# Commissioning Community Development For Health

## A concise handbook

Health Empowerment Leverage Project
www.healthempowerment.co.uk

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*Contents*



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# Executive summary

1. The purpose of this handbook is to help Clinical Commissioning Groups (CCGs) and other agencies to commission community development. It is tailored to current policy in England but its principles are universal.

2. The development of community strengths must become an integral part of local health strategy so that all sections of the population can become fully involved in improving health.

3. Community development (CD) is action to support residents' independent collective activities and involvement in public services. CD builds social capital and enables people to organise to identify shared needs and aspirations. It addresses imbalances of power, and brings about change founded on social justice, equality and inclusion.

4. Communities are not simply 'there' to be 'harnessed'. Local populations and networks are in variable states of energy, organisation and influence. Communities in disadvantaged areas are often disorganised and disempowered. Community activity needs to be built up from within to generate health and exert influence.

5. Levels of activity, and density of community and voluntary organisations, differ widely from one neighbourhood to another. Areas with the greatest health needs often have sparser community activity and organisations.

6. Increase in community activity contributes to health directly by building up social capital, and indirectly, by improving dialogue between residents and agencies, and influencing the shaping and delivery of services.

7. Best methods will be known by their results. We do not endorse any particular method or label. CD, like other disciplines, can be variable in quality. The best methods are whatever best prove to strengthen community involvement in health.

8. Experienced community development workers are needed to lead this work, and existing health personnel can be trained to contribute to it.

9. For significant health improvements and savings, a whole-local-population approach is required, focusing on neighbourhoods. CD is needed everywhere but most urgently in the most disadvantaged neighbourhoods. We recommend a model for a CD programme building up over five years to cover a CCG. The first and second waves of priority neighbourhoods receive 18 months of intensive support followed by 18 months' maintenance, whilst support is extended to neighbourhoods with less intensive needs in the final 18 months.

10. The first stage in each neighbourhood is establishing the current level of community activity and the profile of existing groups and organisations. Existing initiatives must be respected and helped to grow whilst new activity is fostered.

11. CCGs and Local Authorities need to become more responsive to the needs and initiative of the communities they serve, supporting growth in community activity, and adjusting commissioning and delivery in response to communities' priorities.

12. An outline model contract is provided, together with examples of KPIs. Options for staffing are discussed, and ways of reducing cost through partnership with other agencies.

13. Permeation of the health service ethos. Whilst CD needs to be driven by a dedicated project and expert team, its ethos also needs to permeate all relationships between health agencies and the local population. This includes contractors carrying out other functions for the CCG. All professionals who interact with the community should become aware of how the community works, and should be guided to ways they can contribute to its development.

14. Measurement. The handbook shows how the methods and outcomes of CD can be put onto a more objective basis than has usually been done, measuring activity, whilst maintaining the CD principle that communities determine their own forms of development.

15. Baselines and outcomes can be measured using established instruments. These are set out in an accompanying short paper, *Measuring Community Development in Health, A Menu of Sources and Questions,* free to download at www.healthempowerment.co.uk. The responsiveness of health agencies to community initiative and involvement also needs to be assessed. Some valuable changes may be genuinely innovative and therefore not specifiable in advance. Assessment must look for unintended effects both good and bad.

16. Costs. To make a marked impact across the CCG in five years requires significant resources, but a combination of partnership, secondments and in-kind contributions may considerably reduce the necessary input from the CCG. Seedcorn grants to community groups may be needed, and there would be costs for premises and equipment. We suggest the CCG should take a lead with an appreciable financial commitment, and negotiate contributions from partners.

17. A pilot edition. We see this first version of this handbook as a pilot edition, to be improved by feedback. We welcome further dialogue and propose to produce a revised edition after a period of further evidence-gathering.

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# 1. Introduction: The role of community development in health

## Purpose

If community engagement is to make a long-lasting contribution to health, it must be embedded deep in the community. The main instrument for achieving deep engagement is community development. In plain terms, this practice consists in supporting social groups, networks and initiatives that are run by residents themselves.

The problems of the health service will not be solved without a serious approach to mobilising communities' own efforts. The extension of community control and initiative is the factor which transforms health into a social movement alongside the care and treatment needed from professionals.

There are three main types of health benefit in boosting this community sector, especially amongst disadvantaged sections of the population:

- first, for participants themselves, through the very process of participation;
- secondly for other residents, through expansion in local activities, mutual aid and social networks;
- and thirdly through improvements to the locality through better dialogue and negotiation between local communities and public services.

We need to move on from projects to longer-term strategies addressing whole neighbourhoods. The purpose of this guide is to provide a commissioning framework to help Clinical Commissioning Groups (CCGs), local authorities and other agencies do this.

### Theory of change

Community development in health is based on the theory and wide experience that:

- people feel better and stronger if they take action on their own behalf together with others. Social action generates health gain;
- a higher level of community activity, involving more residents, more varied activities and greater resident influence on services, improves health and wellbeing, and reduces recourse to primary care and A&E;
- community activity and its health-creating properties can be increased by stimulating and supporting it using CD's characteristic non-directive methods;
- building up 'non-health' groups also boosts health, through social determinants such as housing, employment, policing, environment, education and generic effects on volunteering and mental health'

- increased volume and interaction of community activity produces more representative networks for agencies to consult the community on service change, spread health information and signal help to carers.

# What is community development?

We use the term community development (CD) to mean action to raise the long-term level of health and wellbeing, by helping local communities to strengthen their own action on health and on all the local conditions that affect health. CD activity can be identified by these characteristics:

- support for, or facilitation of, autonomous community groups (groups accountable to their members, not to an external body)
- a developmental approach, ie widening activities, issues, membership, skills and influence
- an emphasis on fostering equality and empowerment.

