



# Building healthy communities:

A community empowerment approach

By Rachel Gregson with Liz Court

**John laing**  
making infrastructure happen

**df** community  
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# Foreword

Health affects us all, so healthcare should involve us all. Health service providers have a duty to empower people to become more involved in their own healthcare, and in how services are delivered. As expressed in the Local Government and Public Involvement in Health Act (2007), the NHS Constitution, and the duty to involve, policymakers are clear: empowerment is now part of the health sector's responsibilities.

This duty also presents a great opportunity. By involving patients and the public in your work and decisions, healthcare becomes more responsive to local needs, and people are empowered to take greater responsibility for their health. Some health organisations have already embraced the community empowerment approach, while others still struggle with the idea. The Community Development Foundation (CDF) has produced this guide to help decode empowerment for health professionals – what it is, how it works, and how you can benefit from it.

Empowerment offers an opportunity to increase both the responsiveness and the efficiency of health services. In the current economic climate, service providers cannot afford to put money into unused and underused services. Empowering and involving patients and the public can prevent this from happening. It's also in

line with the increasing focus on personalised budgets, and therefore services, since it ensures services develop to meet local and individual needs.

Community empowerment also gives us an opportunity to improve people's physical and mental health. Many of the case studies presented here show how communities can get involved in preventing ill health, such as training young people to give advice on sexual health to their peers, or launching a health champions programme to raise awareness of lifestyle-related illness. Getting involved in decision-making and delivery of services also means building social capital – the strength of networks and relationships between people – which in turn improves their sense of wellbeing. A community empowerment approach makes healthcare services more responsive now, and will also improve people's health in the future.

We at CDF are grateful to Laing's for their generous support, which has made this publication possible. We are also grateful to many in the community development and health sectors for their contributions and support over the course of this project. We hope the ideas in this guide offer inspiration in return.

**Alison Seabrooke**

*Chief Executive*

*Community Development Foundation*

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# Community Development Foundation (CDF)

We are the leaders in community development strategy and delivery. We manage programmes that fund projects in our communities, carry out research into what works, and use that to improve policy and practice. As a charity and a public body, we have a unique partnership with both government and those making change on the ground. We strengthen local voices, help shape communities and change lives.

Our work includes:

- advising government and other bodies on community involvement, civil renewal and community cohesion, and measures to build strong, active communities and promote community development
- supporting community work of all kinds through networks, links with practitioners, collaborative work with partner organisations, funding and management of local projects, and
- carrying out research, evaluation and policy analysis to identify good practice in all aspects of community development and involvement, and promoting good practice through training, conferences, publications and consultancy.

CDF has worked with communities for over 40 years. Whatever your interest in community development, we offer services to help you achieve your aims, and make the most of your resources. Contact us to find out more:

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# Introduction

## Who is this guide for?

This guide is for everyone who works with the public in the health sector, especially:

- commissioners of services
- community engagement and patient involvement leads
- managers of patient advice and liaison services (PALS)
- communications teams
- outreach and community-based staff, and
- voluntary sector managers.

## What is this guide about?

This guide shows how community empowerment can help to achieve healthier neighbourhoods. Involving local people in making decisions about health provision and encouraging them to participate in health-promoting activities increases their sense of wellbeing. Empowerment work can also improve the take-up of services. Taking a fresh approach to patient involvement and investing in empowerment

work with the public will lead to:

- improvements in people's health
- more efficient use of resources, and
- finding new ways to deliver services.

Community empowerment is a vitally important part of tackling health inequalities and improving understanding of health matters. This can help ensure that people from disadvantaged or vulnerable groups have better access to services, and that these services can be tailored to their circumstances and needs.

The Local Government and Public Involvement in Health Act (2007) requires public bodies, including health trusts and hospital foundations, to work with their local communities in ways that give them a greater say over decisions.

In particular, the duty to involve came into effect in April 2009, and this changed how you should commission, develop and provide health services. The duty moves beyond the idea of consulting people and asks you to 'empower' local communities so that they can work with you to shape the future of health provision in their area. The duty expects all NHS organisations to find or create opportunities for people to participate actively in decisions that affect the design, delivery and quality of local health services. There is a growing body of evidence that empowerment is essential to building healthy communities.

Core standard C17 of the Healthcare Commission's assessment framework states that 'the views of

patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services’.

The NHS Constitution includes the rights of patients to be involved in decisions about their care and the provision of health services for their community (NHS, 2009). *Taking the lead – Engaging people and communities* (Department of Health, 2008, p. 3) explains that ‘Our challenge now is to make the engagement and empowerment of people and communities mainstream in the commissioning of services. To be world class commissioners we need to know the needs and preferences of our local communities, work with our partners on the health and wellbeing agenda and work with local people to tackle health inequalities’. This involves listening, understanding and responding to communities. Local involvement networks (LINKs), or the local HealthWatch, as they will become (see p. 16), are central to making this work in practice.

Empowerment should therefore be regarded as mainstream work: it is everyone’s business, from the chief executive to the receptionist, and it will be most effective if all health service staff share a common commitment to actively engaging community members and respecting their views and experience.

The terms ‘empowerment’ and ‘engagement’ are often used interchangeably, but they do not mean the same thing. In *An action plan for community empowerment: Building on success* (Communities and Local Government, CLG, 2007, p. 12), the government defined them as follows:

**Engagement:** ‘the process whereby public bodies reach out to communities to create empowerment opportunities’.

**Empowerment:** ‘the giving of confidence, skills, and power to communities to shape and influence what public bodies do for or with them’.

The next chapter explores this distinction in more detail but for now, it is helpful to recognise that your organisation can change the way it consults or reaches out to communities and can also support capacity-building that enables communities to become more informed and more influential. Empowerment requires change: changing relationships, changing attitudes and changing expectations. This guide will help you to move beyond what you are already doing to engage with communities. It will help you to develop an approach that is more about partnership and participation.

Many of you will already be accustomed to working with public or community ‘lay’ representatives on trust boards and in LINks. You may be directly involved with various voluntary and community organisations in health promotion projects or area forums. There is increasing interest among policy-makers and practitioners in the concept of ‘co-production’, which means patients and professionals sharing responsibility for health outcomes.

In the UK, many self-help groups are organised around different health needs and conditions, many operating at a very local level, while others have grown into



major national organisations. All are based on mutual support, with some also doing advocacy work. Together these groups, forums and organisations make up the voluntary health sector, and provide a valuable source of experience and innovation.

By working in partnership with different bodies from this sector, on both specific projects and general inter-professional work, statutory agencies have much to gain. The ‘expert patient’ is an example of this approach, where the individual is encouraged to manage their condition with active support and treatment from relevant health professionals. This cross-sectoral approach appears to be very effective in reducing harm and preventing accidents, for example in cutting the number of falls among elderly people living at home. As the empowerment ladder in the next chapter shows, cooperation between statutory services and organisations run by communities is a form of empowerment that has multiple benefits.

This guide is mainly concerned with ways of working with groups of people rather than individuals. It builds on experience and evidence from health provision, alongside a range of other service areas. The National Empowerment Partnership (NEP) accumulated a vast number of case studies from around the English regions and a summary of these, extracting the key lessons for practice, is available from the CDF website (Neumark, 2009). The National Institute for Health and Clinical Excellence (NICE) produced a report in 2008, reviewing the available evidence on community engagement and setting out

a series of recommendations on what works in practice (NICE, 2008). In 2009, the Healthcare Commission also published guidance entitled *Listening, learning, working together*, which you may find useful.

Using best-practice case studies, this guide shows how empowerment can make a difference to local communities by enabling them to play a full part in planning and delivering a world class health service that takes into account local needs and priorities. We recognise there are many barriers to implementing community empowerment strategies, including the lack of capacity in health institutions and communities. We will therefore also share some of the pitfalls and provide tips on how to improve your knowledge and skills to overcome the challenges.

It is well known that the more opportunities people have to make a difference in their local community, the better they feel about the services and agencies that provide those services. Their positive feedback reflects greater customer satisfaction and leads to better staff performance. Finally, studies of cost-effectiveness indicate that investment in the skills and resources needed for good community engagement offers excellent value for money, leading to efficiency savings and less waste (Burton et al., 2004). In times of recession, this can be a persuasive argument to use with health funders and commissioners. That's why empowerment is good for the health sector and good for the communities you serve.

