

Connected Communities

Connected Health and Social Care Communities

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CONNECTED HEALTH AND SOCIAL CARE COMMUNITIES

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Executive Summary

In the context of service integration and development, communities in Health and Social Care require interrogation: analysis enables identification of community in relation to governance, professional practice and user/citizen constituencies. Knowledge, understandings and identities within different communities need recognition if cross-community engagement and development work is to be undertaken; those who themselves cross communities or identify with multiple health and social care communities may be valuable 'connectors', in either formal or informal roles. In contrast to predominant theories in organisational studies (e.g. functionalist; social learning), humanities offers the lens of virtue ethics with which to examine connectedness in communities and change over time. Workshop activity found that whilst policy can be disruptive of pre-existing communities in health and social care, communities can respond, to affirm their purpose and seek joint understandings of purpose with others. Future research should explore how communities in health and social care respond to changing circumstances, and what factors influence whether community forms and capacity are enabled or threatened by policy and practice developments.

Researchers and Project Partners

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Key words

health care; social care; wellbeing; community engagement; policy; virtue ethics

Introduction

'Health and Social Care Community' can be used to describe shared identity, organisation and purpose in relation to governance, professional groupings, practices and user-based activities. In the context of service integration, development and personalisation, interconnectedness within and between communities require interrogation if 'communities' and their ability to sustain and change are to be understood.

The scoping review mapped out:

- *Conceptualisations and meanings of 'community' in health and social care:* what is being invoked by 'community' in the health and social care domain?
- *Personalisation and health and social care communities:* what is the relationship between personalised policy and practice, and communities?
- *Connectivity within and between health and social care communities in the context of policy:* how does connectivity function in changing governance and user community contexts?

The methods used were:

- *Literature review:* examining knowledge and debate concerning 'communities' in health and social care.
- *Networking/Collaborative Activity:*
 1. Workshop learning event to identify key communities in the lived experience of participants to inform the literature review.
 2. A seminar event with invited participants to present findings and identify future directions in 'health and social care communities' research.

Conceptualisations of Community in Health and Social Care

Community in Social Science

Tönnies (1887/2002) differentiation between community or *Gemeinschaft* (regulated through relationships, values, and traditions) and society or *Gesellschaft* (associated with rationality, institutions, and formal role allocation) is the bedrock for later work on community in social science. Historically the varying academic definitions of 'community' has been problematic (Hillery,1955) though it has been said that too tight a definition might threaten capture of the many ways in which people construct communities

through action and/or ascription (Alleyne, 2002). The term community retains strong presence within social capital literature (cf Putnam, 2000), focused on community relationships, place, social networks, a 'sense of community' and community participation/involvement (Ching-Hsing, 2008).

Community within health and social care

Care must be taken to identify misuse of the term community in policy to instil a sense of wellbeing (Craig, 2007) or redemption (Brent, 1997). Jewkes and Murcott (1996; 1998), writing about community participation and health, argue community is highly contested by conceptually concerned academics and often presented as self-evident by policy makers. Analysis enables identification of community in relation to governance and to professional and user/citizen constituencies.

The NHS and Community Care Act 1993, arguably driven by funding rather than care in the community considerations (Lewis, 1999), is the precursor to the increased reference to 'H&SCCs'. The governance based notion of '*health and social care communities*' (H&SCCs) has developed during service transformation with a focus on the development of cross-agency strategy (NHS Executive, 1999; Peck, Towell and Gulliver, 2001; Martin et al. 2004; Glasby, 2005). Early uses of 'H&SCCs' tended to refer to shared information needs for service planning (Long et al, 1992; Stevenson, 2001) and shared responsibilities to provide information to service users (Blackburn, 2001). In this use of 'H&SCCs', the partnership work of commissioners and providers has been the predominant focus, thus prioritising shared needs and activity over differences (in values, priorities, cultures) between parts of the 'whole'.

Professional communities based on identity, action and shared interests have been important before and since the NHS was founded: alongside local communities of practice (Lave and Wenger 1991), communities of professionals exist through formal organisations engaged in practitioner regulation, status building and protection of members (Harrison and MacDonald, 2008). A 'health policy community' literature has identified key professional actors engaged in national and local policy developments (e.g. Salter, 2003).

