Public Health England

Protecting and improving the nation's health

Tools to support 'Place-based approaches for reducing health inequalities'

Tool C: Service to community

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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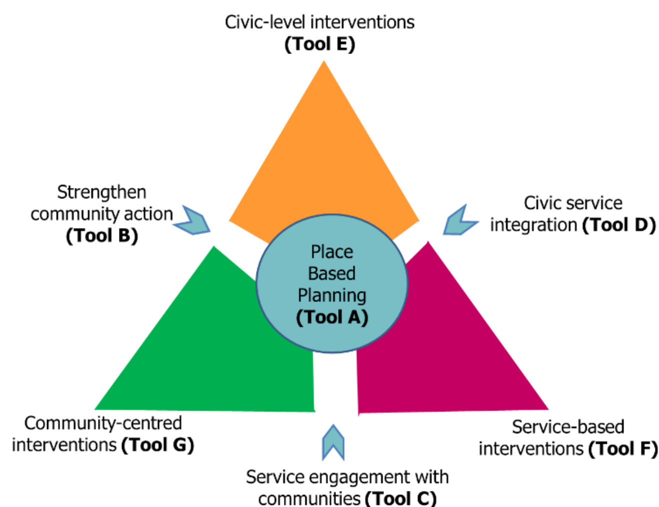
Introduction to 'Place-based approaches for reducing health inequalities' tool set

Chapter 4 of the 'Place-based approaches for reducing health inequalities', describes the Population Intervention Triangle (PIT) as a model for planning action to reduce health inequalities. A series of tools exists to support local areas apply the principles set out in each part of the model.



How to use the tools

All of these tools have been developed to use either through:

- self-guided means
- a Peer-Peer Support process (for example Sector Led Improvement) or
- facilitated workshops

If you would like further information about potential practical support for the application of these tools then please contact health.equity@phe.gov.uk.

It is important to note that local areas should not work through all tools in one go. It is recommended to start with Tool A on Place Based Planning, which examines key elements of place-based working as a whole. Then local areas can pick and choose which section of the model could benefit from further investigation given local circumstaces.

Tools A, B, C and D provide a a checklist of questions based on experience of what makes a difference to that component of the model. Most of these tools start with a series of statements progressively rated from emerging to thriving for each part of the checklist. This informs what good practice looks like in this area. It also enables users from different parts of the system to individually rate which statement in each of the 10 Steps would best describe the current situation from their perspective. This discussion can then be useful and creative to explore reasons for the different partner perspectives. The colour rating also allows agreed prioritisation amongst the steps of how to move the system towards further improvement. Armed with those priorities, the more detailed Diagnostics in the annexes of the tools add more information on what potential action may benefit those priorities. Therefore, users do not need to run through all parts of the detailed diagnostic content, instead they should simply pick out their priority areas to inform potential improvements.

Tools for E, F and G are pre-existing documents which readers can use to inform further action on the apices of the triange: civic, service and community interventions. The links to these tools are provided in Chapter 4.

Checklist for this tool – Tool C

1 Prioritisation and targeting
2 Defining 'communities'
3 Practical asset mapping
4 Community-centred approaches
5 Shared community profiles
6 Neighbourhood action plan
7 Coordinated partner behaviour
8 Outreach and in-reach models
9 Linking to the disengaged/excluded
10 Transfer to community ownership

Screening Tool C: Service to community

	Emerging	Developing	Maturing	Thriving
Prioritisation and targeting (1)	Priority for resources based purely on community ability to self-promote, or strong champions in positions of influence.	Communities in greatest need identified with ranked objective measures eg deprivation scores: IMD or part domains such as housing; income; education; health.	Ranking augmented by shortlist of target communities constructed by consideration of detailed assessment of relative needs and assets, and benchmarking of key service outcomes.	Overarching strategy with plans to provide graduated attention and support based on relative need over time: most disadvantaged to move the furthest fastest.
Defining 'communities' (2)	Communities primarily defined based on LSOA; MSOA etc. for ease of analysis. Range of overlapping service boundaries exist.	Electoral wards adopted as a common currency of place-based working across services.	Neighbourhood and cultural communities self-defined through consultation with residents. LSOAs, MSOA's clustered to fit.	Public sector service organisational boundaries co-terminus and built up taking account of communities and community infrastructure
Practical asset mapping (3)	Little account taken of community assets or locally identified deficits. Barriers in top-down Place-based planning.	Large detailed stocktake of assets compiled with external support, and held electronically as a shared resource. Not maintained, and may be out of date.	Useful database kept systematically updated by partners, with shared resource. Easy to access and use by staff and public. Drives a range of informative products and access points.	Real-time knowledge of key assets (eg local leaders; well used community venues and infrastructures) are shared systematically by working partners/community leads.
Community-centred approaches (4)	Community perspectives to influence service engagement depends on consultation on plans with formal representatives at certain stages.	Externally commissioned and delivered review of community perspectives based on academic or market research principles. Feedback at community event.	Participatory research based on training and support of community based researchers (CBR) as peer led assessment of needs; wants; barriers and aspirations.	CBRs feedback findings into community. Help inform/own compilation and analysis of results and explore and test out ideas for action. Continue to monitor ongoing perceptions as work streams progress.