## What is in this guide?

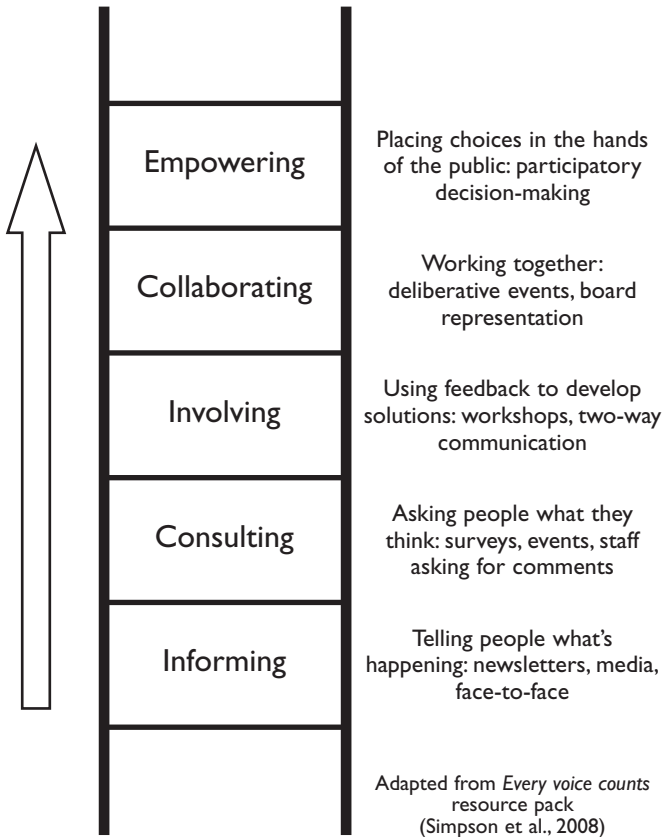
- **Chapter 1** explains what empowerment is and how it works in practice.
- **Chapter 2** shows why empowerment is important in the health context and how it fits in with legal requirements, world class commissioning and NHS strategy.
- **Chapter 3** sets out the four key principles for making empowerment work: community development, leadership, partnership working and capacity-building.
- **Chapter 4** considers some common challenges you may encounter in empowerment work, and how to overcome them. It includes a number of guides and toolkits you may find useful.
- **Chapter 5** presents case studies that demonstrate the difference an empowerment approach has made to the levels of health and well-being in various communities.
- **Chapter 6** asks ‘where next?’ and suggests how you can continue to learn about empowerment and community development.

# What is empowerment?

**This chapter explores what empowerment is, and how it works in practice.**

As mentioned earlier, the terms engagement, consultation, involvement, participation and empowerment are often used interchangeably. There is some overlap between these terms, but in the context of strategies for increasing community influence they represent differing degrees of power. The ‘empowerment ladder’ opposite is a simple representation of the main steps and activities involved in working towards full community empowerment.

However, the Communities in Control: Real People, Real Power white paper (CLG, 2008, p. 2) defined empowerment as ‘passing more and more political power to more and more people, through every practical means’. Within health settings, empowerment is about increasing people’s capacity and willingness to influence decisions that affect the quality and delivery of services provided by government and others. For communities to have a real and lasting influence on decision-making, some capacity-building has to happen – within the communities and also in the agencies seeking to engage them. This may involve learning new skills and knowledge, and it will certainly



require changes in organisational culture and liaison procedures.

Empowerment goes beyond the traditional methods of information sharing and consultation such as public meetings, getting people to fill in questionnaires, tick lists or give feedback on services received. As the

ladder diagram shows, empowerment involves a change in power relations, enabling people to have more control and responsibility for their own health, for example at the personal level through individual care budgets, which can encourage them to be more active in the community. Health promotion strategies, especially when initiated by the community, are another form of empowerment and often result in projects or networks whose benefits last far longer than the original intervention.

This guide focuses mainly on how the combined processes of engagement and empowerment help people actively participate in shaping services for the benefit of the wider community through improved service planning and delivery. It is concerned with how communities can be involved in both strategic and operational decision-making – both planning and running services: stating preferences, determining priorities, shaping provision and evaluating practice.

CLG has developed a useful diagnostic tool, called the CLEAR model (Lowndes and Pratchett, 2008). It is based on experience in several contrasting places in England and identifies the most common obstacles to empowerment, while suggesting ways to overcome them. CLEAR is an acronym which highlights five factors that make participation more effective in empowering communities (see opposite).

The CLEAR model:

**C an do** – people have the resources and knowledge to participate

**L ike to** – they have a sense of ownership that strengthens participation

**E nabled to** – they have opportunities to participate

**A sked to** – they are mobilised through public agencies and local organisations

**R esponded to** – they see evidence that their views have been considered

In the following chapters, especially in the case studies, this guide considers how these factors are reflected in the methods described.

# How will empowerment benefit you in your work?

**This chapter looks at why empowerment is important to the health sector: how it can improve health outcomes, how it works in law, and how it connects to world class commissioning.**

In recent years, government has applied major changes in policy designed to secure a different kind of relationship between health professionals, patients and members of the public. This framework for empowerment aimed to increase levels of mutual respect and responsibility, with the overall goal of enhancing health and wellbeing across the whole of society. The legal duties and performance management criteria urge health institutions and agencies to relate more effectively to communities. The benefits of participation for the public are evident in better health and improved services. ‘Non-professionals’ are encouraged to work out what being healthy means to them and they are then supported in developing a way to achieve this standard in their own health, rather than having one imposed on them. This guide sets out how empowerment practice builds healthy communities and outlines the key principles that underpin this approach.



## Empowerment: benefits and health outcomes

The Healthcare Commission's study, *Listening, learning, working together* (2009), shows evidence that where people are genuinely involved in developing their own and their community's health services, three things happen. First, local services become more responsive to local conditions. Second, health needs are met with fewer repeat visits to healthcare providers. Third, there is improved access to services and increased accountability and satisfaction. The report also revealed that NHS agencies had a long way to go to achieve effective empowerment.

When people participate in community and volunteering activities, such as self-help groups, time-banking schemes or as health champions, their reported health improves and they become more aware of how they can take responsibility for maintaining it themselves. This may be particularly significant for people from disadvantaged communities facing greater levels of risk from smoking, alcohol misuse, accidents and poor diet.

Tackling the causes of persistent health inequalities can help lessen reliance on frontline services and improve life ambitions. Community members are often well aware of the underlying causes of poor health because they understand the conditions that create or perpetuate illness. By helping communities to investigate and articulate these, healthcare providers can devise remedies that suit local circumstances and tackle the real issues in people's lives.

Helping to design and deliver local projects and services can help build confidence, ownership and a sense of community. Taking part in community groups and activities is a key part of increasing personal wellbeing. It also builds ‘social capital’ – the networks and norms that support cooperation and trust, holding communities together and providing a certain level of mutual care. A growing body of evidence suggests that individuals supported by high levels of social capital tend to recover more quickly and are more resilient to disease (Halpern, 2005). There are parallel findings relating to mental health (McKenzie and Harpham, 2006).

### **Empowerment: the legal and policy context**

Lord Darzi’s 2008 report *High quality care for all* says that high quality care for patients and the public should be achieved by ‘giving patients more rights and control for their own personal care’. People can be encouraged to take more responsibility for their own health – working with their doctor to find the most appropriate and effective healthcare solutions for their situation.

The 2007 Local Government and Public Involvement in Health Act places a duty to involve on NHS bodies, requiring them to consult and involve members of the public and patients when planning services. The guide *Duty to involve: Making it work* (Pitchford et al., 2009) is a practical guide to what is involved.

## Empowerment: public liaison and accountability

Over the years, there have been several systems for involving the public in the management of health services, including the old community health councils, the patient and public involvement forums (PPIs) and more recently the PALS. PALS exist to make sure patients' and community concerns reach the right people so that problems or complaints can be resolved.

