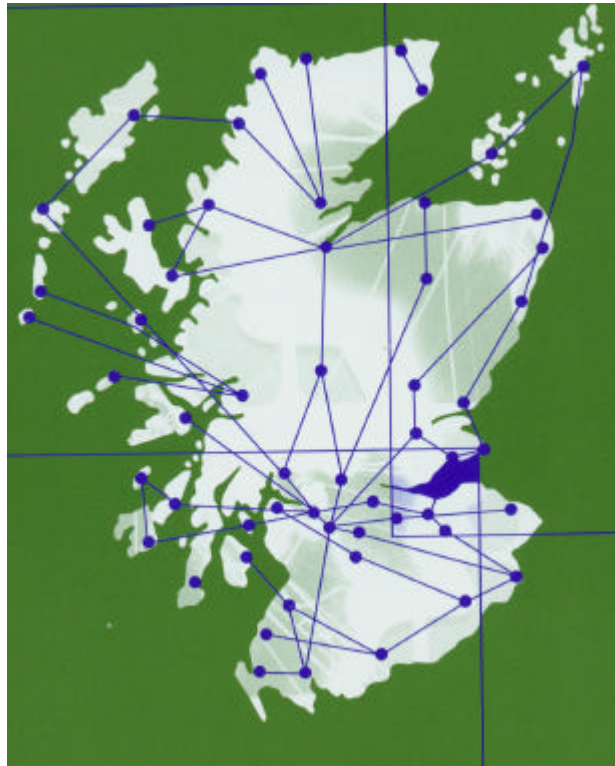




Community Health Exchange

'Community Planning'

21<sup>st</sup> November 2001



## Introduction

Community Planning came into being in 1998 when the then Scottish Office and CoSLA established a working group to address the local implementation of strategies and plans affecting Council areas.

At that time some areas were developing as many as fifty different local strategies and plans, with the majority being implemented separately by council departments and other public sector agencies. There was a need to bring together local authorities, local agencies and community and voluntary organisations to develop and implement a common goal on health, social, economic and environmental policies.

It was intended that the community planning process would provide the framework to streamline, integrate and generally improve the delivery of services and approaches to crosscutting issues such as area regeneration, social inclusion and sustainable development. Four key concepts were envisaged:

- ?? A strategic vision for the whole area
- ?? Community consultation and involvement
- ?? Partnership Working
- ?? Community Leadership

The Working Group recommended five pathfinder areas to pilot the community planning process including: Highland, Perth and Kinross, Stirling, Edinburgh, and South Lanarkshire. The pilots identified that community planning meant very different things to different agencies and communities. Some people viewed it as a process whereby services would simply become more refined and integrated. Others saw the potential for a significant culture shift in partnership working between local agencies and communities. Many saw the potential for developing community leadership, along with greater community involvement in shaping and delivering services.

In June 2000, the Minister for Communities announced the Scottish Executive's commitment to legislate to enable local government to play a full role in the renewal of communities. The consultation paper '*A Power of Community Initiative, Community Planning, Political Restrictions on Council Employees*' followed, the results of which will inform the introduction of new local government legislation in early 2002. The Community Planning Task Force was established in December 2000 to oversee the promotion of the process throughout the country. Serviced by CoSLA, the Task Force has representation from all relevant sectors and seeks to involve interaction with the wider community through its website and other consultative channels.

The Task Force views engagement with local communities as a key component in the development and delivery of the shared vision **'in a way that genuinely reflects their needs, aspirations and priorities.'** There is, however, recognition that the desired level of community involvement makes a huge assumption that people identify with their locality, understand how public policies work, know how to plan and follow through a project and are willing to devote a great deal of their own or their organisation's time to pursuing these ends. There is an expectation that people will get involved at three different levels.

