Community development – improving population health

{Smart Guides} to ENGAGEMENT

For better commissioning

Community development – improving population health

Part of the **Smart Guides to Engagement** series, this guide helps clinical commissioning groups (CCGs) understand and invest in community development (CD) to improve the health of their population. Community development is the practice of helping residents to act together to improve their conditions. It is used most in disadvantaged areas with health and other inequalities.

Disadvantaged neighbourhoods often display concentrations of ill health and make high demands on the resources of the NHS and other local services. Studies show that within a locality of around 200,000 people, long term conditions and emergency hospital admissions are likely to be disproportionately high in a small number of neighbourhoods. If prevention and early intervention can be boosted in these areas, the health and wellbeing of the whole area would benefit substantially. This can be aligned with quality, innovation, productivity and prevention (QIPP) objectives.

Conditions in disadvantaged localities may include poor housing (damp, overcrowding), environment (pollution, noise) and educational levels (low health literacy), and high unemployment (low incomes, job insecurity, young people not in education or training). The housing picture may reveal concentrations of single parents or vulnerable elderly people. Experience of petty crime and insecurity may exacerbate anxiety and depression.

CD – the collective dimension for community improvement

None of this will be news to local GPs, A&E departments, community nurses and others dealing with health inequalities every day. The question is: how to change it? The collective dimension and local resident leadership are often what's missing. This is what community development provides.

CD works mainly through forming or strengthening voluntary community groups and networks. Community groups are rooted in people helping themselves and others and negotiating improvements in local conditions from public agencies. These groups are mostly small and very local but they are the largest part of the voluntary sector.

Some are clearly related to health but many more have incidental health benefits. Tenants' associations, residents' associations, carers' groups, support groups for people with particular conditions, voluntary social clubs, youth clubs and sports clubs, parent-teacher associations, mother and toddler groups, women's health groups and patient participation groups all come under the CD umbrella.

Such groups can be strengthened by a neighbourhood partnership, which also acts as a vehicle for dialogue and coproduction between residents, the health service and other local services. This is how CD improves health protection, reduces health inequalities, boosts patient and public involvement and improves health behaviours.

CD can also:

- **Make the link between local authorities and CCGs through action on the ground**
- **Create wider links with education, housing, safety and other services**
- **Extend the impact of public health**
- **Widen community engagement**
- **Make practices' job easier by enabling links with communities that they would otherwise need to develop**
- **Create opportunities for local people to lead changes and develop their capacity for sustained community leadership.**

Community development can therefore play a big role in getting the CCG through the authorisation and establishment process and sustaining an active relationship with local residents thereafter. Investing to achieve these multiple engagement outcomes makes CD excellent value for money.

Resources for community development

The main resource needed is community development skill and experience. Community development has been used most by local authorities and voluntary organisations, less by health agencies. But under present conditions much of it has been reduced.

Where it has been used by PCTs, it has often been regarded as a marginal public health technique, masking its full value and potential. However, many other workers and some residents may have the potential to contribute to CD or may already use some element of CD techniques. These could be boosted by better awareness and co-ordination.

CD resources can be gathered from several agencies, reflecting the general public services' need to engage with local communities. One option is to link a local CD strategy into existing roles such as community nurses, health trainers, social services staff, police, housing workers, environmental workers and others already on the ground.

The resourcing pattern will need to be customised to the area. A great deal may be done by commissioning a small specialist team to lead a wide network of existing roles, boosting the CD element already inherent in them. The pattern may look something like this:

CD resourcing example

CCG area population: 150,000
Number of neighbourhoods: 15
Most disadvantaged and health-costly neighbourhoods: 3

Recruit new health-based community development team – one per priority neighbourhood plus small operating budget: overall cost estimate £125,000 a year for three years. Core team of three:

- **Drives health-oriented CD in the three priority neighbourhoods**
- **Boosts the CD element in the work of other frontline workers**
- **Links with existing local authority and voluntary sector CD workers, boosting the health effects of their work.**

Doing CD

The remit of the CD project or team would be to:

- **Establish communication and accountability to the CCG, health and wellbeing board (HWB) and local authority**
- **Establish baselines for levels of community participation, extent and strength of community groups, and the effects of community groups and activities on health**
- **Create a three-year neighbourhood development plan**
- **Locate and lead the natural community development input of various frontline workers**
- **Organise neighbourhood-wide networks or partnerships of community groups, projects and actors**
- **Drive a major expansion of community activities, groups and their impact**
- **Negotiate changes in services and agency cultures so they become more responsive to communities and engage in co-production**
- **Monitor milestones and outcomes against the baselines**
- **Feed intelligence to health commissioners on conditions and issues in the community**
- **Report back to the HWB or other lead agency for this initiative and make recommendations on how to achieve further improvements.**

There should be a link with LINk/local HealthWatch. CD can help them connect much more widely to community groups.

