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Healthy Communities Team
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The Local Government Association is the national voice for more than 500 local authorities in England and Wales. The LGA group comprises the LGA and four partner organisations which work together to support, promote and improve local government.

4ps I&DeA LACORS LGE

reaching out community engagement and health



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feedback form

Did you find reading the community engagement and health publication informative?

Yes No In parts

Do you think it will be useful in developing your organisation’s approach to community engagement and health?

Yes No Maybe

What did you find most useful?

.....

Least useful?

.....

What future publications would you like to see the Healthy Communities Programme produce?

.....

.....

About you

Name

Role

Authority/Organisation

Email address

Are you happy for the Healthy Communities Programme to contact you in the future?

Yes No

reaching out
community
engagement
and health

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and your contact details.

1. introduction

'When people are involved in making the decisions which affect their lives their self esteem and self confidence rise, in turn improving their health and wellbeing. And, of course, many local people have a good understanding of the community's main health problems and of priorities for action. Real change can come only from the local community itself by harnessing the energy, skills and commitment of local people in setting clear objectives for change and forming new partnerships for action.'

(Department of Health: Saving Lives, Our Healthier Nation 1999)

This publication has been produced by the Healthy Communities Programme which is managed by the Improvement and Development Agency (IDeA) and funded by the Department of Health. The programme aims to build the capacity of local authorities to tackle health inequalities, develop leadership to promote wellbeing and foster a joined up approach to health improvement. The programme works closely with the National Institute for Health and Clinical Excellence (NICE) (see page 24 for an explanation of NICE's work), and we are pleased to be producing this booklet in conjunction with them.

The quotation on the left sets out one compelling reason for involving or engaging communities in the planning and implementation of health promotion and health services: engagement can improve health, even in the narrowest sense of improving outcomes from medical conditions. We hope the health and wellbeing benefits of community engagement are demonstrated in this publication. They are also supported by the recent report from the Local Wellbeing Project a joint IDeA, Young Foundation and London School of Economics initiative, looking at how community empowerment impacts on wellbeing positively. (For more information see www.idea.gov.uk/idk/core/page.do?pagelD=8428462).

But this is not the only reason why there is now a consensus that community engagement is important. In recent years, there has been a recognition that public services need to be more directly accountable to the people who both pay for and use them. It is not enough for accountability to happen 'upwards' through the Government to Parliament and the people. Accountability must also have a local component, so that decision makers are answerable to the very communities affected by their decisions. One way to make decision making more locally accountable is to make it more open and transparent, for example through scrutiny by elected representatives. Another is to engage local communities in the decision making process itself. As citizens in a democracy, we want decision makers to answer to us for the quality of our public services. As patients and users of services, we want decision makers to listen to us, understand our experiences of services and shape them accordingly. As members of the communities we live in, we want that dialogue to have a local dimension.

These powerful arguments – which have parallels across all the public services - have underpinned a series of national policies and legislative changes designed to enable the full participation of local communities and their elected representatives in both the commissioning and the delivery of health services.

The policies and legislation also reflect a growing recognition at all levels of government that no one organisation alone can resolve many of the nation's most fundamental health problems. In particular, many government policies and local authority strategies explicitly recognise the role of local government in relation to health improvement and tackling health inequalities. Almost everything local authorities do can contribute to the wider determinants of health (see explanation of the wider determinants in appendix 11). Not only social services which have obvious links to health services, but also housing, education, leisure and environmental services, planning, transport and economic development all have an impact on health. Local authorities have specific powers to take action to improve the environmental, social and economic wellbeing of their communities. These powers, along with their statutory responsibilities and their community leader role, give them wide scope for action and participation in partnerships for health.

In giving new powers and duties to local government, the voluntary sector and other key stakeholders in the public's health, the Government has acknowledged the need to work in partnership.

fitting services round people

Sheffield – Enhanced Public Health Programmes

In Sheffield there is a 14-year difference in life expectancy between the best and worst off neighbourhoods.

- **the Enhanced Public Health Programmes (EHPs) are funded by the Primary Care Trust (PCT) and the Neighbourhood Renewal Fund. They are developed and delivered in partnership with the local community, utilising local health data. Communities of interest and vulnerable groups, including black and minority ethnic communities have been a priority. One of the key principles of the approach is community engagement and empowerment**
- **the Introduction to Community Development and Health (ICDH) course (with over 300 participants to date) provides a stepping stone for further initiatives. It enables learners to explore what affects an individual's health and how to improve health at a community level. In the EHP areas it has demonstrated success in improving the health of local people and empowering them to become advocates for health in their own area, as well as enabling graduates to move onto further learning, voluntary work or employment. Such is the success of this programme that the local partners would like to see a national policy that all worklessness programmes should include issues of empowerment and health**
- **the EHPs have demonstrated an improvement in life expectancy and in the overall health gap between these neighbourhoods and the Sheffield average using a 'basket of indicators.' The majority of indicators for EHP areas have improved at a faster rate than for Sheffield as a whole between 2004 and 2006. The EHPs have resulted in a whole system cultural change in the way Sheffield delivers the reduction of health inequalities. It is now targeted, tailored, community led and a central part of the PCT public health service plan.**

Sheffield City Council recently won a Beacon award for their efforts to reduce health inequalities.

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'The key to success will be effective local partnerships led by local government and the NHS working to a common purpose and reflecting local needs.'

(Choosing Health, Public Health White Paper, November 2004).

In jointly commissioning and developing services, it is equally important for PCTs and local authorities together to engage the public in their work, not only as an end in itself to increase local accountability, but also with the aim of improving services through the involvement of service users themselves. The Government's aim is to devolve power to neighbourhoods and create a more patient-focused NHS. In line with this remit, the White Paper, *Our Health, Our Care, Our Say*, published in January 2006, developed these objectives further, with the **'move towards fitting services round people, not people round services'**.

This is the third IDeA publication in a series on the new landscape of health and well being (see Appendix 1 for details of the first two publications). It is intended to complement and build on the recent guidance on community engagement to improve health published by the National Institute for Health and Clinical Excellence (NICE, February 2008). It aims to raise current issues, stimulate thinking around how community engagement can be used in health improvement, and provide useful practical examples of joint working. We hope to revisit this topic again in

the future, when some of the issues around community engagement (e.g. Local Involvement Networks (LINKs) and guidance and new legislation arising from *Communities in Control*, the white paper on community empowerment) have developed further.

In this publication we look not only at community engagement strategies with a view to health promotion and improvement, but also at how community engagement works, through the democratic process, as a means of holding decision makers to account. We discuss the role of the voluntary sector in supporting community engagement in health and the role of local authority health overview and scrutiny committees in engaging communities in their work. We hope that this publication will be useful to community health development workers in local government and the NHS, NHS patient and public involvement staff, Directors of Public Health, Directors of Adult Social Services and of Children's Trusts, local authority Cabinet members for health and social services and members of health overview and scrutiny committees and their staff. We hope it will also be a useful tool in developing a wider understanding and interest in the role that all council services, far beyond those directly delivering health and social care, can play in improving health.

2. the policy context of community engagement in health

‘Community engagement is built on the principles of equality and social justice. It acknowledges that barriers to public health and social care services exist for many people and that those barriers are often rooted in the failure of agencies to adequately recognise the complex social, cultural, religious, economic and generational experiences of distinct communities.’

