

A Shared Responsibility

Tackling Inequalities in Health
Across Greater Manchester

July 2015



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FOREWORD

A healthy life is something we all have a right to expect, but can only enjoy fully if we collectively accept responsibility and work together towards a healthy community. There are striking differences in the health of the richest and poorest in society. Vast discrepancies in the provision of care have led to significantly lower standards of health, wellbeing and life expectancy in our most deprived communities.

Despite widespread acceptance of this problem, there remains a lack of awareness as to how it can be resolved. Although funding, resources and infrastructure all have a part to play, increasing and improving these will not, of themselves, provide a solution. Previous attempts to do so have not only failed, but also increased the burden of demand.

It is clear that if we are to have a meaningful impact, there must be a shift in social attitudes.

Over the last fifty years the accepted view has been that health is something others provide for you. In fact, everyone must take an active role in their health and wellbeing. Bringing about this change in thinking poses a particular challenge amongst the residents of rundown estates, where poor health, worklessness, welfare dependency and family breakdown are common.

This is where the real battleground lies. Often coping with multiple and severe disadvantages, marginalised individuals face significant, additional health challenges compared to the rest of the population. And at present, these deprived communities already have some of the poorest healthcare provision. This, coupled with hard-pressed health professionals, leads to some of the worst health outcomes. The only way to see real change is by enabling people to take genuine responsibility –both for their own health, and that of their family and neighbours.



Many structural shifts to health provision and welfare are already underway, particularly here in Manchester with new devolved responsibilities. However, without the changes outlined in this report, the required scale and depth of transformation will not be achieved.

In order to make it happen we must involve as many people and resources as possible within our communities. We have to enlist other agencies that have regular direct contact with individuals, such as housing associations, the fire service and police. There are also many voluntary organisations doing invaluable work, and a willingness in the community to get involved – but there is much more scope to further develop this involvement.

In this report we have used case studies to provide examples of how community-based organisations are making a real difference.

This is only a small sample and does not cover all of the areas of activity that can be found in many communities.

In most cases it is the volunteers who are vital. There is no question that these organisations are a force for good; we now need a concentrated effort to encourage new groups to form, and existing organisations to grow, particularly in the areas of greatest need. The financial ask is small but the savings across society in welfare and health costs are potentially huge, not to mention the improvement in quality and length of life.

This report highlights the approaches and methodologies that can truly work at a neighbourhood and personal level to counter the inequalities in health to be found in our most deprived communities. Our report shows the power of the volunteer, the importance of place and the importance of accepting our shared responsibility for better health.

Now it is time for the Greater Manchester Prevention and Early Intervention Board, along with other partners, to take the findings in this report and turn them into a practical and resourced plan of action.

We must focus on the communities that are most in need and tailor solutions to meet their requirements.

We know that 'business as usual' is not an option, so it's critical that all the key players come together to craft a plan to do things differently, and better. Greater Manchester's future plans for health need to address lifestyles, responsibilities and disease prevention as much as they should treatment and cure.

A handwritten signature in black ink, appearing to read "Michael Oglesby", followed by a short horizontal line.

Michael Oglesby CBE DL

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EXECUTIVE SUMMARY

This report is for leaders in government, health, education and housing who want to tackle health inequalities, reduce public service demands, boost attainment and increase productivity.

It concludes a two-year study of projects that are already improving health outcomes within the most challenging communities across Greater Manchester. Drawing on these examples it offers the first description of how 'health as a social movement' can be delivered.

Unlike calls to action based on existing public service models, at the heart of this report is a new frame of reference. The 'personal health narrative' is identified within the case studies, describes a strong Theory of Change and unlocks people's role as producers of health, not just consumers of services.

At a strategic level, the report identifies the impact for national health organisations, local authorities and Health & Wellbeing Boards. In particular the report describes how the personal health narrative can be applied to the challenges of health and social care integration and the effective development and deployment of e-health technologies.

Specifically and practically the report:

- Describes, starting with the GP patient consultation, how GPs, schools, housing providers and other services can use the personal health narrative to better align and focus support for critical aspects of wellbeing and address non-clinical determinants of health.
- Shows how Commissioners can use the personal health narrative to work effectively with the voluntary sector, identify more comprehensive measures, drive better outcomes and align initiatives with people's instincts to care for others.
- Offers the basis for innovative forms of investment funding and identifies the elements of an area specific health performance bond.

Finally, the report highlights how the value placed on health by the public is at the heart of wider societal change – health as a social movement – and the health of the next generation.

OVERVIEW OF REPORT

The Oglesby Charitable Trust's first report into health inequalities (October 2012) noted those parts of Manchester with the poorest health outcomes were often the least well served by traditional health services. It pointed to the challenges posed by complex circumstances and of co-morbidity. It noted that drivers of health frequently lay beyond the reach of the health profession and public services. It concluded that while inequalities highlighted these needs, a better narrative was needed to develop an effective response.

This second report addresses a question at the heart of this conundrum: how can people be encouraged to take greater ownership of the factors that drive their own health outcomes? Behavioural and lifestyle factors are critical drivers of present and future health outcomes. They are a particular challenge for those communities characterised by poor education and high levels of benefit dependency, unemployment, family and relationship breakdown and, too frequently, crime.

We need to talk about health

Section 1 presents the threat that the poor health of Manchester's residents offers to the development of a new Northern Powerhouse economy. The spotlight of inequalities reveals a stark truth: people live longer, better quality lives in some parts of Manchester than others. Action is a moral imperative and matter of social justice and must happen against a backdrop of public health reforms driven by plans for integration of health, social and mental care; pressure on costs; the ever rising expectations of residents and growing demands for services.

The communities characterised by poor skills, high benefits take up, poor education outcomes, family and relationship breakdown, low employment and crime are also those with poor health outcomes. The problems that arise from poor mental health, or addictions, or inappropriate, repeat A&E admissions that can follow, illustrate this. Their health outcomes need to improve and the demand on services needs to be reduced.

Better management, communication and early intervention help stop underlying conditions develop into secondary, acute problems that consume expensive services. More efficient and effective working through integration of health and social services will also be an important improvement. However, in the debate about tackling health inequalities, much emphasis from the health service has been directed towards improving access to preventative and therapeutic services for the most vulnerable. Whilst this is important it hasn't altered the inequalities seen today. A more radical prescription is needed that moves beyond the boundaries of conventional health care and offers a new model of working.

What Really Works?

Section 2 describes the work of the Trust, starting by looking for the projects that were practical, effective and relevant. In simple terms, projects turning the lives of the poorest and most vulnerable in society around with an improvement in their health outcomes.

These projects needed to be working in the most difficult communities, on the most stubborn problems amongst the most challenging demographics. Projects also needed little new money and were inherently sustainable – an essential response in a time of constrained public spending. These were challenging criteria not least because they do not conform to traditional clinical classification such as condition, or funding identifiers. In the end, this process of case study selection crystallised around one key characteristic: enabling people to take responsibility for their own health and supporting others to do the same.

Over four hundred projects were considered, mostly in the UK. Nearly forty were reviewed in detail through a mixture of interview, visits and desktop reviews. Nineteen are presented here ranging from multi-million pound, government backed national charities to community initiatives run at the grass roots, on a shoestring budget. They cover every stage of life and deal with the most vulnerable in society – the very old, the very young, the disenfranchised, the immigrant and the dispossessed. All deal with the toughest public health issues – poor mental health, elder care, obesity, substance abuse, sexual health and chronic conditions (dementia, heart disease and more). Thirteen of these projects are located within the most challenging areas of Greater Manchester including Cheetham Hill, Harpurhey, Moss Side, Gorton, Whalley Range, Salford, Ancoats, Levenshulme, Oldham and Tameside.

Importantly, they address key issues at the heart of the present debate about the cost of healthcare, reducing demands on services and the delivery of health services in the future. They offer relevant and timely comment on developing good habits in the next generation and providing the very youngest with a healthy start to life; tackling obesity; improving health and providing better care for the weakest and most vulnerable; reducing inappropriate Accident & Emergency or urgent care attendances; supporting an ageing population and responding to a rising tide of dementia diagnoses.

While not all of the projects saw themselves as ‘health’ initiatives, each of the projects displayed an instinctive awareness of wellbeing and the relationships that create space to surface hidden needs, provide instinctive care for others – and form the fabric of Simon Stevens’ ‘social movement’.

A New Health Narrative

Section 3 presents a thematic analysis of the case studies, showing a strong overlap with five aspects of personal flourishing:

- People are made to feel safe, accepted and that they belong. The projects are local and a familiar part of the community, not remote and impersonal institutions and buildings offering centralised services.
- Each person is valued, regarded as an individual and viewed holistically. This contrasts with production line approaches to health systems that are problem focused and struggle to comprehend or respond to the whole person. The particular challenges of poor mental health and wellbeing in children and young people and potential for help through schools is discussed.
- People are seen in the context of their relationships with others and responsibility towards/for them. They are not regarded as disconnected, or isolated, nor are they viewed first as medical cases or 'conditions'. Family, schools and housing providers are identified as key 'institutional' links for the case studies.
- People are encouraged to develop a sense of purpose, influence and control over their health. No dependence on professionals and institutions is fostered. Reducing demands on services and improving health outcomes starts with empowering and enabling people to make good decisions before they become patients. Crucially, this happens beyond the reach of traditional public health service approaches.
- People are helped to develop a vision and ownership of their health future. After care and ongoing support is not someone else's problem, or a separate issue for another department. Understanding the process of change is key to planning ahead, measuring performance and tracking the financial and other benefits to individuals and communities.

Together these themes outline a new, **personal health narrative** for individuals. This is a new model of health that positions the person as a producer of their health, before they are a consumer of health services.

Technology is at the heart of several case studies, reflecting its established role as an important enabler of improvements in health outcomes. Just as importantly, access to technology is ever increasing within the general population. Technology also offers opportunities to bridge social divides and transcend sector boundaries: the key to this is a person centred approach, rather than technology or consumer led thinking.

Producers of Health

Section 4 presents and builds on the conclusion that people are producers of their health before they are consumers of health services. Four specific conclusions are presented:

- The groups and individuals highlighted within the case studies demonstrate a sustainable, positive impact on health outcomes. Positioning people as producers of their own health, as well as consumers of health services, has a 'double-bottom line' impact and is consistent with a personal health narrative perspective, rooted in a robust understanding of change.
- The approaches within the case studies complement public health services and are working effectively alongside them. Voluntary and community groups can reach beyond public services and address complexity in a way public services find daunting. There is a natural authority that flows from the strong values based approaches of many case studies.
- Small, inexpensive but significant changes to public service approaches would greatly increase the capacity, reach and impact of these groups. The use of a consistent, universal reference framework, derived from the personal health narrative, would deliver greater effectiveness; enable scale and the spread of more work. A framework for understanding health as a social movement is presented. The 'Well North' programme is offered as a contemporary example of this thinking.
- These form essential ingredients for health as a social movement in Manchester, which must be rooted in public services, but also the responsibility of 'producing' health within the community, the work of voluntary and community groups and a refreshed understanding of the public value of health.

Building the Bridge from Both Sides

Section 5 moves the discussion to delivery. It notes changes are required from within both public and community sectors captured in four recommendations.

1. **Adopt the person centred health narrative as a simple, effective framework for the relationship between people and health professionals.** *The GP Consultation has been described as the 'heart of general practice' and the 'central act of medicine'. An estimated 400 million consultations are carried out each year in the UK. Using this narrative helps empower patients as co-producers of their own health, highlights the opportunities and responsibilities of the patient to influence and act upon their own health. It also helps frame wider issues of wellbeing and a broader context of health with obvious importance for the diagnosis and prescription for the patient.*

2. **Use the personal health narrative to recognise and promote the role of families, schools, housing providers and other institutions to improve wellbeing and health outcomes for the next generation.** A common framework has the potential to improve communication, collaboration and coordination between institutions and services. This can only reduce waste, increase efficiency and improve transitions. At a more developed level, it offers the basis of a seamless, single public service that is flexible and adaptable, centred on individual outcomes. The personal health narrative positions a stable family life, a home and an education as important contributors to wellbeing and long-term health outcomes. This clear relevance of other institutions to health outcomes opens up new opportunities for other institutions to see where and how they can support and encourage residents as producers of their own health, in particular schools and housing providers through parent-school charters and Tenancy Agreements.
3. **Use the personal health narrative to develop guidance and financing mechanisms that better align commissioning processes, objectives and measures with.** The personal health narrative offers a framework, based on a robust Theory of Change, and could form the basis of, practical guidance for commissioners who must identify outcomes, understand how they are developed and identify the leading indicators that will track them. This monitoring in turn informs a richer set of performance indicators and the tools for managing delivery and improvement, including ensuring continuity of funding where it is required. In effect this means adopting an investment versus cost based approach to commissioning. Taken together, the recommendations within this report also present local health and public sector Commissioners with all the elements to adopt alternative funding approaches, including performance based bonds.
4. **Use the personal health narrative to guide the deployment of e-health ('connected health') technologies in support the resident as producer of health.** The case studies deploying technology point to its potential for influencing behaviours through innovative application of an existing technology. Commissioners can use the personal health narrative to drive development and an understanding of the support technology offers to the themes within the personal health narrative. A sensible next step would include a sector wide review of e-health identifying opportunities to encourage the resident as producer of health, by supporting the personal health narrative. A conversation with the private sector, perhaps through an allied conference would also be helpful.

What's Next?

Each recommendation identifies a range of avenues for leaders of public and private organisations to progress the recommendations across health, education, housing and other care providers. These are practical and strategic – ready for adoption by local authorities, Health and Wellbeing Boards, government departments and individual GP practices and schools alike. They also include specific opportunities to promote the unique position and strengths of Manchester, placing it at the forefront of international research into the impact of e-health technologies on health inequalities.

Health Generation

Further, in Section 6, this report returns to the politics of Simon Stevens' vision of the NHS and health as a 'social movement', the deliverability of the recommendations and the impact they might have.

Like the case studies within this report, the recommendations are effective and relevant to the circumstances of the poorest in society. They contain essential characteristics of sustainable, scalable and affordable reform.

More than this, the recommendations and this report target fundamentals. The personal health narrative model is a universal one and its applicability to the GP Consultation has the potential to affect every aspect of health care delivery. The key aspects of institutional reform (strategy, structure, culture and execution) are provided for in the recommendations. The qualities of social movements are also addressed, such as rethinking concepts of public value and the dynamic of key relationships between people, professionals and politicians.

Finally, this report notes the opportunity it presents to mark the start a city-wide conversation with residents about the health of the next generation in Manchester. This report sets out the role and responsibility of residents in producing the health and wealth of their place – and Manchester as a whole. Any change in assumptions about the work of public services and the expectations on residents amounts to a new deal, or social contract, between residents and service providers. This central assumption must be negotiated at a neighbourhood, community and society level. It is essential therefore that a conversation is started with residents about the changes and the opportunities these present, as well as the challenges that lie ahead.

Summary

Greater Manchester is home to hospitals offering world-leading health care. Its Universities are home to leading medical and scientific research faculties. Innovative public-private health care research partnerships have been forged in Manchester. DevoManc has confirmed Manchester Council's reputation as an innovative local authority region in the UK and the strength of its local political leadership.

Beyond private and public sector excellence, this report demonstrates that Manchester is also home to leading social and voluntary sector innovations in health care. These are successfully addressing some of the toughest problems facing our public health services today, in the most difficult places, with the most marginalised people. This report makes the case that the principles at work in these projects and groups can be adopted and adapted to create a true partnership between professionals and patients, politicians and people. More than that, this report breaks new ground in the public debate by setting out a means to do it.

The defining question of this generation is the problem of poor health outcomes in spite of technological advances. In answering the questions of 'what to do?' and 'how to do it?' this report poses another question for leaders across Manchester: as well as mobilising institutions and reforming services, can they unlock the contribution of the next generation to the production of their health – and the wealth of the region?

1.0 WE NEED TO TALK ABOUT HEALTH

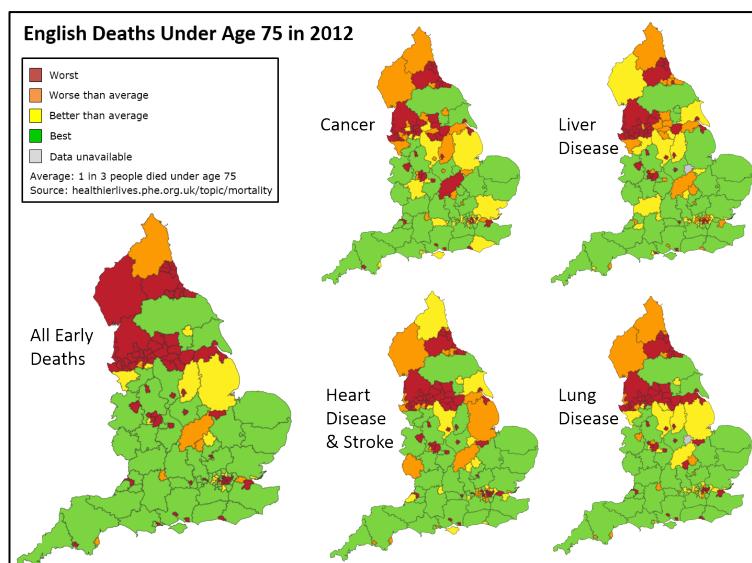
1.1 The Northern Powerhouse

At the heart of new opportunities for Greater Manchester sits the vision of a new, economic Northern Powerhouse, enabled by funds and propelled by powers devolved from Westminster. However, the engine of this great Powerhouse does not turn on money and power alone but the health, wellbeing and skills of its workforce.

And it is the poor health of residents that may pose the greatest economic challenge to Manchester and this present generation. Long-term health problems, disease and mental illness choke productivity before it can start driving higher living standards and raises tax revenues. Two-thirds of out of work claimants in Manchester suffer from poor mental health. Residents born just a few miles apart, even within the same ward, can have a projected life expectancy that varies by up to twelve years. Each year around 40,000 more people die under the age of 75 across the North compared with the South of England (see Figure 1).

The result of this is clear: Manchester and the North West region lag behind the South East and London in terms of economic output, productivity and employment.

Figure 1: Mortality Rates in England (2012)



Today in Manchester, worklessness and ill-health spring from the same soil – they flourish in each other's shade. The deprivation in many of Manchester's wards and communities is described in both economic and health terms. Where household earnings, employment and skills are low, so too lives are shorter, chronic disease is more prevalent and health services are harder to access¹.

¹ See 'The Inverse Care Law', Julian Tudor Hart, February 1971

1.2 What will Manchester do?

The devolution of Greater Manchester's health budget is not only a powerful statement of confidence in local governance², it also raises an important question: how can Manchester address these health inequalities?

Today, expectations of health services remain high but budgets are constrained. Although the NHS was born in Manchester (or if not born, symbolically delivered), in an era when optimism was high and resources were booming, today it must now make difficult, political and practical decisions on acute and public health provision. Governance must be reformed and a new Joint Commissioning Board must navigate arrangements across a complex and plural local health administration landscape.

Manchester does have considerable strengths and resources on which it can draw. Manchester has long been at the front of responses to social change. When the industrial boom saw an influx of people that threatened to overwhelm hospitals³, dispensaries were provided to offer effective support. Established and strong local political leadership, academic resources and commercial partnerships exist to make devolution work. Motivation exists, if it was needed, in the form of even greater devolution: health is just one part of the total £22 billion Whitehall public service spend across the region, £8 billion of which is for welfare. And the national context is supportive: calls for reform and support for a local approach are evident within Simon Stevens' 'Five Year Forward View' for the NHS, familiar principles of personalised care, the 'DevoMax –DevoManc' report and 'The Big-Data Revolution in Healthcare', the 'Due North' report of Public Health England and the Department of Health's own priority of integrated care.

But the challenges facing Manchester's health services are not just clinical, structural or systemic. They are demographic, cultural and behavioural. As a nation, average life expectancy is increasing⁴ and the diseases that kill us do so more slowly, but the main drivers of health outcomes for this generation remain poor lifestyle choices.

² For an overview of the process, politics and personalities in this decision, see <http://www.theguardian.com/public-leaders-network/2015/feb/27/greater-manchester-experiment-health-social-care-budget> (retrieved February 2015)

³ See http://en.wikipedia.org/wiki/Ancoats_Hospital (retrieved June 2015)

⁴ See 'Time to think differently: Life Expectancy', The King's Fund, 2012 <http://www.kingsfund.org.uk/time-to-think-differently/trends/demography/life-expectancy> (retrieved September 2015)

Devolution does not alter this public health challenge. It does not release the brake poor health is applying to economic performance. Nor does it change the stark reality of Manchester's position on the wrong end of health inequalities. It offers no more money for investing in new ways of working. It does not reduce the growing demand for services. It does not tackle the strain on community and home that poor health brings. It does not foster confidence in the weak, mend strained relationships or revive shattered dreams. It does not salve the keening sadness of premature death.

The integration of existing provision, refinement of techniques and efficiency improvements change systems but not behaviours. They barely touch non-clinical, social and demographic challenges. Such initiatives are also struggling to realise savings⁵. Even if they do money alone is not the answer. Better technology, new drugs and greater understanding of disease are important and need funding, but they will not deliver the gains required in population health. Marginal gains, for example in the diagnosis and treatment of rare strains of disease will not move public health forward far enough, fast enough. There simply is not the time for an evolutionary development; the problem is growing too fast. As former Health Minister Normal Lamb MP noted, the demographic pressure alone means that 2020 will be 'the election of social care'.

⁵ See Conclusion 12 of Health Select Committee report (February 2014),
<http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/793/79308.htm> and
<http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/793/79305.htm#a1> (retrieved March 2015)

1.3 A Radical Prescription

This report is not another call for action. The difficulties are well known⁶: in Manchester, poor health outcomes are found in well-defined post-codes, collocated with other well defined social problems.

Instead, this report seeks to describe how the public health challenge can be met in Manchester.

To do so it moves beyond the boundaries of our healthcare systems and institutions. It seeks to look at problems as they are experienced by people, in their own communities, not through the lens of current public services. This follows the direction set by others who identified health as a matter of social justice⁷, understood the importance of patient ‘activation’ and involvement in their own care⁸. This also acknowledges the important success of projects such as CREST/HELP⁹ and recently, Simon Stevens’ call¹⁰ for a reinvention of the NHS and health as a ‘social movement.’

The first step is the to frame the right question. The report starts simply with, ‘What works?’ What makes a difference? Where are lives being turned around? What are the approaches that emerge when unencumbered by the methods, techniques and systems public services have developed to organise themselves – and the institutions that house them?

Such a foray beyond the walls of our institutions, surgeries and hospitals into our most deprived areas opens up the possibility of a radical change in the way we conceive health care. It asks profound questions about responsibility, prevention, lifestyle and the best way for services to provide support, as much as it does about care. Insights could yield ways to realign, redeploy and perhaps even repurpose existing institutions rather than replace or reject them.

⁶ There is a strong argument to be made that health services are at Kuhn’s ‘Model Crisis’ stage, requiring a new model and paradigm shift ('Model Solution'). See ‘The Structure of Scientific Revolutions’, Kuhn T. (University of Chicago Press, 1962)

⁷ See ‘Fair Society Healthy Lives’, the Marmot Review, February 2010

⁸ See ‘Supporting People to Manage their Health’, The King’s Fund, May 2014
<http://www.kingsfund.org.uk/publications/supporting-people-manage-their-health> (retrieved September 2015)

⁹ See ‘HELP’, Department for Health, November 2011 http://www.healthempowerment.co.uk/wp-content/uploads/2012/11/DH_report_Nov_2011.pdf (retrieved March 2015)

¹⁰ See ‘Five Year Forward View’, National Health Service, October 2014, <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> (retrieved May 2015)

2.0 WHAT REALLY WORKS?

Framed by this simple question, projects and organisations were reviewed to identify those that were delivering effective and relevant support in the poorest communities. The selected case studies are introduced below in Section 2.2 and set out in more detail in Appendix 1. The Methodology used to identify, select, analyse and present the case studies is outlined in Appendix 2.

The Importance of Wellbeing

This was not a simple task for a surprising and simple reason: the distinguishing aspects of the projects sought were not recognised or prioritised within established public sector definitions. As a result, the language, characteristics, even this way of thinking about health improvements was confusing to many. Project approaches and sometimes outcomes simply weren't described in the way public services thought of or conceived them.

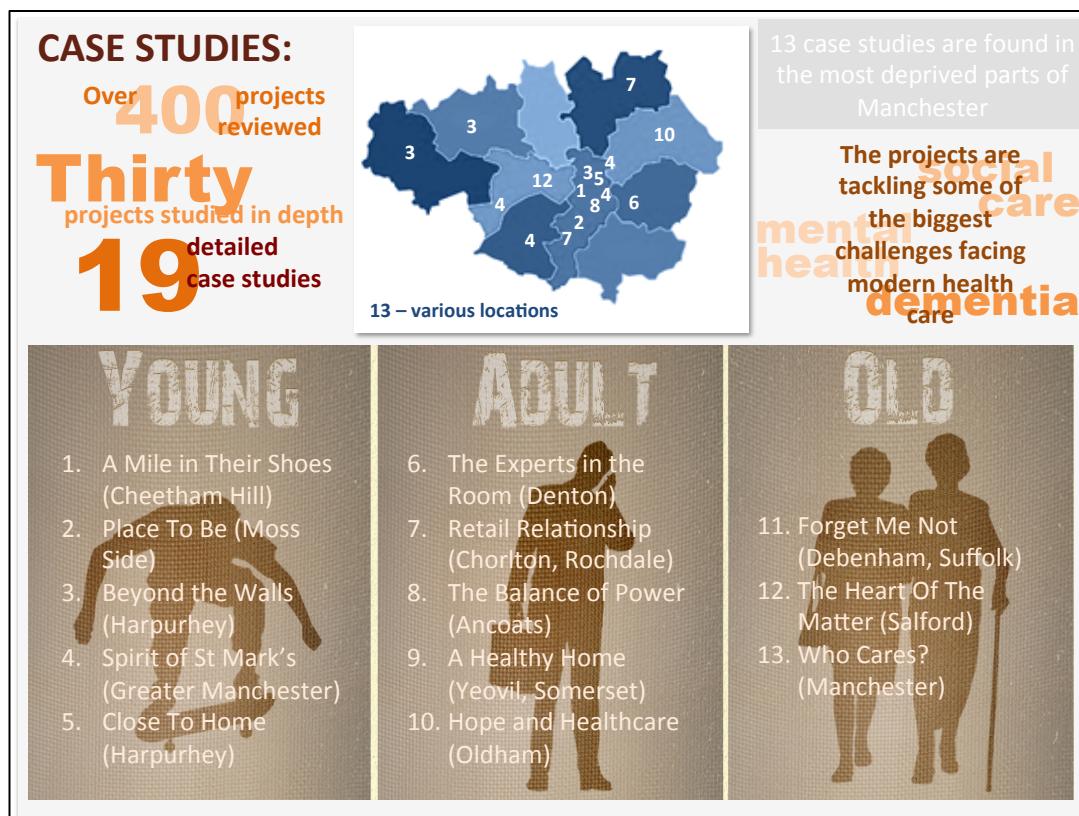
The case studies all demonstrate the effectiveness and impact of people taking responsibility for their own health and that of others. While not all of the projects saw themselves as health initiatives, each of the projects displayed an instinctive awareness of wellbeing. Different aspects of care and provision for human flourishing were reflected strongly across the different approaches and formed the basis of the analysis (see Appendix 2).

Over four hundred projects were reviewed, thirty were considered in detail and over twenty projects taken forward in nineteen case studies. Thirteen of these projects are located within deprived areas of Greater Manchester including Cheetham Hill, Harpurhey, Moss Side, Gorton, Whalley Range, Salford, Ancoats, Levenshulme, Oldham and Tameside.

2.2 Practical, Effective, Comprehensive

The case studies address key issues at the heart of the present debate about the cost of healthcare, reducing demands on services and the delivery of health services in the future. They offer relevant and timely comment on developing good habits in the next generation and providing the very youngest with a healthy start to life; tackling obesity; improving health and providing better care for the weakest and most vulnerable; reducing inappropriate emergency admissions; supporting an aging population and responding to an increase in dementia.

For ease of reference, the case studies are organised in a simple 'life-course' order below. One of the advantages of this referencing is an alignment with the experience of life and the human condition. This helps provide insight into consequential effects of actions on subsequent stages of life.

Figure 2: Case studies infographic

Perinatal and Early Years

The first two case studies deal with conception, pregnancy, sexual health and early years within the family:

- '*The Gold Within*' tells of the work of Love4Life with vulnerable young girls and new parents on estates in Loughborough. They work to develop stronger identity and promote the self-confidence and esteem that reduces risk taking behaviours, anti-social and criminal behaviour. They are seeing better life choices such as school attendance and aspirations improving and being sustained.
- '*A Mile in Their Shoes*' speaks powerfully of the work of Home Start North Manchester with new families and young mothers in Cheetham Hill. By providing a supporter to parents struggling to raise very young children, the broader context of wellbeing and its determinants in the home are addressed. Mothers are empowered to regain control and influence over factors that determine the health and wellbeing of their children. It demonstrates that involving families in the process of self-development increases their capacity and resilience over the long term, reducing demands for expensive services. Some of the best evidence for this comes from the lives of the volunteers, as many had themselves benefitted from support in the past.

