How to develop and implement a strategic framework for community engagement to support achievement of health and social care goals: the ‘Five Elements’ model
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**Document purpose**  
Best Practice Guidance

**Gateway reference**  
13670

**Title**  
How to develop and implement a strategic framework for community engagement to support achievement of health and social care goals: the 'Five Elements' model

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**Publication date**  
05 Mar 2010

**Target audience**  
PCT CEs, NHS Trust CEs, Care Trust CEs, Foundation Trust CEs, Directors of PH, Local Authority CEs

**Circulation list**  
SHA CEs, Medical Directors, Directors of Nursing, Directors of Adult SSs, PCT PEC Chairs, PCT Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Voluntary Organisations/NDPBs

**Description**  
One in a series of "How to" guides published as part of the "Redoubling efforts to achieve the 2010 national health inequalities life expectancy target" resource pack

**Cross ref**  
Systematically Addressing Health Inequalities

**Superseded docs**  
N/A

**Action required**  
N/A

**Timing**  
N/A

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For recipient's use
How to develop and implement a strategic framework for community engagement to support achievement of health and social care goals: the ‘Five Elements’ model

Systematic and scaled interventions by frontline services (B)

Partnership, vision and strategy, leadership and engagement (A)

Personal health

Community health

Population health


FOREWORD

The Health Inequalities National Support Team (HINST) has chosen to prioritise community engagement as one of its ‘How to’ guides for the following reasons:

• Community engagement is one of the three fundamental apices of the HINST population impact triangle (along with population-level interventions and systematic scaled-up use of services). Often, it has been observed that community engagement initiatives have been ad hoc and have favoured those communities with existing leadership, organisation and resources and who are, therefore, well placed to win bids for further development. Community development initiatives are also often small-scale, and particularly in the health sector, can be rather peripheral and disconnected from mainstream activity.

• Specifically, within the ‘Christmas tree’ diagnostic this guide addresses the following components:
  – accessibility (4)
  – engaging the public (5)
  – expressed demand (7)
  – equitable resourcing (8)
  – responsive services (9)
  – supported self-management (10).

• Action in this area of work will contribute to the Quality and Productivity Challenge by facilitating engagement of previously seldom seen, seldom heard individuals, families and groups. This will enable them to benefit more systematically from community-level interventions, primary- and secondary-prevention activities and can facilitate earlier presentation with health problems to reduce impact and downstream costs.

• Successful adoption of processes, similar to those outlined here, would demonstrate good use of World Class Commissioning (WCC) competencies:
  – local leader of the NHS (1)
  – collaborates with partners (2)
  – patient and public engagement (3)
  – assess needs (5)
  – stimulates provision (7)
  – innovation (8).
How to develop and implement a strategic framework for community engagement to support achievement of health and social care goals: the ‘Five Elements’ model

CONTEXT

As with other aspects of a systematic approach to community engagement, it is essential both to fulfil legal requirements for statutory organisations in relation to the ‘duty to involve’ but also as part of WCC and the NHS’s Quality and Productivity Challenge. To effectively tackle health inequalities and avoid the vast amount of waste and/or additional costs incurred from under-used services, poor self-management of long term conditions and commissioned activity and services which fail to move beyond pilot/short term funding, a planned and systematic approach is crucial.

The ‘Five Elements’ model provides a framework to plan, deliver, monitor and evaluate community engagement work – from cross-agency/cross-district strategic approaches to individually commissioned initiatives and services.

In accordance with other aspects of a systematic approach to addressing health inequalities, it is crucial that community engagement work be approached strategically, if it is going to have a population-level impact. To ensure that communities who have the worst health outcomes are fully engaged with the change management processes and outcomes, a fundamental shift in approach and in the scale of interventions is necessary.

Interventions in communities with poor health frequently focus on resourcing small community projects that are usually short term funded. Although these projects may achieve good outcomes and provide a stimulus for change for some individuals or even groups of people, they are usually isolated from the mainstream work of the NHS and local government, even if nominally commissioned by them.

People are part of many different and overlapping communities but for the purpose of this ‘How to’ guide, three broad areas for approaching community are considered:

- communities of place: e.g. neighbourhood, village and estate
- communities of interest: e.g. workplace, sports group and social group
- communities of identity: e.g. ethnicity, sexual orientation and disability.

Clearly the above are not mutually exclusive segmentations.

There are a range of statutory duties in relation to both the ‘duty to involve’ and the equalities requirements. See Appendix I for further information.

The commercial world is fully aware that to successfully implement any major change it needs to engage all stakeholders – including its customers and its potential and future customers. The challenge of shifting to a ‘fully engaged’ scenario and achieving the scale of changes in health status and outcomes for significant portions of the population that are needed to ‘close the gap’ between Spearhead areas and the English mean, and between the most affluent and least affluent sections of a local population, requires the full engagement, commitment and cooperation of all those who will need to participate actively in driving change. This includes citizens, residents, patients and service users. WCC requires engagement of local populations in:
• needs identification
• priority setting
• service planning
• service delivery
• quality and outcomes assessment.²

The NHS Operating Framework for England 2010/11 and NHS 2010–2015: from good to great both highlight the benefits of fully engaging communities in all aspects of their health and well being including personal lifestyle change.³

The model below provides a simple, but comprehensive tool, to enable community engagement to be:
• planned
• co-ordinated
• strategically integrated
• appropriately resourced
• stimulated/delivered
• performance managed and evaluated.

Most importantly, if used systematically and strategically, it will ensure that community engagement will impact on all the required levels to facilitate major transformational change in:
• individuals
• communities
• wider population areas
• professional practice, skills and approaches
• commissioning needs assessment, priority setting and resource allocation
• partnership integration and delivery of large-scale targets, such as Local Area Agreements (LAAs).

This ‘How to’ guide describes the model, and the different elements within it, and applies this to specific scenarios illustrating how it can be used.
The ‘Five Elements’ Model

This strategic framework contains five key elements that must be addressed to ensure that either a whole local partnership and/or a single organisation’s overall approach to community engagement is strategic and impacts on change at all levels. It can be also used in relation to specific community engagement initiatives. Often engagement work is simply focused at ‘grassroots’ level (small projects with time limited and sparse resources) with little use made of existing community or professional infrastructures. Those infrastructures may need creating or strengthening, but will pay dividends in relation to the longer term sustainability of ‘grassroots’ level initiatives, and in expanding their reach and impact.

