

Better Together

A guide for people in the Health service on how you can help to build more cohesive communities

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1. Executive summary

Many communities in Britain, as in other countries, are experiencing rapid change. Traditional industries have been replaced by new types of employment; women play a much more active role in the workforce and we live in much smaller family units than we did a generation ago. Our horizons have been widened by the internet, private motor cars and cheap air travel and many of us choose to move from our homes to seek work, new experiences or a better environment. So places change. As some people move away and new people replace them the nature of places may become more diverse in culture, faith, ethnicity and needs. This opens up new opportunities which can enrich people's lives but it also presents new challenges as old social networks break down and new ones develop.

Community cohesion occurs where there are strong and positive interactions between people from different backgrounds but sometimes it needs a helping hand. This guide suggests that the Health service could, and should do more to provide that helping hand – and that it will improve health outcomes. The key points are as follows:

- Part 2 sets out the key issues that have emerged in the course of producing this guide, and contains a number of recommendations about the kind of actions that NHS bodies could take to make a major contribution to community cohesion.
- In Part 3 (the Introduction), we outline the purpose of the guide and say how it can help different people. We give a definition of community cohesion, suggest how you might use the guide and describe the process we used to develop it.
- In Part 4 we explain why community cohesion should be a major issue for people working in the Health service. The NHS is required by law to engage with communities, to comply with a range of anti-discrimination legislation and to work in strategic partnerships to achieve agreed public policy outcomes (which increasingly include community cohesion). The activities covered by these legal requirements lie at the heart of community cohesion.
- Community cohesion is part of an area's stock of social capital. Where it is strong there is a positive impact on health with improved life expectancy and reduced health inequalities. Where it is weak, the reverse tends to be true. By addressing community cohesion issues Health bodies and their partners have a positive impact on health determinants.
- Whilst community cohesion contributes to health it is also true that health contributes to community cohesion. When people are fit and well they play a more active role in their community's life.
- In most parts of the country Local Government leads partnership work on community cohesion but Health is a sleeping giant with the potential to play a much bigger role because of the huge impact it has on most peoples' lives.

- There is also a pragmatic reason why it makes sense for Health bodies to address community cohesion. By doing so, you will strengthen and enrich your approach to several key NHS priorities: World class and practice based commissioning, joint strategic needs assessment and local area agreements, improving wellbeing, promoting equality and diversity, reducing health inequalities, engaging with and empowering communities, implementing the Darzi report recommendations, tackling issues of mental health, community safety and the harm caused by abuse of drugs and alcohol.
- In Part 5 of the guide we trace the development of ideas about community cohesion and discuss some of the elements which define the concept. We consider how to measure community cohesion and suggest a basket of measures including the national indicators for PSA 21 (about how people feel about the state of social interaction in their community) and various local indicators relating to local issues. In 2008, 92 Local Strategic Partnerships selected one or more of the four national PSA indicators on community cohesion thus making a partnership commitment to cohesion.
- Part 5 also considers what we mean by 'community' and suggests that we need to engage with seldom heard groups such as young people, disabled people and their carers, people with mental health problems, new migrants and BME communities. Some examples of how this has been done well are included in Part 6 under question iv.
- We examine the causes of tensions within and between communities and consider a set of principles that are needed to underpin community cohesion strategies. This includes a discussion of the Government's recent proposals to combat violent extremism.
- Part 6 focuses on ten key activities through which you can have the greatest impact on community cohesion and sets out a series of ten challenging questions to help you work out how you can adapt your approach to that activity to improve the impact. For each of the ten sets of questions we have explained why they are important and we have given some examples of good practice. The questions cover leadership and partnership, promoting positive relationships, achieving positive interactions, engaging with all communities, locating services where they are accessible and encourage interaction, involving suppliers, communicating effectively and countering myths, using information to understand your communities, investing in your people and promoting NHS jobs to all communities.
- In part 7 we discuss some different ways of developing your community cohesion strategy (e.g. developing a bespoke community cohesion strategy, building cohesion into your equality and diversity strategy or building it into your overall service strategy) and we suggest which approach might be appropriate for different circumstances.
- In the course of producing this guide we have worked with several groups, using the ten challenging questions to identify a number of key issues and the kind of action programmes that will address those issues (as set out in Part 2). In Part 7 we emphasise the importance of adopting a similar approach in the way you develop your plans and strategies for your local area.

- We refer to a range of existing guides that provide help and examples of good practice in community cohesion. Many of the case studies described in these guides are from Local Government experience but there are plenty of examples that can be adapted to a health environment.
- We describe a range of tools that can be used to assess the needs of different communities and to assess the impact of new policies and developments on different communities. These are key tools in understanding and responding to different community needs and are fundamental to the process of improving community cohesion.
- In part 8 we identify seven key processes that are common to most effective management systems and we suggest how the ten sets of questions from part 6 can be used to build community cohesion into the appropriate management processes. The key processes are: developing vision, values and strategy, developing partnerships, engaging with communities and understanding their needs, planning and commissioning your programmes, managing resources (finance, information, people and other resources), delivering services and evaluating performance and learning from results.
- Finally there are two appendices with notes on the case studies and pointers to where you might look for further help

2. Key issues and recommendations

In the course of producing this guide we worked with a number of different groups to identify a set of key issues about the way community cohesion is addressed by the NHS and to consider the kind of action programmes that would improve the NHS contribution to cohesion. Our findings are as follows:

Key issues

1. The issue of terminology

We found that the term ‘community cohesion’ is not widely used within the Health service and there is some confusion about what it means. Some people thought the work they were doing under the label of ‘equality and diversity’ was contributing to community cohesion but that was not always the case. Equality and diversity is mainly about how we identify and respond to the different needs of individuals and groups. Tackling inequalities is, of course, an important component of community cohesion too, but cohesion goes much further to break down the barriers between communities, developing interaction and mutual understanding to avoid conflict and taking a much more proactive approach to build a society based on trust and shared values. We think it is important to make that distinction clear and to be explicit about the objectives you are trying to achieve.

How can we encourage people to adopt the term ‘community cohesion’ where appropriate?

2. Not just race and faith

We found that there is a perception amongst many people in the Health service that community cohesion is about race and faith but there are other differences that divide communities (such as age, social class, disability, sexual orientation and ill health). Community cohesion is about promoting positive interactions across all such divisions. Nationally this has been recognised by the establishment of the Equalities and Human Rights Commission (EHRC) which brings together several different strands of equality and diversity. At a local level it means we need to promote more positive images of people who others perceive to be different (e.g. how old and young people perceive each other, how disabled people and people with long term illness or mental disorders are viewed by others). We need to promote positive interactions that break down barriers and challenge myths and stereotypes across all such divisions.

How can we ensure that all aspects of perceived difference are addressed in community cohesion programmes?

3. Priority and commitment

Everyone we talked to recognised that community cohesion is an important objective, but some felt that it is in competition with other policy initiatives which are given a higher priority. In many Trusts community cohesion is seen as an extra responsibility for specialist equality and diversity officers and not necessarily as something that needs to be owned and championed by leaders. In Part 4 we have suggested that a focus on community cohesion will help you to comply with several legal duties and to achieve some of your other NHS objectives. Community cohesion depends upon the creation of a stock of social capital and it is clear that positive interaction, with more people volunteering and looking out for each other, has huge health benefits.

Is local action sufficient to influence priorities at a local level or is there a need for community cohesion to be included as an indicator in the NHS performance framework to provide a more formal incentive?

4. Understanding how communities are changing

We know that many communities are changing rapidly but our information systems are rarely able to provide adequate measures of the scale and nature of that change. In some parts of the country local agencies are working in partnership to develop better systems of shared intelligence. In these areas the Local Strategic Partnerships (LSP) are able to adopt effective strategies to meet changing needs but in other areas there is still a silo mentality and people are reluctant to share data with others. There is scope for the NHS to play a much greater role in this aspect of partnership working. Records of GP registrations, for example, can be a rich source of data on demographic change when combined with other sources like the annual schools census.

How can we encourage a more fundamental commitment to improving shared intelligence systems through partnership working?

5. Building community cohesion into community engagement

As communities become more complex it is vital that methods of community engagement respond to that complexity. We found many examples of good community engagement including ways of engaging with 'seldom heard groups' about their health needs. However it appears to be rare for community engagement to include an exploration of how individuals and communities interact.

How can we ensure that we understand the way people with different characteristics feel about each other and the impact this may have on health?

6. Challenging the practice of single group funding

There is a longstanding practice in Health and Local Government of providing funding to particular community groups that may be vulnerable or in need of support. This practice has had many benefits in promoting equality, but it has recently been pointed out that it can also foster resentment, segregation, separate development and inhibit interaction between communities. In Part 4 (at question ii) we discuss this issue and suggest that, whilst funding policies should still recognise particular needs, they need to be applied in different ways and be based on a clear analysis of their impacts.

How can funding policies be designed to encourage integration whilst still addressing particular needs?

7. How does community cohesion fit with patient choice?

The Government's initiatives to increase patient choice should provide a stimulus for improved quality and make services more responsive to patients. However the benefits may not come automatically to all communities. Trusts will need to monitor how it is working to ensure that all sections of communities see the service as being 'for them'.

How can we ensure that service changes are having a positive effect on social interaction and community cohesion?

Recommendations

1. Community cohesion should be understood, owned and championed by the strategic leaders of NHS bodies, both within your organisations and in local strategic partnerships.
2. Leaders should recognise that community cohesion is not an additional specialist duty but an important part of mainstream service design. Parts 6, 7 and 8 of this guide offer advice on how this might be done.
3. Leaders should ensure that the concept of community cohesion is understood and supported by staff at all levels of the organisation.
4. Leaders should ensure that the design of service delivery models includes ways of promoting positive relationships between people of different backgrounds and identities, whilst continuing to tackle inequalities.
5. Funding policies should be designed to encourage integration and positive relations between people from different backgrounds. Single group funding should be used only in exceptional circumstances (see the discussion of this in Part 6, question ii).
6. All NHS bodies should adopt models of community engagement which involve all the diverse communities in their areas and encourage positive interactions to get them working together on a shared agenda.
7. Community engagement should foster the use of English language (or Welsh in Wales) and material should only be translated into other languages - and interpretation be provided - when necessary on an individual or particular basis (see the discussion of this in Part 6, question iv).
8. Proposals for the location of new or redesigned services should take into account the impact on different communities and the impact on perceptions of fairness.

9. Community cohesion should be built into the community engagement process at each stage of the commissioning cycle (see the discussion of this in Part 4, section on 'World class and practice based commissioning').
10. All NHS bodies should adopt a proactive approach to promoting equality, diversity and community cohesion including actions to counter myths and stereotyping.
11. All NHS bodies should play an active role within Local Strategic Partnerships (LSPs) to help in the development of shared intelligence systems which improve understanding of how local communities are changing (see Part 6, question viii).
12. All human resource managers in NHS bodies should promote community cohesion through the approaches they adopt for the recruitment, development and training of people and be aware of the impact of the make-up of their workforce on the wider community.

3. Introduction

Purpose

This guide has been produced to help people working in the Health service to understand how their work can have an impact on community cohesion and, conversely, how community cohesion can impact on health, wellbeing and health inequalities. It offers practical advice on what types of policies and actions can help to improve relations between people from different backgrounds and indicates where tensions are likely to arise and the kind of actions that may increase competition between different communities. It is important to health practitioners and commissioners because there is plenty of evidence, referred to in part 4 of this guide, that cohesive communities are healthy communities and vice versa. Local Strategic Partnerships are strengthened where the health sector plays a major role, contributing to the wider vision for the area, in which diversity is valued, negative views are challenged and services meet the needs of the local population.

What is 'community cohesion?'

Community cohesion is about building positive and harmonious relations between people of different backgrounds of ethnicity, faith, age, gender, disability, social class, education or sexual orientation. It is defined by the Government as follows:

“Community cohesion is what must happen in all communities to enable different groups of people to get on well together. A key contributor to community cohesion is integration which is what must happen to enable new residents and existing residents to adjust to one another.

Our vision of an integrated and cohesive community is based on three foundations:

- *People from different backgrounds having similar life opportunities*
- *People knowing their rights and responsibilities*
- *People trusting one another and trusting local institutions to act fairly*

And three ways of living together:

- *A shared future vision and sense of belonging*
- *A focus on what new and existing communities have in common, alongside a recognition of the value of diversity*
- *Strong and positive relationships between people from different backgrounds.”*

Source: The Government's response to the Commission on Integration and Cohesion (Communities and Local Government (CLG), Feb 2008)

Who the guide is for and how it can help you

The guide is aimed at managers, commissioners and practitioners responsible for making policy or for commissioning or delivering health services. It will also be useful to people involved in scrutinising decisions about health policy.

- **Strategic leaders (senior managers, nonexecutive directors, directors of public health, policy planners etc)**

It will help you to improve performance in line with the NHS performance framework by identifying and addressing community cohesion issues and ensuring that your plans are culturally sensitive and based on a clear understanding of the nature of local communities and their health and wellbeing needs. It will help you to contribute to “place shaping” through Joint Strategic Needs Assessments, Local Area Agreements, and Multi Area Agreements and it will help you to comply with anti-discrimination legislation and your duty to engage with communities.

- **Commissioners**

It will help you to assess the health needs of different communities, assess the consequences for health and wellbeing of new proposals affecting health determinants and commission services that are sensitive to community needs and changing demographic profiles.

- **HR managers and workforce planners**

It will help you to recruit and develop a workforce that is representative of, and sensitive to the needs of, all parts of your community.

- **Practitioners (including GPs and other service providers) working directly with the public, patients and the voluntary and community sectors**

It will help you to ensure that your services are based on a clear understanding of the diversity and different needs of communities within your locality and of how those communities interact.

- **Service users, members of Local Involvement Networks and Overview and Scrutiny Committees:** It will help you to make informed contributions to the debate about local health issues based on a clear understanding of the diversity of needs in your locality.

There are other resources available to help you with these areas of work but we believe this guide has a very specific focus on the relationship between health and community cohesion. Where appropriate we have provided references and links to other guides so this work complements rather than replaces previous guides.