School Years

Six case studies cover work with young people – the next generation – during their school years:

- '*A Place To Be*' describes how Place2Be has seen clinical recovery of a quarter of the high-risk children with whom it works to develop mental and emotional resilience. The case study focuses on the safe place and relationships developed in Claremont Primary School, Moss Side. The hugely diverse school population includes young people with life stories ranging from 'simple' issues of peer pressure to immigration, sudden displacement as a refugee and the trauma of events witnessed within war torn homelands.
- '*Real World Relationships*' illustrates the empowerment and hope that comes when young people hear people talk candidly about their experience of relationships ('Students Exploring Marriage Trust') and being a teenage parent ('Straight Talking'). Young people without positive role models in their homes, wider family and community lack context to evaluate powerful societal messages of broken, short-term relationships and understand the health impacts. Providing young people with examples of relationships and choices made demonstrates the health and wellbeing benefits of mental and emotional resilience from strong, lasting relationships and a stronger relational framework for sexual activity – including potential for mitigating the risks associated with early first sexual experience.
- '*The Proof of the Pudding*' highlights various school-based healthy eating initiatives that use social aspects of preparing food and eating it ('Come Dine With Dads', Cheetham Church of England Primary Academy) to encourage healthier eating habits. Crucially, it describes the work done to convey healthy eating practices beyond the school walls and into family homes by building better parent-pupil relationships.
- '*A Healthy Profit*' tells how the work of one commercial catering company (Aspens Caterers) is changing pupils' behaviour and securing a competitive business model by co-producing local service offerings that integrate food, eating, production, preparation and service with curriculum and extra-curricular activities.
- '*Close to Home*' tells of the impact Manchester Communications Academy are having on health and wellbeing of children, young people and their families in Harpurhey through their innovative approach to community engagement.
- '*Beyond the Walls*' highlights the safe, inspiring places created by OnSide Youth Zones based on the original Bolton Lads & Girls Club. Youth clubs for decades have played an important role in the development of young people. At Youth Zones, not only do young people have access to state of the art recreation and sporting facilities, they learn and participate in a wide range of other activities. Crucially, the influence of relationships with families and the community formed at The Factory, Harpurhey, is key to the positive influence they have on health outcomes in the community.

Sport

One study focuses on the opportunities sport presents for all ages:

- '*The Spirit of St Mark's*' appeals to the rich tradition of humanitarian community projects from sports clubs in Manchester. It contrasts the approaches taken by larger clubs able to leverage their brand and status (Premiership football club Manchester City FC with Sale Sharks Rugby Union FC, Lancashire County Cricket Club) and two smaller community based projects. The impact the different health based projects have had ranges from weight loss in middle aged rugby fans to the improved diets young footballers have adopted after conducting their own experiments on nutrition and performance in games.

Family, Community and Housing

Family, community and housing are at the heart of four further case studies:

- '*Handled with Care*' outlines the vital work of the three thousand members of Manchester Carers Forum; highlighting the estimated £15 million of value they save public services each year in time alone, representing a fifty-fold return on the £300,000 of public funding they receive. The act of care giving is instinctive, intensely personal and its combined impact is enormous. Consider the mother and child at her breast, the strength of families that lasts generations, or the estimated 4.5 million carers in the UK that far outnumbers workers within the public sector. Entire institutions such as the Royal National Lifeboat Institution depend on their volunteer networks and staff¹¹. These raise important questions: how to promote care and let it flourish without stifling or subverting it? How to complement it with help and support where it is needed – or missing?
- '*The Heart of the Matter*' is a patient inspired, organised and led initiative, Salford heart Care, supporting patients in Salford with a history of heart disease and their families to live with their condition. Formally recognised as 'an important part of the rehabilitation pathway and a unique service in Manchester' this service is providing essential post-operative care, reducing mental illness, increasing patient resilience and promoting independent living amongst its members.
- '*A Healthy Home*' describes the work of Yeovil4Families in Somerset, which is being adopted as a sector leading model for working with families by local authorities across the UK. Based on building relationships and 'walking a mile' with troubled families, volunteers help families set goals and reclaim control over their lives, seeing them unpick the complex links between education, worklessness and ill health; in particular mental illness.

¹¹ See <http://rnli.org/aboutus/aboutrnli/ourpeople/Pages/Volunteers.aspx> (retrieved July 2015)

- '*Our House, Our Home, Our Health*' tells the work of the Great Places Housing Association and two community projects in the East of Manchester. Housing Associations have a unique relationship with tenants. This case study challenges them to make the most of the opportunity they have to improve health outcomes for residents. These projects support people, families and the community and improving health outcomes in areas of high immigration and deprivation. The example of Connected Communities in the South West of England, on whole estate transformations is also cited. Their use of a similar assets based, resident led approach raises an exciting question: just what health improvements could Housing Associations help their tenants achieve if they were intentional about such an approach?

Adulthood

One case study focuses on adults who are at their lowest ebb and the work of a project helping them transform their lives:

- '*The Balance of Power*' tells of lives being transformed at The Mustard Tree project in Ancoats, Manchester. The vision is one of progression and improvement, not containment or maintenance. Over four thousand people who were homeless, hungry, addicted, seeking asylum or disconnected from society and support have moved from a place of dependence and powerlessness and hopelessness to one of independence, self-determination, hope – and health – by helping themselves and others in the process.

Old Age and Elder Care¹²

Another case study considers projects dealing largely with older residents and their care:

- '*A Meaningful Response*' tells the extraordinary story of The Debenham Project in the village of Debenham, Suffolk, where residents have gradually developed a 'dementia friendly' community that is supporting those with dementia, enabling them and their carers to live active, independent lives.

¹² This analysis of a data set in the South West of England showed that the correlation of age alone to cost of treatment is just 3% compared to co-morbidity of almost 20% (slides 6-8)

Public Service and Commercial projects

The four final case studies cut across the life-course narrative. Three closely fit current public service patterns, considering the work of two GP surgeries and local pharmacies; two also employ established technology to empower patients and enhance research:

- ‘Hope and Healthcare’ Hope Citadel General Practice, Oldham is seeing sector leading health outcomes in ‘one of the hardest places to do good healthcare in the country’. There is no need for the poorest to have the poorest services or outcomes. Understanding people and helping them share their priorities and building relationships by listening to their stories is at the heart of their work, as demonstrated through refinements to the patient-GP consultation, the use of social prescribing and their leadership role in the community. All of this is evidenced clinically and visible through patient engagement, sustainable behaviour changes and pro-social lifestyle choices of residents. As with Housing Associations, this poses a profound challenge to the existing ways of working for GPs.
- ‘The Experts in the Room’ shows how Dr Amir Hannan is applying technology to patient records in his Denton GP surgery, in a way that is empowering patients, transforming the patient-GP consultation and rebuilding the trust in Harold Shipman’s old surgery. This thinking again poses a profound problem to established approaches, roles and ways of working.
- ‘Patients Like Me’ explains how connecting patients with each other can improve patient experience, help them manage their condition and inform the development of new medicines and treatments. Crucially, this knowledge sharing is achieved online, through technology and points to an interesting role for the social networks accessed by phones that are now present in every part of society. This approach of developing patterns from within an essentially self-organised user base of approximately a quarter of a million users, that have been otherwise unobserved is contrasted with the approach of Health Talk Online, an academic, research based site with very structured links between patients and researchers. The differentiation offers an insight into the potential of the NHS as social movement.
- ‘Retail Relationship’ highlights the impact of the local pharmacist¹³ on health outcomes within deprived communities. It describes the strong customer relationships that are being fostered by Kapoor Pharmacies in Chorlton, Whalley Range and Oldham using the Healthy Living Pharmacy model. The success of this model lies in a ‘good for the community and good for business’ rationale and points to its potential in preventative work, relieving pressure on acute services. It has also led to its unilateral adoption by a national chain of local pharmacies into their business model, as well as a roll-out programme by the UK government.

¹³ There is a tradition within Manchester of responses to local health crises. See <http://www.ancoatsdispensarytrust.co.uk/historicalbackground-12.html> (retrieved August 2015)

3.0 ANALYSIS: A NEW HEALTH NARRATIVE

A recurring response to the first Oglesby Trust report into health inequalities in Manchester (2012) was:

"We know we need to work more closely with the community – but no-one knows how to."

This reflected observations in the report that the key drivers of health outcomes were often not clinical but social and behavioural. Not only do they fall outside the sphere of clinical influence, but they have also proved resistant to traditional approaches of better education, more information and communication.

Five common themes were drawn from within the case studies:

1. People are made to feel safe, accepted and that they belong.
2. Each person is valued, regarded as an individual and viewed holistically.
3. People are seen in the context of their relationships with others and responsibility towards/for them.
4. People are encouraged to develop a sense of purpose, influence and control over their health.
5. People are helped to develop a vision and ownership of their health future.

These point to practical and effective ways public services can encourage residents to understand and take up responsibility for helping themselves and each other – starting the work of changing behaviours and society in the process. Together they start to frame a new health narrative.

The important role technology can play in supporting health outcomes was also noted.

3.1 Safety

Theme: People are made to feel safe, accepted and that they belong.

A designated place where people can feel safe, receive care, support and information was often a central characteristic of a project. Such a place may be open to some (children, vulnerable adults etc.) but welcomes them in all their diversity, as they present to the organisation.

Place recurred as a concept and word across the case studies. Projects and groups were either identified with a place that was secure and/or they provided such a place. This was explicit in the names of some, such as Place2Be and Great Places. Others carry the name of the place they operate in, such as Salford Heart care, Yeovil4Families, HomeStart. Very often case studies were characterised by strong roots within a community, such as Manchester City FC ('The Spirit of St Mark's'). They focus the work of their Foundation on the schools and communities around their stadia and they emerged from a project rooted within a church parish (albeit a different area of Manchester). These projects are local and a familiar part of the community, not remote and impersonal institutions and buildings offering centralised services.

How does it work?

A safe place facilitates processes of recovery and reflection. Place2Be is collocated within schools, and have their own room where sessions are conducted, workers are based and children's work is kept securely. Places are also important for meetings and conversation. An important foundation of the work of Place2Be is the agreement they reach with children to frame the activities and conversations that take place within their room, during their sessions. Schools are also the context for Explore and Straight Talking to provide a safe place for young people to ask probing questions ('Real World Relationships').

Closely allied to place is a sense of 'belonging'. This is the link between a person and place and a larger group of people who live there, such as family and community. These important links or connections are developed fully below, but are evident in a number of projects.

For example, the Beacon and Old Hill Estate, Falmouth profiled in 'Our House, Our Health, Our Home'. Or the links between parents, partners and child(ren), the family and home at the heart of the work of HomeStart. Likewise, the Debenham Project is the response of residents to problems of dementia within their own village.

These aspects of belonging, links and safety are also present in the virtual 'place' created by the online support group, Patients Like Me. The Youth Zones of Onside are intended as 'inspiring places' as well as safe and secure places for young people. Aspens also develop the links between food and place – what is grown locally and its benefits for students.

How does this contrast with conventional health services?

Clearly modern public services offer a well-defined place for their service delivery – and invest heavily in the safety of visitors and patients. Indeed the major failings of health services in recent years have been characterised as a failure of safety of patients under the care of institutions (Stafford Hospital) and even within patients' homes (Shipman).

However, there are tensions within this approach. Centralised secondary, tertiary and specialist is located away from most people's own community. Health becomes something that is produced away from the home and community in institutions. It can be difficult for people to access such places. Indeed, some safety measures have an unintended consequence – limited opening hours or access, security screens, passes and even uniforms create barriers to access and belonging. The safety of communities is undermined subtly in other ways. Negative labels quickly attach themselves to these areas, such as 'deprived', 'poor' or 'unequal'. This perspective, informed by shortcomings, failings or deficits is discussed further below.

Dealing with people 'where they are' has more than just a geographical or spatial meaning. An ability to work with people as they come through the door, at whatever point in their life they come into the project, at whatever place on their personal health journey they are at, is an important quality of many of the case studies listed.

Salford Heart Care is located firmly within a community of Manchester. It is also focused on helping those at a particular phase of their recovery from heart disease, often post surgery. However, it has adapted in response to the changing demographic of its clientele and the increase in young people affected, often the consequence of drug use. Likewise the Mustard Tree often makes first contact with people at the lowest point of their lives: homeless, voiceless, friendless, in a strange land, without hope or help. Yeovil4Families takes families as they find them and demonstrates a universal acceptance but individual, case-by-case response.

Working alongside conventional health services

The difference in health outcomes between different places in Manchester and the UK was a key driver to this report. To effect a change in health outcomes, these characteristics must be a part of both cause and solution to the problem, not just its description.

Key to this is the places that help define communities. Familiar, local, fixed points around which people's lives move. These 'anchor institutions' may be sports clubs, schools, churches or other places of worship. Just as hospitals provide excellent, reactive acute care and clinical services, but remote from communities, so too preventative work is proactive and takes place within communities.

Manchester Communications Academy has changed the traditional public sector delivery model of a school. It demonstrates what belonging to a community – its place within it and ties it – can do to influence change within students, families and the community.

Within the health sector, a presence within the community is not enough. Likewise, Hope Citadel GP surgery (Hope and Healthcare) and Kapoor Pharmacy (Retail Relationships) demonstrate that being in a community is more than a statement of geography: it is embracing membership, belonging to a community and being a part of its life, ebb and flow.

Great Places (through projects like Levenshulme Inspire/Northmoor Community) provides facilities where people can be safe, belong and deal with the challenges of life they face. However, these projects hint at much greater potential to influence healthy outcomes in the lives of tenants, just scratching at the surface of what might be possible.

3.2 Regard for the whole person

Theme: Different people with different journeys and circumstances are each respected, valued as individuals and regarded holistically.

In contrast to the tangible qualities of the first theme, this addresses intangible factors and is allied to questions of values, character, attitudes and choices as well as factors such as education and experience.

Some projects deal with well-defined demographics, such as primary school pupils. Others, such as the Mustard Tree and Yeovil4Families deal with highly diverse groups, such as the homeless, the vulnerable and families in all their different shapes and forms. The GP practices in Oldham and Denton, as well as Kapoor Pharmacies, must deal with the diversity that walks through their doors. National organisations such as Place2Be and HomeStart have developed approaches that are sensitive to identity. Still others such as PatientsLikeMe derive their strength and value from the different experiences of those who use them, finding new connections and points of characterisation from their individual stories and experiences.

However, systems struggle with individuality and diversity. They are designed for conformity and consistency. Production line approaches to health systems that seek efficiencies from similarities and are problem-focused struggle to comprehend or respond to the whole person.

How does it work?

Underpinning the different case studies was a sense of value for and respect for the uniqueness of individuals. People are given room to be different, not expected to behave or conform in specific ways beyond modest community rules.

This respect for individuals is reflected in the diversity of the projects themselves – there are no identikits, even in the more corporate models. Rather there is a common reference to the importance of values. A strong guiding value set is a characteristic of this theme and recurred in the founding stories of several projects such as Spirit of St Mark's, Hope and Healthcare, the Mustard Tree, Yeovil4Family. This may account for the strong representation of faith groups who account for some twenty per cent¹⁴ of all voluntary and charitable activity in the UK. Several of the case studies self-identified as Christian and demonstrate traditional values associated with Christianity, such as kindness, generosity, compassion and helping people realise a transformation of themselves and their situation.

A further key is leadership. Beyond the individuals they help, and the nature of the groups, these values were frequently manifest and modelled in the project principals. Simply, they 'walked the talk'. This integrity gives their leadership an authenticity and authority that people respond to. It is demonstrated by shared experience (Salford Heart Care, Patients Like Me, Debenham Project, Manchester Carers Forum, Home Start), a commitment to the locality (Retail Relationships, Great Places) and the initiative, drive and vision demonstrated by the founders (Abraham Moss Warriors JFC, Hope and Healthcare).

How does this contrast with conventional health services?

Public services are committed to principles of education, information and research; seeking better understanding of individuals and their conditions. This link is clear within the work of schools and Manchester Communication Academy. Education is important both in prevention of health problems but also long term responses to and management of chronic conditions. However, some of the case studies take education several steps beyond simple knowledge transfer.

PatientsLikeMe also validates people's experience and enables them to support and educate each other, exploring their conditions, making sense of their experience and sharing coping mechanisms. In addition, by allowing data to be gathered from willing participants, it furthers research by helping understand patients' experience of conditions and treatment. The patient record developed in Denton (Experts in the Room) positions patients in the same way, as knowledgeable about their experience of their condition and treatment. These can be contrasted with the 'Health Talk Online' website which does not enable patients to connect with each other, instead gathering information for professionals to analyse and glean insight from, albeit ultimately to return it to patients in the form of research findings and better interventions and advice.

¹⁴ See 'Questions of Faith', New Philanthropy Capital, December 2014

Yeovil4Families is one of the partners delivering the government's Troubled Families Initiative. This focuses on key measures of anti-social behaviour, worklessness and school attendance.

However, the work starts by taking time with families to understand their priorities. These then become the first focus for support and actions.

Working alongside conventional health services

The traditional positions of patient and professional shape the traditional health care setting. The approach to consultation and diagnosis is built around a process of diagnosis and prescription ('find and fix'). While this yields a description of people's condition, understanding the context of their condition is a key part of several case studies (notably the work at Hope Citadel, Place2Be, Yeovil4Family and Mustard Tree). This helps the person (and the enlightened professional) make sense of their condition and circumstance; it becomes their unique story. This is an important observation that is picked up later within the recommendations of this report. It is also highly relevant to the challenges of poor mental health and wellbeing (see Box Out, 'Focus on Mental Health and Wellbeing'.)

This in turn unlocks several further benefits. It captures their sense of 'place' along their journey (see previous theme 'where they are'). It also fosters a whole-person view of people. This in turn encourages the process of confidence building, self-esteem and resilience to cope with life's challenges (Place2Be, Love4Life, Explore, Yeovil4Families).

From this whole person view, it is possible to consider responses such as 'Social Prescribing'¹⁵. This is an attempt within a clinical setting to respond to personal, social, economic and environmental issues that may be presented as clinical symptoms. Over diagnosis, over treatment and the 'over medicalisation' of health systems¹⁶ – to the extent that they start to threaten societal and individual wellbeing – are concerns for many health professionals forced to deal with the consequences of non-clinical problems.

One example is end of life care and treatment choices for patients with terminal cancer. He cites studies showing the greater longevity amongst those patients who forego painful and debilitating courses of last resort treatment, in part because of the greater quality of life experienced. He cautions that for social prescribing to work, its limitations must be clearly understood and that doctors and patients must 'become reacquainted with the health producing capacities of citizens and communities'.

¹⁵ See 'Developing a Social Prescribing Model', District Councils Network, February 2015, <http://districtcouncils.info/files/2015/02/New-Models-of-Care-Social-Prescribing.pdf> (retrieved August 2015)

¹⁶ Dr Atul Gawande, BBC Reith Lectures, 2015. See <http://www.bbc.co.uk/programmes/articles/6F2X8TpsxrJpnsq82hggHW/dr-atul-gawande-2014-reith-lectures> (retrieved July 2015)

3.3 Connections to Others

Theme: All case studies placed people in the context of their relationships with others and responsibility to them.

People are connected to others, not considered in isolation, and are viewed first as people, not medical cases or 'conditions'.

Several case studies are explicit in their focus on relationships. Explore promotes the beneficial impact of marriage and strong relationships on mental health and support during times of physical ill health. Straight Talking creates encounters for young people to share learning on relationships and promote greater self-esteem.

Other case studies focus on enabling relationships. HomeStart offers direct support to the nurturing relationship of mother and child. Manchester Carers Forum demonstrates the instinctive response towards the needs of others and the beneficial impact this 'milk of human kindness' can have. Relationships are also at the heart of the dementia friendly community of Debenham and technology based case studies such as PatientsLikeMe, albeit fostering online relationships.

Family is a recurring factor and a relationship of tremendous significance (see below). Note that this is not a statement about the *form* a family takes or the *quality* of the relationships within it, simply that the connections exist and are important to the individual. Indeed research from India and the US points to the impact of empowering family care.¹⁷

Projects involved in the task of educating and informing to foster healthy habits and active lifestyles have found it essential to work through families to develop a supportive environment for the formation of positive habits. Cheetham Primary Academy sees the family as key to taking healthy eating practices from the classroom into the home. Likewise Sale Sharks in promoting healthy habits amongst former players.

Even the work of Yeovil4Families and Love4Life with dysfunctional families that are frequently not functioning well or strong, shows the potential for having a positive impact and contribution to the wellbeing of their members.

How does it work?

Connections are hugely powerful and influential. The list of issues that characterise communities with poor health outcomes will almost certainly include poor connections or low social capital: sparse or dysfunctional social networks, low trust and cooperation between residents, poor relationships between residents and public agencies (both health and other), high levels of crime and anti-social behaviour.

¹⁷ One example of 'reverse innovation' of family involvement was developed in Bangalore, India and brought to Stanford, USA. See <http://www.health.org.uk/blog/unleashing-caring-potential-families-taking-innovation-india-us> (retrieved March 2015)

It simply is not possible to describe any of the case studies without considering relationships. However, the importance of relationships is more than a truism. While any organisation or project works to some degree on the principle of relationships and communication, and the selflessness of volunteers, what is notable about the case studies here is their focus on and leverage of the principles of relationship as part of their approach.

Practically, relationships must adapt to fit the different stages of growth and recovery that people experience and the different support and care that people need. Relationships encompass the transitions between different organisations that so often become the epitaph of those who 'fall through the cracks'. This is driven not only by instincts to care and nurture, but a sense of responsibility towards one another, informed by the value placed on individuals (see previous Theme) and respect afforded to them.

Relationships also have a peculiar resilience. The sacrificial and selfless work of many of the Manchester Carers Forum members demonstrates this point:

"People may be bad at looking after themselves but still be good at looking after others."

The commitment of volunteers to strangers is more than simple financial benefit to the organisation and an exchange of goods. It is affirming, healing and human – a nurturing connection that many have been deprived of at key times during their lives.

How does this contrast with conventional health services?

By comparison public services promote safe but sterile, worthy but impersonal corporate values (excellence, care etc.) They are all too often impersonal institutions, housed in soul less buildings, under faceless governance and administration.

Even within the services they deliver, relationships with hard working and dedicated professionals are designed to be impersonal and detached, a learned behaviour that is considered and recognisable as professional. However this carefully cultivated, neutral approach struggles to be engaging or affirming. The high profile #hellomynameis campaign¹⁸ was inspired by Dr Kate Granger's personal experience of treatment at the hands of anonymous fellow medical professionals and care providers.

This is a consequence of the individualism and reductionism that characterise our public services and values. Too often people are treated as conditions, a collection of symptoms for which there is a diagnosis and a prescription to match. However, regarding people as individuals is not enough; ignoring them once they fall outside a definition of need or rights to a provision of service is a cliff edge of care many are ill equipped to survive.

There is an irresistible logic for working though others – but the medium for this is the voluntary relationships that sit outside services. This is driven by strong, natural instincts. It is not something that can be delegated adequately to professionals, however well intentioned, expertly trained and compassionately delivered. Consider one of the greatest contributors to premature death in the elderly: loneliness. GP appointments and visits from care workers, programmed into slots of ten or fifteen minutes may deliver meals or advice, but are no prescription for companionship and care. Disconnection from society is a cause of the problem, and reconnection a powerful solution.

¹⁸ See www.hellomyameis.org.uk (retrieved September 2015)

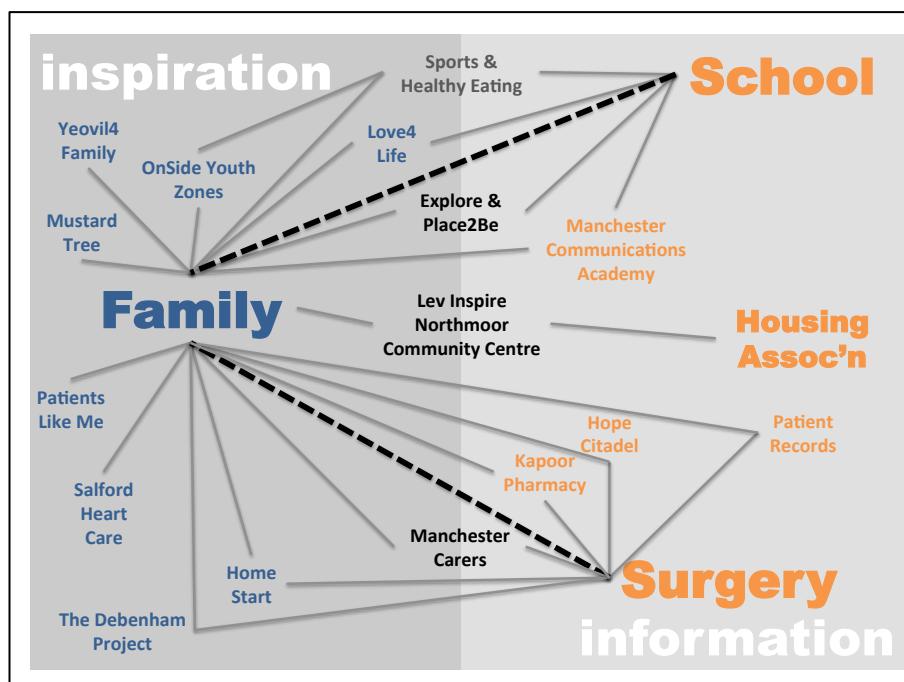
The Salford Heart Care project builds on this sense of responsibility and care. It was founded on one man's thought for others who would come after him, shaping a vision and fuelling a determination that they would have the offer of emotional and physical support post surgery that he did not.

When approaches do not acknowledge and respect this principle of social connection, 'friction' is created. Hindrances, resistance and pressure inevitably start to develop. However, this principle of working with the grain presents an opportunity to tap into some of the energy and momentum that social movements possess and deliver their impact upon the health outcomes of society. An understanding of the dynamic of relationships is at the heart of this success.

Working alongside conventional health services

It is a simple but important observation that every case study has a strong association with the family. Everything from caring (Manchester Carers, Salford Heart Care) to mental health (Place2Be) and the very young (Home Start) to the elderly (The Debenham Project) are defined in part by the work they do with families. Within the case studies there is also a natural association of projects with two principal, local 'institutions': the school and GP surgery. These are shown in Figure 3, below. A third 'institution', which is distinct but only occurs within a couple of case studies, is the housing association.

Figure 3: Patterns of institutional associations across case studies



This mapping underlines the centrality of the family's role: links can be seen to cluster around clear axes (shown as dashed lines) between family and school, family and the surgery and also the housing provider. Put another way, none of the case studies had a solely institutional focus and link. Arguably the task of integrating physical, mental health and social care is one that must embrace the community and wider community, across sectors, not just within and between institutions.

This link to institutions is not a surprise. The family is a natural institution within society and across cultures, which frames procreation, nurture, development and care between generations. Man made institutions establish values over time and within society: schools promote and preserve the lessons of one generation to the next; the health service is a statement of value placed on care by society.

Figure 3 also illustrates the close links between voluntary groups and public institutions. Every case study has links to an institution. Even those not connected to schools or surgery within the figure (such as PatientsLikeMe, Salford Heart Care, Yeovil4Families etc.) are connected to the wider health care profession (academic institutions, research, hospitals etc.) or another institution (police, council etc.) for example, providing for the safety of the environment and individuals through their various services. However, the school, surgery and housing provider clearly occupy key positions within the support network of a family and the individuals within it:

A third observation is the contrast between projects associated with public sector bodies, notably Manchester Communications Academy and the GP practices, and those formed in the community such as Salford Heart Care, Yeovil4Family. There are distinct differences between community and institutional thinking, such as governance, scale and operations, also reflected in language, culture, structures and organisation.

These are characterised broadly here as 'information' and 'inspiration' and given their links, can be seen as complementary, not contradictory or in conflict. Five of the case studies (two GP surgeries, Pharmacies, Claremont Primary School and MCA) closely fit current public service patterns but were included for their significant and relevant innovation. Each of these has learned to break down or overcome their structural approaches to reach across and make connections with the community. This is the important achievement of reaching beyond their own boundaries to influence the families and communities that their patients and pupils and customers live and move within.

This effort to bridge a cultural divide was also evident in the other direction. For example, in groups and projects typically organised around the human experience and need identified within the community (for example Manchester Carers or the community sports clubs profiled) the issues and service approaches were secondary. These were adopted as a focus and learned language in order to work with or link to public services.

3.4 Fostering influence and control

Theme: People are encouraged to develop a sense of purpose, influence and control over their health.

This can be contrasted with a common unintended consequence of public services: the inferred dependence on professionals and institutions to provide health. An example of this was found in an American study¹⁹ of the difference in perceptions of preventative health care between veterinary health professionals and their clients. The professionals regarded prevention as clinical processes such as neutering, vaccinations and parasite control while pet owners considered it to be the things they were responsible for – nutrition, exercise and wellbeing.

How does it work?

In an age when many people feel increasingly powerless – against global forces impacting their jobs, market forces affecting what they can consume, political forces shaping their society in ways they may disagree with, circumstances that they may only be partly responsible for – the message of control is an empowering one. This comes through asserting values through actions that in turn yield outcomes.

Even small gains foster a sense of control and the hope of some influence over the future. It might be a few pounds lost because of exercise taken, in order to wear certain clothes for a family occasion. Or enjoying a game of football in the park with a grandson, without coughing and losing breath because of giving up smoking.

This working with people's strengths – their priorities, significant relationships and abilities – characterises an approach taken within the case studies. It contrasts with a 'find, fix and/or fill' approach to problem solving. It is particularly applicable to address determinants of health that lie outside the medical field: what we eat and drink, how much exercise we take and whether we smoke or not. It is also one that complements the existing medical model. One that is centred on the person and aligns with them.

Ultimately, this is also a practical approach. The projects work to harness people's own attention, interest, drive and actions, tapping into their motivation, strengths and the 'hidden' assets they can access. These include themselves and the assistance of their families, neighbourhoods and communities²⁰ where and when it is needed.

