

A CHARTER FOR COMMUNITY DEVELOPMENT IN HEALTH

We hope people and agencies will see this Charter as both a challenge and a solution to making it easier to improve equitable access to health for all.

This Charter addresses all those with decision-making power at local and national levels, including CCGs, Commissioning Support Teams, Health and Wellbeing Boards, Foundation Trusts, Local Authority public health departments, LETBs and their members, Councils, local councillors and local GPs and NHSE, DH and DCLG. It also addresses those with a duty and role to influence those decision-makers – organisations like Healthwatch and Governors of Foundation Trusts. The approach championed by this charter will help them in the delivery of their duties to local people, which includes consultation and engagement more broadly as well as their new duties around the social determinants, quality of life, isolation, reducing obesity, mental health and premature mortality.

WHY NOW?

1. We welcome the improved health, longevity and health behaviours over the last 20 years, brought about by intelligent increased spending on the NHS and public services. However, these gains are under threat.
2. Health inequalities persist. People in our least affluent neighbourhoods face earlier death and higher rates of ill-health, and these inequalities will worsen as the weight given to deprivation in funding formulae is weakened.
3. The NHS and LAs face deep financial cuts. These, combined with what sometimes appears to be inappropriate outsourcing of the public sector, threaten services to our most vulnerable communities.
4. High cost, high-tech services that are done to people may show diminishing benefits.
5. We now have robust evidence that involving individuals and communities in defining problems and solutions with statutory agencies leads to better outcomes, often at lower cost. The quality of life in a community (its level of social capital) and the level of involvement of individuals, as residents, volunteers or workers, have a marked impact on health and life expectancy.
6. Working with communities of geography, interest and identity can make life easier for commissioners and providers by inviting responsibility, increasing agency and autonomy, and reducing dependency.

PRINCIPLES FOR SOCIAL ACTION IN HEALTH

1. Enable people to organise and collaborate to:
 - a. identify their own needs and aspirations
 - b. take action to exert influence on the decisions which affect their lives
 - c. improve the quality of their own lives, the communities in which they live, and societies of which they are a part.

2. Address imbalances in power and bring about change founded on social justice, equality and inclusion.
3. Active communities make a marked difference to their own health and life expectancy.
4. Co-production between communities and service providers thrives if communities are enabled to become leading players in their own interests.
5. A **needs-and-assets** based approach – look for the strong, not the wrong. Even the poorest communities will have some footholds in terms of community groups and willing activists, but they have fewer than well-off areas, facing more obstacles, and with great development potential.
6. Community development and related activities play a key role in helping develop strong social capital in communities and therefore having a positive impact on the health and wellbeing of residents.

WE CALL ON NHS ENGLAND, PUBLIC HEALTH ENGLAND AND THE DEPT OF HEALTH TO:

Develop policies that would make community development part of the normal approach to participation, change, health improvement and reducing health inequalities. These should include:

1. Every HWB and CCG to have a community development strategy, linking with community engagement by Local Authorities, police, community sector organisations and other services.
2. Joint Strategic Needs Assessments to become Joint Strategic Needs and Assets Assessments, with a profile of the strengths of the local community as seen in the condition of its groups, organisations and partnerships and in the protective factors for health and wellbeing.
3. Support for investment in community development and social value.
4. Seeking opportunities that support devolvement of power and decision making about service commissioning, delivery, monitoring and resource allocation to communities in a way that is not determined by competition rules nor by commercial confidentiality.
5. All CCG constitutions and plans to include a requirement to collect evidence of community development in their area. All Foundation Trusts to demonstrate in their Annual Quality Report to the Community how the evidence collected by CCGs has been used to enhance services delivered by the Foundation Trust.
6. The continuing assurance process for CCGs to highlight needs and assets-based work.
7. The CCG Quality Premium to reward evidence of needs and assets-based approaches.
8. Health Education England and LETBs should ensure workforce capacity and capability in community development.

9. Public Health England should highlight assets-based approaches and community development in its guidance and develop a community development work programme.
10. Public Health England should support local authorities and other public health bodies to commission and deliver evidence based community development.
11. Local Area Teams should promote community development in their constituent CCGs.
12. Needs and assets-based working should be incorporated into work on integration. We have seen how communities stimulate cross-sector working.

WE CALL ON HEALTH AND OTHER AGENCIES TO:

1. Inspire residents to become key players in developing their own health and well-being.
2. Be prepared to listen, respond and begin to work in new ways. This can be turbulent but is highly productive both for communities and the agencies who serve them.
3. Harness the interventions that have the best evidence and are most reproducible. These include community development, community building or community transformation. Community development can be mainstreamed to a much wider group of agencies than ever before. Initiatives often coalesce into resident-led partnerships.
4. Develop, through community building, community-led neighbourhood partnerships of residents and service providers. These can:
 - a. play a key role in improving health and wellbeing in local communities,
 - b. reduce silo thinking,
 - c. improve services and make them more accountable to local people.
 - d. bring the whole system, of residents, services and elected representatives, to bear on complex issues and problems;
 - e. encourage a greater level of accountability between residents and services.
5. Recognise that active communities need expert support. Community development workers could play a key coordinating/senior practitioner role in supporting other public sector staff to work as effective partners alongside communities.
6. Consider making the following commitments:
 - a. People are keen to take more responsibility for the quality of their own lives – we undertake to promote people’s ability to do so.
 - b. People are keen to be of service to others in their community – we undertake to find ways to enable people to do so.
 - c. People are keen to learn to manage their own health and wellbeing – we undertake to facilitate this learning and work with people to support self care.
 - d. People are keen to make friends and extend the range of their community – we undertake to promote public events where people can meet each other.

Produced by the Community Development Group under the auspices of the NHS Alliance.

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