In 2008, the system of LINKs was established as a means of involving the public in health and social care decision-making.<sup>1</sup> Unlike PALS, LINKs are independent bodies set up to ensure that NHS agencies are listening to communities' concerns and are accountable for services. LINKs are managed via local authorities, who contract an organisation to act as the LINK's host. It is up to the host organisation to support and facilitate the activities of the LINK, such as recruiting LINK members, engaging with communities and understanding how health and social care can best meet local needs. The LINK directs the work of the host in relation to health and social care issues.

LINKs, or the local HealthWatch, as they will become, can play a major role in empowerment strategies. By providing an independent voice for local communities and organisations, they offer service commissioners

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1 See *Make it happen! Engaging and responding to communities: A brief guide to local involvement networks* (Department of Health/NHS Alliance, 2010)

and provides a robust and representative foundation for consultation and service development.

According to the Department of Health's website, LINKs can:

- request that health and social care commissioners provide information about their services and ensure they send it
- issue reports or make recommendations about a service and ensure they receive a response from commissioners
- refer matters to the local council's overview and scrutiny committee
- enter the premises of certain services and view the care provided.

Currently, LINKs have a great deal of potential influence over how services are delivered. Depending on how different LINKs exercise their responsibilities, they could be operating in the lower to middle range of the empowerment ladder, by providing feedback and systematically asking for communities' views.

However, LINKs are changing. The white paper, *Equity and Excellence: Liberating the NHS* (July 2010), announced the creation of HealthWatch England, a new independent consumer champion within the Care Quality Commission. The white paper states that LINKs will become the local Healthwatch, creating a strong local infrastructure. 'At a local level local HealthWatch organisations will ensure that the views and feedback from patients and carers are an

integral part of local commissioning across health and social care.’ Although detail is yet to be confirmed it sounds as if the local HealthWatch will incorporate most of the attributes of LINKs that made them a good vehicle for involving communities in healthcare decision-making and strategy.

### **Empowerment: essential for world class commissioning**

World class commissioning requires primary care trusts (PCTs), as local leaders of the NHS, to ‘engage with the public, and actively seek the views of patients, carers and the wider community’, building a relationship with the public that is ‘inclusive and enduring’. They should also work with community and statutory partners: local government, healthcare providers and voluntary organisations, to create the best possible services.

The world class commissioning documents do not refer to community empowerment by name, but it lies at the heart of their ideas: only a truly empowered community can have a strong and positive impact on planning and improving services. For more on world class commissioning, see *World class commissioning: Competencies* (Department of Health, 2007).

## Making empowerment work

**This chapter describes four principles that underlie community empowerment in the health sector: adopting a community development approach; providing committed leadership; partnership working; and capacity-building. Below we suggest things you can do to encourage your organisation to empower the communities it serves.**

### **I. Community development methods and values**

Community development enables local people to play more active roles in decision-making and collective organising. It recognises the complexities and diversity of community life and aims to harness local energy and enterprise to solve local problems for the common good. This community-oriented approach offers health professionals a powerful way to engage people in improving the health and wellbeing of their communities.

Community development is a recognised occupation with a set of values, principles and practices. Adopting a community development approach to empowerment will go a long way to ensuring that

individuals and communities develop the capacity and confidence to become partners and co-producers with health professionals in building and maintaining healthy communities.

*The community development challenge* report (CLG, 2006, p. 17) sets out the distinctive contribution of community development practice as:

- 1 helping people see that they have common concerns and could benefit from working together
- 2 helping people to work together on these issues, often forming an independent group
- 3 supporting and developing groups within an ethical framework, so increasing networking
- 4 promoting values of equity, inclusiveness, participation and cooperation
- 5 empowering people and their organisations to influence public services, and
- 6 advising and informing public authorities on community perspectives, so assisting them to strengthen and work in genuine partnership with communities.

People working with communities may use one or more components in their work, depending on their role and circumstances, but all six components must be pursued if people are to be truly empowered to influence and transform the services they receive and the conditions they live in.

When these six components are combined they reinforce each other to deliver the main values of community development as defined by the ‘national occupational standards’ (Federation for Community Development Learning, 2009), namely: justice, equality, collective action, empowerment and shared learning. A key aim of community development is to ensure that the many voices in a community, however small, are recognised, heard and taken into account. The community development components and principles make a useful check-list for health professionals to plan and evaluate their work with local communities. In particular, they should ask how greater community involvement affects decision-making and the quality of service provision.

## **2. Leadership and management**

Clearly, new ways of working are more likely to succeed if there is management support. For community empowerment it is essential. As our case studies in chapter 5 show, empowerment programmes do not necessarily require large sums of money. What is needed is a commitment at executive and management levels to community empowerment, and belief that it will produce better services and community relationships and will also be cost effective in the long term.

## **3. Building partnerships**

Working in partnership with colleagues and stakeholders has become an expected way of delivering services. However, it is sometimes difficult



and time consuming – you may well have come across partnerships that have not always been as productive or friendly as they might be.

The greatest challenges often arise from making partnerships work across the different sectors and professional disciplines, particularly with organisations that have not worked with statutory bodies before. LINKs, or the local HealthWatch, as they will become, can sometimes be valuable catalysts in encouraging connections between such organisations.

Good practice in building the partnership is critical in ensuring that community members can be fully engaged in the decision-making processes. Good partnerships require clarity of purpose and shared goals. Through cooperating to address health inequalities and through shared learning, you will establish the relationships needed to achieve sustainable, just and local outcomes. Empowerment will only result where people have been engaged effectively so that they build up trust and confidence in the partnership and health professionals.

Where several organisations are involved in a project, all with different backgrounds, needs and aims, it can be difficult to keep everyone moving in the same direction. Local authorities and the NHS are vulnerable to changing directives from above, while smaller community and voluntary organisations can be affected by funding difficulties, changes in personnel or internal tensions. Some of these problems are inevitable, but you can minimise the potential impact on your community

empowerment work by negotiating shared goals from the start. This means enabling all the groups involved to express their needs, and finding ways of accommodating the range of perspectives in a community.

It is important to acknowledge that there will be conflicts of interest and differences of opinion – tensions cannot always be avoided but are best brought into the open through dialogue and exploring the basis for disagreement. This can take time and skilled facilitation, but can lead to better relationships and mutual respect in the long run.

In the health sector and in the context of reduced public spending, it is essential to identify priorities. The basis of an effective partnership is for partners to understand competing demands and to involve communities by explaining constraints, managing expectations and working out acceptable compromises in how services are delivered. Conflict resolution and mediation skills will become increasingly useful for all concerned, including health professionals. Feedback and explanations will ensure that communities continue to have confidence in the empowerment strategy, even where their concerns may not have been directly addressed.

## **4. Building the capacity of partners**

Genuinely empowered communities need to be able to work with health professionals and to take part in making decisions that affect their health services. Increasing personal and collective capacity within

institutions and communities is an important part of empowerment that aims to involve local people as partners in improving local health and wellbeing. Peer educators, health champions or governors of a trust can reach into local communities and build interest and trust in working with health professionals. Effective capacity-building, based on community development principles, leads to greater long-term impact and more inclusive participation.

Capacity-building for effective partnership is key to ensuring that community members can participate in settings where there can be an imbalance of power and information. The ‘national standards for community engagement’, developed by the Scottish Community Development Centre (SCDC), offer a useful framework for engaging community members as partners. The standards also provide indicators for measuring effective engagement and process. (For more information, see ‘useful resources and guidelines’ at the end of chapter 4.)

Capacity-building takes many forms but generally involves people learning together to develop the skills, knowledge and confidence they need to:

- understand the context and options for decision-making
- discuss implications, and
- evaluate different points of view.

Joint training with community members, voluntary sector professionals and health service staff is a good way for people to get to know one another and to

understand the various perspectives that will inform the partnership's work. It is important to discover what people want from training and how it can best be delivered to suit their needs and cultural preferences. Think about using one-to-one conversations to do this and to identify any specific barriers that may prevent or discourage people from learning. Try not to make assumptions about what people can do (for example in your choice of ice-breakers or group exercises) and leave plenty of time for participants to share their own ideas and experiences, as this will build trust and understanding.