To fully realise health improvements, systematic and transformational change needs to happen, both in the lives of individuals, families and communities, and also in the way services are planned, commissioned and delivered. Services need to respond and adapt more appropriately to community needs. Moreover, individuals and communities must be better supported to make changes and take on health and well-being lifestyle challenges. Therefore, there has to be access to decision-making structures, and strategic leadership roles must be built into community engagement work or strategy if it is to have a strategic impact. It has to be able to connect through to, for example, workforce development, and to impact on commissioning and service redesign, as well as working directly with local communities.

Ensuring work and initiatives in all four outer boxes (shown in the figure below) is effective in its own right, but also mutually strengthens, reinforces and expands the impact of the other elements, and enables any useful learning, is the role of the central ‘overview and co-ordination’ box. Those who lead the work in the central box will also be key to ensuring the arrows flow – either through initiating communication and information sharing pathways, and/or developing mutual working links and partnerships across the four outer boxes.

Strategic community engagement: the ‘Five Elements’ model
The ‘Five Elements’ model works as:

- a review tool to monitor and evaluate the impact of a particular initiative, and where it needs to be strengthened to maximise impact
- a tool to share work across agencies/sectors, and/or a locality or community of identity/interest
- a model to focus planning of initiatives and activities in a strategic, rather than ad hoc, short-term project-focused way.

The arrows, and people whose roles include ensuring the arrows work in reality rather than just on paper, are as important as what occurs in each box. For example, connecting community infrastructure to professional infrastructure, as illustrated in case study 1, where community centres and mosques were connected to diabetes specialist professionals.

Activities and the people/resources required to deliver those activities must be identified for each of the ‘Five Elements’. It cannot be assumed that all ‘Five Elements’ will be in place and readily available to be accessed. Indeed, in many cases, there will be a need to resource and/or stimulate development of some of the different elements. However, this will not always mean new resources/roles, but often a better focusing/coordination of existing roles, initiatives and infrastructures.

Partnership working across a joint community engagement strategy and action plan, and a joint third sector Compact ensures maximum effectiveness of resources dedicated to a systematic and strategic approach to community engagement, thereby avoiding overlap and waste of resources on ineffective or limited impact initiatives.

**The ‘Five Elements’ in more detail**

1. **Grassroots community work**
   This element involves outreach and development work directly with local people to enable individuals (especially those from often excluded/overlooked communities) to come together to organise around important issues. This could result in people accessing additional support or resources, establishing new groups or services, pressing for involvement in decision making forums and structures and directly influencing priorities and policies.

   Traditionally ‘grassroots’ community work was concerned with ongoing coordination and stimulation of collective action, but when considered in relation to widening access to services, it could also focus on individuals who may or may not contribute to collective action, or simply be more effectively engaged as individuals and families.
2. Community infrastructure
This element is concerned with enabling community groups, third sector organisations and venues to network, thereby strengthening social capital and giving communities a stronger and more cohesive voice. Supporting community infrastructure extends reach (for example, connecting groups primarily focusing on young people with those primarily engaging with older people) across a community of identity and interest or geographical area. The connections can be virtual (e.g. a newsletter or email list) or real (e.g. as in joint working on common initiatives).

Effective community infrastructures can network at locality level and across a district or city. They allow for sharing of information, learning and views and perspectives, as well as joint action.

3. Professional infrastructure
Within any locality, or in relation to any community of identity and interest, there are likely to be a wide range of professionals with roles varying between development, engagement and service delivery. This element recognises that, just as with community infrastructure, cross-agency/professional networking is important to maximise the workforce skill-base that can be harnessed into a particular initiative or community. The delivery of cross cutting policies, and the feedback into a range of key local agencies/directorates of larger organisations, are also important aspects of this element.

4. Organisation development
Organisation development (or OD) aims to improve the effectiveness of organisations by providing the skills and mechanisms to pro actively manage, rather than merely react to change. All ‘Five Elements’, if properly understood, resourced and supported, involve change management. However, this element, more than any of the others, is concerned with larger scale change management in organisations and partnerships. Information, feedback and learning from the three elements outlined above, need to have routes and nominated people to link externally generated and connected experience, knowledge and information back into policy changes, workforce development, commissioning decision-making etc.

5. Overview and coordination
The four elements featured above, are inter-dependent and mutually inter-connected in an effective, strategic approach to community engagement. Each element may involve different people or ‘teams’ (virtual or real) leading or coordinating, often based in different parts of an organisation, in different sectors, and/or community based. Thus, it is crucial if community engagement is to be systematic and planned, rather than ad hoc and only impacting on small scale change, that all elements are harnessed and coordinated.

The cross cutting arrows depicted in the ‘Five Elements’ model are equally important as the five boxes. The arrows represent information flow, knowledge, skills, needs, concerns, etc. Someone (and usually a team) needs to be responsible for developing and coordinating the overview and ensuring the arrows flow in all directions (e.g. not just from organisations to communities but also vice versa). Imagining the model as three
dimensional may assist in understanding that the ‘overview and co-ordination’ function should not lead to a group or team who control, or worse still, absorb all that flows in from and across the arrows, but rather that they open, and keep open the channels that allow the other elements to inter-relate and interact. For example, case study 7 reveals the importance of the channels into the ‘Organisation development’ box from the African Caribbean health needs assessment (HNA) were ‘blocked’ (or had not been opened initially). A systematically designed process would have taken steps to ensure the channel was open before the work was commissioned. A small community group, or even a larger commissioned provider organisation, is unlikely to have all the contacts and inside knowledge of how decision-making works in a primary care trust (PCT) or local authority.

This element often identifies what organisation development must occur, as structures or lead roles to resource, coordinate and/or respond to community engagement work, may not actually exist (for example, disease specific pathway groups may not connect into commissioning structures and lead budget holders).

WHAT WOULD GOOD SYSTEMATIC AND STRATEGIC COMMUNITY ENGAGEMENT LOOK LIKE?

The first five case studies below illustrate how the ‘Five Elements’ model works in practice, when a strategic approach, encompassing work in relation to all Five Elements, is used. The final two case studies take two examples of community engagement work that, despite commitment and good work in relation to some of the elements, remained limited in impact and were not sustainable beyond their short term funding. In these latter case studies, only some of the Five Elements were incorporated in the approach.