(Faculty of Health, Centre for Ethnicity and Health and Institute for Philosophy, Diversity and Mental Health, <http://www.uclan.ac.uk/facs/health/ethnicity/communityengagement/>)

Over the past decade, government policy has promoted the involvement of people from local neighbourhoods and communities in the development and delivery of improvement programmes. Examples have included Neighbourhood Renewal Programmes, Sure Start and Health Action Zones. The Government has attempted to link national strategies with local design and implementation by putting community engagement at the heart of such initiatives. The new structure for Sustainable Community Strategies and Local Area Agreements depends on Local Strategic Partnerships that are actively involved with communities, both of place and of interest. As we go to print, a proposed new NHS Constitution, setting out the rights of health service users, has been issued for consultation and the Government has just published a white paper, *Communities in Control*, which proposes a wide range of measures to increase existing local democracy and to give additional powers to individual citizens to participate in and influence local public sector decisions. Community engagement has become an embedded feature of government policy, an act of faith that now extends across all the political parties.

In the joint publication on community cohesion involving the Local Government Association (LGA), the IDeA and other partners; a cohesive community was defined as one where:

- there is a common vision and a sense of belonging for all communities
- the diversity of people’s different backgrounds and circumstances is

appreciated and positively valued

- those from different backgrounds have similar life opportunities; and
- strong and positive relationships are being developed between people from different backgrounds and circumstances in the workplace, in schools and within neighbourhoods.

In the light of this definition, it is easy to see why engaging and empowering communities are linked to community cohesion. Bringing together and giving greater control to the different groups of people who make up communities ought to contribute to an understanding of each others strengths, needs and differences. Initiatives to engage people in improving health and reducing health inequalities are one way of showing a commitment to and building community cohesion, as well as being a good in themselves.

‘Community’, of course, is a contested concept. The term has been used to suggest a romanticised and idealised world of mutual support from family, friends and neighbours, free from political conflicts and debate. Actual neighbourhoods, usually in the most deprived areas, are compared with this vision and found wanting. They are said to have lost the magical ingredients that make up ‘real’ communities, a loss that is thought to be revealed in the needs of local residents who are not coping and who need extra help. Such an analysis can be disconnected from the wider social and economic picture. In this analysis, community development is to be provided for poor people in dysfunctional places, to help

them rebuild the social capital that the rest of us take for granted.

In fact, the real problem is as likely to be that wider economic and social circumstances have put extra stress onto the most vulnerable people in these hard-pressed localities; and our public services have struggled to deal with this. Often the people living in these localities have shown real strengths in providing mutual support and helping each other out. They need access to the same good quality services that we all expect, an adequate income and employment. These are some of the basic determinants of good health.

The picture is further complicated in deprived areas as networks have grown up in response to the perceived or actual needs of these communities. They form part of what is sometimes called the cash or underground economy. Networks can sometimes have a negative impact as they may function to exclude individuals, groups or agencies. In areas where the underground economy's link to crime is strong they can be controlling. When working with communities it is important to ensure local community leaders are working in the best interests of local people and not taking a partial or biased approach, which could be in opposition to attempts at community engagement from outsiders.

In an understanding of 'community' more anchored in the reality of people's lives, it is helpful to make the distinction between 'communities of place' and 'communities of interest', and to recognise their interdependency.

Communities of interest are generally held to be groups of people who are bound together because they share an identity (for example 'the Chinese community' or 'the gay community') or who share an experience or concern (for example homeless people or young carers). Communities of place are people who are bound together because of a locality - where they live, work or spend a large part of their time. In these senses, in the modern world, most of us belong to many communities. We are increasingly attached to complex social networks, associated with our ethnicity and family background, our religion, our age, our patterns of friendship, where we have lived, worked and studied, where we live and work now and the emerging lives of our children. We may feel as well connected to friends and relatives across the globe as to the people on our street.

Even so, the nature and quality of the place where we live is important for us all, and especially for people living with the risk of poverty and poor health. People's local environment, such as housing conditions and access to green space; their local social and economic conditions, such as employment opportunities and how socially isolated they are; and access to local health facilities significantly affect their health. So does the level of control they have over their circumstances and the extent to which they have a say in what happens to them. Although this has for long been well known to community development workers, public health specialists and social reformers – and, of course, to the people who live in

areas of deprivation – it is only relatively recently that it has been explicitly recognised in academic research on health and in government policy.

Three brief examples will illustrate some of the differences in scale and approach to community engagement.

1. reaching out to a community of place

Sunderland – the Community Wellness Programme

Poor health in Sunderland is a legacy of heavy industry and deprivation. Recognition of the need to work closely with local community groups to target those individuals who do not attend other health facilities, resulted in the Community Wellness Programme being developed.

- City Council and PCT staff have worked with local people in the most deprived localities in a systematic way to create a network of well-being centres
- these connect up primary care, leisure facilities, children's services and community development staff. This has involved active listening to find out what people wanted, and including them in the co-design of the services
- providing opportunities in the heart of a community where local people have easy access to a high quality service has proved exceptionally successful, with 2000 users participating in the first 9 months of the programme
- since the programme commenced, 88 community staff and volunteers have received training to support delivery of the physical activity sessions, enabling 45 weekly sessions to be delivered across the city
- four volunteers are successfully working towards NVQ qualifications in Exercise to Music.

The model reflects the priorities of residents, who remain involved in reviewing the outcomes from this work and developing new ideas. This is a good example of working with communities of place.

Sunderland City Council recently won a Beacon award in recognition of their efforts to reduce health inequalities.

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2. working with a community of interest

East Leeds – improving patients' experience of specialist services

In East Leeds, the respiratory services were redesigned with the involvement of patients and their families, community health and primary care staff and the hospital team.

- there were benefits in patient satisfaction, reduced admissions and shorter lengths of stay
- the changes were unsettling for some, and the processes of involvement helped patients to learn more about options for their conditions and become more self confident
- the local authority health overview and scrutiny committee examined the initial proposals, monitored the changes and reviewed progress after one year.

This is a good example of working with a small community of interest.

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3. a community of interest and place

Knowsley – smoking cessation services

The stop smoking services in Knowsley have been highly successful, in part because staff got to know the local communities in depth, using a social marketing approach.

- the focus has been on access to those most at risk and building motivation for individual change by paying attention to the benefits of quitting
- the programme is comprehensive, systematic and designed to meet the needs of particular segments of the population.

This example is a hybrid, working with communities of interest within a specific locality and mixing together elements of community development, health promotion and social marketing.

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The Department for Communities and Local Government has defined community engagement as **'the process whereby public bodies reach out to communities to create empowerment opportunities'** and community empowerment as **'the giving of confidence, skills, and power to communities to shape and influence what public bodies do for, or with them'** (CLG 2007, p12). Another term used in this context, **'community development'**, is about **'building active and sustainable communities based on social justice, mutual respect, participation, equality, learning and cooperation'** (NICE, 2008, p38). Although community development and community engagement refer to different but complementary activities, in its guidance, NICE has used the term **'community engagement'** as an **umbrella term to cover both and to cover 'community involvement'**, the term was recently used in legislation to describe the NHS's work in this area.

In 1999 the World Health Organisation published *Community Involvement in Health Development*. It set out five key benefits of community involvement:

- coverage and the involvement of more people
- efficiency and the better coordination of resources
- effectiveness as a result of more relevant goals and strategy
- equity through focused provision for those in greatest need
- the growth of self-reliance and local capacity.

There are many ways that communities can be engaged in health improvement. These can range from large-scale public, formal consultations, with the involvement of democratically elected representatives, to intensive ongoing involvement of small groups of patients in developing services around a common medical condition, to empowering and appropriately remunerating members of small neighbourhood communities to act as advocates, health trainers or community development workers.

community engagement to tackle health inequalities

Derwentside – working with local people for local people

In Derwentside (another authority that recently won a reducing health inequalities Beacon award), in County Durham, the collapse of the mining and steel industries left a legacy of socio-economic problems and ill health. A comprehensive community engagement framework assisted local partners to identify community priorities and work with local residents.

