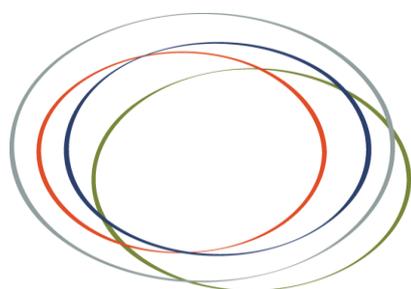# Empowering Communities for Health:

Business Case and Practice Framework

Health
Empowerment
Leverage
Project

November 2011

Empowering Communities for Health: Business Case and Practice Framework

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Compiled and edited by Gabriel Chanan

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Empowering Communities for Health

Business Case and Practice Framework

Contents

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www.healthempowermentgroup.org.uk
September 2011

Empowering Communities for Health
Business Case and Practice Framework

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.

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

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 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 possible 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 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.

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[2] See www.healthempowermentgroup.org.uk

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 to do 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. This 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 simultaneously: (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.

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Health Empowerment Leverage Project, Sept 2011

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1. INTRODUCTION: CONTEXT AND APPROACH

Origin

This report shows how local residents and public services in disadvantaged areas can be mobilised to improve health and reduce health inequalities by working together on an open agenda of local development.

The Health Empowerment Leverage Project (HELP) was formed in 2009 as a small independent working party attached to the NHS Alliance (www.healthempowermentgroup.org.uk). The aim was to promote better collaboration between health agencies and local communities. It had a particular interest in the potential for community development to play a wider role, in relation both to innovation, prevention and participation. The combined experience of the members included general practice, health visiting, community development and research.

The Department of Health was at that time considering that community development had significant benefits for health and patient and public involvement but it was unclear how far there was a business case for health agencies to invest in the approach. At the end of 2009 the Department of Health commissioned HELP to explore and demonstrate a business case for the use of community development in health in England. The purpose was confirmed and renewed following the general election in 2010. This is the main report of that commission.

The need for all health professionals to consider the community as relevant to their work has never been more urgent (Department of Health, 2010a). Health challenges are particularly intense in disadvantaged neighbourhoods, where life expectancy is frequently up to ten years lower than in nearby better-off neighbourhoods. Poor health reflects poor social conditions in terms of employment, poverty, housing, environment and education. Conversely, improvements in these conditions correlate with improvements in health (Marmot, 2010). Ideally all these conditions would be improved but the immediate challenge for health is to improve health even under existing conditions.

Approach

We approached the task from several angles:

> (i) conducting an online survey of a range of PCTs in August 2009 to get an initial impression of how widely they were using community development and what its effects were thought to be

> (ii) reviewing literature to gather secondary evidence on the connections between strong communities and health outcomes

> (iii) identifying a form of community development fieldwork that we thought most likely, on the basis of evidence, to be able to demonstrate health benefits within a relatively short timescale

(iv) carrying out a pilot field project in a neighbourhood in each of three PCTs in different regions

(v) investigating how far it would be possible to align CD intervention with health statistics in the pilot neighbourhoods and produce a business case

(vi) opening dialogue with other organisations and projects interested in health and community development, and monitoring relevant aspects of health policy.

Why community development?

Advocates of community development in health argue that it is the key to a purposeful increase in community activity and influence in disadvantaged areas (Henderson et al, 2004). It should act as a catalyst for change both in communities and health agencies.

There is a set of National Occupational Standards for Community Development which define this practice as:
> *a long-term value-based process which aims to address imbalances in power and bring about change founded on social justice, equality and inclusion. The process enables people to organise and work together to:*
> o *identify their own needs and aspirations*
> o *take action to exert influence on the decisions which affect their lives*
> o *improve the quality of their own lives, the communities in which they live, and societies of which they are a part (LLUK, 2008)*

Community development has a history of 50+ years both in the UK and abroad but has been used unevenly or minimally by health agencies in the UK. Aiming to alleviate poverty and inequality, it characteristically works in disadvantaged neighbourhoods, supporting community groups to improve local conditions, both by their own activities and by pressure and negotiation with public services. Working with communities of interest or identity such as ethnic or cultural groups is another important focus.

Most employment of community development workers has been by local authorities, voluntary organisations or partnerships of different public agencies. Some health agencies have employed small teams of CD workers, usually as part of their public health establishment.

Our initial investigations suggested that an appreciable minority of PCTs were using some form of CD but that, overall, CD was marginal to PCTs and the health field. Even in those PCTs which had a CD team the CD work was often somewhat marginal and its potential significance for commissioning and intelligence on the community was underdeveloped.

However, there are a variety of front-line roles, both in health and other agencies, which make some use of CD techniques or have potential to do so.

NICE's review of community engagement and development found extensive circumstantial evidence of effectiveness but very little hard evidence. The sparsity of evidence was largely because most of the relevant initiatives were short-lived or poorly defined and did not collect systematic evidence (NICE, 2008). Where CD was

part of a sustained programme its effect was often absorbed into other criteria rather than measured separately.

Fluctuations in CD provision

The 15 years from 1993 to 2008 probably saw greater investment in community development than in any comparable period. Nevertheless, as a national movement and discipline, CD remained relatively low profile, being mostly under the umbrella of large regeneration programmes such as the Single Regeneration Budget, European social programmes and Neighbourhood Renewal. These programmes undoubtedly contributed to improvements in health alongside other issues, but mostly with little specific measurement of health effects and often with little participation by health agencies.

Between 2008 and 2011 there has been a decline in the use of community development in England, initially due to the ending of Neighbourhood Renewal and then as a result of general cuts in local services. There has been greater continuity in Scotland, Wales and Northern Ireland, though the same pressures continue. This report is focused on England, but the issues are universal.

The 2010 White Paper on health highlighted the need to make the health system more responsive to users by shared decision making, 'putting patients and the public first'.

Sections of the White Paper on public health and adult social care (Department of Health, 2010b and c) indicated the need for a more active role for local communities. Where it existed, CD in health was generally located within the Public Health section, seen as part of prevention and reducing inequalities. Public Health as a whole however has often found itself in a somewhat marginal and vulnerable position in relation to the main health system (Hunter et al, 2010) so CD has been in a sense doubly insulated from the health mainstream. Earlier in the year the Audit Commission's review of public health had judged that the field of public health as a whole was poorly defined and lacked a central strategy and overall cost-benefit picture (Audit Commission, 2010).

An update of the new public health policy in June 2011 announced 'a new approach, reaching out to local communities...(with) new opportunities for community engagement and to develop holistic solutions to health and wellbeing embracing the full range of local services' (Department of Health, 2011).

Current policy to move public health back into local authorities whilst linking local authorities and health agencies more closely through local Health and Wellbeing Boards could create in principle a more dynamic relationship between public health and primary and acute care. Community development however needs to span all parts of the health system, and create partnerships which address the wider determinants of health.

HELP fieldwork projects and antecedents

The HELP pilot field projects were carried out in a disadvantaged neighbourhood in each of three contrasting PCTs during 2010 and 2011. The account of them here (in chapters two and three) covers the period up to mid 2011.

For its fieldwork projects HELP adopted the 'C2' method that had been pioneered in Cornwall since 1995 (short for Connecting Communities, see www.healthcomplexity.net). This method draws out and prioritizes issues that matter most to local residents; helps agencies deliver more responsive services; and so provides an accelerated form of community development designed to achieve effects economically within a given timescale.

Creating a practice and evidence framework

We also looked at health planning frameworks, budgets and statistics to see what our evidence would need to look like in order to be relevant to health planning and budgeting, and to establish what the connection between practice and evidence could be expected to be. We worked in effect to a theory of change expressed broadly like this:

> (i) **Baseline**. The starting condition is a neighbourhood with multiple disadvantages and low levels of health. These conditions entail disproportionately high demands on the health budget and other public agencies. A concomitant factor is a low level of community organisation, articulation and negotiation with public services. Correspondingly, the public services have a low level of engagement with the community.

> (ii) The **hypothesis** is that the level of health and general conditions in the neighbourhood can be significantly improved, with very little new investment, if the level of community organisation, dialogue and collaboration with public services is raised in such a way that it increases community confidence, organisation and ability to negotiate with public services, whilst services staff are enabled to take a more flexible, cross-issue, problem-solving approach to their work in the neighbourhood.

> (iii) These effects can be driven most effectively and economically by the **mechanism** of a neighbourhood partnership, designed to be the visible central point of an expanding wave of optimism and purposeful activity both in the community and the agencies. This wave needs to gradually affect and involve the bulk of the local population even though most residents will probably never come to a formal partnership meeting. Expansion of activity means more volunteering and social networks, and less isolation and exclusion, whilst specific initiatives such as a new park, dental surgery, playscheme or youth club each generate a further wave of benefits to users in terms of health and other issues.

Early findings

We soon found that whilst health agencies had a mass of detailed information about the health of their constituent populations this was mostly organised by individual health conditions and was often not available in the form of neighbourhood profiles. This meant that it would not be a straightforward task to establish a neighbourhood-

wide health baseline against which to measure the effect of a community development intervention.

Secondly, whilst it was manifest that poor local conditions, both physical and social, were having an adverse effect on residents' health, it was equally clear that improving those conditions would take some time to show up in health statistics. The short-term products of CD intervention were outputs such as the setting up of the local partnership, increase in participation and volunteering, increase in community organisations and collaboration with public agencies, sometimes leading to acquisition or improvement of local amenities such as a park, dental clinic or youth club. The key question therefore was how these visible outputs would lead to health improvement outcomes.

Towards the business case

Numerous local community development project reports show credible gains in terms of improvements in local residents' confidence, level of community activity, volunteering and reductions in isolation amongst some fraction of a local community (case studies in Home Office, 2004; CD Challenge, 2006; CLG, 2006; CLG, 2008a, Twelvetrees, 2008; Gilchrist, 2009; and see chapter five below). But there has been little specific analysis of cost benefits of CD, perhaps because it is usually seen as a method within a larger context of other social issues and services.

An unusual attempt to ascribe financial value to CD was made in a report from the New Economics Foundation commissioned by the Community Development Foundation in 2010 (NEF, 2010). Using the Social Return on Investment (SROI) method, the report finds a social return to the value of £3.5m for an investment of £233,655 in community development activity by four local authorities, a return of 1:15 on the authorities' investment.

Apart from this, funding for CD has rarely been accompanied by quantitative evaluation. Projects have mostly been expected to evaluate themselves, and a number of models and guides to self evaluation have been produced (eg Barr and Dailly, 2006). Local authorities or other large bodies including PCTs have, at times, had significant teams of CD workers and developed explicit strategies including planning and evaluation frameworks for CD. Little of this literature however has filtered into the public domain: it is a rich seam of experience that remains to be mined.

Generally the ethos both of funders and practitioners has been tolerant of project-centred reporting, largely impressionistic and lacking in quantification. 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.

2.   THE FIELDWORK METHOD

Community development comprises a variety of methods. The central technique shared by all variants is supporting and strengthening independent voluntary community micro-organisations ('community groups'). For our fieldwork pilots to yield demonstrable outputs in a relatively short period, and to link these outputs with proven outcomes, we judged that we should adopt here a tried and tested model rather than just an exploratory one.

We chose to build our pilot fieldwork on the 'C2' method developed in Cornwall by Hazel Stuteley and the Peninsula Medical School. 'C2' is shorthand for *Connecting Communities*, a particular method of accelerated neighbourhood development which empowers both local residents and public service workers to improve health, wellbeing and local conditions in disadvantaged areas.

The reasons for focusing on this method were:

> it had emerged from a health context

> it took, however, a broad approach, encompassing other agencies and issues having indirect effects on health

> the method focuses on achieving certain clear outputs within a given timescale

> there was a track record of three local projects with high reputations of achievement using this method, and all three were still thriving some years after the intervention; and in addition

> the three past projects were accessible as living models and generously willing to share experience with our new pilots (through the good offices of the C2 unit).

Much of the ethos and techniques of C2 are characteristic of all good CD but there are also distinguishing features. These are discussed in Appendix A.

The brief description which follows draws on a separate handbook produced concurrently as part of a training package developed at the Peninsula Medical School[3]

The method connects communities in three ways:
- within themselves – networks and cooperation amongst local residents
- with local service providers and public agencies – building a parallel community of interest amongst the front-line workers
- with other communities – getting and giving inspiration directly from one place to another.

C2 was originally developed out of work by two health visitors, Hazel Stuteley and Philip Trenoweth, in the Beacon estate in Falmouth in the 1990s. As a response to coping with an impossibly demanding case load they led an intervention which

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[3] *Transforming Challenging Neighbourhoods: Building Partnership the C2 Way*. Contact: susanne.hughes@pcmd.ac.uk

reversed the decline of a heavily stigmatised estate. The Beacon project became a national flagship for resident-led community renewal and health improvement (Stuteley and Cohen, 2004). The method was consolidated in further interventions and research in Redruth and Camborne in 2002-4 and formulated into a replicable model following two years' further analysis by researchers from the Health Complexity Group (HCG) at the Peninsula Medical School, Exeter. The HELP programme is a further development taking place in parallel with the establishment of training in C2 based there.

The seven step model

At the heart of the C2 process is a framework of seven steps (or eight if you include the fundamental ground preparation, which can be regarded as step zero). The seven steps are expected to take between one and two years to carry out on the ground, but are open-ended in the sense that their legacy is a functioning neighbourhood partnership which goes on under its own steam to produce new community action and new benefits.

Panel 2.1 is the basic description of the seven step model. The aim is to bring together residents and service providers around the joint purpose of making the neighbourhood a better place in which to live and work.

The approach can be described as a process of building community solidarity from the inside out, while simultaneously building agency solidarity from the outside in.

The health context

C2 began in a health context and health remains its central policy reference point. Fundamental to the approach, however, is the way that all other social issues and agencies also contribute to health. Addressing the conditions and concerns of the community as a whole brings the other public agencies into play in a natural way, and they in turn can see the reciprocal benefit of creating the conditions for improving residents' health. Depression, poor diet, lack of exercise, teenage pregnancies, domestic violence, antisocial behaviour, crime, poor education, accidents and emergencies, falls among the elderly and many other factors can be ameliorated by neighbourhood improvements.

This approach contrasts with, but complements, traditional community health interventions, which start from specific health issues such as smoking or obesity and pursue solutions to those. Starting with residents' expressed concerns (which may or may not include particular health conditions) builds confidence and an expanding agenda which ultimately results in better all-round health.

This process is therefore part of Patient and Public Involvement or Engagement (PPI/E)in the widest sense, and is vital to the immediate and long term health agenda no matter how the health reforms launched by the Coalition government in 2010 are finally resolved.

Panel 2.1: The Seven Step Model:
From Isolation to Transformation

STEP 7
Partnership firmly established and on forward trajectory of improvement. Two or three key residents employed and funded to co-ordinate activities. Measurable outcomes from community action plan and evidence of visible transformational change, e.g. new play spaces, improved residents' gardens, reduction in ASB, all leading to measurable health improvement and parallel gains for other public services

STEP 6
Evidence of community strengthening and self organization characterized by setting up of new groups and activities increasing social capital, catering for wide spectrum of age groups and targeting health priorities. Accelerated responses in service delivery from partnership agencies, leading to increased community trust, co-operation and reciprocal uptake.

STEP 5
Monthly partnership meetings, providing continuous positive feedback loop to residents. Celebration of visible 'wins' e.g. successful application to funding streams which support community priorities, and promote positive media coverage, leading to improved community confidence, more volunteering and increasing momentum towards change.

STEP 4
Constitute partnership which operates out of easily accessed hub within community setting, opening clear communication channels to wider community e.g. regular newsletter, estate 'walkabouts', links with other community groups and interface with strategic organisations.

STEP 3
Steering group hosts 'listening event' and produces report on identified issues, fed back to residents within 10 days. Commitment established for resident led, multi-agency partnership to tackle issues. Exchange visits undertaken to meet communities who successfully self-manage.

STEP 2
Deliver workshop to consolidate steering group and embed skills needed to support residents to lead change and become self-managing. Jointly plan 'listening to community' event to identify and prioritise neighbourhood health and well-being issues.

STEP 1
Identify and nurture key residents. Establish steering group of front line local service providers with a small reference group of key residents and other stakeholders who share common interest in bringing about change and improvement within a targeted neighbourhood to undertake a joint development process & action plan.

The C2 track record shows that certain steps are most likely to lead towards a local partnership between neighbourhood residents and public agencies which can operate in this flexible but purposeful manner. The approach is wholly flexible about which local issues should be the focus for dialogue and action at which stage of development. This enables local residents to choose their priorities and pathways, and thus take possession of the development process.

All major social issues are relevant to all localities, and you can be sure that concerns with safety, education, employment, housing, the local environment, welfare and related issues will all surface at some point. But because this is known, it makes sense to involve the major local agencies concerned with these issues from the start.

Key success factors

C2 shares with mainstream community development the experience that all local communities contain people who are capable, if necessary with support, of leading changes to improve their neighbourhood conditions and relationships. It also shares the conviction that the necessary changes are likely to be a mixture of internal change – relationships within the community itself – and negotiation with public services, who control so many important features of the locality.

Less common in community development are these features of the present approach:

> (i) the central objective of establishing a dynamic neighbourhood partnership within a two-year timeframe;

> (ii) seeing the front-line workers of the local public service as themselves likely to be in need of being brought together as a community of practice, developing their relationships both amongst themselves and then interactively with the residents;

> (iii) combining complete openness to residents' priorities with the knowledge that neighbourhood conditions are always to a large extent combinations of the social factors addressed by the major public agencies, and anticipating a coming-together of community and agency perspectives.

The method approaches both residents and agency staff as human beings and dynamic players in local development. It fosters in fact not one community but two: the community of residents and a parallel local community of practice populated by professionals from local agencies. But since the professional agencies have a 'head start' in terms of organisation and resources, getting a true balance requires building up the leadership of the community participants. On the other hand, because agencies are institutions with fixed structures and rules, it can take more effort to introduce flexibility into the agencies' process, whilst residents, once active, can move flexibly to expand their horizon and agendas. But these two communities are welded together through the partnership mechanism so that, in the words of one community leader, they become 'us and us' instead of 'us and them'.

The facilitator role

Applying the method requires skilled facilitation, and this is the primary cost. The amount of time required for this role depends on conditions in the community, the readiness of agencies to engage in the process, and on how well the facilitating role may fit with the remit of existing jobs or be an agreed extension of them. We return to the cost of facilitation under costs, in chapter six.

The facilitation is directed towards these objectives:

- developing greater resident efficacy and increased volunteering, that comes from a sense of communities taking control of their situation
- development of social networks and improved social capital
- better feedback to decision-making within local agencies, influencing commissioning and deployment of health
- improved reach by public health professionals and programmes into local populations especially the most disadvantaged and most often excluded groups
- addressing problems identified by residents which are known to be key social health determinants such as housing and crime
- escalation of health up the scale of residents' priorities, by establishing trust and enabling a more open dialogue about health
- synergy with neighbourhood strategies of the local authority and other agencies.

