PUTTING COMMUNITIES IN THE LEAD ON HEALTH AND SOCIAL CARE

By Samira Ben Omar

In our Joining Forces cell, a key insight is that we should stop trying to control from the centre. Instead we should be creating a culture in which people at every level have the power to be leaders for system change. Here Samira Ben Omar explains why this is so important in the field of health and social care.

Until recently I led on system change as well as partnerships and engagement for the North West London Integrated Care System. In this role I came to truly understand that communities and grassroots organisations were far more central to the task of producing better health and care outcomes than had been generally accepted. And also that we needed to fundamentally rethink our relationships, and do much more to create the conditions for those in the communities we serve to play a central part in bringing about sustainable transformation in addressing inequalities in health and care.

Here are some things that I learned:

- The public sector is always limited in what it can achieve alone. A lot of the time those of us in the public sector health and social care system assume that it is primarily our own efforts that will produce the big changes that are needed. The reality is that maybe 80 per cent or even 90 per cent of what impacts on health happens outside healthcare settings. The quality of housing, job security, the sense of community to name just a few examples.

- Local communities are more resourceful than we think. A lot of the solutions to the challenges that the system struggles with and that are needed to make a difference already exist – a huge amount is going on all the time. But we don't always see it because it is out there in the community, not easily visible to us when our policies and strategies are developed in our offices, while the day-to-day reality of access and experience and quality of care for our residents and communities – especially those most excluded – happens on the ground, on the estates and in neighbourhoods.

- There is often a disconnect between the mainstream policy narrative and the reality of community life. A prime example of this was in the early days of lockdown when everyone was told that if they needed to self-isolate they should avoid sharing a bedroom, bathroom or a kitchen, and that older people and those clinically extremely vulnerable should self-isolate. This type of narrative – while it applied to many – simply did not resonate with very large numbers of people, especially those living in overcrowded conditions, those in multi-generational and multi-occupancy households across the country.

- Communities do most when they can decide for themselves. Communities work best when people decide to take action together, when they exercise their own agency, and when they are motivated by a shared and clear purpose rather than prescribed targets defined by someone else. Some years ago, I set up a Community Champions scheme. As part of a lung cancer awareness initiative, the champions were asked to make contact with 600 people, and the fact that the campaign resonated with them meant that they reached 3,000. The target they had been set had no relevance for them, and when they decided to ignore it and follow their own motivations, they achieved a lot more.

- Community spaces are the lifeblood of local action. In the immediate aftermath of the Grenfell Tower fire it was the local community, the churches, temples, synagogues and mosques for example, that stepped in to offer help, not only to residents but also to every public sector organisation, so that they could deliver support to those directly affected by the fire. And we saw the same thing more recently in the pandemic where for example the local Gurdwara – among others – delivered over 500 food packages to NHS Health and Care staff, as well as thousands of meals to homeless people – on a daily basis.

So, what are the preconditions to create a culture in which people at every level – including in the community – are able to be drivers of the big system transformation needed to achieve better health outcomes, not least in this new world of 'Integrated Care Systems'?

Firstly, we need to undo and unlearn some of our own embedded behaviours. In the public sector it seems we are conditioned to do ever more: organise, design and deliver more programmes. Yes, these things are often critical and very much needed, but they cannot be the starting point for achieving change and transformation. The nature of the relationship that we establish with our communities – and indeed our frontline staff – is the sustainable element and that relationship can only be built on the basis of honest, transparent and non-gendered conversations where the starting point is about the person and the conversation starts with 'How are you?'

We need to acknowledge that as health and care organisations, we sometimes create and frame things in our own image and then we wonder why we find it difficult to engage with wider communities or why our lay membership is not representative of our communities.

The answer to this is simple: we set up committees in our image and we only attract people who are familiar with our ways of thinking and doing (a very substantial number of our lay representatives tend to be retired civil servants, teachers, health care professionals, NHS managers etc). I believe that to address this we need to separate the function of committees as formal routes to engagement – which are necessary for governance and assurance purposes – from the role of creating and nurturing a kind of collaborative space, where power-sharing is explicit, where no one person owns the agenda, and where those who participate, including local people, can bring forward proposals and make things happen – on their own terms.

We also need to become explicitly committed to talking about racism and discrimination and their impact on health and care outcomes. We didn't need the pandemic to tell us that racism exists in the NHS and other public sector institutions, but it was a stark national and global reminder – the pandemic highlighted the disproportionate impact on people in areas of high health inequality, as well as among people from Black, Asian and minority ethnic groups. We cannot forget this, and we have a duty to keep this agenda at the forefront of every conversation on the impact of policies and strategies on our communities.

We have to commit to valuing the stories that people share with us as a valid and robust form of research equal to the quantitative data that we acquire. We also must commit to measuring what people value. People value trust and trusted relationships, and we don't have to go that far back to truly understand this. If we have learnt nothing else from the national COVID vaccine roll-out, we have absolutely learnt the power of trust and trusted relationships to deliver the outcomes required and improve vaccine uptake, especially among those most affected by COVID.

Finally, this essay represents only my humble reflections and I have to admit that I have been intentional in some of the provocations here and to that end I invite you to challenge me – I invite you to a different type of conversation.

Samira Ben Omar has over 25 years' experience working in the public sector and the NHS. Her work has particularly focused on policy development, transformation, equality, participatory research and initiating grassroots community-led programmes and social movements for change. She is currently working as an independent consultant and sits on the King's Fund General Advisory Council.