- the Primary Care Trust with the council developed a community engagement network, committing cash and resources
- the District Council and PCT jointly appointed a Director of Public Health who led a series of community engagement exercises to develop a local health inequalities strategy
- the community has seen the development of a tangible and structured approach which continuously offers them opportunities to participate
- the voluntary and community sector has played an important role, with one third of Local Strategic Partnership members being voluntary sector representatives
- capacity building programmes have helped the community to nurture local champions, make decisions and deliver projects and services. Notable examples are the Craghead partnership which formed a Development Trust to run its own village hall and post office; and the Green Corridor Neighbourhood Management initiative which has employed its own health promotion worker in a deprived community
- an elected Young People's Forum has its own budget and projects, including two skate-parks and a youth bus which works with 'hard to reach' young people. In partnership with the PCT the bus undertakes health promotion, as well as anti-drug and alcohol workshops together with some fun and games for young people. The bus also carries out major pieces of consultation, for example on the Youth Strategy.

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answering to local citizens for the quality of health services

Cornwall and Isles of Scilly PCT's review of health services

High profile, negative issues challenged the Cornwall and Isles of Scilly PCT on its formation in 2006. These included anger about the future of local hospitals and concerns about care for people with learning disabilities. As part of the drive to re-engage with the public, rebuild trust and improve healthcare, the new PCT immediately announced a strategic review of health, with an independent chair and reference group, reaching out to more than 500,000 people in a rural area.

- an engagement document was publicised and widely distributed
- 'Question Time' events, involving almost 1000 people, took place, with panels including the PCT, NHS Trusts and Adult Social Services
- seminars were held with local authorities, MPs, NHS staff and Patient and Public Involvement (PPI) Forum members
- 'Select Committee' hearings were also held across the county. As a result, a number of links have been established, including a self-help group for people with Chronic Obstructive Pulmonary Disease.

The PCT's report on the review and the resulting strategy was presented to the local health overview and scrutiny committees and thousands of copies were distributed, and received approval.

People needed reassurance that the dialogue with local communities would continue. A Healthy Futures Board was established, meeting monthly and including Adult Social Care and PPI Forums. The Independent Reference Group continues to meet quarterly to review progress. Progress is also reported regularly to the overview and scrutiny committees.

The deliberately open style of the review has been followed up by new communication and engagement strategies. Monthly engagement events are focused around the PCT Board meeting, held in a different location each month.

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community empowerment through physical activity

WOW! Wear Valley Wellness on Wheels project

Wellness on Wheels (WOW!) is the first partnership-based working mobile wellness centre. It was developed in 2004 by Wear Valley District Council, Durham Dales Primary Care Trust, Wear Valley Sport Action Zone, Sport England and Technogym.

- **WOW! travels round the Wear Valley stopping for 10-week blocks**
- **the 44 foot mobile unit promotes physical activity and encourages lifestyle changes within local socially deprived rural communities**
- **during a stay, the WOW! Team works closely with that community to encourage them to take part regularly in physical activity and understand its benefits.**

What makes this project an interesting example of community engagement and more than just a way of delivering a service, is that the mobile gym acts as a consultation tool to establish demand and identify potential locations for permanent facilities, which volunteers are trained to operate themselves. Further funding was received in 2006 to enable the WOW! project to create small permanent fitness facilities in locations visited by the mobile unit. The aim is to empower communities to develop and deliver their own physical activity provision.

During the time that the unit is in place, the WOW! team works with the community to identify a management committee which then develops a sustainable business plan and identifies an appropriate location. Volunteers take part in a training programme to allow them to supervise activity within the fitness suite.

The WOW! project provides new clubs with a loan of £15,000 for fitness equipment. The club then has 12 months to pay the money back. There are now 7 community fitness suites with a total of 72 trained volunteers.

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imaginative engagement with a unique community

Fenland District Council – supporting Fenland’s Traveller Community

Fenland District Council has developed an imaginative, holistic programme of community engagement to support Fenland’s Traveller Community with its distinct lifestyle in this remote rural area.

- the district council provides Travellers with access to health care, housing, amenities and many types of learning experiences. The aim is not only to offer formal education opportunities, but to educate the Gypsy Traveller community and the settled community on how they impact on each other’s lives and to expose myths. This includes cultural awareness training for district council staff and elected members
- a particular objective is to build capacity within the Travelling community through training for new skills and mainstream jobs. This programme, which includes first aid and food hygiene courses, assisted 26 Travellers into employment during the first quarter of 2007/08
- while undertaking its housing needs assessment, Fenland District Council looked at all the needs of Gypsy Travellers, including education and health and the specific needs of younger and older people. For this project, the council, in partnership with Buckinghamshire Chiltern University College, trained a number of people from within the Travelling community in a fully accredited social research qualification. This helped the council develop a more accurate picture of the needs of this diverse community to inform planning for private site provision
- the council also funds Travellers’ Community Forums and provides training to organisers. The council also hosts Traveller Fairs, advice forums with the council and partner organisations including the PCT, open to Travellers from both local authority and privately-run Traveller sites.

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The previous examples and the case studies throughout the text are illustrations not only of engaging with different kinds of communities, but also of the need for statutory and voluntary partners to work together. The advantages of joint engagement strategies are obvious. They include:

- increased capacity to engage people at the interface between health and other services, such as social services (an area in which services have been less than seamless in the past)
- opportunities to use and build on existing networks and methodologies previously tested within the different sectors
- a way of bringing together commissioners and providers across services to listen and respond collectively to service users and the public – an opportunity for people to get out of their ‘silos’
- the avoidance of duplication of effort, which as well as being a waste of resources can cause ‘consultation fatigue’
- reducing the chances of failing to engage with all relevant parts of the community.

The Centre for Ethnicity and Health at the University of Central Lancashire has developed a model showing the different stages and levels of community engagement.

There are other useful models for those involved in community engagement. For example, the Scottish Centre for Regeneration has published a guide to help people understand community engagement and its impact. The Community Development Exchange has produced a useful short document, *What is community development?*, available on its website along with a number of other helpful documents on community development.

The Department of Health’s community engagement guide, although written specifically to support NHS organisations participating in the Pacesetter programme (see explanation in Appendix 1), includes general discussions about community engagement and the nature of communities, as well as specific discussions about community engagement and health and practical pointers for local strategies and activities. The inspection bodies have also recently recognised the importance of community engagement. The Audit Commission and Healthcare Commission report *Are we choosing health?*, highlights the importance of involving communities in developing local delivery plans and building the capacity of local organisations. References to all these documents and others referred to in the text are given in Appendix 1.

Centre for Ethnicity and Health – Community Engagement Model



from Migration, Marginalisation and
Access to Health and Social Services:
Overcoming Barriers, Correlation Network,
Amsterdam, 2007, p57.

co-ordinated community engagement through partnership

Derbyshire Community Engagement Group (DCEG)

A network of local authorities, other statutory partners (police, fire service and the health sector) and the voluntary sector has been set up with the aim of co-ordinating engagement activity across the county, to build capacity and reduce duplication.

The group meets on a bi-monthly basis to discuss common issues, progress joint projects, share best practice and monitor progress against the work plan. Its aims and objectives are contained in a Concordat agreed by all participants. The Community Engagement Group is supported by a Technical Working Group which provides a quality assurance mechanism for proposed methodologies, and considers technical issues, such as software and analysis systems.

Key achievements over the past three years include:

- training including facilitation skills, statistical analysis and designing questionnaires
- setting up the Derbyshire Facilitators Network - a network of people whose jobs broadly involve consultation, public participation and partnership working
- Citizens Panels – the Derbyshire Citizens’ Panel comprises approximately 8,000 Derbyshire residents. It is a joint venture between the county council, the police and each of the district councils in Derbyshire
- good practice, current policies and experiences – shared through talks and presentations by group members
- enabling partnership working – providing a forum for practitioners in community consultation and engagement. This has led to benefits through partnership working on a number of projects.

