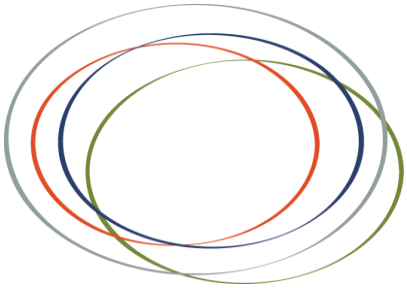

Health
Empowerment
Leverage
Project

Empowering Communities for Health

Business Case and Practice Framework

November 2011

EXECUTIVE SUMMARY

The summary falls into these sections:
1. Purpose; 2. Approach; 3. Communities and health; 4. Fieldwork method; 5. Outputs: community strengths and service changes; 6. Linking outputs to health outcomes; 7. Costs and benefits; 8. Implications for health policy and commissioning; 9. Implications for community development strategy; 10.Conclusion

1. Purpose

The Health Empowerment Leverage Project (HELP) was created in 2009 as a working party of the NHS Alliance. Its aim was to promote better collaboration between health agencies and local communities, with a particular interest in the potential for community development to play a wider role in relation to innovation, prevention and participation. At the end of 2009 the group was commissioned by the Department of Health to explore and demonstrate a business case for the use of community development in health. The purpose was confirmed and renewed following the general election in 2010. This is the main report of that commission.

2. Approach

HELP approached the task through five strands:

1 A review of literature on community activity and development and their relation to health

2 Running three neighbourhood projects in contrasting PCTs

3 Examining how community development outputs impact on health, and how health statistics can reflect these impacts

4 Examining costs and benefits and drawing together the business case

5 Analysing the neighbourhood experience and examining its implications for the changing policy context, for community development practice and for wider collaboration between health agencies and local communities.

3. Communities and health

The distinctive technique of community development (CD) offers support for independent voluntary local community groups, organisations and networks, producing wider and more effective community activity. It is effective through ensuring that the agenda is driven by residents and owned by them. This 'bottom-up' stimulus also complements and widens the platform for public health outreach initiatives and 'top down' community engagement by public agencies.

We found a wide variety of studies which provide evidence of the benefits for health of community activities, organisations and networking. Some of the impacts are direct, through the effects of participation on the individual; some are indirect, through influence on service changes and consequent improvements to the locality. Some of the effect on health is through initiatives about health behaviour and provision; some is through improvements in education, housing and amenities or reductions in crime and anti-social behaviour; and overall through improvement in social trust.

CD has particular value in disadvantaged areas where demands on the health service are high and inequalities in health are wide. In such areas there is often a baseline of:

low social capital
sparse or dysfunctional social networks
low trust and cooperation between residents
poor relationships between residents and public agencies (both health and other)
high crime and other disadvantages.

However there has been little quantitative evaluation of community development as a form of practice.

4. Fieldwork method

The HELP field projects were run in Smiths Wood, North Solihull; Townstal in Dartmouth, Devon; and Putney Vale in Wandsworth, London.

For its field projects HELP decided to concentrate on a particular form of community development, the creation of a neighbourhood partnership. It adopted a method known as 'C2', which had a reputation of exceptional success in several sites in Cornwall during the preceding decade, in particular in Falmouth (the 'Beacon' project), Redruth and Camborne (www.healthempowermentgroup.org.uk).

This method centres on establishing a long-term creative problem-solving partnership between residents and front-line services both from health and other agencies. The partnership is led by residents but generates parallel action and learning amongst agency staff. Development of confidence, skills and co-operation amongst residents is paralleled by new responsiveness, capacity and relationships amongst the public service partners.

The aim is not only to widen and multiply available activities but to create a cumulative momentum so that such developments are self-renewing, and the whole atmosphere of the neighbourhood becomes more positive. The method is described

more fully in a separate manual published as part of training in C2 at the Peninsula Medical School[1] and in the second chapter of the report summarised here.

