# Community mobilisation at the boundaries of the NHS

## *Insight into phase one research and discussion*

22 September 2020



**This project is supported by The Health Foundation**

**Please contact Neil McGregor-Paterson if you would like additional information:** neil@realitasconsulting.co.uk

# Meeting notes

- This Forum considered the provisional outputs from phase one of The Health Foundation supported project, and provided a platform to consider how to source additional case studies focussed on specific communities.

- Key outputs from the Forum were:

  - The need to reconsider the phrase 'mobilised communities' This is not a term used by providers, community organisations or people. It also has military connotations. 'Coming together to make things happen' is better.

  - When we are explaining what we are assessing, we need to contextualise this, we should explicitly reflect the pandemic context

  - There is spontaneous coming together of people within communities to self-organise and meet the needs of their communities, although this is often stimulated by established organisations

  - Recognition of the need for funding – with no money there are limits to what people can do

  - People and communities need contacts within the system to make things happen

  - How can you define a community? There are areas where there isn't the same definition as community e.g. GLBT vs individuals with mental health who don't have defined community. This makes it much harder to engage with the system who see then as single voices.

- **The following slides reflect the original presentation and have not incorporated the comments above**

# Today's agenda
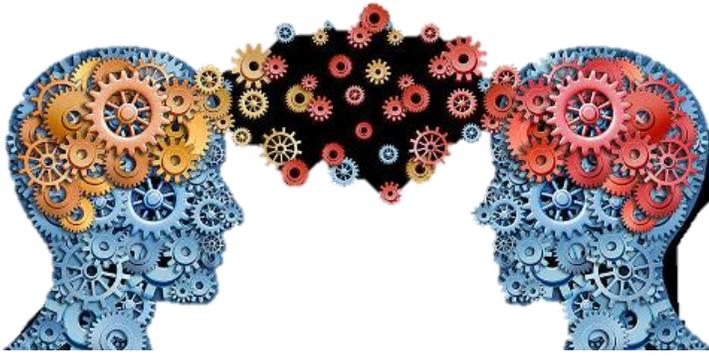
- Recap on project aims

- Project progress

- Call for more case studies

- Insights from phase one desk research, and discussion

- Summary and close

# The project seeks to answer

How can the NHS work with mobilised communities to increase prevention and health creation? Learnings from COVID-19

Can Health Creation help make sense of the COVID-19 community mobilisation for the NHS?

➢Critically, we are considering this through the lens of 'mobilised communities' and not through the lens of providers that have mobilised communities

# Specific Project Aims

- Uncover, explain, make sense of and increase the profile of community mobilisation while it is happening and visible through the COVID-19 response

- Identify the implications for NHS systems and practice towards enabling and sustaining community-led approaches to health and wellbeing beyond COVID-19

# Through the lens of mobilised communities

**PROJECT TEAM**

CROSS SECTOR SOUNDING

| Desk Research | Briefings | Case study sourcing | Forum chat | *Interim report* | Selection of 6/7 examples for in-depth analysis | *Final report* | Launch |

July

December

# Case study submissions

**Outputs**
- 38 submissions
- Seven with potential to take forward

**Need support in identifying communities most affected by COVID-19 e.g.**
- BAME
- Gypsy and traveller
- Learning disabilities
- Mental health challenges
- Chronic long-term conditions
- Cancer



Can you support us some additional case studies?

# Mobilised communities?

**Community mobilisation** ➡ **Mobilised communities**

Involves people coming together to identify the things they want to change, working out what resources they have at their disposal and formulating a plan for how they can use them to be successful

Pre-requisite to mobilisation communities

People working together to make things happen; identifying and planning for further change

**?** Does this resonate?

Are external agents normally catalysts?

# Thinking on principles of mobilised communities

## Insight, skills and understanding

- People involvement
- Reflect diversity
- Language specific
- Culturally specific and sensitive
- Disease specific
- Multiple disparities
- Understand broader issues

## Infrastructure and co-ordination

- Fascilitating and catalysing
- Organised capacity
- Accountable leadership from within at all levels
- Anchor institutions
- Established organisations refocusing

## Clarity of focus

- What?
- Why?

## Community trust and confidence

- Relevence of support
- Accepting of support

## Provider/agency relationships and respect

- Guidance and support
- Established/tap into infrastructure

## Effective Communication

- Between people
- Within communities
- Peer-to-peer
- Social media
- Traditional
- Between agencies

## Recognition that:

- systems cannot meet all the needs of their communities
- people can self-organise around the needs of their communities

# Why are some more adept at mobilising?



- Connected
- Collaboration not competition
- Minimal hierachy
- Super localisation
- Commitment to speed and agility
- Ability to tap into specific expertise and support
- Manage conflict and disagreement; remain politically neutral
- Provider as: enabler, catalyst, funder and shifter of power

# Barriers?

- Lockdown, social isolation
- Lack of funding
- Bureaucracy
- Digital literacy
- Poorly established infrastructure; no social infrastructure
- Distrust of authority; discourse within communities
- Lack of specific community involvement in mobilised support

Can health creation help make sense of COVID-19 community mobilisation for the NHS?

# Health Creation...

…must sit alongside prevention of illness and the treatment of ill health through services and medicines

… happens when local people and professionals work together as equal partners and focus on what matters to people and their communities

People need



Control
Contact
Confidence

...to be well

The 5 features of health creating practices
- Listening and responding
- Truth-telling
- Strengths-focus
- Self-organising
- Power-shifting

# Digital Forum 2 October 2020

Dr Chris Tiley, GP at Lander Medical Practice in Truro

Exploring steps Primary Care Networks can take to engage with communities and local partners to address health inequalities