mechanisms, which hinder their ability to provide support.

https://locality.org.uk/resources/adapting-expanding-and-embedding-community-and-culture-into-health-ecosystems

- **Share power with communities**

Empowering communities to take control over the issues that matter most to them leads to better solutions and improves health and wellbeing. **Place-based** approaches that devolve decision-making to communities, such as participatory budgeting, have been shown to improve health outcomes and benefit systems. https://www.local.gov.uk/topics/devolution/devolution-online-hub/public-service-reform-tools/engaging-citizens-devolution-5

Distributing power in this way requires an element of **flexibility and risk** from systems. Communities must be provided with time, space and resource to develop ideas to develop innovative solutions. Pilot and test-and-learn approaches can help systems to mitigate risk to systems, but short-term project funding should be avoided to maintain the relationships established and avoid community fatigue.

- **Equitable and sustainable partnerships**

To reap the benefits community-based organisations can bring to a prevention-focussed approach to health that tackles inequalities, sustainable infrastructure on which to build equitable and sustainable partnerships between communities and systems must be established. Funding and commissioning should shift away from short-term, project-based, towards longer-term models, that recognise the time and resource required for community capacity building and relationship building (see section 2.3).

Example: This toolkit, developed by the Health Equity Liverpool Project, Liverpool School of Tropical Medicine, provides guidance to establish and resource creative, community-led approaches to preventing and promoting health equity, and aims to support capacity building among community organisations. https://sway.cloud.microsoft/aUd5LEoqMUhv8GAs?ref=Link

- **Evidencing the value of community-based preventative activities**

See section 1.6

Q5. Specific policy ideas for change

National-level

Short-term

Embed lived experience and community expertise into the development of the 10-year plan.

Medium-term

Adopt a cross-departmental approach to health, recognising the need for a whole-systems approach to addressing health inequalities, and the vital role of community organisations in this system. HM Treasury must also recognise the value of investing in community assets as part of a preventative approach to population health. This is vital to the sustainability of the NHS in the long-term.

This should be accompanied by a Health in All Policies approach to policymaking. Community assets should be considered health assets and invested in as such. Departments outside of DHSC should consider their role in keeping the population healthy, and in addressing the wider determinants of health and health inequalities. Arm's Length Bodies such as Arts Council England, Natural England and Historic England should have health as a key strand of their missions.

Research funders such as UKRI and NIHR should invest in multi-disciplinary and cross-sectoral research that fully incorporates lived experience and community expertise. Research that develops methodologies to adequately measure and articulate the full value of community-based and preventative approaches over time is necessary to demonstrate the impact of these approaches on systems and justify further investment.

System-level

Short-term

Fund existing community assets to contribute to health and wellbeing.

ICSs should facilitate equitable and sustainable partnerships across sectors, crucially incorporating community-based organisations across neighbourhoods (including primary care), at place, and at strategic level. The Mobilising Community Assets Programme has shown benefits to individual and population health and system targets when this is done well.

Medium-term

Funding models that allow community-based organisations to thrive must be established. Research funding has catalysed the formation of effective cross-sectoral consortia. Systems should develop infrastructure that ensures these partnerships are sustainable.

Resource should also shift towards prevention, including support for community-based organisations. Decisions over how this resource should be spent should be devolved to place or community-based partnerships.

Core20PLUS5 should be expanded to incorporate the increasing number of people living with one or more long-term conditions and not limited to the current five clinical priority areas.