



# Commissioning Community Development for Health

**A concise handbook**

by Gabriel Chanan and Brian Fisher

Health Empowerment Leverage Project



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# Foreword

This handbook appears at an opportune time. The NHS is beginning to see that communities can offer solutions, not be seen as merely part of the problem. Policy-makers are beginning to take communities more seriously.

The Five Year Forward View famously talks about harnessing the renewable energy of communities, dedicating a whole chapter to consider a future NHS, which looks at a new relationship with people and communities<sup>1</sup>. The recently published Next Steps on the Five Year Forward View talks of a need to 'focus on the assets available to catalyse change in communities'.

Realising the Value has explored the evidence and experience of working with communities in different ways. The Care Act places responsibilities on local authorities closely aligned with the ideas in this document, as does TLAP's Shared Commitment paper.

So, policy makers are alive to these possibilities. We now need practical interventions that can make a real difference on the ground. That is what this handbook tries to do.

Community development is one way of putting policy into practice. It is tried and tested and offers great promise.

Although local authorities have long experience of community development, it is relatively new to the NHS. Evidence is good that community development will protect health because it supports people to take more control of their own lives and immediate environment. It therefore needs to be part of the NHS 'out of hospital' offer.

The handbook is designed to be a practical guide for commissioners. We know that this kind of approach has to be cross-platform, at the very least including local authorities - and that point is made in the document. But this handbook is designed specifically for CCGs, federations and sustainability and transformation partnerships (STPs) offering background and practice.

There is no doubt these are tough times financially but the HELP project has seen first-hand the difference investment of this kind can make.

We hope it is a good basis for changing practice, for developing a responsive

statutory sector, for improving health – and for communities to take their place in the NHS.

This first version of the handbook is 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. For feedback please contact [gabriel.chanan@talktalk.net](mailto:gabriel.chanan@talktalk.net); [brian@paers.net](mailto:brian@paers.net)



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<sup>1</sup> NHS England Five Year Forward View, 2014 <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>



“There is no doubt these are tough times financially but the HELP project has seen first-hand the difference investment of this kind can make.”



## Catherine Wilton

Coalition for Collaborative Care Director

There is a growing and welcome recognition by the NHS and its leaders of the vital role community-based approaches can play in improving services and health outcomes for everyone.

This was a recurrent theme in the Five-Year Forward View and has been given further weight in the recently published delivery plan, which calls for people and communities to be given a real voice in the delivery of health and social care.

In addition, the final report of the Realising the Value programme both complemented the vision of the Five-Year Forward View and provided the evidential base that these approaches provide practical and cost effective solutions at a time when resources are stretched.

With these crucial building blocks in place, the publication of this handbook, developed by the Health Empowerment Leverage Project (HELP) and specifically tailored for commissioners, is timely and opportune.

The Coalition for Collaborative Care, with its network of partners, has championed these interventions since its inception, but we recognize the need for practical action that can make a real difference on the ground.

We hope the guide is a good basis for changing practice, for developing a responsive statutory sector, for improving health – and for communities to take their place in the NHS.



# Clenton Farquharson MBE

Think Local,  
Act Personal Chair

For more than 20 years I have been a passionate advocate for the benefits of community development within the health and social care sector and acutely aware of the obstacles that we are faced in making this part of mainstream thinking within the NHS.

So for me, the biggest issue is how we move away from the rhetoric and theorising to make it a reality that communities are truly empowered and given a voice in the health service.

I am hoping the publication of this handbook, with its evidence-based approach, targeted at CCGs, federations and STPs can act as another catalyst for change.

My work with Community Navigators, where stakeholders are brought together on an equal basis, and as a tutor of the Leadership for Empowered Communities Programme with C4CC, has given me a unique insight across the sector.

I have met many managers, commissioners and clinicians who know that community

development is the key to creating the public services we want and so much need.

Commissioners can play such a pivotal role as enablers to create the space for investment in individuals and disadvantaged communities.

It involves them moving away from the notion of patients as commodities, passive recipients of a service, to treat us as citizens, with rights, but also responsibilities.

They must remember it is all about people, who want to live in healthy communities, to be able to feel able to be what we are, to have ownership of our own community and have a positive outlook for the future.

If the practical advice and support offered in this handbook can shape thinking in the future around this vital agenda then its publication will have been even more worthwhile.



# Dr David Paynton

Royal College of General Practitioners (RCGP)

Social isolation is said to have the equivalent impact on mortality as smoking 20 cigarettes a day but feeling connected to others in our community can help bring a sense of purpose as well as providing mutual support which we all need at different times in our lives.

The Royal College of GPs has been promoting care and support planning for some time, as a crucial means of understanding what is important to people in the context of their lives. It is all about creating a sense of control. Community development needs to receive similar attention and to be seen as a crucial part of making our NHS sustainable.

This is not about using volunteers to replace statutory services, it is something quite different. It is about harnessing local talents to create something extra, bringing people together and enhancing health and care services by empowering local people to be in control.

The evidence is clear, mobilising the strength and talents that lie in the community helps improve a sense of wellbeing as well as reduce costs to the local health system. A neighbourhood walking group going out to the local park twice a week needs minimal resources but can be more effective than the pills we prescribe.

That is why we are proud to support this handbook. GPs are busy professionals but as member of a clinical commissioning group and as advocates for their community they have an important role in supporting community development.

GPs, with their commitment to continuity, know their community and its population well and are uniquely placed to support this work.

Many GPs working "with" as well as "in" the community see this as a legitimate part of their wider role utilising their knowledge, staff and sometimes their surgery as a critical enabler.

We hope this handbook together with its practical tips and seven step framework for community development will be widely read and then translated into real action on the ground, especially in disadvantaged areas where community development has the most to offer.