There are likely to be a number of people in existing roles in the locality who may be somewhat familiar with these issues. These might include health visitors, health trainers, voluntary organisation workers, teachers, faith workers and others. Few however would be likely as a matter of course to have in their existing role the scope and skills to address them as their central concerns. To make an impact on these issues requires an ability to deal with them at both strategic and ground level, knitting together the detailed concerns of individual residents and the functions of large professional departments. Facilitators need both the emotional insight to work directly with residents who may be undergoing stress, and the authority to negotiate with specialist professionals.

There may be people already working in the locality who have this potential but it needs to be identified and then brought out by the specific type of training developed by 'C2'. It also needs the backing of their managers and therefore a propitious climate in the employing organisation. We therefore treat the facilitator role as a distinct occupation, a particular kind of community development worker, and we cost it as such in our later discussion of costs and benefits (chapter six). There may however be potential in a particular locality for fulfilling this function by adaptation of an existing role.

3. THE FIELDWORK PILOTS

(1): TOWNSTAL, DARTMOUTH

Townstal is an estate of about 4,000 people on the edge of Dartmouth, at the top of a long hill which isolates it from the main town. Most of the public services are located in the main town and difficult to access from Townstal. In the 2007 Index of Multiple Deprivation the Dartmouth town area had average levels of deprivation, but higher rates were seen in the Townstal area, especially around income, employment, and crime.

The 2009 Joint Strategic Needs Assessment for the area showed that whilst much of Dartmouth is prosperous, it has a higher proportion of children with special educational needs and lower GCSE performance than the Devon average, and this is probably due largely to Townstal, which has a relatively high proportion of children in deprived households. A separate Child Wellbeing Index, also from 2009, indicates that levels of deprivation affecting children were above the Devon average, with particular issues around health, income, education and children in need. Levels of A&E attendances in Dartmouth were above the Devon average.

The intervention in Townstal began in 2009, when the HELP project itself was embryonic, through contact with a police inspector who had seen the effects of the C2 Beacon project in Falmouth and believed that local problems of crime and anti-social behaviour could be alleviated by a similar multi-agency approach here. HELP later made the health connection, and NHS Devon became a major partner.

We describe this case study in terms of the seven steps outlines in the previous chapter. The subsequent case studies are more condensed.

Step 1

The process started with scoping visits to meetings of the town council and local PACT (Police and Communities Together). A small group of residents were identified who were enthusiastic for change, and further scoping visits were made through their local knowledge. HELP facilitators attended community groups to talk with residents and listen to their lived experience and to find out what service provision was available and what other work was happening in the area that could be built on

With the exception of the key residents, most of the people whom the HELP facilitators met on their walkabouts were very negative about the status of Townstal and its relationship with affluent Dartmouth town. They felt that they were forgotten about at the top of the hill whilst being unfairly stigmatised as the source of all the anti-social behaviour in the area.

Although Townstal is part of Dartmouth the residents felt there was a huge divide, with shops that they could never afford to shop in and all the major services sited in the main town, including the nearest GP surgery. Townstal had very little – not even somewhere for the young mums to meet for a coffee or a decent play park they could take their toddlers to.

Some residents attributed shortcomings of the estate to a few 'problem' families that had been brought into the estate from other towns, whom they blamed for drug dealing and anti-social behaviour. There was a feeling that the services did not care or were unable to do anything about local issues. This perceived lack of responsiveness from the services also applied to smaller issues like litter, fly tipping and dog mess. There was cynicism about the ability of housing, police and the council to deliver good quality service.

A local health visitor provided names of key people she worked with in other areas of local service provision and from there further contacts were made until a good array of front line workers from different services had been gathered to try to establish a steering group for the new intervention.

Visits to the Cornish C2 sites were organised at an early point as it was felt that this would embed the vision of what a neighbourhood partnership could look like and achieve, as the concept appeared to be poorly understood by residents and agencies alike. The visits proved to be a real eye-opener to residents and professionals alike, provoking the comment 'If they can do it, so can we!'

Steps 2 and 3: First workshop and listening event

Facilitated by Hazel Stuteley (C2/HELP) and Dr Katrina Wyatt (Peninsula Medical School) the first workshop was held on 14th Feb 2009. It was attended by councillors, other residents, representatives from education, police, housing, health trainers, Devon PCT, South Hams District Council, and the Children's Centre. It attracted favourable comment in the local paper, the first of many positive articles.

Focusing on developing skills needed to co-create a receptive context in a neighbourhood setting, the workshop elicited commitment both from agencies and key residents to work together, starting with planning a 'Listening to Townstal' event. Residents and service workers distributed the invitations throughout the estate, having doorstep conversations wherever possible. Local shops, supermarkets and businesses provided donations for entertainment, refreshments and a raffle.

Fifty residents and 18 services staff attended the event. The staff acted as hosts, speaking with and helping residents, serving drinks for them and breaking down the 'them and us' division.

The top priorities which emerged were:
- Local access to NHS dentist and doctor
- Issues around binge drinking and drugs
- Anti-social behaviour
- Parking and transport
- Young people's issues
- Policing
- Litter and amenities

Widening the dialogue

The listening event opened up a dialogue which was continued through further public meetings, walkabouts on the estate and negotiations with services.

Word spread and groups of residents attended to voice their concerns. The agencies soon showed that they had got the C2 message that quick action on practical issues would build trust and guide community energy into positive channels. When it snowed early in 2010, Highways was contacted and it was quickly agreed that Townstal would receive more grit bins.

An angry group of residents brought up issues over litter accumulating in certain areas. The council representative fed this back and within weeks an additional road sweeper was allocated to the problem areas. (The following year however cutbacks would make this an issue again).

On other walkarounds residents were able to put over other issues, such as maintenance, taking away abandoned white goods and parking allocations, all of which were resolved over a few weeks by one of the housing associations.

Once they saw changes, even on small issues like litter, and residents knew they had a forum to make changes happen, resident support for TCP started to grow.

Step 4: Formalising the partnership

Townstal Community Partnership was formally constituted as a resident-led, multi-agency partnership in July 2009. From then on, monthly meetings were held at the local community hall and an executive committee met bi-monthly or more if necessary. The partners included:

- Residents as individuals or representatives of community groups
- Devon County Council – from Children's Trust to Highways
- South Hams District Council – specially the departments for Community development, Youth safety, Landscape, and South Hams Connect Service
- Housing Associations: Tor Homes and Guinness Trust
- Devon and Cornwall Police
- Head Teachers from local schools and new Academy
- Local Councillors – at Town, District and County levels
- NHS Health Trainers including school nurse
- Devon PCT – Public Health Directorate
- Devon Youth Services
- local solicitor
- Fire service
- Local Barnados Children's Centre
- South Hams CVS
- Other local community organisations/groups
- Local businesses both independent and large supermarket chains

A major breakthrough was the partnership's collaboration with South Hams District Council on the refurbishment of Collingwood Park, an open green space on the estate which had long been derelict. £50k had been allocated for the basic refurbishment of the park from the Government's Playbuilder Fund through Devon County Council[4] but as a result of TCP's involvement the plan was much improved and a further £45k allocated to carry it out. Key points were:

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[4] www.devon.gov.uk/play

- local children and the school were involved in redesigning the park. The architect incorporated their ideas into the final design and children monitored the changes and took part in the official opening

- local residents agreed to carry out part of the warden duties

- the involvement process created a strong sense of local residents' ownership and protection of the amenity.

The park rapidly became a constant hub of activity. More people spent more time in the open, children were more active, and there was more social activity and networking. Residents were becoming more optimistic about the locality.

TCP continued working with schools, firstly by a logo-designing competition for the partnership, with judging and cash prize donation by the local Sainsbury's manager – a local resident; then working with the secondary school children and the teachers to deliver lessons about 'community' for a week to all year groups. The lessons were about a sense of community in Townstal with the children taking part in a mini listening event about what they thought was good and not so good for them living in Townstal.

Further developments – steps 5, 6 and 7

Townstal Community Partnership had their first AGM in July 2010 and set out further long-term action points. As the initial residents' issues were resolved, the monthly meeting saw less anger and more new faces. Representatives of other pre-existing community groups came along to join forces and secure support for their projects. A local sculptor and architect put forward plans for regenerating local recreational space in Townstal. Dartmouth Area Local Access Group (DALAG) proposed to transform the former landfill site in community walks. The Flavel, a local cinema and culture centre, wanted to create new activities for young people of the area. All saw the potential of TCP as a means to create more citizen power to support – and benefit from – their causes.

Achievements in TCP's second year included:

Getting an NHS dentist located on the estate for the first time

A variety of residents' concerns resolved through multi-agency action

The police now getting more public information on crime and anti social behaviour and working closely with Tor Homes have been able to work faster and more effectively in tackling this

Better responsiveness of the housing associations to requests for repairs and garden maintenance. Caretakers have been employed in one of the most problematic blocks of flats and the housing association have reported a much better relationship with the tenants.

Reduction of speeding traffic, improvements in parking and reduced litter

The two housing associations working collaboratively with one another and the police, which helped address anti social behaviour problems

Monthly community bingo

The first ever Townstal festive gathering, 2009, set to be an annual event

Halloween party at the community hall with funding from Guinness Hermitage. 170 people attended.

Presentations on TCP activities to the Children's Centre, Devon police, the Local Strategic Partnership and a Department of Health conference.

Monthly newsletters – particularly important in an area where there are no free newspapers.

The Dartmouth library arranged for the provision of five laptops in Townstal for the running of a job club through the TCP hub. These would be used both to run a 'cyber cafe' for young people and a 'silver surfer' club for the elderly.

TCP were winners of Devon and Cornwall Police Neighbourhood Watch Association annual awards in 2010, and the partnership was selected as the 'Making a difference locally' good cause for 2010.

Devon PCT has also used the experience of the Townstal project as a model to apply in Teignmouth, from where a group of staff and residents visited Townstal in June 2011 for inspiration and support

Further Townstal achievements are discussed in chapter four.

Finally the partnership has its own website – another product of collaboration between residents and agencies. Devon Towns Forum contacted the partnership via the council to offer to bid to establish the website, which can now be accessed at: www.townstalcommunitypartnership.org.uk

Residents' survey

Our original intention was to carry out before-and-after resident surveys on the three pilot sites to establish the baseline and change in social capital. Reviewing a variety of sources we found no ready-made survey which we felt would capture the essential dynamic of the HELP method, and compiled our own, using some well established questions and some we devised. We did not then have time or resources to carry it out in full but piloted it in Townstal in mid 2010 and obtained sufficient replies to suggest that we had the essence of an instrument which, on a larger scale and with the right timing, would provide much of the necessary evidence.

The 36 completed responses from street interviews provided this spread of responses, which illustrate the kind of evidence that would show meaningful change in social capital:

28 felt that Townstal was a good place to live.

18 felt it had improved over the past year, nine that it had got worse and 9 that it had stayed the same

24 had heard of Townstal Community Partnership

26 felt they belonged to a community in Townstal,9 did not

23 felt it was easy to make new friends or acquaintances in Townstal, 12 did not

29 people knew more than ten people in the area, 7 less than ten

23 people took part in activities, 19 of them once a week, 11 did not

20 people thought there should be more activities available in the local area, 4 did not

28 people thought there were more activities available now than there were a year before

13 people felt safe going out in the area after dark, 22 did not or were not sure

After answering questions about a variety of issues in the locality (roads, pavements, traffic, litter, housing, youths, noise, things to do, places to meet and open spaces) 13 people felt that one or more of these issues had affected their own or another person's health, 21 did not

22 people felt that they could influence decisions affecting the local area, 6 did not

17 people felt they could improve life in the area a lot by working together and influencing the authorities, 13 felt they could improve it a little, 2 felt not

If a survey of sufficient size and balance were to be carried out it would be able to tell us more about whether the partnership was known to many residents and making a difference to their lives. It would be important to find ways to ensure that elderly and housebound people were adequately represented. Even this glimpse suggests that progress was being made and that there was potential for further active involvement but the number of people who might feel unsafe going out after dark suggests this could be a big factor in holding back involvement.

The questionnaire in full is provided in Appendix C, together with suggestions for how the local community sector can best be surveyed.

Prospects

At the point where this account has to break off (June 2011) the community partnership in Townstal is flourishing but also - no doubt in common with community initiatives across the country - facing dilemmas stemming from public service cuts. A great momentum of improvement and optimism had been set in train, with some residents evidently much more active than before, but complementary input from public agencies, whether in terms of time or money, was increasingly at risk.

The Townstal recycling centre was closed due to Council cuts, and flytipping promptly increased. Those residents who could do so now had to drive 12 miles to Totnes and pay £45 to dump excess rubbish. However as a result another multi agency 'Big Tidy Up' was organised by the partnership, and plans put forward for the housing associations and the council to jointly fund a central skip and have three-monthly tidy ups.

Some of the long-established voluntary organisations in Dartmouth were seen as still slow to find ways to connect with Townstal. One which did connect with initial enthusiasm used their association with TCP as evidence of community involvement in order to get a grant but did not pass on any benefits to TCP.

The Community hub had been open for a day a week since January 2011 in the existing community hall for residents to get information, access public services and organise activities. It was regularly used by the job club and by the housing associations for drop-in sessions for tenants' advice and assistance. There was a clear need for a permanent hub open all week. A bid had been put in to the South West Regional Development Agency for long term support for a hub but as RDAs were due to close it was not clear what the prospects were.

The group were also urgently looking for funding for the coordinator, herself a local single mother, who worked tirelessly to ensure that both the partnership and the youth club continued to flourish.

THE FIELDWORK PILOTS

(2): SMITHS WOOD, NORTH SOLIHULL

Solihull is an urban centre with a rural hinterland on the outskirts of Birmingham. It is mostly an affluent borough. There is however considerable deprivation in the north of the borough, with a life expectancy differential of 7- 8 years between south and north. Reducing this gap has been a priority for Solihull Care Trust (the PCT for the area) and will undoubtedly continue to be for any successor agency. The increase in elderly population is also expected to be even greater than elsewhere: according to a recent Joint Strategic Needs Assessment, over the next ten years the over-65s population is expected to increase by 26% and the over-85s by 58%.

The HELP fieldwork story in Solihull began in early 2009 when a GP lead commissioner contacted Hazel Stuteley and invited her to run a C2 workshop for Care Trust practitioners concerned with health inequalities. The workshop was attended by the Director of Public Health who was keen to implement it in North Solihull and so when HELP was set up, Solihull was a natural choice.

Early connections

An important early connection by the GP lead was made with the LA Neighbourhood Manager responsible for the most disadvantaged neighbourhoods served by his practice. The GP attended a multi-agency Neighbourhood Management team meeting in Oct 2009 to discuss the potential for delivering HELP and C2 in a targeted area of their choice. There was a well-established high-level partnership between the local authority and the Care Trust but this was the first time the Care Trust had input into neighbourhood-level meetings.

The collaboration was well received. The focus of the meeting was around a plethora of community issues, though there was no resident representation. It was agreed to work with HELP to pilot C2 locally, and subsequent discussions identified Smiths Wood as the most suitable initial area for intervention.

The neighbourhood

Smiths Wood is one of the more disadvantaged areas in North Solihull and had fewer community groups than other areas. The population of the part of Smiths Wood with which the project was mainly concerned was approximately 4,300. Frontline staff described it as heavily stigmatized, with a history of poor engagement with service providers, low social capital and correspondingly high levels of poor health and anti-social behaviour.

Perceptions of the Smiths Wood community by agency staff were that many residents were mistrustful, angry and hard to engage. Some saw the residents as leading chaotic lives, but recognised that the area had endured difficult conditions.

There had been a major physical regeneration programme over the preceding five years, and much resident discontent was focused on this. It was said that the housing redevelopment had disrupted the community; that old people's bungalows had been knocked down and their occupants relocated; and that the local pub had been knocked down. Residents had been offered the vision of a range of social

benefits and new neighbourhood amenities, but budgetary constraints in recent years meant that not all of this had materialised.

The following comments from residents were not untypical:
- 'They've ripped the heart out of this community'
- 'It's not a nice place to live any more and it's getting worse'
- 'We were promised so much and they let us down. They don't care'
- 'Incomers are favoured above long-term residents'
- 'We've been angry for years but no-one's listening…..it makes you ill'.

The regeneration company had set up resident liaison groups in each of the affected neighbourhoods but these were only convened infrequently, and did not appear to have had much influence. Some of their members however were to become active in the new initiative.

Gathering and listening

Service provider engagement in Solihull was stimulated by the Neighbourhood Manager in early 2010. The operational phase began in March 2010 by bringing together a wide range of service providers to introduce them to the method of intervention. About 30 people attended, variously from Solihull Council, Solihull Care Trust (the PCT for the area), police and schools.

A range of local agencies including police, ASB officers, Housing officers, Regeneration and Youth Services all signed up to support the 7 step intervention. So when the first connecting stakeholders workshop took place it was well attended by a diverse range of agencies, as well as a small number of key residents.

Over ensuing weeks, four public meetings were held, to explain to residents the idea of setting up a resident-led partnership. About 200 residents attended in all. Some reactions were initially hostile but relationships soon improved when it became clear that this process was designed to give residents more influence, and momentum gathered as agency commitment became more visible to residents.

A postcard invitation was distributed to 1000 households in the area in the week before the 'Listening to Smiths Wood event by residents and agencies on the planning team. Wherever possible they had a doorstep conversation to explain the aims of the initiative. It was not expected that more than a fraction of these residents would attend the meeting itself but spreading awareness and interest was itself an important part of the process.

The listening event took place on a Saturday morning, 15th May, at Smiths Wood Primary School. Approximately 60 residents and 20 service providers attended. The event began with a short film specially created for the event by residents from Townstal Community Partnership (TCP – see previous case study). The Chair of TCP said that residents there had been in the same position twelve months previously, feeling that they were not being listened to, but had now achieved an enormous amount.

Following discussion and listing of a wide range of issues raised by residents, the following themes were prioritised by votes of the residents present:

Issue	No. of Votes
ASB/Crime	42
Community Issues/Facilities	32
Environment	30
Drugs	28
Regeneration	18
Transport	10

The same group of people reconvened a week later to receive a report of the consultation, and produced an action plan based on these priorities. Development then gathered pace as both residents and agencies took up the prioritised issues and created new activities to advance them.

Towards partnership

The Head of the school which had hosted the meetings, and neighbouring schools and Heads since, were very supportive. They were concerned to generate wider community engagement following closure in recent years of two local schools and amalgamation into a newly built school which had caused widespread unrest. The extended schools service in particular became one of the lead agencies contributing to the success of SWANN, offering free meeting venues, costs of a minibus for exchange visits to other projects, and staff time to give hands-on support to the emerging partnership. A number of local shopkeepers also gave support, and later said they had benefitted from being involved even though they had done so simply out of goodwill.

Visits by the Neighbourhood Manager and Headmistress to HELP projects in the South West accelerated momentum towards the setting up of the Smiths Wood partnership. The partnerships in Falmouth, Redruth and Townstal all hosted visits, in which residents and agencies spoke eloquently about the benefits and transformative changes to their neighbourhoods, which are still going strong.

The Smiths Wood partnership was set up in July 2010 under the name SWANN – Smiths Wood Area Neighbourhood Network. HELP's intention was that it should be a formally constituted multi-agency partnership with resident leadership, on the model developed in previous HELP projects. In the event it was set up as a resident organisation, with service providers attending, and also meeting separately.