The chart below describes what good community engagement, incorporating the ‘Five Elements’ approach, would look like in principle. The subsequent case studies reinforce further the value of using this comprehensive approach.

To be effective, the ‘Five Elements’ approach must be systematically adopted within organisations and partnerships and ‘industrically scaled’. This may include, for example, being built into an organisation and/or partnership ‘Community engagement strategy’, so that it becomes a normative way of working across the entire organisation/partnership. Commissioners, when commissioning community engagement work, should always consider all ‘Five Elements’. Communications and stakeholder engagement strategies should also adopt this approach to ensure a ‘holistic’ approach rather than more limited, one way communications. Ultimately, this approach complements the WCC engagement cycle, which builds in engagement at all levels and stages of commissioning.5

The ‘Diagnostic questions’ section below has been developed into a performance management checklist which can be downloaded from the HINST pages of the Department of Health website (www.dh.gov.uk/hinst).
### 1. ‘Grassroots’ community work

<table>
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<tr>
<td>Are there paid staff and/or volunteers (trained and supported) who have the knowledge, skills, credibility and time to undertake outreach to the communities that are targeted by a particular engagement activity?</td>
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<tr>
<td>Are these staff/volunteers regularly supervised and supported to deal with difficulties and to identify learning and any additional training/professional development needs?</td>
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<tr>
<td>Are they aware of how their ‘grassroots’ work contributes to the wider strategic impact of the community engagement initiative?</td>
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<tr>
<td>Are they able to directly feed into, or at least receive feedback on, how their findings/successes are being progressed within the wider strategic framework of their organisation/partnership?</td>
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### 2. Community infrastructure

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<td>Has the existing local community infrastructure – community groups, formal and informal networks, voluntary organisations, community newsletters, key local individuals/access locations (e.g. shops, schools and faith centres) – been mapped?</td>
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<tr>
<td>Have contacts been built with all these individuals/groups/networks who can be useful partners in the initiative and add to the credibility and trust of those working at the grassroots level above been established?</td>
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<td>Have key community initiative leads been invited to be part of the coordination/overview team? If this is not feasible/desirable, are there mechanisms to keep them regularly informed and engaged in indentifying any wider implications for their initiatives/communities and in promoting successes and assisting with surmounting barriers?</td>
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<tr>
<td>Has a clear ‘win-win’ been negotiated, so that the different players in the community infrastructure can clearly see the benefit in partnering the work (this may be as simple as a shared desire to improve things locally)?</td>
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<tr>
<td>Is there clarity about what role/contribution different players in the community infrastructure are being asked to play? This may be tangible, such as providing a venue, but is likely to also have underlying, less tangible elements, such as providing credibility and enhancing trust by hosting an event/service/initiative, or even promoting something that is being hosted elsewhere, to the community members.</td>
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<tr>
<td>Element</td>
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<tr>
<td>2. Community infrastructure continued</td>
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<td>3. Professional infrastructure</td>
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<td>Element</td>
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</tbody>
</table>
| 3. Professional infrastructure continued | Is there clarity about what role/contribution different players in the professional infrastructure are being asked to play? This may be tangible, such as providing a venue but is likely to also have an underlying, less tangible element, such as providing credibility and enhancing trust by hosting an event/service/initiative, or even promoting something that is being hosted elsewhere, to patients/service users. Often, it will be particular skills, such as clinical skills, or professional knowledge and expertise, that are required to complement the skills of those working in the other four elements.  
If, despite all the above, there are clear gaps in the professional infrastructure, are there mechanisms/resources to develop those aspects of professional infrastructure that are not in place, and which may undermine/limit the effectiveness of the community engagement initiative, if not addressed? This could be lack of specialist roles in an area or if attempts to engage certain professionals fail (e.g. if a local GP practice will not participate in community outreach health checks in their area). |
| 4. Organisation development | Is community engagement a ‘golden thread’ running through all key organisational and partnership strategies and action plans?  
Is there understanding of, support for, and acceptance of the value and importance of community engagement by senior managers and senior management structures within organisations and partnerships?  
Are there senior-level champions who comprehend the need for a strategic ‘Five Elements’ approach to community engagement and who can ‘oil the arrows’ when connections between the different ‘Five Elements’ get blocked or are difficult to negotiate?  
Does the community engagement initiative have a clear strategic link to organisational/partnership priority targets and strategies? Are those leading on the targets/strategies proactively aware/been made aware of these links and how the community engagement initiative can contribute to meeting those targets/delivering the strategies?  
Have key strategic managers/target delivery leads been invited to participate in the coordination/overview team? If this is not feasible/desirable, are there mechanisms to keep them regularly informed and engaged in identifying any wider implications for their roles/areas of responsibility and in promoting successes and assisting with barriers? |
### 4. Organisation development continued

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<tr>
<td>Are there clear links into the parts of the organisation/partnership where key decisions regarding priorities, resource allocation, contracting, etc. take place? Do the people in the coordination and overview roles in a community engagement initiative have the credibility, role authority and access routes to feed in implications and findings from community engagement work to directly influence commissioning/procurement and key partnership forums, e.g. pooling budgets or coordinating work, across spectrums and organisations?</td>
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<td>Do wider implications that emerge from a strategic approach to engagement, such as workforce development, professional training needs, matrix/multidisciplinary/cross-sector team working, have a route to feed into OD leads, Human Resources and OD strategies, third sector Compacts, LSP structures and decision-making processes and other organisation/partnership-wide strategic agendas.</td>
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### 5. Overview and coordination