?? general activities which increase well-being

?? the process of developing the community plan

?? the implementation and delivery process

## The Seminar

### Background

CHEX – Community Health Exchange - has over the last year organised a series of seminars designed to respond to areas of interest identified by those in the Health Exchange. The main thread running through all seminars has been the role of community health organisations in supporting communities to shape and influence health and social policies. While the Seminars have been primarily aimed at community health projects and community and voluntary organisations, they have also been open to all community health agencies within the Health Exchange.

This Seminar was designed to exchange information and ideas on good practice in community involvement and inform the CoSLA Task Force Working Group on its outcomes.

It was an opportunity to explore methods of involvement, identify barriers to involvement, and look at ways in which certain community planning partnerships have addressed these barriers. The prime intention was to explore the essential elements in working towards meaningful involvement and inform the Task Force of ways to ensure that community planning is rooted in decision-making processes that genuinely reflect the priorities of community organisations as well as that of local agencies.

Participants - volunteers and professionals - came from a wide variety of backgrounds with varied responsibilities and remits – Community Area Forum, Voluntary Organisations, Local Authorities, Health Boards, Health Councils,

and Primary Care Trusts. The wealth of experience and expertise provided a platform for diverse perspectives and a range of positive recommendations. The Seminar was informed by three instructive and lively inputs from the experience of Aberdeen community planning partners. Representatives from the Council, and Grampian Health/Great Northern Partnership Social Inclusion Partnership highlighted the strategic and operational background to involving and working with communities.

## Input One

### **Kath Beveridge, Assistant Director Community Development, City of Aberdeen Council**

Kath placed community planning within a national context, highlighting the political thinking behind the need for a concerted framework to address the plethora of local strategies that existed prior to 1998.

In Aberdeen, as in other urban areas, there were approximately 50 different strategic plans with 100 to 150 different partners involved. Many of the same people were involved in different partnership arrangements. Conflicting policies and the fragmented delivery of strategic budgets militated against joint working. There was no overall co-ordination of who was doing what, and the then Scottish Office was keen to turn around the competitive nature between agencies and develop a more streamlined process aimed at a joined-up way of working. Confusion and tension existed between priorities identified at a national level and those that were seen as important at local level. Not only was there a requirement for an overall strategy, but also an agreement on realistic targets that were deliverable at a local level. There was a real need to develop a common vision, co-terminus arrangements between partner agencies, and a commitment to partnership working with local communities.

This modernising agenda sought to move away from agencies competing against each other to a more collaborative way of working. Together with a concerted effort to work with communities through processes which embraced the aspirations and priorities of local people.

The development of the Community Planning process in Aberdeen benefited greatly from the lessons learned from the five pathfinder areas. In addition, the research findings produced by Professor Stewart of the Institute of Local Government, Birmingham University, which investigated the concept of governance and demonstrated the need for more 'permeability' i.e. more in-depth commitment to and manifestation of collaborative working, greater trust between all partners, mutual accountability and the use of common language, which all partners would understand.

To date, Local Authorities have been perceived as the lead agencies in initiating and developing community planning. However, there needs to be a shift in altering this perception to an understanding that all partners should have collective responsibility in leading and implementing the initiative. This is a major challenge, especially as radical transformations are being experienced in key institutions such as Scottish Homes in becoming Communities Scotland and with the new Unified Health Boards.

There is tremendous pressure on all agencies and community organisations to meet the high expectations for the delivery of community planning – meetings to attend, papers to produce, seminars to attend, presentations to give! This detracts from the ability and capacity of agencies to address the development of meaningful dialogue between each other and with community organisations. There is a need for protected time, whereby agencies and community organisations can discuss their role, remit, expectations, problems and explore mutual advantage in a non-threatening, informal way. This could be taken into more formal arrangements with an agreed 'Terms of Engagement'. This would establish **how** agencies would work with each other and with community organisations.

We need to continually learn from each other's experiences, and the Task Force is in a prime position to create opportunities for information exchange and to disseminate lessons from within and outwith Scotland. There are some very useful lessons to be learned from the development from similar processes in England and Wales.