# Executive summary

- 1. The purpose of this handbook** is to help local authorities, CCGs, federations and sustainability and transformation partnerships (STPs) footprints to commission community development. The principles will also be helpful if local bodies wish to employ community development workers. The handbook is tailored to current policy in England but its principles are universal.
- 2. The development of community strengths** needs to be an integral part of local health and wellbeing strategies so that all sections of the population can become fully involved in improving health and wellbeing.
- 3. Community development** is action to support people's independent collective activities and involvement in public services. Community development builds 'social capital' and enables people to organise in order 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 may need more support than others. Community activity needs to be built from the bottom up to generate health and wellbeing 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 and care 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 local people and organisations, and influencing the shaping and delivery of services.
- 7. A number of studies** have estimated substantial health savings from greater community involvement. To make a significant impact on population health, community engagement must achieve critical mass.
- 8. Best methods will be known by their results.** We do not endorse any particular method or label. Community development, like other disciplines, can be variable in quality. The best methods are whatever best prove to strengthen community capacity and local health and wellbeing.
- 9. Experienced community development workers** are needed to lead this work. Existing staff in the health, social care and voluntary sector workforce can be trained to contribute to it.
- 10. For significant health improvements** and savings, a whole-local-population approach is required, focusing on neighbourhoods. Community development is needed everywhere but most urgently in the most disadvantaged neighbourhoods. The Health Empowerment Leverage Project recommends a model for a community development programme building up over five years to cover a targeted population such as a CCG or local authority area. 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.
- 11. 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.
- 12. CCGs, local authorities, federations and STPs** 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.
- 13. An outline model contract is provided,** together with examples of Key Performance Indicators (KPIs). Options for staffing are discussed, and ways of reducing cost through partnership with other agencies.
- 14. Community development** needs to permeate the culture of local public and community sector supports. Whilst community development needs to be driven by a dedicated project and expert team, its ethos also needs to be adopted by health agencies and other public sector organisations, including voluntary and community groups. This includes contractors carrying out other functions for the commissioning organisation. Front-line workers can be supported to play a connecting role at a local level.
- 15. Measurement.** The handbook shows how the methods and outcomes of community development can be put onto a more objective basis than has usually been done, measuring activity, whilst maintaining the community development principle that communities determine their own forms of development.
- 16. Baselines and outcomes** can be measured using established instruments. These are set out in Appendix 5. 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.
- 17. Costs.** To make a marked impact across a local population or neighbourhood in five years requires resources, but pooling of resources may considerably reduce the necessary input from the lead organisation. Staff, training and seed corn grants to community groups may be needed, and there may be costs for premises and equipment.

# 1. Introduction:

## The role of community development in health

### Background and context

#### The Five Year Forward View argues for a 'radical upgrade in prevention and public health' and views the empowerment of people and communities as central to tackling the causes of ill-health.

The Next Steps on the NHS Five Year Forward View<sup>2</sup> talks of 'engaging with communities and people in new ways', transitioning to a population-based integrated health systems. Delivering on what is then a concerted shift from acute interventions to a rebalancing of care and support, that places communities and citizens' front and centre, requires a new approach, recognised in the recently published Shared Commitment and Call to Action for Engaging and Empowering Communities<sup>3</sup>.

In addition, the Care Act (2014) formally recognises the value of community assets in promoting wellbeing and supports a coproduced, strength-based approach which identifies personal, community and social networks. The Act redefines social care as the achievement of wellbeing, holistically described, and therefore beyond the scope of formal care services.

Making these aspirations a reality needs a radical shift in ways of working and thinking, from 'community-based' projects to longer-term strategies addressing whole neighbourhoods. It will not happen without a serious approach to mobilising communities' own efforts. Community development - the practice of supporting social groups, networks and initiatives that are run by local people - is a tried and tested method of achieving this. And in financially tough times for the NHS, it is even more vital to invest in far-seeing, preventive solutions, despite the intensity of immediate pressures.

The Health Empowerment Leverage Project (HELP) project was funded by the Department of Health from 2009 to 2012 to carry out three pilot projects and review other experience to demonstrate the value of community development in health. Its initial report<sup>4</sup> [1] established that a relatively marginal investment in strengthening community life could produce multiple benefits for health, and prospective long-term reductions in cost to the NHS, especially in disadvantaged areas. Continuing to gather evidence and inject insights into policy and practice, HELP has found

that there are many decision-makers in the health system who recognise the importance of strengthening community life but have no model for how to go about commissioning it.

**This handbook aims to start meeting this need, explaining concretely how community development expertise can be engaged in the health context, how it can be applied neighbourhood by neighbourhood, and what kinds of results can be expected for a given investment within a medium time-frame across a locality.**

\* While a 'community' can describe groups or networks of people linked by identity or interest, this handbook describes a 'place-based' way of working that encourages people to connect with each other in their neighbourhoods. We do not endorse any particular method of community development practice; 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.

### Evidence and cost-benefits of community development

**There are three main types of health benefit realised through a community development approach, especially amongst disadvantaged sections of the population:**

- For participants themselves, through the very process of participation;
- For other people in the community, through expansion in local activities, mutual aid and social networks;
- Through improvements to the locality through better dialogue and negotiation between local communities and public services.

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<sup>5</sup>.

A number of studies have

estimated substantial health savings from greater community involvement.<sup>6</sup> To make a significant impact on population health, community engagement must achieve critical mass. This requires a strong element of high quality community development.

### Theory of change – how it works

**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 people, more varied activities and greater influence by people on local 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 being stimulated and supported using community development's characteristic methods. This involves starting with what's important for people and communities

and building trust and relationships at a local level from the ground up;

- People who are involved in local groups and associations are more likely to be healthier and happier<sup>7</sup>
- 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.

<sup>2</sup> www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

<sup>3</sup> www.coalitionforcollaborativecare.org.uk/news/engaging-and-empowering-communities-a-shared-commitment-and-call-to-action

<sup>4</sup> www.healthempowerment.co.uk/wp-content/uploads/2012/11/DH\_report\_Nov\_2011.pdf

<sup>5</sup> Brian Fisher (2016), Community Development in Health, A Literature Review. Revised edition. Health Empowerment Leverage Project, www.healthempowerment.co.uk

<sup>6</sup> Suzanne Wood et al (2016) At the Heart of Health: Realising the Value of People and Communities. Nesta / Health Foundation

# 2. Understanding community development

## What is community development?

**Community development is action to raise the long-term level of resilience, cohesion or health and wellbeing in a community, helping local people to strengthen their own action on things that are important to them.**

National Occupational Standards for community development describe it 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, the communities in which they live and societies of which they are a part.<sup>7</sup>

Community development activity can be identified by these characteristics:

- Support for, or facilitation of, community groups (that are accountable to their members, not to an external body)
- A developmental approach - widening activities, issues, membership, skills and influence
- An emphasis on fostering equality and empowerment.