The SWANN committee met monthly in Smiths Wood Primary school to progress activities, and held public meetings for residents every two months. Partners include the Local Authority, Health Trainers, Public Health Analyst, SUSTAIN (the local voluntary sector umbrella group), Police Sergeant, Police Community Support Officers, Fire Service staff, Head Teachers, Housing Officers, Transport Manager and Park Rangers.

Outputs

The Neighbourhood Manager arranged for the community to have 18 months' use of two empty shops in the heart of Smiths Wood, courtesy of the Borough Council. Both were in dire need of cleaning, painting, decorating and furnishing, all of which was organised on a voluntary basis, with young people painting murals and designing the shop frontage. The Council also provided a grant towards outgoings, and further

funds are raised by selling recycled goods and clothes and hiring out the space cheaply to community groups.

The shops rapidly became a community hub, hosting a variety of activities, some created by residents and some by service agencies. SUSTAIN provided hands-on support and training for members in committee skills and computer use. Some of the activities were wholly new, others existed before but were increased or reached new participants through SWANN. Subsequently some of the activities separated from SWANN.

Activities in the first year to 18 months included:

- Child Poverty Needs Assessment carried out by Poverty Action Team
- Establishment of a phone advice service for resident housing and other queries
- 'Around Again' swap shop for school uniform and nearly new children's clothing
- Food hampers and Xmas Grotto in school put together by young parents engaged via SWANN public meetings
- Park Rangers, improving community woodland areas
- New dental services via mobile unit
- Care Trust Health Roadshow
- Launch of Care Trust Healthier Communities Strategy
- Weight management for local mums.
- Sexual Health advice for young people
- Smoking cessation especially for ante-natal mums
- Establishment of safe buggy-walking route for parents of young families
- Health trainers (one to one lifestyle/ health behaviour advice) - four sessions weekly
- Poverty action group: advice on debt, maximizing income and benefits
- Age Concern: intergenerational initiatives. Young mums' mini bus outings with older folk. A knitting club for all ages.
- Flat-pack furniture rejects donated by Homebase and distributed to families in return for small donation (arranged by employee local resident whose wife had benefited from help with drug and alcohol dependency)
- Christian Renewal Centre supplied food hampers for those in acute need
- Pedal power: Aimed at 'families with complex needs' referred by police, social services and families themselves, this was a police-led bike club where young people restored ex-stolen bikes, and were given helmets and advice on safe cycling. The bikes were then given to the families, on completion of cycling proficiency course. Older siblings and dads taught the younger children.
- REGEN, the local regeneration partnership, asked SWANN members to have input into the design and landscaping of five local green spaces.
- Smiths Wood Heritage Project became an active partner, inviting young people to engage in local woodland management, coppicing and den building. Uptake was excellent. Outcomes included:
  - accredited training in woodland management
  - improving habitat diversity in Smiths Wood woodland
  - positive outdoor experiences eg fire lighting, cooking and wood carving.

Widening impact and changing context

All this took place against a background of both public services and specialist charities beginning to have to retrench due to budget pressures. For example a counselling service run by the NSPCC was axed, leading to noticeable increase in untreated mental health problems with children and young people. Extended Services and HELP sought to negotiate for the Care Trust to provide support group activity and home visiting to compensate.

There were also tensions within the group which were traced to its having been set up on the model of a community-based charity rather than a fully cross-sector partnership under community leadership.

Nevertheless, the rapid spread of successful activities in Smiths Wood attracted wide interest from the other north Solihull neighbourhoods of Kingshurst, Chelmsley Wood and Fordbridge, with service providers transmitting lessons across the area, and the four neighbourhoods beginning to compare experiences and look to establishing their own partnerships and long-term collaboration.

THE FIELDWORK PILOTS

(3) PUTNEY VALE, WANDSWORTH

In Wandsworth we first met with members of the Public Health (PH) directorate, the PCT community development (CD) team, and a longstanding member of the Professional Executive Committee (PEC) in early 2010. It quickly emerged that there were dilemmas which the HELP team could possibly help to resolve.

The PCT, supported by the Professional Executive Committee, had an eight year history of employing community development workers to do outreach initiatives and health promotion. The community development (CD) team consisted of four permanent staff, called CD Coordinators (CDCs), allocated to neighbourhoods, plus two specially funded posts, one to work with older people and one to work with BME communities on mental health. Two CDCs were due to leave, with no plans to replace them, causing questions around capacity.

Despite having delivered effective outreach initiatives across Wandsworth with major impact, the CD work was not widely known , and the team felt it would be useful if their work was better understood across the PCT beyond the public health directorate. It was hoped that the joint appointment by Wandsworth Borough Council (WBC) and the PCT of a new joint public health director would improve their integration.

The borough council itself had no dedicated CD workers, which meant that the CDC team, who continually picked up housing, safety and environmental problems in course of their work, often had difficulty in locating corresponding personnel within Wandsworth Borough Council (WBC) to signpost to residents to resolve these issues.

The team also believed that a more coordinated approach could have more impact in terms of strengthening communities, enabling residents to act collectively to tackle issues. This could only happen with active WBC involvement, to address issues such as the unhealthy state of some of the council housing.

Identifying the site

Following explanation of the HELP fieldwork model, four possible sites were looked at on 'walkabouts' with the community development workers to meet residents and get a sense of the lived experience for them. There were also informal meetings with partner agencies including WBC, Met Police, SureStart and a lead GP commissioner to forge new relationships and begin to build a community of practice as a foundation for the intervention.

The sense that HELP staff got from residents and agencies on the meetings and walkabouts was rather defeatist. There was a feeling that consultations had been tokenistic and that on some issues residents were not listened to and were let down, though issues around graffiti and collection of white goods and old furniture had been handled well.

Putney Vale was identified by the community development team and HELP staff together as being likely to benefit from the new initiative.

Dilemmas of Putney Vale

Putney Vale consists of 370 households, population circa 1000, including significant numbers of Polish families and a small number of Somalis. The resident profile was mixed, with transient and indigenous families who had lived there since the estate was built to accommodate post-war housing shortage.

Built in the mid 1950s the housing stock mainly consists of ex-local authority owned maisonettes, low rise blocks of flat and mixed terraced and semi detached homes. Approx 65% was owner occupied and privately let, the remainder WBC owned. Putney Vale had high levels of multiple deprivation. The CDCs and others described the estate as isolated and abandoned; not just geographically (by the A3), but as a community where service provision was low and where services had been lost and not replaced over the last decade, notably the primary school, community hall and youth club.

The walkabout in Putney Vale was hosted by Shirley Price, Treasurer of the Residents' Association, and the CD worker for the area, Simone Farr. The residents' association, formed in 2007, had worked successfully to bring about some improvements, eg the community garden, but there were still many unresolved issues for the estate.

The residents spoke passionately about the need for major neighbourhood reform. The lack of any community hub or communal meeting place loomed large and increased their sense of isolation. They felt that lack of social provision, especially for young people, played a major role in anti-social behaviour and poor levels of cohesion. Following initial uncertainty about the impact of the newly built Asda store, it was now seen as a positive factor, for example through its café and by the fact that bus routes were improved to enable people to access it.

Setting the seven step process in motion

Putney Vale Residents' Association (PVRA) spread the word about the HELP intervention to the whole community via door knocking and newsletter, and the seven step HELP process was set in motion.

Step 1 was a multi-agency workshop to begin forming new relationships and for agency staff to learn skills of supporting residents towards self-management. This was held on May 12th 2010 in nearby Roehampton Campus. It was attended by six key residents and 18 service providers drawn from SureStart, Police, WBC, NHS Wandsworth, Dept Health, WBC Community Transport, Children's Service and Youth Service.

It was a day full of positive energy from everyone involved and successfully 'bonded' attendees who all undertook training sessions to learn how to deliver the next stage i.e. 'Listening to Putney Vale' to establish community issues of most importance to residents.

The listening event was held in a marquee in the centre of the estate, and over 100 residents attended, representing an estimated 20% of households on the estate. The event was facilitated and hosted by local service providers including Wandsworth Housing Department, Wandsworth Older People's Forum, Wandsworth PCT, SureStart and the Police. Residents attending included children, parents, teenagers,

and adults, through to senior citizens. There was a mix of BME groups including east European, Somali and South American.

Residents all gave their views on what was good and what could be better about living in Putney Vale. With activities for children as well as adults, the event buzzed with both pleasure and purpose. Through a process of listing and discussing the issues brought up by residents the following priorities emerged, backed up by detailed information:

Putney Vale Priorities

Issue	Number of Votes
Community and Youth Facilities	48
Anti-social behaviour	35
Environment	23
Transport	20
Housing	18

Subsequent steps

Two public meetings, in June and July, well attended both by residents and agencies, followed the Listening to Putney Vale event. It was clear that the residents of Putney Vale needed support from local agencies on their priority issues. These events provided a foundation for collaboration and placed the voice of Putney Vale residents at the heart of the decision making process.

One of the 'accelerators' in the 7-step process is 'twinning' a developing neighbourhood with an exemplar site which had similar issues and is now transformed and self-managing. At the July meeting a resident neighbourhood manager and a police sergeant from Redruth North in Cornwall were guest speakers. They later provided support and mentorship for setting up the PV neighbourhood partnership and a return visit to South West sites was planned.

Kevin and Marc, the visitors from Redruth North Partnership (RNP), outlined what a neighbourhood partnership looks like, ie resident led and supported by partner agencies. They told the story of how Redruth Neighbourhood Partnership had transformed the area of Redruth North over several years, addressing issues as prioritised by residents. They emphasised the need to think big but start small. Marc spoke about 'Operation Goodnight', a voluntary child curfew which had reduced ASB by 67%. It was successful because the community as a whole supported it and the focus was on supporting parents to keep their children safe after 9pm. Kevin also described community-led social enterprises set up by RNP which had become self-supporting.

The estate was already benefiting from community activities stimulated and supported by the PCT's own community development team, notably a very successful Reminiscence project, Tai Chi sessions and Falls clinics, part of ongoing work with the Older People's Drop In. A climate of trust amongst residents had been was created by the CD team over a considerable period, which helped to ensure that residents were readily willing to join in the new initiative. Other activities included

- Bollywood Dance sessions
- Army Assault course sessions at Purbright

- SureStart parent and toddler sessions

To demonstrate the need and likely usage of the much needed community hub, a further programme of activities requested by residents was put together by NHS Wandsworth and the local neighbourhood Police beat team. A total of 18 sessions were run during school holidays, and attendees totalled 445 across the whole age spectrum. This 'summer of fun' was celebrated at a very well attended community barbecue in August.

The first steps toward setting up the partnership formally were agreed in October and a draft constitution was circulated. A community liaison officer from Roehampton campus of Kingston University and other partner agencies pledged support. A resident petition led to a meeting with the Council about the possible reinstatement of Newlands Hall as a resident-managed hub.

In December Putney Vale Neighbourhood Partnership held its inaugural meeting where officers were formally elected, with residents in key positions of Chair, Vice Chair and Treasurer. The constitution was adopted and partner service providers from WBC, Police, NHS, SureStart, Anglican Church, Kingston University and Roehampton Forum signed up. The community liaison officer from nearby Roehampton campus made a room available free of charge for meetings.

An action plan for the Partnership was formulated from the residents' priorities. Main issues remained antisocial behaviour, facilities for children and young people, the need for a branch GP surgery and environmental and housing problems.

The January 2011 meeting of the Partnership set up sub-groups to pursue key issues. These were:
- A. Housing and environmental issues
- B. Children's and youth activities
- C. Older people
- D. Community facilities

Soon afterwards, Vice-Chair Shirley Price was able to report that following the Partnership's petition, which had secured 545 signatures, the Council's Overview and Scrutiny Committee had given an encouraging response to the plea for the community building and that a recommendation would be made to the Council in April. The building was in due course restored to community use and the four sub-groups made steady progress on their agendas.

4. INFLUENCING SERVICE CHANGE

Service change is often seen as something that needs to be driven from the top by:
- developing new services
- reshaping existing services and
- improving access.

Many productive changes however can only be prompted at ground level where the detail of particular neighbourhood situations is known to residents and front-line workers. But the ability of those workers to act on the emergent issues depends also on change at a higher level, in the form of enlightened management: are the front-line workers given sufficient flexibility to enter into joint problem-solving with residents and with other agencies? Are the middle and senior managers geared to listen to the front-line experience and consider its implications for wider changes?

In order to make changes effectively, agencies need to:
- understand their populations
- communicate with them and
- become flexible and responsive to the populations they serve.

The pilot projects described in chapter three could not have produced their varied outputs in such a short time without practical responses by local public service staff to the issues raised by residents through the neighbourhood partnerships.

A little more detail on our pilot projects illustrates how service change can emerge from the neighbourhood partnership process. These examples are from our Townstal and Smiths Wood projects.

Examples– developing new services

In Townstal, Tor Homes commented that the partnership had helped them build a new relationship with their tenants. They agreed to install new improvements and security entrances as they were confident these would not now be vandalised as they had been in the past. They introduced litter pick days through the national 'Big Tidy Up' initiative, with help from the community. Year one was organised through Townstal Community Partnership (TCP) with both Tor Homes and Guinness Hermitage, and was seen as highly successful. Tor also employed two caretakers to help with maintenance and keep the dialogue with residents going – realizing that dealing with small issues quickly would encourage residents to look after the property better.

A new youth forum was set up but the youth worker who was a major link with it took redundancy as a result of cutbacks. However, its energies were transferred into re-energising a dwindling youth club run by residents. The club merged with TCP and ran free sessions for all ages, which had been asked for by the young people and very well attended. With TCP support, adult volunteers rallied round, and the young people gained a sense of responsibility and felt comfortable enough to open up sensitive issues on which they wanted advice, such as sexual health.

Reshaping existing services, improving access

Although the TCP youth forum was short lived it had some long-term effects. It gave young people experience of organising, widened activities for the whole age group in the estate and brought a further group of agencies into the partnership. The new Dartmouth Academy school, opened in Sept 2010, played a key role with TCP in the forum and generating new activities. These included:

- Funding was found for the Police Community Support Officer to revive a regular free football session for 13 – 17 year olds. The Fire Service committed two staff to help with this

- Access to previously little-used sports and canoeing equipment at Dartmouth Youth Club, and the use of a minibus, enabled young people to set up a new sports club and compete at outside venues

- The Children's Centre offered free training on health and safety and safeguarding children to volunteers who signed up to run clubs

- A Friday youth club previously run by Devon Youth Service and about to be cut was instead hosted in the community hall, with volunteers from the police.

Understanding and communicating with the population

In Solihull (site of the Smith's Wood project) The PCT saw change in terms of service planning – moving from 'just saying we work with communities to actually knowing what the community wants'. They saw the neighbourhood partnership as an educational tool, helping the PCT to think about how it could be working with other areas. The PCT had also begun to use the partnership as a way of communicating with residents, for example on rearrangements following the closure of a GP practice, which were well received because trust had been built up. Once the partnership had a base (shop spaces donated for a time by the local authority) the PCT arranged for health trainers and others to run sessions there, widening their access to the community.

Agency confidence

A police sergeant working in the area attributed improvement in the ability to police Smiths Wood to working with a partnership that represented all the different agencies. Without that, he said, it was unlikely that the police-run bike repair workshop for young people would have been created. The local regeneration partnership also attested to the value of having an organisation that could potentially play a role in managing the regeneration legacy.

Improved agency flexibility

Back in Townstal, the Dartmouth Connexions service for young people was closed, leaving no provision of counselling services, advice on housing and other matters. Local young people who needed the service would now have to travel to the Torbay area. The issue was raised at a Partnership public meeting. Strong representation from the residents ensured that the service continued but it again came under

threat in Dec 2010, and the Partnership, together with the Academy, again ensured that it stayed in the town, this time hosted by the school.

In addition, a local solicitor gave time to run a free outreach service to advise residents on legal matters through the Partnership. This became a popular weekly service, joined by the benefits section of South Hams DC providing benefits advice.

On another issue, a young child had found discarded needles dropped from the flats above onto a neglected area where children played. A walkabout was arranged with police, the housing association and the local council. It transpired that the neglect was due to the fact that no one knew whose responsibility the land was, which initiated a collaboration between the residents and the agencies to create a map of the area showing all land ownership and responsibility. The police also spoke with Public Health who communicated directly with all known drug users in the area about disposing of syringes safely.

Neighbourhood partnerships are contagious

The Smiths Wood partnership in Solihull led to interest from local residents and professionals in exploring the potential for setting up similar partnerships in the nearby areas of Kingshurst, Chelmsley Wood and Fordbridge. A Child and Family Support Worker in Chelmsley who had innovative ideas for helping the community there said what was needed was a suitable partnership that could speak on behalf of the community – without this her work was a continual struggle.

It is invidious to try to compare neighbourhoods in any detail – each has its own character and history – but what is clear is that there has been more new community activity where HELP-type partnerships have been set up than in similar neighbourhoods without them.

Community participation as collaborative productivity, not just advice

What the HELP projects show – though only in early stages – is the deeper change that can be mobilised by focusing on community participation as collaborative productivity, not just advice to agencies. Collaboration generates better accountability, hence improvements in services, and a spreading sense of the neighbourhood being on an upward not downward spiral, which is itself health-giving.

Spread of awareness

Whilst the role of the minority of residents at the centre of the collaboration is vital, so also is the spread of awareness and the sense of ownership of development to the mass of the neighbourhood population. And whilst improvements to public services delivery are a major product, so also are new forms of delivery in which production is shared between residents and service providers. Indeed, in terms of prevention, behaviour change, reducing crime and anti-social behaviour, and spreading information and education, nothing is more productive than participation itself.

Examples from other sources

More efficient and responsive services
Co-production literature also offers examples of more efficient and responsive services (Boyle 2009). Loeffler (2010) provides a taxonomy of the ways in which co-production can assist in supporting services to become more efficient and responsive.

Service change through targeted CD
The Healthy Communities Collaborative to reduce falling by elderly people contributed to service change in a variety of agencies (Coulter, 2009). Examples of successful methods included:

- Joint work with a local authority to improve lighting within a sheltered housing complex to reduce falls
- Use of older people's drama groups to convey information on hazards and risks of falling
- Work with schools to raise children's understanding of older people's situation
- Work with voluntary agencies to provide home handyman schemes to help older people avoid hazards in the home and garden
- Work with residential care providers to prevent polypharmacy
- Work with a Highways Agency to eliminate dangerous surfaces on walkways around older people's homes.

Conclusion: getting policy on the right track

Both New Labour and the Coalition government have described community empowerment as a shift of power from agencies to communities. Our experiences suggests 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. This is not a zero sum game.

Ironically the Coalition Government's big society concept somewhat confuses the issue by its primary focus on communities *taking over* public services rather than collaborating with them. The intrinsic role of the citizen as a coproducer *with* public services still slips through the net (PACES, 2010).