5. Outputs: community strengths and service changes

The effects of the pilot projects over 18 months were that local communities and service agencies together created a range of new or extended local developments such as:

increased volunteering
wider social networks
better awareness and cooperation between community groups
legal and benefits advice
sessions on weight management and smoking cessation
sports activities
youth club
renovation of local play and recreation park
sexual health education
new dental services
community premises
safe cycling club
improving woodlands
young people's dancing
cooperation between housing associations
reductions in anti-social behaviour
greater trust and understanding between residents and agencies
the long-term partnership itself, with self-renewing potential

Some of these, like increased volunteering and wider social networks, were intrinsic to the community – they were primarily about residents' relationships with each other. Others, like weight management, safe cycling and dental service, were new or improved provision by agencies in response to community demand or interest. Yet others, like the renovation of the park, youth club, community premises and improving woodlands, were collaborations between residents and agencies.

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

Whilst residents who were active benefitted most, all residents benefitted from the better atmosphere, new amenities and improved services; and services themselves benefitted by closer contact with the community and with each other. Dialogue and collaboration with communities gave them better intelligence for commissioning and engendered more trust and cooperation from service users.

6. Linking outputs to health outcomes

To assess health outcomes we looked at the kinds of activity that emerged on our pilot projects and their antecedents. We then reviewed the known research on how such activities impact on health. We identified a number of major health conditions known to be alleviated by community activity, looked at their incidence in a disadvantaged neighbourhood, estimated a modest level of prevention through the

[1] *Transforming Challenging Neighbourhoods*, Exeter: PMS, 2011. Contact: Susanne.Hughes@pcmd.ac.uk

effects of community activity, and calculated the savings entailed by such prevention.

One of our pilot project areas, Solihull, was generously able to help us with detailed figures which allowed us to look at the incidence of some of the major health conditions and factors which the research had shown to be alleviated by CD. We used this to illustrate the level of health costs in a disadvantaged neighbourhood and the savings that could be made by increased community activity and influence.

Cardiovascular disease, depression and obesity were three widespread conditions which the research showed to be alleviated by general community activity. Experience from previous community development projects[2] suggests that CD could also have beneficial effects on:

- childhood asthma
- children at risk
- teenage pregnancy
- crime
- educational attainment
- housing conditions
- environmental conditions / open spaces
- employability.

Other projects suggested that, by specifically targeting them, CD could also contribute to improvements in:

- emergency ambulance calls
- A&E attendance
- emergency hospital admissions / readmissions
- elderly self care
- preventions of elderly falls.

Some of the health benefits, such as alleviation of depression and prevention of falls, could show up quickly. Others, such as alleviating obesity and cardiovascular disease, might take much longer.

Given the 18-month career of the project thus far statistical results were not yet available. Erring on the side of caution we made an estimate that the range of activity generated by a two-year community development project of the kind we had demonstrated would prevent 5% a year of the known events in respect of a limited selection of the relevant health conditions. We would expect the benefits to last at least three years - many effects would undoubtedly continue much longer. From the cost of treating each of these conditions we were then able to calculate how much health expenditure the CD project was likely to have saved. Associated savings in primary care are not yet fully explored.

7. Costs and benefits

We estimate costs of CD intervention of the type we used in a disadvantaged neighbourhood of 5,000 people as being an average of £72,750 a year for two years (at 2011 prices), comprising facilitator, support and training, evaluation and a small pot to assist start-up of new activities.

Other forms of CD, and further development of these partnerships after the two years, might well be desirable but we estimated the value from these interventions

[2] See www.healthempowermentgroup.org.uk

alone. Given the initial momentum, activity and effects would continue for several years, as earlier C2 projects have demonstrated.

Costs could be considerably reduced for projects addressing several nearby neighbourhoods, and for follow-on projects after two years.