## Other key features

**Community development in health strengthens people's own collective efforts to improve their health and conditions.**

Community development 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.

Community development 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 or projects working on health issues to those that affect health and wellbeing through other issues: projects / groups that come together around housing, environment, sports, faith, employment, crime prevention and the arts.

Community development 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.

Community development 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 staff can also be trained. This can be enhanced by tapping into existing assets such as staff from local statutory and voluntary organisations.

Asset-based community development<sup>8</sup> builds on positives: the leaders, skills, strengths of individuals and communities, rather than just on need, building on the 'strong' and not the 'wrong.' No form of community intervention can work unless it is asset-based, in the sense of placing high value and expectations on people's own initiatives and ownership of the action. On the other hand, even asset-based approaches seek improvement, with a focus on those people who are enduring the greatest disadvantages. So we continue to speak about both needs and assets.<sup>9</sup>

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<sup>10</sup> 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 people, another only four. Usually a small proportion of local people would be active and

organised, a majority inactive and uninvolved, and some quite isolated.

The ability of local people 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<sup>11</sup>. 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 and social 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 and wellbeing of the population.

Larger voluntary organisations often have the loudest voice in dialogue with local public agencies. But they can often

be providers of services, rather than a way for local people to have a voice. 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, are not part of the voluntary nor community sector and, 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.

Small groups have 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<sup>12</sup>, but have few resources and little recognition. Many are isolated, reach only handfuls of people and are invisible to big institutions. Community development is a dedicated instrument for driving this growth.

The vision of a fully participating, health-promoting and health-creating local population requires a more

<sup>7</sup> [www.nesta.org.uk/sites/default/files/group\\_activity\\_for\\_health\\_and\\_well-being.pdf](http://www.nesta.org.uk/sites/default/files/group_activity_for_health_and_well-being.pdf)

<sup>8</sup> 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 (L&DEA)

<sup>9</sup> 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

<sup>10</sup> Marshall, T.F, et al (1997), Local Voluntary Action Surveys ('LOVAS'). London: Home Office Research and Statistics Directorate.

<sup>11</sup> Home Office (2004), Firm Foundations

<sup>12</sup> See for example [www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/eval-voluntary-sector-2013-bolton.pdf](http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/eval-voluntary-sector-2013-bolton.pdf)

interactive relationship between local communities and local public bodies. A study in 2008-10 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.

Community development is more than community engagement. Some traditional community engagement strategies simply describe consultation and stakeholder involvement activity and often focus on the larger, professionally-run organisations.

Community development is not a substitute for essential services nor an approach that can be driven solely top-down. Community action depends on people: it should be bottom-up, local and developed in response to the community assets and issues that exist in each place.

To effect significant health and wellbeing improvements and savings, we argue that community development needs to be applied more systematically than in the past, by adopting a whole-local-population approach, focusing on neighbourhoods.



“Community action depends on people: it should be bottom-up, local and developed in response to the community assets and issues that exist in each place.”

# 3. Designing the brief

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 process, below.<sup>13</sup>

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

## The C2 Seven Step Framework



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<sup>13</sup>Fuller information on C2 is being updated at [www.C2connectingcommunities.co.uk](http://www.C2connectingcommunities.co.uk)

## A. Scale

**As a model, we assume an area covering a population of 200,000 living in 30 wards, each with an average population of about 6,500.**

Community development 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 the right size and setting for community development because it is here that most social networks and community groups operate.

Additionally:

- It provides a comprehensive population base
- It can involve GPs, councillors and be related to primary care and other local services
- 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.

## B. Growth by stages

**We recommend that a community development programme grows into its locality by stages, gathering intelligence and credibility as it goes.**

If, for example, an STP footprint wanted 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 three to six priority neighbourhoods, establishing baselines and relationships – six months
2. Piloting fieldwork in the priority neighbourhoods – 18 months
3. Consolidating pilot fieldwork and extending to a further three to six neighbourhoods – 18 months
4. Consolidating existing fieldwork and extending to further neighbourhoods or the whole CCG area -18 months

## C. Active commissioning

**Whilst community development needs to be driven by a dedicated project and expert team, its ethos also needs to gradually permeate all relationships between statutory and voluntary agencies and the local population.**


This includes contractors carrying out other functions for the organisation, so needs to be reflected in service specifications. Staff who interact with the community should be supported to understand how the community works, what its local groups and organisations are, and how they can be helped to fulfil their role as front-line workers in connecting people together.<sup>14</sup> For some community and voluntary organisations, a good relationship with statutory agencies may be just as important to them as funding.

A steering group for the project should act as a multiple communication pathway - supervising the project, learning from it and transmitting learning to all stakeholders. GPs and GP Practices will be particularly important in the spread of this ethos, as are other front-line staff such as health visitors, social care providers and local councillors. Local citizens should always be involved in the co-design and steering of strategic activity. Patient Participation Groups, Healthwatch and local umbrella organisations for the voluntary and community sector may act as links to other community groups and the sector as a whole.

## D. The statutory sector must be responsive to the issues raised

**When embarking on community development activity the local statutory agencies must be prepared to be responsive to what emerges and be prepared to work in true partnership.**

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 the agencies that can help change things as uninterested and impossible to influence.



**“A steering group for the project should act as a multiple communication pathway - supervising the project, learning from it and transmitting learning to all stakeholders.”**

<sup>14</sup>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](https://apps.opendatacommunities.org) Indices of multiple deprivation were last published on 30.9.2015

## E. Selecting priority neighbourhoods

### The designation of meaningful boundaries depends on local knowledge which cannot be standardised.

Local people will know through lived experience, and CCGs, local authorities 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 and social care (or care and support) 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. Sometimes there are stark contrasts, for example gaps of five or even ten years in average life expectancy between people in different neighbourhoods. Priority neighbourhoods should receive the earliest and most community development input. As community development achievements there become known, adjacent neighbourhoods will emulate them, and cross-neighbourhood links should be built to drive local momentum.

It is best to designate the priority areas in terms of wards or Local Super Output Areas (LSOAs)<sup>15</sup>, 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 community development 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.