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going beyond the obvious

Merseyside Fire and Rescue Service – a health beacon

Staff and service leaders of Merseyside Fire and Rescue Service are clear that in helping to improve health, the service is also reducing the risk from fire. Those leading the health improvement programme believe that partnership with the health service, the community and other local partners is key.

Fire stations offer excellent venues for health initiatives – with facilities such as gyms, kitchens and meeting rooms, and, very importantly, firefighters are highly respected and act as positive role models.

The service employs specialist advocates to promote the safety and wellbeing of communities, including deaf people; people with drug and alcohol problems and people with disabilities. Staff work closely with social services, health professionals, statutory and non-statutory organisations. Individual projects include:

- **Advocates:** Merseyside Fire and Rescue Service employs more than 40 advocates across a variety of skills areas to target vulnerable and disadvantaged communities

- **Market garden:** use of land at Bromborough Community Fire Station for local youngsters to grow fruit and vegetables and then use them in healthy recipes
- **Start Right:** aims to reduce childhood obesity and encourage healthy lifestyle in children aged 5-8 and their parents, using firefighters as positive role models
- **Heartbeat Gyms:** outreach gyms in Community Fire Stations help promote rehabilitation for people with cardiac problems
- **Fire Fit Kids:** firefighters deliver fun, high energy physical activity programmes to school pupils.

Merseyside Fire and Rescue has also been commended for its commitment to the health and well being of its own staff, with access to physiotherapy, free fruit as well as the promotion of healthy living schemes such as Cycle To Work. The service has also recently won a Beacon award for its activity to reduce health inequalities.

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3. the role of local government

'If local authorities want to improve community relations they need to tap into and learn from the ways that people interact organically within communities, rather than solely add more opportunities for participation in council activities.'

(Involve.org.uk, 1 May 2008)

local councils as community leaders:
engaging the whole community in wellbeing design

Brighton – extra care housing for older people

One of the first extra care housing for older people schemes to be funded by the Department of Health, New Larchwood in Brighton, opened in summer 2006. The scheme was developed and built by Hanover Housing, with care and support funded and provided by Brighton & Hove Council. The underlying principle is that extra care should support the health and wellbeing of its tenants and the wider community.

- the design and building programme was supported by an active stakeholders group representing the partners, local people and voluntary organisations
- at the time that the building was being developed, the local GP ceased practicing. Following widespread local consultation the PCT funded the design and build of GP and Practice Nurse facilities within the new building and then tendered for a service, which it funds
- a community development worker was employed through the voluntary sector to develop services for older people within and surrounding the scheme. A community café in the communal area became the focus for his work and he developed a volunteer-run café with local residents as well as scheme tenants. He is also organising use of an allotment managed by the tenants which provides supplies for the café. The community development worker also organises an over 50s group with people living in the community which is very popular
- alternative therapies are successfully run from the communal facilities again for the benefit of tenants and other local people.

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Local authorities are closely connected to community engagement for health. As leaders of community planning, they are expected to know the needs and aspirations of their local population. As key partners within the Local Strategic Partnership, they are in a strong position to help other agencies understand local communities. As the body with statutory responsibility for health overview and scrutiny committees, they are developing their role in publicly holding services to account and providing a forum for public debate and public sharing of service users' experiences. Local Involvement Networks (LiNs) are now coterminous with local authorities and complement the work of health overview and scrutiny committees. There is enormous scope for these new organisations to make positive connections with local community and voluntary groups and to make links back to the formal processes of overview and scrutiny.

The community empowerment white paper, *Communities in Control*, proposes the extension of the remit of LiNs beyond health and social care, which may mean that they develop relationships with other parts of local authorities, including areas such as housing and education which have a significant impact on health.

Local councillors are important participants in their localities. They carry the mandate and legitimacy of democratic election, and usually have a wide knowledge about local needs and aspirations. They are local champions for improvement, and they monitor

the impact of social change and public policy in their areas. They may be members of the executive board or cabinet, or part of the overview and scrutiny processes. Hopefully they will have built up good relationships with local health colleagues.

Sue Johnson, Joint Head of IDeA Healthy Communities Programme believes that there is still more to be done to develop these relationships. **'NHS staff, being part of a national service that has traditionally reported 'upwards', may not fully appreciate the role of local democracy and accountability in health, or appreciate councillors' experience and local networks'** says Sue. **'And councillors may feel that the NHS does not take a sufficiently holistic approach to the interrelated social and economic needs of the communities it serves. There is still a tendency for the NHS to neglect the role of local authorities in official publications, even those that deal with community participation. And there is still a tendency for some councillors to expect residents to come to the town hall to interact with local government, instead of reaching out proactively to communities. But the examples and case studies in the publication show that the barriers are being broken down in many areas.'**

The independent Health Commission set up by the Local Government Association and chaired by Niall Dickson, Chief Executive of the King's Fund recently published its final report *Who's accountable for health?* which contains a list of recommendations it believes would strengthen the accountability links between the NHS and local government. The recommendations explore a number of ideas, including:

- the option of transferring the commissioning of health services to local authorities
- the involvement of local authorities in the selection of PCT chairs and non-executive board members
- the transfer of the public health function to local government control.

The commission also looked at community engagement in the wider context of democratic accountability. In addition to the recommendations above there were a number about ensuring that patients and the public are better informed about how they can access the health system and make their voices heard.

So far, none of the proposals that would involve structural change or changes in governance appear to have found favour with the Government, although recent government policy documents speak of developing the general local government overview and scrutiny function.

health scrutiny and community engagement

'I want to argue that there is a perfectly acceptable role in public life and that it is the job of holding powerful people to account.'

(Jeremy Paxman, CfPS Annual Conference 2003)

The Centre for Public Scrutiny (CfPS) supports anyone with a non-executive role in the public sector. Since 2004 its Health Scrutiny Support Programme (funded by the Department of Health) has been helping council overview and scrutiny committees (OSCs) to scrutinise public health and healthcare issues.

In addition to its work on health scrutiny, the Centre is now working on developing the role of and support for LINKs, the new networks being set up to enable greater public involvement in local health and social care issues. LINKs are co-terminous with local authorities with social services responsibilities and have powers to refer issues of concern to health OSCs. There is an expectation that LINKs will play a complementary role to health OSCs, acting as one form of conduit or bridge to NHS patients, members of the public and voluntary and community groups with a health and social care interest. It is part of LINKs' role to engage with the most isolated and vulnerable people and those whose voices are seldom heard. Most, or even all LINKs are likely to be

South Tyneside Council – neighbourhood services scrutiny committee – public engagement in scrutiny

Recognising that it was no longer good enough to consult with 'the same old faces', the Committee's challenge was to find a way of engaging with the people who did not normally present themselves but had the appropriate life experience of particular areas. The committee decided to use the topic of the effects of alcohol in the community to develop its engagement with the community. A 'hub group' was set up including representatives from the council, the PCT and the voluntary sector. The hub group then worked with a voluntary sector facilitator to identify organisations and individuals within the community with an interest in the issues. This extended group decided what to ask people and how to consult, in conjunction with the local community. The review used a community engagement model which allowed the community both to develop survey questions, undertake the survey and feed back. The group involved in this work were able to combine it with an NVQ in research skills.

This review demonstrated the power of grassroots involvement in research for scrutiny issues and advanced the council's thinking about how might set up a Local Involvement Network (LINK). The project model worked well because the ownership was solidly with the people with whom the involvement was being sought and enabled people not normally engaged to be engaged. The council has started to use this technique in other areas. Council members and officers attribute the success of this project at least partly to their willingness to take a back seat and allow the survey group to develop the topic according to the interests of the community.

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Leeds City Council – adult health and social care scrutiny board – community development in health and wellbeing

This inquiry looked how ‘community development’ can reduce health inequalities.