It is hoped that the Statutory Guidance on Community Planning, to be implemented in 2002, will strengthen and enhance systems of democratic accountability and provide clear recommendations on how agencies should work in equal partnership with local communities.

## Input Two

### **Ailsa Duncan, Principle Development Officer Community Planning, City of Aberdeen Council**

Ailsa described the implementation of the community planning process in Aberdeen, highlighting the significance of each stage, the building blocks required, the setting of achievable targets, and the implications of community involvement.

Introduced in 1998, community planning was launched with a major initiative - 'Imagine Aberdeen'. Immediately, people related to something tangible and not an abstract process being undertaken in a vacuum and distanced

from people's real lives. While it was consciously pitched at raising expectations and aspirations, it also sought to establish realistic goals and deliverable achievements.

Local communities were asked what significant changes they would like to see in Aberdeen over the next ten years. Their responses formulated the document *'You Said It'*, which laid out overarching themes in fourteen challenge areas covering all aspects of living in Aberdeen, from accessing health services and eradicating homelessness to better transport arrangements and business developments. The challenge to the community planning partners was to establish mechanisms and processes, which would turn these aspirations into reality on the ground.

A Core Group was set up with senior officers and community representatives. A Lead Officer's Group was formed with representation from middle management from all partner agencies. Unified Action Programme Teams (UAP) were introduced to establish Action Plans, which set out the aspirational targets. Along with actions and timescales, all neighbourhoods were to have community plans by 2006. The Community Plans will aim to be:

- ?? People focused
- ?? A place for all strategies and plans in the city to come together
- ?? A vehicle for joint planning, decision-making and taking action in the City
- ?? A framework, which will reflect commitment to
  - Neighbourhood planning and service delivery
  - Communities of Interest
  - Continuous Improvement

Partners have now reached a significant juncture and they now need to address further developments in working together to achieve expected outcomes. Completion of the first phase will be marked with a formal launch of the Plan – 'Aberdeen Futures, a Social, Economic and Environmental design for our City' – on 28<sup>th</sup> November.

The second phase is aimed at re-shaping partnership working and will focus on initiating a City Alliance with a City Assembly. Forums will be initiated to address specific challenges such as priorities from communities of interests and neighbourhood developments; a Civic Forum will aim to develop a citywide focus; and a data sharing partnership group will be gather 'city intelligence' to inform the ongoing development of the community planning process.

Although there are more integrated mechanisms for planning and delivery of services in the City, there remains a need to continually reach out to people who are more excluded to involve them in the process. Involving people on the edges should be a major plank of the community planning process.

## Input Three

### **Marlene Westland – Grampian Health Board/Great Northern Partnership**

Marlene (currently on secondment from Grampian Health Board) described the structures and experience of involving local communities through the work of the Great Northern Partnership. The work dovetails into the community planning process.

The Great Northern Partnership is one of 48 Social Inclusion Partnerships (SIPs) in Scotland designated by the Scottish Executive to tackle social and economic disadvantage and health inequalities. The SIP covers four communities, including Middlefield, Alexander/Hayton, Printfield, and Ferrier/Sandilands

The Partnership includes representation from a range of agencies and organisations:

- ?? Chair (community representative)
- ?? Community Representatives (16)
- ?? City Councillors
- ?? National Health Service
- ?? Communities Scotland (previously Scottish Homes)
- ?? Scottish Enterprise Grampian
- ?? Job Centre Plus
- ?? Aberdeen Council of Voluntary Organisations
- ?? Grampian Police

The Partnership implements policy and services through the Partnership Group, Policy and Resources Group, and Themed Action Groups on Health and Wellbeing, Employment & Enterprise, Education and Community Learning, Housing and Area Renewal.

The key principles are partnership working, community development, health and wider regeneration, health impact, and additionality.