How to use the guide

The guide uses a series of questions designed to help you think about the relationship between health and wellbeing and community cohesion in the particular communities you serve and to develop strategies that are appropriate to your circumstances. It provides you with links and references to information and documents that may help you and it draws on a number of case studies to show how different approaches have been used around the country but it comes with a “health warning”. Whilst it identifies some key issues and suggests the kind of action you might take to improve your contribution to community cohesion, it is not a toolkit telling you exactly what to do. It is an aid to your thinking to help you develop your own approach.

How the guide has been developed

The guide was commissioned by the Department of Health and has been prepared by Andrew Lawrence, principal associate of the Institute of Community Cohesion (iCoCo). It draws on work that iCoCo has carried out across the country on all aspects of cohesion in which we have worked with health and other practitioners to assess local cohesion issues and to develop responses and longer term strategies and plans. A key part of the guide is a series of ‘Ten challenging questions’ which were developed by a group in the North West region led by Dominic Harrison and supported by Sabir Hussain and Dr Sheila Marsh. The group involved representatives from PCTs, Health Trusts, Local Authorities, Common Ground North West and Lancaster University. We worked with the North West group in the early stages of their work. The North West group will publish a report containing the ten questions soon; we have included them in this guide (at part 6) with a series of supplementary questions to help you assess how well your organisation is doing on community cohesion and to provide some pointers to help you develop your strategy.

We have illustrated many of the key points by referring to material gathered from experiences throughout the country. We have also suggested how you could build community cohesion into your management system, using the ten questions at the appropriate stages. We have been helped by a group of ‘critical friends’ who have provided constructive criticism of drafts and we have used the draft guide to identify key issues at a series of workshops, culminating in a national workshop hosted by Derby PCT on 28th October. As a result of this process we have been able to make recommendations on the kind of actions that NHS bodies could take to make a much greater contribution to community cohesion. The pioneering work carried out in the North West is currently being developed further by an action learning set approach which is being applied to a number of ground breaking projects in that region.

4. Why community cohesion is an important issue for people working in Health services

The legal context

There is no specific legal duty, like that placed on schools, requiring NHS bodies to promote community cohesion. However, community cohesion consists of a package of issues and policy objectives many of which carry a statutory duty or a policy incentive. A focus on community cohesion is therefore an effective way of complying with those specific duties and achieving a set of desired results. Here are some examples of those elements of a community cohesion package that carry a statutory duty:

- There is a legal duty to contribute to strategic partnerships and Local Area Agreements. Many LAAs have now adopted one or more of the national performance indicators on community cohesion so, where this is the case, there is a legal duty to contribute to cohesion through that route.
- There is a legal obligation on NHS bodies to consult the public on a range of policy and service issues. Since community engagement is at the core of community cohesion this makes it part of the cohesion package.
- Like other public bodies, NHS institutions have a duty to comply with a range of anti-discrimination laws (race, disability, gender etc). Again these are central to the cohesion package. Community cohesion is broader than any of the individual areas of equality and diversity because it is concerned with how communities relate to each other as well as the rights of specific “minority” groups.

In addition to any legal duties, the case for a focus on community cohesion rests on three other key arguments: the first is that community cohesion is an important contributor to health; the second is that health is an important contributor to community cohesion and the third is that community cohesion can contribute to the achievement of several other key NHS priorities. These arguments are developed below.

Community cohesion is an important contributor to health

Health and community cohesion are inextricably linked. Health tends to decline (with premature mortality and increased morbidity, particularly in stress related conditions) in communities where levels of interaction are low and where people feel insecure. In more cohesive communities the reverse is true and it is much easier for public services to develop a dialogue with local people and to be sure that services are meeting local needs. Where such a dialogue has developed it helps public service agencies to understand the effects of their decisions on different groups within a community. It can, for example, help them to assess whether actions they are considering to meet the needs of one group may generate negative perceptions in other groups and enable them to address the issues that might arise.

On the website reviewing his celebrated book “Bowling alone: the collapse and rise of American community” (2000) Robert Putnam suggests that, “*Joining and participating in one*

group cuts in half your odds of dying next year”. Putnam charts a decline in social capital in USA associated with a range of factors including changing patterns of work, television, computers and the changing role of women. He shows that Americans have become increasingly disconnected from family, friends, neighbours and democratic structures but he makes suggestions about how they can reconnect. An important lesson from Putnam’s work is that where people connect well in cohesive communities the stock of social capital increases and that includes the state of people’s health.

Similar work in Britain has also found a strong relationship between high stocks of social capital and improved health outcomes (see Petrou and Kupek, 2007).

The CLG report of 2005, ‘Predictors of community cohesion: multi-level modelling of the 2005 citizenship survey’ (page 31), found that “*The strongest negative socio-demographic predictor of cohesion is whether an individual has a limiting long-term illness or disability. The undermining effect this has on their perception of cohesion is approximately twice as strong as the next negative predictor.*”

Most people would acknowledge that community cohesion is an important objective in its own right but, for health service managers, its significance goes beyond that. In many communities it is one of the important determinants of health and health inequalities. Where conditions are favourable, community cohesion increases social capital and reduces health inequalities and this in turn improves community cohesion to complete a virtuous circle. However, where there are factors that increase community tensions or reduce social interaction, community cohesion is undermined, social capital is reduced and health inequalities are likely to increase. The challenge for public service planners is to engage with all communities, anticipate problems and work out the appropriate interventions. The Commission on Integration and Cohesion’s report, ‘Our shared future’ (2007), provides an analysis of the factors influencing the state of integration and cohesion. Clearly they vary from place to place but there is clear evidence of a pattern showing that cohesion is improved where there is a strong partnership and common vision amongst key public agencies and a clear commitment to community engagement.

Sheila Adam (2008) traces the development of local partnerships that have been encouraged by the Government to deliver programmes that strengthen neighbourhoods and communities. She notes that NHS guidance since the late 1990s has consistently emphasised the importance of partnerships to manage earmarked programmes and to “*bend the mainstream*”. Local Delivery Plans include the requirement to work through Local Strategic Partnerships and Local Area Agreements and earmarked resources have been provided to promote joint action including Sure Start, Teenage Pregnancy Strategy, Neighbourhood Renewal Programmes, Area Based Grants and the New Deal for Communities. All these initiatives require NHS engagement, with the potential to achieve both community cohesion and health gain. Adam recognises that NHS organisations that are faced with many conflicting pressures, including reconfiguration, serious financial shortfalls, ever increasing expectations and the need to promote patient choice, may be tempted to regard some of the partnership initiatives as optional. However Adam argues that the NHS must hold its nerve and support the partnership

programmes. She believes that such programmes should be clearly prioritised (with incentives) in our performance management framework. She is hopeful that Local Area Agreements will help through their stretch targets, freedoms and flexibilities but she also calls for more research to develop a much stronger evidence base to help in evaluating programmes and to ensure we are investing in what works best.

The link between indicators of poor community cohesion and health inequalities has recently been explored in research by the Neighbourhood Renewal Unit for the Audit Commission, in a review of community cohesion in the Cheshire and Mersey Local Strategic Partnership area. The research suggests that there is a correlation between a lack of cohesion and inequality in life chances at the local level leading to poorer outcomes between and within communities or neighbourhoods. Common characteristics of areas lacking in community cohesion are economic inequality, high incidence of poor mental health, and variable access to appropriate and high quality services. Lack of cohesion is also associated with higher levels of crime, fear of crime and antisocial behaviour. Often this is targeted at people from marginalised or otherwise vulnerable groups, but there may also be higher levels of crime committed by people from within these communities. Inequalities associated with lack of community cohesion typically reflect the experience of more recent arrivals to an area, particularly people from minority groups. But they are also commonly experienced by people who have lived in a specific area for a long time, sometimes all their lives, but who are marginalised or otherwise vulnerable. This might include people with poor educational attainment (reflected in their literacy and numeracy skills), children who are looked after or otherwise vulnerable, gypsy and traveller communities, and people on low incomes.

In 2004 **Common Ground North West**, a regional level NGO recognised that community cohesion can contribute to improving health and reducing health inequalities. They have worked with the regional health sector, the voluntary sector and Local Authorities to promote community cohesion through the development of community assets and understanding of the effects of conflict, racism and prejudice on the well-being of communities across the region. They established an open regional network and an annual conference to share best practice. Working with GONW they helped to generate the ten challenging questions that are used later in this guide and a guide for practitioners addressing issues that are specific to the North West region (see North West group, 'Community cohesion: developing the NHS contribution', to be published soon).

Health is an important contributor to community cohesion

People's state of mental and physical health affects their ability and motivation to engage in community activity. When people are fit and well they play a more active part in community activity than when they are ill or depressed.

Jo Farrington, a Public Health specialist for Oldham PCT is part of the North West group. She has commented that:

"A cohesive community is one in which people are strong in their own identities, respect others and are able to tolerate difference. People's sense of identity and self is challenged by ill health, particularly long term chronic problems which involve profound shifts in, or loss of identity. This impinges on their social and emotional relationships.

Physical ill-health can restrict movement or sensory participation in the social and economic life of a community

Mental ill health, including Common Mental Disorders of anxiety and depression, often causes people to withdraw or be fearful of social contact particularly with the unfamiliar. Thoughts and behaviours, such as becoming inward looking and catastrophising can contribute to resentment, fear and anger towards others".

In most areas of Britain where community cohesion is seen as a priority, the lead is taken by Local Government. There are exceptions, particularly in the North West region, but in most areas Health is the sleeping giant of community cohesion and could become a much bigger player. Health services play a big part in most people's lives. The NHS is the biggest employer in the country with almost 1.3 million employees. It has a presence in almost every neighbourhood in the country and it has frequent contact with most of the population. It plays a key role in supporting regeneration of disadvantaged areas through employment, training, procurement and capital programmes. Public surveys repeatedly show that it is highly valued by its users so its potential to contribute to community cohesion is enormous.

The Health service has a proven track record of promoting equality and recognising and responding to diversity. You can bring that strength to Local Strategic Partnerships. A huge strength of the NHS is the way it has embraced equality and diversity values both within its workforce and in making services accessible and responsive to the needs of people from diverse communities. Many PCTs have used Health Equity Audits and Equality Impact Assessments to identify and address different needs and inequalities within their communities. Initiatives like 'Race for health', specific cancer screening programmes for women of Asian origin, organ donation campaigns targeted at particular minority ethnic communities and the Single Equality Scheme Learning sites are great examples of how the NHS excels in this area. This is a strong foundation from which to build your approach to community cohesion.

Community cohesion can contribute to the achievement of several other key NHS priorities:

World class and practice based commissioning

Commissioning is all about understanding the needs of your community and securing the best ways of meeting those needs. The commissioning process consists of five main stages and an understanding of the principles of community cohesion will help at each stage of the process:

- Stage 1 – Assessing the needs of your local population. To do this effectively you need to engage with all the different communities in your area, understand their concerns and how they interact with others. Understanding the needs of people who do not usually engage with public bodies can be difficult but is vital if commissioning is to produce equitable services and community cohesion is to be strengthened.
- Stage 2 – Identifying priorities. Decisions about priorities can benefit some groups more than others and this can lead to resentment if the process is seen as unfair. You need to be clear how you will address health inequalities as part of this stage. It is really important to ensure that the process is open and transparent and that all interests are taken into account.
- Stage 3 – Identify and stimulate potential providers. If your local community is changing it is important to find providers who are innovative and able to respond to diverse and changing needs.
- Stage 4 – Procure services and secure contracts. At this stage you need to ensure that the process is fair with a level playing field for all potential providers and then to establish a clear agreement with your chosen providers on what outcomes are expected and how they will respond to different communities.
- Stage 5 – Monitor, evaluate and review performance. Patient and public involvement should be included at each stage but it is particularly important at this stage where you should consider the impact of services on different communities (including non-users as well as users of services), whether there has been any impact on health inequalities and other shared targets, whether performance data is adequate and how to use the results of evaluation to inform the next commissioning cycle.

‘The Commissioning Framework for Health and Wellbeing’, published by the Department of Health in April 2007, summarises the characteristics of effective commissioning as:

- Putting people at the centre of commissioning
- Understanding the needs of populations and individuals
- Sharing and using information more effectively
- Assuring high quality providers for all services
- Recognising the interdependence of work, health and wellbeing
- Developing incentives for commissioning for health and wellbeing
- Making it happen: local accountability
- Making it happen: capability and leadership

With the introduction of Joint Strategic Needs Assessment, the commissioning process will be undertaken as a partnership between Health and Local Government as a key element of the broad strategy for an area. The next section considers how this will work.

Place shaping through Joint Strategic Needs Assessment and Local Area Agreements

‘The Local Government and Public Involvement in Health Act’ (2007) places a duty on Local Authorities and Primary Care Trusts to identify the issues for priority action through Local Area Agreements in the form of a Joint Strategic Needs Assessment. The JSNA will be the key document in identifying health and wellbeing needs and translating these into priorities for commissioning services, but the guidance document published by the Department of Health in 2007 makes it clear that the JSNA should not simply be seen as a tool for health and social care but should inform the Sustainable Community Strategy and the LAA targets. JSNA will be both a process for identifying the current and future health and wellbeing needs to inform planning and commissioning and a tool for identifying the ‘big picture’ for health, wellbeing and inequalities in an area. It will have the following characteristics:

- It should aid understanding of current and future needs over the short term (3 to 5 years) to inform LAAs and over the longer term (5 to 10 years) to inform strategic planning.
- It will be the joint responsibility of Directors of Public Health (many of whom are now joint appointments), Directors of Adult Services and Directors of Children’s Services.
- It will include the active involvement of communities, service users, the third sector and other providers to develop a comprehensive picture of needs, particularly of vulnerable groups.
- It will sit on a clear evidence base of interventions that will most effectively meet local needs.
- It will include a core data set covering five domains: demography, social and economic context, lifestyle and risk factors, burden of ill-health and disability and services.
- The process of JSNA will include: identifying existing mechanisms for engagement, drawing and aligning evidence from existing assessments and plans, collecting, collating and analysing information from a range of agencies including LSP partners, service providers and community groups to identify gaps in service and unmet needs, using community involvement to provide information not available from other sources and aligning with three-yearly LAA cycles and with Children and Young People’s Plan.

The Department of Health guidance emphasises the importance of community and user engagement at all stages of the JSNA, in particular supplementing the core data set with information from consultations, existing networks and forums. It states that: *“Clear and relevant community engagement can facilitate and empower people by giving them the chance to voice their needs, whilst local ownership of the process will increase the relevance of services, improving their uptake and sustainability.”* The guidance acknowledges that engaging with vulnerable and seldom heard groups will be particularly challenging but since they often have the most acute health needs and the poorest health, it is particularly important that such groups are involved.