The Scrutiny Board visited numerous projects across the city that adopted a community development approach to help address particular health needs and met people who had really benefited from community development. The Board set up a small grants scheme where community organisations could bid for funding to support a community health development project. One of the inquiry’s key successes was the launch of a Community Health Development Network for Leeds, which the Board helped to fund in its developmental stages.

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supported or managed by voluntary sector organisations which already have connections with their communities. They will have an understanding of different forms of engagement and how to reach out to different groups and communities. This ought to mean that LINKs and health OSCs will be in a position to add value to each other’s work. Suggestions for the further extension of LINKs’ activities beyond health and social care (as referred to earlier) may further develop the relationship with local government and its scrutiny function.

Tim Gilling, the Centre’s Health Scrutiny Programme Manager believes that the scrutiny role is a dynamic one, providing opportunities to be creative and innovative. **‘Many non-executive councillors are working in ways that are far removed from the traditional image of stuffy council chambers and long, tedious meetings’**, says Tim. **‘This is because the Local Government Act 2000 freed most councillors from the ‘politics of decision making’, allowing them to hold their executive (or cabinet) colleagues to account for the decisions they take and their impact on local communities. They are also able to look outside the council at services provided by other agencies that impact on the local area. Nowhere has this been more significant than in health, with real opportunities for councillors to challenge health inequalities and to make a difference to how services are planned and run’.**

One of the CfPS principles of good scrutiny is that it **‘enables the voice and concerns of the public to be heard’** (CfPS 2005). The previous two examples of innovative scrutiny show how this works in practice.

What these examples show is that the community voice, combined with councillors’ mandate to act with and on behalf of the public, can be a powerful lever for change. The framework for locally accountable health and care sometimes appears incoherent - councillors as ‘guardians and shapers’ of the local area have a real role to ‘join up’ the various mechanisms that exist, putting the empowering of communities at the heart of everything they do.

4. the role of the voluntary sector

'Many voluntary and community organisations (VCOs) have a distinct advantage in engaging with and understanding the needs of users for various reasons including their specialisation, independence and the fact that their governance structure and staff are often rooted in their service user groups.'

(National Council for Voluntary Organisations, www.ncvo-vol.org.uk)

VCOs often have a holistic view of the activities undertaken by public sector organisations in an area. In ensuring that the NHS and local government engage effectively with residents and communities non-statutory partners can bring a different perspective, expertise and knowledge to discussions. The voluntary and community sector (VCS) can play a key role in helping to identify and set priorities, and in monitoring the performance of local services, with greater use of peer-led and citizen review. Voluntary organisations can provide a strong community empowerment and community development ethos along with infrastructure and encourage discussion and debate about the big strategic issues, as well as important local issues, so as to increase understanding.

LINks will provide a new opportunity for local voluntary organisations to contribute to the embedding of community engagement in the activities of the health sector. Voluntary organisations are likely to win contracts to act as 'host' organisations for LINks. They and their members are also likely to become members of LINks and to play an active part in their work. In particular, they can help to ensure that LINks have a patient, service-user and public voice on mental health and long-term care as well as on acute health services.

In the near future, LINks may well provide one of the few opportunities local communities and groups with a health interest have to become involved. The new Working Neighbourhoods Fund is likely to lead

to the closure of many community empowerment networks (CENs), as the ring-fenced funding for the networks will be subsumed into the wider fund. This means that local authorities may find themselves under considerable pressure to develop their own role in supporting public participation, particularly in the most deprived communities. Support for LINks will be one way of doing this, but it will need to be coordinated with the council's wider public engagement work and any support it is providing for a CEN, or alternative 'representation' structure, in its area. The Empowerment Fund, proposed in the white paper, *Communities in Control* may provide a new channel for community and voluntary sector organisations to turn key empowerment proposals into practical action.

Involving voluntary organisations is not and should not be seen as a proxy for engaging local communities and service users themselves, although many organisations do provide a useful gateway to the community. However, the voluntary sector can promote public engagement in the NHS in a number of ways. Ensuring that their users and members have access to good quality health and social care is a concern for many voluntary and community organisations, not just those with a specific 'health' remit. This means that there is usually a core of significant interest in and activity on these issues locally.

engaging with a community's tradition of voluntarism

London Borough of Greenwich – Food Co-ops

Greenwich Council (another recent Beacon award winner for reducing health inequalities) provides co-ordination for the Healthy Greenwich Network, a collaboration which includes the PCT, Age Concern, Greenwich Cooperative Development Agency and others. Central to all projects is a community health needs assessment, conducted at the start of any initiative. Once a community has been identified and key community leaders invited to participate, an audit is undertaken to assess the presence and quality of community facilities including fresh produce, retail food outlets, green space and sports facilities, community venues and youth clubs and what local people want. Findings are discussed at a community event.

The healthy food strand of the Network, the Greenwich Community Food Initiative, is supported by the PCT and the council. Greenwich has a strong tradition of community-owned co-operatives, and food co-ops have emerged out of the community health needs assessments. The Greenwich Cooperative Development Agency works with local volunteers to establish a co-op in an area. The co-operatives buy fruit and vegetables wholesale and supply them to the market stalls.

At the end of 2007, there were 15 street based co-ops in priority areas, 8 school deliveries, and 8 wholesale deliveries. The co-ops themselves were 70 per cent financially sustainable, supported 25 volunteers, provided 4 jobs, and conducted more than 18,000 transactions that year. The plan is that they will become fully self sustainable.

The school-based food co-ops provide an opportunity for parents and others to purchase affordable, good quality fruit and vegetables at convenient times. One of the key successes is that children have been buying fruit from school co-ops and eating it at break time.

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As well as having direct knowledge of local needs and preferences, and experience of engaging with local people, voluntary groups also provide a channel of communication to local communities. As such they can enable a diversity of views to be expressed and give voice to a range of different interests and concerns. Most crucially they can provide a link to those who would otherwise find it difficult to participate or make their views heard. Local infrastructure organisations, such as councils for voluntary service (CVSS), can be a good starting point for community engagement, having experience of working with and supporting local voluntary and community organisations and involving them and their users and members in debates about local needs, priorities and services. CVS and other local infrastructure organisations have for several years been playing a co-ordination role for VCS representation on Local Strategic Partnerships and indeed in some areas VCS health networks already exist.

As the Compact on relations between Government and the voluntary and community sector makes clear, involving the sector in the design of programmes, and doing so at an early stage, leads to better outcomes. The Compact is 'a jointly agreed way of involving and consulting the voluntary sector' and is increasingly used as a tool to improve partnership working and boost sector involvement. The Commission for the Compact, an independent organisation, supporting the Compact's objectives has a huge range of material on its website,

including examples of good practice in community engagement through the voluntary sector.

Communities and Local Government have recently worked with a number of VCS organisations to produce a consultation document entitled *Principles of representation: A framework for effective third sector representation in Local Strategic Partnerships* available at www.communities.gov.uk/publications/communities/principlesofrepresentation

Urban Forum, NAVCA (National Association for Voluntary and Community Action) and IDeA are also about to publish a guide to developing a comprehensive engagement strategy, with the aim of encouraging LSP partners to develop a co-ordinated approach to community engagement.

5. the NICE guidance on community engagement and health

'The idea behind [NICE's] public health programmes is to connect with the wider determinants of health, with the upstream dimension of public health activity, and the broader canvas on which public health is both delivered and determined.'