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<tr>
<td>How does this initiative fit into the overall strategic approach to community engagement of the organisation/partnership? Where does the person/team leading the coordination and overview work feed/report into? How is this collated to provide evidence for WCC and LAAs? How does it feed into and impact on clinical pathways? Commissioning boards? Neighbourhood forums? The local strategic partnership (LSP)? What other structures are there, where it would be useful to provide collated learning and identified needs/changes that must be connected to wider organisational planning and decision-making forums?</td>
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<tr>
<td>Is there a person/team in place who has/have the authority, skills, knowledge, credibility and time to plan, monitor, review and evaluate the community engagement initiative correctly to ensure that there is a clear strategic fit to overall targets and objectives and that the work stays relevant to organisational/partnership priorities?</td>
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<tr>
<td>Is there a clearly acknowledged leadership role for the individual/team/group responsible for coordinating and keeping an overview of the other four elements of any given strategic community engagement initiative?</td>
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<td>Does this person/team have a shared vision at the outset of what they aim to achieve; the outcomes they plan to deliver, and the changes they are attempting to move forward, in relation to all Five Elements? Is there flexibility to respond to unexpected successes/new opportunities and/or difficulties that may occur once the community engagement initiative is underway?</td>
</tr>
</tbody>
</table>
Element | Diagnostic questions
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5. Overview and coordination continued | Does this person/team have a shared vision at the outset of what they aim to achieve; the outcomes they plan to deliver, and the changes they are attempting to move forward, in relation to all Five Elements? Is there flexibility to respond to unexpected successes/new opportunities and/or difficulties that may occur once the community engagement initiative is underway? Does this person/team have the networks needed to make connections between a particular initiative and other relevant work/strategic drivers that emerge and that can be built in to expand the impact of the work? Does this person/team have access to mechanisms to share/communicate the work and the authority (or clear access to those more senior) to ensure that the work feeds in at the relevant levels of the organisation/partnership to impact on change, as and where required?

THE MODEL IN PRACTICE: CASE STUDIES OF A STRATEGIC APPROACH TO COMMUNITY ENGAGEMENT

All the case studies below have examples of activity/impact in all elements of the ‘Five Elements’ model and can show evidence of impacting on change at a range of levels – community, community infrastructure, professional infrastructures and practice, and in relation to wider organisational/strategic change.

The diagrams to illustrate each case study contain some abbreviations. Please refer to Appendix 2 for an explanation.
Addressing inequalities in diabetes management using community engagement in NHS Bradford and Airedale

This case study illustrates work, using the ‘Five Elements’ model as a planning and review tool, which was developed as part of strategic work to tackle inequalities in health, with a specific focus on diabetes, by the Community Development Service of NHS Bradford & Airedale. There were three main stages in the development of this work described below.

Stage One: identifying the four main challenges that contribute to health inequalities in type II diabetes. Community engagement was seen as a crucial element in addressing these challenges.

Stage Two: developing engagement action plans to address the first four challenges.

Stage Three: identifying which communities to target initially, as part of a planned district wide initiative over three years.

The first challenge identified was that there were still many local people who were unaware of the link between type II diabetes and lifestyle. There were also significant numbers of people who were unaware of the various identified risk factors putting certain population groups at increased risk of developing diabetes and often at earlier ages. The general level of awareness of the early indications of diabetes onset was low – amongst local people and many health, social care and community service providers (unless specialists in this field). The response to this first challenge was to increase information access and widen awareness through specifically targeted materials, expand knowledge amongst workers (e.g. children’s centres; community workers; faith centre staff) with community knowledge and good community links, and to plan and deliver a range of partnership activities and events.

The second challenge had already been highlighted when HINST had visited Bradford & Airedale in early 2008. This had illustrated that there were significant numbers of people missing from GP practice registers in Bradford & Airedale who were likely to be diabetic, based on the population profile. Specific work to raise awareness with local people and health and other professionals of the levels of under diagnosis was accompanied by the offer of risk-assessment sessions in a range of NHS and community venues, planned, promoted and delivered through a range of partnership and joint working initiatives.
The third challenge concerned patients’ self-management of their own diabetes. HINST work had highlighted, through the relevant Quality and Outcome Frameworks (QOFs), that significant numbers of diabetics on practice registers had uncontrolled blood sugar. Subsequent discussion with specialist community and acute diabetes service providers confirmed that certain communities were less engaged with services. In addition, that some services (e.g. diabetes education and self-management support) were only available to a limited number of newly diagnosed diabetics, and were often not easily accessible by many of those in greatest need. The action plan for this part of the work looked at initially outreaching to a range of people who were not using services (e.g. Did Not Attends [DNAs] at specialist clinics or when invited by their GPs for regular monitoring) or whose blood sugar and other health management needs (e.g. blood pressure) were often poorly controlled when they did attend. The purpose of the outreach work was to discuss health and well being from an individual’s perspective, explore views on the services they were (or were not) receiving, and discuss any other information needs/concerns. This would then enable the PCT to better identify what sort of services and support might need to be commissioned to address their needs and tackle the inequalities issues.

The fourth challenge, identified at the outset of this work, focused on the variations in patient care shown by investigation of QOF data. The Diabetes Commissioning/Pathway Group were already looking at restructuring the way that diabetes clinical management and support was delivered across the district. This initiative was primarily concerned with ensuring GPs and other primary care teams were fully aware of, and had easy routes to link/refer people to, lifestyle support change services (e.g. exercise, smoking cessation, health trainers and welfare rights) in their locality.

Coordination was essential to initiate this work and apply the learning and commissioning/service redesign implications from each of the four inequalities challenges outlined above. In this case, the Diabetes Pathway Group was identified as the most relevant coordinating body at a district level. At a locality level, local cross-sector partnerships were formed to coordinate the delivery of the action plans developed in relation to all four key challenges identified with specific geographical communities. A ‘training the trainers’ approach was also formulated to ensure staff and volunteers working in services such as children’s centres, home care services, homeless hostels and faith centres, etc. were able to act as advocates and informed message sharers with their own clientele/service users and communities.
One extra position (‘Specialist Diabetes Community Health Development Worker’) was created, funded for three years, managed within the Community Development Service of NHS Bradford & Airedale, to initiate this work. In order that this position did not become a small-scale initiative, focusing on one or two communities and isolated from impacting any major changes in relation to the overall approach to diabetes prevention, service delivery and support for self-management, the ‘Five Elements’ model was used. This enabled the development of a visual framework to illustrate how the work of the post holder needed to be focused and located within wider diabetes management and tackling inequalities in work streams in the PCT.

**A strategic ‘Five Elements’ approach to addressing diabetes inequalities**

![Diagram of the 'Five Elements' model]

Key:
- p’ship = partnership
- LAA = Local Area Agreement
- LSP = local strategic partnership
- WCC = World Class Commissioning
Maximising the impact of welfare rights work in Walsall

The Welfare Rights Service in Walsall has brought an additional £161 million of actual income received by clients and the local economy over the last twelve years has also benefited significantly. The service impacts on health and well being in a number of ways:

- Maximising income enables better access to warmth, food and other basic necessities, as incomes increase.
- The team targets areas of deprivation, and also undertakes outreach to access people with disabilities or with specific medical conditions, based on an awareness that some conditions may automatically enable people to access additional benefits and grants. Increased income can assist increased mobility and social interaction possibilities.
- The team undertakes a ‘health of the house’ survey, as part of their welfare rights check, and often identifies health concerns/conditions that are not yet known to local GPs and can thus advise the person to seek medical help or alert other services, such as drug and alcohol counselling.