Place-based budgeting

Pressure for economies has led to new ideas about rationalisation of resources between different public services serving the same locality. Ideas were originally floated under the banner of 'Total Place' ((HMTreasury, 2009, 2009a and 2010). The LGA responded – before the onset of current public service cuts - with a proposal on 'place-based budgets', to unify local services under local authority leadership. This would, they claimed produce better, more accountable services at lower cost (LGA,2010).

The early versions of the Total Place literature asserted that this idea 'put the community at the centre'. However, there was little sign of the community being seen as an actual player rather than an amorphous mass of service users. The

potential for improving outcomes, and saving costs, through greater productivity of the community itself was not grasped.

There was a hint of recognition of community potential in the idea of 'empowering the front line', advanced by Sir Michael Bichard in the early literature (HMTreasury 2009 and 2009a). The idea was that one of the things holding back improvement of public services was that the people with the direct experience of how the service was experienced at the point of delivery, the front line workers, had, by virtue of their role, valuable insights into how the services operate in that locality, which could contribute to reform and economy. These insights were not being sufficiently used by the employing agencies.

Debate and experiments on place-based budgeting have largely been focused on budget planning at the principal local authority level. What has been missing is the recognition that at neighbourhood level there is a real community factor in the equation; and that major inequalities within authority boundaries create potential for big wins in reducing spikes in need and spend in particular neighbourhoods. Operating a neighbourhood partnership run by residents with front-line workers of the range of public agencies is in effect place-based budgeting at the point of delivery. However, it works not by complicated financial calculations but by allowing front line workers of all agencies a modicum of flexibility to share in productive problem-solving.

The neighbourhood partnership model opens the way to joining up not just budgets but real productivity:
- of people in their own neighbourhood
- between public services and the community
- between health and other services
- between public health and primary and acute care

This injects depth and energy into the place-based budget idea, making practical links with community participation and reviving the idea of empowering the front line.

5. RESEARCH AND COMPARATIVE SOURCES

Community development has a history of at least 50 years in the UK and globally. There is an extensive literature on its purposes, methods and effects but relatively little systematic quantitative evidence and even less on cost benefits. There is however a considerable research literature on the health and social effects of outputs that are closely associated with CD, such as volunteering, social networks and neighbourhood projects.

In this chapter we briefly review some of these sources as they are both important evidence in themselves, allow a degree of comparison with our projects and form an important link in the chain of evidence. More detail is given in a separate HELP paper by Dr Brian Fisher (2011) which we draw on here.

Social networks are the basis of community activity. They simply mean friendships, acquaintanceships and other links between people, whether on a personal basis, through work or through membership of groups, clubs and organisations. Social networks are important for health in themselves. They are also the basis for any joint activity to improve neighbourhood conditions. Natural and spontaneous though they are, they can be considerably limited by poor local conditions, unemployment, isolation and immobility. Crime and fear of crime, poor public transport and lack of income are other inhibitors.

We look first at the intrinsic importance of social networks for health; then at the evidence that networks can be improved by specific action; then at the role of complex community projects and engagement initiatives which seek to improve health and other factors by some combination of personal and neighbourhood effects.

The health value of community activity

Putnam (1993; 2000) describes social capital as the connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them. He draws together wide evidence showing that taking part in a social network, whether through local organisations or informal contacts, helps to foster trust, a sense of shared values and improved health.

People with stronger networks are healthier and happier (Bennett, 2002). Social networks are consistently and positively associated with reduced morbidity and mortality (Fabrigoule et al 1995; Bassuk et al, 1999; Berkman and Kawachi, 2000)

In a Chicago study, neighbourhood social capital, as measured by reciprocity, trust, and civic participation, was associated with lower neighbourhood death rates, after adjustment for material deprivation (Lochner et al 2003). Lower levels of social trust are associated with higher rates of most major causes of death, including coronary heart disease, cancers, cerebrovascular disease, unintentional injury and suicide (Kawachi et al, 1997).

National surveys of psychiatric morbidity in adults aged 16-64 in the UK show that the most significant difference between this group and people without mental ill-health problems is social participation (Jenkins et al 2008). There is strong evidence that social relationships can also reduce the risk of depression (Morgan and Swann

2004). A number of studies suggest that areas with poor social capital have higher rates of cardiovascular disease in general (Augustin et al, 2008) and in particular recurrence of acute coronary syndrome among people with lower incomes (Scheffler et al, 2008).

Good personal support networks, for example friendship or a confiding relationship, and opportunities for social and physical activities, protect mental health and enable people to recover from stressful life events like bereavement or financial problems (Cooper et al, 1999). Emotional wellbeing protects against stroke, whilst enduring low mood and depression increase the risk of stroke (Jonas and Mussolino, 2000).

Loneliness and low levels of social integration significantly increase mortality. People with stronger networks are healthier and happier (Bennett 2002). Social networks are consistently and positively associated with reduced morbidity and mortality (Fabrigoule et al 1995).

In a study by Lochner et al (2003) neighbourhood social capital, as measured by reciprocity, trust and civic participation, was associated with lower neighbourhood death rates, after adjustment for neighbourhood material deprivation. Higher levels of neighbourhood social capital were associated with lower neighbourhood death rates for total mortality as well as death from heart disease. There was no association, however, between social capital and cancer mortality.

Areas with stronger social networks experience less crime. 'When residents form local social ties, their capacity for community social control is increased because they are better able to recognize strangers and more apt to engage in guardianship behaviour against victimization'(Skogan 1986). Social cohesion, informal social control, and trust are directly related to a community's ability to come together and act collectively to combat violent crime and other antisocial behaviour (Schwartz 1986)

Such areas also experience less delinquency (Sampson et al 1997). Social networks facilitate employability (Clark and Dawson, 1995). People actively involved in community empowerment or engagement initiatives show improvements in physical and mental health, health-related behaviour and quality of life (Piachaud, 2009; Grady, 2009).

A study of the economic value of community activity in terms of reduced crime (CLG, 2009) shows a decrease of 3% in crime for each increase of one point in sense of community in a local population, measured by whether people said they looked out for each other and pulled together to improve the community – key products of community development. Assuming a modest increase of three percentage points in the sense of community as a result of a CD intervention, this produces an average saving of £159,000 for a neighbourhood of 5,000 people on the costs of crime. There would undoubtedly be further knock-on effects on health.

Stimulating social networks

Whilst social networks are mainly the spontaneous product of communities themselves, they can be increased by government programmes and external actors in civil society (Cernea, 1993; Huntoon, 2001; Mondal, 2000). It is possible to build

social capital in a relatively short time through focused programmes (Falk and Harrison,1998).

The deliberate enhancement of social capital through community initiatives is feasible (Schmid 2000, Peterson 2002). Empowerment and engagement initiatives can produce positive outcomes for the individuals directly involved including: increased self efficacy, increased confidence and self esteem, personal empowerment , improved social networks; a greater sense of community and security and improved access to education leading to increased skills and paid employment. There are significant health benefits for individuals actively involved in community empowerment/engagement initiatives including improvements in physical and mental health, health related behaviour and quality of life (Piachaud 2009; Grady 2009).

CD builds social networks (Minkler 2002; Falk and Harrison 1998). The review of community engagement by NICE (2008) finds seven studies suggesting that community engagement has a positive impact on social capital and social cohesion. Russell (2009) finds many examples of community development promoting social networks. Time banks have been shown to improve mental health through their social networking (Lasker et al 2006). The willingness of community members to look out for each other and intervene when trouble arises is negatively associated with being overweight (Cohen et al 2006).

The World Bank has also brought together a range of statistics showing the social and economic benefits of social capital and presenting a strong argument for community development (Knack, 1999).

Marmot (2010) suggests that the state can intervene to create and deepen social networks and capital. Ideally, intervention needs to be local activity in a national context.

Community engagement

Whilst the NICE review (2008) treats community development and engagement as a single issue, we find an important distinction, often roughly described as 'bottom up' versus 'top down'. Although half or more community development workers themselves may be employed 'from the top down', their role is essentially technical aid to communities to deliver communities' own initiatives. Because these initiatives are rooted in the community from the word go, and are fundamentally voluntary, they often engender deeper involvement, wider ownership and longer sustainability than initiatives created by professional agencies.

The two approaches are not, however, in competition – they should reinforce one another. Local councils find community engagement and empowerment, whether in good or difficult times, saves time and money, creating more satisfied communities. Once people in an area take charge of their destiny, they can negotiate new relationships with statutory agencies which can then, in turn, develop new, improved and appropriate forms of service delivery (LGID 2010).

Link-Age Plus is an approach to capacity building that boosts the role of older people as independent and active citizens, participating in and shaping their local communities. A number of sites demonstrate a relationship between involvement and health improvement (Willis and Dalziel, 2009).

The NICE guideline itself offers a wide range of examples of how community engagement can promote health improvement. Evidence from six studies suggests that community networks can contribute to reducing the number of alcohol-related crashes, improve alcohol-related behaviours, prevent injuries to children and promote a healthy diet in children.

The co-production literature offers many examples of more efficient and responsive services (Boyle 2009).

A systematic review of 22 studies evaluating the effectiveness of health promotion interventions to alleviate social isolation and loneliness among older people found that group activities like discussion and self-help groups, bereavement support and counseling, were all effective (Cattan, 2002).

The Department of Health's Partnership for Older People Projects (POPP) developed services for older people aimed at promoting their health, well-being and independence and preventing or delaying their need for higher intensity or institutional care. The evaluation found that a wide range of these projects resulted in improved quality of life for participants and considerable savings, as well as better local working relationships.

Overnight hospital stays were reduced by 47% and use of Accident & Emergency departments by 29%. Reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments with a total cost reduction of £2,166 per person. A practical example is pro-active case coordination services, where visits to A&E departments fell by 60%, hospital overnight stays were reduced by 48%, phone calls to GPs fell by 28%, visits to practice nurses reduced by 25% and GP appointments reduced by 10% (Windle, 2009).

As well as reducing falls the Healthy Communities Collaborative work led to:
- a 12% increase in people's perception of whether their area was a good place to live
- a 12% increase in people's perception of whether individuals showed concern for each other, and
- a 48% increase among participants in the proportion who thought they could change and improve things in their communities (Coulter, 2009).

A report commissioned by Brighton and Hove PCT identified the added value that third sector organisations brought to the delivery of local services. For example the local Expert Patients Programme (EPP) commissioned by the PCT, involving 665 patients, cost £58,063 pa and produced benefits of £147,165, saving the NHS £89,102 (Colewell et al, 2010).

Befriending services – many run by voluntary and community organisations and heavily reliant on volunteers – reduce social isolation, loneliness and depression, particularly among older people. In a scheme called Community Navigators, volunteers trained to reach out to vulnerable people, provide emotional, practical and social support. Work with hard-to-reach individuals to provide benefit and debt advice cost around £300 per person, whilst economic benefits from less time lost at work, savings in benefits payments, contribution to productivity and fewer GP visits could amount to £900 per person in the first year alone. There were likely to be other pay-offs such as quality of life improvements from better mental health which also have economic value (Knapp, 2010).

Multifaceted community projects

Whilst the HELP method has some distinct characteristics and, historically, grew directly 'from the ground up', it is part of a wide landscape of local social projects. These are too extensive to do justice to here, but we note some main points of comparison.

Neighbourhood management (NM) is a process which brings the local community and service providers together at a neighbourhood level to tackle problems and improve services (NNMN, 2005). The 35 NM 'Pathfinder' projects used community engagement as a key tool. Improvements were made in health, children's services, community safety and environmental (SQW, 2008 and 2008a). An example with a high reputation for achievement through community involvement was the project in Manton, an area of Worksop (Taylor, 2007).

The NM model was subsequently adopted by local authorities for many more areas than the original pathfinders, so in this case pathfinders were genuinely influential, but it is not clear that most of the projects included strong community participation.

A NM pathfinder with which we had direct contact was the Westminster Church Street Neighbourhood Management Project. Employing 11 people, the project was established in 2005 to enable communities and local agencies to work together to improve services and how they were delivered. Over half of the management board consisted of representatives from the community. Health played an important role because of the range of health issues facing the local community.

To a large extent the Church Street approach was concerned with influencing and facilitating the actions of other agencies. The project brought services and the community together to explore common issues and implement solutions. An important mechanism was 'Church Street Connectors', a group of 20 to 30 residents who regularly brought local issues to monthly meetings.

An evaluation by Westminster University judged that the project had made an important contribution to marked increases in life expectancy in the neighbourhood over five years. But the effects were so intertwined with other factors that it was difficult to put a figure on them. Services recorded financial data at a service or business unit level rather than on a neighbourhood basis, which made it difficult to identify the financial impact of social improvements (Pill and Bailey, 2010).

Another local development system relevant to the HELP approach is *Community Led Planning (CLP).*This follows a specific process over a given period of time, using a partnership mechanism to achieve all-round development of a small locality. ('Planning' here can include all social issues, not just spatial planning). Originating around the turn of the century, it has been most used in rural areas. It has been applied in thousands of parishes, and there are well-documented case studies (ACRE, 2011)

CLP has been spreading more slowly into urban neighbourhoods. It may be that many rural neighbourhoods still have more geographical and social cohesion and self-reliance than many urban neighbourhoods, and are therefore generally readier for this approach. Certainly many disadvantaged urban neighbourhoods have a much greater ethnic mix, less obvious boundaries and higher population turnover.

The parish basis of CLP makes it easy to specify the population boundary and therefore to get evidence of majority consent to a development plan. The parish council may be, or become, a basis for partnership between residents and public agencies, though it could be another grouping that takes the lead. The 'community empowerment' section of the Coalition government's Localism Bill (HMG, 2011) seems designed to try and bridge these urban-rural differences by giving new powers to parish councils where they exist and, where they do not, setting out a process whereby a neighbourhood community group can become accredited to take on the same powers.

Delivering Race Equality in Mental Health Care. In an unusual programme addressing communities of interest the Department of Health commissioned a community development programme under this title in 2005 (IDeA, 2005). We were in touch with one of the projects in this programme, Sheffield BME Community Development Team. Part of Sheffield NHS, the team consisted of five people and worked with a range of BME communities across the city to:

- help communities identify key concerns
- support communities to develop links across community groups and services
- support community organisations to have a voice in the commissioning process and increase awareness and understanding of mental health provision.

Some of the work was specifically concerned with mental health issues, but much of it was about generic issues in these communities. The CD team provided information and advice on health matters to the groups and worked with the PCT and service providers to develop closer links between the services and BME communities.

Sheffield PCT believed this work had helped reduce health inequalities and had played a key role in providing information to the PCT and other services that informed policy and commissioning. However there was little collection of evidence to indicate impact and whether the PCT was getting value for money. The PCT saw a need to develop a more quantitative based business case approach. The collection of clinical data was well established and understood, the community approach was not.

Origins of C2. A review of the longer term effects of the first C2 project on the Beacon Estate in Penwerris, Cornwall, found major improvements between 1995 and 2000 in education, health, employment and crime (Stuteley and Cohen, 2004; Durie et al, 2004). Improvements appeared to outstrip national trends at the time, and the sense of an overall positive momentum of development driven by the project was attested in successive meetings of residents and service providers. The creation of the neighbourhood partnership opened the way to securing a national Capital Challenge grant of £1.2m, which was then topped up by a further £1m from the local authority. The resident-led partnership negotiated successfully for a leading role in how the grant was used. The resulting improvements to the estate's housing were therefore felt as owned by residents, reinforcing what they were doing through a plethora of new community groups, social projects and volunteering. The dynamic interaction of the physical and social improvements provided an impetus to self-generated improvement which is still reaping rewards in 2011.

Analysing cost-benefit: the SROI method. A rare study focusing on the financial value of community development was made in a report from the New Economics Foundation commissioned by the Community Development Foundation in 2010 (NEF,

2010). The CD programme consisted mainly of supporting independent community groups. The Social Return on Investment analysis found ways to attribute monetary value to resilience, self-esteem, positive functioning, supportive relationships, trust and belonging.

The NEF report found a social return to the value of £3.45m over eight years from an investment in community development of £233,655 by four local authorities (in four separate areas). From the LA point of view this was a return of almost 15:1. Interestingly a much earlier CDF report (Bell, 1992) also found a value of 15:1 for CD investment in a town-wide project on the basis of the amount of volunteering generated by the input of CD workers.

Whilst some parts of the SROI analysis are questionable, the study is valuable for its model for quantifying the effects on non-participants in the neighbourhoods in question as well as participants. Most CD interventions inevitably work directly with a small fraction of the community yet aim to produce benefits for the bulk of the local population. These would come about by two means: firstly a change in the general climate of hope and improvement, and secondly through specific improvements in local conditions obtained by the active groups – new amenities and improved services. But this transfer of value to the majority is rarely examined.

In the NEF analysis beneficiaries in the community were divided into the small fraction who ran the groups ('Stakeholders 1'), a larger fraction who participated in them ('Stakeholders 2') and the rest of the neighbourhood population, by far the majority, who did not participate ('Stakeholders 3'). Although the benefit for Stakeholders 1 and 2 was much greater per person, the total weight of benefit lay more heavily with the majority population who did not participate, each of them benefitting slightly. Scaling up each type to the size of the population, three quarters of value accrued to the non-participant population because there were so many more of them.

6. COSTS AND BENEFITS

The benefits of better collaboration between health agencies and local communities reach into every aspect of the health system. Here however we examine the investment purely from the viewpoint of saving costs of treatment.

Costs

The cost of community development (CD) is the cost of intervention in two existing systems: the residential community and the local public services. The effects are largely about acting as a catalyst to these systems and enabling them to be more productive both separately and together. CD is therefore not so much a separate service as a dynamic change in existing services and communities. It can generate far-reaching change with relatively limited resources. But there are staff and other costs, and we calculate these below.

The direct practice of community development consists in supporting any and all people living in a given neighbourhood in developing joint activities, groups and networks, addressing their own shared objectives. These are likely to take the form of activity by self-determining groups of residents to obtain an improvement to their locality, whether through their own efforts (eg setting up a voluntary youth club) or through influencing delivery of services (eg negotiating to get a new surgery or dental clinic). Often they will entail a joint endeavour (eg local authority renovates a park, residents provide voluntary wardens, as in our Devon project). Some activities arising from CD may be specifically about health but all are health-giving by virtue of the fact that they increase social networks and cooperation, give people purposeful roles, optimism, new information, skills and social status.

CD is not the same as community engagement, which means the efforts made by a particular service or agency to engage the population in that service. But CD does create wider pathways for community engagement to take place. For example the development of the HELP project in Smiths Wood, Solihull, led to the local council making two unused shops available to the community and this in turn enabled health staff to reach more residents with sessions on weight loss, smoking cessation and healthy eating. For health purposes, therefore, community engagement and development are complementary. But our calculations here are for the CD element.

A time-limited intervention with a long-term perspective

The form of CD we demonstrated in our pilot projects is a time-limited intervention of up to two years to set in motion an organisational and local cultural change in a disadvantaged neighbourhood of approximately 5,000 people. In contrast with single outreach initiatives, CD activity on this model is self-renewing by setting in motion a long-term, self-governing multi-issue partnership. This generates new activities of its own because it is driven by residents and front-line workers, for both of whom it has direct value. Further CD intervention or support may be desirable after two years but the benefits we calculate here flow from the two-year intervention alone.