Improving Wellbeing

The concept of wellbeing was introduced through the Local Government Act of 2000. The Act included a new power of wellbeing for Local Authorities to take whatever action they consider necessary to promote or improve the economic, social or environmental wellbeing of their area. This was followed by the development of a series of Quality of Life indicators that are now used by Local Authorities and their partners to track changes in wellbeing and the quality of living conditions at the local level. Such indicators are now included in the new Local Government performance assessment framework, Comprehensive Area Assessment (CAA), reflecting a drive to improve wellbeing and quality of life.

In 2006, the Government's Whitehall Wellbeing Working Group developed a statement of common understanding of wellbeing for policy makers as follows:

“Wellbeing is a positive physical, social and mental state. It is not just the absence of pain, discomfort and incapacity. It arises not only from the actions of individuals, but from a host of collective goods and relationships with other people. It requires that basic needs are met, that individuals have a sense of purpose, and that they feel able to achieve important personal goals and participate in society. It is enhanced by conditions that include supportive personal relationships, involvement in empowered communities, good health, financial security, rewarding employment, and a healthy and attractive environment.

Government's role is to enable people to have fair access now and in the future to the social, economic and environmental resources needed to achieve wellbeing. An understanding of the combined effect of policies and the way people experience their lives is important for designing and prioritising them.”

It is clear from this definition that community cohesion is a key contributor to wellbeing. A report by Nicola Steuer and Nic Marks, 'Local wellbeing: can we measure it?' (2008) proposes the use of a number of indicators that are directly related to cohesion. These include the national community cohesion indicators from PSA 21 (see section on "How can we measure community cohesion" in part 4 below), measures on support and engagement (e.g. civic participation in local area, participation in local volunteering, percentage of people who feel they have other people to turn to or discuss problems with and the percentage of people who are satisfied with the support they receive from others). The report also proposes a number of indicators under the heading of health and mental wellbeing including mortality rates, adult participation in sports, self reported measure of overall health and wellbeing and self reported limiting long term illness.

Promoting equality and diversity

During the preparation of this guide a number of people suggested to us that the NHS does not need to do anything new on community cohesion because it is already addressing the issues through its work on equality and diversity. We would agree that the equality and diversity work is a strong foundation but community cohesion is concerned with the wider social context of how communities relate to each other. It includes the need to cater for diverse needs of different communities but it also involves consideration of how communities perceive and respond to each other, for example, how young and old people perceive each other or how people of Pakistani, Afro-Caribbean or Indian origin perceive each other. Certainly some NHS organisations are already working on this but others are not. To develop the Health contribution further we need all organisations to expand from a view of equality and diversity for individuals to a consideration of how you can promote equity and a perception of fairness in the way you manage resources and address the needs of diverse communities. You need to build on your success in meeting the needs of individual patients in the way you address community aspirations.

Reducing health inequalities

Whilst Health service work on equality and diversity goes a long way towards addressing community cohesion issues, the same can be said for the work that is done to reduce health inequalities. Dealing with social injustice helps to reduce health inequalities and improve quality of life measures. When this work is based on a clear understanding of the social context affecting different communities, it is making a powerful contribution to addressing community cohesion as well as reducing health inequalities. When it treats each group separately without reference to the wider context, it has far less impact. There are numerous examples of the former approach. Here are just a few of them:

In **Oldham** a project entitled 'Cottoning on', led by Oldham PCT, recognised the importance of community cohesion to Public Health. They have developed a wide range of projects to promote healthy living to seldom heard communities, working with those communities to identify how they can best make services more user-friendly. Projects include:

- Improving mental health support to South Asian women
- Supporting BME women to develop healthier communities through volunteer activity
- Training for young parents in parenting and health
- Easy access to web-based health information for young people
- Involving young people in developing a fitness trail and promoting healthy lifestyles.

Contact: jofarrington@nhs.net

The 'Mamta' project, based at Foleshill Womens' Training in **Coventry**, is commissioned by Coventry PCT to work with health professionals to provide culturally appropriate services in one of the most disadvantaged areas of the city. The project targets local health inequalities for women from ethnic minorities in the Foleshill area by addressing root causes of ill health, removing barriers that prevent some people accessing services and offering a safe environment to support and advise women on health matters. Mamta means "motherly love" in many South Asian languages and the project empowers women to take control of their own and their children's health. It is playing a key role in reducing infant mortality, improving maternal care and improving child health and development amongst the targeted groups.

Contact: Noreen Bukhari at mamta.project@fwt.org.uk

Many PCTs take a proactive approach to public health, taking the message into the heart of minority communities. **Barnet** PCT set up a "Stop smoking clinic" at Finchley mosque resulting in improved confidence in public services amongst local Muslim communities. **Stockport** PCT uses a "Health check day" at the town's main shopping centre as a way of engaging with seldom heard groups. This involves a free "Heart MOT" with a doctor, blood sugar, blood pressure, height and weight checks and advice on diet, weight and how to stop smoking.

Central Lancashire PCT's award winning 'Barbershop' is a community magazine. It markets positive mental health to men living in areas of deprivation. It has a multi-cultural focus, addressing issues of faith, culture, race and mental health and wellbeing. It promotes understanding and cooperation between different communities. Produced in an urban style, it features articles, personal accounts, interviews and unique comic-book case studies of real life experiences of mental health. Barbershop is more than just a magazine. It is a community empowerment package, including training, peer mentoring, publications, sporting events and a viable local business.

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'The Lansbury project' in **Tower Hamlets** is led by Poplar Housing and Regeneration Community Association (HARCA) which represents a community of white British, Bangladeshi, Somali, Afro-Caribbean and Chinese people. It was set up in response to a HARCA survey which found that local residents wanted better access to both health services and affordable fresh food. Tower Hamlets PCT, St Bartholomew's Hospital, local GPs, Tower Hamlets college and local community groups are all key partners supporting a wide range of projects that bring the diverse communities together: Healthy eating workshops, Cook and eat clubs for older people and parents living on a low budget, community health and fitness programmes, training to help residents run health promotion workshops, support for social enterprises including a food co-operative and work with the Education Action Zone to introduce healthy living issues into the school curriculum.

'Well London' is an alliance of the **London Health Commission** and a range of other public, community and voluntary sector organisations delivering a lottery funded 5 year programme of community based projects to promote mental health and well-being, improve healthy eating choices and promote access to open spaces and increasing physical activity across the capital. The programme works by engaging with communities, building community capacity and ensuring access to all sectors of the community.

Community engagement and empowerment

Community engagement is an essential part of any approach to community cohesion. It is how we take the pulse of local communities. Question (iv) of the ten challenging questions in part 6 of this guide provides some suggestions about how to assess your effectiveness in this crucial area and points out some examples of good practice. Your approach to community engagement needs to be underpinned by up to date data on the population you serve so that you know who is living in each community and understand the area's diversity. Question viii of the ten questions discusses how you can ensure you have the best information available.

Two very helpful documents have been published during 2008 on the subject:

The first one is aimed specifically at health practitioners. 'A dialogue of equals: the Pacesetters Programme community engagement guide' (2008) written by Stafford Scott, is a guide to help NHS staff with responsibilities for patient and public involvement to understand better how to identify and create opportunities for engaging with seldom-heard communities or marginalised groups. It explains what is meant by community engagement and why it is important to involve people (rather than just consult them). It gives advice on how to develop a community engagement strategy, defines what is meant by a community, how to understand the difference between patient needs and community aspirations and it contains practical tips on how to engage with different community groups, illustrated with plenty of examples of good practice.

The second document is aimed at a more general audience, including Local Authorities as well as people in the Health service. 'Community Engagement and Community Cohesion' (2008), written by a team for the Joseph Rowntree Foundation argues that Government policies for community engagement and community cohesion have been developed in parallel and need to be brought together. It explores how this can be done, particularly focusing on how new arrivals can be involved and how we can promote solidarity and cohesion rather than competition and conflict between newer and more established communities. Some of the key points are:

- Informal networks are valuable but be aware that traditional leaders do not necessarily represent the voices of women and young people.
- New communities are diverse but they all experience a number of common barriers such as lack of information, difficulties in the use of English, lack of time or barriers to recognition.
- These barriers are often exacerbated by the growing fluidity and fragmentation of government structures. A "shifting landscape of service provision and governance" is bewildering and makes engagement more difficult.
- The most appropriate way of engaging with new communities who are dispersed across Local Authority areas may not be at neighbourhood level. We need structures that enable engagement at other levels.
- The research identifies a range of examples of good practice in addressing these issues, particularly by providing community development and outreach support.

Implementing the Darzi report

The final report of the 'Next stage review of the NHS' by Lord Darzi, 'High quality care for all' (2008) sets out a vision for the NHS of an organisation:

"That gives patients and the public more information and choice, works in partnership and has quality of care at its heart – quality defined as clinically effective, personal and safe."

The report recognises that people want a degree of control and influence over their health and health care and acknowledges that special efforts need to be made to personalise services "for those who for a variety of reasons find it harder to seek out services or make themselves heard". It contains a series of proposals to improve quality by involving people and giving them more choice and by working in partnership. This is entirely consistent with the principle of community cohesion promoted in this guide. In part 6 under question (iv) we say more about how the Darzi proposals for improved partnership working fit with community cohesion.

Mental health issues

It is generally recognised that there is a relationship between common mental disorders such as anxiety, depression and alcohol dependency and low levels of social interaction, withdrawal and fear of contact with others. Research by Dr Jane Parkinson in Scotland in 2007 has developed a set of indicators of both positive mental health and mental health problems. Parkinson's report identifies 55 indicators including high level constructs such as life satisfaction, depression, anxiety, suicide and drug related deaths and three sets of contextual constructs including individual factors such as emotional intelligence, healthy living, spirituality; structural factors such as social inclusion, discrimination and equality and community factors such as participation, social networks, social support, trust and safety. The report recommends further longitudinal studies to help investigate whether identified associations between mental health and key personal, social and structural factors are causal (and the direction of causality) or merely coincidental. In the meantime there is sufficient empirical evidence to support the argument that mental health problems can be eased by addressing the contextual factors.

Community safety, drug and alcohol abuse and anti-social behaviour

Primary Care Trusts are required by law to contribute to Community Safety Partnerships and can play an important role in sharing information and developing strategies that address crime and anti-social behaviour. They play a leading role in Drug Action Teams which address the harm caused by drug addiction and drug related crime through programmes of treatment, education and action on supply. Increasingly they are involved in partnership programmes to address the harm caused by alcohol abuse, which is becoming a serious health problem for many young people and fuelling a high proportion of violent crimes and anti-social behaviour. In many town centres and even in small rural communities these problems have divided communities, undermining community cohesion and generating fear amongst many residents. Effective response to these issues requires a clear strategy developed by a partnership of agencies (including PCTs, Police, Local Government, licensees licensing authorities, A and E Departments, planners, etc). It also requires a well developed approach to community engagement involving a wide range of different interest groups to understand different needs and views and to generate solutions that are fair to all.

5. The Nature of community cohesion

How the concept of community cohesion has developed

The term 'community cohesion' has been around for centuries in the writings of political theorists. It is widely used to describe a state of harmony or tolerance between people from different backgrounds living within a community. It is linked to the concept of social capital and the idea that if we know our neighbours and contribute to community activity then we are more likely to look out for each other, increase cohesion and minimise the cost of dependency and institutional care. In recent years cohesion has become an important goal of public policy in response to disturbances in Bradford, Burnley and Oldham in 2001 and the emergence of extremist views on the far right of British politics and amongst radical Islamists. In these circumstances there has been an increased emphasis on how we create a sense of belonging and place, based on a more inclusive set of identities, contributing to Britishness, citizenship, mutual respect and trust. But the wider vision embracing the importance of social networks and community spirit remains as important as ever. Several definitions have been offered by different observers, each featuring the core concepts of unity and respect for difference but with some variation of emphasis on how cohesion can be achieved. In this section we set out the most important offerings and trace how the concept has evolved over the last few years.

The core concept is captured quite clearly in the definition used by the Local Government Association (LGA) in two guides written in 2002 and 2004 respectively:

"A cohesive community is one where:

- there is a common vision and a sense of belonging for all communities;*
- the diversity of people's different backgrounds and circumstances is appreciated and positively valued;*
- those from different backgrounds have similar life opportunities; and*
- strong and positive relationships are being developed between people from different backgrounds and circumstances in the workplace, in schools and within neighbourhoods."*

Source: 'Guidance on community cohesion' (LGA, Dec 2002) and 'Community cohesion – an action guide' (LGA, 2004).

An analysis of the concept of community cohesion by Dr Rosalyn Lynch of the Home Office Research, Development and Statistics Directorate is given in Appendix C of the 'Cantle report' (the report by the independent review team into the disturbances in several northern towns in 2001). Lynch examines earlier definitions and those factors that are likely to limit achievement of community cohesion (e.g. segregationist housing policy, "white flight" caused by the actions of some estate agents and segregation within schools). The same report (in Chapter 3) refers to work by Forest and Kearns which describes five domains of community cohesion:

- Common values and a civic culture – common aims and objectives, common moral principles and codes of behaviour, support for political institutions and participation in politics.
- Social order and social control – absence of general conflict and threats to the existing order, absence of incivility, effective informal social control, tolerance, respect for differences, inter-group co-operation.
- Social solidarity and reductions in wealth disparities – harmonious economic and social development and common standards, redistribution of public finances and of opportunities, equal access to services and welfare benefits, ready acknowledgement of social obligations and willingness to assist others.
- Social networks and social capital – high degree of social interaction within communities and families, civic engagement and associational activity, easy resolution of collective action problems.
- Place attachment and identity – strong attachment to place, inter-twining of personal and place identity.