The key community issues are mental health, housing, local access to primary care structures, local access to affordable good quality fresh food, transport, fear of crime and safe play areas for children. The approach addresses both life circumstances and lifestyle issues and long term priorities have been identified for specific health action including:

- ?? Assessing health needs
- ?? Ensuring a range of health services
- ?? Ensuring that health is integral to all Great North Partnership strategies

- ?? Community participation
- ?? Measuring progress

The key elements in making this happen are:

- ?? Funding from the Scottish Executive
- ?? Community Involvement
- ?? Common goals
- ?? Commitment from partners
- ?? Innovation and creativity

The elements are turned into practical initiatives through:

- ?? Early Years Action
- ?? Youth Strategy
- ?? Community Learning Plan
- ?? Community Food Initiatives
- ?? Drugs Plan
- ?? Community well-being initiative
- ?? Active living/physical activity through sports development

Key challenges for the Partnership have been matching local priorities with top-down priorities. Often, local communities do not view top-down priorities as important, which applies to those set by both the Scottish Executive and by local agencies.

The Partnership needs to continually support the promotion and development of community involvement to ensure (a) meaningful participation from those who are already involved, and (b) reach out to individuals and groups from the wider community.

## Work Groups and Plenary Session

### Key Themes

### **ISSUES, EVIDENCE AND OPPORTUNITIES**

The workshop and plenary session addressed issues, evidence and opportunities to ensure meaningful community involvement in the Community Planning Process. There is a commitment to communicate these outcomes to the Community Planning Task Force and to other partners involved in community planning.

## **The Communities' Agenda**

There needs to be understanding and recognition that communities do have their own priorities, which are often different from that of public sector agencies. Paternalism is rife. Many public sector agencies assume that local people will want to work on priorities determined by the Local Authority, Health Board, SIP or Housing Agencies. Agencies need to be prepared to work with communities on agendas, which reflect their concerns, and to work through processes of negotiation and compromise in the same way that they do with each other.

People's views need to be taken seriously. While this is an obvious statement, many professionals do not consciously listen and act on what people are saying. They may go through the motions of listening, but they all too easily dismiss points of view and then proceed with a professional mind-set.

## **Investment in Community Development**

If community planning is to yield the substantial benefits from effective community development, there needs to be substantial investment in the community development approach. Adequate resources for training and development work should be allocated to empower individuals and groups within the decision-making processes.

Recognition that quick fixes and 'one-off' consultations will do little to encourage or support people in the community planning process. In particular, those who are most excluded - e.g. people with mental health problems - need to feel confident about participating. Adequate support and time is required to assist those in becoming involved in challenging new experiences

## **Innovative Methods - 'Planning for Real'**

Aberdeen has introduced an interactive method – 'Planning for Real' - which enables people to have a vision and test out that vision in model plans. Community groups, voluntary organisations and school children have built models of their area, incorporating ideas for housing, schools, shops and community facilities. Being able to present tangible proposals in a model has stimulated and encouraged interest from the wider community. In particular, children have influenced their parents to come along and look at their work and comment on the model.

## **'Consultationitis'**

Many communities have been consulted again and again and have had little in the way of feedback and further involvement or been shown any clear evidence that the results from the initial consultation have made any difference in affecting policy change. While consultation is very welcome, national and local agencies need to build on previous consultations and develop further building blocks that aim to deliver action.

### **Role of Community Development Initiatives**

There is a real need for community development initiatives/projects to ensure good practice in community development. Some participants felt that community development initiatives can sometimes end up as gatekeepers to information and community contacts and that they take on inappropriate roles. Instead of consistently practicing methods of community empowerment, which enable local people to voice and act on their priorities, they carry out a proxy role, which undermines community empowerment and leads to further dependency.

