EXTRACTS from
*Commissioning Community Development for Health*
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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 primarily action to support residents’ independent collective activities. This also enables them to become partners in ensuring the maximum effectiveness of 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. It is not an alternative to public services. Services and communities tend to thrive together or decline together.

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 to some extent be measured using established instruments. A selection of these is set out in Appendix 6. 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.
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.

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.

It is best to designate the priority areas in terms of wards or LSOAs\(^1\), 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.

\(^1\) 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
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.

**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.

Commissioners will want 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.

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.

It is reasonable for commissioners to expect CD providers to accommodate pre-set objectives, so long as they are set at a level of generality which leaves room for community self-determination. The solution lies in distinguishing between the flexibility essential to **fieldwork method** and the **overall objectives** required in **strategic commissioning**.

Communities need to be able to determine their own goals and action. But their chosen initiatives almost always fall into some combination of six generic factors. Objectives should be laid down in terms of the six broad factors applied across neighbourhoods as a whole, leaving communities and CD practitioners free to fulfil them by a number of alternative types of development through self-determining community groups.

**The six common goals** are:

1. Increased community activity.
2. Strengthened community groups, projects and networks (condition of the community sector)
3. Increased mutual aid and support amongst local people (social capital).
4. Direct and indirect health benefit from community activity (directly by the activity, indirectly through improvements in neighbourhood conditions).
5. Better support and recognition for community activity.
6. Better dialogue and co-operation between the community, health agencies and other local agencies.

The factors are mutually reinforcing. More resident activity generates more community groups and vice versa (1 and 2). Whatever their particular focus, community groups by their nature also generate friendships and mutual aid (3.) Participation is in itself good for participants’ health and mental health, whilst the objectives which groups set
themselves are frequently about improvements in neighbourhood conditions (4). Better support and recognition from public agencies for this cluster of activity helps it to expand (5), enabling the community to become a strong partner in public service, so long as the professional agencies are sufficiently responsive to their voice and influence (6).

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; and how responsive agencies will be to negotiation and influence. Effects are complex and cumulative – a critical mass of community activity creates a variety of types of health gain.

Evaluation of a CD initiative should not try to prove one-to-one health effects from individual actions, but examine whether the CD intervention as a whole increases the six outcomes listed above. Assessment should be based on population-wide measures per neighbourhood, supplemented by case studies of a selection of community groups. 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.

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

<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 are unaware of any 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>
</tr>
<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. Few examples of services modified or improved by community input</td>
<td>Public agencies aware, supportive and responsive to residents and community groups. Varied examples of services modified or improved by community input</td>
</tr>
</tbody>
</table>

**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.

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.

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