## F. Cross-sector partnership

### Designing community development across the full spread of community groups is an excellent basis for organising partnerships across statutory and voluntary sector services operating in a place - health, local authorities, local employers, police, fire service, housing associations, schools etc.

This open agenda means that community development workers can accommodate all community choices whilst looking especially for the health and wellbeing benefits. Ideally the full array of professional agencies will take a coordinated approach to their joint partnership with local communities. However, this is not

always easy to organise, and statutory bodies should not wait for ideal conditions before embarking on their community development strategy. We find that other agencies will often be drawn in through their own community connections once action is under way.

## G. Have a robust community development strategy

### A community development strategy prioritises community groups rather than professionally-run voluntary organisations which provide specialist services; smaller community groups.

Many smaller community groups are under the radar and provide essential mutual aid and community voice; Also important for the strategy are 'overlap' organisations which perform both professional and community group functions. A community development 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.

Groups may or may not have come together specifically about health. 'Non-health' community and voluntary groups must be

included. They are active on social determinants of health, and have health effects through volunteering and social networks.

## H. Finding footholds

### No neighbourhood or community is a blank canvass. It is essential to shape the community development intervention around whatever community activity is already going on in the neighbourhood and every area has its own unique factors.

Around 30% of voluntary and community organisations see themselves as contributing to community development<sup>16</sup>. 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 community development input in the past but where it has been reduced in recent years. Existing community development work, and individuals with deep local knowledge, may not be obvious. Community development may be operating under a different

name and be blended in with the community. A new programme might aim to boost existing patches of community development and link them into a more powerful framework. It is important not to bypass existing groups.

## I. 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 people. 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 appear to favour some people 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.

## J. Finding suitable contractors/ staff

### Given the unevenness of community development 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 2 provides an outline model contract between the commissioning organisation and a community development contractor. Appendix 3 gives examples of KPIs and milestones.

<sup>15</sup>NAVCA (2014) Voluntary Sector Annual Survey, Findings from the Health and Care Voluntary Sector Strategic

<sup>16</sup>NAVCA (2014) Voluntary Sector Annual Survey, Findings from the Health and Care Voluntary Sector Strategic Partnership Survey. Sheffield: NAVCA

# 4. Evaluation, baselines and indicators

**Community development emphasises that communities must be allowed to determine their own objectives and actions.** There is a tension between this and the rigidity of 'top down' agendas that public agencies may have, and the formal methods of evaluation that go with them.

Whilst many community development practitioners would be concerned at the idea of a community development agenda laid down in advance, we recognise that without this, statutory agencies cannot plan a comprehensive community development strategy that will make a cumulative impact on population health.

The solution lies in distinguishing between the flexibility essential to fieldwork method and the planning required in strategic commissioning. 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. Members of the community need to be able to determine their own goals and action.

Notwithstanding the need for communities to have control over the agenda, we find that the chosen initiatives

that emerge from community development almost always fall into some combination of six well-known generic objectives. These broad 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. Increased community activity
2. Strengthened community group, 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.

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 people 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. There are well established indicators of community development or engagement but no standard model for assessing outcomes.

Evaluation of a community development initiative should not try to prove one-to-one health effects from individual actions, but examine whether the community development 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 community development outcomes themselves, so that these can be compared to health and other social outcomes.

Figure 2 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 community development input. This is not a 'target-driven culture': authentic community development 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.

“The solution lies in distinguishing between the flexibility essential to fieldwork method and the planning required in strategic commissioning.”



**Figure 2: Simplified example of objectives and results for a priority neighbourhood over two years. Further details can be found in appendices three and five.**

Factor	Type of indicator	Baseline examples	Outcome examples
1. Community activity	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. 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 in the n'hood, including a community hub; good networking; wider range of issues and activities; high confidence and ambition
3. Mutual aid/ 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
4. Health benefit from community activity (direct and indirect)	(a) Number of residents who say their health has benefited from community activity; (b) improvements in the neighbourhood attributed to community activity	(a) 5% of residents say their health has benefited from community activity;	(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
5. 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
6. 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.	Public agencies aware, supportive and responsive to residents and community groups. Varied examples of services modified or improved by community input



# 5. Staffing, skills, location and costs

**It is recognised that these are tough times financially, though we argue the gains from a community development approach more than pay for the investment.**

Community development is often successful when it operates at an arm's length from the public authorities, though some models, including Local Area Coordination (LAC)<sup>17</sup> have proven successful when workers are embedded within statutory organisations. The following provides an ideal model for commissioning a staff team for a significant project, but the skill sets and principles apply when employing any community development workers.

## Staffing and skills

**Experienced community development workers are needed to do this work to the highest quality but with highly skilled leadership other front-line workers can be trained to contribute to this work.** Potential staff need to be able to show both a high level of community development skills and an ability to gain the confidence of the people in the locality. A community development team should have a mixed ethnic and

gender profile and an ability to empathise with people in all conditions. A dedicated community development team has the value of:

- A visible presence and identity for community development in the locality
  - Peer support and guidance amongst the community development 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 community development and objective evidence of outcomes.
- The following skills should be present in the team:
- Understanding of how communities work
  - Understanding of 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 while focussing 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

A skeleton job description for a community development project leader/co-ordinator is provided at Appendix 4. 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).

## Structure

**An ideal structure may look like this:**

- An overall leader/coordinator
- Business support/admin officer
- Research officer
- Three neighbourhood teams, each consisting of a neighbourhood team leader and three fieldworkers.

Each of the neighbourhood teams concentrates on one or two priority neighbourhoods for about 18 months, then moves on to additional neighbourhoods for further periods whilst providing a maintenance service to the earlier ones. The research officer would lead on gathering intelligence, liaising with the independent evaluators on baselines and indicators, monitoring progress, communicating and reporting.

A proportion of time should be allocated to providing intelligence and training for the commissioning organisation and other agencies. Advice to the commissioner/s should include how to build a community development-friendly element into other contracts. For example, hospitals can be asked to provide meeting space for community groups.

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

## Location

**What is essential is 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 designated area in five years requires significant resources, but a combination of partnership, secondments and in-kind contributions may considerably reduce the necessary input from the commissioning bodies.**

The team proposed above would mean a project establishment of 15 staff. Provision should also be made for seedcorn grants to community groups, and there would be costs for premises and equipment.