Service user communities have increasingly engaged in health and social care consultation (Cook, 2002) though their influence within the wider policy community has been questioned (Salter 2003). There is a tension between citizenship engagement and user participation, and whether involvement operates as a technocratic or democratic process with implications for identity and experience of community (Martin, 2008). Emmel and Conn (2004) review approaches of providers to community engagement and identify that imposed definitions of community may not correspond to lay-people's own identity: more included members within an (ascribed) community are likely to be represented, and others may remain invisible; further, there is evidence there are multiple perspectives on health (broadly defined) within communities (East, 2002). Engagement of 'communities' in policy/practice development and consultation requires

close scrutiny on the extent to which partial communities and select perspectives are represented.

Workshop contribution

Identities, ascribed identities and the role of organisations in defining community/ies were central to discussion. The value of the 'reticulist' (who can carry knowledge and understanding between communities) was posited, recognising that knowledge and cultures in different sites requires acknowledgement and understanding. Change over time and increased barriers around communities (e.g. practice-based; service-user group) were identified as linked to resources and competition. Concerns included marginalisation and restriction of engagement through top-down definitions of community.

The citizen in health and social care communities

Conceptualising the individual

Community care and health policy has conceptualised the individual in order to administer services and involve individual representatives of (e.g. 'user'/'patient') communities. Individualisation in policy has involved liberal notions of citizenship, a communitarian focus on responsibilities, neo-liberal consumer choice agendas and social movement activism (Newman et al 2008). Patient groups, citizenship focused groups (e.g. disabled people; older people) and carers have organised into groups of identity and purpose in order to influence policy and practice (Parker and Clarke, 2002; Priestley, 2002). The analytical focus and politics within such forms of organisation can mean that there are differences in perspective and action between communities, such as between disability activist and biosocial identity based groups (Hughes, 2009). Community identity in direct relationship with services, and self-determination and choice and control within communities, are different but overlapping elements of citizens' H&SCC experience.

Personalisation: rights through markets?

Personalisation models developing across health and social care can be understood both as reflective of concerns to increase service user choice through the market/quasi-market (consumer focused) and as a response to rights based claims for more responsive and appropriate services which support individuals and their wider social

participation and community memberships. It has been argued that personalisation has been formulated in a context where social care is being individualised and marketised (Ferguson, 2007) and the extent to which market-consumerism empowers citizens or communities of users of care services is contested (Baldock, 2003; Scourfield, 2007). Ensuring that personalised approaches enable choice and control of citizens in their communities, and resisting the potential threat to collective/community approaches to social and personal support has been identified as a challenge (Sapey and Pearson, 2004).

Workshop contribution

Top-down versus citizen-led approaches to community building were discussed: health/patient-focused ascriptions of community membership were viewed as having a narrower 'vulnerability' focus and individualising impact, whilst a wider community development remit was seen as more empowering, encompassing more citizens, and involving wider influencers on well-being (e.g. housing). Whilst community building with/by citizens in the health and social care arena was viewed positively as a balance against consumer-based engagement, there was concern that individuals in communities who can mobilise themselves will fare better, risking strengthening inequalities. Individuals who belong to local communities acting as 'connectors' between structures and citizens were seen as a potentially inclusive model: this was explored in the literature following the workshop, and reflects developing 'community navigator' practice in the UK (e.g. Care Navigators: Turning Point, 2010; Bruce et al 2011).

Connectedness in health and social care

Conceiving the bonds of community

We consider here three theoretical lenses for exploring community connectedness: two from organisational studies (structural functional and social learning) and an alternative from humanities (virtue ethics). The latter has had minimal application in this context offering opportunities for opening new insights (Conroy 2010).

Structural functionalism

Durkheim (1912) was concerned with how societies and communities maintain internal stability and survive over time, and perceived all social and cultural phenomena as being functional, i.e. working together with specific functions and achieving a 'bodily' state of equilibrium. Individuals in the community have relevance only through their status-based and role-based connections. SF theorising often leads to a technical 'lever' or systems focused approach to organisation and outcomes. It has been critiqued for

offering accounts distanced from social reality (Cameron et al 2001), for misdirecting attention towards best practice recipe guidelines that do little to improve the delivery of services (Dawson 2003), for being disruptive of practice ethics (Conroy 2010) and for not taking into account people's self-interest, manoeuvring, manipulation and competition (Leach 1966). Whilst offering a way to visualise a community as a connected set of entities and roles, efficacy and ethics require consideration.