A similar but more concise definition is given in the Home Office report 'Improving opportunity, strengthening society' (January 2005) which describes a cohesive and inclusive society as one in which:

- Young people from different communities grow up with a sense of common belonging
- New immigrants are integrated
- People have opportunities to develop a greater understanding of the range of cultures that contribute to our strength as a country
- People from all backgrounds have opportunities to participate in civic society
- Racism is unacceptable and extremists who promote hatred are marginalised

The concept is developed further in 'Our shared future', the report of the Commission on Integration and Cohesion chaired by Darra Singh (June 2007). The report sets out four key principles that the review team believe underpin an understanding of integration and cohesion:

- A sense of shared futures – an emphasis on what binds communities together rather than what differences divide them and prioritising a shared future over divided legacies.
- A new model of rights and responsibilities fit for purpose in the 21st century, one that makes clear a sense of citizenship at national and local level, and the obligations that go along with membership of a community, both for individuals and groups.
- An ethics of hospitality – a new emphasis on mutual respect and civility that recognises that alongside the need to strengthen the social bonds within groups, the pace of change across the country reconfigures local communities rapidly, meaning that mutual respect is fundamental to issues of integration and cohesion

- A commitment to equality that sits alongside the need to deliver visible social justice, to prioritise transparency and fairness, and build trust in the institutions that arbitrate between groups

The most recent definition is contained in the Government's response to the Commission on Integration and Cohesion (CLG, February 2008) as set out in the introduction to this guide:

“Community cohesion is what must happen in all communities to enable different groups of people to get on well together. A key contributor to community cohesion is integration which is what must happen to enable new residents and existing residents to adjust to one another.”

Our vision of an integrated and cohesive community is based on three foundations:

- *People from different backgrounds having similar life opportunities*
- *People knowing their rights and responsibilities*
- *People trusting one another and trusting local institutions to act fairly*

And three ways of living together:

- *A shared future vision and sense of belonging*
- *A focus on what new and existing communities have in common, alongside a recognition of the value of diversity*
- *Strong and positive relationships between people from different backgrounds.”*

Source: The Government's Response to the Commission on Integration and Cohesion (CLG, Feb 2008)

The evolution of the concept through the works listed above shows that the core concept based on a common vision and respect for diversity has been retained but with an increasing emphasis on the importance of integration and shared citizenship. This has important implications for the way we develop our policies and approaches to community cohesion. iCoCo takes the view that tackling inequalities remains a key component of community cohesion and where any community or group is clearly disadvantaged it is far less likely to have any effective stake in society. Community cohesion plans therefore need to be able to say how they will address key areas of disadvantage.

For further information on 'The development of community cohesion: a guide to publications' see: <http://www.cohesioninstitute.org.uk/resources/Pages/aboutcommunitycohesion.aspx>

How can we measure community cohesion?

Since community cohesion is about the degree of harmony and mutual respect in our communities we need indicators that measure the strength of our social capital as reflected in our social networks, degrees of positive interaction and both shared and individual sense of identity. We also need measures which help us to recognise when underlying tensions in a community are rising to a point when they might turn into riots and violence on the streets. Some of the main lessons from recent work on this subject are as follows:

- It is helpful to have a national framework for measuring cohesion over a reasonable period of time on a consistent basis enabling us to identify national trends. The “Our shared futures” report of the Commission on Integration and Cohesion recommended that there should be a single national Public Service Agreement (PSA) target and the Government has now adopted a new cross-government PSA (PSA21) “to build cohesive, empowered and active communities”. This will be measured against four national indicators:
 1. The percentage of people who believe people from different backgrounds get on well together in their local area
 2. The percentage of people who believe they belong to their area
 3. The percentage of people who have meaningful interactions with people from different backgrounds
 4. The percentage of people who feel they can influence decisions in their locality
- Where Local Strategic Partnerships decide that improving community cohesion is a priority within their Local Area Agreements, these indicators will be used to assess performance and provide an incentive for action. In 2008, 92 areas have selected one or more of the four indicators (mainly the first one) for their Local Area Agreements thus making a partnership commitment to community cohesion. There are also some very clear and important ‘hard’ indicators which are used nationally and locally, such as the level of hate crime and the extent and nature of racist literature and extremist activity.
- In addition to national indicators it is essential to identify local indicators that reflect those factors which are particularly significant to the locality. The ‘Our shared future’ report (page 58) identifies five types of area where perceptions of cohesion may be below average and targeted action on integration and cohesion may be needed. The risk factors and hence, the action required, are different in each case. For example, one of the area types is “Changing less affluent urban areas” such as coastal towns where there is high demand for low skilled labour resulting in increased numbers of migrant workers and competition for jobs. In other areas the risk factors may be about pressure on the local housing stock, economic decline and deprivation, cultural differences, particularly in areas that are experiencing levels of migration that are new to the area, or special factors such as arrests for alleged terrorism or proposals for the location of a centre for asylum seekers. This variation in local experience points to the importance of

adopting a basket of indicators that suits the local conditions. Health managers and commissioners can play an important role in helping to choose the appropriate indicators as the health and wellbeing needs and concerns about equity of health provision will vary between the different types of area.

- In developing a basket of local indicators it is helpful to choose a mix of perception indicators, which give a picture of people's current feelings obtained from local residents' surveys, and some objective indicators that focus on underlying risk factors. In the research we have done for several Local Authorities, iCoCo has found it helpful to measure the degree of segregation in a community (e.g. high degrees of concentration of families from particular ethnic groups in certain housing estates or high concentrations of pupils from an ethnic group in a small number of schools). Many of the publications on community cohesion contain useful suggestions about the types of indicators that may be helpful (see The Home Office, July 2003; LGA, 2004 and iCoCo and Metropolitan Police 2008). The LGA action guide of 2004 describes how data from the Home Office biennial Citizenship survey can be used to monitor data on rights and responsibilities, racial prejudice and discrimination, neighbourliness, active community participation and family networks and parenting. However few of the publications provide advice on the type of health or health inequality indicators that could be included. Indicators that highlight sudden changes in pressures on services due to new migration can be particularly useful (e.g. a rapid rise in demand for maternity services from young migrant workers from eastern Europe or an increase in diseases like diabetes that have a high incidence amongst particular ethnic groups). If new trends are identified at an early stage and appropriate action taken, it is clearly helpful in tackling the health issues and it is also much easier to avoid the negative perceptions about particular groups that can easily build up if settled residents feel that resources are shifting away from them.
- Having decided on the indicators you will use to measure cohesion, it is important to establish a baseline and ensure that systems are in place to collect and analyse data on a consistent basis and to monitor the data at regular intervals. Experience in the community cohesion pathfinder and shadow pathfinder areas shows the benefit of working with other areas and adopting similar indicators.
- Health practitioners can play a key part in monitoring tensions and in intervening before they become more serious. iCoCo has developed a tension monitoring toolkit (see iCoCo 2008(i)) which is being used by local partners and is based upon the sharing of data and intelligence about what is happening on the ground. Find out if you are represented on the local tension monitoring group and how you can contribute to it.

In the North West, four Local authorities (**Rochdale, Bury, Oldham and East Lancashire**) worked together to develop a consistent approach to monitoring cohesion, benefitting from one another's experience and providing a framework for benchmarking (see LGA 2004).

Bradford shadow pathfinder offers a good example of a well thought out basket of indicators. As part of their community strategy they developed a set of indicators that describe seven dimensions of community cohesion. The indicators (which cover employment, education, areas of stress, perception, community participation, residential segregation and crime and disorder) are measurable, outcome focused, relevant and concise.

What do we mean by a 'community'?

In discussing 'community cohesion', we need to be clear what we mean by the word 'community'. Stafford Scott provides a very helpful discussion of how to approach this on page 15 of 'A dialogue of equals' (2008):

"One of the factors which makes community engagement so complex is that there is really no such thing as "the community". The term is used to describe the thousands, if not millions, of individuals who live in a given area and may also work there to help local people. When we talk of communities, we can have different things in mind. At "Pacesetters", our understanding of a "community" includes those people who are linked to a particular locality, through residence, work or regular visits. It includes "communities of interest", by which we mean people who have a shared experience that transcends their geographical location.

The key thing to keep in mind is that a community always consists of a number of other communities, be they based on ethnicity, gender, age, disability, location etc. In essence, all communities are linked and intertwined in a myriad of different ways. No individual community is so different from the rest of society that its particular needs should not be understood. For those who carry responsibility for delivering public services, engaging with the community means ensuring that everyone in their local area is given the opportunity to comment on the services provided for them and on the trust's priorities. It also means involving them in major decisions that will improve their quality of life. This is meant to be a two-way process – a true dialogue of equals – with NHS organisations benefiting from the imagination and energy of local people."

This message is really important for anyone working on community cohesion because it highlights the importance of finding ways of involving those groups who are seldom heard, who feel marginalised by the rest of the community in which they live and do not feel they have a stake in society. This might apply to some ethnic groups, disabled people, carers who have no support or respite or to young people who are not in education, employment or training.

Communities need to be better understood and 'mapped', even when they are recognised as separate entities. For example, iCoCo has been asked to provide details of local Muslim communities which are, in themselves, very diverse. In truth, they are seldom organised around any one theological, ethno-national, or community heritage group and have many different needs and aspirations. It is important to recognise the diversity within communities from the outset and to be prepared to listen to the range of different voices, avoid the 'gatekeepers' of communities and to reach under-represented sections such as women and younger people (see iCoCo's study, 'Understanding and appreciating Muslim Diversity', 2008). The same is true of all minority communities and of course the white community is equally diverse. The pace of change in all communities is also accelerating and it is important to keep the nature of each community under review to ensure that services are reaching all sections and especially those in most need.

What are the causes of tension between communities?

The Cantle report (2001) was commissioned by the Government in response to disturbances in a number of towns and cities in the spring and early summer of 2001, involving large numbers of people from different cultural backgrounds and resulting in destruction of property and attacks on the police. The review team found evidence of physical segregation of housing estates and inner city areas and was particularly struck by the depth of polarisation in the towns and cities that it visited. They found evidence of separate educational arrangements, separate community and voluntary bodies, employment, places of worship, language, social and cultural networks. This separation was so evident that the review team concluded that many communities were operating on the basis of parallel lives that do not seem to touch at any point, let alone overlap and promote any meaningful interchanges. Many of the well intentioned regeneration programmes aimed at tackling the needs of disadvantaged people were failing to bring people together and were increasing the sense of division and unfairness.

The 'Our shared future' report (2007) reminds us that British society has for centuries experienced social change and welcomed migrants who have strengthened our economy,

"but since the end of the second world war we have seen the kind of social change that can prompt significant challenges to our models of fairness and equality".

The introduction to a set of essays recently published by the Smith Institute (2008) argues that

"We live in a time of rapid change generated by globalisation, demography and technology. Britain, despite its status as one of the world's richest economies and most diverse societies, is still a place of inequality, exclusion and isolation. Segregation between communities seems to be growing in some parts of the country. Extremism, both political and religious, is on the rise as people become more disillusioned and discontented".

In this climate, it is difficult to resolve conflicting needs and competition for resources between different communities. External events such as the wars in Iraq and Afghanistan and terrorist attacks in New York, Madrid and Bali can increase divisions and myths can grow through emotive media coverage.

'Our shared future' (2007) recommends a number of actions that need to be taken at national level but most of its recommendations are about local action. The commission found that there are big variations in cohesion across the country and that this *"often seems to be the result of local characteristics, initiatives or political leadership – relying on a clear local vision or activities to address challenges head on"*.

They recommend four main principles that need to be adopted by local strategies and applied in the local context:

- Developing shared futures
- Strengthening rights and responsibilities
- Building mutual respect and civility
- Making social justice visible

By applying these principles in a local context we can start to turn parallel lives into more integrated communities but it will require commitment from all key agencies and from community leaders. The health community can play a key role in helping to promote a positive vision of diversity in local areas, promoting a sense of belonging, tackling negative views and busting myths. How you communicate with communities can be an important part of a local partnership effort to promote cohesion and develop a new narrative about the nature of your local area. We give some examples of good practice under question vii of the ten challenging questions in part 6 of this guide.

Combating violent extremism

The Government has this year published its strategy for tackling violent extremism (HM Government 2008). The strategy, informally known as 'The prevent strategy', says that we have faced a sustained threat from terrorism over many years but that terrorists and those who support them are a tiny minority of the population. It says the greatest threat is currently from those who distort the peaceful religion of Islam to attempt to justify murder and attacks on our shared values. The strategy also identifies other extremists on the extreme right of politics who sow division by promoting simplistic and divisive views. The strategy describes what the Government is doing to undermine extremist ideologies, strengthen institutions, support individuals at risk of radicalisation and address the grievances on which extremists prey. Whilst the prevent strategy is clearly important in terms of public security it should not dominate the community cohesion agenda. The prevent strategy is about dealing with the security threat posed by a tiny minority of people who engage in violent extremism, whereas community cohesion is about the day to day issues faced by a much larger section of the community. Clearly each of these areas of public policy affects the other but we need to keep a clear perspective about the difference.

6. Ten challenging questions to help you to contribute to community cohesion

Introduction

In this part of the report we set out ten challenging questions that can be used by health bodies to stimulate thinking about how you can contribute to community cohesion (and how your approach to community cohesion can help in improving performance in the delivery of health services). The ten questions were generated by a discussion between iCoCo and a group of health planners and practitioners in the North West region, led by Dominic Harrison and supported by Dr Sheila Marsh and representatives from health bodies, Common Ground North West and a team from Lancaster University. The group will soon be publishing the ten questions in the form of a guide to help health bodies in the North West to develop their own approaches to community cohesion and the work is being developed further through a series of action learning sets focusing on specific projects. We are grateful to the group (particularly Sabir Hussain and Gulab Singh MBE) who have encouraged the use of the ten questions as part of this national guide and for their help in developing the guide. The ten questions focus on the key areas of activity through which you can have the greatest impact on community cohesion. These are as follows:

- i. **Leadership and partnership.**
- ii. **Promoting positive relationships between people from different backgrounds.**
- iii. **Achieving positive interactions for all.**
- iv. **Engaging with all communities.**
- v. **Locating services, creating public spaces.**
- vi. **Involving suppliers and service providers.**
- vii. **Promoting cohesion, equality and diversity and countering myths.**
- viii. **Using information to understand change.**
- ix. **Investing in your people.**
- x. **Promoting NHS jobs to all communities**

For each of the ten questions the following commentary is provided:

- An explanation of why the question is important.
- A set of more specific 'self assessment questions' to help you use the ten questions as a means of assessing how your organisation is doing in contributing to community cohesion. This might also provide you with some ideas about how you might embed community cohesion principles into your policies and strategies.
- Some examples of good practice.

i. What leadership are you offering on community cohesion from your board, within your organisation and with your partners?