There is a strong argument for partnership and pooling of budgets 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 similar dilemmas of resourcing and where the impact / benefit is felt.

<sup>17</sup>LAC www.lacnetwork.org

# Appendix 1: Community development, engagement, participation and current policy

The need for community engagement is embedded in health policy and guidance<sup>18</sup>. The terms participation and engagement refer mainly to communities being involved in planning services locally. In most places, the planning agenda is set by the NHS and communities' opinions are sought to fine tune.

Community development can help local people set the agenda for planning services themselves, creating a very different dynamic and relationship with statutory services.

It is to be hoped that before long it will be structured into public health policy in a concrete way, and that it will give due weight to the function of supporting communities' own groups, initiatives and influence thereby encompassing also 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'.

In addition, Sustainability and Transformation Plans (STPs), need to reflect a 'shared vision with the local community'<sup>19</sup>. NHS England expects the STPs, together with accountable care organisations, will help to deliver on the Five Year Forward View and the key priorities set out in the delivery plan<sup>20</sup>.

Health systems in the rest of the UK, and across the world, face the same needs in different ways.

Community development focuses on the other half of the shared vision: what needs to happen amongst local people themselves ('bottom up' as opposed to 'top down').

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.<sup>21</sup>

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 . 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.

<sup>18</sup>See for example the new guidance on Involving People in Health and Care <https://www.nhs.uk/participation/involvementguidance/>

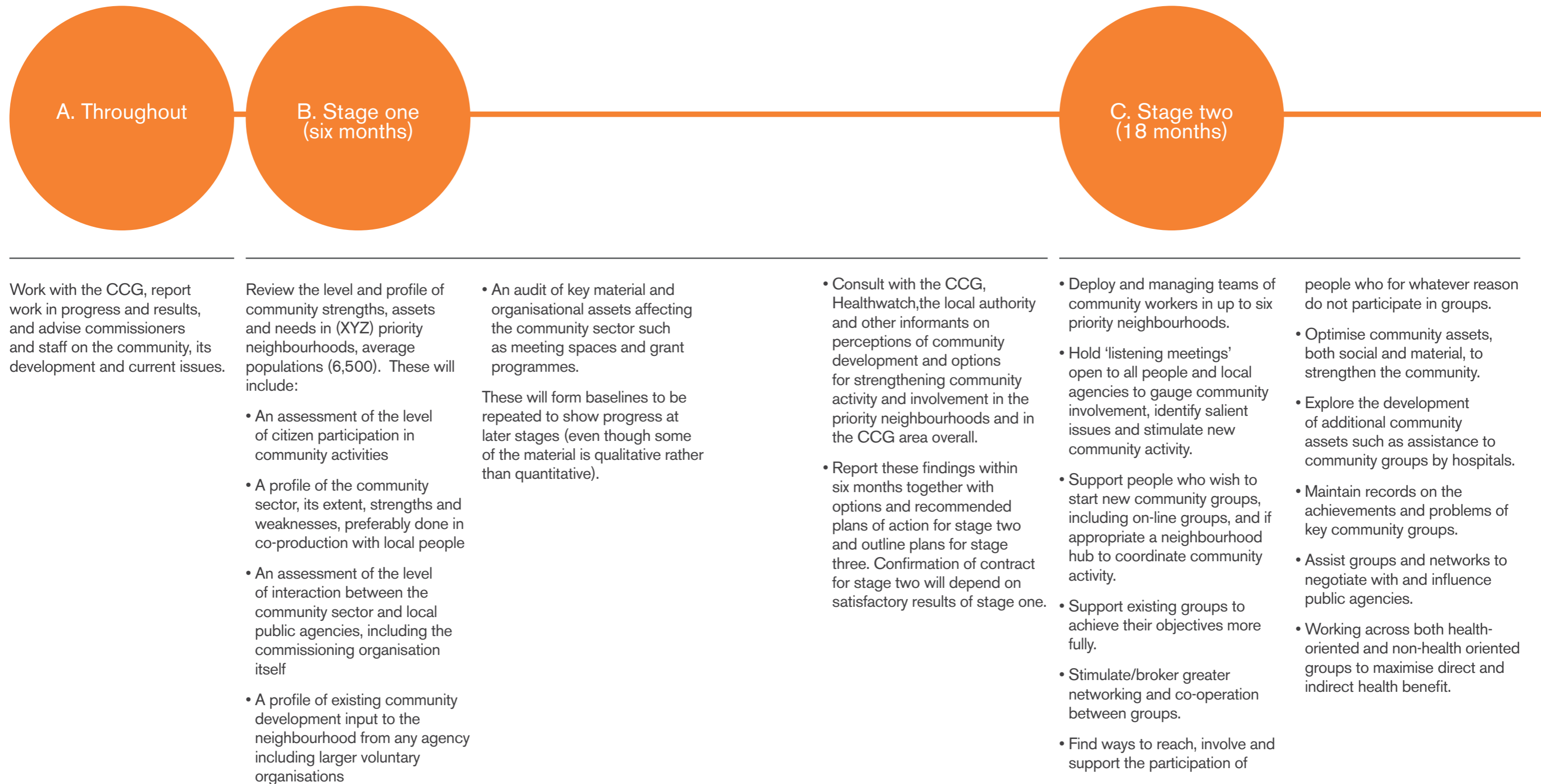
<sup>19</sup>Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 NHS England, Dec 2015

<sup>20</sup>[www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf](http://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf)