¹⁹ From a study of two million social media comments made by the clients of Banfield Pet Hospital, Oregon, USA (August 2015). See <https://www.avma.org/News/JAVMANews/Pages/151001r.aspx> (retrieved October 2015)

²⁰ For further reading reference 'Glass Half Full' (2010) and 'What Makes Us Healthy?' (2012) see <http://www.scdc.org.uk/media/resources/assets-alliance/What%20makes%20us%20healthy.pdf> (retrieved July 2015)

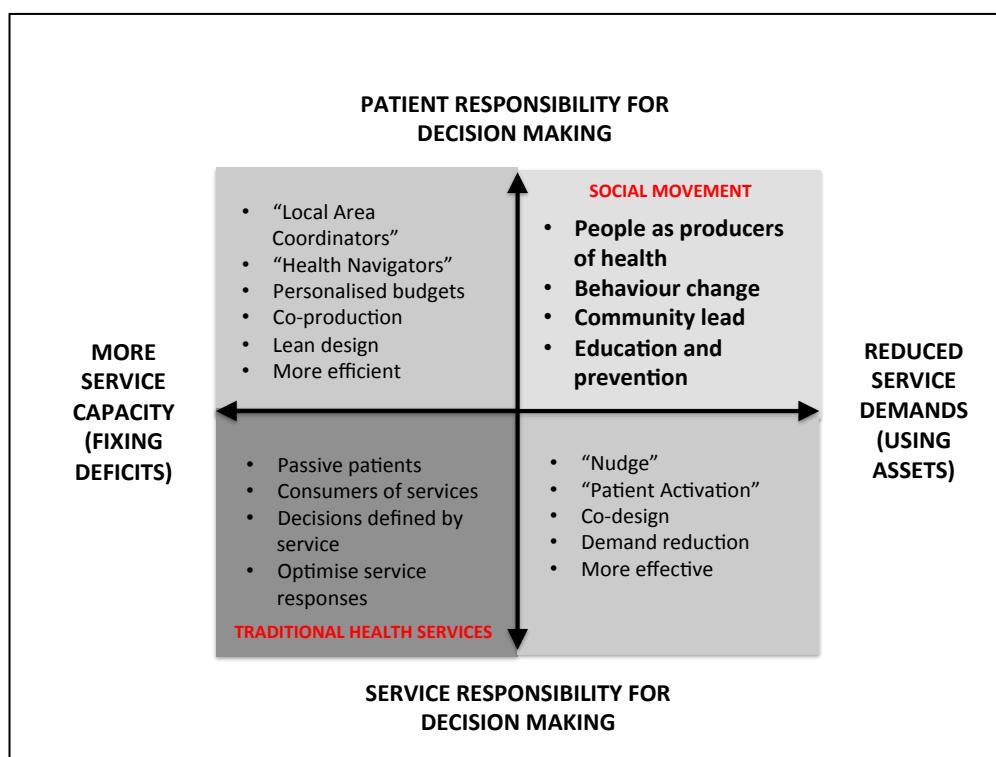
Beyond assistance, the impact of example and influence of peers on actions is well documented. Actions are informed by relationship through cooperation, collaboration (or even conflict). People are very sensitive to the motives of those around them and the purpose behind them, both for good and for ill. In this way relationships are key to encouraging behaviour change in those drivers of health – eating, exercise, alcohol consumption and smoking – that lie beyond the reach of clinical services and support.

How does this contrast with conventional health services?

Working with people, identifying a narrative that informs purpose and engaging people as producers of health is a strong response to criticisms of the National Health Service, as a 'national sickness service'.

It is possible to understand the development of public health services along two dimensions. First the level of decision-making by patients (or people) and the services, and whose priorities prevail). Second where the focus lies, increasing capacity to meet demand, or reducing demand to reduce service costs. This is mapped out in Figure 4, below.

Figure 4: Health as a Social Movement and Other Public Health Service Initiatives²¹



²¹ Based on an original model in 'Future Local Public Services', i-Network, 2015. See <http://i-network.org.uk/the-2015-18-local-public-service-journey/> (retrieved August 2015)

Traditional public service approaches, concerned with meeting demands and optimising service configuration to do so, occupy the bottom left quadrant of the grid. They have a critical part to play in responding to emergencies, acute conditions and technical and medical interventions. They are also expensive.

It follows that much of the improvement activity within the health service is aimed at reducing service demands on this area. This is achieved in two ways: through ‘nudging’ better responses, managing demand, increasing efficiency and producing less waste within health care systems (in effect, moving the activity to the bottom right quadrant). Alternatively, and concurrently, improvements seek to activate and engage patients better in co-production and delivery of health care services (in effect moving the demand to the top left quadrant).

However, some initiatives, while worthwhile in themselves, run counter to this aim of reducing service demands. For example, co-production might also be considered the co-option of people into the support and production of health services for their own consumption. Likewise, co-commissioning and personalised budgets allow for more effective spending of funds by responding to the specific requests and requirements of patients²². Similar examples of co-production and patients working within the health system include Patient Navigators – people trained and appointed to direct others through the care system – and Local Area Coordinators who are trained to help vulnerable adults to manage dealings with multiple support agencies.

A further expression of this thinking lies in the developing ‘patient-citizen’ narrative (e.g. NHS Citizens to assist with the governance of health care²³.) Affording the status of citizenship to patients within a vast system, while a worthy promotion of rights and excellent service, also confuses differentiation between those who are citizens who might access services and those who are ‘citizens’ of a system within which they are patients. Once more, this overlooks the impact people have on their health, often before they become patients.

The Development of Personal Care

This report and these case studies, start to explain better how to encourage people to take greater ownership of producing their health. In other words, reduce demands on services through better, more informed personal decision making. The care of an elderly patient with COPD (described in the Box Out) offers just one illustration of this process.

²² For examples and a wider discussion read ‘Personal Health Budgets – A Revolution in Personalisation’, 2020 Health (July 2013). See <http://www.2020health.org/2020health/Publications/Publications-2013/PHB--a-revolution-in-personalisation.html> (retrieved September 2015)

²³See NHS Citizen initiative, <https://www.nhscitizen.org.uk> (retrieved July 2015)

Illustration: care for an elderly patient with chronic COPD, requiring maintenance of a 24-hour oxygen supply.

Traditional health services focus on service centred decisions – it is easier to control what can be managed (lower half of the grid). Responses might be to provide overnight care by admission as an in-patient (bottom left quadrant). Alternatively, a trained carer is engaged to monitor through the night, in the patient's own home, to ensure the oxygen is maintained at all times. This reduces costs and releases a much needed hospital bed (bottom right quadrant) but remains a service centred decision.

A different approach is to involve others and make decisions that are decided around the patient (upper half of the grid). One example might be to involve a family member, friend or voluntary carer, perhaps a neighbour or resident in the patient's community to take on the role, with some basic training (top left quadrant). This increases the patient's comfort and reduces the cost of providing expensive employed care. The work of early diagnosis and prevention lies in the right half of the grid. Early diagnosis is captured through identifying those at risk (over forty years with a history of smoking) who visit the GP's surgery. A simple spirometry test (bottom right quadrant) will help challenge the patient, with the hope this will enable management and delay progression of the disease (unfortunately, in the context of over medicalisation, it may also raise the expectation of treatment without any change of behaviour).

However, even more preferable are preventative measures (top right quadrant). These are initiatives addressing behaviours and choices within society, outside the reach of the clinical. They include the different themes identified in this analysis: creating a safe place by removing the example of smoking from the home, drawing on the example and brand of Sale Sharks RUFC or CITC to help shape values, education and information, changing the conversation and norms amongst peers (e.g. children and young people at school) and ultimately changing the actions and behaviours people make for themselves.

This ownership sits within, even defines, the top right quadrant of the grid in Figure 4 and includes some management of chronic conditions, greater mental and physical wellbeing, lifestyle management, better decision-making and reduced risk-taking behaviours. This is particularly relevant for those problems that are driven by non-clinical factors such as excessive eating, insufficient exercise, drinking too much alcohol and smoking. It is also relevant for elder care, patient rehabilitation and more.

At its simplest, this top right quadrant frames a response to many of the present drivers of the expensive demand from services that lie within the bottom left quadrant. This is a simple progression or shift towards community based approaches. It both reflects the importance of community nursing²⁴ but also reveals the current limitations²⁵ of thinking on potential for community involvement.

²⁴ See 'Care in Local Communities; A new vision and model for district nursing', NHS Commissioning Board, January 2013,

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213363/vision-district-nursing-04012013.pdf

The response of professionals and politicians to such innovation has ranged from dismissive ('not evidenced') or competition for attempts to create/protect public service alternatives or duplicates. However, duplication simply falls into the bottom half of the grid, becoming service centred. Funding also draws the venture into the bottom half of the grid as values and approaches assert gradual control over the service. Importantly, this figure positions a health social movement as a 'next step' convergence of the two innovation strands in health care: a product of both greater responsibility for decision making (top left quadrant) as well as smarter, more customer centric design (bottom left quadrant).

Working alongside conventional health services

This perspective also highlights the importance of a broader approach than just health care services. Health is not something that is prescribed, nor is it binary ('broken' or 'fixed'). Rather it is constantly moving, changing, improving or deteriorating. It is only one aspect of wellbeing. For examples, patients may speak of benefits realised through struggles with their own health.

The link of health to wellbeing, influenced by different agents, environments and initiatives is not new. They have been developed in the study of 'health economies' within which people and groups act variously as producers, consumers and citizens. Early work²⁶ focused on 'the medical-care industry, not health.' One influential model²⁷ compared health to a unique form of capital that can grow through investment or depreciate through consumption. This requires people to act as utilitarian agents who make rational investment calculations in narrow terms of increased personal utility. Indeed one popular model of a health economy²⁸ identifies distinct aspects that are all predicated on a starting position of needs and consumption as driving behaviours.

However, the case studies within this report make different assumptions and reach different conclusions. They see individuals as producers of their own health through non-rational choices and behaviours – as well as consumers of health and other services. They demonstrate how the work of fostering a personal ownership of, responsibility for and action towards better health outcomes complements the approach of essential traditional health services.

²⁵ Government guidance on community approaches positions communities as supporters of public services, see (e.g. pages 17,18)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402887/A_guide_to_community-centred_approaches_for_health_and_wellbeing.pdf (retrieved June 2015)

²⁶ Reference 'Uncertainty and the welfare economics of medical care', American Economic Review 53 (No 5), Arrow (1963), see http://sws1.bu.edu/ellisrp/EC387/Papers/1963Arrow_AER.pdf (retrieved May 2015)

²⁷ Reference 'On the Concept of Health Capital and the Demand for Health', Grossman (1972), Journal of Political Economy 80 (No 2). See http://www.jstor.org/stable/1830580?seq=1#page_scan_tab_contents (retrieved May 2015)

²⁸ Williams, A. (1987), 'Health economics: the cheerful face of a dismal science', in Williams, A., Health and Economics, London: Macmillan

This parallel work has consequences for traditional services beyond reducing demands or leaving ‘a bit less to do’. This work contests particular assumptions of what is best (for example, care provision, as demonstrated by Manchester Carers), what is valued (as demonstrated in the work of Explore and Straight Talking to understand relationships as the context for intimacy, not just providing biological and health information) and what is motivating (as employed by Yeovil4 Family in goal setting by the family).

A further distinction is a greater emphasis on prevention through healthy habits and resilience to cope and recover when problems occur. By enabling people to take ownership of health outcomes for themselves, their families and their communities, they are working outside the reach or territory of traditional health services. Their positive impact on health – in the most difficult places, with the most intractable problems – cannot be ignored and is truly preventative. It also comes by placing the person at the centre of considerations, not the health care system, or organisation, whose role is to provide support where and when it is needed and called upon.

3.5 A future focus

Theme: Helping people develop a vision and ownership of their health and future.

The future for each of us is different and it is essential we take some responsibility for our future health. Some projects have this future view woven deeply within their identity (such as Place2Be, Love4Life), founded on the assumption of a positive, lifelong impact of their work. Such an assumption is implicit within those groups working with children to develop healthy eating and activity habits.

Explore Marriage and Straight Talking highlight the importance of choices and the consequences they can have for the future. Notably the project that Abraham Moss Warriors FC players conducted with their players showed them the impact diet had on performance in games and led to a change in the way the players decided to fuel and hydrate before, during and after their games.

Several case studies (notably Yeovil4Families, The Mustard Tree, HomeStart) are explicit in working with those they support to develop their own goals or vision for the future before working with them to attain those goals. Others are clear that they work to enable a better future in mind – Salford Heart Care supports a future after major heart surgery (a particular challenge for young people with problems) and the transition at the end of institutional support.

How does it work?

A stand out characteristic across all case studies was the importance of helping participants create a compelling sense of their future. Love4Life gave the example of how one young girl’s future was transformed by her desire to work towards becoming an accountant. This also formed an integral part of the ‘story telling’ of Hilltop Surgery.

Goal setting and defining a preferred future links strongly and intuitively to the preceding theme: ‘What can I do to influence the future I would like to see?’ It has a positive outward looking focus, helping individuals look up, ahead and beyond their present situation. More than that, specific goals and defined outcomes, however they are articulated, bring purpose and intent to actions. In doing so, they transfer ownership of circumstance and condition. Actions become the means by which people write the next chapters of their own lives, as echoed in ‘The Experts in The Room’.

How does this contrast with conventional health services?

Conventional health care approaches, focused on a condition and treatment, must frequently stop at the point of physical recovery from an operation, or a prescribed course of treatment. The broader context of wellbeing, which may have triggered the condition or problem, is not always considered.

The alcoholic is treated for cuts in A&E but the underlying mental health problems remain after discharge. An elderly person may recover from a hip replacement, but the isolation, malnutrition and self-neglect which led to the fall remains unaddressed.

A forward-looking perspective also extends to the future of the organisation, in a way that until recently, many public sector bodies would not have had to consider. Sustainability is vital and difficult decisions about shape, delivery and existence were frequently described by the case studies. When projects and groups did talk about growth it was notable that this was not in terms of budget, firstly, but in terms of spread. This seemed to reflect opportunities that presented as much as demands for services. This is an important characteristic, reflecting the close link to 'place' and the local roots and connections that informs the identity of many of the projects, discussed above. It takes time, thought, effort and care to transplant a successful project from one area into another – and resources are only one part of the calculation these groups were making.

Another key feature of discussions about the future involved leadership and succession planning. This is an important hurdle for groups to navigate as they develop and within the case studies identified, a range of responses was evident. Some were still led by their founder, and questions of succession and growth beyond their own abilities are foremost in their mind. Explore and Straight Talking are still run by their founders, but the models they have developed are well defined enough to be passed on to others and their delivery delegated.

At the other extreme, groups such as Place2Be have managed the transition beyond founders and place to develop a national role. Likewise, HomeStart is an established national franchise where effectiveness is largely dictated by the leadership and example of local personnel. This is much more like the concerns of traditional public services, seeking to manage issues of human resources and secure sufficient skilled and talented individuals to support the work of the organisation.

Working alongside conventional health services

Salford Heart Care demonstrates the positive impact of working alongside hospitals. The mental and emotional consequences of living with a serious heart condition are considerable and last well beyond the physical recovery from major surgery. The work of Salford Heart Care and the testimony of local health services demonstrates that ongoing clinical support for those patients can be reduced.

Closely linked to a view of the future is measuring improvement over time. Has the support worked? This also poses a key challenge to practitioners and commissioners working with voluntary groups: what is their understanding and commitment to measurement, reporting and management of performance?

This is highlighted by a growing focus on outcomes in government contracts, the shift to Payment By Results mechanisms and a reluctance to specify overly prescriptive methods. The Troubled Families Initiative is a notable example, allowing – even encouraging – the development and deployment of context sensitive approaches. This has had an impact on the behaviour and learning of social sector groups as well as increasing the actual levels of funding. This is attributed to a greater focus on what works, rather than simply staying in business.

All of the case studies were tracking different aspects of their work although in a wide variety of ways and with varying degrees of rigour. Place2Be and HomeStart demonstrate both an aptitude for measurement and reporting, as well as an eagerness to develop and demonstrate this ability. Sale Sharks RUFC and CITC had linked with academic institutions to track the impact of their work. Hope Citadel are required to gather, monitor and report performance metrics as part of their operational contracts.

It is worth noting here that often the key challenge is not in the fact of measurement or reporting, which all consider important, but in its form and communication – the purpose and nature of the data and its usefulness to others. Each of the case studies was convinced of the importance of their work, the impact it was having and the importance of reporting it. There was plenty of anecdotal evidence that the project was working and having a positive impact.

Different problems were reported, typically for different reasons. In one case, the data that was captured by Hope Citadel was required contractually (e.g. the length of consultation times), but did not reflect the problems in the community (e.g. hidden incidence of hyper tension) or the impact they were having and the effective solutions that were being delivered (e.g. social prescribing). In others, reporting was limited to traditional areas such as activity and inputs – numbers of attendees, participants in the project, connections made etc. – rather than impact and outcomes. Place2Be and HomeStart, as might be expected from national organisations that have received local and national government funding, are sector leaders in terms of reporting, understanding measurement and articulating precise impact statements. Smaller groups by contrast tended to offer anecdotal, ‘whole person’ reporting, one life or story at a time. As a result, some benefits, including health, were overlooked. In still other projects, data captured (e.g. as stories or anecdotes) was not always communicated effectively or in a way that was convincing to others.

When these are understood as good or bad reporting, right or wrong, there is an implicit comparison with a preferred standard. However these are also statements of preference, format and 'language' as they are about the quality of data – the common criticism of voluntary groups.

By way of illustration, an excellent analysis of project inputs and activity, without the desired outcome may satisfy standards of evidence, but is no more helpful to management and improvement of performance than true stories of lives changed that are without numerical analysis.

One of the principal challenges for a voluntary group is a public sector preference for asserting a preferred framework or standard of traditional services that reduces measurement and performance to a financial metric.

As an example, the Crest project in Falmouth (see 'Our House, Our Health, Our Home') has been able to estimate a return on investment of almost £4 on every £1 funding²⁹ for their work with a disadvantaged neighbourhood of 5,000 people over two years (at 2011 prices). The report on their work concludes costs could be 'considerably reduced' if extended to nearby neighbourhoods and over extended periods. The actual calculation compares a:

"...cautious estimate of reducing events by five per cent per annum in our illustrative neighbourhood of 5,000 people... a saving for the health service of £558,714 over three years on depression, obesity, cardio-vascular disease and a small number of the other health factors. This is a return of 1:3.8 on a £145,000 investment in community development over the period... On the same basis, investment in the twenty per cent most disadvantaged neighbourhoods in a local authority area would produce a saving for the health service of £4,242,726 over three years, or just over £1.41 million a year."

They go on to suggest that:

"Adding savings produced by reductions in crime and anti-social behaviour from the same activities produces a further saving of £96,448 a year per neighbourhood, £868,032 across the twenty per cent most disadvantaged neighbourhoods of a local authority and £130 million across England."

As has been discussed, scaling up, replication and transplanting such projects is not straightforward, however with skill, care, time and effort it is achievable. This has considerable merit, linking direct savings (e.g. reduced service costs), indirect savings (e.g. reduced benefit payments) to second and third order gains (e.g. increased productivity and tax receipts). These may even be represented over time as net present values for comparison and presented within confidence limits to accommodate uncertainty.

²⁹ See 'HELP', Department for Health, November 2011 http://www.healthempowerment.co.uk/wp-content/uploads/2012/11/DH_report_Nov_2011.pdf (retrieved March 2015)

What is also clear from these case studies is that the awareness of social impacts, or double bottom line accounting is growing and narrow financial metrics are no longer the only measure. The gap between commissioners within the public sector (or a growing private sector of ethical investors) and practitioners on the frontline is narrowing. There is a clear desire to see a focus on impact and outcomes driving a convergence of these diverse reporting preferences and languages to create a flexible framework.

The Department of Communities and Local Government has issued extensive guidance and spreadsheets of various indicators, accepted ratios and returns to support this. Implicit within this guidance are assumptions (the change theories) linking actions, outcomes and impact. The framework³⁰ of measures needs to reflect both qualitative and quantitative measures, capture a diverse range of behavioural, service and financial impacts (e.g. a reduction in anti-social behaviour, reduced service demands and lower benefit claims) as well as short and long-term outcomes (e.g. greater school attendance and better health and wellbeing). This would not only bridge the language gap between social sector groups and traditional public services, but minimise the diversion and redirection that frequently occurs when public funds are used by voluntary groups.

³⁰ See 'Positively Local', August 2011, pp 32 and 37, <http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/2011/positively-local.pdf> (retrieved August 2015). Note this is an early model.

3.6 Technology and e-health

Advances in technology have been a significant enabler of improvements in health outcomes. From public sewerage to enabling research and the development of advanced medications and treatments, technology has had both direct impacts, for example in medical equipment and procedures, and indirect impact on the health and wellbeing of the population. Technology is now a permanent presence on the current health landscape – despite the uneven progress of more ambitious IT projects – and its impact has been the subject of several recent studies³¹.

Behaviours not treatments

While health technology development, particularly in the last few decades, has focused on understanding biology and refining medical treatments, particularly toward the end of life. The specialist approach left major gaps in understanding and tackling common, complex problems. Technology is now being understood for its impact on patient behaviours. Just one example is the use of social media, following private and other public sector trends³².

Such technology³³ is a feature within many of the case studies presented. At a simple level, it is used to monitor outcomes such as heart rates and weight (Sale Sharks RUFC) and encourage engagement amongst school children (see 'The Spirit of St Mark's' case study). The relevance of such technology to aspects of personal behaviours is underlined in an important observation on an aspect of human interaction with technology. Work by Professor Iain Buchan and the Health Informatics team at Manchester University has identified that is not only the capture of information through technology (such as heart rate monitoring) and the visibility of it (e.g. on a watch or other wrist worn device) that is important, but the behavioural response to visible data. Simply, does the information prompt action?

³¹ See 'Patient, Manager, Expert: individual – A Report from the Sustainable Healthcare Steering Group', April 2014, http://www.collegeofmedicine.org.uk/wp-content/uploads/2014/08/sustainable_healthcare_pdf_report.pdf (open link in browser, retrieved August 2015)

³² See 'Social media is becoming the default media for dealing with customers', BBC, <http://www.bbc.co.uk/news/magazine-34442302> (retrieved October 2015)

³³ Unpublished note on e-health technologies, 2020Health for Oglesby Charitable Trust, March 2014

Technology and Inequalities

Just as importantly, access to technology is ever increasing within the general population. The number of digitally enabled households and individuals grows daily. Stereotypes, for example of age, no longer apply.

The advent of smart phones in particular has placed enormous mobile computing power into the hands, literally, of all parts of society. A simple smart phone handset can be bought for £25, or even given away free, preloaded with a particular application, placing it within the means and abilities of the demographics focused on in this report – the weakest, the poorest and the most vulnerable. The lowest income countries in the world now use smartphones to deliver healthcare for hard to reach communities and the increasing penetration of mobile banking applications, for example, illustrates the potential for health-based applications. Simply put, mobile technologies are influencing the way people interact over health and support one another's health choices and behaviours. As these technologies cross social divides they have the potential to reduce health inequalities.

Connected Health

While consumer health technologies have focused on individual health and wellbeing, the opportunity and challenge is to develop these technologies for improving population health.

'Connected health' describes the new dynamic of patients connected to health professionals or indeed each other, in communities of learning and support. Many patients today describe how they have sought out and found (or even founded) self-help and support forums online or through social media.

This more sophisticated understanding of technology and its intentional harnessing is evident within the 'Experts in the Room' case study and the 'PatientsLikeMe' website. Both of these case studies show how established information technology is deployed to engage, enable and empower patients, with additional benefits for research and understanding of expectations and behaviours for researchers. These case studies reflect a picture of technologies helping people to interact more effectively to support healthier behaviours and better care. This means such 'connected' health technologies should not be considered in isolation as say a drug might be in a clinical trial.

It is clear then, that just as technologies cross social divides and behaviours, so too the underpinning technologies cross commercial and public sectors and their underlying behaviours. Consider again, how social media – reflecting the collective behaviours of thousands and millions of users – has disrupted relationships and changed practice within sectors such as politics, journalism and public relations. While this can be unsettling, it also offers real potential to public services frustrated by their inability to reach beyond the limitations of their service and influence the non-clinical drivers of health.

Where next?

This is still an emerging and rapidly developing space. Health and social care systems are facing a difficult climate of digital change. There is a tsunami of data, a blizzard of isolated uses of the data and a drought of big picture information.³⁴ There are thousands of different databases in the NHS and allied public services that constitute a ‘health system’.

Many questions present: can computers learn to interact with people in ways that encourage rather than irritate? At a community level, can networks of computers interact to support wellbeing in acceptable ways? And can these wellbeing technologies, without medical stigma, be linked into the NHS’ own information systems?

Manchester is well placed, via its early-mover activities such as Connected Health Cities and Connected Health Ecosystem, to drive innovation in this space. MancDev aims to link up its databases so that patient journeys can be followed across the conurbation. The Health North Connected Health Cities pilots now provide an important opportunity to design a ‘digital nervous system’ to analyse the data and optimise services in city regions.³⁵ How can Manchester translate its potential into real exports while tackling its own challenges?

A person centred approach

Therefore this report focuses on one such opportunity: to inform the evolution of ‘me’ into ‘we’ health technologies by modelling the person-centred approach found within the case studies.

A person centred approach or narrative offers a much-needed complement to the technology-led activities that currently dominate the landscape. This may be as much about the deployment of existing technologies in novel ways as it is about the development of new technologies. However, there needs to be more shaping of technologies around health problems, with an understanding of the underlying human behavioural drivers, before conditions develop, as much as technical assistance of clinical responses to conditions once they have developed.

Furthermore, health systems need to make sense of the complex data they are collecting. Such deep understanding requires public trust in the uses of the data – public involvement is a big part of the Connected Health Cities work. Indeed, increasingly, the data required to improve public health will be generated by the public themselves – so the social contract³⁶ to use personal health data for the public good needs to reflect a shared responsibility for health.

³⁴ See ‘Combining Health Data Uses to Ignite Health System Learning’, Ainsworth J, Buchan I, Meth Inform Med 2015 (in press)

³⁵ See ‘Health North Connected Health Cities’, HM Treasury, Budget speeches, March and July 2015

³⁶ Interestingly Manchester also has the right scale. The difficulties encountered by care.data suggest England is too big to forge this contract – but Manchester is well placed to forge its own. See ‘The social licence for research: why care.data ran into trouble’, Carter P, Laurie GT, Dixon-Woods M, J Med Ethics (2015 May); 41(5): pages 404–9

4.0 CONCLUSIONS: PEOPLE AS PRODUCERS OF HEALTH

The initiative for this report and the motivation of the Oglesby Charitable Trust is to address a disparity in health outcomes and improve the health of the weakest, the most vulnerable and deprived parts of society in Manchester.

Four simple, headline conclusions can be drawn from the case studies and the simple analysis offered:

1. The groups and individuals highlighted within the case studies demonstrate a sustainable, positive impact on health outcomes
2. Their approaches demonstrate they complement public health services and can work effectively alongside them
3. Small, inexpensive but significant changes to public service approaches would greatly increase the capacity, reach and impact of these groups
4. These groups and projects are formed from the essential ingredients of health as a social movement

Each of these is discussed in more detail below.

4.1 Demonstrating a sustainable, positive effect on health outcomes

Resilience and sustainability

The achievements of the individuals, charities, voluntary sector groups, professionals and businesses highlighted in this report should not be underestimated. In many cases, their founding, growth and longevity through different stages of organisational growth, often independent of government policy and despite changes in financial support, demonstrate a sustainability and resilience. It also demonstrates a leadership role in tackling a poverty of health outcomes and working:

- In some of the most challenging, deprived communities in the country.
- On some of the most stubborn problems for modern public health service delivery (long term conditions, demographic shifts and chaotic lives)
- With some of the hardest to reach people at every stage of life, through all major life events
- Demonstrating, albeit in different ways, their impact on individual lives

Repositioning people as producers of their health

The simple consistent assumption of each case study was to acknowledge the essential role of people as producers of their own health in the first instance, not just consumers of health services.

At its basic level, current approaches to health care are framed by the relationships between people, professionals and politicians. Power, that is the ability to act, and its sources (resources, knowledge and authority) lie to varying degrees between these parties³⁷. Each occupies well-defined passive and active roles. The patient has a problem, but lacks knowledge and resources, while the professional seeks to identify the problem and provide a solution.

However, the case studies adopt approaches that subtly challenge these assumptions; they encourage and allow different dynamics to develop within these relationships.

Note that the limitations to these approaches are not demographic or social but cultural (the attitudes of professionals) and technological (access to and literacy with computers).

Health care funding reforms in the US have prompted some specialist physicians to move from individual consultations to large workshops with well-defined patient groups. Patients receive the basic advice they need, but also benefit from hearing the questions others are asking and the solidarity of being with other sufferers. Likewise professionals are benefitting from the challenge and stimulus this provides as well as the insights that come from a collective response ('Hands up if you are experiencing the same symptoms').

Other case studies actively empower people, even before they become patients, and without reference to professionals or politicians:

This should not be surprising in Manchester – nor should it be unfamiliar. The shift in power to people and patients from professionals echoes the greater influence local bodies are being given over powers, resources and responsibilities traditionally held by central government departments. Both relationships are more than a zero sum calculation, redistributing finite amounts of resource and power. Both are an intentional enablement that seeks to empower to effect change.

³⁷ See, for example, 'Power Issues in the Doctor-Patient Relationship', Goodyear-Smith & Beutow, December 2001, Healthcare Analysis, Volume 9 Issue 4, pp 449-462

A ‘double-bottom-line’ of social and financial returns on investment

It follows that enabling production should have an impact on outcomes – and even a reduction in costs.

Some case studies, notably Place2Be, HomeStart, Hope Citadel and Yeovil4Family have developed quite robust models for tracking impact and savings to the public purse³⁸. These are both social and financial: a value to society and the savings to the public purse that follow from that. Crest in Falmouth, has provided an independently evaluated, whole community statement of financial impact.

The calculations of financial impact also point to a ‘gearing’ effect: a small amount of money goes a long way (in the case of the whole community intervention in Exeter, nearly four to one return). Conversely, withdrawing even small sums has a significant impact on delivery and is likely to increase costs and demand on services elsewhere in the system. Abraham Moss Side Warriors Junior FC had to reduce its membership by two-thirds when funding was withdrawn. Interestingly, the choice was made to ensure the quality of what was offered remained, rather than try and spread the jam more thinly.

A personal story, underpinned by a robust Theory of Change

A simple example is the theory underpinning the work of sports clubs: more activity and exercise increases fitness, helps manage weight and improves mental and physical health. Likewise healthy eating programmes in schools educate children and provide better food to improve health. However, in isolation, although these theories of change theories are sound, they do not address the choices and behaviours of people that are critical to their successful application. A different, more sophisticated theory is needed.

This is central to the question this report asks: are their consistent elements of the theories of change used within the case studies that successfully encourage people to take ownership of their own health outcomes? The five themes outlined in the previous section are consistent across the case studies: providing a safe place; treating people as whole individuals with strengths and assets, not just conditions; understanding the important influence of connections to others, especially family; taking action to influence their future and goal setting according to the things they value.