(Michael P. Kelly, Public Health Excellence Director, NICE, Public Health (2005) 119 p962)

An important milestone in recognising public engagement as a potential instrument of health improvement is the production of guidance by the National Institute for Health and Clinical Excellence (NICE). NICE is now well known for its evidence-based guidance to health practitioners and organisations on specific drug therapies and other medical interventions. NICE also has a very wide brief of 'providing national guidance on promoting good health and preventing and treating ill health'. As part of this wider remit, at the request of the Department of Health, NICE has looked at the evidence for the effective involvement of communities in the planning, design, delivery and governance of health promotion activities and activities to address the wider social determinants of health. The guidance on public engagement aims to support those working with and involving communities in decisions on health improvement that affect them. This includes those working in local authorities and the community, voluntary and private sectors.

As befits its health improvement remit, NICE has focused in its guidance on how different levels of community engagement could directly and indirectly affect health in both the intermediate and longer term. The guidance recognises that approaches that help communities to work as equal partners, or delegate some power to them – or, indeed, provide them with total control – may lead to more positive health outcomes. Involvement of the right kind can enable people to feel, not only that they have more

control over their own lives, but also that they can contribute to improving life for other people by improving public services. It makes sense that this feeling of being in control and of making a contribution to society could, in itself, improve people's wellbeing.

The job of NICE is to go beyond what common sense tells us and try to find out what evidence there is of what really works. Much of NICE's work since its establishment in 1999 as the National Institute for Clinical Excellence has been to appraise drugs or other medical treatments or technology, drawing on the expertise of health professionals, academic research and the views and experience of stakeholders, including patients and the public. In 2005, NICE was expanded to take on the role of providing guidance on public health. It became the National Institute for Health and Clinical Excellence (although still retaining the acronym NICE), taking on the previous functions of the Health Development Agency. This meant that, for the first time, NICE began producing guidance aimed at local authorities as well as health practitioners, including topics such as reducing obesity, methods to increase physical activity and physical and emotional well being in primary schools. As a result of its extended remit, it has had to take on board new forms of advising on and evaluating health interventions. (A list of published and forthcoming guidance with relevance to local authorities is given in Appendix 3.)

For obvious reasons, the methodology used to assess the effectiveness of public engagement has to be somewhat different from that used to appraise the effect of drugs. The research that forms the evidence base for this type of work does not always compare like with like, uses a variety of more or less rigorous methods and is both patchy and scanty. As Anna Coote, who chaired the group preparing the NICE guidance, and colleagues point out, **'Complex, community-based initiatives are hard to evaluate because of their size and the speed with which they are being rolled out, and because they are trying to address multiple problems within shifting political environments'** (Coote et al 1994, p.xi). When the objective is long-term health gain and/or increased local democracy, assessment becomes yet more complicated. Nonetheless, NICE has tried to base its recommendations on the evidence that is currently available, by synthesising evidence which ranges from some randomised control trials to individual case studies.

In developing the guidance, NICE was able to make an assessment of the barriers to effective community engagement. By turning these barriers upside down, it produced a list of conditions without which community engagement will not work. These are the prerequisites for effective community engagement. They include:

- the coordinated implementation of relevant policy initiatives
- a commitment to long-term investment

- an openness to organisational and cultural change
- a willingness to share power
- the development of mutual trust and respect.

a holistic approach to engagement with older people – an illustration of NICE’s prerequisites for effective community engagement

Bradford Older People’s Network

Bradford Older People’s Alliance is a network of groups representing older people, with a current membership of 80 organisations. It works alongside the Older People’s Partnership Board. The wider membership is kept informed via a monthly newsletter.

Focus groups of around 150 people meet monthly to discuss topics of interest and have lunch. Road shows complement the focus groups by targeting people whose voices have historically been seldom heard – black and minority ethnic people, local community groups, people living in extra care or sheltered housing.

The Older People’s Partnership has 5 action groups to deliver its vision: transport, employment and learning, health, housing and Involving Older People. Older people are active members alongside voluntary and statutory agencies.

One group of older people travels regularly to the University of Huddersfield where they work with small groups of

students to give them an older person’s perspective. Another group has become inspectors (‘quality visitors’) for Bradford’s older people’s residential homes. Another has helped with ‘mystery shopping’ for libraries and leisure centres. Older people have also set up their own drop-in centre in the town centre – ‘Open House for Seniors’, three days a week.

Some of the Network’s clear successes include the provision of an inner city ‘freebus’, an increase in podiatry services, a bowel cancer screening pilot, the development of low level preventive services and an increase in dental health services.

The Network’s facilitators believe the following are the key factors:

- building on what’s already there - the local bowel cancer screening team used the focus groups and road shows to very positive effect
- showing an interest and joining in
- making access easy.

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The recommendations also cover the infrastructure required for effective practice, which includes:

- appropriate training and development
- formal mechanisms to endorse partnership working
- support for effective implementation of area-based initiatives.

The guidance describes the approaches that can be used to encourage local communities to become involved in health promotion activities and area-based initiatives to address wider determinants of health. These approaches include:

- involving community members as agents of change
- running community workshops
- drawing on the skills and experience of individuals and groups previously involved in regeneration activities.

Finally, there is a discussion of how better evaluation can be developed to increase understanding of how community engagement and the different approaches impact on health and social outcomes. Anthony Morgan, the Associate Director at NICE responsible for overseeing the guidance points out, **'There's a very long journey from first engagement with a community to being able to evaluate health outcomes. Because of political constraints, funding for community engagement work tends to be for less than three years. This makes proper long-term evaluation more difficult. One of the lessons we learned from producing the guidance was that there is an important role for Government in commissioning large-scale pieces of research on the impact of community engagements. It should not be left to small community-based projects alone to carry out evaluative research.'**

building in evidence and evaluation to community engagement

Coventry – women's health project

Coventry has a population of 22 per cent ethnic minorities, half of whom are of Asian origin. The City Council's Health Development Unit held focus groups with local Asian women and female sixth form pupils, which highlighted the need for greater awareness of cervical cancer screening. Community groups were contacted and visits arranged to discuss these issues.

A Health Development Officer in the Health Development Unit was appointed to work with women living in minority and 'hard to reach' communities, providing:

- information, support and training on contraception, HIV, AIDS, IVF and fertility treatment, domestic violence, breast feeding, childcare and many other issues
- supporting women attending the Genito Urinary Clinic
- providing a 'drop in clinic' at a GP surgery
- visiting mosques and temples regularly to assist women in making informed health decisions.
- working with local mental health projects in the mainly

Asian communities, e.g. SAHIL – Asian Mental Health project

- providing 'buddy' support to women who have limited use of English, for IVF treatment.

The Health Development Officer also worked with the Street Workers in Sexual Health (SWISH) Project and the Terrence Higgins Trust in providing advice to sex workers.

Independent consultants undertook an evaluation of the project in 2005. This found that the project had empowered Asian women, increased uptake of services and should be extended to other areas. Outcomes included a 76 per cent increase in women attending cervical screening at one GP practice.

This project demonstrates how a knowledge of individual cultures and communities can make a real difference for health practitioners working with 'hard to reach' people living in priority areas. The project has informed the development of other health interventions such as those targeting men's health.

Coventry City Council was recently awarded a Beacon award for its efforts to reduce health inequalities.

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6. the future of community engagement in health

There is little doubt that community engagement as an approach to improving health and health services and as a form of local accountability is here to stay. Its official recognition by NICE as an instrument of public health must surely be a landmark in its history; the very difficulties experienced by NICE in collecting and assessing evidence of effectiveness may well lead to further evaluation and research. A number of other new and forthcoming initiatives could take the practice of community engagement in health yet further into the mainstream.