**Community development (CD) strengthens residents' own collective efforts** to improve their health and conditions. CD brings people and groups together to find common cause and take action on issues that concern them. It assists groups to work with local statutory agencies such as health, housing and police, and guides agencies in how to relate and respond to communities and create the best conditions for them to flourish. Good examples are in the 'Local Lived Experience' teams of Disability Rights UK.[1]

**CD reaches out beyond the larger voluntary organisations** to the hinterland of small, often overlooked groups and social networks, to the sections of the community who are least organised, least vocal and sometimes least healthy. It extends beyond groups working on health issues to the larger number that affect health through other issues: groups about housing, environment, sports, faith, employment, crime prevention, arts.

**CD is based on values of equality, inclusion and overcoming disadvantage**. It is therefore particularly relevant to overcoming health inequalities, and problems connected with poverty and poor social conditions. A set of National Occupational Standards describe the occupation as 'enabling people to work together to: • Identify their own needs and actions • Take collective action using their strengths and resources • Develop their confidence, skills and knowledge • Challenge unequal power relationships • Promote social justice, equality and inclusion in order to improve the quality of their own lives, and their communities and society.' [2]

**CD requires a high level of skill.** It is therefore likely to require specialist workers, or teams with a track record of successful achievement. With experienced leadership, some existing NHS staff can also be trained.

[1] http://www.disabilityrightsuk.org/search/node/local%20lived%20experience
[2] http://www.fcdl.org.uk/learning-qualifications/community-development-national-occupational-standards/

**Asset-based CD[3] builds on positives:** leaders, skills, strengths of individuals and communities, rather than just on need. "Build on the strong not on the wrong". No form of community intervention can work unless it is asset-based, in the sense of placing high value and expectations on residents' initiatives and ownership of the action. On the other hand, even asset-based intervention seeks improvement, with a focus on those people who are enduring the greatest disadvantages. So we continue to speak about both needs and assets.[4]

# The underdeveloped community

Communities do not exist in a ready state to be engaged or 'harnessed'. Communities are not unified organisations, they are fluid populations loosely threaded with networks of family, friendship and co-operation. A Home Office study[5] found that one locality might have 50,000 hours of volunteering per thousand people per year, another only 20,000. One might have 15 voluntary or community groups per thousand residents, another only four. Usually a small proportion of local residents would be active and organised, a majority inactive and uninvolved, and some quite isolated.

**There are large variations in the material assets and infrastructure that enable a community to function.** The ability of local residents to participate in activities or run community groups is critically affected by access to free or cheap meeting spaces, small grants, connection with networks of information and co-operation, and the support of community workers[6]. Many localities have seen reductions in community activity over recent years due to reductions in grants, closure of community centres and pressure on amenities to maximise income.

**The task of engaging the community in health policy** is often loosely equated with support for the voluntary sector. But this goes only part way to involving the population as a whole. A purely top-down approach to involving the community can in practice mean involving only the fraction of it that is most organised and active. This will not make sufficient impact on the overall health of the population.

**Larger voluntary organisations often have the loudest voice in dialogue with local public agencies**. But they are primarily providers of services, rather than a means of access to the whole community. The voice of the community is generally to be found in the smaller, less visible, less well organised - but more numerous - community groups and networks. Also important are community partnerships and umbrella organisations, which link groups and widen involvement. Many people who are socially isolated, neither part of the voluntary nor community sector, need to be drawn into their own community by extending the reach of those groups that are closest to them, or by creating new groups.

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[3] Eg Jane Foot and Trevor Hopkins (2010) *A Glass Half-Full: How an Asset Approach can Improve Community Health and Wellbeing*, London Local Government Association (I&DEA)

[4] 'JSNAs... provide a unique picture of local needs, and if boards choose to include them, assets.' *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies*, Dept of Health,. 2013

[5] Marshall, T.F, et al (1997), *Local Voluntary Action Surveys ('LOVAS')*. London: Home Office Research and Statistics Directorate.

[6] Home Office (2004), *Firm Foundations*

**Small groups, big potential.** The greatest potential for growth in participation is in the small groups and those larger voluntary organisations which support them. Small groups form 90% of the voluntary sector[7], but have few resources and little recognition. Many are isolated, reach only handfuls of people and are invisible to big institutions. CD is the dedicated instrument for driving this growth.

**The vision of a fully participating, health-promoting local population** requires a more interactive relationship between local communities and local public bodies. A study in 2008-10[8] found that most community and voluntary organisations felt unrecognised, undervalued and disconnected from local public bodies. Improving dialogue and interaction with public bodies was more important to them than more funding.

**Top-down initiatives directed *at* the local community by public agencies**, such as campaigns to eat more healthily, do more exercise, stop smoking or support carers, meet only half the community engagement agenda. The other half needs to be support for communities' own actions and initiatives.

# Evidence and cost-benefits of CD

There is extensive evidence that strong social networks protect people against the impact of stressors, both mental and physical. Participation in social networks has been shown to result in multiple beneficial outcomes, both for health, education, crime reduction and other social goods. There is clear evidence that widening the involvement of local people can improve behaviour change and increase the responsiveness of services[9].

**A number of studies have estimated substantial health savings** from greater community involvement.[10] To make a significant impact on population health, community engagement must achieve critical mass. This requires a strong element of high quality CD.

**We do not endorse any particular method of CD practice.** There is debate about the best methods. Like other disciplines, CD can be variable in quality, and practitioners may badge themselves in different ways. We concentrate on how to specify the outcomes that are desired and the evidence to be collected, so that methods and practitioners can be judged by their results.