This question is based on the premise that best practice emphasises the importance of visible vocal leadership in making a successful contribution to community cohesion. The question also recognises that joint action is invariably far more effective than working in isolation.

Self assessment questions:

- Are all the leaders experienced in and committed to the principles of community cohesion, community engagement, equality and diversity and partnership working?
- Are all the leaders clear about the connections and differences between each of those principles?
- Are leaders aware of the diverse range of communities within the area you serve and do they know what divides and unites these different communities?
- Do you have a board level leader with specific responsibility and authority to champion community cohesion?
- In what ways do leaders communicate their commitment to community cohesion (to staff, partners, suppliers and to communities)?
- Do you have an evidence based strategy for community cohesion and does the board receive regular reports about progress and effectiveness in delivering the strategy?
- Does the strategy set clear, measurable objectives for community cohesion and is the level of stated priority matched by an allocation of resources?
- Does your strategy address the key objectives of reducing health inequalities and investing for equality of outcomes that are fundamental to community cohesion?
- Do you subject board level decisions to community cohesion impact assessments?
- Are the leaders involved in partnerships with other key public, voluntary and community sector agencies?
- Are leaders involved in partnership working at different levels (i.e. local neighbourhoods, LSP or district wide, regional)?

Some examples of good practice

In **Coventry** the city-wide partnership sees community cohesion as part of a strategic approach to the city's key issues. Deputy Leader of the Council, Cllr Kevin Foster says:

“There are no easy answers. We can not solve all the problems by just getting different people into the same room. We need a holistic approach which ensures we are aware of the changing issues and do not stick rigidly to strategies that may be out dated or which do not reflect a changing situation.”

He argues that the greatest threat to community cohesion can be failing to address the inequality of opportunity between those born into a wealthy background and those from our poorest communities.

“We need to make sure we understand the differences in life chances between people living in different communities and then address the issues in three ways:

- 1. By tackling prejudice through education and communication*
- 2. By making sure all our services are delivering what different sections of the community need, whilst ensuring equality is maintained*
- 3. By accepting that we won't reach a state when all the issues are resolved and we can cease to work, building cohesive communities is a never ending journey, not a simple A-B route.”*

Such an approach means that all the key public agencies, the voluntary sector and faith groups must work together to ensure that community cohesion is not a strategy on a shelf, but a way of life for local people.

One of the main themes of Lord **Darzi's** review, 'High quality care for all' (2008) is closer working between the NHS and Local Government. The review makes several specific proposals for joint working:

1. Integrated care organisations will be established, based around groups of GP practices and jointly run by the local NHS and councils;
2. From 2009 personal health budgets, designed jointly by NHS, councils, carers and patients, will be introduced for people with some long-term conditions;
3. PCTs, in partnership with councils will be responsible for commissioning wellbeing and prevention services, tailored to local needs but focusing on the six priorities of tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates and improving sexual and mental health
4. By spring 2009, all PCTs must publish strategic plans for delivering the Darzi proposals that emphasise strong partnership working between PCTs, councils and the private and third sectors.

All these proposals present a great opportunity to improve health services and enhance community cohesion at the same time.

Middlesbrough has a Cohesion Partnership which was successful in their bid in 2006 to the NHS to become a national Single Equality Scheme Learning Site. The group consists of a range of organisations including the PCT, Cleveland Police, the Council, Middlesbrough College, South Tees Hospitals Trust, Tees and North East Yorkshire Trust and Tees Valley Housing. They have agreed a common vision for a joint single equality scheme framework and are developing a joint action plan to address shared issues around equality, diversity and community cohesion. The group has publicised its commitment to joint working through the Middlesbrough Equality Pact and organised a joint stakeholder event to launch the framework both for service providers and the wider community stakeholders.

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'Community cohesion: seven steps, the practitioner's toolkit', published by the Government in 2005, contains a chapter on 'Leadership and commitment', with a number of examples of good practice from their case studies. In the **Bury** 'Community cohesion Pathfinder' awareness raising sessions were held for all elected members at strategic and local ward level to build an understanding of cohesion into their leadership role. In **Oldham**, councillors have a community cohesion hour at the beginning of each council meeting. This is an opportunity for councillors to participate in debate about how to improve cohesion, listen to the views of local people and learn from experience elsewhere. One session included discussion with a group of sixth formers who had researched the views of young people. In **Hillingdon**, representatives of a political party with extremist views were distributing material, containing inaccuracies, so a cross-party group of councillors worked together to leaflet commuters at the local tube station, pointing out the inaccuracies and countering the extremist policies. In response to a racist letter published in the local paper three party leaders wrote a joint article countering myths about asylum seekers and describing their positive contribution to the local community. Similar leadership was displayed in **Stoke** where the mayor championed a myth busting strategy, helping asylum seekers to integrate and contribute to the community in the city.

Hampshire County council has adopted policies and strategies to address unfair discrimination against disadvantaged people within its service delivery and supported this with high profile leadership. All Chief Officers report to the chief Executive who champions the "Quality through Equality" strategy.

ii. How far do your work and your service delivery models promote and build strong and positive relationships between people from different backgrounds and identities?

This question is about how we cross barriers in our society and help people to connect through conversations, both about difficult issues and about what unites us. Health inequalities are one of several key factors that affect people's life opportunities and can easily feed into myths, resentment and friction. Projects and services that create chances for people to meet, talk about and tackle issues they have in common can help build bridges and enable mutual support. Some health bodies have recognised that there are opportunities for positive contact where people come together to address their health needs through such activities as 'Cook and taste' sessions or 'Walk to health'.

Self assessment questions:

- Do your mechanisms for community engagement bring people from different backgrounds together or do you deal with each group separately?
- Do patient pathways provide opportunities for dialogue across differences?
- Do they enable people to discuss commonly held concerns such as mental health problems, eating problems, long term health conditions, having a baby, being a carer?
- Do you have ways of encouraging people from different backgrounds to share ideas, advice, information and support?
- How do you support people to achieve a strong identity and sense of self when faced with the challenge of chronic ill health or long term limiting illness?
- Do you encourage and support people for whom English is not their first language to develop their ability to speak English, whilst recognising that they may need some information in their first language?
- Do you involve settled residents in welcoming and supporting new migrants?
- Do you provide support (which may include funding) for community events and projects that are aimed at bringing people from diverse backgrounds together or do you support projects led by individual groups?
- Do you promote positive images of the diversity of people and places within your community?

Some examples of good practice

Single or multi-group funding

There are several ways in which public agencies can help to bring different communities together. One is by the way they manage and distribute community funds. The Commission for Integration and Cohesion recommended that *"funding to community groups should be rebalanced towards those that promote integration and cohesion, and single group funding should be the exception rather than the rule"*.

The main reasons for this are as follows:

1. Separate funding to groups that are seen as 'special' tends to reduce the pressure on mainstream funders to develop funding for the widest range of diverse groups. We need to tailor services for all groups on the basis that they are all special
2. Separate provision reduces the opportunities for interaction
3. Separate provision developed several decades ago, based on a handful of minority communities, and there is now a huge practical problem of making such provision for the wide range of diverse groups that exist in most of our towns and cities today
4. Provision tends to be skewed towards longstanding minority groups, who often have well established community centres, staff and services whereas many newer communities have none of those advantages.

iCoCo supports the Commission's proposals but has commented that it is very important that they are applied with common sense:

The proposals are not intended to prevent funding of general categories such as women, disabled people or young people. Single group identity is more narrowly focused than that;

1. Projects catering for multi-minorities should not be seen as single identity groups. It is sufficient that projects embrace a number of significantly different groups;
2. The aim should not be to reduce funding overall;
3. There may be a temporary need to support new (and some established) communities as separate groups so that they can develop bonds before building bridges with other communities. A project to share good practice between people from Northern Ireland and Oldham confirmed that, in some cases, there may be a need for some continuing separate support that would be phased out gradually;
4. The guidance should make it clear that it is not intended to prevent the use of funding to focus on single identity needs, such as those of Bangladeshi girls, or white working class boys. The guidance should be about **how** they are tackled, not **whether** they are tackled. It should encourage activities that meet those needs through some form of multi-group projects or mainstream programme, thus providing a valuable opportunity to enable communities to learn about each other and grow together.

Some of the difficulties faced by new migrants were highlighted in the Audit Commission's 'Crossing borders' report published in 2007. Long hours, poor English and no knowledge of where to get help, make it hard for them to get trusted advice and information. In some areas there is no information at all available to new migrants. However there are also many good examples of local partnerships providing information.

Excellent **welcome packs** have been produced by partnerships in places like **East Lancashire, Hull and Bristol**. In **Coventry**, the 'New Communities Forum' involves longer term residents in the process of welcoming and informing newcomers. There is also a useful guide published in 2008 by the Government based on research done by the Improvement and Development Agency (IDeA) called 'Communicating important information to new local residents'. This will be a useful tool for frontline service providers as it contains a lot of common sense suggestions addressing bread and butter issues that are often the source of local tensions and undermine cohesion.

In **Plymouth** and **West Cornwall** there has been a large influx of migrant workers, mainly from Eastern Europe, in recent years, attracted by employment in tourism and agriculture. In recognition of an urgent need to assist the newcomers as well as to support those local organisations and individuals (landlords, employers, farmers, teachers and public service providers including health workers) who had direct contact with them, the 'Amber Initiative' was established. As a company with charitable status Amber assists the settlement and integration of the new communities by providing a bridge for them to reach existing communities and public and voluntary sector organisations. Similar organisations have been established in many parts of the country, providing a potential vehicle for health bodies and other public agencies to engage with communities and contribute to community cohesion.

In 2006 **Bolton Hospitals NHS Trust** established a Disability partnership with Bolton PCT, Bolton council, the university and the college to consult and involve disabled people from all its communities. Following a consultation event BADGE (Bolton Active Disability Group for Everyone) was created with representatives from different ethnic groups, equal numbers of men and women and people with different disabilities. The group helps to integrate rather than segregate the different communities.

In **Sefton**, the main public sector agencies have worked together particularly on disability, race and gender issues to create the Sefton Equalities Partnership. They have developed an equality and human rights strategy and a community cohesion strategy which focuses on the needs of specific groups such as gypsies and travellers and migrant workers.

A programme called 'Working in true partnership with Polish people in Gloucestershire' has helped develop a sense of community cohesion among Polish people living in **Gloucestershire** with each other and with British people and other ethnic groups living in the area. The weekly drop-in sessions taking place in the community offering information and support for Polish people help to forge community links and foster community cohesion.

<http://www.idea.gov.uk/idk/core/page.do?pagelId=8249284>

Haringey Libraries are running several projects throughout the year to promote the benefits of health and wellbeing. Residents of all ages and backgrounds are encouraged to consider what they eat. The council is focusing on helping people to maintain a healthy weight by adopting a nutritious diet. The project is helping to bring together people of all ages within the community and from all walks of life.

<http://www.idea.gov.uk/idk/core/page.do?pagelId=8149221>

iii. How are you doing in achieving respectful and positive interactions from public, patients and staff, in relation to older people, people with disabilities, people with mental health problems, people from black and ethnic minority communities and others who are seen as different and how are you addressing disrespect, bullying and abuse?

This question is about how you promote and reinforce a culture of respect for difference and harmonious interaction within the NHS. This is particularly important where there is evidence, or a perception, that patients have little respect for staff and vice versa.

Self assessment questions:

- What policies and strategies do you have in place to ensure compliance with anti-discrimination legislation (single equality and/or race equality schemes etc)?
- Do your policies and strategies encourage integration and positive contact between people from different backgrounds or do they encourage segregation by treating people from different backgrounds separately?
- How do you ensure your policies and strategies are implemented and their effectiveness is regularly monitored and evaluated?
- What training and support do you provide for staff who have direct contact with patients and public to ensure that they adopt behaviours that make people feel welcome and valued by the NHS?
- What training and support do you provide for staff to ensure that they make people feel welcome and valued by the wider community?
- How do you ensure that your staff challenge racism and other forms of unfair discrimination, disrespect, bullying and abuse?

Some examples of good practice

For many people, particularly new migrants and people who have limited contact with others (perhaps because they are house-bound), the NHS represents the face of their local community so it is really important that the face they see is welcoming.

East Lancashire PCT have recognised this across many aspects of their work:

1. They have produced a 'Values and purpose' framework to ensure that staff live the values and are performance managed in relation to those values
2. They use their programme of Equality Impact Assessments to check that policies, procedures and service provision fulfil requirements for equal access and treatment
3. Their HR policies and procedures are used to create a culture of inclusion and engagement, with support mechanisms to handle issues of disrespect, bullying or abuse
4. They have a Mediation service to resolve any issues using a shared responsibility model

The Joseph Rowntree report, 'Community engagement and community cohesion' (2008) describes an approach used in **Newham** to bring people from different communities together. Newham used community forums to engage people. These worked well for some but less well for others so they shifted focus from engagement structures to engagement events, developing a varied programme to engage diverse groups in different ways. These included reading days in local libraries, community festivals and a popular 4 day programme of summer evening concerts in a park celebrating the music traditions of different communities in the borough. People attending the events were asked to answer questionnaires and a range of other more creative techniques were used to gain feedback from people. The evaluation showed that the events were valued but it was felt that more local people should be involved in organising them (thus building community capacity) and there should be more feedback about the action that is taken in response to the views that were gathered.

iv. How are you doing in genuinely engaging local communities, including those seldom heard, in determining what you do rather than commenting on your decisions?

This question is about fulfilling the NHS's duty to enable people to influence what happens to themselves, their families and their communities. It is about going beyond your engagement with individual service users on matters of day to day delivery to engaging with communities on issues about wider health needs and how services are organised to meet those needs. This will help to develop a sense of belonging to a locality that is vital to community cohesion. In many communities the process of community engagement needs to go beyond the identification of needs and issues. It is actually part of the approach to delivering solutions through community development and outreach work.