With our cautious estimate of reducing events by 5% per annum in our illustrative neighbourhood of 5,000 people, there would be a saving for the health service of £558,714 over three years on depression, obesity, CVD and a small number of the other health factors. This is a return of 1:3.8 on a £145,000 investment in community development over the period.

With reduced costs from applying the method simultaneously in three neighbourhoods there would be a likely saving for the local health service of £1,676,142 from an investment of £261,900, a return of 1:6.4

The model for calculating the health benefit of CD would then be available for long term use at the current sites and elsewhere, with targets set at a level to be decided on the basis of local knowledge, and results populated with actual figures as the local health statistics became available.

On the same basis, investment in the 20% most disadvantaged neighbourhoods in a local authority area would produce a saving for the health service of £4,242,726 over three years, or just over £1.41m a year.

Using this form of CD in the 20% most disadvantaged neighbourhoods in England would save the NHS £200m a year.

Adding savings produced by reductions in crime and anti-social behaviour from the same activities produces a further saving of £96,448 a year per neighbourhood, £868,032 across the 20% most disadvantaged neighbourhoods of a local authority and £130m across England.

8. Implications for health policy and commissioning

The business case is not limited to the calculation of savings. Developing better relationships between health agencies and their communities is a fundamental part of long-term change in how we manage ourselves and our society. Dialogue and collaboration with communities gives local public agencies better intelligence for commissioning and engenders more trust and cooperation from service users.

This wider effect on service change is vital to the health service as it seeks to engage with local populations in a new way. Well planned community development enhances both primary care and Clinical Commissioning Groups' (CCGs) approach to prevention, Patient and Public Involvement and overcoming health inequalities. It also enhances CCGs' ability to work collaboratively with their local authority and other partners in the public services, voluntary sector and local businesses. It is a key instrument in the productive aspects of the move to localism, to enhance integration across the public services system.

Commissioners will be pleased with the evidence and experience that shows that communities that grow in confidence gain in health and are likely to experience lower health inequalities. Community capacity and confidence are the bedrock for

health improvement, and need to be linked not only to public health but to the mainstream of the health service.

The approach described here demonstrates significant and surprisingly rapid service change in response to the recommendations of local people. This is not at the expense of other local services – on the contrary, working in this way is liberating for them too. This is a cost-effective way of operationalising in-depth patient and public involvement. It is an approach that should be bought into by the full range of health organisations: GP Practices, CCGs, local authorities, hospitals, Healthwatch and others. Key policy areas which can benefit include:

QIPP. The QIPP agenda (Quality, Innovation, Productivity and Prevention) is driving much NHS thinking and planning. CD has a vital contribution to make to it. Using an invest-to-save approach, the innovative form of CD evidenced here shows that significant amounts can be saved for the NHS and other budgets too. The health promotion aspect of QIPP is also supported, as CD leads to health protection and increased community resilience.

Real placed-based budgets. The idea of place-based budgets across local authority areas or subregions needs to be complemented at the very local level by giving front line workers the flexibility to cooperate creatively with local communities and across issues. Community development is the ideal facilitator of that process.

Health and Wellbeing Boards. Harnessing the natural link between health and the local authority, CD offers a key instrument for the work of Health and Well-Being Boards. One of their roles will be to increase community capacity and public involvement. We show here that CD is at the heart of this objective, and we would expect HWBs to promote its use.

HealthWatch. HealthWatch is likely to become a key local and national organisation to assist patient and public involvement and will have increasing interaction with CCGs over time. CD can inform the work of HealthWatch, particularly as HealthWatch will develop relationships with a wide range of community and third sector groups. Some LINks currently employ CD workers.

Health Inequalities. Another focus of government policy and of Clinical Commissioning Groups and HWBs is the reduction of health inequalities. The evidence is clear, from Marmot and others, that good community capacity and strong social networks militate against health inequalities. CD therefore becomes a basic tool with which other strategies can build. Without strong, vibrant and trusting communities, tackling health inequalities is far harder and less likely to succeed.

