# Locality Community Health Development/Improvement Contracts

## Executive Summary

### Background Information

Evidence suggests that local government and the NHS have important roles in building confident and connected communities and the assets within communities, such as the skills and knowledge, social networks and community organisations are building blocks for good health (South 2015).

Community centred approaches to health are not just community based, they are about mobilising assets within communities, promoting equity and increasing people's control over their health and lives. Building community capacity to take action on health and the social determinants of health, developing volunteer and peer roles and connecting people to community resources is important (South 2015).

The current Locality Community Health Development/Improvement Contracts are delivered across Leeds by 11 Third sector organisations under14 separate contracts, on an area basis under the principle that local organisations understand their local area and its people best. The contracts are historical, originating from the five PCTs, then being placed within the Staying Healthy commissioning arm of the NHS Leeds with a focus on referrals to the Healthy Living Services. Recently, post transfer to Leeds City Council in 2013, a co-production approach has led to a more person centred and holistic service that is more responsive to community needs.

The review has provided an opportunity to assess what is and what is not working across the city, identify gaps and inform the design of an inclusive, holistic service, that is in step with current user needs and the wider health activity in localities, but flexible enough to adapt to change and provide value for money.

The overarching aim of the service is to help deliver the vision of the Leeds Joint Health and Wellbeing Strategy (2013-15) so that: **Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest**, with a particular focus on outcome one (People will live longer and healthier lives) and outcome five (people will live in healthier and sustainable communities).

The health landscape has changed considerably over the last three years, with the abolition of PCT's, the transfer of public health to Leeds City Council and the formation of Clinical Commissioning Groups. Most recently, shrinking public sector funding is impacting on public health budgets and activity, making it imperative that services are well aligned, to minimise gaps in service, maximise user satisfaction and ultimately improve health outcomes and reduce inequalities in health.

### Main Issues

The key issues identified during the review are:

**Focus on what is important to individuals and communities -** To support a future model that focuses primarily on the drive to tackle the wider determinants of health. This includes poor, or insecure housing, welfare reforms, financial exclusion, worklessness, poor mental health, cultural differences and language needs. All of which need to be tackled, before the health of many of those living in deprived communities, BAME groups or communities of interest, can improve substantially.

**Improving lifestyle** is still recognised as an important outcome from this service, as the evidence connecting physical inactivity, poor diet, obesity, alcohol use and smoking tobacco

and other substances to a host of serious health conditions, poor quality of life and poor outcomes is strong. A systematic review by O'Mara-Eves et al (2013) suggests that there is some evidence that community development approaches that improve social inequalities, also improve health behaviours and by extension inequalities in health. Feedback and evidence from the review suggests that physical activity, stress reduction and cooking groups etc are valuable engagement tools, can further enhance physical and mental health and provide key skills for the future.

**Geographical communities -** There is still a health gap between individuals living in the most deprived neighbourhoods of Leeds and the rest of Leeds. There is some variation on the precise health needs of sub population groups within deprived neighbourhoods, but all have health indicators that are much worse than the rest of Leeds. It is therefore imperative that the efforts of the new Locality Community Health Improvement and Development Service remains focused on improving the health of those who are living in the most deprived 5th of neighbourhoods in Leeds.

**Newly emerging communities -** Current providers and stakeholders have reported a recent acceleration of un- met need in newly arrived migrant and Eastern European populations, which is challenging the current model. Issues include cultural differences, diversity of languages spoken, costs of translation services, insufficient English courses being run and the level of competency after courses is often too low to ensure integration and a level of health literacy that can support lifestyle change and appropriate use of services.

The new populations are settling throughout Leeds, sometimes in neighbourhoods in the most deprived 5th of Leeds, but often elsewhere, if housing is available. Many are still disadvantaged because of discrimination and prejudice, existing health conditions or traumatic experience, but are not covered by activity in neighbourhoods in the most deprived 5th of Leeds. Therefore this should be considered in the context of whether other contracts cover their needs.

**Communities of interest -** There are gaps in population groups who have particular health needs, but are not evidenced as accessing the service as much as expected. These include LGBT groups, disabled individuals, carers and those with learning difficulties. Further work to ascertain reasons for this need to be carried out. Citizen questionnaires have revealed potential cultural issues regarding perceptions of the ability of disabled people to participate and there may be other hidden barriers around acceptance of people who are non-heterosexual in some communities that increase barriers to access.

**Impact of current policies -** The current providers report that many more users are turning to them in crisis, as a result of Welfare Reforms. Sanctions, lack of money for food, issues with refugee and asylum processes and mental health issues exacerbated by language difficulties are common. Strengthening links and referral processes with relevant LCC directorates, community learning, CCGs, Job Centre Plus and English language skills providers would help to add and receive value from other contracts and activities that are operating in local areas.