Self assessment questions:

- Have you and your LSP partners identified all the diverse communities within the area you serve?
- Have you discussed with each of those communities how you can best engage with them, recognising that innovative approaches may be needed to engage with seldom heard groups?
- Have you implemented methods of engagement based on those discussions?
- Do you encourage methods of engagement that bring together people from different backgrounds wherever possible?
- Are you developing a constructive relationship with the new Local Involvement Networks in your area?
- How do you ensure that you are listening to all sections of the community and taking account of their comments?
- Who sets the agenda for engagement with communities?
- How often do you change decisions as a result of community engagement?
- How do you make sure that people know what action you have taken as a result of community engagement?
- Are you aware of potential friction between different communities and how do you address those frictions?
- Do you recognise the value of community engagement as part of the approach to addressing needs (i.e. through community development work)?
- Are you aware of how new initiatives, such as patient choice, impact on all the different communities in your area?

Some examples of good practice

Many examples of good practice in engaging with communities (particularly seldom heard groups) are described in the following publications: 'A dialogue of equals' (Department of Health, 2008); 'Community engagement and community cohesion' (Joseph Rowntree Foundation, 2008); 'What works in community cohesion' (CLG, 2007); 'Community cohesion: seven steps: a practitioners' toolkit' (Home Office and ODPM, 2005) and 'Community cohesion: an action guide' (LGA, 2004). The first of these contains, in chapter 2, a helpful discussion, based on Arnstein's ladder of citizen participation, of how to move through different levels of participation from Informing, through Consultation, Co-production and Delegated control to Community control.

Derby City PCT, supported by the Centre for Innovation in Health Management at Leeds University, has established a project which aims to create a dialogue with communities. This is with the aim of developing a better understanding with local communities about respective roles and responsibilities and involving people in co-producing solutions to health issues affecting their communities. The project also aims to create greater involvement of the local people in the commissioning process and to raise the value that communities put on their public sector services. The work is being piloted in two areas: One of these is Normanton which is a very diverse community including a longstanding Asian community and regularly receives new migrant communities. The project has identified tensions between the established and new communities and is addressing these by considering new approaches to supporting the new entrants in understanding the area they are entering and how the existing services can be used. The second area is Sinfin, a fairly isolated and fragmented community of mainly white working class people with high rates of premature mortality. In this project, community development and health workers are considering what is important to the residents in this area and supporting them to consider how they can promote healthy living. They are also planning a 'Health carnival' as a promotional event involving all the local communities.

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In **Coventry** the Community and Voluntary Sector Empowerment Network provides support to new arrivals in the city. Peace House demonstrates the value of working inclusively; enabling refugees and asylum seekers to self organise and address local issues in the context of wider international events. The Eve group, which is part of the network, provides valuable support to help women to challenge the dominance of men's voices and enables them to speak for themselves.

Translation or promotion of English speaking

The question of communicating with people who do not speak English as their first language has been controversial in the past, but there are signs of a consensus emerging. Opinion was divided as to whether translation is a barrier to integration, or whether it is a stepping stone to better language skills. In 'Our shared futures' (2007) (Annex D), the Commission for Integration and Cohesion argued that

"Local Authorities and their partners should consider moving from a position of automatic translation of all documents into community languages, towards a more selective approach – driven by need, and set firmly in the context of communications strategies for all residents."

The Commission found that some public agencies were automatically translating documents into community languages with the best of intentions but without really considering the need for it. They recognised that language barriers can perpetuate inequalities.

"Taking health services as an example, if people don't know how to access services, they may not get the care they need. Even if they go to the right doctor, without good English they might not get the right diagnosis, or understand it, and may not take the treatment prescribed. But that does not mean automatic translation into community languages of the majority of public documents is the answer".

They recommended a series of questions for local partners considering what and how to translate:

1. "Is it essential that this material is translated?"
2. If so, does it need to be translated in full?"
3. Are you using the right data to select the languages to translate this material into?"
4. Have you considered the cost/benefit analysis for this translation?"
5. Have you explored whether other local agencies might already have these materials available in translated form?"
6. Are there practical ways you can support people to learn English even while producing this translation?"
7. Are there practical ways you can keep up with changes within the community?"
8. Will this material be developed in a way that is accessible for all communities?"

An important aspect of the Commission's proposed approach is that courses in English for people who speak other languages (ESOL courses) should be widely available. Unfortunately we have found evidence in some parts of the country of severe shortages of ESOL teachers and pressure on the courses that exist.

An initiative to give young people a voice on major social issues was announced by Communities secretary Hazel Blears on 15th October. Two youth advisors supported by a panel of seven more young people will meet with the Secretary of State once a month to discuss issues ranging from youth homelessness and urban regeneration to community cohesion and the Olympic legacy. This builds on a series of schemes around the country to listen to young people in ways that suit them rather than using more traditional methods. Jane Brooker-Wood of IDeA has been involved in a scheme set up by **Lancashire** PCT. She says:

“Our Lancashire team are truly inspirational. Whenever you need the input of young people on how they should, could and now are involved in the review, assessment, planning and provision of health services, they’re your guys!”

NICE has produced new guidance on community engagement and health. The guidance aims to support those working with and involving communities in decisions on health improvement that affect them (including the NHS, councils, the voluntary and community sector and private sector).

Involving disadvantaged communities is central to the national strategy for promoting health and wellbeing and reducing health inequalities. Community engagement activities can range from one-off consultation exercises through to longer-term activities, which allow communities to play a developed role in planning and delivery of services.

<http://www.idea.gov.uk/idk/core/page.do?pagelId=8038898>

Camden Council has used neighbourhood renewal funding to commission the development of three training courses aimed at improving the health and employability of the community living in the West Euston single regeneration budget (SRB) area. These courses are open to all but are particularly aimed at the local Bengali community.

<http://www.idea.gov.uk/idk/core/page.do?pagelId=6022336>

‘Working our way to health’ aims to improve diet, encourage physical activity and prompt smoking cessation of men living in **Sefton**. This will help to increase life expectancy and reduce incidences of coronary heart disease (CHD), diabetes and cancer. The programme targets men aged 35 and above, who may be unemployed, on incapacity benefit, acting as carers or in low-paid jobs in disadvantaged areas of Sefton. Areas targeted include Bootle, Seaforth and Dunningbridge Road.

<http://www.idea.gov.uk/idk/core/page.do?pagelId=8223589>

Fenland District Council in Cambridgeshire has been focusing on the needs of its **traveller community**. Older travellers have been provided with information on how to lead an independent life. Children are given details about education. Council staff have also been trained in cultural awareness to help them understand the needs of the traveller community better. A brilliant example, which allows travellers in Fenland to mix outside their immediate community.

<http://www.idea.gov.uk/idk/core/page.do?pagelId=8264438>

v. What opportunities are you taking to locate health care provision in the heart of communities and in joining with other public services to create public spaces that all can use?

This question is about how you demonstrate that NHS services belong to the community in the spirit of ‘Our health, our care, our say’. By making primary and community based services really accessible and by linking with LSP partners you can create valued community assets.

Self assessment questions:

- Do you have a vision to guide the location of health care provision within the area you serve?
- Have you engaged with all communities and with your partners in developing that vision?
- Do you have a strategy for how you will achieve your vision?
- Have you engaged with all communities and with your partners in developing that strategy, recognising that it may involve closures and service changes that may be unpopular with some communities?
- Does your strategy include taking opportunities to co-locate health services alongside other community facilities such as schools, libraries, day centres, places of worship etc?
- Do you recognise the importance of health service premises, including waiting rooms, as community spaces and their potential use to encourage positive contact between people using the service?
- Do you carry out health impact assessments and community cohesion impact assessments before deciding on the location of new facilities?
- Do you take account of transport issues for staff and patients from all communities (including access by walking, wheelchair, public transport, cycling, motor car)?
- Do you work with partners to agree joint management arrangements for shared facilities (e.g. one stop shops for reception and information, pooled budgets, shared facilities management)?

Some examples of good practice

There are numerous examples of co-location of facilities by partner agencies to make facilities more accessible. These include many centres which combine health facilities with sports provision creating public spaces focused on health and wellbeing. However, before developing such schemes, it is always important to be clear about the costs and benefits both to the agencies providing the services and to all groups in the wider community. Decisions on co-location or the development of new or redesigned health facilities need to take account of many factors including how to make services accessible to communities but also about wider issues such as the pattern of public transport, the possible displacement of low cost housing (which could be significant in the case of major hospital redevelopments or relocations) and the effect on minority communities. In many large schemes there will be gainers and losers. The proposal to establish polyclinics in London will alter the pattern of access and the continuity of care for many people. Whilst it is intended that this will improve accessibility overall, there will be some losers and it will be important to identify and address issues early in the process. The section on 'Needs assessments, impact assessments and audits' earlier in the guide discusses how Impact Assessments can be used to ensure all angles are covered.

Staffordshire Moorlands, one of the Community Cohesion Beacon council sites, has created integrated public access points in each of the district's three market towns: Leek, Biddulph and Cheadle. The sites offer a one stop shop service with trained staff who can provide a frontline service across a wide range of common services and provide a degree of anonymity and sensitivity. The shop plays host to PCT services, CABx, Connexions, Pensions service, Age Concern, Business Initiative, Turning point, Registration service and a range of other statutory and voluntary services as well as the council's own services. Exit surveys undertaken twice a year for the past four years have achieved 100% customer satisfaction with the one stop service.

vi. How can you involve your service providers and suppliers in contributing to community cohesion?

As a major commissioner of services the NHS can act as a corporate citizen, encouraging service providers and suppliers to adopt ways of operating that encourage community cohesion.

Self assessment questions:

- Do you build in community cohesion objectives into contract specifications for services and for supplies?
- How do you decide what community cohesion outcomes to specify in contracts?

- Do you involve communities in the commissioning process to help in specifying appropriate outcomes?
- How do you ensure compliance with community cohesion aspects of a contract?

Some examples of good practice

Most commissioners require suppliers to meet equality and diversity standards and, increasingly, commissioners involve members of the communities they serve in assessing needs and specifying service requirements.

Case studies needed to illustrate this point

vii. What are you doing to make your work on community cohesion, promoting equalities and anti-discrimination visible and to counter media myths and stereotyping?

Community tensions are often caused by perceptions based on fears and misunderstandings rather than facts. This question is about how you promote the values of equality and diversity, challenge unfair discrimination and counter negative and misleading stories.

Self assessment questions:

- Do you adopt a proactive approach to promoting the values of community cohesion, equality and diversity to your staff and to public and patients?
- What media do you use to promote those values – information leaflets, community events, feeding good news stories to the local media etc?
- Do you work with partners on this?
- How do you know that some communities have negative perceptions about people from other communities?
- If you know of particular negative perceptions do you target them specifically or through more general publicity?
- Do leaders address specific issues through the media to combat myths that may lead to tension and resentment? (e.g. providing facts about how needs vary and how resources

Some examples of good practice

Many PCTs and Local Authorities have built messages about equality and diversity into their communications strategies and some make specific reference to community cohesion. The 'Community cohesion: seven steps practitioners toolkit' (2005), at step 5, explores the advantages and risks of four different approaches to challenging and changing perceptions used by the Community Cohesion Pathfinders – low key, incremental, high profile and indirect (not labelling it Community Cohesion but building 'myth busting' into existing programmes). **Charnwood** and **Bury** both used a low key approach. They found that it built a solid foundation but was slow and not challenging enough to counter some perceptions. **Kirklees**, using a more high profile approach, found that it is essential to equip messengers (front line staff) with the right skill training, particularly how to deal with disagreement and conflict. Several of the pathfinders found that simply encouraging people from different backgrounds to talk to each other on an informal basis is the best way of breaking down barriers between communities so they designed service delivery methods in ways which set up the opportunities for 'banal encounters'. Other lessons from the pathfinders were:

They recommended a series of questions for local partners considering what and how to translate:

1. Use children and young people as a gateway to the rest of their family
2. Build in a process for testing and challenging on a frequent basis, enabling you to establish long term trends
3. Avoid language that conjures up stereotyped
4. Get on with the job and don't waste time on badging things with public sector terminology (like community cohesion or conflict resolution)
5. Don't expect perceptions to change overnight

'REWIND' is a national project, based in **Sandwell**, which works with schools and community organisations, exploring the roots of racism as a social construct. It raises awareness and counters myths about racial characteristics using knowledge of the history of migrations and scientific evidence about evolution. REWIND works across a wide range of public policy areas, training professionals in the fields of Health, Police, Education, Youth Work, Social Work and Community Work. It has proved to be a very effective way of countering racial myths and stereotypes.

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Coventry's Local Strategic Partnership focused on "Realities rather than myths". They did not challenge myths in general but used participative research to identify specific fears amongst members of the community. They then focused on countering those specific fears with facts through meetings and leaflets.

Developing a good working relationship with the local media is another valuable way of countering myths. In its response to the Commission on Integration and Cohesion, the Government relates that **Boston** Borough council were concerned about negative perceptions about the town presented in the media. CLG put them in touch with **Leicester** City Council and the Leicester Mercury (who had a relationship based on presenting clear facts rather than supposition). This provided an environment in which they could explore ways of engaging with the local media around facts. An action plan was then developed that has led to more supportive coverage and better promotion of cohesion.

In **Newcastle upon Tyne**, a local volunteer Hari Shukla collaborated with "The journal", a local paper and with prominent local organisations to create a regular supplement called "Living together". The paper featured stories about the positive contributions all communities are making to the life of the city. They included stories about the contributions made by asylum seekers, pieces about local festivals and progress on tackling discrimination and equality issues (see the 'Community cohesion action guide' (LGA, 2004).

viii) What information can you collect routinely to provide both up-to-date and comprehensive profiles of a rapidly changing population and workforce mapping to enable you and your partners to take appropriate and sensitive action?

This question emphasises the importance of knowing who lives in the area you serve and understanding their needs. In many areas the demographic structure of the population is changing rapidly and traditional sources of information are no longer reliable. You need to work with partners to develop a clear picture of the population you serve so that you can understand how their needs are changing, ensure that resources are deployed equitably and avoid potential tensions caused by perceptions of unfairness. To do this successfully you need to develop clear strategies for collecting and managing information.

Self assessment questions:

- Do you work with partners, particularly the Local Authority, to agree which sources to use to collect information on the changing size and structure of your local population in terms of age, gender, ethnic origin and other significant characteristics?
- Do you and your partners agree protocols and formats for collecting and analysing demographic data e.g. area boundaries, frequency, formats?
- Do you supplement your collection of quantitative data with qualitative research e.g. focus groups and key informant interviews?
- Do you use demographic data to develop patient profiles for use in planning, targeting interventions towards those in greatest need and measuring effectiveness in achieving health inequalities targets?