As one of several safeguards to ensure that our calculations of benefit are conservative, for costing purposes we assume expenditure of two years. The effects are designed to last well beyond the intervention period itself. Evidence from older projects is that CD intervention of this kind produces benefits over five or more years. Three precursor projects of the HELP method ('C2') have now lasted

respectively 21, 10 and 7 years and are still active. The CDF study of community development by 'social return on investment' (NEF, 2010) calculates benefit to the seventh year from one year of intervention.

To ensure, again, that our calculations err on the side of caution, we calculate benefits of just three years from the two-year intervention. The benefits would naturally emerge some time after the beginning of the intervention. The likely time-shift from inputs to outputs and outputs to benefits is illustrated in panel 6.1.

Panel 6.1: Time shift from intervention to benefits (6m periods)

	Y 1	Y1	Y2	Y2	Y3	Y3	Y4	Y4	Y5 and continuing
Planning CD project	▓								
Intervention project		▓	▓	▓	▓				
Activity outputs			▓	▓	▓	▓	▓	▓	▓
Inform commissioning				▓	▓	▓	▓	▓	▓
Results show up in health statistics					▓	▓	▓	▓	▓
Cumulative health benefits						▓	▓	▓	▓
Investment		▓	▓	▓	▓				
Return				▓	▓	▓	▓	▓	▓

Basic unit of costs

For a neighbourhood of 5,000 people, for the first year of a two year intervention at 2011 levels the likely costs would be:

YEAR ONE	£000
Project strategy and guidance	12.5
1 X FTE facilitator inc on-costs	37.5
Office/ admin costs	5.0
Training/mentoring for facilitator	5.0
Training / project visits for key residents and front line workers	7.5
Funding for local meetings and activities	5.0
Evaluation, surveys, focus groups	7.0
Start up for local community hub and part time coordinator	10.0
	£89,500

The costs in the second year would be less, the intensity of the facilitation tapering off as the community partnership becomes increasingly self sufficient (and continues independently in subsequent years):

YEAR TWO
Project strategy and guidance	10.0
1 X 50% facilitator inc on-costs	19.0
Office/ admin costs	3.0
Training/mentoring for facilitator	3.0
Training / project visits for key residents and front line workers	5.0
Funding for local meetings and activities	5.0
Evaluation, surveys, focus groups	4.5
Support to local community hub and part time coordinator	7.5
	£56,000

The total cost for the two-year intervention is therefore £145,500.

The average cost per year is £72,750.

Reducing costs

There are three ways in which this cost can be (and in many cases has been) considerably reduced:

> (i) appointing as CD facilitator a professional already working in the locality whose job specification, objectives and skills already lend themselves towards this role and who can therefore be seconded to it at less than full cost. The facilitator role can also be suitable for job-sharing for mutual support. It is important however that the need to ensure the right skills and aptitudes is not compromised;

> (iii) sharing costs with other agencies on a place-based budgeting or bilateral basis. As we show below, the benefits of this kind of intervention accrue to policing, education and other fields as well as health.

> (ii) carrying out the CD intervention in several neighbourhoods. There could be substantial economies of scale in an expanding programme, where the skills gained in the first year in a single neighbourhood were spread to several neighbourhoods over succeeding years. This pattern began to emerge in our Solihull project.

We estimate that three concurrent neighbourhood programmes could be run at 60% of the basic single neighbourhood cost, ie at £43,650 per neighbourhood per year.

Linking outputs and benefits

Evidence of outcomes must be linked to the outputs of the intervention. The outputs are visible in the form of:

> The seven steps taken to establish the neighbourhood partnership (described in chapter two)

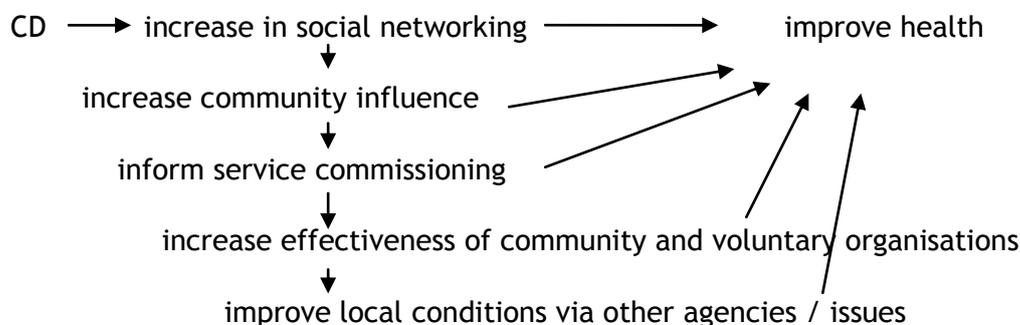New community activities (described in chapter three)

New problem-solving initiatives jointly between residents and public agencies (described in chapter three)

New or changed decisions by agencies and their commissioning officers as a result of the partnership process (described in chapter four)

All these entail previously inactive residents becoming active and previously active residents becoming more active.

An image for the range of mutually reinforcing pathways would be as in panel 6.2:

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Panel 6.2: Mutually reinforcing pathways

CD ⟶ increase in social networking ⟶ improve health
          increase community influence
            inform service commissioning
               increase effectiveness of community and voluntary organisations
                  improve local conditions via other agencies / issues

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Types of evidence ideally required

The evidence of benefit from the outputs would ideally be collected from the five sources below.

1. An annual survey of a sample of residents, to capture their sense of wellbeing, awareness of the intervention , level of participation and volunteering.

2. Survey of the condition of the local community and voluntary sector. This should be based on selected questions from the 2008 National Third Sector Survey in England (see Appendix C).

3. Testimony (via survey, key informants or focus groups) of public agencies about the effects of the CD intervention on the issues they deal with, the conditions for their work and the achievement of their agencies' objectives.

4. Health statistics. These are ultimately the crucial form of evidence for health commissioners and the business case. Success will show up as improvements in health and consequent reductions in health service costs.

There will inevitably be a time lapse between the intervention and the health effects, and health effects will also be affected by other factors taking place at the time. Full evaluation will therefore (a) have to take place after the two year intervention period and (b) have to judge the intervention effect within a broader picture.

5. Statistics from other relevant services, especially police and education.

If planned from the beginning, much of the cost of collecting evidence should be able to be absorbed into the intervention process. Agencies whose front-line staff are involved in the community partnership could be asked as part of the arrangement to comment periodically on the effect this has had on their staff's work and the achievement of their agency objectives – this need be little more than a footnote to their normal appraisal systems.

Maximum use should be made of surveys already planned by the local authority and other agencies. For surveys of residents it may be possible to piggyback on surveys already planned by local authorities, negotiating the addition of a few key questions (see Appendix C for sample questions). Our project costings, above, include a small element to carry out or boost evaluation.

In the 18 months' operation of HELP reported here we have begun work on all these measures and used them in these findings but not completed them.

Benefits

The projects described in chapter three show the kinds of activities and outputs generated by a focused form of community development over 18 months. The research review in chapter five illustrates the widespread evidence that these kinds of output have beneficial health outcomes, linking community activity both to health gain and reduction in demand of health services.

To illustrate the value of these effects in a specific neighbourhood we add the following steps:

(i) identify some of the main health conditions or risks which the research shows to be affected by the kinds of community development outputs exemplified by our pilot projects;

(ii) using as an illustration one of our pilot projects, obtain actual figures on the number of people with those health conditions in a disadvantaged neighbourhood of 5,000 people

(iii) estimate conservatively a proportion of those people whose conditions would be likely to be alleviated or pre-empted by the community activities

(iv) identify the costs that would be saved by that proportion of avoided demand on health services

The actual figures are from Smiths Wood, Solihull, adjusted to 5,000 people (actual population 4,283 in 2009).

There are also likely to be benefits to other public services (eg policing, education, environment). Figures from the same neighbourhood allow us to postulate a similar modest level of saving on avoiding crime and reducing the number of young people not in education, employment or training. A supplementary calculation shows the additional value of these effects. This could be a basis for seeking joint investment in the community development project, thus reducing the demand on the health budget.

There are also probable savings in areas such as children with special educational needs (SEN) where we do not have full figures so these are left out of our calculations, again under-estimating rather than overestimating the value of community development effects.

The calculation of benefits is presented in **Panel 6.3,** followed by explanation and the calculation of cost-benefits.

A more detailed explanation of each item in the benefit calculation is given in Appendix B.

For the purpose of our illustrative calculation, we estimate conservatively that community development activity in each area can prevent 5% of these conditions in a disadvantaged neighbourhood. These are only a few, albeit some of the most common, of the health conditions that are likely to benefit from community activity.

Panel 5.3: Cost benefit model and illustration

A Issue	B Examples of relevant activities generated by community development	C Research base	D Indicator/s	E Example from Smiths Wood, Solihull (5000 base)	F Average incidence in a population of 5,000	G Average cost of treatment over one year	H Estimated 5% p.a. additional saving attributable to CD
1. Cardio-vascular diseases	Spread of greater trust, cooperation, social and physical activity amongst residents. Includes weight management sessions for mums; smoking cessation groups; buggy walking route; health trainer sessions (Smiths Wood, Solihull)	Higher social trust associated with lower CHD. Areas with higher social capital have lower CVD esp amongst people with lower income. Physical activity beneficial.	CVD admis-sions age <75	(08/09) 242 per 5000	09/10 England 91 per 5000	Average cost of admission £4,614	12 admissions @£4614 =£55,368
2. Depres-sion	Wide range of social activities initiated	Social participation and relationships, and an active lifestyle, key to minimising mental health problems . Increase of community activity and social networks alleviates stress, strengthens identity and capabilities; creates positive alternatives to antidepressants	Depression diagnosed through primary care	355 per 5000 based on practice data projected (not coterminous) (09/10)	247 per 5000 (IMS Disease analyser) 'in contact with GP services per year, diagnosed as having either depression or mixed anxiety and depression'.	£1355 p.p service cost based on findings of Kings Fund Paying the Price (2007 costs); also £4694 p.p earnings lost	5% reduction of 18 cases, service saving £24,390

Issue	Examples of relevant activities generated by community development	Research base	Indicators	Example from Smiths Wood, Solihull (5000 base)	Average incidence in a population of 5,000	Average cost of treatment over one year	Estimated 5% additional saving attributable to CD
3. Obesity	Spread of health awareness and literacy, more community and physical activity. New / improved open spaces/ sports facilities negotiated by community groups. Wide range of physical activity, recreational opportunity, provision or renewal of active lifestyle facilities, provision of healthy lifestyle advice and peer support. Renovation of play-park. Woodland activities for young people. Large scale young people's dance.	Obesity associated with wide range of health conditions. Exercise can reduce weight; overweight associated with poor social capital. Dietary advice cost-effective.	% obese, adult and child	08/09 Reception class 985/5000, Year 6 1,110/5000 Adults: ratio of Reception and Yr6 (equally weighted) SWANN / National =1.5 x adult rate for England 24.2% = 36.3% i.e. 1815/5000	08/09 Reception class 480/5000, Year 6 915/5000 Adults: England proportion 24.2% (2006-8), 9.46m (1210/5000)	Adults: derived from data on wider cost of raised BMI and obesity, adjusted proportionately to obesity alone; and estimated future cost of diseases related to BMI minus CHD (£7.32bn 2007); applied to UK adult population: £648.30 per obese person	Adults: rate of 36.3% applied to adult population estimate of 3181 = 1155. 5% is 58, @ £648.30p.a. = £37,601 Children to be added.
Subtotal of issues 1, 2, 3							£117,359

Issue	Examples of relevant activities generated by community development	Research base	Indicators	Example from Smiths Wood, Solihull (5000 base)	Average incidence in a population of 5,000	Average cost of treatment over one years	Estimated 5% additional saving attributable to CD
4. Elderly falls	Increased community and physical activity, tailored for older people, also linked with falls reduction pathway; Tai Chi classes; dance; activity buddies model to support less able and confident	Older people can regain 27% of muscle strength with exercise; Tai Chi recommended; falls programme can improve social capital.	Ambulance calls for falls (may add no. of older people engaging in social and physical activities; hip fracture)	Ambulance calls for falls / back 2009/10 total 120: estimated that 90% are falls (separate category for back pain)	422/5000 people aged 65 and over	Cost saving per fall less per year £800 p.p. in hospital costs, £82 in ambulance costs, and £1883 in avoided residential care costs	5 falls less, @£2765: £13,825
5. Emergency hospital admiss-ions/ readmiss-ions	If health and wellbeing improve, use of acute services will reduce. Potential for using hotspots to inform targeted preventive intervention	Extreme small area variation in emergency admissions associated with deprivation; potential for substantial impact and saving	Emergency hospital admissions	(09/10) 589 per 5000 (509 cases)	440 (08/09)	£1592 (Smiths Wood dataset, Solihull NHS Care Trust)	25 cases, £39,800

Issue	*Examples of relevant activities generated by community development*	*Research base*	*Indicators*	*Example from Smiths Wood, Solihull (5000 base)*	*Average incidence in a population of 5,000*	*Average cost of treatment over one years*	*Estimated 5% additional saving attributable to CD*
6. A & E attend-ance	Areas of high alcohol abuse can be targeted to take community, enforcement, cultural and environmental action to reduce. Equivalent with ambulance calls:	35% of all A&E attendances involve alcohol-related harm, rising to 70% at peak times. Emerging evidence that A&E intelligence can have an impact on targeting police and other resources to reduce violence. Cardiff model of A&E engagement with Crime and Disorder Partnerships has reduced alcohol-related crime significantly.	A&E attendance. Other associated social and health costs to be added.	09/10 1565 per 5000. Detailed analysis being undertaken by Solihull NHS Care Trust. Alcohol and substance misuse identified as major issue in SWANN area	1516 per 5000	Per A&E attendance £86.90	78 cases, £6,779
7. Emerg-ency ambu-lance calls	Redruth (C2 project) work with ambulance service reduced 999 calls and under-age drinking (Stuteley, 2007).	We estimate that this saving would be a concomitant of the items above, but a research base has yet to be established	Emergency incidents (calls resulting in emergency response arriving at the scene)	09/10 967 per 5000 (not age-standardised)	624 per 5000	Unit cost £176.57	48 cases less: £8,475
Subtotal issues 4, 5, 6, 7							£68,879
Subtotal of issues directly related to health budget (1 – 7)							£186,238

Issue	Examples of relevant activities generated by community development	Research base	Indicators	Example from Smiths Wood, Solihull (5000 base)	Average incidence in a population of 5,000	Average cost of treatment over one years	Estimated 5% additional saving attributable to CD
8. Crime and fear of crime	Stronger social networks; positive social and physical activity for young people.	Stronger social networks lead to less crime. Individuals with high fear of crime more likely to be depressed, and in poorer health.	Reported crime	2009/10 1,104 crimes, 1289/5000	2009/10, England: 394 per 5,000.	Est cost of individual crime in SW (based on local pattern) £1,318	Reduction of 55 crimes, £72,490
9. NEET (16-18s not in educa-tion, employ-ment or training	Work with young people to promote social inclusion, including work on confidence, resilience, social skills.	NEET is a major predictor of later unemployment, low income, depression, involvement in crime and poor mental health (Places Database, DfE)	Number of NEET (population denominat or problem in small geog areas)	Number: 52 in April 2011. 14% of number in N Solihull regeneration zone	6.7% of residents aged 16-18 (2008, England)	6.7% of residents aged 16-18 (2008, England)	Public finance cost of NEET, £7986 per head Reduce by 3: £23,958
10 Special Educatio nal Needs (SEN)		Growing area of public expenditure. LAs in England and Wales spent £3.6bn on SEN provision in 2001/02, being 15 per cent of spending on schools. 69% is focused on the small minority of children with statements.		Smiths Wood Community Primary: all SEN (with and without statements): Feb. 2011, 30%, number 131	England Jan 2010, 19.9%; Solihull 15.1%		Reduce by 7 (but value not ascertained or included here)
Subtotal issues 8, 9, 10							£96,448
TOTAL, health and associated issues							£282,686

Explanation

Panel 5.3 is set out to show how we have derived an illustration of savings for the local health service from the impact of community development on a neighbourhood in terms of costs of treatments foregone:

Column A specifies a health condition known to benefit from better community conditions.

Column B gives examples of the kinds of activity or change generated by community development which improve community conditions in the relevant ways

Column C gives highlighted points from the research which show that this health condition benefits from better community conditions. The full details are given in Appendix B

Column D gives the main indicator by which the incidence of the specified health conditions is judged

Column E gives the actual incidence of that condition in our illustrative neighbourhood. (As expected, the incidence in this disadvantaged neighbourhood is alarmingly higher than the England average)

Column F gives the average incidence of that condition in a population of 5.000 across England

Column G gives the average cost of treatment of the condition for one person for a year

Column H gives the cost saved in one year if 5% of the cases in the illustration neighbourhood are prevented.

Subtotals of savings are then given for:

(i) **the first three conditions** (cardiovascular, depression and obesity). Amongst the most costly conditions for the health service throughout the country, these are also, the research shows, amenable to prevention through generally better community atmosphere and conditions, even without specific targeting;

(ii) **four further conditions** (elderly falls, emergency hospital admissions, A&E attendance and emergency ambulance calls) which research and CD experience shows are amenable to prevention through better community conditions if specifically targeted by community development and engagement;

(iii) **three further factors** (crime, young people and special educational needs) which research and CD experience shows to also be alleviated by the same community improvement factors which improve health.

The combined savings from (i) and (ii) would accrue to the health service. Savings from (iii) would accrue to policing and education.

We calculate cost benefits for the health service solely on the basis of (i) and (ii), and present the additional savings for policing and education separately. A health agency could reasonably point to this to suggest joint funding for developing a neighbourhood partnership.

It is very possible there would also be savings in other health areas, such as mental health and teenage conception, and other non-health areas such as housing and employment.

The health improvements would take some time to show up in local health statistics but could then be expected to continue some time beyond the period of intervention. Both because of this and because the community partnership generates new activities in subsequent years, our calculation assumes benefits for three years. However, these benefits may be spread over a longer period. The effects may start modestly and then accumulate as individuals benefit from several types of activity.

Given that we assume benefits only to 5% of people with a given condition in a population of 5,000, the numbers of beneficiaries are small, but as the calculations show, these accumulate to considerable amounts, well beyond the cost of investment

Community development benefits for the first three conditions alone are:

  Benefit for one year: £117,359

  Benefit for three years: £352,077

The cost of producing the three year effects in a single neighbourhood is the two-year CD intervention costing £145,500. The return on CD investment in one neighbourhood for three years is therefore:

  £352,077 (three year benefit) over £145,500 (two year cost) = 1: 2.4

In three neighbourhoods, with the reduced cost due to economy of scale the ratio is:

  £1,056,231 (three year benefit, three neighbourhoods) over £261,900 (two year cost, three neighbourhoods) = 1: 4

If the CD method also targets the four additional health factors, the figures are:

  Benefit in one neighbourhood:

  For one year: £117,359 + £68,879 = £186,238

  For three years: £558,714

Return on CD investment in one neighbourhood for three years:

£558,714 (three year benefit, one neighbourhood) over £145,500 (two year cost) = 1: 3.8

Return on investment in three neighbourhoods, with economy of scale:

£1,676,142 (three year benefit, three neighbourhoods) over £261,900 (two year cost, three neighbourhoods) = 1: 6.4

Applying this model in three neighbourhoods, a health agency could therefore expect to save £1,414,242 over three years or £471,414 a year.