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[7] See for example www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/eval-voluntary-sector-2013-bolton.pdf

[8] https://www.ipsos-mori.com/Assets/Docs/Polls/nscse-national-survey-2010-topline.pdf

[9] Brian Fisher (2016), *Community Development in Health, A Literature Review*. Revised edition. Health Empowerment Leverage Project, www.healthempowerment.co.uk

[10] Suzanne Wood et al (2016) *At the Heart of Health: Realising the Value of People and Communities*. Nesta / Health Foundation

# 2. Designing the brief

## The whole locality and the neighbourhood focus

To effect significant health improvements and savings, CD needs to be applied more systematically than it has been in the past, by adopting a whole-local-population approach, focusing on neighbourhoods and clusters of neighbourhoods, villages, estates or other small areas. These are the best scale for building up community involvement.

Boundaries should not be regarded as rigid, but ward boundaries are useful for examining statistical evidence even if they do not fit closely with perceived neighbourhoods. The territory itself is not necessarily the focus for action – many groups are about other issues – but it is a natural basis for linking groups around their common interest in local services and conditions.

Methods have to be tailored to the conditions of each particular neighbourhood, but experience shows that there are often strong common factors. 'C2' is a method which has proved powerful in a variety of different types of neighbourhood, by setting out a clear process for building a community-led partnership with the array of local agencies. This has been summarised as a seven-step framework, shown as **Figure 1** below. [11]

**Scale.** As a model, we assume a CCG area covering a population of 200,000 living in 30 wards, each with an average population of about 6,500. CD is needed everywhere but most urgently needed in the most disadvantaged neighbourhoods. These are often areas of greatest demand on health services, and therefore areas where greatest savings can be made by more community activity.

The **neighbourhood** (or **village, estate or ward**) is a vital setting for CD because it is here that most social networks and community groups operate. Additionally:

- it provides a comprehensive population base
- it can involve GPs and be related to primary care
- it fosters face to face and word of mouth social networks
- about a third of community and voluntary organisations
- tend to focus on neighbourhood issues
- groups based near each other can co-operate and build networks.

But this does not mean that community activity can only be *about* the neighbourhood. It may be about issues that link neighbourhoods, about national or international issues, or on-line communities. So long as it is an activity of people living there, it is part of that neighbourhood's community life.

Some communities are based on **interest and identity** rather than locality. However, the local context is still the setting for working with them. It is not the business of community involvement or development to *reinforce* communities of interest or identity

[11] Fuller information on C2 is being updated at www.C2connectingcommunities.co.uk

(which by their nature exclude some people) but to respect them and where appropriate work with them, whilst encouraging inter-community links.

**Figure 1: The C2 Seven Steps** [by kind permission of C2 Connecting Communities]

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C2 Connecting Communities

***The C2 Seven Step Framework:*** **From Isolation to Transformation**

STEP 7

Partnership firmly established and on forward trajectory of improvement and self-renewal. Key resident/s employed and funded to co-ordinate activities. Measurable outcomes and evidence of visible transformational change, e.g. new play spaces, improved residents' gardens, and reduction in ASB, all leading to measurable health improvement and parallel gains for other public services.

STEP 6

Community strengthening evidenced by resident self- organization eg. setting up of new groups for all ages and development of innovative social enterprise. Accelerated responses in service delivery leading to increased community trust, co-operation, co-production and local problem solving.

STEP 5

Monthly partnership meetings, providing continuous positive feedback to residents and SSG. Celebration of visible 'wins' e.g. successful funding bids which support community priorities, and promote positive media coverage, leading to increased community confidence, volunteering and momentum towards change. Partnership training undertaken to further consolidate resident skills.

STEP 4

Constitute partnership which operates out of easily accessed hub within community setting, opening clear communication channels to wider community via e.g. newsletter and estate 'walkabouts'. Host exchange visits and meetings with other local community groups and strategic organisations. Identify '2nd wave' of 6-8 new learners to C2 Experiential Learning Programme.

STEP 3

PSG plans and hosts Listening Event to identify and prioritise neighbourhood health & well-being issues and produces report on identified issues, fed back to residents and SSG a week later. Commitment established at feedback event to form and train resident led, neighbourhood partnership to jointly tackle issues.

STEP 2

Establish C2 Partnership Steering Group (PSG) of front line service providers with key residents, who share a common interest in improving the target neighbourhood. Hold connecting workshop and identify team of 6-8 members to attend 2 day C2 '1st wave' Introductory Learning Programme.

STEP 1. C2 begins creation of enabling conditions and new relationships needed for community transformation at strategic, frontline service delivery and street levels. C2 Strategic Steering Group (SSG) established. Target neighbourhood scoped and local C2 secondee appointed. 'Key' residents identified to jointly self-assess baseline community connectivity, hope and aspiration levels.

# Growth by stages

A CD programme needs to grow into its locality by stages, gathering intelligence and credibility as it goes. To make a decisive impact on the level of community activity in a locality over five years, it would be advisable to start three simultaneous projects in one or two priority neighbourhoods each, and then move on to other neighbourhoods by stages. The programme might have four stages, with break clauses between them:

1. **Gathering essential facts about 3 to 6 priority neighbourhoods, establishing baselines and relationships** – 6 months
2. **Piloting fieldwork in the priority neighbourhoods –** 18 months
3. **Consolidating pilot fieldwork and extending to a further 3 to6 neighbourhoods** – 18 months
4. **Consolidating existing fieldwork and extending to further neighbourhoods or the whole CCG area** -18 months

**Active commissioning**. Whilst CD needs to be driven by a dedicated project and expert team, its ethos also needs to gradually permeate all relationships between health agencies and the local population. This includes contractors carrying out other functions for the CCG. All professionals who interact with the community should become aware of how the community works, what its local groups and organisations are, and how they can be helped by better recognition, dialogue and support. Community and voluntary organisations put the need for a good relationship with agencies higher than their need for funding.[12]

**A steering group** should act as a multiple communication pathway, both supervising the project, learning from it and transmitting learning to all health stakeholders. GPs and GP Practices will be particularly important in the spread of this ethos. Patient Participation Groups and Healthwatch may act as links to other community groups and the sector as a whole. CCG contracts with other health providers should all include a community engagement clause and a way of linking to the local CD strategy.