Some examples of good practice

In 2007 iCoCo produced the **COHDMAP** (Cohesion mapping of community dynamics) report, commissioned by the Department of Health to examine ways of improving the information base for understanding demographic change in local communities. The report found that the official methods of estimating population change, particularly in areas where there are high rates of 'churn', were no longer reliable. This is because they take insufficient account of the volatile nature of population change and rely too heavily on the 2001 census (the accuracy of which has been challenged) and on projections forward using indicative data sources that are equally inaccurate.

It examined the potential of a wide range of other sources including GP registrations, the annual schools census (PLASC), the International Passenger Survey, worker registrations for A8 Eastern European migrant workers and many more. The report was then followed by a further report 'Measuring the health of urban populations: a small area study in Coventry and Leicester' (2008), which made recommendations about how improvements could be made to the way some of the data sources are managed and suggested ways that local partnerships could co-operate in collecting and managing information. One of the report's recommendations was that Local Authorities and PCTs should reach clear agreements on the best ways of collating and analysing data at a local level and establish a common postcode directory and protocols for data sharing. The report proposed a model that builds principally upon change in GP list size, with small corrections for the excess of births over deaths and with margins of error determined by the extent of population turbulence, reflected in the changing school population and recent housing allocations to asylum seekers. The report also proposed that local partnerships should supplement their quantitative analysis with qualitative methods including focus groups, key informant interviews and local health forums such as the Hillfields Health Action Group in **Coventry**.

Recognising substantial anecdotal changes in **Derby's** demographic profile, particularly since 2004 and the expansion of the European Union, Derby Community Safety Partnership brought together a wide range of primary and secondary data sets in order to answer the following research questions:

1. What is the city's demographic composition in terms of age, sex, ethnicity and nationality?
2. How is this picture changing, particularly in respect of migration and newly emerging communities?

The study aimed to provide a 'best estimate' of the city's demographic profile to inform neighbourhood profiling, Derby's Community Cohesion Strategy and wider partnership planning and service delivery. The report also made recommendations in relation to future monitoring of population change and migration.

The project relied upon a headline city-wide population figure, which was generated using the ONS mid-year estimates, the GP patient register and the commercial dataset PeopleUK. A population frame was then constructed based on the variables of age, gender, ethnicity, nationality and ward and compared to the 2001 Census picture.

A wide range of multi-agency data sets were used to approximate Derby's shifting population profile and patterns in new migration patterns. These included:

- * GP Patient Register (Derwent Shared Services)
- * School Census (Derby City Council)
- * Derby Places Survey 2008 (Community Safety Partnership)
- * School Leaver Destinations (Connexions)
- * National Insurance registrations (Job Centre Plus)
- * Higher Education statistics (HESA)
- * Electoral Register (Derby City Council)
- * Census 2001 (ONS)
- * People UK (CACI)
- * Workers Registration Scheme ('A8' – Eastern European migrants)
- * Partnership service statistics
- * Qualitative and anecdotal evidence

The project has allowed Derby's Community Safety Partnership to explore the extent to which the local population is growing and diversifying at both city and neighbourhood levels and has offered a further insight into the nature and make up of this population change.

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Whilst it is important to understand the changing size of the population, it is just as important to monitor its changing nature: how the population is changing in terms of its age and socio-economic structure or in terms of ethnic diversity. Where new communities are emerging in an area there may be significant cultural change that public agencies need to understand. This is important in terms of delivering services in ways that are appropriate for different communities and in order to identify possible points of tension. Britain has seen a significant growth in its Muslim community in recent years but it would be a mistake to see that as the growth of a single community. In April 2008, iCoCo produced a guide to the complex relationships within the Muslim community: 'Understanding and Appreciating Muslim Diversity: Towards better Engagement and Participation'. Guides such as this, based on sound research principles are essential tools in the management of public services in a multi-cultural society.

ix. How are you investing in the basic skills of your workforce to increase their self-esteem and capacities?

This question is about how you help to develop the NHS workforce (the largest workforce in the country) in a way that contributes to community cohesion. You can do this by helping staff especially those from disadvantaged communities to build up their skills and confidence, to feel they belong in their local community and to become role models and ambassadors for community cohesion.

Self assessment questions:

- Do you work with local colleges and other training resources to develop programmes for staff who need/want to improve their skills in literacy, numeracy and language (particularly English)?
- Are you aware of the national "Skilled for health" initiative and have you considered using it locally?
- Do you provide training and information for staff on understanding and respecting difference within the workforce and the wider community?
- Do you evaluate the effectiveness of any training you provide or commission and take appropriate action to improve effectiveness?

Some examples of good practice

'Skilled for Health' is a national programme that combines essential skills with health improvement. It aims to address both the low skills and health inequalities prevalent within traditionally disadvantaged communities. The programme is managed by a national partnership involving Department of Health, Department of Innovation, Universities and Skills and the learning and health charity ContinYou. It is working with low-skilled workers at a number of national sector sites including the prison service, the Royal Mail, Army families and the NHS workforce and at community sites in four regions. The programme commenced in May 2007 and will be completed in March 2009.

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The **Kirklees** Pathfinder provided training to frontline staff, managers, community activists and elected members to increase skills, understanding and confidence to build community cohesion into mainstream service delivery. This was important in terms of personal development as well as strengthening the approach to equality, diversity and cohesion.

Blackburn with Darwen Council worked with Lancashire Learning and Skills Council, TUC Learning services, trade unions and employers to raise awareness of cultures and communities in the workplace. They produced a cohesion toolkit to help with the development of cohesion in the workplace through training and staff development. Using a structure of targets and evidence of achievement the toolkit proposed an 'Investor in Cohesion' award for cohesion in the workplace. The toolkit contained carefully written and tested material to help staff, led by a trainer, to explore and understand different aspects of culture, faith, race, gender and disability. The objective is to help staff who may be from widely different backgrounds and experience to appreciate and value those differences and to work better together because of their improved understanding.

See 'Community cohesion – an action guide' (LGA, 2004)

The NHS employs many people who do not speak English as their first language. In designing training and development programmes for such staff, it is important to consider the issue of language. Should we automatically translate material into community languages or should we encourage people to speak English. In the discussion of good practice under question iv above we have set out the arguments for an approach which encourages the use of English but provides tapering support using translation for a temporary period.

x. How are you doing in promoting NHS jobs to all local communities, supporting those who join you and making visible your success as an employer that welcomes diversity?

By employing local people and making them feel valued as part of the NHS and of their local community you can make a significant contribution to community cohesion. At the same time, given that employment is a key determinant of health, you will be helping to reduce health inequalities.

Self assessment questions:

- Do you have a detailed profile of your workforce in terms of age, gender, ethnic group, place of residence and disability?
- Do you know how representative your workforce is of the local community?
- How does your workforce profile vary between senior, high paid posts and more marginal lower paid posts?
- What policies and approaches do you use to change your workforce profile (at all levels) so that it more closely matches the profile of the local population?
- Do you make special efforts to recruit people from the local community? How do you do that?

Some examples of good practice

The NHS has an excellent record in promoting a positive and inclusive ethos and in recruiting and retaining people from a wide diversity of backgrounds (of race, faith, gender, age, disability and sexual orientation). This does not happen by accident. It is important to continually monitor whether the workforce is representative of a changing wider community and whether there are any barriers for people from new communities. **East Lancashire** PCT works with schools to promote work within the NHS and provide an extended range of work experience placements.

7. Practical approaches to community cohesion

Different ways to develop your strategy

There are several ways in which Health bodies can address community cohesion. The important thing is to do the strategic thinking thoroughly and build it into whichever approach best suits the issues in your locality and the way you operate as an organisation. Remember, community cohesion issues vary enormously from place to place and can only be compiled on a highly localised basis. The ten challenging questions in Part 6 should help you to identify a number of key issues and priorities for action. These can then be developed through one of the following vehicles:

- Develop a specific Community Cohesion Strategy for the Health sector which complements that of the wider partnership. This approach might be appropriate if cohesion is a particularly significant issue in your area and you want to send out strong messages to the community that you see it as a high priority.
- Make sure your Equality and Diversity Strategy covers community cohesion by extending its scope if necessary. This approach might be more appropriate where you already have an established and successful Equality and Diversity Strategy but it needs to move from addressing the needs of individual patients to addressing community perceptions and aspirations.
- Addressing community cohesion as part of your overall service strategy. This approach is about mainstreaming community cohesion. This is probably where you want to end up but you need to take care that cohesion does not get lost amongst many other issues.
- Make sure you have the data and intelligence to provide an up to date analysis and understanding of the local community. This might be built up through the development of an information strategy or simply by ensuring that it is an essential part of any of the other three approaches.

Whichever approach you choose we would strongly advise you to work in close partnership with other agencies that are charged with responsibility for developing community cohesion in your area, particularly the Local Authority. Use the ten challenging questions to help you identify key issues and priorities and develop your strategy in the way that best suits your local circumstances. In part 8 of the guide we have provided some suggestions about how to build Community Cohesion issues and action plans into your management system. We identify seven key processes that need to be addressed:

- Developing vision, values and strategy
- Developing partnerships
- Engaging with communities and understanding their needs
- Planning and commissioning your programmes
- Managing resources (financial, information, people and other resources)
- Delivering services
- Evaluating performance and learning from results

These seven key processes can be used as a checklist for your strategic analysis whichever of the four approaches you choose to adopt.

Guides and toolkits

In developing your approach to Community Cohesion there are several guides and toolkits that may be helpful. We would recommend that you look at the following:

- 'Community cohesion – an action guide' (LGA, 2004). This was aimed primarily at Local Authorities but it contains a lot of helpful guidance and numerous examples of good practice that may be helpful to health service professionals.
- 'Community cohesion: seven steps: a practitioner's toolkit' (Home Office/ODPM, 2005). This toolkit was designed with practitioners from all agencies that are concerned with community cohesion in mind. It sets out seven steps to developing community cohesion with numerous examples of good practice from the Community Cohesion Pathfinders programme (an 18 month programme involving 14 Pathfinder areas and 13 Shadow Pathfinders).
- 'Understanding and monitoring tension and conflict in local communities: a practical guide for Local Authorities, Police service and partner agencies' (iCoCo and the Metropolitan Police, 2008). This report focuses specifically on how to understand and monitor tensions in your community. It contains advice on how to set up a tension monitoring system, tools for understanding local community dynamics and advice on interventions from experience around the country. See also the section on 'Tension monitoring and resolving conflict below'.
- 'What works in community cohesion' (DCLG, June 2007). This is a long report packed with learning points about the types of project and approach that have been seen to 'work' in six case study areas that were visited by the study team. The areas studied were Blackburn, Birmingham, Bradford, Hull, Peterborough and Tower Hamlets.
- 'Understanding and appreciating Muslim diversity: towards better engagement and participation' (iCoCo, April 2008). This report, which is based on research in many local communities, describes the principal components of British Muslim communities. It highlights religious and ethnic diversity and illustrates where these intersect to influence the establishment of leadership structures and networks primarily at local level.

Needs assessments, impact assessments and audits

NHS commissioners, planners, policy makers and practitioners across all sectors use a range of approaches to assess health needs, inform decisions and assess impact. In this section we look at six of the approaches that are relevant to the relationship between health and wellbeing and community cohesion. The first five are described in a guide produced by the Health Development Agency in 2005 'Clarifying approaches to: health needs assessment, health impact assessment, integrated impact assessment, health equity audit and race equality impact assessment':

- Health Needs Assessment (HNA) is a "systematic method for reviewing the health needs and issues facing a given population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities". Its value to community cohesion lies in the fact that it identifies particular populations whose needs are assessed. PCTs have specific responsibility to carry out HNAs following the publication of 'Shifting the balance of power within the NHS' in 2001, but they are generally undertaken as a partnership activity with people from other sectors who are also concerned with inequalities and improvements in public health.
- Health Impact Assessment (HIA) is an approach used to "identify the potential health consequences of a proposal on a given population". It is also used to "maximise the positive health benefits and minimise potential adverse effects on health and health inequalities". It can be applied to health related proposals or, more frequently, to proposals involving other determinants of health (housing, urban regeneration, education, transport, economic development and planning).
- Integrated Impact Assessment (IIA) is an approach that "assesses the impact of proposals and strategies on issues that previously may have been assessed separately". It can be seen as a health determinants impact appraisal tool and, as such, it is ideal for considering issues around community cohesion.
- Health Equity Audit (HEA) "identifies how fairly services or other resources are distributed in relation to health needs of different groups and areas, and the priority action required to provide services relative to need". This approach is ideal for looking at cross-cutting issues on a partnership basis. It can also be a useful tool for Local Authority Health Overview and Scrutiny Committees as part of their scrutiny reviews.
- Race Equality Impact Assessment (REIA) is designed "to work out how an organisation's policies or functions will affect people from different racial groups, pre-empting the possibility that the policy could affect some racial groups unfavourably. REIA looks at proposed policies as well as enabling the monitoring of policies once implemented". In many places REIAs have been widened to cover other vulnerable groups in addition to racial groups. An example from north London is described below.
- Community Cohesion Impact Assessment (CCIA) is designed to test whether proposals will have a positive or negative impact on community cohesion and community conflict in an area. It is described in 'Community cohesion impact assessment and conflict prevention tool' published by CLG in 2008.

An Equality Impact Assessment has been used in North London to assess five options for **Barnet, Enfield and Haringey**'s clinical strategy. Drawing on existing consultation results, the review team carried out an initial screening of the five options to identify any negative impacts on a range of identified groups (black and ethnic minority groups, women and men, disabled people, lesbian, gay, bisexual and transgender community, people with different religious and belief systems, people in different age groups and people in different social and economic classes). Each option was assessed to identify impacts on the groups in terms of accessibility, affordability, sustainability, deliverability and safety. Where possible any mitigating factors were identified. The options were then refined to take account of the impacts identified and the revised options were subject to wider consultation.