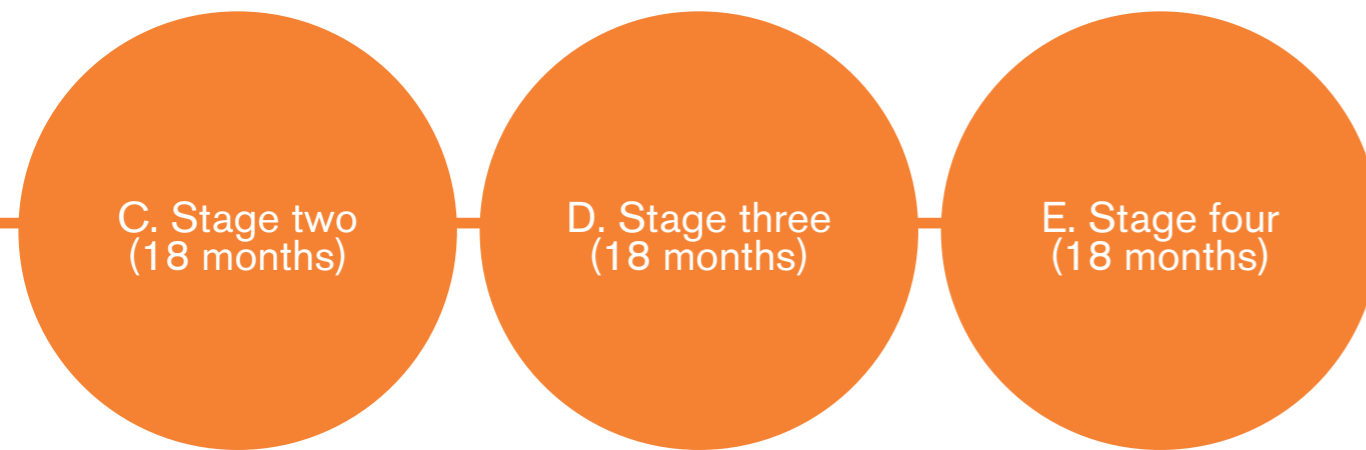
<sup>21</sup>[www.healthempowerment.co.uk/wp-content/uploads/2014/07/NHSA-CD-CHARTER-FINAL-7-July-2014.pdf](http://www.healthempowerment.co.uk/wp-content/uploads/2014/07/NHSA-CD-CHARTER-FINAL-7-July-2014.pdf)

# Appendix 2: Outline model contract

X 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:



# Appendix 2: Outline model contract



- Liaise with other public and professional agencies working in the area to facilitate all these forms of development.
- Advise the CCG and other professional bodies on community development.
- Monitor 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.
- Summarise learning from stage two and make recommendations for stage three.

Confirmation of contract for stage three depends on satisfactory results of stage two.

- Carry out baseline studies in an agreed number of additional neighbourhoods
- Repeat the actions of stage two in the additional neighbourhoods
- Maintain an 'after care' service for the community sector in the original priority neighbourhoods
- Stimulate and exploit opportunities for cooperation across the original priority neighbourhoods and the second wave ones

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

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

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 designated area, not having been identified as priorities, will have less pressing community development 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 3: Example KPIs and Milestones

<b>Stage 1</b> <b>Months 1 - 6</b>	Liaise with commissioners re selection of priority neighbourhoods
	Review of community strengths, assets and needs and any existing community development provision in priority neighbourhoods
	Establishment of baselines
	Consultation and relationship-building with key individuals and organisations in the community and in relevant agencies
	Recommendations on action in Stage 2
<b>Stage 2</b> <b>Months 7 - 24</b>	In the priority neighbourhoods: <ul style="list-style-type: none"> <li>• Increase in number of people active in the community</li> <li>• Community groups and organisations strengthened</li> <li>• Increase in community activity</li> <li>• Increase in productive interaction between communities and CCG</li> </ul>
	Transfer of community development knowledge to the commissioning organisation and its partners
	Progress report against baselines and any other developments
	Liaison with commissioners around selection of second wave neighbourhoods
	Establishment of baselines for second wave neighbourhoods
	Recommendations on action in Stage 3
<b>Stage 3</b> <b>Months 24 - 42</b>	Maintenance support to community groups in the priority neighbourhoods.
	In the second wave neighbourhoods: <ul style="list-style-type: none"> <li>• Increase in number of people active in the community</li> <li>• Community groups and organisations strengthened</li> <li>• Increase in community activity</li> <li>• Increase in productive interaction between communities and CCG</li> </ul>
	Transfer of community development knowledge to the commissioning organisation and its partners
	Progress report against baselines and any other developments
	Liaise with commissioners re selection of third wave neighbourhoods
	Establishment of baselines for third wave neighbourhoods
	Recommendations on action in Stage 3

# Appendix 4: Skeleton job description for project leader/ coordinator

<p><b>1.</b> Establish working relationships with the CCG and other local public service agencies (including private agencies carrying out public service work).</p>	<p><b>2.</b> 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)</p>	<p><b>3.</b> 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.</p>	<p><b>10.</b> Guide neighbourhood teams and individual workers in applying varied and creative methods to strengthen community groups, increase people's participation, increase mutual aid, and increase constructive influence of local people on public services.</p>		<p><b>11.</b> Stimulate and advise local agencies on increasing their responsiveness to community initiative and participation.</p>
<p><b>4.</b> Organise collection and analysing of information on the condition of local community life and levels of activity and effectiveness in different local neighbourhoods.</p>	<p><b>5.</b> Identify and make recommendations on priority neighbourhoods to receive community development input.</p>	<p><b>6.</b> Recruit and/or deploy community development fieldworkers, and establish neighbourhood teams, possibly in negotiation and collaboration with other agencies.</p>	<p><b>12.</b> Produce periodic reports on work carried out, results achieved and lessons learned.</p>	<p><b>13.</b> Disseminate results, boost public and professional understanding of what has been achieved.</p>	<p><b>14.</b> Assess risks, troubleshoot problems and organise collaborative solutions.</p>
<p><b>7.</b> Guide teams in establishing neighbourhood-specific objectives and how they will be assessed and reported.</p>	<p><b>8.</b> Manage and support staff, allocate individual objectives and establish reporting methods.</p>	<p><b>9.</b> Establish the identity and publicise the progress of the community development strategy and project amongst local communities and professionals.</p>	<p><b>15.</b> Formulate recommendations on how gains can be consolidated and extended in the future.</p>		

# Appendix 5: Evaluation indicators and guidance

Two elements are particularly important in measuring the impact of community development in a particular locality - establishing the level of community activity by local people and establishing the strength of community groups (the community sector).

These are the direct factors that community development works on, and which therefore need to show improvement before and after a community development intervention, before it can be established whether such changes correlate with improvements in health or other social issues.

Statistical correlations with population health improvement would take a few years to emerge, but increases in individuals' activities and strength of community groups can show up year on year, and can inform judgements about direction of travel and emerging effects. A selection of questions from established sources is given below with brief explanations.