The sessions should be engaging and relevant, pitched at the right level so that nobody gets left behind or confused by too much jargon. Provide ongoing support to build long-term commitment, and arrange regular meetings for partners to keep abreast of developments and get feedback on how decisions are being implemented (or not). Make sure that all information given out, particularly about health concerns, is accurate and backed up with evidence. Where appropriate, the information should be NHS approved, but bear in mind that it might be challenged and provoke debate. Any discussion should ensure that alternative traditions and different approaches to health issues get a hearing.

The next chapter examines difficulties you may face when starting to develop an empowerment strategy or to empower the community members you work with, and we suggest some useful resources.

In chapter 5, we go on to show how these empowerment principles and processes have been used in actual projects, and how they have helped empower communities to improve and manage health at the local level.

We conclude in chapter 6 by discussing next steps and listing some useful websites that you can use in your work.

# Empowering people: overcoming the challenges

**This chapter describes some of the common reactions that health professionals and others may express in response to the idea of empowerment. We have suggested things you can do to help your colleagues adopt an empowerment approach, with signposting to useful publications and toolkits.**

Empowering communities brings considerable benefits. But with limited resources and competing priorities, a key challenge will be to persuade busy and sceptical colleagues and their communities that they should get involved in community empowerment work.

The following scenarios illustrate a few of the day-to-day challenges you may face when developing or applying empowerment strategies and activities in your own organisation. It's not surprising that people are wary of projects that seem new or difficult, but the more you understand the benefits of using an empowerment approach in your work and commit to it, the more you will be able to get others on your side.

Encouraging staff members and others to use an empowerment approach offers an opportunity to put into practice the empowerment principles. An important starting point is to find out what stage


other people have reached in their understanding of empowerment. This means making opportunities to share experiences, reflect on what has been good (and not so good) and identify ways of working together to make progress.

## Supporting and working with staff members ...

NHS and local authority staff cannot be expected to

become experts on

empowerment overnight. Empowerment work should be planned and co-ordinated by people who have experience and knowledge of working directly with communities, for example community development workers or health visitors. However, everyone working in the health sector needs to acknowledge that they have a role and to align their work accordingly. This may take some adjustment in attitudes and professional style, but you can do much to support your colleagues.



**Empowering communities?  
That's not my job and it's  
not in my job description.**

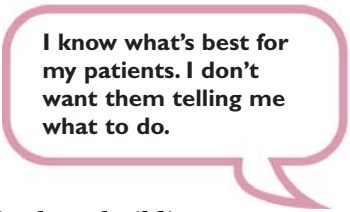
### *Suggested first steps*

- Find out whether other staff already know about the duty to involve and are aware of its implications.
- Talk to them about how they may have worked with communities in the past, including any engagement work.

- Contact colleagues in other health trusts to find out what they are doing and maybe set up a practitioners' network for people to co-ordinate and share their activities.
- Prepare a briefing paper for your line manager, outlining why your health trust should adopt a community empowerment strategy.

## Supporting and working with doctors ...

Empowering people isn't about encouraging patients to tell doctors what they want or what to do or demanding unsuitable treatments. It is about building patients' health literacy with knowledge and skills about different conditions and treatments, so they can communicate better with their doctor and learn how they might take more responsibility for their own health.



**I know what's best for my patients. I don't want them telling me what to do.**

Doctors have a key role in supporting empowerment work in local communities.

Working with their patients, particularly people with long-term conditions, is the best way to get results that really work and to reduce the need for further treatment. The NHS expert patients programme (Donaldson et al., 2001) shows how encouraging people to take control of their own health makes a real difference to their quality of life.



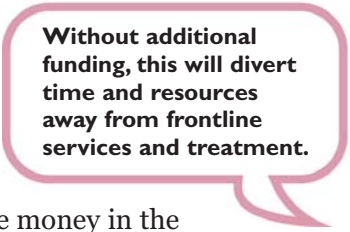
Health trainers and community champions work with individuals to build their confidence when visiting the doctor's surgery. By listening to people's ideas and concerns, health champions can motivate them to change problematic behaviour as well as supplying advice and information which can help them lead healthier lives. It is important to be familiar with the evidence and guidance available from the NHS Direct website and to avoid giving out information that has not been NHS approved.

### *Suggested first steps*

- Call the doctor and have an initial chat to introduce yourself.
- Find out whether the doctor knows about the duty to involve and empowerment.
- Arrange a face-to-face meeting.
- Prepare a short briefing paper about the duty to involve and community empowerment.
- Talk to the doctor to find out what engagement work has been done in the past.
- Explain what your organisation wants to do and the importance of the GP role.
- Find out whether the doctor would like to learn more and how they would prefer to do this.
- Work with community members to run a half-day briefing session for professional staff, which will explore how to improve communication and involvement around health issues in the area.

## Supporting and working with chief executives and senior managers

Involving communities in decision-making will ensure that services are better targeted and more effective. This will not only improve people's health but can reduce inefficiencies, decrease demand on frontline services and save money in the long run. Developing a strong community empowerment strategy is a good investment of time and money.



**Without additional funding, this will divert time and resources away from frontline services and treatment.**

Community empowerment work does not have to involve a huge financial commitment. It should be possible to use pre-existing bodies, such as the LINKs, or the local HealthWatch, as they will become. You can develop small-scale programmes, such as training a cohort of health champions, that have long-lasting effects. Participatory budgeting offers a tried and tested means of empowerment, where local people are involved in making decisions on how a defined public budget should be spent. This requires very little extra money but genuinely empowers communities to set priorities and has immediate results. Rather than creating new structures or investing in costly consultation exercises, empowerment processes work best by going 'with the grain' of what communities are already doing (or wanting to do) and using this knowledge to forge new relationships and opportunities for engagement.

### *Suggested first steps*

- Build the business case for your empowerment strategy, demonstrating ‘value for money’ by showing how specific inputs can result in particular outcomes and efficiency savings.
- Work with the local voluntary and community sector to create a sound evidence base for how empowerment might work and what challenges will be encountered:
  - identify particular local priorities
  - identify groups in danger of being left out of plans
  - find out about levels of service uptake
  - carry out surveys and hold focus groups, which are useful in gathering evidence of local need and patient/customer experience
  - establish benchmarking indicators, and
  - explore evaluation models.
- Arrange a meeting with the senior management team to share these findings and to present the business case.
- Prepare a briefing paper with some proposals on how the organisation can fulfil the duty to involve and address the other policy requirements set out in chapter 2. This should include supporting evidence and practical examples of what has worked elsewhere. The publications by the Department of Health and the Healthcare Commission already mentioned will be helpful in this regard.


- Encourage senior management staff to share what they already know about working with communities and to speak honestly about their reservations.
- Explain what you want to do and how it will help the organisation in meeting its vision and performance management targets.
- Invite them to the community-led seminar you have organised for other staff.

## Supporting and working with community members, including local residents

Communities often complain they are frequently consulted yet seldom hear what has happened as a result of making the effort to share

their views and concerns. Understandably, they become less inclined to attend the public meeting, or complete the survey. Information is sometimes not presented in ways that people can understand or there is too little time to fully discuss all the options and implications of a particular proposal.

Communities are diverse and complex. There will be differing opinions and even some antagonisms, which will need skilful mediation if you are to reach broad agreement about how services should be organised or budgets spent.



**You are always talking to me but nothing ever happens. Why is this different?**

Consultation overload can be a real issue, especially for organisations that represent minority groups. It occurs when many different organisations are consulting about different issues at the same time. It is sometimes referred to as consultation fatigue, when communities run out of energy to respond. It can also be highly confusing for all concerned. Make sure you link up with other agencies in the area who may be seeking community involvement, so you can co-ordinate empowerment work, perhaps through the local strategic partnership or a neighbourhood management board. This will avoid duplication and confusion over how various consultation exercises overlap or contradict one another. Some groups, such as homeless people, have been neglected in the past, making it hard to prove you're serious about working with them. Building up relationships with these communities is likely to take longer, and getting consistent participation can be difficult.

As we saw in chapter 1, empowerment is more than giving information and canvassing views on a limited range of proposals. For communities to believe they really can influence decisions about how their health services are delivered, they need to see results and to know their voices are being heard in debates about priorities and provision. This may involve dialogue, difficult explanations and compromises, but as long as this is based on trust and mutual respect, it will be experienced as genuine empowerment.

