HEALTH CREATION: COMMISSIONING COMMUNITY DEVELOPMENT FOR HEALTH

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Increasing inequality

Austerity

Shrinking the state + Austerity

Threat to community life

Increasing inequality

A crisis in democratic accountability
RESILIENCE UNDER PRESSURE

• Hollowed out communities
• Threat to mental health
• Attenuation of social networks
• Weakening of associational life
• Deterioration in health
COMMUNITIES - TAKE BACK CONTROL!
• NHS organisations see the need for a new relationship with communities
• They often feel unsure how to create that
• THIS:
  • Explains CD
  • Summarises evidence
  • Outlines a 5y commissioning plan
  • Includes KPIs and basic evaluation guidance
COMMUNITY DEVELOPMENT

• SUPPORTS COMMUNITIES TO:
  • Identify the issues that matter to them
  • Work out solutions themselves
  • And work in collaboration with statutory services

• PARTICIPATORY DEMOCRACY AT WORK
  • Contact
  • Confidence
  • Control
WHAT COMMUNITY DEVELOPMENT CAN DO, ALL AT THE SAME TIME

• Statutory services become more responsive
• Promotes health protection and community resilience
• Helps tackle health inequalities
• Has an impact on behaviour change
• Saves money
Stronger and deeper Social Networks

RESILIENCE
Health protection
Resilience to economic adversity
Better mental health

ENHANCED CONTROL
Can negotiate with services
More strength for self-care
Health inequalities reduce
OUTCOMES – HEALTH

6-Month Survival after Heart Attack, by Level of Emotional Support

Sources of support

- 0
- 1
- 2 or more

Percent died

Men

Women
SOCIAL NETWORKS REDUCE MORTALITY RISK

• 50% increased likelihood of survival for people with stronger social relationships.
• Comparable with risks such as smoking, alcohol, BMI and physical activity.
• Consistent across age, sex, cause of death.

• 2010 meta-analysis of data [1] across 308,849 individuals, followed for an average of 7.5 years

COMMUNITIES TAKING BACK CONTROL IMPROVES HEALTH
Two kinds of relationship with communities

Outreach, bridging, referring

Social prescribing; projects targeted at patient categories

Arm’s-length support for communities’ own initiatives

Community development; asset-based approaches

A comprehensive approach to population health needs both – and not confused with each other
CD Project design

Scale / timescale (eg 200K popn/ 40 n’hoods/5 yrs)
Lead body
Partnership framework
Team / skills
Priority neighbourhoods
Theory of change
Evaluation – outcomes - integration
Theory of change

• Participation boosts participants’ health

• Boosting community groups across all issues and interests secures maximum participation and mobilises the social determinants

• Strengthened groups also improve neighbourhood conditions through own activities and negotiation with services

• Multiple pathways to health need complex long term evaluation

• Immediate and ongoing evaluation should focus on evidence of increased participation, stronger community sector and improved relationships between communities and public services
A CCG 5 YEAR PLAN

• Core team must have experienced of successful CD leadership
• Extended team can include secondee from across public services – via partnership, parallel outcomes, minimal costs
• Bring together isolated community involvement workers under a CD strategy
• Headline aim: build up the 90% of small groups - big potential
RESIDENT-LED PARTNERSHIPS at neighbourhood level

Residents’ experience drives change
a core reaches out – widening networks of participation
health and other public services must respond
Boosting community groups is the most economical way of spreading participation.

Small, low-profile community groups are the largest part of the sector.


From Dayson et al *The Value of Small*, Centre for Regional and Economic Research, Sheffield Hallam University, 2018
First stage – 24 months

- Identify priority neighbourhoods
- Establish current level of community activity / profile existing groups
- Boost all forms of participation, including pre-existing

Second stage – 18 months

- Extend to second wave of neighbourhoods while maintaining service in first

Third stage – 18 months

- Extend to neighbourhoods with less intensive needs / maintenance in first and second waves / evaluation results and forward planning

Throughout: LINK CD WITH PRACTICES
<table>
<thead>
<tr>
<th>Factor</th>
<th>Type of indicator</th>
<th>Baseline examples</th>
<th>Outcome examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Community activity</td>
<td>Number of residents who say they are active in the community</td>
<td>7% of residents say they are active in the community</td>
<td>12% of residents say they are active in the community</td>
</tr>
<tr>
<td>2. Condition of the community sector</td>
<td>Range and effectiveness of community groups</td>
<td>Ten groups functioning in the neighbourhood; poor networking; limited range of issues and activities; low confidence and ambition</td>
<td>15 groups functioning groups in the n’hood, including a community hub; good networking; wider range of issues and activities; high confidence and ambition</td>
</tr>
<tr>
<td>3. Mutual aid/social capital</td>
<td>Number of residents who say they are giving and receiving mutual aid and support and have sufficient friends</td>
<td>Many people isolated, many sections of population disconnected</td>
<td>Fewer people isolated, sections of population more integrated, more residents giving and receiving</td>
</tr>
<tr>
<td>4. Health benefit from community activity (direct and indirect)</td>
<td>(a) Number of residents who say their health has benefited from community activity; (b) improvements in the neighbourhood attributed to community activity</td>
<td>(a) 5% of residents say their health has benefited from community activity; (b) 60% of residents recognize community-driven improvements in the neighbourhood in the past two years</td>
<td>(a) 10% of residents say their health has benefited from community activity; (b) 60% of residents recognize community-driven improvements in the neighbourhood in the past two years</td>
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<tr>
<td>5. Support and recognition for community activity</td>
<td>Level of support and recognition</td>
<td>Residual CD input. Few meeting spaces or grants for community groups. Low profile of community groups and organisations.</td>
<td>Dedicated CD input. Several meeting spaces and grant schemes for community groups. Community groups and organisations seen as key partners</td>
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<tr>
<td>6. Interaction between the community and health and other agencies</td>
<td>Testimonies from key informants and survey of agencies</td>
<td>Public agencies remote from residents, few connections with community groups.</td>
<td>Public agencies aware, supportive and responsive to residents and community groups. Varied examples of services modified or improved by community input</td>
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</tbody>
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NHS Alliance and Health Empowerment Leverage Project can help

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THANK YOU FOR LISTENING