## A. Establishing the level of community activity by local people

This objective can be measured quantifiably on a ward basis by a survey of at least 300 residents. It should be possible to show statistically significant improvements over five years if there is a marked expansion of opportunity for community activities arising from the formation of new groups, expansion of existing groups and activities provided by professional voluntary organisations.

It is not to be expected that statistical increases would necessarily reach significance within the first one or two years whilst momentum is building up, but an annual survey would show direction of travel. However, the ward as a population base for measuring community activity should not be regarded as a boundary for such activity: activities should be allowed to spill over to nearby areas and residents where natural.

## B. Establishing the strength of community groups

Periodic surveys of the community and voluntary sector across the whole area will provide useful information about the impact of activity over time. At neighbourhood/ward level there would not be sufficient organisations to produce statistical significance. Building up the ward level picture is integral to the community development work. A community development team could supplement the profile of groups with case studies of the career of particular groups and organisations.

### Menu of questions

Possible questions for (A) and (B) are listed here, drawn from some key sources. Additional or alternative questions may need to be developed and piloted locally, perhaps designed by and with local people. Words in square brackets are our modifications. Numbering identifies questions in this appendix - these are not the numbers in the original sources. For fuller detail please see the sources cited. Surveys should be as short as they can be whilst capturing the essential information, and questions should be piloted locally before being widely used.

## Survey of residents to establish level of community activity

Source 1: Office of National Statistics Social Capital Survey<sup>1</sup>

1. In the last 12 months, have you been involved with any groups of people who get together to do an activity or to talk about things? These could include evening classes, support groups, slimming clubs, keep-fit classes, pub teams and so on.
2. In the last 12 months, have you taken part in any (other) group activities as part of a local or community group, club or organisation? These could include residents' associations, sports groups, parent-teacher associations, school or religious groups etc.
3. And in the last 12 months, have you taken part in any (other) group activities as part of a national group, club or organisation? These could include pressure groups, charities, political groups, environmental groups and so on.
4. During the last 12 months have you given any unpaid help to any groups, clubs or organisations?
5. Thinking about the unpaid help you have mentioned, would you say you give this kind of help 1. at least once a week 2. at least once a month 3. at least once every three months 4. or less often? 5. Other 6. Don't know
6. Some people have extra responsibilities because they look after someone who has long-term physical or mental ill health or disability, or problems due to old age. May I check, is there anyone living with you who is sick, disabled or elderly whom you look after or give special help to, other than in a professional capacity?
7. Now I'd like to talk about any unpaid help you may have given people who do not live with you. In the past month have you given any unpaid help (of this kind)?
8. Now I'd like to talk about any unpaid help you may have received. In the past month have you received

any unpaid help? Please do not count help from people who live with you or from an organisation or group.

9. How often do you meet up with [some] friends? [Every week/month/less than monthly]
10. How often do you meet up with [any] relatives who are not living with you?
11. If you had a serious personal crisis, how many people, if any, do you feel you could turn to for comfort and support?

<sup>1</sup> Rosalyn Harper and Maryanne Kelly, Measuring Social Capital in the UK: Harmonised Question Set, London: ONS, 2003

<sup>2</sup> <http://webarchive.nationalarchives.gov.uk/20120919132719/http://www.communities.gov.uk/documents/statistics/pdf/1547220.pdf>.

<sup>3</sup> <https://www.gov.uk/government/publications/community-life-survey-2014-to-2015-data>

# Appendix 5: Evaluation indicators and guidance

## Source 2: National Citizenship Survey / Community Life Survey.

The National Citizenship Survey was carried out by CLG for many years till 2009. Previous surveys are available in archive<sup>2</sup>

The Cabinet Office then recreated largely the same survey under the title Community Life Survey, which is current.<sup>3</sup>

Two of the original questions were:

12. Do you feel able to influence decisions affecting your local area?
13. Would you like to be more involved in decisions in the local area?

### Other questions covered:

Levels of formal volunteering (via organisations), informal volunteering (via neighbours etc) and employee volunteering; giving to charity; chatting to neighbours; satisfaction with

local area; civic engagement, defined as

#### (a) participation

(eg contact representatives, attend demonstration);

#### (b) consultation

(eg respond to consultation/ go to a meeting/ be in a discussion group);

#### (c) activism

(eg be a school governor/ local councillor/ magistrate); would like to be more involved in decisions of the local council; social action in your area, defined as people getting together to support a community project in their local area, e.g. trying to set up a new service or amenity to help local residents, or organising a community event e.g. a street party; loneliness; agree that people in the neighbourhood pull together to improve the neighbourhood; local area has got worse / better/ stayed the same over the past two years; belong to neighbourhood; belong to Britain; local cohesion (people from different

backgrounds get on well together); feel can influence decisions affecting the local area; think it's important to feel you can influence the local area.

## Source 3: Understanding Society, UK Longitudinal Household Study<sup>4</sup>

14. I feel like I belong to this neighbourhood.
15. The friendships and associations I have with other people in my neighbourhood mean a lot to me.
16. If I needed advice about something I could go to someone in my neighbourhood.
17. I borrow things and exchange favours with my neighbours.
18. I would be willing to work together with others on something to improve my neighbourhood [or locality].

## Source 4: Social capital, based on General Household Survey<sup>5</sup>

19. Would you say this neighbourhood is a place where neighbours look out for each other?
20. Over the past six months, have you done a favour for a neighbour?
21. Over the past six months, have any of your neighbours done a favour for you?
22. Do you think that, by working together, people in your neighbourhood [or area] can influence decisions that affect the neighbourhood [quality of life in this area] ?

### Additional/ alternative suggested questions for residents' survey:

23. (a) Do you do any social, community or leisure activities where you meet other people? (b) If yes, how often? (Once

a month or more / About once in three months / Less often than once in three months)

24. (If any activity:) Has the activity had any effect on your health or general wellbeing?
25. (a) Is there a choice of such activities that would interest you that you can easily get to and afford? (A wide choice – plenty to choose from/ A fair number / Very few – not enough choice)
26. In the past twelve months have you become aware of any groups or activities in the area that are new or that you didn't know about before?
27. Do you know about (name specific groups)?
28. Would you like to see any new groups or activities set up in this area? (If yes:) What would they be about?