Investment in the 20% most disadvantaged neighbourhoods in a local authority or CCG area (say nine neighbourhoods out of 45) would produce a health saving of £4,242,726 over three years, or just over £1.41m a year.

Adding conservative estimates of public expenditure benefits through reductions in crime and NEET in one area produce an additional saving of £96,448 over one year in one neighbourhood, or £289,344 over three years in one neighbourhood.

These calculations show that investment in neighbourhood partnerships by a health agency is highly cost-beneficial even purely in terms of reducing the cost of a number of specific treatments in a limited number of residents. As we have stressed, however, neighbourhood development is about the whole community and all the agencies that serve it. The wider effects and long term changes are harder to quantify but are part of deeper changes.

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7. A COMMISSIONING FRAMEWORK

Purpose and objectives

In the absence of a widely available business case community development has mostly been used only marginally in health service planning. This has meant that health planning has been lacking a major dimension. The last chapter has demonstrated how the health effects of community development can be valued. This makes community development planning available in a form which can be integrated with health planning overall, thus adding a major instrument to the armoury for achieving greater impact with reduced costs.

The overall purpose of commissioning community development in health could be stated as: **To strengthen the community life of the local population in such a way as to lead to cumulative health improvements, improved patient and public involvement in planning local services and more effective and economic use of the resources of the health service.**

More specifically the contribution of CD is that it:

> helps the health services to reach disadvantaged people and reduce health inequalities

> fosters social networking, which is known to be intrinsically health giving

> channels community intelligence into health commissioning and helps communities to hold health agencies to account

> provides a natural way to mobilise other public services to contribute to health (whilst reciprocally benefitting their own concerns)

> leads to improvements in the conditions of disadvantaged neighbourhoods, which in turn contribute to improvements in health

> adds a collective dimension to patient and public involvement thus involving many more people.

Who should commission?

The local Health and Wellbeing Board would be the natural planning point, as being the bridge between the health service and the local authority. But it may seek to delegate this to a special working party or to another body who would report back.

The local authority may already provide or commission CD for other purposes or as part of its new public health responsibilities. However, provision of general CD declined between 2008 and 2011 due to the ending of a number of national programmes followed by cuts in public services.

Resources for, and oversight of CD would suitably be shared by the main health budget and local authorities since CD amplifies Public and Patient Involvement and creates savings for primary and acute care as well as for public health. A contribution could be sought from the patient and public involvement premium of

GP practices since CD will create networks to enable them to link much better with the community as a whole.

It would also be suitable to seek input, whether in money or officer time, from other local public agencies since they too will benefit from this approach. Indeed, local authorities, police and schools may well already be more oriented to collaboration around community development than health agencies are.

Project facilitators may need to be recruited or may be able to be seconded part or full time from an existing community development or similar job in the locality, minimising recruitment costs. Either way, it is essential that they have a high level of practical community development skills, but also have training in establishing or strengthening neighbourhood partnerships in the way we have described[5].

Why focus on neighbourhoods?

Clinical Commissioning Groups and Heath and Wellbeing Boards are expected to develop strategies for reaching the whole of their local population. As our figures from Smiths Wood illustrate, demand on health services is much heavier in some neighbourhoods than others – mostly poorer ones. Although GP practices mostly encounter the community on a one-to–one basis, GPs have a strong sense of place and locality. Patient Participation Groups and Healthwatch could have a growing role by linking into the network of other local community organisations.

At neighbourhood level the daily interaction of people, the building of social capital, the face to face influence, in short people's influence on each other, is a real operative factor in health behaviour and health literacy. This is the level at which community action can best make a difference to conditions affecting health, without major new financial investment, through better coproduction between community organisations and public agencies across the board. Fostering a dynamic community partnership dedicated to local improvement is a highly economical way to enable interaction between the health service, the other public services and the local population.

The projects in the small portfolio of HELP and its 'C2' antecedents have mostly taken place in neighbourhoods or estates with fairly obvious boundaries but have not had a systematic mechanism for checking the approval of a majority. The 'community empowerment' section of the Localism Bill (CLG, 2011) is set to give new local development powers to parish councils and, where these do not exist, to another community group. This would entail the designation of a neighbourhood boundary, hence a specified population, hence allow the authentication of a neighbourhood plan by the approval of a majority.

The Localism Bill

The provisions of the Localism Bill and the Open Services White Paper (HMG, 2011) cannot guarantee creative development and participation, and the specific powers focus mainly on physical planning, but they could also be a stimulating framework for addressing wider social issues. The Bill claims that it will:

- '*make it easier for local people to take over the amenities they love and keep them part of local life*

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[5] C2 training can be contacted via Susanne.Hughes@pcmd.ac.uk

- *ensure that local social enterprises, volunteers and community groups with a bright idea for improving local services get a chance to change how things are done*
- *give people a new way to voice their opinions on any local issue close to their heart*
- *enable local residents to call local authorities to account for the careful management of taxpayers' money' (CLG, 2011, p18)*

JSNA

The most recent Joint Strategic Needs Assessment (JSNA) for the area should be consulted to help assess needs, but at the same time the community participation element in the JSNA may itself need to be strengthened. In relation to the JSNA, a community development perspective could:
- help identify and reach populations who are otherwise hard to hear
- help those populations articulate their needs and ensure that their voices travel to the correct parts of the CCG and the LA
- act as a bridge between populations and statutory agencies

Existing community development

Despite the decline in formal CD provision there may be a number of pockets of provision still extant. Workers may be aware of each other and possibly linked in an informal network. These should be approached both for intelligence on the present situation and as possible collaborators in the new intervention.

Other related roles

Beyond formal CD provision by name there may be potential or latent provision in the form of other front line roles which use or incline to CD methods in some aspect of their work. This could include housing workers, health visitors, health trainers, community wardens, police community support officers, voluntary and community organisation workers, faith workers, sports officers and others. Chanan and Miller (2009) found partial CD being carried out in, for example, policing, housing, education and neighbourhood management, and set out a framework for linking CD across public services.

The best hope of making a significant difference to the health of the whole local population without major new resources is to mobilise the fragments of latent and quasi community development within the area and strengthen them alongside development of the neighbourhood partnership. In some cases the relevant agencies may be interested in buying into a joint plan by allocating a proportion of their workers' time to joint working; in others a degree of coordination may be achieved by networking and mutual referral.

What should be commissioned?

We suggest that HWBs and their partners should commission two-year neighbourhood partnership development programmes in the 20% most disadvantaged neighbourhoods in the territory. With a period of preparation and evaluation the full process may take three years. This programme might consist of:

six months to map needs and provision

a year to establish or reinvigorate partnerships in priority neighbourhoods

> a year to consolidate the partnerships and extend their activities
>
> six months to evaluate, reprioritise and assess whether there is need for a next phase, either in these or other neighbourhoods.

The steps would include:

1. Establish baseline neighbourhood health profile

1. In each priority neighbourhood, survey the level of social capital in terms of residents' views and the condition of local community organisations (see Appendix 3)

3. Establish neighbourhood partnership and galvanise community activity

4. Add links to community engagement and public health outreach initiatives

5. Monitor outputs

6. Assess changes annually in:
   - population health profile / selected health indicators
   - social capital (resident survey)
   - condition of the community sector

7. Report annually to the commissioner and stakeholders.

A policy emphasis on communities *taking over* public services is less likely to bear fruit than an emphasis on both communities and public services becoming more effective and economical by better cooperation. Where communities become more effective they reduce costs in public services not by taking them over but by reducing pressure and demand on them.

Our model assumes that the main services remain broadly in place and retain the community engagement ethos which they had begun to develop - mostly with all-party support – over the past generation. Our model also assumes (and our pilot projects like most other CD, demonstrate) a wealth of inactivated capability in communities, even in disadvantaged areas.

The CD intervention is therefore 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.

Our deduction from HELP experience is that partnership building is real if it takes place at the very local level – the neighbourhood – where front-line workers of different agencies actually encounter one another and meet residents face to face.

On 'Complexity' principles, what is most necessary for effectiveness is not having a cascaded plan for what these workers will do in order to join up but creating the conditions to foster this. The prime condition is being given a proportion of working time to participate in flexible partnership problem solving.

All agencies should give their front line staff 10% of time for participating in flexible local problem-solving jointly with the community and with other agencies, irrespective of whatever other restructuring is taking place. This would release into the community (and into the total public service mix) a huge resource to enable joined up solutions.

The mutual adjustment between communities and agencies is therefore not a shift of power from agencies to communities, as it is frequently described. It 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 are empowered to achieve more effective outcomes. This is not a zero-sum game.

Outputs and outcomes

Finally, types of output and outcome that can be audited are summarised in Panel 6.2.

Panel 6.2: Types of output and outcome of the CD intervention (3 years)

OUTPUTS	
New or reinvigorated neighbourhood partnership	
Increased community activities	
Increased volunteering	
Better community intelligence to health commissioners	
Better collaboration between different services	
More effective community organisations	
Enlarged platform / wider reach for community health initiatives	
OUTCOMES	**MEASURED OR VERIFIED BY**
Increased social capital	Survey of residents; testimony of front line workers
Improved capability of local community organisations	Community sector survey; testimony of front line workers
Better targeted health commissioning	Health commissioners
Reduced incidence of selected health risk conditions	Health statistics
Narrowing of gap on selected health conditions, social determinants and service demand between the disadvantaged neighbourhood and the average for the larger locality	Health statistics
Improvements on other services and conditions affecting health	Other sector data; survey of residents/ testimony of staff of non-health agency partners

CONCLUSION

'A clear focus on people, places and empowerment is the key to achieving change at local level, as local communities are best placed to shape investment to meet local needs... across the life course' (HMG, 2011a, 2.14)

This report shows how community development can be used systematically to improve health in disadvantaged areas and pay for itself several times over in doing so. The chain of evidence is commonsensical and yet has been largely neglected hitherto. Widespread research shows that social networks and community activity are major factors in ensuring health and wellbeing. They are also essential to cooperative action to improve disadvantaged areas.

People living in such areas are more dependent on the locality than those who have more money and mobility, yet participation is more difficult for them because of worse conditions, higher crime and antisocial behaviour and poorer health itself. Public services too are often poorer – under greater strain because of greater needs but impeded or discouraged by hostility and seemingly relentless cycles of negative events.

Community development supports people to come together to take positive action for their own wellbeing and in the interests of the neighbourhood as a whole, building social networks and positive action where they are desperately needed. Participation in constructive activity is itself health-giving, and the practical results of activity also benefit the wider community who are not directly participating, and gradually draw more of them in. Whilst residents who are active benefit most, all residents benefit from a better atmosphere, new amenities and improved services; and public service staff benefit from a better relationship with the community.

Much community development in the past has carried out these functions in a piecemeal way, either because of short term funding or limited strategies. Some programmes supported by government have shown what can be done by a more strategic approach across a neighbourhood but these programmes are now mostly ended.

Whilst reviewing this background and the research emanating from it, we ran three pilot projects over 18 months using the more strategic basis and applying a model with a high reputation, 'C2', to apply certain extra elements, in particular:

(i) joint development of skills amongst both key residents and public service workers;

(ii) establishment of a formal long-term partnership between the community and the service agencies;

(iii) fostering a wide range of initiatives and expanding involvement by mobilising public agencies' support through the partnership to pursue community priorities for neighbourhood improvement;

(iv) clear time-frame for establishing the basic pattern of development;

(v) creating a model for collecting systematic evidence and demonstrating health outcomes and economies.

Using detailed information from one of our pilot projects, we illustrated the high incidence in a disadvantaged area of a number of particular health conditions which previous research had shown to be susceptible to community-focused improvement. Relating these to the cost of treatment we showed how much of the local health budget could be saved if community development, with some focused intervention, prevented just 5% of the incidence of this limited selection of health needs. Savings of £1,600,000 were conservatively estimated from an investment of £262,000 over three neighbourhoods, a return of 1:6.

The financial value in terms of treatment, however, whilst important and reassuring, does not reflect the full significance of the intervention. 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' approach to prevention, Patient and Public Involvement and overcoming health inequalities. It also enhances Clinical Commissioning Groups' 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. We conclude by highlighting six aspects of current change which need some community development input in order to be fully effective.

Service change. 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.

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.

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 to do and less likely to succeed.

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.

Implications for CD commissioning and strategy. 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.

APPENDIX A: IMPLICATIONS FOR COMMUNITY DEVELOPMENT STRATEGY AND PRACTICE

There was a widespread decline in provision of community development in England between 2008 and 2011 due to the ending of Neighbourhood Renewal, New Deal for Communities, Neighbourhood Management and other regeneration programmes, followed by cuts in public services. In 2004 it was estimated that there were some 15,000 community development workers in England (20,000 in the UK). About half were employed by public authorities, and half by voluntary and community organisations. Health authorities employed a small proportion (Taylor, 2004). It is unlikely that there are as many as a third of that number in 2011.

Between about 2000 and 2010, however, elements of community development method had been taken up in a variety of other professions. This spread was due on the one hand to the adoption of community engagement as a policy requirement in most public services, and on the other hand to front-line workers' direct experience that they could be more effective if they supported communities' own problem-solving capacities. However, the scattered elements of CD were often rather weak and spasmodic (Chanan and Miller, 2009).

As the research review in chapter five shows, community development carried out by any route has benefits for health. To this extent, the general decline in CD provision will have affected health adversely. However, new investment in CD by health agencies can not only compensate for the decline in general CD but improve its effectiveness for health and other issues, by adopting a more structured approach in the way in which CD is commissioned, to overcome weaknesses that were apparent in CD even when it was at its height (CD Challenge Group, 2006). It could also link with the varied quasi-community development practice taking place within other occupations in the locality and give them a central point of reference, guidance and networking.

All areas may contain a good deal of latent or potential CD activity. Several front line occupations contain, explicitly or implicitly, actual or potential elements of CD within their remit. Examples may include youth workers, health visitors, health trainers, regeneration workers, tenant participation officers, police officers, police community support officers, teachers, voluntary sector workers as well as community development workers by name. The CD element in these roles – supporting independent community groups, organisations and networks - could be boosted at little cost as part of a neighbourhood-wide reconfiguration of CD contributions through better leadership.

Many disadvantaged areas have had some form of community development over the past decade but this will often have had less impact on health than it could have done for a number of reasons:

> (i) **Health orientation**: projects may not have explicitly included health objectives or the participation of health agencies so opportunities were missed to link into health issues.

(ii) **Lack of coordination**: CD in a neighbourhood was often fragmented and erratically funded around a scattering of projects, so opportunities for coordinated and cumulative effect could not be realised.

(iii) **Weaknesses** in the CD tradition itself: lack of measurement and lack of strategy for developing alliances across other public services, hence a tendency to isolationism.

There is no single complete answer to these shortcomings but we have attempted, both through the pilot projects and this report, to move towards a more productive strategy for community development. The key departure is that HELP goes into a neighbourhood with the specific expectation of setting up (or strengthening if it already exists) a resident-led neighbourhood partnership with local agencies. This approach builds on experience from neighbourhood renewal (Duffy, 2008) and neighbourhood management (NNMN, 2007) but adds in particular:

- health as a central reference point and objective
- a model for objective measurement of outcomes
- a particular model of neighbourhood partnership which embeds community leadership but also ensures an integral role for front-line workers from the range of local public agencies.

Amongst other CD models it has most in common with Community Led Planning (ACRE, 2011) with its specific steps towards establishing a long-term neighbourhood plan and its reconciliation of resident leadership with help from public agencies.

We are conscious of a danger of creating a caricature of 'traditional' CD - in reality there are many variants - but at the risk of oversimplification we need to pinpoint some key differences of approach. (Panel B1).

Panel B.1 Six points of divergence in community development models

Traditional CD	*HELP / C2*
1. Main focus on support to individual community groups, with emphasis on exclusive resident control	Main focus on developing intersectoral neighbourhood partnership as source both of new groups and activities and new opportunities for existing groups. Partnership community led but includes representatives of public services as full members where their agencies allow
2. Issues only taken up if raised by residents	Potential for take-up of all main issues anticipated by involving wide range of service providers from the start to listen to the community's priorities
3. Building residents' skills and confidence	Building skills and confidence both of residents and front-line workers
4. Viewpoint of public services and community seen as liable to be incompatible	Viewpoint of public services and community seen as potentially convergent through joint learning and development whilst recognising very different starting points and experiences
5. Indefinite timescale. CD seen as bound to take many years	Clear timescale for main intervention – two years to establish and consolidate the partnership. This opens the way to long-term self-renewing development, which can also be enhanced by further CD input
6. Qualitative self-evaluation by participants, with emphasis on process	Evaluation of impact on all stakeholders including non-participants, with emphasis on outputs and outcomes, and linking outputs to local health outcomes

Democracy, scale and coordination

CD is sometimes accused of being unrepresentative and undemocratic. Speaking of small groups as 'representing' the community merely engenders unnecessary tension in relation to elected representatives. This needs to be overcome by practitioners on the one hand and by clear commissioning criteria on the other.

Communities do not necessarily develop in a formally democratic pattern. Small groups of key residents take action which they believe to be in the interests of the whole community and which are in effect ratified by popular approval – or isolated by popular rejection – as they emerge to the awareness of the majority. It is part of the CD practitioner's skill to assess and guide activities to be in the common interest.

It is precisely because CD is not formally democratic in its process that it does not, and should not attempt to, replace formal local democracy, but should be transparently accountable to it and should seek to enlist the support of elected members and appointed officers. Conversely those who commission it and hold it accountable should give it the scope and flexibility it needs to nurture positive action in situations which may entail tension between residents and agencies or between different groups of residents.

Local residents and public agency staff naturally have different perspectives on the issues affecting the neighbourhood. This has sometimes been exaggerated into a structural opposition between the viewpoint of the residents and the viewpoint of the agencies; as if the CD worker needs to be 'on the side of the community' and therefore against the public service agencies; stuck in the phase of anger which is often an early stage in bringing residents and agencies together rather than seeing the bigger picture within which that confrontation is sometimes a necessary stage.

Widening legitimacy and participation

If CD effects are to show up in health statistics they 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. CD literature sometimes speaks of 'ripples' from the centre of action to the periphery but there are very few studies or evaluations which specifically examine this 'scaling up' process.

The solution is firstly to openly adopt a model of the community that reflects the real nature of how communities develop from within; secondly to use authentic neighbourhood-wide surveys (or statistical samples) to check the impact of the active minority on the majority; and thirdly to ensure ever-widening circles of participation.

Different segments of the community can be depicted in a simplified way as in panel A2.

From the experience of participation itself, the active minority (circle A) gains skills and information, widens its social networks, gains recognition by authorities and

increases its employability. These are intrinsic participation outcomes for a small proportion of the community (they could be called Level 1 outcomes).