**Key issues for the future service specification are:**

- **A need for more consistency -** Whilst many agencies delivering the current service are highly skilled in identifying client's needs and working with others to provide a holistic approach to health and wellbeing, there is a case for increasing consistency of practice, particularly around monitoring and tracking across the whole service.

- **Links to other work -** The service should dovetail with other work and funding streams that are being developed by other commissioners in local areas e.g. CCGs. LCC and other public health initiatives such as the 'Health Breakthrough' and

Integrated Healthy Living Service. In a constantly changing health landscape and variation in practice within each 'area,' future proofing and a service model that gives each area flexibility, to direct resources to its own priority neighbourhoods is important.

- **Quality standards -** If providers deliver courses in key public health areas e.g. healthy eating, and Cook4Life, quality and consistency of message should be assured, by accessing the public health training programme. Similarly, staff training to improve the quality of equality and diversity data collection and monitoring, needs to be included in the service specification.

- **Local knowledge and connections -** There is a continuing need to build trust and self-reliance, to make communities stronger, resilient and more sustainable. This was recognised by stakeholders, users and the literature. This can be done by ensuring delivery partners maintain a local community presence, know the community well and have a historical memory, built up over many years.

**Resources and Value for Money**

**National Institute for Health and Care Excellence (NICE)** guidance endorses community engagement as a strategy for health improvement. Whilst cost effectiveness evidence is still limited, research suggests that community capacity building and volunteering, brings a positive return on investment (South 2015).

**The Kings Fund Report on Inequalities in Life Expectancy (2015)** highlights the overall importance of 'Place' above all over indicators. It also gives an estimation for percentage of contribution for wider determinants of every 10% difference between areas for every month of life expectancy (employment - 11.8%; housing deprivation - 2.2%; and income deprivation among older people - 6.1%) and some lifestyle factors (binge drinking - 4%; fruit and vegetable consumption + 6.9%).

**The monetary value of volunteering**, which is a key facet of the current Locality Community Health Development/Improvement Contracts and will be further encouraged in future is calculated to be £13,500 per person per year (Cabinet Office 2011).

**There is high 'social value' return** on this work including the wellbeing of individuals and communities, social capital and the environment. Public bodies are required to consider how they might improve the economic, social and environmental well-being of the area at the pre-procurement stage of public service commissioning.

**Several of the current providers have submitted details of match funding**, which has been secured over and above the public health commissioned activity, but generated as a result of public health initial investment .This provides a multiplier effect in local communities. Examples are £77,685 generated from an initial £60,000 over the year, £36,000 generated from an initial £80,000, whilst a third has secured £15,900 over the last two quarters, as a result of £80,000 activity funding. These three organisations, with another commissioned organisation in a consortia, also secured £70,000 funding to employ a men's health worker (a gap identified by this review).

**The review suggests that most current providers are providing a quality service** for users, within the funding they have available, but there is some variation in terms of cost per service user. Considerations within the service specification will improve consistency to ensure that in future, the whole service operates at optimum levels of cost effectiveness, without loss of quality.

**The review has examined how current resource is allocated** across the three areas and found historic inequity across the patch. Current costs per head of deprived population has shown stark differences in funding between the three areas, translating into £4.05 being allocated in East North East, £4.47 per head in South & East and £8.38 per head in West and North West**.**

**Recommendations**

- The review supports a service model, which provides flexibility for each of the 3 Leeds city council areas to focus on meeting the needs of the poorest (i.e. those living in the most deprived 5th of Leeds) geographical communities and the communities of interest within it. However, note needs to be taken in relation to the inequitable present allocation for each wedge.

- There are deprived neighbourhoods, with high levels of poor health and substantial health improvement need in all three areas of Leeds. The future service will need to provide a tailored approach, as well as being able to address issues that are common to all of Leeds deprived.

- The review supports continued activity, predominantly around tackling the wider determinants, but with flexibility to provide lifestyle support/activities according to user's and community needs.

- It is crucial that the service is flexible enough to work at the users/communities pace, is relevant to the user's position in the stages of change cycle and also local needs and able to provide further on-going support if necessary.

- Require providers to engage with community leaders and target communities, using a community development approach and methods such as appreciative enquiry to determine what methods will 'work' for particular communities e.g. BAME/ newly emerging communities and their environments.

- Require providers to demonstrate how they will target and engage different sub populations of their local community. For them to have a credible plan for outreach and partnership activity with other local organisations such as churches, mosques, temples, Volition, Leeds Forward, Carers Leeds etc.

- Consider how the model could be expanded to enable all parts of the service to access specialist BAME support, including language support, potentially linking to volunteer development programmes or each provider (if multiple providers) having specialist skills in community language, which can be shared across areas.