And finally it proposes a range of interventions to respond to tensions:

- Problem solving
- Community meetings
- Community facilitators and 'honest brokers'
- Conflict resolution
- Mediation
- When to work separately and when to work in partnership
- Communications to promote cohesion

Tension monitoring and resolving conflict

In order to understand the state of relations between different communities we need to be able to 'read the signs' and we need to have resources and techniques to mediate between groups and to help them to resolve conflicts when they arise. iCoCo and the Metropolitan police have worked together to develop a practical guide for Local Authorities, Police services and partner agencies on 'Understanding and monitoring tension and conflict in local communities' (2008). Whilst the initiative for this is largely Police-led, it is useful for other agencies (including Health) as it will help in our understanding of how our local communities tick. The guide describes seven steps that need to be followed to set up a tension monitoring system:

- Set up a tension monitoring group and identify lead officers
- Gain commitment and buy-in
- Use the "Experienced, Evidenced, Potential (EEP) system" (or ensure you draw on evidence and experience).
- Use the Community Impact Assessment process
- Establish governance arrangements
- Establish reporting arrangements
- Develop an annual plan

It then describes four tools for understanding local community dynamics:

- Knowing the community - understanding how people are feeling
- Capturing and pooling what we know
- Making the best use of 'open sources'
- Using data more effectively

In **Tower Hamlets** a project called 'RESOLVE' has been run by the council's mediation service and the youth service rapid response team. It recruited and trained young people in mediation and facilitation. It has helped to reduce tensions because of its presence "on the street" and by supporting young people who became role models, in some cases by going on to become youth advocates (LGA, 2004).

In **Slough** a project called 'Aik Saath' was dedicated to promoting peace and racial harmony through teaching conflict resolution. It works with young people aged 14 to 20, conducting training in schools and running workshops to raise awareness of conflict, how it might be manifested, effects of conflict and how to resolve it (LGA, 2004).

Coventry uses a rapid response team to identify tensions between groups at an early stage. They respond quickly to symptoms like graffiti and race hate crimes. In 2006 during the war in Lebanon the council worked closely with the Israeli and Palestinian communities in the city to prevent local conflict (Joseph Rowntree Foundation, 2008).

8. Building community cohesion into your management systems

Introduction

In this section of the guide we have identified seven key processes that are common to most effective management systems and we have set out how the ten challenging questions might be applied to the appropriate processes. The seven key processes are:

- Developing vision, values and strategy
- Developing partnerships
- Engaging with communities and understanding their needs
- Planning and commissioning your programmes
- Managing resources (financial, information, people and other resources)
- Delivering services
- Evaluating performance and learning from results

Developing vision, values and strategy

The process of developing vision, values and strategy is crucial to an effective approach to community cohesion. The process needs to ensure that the values of equality, diversity and cohesion are emphasised in the vision statement and that the strategy sets out how they will be translated into action in the way services are delivered. All ten of the challenging questions can be applied to this process as follows:

- How will leaders emphasise the values of cohesion during the process of developing the vision and strategy?
- How can you design a strategy that will promote positive relations between people from different backgrounds?
- Which of the four different ways of developing your strategy suggested in Part 7 is most appropriate to your circumstances?
- What measurable outcomes do you need to achieve in terms of respectful and positive interactions with people from different backgrounds and how will you achieve measurable reductions in disrespect, bullying and abuse?
- How will you involve all communities in the development of vision, values and strategy and how will you ensure they continue to be involved in your models of service commissioning and delivery?
- What measurable outcomes do you want in terms of improved accessibility of services for all, reductions in health inequalities and investment for equality of outcomes?
- What do you need to build into your commissioning processes to ensure you involve your service providers and suppliers in contributing to community cohesion?
- What measurable outcomes do you need from your communications strategy to demonstrate that you are successful in promoting equality and diversity and countering myths?

- What do you need to build into your information strategy to ensure you fully understand community needs and to monitor how far you are achieving them?
- What measurable outcomes are you aiming for in terms of staff development?
- What measurable outcomes are you trying to achieve in terms of local recruitment and promoting diversity in the workforce?

Here are some examples of how various public agencies have designed their processes for developing vision, values and strategy:

Tameside Council held a 'Building stronger communities' event involving partner agencies (including NHS bodies) and over a hundred members of the public. The event enabled key stakeholders to:

1. Define what community cohesion meant to them
2. Articulate what they like and dislike about Tameside
3. Identify trigger points for friction
4. Express hopes and concerns for the future of communities in Tameside
5. Work with others to build a vision of stronger and supportive communities
6. Identify key issues for organisations and individuals
7. Highlight examples of community cohesion role models or local champions.

Many of those chosen were youth and health workers (local people doing extraordinary things).

The LGA's 'Community cohesion action guide' (2004) contains many examples of how community cohesion has been built into the development of vision, values and strategy:

The **Stoke-on-Trent** pathfinder published a 'Community cohesion charter' to present cohesion in a user friendly way and to address local issues.

Hounslow (part of the West London Community Cohesion Pathfinder) developed a comprehensive plan demonstrating how the whole council and its partners would address community cohesion issues.

Bradford Vision (the Bradford Local Strategic Partnership) developed an action plan focused around four thematic work areas: equity of access and outcomes, civic pride, participation and citizenship, community relations, community safety.

Sandwell council hold an annual stakeholders' conference with strong contributions from the PCT.

Preston Strategic Partnership developed its health and wellbeing strand and action plan based on community cohesion as a crosscutting theme with health interventions delivered in collaboration with local neighbourhood partnership working.

Developing partnerships

Joint working by key public agencies at the strategic level in Local Strategic Partnerships is required and supported by a range of legislation and will get a further boost through the proposals in the Darzi report 'High quality care for all' (2008). It is essential for developing 'joined up' strategies to address key issues affecting the community and it is needed to address specific issues on the ground. Implementation of service delivery can also be enhanced through greater involvement with local neighbourhood partnerships for health and wellbeing. All ten of the challenging questions can help you in the process of developing partnerships. The following questions are particularly important:

- Which agencies have the most potential for collaboration and development of synergy?
- What are the areas in which you should be working in partnership with them and what are the areas where you should work separately?
- What arrangements do you need to make with your partners for collaboration, both at a strategic level and at a local or project level?

Here are some examples of how agencies work effectively in developing partnerships.

Blackburn with Darwen has a multi agency forum to co-ordinate services for asylum seekers and refugees. The forum organises welcome events, information provision, meetings with Police, Education department and the PCT asylum seekers health team. People are given a tour of the town and the library service has developed a 'Story teller' initiative to enable asylum seekers to talk about their life experiences, improve their English and build confidence. This initiative sits within the more strategic level partnership which uses the phrase 'Belonging to Blackburn with Darwen – many lives, many faces' to emphasise the inclusive values that the partnership wants to promote.

See 'Community cohesion action guide' (LGA, 2004).

Coventry's Local Strategic Partnership board demonstrates the importance of including representatives from the voluntary and community sector. The board developed a Community Engagement Strategy which was significantly rewritten in response to community sector representation. Coventry uses a system of Neighbourhood Management which ensures all neighbourhoods have a voice but they found that this was tending to overshadow interest groups that are dispersed across the city meaning that their voices were less well heard. In response to this, the Coventry Ethnic Minorities Action Partnership was set up to facilitate democratic representation from BME groups in local structures of governance including the Local Strategic Partnership. It has organised several very successful consultation events with over 100 groups participating. In addition, Coventry New Communities Forum was set up to enable the voices of people from new communities to be heard more effectively. The forum links about 45 informal networks and acts as a channel of communication for the council and other agencies, providing information about access to services and a voice for people from new communities.

There are many examples of community cohesion being developed through multi faith forums (**Leicester** Council of Faiths, **Leeds** Faith Community Liaison Forum, **Southwark** Multi-faith Forum, **West Midlands** Faiths Forum and many others). The **Oldham** Inter-faiths Forum was important in the wake of the 9/11 terrorist attacks in USA and the London bombings in 2005, when there were fears about attacks on local Muslim communities. It became a powerful focus to promote community cohesion, linked to the Local Strategic Partnership by a catholic priest who was on both organisations. The forum organised a number of key events including prayers for peace, a festival of light and a show of unity attended by hundreds of people. Off shoots of the forum have emerged including a women's interfaith network and young peoples interfaith network. Oldham also has a youth council which was set up in 2006 in response to civil disturbances involving young people in the city. Young people now have a voice. They were involved in the appointment of the council's Executive Director of Children and Families. In 2007, over 4,600 young people voted in borough wide elections for youth council members.

Engaging communities and understanding their needs

The way you engage with communities and understand their needs should be a key part of your management system. The fourth of the ten challenging questions in part 6 of this guide is all about how you engage with communities, so we will not repeat the questions and examples of good practice here but simply refer you to that section.

Planning and commissioning your programmes

To achieve successful results, you need to turn your strategies into action through well planned programmes of work. As with the development of vision, values and strategy, all ten of the challenging questions can help you with this process. The following questions are particularly important:

- How should leaders promote the values of equality, diversity and cohesion in each programme and project?
- What outcomes are you trying to achieve for each community and is there any conflict or contradiction between different desired outcomes?
- Have you assessed the risks that might affect the success of the programme and what arrangements do you have to review objectives and targets as circumstances change?
- What arrangements have you made for management and accountability? It is particularly important to be clear about this when you are working in partnership. Who is responsible for leading the work? Have you allocated clear roles and responsibilities?
- Have you established clear baselines?
- What are the timescales you are working towards?
- What milestones do you need to set?
- How will you involve the interested communities?
- How will each programme or project affect the accessibility of services for different communities?
- What measurable outcomes will you expect from providers and suppliers for each programme or project?
- How will you communicate with partners and communities and promote cohesion in the way you manage this programme or project?
- What information do you need about the communities that may be affected by this programme or project?
- What training or support do staff require to deliver successfully on this programme? How can this programme help to develop staff competencies on community cohesion issues?
- What arrangements do you need for monitoring and evaluating success?
- How will you ensure sustainability of the work you are doing? If you are working with temporary funding, what is your exit strategy?

The **Stoke-on-Trent** Pathfinder developed a programme planning tool that linked to their health impact zone, using quality of life indicators that record the positive and negative perspectives around health, transport, housing and environment. This has provided a sound basis for developing their programmes for addressing cohesion issues.

Managing resources

Well intentioned strategies and programmes need resources if they are to produce the intended results for community cohesion, so what questions do you need to ask about how you are managing the key resources of finance, information, your workforce and other resources like technology, land and buildings?

- **Finance**
Do you know the cost of all your programmes? Have you allocated sufficient resources and how do you control expenditure to ensure value for money? How do you explain your allocation of resources to communities so that they understand and perceive it to be equitable?
- **Information**
The eighth of the ten challenging questions in the previous section of this guide is all about how you manage information for community cohesion. Please refer to that section.
- **People**
Please see questions 9 and 10 of the ten challenging questions in the previous section of this guide.
- **Other resources**
Do your plans and programmes for community cohesion require additional resources such as new IT systems or alterations to the way you use land and buildings? Have you considered the costs and benefits of using these resources?

Delivering your programmes

All ten of the challenging questions are relevant to the way you deliver services and can be applied to the way mainstream services or specific projects are managed on a day to day basis. The questions posed in the section above on 'Planning and commissioning your programmes' are also relevant to the way you manage their delivery.

The practitioner's toolkit, 'Community cohesion: seven steps', published by the Government in 2005, reported that where the Community Cohesion Pathfinder councils have succeeded in mainstreaming or sustaining their community cohesion projects it was because of one or more of the following factors:

1. A strong level of buy-in from the Local Strategic Partnership
2. Community cohesion proofing of long term planning documents
3. Community cohesion projects integrated with existing long term programmes (e.g. community safety or urban renewal)
4. Training and development for those delivering community cohesion messages
5. Committed individuals recruited to lead key projects and to ensure viability
6. Stakeholders (especially those in the voluntary and community sector) act as visible champions of projects
7. Innovative projects generated such demand that it was easy to justify alternative funding
8. Alternative funding or sponsorship was found outside the Pathfinder programme to continue the work

Evaluating performance and learning from results

The following questions should help in evaluating performance on community cohesion:

- Have you considered and researched the range of potential performance indicators, especially those already being used by partners, and established a basket of indicators that covers the range of results you want to achieve?
- Do your performance measures cover inputs, processes, outputs and outcomes?
- Have you included qualitative measures as well as quantitative measures?
- Have you involved all communities that might be affected in setting your performance indicators and targets?
- Are you monitoring the impact of patient choice on all the communities in your area?
- Have you established a clear base line?
- Have you set up arrangements to gather the information you need to monitor performance?
- Have you allocated sufficient resources to meet your objectives and how will you manage risk?
- How are you finding out about good practice elsewhere and learning from it?
- How are you contributing to other people's learning?
- What arrangements have you established for reviewing performance regularly during the project and for responding to changing circumstances? How will you involve affected communities in this?
- What arrangements have you established for reviewing performance at the end of the programme or project? How will affected communities be involved in this?
- What will you do with the learning from this work and how will you share that learning with affected communities and others?

Appendix 1

Notes on cases of good practice

Examples of good practice have been included throughout this guide. In some cases they have been drawn from other published guides and reports. Where we have done this, we have acknowledged the source and further information can be found through the sources which are all listed in the next section. Where possible we have provided a web-link. Other examples of good practice have been provided by people responsible for the projects concerned. These have come in response to calls for case studies through the iCoCo Practitioners' Network, NHS Single Equality Scheme Learning site leads, personal contacts or through contacts made by Gulab Singh MBE, of NHS Central Lancashire in the North West region.

We would like to thank everyone who has kindly contributed information.

Appendix 2

Where else you can find help

Networks

In addition to producing this guide we hope that this project will stimulate the development of networks to champion community cohesion within the NHS. There is already a strong network within the North West region which is committed to further development using a series of action learning sets to enable projects to be enhanced through peer discussion. It is hoped that similar networks will be developed in other regions. These networks would encourage mutual support and the sharing of best practice.

To try and kick start the development of networks we organised the following events using draft versions of the guide as a focus for discussion:

- An initial meeting in Coventry and three further meetings in Manchester of a North West critical friends group at regular stages through the process.
- A meeting with the Equality and Diversity leads for each of the Strategic Health Authorities (21st July)
- A national critical friends group meeting in London (29th September)
- A workshop to discuss the draft, to identify key issues and to showcase some examples of good practice in Derby (28th October)
- A launch of the final version of the guide in London (December)

Websites

For further information about community cohesion see the following websites:

iCoCo website: www.cohesioninstitute.org.uk

CLG website: www.communities.gov.uk

References

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