As a result of its activities there are improvements to conditions in the locality. For example the health agencies respond by relocating a surgery or dental practice; the housing department or housing associations respond with quicker repairs or more efficient heating; the police respond by removing abandoned cars; the parks department responds by renovating a piece of derelict open land (level 2 outcomes).

_____

Panel A2: Different levels of involvement within a community

A. Active residents

B. Supportive

C. Aware but uninvolved

D. Unaware

_____
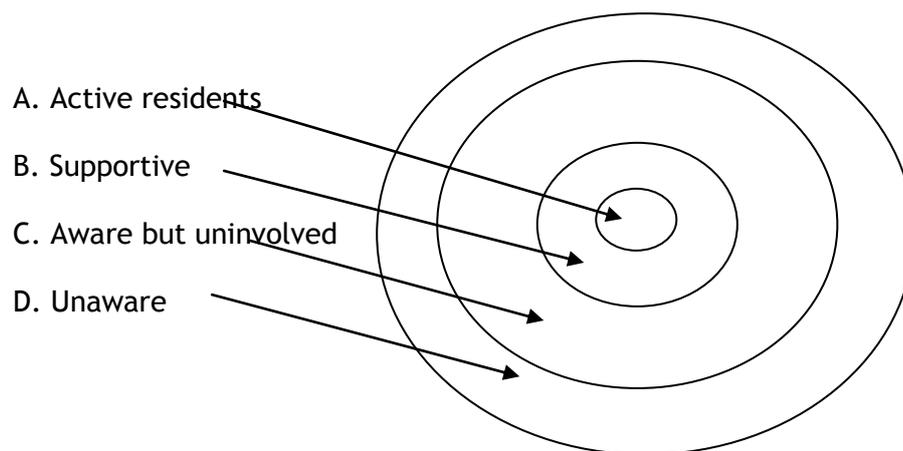
As a result of level 2 outcomes, new volunteers are recruited (eg to patrol the park, to produce a newsletter, to negotiate with the social landlord). These are circle B, and would come perhaps mainly from people who are accessed by the already active residents. As they become supportive they also begin to share in the benefits of the active core (level 3 outcomes).

A further result is the impact of the new or improved amenities themselves. These reach potentially the whole population (level 4 outcomes). Many residents may know nothing about the developments that have been taking place until they see a park being opened, a dental clinic appearing, repairs to houses being speeded up. As a result they start using the new amenities and may ask their neighbours what is happening, attend a meeting or see a newsletter, and some thus become part of the aware or involved community.

Thus all four levels of outcome contribute to better health and other benefits.

The CDF/ SROI study (NEF, 2010) is unusual in distinguishing involved and uninvolved residents and concludes from its calculations that whilst the benefits of CD are most intensive for the active, the total value of benefit for the uninvolved is much greater as there are so many more of them. Certainly it is necessary for benefits to reach the uninvolved if they are to affect health statistics for the neighbourhood.

> *'The wider community benefits from the fact that a significant number of CD activities achieve an improvement in the delivery of various public services as community needs are better articulated and reflected'*
> *(NEF, 2010, p25).*

For some people non-involvement may be a conscious choice. Their personal networks or communities of interest (not necessarily bounded by the neighbourhood) may matter more to them than activities in the neighbourhood. Or they may be concerned with the neighbourhood but just not want to play an active role. Research by IpsosMORI reanalysing data from the New Deal for Communities national evaluation, shows that many people can *feel* influential in local affairs without personally taking part. At the same time some who do take part may not feel influential – perhaps because, having made more effort, they have higher expectations of reward:

> *'People do not need to have been involved in NDC activities to feel influential, and vice versa. Two thirds of those who feel they c an influence local decisions have not been involved in any NDC activities and 51% of those who have been involved still do not feel they have influence over local decisions'. (Duffy et al, 2008)*

It may also be that some people experience influence through voluntary and community activities other than those linked in to the CD initiative.

A vision of an ultimately 'developed' community would not necessarily show everyone being active and influential all the time. It might well show a majority of residents aware and approving of an active minority and feeling that the results of the activity are beneficial. The problem with inert neighbourhoods is not that a majority of people are not active in a centralised initiative but that there is not a sufficient, capable, credible minority taking that role and endorsed either actively or passively by the neighbourhood population as a whole. Wide CD experience suggests that this is rarely if ever because there are no people in the neighbourhood capable of taking the active role. The potential may be hidden because personal relationships and networks in the neighbourhood are poor, and residents have retreated from the social space into personal survival mode:

> *'The material and psychological disadvantages of living in a neighbourhood with a poor reputation include discrimination in the labour market and in accessing finance; people's self-esteem can be damaged by living in a notorious area. As a means of dealing with these negative effects, residents... may engage in distancing strategies...' (NEF, 2010, p 25).*

APPENDIX B: **Illustrative Cost Benefit Model in Detail**
<div align="right">Steve Griffiths</div>

There is strong evidence that social capital has health benefits, and that conversely, poor social capital is associated with poor health, with regard to overall health and wellbeing, life expectancy, and specific conditions (Bennett, 2002; Fabrigoule et al, 1995; Bassuk et al, 1999; Berkman and Kawachi, 2000; Lochner et al 2003). Kawachi et al found that the odds ratio for self-rated fair or poor health associated with living in American states with the lowest levels of social trust was 1.41 when compared with high-trust states.

As part of his study, he looked at the link between self-rated poor health and mortality, and found:

> 'A recent review of 27 community studies concluded that even such a simple global assessment (self-described excellent / very good / good / fair / poor health used by the Behavioral Risk Factor Surveillance System (BRFSS)),appears to have high predictive validity for mortality, independent of other medical, behavioral, or psychosocial risk factors.   For most studies, odds ratios (ORs) for subsequent mortality ranged from 1.5 to 3.0 among individuals reporting poor health compared with excellent health. The risk of mortality for self-rated poor health often exceeded that of smoking when these rates were reported in the same study. Furthermore, self-rated health has been shown in longitudinal studies to predict the onset of disability.' (Kawachi et al, 1999)

These findings suggest that a shift in a community from low level of social trust to high level, i.e. equivalent to changing a low-trust American state into a high-trust one, could produce a reduction in proportions with self-rated fair or poor health of 29 percentage points (100/141=0.709); and that this would be associated with corresponding reductions in mortality and improvements in health.

Such a margin of change would mean a sea-change in health. How do you move from low to high social trust in a community? This is what community development sets out to do, through stimulation of new community activities, groups, initiatives and networks. The HELP model adds a clear framework and mechanism for creating long-lasting momentum through residents' partnership with local public agencies . We used the findings from Kawachi and many other sources to create a transparent model to explore evaluation of HELP interventions. This model is the basis for the calculations in Chapter 6 of this report and is intended to be replicable.

The model contains an element for calculating cost savings associated with improvements in particular health indicators (which would be set against change in comparable control areas).   The choice of indicator could be varied at a local level according to the prevalence of certain conditions, and relevant interventions as they develop. The model could initially be set up as a hypothesis, with targets at a locally decided level, and then populated by actual data as they emerged.

Health savings are the main focus of this illustrative model of cost benefits from investing in community development through the HELP approach . Other savings would accrue to policing, education, DWP and other services. The multifaceted nature of the benefits may suggest that health agencies should seek to engage other

local services in sharing the cost of the investment through a place-based budget or other mechanism.

An illustrative saving level of 5% is given in the menu of indicators below, comprising 2.5% as a result of a specific, targeted intervention affecting a proportion of the population agreed to be sufficiently significant; and an additional 2.5% added value where research supports the hypothesis of an improvement in social capital leading to a relevant health improvement, in the community in general or in specific groups of individuals, as supported by the literature: together a notional 5% to be achieved.

This is supported by findings that integrated health and well-being services can realise significant financial benefits. For example, studies have illustrated that integrated early intervention programmes can generate resource savings of between £1.20 and £2.65 for every £1 spent (POPPs, LinkAge Plus, Supporting People, self care schemes). Furthermore, for every £1 spent on balance/Tai Chi classes by the taxpayer in LinkAge Plus areas there is a health and social care saving of £1.35 (Turning Point / Connected Care, 2010).

The template below would evolve as relevant activities were generated, as is currently happening in the HELP pilots in Solihull and Townstal. The transparency of the model would allow local negotiation to consider risks of double-counting in cost savings and to avoid them.

The model reflects the multi-dimensional impact of streams of activity. For example, many of the research findings relevant to Cardiovascular Disease report a beneficial impact in relation to mental health; and the dance activities in Camborne reported under the heading 'Crime' clearly increase physical activity, and in the reported research context would have an impact on mental wellbeing.

1. Cardiovascular diseases
1.1 Community development effect
Spread of greater trust, cooperation, social and physical activity, empowerment and resilience among residents. Development of community resources and networks to host and foster extensions of care pathways to encompass a preventive community activity resource base which reduces incidence of CVD, assists rehabilitation, and reduces demand of the acute health sector.

1.2 Research base
Higher levels of *social trust* are associated with lower rates of most major causes of death, including coronary heart disease (Kawachi et al,1997).

A number of studies are consistent with the idea that areas with poor social capital have higher rates of cardiovascular disease (Augustin et al, 2008), in particular among lower-income individuals (Scheffler et al, 2008).

Loneliness and low levels of social integration significantly increase mortality. People with stronger networks are healthier and happier (Bennett, 2002). Social networks are consistently and positively associated with reduced morbidity and mortality (Fabrigoule et al, 1995).

Research also reports significant health benefits for individuals actively involved in community empowerment/engagement initiatives including improvements in

physical and mental health, health related behaviour and quality of life (Piachaud, 2009; Grady, 2009).

On average, an inactive person spends 38% more days in hospital than an active person, and has 5.5% more family physician visits, 13% more specialist services and 12% more nurse visits than an active individual (Sari, 2008).

Cost-benefit analyses of cycling and walking infrastructure generally produce high benefit-cost ratios (BCRs). The median BCR in one such analysis was 5:1 which is counted as 'high value for money'. It appears that health benefits make a significant contribution to the high BCRs for cycling and walking projects (Cavill et al, 2008)

Physical inactivity is a significant, independent risk factor for a range of long-term health conditions (Foster et al, 2009).   An active lifestyle:
• has a substantial impact on the risk of major non-communicable disease, including coronary heart disease (CHD), hypertension, type 2 diabetes, chronic kidney disease and some cancers;
• supports weight management – physical activity by itself can result in modest weight loss of around 0.5–1kg per month.
• can reduce the risk of stroke, and be used to treat peripheral vascular disease and to modify cardiovascular disease (CVD) risk factors such as high blood pressure and adverse lipid profiles (Department of Health, 2004).

Advice on physical activity should embrace the broader concept of health and activity – walking, dancing, playing with the grandchildren, or gardening (McMurdo, 1999).

A paper by Lomas (1998) offers an estimate of SROI for CD in heart disease. He estimates, based on available evidence from elsewhere, to what extent CD activities would reduce cardiac disease and compares those outcomes with those from more conventional approaches. He compares potential heart disease deaths in men prevented per 1000 exposed to each 'intervention' per year:
> Social cohesion and networks of associations would prevent 2.9 fatal heart attacks or heart failure
> Medical care and cholesterol-lowering drugs would prevent 4.0 fatal heart attacks in screened males
> Routine access, free care would prevent 2.1 all cause deaths in high-risk males over 50 years old

1.3   Examples of relevant activities (from HELP pilot project in Smiths Wood, Solihull)

- Weight management

- Smoking Cessation

- Buggy Walking route for parents of young families

- Health trainers (one to one lifestyle/ health behaviour advice)

- Pedal Power: bikes supplied by Police, aimed at 'families with complex needs' referred by police, social services etc. Bikes restored and given to families with safety gear and on completion of cycling proficiency course. Older siblings and Dads teaching younger ones.

- Young people engaged in local woodland management, coppicing and den building. Outcomes are accredited training in woodland management; improving habitat diversity in woodland; positive outdoor experiences eg fire lighting, cooking and wood carving.

- Empty shops allocated by Council for use by community groups on a free lease. Cleaned, painted and decorated via voluntary activity, with young people painting murals and designing shop frontage. The shops attained an almost instant status as a community hub.

- Zumba dancing sessions

1.4 Indicator/s

CVD hospital admissions under age 75.

Mortality rate from cardiovascular disease has been a key health indicator for successive governments. It is a proposed health outcome indicator for the Coalition Government's Public Health Outcomes Framework (Department of Health, 2011). Circulatory diseases account for 35% of geographical health inequalities for males, and 30% for females (Health Inequalities Unit, 2008).

However, mortality rates are a long-term indicator to influence. Hospital admission rates are an indicator located further upstream. They are available at very local level in significant numbers, and offer a clearer focus for collaboration between health and other services in addressing the determinants of ill health, and prevention and rehabilitation pathways which engage and empower local people through community development. Finally, there is a strong and established link between deprivation and emergency admissions, with spending hotspots on acute services which have great potential for realising tangible savings to support a strategic shift towards prevention and early intervention, as well as addressing health inequalities (Griffiths, 2009). This is entirely in accord with the Government's new Public Health Outcomes Framework.

1.5   Average incidence in a population of 5,000
09/10 England 91 per 5000 (NHS Information Centre,2010)

1.6   Baseline from Smiths Wood, Solihull (adjusted to 5000 base)
(08/09) 242 per 5000

1.7   Cost of treatment
Average cost of admission £4,614 (NHS East Lancashire, 2010)

1.8   Illustrative 5% additional saving attributable to CD
12 admissions @£4614=£55,368

2.   Depression
2.1 Community Development Effect
Increase of community activity and social networks alleviates stress, improves confidence and resilience, reduces the risk of depression, creates positive alternatives to antidepressants.

2.2   Research Base

National surveys of psychiatric morbidity in adults aged 16-64 in the UK show that the most significant difference between this group and people without mental ill-health problems is social participation (Jenkins et al, 2008).   There is strong evidence that social relationships can reduce the risk of depression (Morgan and Swann, 2004).

Good personal support networks, for example friendship or a confiding relationship, and opportunities for social and physical activities, protect mental health and enable people at any age to recover from stressful life events like bereavement or financial problems (Cooper et al, 1999).

Men and women who scored highest in a survey on emotional health were twice as likely to be alive by the study's end. The link between subjective feelings of happiness and good health held even after controlling for chronic disease, smoking, drinking habits, weight, sex and education (Goodwin, 2000).

A systematic review of 22 studies evaluating the effectiveness of health promotion interventions to alleviate social isolation and loneliness among older people found that group activities like discussion and self-help groups, bereavement support and counseling, were all found to be effective (Cattan, 2002).

An active lifestyle:
• reduces the risk of depression and promotes many other positive mental health benefits, including reducing state and trait anxiety; improves physical self-perceptions and self-esteem; and can help reduce physiological reactions to stress;
• has been found to be just as effective in the treatment of mental ill health as anti-depressant drugs and psychotherapy (Mutrie, 2000; Biddle et al, eds., 2000)

Recent cross-sectional studies and controlled trials have suggested that exercise, such as aerobic classes and t'ai chi, provides both physical and psychological benefits in elder populations. These benefits include greater life satisfaction, positive mood states and mental well-being, reductions in psychological distress and depressive symptoms, lower blood pressure and fewer falls (World Health Organization, 2004; Li et al, 2001).

See also 1.2 above.

2.3 Example from HELP, C2 or similar projects
Wide range of activities to build social capital throughout HELP projects (see above)

2.4 Indicator/s
Depression diagnosed by primary care, based on data from 5 GP Practices serving area, applied proportionately. Ideally would be specific to geography, based on postcode analysis.

2.5 Average incidence in a population of 5,000
247 per 5000 *(IMS Disease analyser)* 'in contact with GP services per year, diagnosed as having either depression or mixed anxiety and depression'.

2.6 Baseline from Smiths Wood, Solihull (5000 base)
355 per 5000 based on practice data projected (09/10)

2.7 Average cost

£1355 p.p service cost; also £4694 p.p earnings lost (McCrone et al, 2008).

2.8 Illustrative 5% additional service saving attributable to CD
(not including the personal earnings lost)

5% reduction of 18 cases, service saving £24,390.

3. Obesity
3.1 Community Development Effect

Spread of health awareness and literacy, more community and physical activity.
New / improved open spaces/ sports facilities negotiated by community groups.

3.2 Research Base
Being obese and being overweight both increase the risk of a range of diseases that can have a significant health impact on individuals, although the risks rise with BMI (Body Mass Index) and so are greater for the obese:
* 10 per cent of all cancer deaths among non-smokers are related to obesity
* the risk of Coronary Artery Disease increased 3.6 times for each unit increase in BMI
* 85 per cent of hypertension is associated with a BMI greater than 25
* the risk of developing type 2 diabetes is about 20 times greater for people who are very obese (BMI over 35), compared to individuals with a BMI of between 18 and 25
* up to 90 per cent of people who are obese have fatty liver. Non-alcoholic fatty liver disease is projected to be the leading cause of cirrhosis in the next generation
* obesity in pregnancy is associated with increased risks of complications for both mother and baby
* social stigmatisation and bullying are common and can, in some cases, lead to depression and other mental health conditions (Dept of Health, 2008).

The majority of children and young people classified by the HSE 2007 as overweight (77.3%) consider themselves to be about the right weight as do 46.3% of children classified as obese.   65% of children and young people classified as obese are trying to lose weight.

The Chief Medical Officer advises that children and young people should participate in a minimum of 60 minutes of at least moderate intensity physical activity each day. 32% of children and young people age 11–15 believe that people their own age should take part in physical activity every day of the week (Roberts and Marvin, 2011).

An active lifestyle supports weight management – physical activity by itself can result in modest weight loss of around 0.5–1kg per month (Foster et al, 2009).

Collective efficacy - the willingness of community members to look out for each other and intervene when trouble arises - is negatively associated with BMI, risk of overweight, and overweight status, when levels of neighbourhood disadvantage have been taken into account. This suggests that future interventions to control weight by addressing the social environment at the community level may be promising (Cohen et al, 2006).

There is little evidence specifically on the cost effectiveness of non-pharmacological interventions such as diet, physical activity and behavioural treatment in the treatment of obesity. Notwithstanding the limited evidence in an already obese population, these types of interventions appear to be a cost-effective use of resources (NICE, 2006). Dietary interventions seem particularly cost effective due to the low levels of staff contact needed, as do group interventions (Goldfield et al, 2001). The degree of cost effectiveness of non-pharmacological interventions is highly sensitive to the duration of benefit. If weight loss relative to trend remains constant for 5 years post intervention before returning to baseline, the cost per QALY in the best-performing non-pharmacological studies ranges from £174 to £9971 (NICE, 2006).

3.3 Example from HELP, C2 or similar projects
See CVD section above for material on physical activity, healthy lifestyle advice.

Renovation of park with new play facilities (Townstal); establishment of skateboard park and other facilities (Redruth, Beacon project).