The service has also undertaken its own follow up work to get an overview of the expenditure patterns of individuals who benefit from increased income. It is invested in taxis (additional income for taxi drivers and enabling more social interaction for older/disabled people). Research from the University of Strathclyde indicates that an additional job is created for every £41,000 brought into a local area and this is reinvested in the local economy. Further income is brought into the local economy through increased draw-down from central to local government and the NHS, as part of the national formula for aggregating financial distribution from national government to local areas, based on the percentage of people in receipt of certain benefits.

As well as undertaking outreach work and offering ‘drop-in’ sessions, the service works at promoting knowledge of its services via community and professional infrastructures to ensure a wide range of community organisations and professionals, for example, those working with housebound people, are aware of the importance of maximising people’s incomes, and can refer people easily. The service coordinates all its work, and that of other welfare rights services locally, and feeds in regular income generation figures, and additional proposals for increasing reach and effectiveness, at a range of levels into local authority structures. It also links its outcomes into relevant LAA targets through various partnership structures.
The service works at the different levels outlined in the ‘Five Elements’ model.

A strategic ‘Five Elements’ approach to income maximisation

1. Grassroots community work
   - Door-to-door outreach
   - Increased income for individuals and families
   - Undertake health checks and signpost to other services

2. Community infrastructure
   - Work in partnership with community events and groups
   - Use community centres and venues to promote the service

3. Professional infrastructure
   - Train wide range of professionals to signpost to WRs
   - Work in different agency settings, e.g. GP practices
   - Work with different partners, e.g. schools

4. Organisation development
   - Increased income for whole district through increased national draw-down enables whole system impact
   - Increased the profile of WR and income maximisation as important for all partners.

5. Overview & coordination
   - Coordinates its own and district-wide WR work
   - Evaluates in terms of extra income for district & impact of all the subsequent extra expenditure and feeds this into LSP and LAA targets

Key:
WR = welfare rights service
LA = local authority
VCFS = voluntary, community and faith sect (also known as third sector)
LSP = local strategic partnership
LAA = Local Area Agreement
Tackling men’s cardiac health in Birmingham

The three PCTs in Birmingham collectively financed a major outreach initiative targeting men aged between 40 and 65 years in the 11 most deprived wards of the city. Birmingham Health and Wellbeing Partnership (BHWP) funded the Improving Male Life Expectancy Programme in Birmingham.

The work emanated from stark statistical data illustrating that men from particular wards of the city were, on average, dying several years earlier than men from more affluent wards. The biggest single cause of death was CHD. This programme was established prior to the DH’s vascular checks programme but illustrates many of the features promoted by the guidance as good practice.8

The programme initially undertook social marketing research to identify the barriers to men using existing health services. The multi-ethnic nature of Birmingham’s community meant that the research had to consider the perspectives of men from diverse ethnic and racial backgrounds, in addition to other factors, such as whether men were employed.

This initial research shaped an outreach programme that has proved to be very successful in engaging men in addressing their own health and well being. The project team was very small and relied on commissioning a range of partners; some, such as a call centre, were rather different partners to those usually contracted by the NHS.

The Healthy Heart Service had 12 full time workers, promoting blood pressure monitoring, cholesterol testing, smoking cessation, healthy eating and physical activity and awareness. Community development approaches were used in workplaces, sports clubs, faith groups, retail outlets, etc. Work was supported by stop-smoking and blood pressure campaigns; a ‘health check’ bus; a heart ‘MOT’ service (checkover), delivered through 20 city pharmacies; case finding via patient records; cardiovascular disease (CVD) clinics in NHS and non-NHS settings, e.g. health centres, football clubs and churches, including evenings; and a call centre contacting at risk men for CHD.

The main features of the programme included:

• outreach to individual men via media, word-of-mouth and personal phone calls
• partnership working with male orientated community venues and groups, including faith centres and sports venues
• partnership working with health and well being professionals to come together as virtual teams to deliver the programme
work with commissioners (PCT and practice based commissioning) to learn the lessons from this approach and to also ensure that once men who had existing problems or who were at risk of developing health problems had been identified, they could access the relevant health and well-being/lifestyle change services and support

coordination of the above elements to ensure a systematic and strategic approach across the 11 areas and the three PCTs.

This approach illustrates the ‘Five Elements’ model. Outreach to men to engage them in their health is happening in other areas of the country. However, it tends to focus in the ‘grassroots’ and community infrastructure boxes of the ‘Five Elements’ model and to be ad hoc rather than planned, systematic and industrially scaled in reach and impact.

A more detailed outline of this project can be found in ‘Closing the gap: finding the missing thousands’ (see Masterclass Report 2).

A strategic ‘Five Elements’ approach to men’s cardiac health

Key:
CVD = cardiovascular disease
LAA = Local Area Agreement
LSP = local strategic partnership
p’ships = partnerships
Identifying and addressing the health needs of lesbian, gay and bisexual (LGB) communities in Bradford

In 2006, the Equity Partnership, an LGB voluntary sector Infrastructure Support Organisation (ISO) supporting over 40 LGB community organisations in Bradford and across the wider Yorkshire and Humberside region, was commissioned by Bradford City PCT to undertake an HNA of the LGB community in Bradford. This was completed in 2008 and, subsequently, led to a number of strategic interventions. These provided further support and engagement of the Bradford District LGB communities and facilitated the commissioning of services and raised awareness and organisational capacity to respond to specific health and well-being needs identified. These have included:

- establishment of a cross-NHS (commissioners/providers) and LGB community working group to initiate the LGB HNA
- commissioning of a three-year post/project to further engage the local LGB population through:
  - a 2009 follow-up HNA and to align the HNA with the small amount of national research into LGB health needs
  - delivery of health initiatives aimed at LGB groups and individuals to respond to issues raised in the initial HNA, including smoking; sexual health; and diet and exercise
  - delivery of training in LGB awareness and challenging homophobia and heterosexism among NHS, housing and social care managers and front-line staff
  - information, aimed at LGB people, in relation to rights and legal duties of service commissioners and providers, and signposting to services such as Patient Advice & Liaison Service (PALS)
- commissioning of an LGB mental health project and worker
- establishment of LGB Staff Networks at the PCT, one of the main acute foundation trusts and the mental health/learning difficulties NHS trust
- links made to explore the feasibility of the PCT becoming a ‘Stonewall Champion’
- specific engagement initiatives to get lesbian perspectives on cervical smears to inform re-commissioning
- NHS Bradford & Airedale nominated lead for sexual orientation in the Equality and Diversity Team
- successful bid for a Department of Health ‘Pacesetters’ project and funds, to target work in relation to lesbian sexual health
- commissioning of sexual health outreach work aimed at men who have sex with men
- engagement of NHS staff and Equity Partnership staff in the various national events and conferences held in relation to LGB health and well-being, including presentations and workshop delivery
- compilation by the Equity Partnership of a guide to making organisations and services LGB friendly,\(^\text{14}\) which has been posted on the website of NHS Bradford & Airedale
- support to managers in Bradford Teaching Hospitals NHS Foundation Trust to undertake Equality Impact Assessments in relation to sexual orientation.

The ‘Five Elements’ model enables mapping of the various strands of work in relation to LGB health and well-being. Although there is agreement that there is much more to do to fully meet the needs of LGB people, the ‘Five Elements’ model provides a framework for ensuring that the HNA is part of a coordinated strategic approach rather than an isolated piece of work. In this instance, ‘grassroots’ level championing of the LGB health agenda initiated most work that features in the other four boxes; although there are now several people whose role it is to make the arrows connect up the work within the various elements.

### A strategic ‘Five Elements’ approach to lesbian, gay and bisexual community engagement

<table>
<thead>
<tr>
<th>1. Grassroots community work</th>
<th>2. Community infrastructure</th>
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<tbody>
<tr>
<td>Information, classes and groups for LGB people re: different health and well-being issues</td>
<td>NHS LGB staff networks</td>
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<tr>
<td>NHS LGB staff networks Service delivery of specific services targeted to LGB communities</td>
<td>Staff training courses ‘Stonewall Champions’ Equality impact assessments</td>
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<th>5. Overview &amp; coordination</th>
<th>Key:</th>
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<tr>
<td>NHS LGB Coordinating group Equity Partnership as ISO for LGB groups</td>
<td>LGB = lesbian, gay and bisexual</td>
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ISO = Infrastructure Support Organisation  
HNA = health needs assessment
Increasing engagement in cancer screening in North East Lincolnshire

North East Lincolnshire NHS Care Trust Plus currently has five different community collaboratives. ‘Older people’s’ and ‘Early detection of cancer’ began with Neighbourhood Renewal funds. The success of these two initial programmes led to the development of three additional programmes – the ‘CHD collaborative’; the ‘Worklessness collaborative’ and the ‘Skin integrity collaborative’. These programmes are now an integral part of the work of the Care Trust Plus. The term ‘collaborative’ refers to local volunteers and other key stakeholders, including local primary care teams, specialist nursing teams and other local services and professionals (e.g. Fire and Police Services, Housing, and Acute specialists) working together on common health and well-being issues. All partners are regarded as ‘equal’ and the joint working is facilitated by an experienced, dedicated coordinator.

The Early Presentation of Cancer Symptoms Healthy Communities Collaborative Programme focuses on three of the major cancers in the district; each collaborative initially focused on a different geographical locality, although they are now being expanded across the district:

• bowel cancer
• cervical and gynaecological cancers
• prostate cancer.

Work is targeted at areas where it is apparent that local people are less likely to detect cancer symptoms and/or are less likely to seek help. A paid member of staff who supports three teams comprising volunteers from the local community coordinates each of the three localities.

The community volunteer teams have worked closely with healthcare professionals to create their own unique, targeted approaches. Health professionals share their knowledge and expertise with community members enabling them to develop a detailed understanding of those at high risk of particular cancers and, thus, identify the potential audiences for particular information. The community team then engaged with local people to gain a better understanding of the main barriers, motivations and challenges that might limit early presentation and detection of potentially life-threatening symptoms.
Once this stage had been completed, the collaboratives commenced designing information and resources to best target the relevant population groups, based on their local knowledge. Information and key messages have been tailored to and tested out in localities. Different mediums – such as beer mats; bookmarks and calendars; and young women talking on local radio to other young people – are some of the ways in which the collaboratives have sought to produce materials that present information that is readily accessible and well received. The community team members are seen as ‘passports’ to their own communities, creating a very different approach to delivering healthcare messages.

A measurement framework was developed from the outset which facilitates assessment of monthly impact and improvements within each collaborative and enables a snapshot of impacts over a given period. This also enables Care Trust Plus to demonstrate achievement against its mission, values and organisational priorities. Baseline research was undertaken at the outset of the collaboratives that permitted measurement of changes and the impact of the work.

Some of the initial outcomes have been:
- 31% increase in bowel cancer referrals
- 23% increase in confidence about identifying the early signs of bowel cancer
- 12% increase in knowledge about where to go for help across health and social care services
- 65% increase in the number of prostate cancer referrals.

The collaborative teams have developed strong links with primary care practices. Three staff have been recruited from primary care backgrounds to provide insight and a link into how service improvements can be initiated and translated into good practice.

This work has taken a systematic and strategic approach to community engagement from the outset. Community members recruited to be part of the collaborative teams are now getting involved in other areas of community engagement work, including standing for election on the Care Trust’s commissioning boards.
The ‘Five Elements’ model maps some of the key elements of the work and highlights the strategic, rather than the small local project, approach that Care Trust Plus has taken, with such positive preliminary results.

A strategic ‘Five Elements’ approach to cancer community collaborative working

1. Grassroots community work
   - Outreach to recruit collaborative members
   - Outreach to identify barriers
   - Targeting of information and signposting

2. Community infrastructure
   - Collaboratives bring together local people to work cooperatively
   - Develop new, and link into existing, community groups and networks

3. Professional infrastructure
   - Primary care staff recruited to bridge changes to develop more accessible and responsive primary care
   - Professionals ‘train’ local people and share knowledge and expertise

4. Organisation development
   - Baseline and ongoing measurement of impact
   - Integrated into mainstream commissioning and delivery
   - Collaborative members standing for election to commissioning boards

5. Overview & coordination
   - Coordinator posts
   - Collaborative members and teams linked into other trust community engagement work to expand learning and sharing

WHAT HAPPENS WHEN A ‘FIVE ELEMENT’ STRATEGIC APPROACH IS NOT USED?