Power. This process is not a zero-sum game. Both residents and agencies gain. Experience shows that while residents gain confidence and influence, agencies gain understanding, improve communication and enjoy their work more. It is not a matter of transferring power from one to the other but of building more effective and beneficial power together.

Both New Labour and the Coalition government have described community empowerment as a shift of power from agencies to communities. Our experiences suggest that this is misleading, and causes unnecessary tension. The process is rather a gain in power for both systems: the community gains greater power over its conditions and the way the public agencies serve it; the public agencies gain greater power to carry out their job effectively and economically.It is not a zero sum game.

The CD intervention is not so much an additional service as a stimulant bringing alive the interface between these two systems, those of residents and agencies, with their very different cultures. This requires some cultural change on both sides. Communities need to adopt some of the organisational formality of public agencies, and agencies in turn need to loosen the formalities and make space for more flexible problem-solving.

9. Implications for community development

Whilst our pilot projects concentrated on a particular form of CD, our experience and analysis also has implications for improving strategy, methods and evaluation in community development in general.

Commissioning CD for health is an opportunity not only to revive or extend CD but to overcome some of its past weaknesses by applying a clearer framework and giving it a more purposeful orientation to health. The features of our recommended model include:

- all major local agencies enlisted to contribute to health improvement – with reciprocal benefits for their own service
- a clear time-frame to establish long term self-renewing partnership between the community and the full range of public services
- training in new skills and relationships both for active residents and for front line workers of public agencies
- an outcome-oriented approach, with a model for relating CD outputs to evidence of health and other improvements.

10. Widening legitimacy and participation

This fresh approach to CD offers the opportunity to overcome some of its past weaknesses whilst drawing on its substantial strengths. Our model for amplifying the CD process, understanding its inner dynamic and collecting better evidence points the way to showing how it benefits the whole population, not just the active minority, and why it does not compete with local democracy but supports it.

To affect health statistics and costs, community development must affect the majority of the neighbourhood population, not just the minority who are active. Typically (and in our own pilot studies) there will be a handful of ‘key’ residents at the centre of the action, supported by some scores, or possibly hundreds, coming to occasional public meetings or undertaking some volunteering, within a neighbourhood population of around 5,000. The active few gain particular benefits but this model shows how the rest of population benefits too.

The solution is to ensure ever-widening circles of participation and to use authentic neighbourhood-wide surveys (or samples) to check the impact of the active minority on the majority. The active minority acquires skills and information, widens its social networks, gains recognition by authorities and increases its employability. As a result of its activities there are improvements to conditions in the locality. These in turn benefit the health and wellbeing even of those who have not taken part in the development. Some of these however gradually get drawn in to activities and share even more in the multiple benefits of the active minority.

11. Conclusion

The present report is far from being definitive but we believe we have broken new ground and provided some steps towards a better model of evidence for the importance of community development in health.

The combined fieldwork and research review of this project shows that increasing the breadth and effectiveness of community activity has three beneficial effects: (i) it gives people greater control over their own lives, enabling them to feel better and be healthier; (ii) it enables them to cooperate with others to improve their shared conditions; and (iii) it enables them to participate in dialogue and negotiation with public agencies, making those more accountable and responsive.

The combination of these activities within the community and in the service agencies has these effects:

- increases health protection for communities and individuals
- assists with behaviour change
- improves the effectiveness of patient and public involvement
- improves commissioning and service delivery
- helps reduce health inequalities.

Community development interventions recover their own costs and contribute significantly to savings in health expenditure.

Health agencies should therefore take a lead in commissioning community development for health, in association with local authorities and other partners. For example Health and Wellbeing Boards could give a major boost to community involvement in health by overseeing the commissioning of two-year neighbourhood partnership development programmes in the 20% most disadvantaged neighbourhoods in their locality.

Health Empowerment Leverage Project, Sept 2011

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