3.4 Indicator/s
% obese, adult and child.

3.5 Average incidence in a population of 5,000
08/09: Reception class: 480/5000; Year 6: 915/5000
Adults: England proportion 24.2% (2006-8), 9.46m (1210/5000)

3.6 Baseline from Smiths Wood, Solihull figures (5000 base)
08/09: Reception class: 985/5000; Year 6: 1,110/5000
Adults: ratio of Reception and Yr6 (equally weighted) SWANN / National = 1.5. Adult rate for England 24.2 x 1.5 = 36.3%, i.e. 1815/5000

3.7 Average cost
Adults: derived from data on wider cost of raised BMI and obesity, adjusted proportionately to obesity alone; and estimated future cost of diseases related to BMI minus CHD (covered in Part 1 above) (£7.32bn 2007) (McPherson et al, 2007); applied to UK adult population: £648.30 per obese person.

3.8 Illustrative 5% additional saving attributable to CD
Adults: rate of 36.3% applied to adult Smiths Wood population estimate of 3,181 = 1,155.   5% is 58, @ £648.30p.a. = £37,601

4.   Older people: social and physical activity and reducing falls
4.1 Community Development Effect
An increased level of community activity, particularly physical activity suitable for older people (including walking groups) provides a network which can raise the level of physical and mental wellbeing, improving muscle strength and balance; and with neighbourhood-level commissioning of community groups this can be tailored to reduce the risk of falls and assist recovery.

4.2   Research Base
See references to physical activity 1.2 and 2.2 above.
Ageing and inactivity leads to muscle loss and increases falls risk. Only 14% of 75 year olds are sufficiently active to maintain health (Skelton et al., 1999).   Older

people can regain 27% of muscle strength reversing age related decline by 15 years by attending one exercise class a week and doing home exercises (Skelton and McLaughlin, 1996).

NICE find a programme of muscle strengthening and balance retraining, individually prescribed at home by a trained health professional, and a 15-week Tai Chi group exercise intervention, to be beneficial (NICE, 2004).

A randomised control trial offering community-based support to older people who had experienced falls resulting in emergency ambulance calls but who were not conveyed to hospital achieved a halving of subsequent falls compared to a control group.   The intervention offered training in strength and balance, assessment of hazards in the home and modifications to the environment, advice and practice in getting up from the floor (provided by the occupational therapists), and group sessions on fall prevention in local community centres including one hour of muscle strengthening and balance training (Logan, 2010).

Through the Healthy Communities Collaborative, there was evidence of an improvement in social capital within the communities involved in the reducing falls programme, resulting in:
• 12% increase in people's perception of whether their area was a good place to live
• 12% increase in people's perception of whether individuals show concern for each other
• 22% increase in the number of people who knew where to get advice about falls
• 48% increase among participants in the proportion who thought they could change and improve things in their communities (Coulter, 2009).

Cost saving per fall less per year was identified by the Healthy Communities Collaborative as £800 p.p. in hospital costs, £82 in ambulance costs, and £1883 in avoided residential care costs.   Hip fracture costs £18,421 per patient (National Hip Fracture Database, 2010) (not yet in projection here)

For every £1 spent on balance/Tai Chi classes by the taxpayer in LinkAge Plus areas there is a health and social care saving of £1.35. This suggests that balance classes are a highly effective way to reduce the incidence and associated costs of falls, leading to fractures, hospitalisation and operations (Turning Point / Connected Care, 2010).

4.3   Example from HELP, C2 or similar projects
LinkAge Plus and other projects have supported peer group physical activity, with buddying (Activity Buddies on a British Heart Foundation model) providing support to the less able and less confident with mutual benefit. Dance tailored to older people by East London Dance, engaging a passion (and skill) for healthy activity shared by many in their younger days.   See the Well Centre, Bonny Downs Community Association, East London, for a wide range of healthy community activities, including Tai Chi and dance classes.

4.4 Indicator/s
Emergency ambulance calls for falls.
Number of older people engaging in organised social and physical activities in area;
Hip fracture data – to be obtained.

4.5   Average incidence in a population of 5,000
Ambulance calls for falls 422/5000 people aged 65 and over (Department of Health, 2009; Age UK, 2010).

4.5   Baseline from Smiths Wood, Solihull figures (5000 base)
Ambulance calls for falls / back 2009/10 total 120: estimated that 90% are falls (separate category for back pain)

4.7   Average cost
Cost saving per fall less per year was identified by the Healthy Communities Collaborative as £800 p.p. in hospital costs, £82 in ambulance costs, and £1883 in avoided residential care costs

4.8   Illustrative 5% additional saving attributable to CD
5 falls less, @£2765: £13,825

5.   Emergency hospital admissions
5.1   Community Development Effect
If levels of health and wellbeing improve due to increased social capital and healthy activity, use of acute services will reduce. There is major potential for added value through focused community investment (commissioning) in areas of very high levels of emergency admissions, associated with high levels of deprivation – there is a strong association between deprivation and emergency admissions, and therefore geographical hotspots of spending on acute services part of which can be reinvested in preventive community level activity, reducing demand too of primary care.

5.2   Research Base
Research in the London Boroughs of Sutton and Merton mapped the annual cost of emergency admissions of people aged 50 and over in small area format (SOA, average population c.1500).
The variation was extremely wide, from £2,677 to £622,540. These were both outliers: but there were seven SOAs with HRG costs above £350,000, and seven below £50,000. The variation between quartiles was also very wide: the top quartile of SOAs accounted for £17m (42% of costs of admission of people aged 50 and over); and the bottom quartile for £5m (12% of costs) (Griffiths, 2009).

5.3   Example from HELP, C2 or similar projects
Remarkably given the evidence presented in this paper, this has not been tested in health-related community development.

5.4   Indicator/s
Emergency hospital admissions

5.5   Average incidence in a population of 5,000
440 (08/09)

5.6   Baseline from Smiths Wood, Solihull figures (5000 base)
(09/10) 589 per 5000 (509 cases)

5.7   Average cost
£1592 (Smiths Wood dataset, Solihull NHS Care Trust)

57.8 Illustrative 5% additional saving attributable to CD
25 cases, £39,800

6. Accident and Emergency attendance
6.1 Community Development Effect
There is a strong case for linking community development to reduce crime and alcohol abuse with intelligence regarding A&E attendance, in order to reduce alcohol-related violence and health expenditure related to it.

6.2 Research Base
35% of all A&E attendances involve alcohol-related harm, rising to 70% of A&E attendances at peak times.   In a recent A&E study:
- 41% of attendees had been drinking
- 14% were intoxicated
- 43% identified as problematic users
- Cost - Up to £1.6bn to the NHS

PCTs have a duty to work in partnership with other responsible authorities to tackle crime & disorder. There is emerging evidence that A&E intelligence can have an impact on targeting police and other resources to reduce violence (Sheehan and Nurse, 2006).

Emergency Medicine can contribute to community violence prevention by working with public health and local crime reduction/community safety partnerships to measure community violence; identifying serial (repeat) attenders and referring them to agencies, for example to women's' safety units, who can intervene to reduce the chances of further harm; auditing hotspot locations for violence such as particular bars and nightclubs; being committed to decreasing community violence as well as treating the injured; initiating and participating in local safety campaigns, working with local media (Shepherd, 2007).

6.3 Example from HELP, C2 or similar projects
REACH, the Redruth Enabling Active Community Health, is an example of close collaboration between a community project using the C2 approach from which HELP is derived, and an emergency service. It was a partnership between the Redruth North Partnership and the South West Ambulance Service. Its aim was to provide easy community access to a known and trusted practitioner (an emergency care practitioner/paramedic), while reducing the numbers of inappropriate 999 calls. The initiative won an NHS Health and Social Care Award for reducing health inequalities in July 2006. Outcomes included 210 patients treated between 2004-2006 on site, a 30% drop in incidence of under-age problem drinking and an 18% reduction in emergency call outs (Stuteley, 2007).

6.4 Indicator/s
A&E attendance

6.5 Average incidence in a population of 5,000
1516 per 5000

6.6 Baseline from Smiths Wood, Solihull figures (5000 base)
09/10   1565 per 5000

6.7 Average cost

Per A&E attendance £86.90

6.8 Illustrative 5% additional saving attributable to CD
78 cases, £6,779

7. Crime and the fear of crime
7.1 Community Development Effect
Concern about crime is among the first priorities of many communities; and this is reflected in successive HELP Listening Events. Lower crime is associated with social capital which is positively associated with health. There is also a link between fear of crime and health: levels of fear of crime are not always consistent with actual crime in a community. It is therefore beneficial to health to reduce crime and the fear of crime.

7.2 Research Base
Those areas with stronger social networks experience less crime (Skogan, 1986), and less delinquency (Sampson et al, 1997).

In a Chicago study, overall, neighbourhood social capital - as measured by reciprocity, trust, and civic participation - was associated with lower neighbourhood death rates, after adjustment for neighbourhood material deprivation (Lochner et al, 2003).

The fear of crime refers to the fear of being a victim of crime as opposed to the actual probability of being a victim of crime (Hale, 1996; Farrall et al, 2007). Individuals with high fear of crime are twice as likely to suffer from depression. Fear of crime is associated with decreased physical functioning and lower quality of life (Stafford et al, 2007).

7.3 Examples of relevant CD activity
See examples above of work to improve social capital. Positive trends in crime reduction in Beacon (Falmouth), Camborne, Redruth North, Townstal.

- Large scale youth dance activities run by Camborne Neighbourhood Police Team, using the HELP approach to work with 325 children, many of them linked, as perpetrators or victims, to anti-social behaviour or crime. This has been subject to qualitative evaluation, with a finding that relationships between children and police were substantially improved (Camborne (2006)

- Two caretakers employed in one of the most problematic blocks of flats: better relationship with the tenants means that housing association felt confident to install an expensive security system again without fear of the repetitive vandalism that was occurring - Townstal, Dartmouth.

- Police Community Support Officer set up free local football session with youth between 14-16 – after week 6 there were 30 attendees – continuing with joint funding, supported by two staff from the Fire Service (Townstal, Dartmouth).

7.4 Indicator/s
Reported crime

7.5 Average incidence in a population of 5,000

2009/10, England: 394 per 5,000.

7.6 Baseline from Smiths Wood, Solihull figures (5000 base)
2009/10: 1,104 crimes.   Rate 1289/5000.

7.7 Average cost
Est. cost of individual crime in Smiths Wood (based on local pattern) £1,318.

7.8 Illustrative 5% additional saving attributable to CD
Reduction of 55 crimes, £72,490

8. NEET (Not in education, employment or training between the ages of 16 and 18)
8.1 Community Development Effect
Work with young people at risk to promote social inclusion, including work on confidence, resilience, social skills.

8.2 Research Base
Major predictor of later unemployment, low income, depression, involvement in crime and poor mental health (Places database, DfE)

8.3 Example from HELP, C2 or similar projects
See youth activity examples in 7.3 above.

- Greenfingers project in Redruth North aimed at unemployed disaffected young people, (NEET) (partnership between Redruth North Partnership and Cornwall College, offering NVQ level 1 in horticulture, while improving estate gardens of older people and those with disabilities) in return for free driving lessons. Now higher levels of participation in NVQ and other learning, a fall in youth unemployment and the creation of gardens and open space.
- Life skills courses, IT skills training (Beacon, Falmouth)
- Response to service cuts through Community Partnership: school in Townstal hosting Connexions outreach for young people (previously removed from Dartmouth); youth club continues after withdrawn by Youth Service, staffed by police out of uniform (Townstal, Dartmouth)

8.4 Indicator/s
Number of NEET (population denominator a problem in small geographical areas).

8.5 Average incidence in a population of 5,000
6.7% of residents aged 16-18 (2008, England)

8.6 Baseline from Smiths Wood, Solihull figures (5000 base)
Number: 52 in April 2011 (2010 figure requested).   14% of total in N Solihull regeneration zone

8.7 Average cost
Public finance cost of NEET, £7,986 per head (Coles et al 2010).

8.8 Illustrative 5% additional saving attributable to CD
Reduce by 3: £23,958.

APPENDIX C: COMMUNITY SURVEYS

Two types of community survey are recommended, one with residents as individuals, the other with community groups and organisations.

Most resident surveys and consultations in the past have been geared to finding out whether residents were satisfied with the public services. The inadvertent subtext of these is that residents are passive consumers of services, either satisfied or not, but in either case not seen as producers of their own local conditions.

The general health effect that CD produces is by assisting residents to see themselves, and act, as producers of their own conditions (including coproduction with the public services). This sense of collective local autonomy is therefore what needs to be captured alongside views on the material conditions.

(i) RESIDENTS

The following questions were used in street interviews with residents in the Townstal pilot project. The initial results are given in chapter three above.

(Preamble then:)

1. How long have you lived in [...]?

2. Do you think that [...] is a good place to live?
☐ Yes ☐ Not sure ☐ No ☐ No answer

3 Has it improved over the past year or got worse or stayed about the same?

improved a lot / improved a little / stayed same / got a bit worse / got much worse

4 Is there anything in particular that has made it better or worse?

5 Have you heard about (name of community partnership / initiative)?

yes / no/ not sure

5a (if yes) **What do you think about it?**
(record as generally positive/ neutral/ negative + any spontaneous comment)

5b (if no or not sure) **Would you like them to contact you to tell you what's going on?**

6 Do you feel you belong to a community in [….]?

Yes   Not sure   No   No answer

6a   Why?

7 Do you feel that it is easy to make new friends or acquaintances in [….] ?

1 Yes   2 Not sure   3 No   4 No answer

8. How many other people do you know in this area ?

☐ less than five   ☐ 5-10   ☐ More than 10

9. Do you take part in any activities in the local area?
(Prompt: such as clubs, societies, bingo, sports, community groups)

1 yes   2 no   3 not sure / no answer

9a (If yes) About how often do you take part?

1 once a week or more   2 about once a month
          3 about once every few months   4 once a year

10 Do you think there should be more activities available in the local area?

1 yes   2 no   3 don't know

11 Are there more or fewer activities available now than there were a year ago?

1 More   2 fewer   3 same   4 don't know

12   Do you feel safe going out in the [estate / neighbourhood] after dark?

☐ Yes   ☐ Not sure   ☐ No   ☐ No answer

13. I'd now like to ask you what you think about a number of issues affecting [...] residents. For each of these please say whether:
- This is not a problem
- This is a slight problem
- This is a big problem
- It was a problem but has now been dealt with

[Say you will take a note of any additional points the person wants to raise]

i) Upkeep of pavements/roads
- This is not a problem
- This is a slight problem
- This is a big problem
- it was a problem but has now been dealt with

i) Appearance of [...] – including litter/dog mess
- This is not a problem
- This is a slight problem
- This is a big problem
- it was a problem but has now been dealt with

iii) Traffic on the estate
- This is not a problem
- This is a slight problem
- This is a big problem

- it was a problem but has now been dealt with

iv) Repairs/maintenance of housing
- This is not a problem
- This is a slight problem
- This is a big problem
- it was a problem but has now been dealt with

v) Youths congregating
- This is not a problem
- This is a slight problem
- This is a big problem
- it was a problem but has now been dealt with

i) Nuisance noise
- This is not a problem
- This is a slight problem
- This is a big problem
- it was a problem but has now been dealt with

vii) Things for young people to do
- This is not a problem
- This is a slight problem
- This is a big problem
- it was a problem but has now been dealt with

viii) Places for people to meet
- This is not a problem
- This is a slight problem
- This is a big problem
- it was a problem but has now been dealt with

ix) Open space for walks, sport or recreation
- This is not a problem
- This is a slight problem
- This is a big problem
- it was a problem but has now been dealt with

Finally some questions about you, if that's ok. If there's anything you don't want to answer, that's fine.

14. What is your age ?

15. Can I ask a little about your health? On a scale of 1-10 how where would you rate your overall state of health? (1 is not healthy, 10 is very healthy)

1	2	3	4	5	6	7	8	9	10

16 Do you think that any of the problems we mentioned a few minutes ago have affected your health or the health of someone you know?

yes, self (specify problem); yes, other person (specify problem); no; don't know

17. Do you agree or disagree that you can influence decisions affecting your local area?

strongly agree/ agree/ neither/ disagree/ strongly disagree

18   Do you think that people in this area could improve life here by working together and influencing the authorities?

Yes – a lot / yes, a little/ no/ don't know

19 Do you think there is anything more that could be done in this area to help people keep safe and healthy?

20. Is respondent Male ☐ or Female ☐

21   How would you describe your ethnicity

22. Would you be willing for us to contact you again in 12 months' time?

23. If yes how can we get in touch? (take details)
_____

(ii) COMMUNITY GROUPS AND ORGANISATIONS

The second aspect of the condition of the community – often just as much neglected – is the **state of the local community sector**, that is the independent voluntary groups and organisations. There are copious government and non-government documents which invoke the existence of local community groups. Remarkably overlooked however is the question of whether there are enough of them in a given neighbourhood, and whether they are functioning well enough, to reach and support the local population.

There are few studies or projects which ask the relatively straightforward questions: how many community groups are there in this locality? Who is involved in them? Who benefits from them? How are they getting on? Are they becoming more effective or less? Are they flourishing or dwindling? Yet the profile of these groups is fundamental evidence of the state of local social capital.

In the era of public service cuts it is clear that there is likely to have been decline in the number of functioning local community and voluntary groups despite their centrality to the 'big society' concept, which was launched in 2010 as a new policy with no baseline.

One of the reasons for neglect is the fragmentation of community development (see Appendix A). Most CD initiatives and evaluations tend to focus just on the group or groups they are working with rather than establishing an objective profile of the state of groups in the neighbourhood as a whole. Even whole-neighbourhood initiatives (including our own pilot projects) tend to centralise their focus on their own activities.

The organisations likely to have the most comprehensive overview of local community organisations are the local voluntary and community sector umbrella groups, often called Councils of Voluntary Service in urban areas and Rural

Community Councils in rural areas. Many of the umbrella groups have from time to time surveyed their constituency and will have a more or less recent profile of information on their members. They will generally acknowledge that their lists may not be comprehensive, but they would normally be the first port of call in any attempt to establish a baseline.

In 2008, however, and again in 2010, the Office for the Third Sector (which later became the Office for Civil Society) commissioned a remarkable survey of the condition of local voluntary and community organisations throughout England. Findings are available on a wide range of questions about what the organisations are doing, how well they think are doing, how optimistic they are about the future, their funding and how well they are respected, supported and listened to by local statutory organisations (Cabinet Office, 2011).

The findings are at local authority level, not neighbourhood level, and are acknowledged to under represent small community groups. What is important however from our point of view is the availability of well-tested questions on the condition of local community organisations which could be used at neighbourhood level. A selection of the most relevant questions is:

Which are the main clients/ users/ beneficiaries of your organisation? (+ list)

What are the main areas (issues) in which your organisation works? (+ list)

What are the main roles your organisation undertakes? (+ list)

Thinking back over the last 12 months, to what extent do you think your organisation has been successful, or not, in meeting its main objectives?

Thinking back over the last 12 months, to what extent do you think your organisation has had sufficient or insufficient (of the following) resources to meet its main objectives? (+ list)

Looking forward over the next 12 months, how confident, or not, are you that your organisation will be successful in meeting your main objectives?

How would you rate the support available in your local area .. to help your organisation...? (+ list of activities)

Plus questions about whether local statutory bodies in the area value, understand, inform, consult and involve the organisation.

The exact form of these and the other questions, and the national and local findings for 2008 and 2010 can be found at www.nstso.com .

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