## Survey of the community and voluntary sector

The aim here is to see how strong the local community sector is, neighbourhood by neighbourhood, the range of issues it addresses, number of volunteers it attracts, support it can access, and how well the sector and the public agencies relate to each other. The National Survey of Charities and Social Enterprises study cited below showed that in 2008 and 2010 only 16% and 18% of community and voluntary organisations across England felt they had a positive relationship with local public bodies. By 'positive relationship' they did not primarily mean funding but contact, feeling valued and supported and having influence.<sup>6</sup> A number of local authorities worked to improve the relationship and ran their own subsequent surveys. For example a study in Hounslow in 2013 showed that a marked improvement had been achieved, although many organisations were facing major

<sup>4</sup> <https://www.understandingsociety.ac.uk/documentation/mainstage/questionnaires>

<sup>5</sup> Coulthard M., Walker, A. and Morgan A (2001). Assessing people's perceptions of neighbourhood and community involvement. A guide to questions for use in the measurement of social capital based on the General Household Survey module. London: Health Development Agency. Contact: Antony Morgan, antony.morgan@gcu.ac.uk

resource problems.<sup>7</sup>

There is no perfect way to distinguish community groups from professionally-run voluntary organisations but it is important to make some estimate because they perform basically different functions. Health policy about the voluntary sector tends to place main emphasis on the sector's role as a service provider. We are interested in organisations/groups that generate social capital. Some provider organisations do contribute to community development by providing social and community activities or affordable meeting space and general help to smaller groups.

The community sector cannot be identified in advance of a survey of the voluntary and community sector as a whole - it has to be established by surveying all voluntary and community organisations in the neighbourhood or locality, then creating a subset of those below a certain level

of income, eg £10,000 p.a. A good model for doing this is the series of studies of the voluntary sector in Manchester, carried out by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University in 2013.<sup>8</sup> CRESR found that around 90% of community and voluntary organisations had less than £10,000 income pa, whilst around 90% of funding the sector went to the 10% of larger organisations.

The organisations with £10,000 or less can broadly be regarded as the community sector – they clearly do not have enough resources to have even one full time member of staff, and many have none. But there is no need to go into major semantic or statistical debates in order to see what is happening here: the great majority of the voluntary-community sector are small community groups, and it is these which both express, foster and indicate independent

local community activity.

Lists of voluntary and community sector organisations may be held by the council, local umbrella groups, libraries, the CCG and other public agencies. However, these may not be comprehensive, and are unlikely to be segregated by neighbourhood or ward. In particular they are likely to miss many of the small community groups. They must therefore be supplemented by local intelligence in the neighbourhood itself. To count as a community group for CD purposes, a group should have a name, a designated contact person and be open to other residents to join.

#### Source 5: National Survey of Charities and Social Enterprises [NSCSE]<sup>9</sup>

This survey was carried out in 2008 and 2010.

1. Thinking back over the last 12 months, to what extent do you think your organisation has been successful, or not, in meeting its main objectives?
2. Looking forward over the next 12 months, how confident, or not, are you that your organisation will be successful in meeting its main objectives?
3. Overall, how satisfied or dissatisfied are you with the support available to your organisation in your local area?
4. Do you currently get any support from other charities, social enterprises and/or voluntary organisations in your local area? (e.g. Council for Voluntary Service, Local Social Enterprise Network, Co-operative Development). Agency, or other capacity-

building bodies)

5. To what extent do you agree or disagree with each of the following statements?

#### Local statutory bodies in your local area:

- a. value the work of your organisation
- b. respect your organisation's independence
- c. understand the nature and role of your organisation
- d. inform your organisation on issues which affect you or are of interest to you
- e. consult your organisation on issues which affect you or are of interest to you
- f. involve your organisation appropriately in developing and carrying out policy on issues which affect you
- g. act upon your organisation's opinions and/or responses to consultation

6. Overall, how satisfied or

dissatisfied are you with your ability to influence local decisions that are relevant to your organisation?

7. Taking everything into account, overall, how do the statutory bodies in your local area influence your organisation's success? [Very positive influence / Positive influence / Neither positive nor negative influence / Negative influence / Very negative influence / Don't know / No answer]
8. Please tell us the approximate number of full-time equivalent employees currently in your organisation.
9. Please tell us the approximate total number of volunteers, including committee / board members, that your organisation currently has.
10. Please indicate below your organisation's approximate annual total turnover or income from all sources. [No income / < £5K / £5-£10K / £10-£100K / > £10k].

<sup>6</sup> Cabinet Office (2010), Thriving Third Sector. <http://pacesempowerment.co.uk/wordpress/wp-content/uploads/2014/03/0-0-Thriving-Third-Sector-report-as-published.pdf>

<sup>7</sup> London Borough of Hounslow (2013) Voluntary and Community Sector Survey, [http://www.hounslow.gov.uk/voluntary\\_community\\_sector\\_survey\\_2012.pdf](http://www.hounslow.gov.uk/voluntary_community_sector_survey_2012.pdf)

<sup>8</sup> [www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/eval-voluntary-sector-2013-bolton.pdf](http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/eval-voluntary-sector-2013-bolton.pdf)

<sup>9</sup> <https://www.ipsos-mori.com/Assets/Docs/Polls/nscse-national-survey-2010-topline.pdf>

# Appendix 6: 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 people.

**Community development:** action to support people's 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 people.

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

**Community groups:** Weak meaning: categories of people,

such as young, elderly or people with a particular health condition. Strong meaning: independent local organisations of local residents, 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.'<sup>10</sup>

## Abbreviations

**ACO** Accountable Care Organisations

**ACS** Accountable Care Systems

**CCG** Clinical Commissioning Groups (responsible for administering the bulk of the health budgets across localities in England)

**DCLG** Department for Communities and Local Government

**JSNA** Joint Strategic Needs (and assets) 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

**STP** Sustainability and Transformation Partnerships

**Ward** Electoral division in local authorities, population about 6500



<sup>10</sup>Office for National Statistics. [www.ons.gov.uk/ons/guide-method/user-guidance/social-capital-guide/the-social-capital-project/guide-to-social-capital.html](http://www.ons.gov.uk/ons/guide-method/user-guidance/social-capital-guide/the-social-capital-project/guide-to-social-capital.html)



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