Communities come in all shapes and sizes. Different sections of the community operate on different time

scales and have different traditions for coming together. Most communities have rifts and tensions, and are unlikely to speak with one voice or want to be represented by a single leader. You must be flexible in how you work with different groups in the community, taking into account their own knowledge of what works for them – ‘one size fits all’ approaches tend to be ineffective and usually exclude the contributions of the people you most need to engage.

### *Suggested first steps*

- Identify and make contact with active groups in the local community.
- Find out what they are doing and what support they might want.
- Contact your voluntary and community association to find out what is going on locally.<sup>2</sup>
- Be alert to gaps in provision and to community issues, and work with others to encourage the setting up of new groups around health and wellbeing.
- Encourage networking between local groups to share experiences, perhaps by setting up a local forum or supporting a newsletter or website.

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2 NAVCA – the national organisation for local third sector infrastructure bodies ([www.navca.org.uk](http://www.navca.org.uk)) – will be able to give you details of local intermediary and umbrella bodies that would be a good starting point.

- Take positive steps and anti-discriminatory measures to make sure that seldom-heard and under-served groups are involved directly in decision-making forums.
- Use the ‘national standards for community engagement’ (see below) to make sure that arrangements for involving communities in decision-making and service delivery are empowering and inclusive.

### Useful resources and guidelines

- The NICE guidance, *Community engagement to improve health*, published in 2009, includes some helpful ideas about what works in practice.
- The Community Development Foundation’s (CDF’s) website, under the National Empowerment Programme section, has a library of case studies, toolkits and research reports on what works in community empowerment. It has also published guides on how to use community development methods in a variety of policy settings, including health and mental health. The guide on the duty to involve will be particularly useful. See [www.cdf.org.uk](http://www.cdf.org.uk).
- SCDC developed a set of 10 national standards for community engagement, which were published in 2005. Based on thorough consultation with communities and practitioners, these establish best-practice principles for partnership working and can be used to assess

progress and performance against clear criteria. See [www.scdc.org.uk/national-standards-community-engagement/10-national-standards/](http://www.scdc.org.uk/national-standards-community-engagement/10-national-standards/)

- SCDC has adapted its popular LEAP planning and evaluation model for health practitioners working with communities. You can obtain this from <http://leap.scdc.org.uk/leap-framework/planning-evaluation-cycle/>
- The Community Health Exchange publishes material about health and empowerment using examples of projects and organisations in Scotland. See [www.chex.org.uk](http://www.chex.org.uk).
- The Department of Health has published a guide to the pacesetters programme, *A dialogue of equals – The pacesetters programme community engagement guide* (Department of Health, 2008). Pacesetters is a partnership between local communities that face health inequalities, the NHS and the Department of Health. The overall aim of the programme is to deliver equality and diversity improvements and innovations.
- There is a downloadable resource pack on taking strategic action for engaging communities – the SAFEC model – see *Taking strategic action for engaging communities: A self-assessment resource for public sector organisations* (Popay, J. et al., 2005), available from [www.nccce.lancs.ac.uk/safec/docs/resource\\_pack.pdf](http://www.nccce.lancs.ac.uk/safec/docs/resource_pack.pdf)



- The Federation for Community Development Learning (FCDL) has produced 18 resource packs, which cover all aspects of community development work in practice. You can download these from [www.fcdl.org.uk/publications/documents/OCN\\_resource\\_packs/index.htm](http://www.fcdl.org.uk/publications/documents/OCN_resource_packs/index.htm)
- The Kings Fund published a policy paper, *Finding out what works: Building knowledge about complex, community-based initiatives* (Coote, A., Allen, J., Woodhead, D., 2004), which reviews a range of community-based initiatives and explores some of the difficulties in evaluating complex projects in relation to health outcomes. See the publications section of the Kings Fund website at [www.kingsfund.org.uk](http://www.kingsfund.org.uk)

# Empowerment in practice: case studies

**This chapter explains how a range of organisations across the health sector are developing empowerment in different ways. Some of the examples are small scale while others have large budgets. Some are very local and others cover much larger areas. What the staff involved have in common is imagination, commitment, and a desire to make things work.**

For each of the 10 case studies in this chapter, we have indicated where the practice sits on the empowerment ladder (outlined at the beginning of chapter 1), ranging from the top of the ladder through to the lower rungs. You will notice that many of the case studies involve organisations working together. Sometimes they do this as a formal partnership, where there are agreed shared goals and protocols about how resources and responsibilities are allocated. Often the arrangements are looser, where they co-ordinate activities informally through forums or networks.

As you read through the examples, make a note of what skills, strategies and insights the practitioners are using. How does their understanding of local communities inform their approach? What do you think are the key principles underlying the effectiveness of the practice in each case study?

## Case study 1

### Thornhill Plus You:

### Resident involvement in health funding decisions

This is an example of practice that sits at the top of the empowerment ladder.

#### Background

Thornhill is an estate on the eastern edge of Southampton. Thornhill Plus You (TPY), a New Deal for Communities programme, received funding every year from Southampton Primary Care Trust to reduce local health inequalities. In 2007, TPY's Community Health Group decided to get local residents more involved by giving them an active role in decisions about the allocation of grants.

#### The project

The Community Health Group awarded £50,000 of its funding through participatory budgeting, a process of involving local people in deciding which projects received funding to carry out health-related work. This was the first time participatory budgeting had been used to set health spending in the UK.

TPY managed the initiative. Not-for-profit organisations and community groups were invited to apply for funding for projects costing between £1,000 and £10,000 designed to improve the health and wellbeing of Thornhill residents. Posters were put up around the neighbourhood, leaflets sent home

with school pupils, and adverts placed in the local paper and TPY's e-bulletin.

The event, branded 'Your health, your community, your vote', took place in June 2008. Free childcare and transport were provided to enable as many people to attend as possible. Each bidder gave a three-minute presentation and residents had to indicate how much they thought the project would provide community benefit on a scale of one to five. Once the scores had been counted, applicants received funding for their projects in order of popularity until the £50,000 was used up.

### **Achievements**

The Community Health Group was determined to make participatory budgeting work, although it had never been used in similar circumstances before: 21 organisations submitted bids amounting to £134,000, including projects focusing on sexual health, bullying and increasing physical activity, and a local crafts group, and 52 residents attended the event, along with local councillors and an MP.

Feedback from the event was very positive and the Community Health Group decided to use a similar format for the following year.



It was really good and has to be one of the best things I've been involved in.



It is a fantastically fair way to allocate funding. Can't express how impressed I was.



## Big thanks for making my vote count!

### Making it happen

An internal evaluation of the process highlighted a number of improvements for the next year, including supporting more local groups to bid and providing more information to residents about what participatory budgeting involves.

### *What worked in practice?*

- Innovative use of participatory budgets to engage communities and drive change.
- Cooperation with local voluntary and community groups.
- Providing imaginative, relevant and accessible information.
- Tackling issues of access and equalities.
- Diverse projects to improve health and wellbeing.
- The community was fully involved in identifying local priorities.
- Supportive elected representatives.
- An evaluation was carried out to capture and share the learning.
- The participatory approach has built trust and confidence in the Community Health Group.

## Case study 2

### **Pennine Care Trust:**

#### Recruiting and supporting trust governors

This is an example of practice that directly involves community members in deciding how services are delivered and resources allocated. It is at the top of the empowerment ladder.

### **Background**

Pennine Care NHS Foundation Trust provides mental health and specialist services dealing with substance misuse to almost 1.2 million people. Authorised in July 2008, it is the 100th NHS Foundation Trust. Its status gives it new freedoms while requiring it to be directly accountable to local people. As with all trusts, this creates challenges: recruiting an inclusive and representative public membership; encouraging the members to stand for election as governors; and preparing them to fulfil their role.

Pennine Care Trust supports local people and builds their capacity to fulfil these roles, empowering them to take part in deciding health service provision for the whole area.

### **The project**

People will only want to be members and governors of a trust if they see value and purpose in doing so. The trust developed a thoughtful ‘membership offer’ to appeal to all sections of its community, including

service users and carers, and used a variety of approaches to recruitment, making it clear that people could get involved at a range of levels.