### **Sign posting the differences in types of community involvement**

Currently, many health professionals view community development, community volunteering, user involvement, consumer involvement, public participation and patient involvement all in the same light. There is limited understanding of the significance and implications involved in encouraging different types of involvement. There is a need to produce quality publications like *'Community Involvement in Health'*, Jan Smithies/Georgina Webster, (Ashgate, Oxford, 1998) (ISBN 1 85742 428 X) which highlight the significance of each approach.

### **Guidance on 'good practice in community development'**

There is a need for central guidance on what constitutes good practice in community development and what does not. It would be valuable for the Community Planning Task Force to compile existing guidance and adopt good practice guidelines.

### **Responding to diverse needs**

Communities are not homogenous. An obvious statement, but often they are treated as if they are in relation to community involvement. If social inclusion is to move from being a buzz term to being a reality, then giant steps have to be taken in reaching out to and involving people who continue to feel and experience exclusion in decision-making processes. National and local agencies need to be fully aware of the implications of involving people with learning difficulties, physical disabilities, mental health problems, and introduce terms of engagement which address these particular needs and circumstances. Priority should be given to listening to local voluntary organisations that work directly with people with learning difficulties, and learning from national training initiatives such as 'Allies in Change', which have explored different methods of engaging with people with mental health problems.

Transport remains a major issue in involving rural and semi-rural communities. Assumptions continue to be made that people are able to travel to meetings, events and seminars in town centres. Creative ways need to be found to reach people where they live, whether through the use of existing local services and networks or by using Information Technology, like, for example, initiatives such as 'Lift Off' a Poverty Alliance initiative designed to connect communities with consultations on national policies.

- a) Ways need to be found to meaningfully involve people with disabilities. These include:
- ?? Ensuring venues are fully accessible to all people with disabilities. This means, at the least, a ramp at the door, wheelchair accessible toilet, wheelchair accessible building and handrails at appropriate points.
  - ?? Consideration of meeting with people with disabilities in specialist groups.
  - ?? Provision of material in different formats, in large print, Braille and on tape.
  - ?? Payment for specialist transport where appropriate.
  - ?? Use of targeted questionnaires and phone interviews.
  - ?? Consideration of use of telephone/web/video conferences.
  - ?? Use of recognised community design standards for people with disabilities.
  - ?? Consideration of use of markation signs to explain material to people with learning disabilities.
- b) Active contact should be made between planners and organisations which represent people with disabilities. A continuing dialogue needs to take place which shapes planning policy.
- c) Staff included in planning should attend disability awareness training.
- d) Efforts should be made to educate the community about the needs of people with disabilities. This can help reduce the chances of discrimination.
- e) Community groups should be actively encouraged to include people with disabilities in their activities. This can help ensure that there is less of an 'us' and 'them' attitude when people with disabilities enter the planning process.
- f) Finance should be made available to enable a carer to attend a meeting with an individual with disabilities.
- g) All consultation should be fully inclusive and take account of the fact that at least 13% of the population have some form of disability.
- h) Key national organisations, such as Woods For All, ENABLE, Capability Scotland, RNID, RNIB, should be consulted where a local equivalent does not exist. They can guide on common issues to be addressed in the local community.

### **Capacity Building for Health Professionals**

Many health professionals are being introduced to community involvement for the first time, with limited opportunity for learning new ways of thinking and skills development. There needs to be significant investment in training and staff development to ensure that staff are confident and equipped to engage

with communities in a positive and effective way. Agencies should seek to access and build on existing training provided locally by the public and/or voluntary sectors and nationally by the Health Education Board, Community Action Resource Team, Primary Care Community Health Initiative and Learning Evaluation, Scottish Community Development Centre and Community Learning Scotland.

It is important that community development is built into existing posts and not grafted on artificially or designed to turn health professionals into full-time community development workers. Opportunities should be created whereby health professionals can gain a good understanding of community development approaches and the knowledge of when and where to apply them.

The role of the new Public Health Practitioners in Local Health Care Co-ops and the new joint posts between Councils and Health Boards will be key in assisting other professionals to seek appropriate training and development.