**The statutory sector must be responsive to the issues raised by CD**. Commissioners need to be responsive to ideas and initiatives that come up from the community. This can be a serious challenge to the culture of a CCG or Local Authority. Without this approach, however, much energy, time and resources will be wasted as communities perceive as unyielding the agencies that can help change things.

**Selecting priority neighbourhoods.** The designation of meaningful boundaries depends on local knowledge which cannot be standardised. CCGs and their partners will already know from their Joint Strategic Needs (and assets) Assessments (JSNAs) where there are particular concentrations of certain conditions, or demographic factors affecting health service demand. Local intelligence, together with the JSNA, will show some neighbourhoods to have greater disadvantages and health needs than others. Local authorities will be familiar with the pattern, which often has a long history.

[12] Cabinet Office (2010) *National Survey of Charities and Social Enterprises* https://www.ipsos-mori.com/Assets/Docs/Polls/nscse-national-survey-2010-topline.pdf )

Sometimes there are stark contrasts, for example gaps of five or even ten years in average longevity between residents in different neighbourhoods. Priority neighbourhoods should receive the earliest and most CD input. As CD achievements there become known, adjacent neighbourhoods will emulate them, and cross-neighbourhood links should be built to drive CCG-wide momentum.

It is best to designate the priority areas in terms of wards or LSOAs[13], so that the emerging picture of community activity can be related to the statistical picture of health and other social issues. This does not mean that the CD fieldwork needs to be strictly limited by those boundaries. Some community groups and networks work across boundaries, and practice should be guided by reality on the ground.

**Cross-sector partnership** . Designing CD across the full spread of community groups is an excellent basis for organising partnership with other types of agency (local authorities, local employers, police, fire service, housing associations, schools etc). This open agenda means that CD workers can accommodate all community choices whilst looking especially for the health benefits. Ideally the full array of professional agencies will thus take a coordinated approach to their joint partnership with local communities. However, this is not always easy to organize, and CCGs should not wait for ideal conditions before embarking on their CD strategy. Other agencies will often be drawn in through their own community connections once action is under way.

# A CD strategy should be drawn up alongside the community engagement strategy

This would prioritise community groups within the whole landscape of the voluntary and community sector. Professionally-run voluntary organisations provide specialist services; community groups provide mutual aid and community voice. There are important 'overlap' organisations which perform both functions. Community engagement strategies often focus on the larger, professionally-run organisations. A CD strategy emphasises the (otherwise largely neglected) community group end of the spectrum, including the potential for some groups to grow into professionally-run voluntary organisations.

It may or may not be specifically about health. 'Non-health' community and voluntary groups must be included. They are active on social determinants of health, and are also having health effects through volunteering and social networks.

**Finding footholds.** No neighbourhood or community is a blank canvas. It is essential to shape the CD intervention around whatever community activity is already going on in the neighbourhood. People are struggling to cope with their situation, and every area has its own unique factors. Around 30% of voluntary and community organisations see

[13] Statistical data on health, employment and other social factors are collected at the level of Lower Super Output Areas, average population 1,500. See: apps.opendatacommunities.org Indices of multiple deprivation were last published on 30.9.2015

themselves as contributing to CD[14]. Existing groups must be respected and offered help. A neighbourhood of 6,500 people may have very few groups operating there or as many as 30 or 40 (not necessarily all based within the neighbourhood).

There are many disadvantaged neighbourhoods in England which have had some CD input in the past but where it has been reduced in recent years. Existing CD work, and individuals with deep local knowledge, may not be obvious. CD may be operating under a different name and be blended in with the community. A new programme might aim to boost existing patches of CD and link them into a more powerful framework. Existing groups should never be bypassed.

**Hubs and spokes**. A neighbourhood hub or forum can be a powerful focus for new activity and for creating a greater sense of unity and shared purpose amongst residents. But care has to be taken not to override existing attempts, or to make claims about representing the whole neighbourhood. It must be ascertained whether there are parish councils, community-based regeneration schemes such as 'Big Locals', 'anchor' organisations or interfaith forums. A centralised approach can inadvertently appearing to favour some residents or groups more than others. Like small businesses, community and voluntary organisations are to some extent in competition as well as cooperation, for volunteers, funding and publicity. Development may sometimes work better as a loose confederation than under a centralised leadership.

**Finding suitable contractors**. Given the unevenness of CD experience in England and the current lack of a national body for this discipline, it may not be easy to find practitioner teams or organisations who can readily meet the kind of vision presented here. The use of this demanding framework should help to raise the sights of potential contractors. At the same time, the language of 'asset based approaches' has become fashionable, so track records of achievement on the ground should be looked for.

**Appendix 3** provides an outline model contract between the CCG (or partnership) and a CD contractor. **Appendix 4** gives examples of KPIs and milestones.