³⁸ Abridged case studies can be seen in Appendix 1. Full versions are available through the Oglesby Charitable trust website.

Together they point to a simple, personal health narrative, underpinned by a robust 'Theory of Change' to enable agency and personal production of health, and inspire personal ownership of or responsibility for health outcomes.

There are precedents for this kind of thinking, for example in the development of a birth plan with expectant mothers³⁹. This is rooted in an understanding of circumstance and pregnancy (Theme 1), the mother's choices and existing medical conditions (Theme 2), a choice of supporters (Theme 3), agency over delivery options and other choices (Theme 4) and scenario planning (Theme 5). Its importance is reflected in the midwife's duty to respect this where appropriate and practical during labour, the delivery and after care.

This approach can bring a constructive challenge to prevailing narratives about different conditions or life stages, old age for example. Current social narratives diminish the expectations and experience of this stage of life. They frequently, often unintentionally, define the elderly in terms of economic contribution to society (diminishing), as consumers of expensive public services, living longer lives (increasing) separated from society in the care of the state.

The personal health narrative offers a powerful counter to this. It unlocks the ability of older aged people to define their own role, their expectations of independence in later life, their desire for company, preferences for end-of-life care and more. This is evident in the Debenham case study and the work of Manchester Carers and provides a consistent framework for incorporating thinking about living longer, better lives with greater independence and inter-dependence.

³⁹ It is interesting to note that an expectant mother may not consider herself a patient, although she may be using professional support and clinical services for a natural life event. See comments on 'over medicalisation' in preceding sections.

4.2 Complementing public health services and working effectively alongside them

Section 3 highlighted the contrasting approaches of case studies and public health services, as well as the ways in which their work complemented and could or is working successfully together.

Beyond the reach of public health services

The limitations of public services in reaching some parts of society and tackling behaviours versus addressing clinical conditions are a real but inconvenient truth for those vested in a traditional public service world-view. Public services have been hugely successful in improving lives and tackling public health problems in society over the last century. However today's problems are impervious to these established approaches; they lie entrenched in pockets of society, presenting new challenges such as influencing behaviours and responding to demographic changes.

The strengths of the voluntary sector, principally flexibility, persistence and reach, are well known. As these case studies demonstrate, they are also able to work effectively beyond the reach of public services, changing behaviours, finding new approaches to demographic problems wired into the nature of society.

Using social metrics helps simplify complexity

Several of the case studies demonstrate that approaching individual circumstances through story and personal narrative⁴⁰ points to a way of making sense of complexity. By definition a chronological narrative highlights context and can embrace multiple conditions within an individual. Furthermore, it allows for problems and strengths, difficulties and opportunities, to be profiled however significant. It may also yield insight into triggers for conditions: the patient who presents for insomnia, turns out to be self-medicating through cannabis use, which is compounding respiratory problems, but is in fact a response to the stress of financial worries arising from an accident at work and a prolonged period of absence.

These 'unseen' aspects can form an important complement to the 'seen' world of the clinical. Indeed, this person centred approach has echoes of, but should not be confused with, personal budgets, or personal health records. While not satisfying a forensic or clinical standard of proof, they offer a way of reframing and re-presenting the challenges posed by complexity.

⁴⁰ See 'Creating new value with patients, carers and communities', KPMG 2014, <https://www.kpmg.com/Global/en/IssuesAndInsights/ArticlesPublications/what-works/creating-new-value-with-patients/Documents/creating-new-value-with-patients.pdf> (retrieved August 2015)

A community leadership role

Public services have long been perceived as leaders within the community. A key role of leadership is sense making. Developing a personal story with a patient, or service user/client reinforces this role, offering people a way of making sense of their own condition. In doing so, the group or professional or business owner helps deliver a leadership role within the community.

For the patient, making sense of their condition and situation is a key step to taking ownership of health outcomes. This was evident in a number of case studies, notably Hope Citadel, Yeovil4Families and the Mustard Tree. This is more than education through information about the science or physiology of their condition, it empowers their decision making about the precursors to poor health and brings awareness of the influence that they can exert over their own health outcomes, the control they have over their destiny.

The importance of values

At the heart of these conversations are values – what is produced, by whom and how it is valued. **A healthier future holds real value for people.** It is the chance to shape ‘my’ story and give it an ending that ‘I’ value. However, fluency with the language of values and understanding their importance has been lost, eroded, or undermined in many aspects of public services. Why else reminders to care for patients?⁴¹

Values are what have driven the work of professionals for decades. They drive the work of people such as the Manchester Carers, and inspired the foundation of many groups included within this study. Some are overtly connected to church and faith groups for whom values are key – see the growth and importance of what is now Manchester City FC’s community work in ‘The Spirit of St Mark’s’. This is also reflected in the theme of ‘a safe place’: the place of worship offered and occupied by the church and other faiths is an important, often historical, fixture at the heart of communities. In the case of Christianity, this even defined original ward and parish boundaries that form the basis of our public administration.

Finance is not the key currency here, but value creation. However, reconnecting people with their health in this way has a beneficial effect on the economy – releasing the brake on the Northern Powerhouse. People acting with purpose for their benefit, in a way that also delivers a societal good.

⁴¹ See ‘High Impact Actions for Nursing and Midwifery: The Essential Collection’, 2010, http://www.institute.nhs.uk/building_capability/general/aims/ (retrieved August 2015)

4.3 Increasing the capacity, reach and impact of groups

A constructive response to the preceding conclusions is neither to ignore public services, or try and replicate voluntary sector qualities within them. A traditional view is that even where acknowledged, the strengths of voluntary sector groups and individuals are inaccessible, or too difficult to harness and deploy as public services.

However, the case studies demonstrate that they not only complement one another but can and do work together effectively. More than that, it is evident that with small, inexpensive but significant changes, there is good reason to believe that the impact of their collaborations on health outcomes can be extended greatly.

Developing a consistent framework of reference

It has long been a point of conflict that the language and measures adopted in public and voluntary sector work are different and apparently irreconcilable.

In simple terms, the language, measures and standard of evidence of one domain, such as traditional public health services viewed through a clinical lens, are not the same as those of another, such as a social movement. Best practice and good practice exist in both. But it is a mistake to judge and dismiss one domain by the standards of a different domain. Equally it is likely to be counter-productive to require or impose one to present itself in the language and with the standards of another.

The themes identified in the preceding sections offer the basis of a better understanding and communication between domains. They point to the possibility of a common framework for translating the work, findings and performance of social and clinical domains, reconciling priorities of wellbeing with health and placing them within a coherent Theory of Change.

Enabling scale and spread

The question of growth, scale and/or replication is often posed of organisations seeking to work with or alongside public sector partners. The assumption is again one of replicating public service thinking: scale and size are good from a national or regional systems approach.

Two groups who stand out in terms of their plans for growth are Place2Be and Kapoor Pharmacies' use of the Healthy Living Pharmacy model.

- Place2Be's very local, school by school, focus has placed them well to respond to national changes in guidance, requiring provision for the emotional well being of school pupils.
- The Healthy Living Pharmacy model, after piloting in pharmacies in Portsmouth, was quickly adopted by others, such as Kapoor Pharmacies, for its strong business model. It has demonstrated that it made commercial sense for the owners and good sense for the customers and is now being rolled out nationally.

However, most of the case studies had their own vision of the their future, the course and direction they were exploring and the obstacles along the way. A recurring obstacle was a lack of funding, but at least equal concern was given to preserving quality, culture, values and ethos.

Many groups framed opportunities in terms of improving effectiveness and increasing impact, rather than scale of organisation. HomeStart North Manchester speak simply of reducing the waiting list for their services, seeing their work in the context of colleagues in other HomeStart groups across Greater Manchester and the UK.

This raises a question of replication or spread. Salford Heart Care had experienced considerable growth through opportunity, only to find that it was unsustainable, having to close centres as resource was withdrawn and take up of the service was less than predicted. Their subsequent response has been to model their approach and set up a company vehicle, ready for development into a type of franchise operation. This would allow close (quality) control over proven ways of working, the ethos behind the way they work and leverage potential franchisees' access to funding.

An investment vs. cost approach to commissioning

Much of the political debate about health is reduced to an overly simplistic matter of finance. Sufficient public funds are crucial – but alone they do not guarantee effectiveness or success. As this report has sought to explore, there are many other factors in determining effectiveness or measuring success (e.g. see Section 4.1 and the ‘double bottom line’ impact.)

However, some case studies illustrate clearly how there are opportunities to invest in better outcomes. For example, a three-minute increase in GP patient consultation time by Hope Citadel (see ‘Hope and Healthcare’ case study, Appendix 1) is at the heart of far more significant improvements in health outcomes for their patients.

Taken in isolation this is additional cost, but in the context of the results produced, it saves the time and money of future service demands. This highlights the importance of what is commissioned, how it is measured and over what time frame and scope. Commissioning activity without thought to outcomes, misunderstanding impact over too short a time frame leads to poor service and use of public money. Mistaking the quantity of consultations for their quality, setting the wrong targets to drive inappropriate behaviours, ignoring hidden demand within communities, creating ‘waste’ in other parts of the system and not accounting for ‘the fruit that falls in another field’ all follow. Intelligent commissioning of effective services understands their impact on the individual, through the right measures, a wider understanding of wellbeing, a person centred approach and over the appropriate time frame.

Recent years have seen the development of new funding mechanisms such as payments-by-results and outcomes based incentives (the basis of Social Impact Bonds). These have helped foster good practice, as commissioners, funders and socially minded investors want to understand how their money will produce a particular outcome. The first health based Social Impact Bond (worth £1.65 million) was launched in spring 2015⁴². This is a reflection of the double-bottom line thinking identified in Section 3.1. The understanding of impact is crucial and at its heart is an investment versus cost savings approach to both commissioning of services and de-commissioning.

Small changes – significant outcomes

None of these steps are large – they reflect changes in approach more than direction and would be acknowledged by most as necessary and sensible. That is not to diminish the difficulty in changing thinking and cherished routines, practices or traditions.

Nor are they expensive. A framework if made available can be integrated or adopted with little additional cost. Investment is more about moving spend – with the challenges that decommissioning presents, especially where it can be seen to having impact (e.g. the additional consultation time required in Hope Citadel referred to above). A sensitive understanding of projects and their application and relevance to an area is intelligent design and sensible commissioning.

What is more, an early example of this combined approach – a new framework of thinking, innovative approaches to finance investment and understanding scale and spread – exists in the Well North project.

⁴² See ‘Ways to Wellness’ project by Bridges Ventures, <http://bit.ly/1W1T9pl> (retrieved October 2015)

Illustration: Well North⁴³

Well North is a new collaboration of Public Health England, the University of Manchester and other local partners aimed at 'improving the health of the poorest, fastest' across the North of England. Launched in April 2015, it is a bold innovation, combining public sector reform and community working. It was conceived and brought to commissioning by the late Professor Aidan Halligan, shaped by his experiences in delivering excellent healthcare to the homeless through Pathway.

The aims are simply stated: address health inequalities, improve resilience and reduce worklessness. Its approach echoes strongly the themes discussed within this report.

Great importance is placed on developing leadership, strengthening internal community networks and building local voluntary sector capacity. At the same time, the initiative promotes excellence and innovation in clinical services. Data analysis is used to surface hidden need ('making the invisible, visible') and target specific neighbourhoods; professional collaboration is fostered and a rigorous continuous evaluation of methods and approaches is embedded in working practices. One example of this combined approach is the encouragement of social prescribing.

At the heart of these relationships lie shared values of compassion and justice.

Great care has been taken to ensure an alignment of these values, and a sharing of risk, more than simple contractual obligations. GPs and Community Nurses are encouraged to take time to learn about the whole person. The same care has been taken to adapt the principles of the project to work through the local public services in an area to ensure effective delivery; more sculptor than cookie cutter in its approach.

This kind of hybrid public/voluntary sector initiative points towards what the NHS as a social movement might look like. The project has received central funding of £9 million, match-funded by local authority partners. It adapts to the strengths of different agencies as much as the needs of their different localities.

It is too early to comment on success of the programme, however, reaching beyond traditional institutions, deep into communities, working with and through local partners, mobilising local assets and addressing hidden needs all mark a step change in behaviours and understanding of the role of public health services.

⁴³ Millar Consulting was an advisor to Professor Halligan during the development of the Well North project (April to December 2014). See Briefing and Executive Summaries on the pages of the Manchester Academic Health Centre website, <http://www.mahsc.ac.uk/friends/well-north/> (retrieved September 2015)

4.4 Health as a Social Movement in Manchester

Building the bridge from both sides

It is not enough for public health services to manage and organise residents and the communities it sits within, changing them to be more like itself. Indeed, reforms cannot come from just the NHS; a bridge cannot be built from one side alone.

Simon Stevens' call for health to develop as a social movement represents an enormous challenge to established ways of thinking about health care and health economies. All concerned – producers (professionals), consumers (people) and politicians – are intellectually, culturally and financially invested in the status quo.

However the description of this space offered in Figure 4 (see Section 3.4) and the convergence of greater responsibility for people in decision-making with better systems understanding start to make sense of health as a social movement.

A 'social movement' is first social, the relationships and connections formed are central to its identity and impact. It must acknowledge and spring from the universal, underpinning relationships between people, professionals, politicians. These are what define the limits of current health care approaches. The 'fence' the clinician struggles to reach beyond is not just physical or institutional but relational, defined by these connections and the assumptions of roles created by them. These relationships bring an emphasis on the medical and clinical. These define service delivery and are based on what can be controlled and actions that can be taken by the professional. However they reinforce a needs based approach, an imbalance of power and control, unwittingly fostering a dependency and demands.

A 'social movement' is also an agent of change. It is dynamic, progressive, challenging to the status quo, mobilising people for its cause. It develops influence that reaches beyond spheres of control, affirms value and equality of power between individuals: aligns, engages and enables rather than disempower, foster dependence, control behaviour or coerce people.

Technological advances in communications and mobile computing enhance social movements. It reflects the creation of power within the professional public relationship, supports the repositioning of people as producers of their health and democratises knowledge. Applications on smart phones are an example of technology for people, not just professionals. In so doing, they illustrate a shift from people as consumers of health services to producers of their own health – a trend evident in retail and consumer⁴⁴ behaviours.

A movement is an inseparable part within the host society. The centrality of the family, and the close links between institutions, voluntary and community organisations highlight what the NHS as a social movement might look like: a network with multiple links between people, groups and institutions, connecting people and specialist health services via voluntary, charitable and familial intermediaries. A health movement might still provide free health care to those that need it, but a care nurtured by and springing from a society that still held onto the value that conceived it: good health.

⁴⁴ See 'The Journey to the Interface', Demos, July 2006,

<http://www.demos.co.uk/files/journeytotheinterface.pdf?1240939425> (retrieved August 2015)

Creating Public Value

For the state, the value lies in unlocking people's power to produce their own health and help others to do the same. The role of the state then changes subtly from one of health provider, on whom the responsibility for wellbeing falls, to health enabler, supporting, assisting and complementing our own responsibility for health and wellbeing. In short, a new public value proposition for health care.

This resonates strongly with the expression and statement of values that form the heart of any social movement. It also echoes the values that have inspired much of the work of the case studies within this report (see Section 3.2).

They attract people and organisations, holding them to the issue through difficult times. They reach beyond contractual and financial ties. They inform the journey, giving direction and helping navigate difficult choices. They offer important context for difficult decisions that are uncomfortable, even distressing, in the short term. They provide impetus and energy for the change to endure and persevere through transition, in anticipation of what lies ahead. They are also reflected at each level of the movement – in the actions of the GP, the community group, the family and the politician.

There are examples of this within the case studies presented. The creation and use of the Denton Patient Records ('Experts in the Room') illustrates how value identified by patients (in being able to trust the GP) is then created by the actions of the surgery (in promoting openness). The consequence is to build relationship, change the roles and dynamic of the patient and doctor, unlocking the patient's insights and increasing efficacy of treatment. This can also be seen as an echo of the devolution of powers from Westminster to Manchester. The changes in relationship enable greater local action and unlock additional capacity at a local level.

5.0 RECOMMENDATIONS: BUILDING A BRIDGE FROM BOTH SIDES

Practical, principled and robust recommendations are outlined here along with the actions to progress them. Together they respond to the original question behind this report: 'How can people be encouraged to take greater ownership of the factors that drive their own health outcomes?'

These recommendations are more than a list. They are coherent and linked one to another. Section 6.0 describes how these offer affordable, effective and deliverable responses, how they are consistent with principles of devolution and align with key personal, professional and political relationships.

1. Adopt the person centred health narrative as a simple, effective framework for the relationship between people and health professionals
2. Use the personal health narrative to recognise and promote the role of families, schools, housing providers and other institutions to improve wellbeing and health outcomes for the next generation
3. Develop guidance and financing mechanisms for Commissioners that use the personal health narrative to
 - a) Shape outcomes and align performance measures with personal and community instincts to care
 - b) Encourage development and deployment of person centred not technology led e-health technologies.

Integrating Health and Social Care

Importantly, the recommendations also offer a range of strategic and practical responses to the challenge of integrating health and social care. Placing the person at the heart of the recommendations is the key to shifting from consumption of health services to production of health. This also serves to empower those dispossessed within the poorest communities; activating patients and energising communities reduces demands and addresses aspects of wellbeing.

Broadening the responsibility for health concerns beyond narrow clinical spheres makes the case for and creates opportunities for the greater involvement of other institutions such as schools, housing associations and others. Guidance for Commissioners further offers opportunities to revise incentives, enable supportive behaviours (such as social prescribing) and embrace innovative finance and delivery vehicles.

5.1 A personal health narrative

Recommendation 1

Adopt the person centred health narrative as a simple, effective framework for the relationship between people and health professionals.

Why is this important?

The evidence of Hilltop Surgery (see ‘Hope and Healthcare’ case study) points to the impact a story-based approach has on health outcomes and its usefulness within the GP patient consultation.

The relationship between patient and doctor has been described as the ‘heart of general practice⁴⁵.’ The patient consultation in particular is described as the ‘central act of medicine⁴⁶.’ Indeed, an estimated 400 million consultations are carried out each year in the UK. A person centred approach to health care and the consultation has been a conclusion and recommendation of numerous reports⁴⁷ and is recognised by the Royal College of General Practitioners as ‘an area of core competence’ for doctors⁴⁸.

Many models exist⁴⁹ to help make sense of the GP consultation and maximise the effectiveness of the few minutes spent in the consultation room. However while well positioned to have an impact on health inequalities, the GP is not equipped, encouraged or rewarded in training or practice to pursue this experience or develop this expertise⁵⁰.

⁴⁵ See ‘The Future Direction of General Practice: a roadmap’, Royal College of General Practitioners (2007) page 11, http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/the_future_direction_rcgp_roadmap.ashx (retrieved September 2015)

⁴⁶ See ‘The New Consultation: Developing doctor-patient Communication’, Pendleton, Schofield, Tate, Havelock (Abstract), <http://oxfordmedicine.com/view/10.1093/med/9780192632883.001.0001/med-9780192632883> (retrieved June 2015)

⁴⁷ See ‘Sustainable Healthcare’, College of Medicine, page 20, http://www.collegeofmedicine.org.uk/wp-content/uploads/2014/08/sustainable_healthcare_pdf_report.pdf (retrieved June 2015)

⁴⁸ See ‘Consultation in Practice’, RCGP, page 9, <http://www.rcgp.org.uk/GP-training-and-exams/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-2-01-GP-Consultation-In-Practice.ashx> (retrieved June 2015)

⁴⁹ See ‘The Essential Handbook of GP Training and Education’, Mehay, Web Chapter 4, http://www.essentialgptrainingbook.com/resources/web_chapter_04/04%20consultation%20models.pdf (retrieved June 2015)

⁵⁰ See ‘Tackling Inequalities in General Practice’ Hutt and Gilmour (Kings Fund, 2010), Executive Summary

How does it achieve this?

The personal health narrative, identified from within the case studies presented (Appendix 1 and developed in Section 3.0) demonstrates a good overlap with guidance offered for the person centred care approach to the GP consultation. This is described in some detail in Appendix 3.

Framing the GP patient consultation with the personal health narrative immediately addresses an implied disempowerment within the inequalities narrative, empowering patients as co-producers of their own health. This highlights the opportunities and responsibilities of the patient to influence and act upon their own health.

This in turn facilitates a patient led vision of the future, defined by the things they value, but informed by the doctor's agenda: the person's ownership of health outcomes (see the Focused Care approach of Hope Citadel in the 'Hope and Healthcare' case study that has at its heart the idea of helping patients tell their story – and the outcomes for this approach evidenced within the surgery statistics.)

This extends naturally and easily beyond the individual GP and consultation room to influence the way the Practice perceives itself and its position, role and activities within the community. Hope Citadel, for example, has sponsored a local football team, started a choir, holds public fun/open days, celebrates individual patient achievements etc. In the words of one expert, such an approach is 'tantamount to saying doctors and patients have to stop being doctors and patients and start being citizens together'.⁵¹ This has particular importance in communities with low social capital and the characteristics of deprivation. As Dr John Patterson, Clinical Director at Hilltop Surgery remarked:

"For some of the patients, this is the first time they have ever received a certificate or award for anything in their life."

Although they are not developed here, it should be clear that the principles of a personal health narrative can also be extended to the interactions between patients and other health care professionals, including nurses, health workers, social care workers and mental health workers.

Two further professional relationships illustrate this. Community Paediatricians for example, are very aware of a family's story – particularly in the case of disability. Narrative is also important in the work of Nurse Specialists supporting those with chronic illness – for example working with children and young people with Type 1 Diabetes. In both cases, the challenge is to empower people, helping them realise that lifestyle changes are within their power and that their own expectations will have an influence on the outcomes they see.

⁵¹ Dr Atul Gawande, quoted in 'In Praise of Medical Heretics', Nurture Development, February 2015, <http://blog.nurturedevelopment.org/2015/02/19/in-praise-of-medical-heretics-in-search-of-more/> (retrieved April 2015)

What's Next?

Three actions to consider are:

- **Health and Wellbeing Boards (the Greater Manchester Prevention and Early Intervention Board), Clinical Commissioning Groups, Local Authorities and GP Surgeries adopt the personal health narrative for working in deprived communities.** Adopting a systematic approach such as the personal health narrative across surgeries within a deprived area would make it possible to evaluate its impact in a robust way with limited up front cost for training and preparation of tools. In Manchester this accords well with the Place Based Agreement for Public Health (Memorandum of Understanding).
- **The Equalities and Diversity Committee of the NHS can review the personal health narrative as a part of its culture change agenda for the NHS.** At the heart of the framework is the representation of individuals and their connections to others. This is a hugely powerful tool for enshrining diversity and ensuring equality of opportunity within health organisations and aligned with any wider health movement.
- **The Royal College of General Practitioners' Health Inequalities Working Group review the personal health narrative as an aide for the training and practice of GPs, particularly in areas where health inequalities are high.** This could focus on evaluating the usefulness of such an approach, tools and training for its deployment and appropriate measures for monitoring performance.

One benefit to this approach is opening up issues of wellbeing and the broader context of health. This has obvious importance to the diagnosis and prescription for the patient, creating opportunities and context for practices such as 'social prescribing'.

At present, a particular challenge to this lies in increased consultation times (discussed in Section 4.3). Evidence from Hilltop Surgery supports a three-minute increase in consultation time for a similar, albeit informal, story led approach to consultations. As the RCGP note in their guidance⁵² for consultations:

"Consultations are time-constrained. Longer consultations tend to be associated with better health outcomes, increased patient satisfaction and enablement scores. However, your clinical effectiveness depends on effective consulting skills to ensure that whatever time you have with the patient is used efficiently, rather than consultation length per se. ...if you don't spend sufficient time discovering the reason for the attendance and your patient's expectations of the consultation, then your management plan is less likely to be appropriate, and patient safety and satisfaction may be compromised."

⁵² Op Cit, page 5

This point of balancing a measure of inputs with outcomes is considered in the next recommendation, Guidance to Commissioners, below.

- **Community Nurses, Community Paediatrician's or Nurse Specialists adopt the personal health narrative for development and evaluation with well-defined client groups.** This might include community clinic settings for vaccinations, parent workshops for understanding issues of infant development, or even condition based specialisms such as Children and Young People with Type 1 Diabetes, for whom empowerment and participation in treatment regimes are essential for progress and good outcomes.

5.2 The role of families, schools, housing and other care providers

Recommendation 2

Use the personal health narrative to recognise and promote the role of families, schools, housing providers and other institutions to improve wellbeing and health outcomes for the next generation.

Why is this important?

Healthcare must move beyond health services. Rising costs, changing demographics and the inadequacy of current provision to address non-clinical determinants of health and provide for mental health and wellbeing make this imperative.

Simon Stevens' response – the rethinking of the NHS as a 'social movement' – echoes this. The importance of an appeal that extends beyond service delivery, deep into homes and communities, driven by values, aligned with natural instincts to care and make decisions about our lives and future was discussed in Section 4.4.

Families, schools and housing providers, alongside surgeries, all emerged as key institutions in the case studies (see discussion of Connections in Section 3.3). Every case study drew these institutions into their work as essential partners. The case studies showed how schools ('Proof of the Pudding', 'A Healthy Profit', 'Close to Home') and housing providers ('Our House, Our Home, Our Health') have moved beyond their traditional roles, using their influence and the relationships forged with parents and tenants, to have a positive impact on health and wellbeing outcomes.

How does it achieve this?

First, adoption of the personal health narrative offers an intentional challenge to the narrow assumptions about where responsibility for good health sits. It firmly positions a home, an education and a stable family life as important contributors to wellbeing and long-term health outcomes. As was noted in the discussion of mental health and wellbeing (see Box Out in Section 3.2), the long-term mental health and wellbeing of children is of huge importance to the individuals concerned, their families, society – and the cost of delivering expensive public service support.

At the same time, positioning the person as a producer of health opens up new opportunities for other institutions to see where and how they can support and encourage residents as producers of their own health.

Families

The case studies identified a key role for the family – a form of hyper-local social institution – in the wellbeing of people (Section 3.3). Whether it was the support of family members in the weight loss programme at Sale Sharks, the involvement of parents in school activities at Cheetham Primary, bringing families into schools through Place2Be or HomeStart and Yeovil4Family’s work offering direct support to strengthen families, the family always had a key role, for good or ill, in the story and recovery of people involved in the projects. A good example of this is the work of the charity, OnSide, whose staff can form strong links with families where invited, helping ensure that the impact of their work with the young people is supported in the home. This is no surprise and resonates with a large body of work exploring the impact of health workers supporting families⁵³. It should be a matter of good practice therefore to consider, as these projects did, the family context, and actively seek to accommodate and involve them.

Schools

The agreement between parents and schools over the education of children is the basis of the relationships formed. This forms the key opportunity for influence and support. It also has a critical role in shaping the behaviours of the next generation and their health outcomes. Viewing these through the lens of the personal health narrative unlocks their role in promoting better personal health outcomes. The impact of this on a Home-School Charter is explored in Appendix 4 (Figure 8).

Manchester Communications Academy offers an outstanding example of a school integrated within a community. Traditional boundaries and obstacles to integration and close working are diminished to the extent that the building and its facilities are used outside traditional school hours, well into the evening and on weekends, and residents of all ages participate in their own activities, on school premises, even within school hours.

The personal health narrative acts as an effective lens for these activities giving the approach an intent and focus: to improve the health of residents and promote ownership of their own health outcomes.

⁵³ Op Cit, College of Medicine, Page 40 for case studies in Wales and Brazil.

Housing

Likewise there is an unrealised potential for the health of tenants to be improved by regarding the Tenant Agreement with a housing provider through the same personal health narrative lens (also discussed in Appendix 5, Figure 9).

This is a considerable shift in thinking for the majority of social housing providers, beyond simple house and balance sheet building, to creating homes and influencing lives for the better. Great Places is starting in the right direction, by building from a strong sense of ‘place’ and developing relationships with tenants.

Application through other institutions

The three examples of important public sector relationships given here – the GP consultation, a parent-school agreement and tenant-housing provider agreement – illustrate the portability and flexibility of the personal health narrative. This makes it a potentially powerful tool through which almost any existing relationship can be reviewed. This will give every institution access to participation within a social movement for health. Even more than that, it creates a common framework through which institutions can move beyond their service ‘silos’, coordinating actions, resourcing and performance against an intentional approach to change.

This is a challenge to established service delivery ‘silos’, with problems of responsibility and reach. It might also be resisted as more work in times of less public money. However, at its most basic, a common framework has the potential to improve communication, collaboration and coordination between institutions and services. This can only reduce waste, increase efficiency and improve transitions. At a more developed level, it offers the basis of a seamless, single public service that is flexible and adaptable, centred on individual outcomes.

In short, this offers a simple and robust framework to consider the convergence and integration of health and social care services.

What's Next?

Four directions present for consideration by families, education, housing and other care service providers:

- **Department for Communities and Local Government includes improvements in mental and physical health and wellbeing outcomes as a success indicator within its Troubled Families Initiative data set.** The personal health narrative embraces the current set of indicators and would provide a constructive framework for family support and interventions – at the same time tracking positive mental and physical health outcomes.
- **Department for Education and schools adopt the personal health narrative for pupils to increase their agency over choices and health outcomes.** This offers a context with which they can understand the impact of non-health related matters and choices (such as relationships, confidence and identity) on their health outcomes. This also serves to introduce students to the notion of themselves as producers of their own health and wellbeing outcomes, with agency and influence over them, not just consumers of services there to 'fix you in the future'.
- **Housing Associations review Tenant Agreements and the relationship they hold with tenants through the lens of the personal health narrative,** as a way of driving better choices and improved health and wellbeing outcomes amongst tenants.
- **Department for Communities and Local Government and Local authorities adopts the personal health narrative as the framework for health and social care integration in devolved areas.** There is clear relevance of the narrative as a common framework that can embrace many different services to areas where new governance structures, funding and decision-making approaches are being implemented.

5.3 Guidance for Commissioners on delivering better health outcomes in poorer communities

Recommendation 3a

Commissioners use the personal health narrative to develop guidance and financing mechanisms that better align commissioning processes, objectives and measures.

Why is this important?

Commissioners not only provide funding, they have a direct impact on outcomes and create a challenging but supportive environment for them through the performance and management measures they adopt (see Section 4.3).