### **Capacity Building for Agency/Council Heads & Middle Managers**

While there is general acknowledgement from Heads of Councils and Agencies for practitioners to undertake capacity building in community involvement, there is little indication that they themselves should undertake similar awareness raising and training. There was feeling that policy makers in these positions are often cocooned from understanding the real implications of working directly with community organisations. It would, therefore, be valuable to provide awareness raising sessions on community development directly targeted at Agency Heads and Middle Managers.

Also, there should be more opportunities for Agency Heads and Middle Managers to go out and meet directly with community organisations to informally explore issues and possible solutions.

### **Capacity Building for Communities**

Community representatives are being expected to participate in community planning processes with little priority being given to their training and development needs. Training and development should be prioritised with people being supported in accessing training on a wide range of issues such as partnership working, negotiating skills, and decision-making.

Substantial commitment should be given to creating opportunities for community organisations to test out skills in negotiating and influencing decision-making. Too often people are thrown in at the deep end and expected to argue and develop their case with limited information and experience. Community representatives need to receive the same back up enjoyed by public sector representatives. There are good examples from the Aberdeen experience and elsewhere in Scotland, where local people are being fully supported in decision-making processes, and this needs to be replicated throughout the country.

Community organisations should be supported in accessing local training programmes and national training initiatives eg use of resources such as Health Issues in the Community (CHEX).

### **Incentives for effective delivery**

Currently, at a national level, there is exploration of providing incentive funding to community organisations that would acknowledge and award the effective delivery of expected outcomes. This should be assessed and evaluated for its overall effectiveness in encouraging and sustaining meaningful involvement.

### **Participation Costs**

While there is greater commitment by local authorities and other public sector agencies to pay out- of- pocket expenses e.g. childcare, caring for a relative, travel costs to community representatives, there is still a tendency for payments to be informal, ad hoc and unrealistic.

There should be clear guidelines on the payment of out-of-pocket expenses, which should be applied automatically and systematically by all local authorities and other agencies.

### **Bottom-Up versus Top-Down Priorities**

The constant tension between bottom-up priorities versus top-down priorities needs to be openly addressed by all those active in the community planning process, both at local and national level. While top-down priorities reflect national political imperatives and should provide standards throughout the country in strategic developments, there needs to be further commitment to priorities identified by communities and local agencies based on local research and needs assessment.

### **Partnership working & Competitive Cultures**

Despite significant moves being made in partnership working and addressing cross-cutting agendas, like regeneration, social inclusion and sustainability, community organisations still experience the negative effect of competition between agencies, individual departments and employees. To a certain extent this is understandable, with current budget allocations, the status afforded to certain partners and resources made available for specific priorities. However, if community planning is about working towards common goals with mutual advantage, there needs to be greater articulation of that mutual advantage and the added value derived from partnership working. Communities need to both feel and experience the benefits from the huge investment in partnership working which underpins the community planning process.

### **'Terms of Engagement'**

Aberdeen community planning partners are currently developing thinking on setting agreed 'Terms of Engagement' between partners. This would set out

expectations on **how** partners will operate and take into consideration individual roles, remits and responsibilities. It will also address communication systems and decision-making processes. The merits of this initiative should be evaluated to inform potential replication across the country.

### **Targets – Outputs and Outcomes**

While clear targets are fundamental to the delivery of any initiative or programme, they should be established both for product and process, outputs and outcomes. Too often the emphasis is on the product and not the process. Targets should be set for effective community involvement e.g. skills development for individuals, capacity building in local organisations, strengthened networking between community organisations, as well as those for practical outputs such as new Healthy Living Centres.

Departments, agencies and organisations still tend to work towards individual targets and indicators set to measure their own input, output and outcome. While it is important to evaluate the work of individual agencies/organisations, there should also be common targets, which crosscut all community planning initiatives and encourage partners to work together in achieving common targets.