There are a myriad of examples of where good community engagement work has failed to impact on larger-scale change, or failed to be rolled out and expanded as a way of working across a wider geographical area. This is a waste of intelligence and money and means that only short-term, limited outcomes are achieved.

The two examples below indicate where things can go wrong. The pale blue boxes in the diagrams indicate that several of the ‘Five Elements’ were not addressed at all, or not fully addressed. In both instances, the initiatives were driven by front-line staff and/or community organisations and the community engagement initiatives were never fully embraced by the mainstream organisations they were seeking to influence. That is not to say initiatives should not start ‘bottom up’ but these examples illustrate the difficulties in ensuring that such initiatives are not marginalised. Key champions in the health economy must ensure that such initiatives are linked into the right people/places and are co-owned at an early stage if resources invested are going to deliver sustainable outcomes.
Engaging South Asian communities in diabetes health checks

In one local authority area, the numbers of people from the three main South Asian communities (Pakistani, Bangladeshi and Indian) comprise 25% of the total population. However, in some wards this can approximate 80% and, in terms of births at one of the main hospitals, the figure was just over 50%.

A lottery funded Healthy Living Project, working closely with a GP and specialist diabetes nurse, successfully collaborated with a drugs company to finance a major outreach initiative to identify South Asian people living within a local ward who had undiagnosed diabetes or glucose intolerance. The three professionals formed themselves into a ‘virtual’ team to undertake the initiative.

Following a range of preparatory outreach work and meetings with the local community and its faith leaders, the finance enabled the virtual team to hire in nurses from a pharmacy company to work with them on targeted days and evenings, at sessions held in Mosques and community centres. Outreach to workplaces, such as taxi firms and Asian restaurants, was also built in.

Attendance at the outreach events was very high. Awareness raising and information sharing were features of the sessions, alongside the risk assessment and testing. Levels of undiagnosed diabetes and glucose intolerance among the population were at levels that seriously concerned the team involved, as did the relatively young age-profile of those found to already have a problem.

Where people were registered with practices that were not involved with the outreach work, then the team could only advise the individual to visit their GP urgently. There has been no formal way of monitoring these people to determine whether this was what they did, and the consequences of that consultation.

Despite winning a national award, and various attempts to showcase the work and its findings, the team found little interest from other GPs and local commissioners. The funding ran out and the team was unable to undertake any further events without a core clinical team to work with them (otherwise long consultation delays would have deterred many people from participating). Two members of the core team have since moved jobs and the Healthy Living Project no longer exists.
If the ‘Five Elements’ model is applied, it can be seen that although this work was highly successful on a small scale, and could have been extended further across the whole area, rather than just in one ward, and the approach expanded to other health issues (such as cancers and CVD), it was unable to elevate the approach and learning. There was little organisation development work, as the three main players did not have those connections, and very little in the professional infrastructure element, as they had to hire external nurses on a sessional basis. The three core members of the team were in the overview and coordination box, but were unable to obtain wider involvement of people at a more senior level, and were without the role authority to use the learning to impact on wider change, either prior to, during or after the outreach work they undertook.

This work was undertaken by committed, but quite marginalised staff who, although having important roles locally, were unable to convince their district-wide GP and specialist nursing colleagues and, thus, get ‘commitment’ from diabetes pathway and primary care colleagues, or the wider commissioning infrastructure.

At the outset, the team initiated and delivered the outreach work, feeling that if they could demonstrate success then the work would be taken more seriously. Alas, this did not happen. Employing freelance nurses meant that the wider nursing workforce were not exposed to the ways this work could have an impact. Most sessions were conducted in the evenings and at weekends, which were the best times to reach the community but not times when most mainstream NHS services engage. Despite changes in role, the members of the virtual team continue to promote and believe in this approach, motivated both by the numbers of people they were able to engage and also by the high numbers of people they identified with previously undiagnosed diabetes or impaired glucose intolerance.

Most of those participating in the sessions were motivated by their Imams (who had been motivated by the Healthy Living Project community worker) and through word-of-mouth from family, friends and neighbours who had been to other events/sessions. They would not necessarily have gone to their GPs, as most were unaware they had any symptoms, or if they were aware, that those symptoms needed clinical attention. Significant numbers of people under 40 years of age were identified, which would put them outside of routine NHS Health Check call up by their GP practice.
If the organisations/teams that the three core staff belonged to had adopted a systematic and strategic approach to community engagement, then there would have been clearer senior level understanding of the importance of this work, and clearer pathways to share and mainstream the learning from this successful but, unfortunately, discontinued work.

A non strategic approach to diabetes case-funding

1. Grassroots community work
   Outreach to faith leaders and door-to-door calling to spread the word
   Targeting of information and signposting to the events around the local area
   Materials in community languages and using many visual, culturally appropriate communications

2. Community infrastructure
   Mosques & community centres on board & hosted events and sessions
   Local businesses, such as taxi companies and restaurants, also agreed to host sessions for their staff

3. Professional infrastructure
   Freelance nurses recruited, so no ongoing links to local nursing and GP professional infrastructures and, thus, no local champions beyond the core team

4. Organisation development
   The value of the work and its potential to be mainstreamed was not understood by key people in the PCT or PBC

5. Overview & coordination
   Only the three core virtual team members
   No ownership in PBC or wider PCT commissioning

Key:
PBC = practice-based commissioning
PCT = primary care trust
HNA of African and Caribbean communities in a PCT area

Staff within a North of England PCT decided to commission an HNA of its African and Caribbean community. A small amount of funding was allocated via the organisation’s equality and diversity (E&D) team to a local network – the Black People’s Alliance, co-ordinated by a local black and minority ethnic (BME) third sector organisation – to undertake this work.

The Black People’s Alliance spent some months outreaching to people from different genders, ages and ethnic and racial backgrounds (Caribbean, African and other non-Asian communities) to identify local health needs. It struggled with some of the more recently arrived African communities, as it did not have the budget to employ specific language interpreters/interviewers. The PCT did not make the connections with this work across to its own interpreting service.

A report was published and widely distributed amongst the various communities and sent to various agencies and key individuals, as well as the PCT.