How does it achieve this?

The introduction of payments-by-results funding and other outcomes based incentives have required an understanding of how an investment will produce a particular outcome.

Use of the personal health narrative or alignment with its themes (and by implication its underlying Theory of Change) will increase the setting of outcomes, understanding of proposed interventions and opportunities for tracking performance. These all improve probability of better outcomes, and encourage an investment versus cost perspective.

Furthermore, over the last five years, considerable investments have been made into the development of social enterprise capital markets⁵⁴ fostering innovative approaches to financing and delivery vehicles. The intention is to access private capital that seeks to invest in projects and groups that deliver social ‘goods’. There is evidence⁵⁵ to suggest that these opportunities are maturing rapidly, with clear lessons emerging about what works, and what does not.

The conclusions of this report align with much of the rationale of such alternative financing mechanisms. Specifically, the report has identified projects that are doing a social good by improving health outcomes, reducing public service demands and doing so in well defined areas.

However, the limitations on public spending make it hard to release upfront investments. Nevertheless, alternative funds do exist, along with an irresistible imperative to change;

⁵⁴ See ‘Building a Social Impact Investment Market: the UK Experience’, UK National Advisory Board to the Social Impact Investment Taskforce, September 2014,

<http://www.socialimpactinvestment.org/reports/UK%20Advisory%20Board%20to%20the%20Social%20Investment%20Taskforce%20Report%20September%202014.pdf> (retrieved September 2015)

⁵⁵ See ‘Choosing Social Impact Bonds: A Practitioners’ Guide’, Bridges Ventures and Bank of America Merrill Lynch, October 2014, <http://www.bridgesventures.com/choosing-social-impact-bonds-practitioners-guide/> (retrieved July 2015)

reference the ‘burning platform’, ‘demographic time-bomb’ and other metaphors for the crisis facing public services.

What's Next?

Three clear opportunities for Commissioners follow from this recommendation:

- **Develop and deploy the personal health narrative as a tool for Commissioners, aligned with the Commissioning Cycle.** The personal health narrative offers a framework, and could form the basis of, practical guidance for Commissioners who must identify outcomes, understand how they are developed and identify the leading indicators that will track them. This monitoring in turn informs a richer set of performance indicators and the tools for managing delivery and performance.
- **Develop and evaluate the underpinning Theory of Change.** This work has commenced separately and has a projected publication of early 2016.
- **Develop a health outcomes financial bond for targeted communities.** This report presents local health and public sector Commissioners with the outline of an alternative funding approach described by:
 - Targeting well defined problems and areas (by postcode)
 - Examples of whole community interventions and cost saving modelling
 - An existing network of interventions with a measurable impact on health outcomes in similar areas, on similar problems
 - Guidance on characteristics of successful interventions
 - A framework for commissioning, monitoring and managing responses

5.4 Technology enabling people as producers of their health

Recommendation 3b

Commissioners, funders and institutions use the personal health narrative to guide the development and deployment of e-health ('connected health') technologies in support of the resident as a producer of health.

Why is this important?

Section 3.6 outlined the opportunities and importance of a person centred influence on the development and deployment of e-health technologies. The personal health narrative offers just such a broader health and wellbeing framework for innovation pathways and product design.

How does it achieve this?

The personal health narrative and the themes within it complement three dominant development perspectives: technology led (i.e. new features and capabilities looking for application), health led (i.e. condition or treatment specific developments) and consumer led (i.e. driven by spending and design, not necessarily those in greatest need, or those with limited access to resources). It equips developers and academics with a framework for understanding the underlying behavioural drivers, before conditions develop, as much as a response to a clinical understanding of the conditions once they have developed. This wider view also opens up possibilities for the application of existing technologies – but in new ways.

For example, the principles within the personal health narrative mean it offers constructive challenge to existing thinking and service patterns. It ensures innovators and developers will also consider a premise of 'What innovations will help people as producers?' rather than reinforcing assumptions or assertions that 'This innovation will help patients as consumers'.

What Next?

There are three actions to consider:

- **Commissioners can use the personal health narrative to harness their deployment of health technologies in support of the different themes within the personal narrative.** For example, the case studies deploying technology reflect the potential for improving social connections, supporting healthier behaviours and enabling better self-care. Social media campaigns are engaging with residents to 'tell their stories' and generate the stories of local places. The framework explains the value and relevance of such an initiative and helps place it in the context of the personal health narratives developed with the GP (reference 'Hope and Healthcare' case study).
- **National Health Institutions with responsibility for (or a sector led interest in) strategic oversight of health technologies can lead the direction of e-health development by conducting a sector wide review of e-health technologies,** identifying opportunities to encourage the resident as producer of health, for example using the lens of the personal health narrative (see Section 3.6).
- **Manchester University in conjunction with relevant partners host an international technology and health inequalities conference** (late 2016) to introduce the personal health narrative and frame/initiate a conversation with e-health vendors, suppliers and developers. Issues such as wellbeing, generating public value, a refreshed social contract and mass public participation can all be identified within streams. This would demonstrate the sector spanning remit of this work (academia, private, public sectors) and focus and showcase Manchester's role and lead to address this through its potent combination of governance, industry and academic leads.

6.0 HEALTH GENERATION

6.1 A Social Movement

Together these recommendations set out a political challenge: testing the value of health, the expectations of the public and redefining services around these. Acknowledging such a conversation, with residents, on the health and wealth of Manchester will help define the next generation of health care within the city – and possibly across the nation.

The pieces are in place

Stevens' call for a social movement was not an incitement to take back or even take to the streets. A true movement may develop quickly but must have the right conditions to develop. Importantly, the environmental factors⁵⁶ needed for the development of a social movement around health are in place:

- A communications network that can be co-opted. Social media is ubiquitous and provides a co-optable communications network. The access to information it offers represents a democratisation of knowledge and will result in a shift in power within traditional relationships and is already reforming retail.
- The pressure for change. A growing concern over austerity, the impact on public services and the devolution of powers over key services to local areas is putting pressure on local politicians. For many these present a crisis and threat to them, their homes and loved ones, or even the services they rely on. These form a compelling pressure for change.

The measures outlined in this report question traditional assumptions about the role and responsibility of residents in producing the health and wealth of their place – and Manchester as a whole. Any such change would amount to a new understanding (the 'social contract') between residents and service providers.

This renegotiation is no surprise. Each of the case studies highlighted within this report negotiates with participants the expectations upon them. They agree, sometime explicitly, on who is responsible for what actions and outcomes. This negotiation is also picked up in the agreements highlighted in Appendix 4 concerning the education of a child and provision of a roof over residents' heads. Existing, formal relationships such as the Home School Charter, or Tenant Agreements are an opportunity to reinforce the role of resident as a producer of their own health, their child's and their family's.

However, this central assumption must be negotiated at a neighbourhood, community and society level. It is essential therefore that a conversation is started with residents about the changes and the opportunities these present, as well as the challenges that lie ahead.

⁵⁶ See 'On the Origins of Social Movements', Freeman, first published Longman 1983, <http://www.jofreeman.com/socialmovements/origins.htm> (retrieved June 2015)

This carries a challenging but honest, simple but profound message for politicians and administrators. It describes a modified role as broker and enabler, not simply provider or producer. It seeks to create the context within which a personal health narrative makes sense. It is more akin to making the weather, not simply trying to produce more umbrellas.

Local, regional and national politicians each have a crucial and unique role in this negotiation. Changes to institutions, policies and practices will always face resistance from vested personal and professional interests, those for whom the reality of change is more threatening than the eventual outcomes. However given the right context and contained within the democratic process, it is an orderly process. The context for these reforms is already being shifted. Devolution is shifting the big national tectonic plates beneath a complex and plural local health administration landscape. The effects can be seen in emerging plans and strategies, such as 'Living Longer, Living Better'.

Eventually, as the personal health narrative starts to unlock people's assets, energy, motivation and ownership, it starts shaping a conversation within communities themselves. Traditional efforts to reach out into communities through education and information work to a degree but a 'push' approach is expensive, limited and never as effective as creating a 'pull'. Salford Heart Care and Debenham Dementia Care have been impactful precisely because they have taken the initiative.

6.2 Will these recommendations work?

A further, final challenge presents: will the recommendations be effective?

Coherence

The recommendations have a strong internal coherence. They follow from observations and evidence that has been developed with a clear methodology and assumptions. The full case studies are available for inspection, study, challenge and the development of further recommendations.

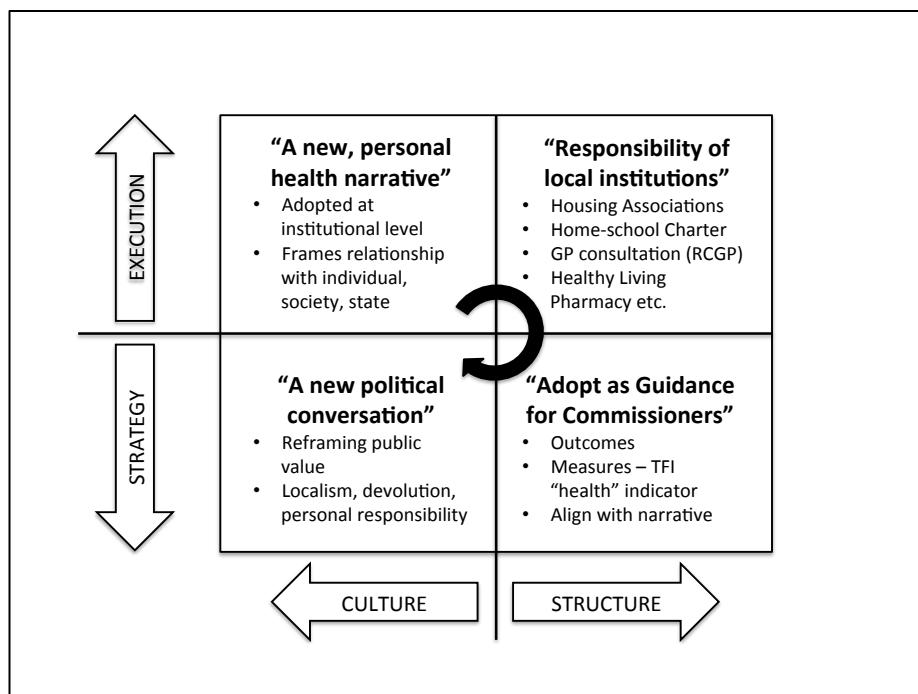
More than that, the recommendations also align with established principles for institutional and organisational change.

Culture Change

It is often stated, 'The NHS is an idea, not an organisation.' Indeed the complexity of bodies, duties, responsibilities and interactions is bewildering to many within the NHS. However,

A study⁵⁷ of successful interventions in corporate growth and performance identified four primary areas – strategy, structure, culture and execution – that interventions must address to have a lasting impact. Secondary areas were identified including leadership and innovation. These areas all feature within the analysis and discussion in this report and the development of the recommendations. The relevance of the recommendations to these key areas are shown simplistically, in Figure 5, below.

⁵⁷ Review of effective management interventions in 'What Really Works', Harvard Business Review, July 2003, <https://hbr.org/2003/07/what-really-works> (retrieved May 2015)

Figure 5: Culture Change and Delivering a Social Movement

The figure shows how the recommendations address questions of execution (how to deliver change) as well as strategy (planning longer term changes). The structure for delivering it (who needs to be involved) is included as well as the culture or attitudes (of people) that influence public services in the long term.

There is clear relevance in each of these quadrants to the individual organisations within the NHS the assumptions on which their services are founded, the way they work with partners and patients, the limit of their actions, the restrictions on their resources and also their accountability for the outcomes they pursue. However, Figure 5 also suggests a wider relevance – not just within organisations that make up the NHS, but across and between them. It points to the idea of health as a social movement.

A personal health narrative is at the heart of the movement. People value their health and want to secure it; this narrative restates a personal ownership of health outcomes, beyond the traditional reach of public institutions. The narrative also reframes health in a wider context. This broader understanding of health and wellbeing immediately points to opportunities for a wide range of bodies to positively influence health outcomes – including those without existing or formal links with healthcare.

- For healthcare institutions, such as the GP practice: the use of the personal health narrative by the GP within the consultation (the ‘central act of medicine’) not only helps reinforce the personal ownership of health outcomes, but gives a framework for wider support such as ‘social prescribing’.
- Local institutions such as schools, housing providers, as well as existing healthcare providers are particularly well placed for this. They can play their part in creating a positive environment and supportive context for people to achieve better health outcomes. The narrative gives them insights on how they can act (e.g. greater community involvement). It also gives them a new lens through which they can view their central relationship with residents. For example, the tenancy agreement held by housing associations and the roles, responsibilities and expectations this sets by both parties to it. Or the agreement between parent/s and their child’s school (sometimes called a Home School Charter) sets out clear roles and responsibilities.

Together these first two recommendations guide front line **execution** and activity in the home and community.

Third, it is essential that the public sector commissioners adopt this perspective. The narrative also provides essential guidance, ensuring measures and outcomes encourage an environment that goes with the grain of what works, encouraging the broader context of health and wellbeing, preventing problems and reducing demands.

Together with the actions of groups and local institutions, the work of commissioners and administrators informs an effective delivery **structure** for supportive actions.

Finally, a wider discourse in society is needed; a conversation on what is health, responsibility for it, the work of communities and groups and the role of public services in enabling this. This is a question of **culture**, centred on an understanding of value and poses a challenge for politicians. Such a discussion reinforces the focus on people not systems and is important for resetting people’s expectations. Not only does it reinforce the personal ownership of health outcomes, it is consistent with the principles of devolution from central government to local government even further, in to communities, families and individuals.

Together with guidance for commissioners this recommendation forms an effective **strategy** from which a social movement can flourish.

Production and public value

Ensuring coherence and strong rationale for delivering change within the recommendations is only part of the story. It is also worth considering whether any effect will last or is sustainable. While this must depend on many factors such as political will, timing, resources etc. these recommendations also provide for important additional factors.

Key areas identified by Stevens include supporting individual and community health and wellbeing, promoting individual and community engagement, resilience and cohesion. These principles are woven through the evidence and recommendations presented in this report. Importantly, the change described by these recommendations encourages people to identify what is of value through personal goal setting, enables them to participate in achieving this and defines the role of public and other services as agents to help them do so. In this way these recommendations work with the grain of society and human nature.

Scalable

The simplicity of the core recommendation – a personal health narrative – unlocks scale through its universal application. It offers a building block that is irreducible and also scalable. It is simple, memorable and personal for the individual. It is also something institutions – schools, surgeries, housing associations or any other – can adopt and appropriate into their own thinking, approaches and operations to strengthen their relationship with people.

It is also something commissioners can replicate and use to inform their own process of measuring performance and progress, by designing in the values, relationships and activity of residents.

Deliverable

All too often health care reforms are slow. Note the delay in implementation of well-evidenced and common sense clinical recommendations, such as the 10 years taken to implement advice on delaying cutting the umbilical cord of an infant, or the 25-year delay in stopping the practice of X-rays for pregnant mothers.

However, these recommendations require little or no additional net financing, nor do they require legislative support. Commissioners can start immediately within the scope of decisions by politicians, institutions. Likewise professionals can act within the guidance of commissioners and individuals on taking ownership of their health outcomes.

The recommendations are non-prescriptive about implementation. As principles, they are neither exhaustive nor detailed, both of which must be considered and completed at a local level (reference Well North for an example). However, the Guidance for Commissioners discussed above includes the parameters that might suggest other forms of financial vehicle:

- Areas of deprivation and poor health outcomes identified by postcode
- Interventions characterised by the themes within this report
- Performance management tracked by metrics against the underpinning theory of change within the personal health narrative
- Outcomes and financial benefit informed by the personal health narrative

6.3 Health Generation

This report makes clear, the health of residents and the increasing pressures on public health services are defining questions for this generation. Further, this report makes clear that to release the brake on economic wealth generation, people must understand their own responsibility for their health. Such acts of ‘production’ happen long before they become patients, and consumers, or are encouraged to co-produce and/or co-design health services. In simple terms, most of us are producers of our own health to some extent before we are consumers of health services.

This responsibility is shared. It extends beyond ourselves to those around us, in our homes and families, on our streets and within our communities. It reaches out for those unable to help themselves. This report illustrates the breadth of imaginative and innovative expressions of care that exist (and others that are no doubt yet to be discovered or developed) within our communities. The case studies in these pages offer just a glimpse of this instinct to care and the energy at work every day in our cities. This is an instinct of care that is not legislated or mandated, but born in individuals moved to care and to act, who accept this shared responsibility.

It is also a responsibility to those who come after us. This report has highlighted the important – even life saving – work being done with children and young people with their families, in their homes and through their schools. It has shown how the principles informing the work of these case studies can be applied intentionally and effectively to existing relationships to transform wellbeing and health outcomes.

This is not a complete solution and there is much to do. In addition to the four recommendations, thirteen possible avenues of development and inquiry have been identified that different institutions and organisations within Manchester and nationally can progress.

But by looking beyond traditional services, this report starts to explain how strengths and abilities can be unlocked, wellbeing increased and health improved – before services are needed and alongside them when they are. It explains how the responsibility for ourselves extends to those around us and those who follow us. It is, perhaps, a step towards making health a social movement and embedding health production within the thinking, behaviours and habits of generations to come.

APPENDICES

APPENDIX 1: CASE STUDIES

The Case Studies that follow are fuller versions of the short summaries that appear within this report at Section 2.2. The unabridged versions compiled by the research team, can be found at the Oglesby Charitable Trust website (www.oglesbycharitabletrust.org.uk)

Case Study

- 1 The Gold Within
- 2 A Mile in Their Shoes
- 3 A Place to Be
- 4 Real World Relationships
- 5 The Proof of the Pudding
- 6 A Healthy Profit
- 7 Close to Home
- 8 Beyond the Walls
- 9 The Spirit of St Mark's
- 10 Handled with Care
- 11 A Healthy Home
- 12 The Heart of the Matter
- 13 Our House, Our Home, Our Health
- 14 The Balance of Power
- 15 A Meaningful Response
- 16 Hope and Healthcare
- 17 The Experts in the Room
- 18 Patients Like Me
- 19 Retail Relationship

Organisation / Project

- Love4Life
- HomeStart North Manchester
- Place2Be
- Explore, Straight Talking
- Cheetham Church of England Primary Academy
- Aspens Catering Services
- Manchester Communications Academy
- OnSide Youth Zones
- CITC, Sale Sharks RUFC, LCCC, Amaechi Basketball, Abraham Moss Warriors JFC
- Manchester Carers Forum
- Yeovil4Families
- Salford Heart Care
- Great Places (Northmoor Community Centre, Lev-Inspire), Connected Communities
- The Mustard Tree Project
- The Debenham Project
- Hope Citadel GP Practice
- Denton GP Surgery
- www.patientslikeme.com
- Kapoor Pharmacies

1. THE GOLD WITHIN

Love4Life, Leicester

Introduction

Vulnerable young women, often from deprived areas, are at particular risk of exploitation and abuse; this difficult truth was highlighted by recent cases of appalling abuse in Rotherham and Rochdale. High rates of crime, real and perceived physical threats, and substance misuse – which are particularly prevalent in deprived communities – have a profoundly negative effect on girls' health and wellbeing.

In such chaotic and risky social environments, how can young women take ownership of their health outcomes and feel empowered to assert control over their lives? How can community-led group support in areas of deprivation foster self-confidence and healthier lives?

Origins of the project

Love4Life supports vulnerable girls at risk of pregnancy and abuse. Launched by Trenna Hulley, a leader at King's Church Loughborough, it is an initiative of TwentyTwenty, a charity dedicated to helping disadvantaged and disengaged young people. TwentyTwenty has secured funding from large grant funders including Children in Need, and has developed a fund raising team.

Through group activities and one-to-one sessions, Love4Life promotes empowerment, independence and confidence. The project encourages a healthy self-image and an awareness of general and sexual health.

The project works with girls aged between 10 and 19, running four groups within housing estates in Charnwood, outside Loughborough. Typically the teens are under pressure to participate in sexual and gang-related activity; have limited contact with biological fathers; have limited support networks; see substance abuse and domestic violence in the home; and have few, or poorly defined boundaries.

Such pressures amount to a damaging, toxic environment that is harmful to their health and wellbeing. Self-esteem and aspirations are diminished, leading to risky sexual relationships, self-harming, opting out of school, developing substance addictions, and eating poorly.

Izzy Neale, is the Support Development Manager at TwentyTwenty:

"We hope that we are helping the girls in Love4Life to be happier, healthier adults and eventually mothers. We want to break the cycles of educational disengagement, anti-social behaviour and young motherhood we often see, hopefully improving the future for their whole family."

Connections and Partnerships

Love4Life maintains good relationships with social services, Child and Adolescent Mental Health Services, and the police. The project receives and gives referrals to these agencies as well as school nurses and family support workers.

Love4Life is advising on the Leicestershire Teenage Pregnancy Partnership's development of a Quality Framework for young parents.

Love4Life groups of around ten girls from a similar age meet on a weekly basis. The supportive peer group format crucially provides a safe environment.

Approach and delivery

Love4Life currently works with 70 to 80 young people each week and over the last year has supported more than 150 girls. The project operates in wards identified by the Index of Multiple Deprivation as priority areas for intervention.

Groups offer a diverse array of activities including dance, Zumba, art, gym trips, self-defence skills and cookery. Sessions on decision-making, online safety, pornography and relationships are also provided.

In addition to building confidence and skills, Love4Life aims to support girls in developing their aspirations. Neale gives an example:

"We encourage the girls to find the gold within – in other words, their potential. One girl was interested in cars but didn't even consider working with them as a possibility. We arranged a trip for her to see planes being made. For the first time she could see engineering as a possible career path, something she would be passionate about pursuing."

Love4Life also offers individual counselling sessions to girls who may not be ready to attend a group; these are helpful in supporting teens with complex and deep-rooted problems.

Success and outcomes

Love4Life has experienced considerable growth and success. Police have reported an 89% decrease in anti-social behaviour from the girls in the groups, and the number of offences has dropped by 82%. Self-reporting tools have demonstrated that the 95% of the girls now know what healthy relationships look like, and 86% have improved relationships at home. All reported a reconnection with school learning.

Love4Life has also had an impact on the girls' physical health, with 80% wanting to continue physical activity. Of the 87 young people who asked for support to stop smoking, ten have quit, and six stopped using cannabis.

One girl who had a positive pregnancy test went onto to finish college and has created a healthy, happy home for her child. Less quantifiable are health benefits from a 'feel good factor': confident girls who feel good about themselves are less likely to be in risky relationships, abuse alcohol or drugs, are less likely to become young parents, and will have better mental health.

Future plans and obstacles

TwentyTwenty hopes to establish a similar group for boys, and is in the process of expanding work to parts of Derby and Sheffield.

Conclusion

Love4Life represents a regular and sustained presence in the girls' lives, building a healthy self-image, fostering trust and friendships. The project demonstrates how establishing a supportive peer network can build confidence and skills, positively impacting on young women's physical and mental health and wellbeing. Grass-roots action at a family and community level can have a profound effect on girls' lives and futures.

2. A MILE IN THEIR SHOES

Home-Start North Manchester, North Manchester

Introduction

Children's first experiences are critical for healthy mental and social development – yet these early years are often the most challenging for parents. The pressures associated with early parenthood are exacerbated in areas of deprivation; parents often cope with little family support, facing additional social and cultural barriers.

Practical advice and support at a grass-roots level is extremely effective, particularly when offered by volunteers with real-life experience. How can parents be sustainably supported in their communities to ensure happy healthy lives for their children?

Origins of the project

Home-Start North Manchester (HSNM) empowers parents to build better, healthier lives for their children by drawing on the expertise of volunteers. Home-Start projects are based on the philosophy that parents equipped with skills and knowledge have an overall positive impact on the child's health, and that there is a strong link between the child's wellbeing and that of the family.

Children in parts of Manchester face particular challenges – their health is on average worse than in other parts of England, with 25,000 children in the region said to be living in 'severe poverty'. HSNM launched in 2007, and covers communities tackling high rates of unemployment, poverty and negative health outcomes. Four wards are above national average for black and minority ethnic groups, which can experience problems related to cultural and social barriers to integration.

Connections and Partnerships

HSNM has developed strong partnerships with several organisations including GMCVO, GM Probation and Public Health. The project is part of the BIG Manchester Partnership, an innovative service that addresses the impacts of domestic abuse, mental ill-health and substance misuse on children.

Connections are at the heart of HSNM's work: most of it is delivered by volunteers. Many of the volunteers have themselves received support from Home-Start, and this has proved a powerful and impactful dynamic, creating a strong sense of trust, resulting in confidence and independence for the new parents. Volunteers are trained to deliver weekly outreach and befriending sessions, which take place in the community or family home.

Approach and delivery

HSMN provides support and practical assistance to 120 families with at least one child under the age of five who has been identified as having additional needs, such as behavioural, educational or health-related.

Volunteers help families map out the journey they need to make in order to improve their confidence, make changes to their lifestyles and build better futures for their children. The project offers activities allowing parents to interact with their children, whilst also learning practical skills such as budgeting, cooking, and establishing routines. This is delivered for as long as is necessary – on average the process takes eight months.

It's a highly personalised, localised and responsive service, which is also very cost effective. The project's approach is founded on principles of early intervention and prevention, empowering families to take responsibility and assume control over their lives.

Peer support is crucial: volunteers are themselves carers or parents with lived experience. Unlike health professionals who have stricter areas of focus, this approach allows broader drivers of health to be embraced, such as the pressures of becoming a new parent, and the impact it has on existing family relationships.

"These volunteers are modelling the change they're talking about," manager Shelley Byrne says. "The intervention is taking place in the community, delivered by members of that community."

Success and outcomes

HSMN has seen significant and consistent improvement among service users, based on the organisation's own MESH (Monitoring Evaluation System HomeStart), a visual tool that examines the goals families set themselves.

By empowering parents and increasing engagement in their children's upbringing and wellbeing, parents are more likely to make better choices. They may be more likely to attend a health clinic, immunise their child and improve basic domestic routines. Home-Start demonstrates that crisis can be avoided and the dependence on statutory services reduced if families are given the right support and skills when it's most needed.

Future plans

Challenges facing HSMN include recruitment and retention of volunteers due to issues around access to childcare, and a low threshold for children's referrals can mean some children enter the service prematurely.

Conclusion

HSMN's peer-led approach and emphasis on forging meaningful connections both within the family and the wider community are fundamental to its success. By addressing the broader context of wellbeing and its determinants, the cost-efficient project empowers families to regain control over factors that determine the health and wellbeing of their children. It demonstrates that involving families in the process of self-development increases their capacity and resilience over the long term, reducing demands for expensive services.

3. A PLACE TO BE

Place2Be, Claremont Primary School, Moss Side

Introduction

Over half of long-term mental health problems develop during school age. Early intervention and treatment not only has a vast impact on a person's lifelong wellbeing, but it can also have significant economic healthcare savings in the long term.

Schools make attempts to address issues like trauma or mental distress, but teachers are ill-equipped to diagnose or cope with such challenges. Meanwhile the quality of statutory services supporting children's mental health and wellbeing is at best variable, leaving a significant gap in care.

What can be done within schools to effect illness prevention and build trust with young people? How can mental and emotional resilience be fostered in children to support them in being happy, confident and settled?

Origins of the project

Place2Be was launched in 1993 to develop mental wellbeing among children and support parents and school staff. The initiative is based on the premise that early support is crucial to building youngsters' resilience.

It has been estimated that around three children in every classroom have a mental health problem – this covers a wide spectrum ranging from anxiety and depression to Post Traumatic Stress Disorder and schizophrenia. Mental and emotional distress can have extremely damaging effects on children's confidence, relationships, learning and physical health.

Place2Be's services are available to around 90,000 children in 230 UK primary and secondary schools. The organisation's current annual turnover is £11.7 million. This is funded by schools (just over 50%), national government grants (15%) and the balance from trusts and foundations as well as continuous fundraising efforts (this year's goal is £3.5 million). This is equivalent to £130 per pupil or £26,000 for a school of 200 pupils.

Place2Be has been working with Claremont Primary School since 2008. The school, based in Manchester's Moss Side, has a highly diverse and transient population. Many children have experienced the emotional upheaval of being uprooted; some from war zones, and several of the young people are coping with severe emotional trauma.

Connections and Partnerships

Place2Be works within the school, collaborating with teachers to support the curriculum and devising sessions such as successful transitioning to secondary school. The project also has strategic links with Action on Addiction and Achievement for All.

Developing open relationships with parents is also fundamental to how Place2Be works. The project occasionally encounters resistance from parents, sometimes based on differing cultural attitudes towards poor mental health, and tackles this by frequent, consistent contact and information. Parent counsellors are also employed specifically to offer additional support for fellow parents.

Approach and delivery

Place2Be offers counselling and therapy for children, helping them establish and develop their sense of wellbeing. These take place three days a week in the school, and are delivered by trained and volunteer counsellors. Lunchtime 'Place2Talk' drop-in sessions allow pupils to discuss surfacing problems. Headteacher Pauline Dempsey is clear on the benefits:

"Place2Be brings me reassurance that trained professionals are here working with an evidence-based approach, giving ongoing support to the children and the school community. They are dedicated solely to this work rather than teachers trying to do both."

Being within the school allows Place2Be to form trusting relationships with children, reinforcing key notions of a safe space. The project normalises matters of mental health and wellbeing and removes stigma of challenges, with parents, teachers and children all encouraged to openly discuss problems.

Within therapy, children are not 'treated' with a prescribed approach for specific difficulties. Rather the sessions focus on stepping-stones to wellbeing – building confidence, resilience, concentration and communication. Sessions take an integrative, child-centred approach enabling freedom of expression without undue interference or demands from the counsellor. Play and creative activities underpin sessions. Children communicate using symbols or metaphors to address issues that may be overwhelming or difficult to understand.

The core issues facing pupils have remained largely consistent over time; these include relationships and emotional problems. The project is also aware of the need to respond to newer emerging issues such as self-harming and cyber bullying.

Success and outcomes

Nearly one-third of the school population (24,757 children) accessed Place2Talk drop-in sessions. Approximately 3% requested one-to-one counselling. More than half of those children, who were deemed high-risk on the SDQ scale, were re-classified as low-risk at the end of the sessions – which is considered 'clinical recovery'.