Getting people to stand for election as governors on the Members' Council was more of a challenge. To build confidence and capacity, the trust organised a series of roadshows, provided information packs, and offered an advice and guidance helpline number. Roadshows combined information; a personal view from someone already in the role; and advice, reassurance and guidance on the practicalities of completing nomination papers.

All trust members were entitled to vote for governors, either directly or through elections organised by the Electoral Reform Society. Once the governors were elected, the trust undertook a training and support needs analysis for all new council members, finding out about people's past experience and holding several introductory sessions. This was supplemented by an induction programme tailored to individual and group needs, which covered how the NHS works, the challenges and opportunities faced by the trust, and the new governors' roles and responsibilities.

### **Achievements**

The trust has recruited more than 11,000 members to date from across the whole community. Its Members' Council elections have reached beyond the 'usual suspects' of habitual volunteers to recruit many patients and carers as governors.



We are delighted that we now have a very engaged, enthusiastic and confident group of people who are already adding significant value to the way in which we work and in shaping our plans for the future.

**Pennine Care Trust**

### **Making it work**

People across the communities served by the trust were willing to step forward for these roles but needed information, support and encouragement to do so – the roadshows in particular were crucial for this. Having a structured approach to induction and spending time developing relationships with council members has also been essential.

### *What worked in practice?*

- The trust recognised that inclusive and representative public engagement would make them more accountable to local people.
- The trust realised that recruitment must reach beyond the ‘usual suspects’ in the local community.
- Membership is designed to be inclusive, with different access levels and activities.
- Informal drop-in roadshows allowed a wide reach across the community.
- Providing advice, information and guidance in an informal setting encouraged high rates of participation.



- Support needs analysis is used to get to know new council members and make sure they get proper support as representatives.
- Tailored induction and training ensures council members understand their roles and responsibilities.

### Case study 3

#### **Healthwise Hull:**

#### Reducing health inequalities with health champions

The case study described here is about capacity-building, in which community members collaborate with health professionals. It is high up on the empowerment ladder.

#### **Background**

Healthwise Hull is a health champions programme run by the Goodwin Development Trust, an award-winning social enterprise founded in 1994 and serving the Thornton district of Hull. The scheme aims to address Hull's high rate of lifestyle-related illness: it is the 11th most deprived local authority in the UK, with life expectancies well below the national average. Lowering rates of smoking, obesity and alcohol abuse could make a big difference to the health and longevity of local residents.

#### **The project**

The project offers 100 Hull residents a year-long course in 'Introduction to health issues', leading to a

level one qualification with the Open College Network (OCN). Courses are run by the staff of the Goodwin Development Trust over five half-day sessions, and cover smoking, nutrition, exercise and mental well-being. They aim to help individuals make their own choices about health and to give information and advice through local community and social networks.

Once people have completed the course, they receive a health champions certificate, and are offered the chance to progress to OCN level two. Each health champion is asked to pass on their message to at least 10 of their family and friends, meaning the project is expected to reach at least 3,000 people in total.

### **Achievements**

The scheme has attracted a very diverse group of champions – some drawn from existing community groups, while others are recent arrivals to the country. This ensures it reaches a wide range of people, including those who might otherwise find it difficult to access statutory health services. The project has secured three years of lottery funding from Altogether Better, which is a five-year programme to help people and communities across the Yorkshire and Humber region to eat better, be more physically active and improve their mental health.

### **Making it happen**

Champions are recruited in a variety of ways, using leaflets, recommendations by community health development workers and word of mouth. Getting the training right has been crucial: courses have to be

robust, positive and appropriate for people who do not have much recent experience of education. Training has been specifically tailored to each group, which has helped to keep the health champions involved over the long term.

Success has been largely down to multi-agency networks, as the trust works with a range of organisations involved in health and communities across the city.

### *What worked in practice*

- Local social enterprise has been the driving force in tackling endemic health problems.
- The training is accredited, encouraging residents to become local health champions. They have gained certificates to validate and recognise their new skills and qualifications.
- Training high numbers of champions has secured long-term sustainability.
- The project uses social networks to reach into the wider community.
- The project achieves wider engagement by encouraging existing champions to recruit others to join the programme.
- Accessible and tailor-made training has been developed to avoid marginalising particular groups.
- Multi-agency networking between sectors has ensured the involvement of a wide range of organisations.

## Case study 4

### **Denaby Main Forum:** Peer-led sex-and-relationships advice

This example captures the cooperation aspects of empowerment and sits near the top of the empowerment ladder.

### **Background**

Peer champions – in this case, young people in Denaby Main, a former mining village in Doncaster – were trained to work with other young people, to encourage them to live healthier lifestyles, particularly with regard to sex and relationships. The project was run by Denaby Main Forum, a community organisation aiming to improve the quality of life for people in the local area.

Doncaster has high rates of teenage pregnancy and substance misuse – in 2006 the rate of pregnancy among young people was 38 per cent above the England average. The scheme was set up to address people's reluctance to use NHS services or learn from sex education in the classroom. Peer champions became trusted sources of information on sexual health, whom young people could approach informally and without (too much) embarrassment.

### **The project**

The scheme empowered young people to get involved in improving their own health and that of their friends and peers. A member of staff from Denaby Main Forum went into local schools and youth groups

to talk to young people about the project and recruit suitable peer champions. These tended to be slightly older than the groups they were targeting, as evidence suggested this made them more likely to be trusted.

The peer champions received support and advice on how to spread high-quality information within informal settings. Doncaster PCT and the Terrence Higgins Trust were closely involved with the training, and ensured that the leaflets and posters produced by the young people were factually accurate. Terrence Higgins Trust training also enabled four young people to run chlamydia testing in the community.

### **Achievements**

- Training was given to 246 young people as part of the project.
- Hundreds more young people received advice on sexual health and substance misuse.
- The peer champions were able to give advice informally, attend community events, take part in activities at schools and youth clubs, and run advice surgeries.
- In this way, the peer champions extended NHS services to reach groups that used to stay away.

### **Making it happen**

The year-long project was funded by Doncaster PCT using its Health Turnaround money, facilitated by Doncaster CVS. It was supported by Jigsaw, a local health authority drop-in centre for young people, and by the East Laith Gate House Health Centre.

The reputation of Denaby Main Forum was central to the scheme's success in attracting local young people. Its position of trust and credibility was reinforced. Strong partnership working between the Forum and Doncaster PCT was vital to the delivery of the scheme and to ensuring that all health advice was accurate and appropriate.

To make the scheme even better, those involved felt it would have been helpful to have more capacity and more time. With only one full-time staff member, it was difficult to reach all potential peer champions. The organisers would also have liked to extend the scheme to provide age appropriate information and advice to younger teenagers as well.

### *What worked in practice?*

- Young people were trained as peer champions to provide peer-led health advice.
- Peer champions were empowered through building up their capacity, confidence and skills.
- The peer-led approach achieved a high level of success in reaching its target group.
- The 'taboo' subject of sex education was tackled through shared learning.
- There was effective partnership between the community organisation, the PCT and others.
- Accurate and accessible information was provided.

## Case study 5

### Musgrove Partners:

#### Leading involvement at a local hospital

This arrangement is about involving volunteers in the work of the hospital, so comes midway on the empowerment ladder.

### Background

Musgrove Partners are a group of volunteers at Musgrove Park Hospital, part of the Taunton and Somerset NHS Foundation Trust. Formed in 2002, the partners aim to ensure that the patient voice is heard by all the groups who run the hospital.

Since Taunton and Somerset became a Foundation Trust in 2007, the group's work has been organised into four distinct streams, helping to retain their clarity of purpose while they work alongside governors and members:

- interviewing all staff at band seven (team managers or similar) or above
- working on projects and committees
- acting as departmental representatives – a sounding board for senior staff in specific departments as and when issues arise for discussion, and
- facilitating and reporting on focus groups made up of trust members.