### **Involvement in influencing Acute Services**

While primary care services have taken the key focus on community involvement, there needs to be opportunities for communities to affect the delivery of acute services too. There is recognition that Health Councils currently have an input in influencing acute services, but there was a feeling that this should be promoted and developed with the wider community.

### **Forums**

There is much to be gained both for community organisations and local agencies working through local forums. They create the mechanism for individual community organisations to work together, and provide a stronger platform to raise concerns and priorities. They also provide a channel for local public sector agencies to communicate directly with a large number of community organisations at once and distribute up-to-date information on services and policies.

However, working through Forums also should come with a health warning! They can sometimes be used as expedient measures to short circuit meaningful consultation. They can also become unsuspectingly elitist with core activists acting as gatekeepers of information to the wider community.

Forums need to be properly resourced and supported to have clear aims, objectives and processes that facilitate group representatives working well together and provide effective accountability to the wider community.

### **Accessible data on health care & health inequalities**

Most local authority, health board and health trust areas hold a wealth of information on health care and health inequalities, highlighting statistics on all aspects of health and well-being. Often, however, it can be difficult to access this information, especially for community organisations. It would be valuable, through community planning, to have co-ordinated bulletins, which provide an analysis of data in a lively, accessible format!

## Lessons

### **Lessons from past experience**

Rich experiences and valuable lessons exist on community development in Scotland, particularly from the voluntary and community sectors and local authorities. Many have been written up in case study form and can be accessed from community development journals and publications. (Contact Scottish Community Development Centre, CHEX, Community Learning Scotland for further information). However, one of the most valuable ways of transferring lessons is through talking directly with those who have been involved in the process, whether it be from the perspective of community volunteer, practitioner or policy maker. There should be more seminar opportunities to enable those who have extensive experience in community development to pass on their knowledge and lessons. These could be organised as informal awareness raising events, designed to encourage people to be open and honest about what works and what does not.

### **Lessons from current practice**

More than ever, evaluations, case studies, and story telling experiences are being written up and published in hard copy or promoted through the WEB. More awareness raising seminars would create opportunities for people to share experiences and lessons. Health Networks such as CHEX, Voluntary Health Scotland, UK Public Health Association, West of Scotland Community Health Network and Lothian Community Health Projects' Forum have a major role and responsibility in supporting the sharing of that experience and lessons throughout Scotland.

# ***CHEX Community Planning Seminar***

## ***Participants***

<i><b>Surname</b></i>	<i><b>First name</b></i>	<i><b>Organisation</b></i>
Adams	Carolyn	Aberdeen & North LHCC
Allan	Elaine	Aberdeen Inner City Co-operative
Bendrey	Sharon	Argyll & Clyde Health Board
Beskow	Phyl	Lothian Primary Care NHS Trust
Beveridge	Kath	City of Aberdeen Council
Blair	Marie	Grampian Health Board
Burke	Margaret	Kincardine LHCC
Doggett	Denise	Lanarkshire Primary Healthcare NHS Trust
Duncan	Ailsa	City of Aberdeen Council
Hall	Jennifer	Aberdeen West LHCC
Hatch	Val	Fife Council
Hutchens	Kevin	Aberdeenshire Social Work Services
Inglis	George	CHEX
Lynch	Monica	South East Glasgow LHCC
MacKechnie	Muriel	City of Aberdeen Council
McIntosh	Steve	Aberdeenshire Council
Morgan	Diana	Glenrothes LHCC
Muir	Janet	CHEX
Philips	Jo	Glasgow Council for Single Homeless
Roberts	Rachael	Health Education Board for Scotland
Steel	Jennifer	Denny Area Forum
Struthers	Elizabeth	Grampian Primary Care Trust
Tweedie	Val	Grampian Health Board
Westland	Marlene	Grampian Health Board/Great Northern Partnership
Williams	Jennie	Grampian Primary Care NHS Trust