Over eight in 10 children upset by their difficulties said things had improved as a result of counselling. 79% of parents reported the same changes. Teachers said that 65% of children whose difficulties had disturbed classroom learning, and 70% whose behaviour had been significantly challenging to teachers and their classmates, had improved.

Place2Be's work is overseen by the Research Advisory Group and the Child Outcomes Research Consortium (CORC), which have found their results to be 'significantly better' than other groups working with young people.

Future plans and obstacles

The increased government focus on providing for school pupils' emotional wellbeing ensures Place2Be projects are in demand.

Place2Be has begun research into the mental health outcomes for children whose parents are receiving parent counselling and are exploring possibilities for tracking long-term adulthood outcomes for those who have engaged with Place2Be as children.

Conclusion

Acting early and normalising the conversation about mental and emotional wellbeing creates a supportive environment that is crucial to developing children's resilience and confidence, as well as tackling existing mental health problems. Place2Be offers a familiar and localised service where high-quality meaningful relationships are fostered. Lifelong mental wellbeing can be promoted, and the financial burden of long-term mental healthcare prevented.

4. REAL WORLD RELATIONSHIPS

Explore; Straight Talking, South East/Nationwide

Introduction

The national school curriculum is sorely lacking when it comes to teaching young people about healthy relationships as a proper context for sex and understanding pregnancy as a teenager. Teenagers raising children of their own face additional health challenges, often exacerbated in single-parent families. Children born into an environment where their young parents are ill-equipped to deal with parenting challenges are more likely to have worse health outcomes in the future.

But support and guidance can counteract some of the short and longer term issues. In encouraging young people to consider both healthy relationships and the real implications of becoming a parent at a young age, advice and knowledge should be imparted in a way that is authentic, realistic and non-patronising – and crucially, offered by their peers.

How can the real-life experiences of young parents be effectively used as a positive, genuine resource to educate teens about the realities of parenting, whilst also empowering the parents as educators?

How can realistic, supportive relationships be effectively modelled and discussed in the classroom? And what impact can this have on health outcomes for present and future generations?

Explore

Explore is a charity which educates students aged 15 and over about the reality, value and possibility of long-term relationships. Explore was established in 2000 and comprises 10 staff and a team of 60 volunteers. Funding is through charitable trusts and private donations. Schools make a contribution to the cost of sessions, typically just £2 per pupil to cover travel costs. The charity operates in schools across England, serving more than 70 schools and 6,000 young people each year.

Explore recognises the benefits of good relationship on emotional health, and conversely sees relationship breakdown as a source of disruption, emotional stress and something that is avoidable, even when difficult times come. The charity aims to provide a counter-point to the relationships shown in the media and popular culture, which are often simply portrayed as romantic, sexual, dramatic and short-lived. These stereotypes are compounded when a young person's only experience of relationships within their day to day life is negative, without any role models at home or within extended family. The project illustrates the values and benefits of stability and commitment.

The Explore approach complements the conventional curriculum. Classes of young people aged 15 to 18 meet and question married couples who provide authentic examples of lasting relationships. The encounter helps young people explore how character and values inform behaviours that impact on relationship and wellbeing.

The volunteer couples, usually over 50, are honest and upfront during sessions, with no pre-determined message or script. The hour long sessions, within a half-day programme encourage students to discuss issues around relationships, such as choosing a partner, sex, ill-health, infidelity, disagreements and infertility. Students reflect on the couples' behaviours, values and treatment of each other.

Key to this approach is that sessions are collegiate, with the topics, pace and depth of discussion determined by students. The authenticity of the questions and responses, encouraged by near-anonymity of the couples being questioned, fosters a strong sense of openness and curiosity.

Explore's volunteers also highlight the links between good relationships and health. They explain how a partner offers someone to talk with about health worries, normalise fears and prevent hypochondria – and how a good partner motivates healthy habits, taking care of yourself, eating well and exercise.

Explore's experience of reaching over 50,000 young people on the subject of long-term relationships has created an unparalleled insight into the lack of relationship understanding. Student feedback reveals good awareness of the issues that can damage relationships. They also reveal significant areas of ignorance about positive aspects of relationships and the resilience brought about by forgiveness, adaptation and tolerance.

Typically eight in ten students speak of a session in transformative terms, lessons learned that they intend to apply, of reassurance and a more hopeful view of the future. Nine out of ten students in the session observed rated the session good or very good. Eight out of ten said it had achieved all of its aims (to find out about the importance of lasting relationships, to learn about the importance of being married, and to pick up new ideas or thoughts about what makes lasting relationships). All said it had achieved at least one of these.

No cost benefit analysis has been conducted, largely as a consequence of the diffuse and long-term nature of any benefits. However, a closely related precursor to the approach, adopted by Marriage Care, and evaluated by the Department of Education demonstrated a social value of up to £11 for every £1 spent.

Straight Talking

Straight Talking is a small organisation that uses the powerful real-world experience of teenage parents to communicate messages about sex and relationships. CEO Hilary Pannack launched Straight Talking sixteen years ago to counter-act the additional health difficulties that young people face when they have children.

"Teenage mothers are three times more likely than older women to develop postnatal depression, they are more likely to die in childbirth and their babies more likely to have neonatal illness."

The organisation is funded by the Nationwide Foundation and the Lottery, and educates thousands of pupils in London, Birmingham, Surrey and Trafford. Straight Talking collaborates with local councils and community groups, and has a strong relationship with the Teenage Pregnancy Team in Barking and Dagenham.

Straight Talking offers classroom sessions for teenagers on the realities of parenting, as told by teenage mums and dads. Straight Talking gives a unique and authentic platform for honest conversation about sex and relationships – and open communication is key to the approach.

The central message is not that these parents regret having their children but that most would have preferred to have greater relationship stability and financial security beforehand. The intention is ultimately to reduce rates of teenage pregnancy through encouraging young people to truly understand the challenges of parenting.

Rather than traditional approaches of dictating to young people not to have sex or risk pregnancy, Straight Talking removes the taboo, gives the facts of what life as a teenage parent is like and empowers young people to make their own decisions.

Straight Talking's work in schools typically includes five weekly lessons with young people aged between 13 and 17. Sessions include a variety of activities: visualising telling their parents about a pregnancy, imagining accompanying emotions, the practicalities of being responsible for a baby, and a shopping activity with the budget of income support.

The voluntary peer educators delivering the sessions are aged between 16 and 25 – and one of the crucial aspects of Straight Talking is how it supports both pupils and parents.

In 2009, outcome measures suggested the course gave pupils greater awareness of parenting challenges. Following the course many pupils suggested the ideal age to become a parent as older than the age they had originally indicated.

Straight Talking may have contributed to a reduction in teenage pregnancy rates in a number of areas. Rates of teenage pregnancy in Kingston have reduced by 29% over the lifetime of the organisation. In Barking and Dagenham, rates have reduced by over 12%. This improves health outcomes for prospective parents – and the implication is their children will be healthier if they become a parent later in life.

Conclusion

Explore uses a simple, cost-effective but impactful approach to modelling supportive and loving relationships. Through open and honest discussion, students are empowered to make healthy choices in their own relationships, and encouraged about their prospects of long term relationship stability, impacting on their health and wellbeing.

Pannack says participating young people are often undervalued by society, they typically live in poor conditions, are under considerable stress when raising a baby, and experience stigmatisation. Participation in Straight Talking offers an alternative: an environment in which they can build up their self-esteem and sense of self-worth. This influences their choices over sexual activity, decisions about early pregnancy, leading to an improvement in their long-term health outcomes as a result.

5. THE PROOF OF THE PUDDING

Cheetham Primary Academy, Cheetham Hill

Introduction

Beyond its nutritional and health values, food has a powerful role in social relationships; it is often the centre of attention at community gatherings and can bring the family together at home. Food and cookery can be used to teach crucial nutrition lessons, but also to build relationships between families and strengthen links in the community.

How can a school use food to achieve these strong connections between families and communities? How resourceful and innovative cookery initiatives bring about improved health outcomes?

Origins of the project

Based near Cheetham Hill Road in Manchester, Cheetham Primary Academy places importance on food and its preparation; food is viewed as an essential part of life and an important tool for building relationships between families and within the local community.

Cheetham Hill Road is one of Britain's most diverse streets; over 30 languages are spoken within two square miles. The school has over 600 pupils; most are from minority ethnic backgrounds. The neighbourhood and school also face challenges associated with deprivation – unemployment is high and rates of educational attainment are low. The academy aims to create a positive community that embraces the students' diverse cultures, encouraging an active approach to learning.

Connections and Partnerships

Cheetham participates in the national scheme 'Families and Schools Together' (FAST), in which families are regularly invited to eat their evening meal at the school over eight weeks.

Family relationships are key to their approach and their aims. For example, fathers are encouraged to develop a habit of cooking with their children and the aim is for families to continue communicating and collaborating around such activities.

Approach and delivery

The school offers a wide variety of food and cookery-related activities. These are aimed at teaching the importance of healthy eating, while also developing confidence, curiosity and communication skills.

One programme covers four interlinked areas that give experiences across several creative disciplines. 'Cook It' encourages children to cook for themselves; 'Grow It' gets children to grow their own fruits and vegetables; 'Ask It' discusses a variety of topics to build children's powers of reasoning and decision-making; while 'Film It' develops children's familiarity with media and technology.

These sessions have been integrated with subjects on the curriculum. For instance a historical lesson is delivered by illustrating the impact of rationing on making a cake. As a result of combining cookery with Grow It sessions, pupils have grown rhubarb in the school garden to make a dessert. The lessons encourage balance and ownership over diet, giving understanding of where food comes from and how pupils are involved in the process.

The school has also launched a 'Come Dine With Dads' (CDWD) initiative, modelled on the TV show. Pupils' male role models (including fathers, uncles, brothers, grandfathers) sign up to take part in cooking sessions, covering a variety of dishes and healthy cooking techniques. The project is very popular and is consistently oversubscribed.

45 children have been involved with the sessions alongside their role models. 10 families, considered to be more difficult to reach, have been engaged, including those experiencing language barriers, separated parents, children with special educational needs, families experiencing domestic violence and those under Child Protection Services.

The cost of running CDWD is small. The original six-week block of CDWD sessions was funded by Zest, a Manchester based healthy living project. The cost of ingredients is now funded by the school and an optional donation from participants.

Success and outcomes

The food and cookery projects at Cheetham Primary Academy have improved understanding of nutrition, raised engagement and pupil attainment, and strengthened families. Children's confidence, motivation, behaviour and interest in learning has been observed to improve.

Thanks to the FAST programme, parent involvement with the school was found to increase by 400 per cent; parent-school contact increased by 31 per cent; and total parental involvement increased 111 per cent.

Future plans and obstacles

Both Ali McKernan, higher teaching assistance, and Jenny Wildgoose, assistant principal, describe Come Dine With Dads as an overwhelmingly positive experience, but admit there are challenges. It has been important to recognise that many children may not have a father or male role model to accompany them; in such cases mothers and grandmothers are able to attend.

Conclusion

The challenges of a diverse and deprived community have been used as keys to address the poor health outcomes in the Cheetham area and head off difficulties of divisions within the community. Good food is at the heart of this. Food is employed as a way of uniting fathers and sons, and bringing families and communities closer together.

6. A HEALTHY PROFIT

Aspens and Upton-by-Chester High School, Cheshire

Introduction

Encouraging children to eat healthily means providing balanced meal options, as well as educating them about food and nutrition. But to have a meaningful impact on young people's health, their attitudes must also be influenced.

The environment at school has a key role to play in this. How can schools promote and reinforce healthy choices through genuine and sustainable initiatives?

Origins of the project

Aspens is a national catering consultancy company working in schools, academies and universities. Established in 2008, Aspens' founders aimed to build an organisation that had a different offering to larger and more impersonal catering contractors. High-quality, personalised service with strong values are at the core of its brand.

In 2013, its fifth year of business, Aspens had 50 contracts, doubling to 100 in 2014. The company strives to offer a cost-effective service, and agreements are drawn up with the schools.

Aspens' view is that children should be engaged with food, interested in nutrition and empowered to manage their own diets. The company is working against a backdrop in which one in three British children is currently overweight; schools play a critical role in promoting healthy eating.

Connections and Partnerships

Families and communities are a part of the Aspens approach. Families are taught about the benefits of healthy cooking, creating ownership over the process of making food. At North Birmingham Academy, Aspens run community cookery workshops. Held for parents, these sessions offered the opportunity to cook easy-to-prepare healthy dishes alongside Aspens chefs.

Each Aspens service is integrated within the school, and strong collaborative links with staff are made. At each site a manager monitors the running of the service and has the freedom to develop new personalised projects that meet the needs of each school.

At Upton-By-Chester High School in Cheshire, service manager Vicky Davies' work with the food technology department began through collaboration with a motivated member of staff.

Approach and delivery

Beyond providing a nutritionally balanced meal, Aspens recognises the importance of its role in influencing the food choices young people make. The company provides a variety of healthy options to empower young people and have undertaken a number of tailored projects that promote the importance of food and the benefits of eating well.

In the kitchen Aspens promotes healthy cooking techniques such as oven-baking instead of frying, and omitting additional salt or sugar. Special offers are used to attract pupils' attention to the healthiest options in the canteen and to encourage them to try new dishes.

At Upton-by-Chester, a 'Smoothie Bike' allows pupils to blend healthy fruit and vegetable drinks by pedalling. A 'Ready Steady Cook' session, meanwhile, encourages students to experiment with ingredients, particularly vegetables that they might not otherwise try.

Aspens runs cookery classes for pupils as part of after-school clubs. Many schools have also run 'Uni Survival' sessions to teach basic cookery skills for older pupils preparing to leave school. These classes encourage pupils to take ownership of their nutrition and understand cooking as a skill for life rather than simply another subject in the curriculum.

Success and outcomes

Even where health is not an explicit focus of their work, through encouraging pupils to take an interest in their diet, to make choices and to take part in the processes of preparing and advertising foods, the work that Aspens does with schools helps young people develop positive attitudes towards nutrition and seeing meals as something to be enjoyed. The organisation is beginning to research the links between academic attainment and food choices.

Future plans and obstacles

A further facility with emerging potential to support health lies in the use of a contactless payment system implemented in many of Aspens' schools. This 'Cashless Catering' involves pupils using a pre-loaded card to purchase lunch. Aspens has started to utilise the system both to incentivise certain meal choices through operating a loyalty card / bonus points system, and has been able to use the records from card purchases to track how money is being spent, which products are most popular, and whether children are making healthy choices.

Conclusion

Aspens not only provides nutritious meals but also works to change attitudes to health. The company demonstrates how it is possible to make eating a positive experience, change attitudes to eating and encourage pupils to take ownership of their eating – through a commercial service that is co-produced and integrates eating, service, preparation, curriculum and extra-curricular activities.

7. CLOSE TO HOME

Manchester Communications Academy, Harpurhey

Introduction

In areas of extremely poor health outcomes, where residents face complex social and economic challenges, schools can have powerful impacts beyond their pupils and set curriculum.

Through both involving the local community and placing health at the heart of the curriculum, wider health and wellbeing outcomes can be improved. How can a school effect sustainable change in areas of deprivation? How can the community be engaged in a meaningful way?

Origins of the project

Manchester Communications Academy (MCA) is located in Harpurhey, an area of North Manchester that has some of the worst health outcomes in the country, with high rates of coronary disease and a poor life expectancy.

Established in 2010 and sponsored by British Telecom, the school represents a strategic investment in education as well as social and economic regeneration. The academy, which currently serves 1,200 pupils aged between 11 and 16, considers health and wellbeing to be as important as academic achievement. Moreover, MCA acts as a community hub for local residents; their health is also a key priority.

"We talk about the health problems in the surrounding area so the students know why we are taking this so seriously," says Sue Watmough, who leads MCA's Department of Health and Wellbeing. "We encourage them to take it seriously as well, to take ownership for their health and utilise the facilities available."

Connections and Partnerships

Relationships with students' families and the community form two of the three pillars of MCA's approach. As Watmough says:

"A key feature to our approach is working very closely with the parents to ensure that they are an active partner in their child's learning. We have excellent relationships with our partner primary schools and believe we have gained the support of the local community for this academy."

Approach and delivery

The three pillars to MCA's approach are: involve the community, deliver appropriate curriculum and include the student's family.

Firstly, many local community groups use the academy's facilities. These include mothers and babies; people in recovery from mental health problems; and older people who meet for dominoes, badminton and socialising. MCA's 'Cook4Life' sessions are available to anyone in the local community over 18 and focus on how to create meals on a budget.

The conscious choice to share their facilities and resources has helped anchor the academy within the community.

Secondly, health forms a core part of the school curriculum. MCA has tailored its curriculum and resources to address the specific health needs of their students. An in-house nurse ensures continuity of care, while the MCA's 'Project 60' responds to local health issues in a holistic way. The school doesn't follow the traditional Personal Social & Health Education (PSHE) curriculum. Sessions cover the same topics but are delivered through novel and creative methods. One group discussing the risks of smoking were taken to Harpurhey market to relay these messages to the general public, encouraging students to process messages at a deeper level and to take ownership of their own lives.

The academy uses PE sessions to monitor as well as develop students' health. Health and physical fitness is measured at three points over each academic year, tracking peak flow, blood pressure and Body Mass Index (BMI). The focus given by these measures, as well as clear communication about the importance of health, mean that pupils are aware of their health needs and encouraged to talk about these issues.

Thirdly, MCA recognises that to build on the successes made through education, the school must also work with families. When a child's Health Index indicates a required intervention, parents will be invited into school to talk about concerns and identify problems for the child – as well as discuss their own, or those within their families. Family activities include cookery, exercise classes, mother and daughter gym sessions, and 'Dads and Lads' football sessions.

Success and outcomes

MCA's holistic, community-driven approach has yielded wide-ranging benefits. When the academy's football pitches were used to provide free, supervised use for anyone in the community, local crime rates dropped. The school's Health Index tool has recorded a reduction in the BMI of pupils referred to MCA's specialist exercise classes. Health data in the local areas surrounding the school have also improved since the academy was established (although MCA are careful not to overstate their own influence on this).

Future plans and obstacles

To build on its data set, MCA is developing a 'pastoral tracker' to map demographic information for each pupil including postcodes, Free School Meals, and English as an Additional Language. Through using both sets of information there is potential for identifying students who may be at risk or finding other patterns within the data to inform their ways of working.

Conclusion

MCA demonstrates how a values-based, family and community assisted approach can improve health and social outcomes. Not only has the academy rethought its engagement with the community, using innovative and resourceful means, it has taken the crucial step of placing health on a level footing with other academic offerings.

8. BEYOND THE WALLS

Youth Zones, OnSide, Greater Manchester

Introduction

Professional youth services can often see young people reduced to commodities, lacking genuine relationships and quality of care. A localised, engaging youth club can help to transform young lives and have a vast impact on health and wellbeing that goes beyond the walls of the building, into families and the local community.

Origins of the project

Bolton Lads & Girls Club (BLGC) was launched in the 1800s to provide a safe space for young people, based on the principle that education and physical activity are essential to health and wellbeing. Eight Years ago, BLGC chairman and local entrepreneur Bill Holroyd set up a new charity, now called OnSide Youth Zones to replicate the BLGC model.

OnSide successfully applied for £20 million of Big Lottery funding, opening four 'Youth Zones' in deprived areas of Carlisle, Blackburn, Manchester [known as The Factory] and Oldham in 2012, followed by Wigan in 2013. Subsequent Youth Zones derive fifty per cent of the project's capital funding and revenue from the private sector.

Connections and Partnerships

Each Youth Zone is a private sector-led, independent charity, driven by a partnership between the private sector, local authority, voluntary sector and young people. Collaboration with public health agencies provides advice on body image, nutrition and weight loss. Each Zone works closely with Public Health organisations, pharmacies and NHS smoking cessation services.

Central to OnSide's approach is developing relationships of trust with Youth Zone members, families, the community and partner bodies. This allows OnSide to move beyond simply offering a safe place to go and diversionary activities, and builds the trust that allows them to identify particular issues and offer a support network for the young people, for example through mentoring.

Approach and delivery

OnSide's vision is to offer 'a safe, affordable and inspirational place for young people to go to in their leisure time'. Zones are located in areas of deprivation, and are open seven nights a week, 361 days a year in order to be available when young people need them most. Physical activity forms the core of the Zones' offerings. Approximately 18,600 members attend the Youth Zones, aged 8-19-years-old.

Areas in which Youth Zones are located typically face lower life expectancy, heart disease, cancers, and poor diet – therefore the Zones help to address some of the determinants of poor health outcomes.

Zones pursue an exemplary philosophy of affordable, healthy food provision for users, employees and volunteers. Nutritious, low cost, healthy meals, drinks and snacks are provided. The Factory also runs courses on food preparation and is reconfiguring the building to allow the facility to open as a community café with public access and an associated programme of courses.

Drugs and alcohol awareness is backed up by a zero tolerance policy on the premises. Advice on sexual health, contraception and chlamydia screening is also available for young people and to date, over 2,500 have attended these sessions. Staff are encouraged to develop and nominate programmes against an 'emotional fitness' model, which includes a health parameter.

Mentoring programmes offer one-to-one support for young people over the course of a year. These might focus on issues such as non-attendance at school, family breakdown, self-harm or abuse by others, isolation and bullying. Around 30 young people each month are involved in the mentoring programme.

Members have a clear understanding of both mental and physical health benefits from activity amongst members and in particular that a healthy lifestyle flows from and is linked to the strong relationships underpinning these activities.

The quality of these Youth Zones' builds, as well as the environment created within them, are of the highest possible standard – representing a stark contrast to the provisions of most youth clubs. The reasoning is that young people not only deserve the best but should also aspire to it in their lives.

Success and outcomes

The average weekly attendance of 1,000 young people at a Zone means over one million hours of physical activity have been provided since opening. However, while each Youth Zone records its activities and the attendance of young people, actual participation in activities is only just starting to be measured and evaluated.

Police have reported a 58% drop in youth anti-social behaviour in the area surrounding The Factory. The evidence points to improved social outcomes, reduced crime, raised aspirations, personal wellbeing, positive relationships, and skills for work and life.

Future plans and obstacles

Demand is growing and fifteen new sites have been identified. OnSide is considering an extension of its programme to develop a better understanding of the health impacts they have on young people's lives. The challenge for OnSide is not only financial to fund growth to meet demand, but to understand and leverage the full potential its model is demonstrating.

Conclusion

OnSide's Youth Zones offer high quality venues and programmes that foster relationships of trust, encourage involvement and promote ownership of personal outcomes. Given the involvement of the private sector and the scheme's positive results, it represents good value for money. The Zones' encompassing and health-driven approach is having a positive impact on young people and families.

9. THE SPIRIT OF ST MARK'S

Manchester City FC; Sale Sharks RFC; Lancashire County Cricket Club; Amaechi Basketball Club; Abraham Moss Warriors FC – Greater Manchester

Manchester City Football Club is now a commercial enterprise known to millions around the world – but it had humble beginnings. It was launched as a humanitarian project over a century ago by two church wardens at St Mark's in West Gorton, Manchester. Today the club's charitable foundation collaborates with others to improve the lives of young people in the community near its stadium.

This ethos can be seen in other sports initiatives that reach thousands of people across the city. Sports brands hold a particular significance in communities, particularly deprived ones, and have an important standing in the eyes of young people. Consequently these clubs have a unique opportunity to leverage their powerful reputations to impact health and wellbeing.

Whether these schemes are led by resourceful grass-roots organisations or by globally recognised brands, all seek to boost health outcomes. How do these differing approaches work, and what effects are they having on young people's health and wellbeing?

Manchester City FC's 'Strike a Balance'

MCFC's charitable foundation, City in the Community (CITC), takes a holistic approach to urban regeneration, which reflects the club's roots. The club has a requirement to direct a proportion of earnings into Corporate Social Responsibility work, and CITC has more than 50 staff working in the local community every day. Through their initiatives and by setting a challenging agenda to address health and educational issues, they are in contact with almost 50,000 residents each year.

Strike a Balance was launched in February 2011 as a joint response of CITC, Manchester Healthy Schools and law firm Hill Dickinson. Partners include Central Manchester Health Trust and the University of Manchester; the programme has attracted three years of British Heart Foundation funding.

CITC offers the free five-week programme to 120 primary schools in East Manchester – thanks to the club's worldwide reputation, over 3,500 nine and ten-year-olds take part each year. Each session covers a different aspect of healthy eating and is followed by a football session. The diets of high-profile MCFC footballers are used as models.

East Manchester has the worst record for obesity in Britain; one in four 11-year-olds is obese. Almost 1,500 children across five schools in the neighbourhood of the MCFC Etihad Stadium are weighed in Year 6. Identifying the children whose weight is 'tracking up' is key to understanding those families that have risky lifestyles. Families are then engaged in the process of changing their diets.

Strike a Balance has won numerous awards, including the Community Scheme Project of the Year at the North West Football Awards. It's acknowledged that MCFC is unable to monitor children's progress once they go home, so the club tasked each partner organisation with tracking outcomes, for instance the Health Authority weighs and measures participants, while the university collates results.

Sale Rugby Union FC's 'RU Fit'

Known as Sale Sharks, Sale Rugby Union FC was founded in 1861 and delivers projects through the Sharks Community Trust. As with football's governing bodies, top rugby clubs are required to spend a proportion of revenues on community outreach.

RU Fit is an initiative funded and equipped by Glasgow University, aimed at the high proportion of male sports fans over 35 who are overweight. The scheme encourages healthier lifestyles through association with the club's brand.

Although most of the men are connected to rugby through being former amateur players or supporters, they're considered hard to reach in relation to traditional fitness and weight loss programmes. RU Fit was able to engage men by drawing on the influence of the Sharks players and their status as role models. The club also offers a non-threatening context as well as the renowned professionalism of its coaches.

The 15-week programme focussed on physical activity and also involved classes on healthy eating. Men's families were encouraged to support the participants, and social support continued informally through a Facebook group.

Researchers monitored the men's weight, Body Mass Index and blood pressure before, during and after the programme. After seven months, the majority of participants (average age 43) were losing weight and were fitter.

Lancashire County Cricket Club's 'Healthy Living Family Workshops'

The Lancashire County Cricket Club was formed as a charity in 2012. It is a small enterprise with limited resources, but a dedicated and professional team. Projects aimed at improving the community's health and wellbeing include Thai boxing sessions for nine to 16-year-olds, and an activity club for retirees.

With funding from the Big Lottery, LCCC also delivered a series of health workshops for families, demonstrating how to cook nutritious cost-effective meals from scratch, how to understand food groups and the effect of diet on the body. The fun and interactive sessions were led by a qualified dietician and included visits by past cricket players to talk about their lifestyles and diets.

Amaechi Basketball Centre

Amaechi Basketball Centre also made the transition from humble community project to thriving organisation. Established in 1997 as a non-profit, it has gone from two cadet teams and a small training programme to a large professional centre with a purpose-built facility in Whalley Range. ABC acts as a regional hub for the sport, providing opportunities for all members of the local community.

Two thousand young people play basketball each week and the club runs 16 national league teams. Volunteers are crucial: over 300 unpaid volunteers support ABC, alongside paid team members. ABC has been recognised by the National Governing Body, England Basketball, as a National model of good practice.

Abraham Moss Warriors Juniors Football Club

Launched by footballer June Kelly, after her own promising career was cut short early through injury and ill health, AMWJFC began as a small initiative in 2000, quickly growing to over 300 children. The club is unique in many ways, not least the award of FA Charter Standard Club status multiple times. At its peak more than 520 children attended at a cost of £30,000 pa. This has shrunk back in recent years as funding has been squeezed, but the current cohort of approximately 150 children still embraces nearly 50 different nationalities.

The club places utmost importance on health, and this is changing the lives of the youngsters in the club, as well as their families. The club uses facilities at Manchester Communications Academy, and families are permitted to use the academy's gyms while their children are playing football. An instructor is paid to help the parents and the results have been impressive, with one parent losing 9kg in six weeks.

When it came to the children's own eating habits, they designed their own test to see how their performance was affected by what they ate and drank before and during a game. By measuring and comparing aspects of their performance and fitness (a mixture of tests, results, pass completion etc.) under healthy and 'junk' diets, they concluded that healthier foods with a slow release of energy were better for them. Kelly estimates probably 80 per cent now bring fruit and cereal bars to games rather than chocolate bars, fizzy drinks and crisps.

Conclusion

Top sports clubs are very influential in the lives of many young people, particularly in disadvantaged areas. It's crucial that the companies make the most of their positions by advancing health and wellbeing. Renowned and well-liked sportspeople have a unique ability to foster change and encourage people to take notice.

Commercial, club-led initiatives and grassroots projects both have a clear focus on the community.

Clubs are motivated by legal agreement with their officiating bodies and the desire to engage with communities. Activities are linked to improving health but clubs are also keen to build loyalty to their brand.

By contrast, grassroots projects are based on lifestyle – keeping children happy, safe and healthy. They inherently focus on the strengths and capacities of participants and the community.

Both approaches rely on the notion of creating a safe place in the local area – whether that is driven by a desire to promote a brand or simply to keep children out of trouble. Clubs leverage their reputation to attract participants, while grassroots initiatives attract volunteers based on the virtue of supporting the local community.

In general, clubs have relatively unsophisticated, input based success measures – the number of participants and the money spent. However all have recognised the importance of measuring outcomes over the long-term and the necessity of working with agencies to deliver and measure this effectively.

They have all identified a key challenge: moving beyond the immediate engagement (through brand association) and participation (through 'fun and interactive' activities) to behaviour change and wider social impact, primarily in the family and home. The involvement of the family recurs as a critical factor.

Clubs have tremendous potential in what they can offer communities, and their commitment is genuine. They do however have a legal requirement to invest money through community action. For community-initiated projects the reverse is true: they have a community 'mandate' to act for their children and seek financial support in order to support this.

10. HANDLED WITH CARE

Manchester Carers Forum, Manchester

Introduction

While caring for people with health problems including diseases and chronic illnesses is a natural human response, some bear the burden more than others. Often these are the responsibilities of a parent caring for a child with difficulties. But sometimes managing the household, medication and the responsibilities of an adult life must fall on the small shoulders of a child. These responsibilities can place immense mental, physical and emotional strain on carers. The value of this invisible and unpaid workforce has been estimated at £87 billion, yet the relationship that carers have with public services remains unclear and undefined.