## The project

Twelve volunteers were recruited in 2002, and the group had expanded to 45 by 2006. The partners come from a range of backgrounds, some medical but most not. According to their definition statement:

*The Musgrove Partners exist to help the hospital improve the quality of patient experience. They are an independent group, supportive of the hospital and yet separate from it. They are not a representative group, and bring their own perspectives as patients, ex-patients and members of the community. They have no statutory powers or responsibilities, and act at a practical level. As challenging yet supporting friends of the Trust they can add real value to working groups, audits, discussion groups and committees in many areas of the hospital's life.*

At any one time, the partners are involved in 60 to 70 different projects. Although they are volunteers receiving only travel and parking expenses, they are recruited and interviewed as if applying for a paid job.

## Achievements

The Musgrove Partners are a vibrant, independent and dedicated team whose work is central to the hospital. Their success is due in large part to their personal commitment, and also to the willingness of staff at all levels to work with them in constructive and inventive ways. As one member of staff put it, 'it's great to have someone to bounce ideas off, someone to check we're getting it right'.



## Making it happen

The partners' independent role is a key strength. They are seen as providing a forum where patients are often happier to talk about their experiences than they would be with members of hospital staff. Hearing about relevant but different perspectives is also often helpful for the trust, especially when it enables them to understand the experiences of vulnerable or disadvantaged groups.

The volunteers receive training on how to contribute effectively to committees and project work. They may also gain experience in interviewing and focus group facilitation if appropriate. This ensures that they have the right skills and professionalism to be able to function effectively without losing their ability to hear and convey the 'raw voices' of community members.

### *What worked in practice?*

- Volunteers receive support and training to carry out their independent role.
- NHS staff and trustees value what they do because they work directly with patients and hospital staff.
- The partners act as a channel for feedback and suggestions from community members.

## Case study 6

### Lambeth PCT:

### Toolkit for staff on community engagement

This case study has the potential to increase the involvement of community members so comes midway up the ladder. It is about engagement rather than empowerment.

### Background

Lambeth PCT set out to mainstream PPI so that it was seen as ‘everybody’s business’, and user perspectives were consistently borne in mind in commissioning and service improvement. Research suggested that staff varied in their understanding of what PPI means and needed more support and information.

To meet this need, the PCT created a *Toolkit for involving patients and the public* (PPI Team, 2005), which aimed to help all staff and partners understand PPI and include it as part of their work. This helped them empower patients across the whole range of the PCT’s activity.

### The project

The toolkit was piloted in 2004, and published and promoted for use by all staff and partners in 2005. It was prepared by the PCT’s PPI manager, and includes:

- a clear definition of PPI
- the principles of PPI and guidelines for best practice

- advice on engagement techniques for different purposes
- approaches and techniques for working with people from marginalised communities or in circumstances that make them ‘hard to reach’.

### **Achievements**

Since its introduction, over 400 copies of the guide have been sent out: it is used by the PCT’s own staff, independent contractors, the local strategic partnership and the Voluntary Action Council. It has also been adapted for use by independent user groups.

Staff said that the toolkit was an important resource for them when it was piloted in 2004, and its usefulness was highlighted again when the PCT’s PPI strategy was evaluated in 2006.

### **Making it happen**

Support at senior level was crucial for the toolkit’s successful uptake: it was endorsed by Lambeth PCT’s PPI steering group, its board and the management team. Strong and flexible collaborative working has enabled groups outside the PCT to use the toolkit.

### *What worked in practice?*

- Piloting the first version and incorporating feedback into the final toolkit.
- Including a range of methods so that staff are able to choose the approach that suits their situation.

- Advantages and disadvantages are spelt out so that staff adopt the approach that best fits local circumstances and traditions.
- Because a range of organisations use the same toolkit, empowerment in the Lambeth area has some consistency.

### Case study 7

#### **Gloucestershire Village Agents:**

Empowering the community to help older residents

This example incorporates the informing approach for most people, and capacity building for those directly involved. This falls in the mid to lower rungs of the empowerment ladder.

#### **Background**

Gloucestershire Village Agents are local people who act as facilitators, providing high-quality information and access to services. By visiting older people in their own homes, they have been able to identify many unmet needs. They also run outreach surgeries to help them deal with specific issues and to direct people to services that can help them.

Despite the county's affluent image, rural poverty and isolation are real problems in parts of Gloucestershire. This is a particular issue for older people, who are often affected by a lack of good public transport.

## The project

The scheme is run as a partnership between a voluntary organisation, Gloucestershire Rural Community Council and Gloucestershire County Council. It originated from a desire to bridge the gap between local people and services provided by statutory or voluntary organisations. Research had shown that 83 per cent of Gloucestershire residents would be happy approaching someone they knew within the community for help, and the village agents have become a trusted source of information and support.

Village agents come from a range of backgrounds and all have excellent skills in working with people, as well as being able to work on their own initiative. They attend a two-day induction session and have regular training. Each works 10 hours a week and receives a small weekly payment.

Each agent covers several local villages, and through their work they are able to build up good personal relationships with the people they help. They run advice sessions in town halls and community centres but spend much of their time visiting people in their homes. Village agents help with a wide range of issues, including benefits, housing, health and transport.

The scheme was originally funded through the Department for Work and Pensions' LinkAge Plus programme, and has now secured funding for the next three years.

## Achievements

The village agents have become more knowledgeable about the work of health professionals and other agencies and have been able to use this information to help local residents gain access to services they needed. The scheme has made a huge difference to many local residents and has secured sustainable funding.



**You are an amazing lady.  
Stair rail excellent. I'm running up  
and down like a goat on speed.**

**Client**

Agents were particularly praised for their work in supporting vulnerable people during and after the 2007 floods.

## Making it happen

The scheme has succeeded largely because the village agents develop a good rapport with local residents and understand the communities they work in. Informal and cross-sectoral networks have been important in enabling the agents to work effectively with agencies such as the PCT and local council. They also benefit from strong links with the police and fire services, Age UK, the Affordable Warmth Partnership and other local groups.

### *What worked in practice?*

- Training to build capacity, confidence and skills.
- The role of village agent was designed specifically for representative members of local communities.

- Partnership between a voluntary organisation and the statutory service provider.
- The agent role was validated by offering a small weekly payment.
- Relationships were built up and extended through personal contact and support.
- There was a particular focus on preventing potentially isolated groups from further marginalisation.
- The multi-agency approach improved relationships between local providers.

## Case study 8

### **Torbay Voice (Supporting People):** Involving users in service design

This example illustrates how consultation can be improved to include a greater range of voices: it is on the lower rungs of the empowerment ladder.

### **Background**

Torbay Council's Supporting People team helps people to live as independently as possible by providing support either in customers' own homes or through supported or sheltered housing. They wanted to ensure that their diverse group of clients – including young people, older people, and those with mental health problems, physical or sensory disabilities or learning disabilities – could have their

voices heard when the local council was designing services to meet local need.

### **The project**

The Supporting People service users group has recently been renamed Torbay Voice, and uses community development principles to empower its users to decide on service provision. The group includes people from a range of different backgrounds – mainly service users, people with mental health and learning difficulties in the main – who are united by a desire to make Supporting People the best service it can be.

As well as working directly with service providers, members of Torbay Voice use questionnaires to find out what other users think about the Supporting People services. The survey was designed by the group and uses simple language with pictures to make it accessible to the widest possible group. The group also produces a newsletter for all Supporting People service users.

### **Making it happen**

The success of Torbay Voice has largely been down to the hard work and commitment of the group's members and council staff – meetings are friendly and informal, and the group has produced guidelines to make it easier for everyone to join in. However, the group has formal structures behind it, including terms of reference and a job description for members.



## Achievements

Torbay Voice was the joint winner of the government's regional champion awards for 2008. As a result of this, it has spread its message across the country – members have attended several conferences to tell other local authorities how their group works, and what they learned.

### *What worked in practice?*

- Adopting community development principles to build inclusive and representative public engagement.
- Creating a community-based service users group with a recognisable identity – Torbay Voice.
- Recognising the need to hear all the 'voices' when designing services.
- Accessible public information developed by the community for the community.
- Providing a newsletter.
- The mixture of informal and formal structures allows more effective engagement.
- Effective partnership between council staff and Torbay Voice.

## Case study 9

### The Mental Health Act Commission: Service user panel

This is an example of consultation, enabling service users to express their views and to work cooperatively with NHS staff. It is on the bottom half of the ladder of empowerment.