Social learning: Communities of Practice

A radical and influential understanding of the social learning connection between communities of practitioners has derived from the work of Lave and Wenger (1991). Wenger (2006:1) defines Communities of Practice (CoP) as: 'groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly.' CoP conceives an implicit and situated learning curriculum within the community: new members gradually learn through participation in practice as a social activity. This would suggest that if the community is sliced up and restructured by applying SF theorising then the impact on learning and knowledge can be profound and highly disruptive. Critics claim that this has occurred in regular restructurings of the NHS (e.g. Walshe 2010).

CoP and social learning theorising include notions of community, practice, shared learning and shared knowledge leading to the spread of innovation (Brown and Duguid 1991) but, unlike SF, has little to say about the institutions. Like SF, CoP does not appear to take into account ethics of practice.

Both the above theories are helpful but limited in their ability to understand how H&SCCs construct connectedness and so we now look to the humanities for an alternative theoretical lens.

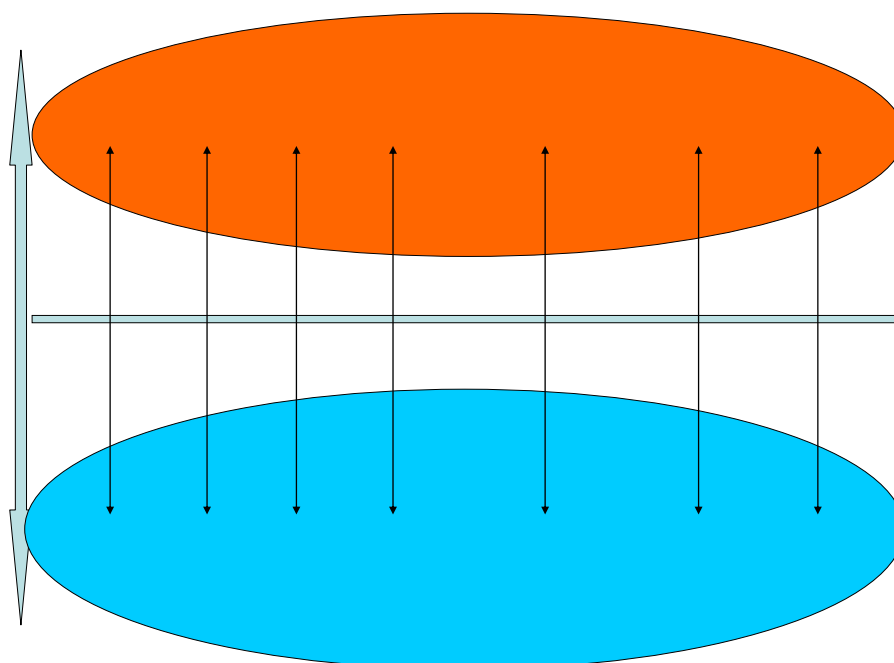
Virtue ethics: a goods, practices virtues and institutions schema

MacIntyre's colossal body of writing on ethics that positions his mid career thesis *After Virtue* (1985) contain very strong arguments of what we have lost in our understanding of community and societal connections. That loss is of shared virtues which operate through practice in service of wellbeing for all in society. In MacIntyre's virtues-goods-practices-institution schema (Moore and Beadle 2006) practice excellence offers rewards for practitioners and citizens (internal goods), binds practitioners in one practice group together, binds different practice groups together across institutional boundaries and further still binds people across sectors in any given community. The theory encompasses dynamic development of community connections by members who are continually clarifying their personal aims by meshing with collective aims in a way that serves the wellbeing of all in society. VE can be viewed as building on SF and social learning theories to encompass the ethical connections between all practitioners in any given society regardless of discipline.