Carers require individualised support that isn't restricted or policed by the public sector, support that recognises the varying nature of human relationships.

How can we appropriately recognise the act of care within families and communities? How can carers be empowered to offer a high quality of care? How can we support our carers?

Origins of the project

The Manchester Carers Forum provides support for people who are caring for patients with a variety of diseases, conditions or chronic illnesses. The forum offers peer support, advice, mentoring and breaks for carers. It acts as 'the voice of the carer', which challenges, informs and educates services, institutions and policy makers. The forum's aim is to ensure that carers' interests and priorities are recognised and included in service planning and commissioning decisions.

The forum was established as an independent charity in 2001 by carers from Manchester. From 1993 the Forum had been a project managed by the Gaddum Centre. Today the organisation comprises six carer support groups operating in North, Central and South Manchester, including two based in GP centres. The forum has 3,000 members, 35 volunteers, including trustees, and seven paid members of staff, many of whom bring lived experience as carers.

Connections and Partnerships

Connections and the natural instinct to help are at the heart of what carers do. It is sometimes said we are better at caring for others than we are ourselves. Many carers are themselves vulnerable or in need of support, but find purpose and dignity in what they can do for others.

The forum has established strong relationships with the public sector. The forum leads an alliance of other care organisations to tender for work and at present have a contract with Manchester City Council, three Manchester-based Clinical Commissioning Groups and the Manchester Health and Social Care Trust.

Nationally, the forum is also linked to Carers UK, supporting their lobbying on behalf of the carers' movement. Its relatively large capacity enables it to visit other parts of the country to advise on how the Carers Forum works and how the model might be replicated in other places.

Approach and delivery

In addition to lobbying and representing carers' interests, the main work of the forum is offering support groups for carers across Manchester. The organisation offers one-to-one support through peer mentors, ideally working with carers before they reach crisis point.

The forum offers additional support for those with substance misuse problems; free legal consultations with a local solicitors' firm; and group respite breaks. It responds to the challenges of **caring** by providing computer skills sessions for **carers**, and running a dementia **carers** peer mentoring and befriending project.

Education is a third important strand of activity. Some carers are involved in the training of social workers and provide placements for them. A number of the forum's trustees engage with the University of Manchester in their Assessed Readiness for Direct Practice training. As a result of these links, a 'frailty tool' for use in the community is being developed in partnership with a company called Intelesant.

Success and outcomes

A crude calculation – based on 16 hours per week at minimum wage levels – suggests that the forum members potentially provide care in Manchester that is worth around £15 million a year, before any employer costs. This is 50 times the forum's present turnover of £300,000, funded from various sources, including The Local Authority, the three Clinical Commissioning Groups, the Mental Health and Social Care Trust and private sector grants.

The growth of the forum offers evidence of its success in its activity: more people are coming to the organisation for help, there is greater capacity to offer support, strong connections have been developed across ethnic, cultural, geographic and disability boundaries, there is a greater credibility with partners and as a result there are good links which support signposting to other services. Long-term objectives are also being realised, with 20 MA students trained in social work.

Future plans

Despite the forum's growth, the reduction in funding from the local authority since 2010 is forcing it to look to other sources of funding, such as Children In Need and independent trusts. Changes to ways of working are being considered.

Conclusion

The activity and determination of Manchester Carers Forum is both a support for carers and a reminder to public services and politicians of the essential work they do – a reminder that the majority of care within society comes first from the action of family, neighbours and volunteers. The support network offered by the forum ensures that carers are able to build their own resilience and capacity.

11. THE HEART OF THE MATTER

Salford Heart Care, Salford

Introduction

Post-operative care of heart disease patients presents a number of challenges. Recovery requires time, dedication and compassion – factors that are difficult for the health sector to provide. Meaningful recovery improves patients' quality of life and health, as well as reducing demands on further medical care.

How can a supportive peer group be galvanised to encourage and foster recovery in heart patients? What is the most effective and sustainable way to bring about high quality care based on volunteering, relationships and community?

Origins of the project

Salford Heart Care (SHC) is an organisation run and led by volunteers, which supports people with heart disease and heart-related problems, as well as their carers and families. The group, which currently has a membership of around 400, was born after Salford resident Bernard Hamilton suffered several heart attacks over a number of years. While hospital treatment addressed the physical effects of Hamilton's heart problems, it offered no rehabilitation, care or advice – so in 1987 he launched a support group.

The cost of premature death, lost productivity, hospital treatment and prescriptions to the UK as a result of heart disease is estimated at £19 billion. Heart and circulatory diseases, including strokes, account for more than 161,000 deaths annually – more than a quarter of all deaths.

SHC focuses on an area of real need: in Salford, early deaths from heart disease and stroke are 40% higher than the national average. Life expectancy for men in Salford is nine years lower than the national average of 80 years. For women it's 11 years lower than the average of 88 years.

It's been established that cardiac rehabilitation that includes education, psychological support and exercise can reduce the risk of a further heart attack by almost a third.

SHC's annual operating costs average £55,000 with an annual income of approximately £50,000. The largest source was £25,000 from a Public Health Services Contract with Salford City Council, but this has been withdrawn. Grants, membership subscriptions, a new local lottery and other fundraising make up the balance.

A 2008 Lottery grant helped establish an Eccles office, and SHC is now a company limited by guarantee and registered charity with its own Community Interest Company, Wellbeing in Action (not trading) and six trustees.

Connections and Partnerships

The goodwill of volunteers – many of whom have experienced loss of a loved one to heart disease, or are recovering themselves from heart surgery – is at the heart of the work of SHC.

The Public Health Services Contract with Salford City Council historically funded activities and long-term support for patients with cardiac-related conditions and provides partial support for the centres at Eccles, Irlam and Cadishead, Walkden and Langworthy. However, this has now come to an end.

Approach and delivery

SHC operates weekly or fortnightly sessions from six centres in Greater Manchester. The group offers practical help and encouragement after hospital care ends, which is typically just six to eight weeks following a heart attack.

SHC's services have expanded to include physical, educational and social activities, for instance tai chi, weight management, group trips and relaxation techniques. Empathy and the value of lived experience are pivotal to SHC's approach. Several volunteers and trustees have personal experience of heart disease.

One of the pivotal features of SHC is that it is driven and delivered by volunteers. The team overseeing the organisation firmly believe that this is one of its main strengths, and why it has a clear appeal to patients.

Success and outcomes

A 2013 evaluation by the Community Health & Social Care Directorate of Salford City Council concluded SHC's service is 'an important part of the rehabilitation pathway' and that 'no equivalent service is provided anywhere else in Greater Manchester'. However, its funding has subsequently been withdrawn. The report notes:

"In the evaluation there was a consensus that the organisation's work has resulted in people feeling more confident to self-care. Several of the participants highlighted that their health had improved as a result of the prevention activities offered. A very obvious benefit has been improved mental wellbeing – isolation, friendship, support, confidence building were highlighted by virtually all."

Future plans and obstacles

Persuading those who have suffered heart attacks to attend an SHC session can be challenging. Volunteers regularly attend the heart attack rehabilitation clinics at Salford Royal Infirmary and Total Fitness to explain what the charity does and invite patients to attend a session. However only around 10% of clinic attendees do so.

In addition to its current structure, Salford Heart Care has considered both direct and franchise models. The first was 'A branch on your doorstep'. Salford NHS PCT requested 20 additional centres in 2007 to reduce travel times. New branches were opened and at its peak, 10 centres were providing fortnightly sessions. However, largely due to apathy from prospective members and the lack of suitable premises, four of these centres closed.

Conclusion

SHC goes beyond the reach of conventional health services, supporting patients with heart disease to live longer, healthier lives. Through a range of activities and support sessions, patients are empowered to self-care, reducing isolation and boosting wellbeing.

12. A HEALTHY HOME

Yeovil4Family, Yeovil

Introduction

A constructive and disciplined home environment often provides the initial basis for good health. Good eating habits, physical activity and seemingly small – but crucial – domestic responsibilities all contribute to mental and emotional wellbeing. Without reinforcement at home, school lessons on healthy eating and exercise can go unheeded.

How can families be sustainably encouraged to bring about this supportive environment in the home, and impact on longer-term physical health?

Origins of the project

Yeovil4Family places individuals within troubled families in Yeovil, providing goal-oriented support to help them develop resilience, confidence and problem-solving skills.

The organisation began as an informal group at a local church, and grew when Somerset County Council began to refer its clients. In 2012, the group was formalised with a successful bid to deliver the county's response to the government's national Troubled Families initiative. To date the service has supported 132 families.

Almost three-quarters of families in the programme experience a range of health inequalities, particularly issues of poor mental health and wellbeing. Yeovil4Family frequently encounters poor emotional wellbeing. Lack of confidence and self-esteem pose significant barriers to employment, with social isolation further undermining any sense of wellbeing.

Connections and Partnerships

By working with families and increasing their resilience, they are able to support the individuals within the family and those they have connections with in the wider community.

Yeovil4Family's method has been adopted as best practice by a number of other authorities across the UK. The organisation has been advising the government's Troubled Families Initiative.

Approach and delivery

Five areas characterise Yeovil4Family's aims and approach. The first is that relationships are central; a family link worker and volunteer mentor provide goal-oriented support for an average of 12 months.

Secondly, genuine respect for clients empowers families and equips them with necessary skills and confidence to overcome future challenges independently. Thirdly, families are encouraged to set their own direction and achieve their own goals.

The fourth principle is 'care not cost', whereby the group uses volunteers who have chosen to be there rather than being paid to do so. Finally, Yeovil4Family is committed to consistency and loyalty, ensuring that the same mentor will return to the family each week despite the difficulties that inevitably arise.

The organisation delivers a tailored service to each family. The family link worker carries out an initial assessment, and then matches the family to a suitable volunteer who provides one-to-one support for one hour a week. These sessions are flexible and might include discussing how to address children's behaviour, support in dealing with financial correspondence or making doctor appointments.

An important part of the process is generating a 'family journey map', which identifies key events from the previous two years, allowing the family to reflect and consider what could be done differently. Rachel Dyer is the Programme Coordinator:

"The maps are great for overcoming different levels of literacy but are also very powerful in illustrating all the things that have happened to a family. Sometimes that is a light bulb moment for them – they might see how everything has spiralled from one event. It also gives the worker a good understanding of what and how the family have been dealing with."

Quarterly reviews are held with the family based around two questions: how big are the issues you are facing as a family and how confident are you in tackling these issues? These are complemented by a wellbeing questionnaire.

At the heart of the organisation's approach is a principle of enabling families to tell their own story, understanding it, then helping to shape it. A volunteer workforce is critical to the project's success.

Success and outcomes

Yeovil4Family has effected change in the lives of many families. The organisation recognises the impact of their work on wellbeing and good mental health in particular. However the work defies easy measure and quantifying by those looking on. Dyer says:

"We measure progress in the lives of people and families, in the relationships they have with us and with others around them. It might be the look on their face, an improvement of their moods – more good days than bad – or it might be the start of empowered decision making. But these are the real milestones on the very personal journeys they are on."

Future plans and obstacles

A possible way forward would be to make poor health outcomes a marker for the Troubled Families initiative. This could mean identifying health issues within the initial assessment (rather than inferring them from contact with other agencies or observation). It could also involve providing simple but effective training such as the Mental Health First Aid course provided for Yeovil4Family workers.

Conclusion

Yeovil4Family has helped to bring about transformations in families' lives that begin with small steps and tasks. Encouraging families to take real ownership over their wellbeing through mapping and telling their stories can have a powerful impact on health outcomes.

Yeovil4Family is a positive illustration of how a charity can effectively administer a government initiative, supplemented and boosted by volunteers.

13. THE BALANCE OF POWER

The Mustard Tree, Ancoats, Manchester

Introduction

The lives of people on the margins of society are characterised by complex circumstances and their health outcomes are some of the country's worst. They frequently cope with multiple issues such as mental and physical health problems, substance misuse, criminal convictions and homelessness.

Public services respond to a clearly defined problem, with a specific remit, meaning that the complexities of vulnerable people's lives often place them out of reach of these services.

In order to reach vulnerable clients, an approach that goes beyond a narrow needs-based solution is required; the power balance upon which traditional service models are based must be redefined. How can vulnerable people be realistically empowered to help themselves, with real opportunities to improve health outcomes?

Origins of the project

The Mustard Tree was launched by Dave and Shona Smith in Ancoats, a deprived area of North Manchester. The charity reaches 4,500 clients from all walks of life, including refugees and asylum seekers; families experience financial, physical or emotional destitution; and those suffering from low-self-esteem or addiction.

The organisation provides free clothing and household goods to vulnerable people across Greater Manchester – but its most significant role is getting people back on their feet and on constructive pathways into society, thereby vastly improving health outcomes.

The Mustard Tree works in extremely challenging circumstances. The life expectancy of a person experiencing homelessness is a staggering 30 years less than the general population, according to a 2011 report by Crisis. A homeless person is more likely to take their own life than the rest of society, and many have acute or multiple health needs; drug and alcohol misuse accounts for a third of all deaths.

Connections and Partnerships

The charity has established several long-term partnerships, including with the Red Cross. In 2004 it launched the Boaz Trust to develop programmes and workshops, and also created a spin-off organisation to generate income and offer work and volunteering opportunities for clients.

Partnerships with statutory, business, and third sector communities – while gaining the trust of commissioners, clients and colleagues – have been key to improving sustainability and protecting The Mustard Tree's long-term future.

Some simple skills have been developed among The Mustard Tree's staff and volunteers, which help to bring about a strong feeling of community. People have a genuine knack for striking up a conversation and taking a genuine interest in what clients have to say. Workers take every opportunity to forge new relationships and build trust.

Approach and delivery

The Mustard Tree intentionally but informally tackles clients' isolation by encouraging people to sit together at meals and work alongside each other as volunteers. A sense of belonging is cultivated through presenting the charity as a safe, secure and non-judgemental space. At the heart of their approach is the conviction that everyone deserves to be treated with respect and dignity, regardless of their social status or background.

By creating an environment in which volunteering and reciprocity is strongly encouraged, The Mustard Tree has reframed the traditional beneficiary and benefactor relationship. It has made a concerted effort to remove the stigma associated with needing help, encouraging clients to take responsibility for their lives and health.

These informal stages – creating a safe place, fostering a sense of belonging, reframing key relationships and offering meaningful activity – help The Mustard Tree go far beyond simply handing out provisions, but support people to meaningfully progress in their lives.

Success and outcomes

The Mustard Tree has seen a proliferation of diverse client-focused programmes of care and support. There is a strong emphasis on counselling and mentoring alongside other health schemes like fitness, dance, free weights and healthy living classes.

Volunteering within the project allows clients to engage in meaningful roles, opening the door to training and paid employment opportunities. Projects run by the charity include work placement, volunteering and training. The organisation has been successful in brokering relationships with Business in the Community, social enterprises and other commercial businesses which provide opportunities for clients to learn new skills, develop routines and strategies to cope with problems on their own.

Future plans and obstacles

The Mustard Tree recognises that while ensuring provision for vulnerable people is essential, efforts must be directed to long-term solutions. This means continually shifting people's gaze from the charity's crisis intervention onto sustainable support and development. If Mustard Tree's crisis referral rate were to drop it would allow the organisation to develop the skills and capacity to handle crisis in a more holistic way and support its aspiration of progression and independence for clients.

Conclusion

The Mustard Tree offers homeless and vulnerable people a unique and personalised approach to the complex and challenging everyday problems they face. This includes support that goes beyond a crisis response to improving health and wellbeing. Crucially the charity achieves this by giving people the opportunity to learn new skills, find employment and develop the confidence to achieve their goals and transform their lives. This holistic approach has great potential to improve the health outcomes of vulnerable people.

14. A MEANINGFUL RESPONSE

The Debenham Project, Suffolk

Introduction

Dementia is a grave and rapidly growing problem amongst the elderly. In May 2015 an estimated 850,000 people in Britain were living with dementia – that number is expected to exceed one million by 2051. Every community is affected, and services are already overwhelmed by the burden and impact of the disease.

Dementia demands a new approach, one that involves effective collaboration between agencies and local communities. How can we bring about a meaningful collective response to dementia, one that sustains patients and their loved ones?

Origins of the project

The Debenham Project is a grass-roots initiative that supports dementia sufferers and their families in the village of Debenham, Suffolk. The scheme was launched in 2009 by Lynden Jackson in recognition that dementia is not just a national problem, but a local one.

The project's catchment area is approximately 50 square miles, serving a population of about 2,100 CHECK. Core annual costs are £8,500, covering administration, insurance, accommodation and venue hire. Initially the Local Strategic Partnership provided £7,500. Currently funding stems from Suffolk County Council, Suffolk Foundation, Sports Relief and personal donations.

Connections and Partnerships

Connections and shared responsibility are at the heart of the Debenham project. Close ties with the community have been established, with the local church a key institution. There are also good links with health service professionals and the voluntary sector. The local GP surgery is very supportive, while a councillor with personal experience of dementia has laid the foundations for a constructive partnership with the county councils and its adult social care services.

Approach and delivery

The Debenham Project runs activities for over 200 person sessions each month (an individual attending an activity constitutes one session). The scheme has 97 registered volunteers, many with particular skills such as graphic design or bakery. Participation doesn't require a formal diagnosis of dementia.

The initiative's aim is to help all patients and families in the local area that are coping with the impact of dementia, offering emotional and practical support. This approach often indirectly addresses related issues such as the isolation and loneliness that older people often experience. The project has not developed a single point of focus, for example a day centre, but is woven through the community, working in several locations and across many different activities. The goal is to provide an integrated response that transcends traditional service limitations.

As a result of the project's strategy, there is a sense of community ownership and responsibility for jointly tackling the pervasive challenge of dementia. A local shop keeper is now likely to contact the family of a dementia sufferer who might have become confused in their shop, rather than just leaving them to manage on their own.

Success and outcomes

Awareness of dementia has been increased in the local area, and other communities have been encouraged to take a similar strategy. The Debenham Project's work has been recognised at county level, for its innovative approach to dementia care in, by, and for the community. Nationally, Debenham was accepted as one of the first 'dementia friendly communities' of the Prime Minister's Challenge on Dementia.

The project describes its achievements in terms of reducing demand on public services, and the scheme's ultimate goal is to avoid dementia sufferers being taken into hospital or remote nursing care. A simplistic comparison is also possible between the costs of the project per head of population, which are about £4, and the health and social care budget for the elderly in Debenham, of approximately £3000 (£6.7 million per annum).

Future plans and obstacles

Debenham is a relatively affluent area, so there are important questions about developing a similar approach in more deprived areas. Within Debenham, the project reaches around 65% of local families who are dealing with dementia – yet it has been estimated that there are about 100 people with dementia in the GP catchment area, and as many as a quarter are unaware of their condition. "This is a significant minority whom we will be unable to reach," says Jackson. "They may not have developed diagnosable symptoms yet. Their family may be concerned. They may not wish to engage – or maybe they are coping."

Conclusion

The Debenham Project illustrates the role of collective action and providing a real community context for dementia. This kind of initiative, along with programmes such as the Age Friendly City initiative in Manchester, friendship circles, good public transport systems, warm and safe places for community meetings are essential elements of a robust approach to aging well. They draw on the resilience of families, goodwill of communities and strong social bonds, and cannot be addressed by medical intervention or clinical approaches.

15. HOPE AND HEALTHCARE

Hilltop Surgery, Hope Citadel Practice, Fitton Hill

Introduction

The doctor's surgery is the central point of exchange between residents and health professionals – yet areas of deprivation pose additional challenges such as the poor health associated with poverty and unemployment. Demanding circumstances, a heavy workload and non-medical mental and social complexities combine to mean that the best and most qualified professionals often do not choose to establish their careers in deprived communities. The irony is that because of these very difficulties, underprivileged localities need the best doctors.

How can these obstacles be overcome to bring about sustainable improvements in the health of local people, particularly in disadvantaged areas? How can compassionate, high-quality care improve the lives of patients and communities?

Origins of the project

The Hilltop Surgery is based in the deprived area of Fitton Hill, on the outskirts of Oldham, yet consistently attracts top GPs and delivers commendable results. Hilltop Surgery and three other surgeries make up the Hope Citadel Practice. Unusually, these were established by a Fitton Hill resident, motivated by a strong sense of social justice, and dismayed at the community's poor GP provision. Laura Neilsen put in a bid to the local PCT and established the surgery, drawing on government funding designated for GP practices in deprived areas. Neilsen:

"It was a fast learning curve and we certainly didn't get everything right first time. In just six months we went from submitting our bid to receiving hundreds of thousands of pounds of funding through the contract."

Connections and Partnerships

The surgery's approach seeks to understand the patient in the context of their family, understanding their relationships and respecting the importance of family to an individual's wellbeing.

These meaningful relationships extend beyond the surgery's doors – the organisation is actively involved in the area, which it sees as a natural part of its role and position within the community. It runs occasional community events, sponsors the local football team and helped launch the Fitton Factor Choir.

The resulting trust of patients and residents is key to the outcomes the surgery is seeing.

Approach and delivery

Hilltop Surgery adheres to a 'Focused Care' method. There is a considerable investment of time and effort in this approach – the typical GP consultation is three minutes longer than the national target of ten minutes. This approach helps to build a trusting relationship, which results in uncovering patients' real needs and issues. Nielsen again:

"These can be hostile places, with predatory opportunists ready to take advantage of the vulnerable, so it's important they're encouraged to develop friendships and circles of friends who are stable and will help them look out for each other."

second characteristic of the Focused Care approach is the importance placed on residents' stories. GP John Patterson, Hope Citadel's Clinical Director:

"We think of ourselves as a 'narrative-based' practice. We teach patients to tell their stories. Then we try to fix those stories – and we share those stories with each other. This is central to the way we work."

The emphasis on encouraging patients to share and take ownership of their own stories is a crucial facet of delivering effective whole person healthcare. It surfaces hidden drivers of conditions, for instance abuse as the real source of mental health problems, or hardship that is the reason behind repeat prescriptions. When Hope Citadel's Hollingwood practice was opened, doctors diagnosed 24 cancers in new patients, i.e. pre-existing, undiagnosed conditions.

A further value is 'humility in the face of brokenness'. Efforts to develop a deep understanding of patients are rooted in awareness of the limitations of even the most gifted well-equipped professional. As a Community Interest Company in a deprived area, GPs know they will work harder and earn less. However the clarity of value and purpose continues to attract top doctors who are keen to serve communities and bring about positive change. Patterson is clear:

"People are attracted to practicing medicine in one of the most difficult parts of the country."

Success and outcomes

The practice has a track record of delivering significantly better results than standard benchmarks – made more remarkable for the deprivation of the area.

Greater trust between residents and Hilltop Surgery has improved preventative care, with the children's vaccination rate reaching 94%. The support and care for individuals in a weight loss group resulted in more weight loss than those in a drug trial. A patient group of 4,000 (across two practices) did not experience a single heart attack in 2012.

Future plans and obstacles

The success of Focused Care in residents' lives has been recognised, and the organisation has been asked to extend the approach and deliver it in neighbouring practices. But Hope Citadel is also struggling to secure funding for its own practice work.

Conclusion

An emphasis on understanding patient narratives, helping them take ownership for their own health combined with compassionate, high-quality care has meant Hope Citadel is transforming a deprived area, boosting health outcomes and improving the community.

16. THE EXPERTS IN THE ROOM

Personal Health Records at Haughton Medical Centres, Denton & Hyde, Tameside

Introduction

Recent innovations in technology and free access to information are providing more opportunities for transparency and trust within public services. Data that was previously closely guarded is now often shared openly. For many on the margins of society, suspicion of public services and their staff is rife. How can new technology be used to promote trust, and encourage a stronger patient-GP relationship? How can openness and accountability be safely and effectively developed?

Origins of the project

Taking on a new practice is challenging for any GP; trusting relationships with thousands of new patients must be established. But when Dr Amir Hannan took on Haughton Thornley Medical Centre in Denton, he had significant additional challenges: the surgery is the former practice of the notorious Dr Harold Shipman who was convicted of murdering fifteen patients (these were specimen cases from a much larger cohort of several hundred suspected cases) in 2000.

Hannan knew that complete transparency and openness was needed, and reasoned that confidence could be restored if patients were able to see their own medical records. Electronic health records were developed for patients at Haughton Thornley in 2003, and were rolled out between 2006 and 2008. By 2014, 11,832 people were using the online system, representing 20% of the practice's patients.

The project was delivered without any additional funding. GP funding stems from the services they provide; there has been no funding earmarked for GP record access.

Connections and Partnerships

Hannan worked with Glen Griffiths, who has experience in building interactive health web platforms, to introduce patients to the concept. Professor Ian Buchan from the University of Manchester developed electronic health records for Haughton Thornley patients.

The decision to enfranchise and educate patients reflects an approach that values them as an asset, fosters a sense of equal open partnership, and acknowledges the importance of patient control.

Approach and delivery

Hannan's core goal was to put patients in control of their health care, not render them passive recipients. Recognising that patients have an expert opinion on their own conditions has become a priority of the project.

The software allows all medical records to be accessed anywhere online. Patients therefore require basic IT literacy – though skills and access are growing in reach and penetration. Recruitment of patients is key to the success of the scheme. Once enabled, patient access to the Personal Health Record is permanent unless revoked on request.

Patients are offered the chance to access their medical records when they see one of the GPs involved in the scheme. The Practice Manager also advocates access. Patient Participation Groups promote the benefits of shared access to medical records, and goodwill has developed over time. A lot of time has been invested sharing the vision and educating patients. But there is clear evidence that patients do need support on how to understand and use their information safely, appropriately and effectively.

Success and outcomes

Research has shown that the electronic system is reducing demand on health services. The surgery has observed: a reduction in GP visits and phone calls; improved use of or compliance with medication; improved prevention and follow-up; improved quality of care and disease management; and a reduction in use of healthcare resources.

Benefits for Haughton Thornley Medical Centre include a considerable improvement in practice efficiency; there are fewer appointments needed per patient and there is a reduction in work absence. There is also a fall in record errors, and an improvement in the practice's environmental footprint.

The take up by patients in different groups (for example, ethnic minorities) is monitored carefully. One example, Bengali patients, is in the region of 40%. The success of this only becomes apparent when compared with national patient access to records, across all demographics, including more affluent, traditionally more engaged and informed demographics, in the order of 5%.

Future plans and obstacles

One obstacle to electronic record access is poor IT literacy among patients. Many in deprived or vulnerable communities are least likely to have internet or computer access, meaning that those who could benefit the most may have the least access. A further challenge is the lack of a national organisation willing to invest in improved GP record access; many have concluded that growth and spread will be market-enabled.

Despite these obstacles, there is certainly scope to scale up and replicate the achievements at Haughton Thornley Medical Centres. About 60% of GP practices across the UK use the EMIS system software that allows for patient access to their record.

Conclusion

Haughton Thornley Medical Centre's electronic medical records have allowed patients' greater control over their own health and wellbeing, fostering a vital sense of empowerment and trust. The innovative and resourceful system is a cost-effective way to improve health services – even in deprived areas and with hard to reach demographics.

17. PATIENTS LIKE ME

PatientsLikeMe; HealthTalkOnline (websites)

Introduction

While conventional healthcare models certainly dispense treatment for conditions, they often do not provide an outlet for patients' actual experiences of diseases – both emotional and physical. They rarely put patients in charge of their own healthcare, emboldening them through real-world statistics and data.

The openness and accessibility of the internet could play a pivotal role in not only democratising patient data, but also improving effective and successful research into conditions based on that data. How can web platforms place patients at the heart of healthcare? What role could technology play in improving health?

PatientsLikeMe

PatientsLikeMe is a website that allows people to share stories of their medical conditions, while aiming to aid healthcare industry partners to understand patients' real world-experiences of disease and its progression. Co-founded in the US in 2004 by brothers James and Benjamin Heywood, and Jeff Cole, the site was prompted by Stephen Heywood's diagnosis of ALS. They built a health-data sharing platform to transform the way patients manage their own conditions, and change how the industry conducts research.

The core values of the website, which in 2014 had over 250,000 members, includes putting patients first, promoting transparency and fostering openness. As a for-profit research company, the website is free from adverts and instead sells aggregated anonymised data to its partners which include pharmaceutical companies and medical device manufacturers.

Anyone can join the website and enter real data on their conditions, treatment history, symptoms and quality of life on an ongoing basis. PatientsLikeMe then produces a detailed longitudinal record allowing patients to gain insight and identify patterns.

Heywood says PatientsLikeMe users had fewer A&E visits and felt their health was under better control than non-users.

HealthTalkOnline

Also prompted by a personal diagnosis, HealthTalkOnline is a website run by UK charity DIPEX that allows patients to share their health stories. The charity describes itself as conducting: 'Research into patients' experiences of ill-health and health related issues and creation of a database of such experiences. Dissemination of these experiences principally via websites for the benefit of the general public, patients, teachers and health professionals to enable them to make better informed decisions about healthcare. Creation of educational materials, based on personal experiences.'

HealthTalkOnline has a well-defined business model to ensure its sustainability and support its team of 20 researchers at the University of Oxford. It is an active fundraiser with a wide network of funders, founders, sister organisations and links to policy makers. Funding has ranged from £260,000 to £462,000 between 2009 and 2014, and stems from organisations that have an interest in one of the conditions.

HealthTalkOnline covers 80 conditions including cancer, autism, depression and motor-neurone disease. Advice is provided on topics such as making decisions about health and treatment, talking to friends and family, and dealing with financial practicalities.

While the PatientsLikeMe data is provided by individuals HealthTalkOnline material is garnered by the Health Experience Research Group (HERG) based at Nuffield College, Oxford. It collates information through up to 50 video interviews per condition and uses 'rigorous qualitative research methods' to present information on the website. The HERG archive now contains over 3,000 interviews with patients, carers and other family members. The website is a unique resource with enormous potential in academic and policy areas.

Conclusion

Both platforms provide free, reliable information about health issues by sharing people's real-life experiences. However while patients are at the centre of both websites, the approaches taken are fundamentally different.