The CD project should look for opportunities to organise community development action in specific clinical areas arising from local knowledge. In a particular place these might include working with:

- **Schools, sports clubs and youth clubs on obesity prevention**
- **Women's groups, carers' groups and mother and toddler groups on nutrition and mental health**
- **Black communities on detecting hypertension and organising how treatment should be delivered**
- **Asian communities on diet and diabetes.**

Blyth Valley Council, Northumberland, decided to reshape itself as a community based council in the mid 90s following a period of shocks resulting from high unemployment, poor housing conditions and the deaths of a number of young people through drug abuse. Drawing in complementary resources from other authorities, 20 CD workers were employed to build up the capacity of the community both to solve its own problems and to co-produce improvements to the area with the public authorities.

Between 1995 and 2005 the number of voluntary and community organisations doubled from 300 to about 600, with a corresponding doubling of volunteers. The danger of Blyth becoming a stigmatised area after industrial decline was averted. It changed from a low housing demand area to an area with demand for new housing and consequent investment by property companies, bringing further money into the area. The council used Section 106 housing receipts to create further community amenities, while the growth in the voluntary and community sector also enabled it to bring in an extra £6.5m from external sources. Key staff were trained in the principles of community development, which they shared through the authority and wider partnerships.

Examples of good CD

Demonstrable increase in the range and vigour of community groups

In a neighbourhood where there had been few known groups, new ones would establish themselves. There would be many more residents participating in them and benefiting from them. They would address many more local issues and health conditions.

More co-operation between communities and public agencies

A neighbourhood previously regarded by agencies as apathetic, beyond hope or a no-go area, sees improvement in relationships, new openings for co-operation and new momentum for improvement. The agencies themselves now feel more motivated, are listening to residents' views and suggestions, have a better understanding of the community, have got to know each other through the community, are less wary of involvement and are investing new energy in making their service deliver best quality to local residents.

Improvements in health

As a result of this accumulation of small changes, there is a general improvement in the atmosphere in the neighbourhood. There is new activity for people to get involved in and depression is reduced. Many new ideas and schemes assist people with particular conditions. A&E attendance and emergency admissions have declined, health awareness and prevention have spread, early diagnosis has increased and people with long term conditions are better able to manage their own conditions with moderate clinical guidance.

The Health Empowerment Leverage Project (HELP) ran three local projects in 2010-2012, in Smith's Wood, North Solihull; Townstal in Dartmouth, Devon and Putney Vale in Wandsworth, London. Over 18 months the local communities and service agencies together created a range of new or extended local developments including:

- Increased volunteering
- Wider social networks
- Better awareness and co-operation between community groups
- Legal and benefits advice
- Sessions on weight management and smoking cessation
- Sports activities
- Youth club
- Renovating a local play and recreation park
- Sexual health education
- New dental services
- Community premises
- Safe cycling club
- Improving woodlands
- Young people's dancing
- Co-operation between housing associations
- Reductions in anti-social behaviour
- Greater trust and understanding between residents and agencies
- The long-term partnership itself, with self-renewing potential.

According to local informants, similar nearby areas, which had not had comparable CD input, showed much less similar new activity.

Getting started with CD – steps CCGs can take now

- Identify neighbourhoods on your patch that are the most disadvantaged and how this affects the health profiles and costs there

- Establish (or commission) the existing profile of any community development in the area and how well it is related to health. Are there CD workers in place, possibly employed by the local authority or voluntary organisations? Or even by health agencies themselves? Is their work adequately linked in to your priority neighbourhoods and health issues? Could they be more effective by better co-ordination? Is additional CD input needed?

- Bring together local CD informants to build a picture of the neighbourhoods and communities. How strong is the community sector (groups and organisations)? How much do local residents participate in community activity and practise healthy lifestyles? Are there community groups addressing all the major social and health issues and needs? Are the groups known and accessible to older people, carers, the housebound, those with disabilities, people with particular health needs?

- Create a three-year CD plan and a team to implement it, drawing on partnerships with other departments and agencies through the HWB and bringing in external expertise if needed.

Get Smarter – find out more

Empowering Communities for Health (HELP, 2011): **www.healthempowermentgroup.org.uk**

The Community Development Challenge (DCLG, 2006): **http://bit.ly/IEpufY**

Federation of Community Development Learning: **www.fcdl.org**

Community Development Foundation: **www.cdf.org.uk**

Kaizen Partnership: **www.kzpartnership.com**

Community Development Exchange: **www.cdx.org.uk**

Pathways through Participation project: **http://bit.ly/nhbIio**

Community Engagement to Improve Health (PH9) National Institute for Health and Clinical Excellence, 2008 **www.nice.org.uk/PH9**

NHS Alliance and N.A.P.P: Effective Practice-based Commissioning: Engaging With Local People: **www.napp.org.uk**

A Dialogue of Equals – the Pacesetters Programme Community Engagement Guide, DH, 2008 (Gateway 9261): **http://bit.ly/IjQxr0**

Community Development Workers for Black and Minority Ethnic Communities. DH, 2004 (Gateway 4211): **http://bit.ly/IFhSrD**

PACES empowerment. Papers on Big Society and community development: **www.pacesempowerment.co.uk**

Twelvetrees, A. (2008) Community Work. Basingstoke: Palgrave Macmillan. Fourth Edition.

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