[14] NAVCA (2014) *Voluntary Sector Annual Survey*, *Findings from the Health and Care Voluntary Sector Strategic Partnership Survey*. Sheffield: NAVCA

# 3. Evaluation, baselines and indicators

## Firm objectives, flexible methods

Commissioners need to lay down clear objectives and specify the kind of evidence of achievement that they seek. It is for practitioners to achieve those results by whatever methods work best.

However, this division of labour is innovative and even controversial in the CD field. As part of empowering the community, CD emphasises that communities must be allowed to determine their own objectives and actions. This is often contrasted with the rigidity of 'top down' agendas imposed by public service agencies, and the formal methods of evaluation that go with them.

Many CD practitioners therefore balk at the idea of a CD agenda laid down in advance. Without this, however, CCGs and other agencies cannot plan a comprehensive CD strategy that will make a cumulative impact on population health. If objectives are set at the right level of generality there need be no conflict between the emerging aims of the community and those of the health agencies. As with all developmental work, there may be tensions, and part of the CD job is to deal with them.

The solution lies in distinguishing between the **flexibility** essential to fieldwork method and the **planning** required in strategic commissioning. The apparent tension between the aims of communities and those of agencies arises from a confusion of broad aims and detailed objectives. Members of the community need to be able to determine their own goals and action. But their chosen initiatives almost always fall into some combination of six well-known generic factors. Measurable changes include increase in residents' community activity, and greater volume and effectiveness of the community and voluntary sector.

**Broad common objectives can be used as a framework for commissioning and evidence** across neighbourhoods as a whole, leaving room for flexibility about details of process. The six common goals are:

1. Strengthened community groups, projects and networks
2. Increased residents' participation in community activity
3. Increased mutual aid and support amongst local people (social capital).
4. Improvements in people's ability to take action on a range of community and life issues
5. Increase in effective influence of local residents on public services
6. Improvements in neighbourhood conditions and services attributable to community activity.

Practitioners wishing to do this work need to accept that the success of the action can be judged by progress on these factors. What cannot be laid down in advance is which

detailed issues will come up and whether local people will want to work on them; which individual community groups and organisations will prove most viable; which residents will become the most active; how responsive agencies will be to negotiation and influence.

**Fieldworkers should not be wholly responsible for producing the evidence**. It is better if it can be commissioned separately, as we explain in section 6. There are well established indicators of community development or engagement but no standard model for assessing outcomes. More detail on this is in a supplementary short paper on measurement, free to download online[15].

**Interactive effects.** Community activity creates a variety of types of health benefit by a variety of routes. Volunteering widens the individual's social network and has direct benefit on mental health. It also contributes labour which strengthens community groups. Groups are thereby enabled to widen their activities, involve more people and network with other groups. Combinations of groups are able to field credible community representatives and negotiate with agencies for service improvement. Effects are complex and cumulative – a critical mass of community activity creates a variety of types of health gain.

# Evaluation

Evaluation of a CD initiative should not try to prove one-to-one health effects from individual actions, but examine whether the CD intervention increases the six outcomes listed above. Case studies of individual groups and organisations are important, but in order to know whether we are influencing population health on a significant scale we also need population-wide measures. Baselines and indicators should be established for each neighbourhood.

It is important to measure CD outcomes themselves, so that these can be compared to health and other social outcomes. A short supplementary paper available free on-line provides a menu of key sources and questions: *Measuring Community Development in Health, A Menu of Sources and Questions*, www.healthempowerment.co.uk (2016)

**Examples**. **Figure 2** (on the next page) shows in a simplified way what some of the objectives and results for a priority neighbourhood might look like after two or three years' significant CD input. This is not a 'target-driven culture': authentic CD indicators are about ensuring more choice and influence by the community. This is no constraint on community control – on the contrary, it is precisely to ensure that community control and satisfaction is uppermost.

[15] Gabriel Chanan (2016), *Measuring Community Development in Health, A Menu of Sources and Questions*. www.healthempowerment.co.uk

## Figure 2: Simplified example of objectives and results for a priority neighbourhood over two years

| Factor | Type of indicator | Baseline examples | Outcome examples |
|---|---|---|---|
| 1. Increase in resident participation | Number of residents who say they are active in the community | 7% of residents say they are active in the community | 12% of residents say they are active in the community |
| 2. Social capital | Number of residents who say they are giving and receiving mutual aid and support and have sufficient friends | Many people isolated, many sections of population disconnected | Fewer people isolated, sections of population more integrated, more residents giving and receiving |
| 3. Self-reported health benefit | Number of residents who say their health has benefited from community activity | 5% of residents say their health has benefited from community activity | 10% of residents say their health has benefited from community activity |
| 4. Condition of the community sector | Range and effectiveness of community groups | Ten groups functioning in the neighbourhood; poor networking; limited range of issues and activities; low confidence and ambition | 15 groups functioning groups in the n'hood, including a community hub; good networking; wider range of issues and activities; high confidence and ambition |
| 5. Interaction between the community and health and other agencies | Testimonies from key informants and survey of agencies | Public agencies remote from residents, few connections with community groups. Few examples of services modified or improved by community input | Public agencies aware, supportive and responsive to residents and community groups. Varied examples of services modified or improved by community input |
| 6. Support and recognition for community activity | Level of support and recognition | Residual CD input. Few meeting spaces or grants for community groups. Low profile of community groups and organisations. | Dedicated CD input. Several meeting spaces and grant schemes for community groups. Community groups and organisations seen as key partners |

# 4. Staffing, skills, location and costs

## Assessing bids

Contractors need to be able to show both a high level of CD skills and an ability to gain the confidence of the people in the locality. A CD team should have a mixed ethnic and gender profile and an ability to empathise with people in all conditions. The following skills should be present in the team:

- Understanding how communities work
- Understanding local public services
- Ability to relate to people under the stress of multiple disadvantage and get people and groups on to a positive development track.
- Ability to understand the development of community groups, support them appropriately at different stages and guide others in how to support them.
- Ability to manage community practitioners both directly and through guidance to other managers.
- Ability to explain community processes to senior decision-makers, coordinate evidence and negotiate long term support
- Ability to take the long view of the development of the neighbourhood but focus on timed milestones.
- Ability to understand social statistics and use them to illuminate policy and practice.
- Ability to carry out qualitative research amongst local people, organisations and agencies

**Staffing.** A dedicated CD team has the value of:

- a visible presence and identity for CD in the locality
- peer support and guidance amongst the CD workers
- a management framework, objectives and milestones by which to compare experiences, coordinate information about neighbourhoods and spread skills from one worker and neighbourhood situation to another
- ability to co-ordinate a systematic approach to CD and objective evidence of outcomes.

**Experienced CD workers** are needed to do this work to the highest quality. With highly skilled leadership, other health workers can be trained to contribute to this work. A skeleton job description for a CD project leader is provided at Appendix 5.

There will be various local options about how teams might be built up and structured (including secondment from other agencies or incorporation of existing smaller teams).

We have suggested starting with three sets of priority neighbourhoods. A credible establishment might be an overall leader/coordinator, assisted by an admin and finance officer, and three neighbourhood teams, each consisting of a neighbourhood team leader and three fieldworkers. Each of the neighbourhood teams would concentrate on one or two priority neighbourhoods for about 18 months, then move on to additional neighbourhoods for further periods whilst providing a maintenance service to the earlier ones. The research/communications officer would lead on gathering intelligence, liaising with the independent evaluators on baselines and indicators, monitoring progress and reporting. A proportion of time should be allocated to providing intelligence and training for the CCG and other agencies. Advice to the CCG should include how to build a CD-friendly element into other contracts. For example, hospitals can be asked to provide meeting space for community groups.

Health visitors, champions or others could be helpful auxiliaries (as could housing officers, teachers, neighbourhood wardens, fire officers, community support officers, social workers, faith workers and many others), but are rarely in a position to lead CD. They need to be co-ordinated by a dedicated CD team. Single CD workers often suffer from professional isolation and have difficulty obtaining CD support and guidance.

**Location.** CD needs to operate at an arm's length from the public authorities. It needs a physical and symbolic location within the place whose population it serves, which the community is able to see as accessible, welcoming and responsive. Ideally it should also include space for community groups to meet at little cost.

**Costs.** To make a marked impact across the CCG in five years requires significant resources, but a combination of partnership, secondments and in-kind contributions may considerably reduce the necessary input from the CCG. In addition to staff costs, premises and equipment, provision should be made for seedcorn grants to community groups.

If the CCG were to resource an entire programme of this kind on its own, the cost would probably be in the region of £0.5m a year. However, there is a strong argument for partnership and matching inputs from local authorities, police, fire, education, social services, environment, employment and other agencies, as all will benefit from increased community effectiveness. Indeed all these services have elements of community engagement in their policies, and face the same dilemmas of definition, implementation and cost as the CCG.

It is suggested that the CCG should take a lead with an appreciable financial commitment, and negotiate contributions from partners. Some of this could be in the form of secondments or low-cost premises. Given the reduction of CD by LAs and some charities in recent years it will often be advantageous to them to second otherwise isolated workers into a supportive team situation. Alternatively, CCGs may prefer to fund extra workers in LA teams or voluntary sector projects, joining their governance arrangements to ensure achievement of the CCG objectives.

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# Appendix 1: Current policy and guidance

The need for **community engagement** is embedded in health policy and guidance[16], but is yet not integrated into operational frameworks. It is to be hoped that before long it will be structured into health policy in a concrete way alongside traditional functions, and that it will give due weight to the function of supporting communities' own groups, initiatives and influence, ie community development Meanwhile this short guide offers a framework which we hope can both be of immediate use to commissioners and contribute towards structural change and wider understanding.

As the principal drivers of local strategy in England, Clinical Commissioning Groups are faced with the dual challenge of optimising medical services whilst involving the whole population in managing its own health. CCG plans for 2016-2021 are required to be 'place-based' as well as 'institution-based,' and need to reflect 'a shared vision with the local community'[17]. Health systems in the rest of the UK, and across the world, face the same needs in different ways.

To operationalise community engagement, current policy adopts **six principles** identified by the People and Communities Board[18], a group set up to advise the Department of Health and Vanguards[19] on the development of this area:

1. Care and support is person centred: personalised, coordinated and empowering
2. Services which are created in partnership with citizens and communities
3. Focus is on equality and narrowing health inequalities
4. Carers are identified, supported and involved
5. Voluntary, community, social enterprise and housing sectors as key partners and enablers
6. Volunteering and social action as key enablers.

The six principles are couched primarily in terms of what the health agencies need to do. Community development (CD) focuses on the other half of the shared vision: what needs to happen amongst local residents themselves ('bottom up' as opposed to 'top down'). But this also requires some skilled facilitation commissioned by health agencies. An independent **charter for community development in health**, launched in 2014, calls on health agencies to enable people to organise and collaborate to:

- identify their own needs and aspirations
- take action to exert influence on the decisions which affect their lives, and
- improve the quality of their own lives, the communities in which they live, and societies of which they are a part.[20]

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[16] See for example *Transforming Participation in Health and Care*, NHS England, Patients and Information Directorate, 2013, https://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

[17] *Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21* NHS England, Dec 2015

[18] www.nationalvoices.org.uk/fyfv

[19] A number of CCGs and other bodies undertaking pioneering work to fulfil new health policy

[20] http://www.healthempowerment.co.uk/wp-content/uploads/2014/07/NHSA-CD-CHARTER-FINAL-7-July-2014.pdf

**Appendix 2** sets out how CD contributes to and amplifies the six principles.

Bridging these complementary perspectives is a **guide to community centred approaches** published by NHS England. This reviews extensive sources of evidence and sorts them into a 'family' of 15 approaches. Community development features as part of 'strengthening communities', associated with asset-based methods and social network approaches, but it also contributes to other areas such as volunteering and community-based commissioning.