The way MacIntyre envisages the collective relationship of practices, the narrative of the institution and their potential disruption is summarised by McCann and Brownsberger (1990) who stress the centrality of *telos* (purpose) to human life. Disruption may involve loss of a shared sense of telos and a corresponding lack of agreement concerning social practices and the virtues that underpin them. For MacIntyre (1985) disruption and corruption derive more often than not from an (individual or collective) bias in focus on external goods (money, status and power) rather than on internal goods.

Workshop illustration: virtue as a mean

In order to apply the theoretical lens afforded by MacIntyre it becomes important to understand the notion of virtue as a mean growing out of engagement with that practice, not predefined. Any community needs rules or an ethos to hold it together: Aristotle in *Nicomachean Ethics* (1958) suggests a set of virtue continuums (Courage, Generosity, Magnificence, Pride, Anger, Truth and Indignation). MacIntyre was careful to avoid such definitions, and we therefore allowed the accounts from our workshop practitioners to define the virtues of connectedness in H&SCCs. Using a virtue continuum lens we mapped stories of connected communities from our workshop participants (Figure 1).



Within the workshop we heard examples of practice which countered policy and practice impositions perceived as potentially disruptive of communities by pre-defining the terms of engagement: the focus was the incremental development of working relationships

within and across communities, engaging with the learning in communities and seeking to develop a common purpose.

Feedback seminar

The seminar suggested that the above theorising was helpful to participants in understanding connectedness as a set of continuums. Participants talked about 'moving from the orange to the blue' and vice versa. It seemed to give them a way of expressing their social reality of connectedness when working in H&SCCs. Notable by their absence, both in the workshop and feedback seminar, were accounts of sacred/profane or moral/immoral continuums which is arguably consistent with MacIntyre's thesis that the resources to maintain such ethical debates have become disrupted.

Recommendations for future research:

Navigators and 'reticulists'

Research should identify opportunities for and barriers to community development, foregrounding people's lived conceptions of community. Multiple community memberships, cross-community engagement, and the experience of managing different identities in different communities (incorporating lay, political or professional health and social care perspectives) should be priorities in future research. The developing research focus on community/care navigators in the UK should be expanded to incorporate citizen navigators (engaging with multiple H&SCCs in a personal capacity), formal (paid and voluntary) navigators (engaged to link people of their own personal communities with services), and professional navigators ('reticulists' who are able to enter different health and social care policy/service realms and engage positively in different structural and cultural environments).

Policy for generative health and social care communities?

The ways that communities transmit their practice ethics (MacIntyre, 1985) and support membership generativity (i.e. their contribution to future generations of their material creations, knowledge and culture: Imada, 2004) require research, policy and practice attention, particularly when models of delivery are experiencing rapid change. By way of example, the recent white paper (Department of Health 2010) issued under the Coalition government presents a solution to the challenge of cost savings which is inherently structural functional: removing layers of 'bureaucracy' (SHAs and PCTs) and handing responsibility for the commissioning of healthcare to new structures (GP Consortia). A CoP lens shows the potential for shared learning and knowledge bonds being lost. MacIntyre's lens presents an even more disturbing loss, of practice ethics that build over time in any community: the generational handing down of practice knowledge and ethics

is highly likely to be disrupted as we have seen previously, in mental health services (Conroy, 2010).

Future research should explore how organisational, practice and user/citizen communities which engage in health and social care respond to change, and what factors influence whether community forms and capacity are enabled or threatened by policy and practice developments.

Complexities of connectedness

Further research should contribute to our understanding of how health and social care policy implementation impacts on communities' lived-experience, health and well being. This paper offers a 'connected continuum' model, based on MacIntyre's virtue ethics (1985), which has been shown to be helpful in understanding more about the complexity of connectedness and its relationship to health and wellbeing and which has potential for application with other communities.

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The Connected Communities

Connected Communities is a cross-Council Programme being led by the AHRC in partnership with the EPSRC, ESRC, MRC and NERC and a range of external partners. The current vision for the Programme is:

"to mobilise the potential for increasingly inter-connected, culturally diverse, communities to enhance participation, prosperity, sustainability, health & well-being by better connecting research, stakeholders and communities."

Further details about the Programme can be found on the AHRC's Connected Communities web pages at:

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