The Local Government and Public Involvement in Health Act 2007 established a new local authority duty to involve local people in local services and policies. We have yet to discover what this will really mean in practice, but it will surely mean a greater emphasis on the ways of working discussed in this document, across the public services. The white paper on community empowerment, *Communities in Control*, proposes to extend the duty to involve and includes a range of additional proposals to give greater influence to citizens over local public sector decisions, including requiring councils to act as “community advocates” for petitions related to primary care trusts, on subjects such as

the level of community health services. The white paper also refers to the proposed NHS Constitution, which encourages primary care trusts to enhance their accountability, including creating a local membership system or developing stronger partnerships with local government. In the immediate short term, this emphasis will be reinforced by the new Local Area Agreements with their requirements for local partnership working and the involvement of communities in developing the LAAs’ priorities.

At the level of individuals’ involvement in their own health, the Government has made clear in recent policy documents, including its *Progress and Next Steps* report on health inequalities, its commitment to social marketing techniques to reach the most disadvantaged people and to extending the network of Health Trainers to every community, to reach out to people at the greatest risk of poor health. Initially employed in Spearhead areas, Health Trainers work with people to assess their health and lifestyle risks, “helping to build their motivation to change”. Health trainers tie in with other initiatives such as the online NHS Lifecheck being developed for different stages of life (www.dh.gov.uk/en/PublicHealth/Healthimprovement/NHSLifeCheck/index.htm), and the plans for the national vascular screening programme.

These kinds of initiatives are an indication of the greater emphasis that is being put by policy makers on individual lifestyles and people’s role in their own health, with some acknowledgement, of the pressures that force people to make the lifestyle choices that they do. They demonstrate a commitment to enable individuals to have more control over their own health whilst also impacting on health inequalities.

As this document is published, the first Local Involvement Networks are going into action across the country. With the potential for involving hundreds or even thousands of individuals and groups in each area, LINKs could be a strong new bridge, as their name suggests, between the statutory public services and grassroots community activism on health issues. They have yet to be tested, however, and will have to avoid the obvious pitfalls of being seen as irrelevant or intrusive by existing networks, being hijacked by special interests, becoming too bureaucratic and formal or, conversely, too loose-knit and disorganised to be effective.

As we have noted previously, despite their recent creation, the Government is already suggesting, in the white paper on empowerment, that the remit of LINKs might be extended beyond health and social care. The white paper indicates that the Government will invite LINKs to come forward if they would like to pilot expanding their remit beyond health and social care issues. Such a development would provide the opportunity for making connections between health and social care and their relationship with other public services; but might also potentially distract LINKs from their current primary focus.

Also very recently published is the report of the national Next Stage Review of the NHS carried out by the health minister, Professor Lord Ara Darzi. In his final report following the review, *High Quality Care for All*, Lord Darzi has emphasised the importance of patients and the public, as well as clinicians, being involved from the beginning in service planning and has given a commitment that local people will be involved in any changes to local services.

participatory budgeting for health

London Borough of Lewisham – a neighbourhood approach

Currently, Lewisham has 5 Neighbourhood Management Areas. A number of Neighbourhood Management Panels have been set up locally, as part of the Neighbourhood Renewal Fund initiative, to enable local people to have greater participation in shaping services and health outcomes for their localities.

In Evelyn Neighbourhood Management area the PCT, local authority and community groups piloted an innovative exercise in participatory budgeting for health. The idea, originating in Brazil, involves a small proportion of the municipal budget being allocated through a process whereby local people effectively commission work from mainstream providers.

The local authority and the PCT decided to try out participatory budgeting as a way of distributing funding that had become available from Department of Health Communities for Health programme.

- a sum of £50,000 was made available and the PCT added £24,000 to this
- a working group comprising

the local authority, PCT voluntary and statutory sector partners acted as steering group for the pilot

- local community groups were invited to submit proposals costing up to £5000
- on the voting days, community organisations gave short presentations and voted on each other's proposals. The presentations were supported by written 'information sheets' relating to each proposal
- the health priority themes were physical activity, stop smoking, diet and nutrition and mental well being.

The feedback from 19 out of 21 groups was that they felt the money was allocated fairly and that they would like to see more funding allocated using this method.

The concept of participatory budgeting is now being considered as a possible avenue for developing Practice Based Collaborative Commissioning in Lewisham, beginning with practices and groups in the two most deprived wards.

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In addition, government ministers are taking a keen interest in experiments in participatory budgeting or 'community kitties' as a way of giving people a direct say in how local money is spent. *As Communities in Control* points out, the Department of Communities and Local Government is working with the Department of Health to explore how participatory budgeting can be used to involve people in decisions about health-related spending. The previous case study of the London Borough of Lewisham gives one illustration of how this might work.

As further evidence of the importance being given to the role of community engagement, Sir Simon Milton, Chair of the Local Government Association, in his foreword to *An Action Plan for Community Empowerment*, says:

'Community empowerment is local government's core business. Councils are elected to put local people first. The only way they can do that is by constantly seeking to enrich their mandate with a lively ongoing exchange with residents about how to improve local quality of life. Maintaining that conversation means continuously improving the opportunities available to citizens to get involved in debate... Community empowerment and participative democracy are an essential complement to direct representative democracy, not an alternative.'

The Secretary of State for Communities and Local Government, Hazel Blears, has praised authorities like Portsmouth City Council which published a directory of things people can do to get involved – from sitting on a neighbourhood forum, to getting involved in patient liaison, 'helping people get the most out of their local NHS'. *Communities in Control* builds on this kind of activity by proposing to extend the principle of statutory rights to information, accountability, and redress, to a range of public services – from neighbourhood police to PCTs, Recent Government documents also focus on empowerment in the context of worklessness and regeneration. For example, the recent report by Dame Carol Black for the Departments of Health and Work and Pensions, *Working for a healthier tomorrow*, suggests that occupational health services should focus not only on those in work, but should also contribute to improving the health of those out of work, **'so that everyone with the potential to work has the support they need to do so'**. This may be an indication of future policy development.

There is also an emphasis on community ownership of public resources (see *Making Assets Work: The Quirk Review* for more information) – in the literal, not just the metaphorical sense – with a new government Asset Transfer Unit being set up to support the transfer of more community services and assets from the statutory sector into community ownership; and a Social Enterprise Unit being set up to support newly created community businesses, including health services.

The jointly developed Communities and Local Government/Local Government Association *Action Plan for Community Empowerment: Building on Success* (CLG, 2007) sets out three key areas for future development:

- widening and deepening empowerment opportunities locally;
- supporting and enabling people to take up empowerment opportunities;
- strengthening local representative democracy.

With all-party parliamentary support for initiatives that embody these principles, these are the areas in which we can expect to see policy development and future legislation in relation to the public services, including the National Health Service.

appendix 1

additional information, resources and links

The wider determinants of health

'Factors which contribute to poor health and health inequalities such as poverty, poor educational outcomes, worklessness, poor housing, homelessness and the problems of disadvantaged neighbourhoods.'