	Emerging	Developing	Maturing	Thriving
Shared community Profiles (5)	Community/ward/practice profiles only constructed as a statistical sub-set of the strategic needs assessment.	External sources of non-attributable data collated with qualitative input from residents, including as participatory research, and frontline staff.	Emerging picture described, communicated, discussed and modified accordingly after community debate to present a working 'picture of place' recognisable to them.	Arrangements to ensure ongoing work-streams keep the intelligence 'topped up', adding increasing layers of local insight to the picture.
Neighbourhood action plan (6)	A range of community focussed goals and actions established separately by different external stakeholders.	Coordinated action plan established, taking some account of goals based on community's own priorities.	Realistic community owned goals central within local plans, with clear visible outcomes to reinforce their confidence in ability to make changes.	Agreed contributions of community and external stakeholders clear. Formal mechanisms to take stock regularly of adherence to mutually agreed principals of behaviour.
Co-ordinated partner behaviour (7)	External organizations across the sectors continue to work into priority communities in largely uncoordinated initiatives.	Inter-agency processes for integrated systems of communication and safe information sharing, reducing duplication and transaction costs..	Modified working practices and structures produce 'collaborative plumbing' eg personalised care plan; shared key worker; unified case management .	Integrated systems put individual and family users at the centre of holistic decision making and setting priority goals.
Outreach and in-reach models (8)	External organizations provide services from a range of estates and points of access: some local, some from distance, each with different entry points.	Service provision options chosen from a variety of public sector/community venues locally so users feel safe and reassured when seeking support.	Local negotiation supports single points of local access, both face-to-face and digital to help address a multifaceted range of problems.	Peer workers recruited, trained and supported to provide an intermediary workforce, reducing cultural barriers to access and use.
Linking to the disengaged/excluded (9)	Some residents deemed stigmatised or not worthy of support by community (criminal past; addictions; street workers} and are excluded or exclude themselves.	Public and Voluntary and Community and Social Enterprise (VCSE) sector service front-line workers trained in (health) coaching and activation skills.	Designated support workers link to excluded groups eg homeless. Peer support workers / community champions adding signposting, referral and advocacy to receptive services, from one remove.	Targeted out reach to isolated / excluded groups. Credible first contact establishing trust, backed with multifaceted support options.

	Emerging	Developing	Maturing	Thriving
Transfer to community ownership (10)	Independent sector community based activities subject to conventional commissioned oversight, performance management and financial controls.	Some mainstream service delivery prioritises development of locally developed and recruited peer workforce for appropriate roles.	Some community centred roles developed by, or transferred to community ownership, eg as social enterprise, community interest company etc.	Ongoing external expert development and support continues, but there is significant transfer of resources, control and responsibilities.

Detailed diagnostic for Civic support to Communities:

Have the most disadvantaged, not just best self-advocates, been prioritised?

Have communities (geographical; characteristic; interest) been identified as priorities on the basis of initial strategic assessment of needs and assets, rather than self-selected, for example through bids to tender?

Has any verification of priority status compensated for lack of parochial leadership or infrastructures, and proceeded to offer support despite initial community scepticism?

Natural communities: self-defined, not initially a statistical construct?

Have neighbourhood 'boundaries' been agreed and negotiated with residents?

Has it been possible to establish acceptable best-fit electronic definitions (Local Super Output Areas; postcodes; wards) for data and analytical purposes?

Bearing in mind possible differing agency boundaries (for example police; children's services; health and social) do natural neighbourhoods work as common building blocks?

Have key assets for engagement been identified?

As part of a wider asset mapping exercise, or in advance of one, have key assets important for the engagement process been identified or shared between working partners. Include (formal and informal) :

- significant leaders
- community infrastructures
- community venues

Have community-based research methods been used to establish real community-based perspectives?

Have enquiries on community perspectives been facilitated systematically using participatory research methods, for example through training and support of community based researchers?

Have these been tasked with identifying :

- needs, wants, aspirations, barriers

- exploring and testing out ideas for action
- Ongoing perceptions as work streams progress?

Are there shared community profiles which describe a recognisable picture of place?

Do these combine analysis of external sources of non-attributable data with collation of qualitative information from residents (for example from participatory research) and frontline staff?

Has the emerging picture been described, communicated, discussed and modified accordingly to present a credible 'picture of place' recognised by the community?

Does any ongoing work stream keep the intelligence 'topped up' and add increasing layers of 'insight' to the picture'?

Have goals/basis of action been agreed to form a neighbourhood action plan?

Are the goals strongly owned by the community, and based on its own main priorities?

Are the goals realistic, with clear visible outcomes so as to reinforce community confidence in the ability to make changes?

Are contributions of community and external stakeholders clear and agreed?

Have principles of behaviour been agreed amongst internal and external stakeholders?

Is there a mechanism to regularly take stock of partners adherence with these principles of working?

Has partner behaviour been modified to facilitiate coordinated working with communities, families and individuals?

Have outside agencies modified working practices and structures individually and together to produce systems of 'collaborative plumbing' (for example key worker/ unified case management arrangements)

Have inter-agency mechanisms of communication and information sharing reduced duplication and transaction costs without unacceptable loss of protection?

To what extent do procedures commonly put the user at the centre of decision making?

Do service outreach/in reach models provide options defined by the community?

Do venues for service provision include options chosen from a range of statutory sector and community venues to ensure users feel safe and reassured when seeking and receiving support?

To what extent does 'collaborative plumbing' and local negotiation support single points of access to help address multifaceted problems?

To what extent have peer workers been recruited and trained to provide an intermediary workforce reducing cultural barriers to access and use?

Does a community links strategy work to embrace the disadvantaged/excluded?

Is there a peer support front-line (for example community champions) adding signposting, referral and advocacy to receptive services at one remove?

Are peer support and agency front-line workers trained in (health) coaching and activation skills (for example Health Chatterers; Connect 5)

Are there systems of targeted 'door-knocking' to contact those with complex dependency? Credible first contact backed with multifaceted support, for example projects with key worker; self-defined goals.

Has there been any transfer of suitable service into community ownership?

Has this been of an extension of existing service, for example peer supported self-help or formalised separation, for example through social enterprise development; community interest company?

Does it involve external ongoing development support at one remove?

Does it involve a significant transfer of resources and responsibilities?