After several months, the group had heard nothing and so attempted to meet the PCT again. The lead member of staff who had commissioned the work explained that he could do nothing with the report as he had no access to resources or decision making. He suggested they go away and formulate an action plan to try and progress the work directly, especially sections relating to community awareness and information needs, using the PCT’s part-time African and Caribbean community development worker. This work had been continuing for some time, but did not address all the strategic and service needs that were identified in the report. For example, both national and local data identified that men of African and Caribbean descent are significantly more likely to develop and die prematurely from prostate cancer than the general population. However, there is no specific, public sector led work in this PCT area to address this issue, and this community does not feature as one to specifically focus on in the cancer pathway or within cancer strategy documents.

Numerous health needs were identified in the research that related to a wide range of people’s lead roles within the commissioning and service provider arm of the PCT (primary care, long term conditions, mental health etc.), as well as the local acute and mental health trusts and adult and children’s services. The Black People’s Alliance, comprised almost entirely of volunteers, was told by the PCT that it would need to build its own relationships and feed into all of these different decision-making and resource allocation leads, as the community was too small to warrant specific PCT resources.
The HNA is now nearly four years old. The composition of the community has changed due to asylum and refugee arrivals. PCT staff have moved on and changed roles. The report, which was financed by public money and took a significant amount of voluntary time to research and write, has still not found a home and has not received a response and none of its findings or recommendations have been acted on.

This example highlights a common problem in commissioning the third sector. They are commissioned to undertake work – be it needs assessment or service delivery – but then not strategically linked into the PCT and partner bodies, where the outcomes of the work can feed back in and be acted upon. It also illustrates that PCTs struggle to fit complex, cross-cutting community needs – be they communities of interest or identity or geographical communities – into commissioning roles, resources and decision making structures, which tend to be organised by disease or service areas rather than around the needs of specific communities.

A non-strategic health approach to needs assessment in African and Caribbean communities
APPENDIX 1: OUTLINE OF STATUTORY ‘DUTY TO INVOLVE’ AND EQUALITIES REQUIREMENTS

Statutory ‘duties to involve’ are now a requirement for both the NHS and local government15 and there are extensive requirements in relation to equalities communities.

In relation to certain communities of interest, existing legal requirements, which will be further strengthened and expanded by the Single Equality Bill, require public bodies (and others) to ensure that certain sections of the population are not unlawfully discriminated against, and that there is equality of opportunity. Public bodies are bound by three statutory equality duties, relating to race, disability and gender. Common to all three duties is the requirement that in conducting its functions, a public body must have due regard to the need:

- to eliminate unlawful discrimination
- to promote equality of opportunity.

In addition:

- the Race Equality Duty includes a requirement to have due regard to the need to promote good relations between persons of different racial groups
- the Gender Equality Duty includes a requirement to have due regard to the need to eliminate harassment16
- the Disability Equality Duty includes requirements to have due regard to the needs:
  - to eliminate harassment of disabled persons that is related to their disabilities
  - to take steps to consider disabled persons’ disabilities, even where that involves treating disabled persons more favourably than other persons
  - to promote positive attitudes towards disabled persons
  - to encourage participation by disabled persons in public life.17

The Equality Act (Sexual Orientation) Regulations 2007 (2007, No. 1263) made discrimination against someone in the provision of goods and services on grounds of sexual orientation an unlawful act by any agency, including most public bodies.

Unless public sector bodies and partnerships ‘fully engage’ with communities of identity and interest, it is quite likely that:

- different morbidity and mortality patterns will not be fully identified or analysed
- specific need of particular communities will not feature in commissioning decision-making
- appropriately targeted services and support for lifestyle change will not be delivered
- a ‘one-size suits and fits all’ approach will continue to dominate.

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APPENDIX 2: GLOSSARY OF ABBREVIATIONS USED IN THE DIAGRAMS

BME – black and minority ethnic
CVD – cardiovascular disease
E&D – equality and diversity
HNA – health needs assessment
ISO – Infrastructure Support Organisation
LA – local authority
LAA – Local Area Agreement
LGB – lesbian, gay and bisexual
LSP – local strategic partnership
PBC – practice-based commissioning
PCT – primary care trust
VCFS – voluntary, community and faith sector (also known as third sector)
WCC – World Class Commissioning
WR – welfare rights
REFERENCES

1 The Wanless Review (Securing our Future Health: taking the long-term view: the Department of Health: 2002) looked at three different scenarios, including a ‘fully engaged’ scenario. In this option the level of public engagement in relation to health was high, life expectancy exceeded current forecasts, health status improved dramatically, use of resources was more efficient and the health service was responsive with high rates of technology uptake. The ‘fully engaged’ scenario was the least expensive scenario modelled and delivered better health outcomes.


4 The ‘Five Elements’ model was developed by Jan Smithies and Georgina Webster of Labyrinth Consultancy & Training, UK and was published in their book Community Involvement in Health: from passive recipients to active participants: Ashgate Publishing: 1998. When used it should be referenced accordingly.


6 For more information on the community engagement diabetes work of NHS Bradford & Airedale contact the HINST Team: hinst@dh.gsi.gov.uk.


9 For more information contact the Equality & Diversity Team at NHS Bradford & Airedale.

10 Now merged along with three other sub-district PCTs into NHS Bradford & Airedale.

11 Unit of Public Health, Epidemiology and Biostatistics, University of Birmingham – A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research.

12 Stonewall Lesbian Health Survey. www.stonewall.org.uk/

13 www.networks.nhs.uk/networks/page/643

15 Department for Communities and Local Government: *Communities in Control: real people, real power:* July 2008; and Department of Health: *Real Involvement: working with people to improve services:* October 2008.

16 Unlawful discrimination and harassment on gender grounds includes discrimination and harassment on the grounds that a person intends to undergo, is undergoing, or has undergone gender reassignment.

17 The relevant provisions in primary legislation are: Section 71(1) of the Race Relations Act 1976, which came into force on 2 April 2001; Section 49A of the Disability Discrimination Act 1995, which came into force on 4 December 2006; Section 76A of the Sex Discrimination Act 1975, which came into force for these purposes on 6 April 2007.

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Ian Melvin, Welfare Rights Team Leader  
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Jeremy Baskett, Assistant Director of Community Engagement and Public Involvement  
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If you want more information on the examples contained in this guide, please contact HINST on 0207 972 3377 or email hinst@dh.gsi.gov.uk