The founders of PatientsLikeMe assume a wider interest in the data beyond academics and other patients. They believe health data belongs to the patient, who can share this with anyone, from caregivers and researchers, to companies and physicians. PatientsLikeMe connects patients, acting as a crowd-sourced information bank with real examples of self-care. It's a community-driven programme, led by patients themselves.

By contrast HealthTalkOnline is an academic venture with a top-down perspective. Patient-to-patient contact doesn't exist; while this may maximise academic benefit, it limits information to pre-determined parameters chosen from a clinical outlook.

HealthTalkOnline is a functional offering of data through a disciplined academic lens, while PatientsLikeMe is personal, connected and empathetic. Both have value, however the latter also offers a glimpse into a possible future of the NHS as a social movement.

18. RETAIL RELATIONSHIPS

Kapoor Healthy Living Pharmacies, Greater Manchester

Introduction

The local pharmacy is an essential part of every community; it's estimated that 438m health-related visits to English chemists are made every year. Staff often develop long-term bonds with customers and their families, making pharmacies well-placed to understand and identify local needs – this is particularly pertinent in areas of deprivation, where GP provision is lacking.

Yet pharmacies are an under-utilised resource; staff skills and knowledge are often overlooked by sector colleagues and the general public. Pharmacies have real potential to play a far greater role in boosting health outcomes than they currently do.

So what can be done to harness this potential? How can pharmacies use their expertise and meaningful relationships with customers to improve the health of entire communities?

Origins of the project

Kapoor's Pharmacy Services has three outlets across Greater Manchester, each in an area with a particular social, economic and health profile. Owner Maneet Kapoor observed the importance of wellbeing to his customers and recognised the powerful role that pharmacies could play in communities' health. He saw that he could build upon their accessibility, their status as a trusted first point-of-contact, and the importance of early action in preventing health crises.

In 2012 Kapoor chose to move away from the traditional pharmacy delivery model to become an early adopter of the new Healthy Living Pharmacy approach. The model was developed in 2009 by NHS Portsmouth and the Hampshire & Isle of Wight Local Pharmaceutical Committee in an attempt to illustrate how pharmacies could become more effective in engaging the general public in improving their own health.

The HLP strategy is based on principles of preventative care and the trusted, personalised service offered by many local pharmacies. An HLP helps customers make better decisions about their own health, by providing an enhanced range of services, which are tailored to the specific needs of the community. This commercial model was developed in Portsmouth and is now being taken up nationally in a market-led, state-enabled approach.

Connections and Partnerships

HLPs forge critical partnerships with their communities, third sector organisations and public sector bodies. The result is a collaborative network that can both promote initiatives and signpost customers.

Importantly, it is the customer interaction that is key. Customers are addressed by first name, and exchange small talk with the staff. HLP staff are actively encouraged to initiate conversations with customers about the current campaign – for instance discussing the effects of smoking with a view to quitting. Key to this is an encouraging, enabling manner, rather than a prescriptive, top-down attitude.

Approach and delivery

Customers entering Kapoor HLP pharmacies encounter busy, vibrant and welcoming environments. A 'Health Promotion Zone' showcases the latest monthly health campaign, while the walls display details of local groups and useful numbers.

Central to the HLP model are the Healthy Living Champions who advise customers on everything from flu vaccinations to sexual health. Champions promote an ethos of self-help and self-management, where customers are empowered to take charge of their own health.

Kapoor Pharmacies has an HLC in each of its three stores. There is no financial incentive: these admirable volunteers play a pivotal role in engaging residents and customers. Champions regularly seek the views and suggestions of customers. HLCs bring back vital information to the pharmacy about what is happening in the neighbourhood. They also work with community groups, for instance checking blood pressure at the Indian Senior Citizens Centre in Whalley Range.

This philosophy of engagement and sharing between pharmacies, staff and with other health care professionals in promoting health and the value of self-care underpins the HLP approach.

Success and outcomes

In Portsmouth – which faces similar poverty, crime and deprivation challenges as Manchester – the HLP model has seen considerable and significant success. Twelve pharmacies were selected to trial the approach, concluding that even small changes can have a positive impact on health.

In just one year, HLPs there increased the number of smokers quitting by 140% (a vital step in narrowing health inequalities in deprived areas), and 81% of participants in a healthy weight programme achieved a 5% weight loss.

Maneet Kapoor believes his Greater Manchester pharmacies have become more responsive and focussed as a result of adopting the HLP method. Pharmacists are now better placed to spot emerging issues such as the first signs of neglect or under-nourishment. Kapoor highlights mental health and wellbeing as a particular area of improvement:

"I was [previously] unaware of the issues involved and the poor access those with mental health problems can have to services... Customers don't always want medicine or a referral to a GP. Sometimes they need... to go for a brew and a walk, take regular exercise or break up their routine with some company. So we have helped set up that kind of group and now we can point them to it. We have seen lives changed, just by giving someone a leaflet."

Kapoor's business has grown and consultations have increased. The number of new customers enrolled on programmes such as smoking cessation has been steadily growing.

Future plans and obstacles

While HLPs represent a sustainable commercial proposition, the commissioning framework is tied to the broader national framework and thus could be patchy and fragmented going forwards. HLPs also still need to overcome a lack of public awareness of what pharmacists can provide in comparison with GPs.

Conclusion

Healthy Living Pharmacies such as those operated by Kapoor across Greater Manchester enable customers to make better decisions and manage their health in the long-term. They are an effective way to empower people to take action on their own health themselves – aided by, but not driven by, someone else. HLPs are a crucial first step in ensuring that pharmacies are doing as much as possible to advance local communities.

Pharmacists are often the first port of call in the health treatment chain and they require no appointment and little waiting time. It's clear that these resources could and should be used far more than they currently are, acting as a significant filter for both doctors' surgeries and accident and emergency departments.

19. OUR HOUSE, OUR HOME, OUR HEALTH

Great Places Housing Group; Connected Communities

Introduction

The quality of our environment, how safe and comfortable we feel, can significantly impact stress and confidence, which in turn affects health and wellbeing. Providing an individual or family with a home is the basis for a strong and distinctive relationship. Discussions have been taking place at a national and local level about the impact of housing associations on their tenants' health. How can these groups most effectively leverage their unique positions to improve health outcomes in deprived areas?

The housing association (HA) sector has witnessed vast changes in the last decade. Capital funding has changed with a reduction in central funding support through the Housing & Communities Agency; the 'tenure for life' guarantee has been removed; and HAs now form part of a tenant's journey to independent living.

One result of this has been a shift to providing a 'home' for tenants beyond bricks and mortar, with many associations investing in the communities that form within estates. The strategic thinking is thus beginning to focus more on residents' lives and their wellbeing.

Because a very high percentage of people in deprived communities live in HA properties, the association's close and regular contact with their occupants grants them a distinctive chance to identify health problems early and contribute to solutions.

Great Places Housing Group

Great Places is a relatively small HA with roughly 1,500 properties in Manchester and the North West. Tenants are often vulnerable and facing disadvantages; they may be young families, older citizens, or in need of care. They are typically less resilient and less able to cope with changes in circumstance.

The group's Northmoor Community Centre was created in 2001 by transfer to the Northmoor Community Association and comprises residential flats, a café, offices and community spaces. Northmoor is in the top 10% of deprived Lower Super Output Areas in the country. NCA's aim is to 'relieve poverty, promote health, advance education and improve quality of life for local residents of Northmoor and the surrounding areas'.

Over 600 people from very diverse backgrounds regularly use the centre, which provides residents with a place to commune and access affordable food. As a result of this stability, crime rates have fallen and house prices have increased.

Meanwhile, Levenshulme Inspire also comprises residential flats over a community facility. Formerly a dilapidated church, a sum of £3 million was raised with support from the Big Lottery, Homes and Communities Agency and Great Places to renovate the building, which reopened in 2010. The project aims to support the people of Levenshulme, which is increasingly multicultural.

The project is run by three full-time staff, 10 part-time staff and a sizeable base of 40 volunteers. Levenshulme Inspire is 65% self-financing through rentals and is currently running at a small loss on its £112,000 annual turnover. Donations, grants and social enterprise revenues make up the shortfall. Three main activities, in addition to the café, are revenue generating.

Great Places is a key enabler for both projects, providing essential staff support, but the approach goes beyond information, signposting and services. It works closely with local councillors and other community groups and together have seen real change in people's lives and their neighbourhoods. The approach and projects are intentionally aligned with residents' interests, following their energy and working on their priorities.

Connected Communities ('C2')

The C2 programme is a scheme on housing estates across the UK whereby seven steps are used to identify residents' priorities. The approach is underpinned by assessments of health and community aspirations.

C2 bases its approach on a 1990s study, which demonstrated that a community-wide programme in a housing association had a marked improvement on health outcomes. The scheme, which involved 6,000 residents from an estate in Falmouth, resulted in an increase in breastfeeding rates; a significant fall in childhood asthma; and a big drop in post-natal depression.

A second project launched dance workshops in the deprived area of Camborne in Cornwall. Over 400 young people participated across two years, resulting in reductions in smoking and alcohol consumption, weight loss, and a fall in asthma pump use.

A Department of Health evaluation estimated a social return on investment of £3.80 for every £1 spent in the programme, subsequently commissioning it as a practice framework.

Conclusion

Housing Associations are uniquely placed to improve health outcomes, particularly in deprived areas, and many are admirably turning their attention to tenants' wellbeing. There is limited but compelling research to show that holistic community programmes within housing estates can have huge health benefits.

But there is much more that can be done by associations across the country to turn this theory into practice. Considering their position on the front line of people's lives, HAs should be utilised as a strong resource to a far greater extent than they currently are.

The impact of whole-community programmes such as C2 raise exciting questions of just what might be possible if Housing Associations embraced similar thinking and shaped their core operations around it.

APPENDIX 2: METHODOLOGY

This section is introduced in Sections 2.0 and 2.1 and gives an overview of the approach to case studies and their:

- Identification
- Selection
- Development
- Analysis
- Presentation

Identification

The process of identifying, selecting and developing case studies for this report has been lengthy and at times frustrating. An outline of the development process is offered here both for reasons of transparency and to demonstrate how the process shaped the development of the report and focus of the project.

Challenge: a different pattern

Public services are predicated on the deficit model of 'find, fund, fix and fill' problems. Their organisation, institutions, buildings and language are organised around these assumptions: issue focused, process oriented, institutionally centric. They are not defined in ways that would challenge these assumptions. These systems and institutions have served the UK well, but as Simon Stevens and others have noted, they alone, cannot deliver modern health services that are able to cope with the demands of the 21st Century.

By definition, new solutions or approaches will not necessarily be framed in the language and definitions of the system. In fact, these can bring unintended obstacles, framing problems in certain ways that have not yielded answers so far. Such an approach could be compared to looking for something at night, but only searching in illuminated areas because that is where things can be seen, not necessarily because that is where they are. A simple example of this was finding that some projects having a positive impact on health and wellbeing did not identify themselves as 'health' projects.

Large bodies of academic literature and extensive databases of voluntary groups by region or authority or issue were available, but short of laboriously contacting each entry, it was not possible to identify the approach projects adopted or sometimes even the social demographic they served from the details provided or the perspectives offered. Therefore projects that could not define themselves in terms of a clear issue, or did not sit on a clear care pathway or delivery mechanism were invisible.

Consequently, despite a wide-ranging search, this does not pretend to be an exhaustive list. The anecdotal nature of references relied on when established databases proved unfruitful, is by definition not comprehensive. Further, even as the report has been written up, new projects have emerged which are relevant and exciting to the task at hand.

Grass Roots Working

A second challenge was the probability that groups sought were working at the grass roots in order to achieve the engagement and responsibility/fostering of ownership. Such groups are often small, motivated and highly effective – but unknown outside their own community, with little or no internet or social media profile. The usual search tools of online databases, catalogues etc. and social media were therefore severely restricted.

As much by trial, error and frustration, a working definition started to emerge, including reference projects and approaches that embodied what was being sought – as well as those that did not.

Creating a reference framework

A crucial step was identifying a neutral reference framework, or at least one that could bridge the gap between sector-based language and reference points, and community inspired work: this was an individual's life course. The stages along that life course – from birth, early years to adulthood, along with key life events formed a reference spine to guide the search process. The key stages identified were perinatal (including new family formation), early years, school (primary and secondary), sports, family, housing, work and elder years.

An area of interest was then identified within each life stage. The areas of interest selected were typically mainstream issues with strong behavioural drivers. For example, one early discussion about the perinatal life stage focused on conception and pregnancy (and other risk taking behaviours with regards to sexual health) while under the influence of alcohol.

Selection

Identifying the issue was helpful in tightening the focus of research and a search for relevant case studies addressing the identified issue was initiated.

Projects and organisations were selected against six key criteria:

- Effective. At the heart of this project is a question about influencing the non-clinical drivers of health. Therefore projects were selected that fostered responsibility for actions and choices in participants through action, behaviour change and/or improved resilience.
- Health focused. Projects had to be able to demonstrate a clear link to improved health and wellbeing outcomes. Many effective projects were focused solely on inputs (e.g. meals served, contacts made) or different outcomes (e.g. skills development). Part of the challenge in identifying case studies was realising that some projects that had a significant impact on health or wellbeing did not track or present their work in those terms and may therefore be labelled or categorised in other ways.
- Affordable. Projects had to have minimal and/or sustainable funding requirements and/or a sustainable/replicable business model. This was important to address concerns over the ability to start a project, establish it and/or demonstrate its value over time.
- Accessible. It was essential that projects were located/working in areas of deprivation – preferably within Greater Manchester or across the North West. A good example is the OnSide Youth Zones that started in Bolton, now have six centres across the north west – and are all located in areas of deprivation.

- Relevant. Likewise it was preferable that projects were tackling broad areas of current concern for health, the economy and public services. Elder care and dementia are growing problems, as is the alarming rise of mental health problems in young people. All are represented in several case studies.
- Deliverable. Organisations were also sought that demonstrated a response to the challenges of replication, scale and working with public services. This also considered issues such as succession planning for life beyond the involvement of an inspirational founder. Place2Be is a national, multi-million pound charity that has achieved just that. Other organisations are just approaching that obstacle.

Development

Finally, each of the projects or groups was visited and in depth interviews were conducted over the telephone and in person by a researcher experienced in qualitative interview techniques against a consistent framework questionnaire.

The findings for each case study were then developed into a broad, chronological narrative. This typically highlighted an engaging perspective, relevant point or personal story. The narrative was used to organise a wide range of perspectives such as the history of the group, its drivers and founding values, key partnerships, the importance of family and community in their work, operational considerations, impact, growth and aspirations etc. The intention of this was not to present dry or academic, statistic laden business cases, but to also capture something of their life, character and impact of the projects on human lives.

Analysis

As indicated, the data reviewed in this project has come from a combination of interviews and desktop reviews of relevant materials and organisational literature available publicly or provided by the organisations concerned. The key data were obtained from interviews however.

Thematic Analysis

A thematic qualitative analysis approach was adopted using themes within a model developed by Millar Consulting⁵⁸. This use of a model could be considered a theoretical approach (or even 'weakly grounded').

The model contains five Themes representing person-centred perspectives on security, identity, community, productivity and destiny. They have an immediate and obvious resonance with aspects of public health working and priorities.

⁵⁸ Working title 'Mending Broken Britain', publication due December 2015

Prevalence of Themes

The representation of themes within the case studies was clear and the correlation was strong.

Figure 6: Incidence of Themes Across Case Studies

Theme Within Model	Occurrences within data
Security	16 (84%)
Identity	15 (79%)
Community	19 (100%)
Productivity	18 (95%)
Destiny	15 (79%)

Furthermore, of the nineteen case studies seventeen (90%) reflected four or more of the five Themes within the model:

Latency

Both explicit and implicit occurrence of the Themes was used to establish this link. For example in the discussion of the occurrence of place within the case studies and its importance to their work and identity, some case studies included it within the name of the organisation (Place2Be, Great Places Housing Association) while for others (Salford Heart Care, Debenhams Project) it was implied.

Comparisons and further analysis

The way that the Themes worked to support health outcomes is considered, along with opportunities for working alongside health services. The challenge these perspectives pose to aspects of health service delivery was considered as well as the contrast they provide with current health services.

Presentation

The narrative style adopted was a deliberate choice, reflecting the qualitative methodology used and helping to capture the spirit of the project and ethos of the groups with quotes and anecdotes.

For readability, the introductions in the body of this report (50 – 150 words each) are also presented in abridged form (ca. 1000 words) in Appendix 1.

Long form versions (ca. 2500+ words each) are available via the Oglesby Trust website for further research or reference.

A short form version of this report has also been produced, with headline summaries of the case studies, for those with a strategic interest in the conclusions and key recommendations.

APPENDIX 3: THE PERSONAL HEALTH NARRATIVE AND GP/ PATIENT CONSULTATION

Section 5.1 (Recommendation 1) highlights the overlap between the Royal College of General Practitioners' guidance for the person centred care approach to the GP consultation, and the proposed personal health narrative as a framework.

The GP Consultation

Current and historical models for the GP patient consultation variously focus on interventions (e.g. the 'Six Category Intervention Analysis'); an holistic understanding of the patient (e.g. the 'Health Belief Model'); the objectives or experience of the doctor (e.g. the Balint Approach) and the consultation process (e.g. the 'Calgary-Cambridge Model') Some offer a synthesis of these (e.g. the 'Disease Illness Model') while still other models are more appropriate for acute conditions, an emergency setting etc.

However, none of these are focused on helping the patient express and make sense of their own story, with the purpose of empowering and enabling the patient as a producer of their own health. Where this does occur, it may be an indirect consequence of triggers within other models (such as the questions within 'Helman's Folk Model') or questioning the patient's ideas, concerns and expectations (e.g. in the 'Health Belief Model').

The strengths of the personal health narrative as a framework include:

- Recognising the diversity of individuals, their history and their social context within family, the place they live and the work they do.
- A process of discovery and engagement – making sense of the present, identifying actions and a vision of health in the future.
- A consideration of the relationship of the doctor and patient and the impact of that interaction (the Balint Approach), supporting a leadership role for the doctor as one who helps the patient tell their story.
- Broadening the understanding of health to include important aspects of wellbeing (mental health, housing, relationships, hope etc.) drives consideration of a wider range of support/intervention/enablement options

Overlap with a Person Centred Approach

There is good overlap between guidance offered for the person centred care approach to the GP consultation, and the proposed personal health narrative as a framework (see Figure 6, below).

Figure 7: Alignment of RCGP Guidance on Consultations⁵⁹ with the Personal Health Narrative

Person Centred Care (RCGP)		Reflected within Themes of Personal Health Narrative
2.1	Recognise that patients are diverse: that their behaviour and attitudes vary as individuals and with age, gender, ethnicity and social background, and that you should not discriminate against people because of those differences	Theme 2
2.2	Be aware of the range of values that may influence your patient's behaviour or decision-making in relation to his or her illness	Theme 2
2.3	Respond flexibly to the needs and expectations of different individuals	Theme 2 Theme 4
2.4	Demonstrate how to use the computer in the consultation while maintaining rapport with your patient	Theme 3
2.5	Share information with patients in an honest and unbiased manner, in order to educate them about their health (doctor as teacher)	Theme 2 Theme 3
2.6	Negotiate a shared understanding of the problem and its management with patients, so that they are empowered to look after their own health	Theme 4 Theme 5
2.7	Achieve meaningful consent to a plan of management by seeing the patient as a unique person in a unique context	Theme 1 Theme 2 Theme 4
2.8	Apply ethical guidance on consent and confidentiality to the particular context of an individual patient	Theme 2 Theme 3
2.9	Apply the law relating to making decisions for people who lack capacity to the particular context of an individual patient	Theme 1 Theme 2 Theme 4
2.10	Understand the importance of continuity of care and long-term relationships with your patient and their family in identifying and understanding the values that influence a patient's approach to healthcare	Theme 2 Theme 3

⁵⁹ RCGP Guidance, 'GP Consultation in Practice' (person centred care), page 9. See <http://www.rcgp.org.uk/GP-training-and-exams/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-2-01-GP-Consultation-In-Practice.ashx> (retrieved June 2015)

It is also clear from this comparison, that:

- Guidance places less emphasis on understanding the person's 'place' (Theme 1, their situation, condition and circumstance)
- Sharing information and advice (point 2.5) is represented more strongly in the guidance
- Similarly, the guidance places a greater emphasis on actions and treatment (Theme 4) than outcomes (Theme 5).

It is also noticeable that rearranging these elements to reflect the narrative formed by Themes 1-5 would provide a natural 'story' for the patient (implied perhaps in points 2.6, 2.7 etc.) The personal health narrative therefore positions the doctor, within that story, as an enabler and support to the patient, who is positioned as the principle owner/producer of personal health.

APPENDIX 4: APPLYING THE PERSONAL HEALTH NARRATIVE TO SCHOOLS

Section 5.2 points to a particular opportunity afforded by adopting the personal health narrative. By specifically positioning people as producers of health, the responsibility for health outcomes is moved beyond the remit of any single (health) institution.

This opens up possibilities for other service providers, agencies and institutions to view their work through the lens of health. Schools have well defined relationships with people, often formalised as Parent-school Charters. The personal health narrative could be adopted to frame support for individuals and their long-term wellbeing and health outcomes.

Examples are offered through Cheetham Hill Primary School ('The Proof of the Pudding, Case Study 5), Aspens Catering ('A Healthy Profit', Case Study 6) and Manchester Communications Academy ('Close to Home', Case Study 7).

Figure 8: Application of the personal health narrative to a Parent-School Charter

Personal Health Narrative Theme	Impact on a Parent-School Charter
Provision of a safe place	<p><u>Objective:</u> Health and wellbeing of the child is promoted when the child sees respect for the school and education at home and in the community and understands their education as a partnership between school, family and community.</p> <p>Schools are required to provide a safe and healthy environment for children to learn in, including providing a healthy diet and physical activity for pupils. Schools can foster this role and the respect with which they are held within their host community.</p> <p>e.g. CITEC is working with local schools to promote physical activity and monitor children's weight. Manchester Communications Academy encourages use of their facilities by the residents of Harpurhey.</p> <p>Parents must understand their role in providing a safe, stable, healthy and affirming environment for home study</p> <p>e.g. Cheetham Primary Academy encourages parents to come into the school to participate in physical and healthy eating activities with their children.</p>

Personal Health Narrative Theme	Impact on a Parent-School Charter
Consideration of the whole person	<p><u>Objective:</u> Health and wellbeing of the child is promoted when schools and parents encourage greater mental and emotional resilience, personal awareness and self-esteem.</p> <p>Schools are required to provide for the emotional and mental well-being of the child. Education has developed a long way from a 'one-size-fits-all' approach.</p> <p>However, for those children with particular problems or challenging behaviours, expertise is available to help them cope (e.g. with drivers of wellbeing outside the school, such as home life and previous experiences). This is before acute interventions by other agencies such as CAMHS.</p> <p>e.g. Place2Be works with children and young people of all ages to improve wellbeing, build resilience and minimise harmful and disruptive behaviours. They provide a safe space within the school and are integrated within the school community.</p> <p>Parents and families are engaged to increase understanding of children's experience, agree work to be done and share the task of supporting the child. Parents are helped to understand their children's behaviours.</p>

Personal Health Narrative Theme	Impact on a Parent-School Charter
Connections to others	<p><u>Objective:</u> health and wellbeing is promoted when schools and parents help children understand relationships better and foster a responsibility towards others.</p> <p>Schools are required to provide for the social wellbeing of the child. Information about sexual health is provided and there is greater understanding of social pressures, the important role of friends, peers and social media (e.g. cyber bullying, exploitation).</p> <p>However, schools can improve relationship education as part of PHSE by bringing real world examples of relationships and partnerships into the school.</p> <p>e.g. Explore provide positive role models for long-term relationships. Straight Talking provide real world examples of teenage parents.</p> <p>Parents must understand the powerful example of relationships they provide to children; their behaviours and conduct towards others, within the home, with extended family outside the home with the wider community.</p> <p>e.g. Cheetham incorporates parents (especially fathers) into appropriate school activities builds important parental affirmation of the child's learning and development.</p>

Personal Health Narrative Theme	Impact on a Parent-School Charter
Fostering influence and control	<p><u>Objective:</u> health and wellbeing is promoted when schools and parents help children understand their role in producing their own health, including better choices and appropriate behaviours (e.g. with regards to over eating, binge drinking, substance abuse, sexual health, lack of exercise etc.)</p> <p>Schools and education provide support for informed choices and encourage appropriate behaviours. They can extend this to developing the child's sense of their role in 'producing' their own health through wise choices, avoiding risk taking behaviours and purposeful activity.</p> <p>Families have an important part to play in supporting healthy eating and physical activity through the choices made within the home such as preparing food rather than eating take-away, providing alternatives to fatty, sugary snacks etc.</p> <p>e.g. Aspens are a catering company that integrates curriculum, food preparation, local produce and nutrition advice to inform behaviours and change attitudes towards food and healthy eating in young people.</p>

Personal Health Narrative Theme	Impact on a Parent-School Charter
Creating a vision of a healthy future	<p><u>Objective:</u> health and wellbeing of children is promoted when schools and parents help children see a healthy future ahead as a consequence of their actions.</p> <p>Schools are well organised to prepare children with the academic and skills basis for a job and career. This can also be extended to include their health and the importance of it to realise the future they imagine.</p> <p>e.g. Aspens Catering engage young people with a broader understanding of food production and preparation to illustrate the benefits and ease of healthy eating.</p> <p>Parents have a key role in shaping the future visions and dreams of children, which are often proxy statements of values.</p> <p>e.g. Yeovil4Families work with families, frequently with children absent from school or falling behind. They encourage them to set their own goals that are important to them and reflect their priorities. Such cumulative small wins (e.g. dressing a child for school, providing a nutritious packed lunch every day) build confidence, resilience, competence and sense of control over larger, longer-term goals.</p>

APPENDIX 5: APPLYING THE PERSONAL HEALTH NARRATIVE TO HOUSING

Section 5.2 points to a particular opportunity afforded by adopting the personal health narrative. By specifically positioning people as producers of health, the responsibility for health outcomes is moved beyond the remit of any single (health) institution.

This opens up possibilities for other service providers, agencies and institutions to view their work through the lens of health. Housing providers have well defined relationships with people, often formalised as Tenancy Agreements. The personal health narrative could be adopted to develop and frame support for individuals and their long-term wellbeing and health outcomes. This is demonstrated by Case Study 19 'Our House, Our Home, Our Health.'

Figure 9: Application of the personal health narrative to a Tenant Agreement

Personal Health Narrative Theme	Impact on a Tenant Agreement
Provision of a safe place	<p><u>Objective:</u> Health and wellbeing is promoted by vesting in the tenant a sense of belonging to their new 'place' and membership of their new community.</p> <p>Housing is expected to provide a healthy, safe and secure environment for tenants to live in. Traditional tenant agreements focus on terms of occupancy and accommodation for a defined term. However, owners of housing stock are heavily vested in a community and have an interest in fostering a thriving 'place'.</p> <p>The Tenant Agreement⁶⁰ is an opportunity to communicate and endorse this perspective with tenants through the approach of the housing provider.</p> <p>e.g. Northmoor Community Centre is an initiative of Great Places. This housing association, as its name implies, is an active agent in the local community, helping to shape the local place, beyond simple housing.</p>

⁶⁰ A further consideration, outside the scope of a tenant agreement is sharing ownership of the housing body itself with residents, giving them a physical stake in the venture and the community.

Personal Health Narrative Theme	Impact on a Tenant Agreement
Consideration of the whole person	<p><u>Objective:</u> The health and wellbeing of tenants is promoted by understanding their strengths as well as their housing need, and helping them explore and develop these.</p> <p>Housing has well defined lifetime standards and is required to make reasonable and appropriate provision for each tenant's needs. However, tenants also have strengths and experiences that they can apply to benefit themselves, other tenants and shape the wider community.</p> <p>e.g. Great Places hosts projects such as LevInspire, encouraging people to learn, explore and develop their skills and abilities. This builds confidence, supports others and can even help them re-enter the workplace.</p>
Connections to others	<p><u>Objective:</u> The health and wellbeing of tenants is encouraged by promoting membership of their new community and shared responsibility with other tenants.</p> <p>Tenant agreements may place expectations on community living, behaviour and conduct. However housing providers can encourage relationships and connections through physical and other considerations. For example, providing accommodation that facilitates shared family life (e.g. a suitable dining area in the home, space for work/life housing or extended family), vibrant community life (e.g. careful design of shared public spaces and locating amenities that are the focus of community life).</p> <p>Tenants can also be encouraged to participate in tenant forums and groups taking responsibility for the life of and assets within the community.</p> <p>e.g. Great Places hosts projects such as LevInspire, encouraging people to learn, explore their identity and develop themselves.</p>

Personal Health Narrative Theme	Impact on a Tenant Agreement
Fostering influence and control	<p><u>Objective:</u> The health and wellbeing of tenants is encouraged by attaching a purpose to their tenancy, and encouraging their participation in the life and activities of the community.</p> <p>Tenant agreements frequently have minimum standards for maintenance of the living space and accommodation, including gardens. This may also extend to shared spaces.</p> <p>However there is an opportunity for the agreement to shape tenants' expectations about a purpose for their tenancy, beyond accommodation. In other words, consider the actions they can take, the choices they can make to influence this chapter of opportunity facilitated by their new accommodation.</p> <p>This then frames expectations, conversations about choices, community involvement and management of behaviours.</p>

Personal Health Narrative Theme	Impact on a Tenant Agreement
Creating a vision of a healthy future	<p><u>Objective:</u> Tenants' health and wellbeing is encouraged by developing a positive vision of their future beyond their current accommodation, where appropriate, and their legacy for the next generation.</p> <p>Housing provision is frequently made for a demographic struggling with a range of life events – new family formation, worklessness, disability, family breakdown, rehabilitation, bereavement or loss of carer/life partner. However there is an opportunity to help tenants develop a vision of their own future which is enabled by better health and can be worked towards during their period of tenancy.</p> <p>These could become shared goals for the tenancy period within the context of the Tenancy Agreement, aligning with principles of reduced assured tenancy agreements and revenue versus capital funding models for new housing.</p>

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