#### Background

The Mental Health Act Commission (MHAC), charged with safeguarding the interests of people detained under the 1983 Mental Health Act, wanted to make sure that the views and priorities of its service users were heard across the commission. The distinct needs of this group, particularly those living in high-security units, meant that the MHAC needed to find innovative ways to enable them influence decision-making.

Since spring 2009, the MHAC has been part of the Care Quality Commission, which has taken on its responsibility to look after people detained under the Mental Health Act.

#### The project

The MHAC's progress towards greater empowerment began with appointing a service user to its board. It then appointed a special advisory group where service users and staff could work together to make decisions.

Over two years, the commission set up a reference panel of people who had experienced detention,

including people from black and minority ethnic (BME) communities and people with learning disabilities. This panel advised the board on decisions relating to service provision and set priorities for engagement. Its decisions were disseminated to the wider organisation through a newsletter featuring the views of commissioners and service users.

### **Achievements**

The reference panel helped bring about a major organisational change towards empowering service users at the MHAC. In particular, it led to the creation of the Acting Together initiative, in which commission staff and service users visited hospitals together to see how things were being done and to make concrete suggestions for improvement.

### **Making it happen**

To overcome the major barriers to working with mental health service users, particularly those in high-security units, commission staff adapted their approaches to users' preferred ways of working – including using video links, direct visits, telephone conversations and email.

### ***What worked in practice?***

- It was important to be clear about roles and representation: in this case, service users participated as individuals rather than speaking for a particular area or organisation.
- The independence of the reference panel ensured that the commission listened to service users' voices and took their experiences into account.

## Case study 10

### **Leeds All Being Well:** Community involvement in health promotion

The activities described here mainly involve informing people, so come on the lower rungs of the empowerment ladder.

#### **Background**

The Leeds All Being Well stall is in the heart of Leeds Kirkgate Market, the largest covered market in Europe. A partnership between the city council and the PCT manages the scheme, which works to improve food hygiene among the 800 market traders and to increase awareness of healthy eating among shoppers. The stall has been especially effective in reaching people from BME communities and other groups who may find it hard to access public health information but who often use the market.

#### **The project**

The stall has a kitchen so that staff can demonstrate healthy recipes and give out samples. It is coordinated by a development worker from a local voluntary group, Zest Health for Life, and often hosts events for local organisations and charities, raising awareness of specific issues and giving advice. These have included the Leeds Vegetarian and Vegan Society, Diabetes UK, and non-food related groups such as FuelSavers.

All recipes are cheap and easy to prepare using food available in the market. People can pick up recipes to

make food at home. Staff give advice on a wide range of topics, and refer people to services which could help.

## **Achievements**

The All Being Well Scheme has been a real success, with over 1,500 visitors every month. Many are repeat visitors, interested in the variety of events held at the stall. By helping people to enjoy cooking healthy food at home, the scheme encourages them to take control of their own wellbeing.

## **Making it happen**

The success of the scheme has been largely down to strong relationships forged between the PCT, Leeds City Council, Zest Health for Life and the local voluntary groups that use the stall. Publicly accessible calendars make it easy for groups to book time for events.

By talking to people face-to-face and in an informal situation, staff have been able to discuss wider health issues and to let community members know about services that are available to them elsewhere in the city.

## ***What worked in practice?***

- A local voluntary organisation has coordinated input from a range of groups.
- They have an accessible and attractive venue in a place that people regularly visit, catering for people who might not feel comfortable in a formal setting.
- Simple and accessible recipes and information encourage people to change their eating behaviour.
- They reach a BME target group who may otherwise feel unable to access this information.

## Learning and tips from the case studies

Some common themes from the above examples suggest key lessons and principles for empowerment. These are summed up below:

- Informal settings allow people to access information and advice more easily, e.g. friendly and accessible meeting places and communication styles.
- It is helpful to offer a 'menu' of different ways for people to get involved, e.g. a choice of levels and routes with flexibility about how people participate and what kind of commitment they make.
- Outreach work in the community and encouraging local people to recruit and engage others will encourage wider local participation.
- Induction, training and support are vital to enable people to act as representatives, champions or advocates. It should be tailored to address the specific needs of individuals from diverse communities.
- Cross-sector and partnership working will ensure NHS staff develop a mix of expertise and that services available to community members are developed accordingly.
- Building good relationships and networks are crucial to the success of community-based initiatives and improved service delivery.

- Opportunities for participation, such as volunteering and getting involved in governance, should be seen as separate from the statutory institutions so that communities and service users can provide independent feedback as ‘critical friends’.
- Collecting evidence to demonstrate the business case for empowerment will help persuade managers and funders to invest in this work.
- Evaluation and action research allows you to learn and share lessons from practice, and to make changes as you go along. This is the key to building real empowerment and inclusion for both staff and community members.

## What next?

**Having read the first five chapters, you should now know more about community empowerment and what it means for you. We hope you will be inspired to develop local empowerment strategies and that you are better equipped with ideas and information to convince your colleagues of the benefits too.**

This is just the starting point. There's a real need in this new area of empowerment in health to share our learning and success with others – some who may have years of experience, and others for whom this is a new venture. This is a step along the way to making empowerment everyday business for the organisations we work in and with. By reflecting on our own experiences, talking to colleagues and listening to communities, we can improve practice, try out new ways of working and experiment a little.

A wealth of material is available on empowerment. If you are interested in taking this further, have a look at the websites of the following organisations and look out for opportunities to network with practitioners who are pursuing similar approaches.



## Useful websites

### **Community Development Exchange**

([www.cdx.org.uk](http://www.cdx.org.uk)) – national membership organisation supporting practitioners working directly with communities.

**Department of Health** ([www.dh.gov.uk](http://www.dh.gov.uk)) – the central government department with key responsibilities for coordinating work on health. Look for guidance on community involvement and empowerment.

### **Equalities and Human Rights Commission (EHRC)**

([www.equalityhumanrights.com](http://www.equalityhumanrights.com)) – an independent statutory body with responsibility to protect, enforce and promote equality across the seven ‘protected’ grounds – age, disability, gender, race, religion or belief, sexual orientation and gender identity. It provides advice to raise awareness of rights and to help implement the equalities legislation, including through providing statutory guidance on the single equality duty and encouraging the use of equality impact schemes.

### **Federation for Community Development Learning**

([www.fcdl.org.uk](http://www.fcdl.org.uk)) – a national membership organisation that focuses on learning for community development and the national occupational standards.

### **Improvement and Development Agency (IDeA)**

([www.idea.gov.uk](http://www.idea.gov.uk)) – the Network of Empowering Authorities (NEA) was a consortium of 18 authorities selected to develop and champion empowerment practice. Resources generated by the

NEA can be found on the IDeA website, along with opportunities to share information and learn from peers. See, for example, the report written for the IDeA, *Reaching out, community engagement and health* (Campbell, F., with Hughes, L., and Gilling, T., 2009).

**Involve** ([www.peopleandparticipation.net](http://www.peopleandparticipation.net)) – provides resources and information for anyone seeking to involve people in decision-making. Through its website you can access a range of practical methods on planning, delivering and evaluating participation strategies; read case studies; and pose questions to experts. There is also an extensive library of reports and articles about participation.

**IZWE** ([www.izwe.com](http://www.izwe.com)) – provides an online framework for civic participation, engagement and empowerment (linking people with decision-makers through social networking); and bespoke internal and external participation and empowerment services.

### **Participation Works**

([www.participationworks.org.uk](http://www.participationworks.org.uk)) – a consortium of children's and young people's agencies that provides an online hub for information, resources, news and networking on the involvement of young people in dialogue, decision-making and influence across a wide range of settings.

**Praxis** ([www.praxis.org.uk](http://www.praxis.org.uk)) – a drop-in centre in east London for refugees and asylum seekers. Its website is full of ideas for welcoming and advising displaced people.

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## NOTES

*Building healthy communities* is a practical guide for healthcare professionals looking to use ‘empowerment’ principles in their work. It includes:

- what empowerment is and four key principles for making it work
- explanations of the Local Government and Public Involvement in Health Act (2007) and other legal requirements
- common challenges and how to overcome them
- best practice case studies, plus listings of useful resources and websites.

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