See ***Tackling Health Inequalities – a programme for action (2003)***

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008268

The Healthy Communities web pages can be found at:

www.idea.gov.uk/health

The IDeA's companion publications are:

The New Landscape in Social Care and Health

www.idea.gov.uk/idk/aio/7355651

Healthy people, healthy places – LAAs and health (2007)

www.idea.gov.uk/idk/aio/7693963

Communities and Local Government (CLG), *Making assets work: The Quirk Review (2007)*

www.communities.gov.uk/publications/communities/makingassetswork

Communities and Local Government (CLG), *An Action Plan for Community Empowerment: Building on success, (2007)*

www.communities.gov.uk/documents/communities/pdf/actionplan

Communities and Local Government (CLG), *Communities in control: real people, real power (2008)*

www.communities.gov.uk/publications/communities/communitiesincontrol

Communities and Local Government (CLG), *Unlocking the talent of our communities (2008)*

www.communities.gov.uk/publications/communities/unlockingtalent

The Community Development

Foundation (CDF) is a non-departmental public body sponsored by the Department for Communities and Local Government (DCLG) and a registered charity. CDF's mission is to lead community development analysis and strategy that will empower people to influence decisions that affect their lives. Its work cuts across Government departments, regional and local public agencies and the community and voluntary sectors. Although not specifically devoted to health, its website has a range of resources and pointers to further information to support those working on community engagement.

www.cdf.org.uk

National Health Service Act 2006

www.opsi.gov.uk/acts/acts2006/pdf/ukpga_20060041_en.pdf

Local Government and Public Involvement in Health Act 2007

www.opsi.gov.uk/acts/acts2007/ukpga_20070028_en_1

National Institute for Health and Clinical Excellence (NICE), *Community engagement to improve health, (2008)*

www.nice.org.uk/guidance/index.jsp?action=byID&o=11929

Department of Health guidance *Strengthening accountability – involving patients and the public (2003)*

www.dh.gov.uk/en/Policyandguidance/Researchanddevelopment/HealthinPartnership/UKNHSpolicy/DH_4128046

Department of Health white paper on involving people in their own health, *Choosing Health: Making healthy choices easier (2004)*

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550

Department of Health white paper on a new direction for the whole health and social care system, *Our health, our care, our say: a new direction for community services, (2006)*

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453

**Department of Health,
*A dialogue of equals: the
Pacesetters programme
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appendix 2

the statutory underpinnings of community engagement

The Local Government Act 2000

introduced the split between the executive and scrutiny functions of local government, setting up overview and scrutiny committees (OSCs) for the first time.

The Health and Social Care Act 2011

made patient and public involvement a legal duty for all PCTs and NHS Trusts.

Under guidance relating to **section 11 of the Act**, the legal duty requires involvement:

- not just for major changes but in the on-going planning of services
- not just for consideration of a proposal but in development of proposals
- including decisions about services delivery.

The same legislation created the health scrutiny function for local authority overview and scrutiny committees, extending their previous scrutiny powers to the NHS and health matters. Under these provisions, OSCs have powers to:

- review and scrutinise the planning, provision and operation of health services in the area
- require officers of local NHS bodies to attend meetings and answer questions
- make reports and recommendations to local NHS bodies and expect a response within 28 days
- set up joint health scrutiny committees with other local authorities and delegate powers to another local authority

Under the legislation, NHS Trusts have a reciprocal duty to:

- provide information and attend meetings of health OSCs when requested
- consult on any proposed substantial developments or variations in the provision of services (the term 'substantial developments or variations' is not defined in the legislation).

And a local authority health OSC can refer a consultation to the Secretary of State if it considers:

- the consultation has been inadequate in relation to the content or the amount of time allowed

or

- that a proposal would not be in the interests of the health service

All of the above provisions were subsumed into Section 242 of the NHS Act 2006.

The Local Government and Public Involvement in Health Act 2007

created Local Involvement Networks (LINKs) to replace Patients' Forums. This Act also requires local authorities with social services functions to commission 'host' organisations (most being voluntary sector organisations) to provide administrative and other on-going support for LINKs. The remit of LINKs extends beyond health services to social care, with powers to visit both health and social care providers. LINKs are intended to be extensive and inclusive networks with both formal and informal structures to promote and support the involvement of people in the commissioning, provision and scrutiny of local health and social care services. NHS bodies are required to facilitate and respond to reports and recommendations made by LINKs.

Section 233 of the Act clarifies and strengthens the existing duty on NHS bodies including Strategic Health Authorities, to involve and consult patients and the public in the planning and provision of services, the development and consideration of proposals for changes in services and decisions about the operation of services.

This Act also provided a statutory framework for Local Area Agreements (LAAs) including a list of partners who have a duty to cooperate with LAAs. These include Primary Care Trusts (PCTs), NHS Trusts and NHS Foundation Trusts. In addition, local authorities and PCTs must cooperate in preparing a joint strategic needs assessment of the health and social care needs of their populations. The legislation about consulting and involving patients, service users and the public means, of course, that they should be involved from an early stage both in joint strategic needs assessments and in the setting of priorities and targets for Local Area Agreements.

Communities in control: real people, real power (2008) a white paper that proposes measures designed both to strengthen existing local democratic structures and to 'pass power into the hands of local communities'. Examples include extending the 'duty to involve' local people in key council and other public sector decisions, requiring Councils to act as 'community advocates' for petitions related to primary care trusts, on subjects such as the level of community health services, and providing better information to

communities about how to take up civic roles such as standing for election as a councillor or becoming a member of a health board.

The white paper also refers to the proposed NHS Constitution, arising from Lord Darzi's review of the NHS, which encourages primary care trusts to enhance their accountability, including creating a local membership system or developing stronger partnerships with local government. There is also a proposal to invite LINks to pilot expanding their remit beyond health and social care issues.

Additional key Government documents which emphasise the role of local government in health improvement include:

Choosing Health: Making healthy choices easier (2004), a white paper with an introduction by the then Prime Minister, Tony Blair, which sets out a series of principles for supporting the public to 'make healthier and more informed choices in regards to their health'.

Our health, our care, our say: a new direction for community services (2006), a white paper which sets out a new direction for the whole health and social care system, promising to bring services closer to where local people live and to make them more 'personalised'.

appendix 3

NICE guidance on public health

Published public health intervention guidance

Public health intervention guidance makes recommendations on types of activity (interventions) that help to reduce people's risk of developing a disease or condition or help to promote or maintain a healthy lifestyle.

Ref / Title / Date Issued

PH1
Brief interventions and referral for smoking cessation
Mar 2006

PH2
Four commonly used methods to increase physical activity
Mar 2006

PH3
Prevention of sexually transmitted infections and under 18 conceptions
Feb 2007

PH4
Interventions to reduce substance misuse among vulnerable young people
Mar 2007

PH5
Workplace interventions to promote smoking cessation
Apr 2007

PH7
School-based interventions on alcohol
Nov 2007

PH12
Social and emotional wellbeing in primary education
Mar 2008

PH13
Promoting physical activity in the workplace
May 2008

Public health intervention guidance in development

Title / Anticipated publication date

Accidental injuries in the home - children under 15
TBC

Accidental injuries on the road - children under 15
TBC

Effective weight maintenance following childbirth
TBC

Prevention of excessive weight gain in pregnancy
TBC

Reducing infant mortality among those living in disadvantaged circumstances
TBC

Preventing the uptake of smoking by children and young people
Jul 2008

Identifying and supporting people most at risk of dying prematurely
Sep 2008

Promoting mental wellbeing at work
Oct 2008

Mental wellbeing and older people
Dec 2008

Needle and Syringe Programmes
Feb 2009

Reducing differences in the uptake of immunisations
Jun 2009

Mental wellbeing of young people in secondary education
Jul 2009

Prevention of skin cancer
Oct 2009

School-based interventions to prevent the uptake of smoking
Dec 2009

Published public health programme guidance

Public health programme guidance deals with broader action for the promotion of good health and the prevention of ill-health.

Ref / Title / Date Issued

PH6
Behaviour change
Oct 2007

PH9
Community engagement
Feb 2008

PH11
Maternal and child nutrition
Mar 2008

PH8
Physical activity and the environment
Jan 2008

PH10
Smoking cessation services
Feb 2008

Looked after children
Sep 2010

Management of long-term sickness and incapacity for work
Mar 2009

Preventing accidental injuries among children
Apr 2010

Prevention of cardiovascular disease
Mar 2010

Promoting physical activity for children
Jan 2009

In addition, NICE has so far published one 'Quick Reference' guide, on obesity, for local authorities schools and early years providers, workplaces and the public (Ref CG43).

Public health programme guidance in development**Title / Anticipated publication date**

Personal, social and health education focusing on sex and relationships and alcohol education

Alcohol-use disorders in adults and young people
Mar 2010

Contraceptive services for socially disadvantaged young people
Aug 2010