**Guidance on community engagement** produced by **NICE** in 2008 was updated and developed further in March 2016[21]. It seeks to ensure that local communities, community and voluntary sector organisations and statutory services work together to plan, design, develop, deliver and evaluate health and wellbeing initiatives. It emphasises:

- using evidence-based approaches
- being clear about which decisions people in local communities can influence
- recognising, valuing and sharing the knowledge, skills and experiences of all partners, particularly those from the local community
- respecting the rights of local communities to get involved as much or as little as they are able or wish to
- establishing and promoting social networks, and
- recognising that building these relationships needs time and resources.

Community development is indicated as a way to give local communities at risk of poor health support to help identify their needs and tackle the root causes.

[21] NICE (2016), *Community Engagement: Improving Health and Wellbeing and Reducing Health Inequalities*. www.nice.org.uk/guidance/ng44

# Appendix 2: CD amplification of the six principles of community engagement in the Five Year Forward View

| *Principles* | *The CD perspective* | *The CD contribution* |
|---|---|---|
| 1. Care and support is person centred: personalised, coordinated and empowering | As this principle is primarily about the relationship between the individual and the healthcare services, it is not a primary target for CD, though background help can be given | Support the development of carers' groups; ensure that personalised care takes account of the individual's community |
| 2. Services which are created in partnership with citizens and communities | In order to be partners with public services, patients, carers and citizens need their own collective vehicles. Services need to respond to communities' initiatives as well as involve communities in their agenda | Help residents develop their own activities and organisations and build skills to negotiate and partner with services |
| 3. Focus is on equality and narrowing health inequalities | There is a neighbourhood effect on equality which needs to be addressed by neighbourhood-level strategy | Focus on building residents' organisations in neighbourhoods of greatest disadvantage |
| 4. Carers are identified, supported and involved | Much care and mutual support also takes place informally through low-profile social networks and 'non-health' community groups | Support the care element in other groups, and use these networks to signal carers' needs and help them develop voice in relation to providers |
| 5. The voluntary, community, social enterprise and housing sectors as key partners and enablers | Development of the community sector is often squeezed out when three or four elements are treated as a single phenomenon (the larger vol-orgs, SE and Housing are primarily providers, Community groups are users and participants) | Provide distinct forms of support to the community sector (the bulk of small autonomous groups and any larger, coordinating groups which are controlled by residents) |
| 6. Volunteering and social action as key enablers | 1.Expanding community groups is the major way to expand volunteering<br>2. CD is a key way to stimulate action on the social determinants of health because of its openness to all types of community initiative, not just the 30% which are explicitly about health | 1. Support expansion of community groups<br>2. Support groups taking action on social issues within and beyond the field of health |

# Appendix 3: Outline model contract

X CCG intends to run a major community development programme as part of its overall community engagement strategy 2017-2022. We are seeking a contractor who will carry out the following tasks:

Throughout: Work with the CCG, report work in progress and results, and advise commissioners and staff on the community, its development and current issues .

Stage one (six months): Review the level and profile of community strengths, assets and needs in (XYZ) priority neighbourhoods, average populations (6,500).

These will include

- an assessment of the level of residents' participation in community activities
- a profile of the community sector, its extent, strengths and weaknesses
- an assessment of the level of interaction between the community sector and local public agencies, including the CCG itself
- a profile of existing CD input to the neighbourhood from any agency including larger voluntary organisations
- an audit of key material and organisational assets affecting the community sector such as meeting spaces and grant programmes.

These will form baselines to be repeated to show progress at later stages (even though some of the material is qualitative rather than quantitative).

Consult with the CCG, Healthwatch, the local authority and other informants on perceptions of CD and options for strengthening community activity and involvement in the priority neighbourhoods and in the CCG area overall.

Report these findings within six months together with options and recommended plans of action for stage two and outline plans for stage three. Confirmation of contract for stage two will depend on satisfactory results of stage one.

Stage two (18 months):

Deploying and managing teams of community workers in up to six priority neighbourhoods.

Holding 'listening meetings' open to all residents and local agencies to gauge community involvement, identify salient issues and stimulate new community activity.

Supporting residents who wish to start new community groups, including on-line groups, and if appropriate a neighbourhood hub to coordinate community activity.

Supporting existing groups to achieve their objectives more fully.

Stimulating /brokering greater networking and co-operation between groups.

Finding ways to reach, involve and support the participation of people who for whatever reason do not participate in groups.

Optimising community assets, both social and material, to strengthen the community.

Exploring the development of additional community assets such as assistance to community groups by hospitals

Maintaining records on the achievements and problems of key community groups.

Assisting groups and networks to negotiate with and influence public agencies.

Working across both health-oriented and non-health oriented groups to maximise direct and indirect health benefit.

Liaising with other public and professional agencies working in the area to facilitate all these forms of development.

Advising the CCG and other professional bodies on community development.

Monitoring progress on the above actions and reporting at agreed intervals to the commissioners or a steering group appointed by them, with a formal report at the end of stage two including indicators against baselines.

Summarising learning from stage two and making recommendations for stage three.
Confirmation of contract for stage three depends on satisfactory results of stage two.

Stage three (18 months)

Carrying out baseline studies in an agreed number of additional neighbourhoods

Repeating the actions of stage two in the additional neighbourhoods

Maintaining an 'after sales' service for the community sector in the original priority neighbourhoods

Stimulating and exploiting opportunities for cooperation across the original priority neighbourhoods and the second wave ones

Monitoring progress on the above actions and reporting at agreed intervals, with a formal report at the end of stage three including indicators against baselines

Making recommendations for stage four. Confirmation of contract for stage four depends on satisfactory results of stage three.

Stage four (18 months)

The content of this stage will be informed by the experience and findings from the previous stages, and discussion with the commissioners

It is assumed that other neighbourhoods in the CCG area, not having been identified as priorities, will have less pressing CD requirements, which can be met whilst a 'maintenance' service is continued in neighbourhoods from stages two and three.

The project as a whole will conclude with a summary of findings across the four stages and recommendations on options for maintaining and further strengthening community development in the future.

# Appendix 4: Example KPIs and Milestones

| | |
|---|---|
| Stage 1<br>Months 1 - 6 | Liaise with commissioners re selection of priority neighbourhoods<br>Review of community strengths, assets and needs and any existing CD provision in priority neighbourhoods<br>Establishment of baselines<br>Consultation and relationship-building with key individuals and organisations in the community and in relevant agencies<br>Recommendations on action in Stage 2 |
| Stage 2<br>Months 7 – 24 | In the priority neighbourhoods:<br>• Increase in number of residents active in the community<br>• Community groups and organisations strengthened<br>• Increase in community activity<br>• Increase in productive interaction between communities and CCG<br>Transfer of CD knowledge to the CCG and its partners<br>Progress report against baselines and any other developments<br>Liaison with commissioners re selection of second wave neighbourhoods<br>Establishment of baselines for second wave neighbourhoods<br>Recommendations on action in Stage 3 |
| Stage 3<br>Months 24 - 42 | Maintenance support to community groups in the priority neighbourhoods.<br>In the second wave neighbourhoods:<br>• Increase in number of residents active in the community<br>• Community groups and organisations strengthened<br>• Increase in community activity<br>• Increase in productive interaction between communities and CCG<br>Transfer of CD knowledge to the CCG and its partners<br>Progress report against baselines and any other developments<br>Liaise with commissioners re selection of third wave neighbourhoods<br>Establishment of baselines for third wave neighbourhoods<br>Recommendations on action in Stage 3 |

# Appendix 5: Skeleton job description for project leader/coordinator

1. Establish working relationships with the CCG and other local public service agencies (including private agencies carrying out public service work).

2. Propose and agree a local community development for health vision, strategy, work programme and reporting cycle with the commissioning body and its nominees (steering group or other mechanism)

3. Develop channels to raise the profile and understanding of community development in the local health community, including GPs, hospital staff, public health workers and others.

4. Organise collection and analysing of information on the condition of local community life and levels of activity and effectiveness in different local neighbourhoods.

5. Identify and make recommendations on priority neighbourhoods to receive CD input.

6. Recruit and/or deploy CD fieldworkers, and establish neighbourhood teams, possibly in negotiation and collaboration with other agencies .

7. Guide teams in establishing neighbourhood-specific objectives and how they will be assessed and reported.

8. Manage and support staff, allocate individual objectives and establish reporting methods.

9. Establish the identity and publicise the progress of the CD strategy and project amongst local communities and professionals.

10. Guide neighbourhood teams and individual workers in applying varied and creative methods to strengthened community groups, increased residents' participation, increase mutual aid, and increase constructive influence of local residents on public services.

11. Stimulate and advise local agencies on increasing their responsiveness to community initiative and participation.

12. Produce periodic reports on work carried out, results achieved and lessons learned.

13. Disseminate results, boost public and professional understanding of what has been achieved.

14. Assess risks, troubleshoot problems and organise collaborative solutions.

15. Formulate recommendations on how gains can be consolidated and extended in the future.

## Key terminology and abbreviations.

**Community:** *Weak meaning*: all the people living in a given area, or all the people who have a similar condition. *Strong meaning*: people who regularly do things together or have consciously shared concerns, interests or identity.

**Community engagement**: actions of public or private agencies to involve residents.

**Community development**: action to support residents' own collective activities and self-motivated involvement in public services; action to build social capital.

**The asset-based approach**: community engagement or development which focuses on the strengths of local communities and residents.

**Community involvement**: (i) people's involvement in their own communities; (ii) interaction between residents and agencies.

**Community groups**: *Weak meaning*: categories of people, such as young, elderly or people with a particular health condition. *Strong meaning*: independent local residents' organisations, often small but important in their locality.

**Social capital:** 'The pattern and intensity of networks among people ... including citizenship, neighbourliness, social networks and civic participation.' [22]

**Abbreviations**

CCG Clinical Commissioning Groups (responsible for administering the bulk of the health budgets across localities in England)
CD Community Development
CLG Department for Communities and Local Government
JSNA Joint Strategic Needs Assessment (collection of local facts and figures on health and other social issues)
KPI Key Performance Indicator
LA Local Authority
LSOA Lower Super Output Area (statistical area of about 1500 people)
NICE National institute for Health and Care Excellence
ONS Office for National Statistics
Ward Electoral division in local authorities, population about 6500

[22] Office for National Statistics. http://www.ons.gov.uk/ons/guide-method/user-guidance/social-capital-guide/the-social-capital-project/guide-to-social-capital.html